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Causal Factors and Potential Solutions for the Persistent Underidentification of Students Having Emotional or Behavioral Disorders in the Context of Schooling

Hill M. Walker, Vicki M. Nishioka, Richard Zeller, Herbert H. Severson, & Edward G. Feil
University of Oregon

This article examines factors associated with the substantial underidentification, referral and service of the student population having emotional-behavioral adjustment problems in school. The identification of students as emotionally or behaviorally disturbed over the past decade is analyzed in terms of their absolute number and distribution across age-grade levels. These results are contrasted with those for students with autism, which show a highly divergent pattern in both level and distribution. The validity of the EBD categorical certification is evaluated in terms of its ability to identify a unique student subpopulation as distinct from students with social maladjustment and learning disabilities. The professional literature related to disincentives and barriers to the proactive screening and identification of students having behavior problems is discussed. Multiple-gating and universal approaches to the screening-identification of students with EBD are illustrated and some guidelines are offered as to their effective application in school settings. It is recommended that schools abandon the EBD certification process to focus instead on assessing behaviorally at-risk students along internalizing-externalizing and severity dimensions.

school population would also qualify as having a diagnosable mental health disorder.

The policy and practice implications of the failure to recognize the mental health needs of school-age students are very serious. The numbers of students who are entering the school house door with deficient school readiness skills and challenging behavior patterns have increased substantially in the last decade (Loeber & Farrington, 1998; Patterson, Reid & Dishion, 1992). A significant portion of this student population is destined to fail school, drop out, adopt a delinquency lifestyle, and encounter a host of adolescent risk behaviors, including heavy drinking, risky sexual practices, and violent delinquent acts (Hawkins, Catalano, Kosterman, Abbott, & Hill, 1999). Unless these students are detected early in their school careers, the risk trajectories they are on will accelerate and may ultimately cause them to be pushed out of school due to the aversive nature of their behavior patterns. Early inter-

Convergent expert opinion and considerable evidence suggest that school settings substantially underrefer, and thus underserve, students with emotional or behavioral disorders (EBD; see Center for Mental Health Services, 1996; Forness & Kavale, in press; U.S. Department of Health and Human Services, 2001). For example, it is estimated that approximately 20% of school-age students experience serious mental health problems (Greenberg, Domitrovich, & Bumbarger, 1999; Hoagwood & Erwin, 1997). Further, Angold (2000) notes that this same percentage of students could qualify for a psychiatric diagnosis using DSM-IV criteria. The actual rate of certification of students as emotionally or behaviorally disturbed, using the Individuals with Disabilities Education Act (IDEA, 1997) criteria and procedures, has consistently hovered around 1% of the school-age population since its first enactment in 1975. It is likely that this small segment of the

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vention and supports can only be provided if such students are screened, referred, evaluated, and judged to be in need of services designed to address their problems (Forness & Kavale, in press; Walker, Colvin, & Ramsey, 1995). School personnel have demonstrated a remarkably consistent reluctance to do so over the past several decades.

This article is focused on a serious policy and practice failure in our public schools. We review IDEA identification rates over the past decade for emotional disturbance (ED) and autism, analyze their distribution by age-grade levels, and offer possible reasons to account for the patterns seen. (We note here that although the terminology preferred by most professionals today is emotional or behavioral disorders, EBD, the federal government still uses emotional disturbance, ED, in its laws and regulations. We therefore use ED frequently to designate the federal category in question.) Next, we examine evidence for the validity of the ED certification process in terms of its ability to identify a distinctive subset of students experiencing mental health and adjustment problems in the context of schooling. Third, we review and discuss the literature on the barriers and obstacles to early identification of students at risk for EBD, as contributed by Forness and Kavale (in press) and Kauffman (1999). Finally, we discuss the role and efficacy of universal and systematic screening procedures having the potential to partially solve the severe underidentification and referral problems that continue to hamstring efforts to serve the needs of this growing student population.

Levels and Patterns of School-Based ED and Autism Certifications over the Past Decade

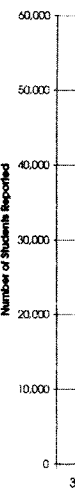
Given the school shooting tragedies of the mid to late 1990s and the increasing diversity of student attitudes, beliefs, and behavioral characteristics, it would seem likely that a heightened awareness of student mental health needs and behavior disorders would

begin pervading the public school culture. However, to date there is little substantive evidence that such a change in the ecology of schooling is occurring as reflected in the number of school-age students who are referred and certified as EBD or diagnosed with mental disorders. Figure 1 depicts IDEA certification rates for EBD students during the decade of the nineties.

Figure 1 contains graphed data of EBD referral and certification rates from the U.S. Office of Special Education's annual reports to Congress on progress in implementing IDEA for the 1993-94, 1997-98, and 1998-99 school years. Although there are relatively slight increases at nearly every age-grade level from 1993-94 to 1998-99, these changes do not strike us as likely reflecting qualitatively different school policies on prevention as accomplished through early detection and intervention. Thus, these data indicate remarkably stable levels, trends, and policies in the response of school systems to the task of accommodating the needs of students at risk for emotional and behavioral disorders.

Of equal and perhaps greater concern regarding the underreferral of at-risk students is the pattern and distribution of ED identification. Figure 1 shows a clear pattern of rising referral and ED identification rates that are strongly correlated with increasing age-grade levels. These rates peak in the 14- to 15-year age range (grades 9 and 10) and replicate almost perfectly across the three years of IDEA data sampled. These results indicate that (a) a majority of behaviorally at-risk students are not identified until well after the point where early interventions could have a substantive, positive impact on their problems; and (b) by deferring the point of referral, school personnel allow destructive patterns of student behavior to develop and expand to the point where they exceed the tolerance levels and accommodation capacities of teachers within mainstream classroom settings. Thus, much larger numbers of referrals and ED certifications in the later grades become the norm rather than the excep-

Figure 1 Students with



tion. In our view, this trend has not been reversed, wherein early identification would occur in the earlier years of a student's school career, thus reducing the need for remediation and prevention efforts that are costly and often ineffective for them later on.

Fortunately, not all students at risk are included under IDEA. This pattern of rising identification rates, once determination, and the need for services and supports is established, is a clear illustration of the need for students with autism to be identified in the same years as those with other EDs.

A different pattern of referral and certification rates over the decade of the 1990s shows a clear increase in identification and certification rates for students considered to be autistic in 1998. Further, these rates, which began to rise with the first year of the decade, decrease gradually over the decade. In our view, this pattern of both identification and certification (referral and certification) represents a significant policy vis-à-vis students with autism (i.e., this g

public school culture. is little substantive change in the ecology of reflected in the number of students who are referred to be diagnosed with mental health problems. IDEA certification during the decade reported from the U.S. Department of Education's annual reports in implementing 1997-98, and 1998-99 there are relatively every age-grade level, these changes do not prevent as early detection and data indicate trends, and policies systems to the task needs of students at behavioral disorders. later concern regarding at-risk students is the of ED identification. of rising referral rates that are strongly age-grade levels. to 15-year age range-IDEA data sampled. (a) a majority of students are not identified, there early intervention-ive, positive impact (D) by deferring the personnel allow student behavior to point where they decrease gradually over the remaining years. In our view, this very different pattern (in both identification levels and their distribution) represents a much healthier school policy vis-a-vis students who may be at risk for autism (i.e., this graph reflects strong efforts

to identify children at-risk for autism at the very beginning of their school careers so appropriate services and supports can be accessed for them). We would like to see a similar pattern for EBD students. However, given the current attitudes of key educational decision makers, such a shift seems unlikely. The increases in autism referral rates and their distribution over the past decade, as contrasted with the lack of same for the school-based EBD student population, probably reflect several important changes in the autism field as well as the continuing presence of disincentives to refer, certify, and serve EBD students. First, in the early 1990s, the definition of autism was broadened so that it became more inclusive of a broader spectrum of symptoms of the disorder. Second, the powerful advocacy of parent-professional groups on behalf of autism grew substantially in the past decade in both size and impact. Third, autism treatments promising remarkable gains and solutions to the condition of autism were promoted aggressively. On the other hand, the specter of parent-initiated litigation regarding provision of a free and appropriate educational program for EBD certified students continues to haunt

tion. In our view, this pattern should be reversed, wherein a larger number of referrals would occur in the early stages of a student's school career, thus enabling early intervention and prevention efforts, so as to reduce the need for them later on. Fortunately, not all disabling conditions included under IDEA legal mandates show this pattern of resistance to referral, eligibility determination, and provision of needed services and supports. Figure 2 provides a graphic illustration of identification rates for students with autism by age and grade for the same years as those represented in Figure 1. A different pattern is evident in autism referral and certification rates during the decade of the 1990s. Thus, Figure 2 documents clear increases in the rates of referral and certification of children and youth considered to be autistic from 1993-94 to 1997-98. Further, these rates are highest beginning with the first year of regular schooling and decrease gradually over the remaining years. In our view, this very different pattern (in both identification levels and their distribution) represents a much healthier school policy vis-a-vis students who may be at risk for autism (i.e., this graph reflects strong efforts

Figure 1 Students with Emotional Disturbance Served by Age (93-94, 97-98, & 98-99 School Years)

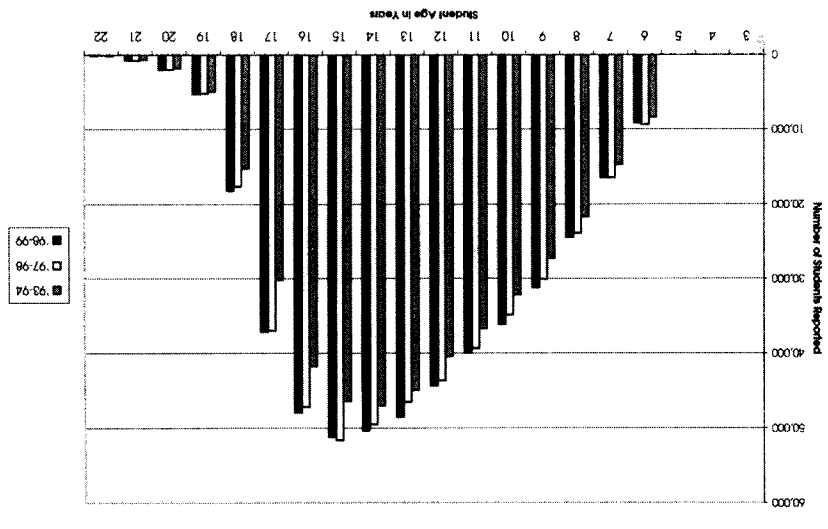
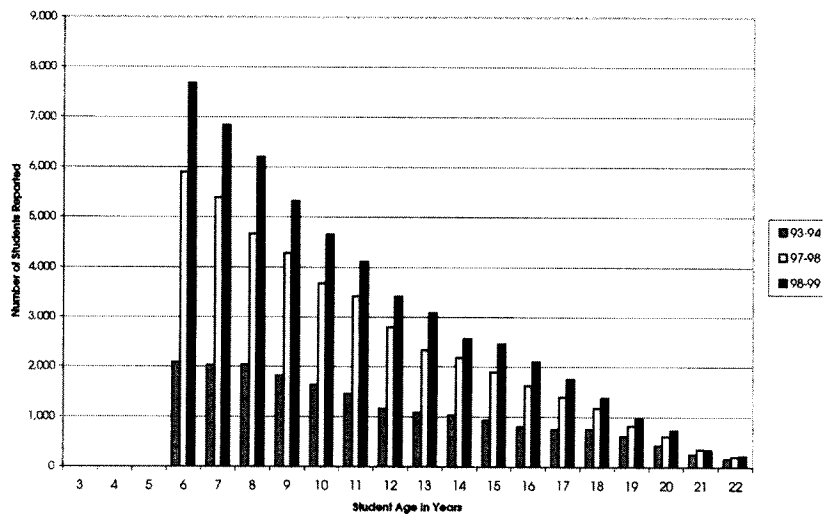


Figure 2 Students with Autism Served by Age (93-94, 97-98, & 98-99 School Years)



school administrators concerned about costs and the avoidance of lawsuits associated with such options as very expensive out-of-state residential placements for certified EBD students. Further, many school administrators strongly oppose EBD certification because of the constraints it imposes on their ability to discipline students experiencing school-related behavior problems. Finally, even with the change in definition and title of the EBD disorder from severely emotionally disturbed (SED) to emotionally disturbed (ED), this IDEA diagnostic category is still considered by many, especially parents, to be stigmatizing. Parents are understandably reluctant to have their children labeled in this manner and frequently opt either for no certification or a more acceptable one such as learning disabled (LD), autistic, or attention deficit-hyperactivity disorder (ADHD) (see Forness & Kavale, in press; Kauffman, 1999). These disincentives, albeit not the only ones, operate powerfully in the denial of services, supports, and early intervention to children and youth in our schools who desperately need them.

Validity of the EBD Certification Process

Over the past several decades there has been an extensive debate in the professional litera-

ture regarding whether students having mild, high-incidence disabling conditions can be reliably distinguished from each other through the typical IDEA evaluation and eligibility determination processes. There seems to be broad agreement that students with mild disabilities are more alike than they are different on most school-related measures used by multidisciplinary teams (Gresham, MacMillan, & Bocian, 1996; Reid, Epstein, Pastor, & Ryser, 2000).

Gerber and Semmel (1984), in a now classic and widely cited article, argue that regular classroom teachers, and not school-based testing experts, are the most informed judges of distinguishing student characteristics in this regard. Therefore, they suggest that the evaluative judgments of multidisciplinary teams regarding student characteristics should be validated against the judgments and informal assessments of teachers rather than vice versa as is typically the case.

The evidence base is solid regarding the ability of our psychometric instruments and procedures to distinguish EBD-certified students from nonreferred students and LD-certified students from nonreferred students, particularly in the social-behavioral domain (Gresham, Lane, MacMillan, & Bocian, 1999; Merrell, 1999; Walker & McConnell,

1995). However, attempts to distinguish students with mild from those having emotionally disruptive disorders have produced mixed results (Forness et al., 2000, for a review). Students identified as EBD have patterns of behavior distinguishable from those of students referred to as LD (Costenbader & Burdick, 1995).

There is considerable concern about the social-behavioral characteristics of these groups and, as Forness et al. (2000) have so aptly observed, the results are strongly across these groups. The ADHD diagnoses. The results suggest that students with mild disorders about the validity of the current classification and the need for approximately 1% of students nationally are in the population, as distinguished by incidence categories, in terms of school performance. In spite of this, the evaluation and certification process mandated under IDEA often appears arbitrary and unreliable due to these characteristics.

As noted earlier, the current certification of IDEA (1997) under the title of this category for severe emotional disturbance (ED) without the 'severe' qualifier, which is applied only to this IDEA category, should have been changed to a category and allowed to include at-risk students who could benefit from services for their emotional and behavioral problems. However, the current certification, such is the case. The current certification has rebuffed the current certification, the federal terminology, and the current certification, most professionals in the field of emotional and behavioral disorders.

In a recent study (Forness et al., 2000) the attitudinal and behavioral differences between groups

1995). However, attempts to reliably distinguish students with learning disabilities from those having emotional and behavioral disorders have produced mixed results (see Reid et al., 2000, for a review). Further, students certified as EBD have proven to be largely indistinguishable from students with antisocial behavior patterns, who are commonly referred to as socially maladjusted (Costenbader & Buntaine, 1999).

There is considerable overlap in the social-behavioral characteristics of these groups and, as Forness and Kavale (in press) have so aptly observed, comorbidity operates strongly across these same groups and with ADHD diagnoses. Consequently, one wonders about the validity of the EBD diagnostic classification and the extent to which the approximately 1% of students certified by schools nationally as EBD are truly a unique population, as distinct from other high-incidence categories, in their actual behavior and performance. In spite of the multidisciplinary evaluation and certification processes mandated under IDEA statutes, ED certification often appears arbitrary and lacking in credibility due to these outcomes.

As noted earlier, the most recent reauthorization of IDEA (1997) allowed for a change in the title of this categorical certification from severe emotional disturbance (SED) to emotional disturbance (ED); it merely removed the 'severe' qualifier, which was a limitation applied only to this IDEA category. Theoretically, this change should have expanded the reach of this category and allowed for a larger number of at-risk students who could be certified as in need of services for their emotional and behavioral problems. However, there is little evidence that such is the case. To date, the federal government has rebuffed those who argue for changing the federal terminology to that preferred by most professionals in the field today, emotional and behavioral disorders (EBD). In a recent study Nishiooka (2001) assessed the attitudinal and social-behavioral differences between groups of 15 boys, each of

whom had been previously certified as emotionally disabled (ED) or learning disabled (LD), and 15 boys, each of whom was labeled socially maladjusted (SM). All boys in the study designated as SM had been placed on a waitlist for placement in an alternative education program for students at risk of school failure due to severe behavior problems of an antisocial or destructive nature. The study participants were 12-15 years of age, came from low socioeconomic backgrounds, and attended school in a suburban school district in the Northwest having high rates of youth crime, school dropout, and poverty. All boys in the ED and LD groups were receiving special education services at the time of the study, and 14 of 15, or 93%, of the boys labeled SM had been previously evaluated but denied IDEA eligibility as ED.

Nishiooka gathered data and information on the following variables: demographic, school history, academic achievement, social competence, behavioral characteristics, personal strengths, ADHD symptoms, and attitudes toward aggression and violence. These information sources were sampled using multiple measures and informants across school and home settings. The parent rating scale used to develop information regarding each boy's problems in home and community settings was the *Child Behavior Checklist* (CBCL/4-18) (Achenbach, 1991). This standardized measure categorizes child and youth problems into eight behavioral syndromes: social withdrawal, depression, somatic complaints, social problems, thought problems, aggressive, attention problems, and delinquent behaviors. A key feature of the CBCL/4-18 is its ability to distinguish children whose problems are either primarily "internalizing" or "externalizing" in nature. The study also utilized the *School Social Behavior Scale* (SSBS; Merrell, 1993), a superb social skills rating instrument that measures the dimensions of social competence and antisocial behavior within the same assessment. This scale has excellent psychometric characteristics and a national nor-

maladjusted students having mild, conditions can be reliable through the and eligibility determined seems to be broad with mild disabilities are different on most ed by multidisciplinary, & Bocian, & Rysler, 2000). (1984), in a now classified, argue that regular school-based testing informed judges of characteristics in this suggest that the evaluative disciplinary teams characteristics should be ment and informal other than vice versa solid regarding the ec instruments and EBD-certified students and LD-certified students, par-behavioral domain William, & Bocian, & McConnell,



mative sample. The SSBS yields six scale scores and also a total score for social competence and antisocial behavior, respectively.

Complete results of this investigation will be published in a series of forthcoming reports. However, we wish to describe partial findings here relating to the participating boys' profiles on social-behavioral dimensions that are home- and school-based. These results provide further confirmation of the growing knowledge base showing that while these three groups can be reliably distinguished from nonreferred students, they are difficult to discriminate from each other on measures that are commonly used to establish their status as ED, LD, or SM (see Reid et al., 2000).

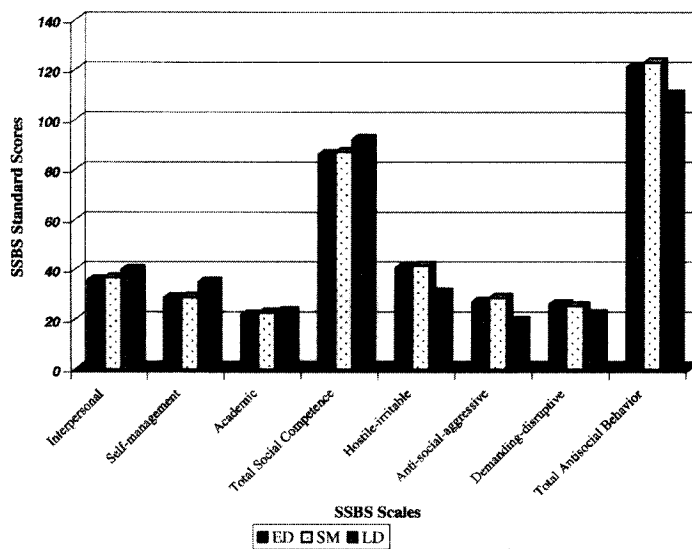
A series of analyses of variance (ANOVAs) revealed no significant statistical differences between students labeled ED and SM across the eight CBCL syndromes, as well as for internalizing, externalizing and total scale scores ($p > .05$). However, students with LD were significantly different from students with ED and SM on the following CBCL scales: delinquent behavior, aggressive behavior, internalizing, externalizing, and total scale scores. These results provide additional evi-

dence that students identified as ED and students labeled SM do not differ on educationally relevant, behavioral measures, in terms of parent CBCL ratings, across dimensions and behavioral characteristics that are predictive of school failure and negative adult outcomes.

Figure 3 graphically illustrates profiles of the three subject groups on the six subscales and total scale scores of the SSBS. These results illustrate substantial overlap for the three groups of boys on each SSBS subscale and on the overall social competence and antisocial behavior dimensions. There were no statistically significant differences between the three groups of boys on the SSBS social competence and any of the subscale scores. Similarly, there were no significant differences between the ED and SM groups on the SSBS antisocial scale and subscales. However, the SM boys had significantly higher scores on the aggressive/antisocial subscale than the LD boys.

Inspection of the data profiles on the other social-affective measures recorded as part of the study reveals a similar lack of differences among the ED and SM groups across attitudinal, demographic, and other social-behavioral dimensions. Taken together, these results

Figure 3 School Social Behavior Scales Scores (SSBS) for Boys with ED, SM, and LD



replicate findings of this issue (McCabe, Peterson, 1994; Reid et al., 1999). In view, call into question diagnosis as distinction that can lay out a path that is (a) distinctive for students experiencing behavioral adjustment (b) deserving of the services provided under IDEA. On reflection, question on whether or not identification and a school-based intervention labeled socially maladjusted to same, turns largely

Obstacles and Barriers for Students At-Risk for Behavior Disorders

Kauffman (1999) provides an insightful analysis of the challenges educators face to consistently screen, identify, refer, and treat serious adjustment problems in the context of schooling. He identifies the conditions and the conditions showing that the real obstacles are often logical and can be addressed by well-meaning individuals. Labeling and thus the effect of these factors on prevention. Indeed, we were to actually press of this student population to do it any do.

The following barriers cited by Kauffman are accounting for school to serve the broad mental health problem concern for labels and the medical model and

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replicate findings of other investigators on
this issue (McConaughy, Mattison, &
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view, call into question the validity of the ED
diagnosis as distinguishing a unique subpopu-
lation that can lay claim to having a disabili-
ty that is (a) distinct from the larger pool of
students experiencing mental health and
behavioral adjustment problems in school and
(b) deserving of the protections, supports and
services provided under the aegis of the
IDEA. On reflection, it appears that the deci-
sion on whether or not a student receives ED
identification and accesses services, supports,
and school-based interventions, or is, instead,
labeled socially maladjusted and denied access
to same, turns largely on chance factors.

*Obstacles and Barriers to Identification of
Students At-Risk for School-Related
Behavior Disorders*

Kauffman (1999) recently contributed an
insightful analysis of the factors that cause
educators to consistently resist pressures to
screen, identify, refer, and serve students hav-
ing serious adjustment problems in the con-
text of schooling. He describes these factors
and the conditions that sustain them, while
showing that the reasons given by profession-
als are often logical sounding and contributed
by well-meaning individuals (e.g., to avoid
labeling and thus stigmatizing a child).
Kauffman (1999) argues that the summative
effect of these factors is to prevent effective
prevention. Indeed, it appears that if our goal
were to actually prevent addressing the needs
of this student population, we would be hard
pressed to do it any better than we currently
do.
The following barriers and obstacles are
cited by Kauffman (1999) as instrumental in
accounting for schools' persistence in refusing
to serve the broad range of students with
mental health problems: (a) expressing con-
cern for labels and stigma, (b) objecting to a
medical model and failure-driven services, (c)

preferring false negatives to false positives, (d)
proposing a paradigm shift, (e) calling special
education ineffective, (f) misconstruing the
least restrictive and least intrusive interven-
tion, (g) protesting the percentage of children
receiving services, (h) complaining about the
costs of special education services, (i) main-
taining developmental optimism, (j) denounc-
ing disproportionate identification, (k) deny-
ing or dodging deviance. Kauffman has contributed
a great service to our field by holding up a
mirror that shows how we basically deny ser-
vices to a fast-growing school population with
severe problems and needs. Through this
denial, we increase the likelihood that these
students will leave school early, thereby losing
access to its protective influences and
encountering a host of nonschool risk factors
that accelerate markedly upon exiting school
(Hawkins et al., 1999; Loeber & Farrington,
1998).

In a similar vein, Forness and Kavale (in
press) have provided some important com-
mentary and analysis regarding the future of
prevention. They are especially concerned
about (a) the lack of understanding that most
educators manifest regarding the potential
benefits of universal interventions that can
achieve important primary prevention goals
and outcomes and (b) the role of school
reform in narrowing the behavioral ecology
and capacity of schools to accommodate the
increasing diversity of today's student popula-
tion. They note that special education is
strongly invested in secondary and tertiary
prevention approaches and that few schools
adopt primary prevention strategies, while
continuing to rely upon structural solutions
that often involve exclusionary practices and
punishing consequences. They offer four pri-
mary reasons to account for this state of
affairs: (a) misidentification, (b) diagnostic
omission of comorbidity, (c) misunderstanding
of developmental psychopathology, and
(d) psychopharmacologic under-treatment.
We believe the observations and analyses

of Kauffman (1999) and Forness and Kavale (in press) provide compelling messages and wisdom regarding a solution to the under-identification and accommodation of students experiencing school-related adjustment problems. If we are to address the needs of this student population and use existing services more effectively, their recommendations should provide a roadmap for changes in both school policy and practice. As we have noted, it is critically important to identify at-risk students as early as possible in their school careers so they can access services and interventions appropriate for them. Unless systematic screening procedures are in place, such access will be idiosyncratic, sometimes random, and largely insufficient to meet existing needs.

The Role of Universal Screening Procedures in Solving the Underidentification of Behaviorally At-Risk Students

There are two approaches to providing universal screening to identify behaviorally at-risk students in the context of schooling. One involves intervention-based screening and the other relies upon traditional assessment procedures. Each is briefly described below.

Universal interventions are generally applied on a class-wide or school-wide basis (i.e., a school-wide discipline plan, class-wide teaching of violence prevention social skills, teacher training in systematic behavior management procedures) to all students in the same manner. Once the intervention is in place and operating effectively, those at-risk students for whom a universal intervention is insufficient select themselves out as requiring more intensive and/or individualized intervention approaches. Thus, the intervention allows such students, through their lack of responsiveness, to essentially identify themselves as being in need of more supports and access to powerful interventions such as those involved in secondary and tertiary prevention approaches. Walker et al. (1995) described

how this process can work seamlessly in schools to accomplish both intervention and screening-identification goals while matching student severity levels to the intensity of available interventions.

Models of proactive, universal screening exist that are effective, efficient, and reasonable in cost (see Merrell, 1999). These approaches screen all students on the same behavioral dimensions and provide opportunities, through structured teacher judgment processes and/or analysis of archival school records, for each student to be identified for problems in social-behavioral domains. Figure 4 illustrates a multiple-gating approach to the universal screening of all students for identifying those at risk for either externalizing or internalizing behavioral disorders. This system was developed by Walker and his colleagues in the late 1980s and has been extensively researched during the past 12 years (see Walker, Severson, Stiller, Williams, Haring, Shinn, & Todis, 1988; Walker, Severson, Todis, Block-Pedego, Williams, Haring, & Barckley, 1990).

In screening stage one, the teacher nominates and rank orders students whose characteristic behavioral profiles match either an externalizing or internalizing behavioral profile. At this stage, every student is given an equal chance to be identified for either an externalizing or an internalizing behavior disorder. The highest-ranked students on these two dimensions then move to screening stage two where they are assessed on a brief checklist of critical behavioral events and on Likert ratings of adaptive and maladaptive behavior by the teacher. Students exceeding normative cutoff points, usually one or two students per dimension, move to screening stage three where they are directly observed in playground and classroom settings. For students who exceed normative cutoff scores on the SSBD observation codes, archival school records are searched to help confirm the accuracy of the three-stage screening process and to inspect students' school history. Students

Figure 4 Multiple-Gating

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Multiple-gating
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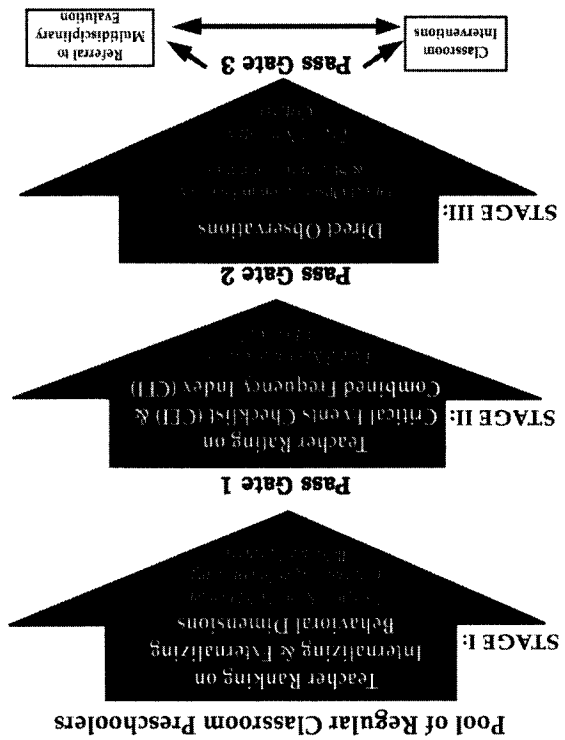


Figure 4 Multiple-Gating Assessment Procedure for Identification

teachers with a uniform information base for use in the screening process. Adoption of either of these universal forms of screening would likely improve the quality of referrals and would be a substantial improvement over current school practices. The intervention-based model of screening has the added advantage of relying upon an intervention procedure that is fair, applied uniformly to all, and is used as the primary basis for screening and identification. Such an approach may be more acceptable to educators in the realm of screening. However, a limitation of this approach is that it may not possess sufficient sensitivity to detect a majority of students needing supports and services. This may be especially true for internalizing behavior patterns. We would thus recommend using the two approaches in combination wherein a multiple gating model is implemented after a primary prevention intervention has been stabilized and is operating

who survive each screening gate and whose archival school records indicate serious problems are then referred for intervention and/or further evaluation. Multiple-gating screening models of this type offer a number of advantages, including: (a) they are highly accurate, in that each subsequent stage of screening confirms or disconfirms results of the preceding stage; (b) each student is provided an equal chance to be identified and their behavioral characteristics are considered, along with their peers' characteristics, on the same dimensions in screening stage one; (c) they are cost-effective, in that the number of students evaluated at each subsequent screening stage is reduced while the intensity and sensitivity of the assessment process increases; and (d) these models usually involve multigent, multitasking and multiple forms of assessment. Multiple-gating approaches are also proactive rather than reactive in nature and provide referring

work seamlessly in both intervention and goals while matching to the intensity of universal screening efficient, and reasonable (Trell, 1999). These students on the same and provide opportunity and teacher judgment of archival school to be identified for externalizing or disorders. This system Walker and his colleagues and has been extended the past 12 years (see Williams, Harting, Walker, Severson, Williams, Harting, &

the teacher nomination, the teacher whose characteristics match either an existing behavioral profile student is given an identified for either an externalizing behavior disorder students on these existing stage three observed in play-stings. For students' cutoff scores on the archival school records confirm the accuracy of the screening process and history. Students

ing seamlessly. Generally, a minimum of three months would be required to achieve this goal so that an informed screening process could occur.

Concluding Remarks

We regard the current state of affairs in schools' accommodation of the mental health and social-behavioral needs of today's students as far less than optimal. Current school practices seem to reflect those that have been in effect over the past two decades. Reforms in policy and practice in this area are urgently needed. In particular, schools should not, in our view, be in the business of denying at-risk students access to services by arbitrarily labeling them as SM, pushing them out of school, and exposing them to the risks that are associated with early school leaving (Loeber & Farrington, 1998).

Our recommendation is that the EBD certification process be replaced with systematic screening and primary prevention approaches that can reach a far greater number of at-risk students in a cost-effective manner. This approach would allow school professionals to better match the intensity of interventions with the severity of behavior problems. There is a huge gap between the 1% of students served as ED and the approximately 20% of students in need of such supports and services. We need a policy that provides them without the prior requirement of an IDEA diagnostic label or certification.

Instead of continuing our vain attempts to discriminate EBD from SM at-risk students, we should refocus our efforts on two dimensions: (a) severity and (b) the externalizing-internalizing behavioral classification system. Our instruments and decision processes are not capable of accurately distinguishing EBD from SM students. However, they are superb at ordering behaviorally at-risk students along a dimension of severity and should be used for this purpose.

The EBD diagnostic category provides no

information regarding intervention or treatment. However, the bipolar externalizing-internalizing classification does (i.e., suggests what to reduce and replace and what skills and competencies to build). This bipolar dimension also has great relevance to the two forms of behavioral adjustment that all students must negotiate in the school setting (i.e., teacher-related and peer-related) (see Walker et al., 1995).

School-based assessment approaches are increasingly based on an externalizing-internalizing dichotomy that has sufficient breadth to capture most of the behavior problems and disorders that are manifested in the school setting (Gresham et al., 1999). Universal approaches to intervention are now available that have proven efficacy with the potential to (a) prevent mildly at-risk students' problems from becoming more severe and (b) create a context in which interventions for achieving secondary and tertiary prevention outcomes can be implemented more effectively (see Eddy, Reid, & Fetrow, 2000; Frey, Hirschstein, & Guzzo, 2000; Hawkins et al., 1999; Greenberg et al., 1999; Sugai, Horner, Sprague, & Walker, 2000).

Schools provide an ideal setting for effective application of these evidence-based intervention approaches. We are hopeful that educators will increasingly access and adopt these cost-effective approaches as we move into the 21st century.

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