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ABSTRACT

This synthesis of the literature examines the characteristics of children with conduct disorders and the special education placement dilemmas they present. The paper distinguishes among the terms delinquency, social maladjustment, conduct disorder, and behavioral disorder. The paper discusses eligibility of students with conduct disorders for services under the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act. Students with conduct disorders are described as falling into a "boundary area," as the federal definition of serious emotional disturbance excludes students who are socially maladjusted, while conduct disorders have long been considered to be a mental impairment in the Diagnostic and Statistical Manual and thus would be eligible for services under Section 504. The paper describes school approaches to more effectively meet students' needs, categorized as universal interventions, selected interventions, functional curriculum and a vocational training program, alternative programs or alternative schools, and diversion programs. Strategies are recommended for improving services to these children and their families, including, among others: revise the current federal definition of seriously emotionally disturbed; ensure that strong prereferral strategies are in place; provide for early identification and intervention; improve efforts to reach out to families; enhance collaboration among schools, mental health agencies, and other appropriate agencies; and improve training opportunities and collaboration among professionals. (Contains approximately 80 references.) (JDD)

CHILDREN ON THE BOUNDARY: THE CHALLENGE POSED BY CHILDREN WITH CONDUCT DISORDERS

By Mary Kemper Cohen

July 1994

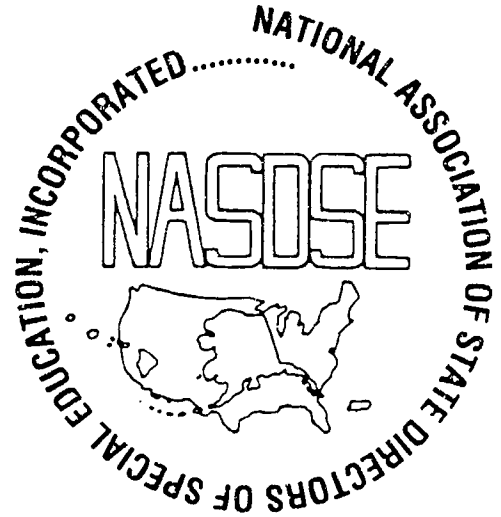

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TABLE OF CONTENTS

ABSTRACT

Children with conduct disorders pose an enormous challenge for the schools. This paper examines the characteristics of these children and the special education placement dilemmas they present. This synthesis of the literature includes a discussion of the eligibility of students with conduct disorders for services under the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act, a description of school approaches to more effectively meet their needs, and recommended strategies for improving services to these children and their families.

CHILDREN ON THE BOUNDARY:
THE CHALLENGE POSED BY CHILDREN WITH CONDUCT DISORDERS

Introduction

Children with conduct disorders pose an enormous challenge for the schools. In some instances, they are considered eligible for special education under the Federal statute, Individuals with Disabilities Education Act (IDEA), even though there is no such specific disability label. In other instances, they are excluded on the grounds that conduct disorders are not included in the State definition, or because they are simply perceived as "bad" or "maladjusted. Regardless of how a school defines them, or whether they are in regular or special education, children and adolescents with conduct disorders (or conduct disordered like behavior) are often problematic for teachers, school officials, and parents. Since most States do not recognize children with conduct disorders as eligible to receive special services under IDEA (Forness, Kavale & Lopez, 1993), these children have been selected for the purposes of this synthesis as an example of children who are "on the boundary" and whose educational needs are often not adequately met by school systems. Some of them pose substantial behavioral and instructional challenges for the regular education staff. Without extra assistance to help them succeed in school, many of these children exit school prior to graduation, and many of them become involved with the juvenile justice system.

There is general confusion among the various labels that have been attached to these children including "delinquent," "socially maladjusted," "conduct disordered," or even "behaviorally disordered." *Delinquency* technically denotes illegal behavior that has caused the individual to come in contact with the juvenile justice system. *Social maladjustment* is a term that may denote rule-breaking behavior, disregard of the rights of others, or inability to function well in social situations. *Conduct disorder* is technically a psychiatric diagnosis that is determined from a list of symptoms involving aggression, destruction of property, deceitfulness, theft, or serious violation of rules which represents a repetitive and persistent pattern of behavior. *Behavioral disorder* is a generic term used by professional special educators to include both externalizing (acting out or aggressive) and internalizing (withdrawn or anxious) behavior that interferes with school progress.

Unfortunately, these terms are often used interchangeably if not synonymously, and use may vary from profession to profession or even region to region. Behavioral disorder, for example, is used as the eligibility term for special education in the State of Iowa but is used to exclude children from special education in the State of California. These terms will all be used throughout this report as closely to the definitions given above as possible, although conduct disorders will be used as the more common term since it does represent an identifiable diagnosis. Note that children or youth in each group, however, often find themselves on the boundary of the educational system.

While the subject of this synthesis is children with conduct disorders, their problems are similar to those of students with emotional disturbance. Statistics related to outcomes for students with *emotional disturbance* who have been served under the law reveal the lack of successful outcomes for large numbers of children in this population. The National Longitudinal Transition Study of Special Education Students (Wagner et al., 1991) found that 49.5 percent of students with emotional disturbance dropped out of school and 3.9 percent were suspended or expelled. The same study also found that almost 20 percent of youth classified as emotionally disturbed who were still in secondary school had been arrested. When youth classified as emotionally disturbed had been out of school for up to two years, the arrest rate increased to 35 percent (Wagner et al., 1991). Note that these are children or youth who are identified and receiving special education and related assistance. Those who do not receive such assistance, who are the focus of this paper, may have even greater drop-out and arrest rates.

Adolescents who exhibit antisocial behavior pose a variety of intervention and service delivery issues. Research indicates that approximately 50 percent of students with antisocial behavior will drop out; 7 to 15 percent will attend postsecondary training; 5 to 10 percent will receive services from adult service agencies; 31 percent will be engaged in work and/or postsecondary training after leaving the public schools; and many will be unemployed or underemployed (Kortering & Edgar, 1988; Neel, Meadow, Levine, & Edgar, 1988; Wagner & Shaver, 1989).

It has been well documented in the research literature that children with conduct disorders often have behavioral problems which hinder their ability to learn (Center, 1990; Kazdin, 1987). Antisocial behavior has been identified as one of the most expensive mental disorders to treat (Robins, 1981). The reason for the high cost is that a large percentage of youth with antisocial behavior continue to receive mental health services and/or have contact with the juvenile justice system, neither of which may provide all of the assistance that these individuals need. Research has shown that there are other effective methods for educating students with conduct disorders (Makin, 1987), and providing appropriate educational services would be less costly in the long run to both State and local communities.

Another reason for focusing on children with conduct disorders is the debate regarding the current Federal definition of children with serious emotional disturbance (SED) and the exclusion of children who are socially maladjusted from the SED category. The recent (1993) Notice of Inquiry published by the U.S. Department of Education concerning the SED terminology and definition brings the issue of students with behavior problems to the forefront. At what point is a student with a conduct problem eligible to receive special education services?

Who Are The Children On The Boundary?

Currently, there are two primary pieces of legislation that protect the educational rights of children and youth with disabilities: the Individuals with Disabilities Education Act known as IDEA (formerly the Education of the Handicapped Act and amendments), and Section 504 of the Rehabilitation Act.

When the Education of All Handicapped Children Act of 1975 was passed, guaranteeing the availability of a free and appropriate education to all students, public schools could no longer close their doors to students with disabilities. Under IDEA (1990), children with disabilities are defined as having "mental retardation, hearing impairments including deafness, speech or language impairments, visual impairments including blindness, serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, specific learning disabilities, deaf-blindness, or multiple disabilities" [34 CFR, Section 300.7(a)(1)].

A child must meet two criteria under this definition: (1) the child must have one or more of the listed disabilities; and (2) the child's disability must adversely affect his education thereby requiring special education or related services.

Section 504 of the Rehabilitation Act of 1973 is a basic civil rights provision which prohibits discrimination toward individuals with disabilities. The statute reads: "No otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Under Section 504, a "handicapped person" is defined as any person who (i) has a physical or mental impairment which substantially limits one or more major life activities; (ii) has a record of such an impairment; or (iii) is regarded as having such an impairment [34 CFR, Section 104.3(j)]. Learning is identified as an example of a major life activity.

These two pieces of legislation, IDEA and Section 504 of the Rehabilitation Act, work together to provide access to appropriate educational services for children with disabilities. Not all children with disabilities require special education services under IDEA. However, Section 504 should, in most cases, pick up where the IDEA leaves off. Because of the difference in the definitions of the eligible populations under these two statutes, an individual with a disability who is not "disabled" under IDEA, could be "disabled" under Section 504. As a result, a school system may be required to provide specialized instruction of services to some students it would not ordinarily serve under the IDEA statute (Cline, 1990).

Under IDEA, many students with behavior problems would be eligible for services under the category of serious emotional disturbance (SED). The current Federal definition of seriously emotionally disturbed reads:

The term means 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.
The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have a serious emotional disturbance [34 CFR, Section 300.7(b)(9)].

According to the Fifteenth Annual Report to Congress on the Implementation of The Individuals with Disabilities Education Act, for the 1991-92 school year, 400,214 students aged 6-21 were identified as seriously emotionally disturbed. For the 198^-90 school year, students with SED represented 8.4 percent of all students with disabilities. In relation to total school enrollment, 0.9 percent of students aged 6-17 were identified as SED.

Many researchers believe that students with serious emotional disturbance are among the most underidentified and underserved in our nation's schools (Smith, Wood, & Grimes, 1988; Forness & Knitzer, 1992; Nelson, Rutherford, Center, & Walker, 1991). The Institute of Medicine (1989) estimates that 3-6 percent of the school aged population should be identified as having severe behavior or emotional problems. However, less than 1 percent of the school aged population is identified as SED.

Because of the exclusionary statement concerning students with social maladjustment found in the Federal SED definition, students with conduct disorders are often considered ineligible for services under IDEA unless they are also found to be emotionally disturbed. This exclusionary clause and the linking of conduct disorders to social maladjustment has caused quite a bit of controversy within the field.

We now turn to the debate concerning the exclusionary clause. First, there is confusion as to what exactly is meant by the term "social maladjustment" as it is used in the SED definition. The Federal definition, with the exception of the social maladjustment exclusion clause, was originally written by Eli Bower. Bower's position indicates that he defined emotional disturbance in terms of children's social maladjustment in school (Bower, 1982). Secondly, the second SED criterion virtually defines social maladjustment (i.e., the inability to build or maintain satisfactory relationships with peers and teachers) (Forness & Knitzer, 1992). Cline (1990) reviewed and analyzed Congressional testimony during the period when the Federal definition of

serious emotional disturbance was being developed and concluded that Congress, in using the term social maladjustment, intended to exclude only adjudicated juvenile delinquents.

The equating of conduct disorders to social maladjustment has also been much debated (Quay, 1987; Nelson et al., 1991, Center, 1990; Slenkovich, 1983). Some individuals have adopted an interpretation of the clause defining social maladjustment to mean conduct disorder and have advised school administrators and State policymaking bodies to deny special educational services to children identified as conduct disordered on the grounds that such children are not seriously emotionally disturbed (Kelly, 1986, Slenkovich, 1983).

Other professionals equate the exclusionary clause of social maladjustment with the specific psychiatric diagnosis of "conduct disorders" in DSM-III-R (Diagnostic & Statistical Manual of Mental Disorders, APA, 1987) (Kazdin, 1987; Forness & Knitzer, 1992), or even externalizing disorders, a term used to describe aggressive behavior (Achenbach, 1985). Such an exclusion ignores research on childhood depression that documents extensive overlap with behavior or conduct disorders, i.e., co-morbidity of depressive and disruptive disorders (Kovacs, 1989; Forness, 1988). In fact, children with disruptive behavior or conduct disorders are the largest subgroup of children identified and placed in SED programs (Forness & Knitzer, 1992; Mattison, Humphrey, Kales, Hernit, & Finkenbinder, 1986; McGinnis & Forness, 1988).

Another consideration in determining who is excluded from services under IDEA is the fact that nowhere is there an agreed upon definition of social maladjustment. The term is not defined in the law, nor is it defined in the regulations. Furthermore, no court cases have been decided in which a definition has been used. As a result, the States are allowed to interpret "social maladjustment" individually.

What Is Conduct Disorder?

In educational literature, the term conduct disorder has been used to describe children who demonstrate a persistent pattern of antisocial, rulebreaking, or aggressive behavior that impairs their ability to function and are considered as unmanageable by others (Forness, Kavale, & Lopez, 1993; Kazdin, 1987).

The other source used to define conduct disorder is the DSM-III-R (APA, 1987). According to the DSM-III-R, the essential feature of a conduct disorder is a "persistent pattern of conduct in which the basic rights of others and major age-appropriate societal norms or rules are violated" (page 53). Furthermore, individuals with this disorder "usually initiate aggression, may be physically cruel to other people or to animals, and frequently deliberately destroy other people's property (this may include fire-setting)" (page 53). Other characteristics of conduct disorder include lying, stealing, truancy, or running away from home. Two major subtypes have been identified with this disorder: (1) *solitary aggressive* -- aggressive antisocial behavior initiated

by the person and not conducted in a group; and (2) *group* -- aggressive antisocial behavior that is conducted as a group activity (Quay, Morse, & Cutler, 1966). In the forthcoming version of DSM-IV to be published later this year, there will be a system to determine both "childhood onset type" and "adolescent onset type" as well as severity specifiers of mild (few if any symptoms beyond those needed for a threshold diagnosis and relatively minor harm to others), moderate (number of symptoms and harm to others between mild to severe), and severe (many symptoms in excess of those needed to make the diagnosis and considerable harm to others).

Some question the appropriateness of using a definition of conduct disorder that is based on a medical model for determining educational placement (Center, 1990; Maag & Howell, 1992). There is little correlation between psychiatric and educational classification systems (Barnes & Forness, 1982; Forness & Kavale, 1987; Sinclair, Forness, & Alexson, 1985) which makes reliance on medical or psychiatric categories inappropriate when making educational placement or programming decisions. Confusion often results when this is tried.

There also is disagreement within the field about the ability to differentiate accurately between students with conduct disorders and students with SED. Currently, a large number of students with conduct disorders are being served in SED settings. Forness and Knitzer (1992) noted that children with disruptive behavior or conduct disorders are the largest subgroup of children actually placed in SED classes. Mattison, Morales, and Bauer (1992) found in a study of 100 boys recommended for SED placement that 79 percent exhibited some type of externalizing disorder (e.g., conduct disorder or attention deficit hyperactivity disorder) as the principal DSM-III psychiatric diagnosis. Only 17 percent exhibited an internalizing disorder as the principal diagnostic characteristic. Wagner (1989) also found approximately 70 percent of students labeled as SED by the schools had externalizing, antisocial behaviors.

In another study of SED-eligible students, the majority received a conduct-related diagnosis (McGinnis & Forness, 1988). One of the largest recent studies followed 812 children and adolescents identified as SED over several years and found that 67 percent met criteria for conduct disorders (Silver et al., 1992).

In addition, surveys of juvenile correctional facilities typically reveal that the proportion of young offenders identified as disabled under IDEA is significantly higher than the proportion identified in the general population (Morgan, 1979; Rutherford, Nelson, & Wolford, 1985; Murphy, 1986).

There is also strong research supporting the co-occurrence of emotional problems and conduct disorders in children (Forness, Kavale, & Lopez, 1993; Kauffman, 1989; CCBD, 1990; Walker and Fabre, 1987). Behavioral, social and emotional conditions may be found in the same child and all three conditions may respond to similar treatments (Reynolds, 1985).

How Are Children Or Youth With Conduct Disorders Served?

Clearly, some of the students with conduct disorders are receiving school services, but how these are accessed and provided is extremely inconsistent (Kauffmann, 1989; Nelson et al., 1991; Peacock Hill Working Group, 1991).

One of the rationales used for excluding students with conduct disorders from the SED category is that students with conduct disorders choose to engage in antisocial behavior. Weinberg (1992) carefully examined the issue of choice in distinguishing students with SED from students with social maladjustment and concluded:

> It seems quite possible that students displaying behavior congruent with a diagnosis of conduct disorder are not choosing their disordered behaviors. Whether they are choosing their disordered behavior or not clearly depends on the factual nature of the situation. The current empirical evidence on the etiology of conduct disorders provides at least some rudimentary evidence suggesting that some individuals exhibiting behavior congruent with a conduct disorder diagnosis may not be engaging in the disordered behavior on a completely voluntary basis (page 102).

Another concern with the exclusion of students with social maladjustment or students with conduct disorders is the inability of current evaluation procedures to differentiate accurately between these groups of students. P.L. 94-142 requires that tests or other evaluation materials used to make educational decisions must "have been validated for the specific purpose for which they are used" [34 CFR 300.532(a)(2)]. Currently, there are no technically adequate measures that have been validated for the purpose of identifying social maladjustment (CCBD, 1990). As a result, schools are making placement decisions without adequate evaluation instruments.

Given that some States have made efforts to ensure that students with conduct disorders are not eligible for services under IDEA, the question one must then ask is would these students be eligible for services under Section 504? This possibility applies to students with AIDS (Thomas v. Atascadero, 1987) as well as students with Attention Deficit Hyperactive Disorder (Rialto Unified, 1989; U.S. Department of Education, 1991). Given that many students with conduct disorders have behavior problems which adversely affect their learning, they could be eligible for services outside of special education under Section 504 (Cline, 1990; CASE, 1992; Nelson and Rutherford, 1990). In the regulations governing Section 504, a recipient of Federal funds must provide a comprehensive evaluation for any person who, because of handicap, needs or is believed to need, special education or related services. Thus, a student may qualify for services under Section 504 by needing only related services, such as counseling. Section 504 provides protection for anyone who has a physical or mental impairment which substantially limits one or more major life activities (e.g., learning). The DSM-III-R and the forthcoming DSM-IV consider a conduct disorder to be a genuine mental disorder. Hence, a school system

may be obligated to provide either special education or related services to some students with conduct disorders as required by Section 504 (Cline, 1990).

If students with conduct disorders could be eligible for services under IDEA, and if students with disruptive behavior or conduct disorders are the largest subgroup of children actually placed in SED programs, why is there such reluctance to identify students with behavior problems as needing services?

One suggested reason why schools may be reluctant to label a student with conduct problems as disabled is because it may limit disciplinary options because of the U.S. Supreme Court decision in *Honig v. Doe* (1988) (Center, 1990; Nelson et al., 1991). In the *Honig v. Doe* decision, the Supreme Court ruled that students with disabilities may not be suspended for more than 10 cumulative days or expelled for actions that are related to their disabilities. Given the challenge of meeting the educational needs of students with antisocial behavior, schools may be reluctant to identify students if doing so would eliminate expulsion as a disciplinary option.

There is also a severe shortage of qualified professionals prepared to teach students with behavior problems. According to the Fifteenth Annual Report to Congress, there are 29,200 teachers of children or youth with SED employed but there is still a shortage of 4,484 teachers in this area. This is proportionately almost the largest shortage in any of the 10 categories for which these data are available, second only to the category of deaf-blind.

Schools may often be hesitant to identify students with conduct disorders as disabled because of liability issues faced by schools regarding possible damage that could be caused to other students or to property.

There is also an unwillingness to identify students with conduct disorders because schools do not want to place students with behavior problems in the same classroom as students with emotional problems. Research is somewhat equivocal on the need for differentiated placement or programming between these two groups of students (Wood et al., 1991; CCBD, 1990).

One of the reasons given most frequently for not allowing students with conduct disorders or social maladjustment to be identified and served is the fear that identifying such students will greatly increase the number of students receiving such services. However, research studies have found that a change in terminology (i.e., replacing emotionally disturbed with behavior disordered) will not significantly increase the number of students served (Knitzer, Steinberg & Fleisch, 1990).

The experience of Colorado and Iowa reinforce the findings of this research. In June 1990, the Colorado State Legislature removed the term "behavioral" from its previously used term. The term significantly identifiable emotional or behavioral disorder (SIEBD) was redefined as significantly identifiable emotional disorder (SIED). This terminology resulted in a declassification of only .72 percent of the total SIEBD population. Of the students originally

classified as SIEBD, 94.74 percent were reclassified as SIED and 4.74 percent were reclassified into another disability category (Kozleski, Cessna, Bechard, & Borock, 1993).

In 1974, the Iowa Legislature passed legislation which tried to differentiate between students who were "chronically disruptive" and those who were "emotionally disabled." Both groups were eligible for special education services, but it was believed that the two groups were in need of unique educational services, hence the different diagnostic categories. However, as schools tried to implement the two categories, it was perceived that the effort made to differentiate between these two groups was not balanced by substantial improvements in programming to meet the needs of the students. As a result, in 1980 the Iowa Department of Public Instruction proposed to the Iowa Legislature the adoption of the term behavioral disorders to replace both the terms emotional disability and chronically disruptive. In 1983, the new terminology as well as a broad definition was passed. There has not been a dramatic increase in the number of students identified as needing special education as was feared when the broad definition was passed. In fact, the rate of increase in identification of such students has decreased (Wood et al., 1991).

The Boundary Area

The public schools have a legal and professional responsibility to meet the educational needs of the school age population. It is also widely agreed that the children attending schools today represent a more diverse population and present a greater educational challenge. Hence, there should be no question that schools are responsible for doing all they can to educate students with conduct disorders.

Students with conduct disorders present quite a paradox to school systems--on one hand, there are those in the field who believe that students with conduct disorders should be excluded from services under IDEA because of the Federal definition of SED which excludes students who are socially maladjusted. On the other hand, currently almost half the States (43 percent) have SED definitions that do not exclude children or youth with social maladjustment (Gonzales, 1991). Furthermore, as cited earlier, a large number of students with conduct disorders are receiving services under the SED category.

What is surprising is that there is no evidence that students with conduct disorders are being identified as disabled under Section 504 of the Rehabilitation Act. Given that conduct disorders has long been considered to be a mental impairment by DSM-III-R, one would believe that if a student had been identified as having a behavior problem that was adversely affecting his or her educational performance and was determined to be ineligible for services under IDEA, then one would ask whether the student would be eligible for services under Section 504. This does not appear to be the situation. In conversations with officials from the Office of Civil Rights in the U.S. Department of Education, as well as with professionals involved in education

at the local and State levels, none was familiar with students with conduct disorders receiving services under Section 504.

If students with attention deficit disorder (ADD) who are deemed ineligible for services under IDEA may then be eligible for services under Section 504, why wouldn't students with conduct disorders be granted this same treatment?

One reason cited is that providing services and program interventions to students with behavior problems may be unpopular (Maag & Howell, 1992), despite the fact that they could be legally entitled to services. Students with antisocial behavior may not have the support of the community or of school personnel; such students often cause one to think of gangs or delinquent behavior and there is little sympathy for such groups.

Sometimes schools feel that the needs of students with conduct disorders could be better met through services provided by other agencies, such as mental health or social welfare services. As a result, schools hope that others will work to address the needs of students with conduct disorders.

Effective Programs For Children And Youth At The Boundary

There are schools and communities that are working to meet the needs, both academic and social, of students with behavior disorders. It is well documented that outcomes for students with behavior disorders can be improved when these students receive special education services (Peacock Hill Working Group, 1991; Kozleski et al., 1993; Carlberg & Kavale, 1980).

While research has given us some clues as to interventions that are effective for students with conduct disorders, there is no "cure" for antisocial behavior just as there is no cure for mental retardation or learning disabilities.

Bullis and Walker (in press) provide excellent advice to keep in mind when approaching interventions for students with antisocial behavior:

> Antisocial behaviors define a stable and durable disability that has, to date, defied professional intervention efforts. Instead, we as a field have to consider and implement long-term in some cases life long interventions to address these problems successfully. In a related vein, one of the great errors professionals make is in seeking the one intervention that will change the student. Hundreds of publications and reports, as well as common sense, document this outcome as simply not probable. Antisocial behaviors are too ingrained and too strong to be altered by any single intervention. Instead, it is clear that effective programs employ multiple, varied types of interventions that are often implemented in more than one setting.

There are a number of interventions currently being used by school systems to better address the educational needs of students with conduct disorders. Some examples follow.

Universal interventions refer to strategies to which all children are exposed. Examples include training an entire classroom of students in a systematic social skills program or in the use of cooperative learning strategies. They are designed to affect the entire group and their impact is measured through the group effects achieved. Universal interventions are usually accepted and respected by teachers and other school professionals since they are perceived to be fair, low cost and relatively "non-intrusive" (Bullis & Walker, in press).

Reid (in press) is involved in an universal intervention strategy for the prevention of antisocial behavior patterns in grades one and five. The intervention is referred to as LIFT (Linking the Interests of Families and Teachers). It is a comprehensive home and school intervention program involving teachers and parents. All children in grades one and five in participating schools are exposed equally to the intervention components. A longitudinal follow-up design is being used to measure long-term effects, but there have been preliminary results. Initial analyses indicate that treatment effects for first grade children are substantial while effects for fifth grade students are minimal. This result, however, is consistent with research showing that younger children respond more readily to intervention than older children (Reid, in press; Patterson, Dishion and Chamberlain, in press).

Selected interventions are designed for children with more severe behavior problems who may not respond well to universal interventions. They are focused on a specific student and are oftentimes delivered by other school or mental health professionals within the regular classroom or on the playground. The advantages of selected interventions is that they can be applied on a case by case basis and are effective; however, they are often viewed as unfair by teachers since a particular child is singled out for assistance (Bullis & Walker, in press).

The RECESS (Reprogramming Environmental Contingencies for Effective Social Skills) Program (Walker, Hops, & Greenwood, 1988) is an example of a selected intervention program. It is designed exclusively for the remediation of aggressive, antisocial behavior among kindergarten to third grade children. The program requires two months for full implementation and can be used in either classroom or playground settings. It also contains a long-term maintenance component that spans school years and follows the child. The RECESS program is implemented initially in free play recess periods and in the second phase, is extended to the classroom settings in which the target child has difficulty following the teacher or school imposed rules. When the RECESS program was evaluated, it was found to be very effective for the majority of young, aggressive children.

Functional curriculum and a vocational training program: Some professionals recommend combining a functional curriculum with a strong vocational training program. A functional curriculum prepares students for productive post school activities (e.g., how to complete a job application). Appropriate vocational placements in the community can motivate

students to engage in positive activities (Thorton and Zigmond, 1988). Shore, Massimo, and Mack (1965) found that a vocationally oriented intervention program had a positive effect on the psychological status of delinquent boys. When planning a vocational training intervention strategy, Bullis and Walker (in press) recommend that: (1) the program begin in high school; (2) students be closely involved in the planning and execution of the program to ensure that they are placed in jobs in which they are interested; (3) the program include a functional curriculum as well as job placements in competitive jobs; and (4) there must be follow-up on the students after they leave the program to ascertain the general needs of the group in the community and to make any necessary program changes.

Alternative programs or alternative schools appear to be one of the more popular strategies for meeting the diverse educational needs of students with conduct disorders. Such programs or schools provide structured environments in which students can receive instruction in both academic subjects and social skills.

For example, Cheney and Sampson (1990) report on the programs and options for students identified as conduct disordered throughout Nevada. The options range from having a child study team or pre-referral intervention team to help classroom teachers plan, implement, and evaluate interventions and alternatives for children not meeting with success in the regular classroom to placement in an alternative school. One program offered to students in grades 4 through 6 teaches fundamental behavioral and social skills as well as academic and self-monitoring skills. Parent participation is required and the goal is to mainstream the students into regular classrooms, eventually returning them to their home schools (Cheney & Sampson, 1990).

The Washoe Alternative Middle School in Nevada is available to students with conduct disorders in grades seven and eight. This is a "last chance" program, and failure in the program will result in exclusion from school. Two full-time teachers and two aides teach all basic subjects to the students in a self-contained classroom setting. Weekly group sessions are held with a school counselor to work on social and interpersonal issues. Students can earn performance points through academic progress and appropriate behavior. The goal is for students to return to their home school when the specific behaviors stated in a return contract are displayed. The contract is developed in collaboration with the school's administration (Cheney & Sampson, 1990).

Diversion programs are often a part of the juvenile justice system network. Diversion programs are designed to prevent children and families from entering the juvenile court process. These community-based programs serve as a mechanism to broker appropriate services for children and youth with behavior problems.

Eliminating The "Boundary Lines"

Never before has so much attention been paid to providing all students with an opportunity to learn and to improving educational outcomes. In the Report of the National

Association of State Boards of Education (NASBE) Study Group on Special Education, Winners All: A Call for Inclusive Schools (1992), school boards are challenged to create an inclusive system of education based upon the needs of the whole student. This report quotes the NASBE Study Group's interim report by saying:

> [There is a] need for education that encompasses the many facets of the "whole" child. That is, in order for a child to develop as an academic learner, his or her schooling must encompass a holistic view that is attuned to the student's non-academic needs. Incorporated within this model is the underlying philosophy that education should be germane and relevant for each student, encompassing at the least three spheres of development: (1) the academic...; (2) the social and emotional...; and (3) personal and collective responsibility and citizenship...(page 12).

As schools discuss restructuring efforts and inclusion efforts, if students on the boundary, including students with conduct disorders, are truly included in the plans and strategies, then one would no longer need to debate the appropriateness of providing services to these at risk students, or, whose responsibility it is to provide the needed services. Schools would just do what was necessary to ensure that the unique educational needs of all students were being addressed.

Determining what students should know and be able to do upon completion of school is another topic often mentioned in school reform and restructuring discussions. Efforts are underway to identify content standards in a number of academic subjects (e.g., science, English, history). Whether or not these standards will be inclusive of all the learners in our schools is not yet known. However, the work of the National Center on Educational Outcomes (NCEO) has great potential for impacting positively on students on the boundary, and, in particular, students with conduct disorders.

The NCEO has undertaken the task of identifying a conceptual model of educational outcomes that applies to all students, including students with disabilities. Educators, administrators, policymakers, and parents have participated in discussions to come to consensus on and identify key indicators of important educational outcomes for all students. The conceptual model identifies eight key "outcome domains": Presence and Participation, Accommodation and Adaption, Physical Health, Responsibility and Independence, Contribution and Citizenship, Academic and Functional Literacy, Personal and Social Adjustment, and Satisfaction (NCEO, 1993). Simply providing students with conduct disorders with opportunities to meet these outcome domains would greatly improve the services many of these students currently receive.

The literature provides a number of suggestions for how students with conduct disorders can be better served by our nation's schools. Such improvement would require policy changes that will put in place the services necessary to improve educational outcomes for the target population. Some of these suggested changes are presented below.

- *Revise the current federal definition of seriously emotionally disturbed:*

The arguments for changing the Federal definition of seriously emotionally disturbed (SED) are numerous (Forness, 1992; Forness & Knitzer, 1992; Nelson et al., 1991; Center, 1990; Cline, 1990; CCBD, 1990) and some of them have been discussed in this paper. Because of the ongoing debate within the field concerning the Federal definition, the National Mental Health and Special Education Coalition, comprised of over 20 parent, mental health, and special education associations, has developed and proposed a new terminology and definition for SED. The Coalition proposes to change the term to "emotional or behavioral disorder." The definition proposed by the Coalition focuses on the behavioral or emotional responses of the student.

Another area of concern regarding the current definition centers on "social maladjustment." Although the IDEA requires that there be a differentiation made between students with emotional disturbance and students who are socially maladjusted (students who may be served vs. students who may not be served), there is no guidance in the law or in the accompanying Federal regulations as to what social maladjustment is or how to differentiate between SED and social maladjustment (Weinberg, 1990; Weinberg & Weinberg, 1990; Cline, 1990). And, as Cline (1990) noted, when the definition was originally passed, only adjudicated youth were meant to be excluded from receiving services, since they would presumably be receiving schooling and related services in the juvenile justice system.

Given the high percentage of students with conduct disorders who do receive services under IDEA, the research supporting the discrepancies within the definition, as well as the research supporting the co-morbidity of conduct disorders with other disabilities, it would seem that the Federal definition is in need of revision.

- *Ensure compliance with IDEA and Section 504:*

As noted earlier, there is evidence that a portion of students with conduct disorders are being served under the auspices of IDEA. However, it has also been determined that the services being provided are inconsistent. Furthermore, given the strong arguments for how conduct disorders can negatively impact on a student's ability to learn, there needs to be efforts made to ensure that these students are considered for possible eligibility under Section 504.

- *Ensure strong pre-referral strategies are in place:*

More and more schools are making efforts to ensure that effective pre-referral strategies are in place, and most address conduct or associated learning and behavioral disorders in systematic fashion (Chalfant & Pysh, 1989; Phillips and McCullough, 1990). Pre-referral strategies are efforts specifically focused at ameliorating either academic or behavioral problems exhibited by children before referring them to special education. Typically when using pre-referral strategies, school-based interventions are conducted either by an individual professional

or by a team of professionals, such as regular class teachers, special education personnel, school psychologists, or school counselors. These professionals handle referrals from either teachers or parents at the earliest signs of learning difficulty. They work with the child's classroom teacher to design and implement strategies in the regular classroom. Such interventions may include curriculum adaptations, behavior management, or modified teaching methods. Parents may also become involved in behavior modification strategies or parent training. It is common during this process for referrals to agencies or professionals outside of the school seeking collaborative work to also be pursued (Forness, Kavale, & Lopez, 1993). Other examples of pre-referral strategies are: providing teachers with additional training to enhance their understanding of and ability to work with children with behavioral or emotional problems; using trained observers in the classroom to help determine whether or not a referral is necessary; creating specialized classrooms or classes to better address the needs of students with behavior problems; or assigning someone with expertise in behavior management to the school-based support team to work with the classroom teacher to develop and implement specific interventions (Knitzer, Steinberg, and Fleisch, 1990).

- *Provide for early identification and intervention:*

Research has indicated that conduct disorders and the accompanying antisocial behavior follow a developmental progression and will get more severe without treatment (Bullis & Walker, in press; Patterson, Reid, & Dishion, 1992; Loeber, 1982; Walker, Shinn, O'Neill & Ramsey, 1987). Conduct disorders may progress very directly from parental failure to monitor behavior in early childhood to academic failure to poor peer relations and/or rejection by peers in the early school years, eventually leading to affiliation with other youth with antisocial behavior in the later school years (Patterson, DeBaryshe, & Ramsey, 1989). As a result of this progression, early identification and intervention is crucial.

There are a number of instruments that can be used to identify and diagnose behavioral or emotional disorders in the early years and school systems should be encouraged to use them. For example, the Systematic Screening for Behavioral Disorders (SSBD; Walker et al., 1988: Walker & Severson, 1990) is a program designed specifically for school-wide screening. The SSBD is a multi-stage system used by the teacher to identify students with specific behavioral patterns. He or she then rates only the top ranked children on brief rating scales and on a critical events index. Finally, those children meeting clinical cutoff points on these scales pass into a final confirmatory stage in which another school professional observes them in the classroom and on the playground.

Another system that uses multiple components is one designed by Achenbach and McConaughy (1987; McConaughy & Achenbach, 1989). This is a comprehensive series of diagnostic instruments which includes checklists for both parents and teachers with accompanying profiles of different disorders, self-report profiles for selected older children, and an observation of either a classroom or a group activity. This instrument has the advantage of having checklists

for very young children (e.g., age two or three), as well as providing for comparisons of home and school data sources.

There are other rating instruments available for single or multiple disorders, especially those that are often co-morbid with conduct disorders, such as attention deficit disorders or depression (Niebuhr & Smith, 1990). These instruments can be used individually or in combination to identify students with conduct disorders.

Prevention of antisocial behavior by employing early intervention strategies appears to be promising. Reid (in press) strongly argues for intervening as early as possible. He also cites evidence that positive outcomes for younger aggressive children (ages three and a half to six) were approximately two and a half times more likely than for older aggressive children (ages six and a half to twelve) (Patterson, Dishion & Chamberlain, in press). There is also evidence that children labeled as conduct disordered or at-risk in first grade responded more favorably to a coordinated home and school intervention strategy than did comparable children in fifth grade (Reid, in press).

Policymakers are beginning to recognize the need for early identification and treatment. For example, the National Institute of Mental Health, in recognition of the need for early intervention services for children with antisocial behavior, has recently established a number of Conduct Disorders Prevention Centers across the country.

In addition, if early intervention strategies are utilized, those that are found to be effective must be administered consistently and continuously (Bullis & Walker, in press). Continuation of the intervention is the only means by which the behavior can continue to be positively impacted.

- *Improve screening and evaluation procedures:*

Clear and strong assessment data must be collected and maintained at each educational level. These data should serve to guide interventions and should include detailed information about the impact of intervention efforts. Only with clear data can sound decisions be made about changes in a student's intervention program. It is also clear that a large number of other undetected psychiatric diagnoses such as schizophrenia, depression, or anxiety disorders have been found as pre-morbid or co-morbid to conduct disorders (Forness, Kavale, King, & Kasari, in press). Other non-psychiatric disorders such as prenatal substance abuse, fetal alcohol syndrome and fragile X syndrome also have conduct disorders as a major part of their symptomatology (Forness & Kavale, in press). Since conduct disorder symptoms may mask or overwhelm the presence of these other disorders, appropriate treatment or intervention may not take place. Careful screening at periodic intervals is thus necessary to insure that other disorders are not missed, since treatment of them may prove very effective in diminishing behaviors associated with conduct disorders.

• *Enhance collaboration between schools, mental health agencies and other appropriate agencies:*

Though there are a number of agencies with which youth with conduct disorders may come into contact, it is important for educators to realize that schools can play a crucial role in the provision and coordination of services. Usually the school system is the one constant through much of the student's early years and adolescence. Furthermore the school is an ideal setting for delivery of integrated services (Bullis & Walker, in press). Research has found a strong need for, as well as benefits of, a wide range of community mental health services and the importance of coordination of these services (Mattison, et al., 1992). Longitudinal data indicates that those students with SED who receive comprehensive services graduate at a higher rate and have lower arrest rates that those who do not receive such services (Dwyer, 1993).

Programs providing comprehensive interventions often include mental health, social service, health and sometimes juvenile justice system professionals and they target the child as well as the family (Wolford, Nelson, Rutherford, & Forness, 1993; Clarke, Schaefer, Burchard, & Welkowiltz, 1992; Nelson & Pearson, 1991; Rosenblatt & Attkisson, 1992).
Ideally, schools should provide comprehensive services; however, at a minimum, schools must provide access to school-based mental health services (e.g., crisis intervention, counseling) if the needs of students with conduct disorders are to be met.

• *Improve efforts to reach out to families:*

Many of the promising intervention models involve not only the student, but also the student's family. It is imperative that schools reach out to and involve the family as a partner. As a result of 30 years of research, Patterson and his colleagues have identified a family interaction profile that places children at extreme risk for the development of antisocial behavior (Patterson, 1982; Patterson & Bank, 1986; Patterson, Dishion & Bank, 1984). The strongest variable in terms of its relative contribution to the development of antisocial behavior is parent monitoring practices. That is, parents of antisocial children tend to use child monitoring practices that are infrequent, inconsistent and sometimes nonexistent. Hence, extensive efforts must be made to provide support and needed services to the families of students with conduct disorders.

The Child and Adolescent Service System Program (CASSP), a Federal children's mental health program, has as its goal serving children in their own homes and communities. They have demonstrated that intensive school and home-based services, coupled with supports to parents can prevent children with mental health and other needs from being placed out-of-district or even out-of-state (Knitzer, Steinberg, & Fleisch, 1990).

Another issue surrounding families is the need to inform families about the rights and protections afforded to their children as well as the resources that are available to them. Parents

need to be informed about the provisions of the IDEA as well as Section 504 of the Rehabilitation Act.

- *Improve training opportunities and collaboration between professionals:*

Given the need to encourage collaboration among various agencies involved in providing services to students with conduct disorders, there is also a need to do "cross training" so that the various professionals involved share a common language and a common view of the students and their families (Nelson et al., 1991). Agencies at the State level (e.g., State mental health agencies and State departments of education) could co-sponsor joint training seminars. State level agencies could also work closely with the institutions of higher education within the State to ensure that faculty (including education, mental health, juvenile justice, etc.) are aware of new policy developments and new intervention models concerning the education of students with conduct disorders (Knitzer, Steinberg, & Fleisch, 1990). If professionals at both the State and local level from all impacted disciplines begin to work with one another, then each can bring their specific professional strength to bear when providing services to students with conduct disorders.

Conclusion

As the students in our country's classrooms become more diverse and resources within the schools become more scarce, it is important that efforts are made to ensure that all students are provided adequate opportunities to learn. These efforts are underway as schools have begun to work collaboratively with other health and human resources agencies. Communities must begin to appreciate that such problems not treated early in the schools will be encountered later, and probably more expensively, in other community settings. Schools must also begin to recognize that it is more economical and effective to address any factor that inhibits a student's ability to learn—be it cognitive, physical, or behavioral—as early and as appropriately as possible by making whatever resources the school has at its disposal available to students and their families.

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