

Archived Information

Modules

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SECTION II

STUDENT CHARACTERISTICS

Children Ages Birth Through Five Served Under IDEA

The infants and toddlers program, Part H of IDEA, was adopted by Congress in 1986.¹ The 1997 reauthorization of IDEA moved the legislation to Part C of the Act. The program is designed to address the needs of infants and toddlers with disabilities ages birth through 2 through “a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention services for infants and toddlers with disabilities and their families.” (20 U.S.C. 1431(b)(1)) All States ensured full implementation of the Part C program for infants and toddlers with disabilities by September 30, 1994.

PURPOSE: To report the number of children served in both the Part C Program and the Preschool Grants Program and the settings in which these children receive services.

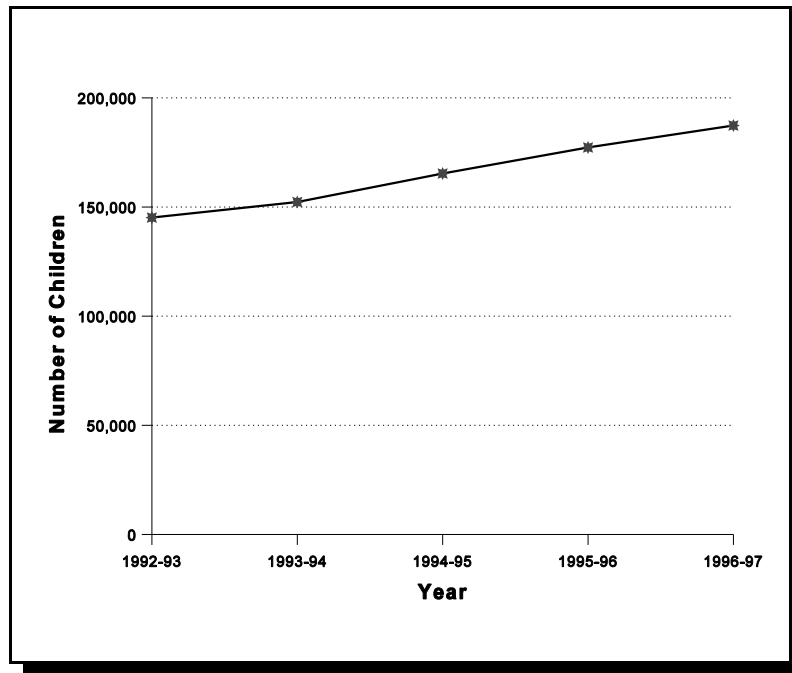
Since FY 1992, all States have been required to make a free appropriate public education (FAPE) available to all children with disabilities ages 3 through 5, in order to be eligible for an award under the Preschool Grants Program under Section 619 of IDEA and other IDEA funds targeted to children ages 3-5 with disabilities. Five States (Iowa, Maryland, Michigan, Minnesota, and Nebraska) and six jurisdictions (American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Palau, and Puerto Rico) provide FAPE from birth, and Virginia does so at age 2 (deFosset & Carlin, 1997). All other States provide FAPE beginning at age 3.

The Number of Children Served Under IDEA, Part C

Over the past 5 years, the number of infants and toddlers served under Part C has steadily increased from 145,179 on December 1, 1992, to 187,348 on December 1, 1996 (see figure II-1 and table AA14, on page A-44). This small but consistent annual increase resulted in an overall

¹ Throughout the rest of this report, the infants and toddlers program will be referred to as Part C.

Figure II-1
Number of Infants and Toddlers Served Under IDEA,
Part C, 1992 Through 1996



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

increase of 29 percent over the 5-year period, as States improved their ability to count children served while eliminating duplicate counts. During this same time period, the population estimates decreased from 11,911,554 to 11,382,432, reflecting a 4 percent decrease.

From December 1, 1995, to December 1, 1996, the total number of infants and toddlers served in the 50 States and the District of Columbia rose from 177,286 to 187,348, an overall increase of 6 percent. However, 18 States reported a decline in the numbers of infants and toddlers served, while 33 States reported an increase in their counts.

Among the States that reported a decline in the number of children served, several attributed the decrease to changes

in data collection methods. Several States have begun using improved data collection systems that will result in the reporting of unduplicated counts.

Among the States that reported an increase in the number of children served, several cited program expansion as a primary reason for the increase. In part, agencies are now providing individualized family service plans (IFSPs) to children previously served under other State programs. Other States noted that increases were related to improved public awareness efforts. These public awareness efforts probably helped the agencies find more eligible children.

The percentage of the population ages birth through 2 served under Part C rose slightly from 1.54 percent in 1995 to 1.65 percent in 1996 (see tables AA14, p. A-44, and AF2, p. A-222). During this same period, the total population of children in that age group decreased 1.6 percent, from 11,570,316 to 11,382,432. In 1996, the majority of States (33) served 1 to 2 percent of their birth to 2 population under IDEA; 6 States served less than 1 percent; 9 States served 2 to 3 percent; and 3 States served more than 3 percent (see table AH1, p. A-228). Looking at the 5-year trend, the percentage of the population served under Part C increased from 1.21 percent in 1992 to 1.65 percent in 1996 (see tables AA14, p. A-44, and AF2, p. A-222).

Early Intervention Environments for Infants and Toddlers with Disabilities

OSEP currently uses eight different settings to collect data on where infants and toddlers with disabilities receive services. These settings are early intervention classroom, family child care, home, hospital (inpatient), outpatient service facility, regular nursery school/child care, residential facility, and other. However, not every State reports or uses each category. States' use of the reporting categories for where infants and toddlers were served varies, as shown in table AH4 in Appendix A. OSEP collects data only on the primary setting (that is, the setting where the majority of services are provided to a child); many infants and toddlers receive services in multiple settings. Some

States report zero (0) for a number of services, indicating that the category is valid in the State, but that no infants and toddlers were served there. States also use a period (.) to report missing data, indicating that the State does not use that placement category. During 1995-96, home was the category with the most valid responses. Only three Outlying Areas did not use this setting to provide services. Residential facilities were not a recognized setting for infants and toddlers in 12 States; an additional 16 States reported no services provided in this setting.

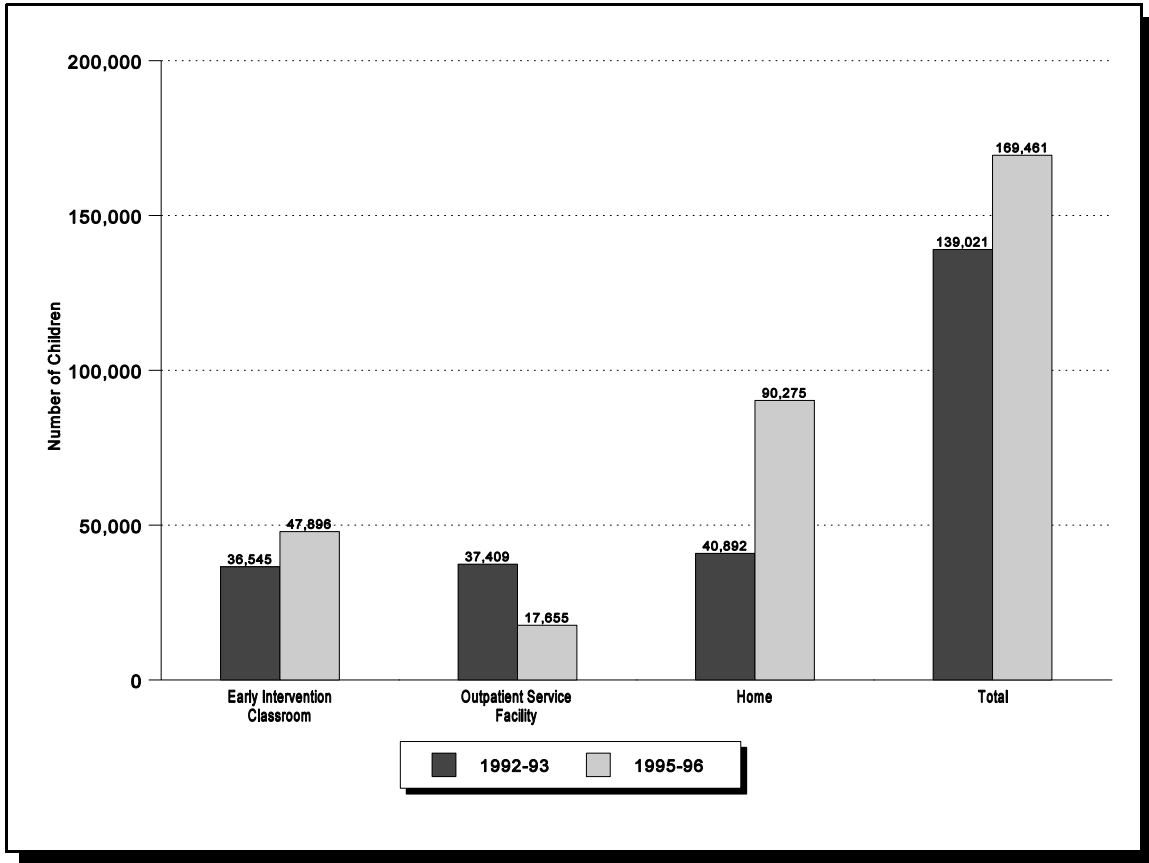
States' use of these categories also reflects the unique service delivery pattern for Part C. For example, Massachusetts served all children in the home setting, while Puerto Rico reported serving all children in outpatient service facilities. California reported an equal number of children in two settings, early intervention classroom and home.

Consistent with the findings above, it is not surprising that the largest number of infants and toddlers were served in the home (90,275 or 53 percent), followed by early intervention classroom (47,896 or 28 percent), and outpatient service facility (17,655 or 10 percent). The remaining settings totaled 13,940 or approximately 8 percent of the total population served. Comparing the placement data from 1992 to 1995, home has been the most frequently used setting. In 1992, home was followed by the outpatient service facility setting and then early intervention classroom setting. However, the percentage of children served at home has increased by 120 percent from 1992 to 1995, and the percentage served in early intervention classrooms rose 31 percent during the same period. The percentage of children served in outpatient service facilities has decreased by 52 percent (see figure II-2).

The Number of Children Served Under the Preschool Grants Program

The Preschool Grants Program, authorized under Section 619 of IDEA, Part B, was established to provide grants to States to serve preschool children with disabilities.

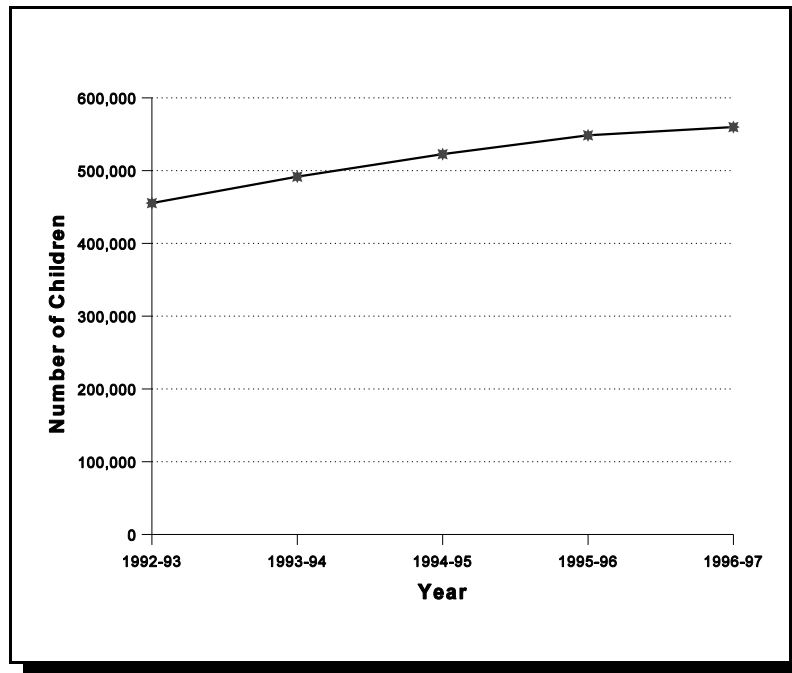
**Figure II-2
Number of Infants and Toddlers Served in Different Settings, 1992-93 and
1995-96**



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Over the past 5 years, the number of children served under the IDEA Preschool Grants Program increased from 455,449 during the 1992-93 school year to 559,902 during the 1996-97 school year. The steady increase that occurred during this 5-year period resulted in a total increase of 23 percent. During the 1996-97 school year, there was a modest increase of 2 percent over the 548,441 children served the previous year (see figure II-3).

Figure II-3
Number of Children Ages 3-5 Served Under the Pre-school Grants Program, 1992-93 - 1996-97



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Based on the estimated resident population of children ages 3 through 5 in the 50 States and the District of Columbia, 4.6 percent of the children in this age group were served under the IDEA Preschool Grants Program. The District of Columbia served the lowest percentage of its resident population (1.5 percent), and Hawaii the second lowest (2.5 percent). Kentucky served the highest percentage (9.5 percent). The remaining States served between 3.2 percent and 7.9 percent (see table AA10, p. A-33).

Educational Environments for Preschoolers with Disabilities

Six different categories and two subcategories (private and public) are used to collect data on preschoolers with disabilities who are served under IDEA. They are regular class, resource room, separate class, separate school (public and private), residential facility (public and private), and homebound/hospital. These categories were developed with school-aged children in mind and, consequently, may not reflect educational environments for preschoolers. Therefore, OSEP provides optional instructions to States for reporting counts of preschoolers in each of the categories. Table II-1 includes a definition of each category as it applies to preschoolers with disabilities.

During the 1995-96 school year, 51.6 percent of children with disabilities ages 3-5 were served in regular classes, approximately a 1 percent increase over the percentage served in regular classes during the previous year. Comparing the data from the 1992-93 school year to the 1995-96 school year, the percentage of children served in regular class, separate class, and home/hospital environments increased, while the percentage of children served in the remaining settings decreased (see figure II-4).

**Table II-1
Educational Environments for Preschoolers with Disabilities**

Regular class includes children who receive services in programs designed primarily for nondisabled children, provided the children with disabilities are in a separate room for less than 21 percent of the time receiving services. This may include, but is not limited to, Head Start centers, public or private preschool and child care facilities, preschool classes offered to an age-eligible population by the public school system, kindergarten classes, and classes using co-teaching models (special education and general education staff coordinating activities in a general education setting).

Resource room includes children who receive services in programs designed primarily for nondisabled children, provided the children with disabilities are in a separate program for 21 to 60 percent of the time receiving services. This includes, but is not limited to, Head Start centers, public or private preschools or child care facilities, preschool classes offered to an age-eligible population by the public school system, and kindergarten classes.

Separate class includes children who receive services in a separate program for 61 to 100 percent of the time receiving services. It does not include children who received education programs in public or private separate day or residential facilities.

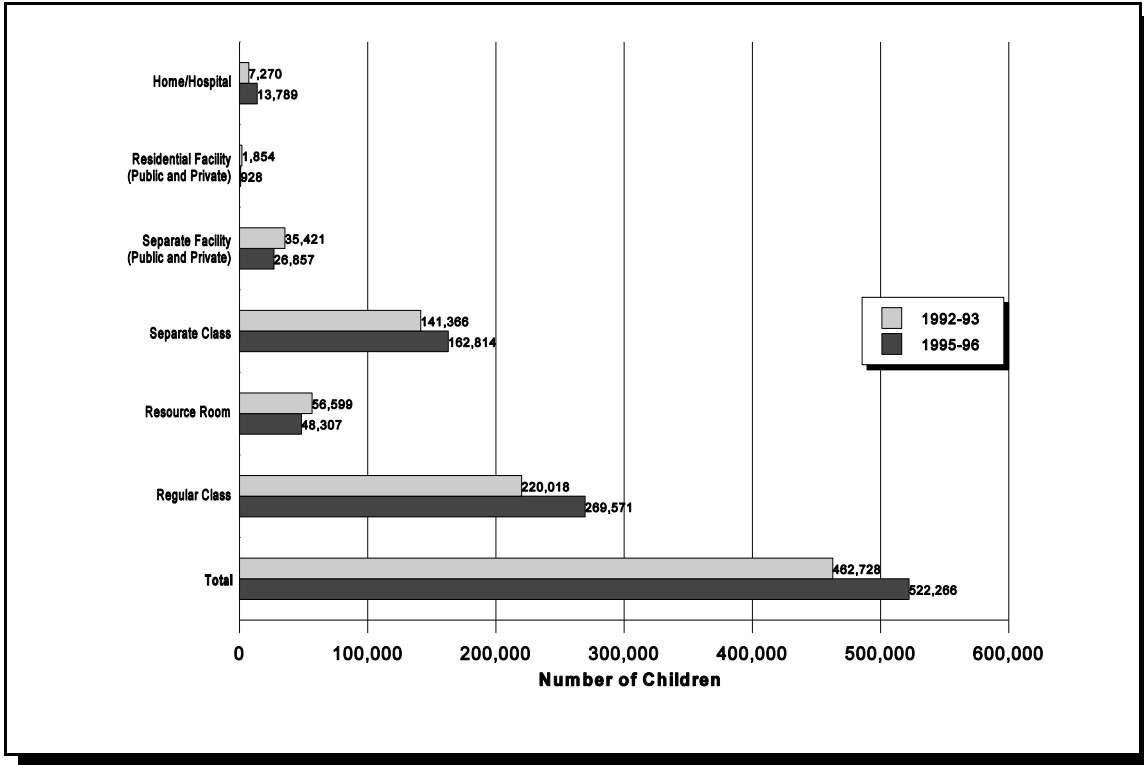
Separate school (public and private) includes children who are served in publicly or privately operated programs, set up primarily to serve children with disabilities, that are NOT housed in a facility with programs for children without disabilities. Children must receive special education and related services in the public separate day school for greater than 50 percent of the time.

Residential facility (public and private) includes children who are served in publicly or privately operated programs in which children receive care for 24 hours a day. This could include placement in public nursing care facilities or public or private residential schools.

Homebound/hospital includes children who are served in either a home or hospital setting, including those receiving special education or related services in the home and provided by a professional or paraprofessional who visits the home on a regular basis (e.g., a child development worker or speech services provided in the child's home). It also includes children 3-5 years old receiving special education and related services in a hospital setting on an inpatient or outpatient basis. However, children receiving services in a group program that is housed at a hospital should be reported in the separate school category. For children served in both a home/hospital setting and in a school/community setting, report the child in the placement that comprises the larger percentage of time receiving services.

Source: OSEP Data Dictionary, 1997, Office of Special Education Programs, U.S. Department of Education.

**Figure II-4
Number of Children Ages 3-5 Served in Different Educational Environments,
1992-93 and 1995-96**



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Summary

In both Part C and the Preschool Grants Program, the number of children served increased steadily over the past 5 years. Also, over this same period, there was an increase in the use of the home setting and in the use of early intervention classrooms for infants and toddlers. In the Preschool Grants Program, more preschoolers are being served in regular class settings than in any other setting. The number of children being served in the resource room category has declined.

References

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Students Ages 6 Through 21 Served Under IDEA

Children with disabilities ages 6 through 21 have been receiving services through Part B of IDEA for more than 20 years. This module discusses the changes in the total number of children served, the age distribution of students served, the disability distribution of students served, and the disabilities distribution across age groups. The information is based on State-reported data required under Section 618(b) of IDEA. Through this requirement, States report data annually to OSEP on the number of children served under Part B of the law.

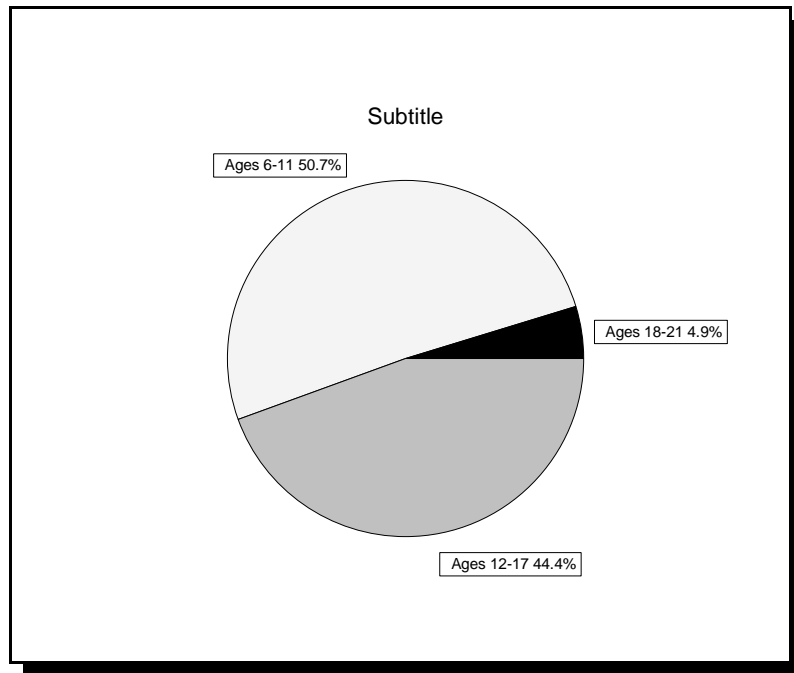
PURPOSE: To describe students served under IDEA during the 1996-97 school year and compare data on the number of students served over the past 10 years.

Changes in Numbers of Students Served

Over the past few years, the number of school-age students (i.e., ages 6 through 21 years old) with disabilities served has increased at a higher rate than the general school enrollment. During the 1996-97 school year, 5,235,952 students ages 6 through 21 with disabilities were served under IDEA, a 3.1 percent increase over the previous year. The prekindergarten through 12th grade total school-age enrollment figures¹ showed an increase of 1.2 percent between 1995-96 and 1996-97 (see table AF6, p. A-226). The resident population showed an increase of 1.7 percent. The increase in the number of school-age children served under IDEA over the previous year was slightly more than the increase in the number of preschool students ages 3 through 5 served (2.1 percent) and slightly less than the increase in the number of infants and toddlers served (5.7 percent) (see table AA14, pp. A-43 to A-45).

¹ The enrollment counts are fall membership counts collected by the National Center for Education Statistics. The enrollment figures include children in prekindergarten through 12th grade.

Figure II-5
Percentage of Students with Disabilities Served Under IDEA, Part B by Age Group in 1996-97



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Age Distribution of Students Served

The number of school-age students served under IDEA has consistently increased since the inception of P.L. 94-142 in 1975. Dividing students served into three age groups, the number of students with disabilities ages 6-11 served increased 25.3 percent, the number of students with disabilities ages 12-17 increased 30.7 percent, and the number of students with disabilities ages 18-21 increased 14.7 percent over the past 10 years.

The relative percentages in each of these age groups has remained stable over the past 10 years. Figure II-5 shows the age composition of students with disabilities in 1996-97. These percentages differ slightly from the average over

the 10 years, which was 51.8 percent for children ages 6-11, 43 percent for those ages 12-17, and 5.2 percent of students ages 18-21 served under IDEA (see table AA14, pp. A-43 to A-45).

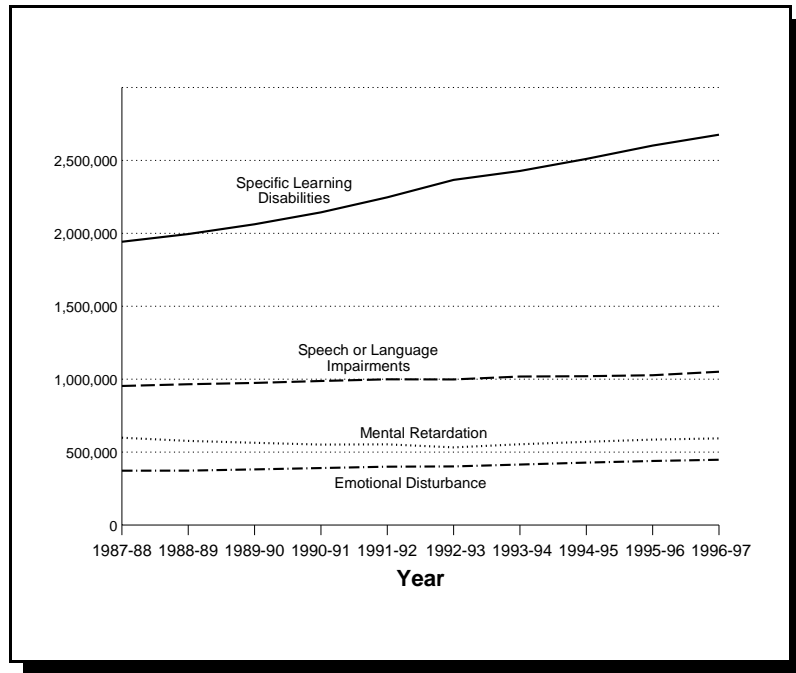
Disabilities Distribution of Students Served

Under IDEA, there are 12 disability categories--specific learning disabilities, speech or language impairments, mental retardation, emotional disturbance, multiple disabilities, hearing impairments, orthopedic impairments, other health impairments, visual impairments, autism, deaf-blindness, and traumatic brain injury--by which to report students served. However, more than 90 percent of the school-age students served under IDEA in 1996-97 were classified in one of four disability categories:

- learning disabilities (51.1 percent or 2,676,299 children);
- speech or language impairments (20.1 percent or 1,050,975 children);
- mental retardation (11.4 percent or 594,025 children); and
- emotional disturbance (8.6 percent or 447,426 children).

Figure II-6 shows the change in the number of students served under IDEA for each of these four disabilities from 1987-88 to 1996-97. The rate of increase for students with learning disabilities was greater than for students with other high-incidence disabilities. The number of students with learning disabilities has increased by 37.8 percent over the past 10 years, as compared with an increase of 10.2 percent for students with speech or language impairments and 20.1 percent for students with emotional disturbance. The number of students with mental retardation decreased by 0.8 percent between 1987-88 and 1996-97. (See also table AA14, p. AA-43 to AA-45.)

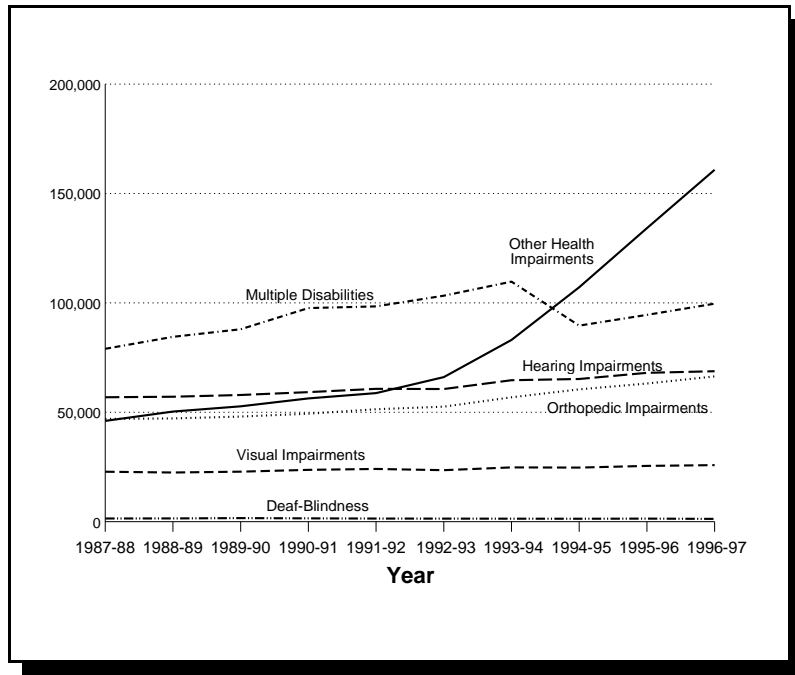
Figure II-6
Number of Children Ages 6-21 Served Under IDEA,
Part B From 1987-88 to 1996-97: High-Incidence
Disabilities



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Figure II-7 shows the number of children served for six of the low-incidence disability categories. Between 1987-88 and 1992-93, the average annual increase for students with other health impairments was 7.5 percent. Between 1992-93 and 1996-97, the average rate more than tripled to 25.0 percent (see table AA14, p. A-45). This is in contrast to the more gradual increases in numbers of students served under IDEA in other disability categories. Table II-2 shows the number of students ages 6-21 served under IDEA in all 12 disability categories in 1987-88 and 1996-97 (see table AA14, p. A-45).

Figure II-7
Number of Children Ages 6-21 Served Under IDEA,
Part B From 1987-88 to 1996-97: Low-Incidence
Disabilities



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

States' most common explanation for the increase in the number of children served under the other health impairments category was increased identification of and service to children with attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD). Other large increases occurred in the newest disability categories of autism and traumatic brain injury.² However, the disability categories of autism and traumatic brain injury accounted for less than 1 percent of the students served in 1996-97. Explanations for increases in these categories

² These disability categories were first reported separately as an option in 1991-92 and as a requirement in 1992-93 as a result of P.L. 101-476, the 1990 Amendments to IDEA.

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**Table II-2
Number of Children Ages 6-21 Served Under IDEA by Disability: 1987-88 and 1996-97**

Disability	1987-88		1996-97		Change	
	Number	Percent	Number	Percent	Number	Percent
Specific Learning Disabilities	1,942,304	47.1	2,676,299	51.1	733,995	37.8
Speech or Language Impairments	953,568	23.1	1,050,975	20.1	97,407	10.2
Mental Retardation	598,770	14.5	594,025	11.4	-4,745	-0.8
Emotional Disturbance	372,380	9.0	447,426	8.6	75,046	20.2
Multiple Disabilities	79,023	1.9	99,638	1.9	20,615	26.1
Hearing Impairments	56,872	1.4	68,766	1.3	11,894	20.9
Orthopedic Impairments	46,966	1.1	66,400	1.3	19,434	41.4
Other Health Impairments	46,056	1.1	160,824	3.1	114,768	249.2
Visual Impairments	22,821	0.6	25,834	0.5	3,013	13.2
Autism	. ^a	.	34,101	0.7	34,101	.
Deaf-Blindness	1,454	<0.1	1,286	<0.1	(168)	-11.6
Traumatic Brain Injury	.	.	10,378	0.2	10,378	.
All Disabilities	4,120,214	100.0	5,235,952	100.0	1,115,738	27.1

^{a/} Reporting on autism and traumatic brain injury was required under IDEA beginning in 1992-93.

Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

generally include improvements in reporting and reassignment to the new disability categories during the reevaluation process. An increase in the category of other health impairments, however, has occurred simultaneously with the separate reporting of students with autism and traumatic brain injury, many of whom may have previously been counted under the other health impairments category.

The increase in the number of students with other health impairments since 1992-93 may in part be a response to a 1991 Department of Education, Office of Special Education and Rehabilitative Services (OSERS) memorandum that explained that students with ADD (and inclusively, ADHD) should be included in the other health impairments category when ADD is a chronic or acute health problem resulting in limited alertness that adversely affects educational performance.³ Consequently, the growth in the other health impairments category may be a combined result of increased identification of students with ADD and the reporting of children with ADD in the other health impairments category. Prior to this time, students with ADD may have been reported in other disability categories.

The distribution of students by disability varies across age groups. Specific learning disabilities is the largest single category for each of the three age groups, accounting for 41.2 percent of students ages 6-11, 62.3 percent of students ages 12-17, and 51.7 percent of students ages 18-21. The percentage of students with speech or language impairments decreases dramatically among older children; 35.1 percent of the students ages 6-11 were identified as having speech or language impairments, while only 5.0 percent of students in the 12-17 age group and 1.8 percent of the students in the 18-21 age group with this disability were served. Conversely, the incidence of mental retardation is more prevalent among older children. This may be in part because students with mental retardation tend to stay in school longer than students with other disabilities. Nearly one-fourth (24.4 percent) of the students ages 18-21

³ OSERS. (1991). *Clarification of policy to address the needs of children with attention deficit disorders with general and/or special education*. Memorandum to Chief State School Officers. Washington, DC: U.S. Department of Education, OSERS.

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were classified as having mental retardation. This percentage drops to 12.6 percent for students ages 12-17, and drops again to 9.0 percent for students 6-11. Emotional disturbance is most common among teenagers; 5.7 percent of students ages 6-11 were identified with emotional disturbance compared with 11.7 percent of the 12-17 age group and 9.7 percent of the 18-21 age group.

Summary

Services to students with disabilities have continued to grow. Among the reasons for this growth are increases in the population and improvements in the identification of students with special needs. The year-to-year increase in the number of school-age children receiving services has been gradual, and increases have occurred at various rates across the disability categories. The largest percentage increases occurred in other health impairments, orthopedic impairments, and specific learning disabilities. There was a reported decline in two disability categories, mental retardation and deaf-blindness.

The Racial/Ethnic Composition of Students with Disabilities

PURPOSE: To present data on the number of minority students with disabilities receiving services and the disabilities of these students.

In the recent reauthorization of IDEA (P.L. 105-17), Congress expressed concern about the disproportionate representation of racial and ethnic minorities in special education and poor educational results for minority students. Congress encouraged the Federal Government to be responsive to the growing needs of an increasingly diverse society, to ensure a more equitable allocation of resources, and to provide an equal educational opportunity for all individuals. In reauthorizing IDEA, Congress found that between 1980 and 1990, the rate of increase in the number of White Americans was 6 percent, while the rates of increase for racial and ethnic minorities were much higher: 53 percent for Hispanics, 13.2 percent for African Americans, and 107.8 percent for Asians. By the year 2000, nearly one of every three Americans will be African American, Hispanic, Asian American, or American Indian. As a group, minority children are comprising an increasing percentage of public school students. (§601(c)(7)(B), (C), and (D))

Congress wrote in the IDEA Amendments of 1997 that “greater efforts are needed to prevent the intensification of problems connected with mislabeling . . . among minority children with disabilities.” (§601(c)(8)(A)) More African American children are served in special education than would be expected given the percentage of African American students in the general school population. IDEA also notes, “although African Americans represent 16 percent of elementary and secondary enrollments, they constitute 21 percent of total enrollments in special education.” (§601(c)(8)(D)) “Poor African American children are 2.3 times more likely to be identified by their teacher as having mental retardation than their White counterpart.” (§601(c)(8)(C)) In addition to being identified with specific disabilities at different rates than White, non-Hispanic students, minority students are also more likely than White students to be served in less inclusive settings (Singh, Ellis, Oswald, Wechsler, & Curtis, 1997).

Congress also noted in IDEA that minority youth with disabilities are more likely to drop out of high school: “The drop out rate is 68 percent higher for minorities than for Whites. More than 50 percent of minority special education students in large cities drop out of school” (20 U.S.C. 1401(c)(8)(f)). Dropout rates for Hispanic youth with disabilities are particularly high: 36.9 percent compared to 31.2 percent for Whites and 30.4 percent for African Americans (Valdes, Williamson, & Wagner, 1990).

In response to these concerns, Congress required States to submit special education child count, educational environment, exiting, and discipline data by race and ethnicity starting in the 1998-99 school year. The race/ethnicity data required under the IDEA Amendments of 1997 will better enable Congress and OSEP to monitor the disproportionate representation of racial and ethnic minorities in special education and dropout rates for minority youth.

Under IDEA, local educational agencies are required to use racially and culturally nondiscriminatory tests and other evaluation materials for identifying students as eligible for special education. Tests must be administered in the child’s native language or other mode of communication, unless it is not feasible to do so. Each State is also required to collect and examine data to determine if race is the basis of significant disproportionality in the identification of students with disabilities or the placement of children with disabilities in particular educational settings. If the State determines that significant disproportionality exists, it must provide for the review and, if appropriate, revision of policies, procedures, and practices used to identify or place students to ensure that they meet the requirements of IDEA.

Race/Ethnicity in Special Education

The disproportionate representation of racial and ethnic minorities in special education is a highly complex issue because it is difficult to isolate the effects of poverty,

limited English proficiency, residence in inner cities, and race/ethnicity on special education eligibility.^{1,2}

For many years, OCR has collected data from a sample of school districts and schools within these districts on the race/ethnicity of students with selected disabilities--mild, moderate, and severe mental retardation; specific learning disabilities; and emotional disturbance. This module presents data for students with those disabilities from the 1994 OCR Elementary and Secondary School Compliance Reports on race/ethnicity.

Discrepancies in disability prevalence and service provision across racial/ethnic categories are most apparent in the mental retardation category. A total of 2.6 percent of Black, non-Hispanic students were identified as having mental retardation. In contrast, 1.2 percent of White, non-Hispanic students were identified as having mental retardation. Hispanic students were less likely than White, non-Hispanic students to receive special education to address mental retardation.

White, non-Hispanic students; Black, non-Hispanic students; and Hispanic students were equally likely to receive services to address specific learning disabilities. American Indian students were considerably more likely to receive such services, and Asian/Pacific Islanders were less likely to do so (see table II-3).

Overall, 0.8 percent of the student population received services for emotional disturbance. The rate was slightly higher for Black, non-Hispanic students than for White, non-Hispanic students and was considerably lower for Hispanic students and Asian/Pacific Islander students.

It is often difficult to distinguish between the effects of poverty and the effects of race on special education eligibility because, in the United States, poverty and race are

¹ See the *19th Annual Report to Congress* for modules on poverty and disproportionate representation of racial/ethnic minorities in special education.

² OSEP intends to include a module on limited English proficiency in a future report.

SECTION II. STUDENT CHARACTERISTICS**Table II-3
Number and Percentage of Students in Special Education by Race/Ethnicity and Disability: 1994**

	White, non-Hispanic	Black, non-Hispanic	Hispanic	American Indian	Asian/Pacific Islander	Total
Learning Disabilities	5.7% 1,587,918	5.7% 407,848	5.7% 308,136	7.3% 32,413	2.0% 31,968	5.5% 2,368,283
Mental Retardation	1.2% 350,699	2.6% 190,885	0.9% 50,091	1.6% 7,152	0.5% 8,197	1.4% 607,024
Emotional Disturbance	0.8% 214,442	1.1% 80,253	0.5% 25,514	0.9% 4,227	0.2% 2,786	0.8% 327,222
Total Student Population by Race/Ethnicity	28,039,068	7,193,038	5,425,976	445,105	1,588,124	42,691,311

Source: U.S. Department of Education, Office for Civil Rights, 1994 Elementary and Secondary School Compliance Reports.

correlated. Poor children are more likely than wealthier children to receive special education (Wagner, 1995). African American children are more likely than White or Asian children to receive special education under some disability categories. While both poverty and racial/ethnic background may contribute to minority representation in special education, data from the National Longitudinal Transition Study suggest that race/ethnicity was not the primary contributor to the overrepresentation of African Americans in special education. Rather, the overrepresentation of African Americans was driven by the overrepresentation of very poor students in special education, at least for most disability categories (Wagner, 1995). This suggests that while some of the disproportion may be addressed through improvements in unbiased and more discriminate assessment, attention must also focus on the broader issue of child poverty.

Summary

The disproportionate representation of racial and ethnic minorities in special education has been an issue for educators for more than 25 years, yet African American students continue to be overrepresented in programs for students with mental retardation. Furthermore, relative to White, non-Hispanic students, Asian students are underrepresented in all four of the disability categories for which the OCR collects data. It has been postulated that poverty, rather than race/ethnicity, may account for some of the overrepresentation of minorities in special education programs. Therefore, without attention to poverty and its effects on children, the use of unbiased assessment alone will not eradicate the disproportionate representation described.

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Gender as a Factor in Special Education Eligibility, Services, and Results

PURPOSE: To discuss differences in the characteristics of male and female students with disabilities, special education services provided to males and females with disabilities, and postschool results by gender.

Although males and females comprise equal proportions of the school-aged population, males account for approximately two-thirds of all students served in special education (Doren, Bullis, & Benz, 1996; Wagner et al., 1991). In many cases, it is not clear if females are underidentified for special education, if males are overidentified, or if real differences exist in the prevalence of disability between males and females.

Much of the research on disability has stressed commonalities among individuals with disabilities rather than addressed differences based on gender (Fine & Asch, 1988). Consequently, little is known about the different characteristics and experiences of males and females with disabilities.

Special Education Eligibility

More than two-thirds of all students receiving special education services are male (Doren et al., 1996; Wagner et al., 1991). Among secondary-aged students with disabilities, males constitute the largest proportion of each disability category except deaf-blindness, which is almost evenly divided between males and females (see table II-4). The disproportionate representation of males in special education seems greatest in the learning disability and emotional disturbance categories, which are often considered the disability categories with the most broadly defined eligibility criteria (Kratovil & Bailey, 1986).

Tables II-4 and II-5 show the percentage of males and females in different disability categories. Table II-5 includes elementary and secondary school students in three disability categories; table II-4 reports data in 11 disability categories for secondary-aged students only.

**Table II-4
Gender of Secondary-Aged Students with Disabilities,
by Disability Category**

Disability	Percentage Male	Percentage Female
Learning Disability	73.4	26.6
Emotional Disturbance	76.4	23.6
Speech Impairment	59.5	40.5
Mental Retardation	58.0	42.0
Visual Impairment	55.6	44.4
Hearing Impairment	52.0	48.0
Deafness	54.5	45.5
Orthopedic Impairment	54.2	45.8
Other Health Impairment	56.0	44.0
Multiple Disabilities	65.4	34.6
Deaf/Blindness	49.5	50.5

Source: Valdes et al. (1990). *The National Longitudinal Transition Study of Special Education Students: Statistical almanac* (Vol. 1). Menlo Park, CA: SRI International.

Not only are females less likely than males to be identified for special education, but the characteristics of identified females differ from those of identified males (Richardson et al., as cited in Gottlieb, 1987). For example, girls in special education score lower on IQ tests than boys. The average IQ for secondary-aged females with disabilities was 74.4; the average for males was 81.6 (Gottlieb, 1987; Wagner et al., 1991). According to parent reports, a greater percentage of secondary-aged females in special education began having difficulties indicative of a disability at very young ages, which may also suggest more severe disabilities (Valdes, Williamson, & Wagner, 1990). Because learning

**Table II-5
Gender of Elementary and Secondary-Aged Students
with Disabilities, by Disability Category^a**

	Male	Female
Specific Learning Disability	69.3	30.8
Mental Retardation	59.0	41.6
Emotional Disturbance	79.4	21.0

^{a/} Percentages may not sum to 100 due to rounding or reporting errors.

Source: U.S. Department of Education, Office for Civil Rights, 1994 Elementary and Secondary School Compliance Reports.

disabilities and emotional impairments are not typically associated with below-average intelligence, the over-representation of males in these categories may skew the mean IQ of males in special education.

Possible Causes of Disproportionate Representation

Researchers and advocates offer several hypotheses for the fact that more males than females participate in special education. It is likely that no single explanation accounts for all of the disproportion but that combinations of factors result in the distribution previously described. First, physiological or maturational differences between males and females may cause higher rates of disability among school-age males. Second, differences in the behavior of male and female students may predispose males to the identification of a disability. For example, female students may adapt better to the predominant school culture and norms. Teachers may also react differently to male and female students, which can result in higher rates of referral and classification for male students. Third, methods used to identify students with learning disabilities, emotional

disturbances, and speech and language impairments may be biased and, as such, may contribute to the disproportionate representation of males and females in special education (Harmon, Stockton, & Contrucci, 1992).

Physiological/Maturational Differences. Some researchers cite physiological or maturational differences between males and females as a cause for some disproportionate representation. For example, girls are believed to have fewer birth defects and more rapid maturation than boys. Females may be less prone to disability because they have two X chromosomes, and one of the X chromosomes may compensate for a defect in the other. Because males have one X and one Y chromosome, they may be more susceptible to disabilities associated with chromosomal abnormalities, such as hemophilia and fragile-x syndrome, which can cause mental retardation (Harmon et al., 1992). Some researchers theorize that differences in the structure of male and female brains may also contribute to differences in disability prevalence. They speculate that male brains are more lateralized than female brains, meaning that one hemisphere is more dominant than the other (Hayden-McPeak, Gaskin, & Gaughan, 1993). For example, functional magnetic resonance imaging (fMRI) shows that phonological processing in men engages the left inferior frontal gyrus in the brain. In women, phonological processing activates both the left and right inferior frontal gyrus (Shaywitz, 1996). Parts of the corpus callosum, which connects the two hemispheres, are also more extensive in females. The exact relationships between these biological differences and disability are unclear (Hayden-McPeak et al., 1993).

Research on differences between young boys and young girls suggests that girls mature more rapidly than boys (Harmon et al., 1992). Many preschool programs stress impulse-control, small-muscle development, and language skills, but many young girls are competent in these areas before arriving in preschool. The preschool experience may raise boys' language achievement scores, thus narrowing the gap between girls and boys (Larson & Robinson, 1989). However, maturational gaps could lead to inflated referrals of males for special education evaluation.

To determine if there are differences in vulnerability to learning failure among young children, Karlen, Hagin, and Beecher (1985) administered a series of tests to all kindergartners and first graders in a sample of elementary schools. The study showed very small or insignificant differences between the percentage of males and females at risk of school failure in urban, rural, and independent schools. However, for unknown reasons, the differences were significant in suburban schools; 31 percent of the boys and 20 percent of the girls were at risk.

Shaywitz, Shaywitz, Fletcher, and Escobar (1990) found significant differences in the percentages of boys and girls identified by their schools as having reading disabilities but found no differences based on achievement and IQ test scores. They also found that children who were identified by their schools as having a reading disability but who did not meet objective criteria for reading disabilities were more likely to exhibit difficulties in behavior, attention, fine-motor skills, and language skills. Conversely, children who were not identified as having a reading disability despite meeting eligibility criteria were likely to have no perceived problems with behavior. When students with learning disabilities also have attention deficit disorder (ADD), their learning disabilities may be more severe and resistant to intervention. Because ADD is more prevalent in males than in females, males may be more likely than females to be identified by their schools as having learning disabilities (Felton & Wood, 1989; Lubs et al., 1991; Lyon, 1996).

School Bias. Males may be referred and found eligible for special education at higher rates than females because of gender differences between female teachers and male students or differences between the dominant school culture and male behavior (Kedar-Volvodas, 1983). Women outnumber men in the general education teaching force (87 percent to 13 percent), particularly at the elementary level, when most students are referred for special education (Cook & Boe, 1995). As long ago as 1976, evidence suggested a bias in teachers' evaluation of students' need for special education based on the student's gender. In a historic study, when given identical descriptions of individ-

ual children, teachers were more likely to refer boys for evaluation than girls (Gregory, 1977). Female teachers may be more likely to identify boys' behavior and learning styles as indicative of a disability, inflating the referral of boys for special education evaluation (Gottlieb, 1987).

Other researchers speculate that some educators may have higher expectations for boys than for girls. If boys do not perform to expected levels, teachers may refer them to special education in greater numbers than girls, for whom they have lesser expectations (Gottlieb, 1987). However, data suggest that boys are more likely than girls to be referred for special education based on their behavior and that girls are typically referred for concerns about academic performance (Clarizio & Phillips, 1986). This finding may contradict the hypothesis that disproportion is due to differing academic expectations.

Assessment Bias. The disproportionate representation of males in programs for students with emotional disturbances may reflect a bias in the ways emotional disturbance is defined and/or the instruments used to identify students as eligible under those definitions. Some assessment tools that schools use to evaluate students do not capture depression, suicidal ideation, or suicide attempts (Caseau, Luckasson, & Kroth, 1994). Adolescent girls experience a higher rate of depression than boys (Boggiano & Barrett, 1992; Kazdin, 1990; Peterson, Sarigiani, & Kennedy, 1991), but the eligibility criteria for services under the emotional impairments category, or teachers' tolerance of the withdrawal or depression exhibited by young women, may reduce females' referral for evaluation and eligibility (McIntyre, 1990). Those girls who receive services for emotional impairments usually exhibit the externalizing behaviors typically associated with boys (Casau et al., 1994).

Services for Males and Females with Disabilities

Once students are identified as eligible for special education, the services they receive do not differ greatly by

gender, and teachers appear to consider an individual student when selecting instructional techniques (Leinhardt, Seewald, & Zigmond, 1982; Wagner et al., 1991). No significant differences exist in the amount of funds expended on special education and related services for males and females (Singer & Raphael, 1988).

Few significant gender differences were identified in secondary course-taking for students with disabilities, although higher rates of home economics and life skills instruction for females and a higher rate of vocational education for males were noted (Wagner et al., 1991). Secondary-aged females with disabilities were more likely than males to receive some support services (see table II-6). The disproportion fell particularly in occupational therapy/life skills training, transportation, and speech therapy (Cameto, 1993).

Educational Results for Males and Females with and without Disabilities

One way to evaluate whether education services are effective in meeting students' needs is to examine student results. These may include in-school results, such as grades and dropout rates, or postschool results, such as employment, wages, and postsecondary education.

In-School Results

Overall, girls with and without disabilities had better in-school results than boys with and without disabilities. They received better grades, were more likely to graduate from high school, and were less likely to be suspended or expelled. Boys did as well as girls on many standardized achievement tests and scored slightly better than girls on 12th grade math achievement.

Test Scores and Grades. Much has been made of perceived differences between males and females in verbal and quantitative skills. Studies of achievement test scores indicate no consistent, sizable differences in verbal ability

Table II-6
Percentage of Secondary-Aged Students with Disabilities Who Received Different Types of Services, by Gender

Services	Male	Female
Job Training	63.2	56.8
Speech/Language Therapy	36.6	43.1
Personal Counseling/Therapy	34.6	33.7
Occupational Therapy/Life Skills Training	28.9	46.8
Tutor, Reader, Interpreter	32.9	32.2
Physical Therapy, Mobility Training	8.5	12.5
Help with Transportation	13.0	18.5

Source: Valdes et al. (1990). *The National Longitudinal Transition Study of Special Education Students: Statistical almanac* (Vol. 1). Menlo Park, CA: SRI International.

between boys and girls (Hyde & Linn, 1988). Results on reading achievement, one aspect of verbal skills, are unclear. The National Assessment of Educational Progress (NAEP) and the National Education Longitudinal Study show girls performing better than boys on reading tests. The High School and Beyond Survey shows boys performing better than girls on reading and vocabulary. Differences in results may reflect the different ages sampled in each survey or differences in the tests given. All three surveys show very small differences in achievement between boys and girls (American Association of University Women [AAUW], 1992), except in writing; data from NAEP show girls performing consistently better than boys on writing tasks (Mullis, Owen, & Phillips, 1990).

Gender differences in math achievement appear to be small and shrinking (Friedman, 1989; Mullis, Dossey, Owen, &

Phillips, 1991). A recent NAEP administration showed few differences between boys and girls in math ability at grades 4 and 8 apart from a slight advantage for boys in measurement and estimation. By 12th grade, some differences arose, and boys showed a small advantage in each area except algebra (Mullis et al., 1991).

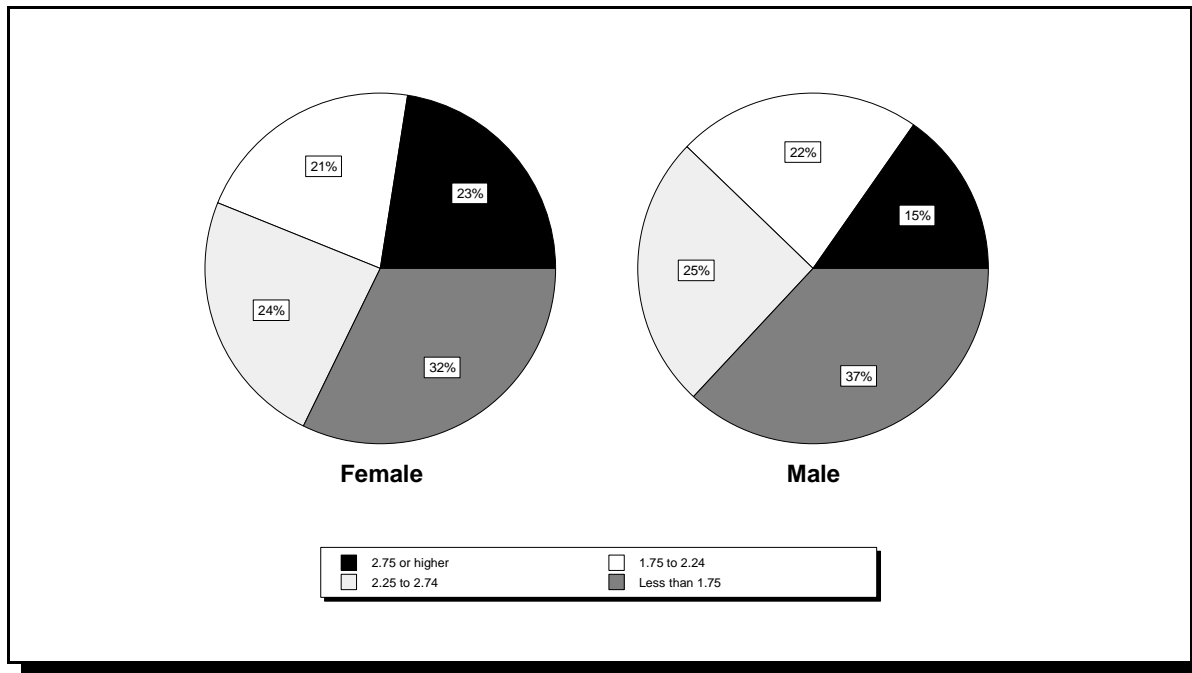
In general education, girls typically receive better end-of-year and end-of-course grades than boys (AAUW, 1992). Again, it is not clear if girls work harder at mastering classroom material, if they have longer attention spans that permit them to acquire knowledge and skills more effectively, or if they are rewarded by teachers for good behavior. Whatever the reason, this pattern of grade accomplishment holds for students in special education as well as in general education. Despite their lower mean IQ scores and the relatively early onset of their developmental difficulties, on average girls in special education receive higher end-of-year and end-of-course grades than boys. Grade point averages for secondary-aged females with disabilities are significantly better than grade point averages for their male counterparts (see figure II-8).

High School Completion. Females with disabilities are slightly more likely than males to graduate from high school and are less likely to be suspended or expelled (see figure II-9). This is also true for females without disabilities (AAUW, 1992). Although females with disabilities drop out of school at about the same rate as males, the reasons differ. Parents report that 23 percent of female dropouts leave school because of marriage or parenthood, compared with only 1 percent of male dropouts (Valdes et al., 1990; Wagner, as cited in Wagner et al., 1991). Both male and female dropouts report disliking school and doing poorly in school (Valdes et al., 1990).

Postschool Results

Despite their better academic performance, females with disabilities have less positive postschool results than their

Figure II-8
Percentage of Secondary-Aged Students with Disabilities with Different Grade Point Averages, by Gender



Note: Percentages may not sum to 100 due to rounding.

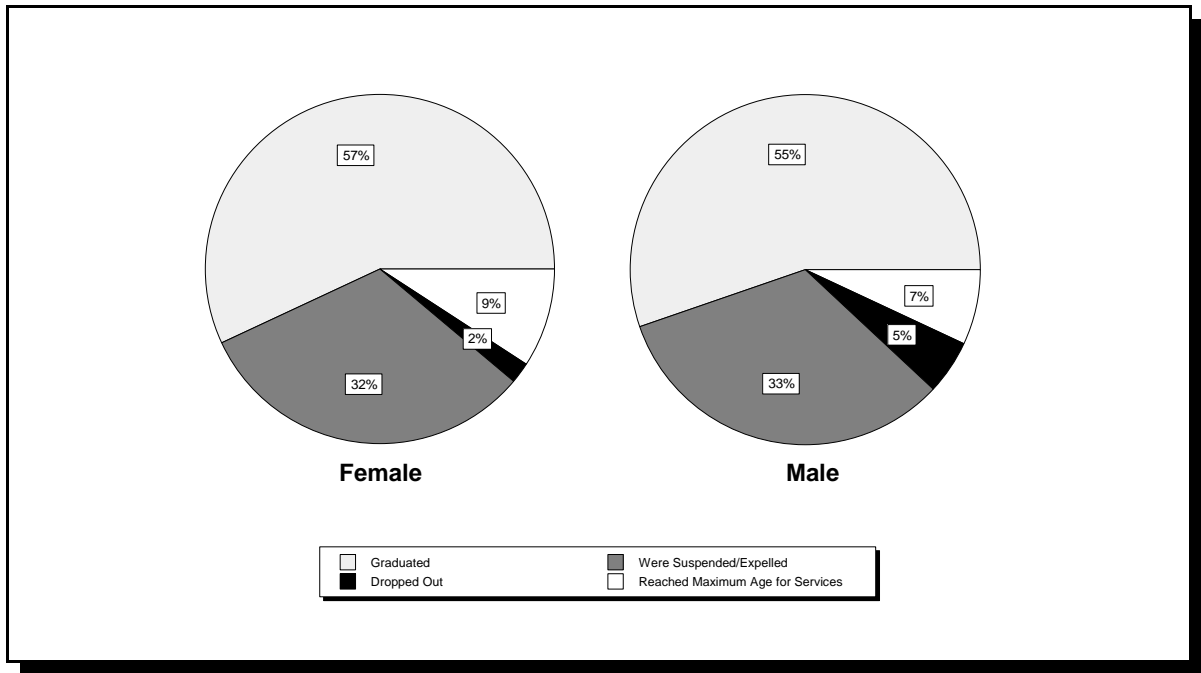
Source: Valdes et al., (1990). *The National Longitudinal Transition Study of Special Education Students: Statistical almanac* (Vol. 1). Menlo Park, CA: SRI International.

male peers.¹ They are less likely to be employed, have lower wages, and are less likely to enroll in postsecondary education or training.

Employment. Young men with disabilities are more likely than young women to be employed and to earn more money (Frank, Sitlington, & Carson, 1991; Hasazi, Johnson, Hasazi, Gordon, & Hull, 1989; Kranstover, Thurlow, & Bruininks, 1989; Sitlington & Frank, 1990; Wagner, 1992). After being out of high school for 3 to 5 years, 65.9 percent of males and 48.6 percent of females

¹ One study (Levine & Edgar, 1994) noted few significant differences in postschool results for men and women with disabilities, except for parenting.

**Figure II-9
School Exit Status of Youth with Disabilities, by Gender**



Source: Valdes et al., (1990). *The National Longitudinal Transition Study of Special Education Students: Statistical almanac* (Vol. 1). Menlo Park, CA: SRI International.

report having been employed in the past year. When controlling for other factors, young men with disabilities earn \$1,814 more per year than young women with disabilities (Wagner, Blackorby, Cameto, & Newman, 1993). Young men earn higher hourly wages than young women and, on average, men work more hours (Sitlington, Frank, & Carson, 1992; Wagner, 1992). The wage gap between men and women is not restricted to those with disabilities, however. In general, women make up 45 percent of the work force, but they work primarily in clerical, service, or professional positions (Fullerton, 1989; Taeuber, 1991). Even when women have the same level of education as men, they earn less.

Several other factors may contribute to the lower incomes earned by women with disabilities. First, many young

women with disabilities have children and, consequently, do not work full time. Three to five years after leaving high school, 41 percent of women with disabilities have children of their own, compared with 28 percent of same-aged women in the general population (Wagner, 1992). As described in the next section, young women with disabilities are less likely than young men to enroll in vocationally oriented courses in high school, which may also limit their level of job competitiveness. In addition, young women with disabilities are less likely than men to pursue additional education, training, and rehabilitation after high school.

Postsecondary Education, Training, and Rehabilitation.

Fewer women than men with disabilities participate in postsecondary education and training in the years shortly after high school. A larger percentage of women take postsecondary courses at 4-year colleges while a larger percentage of men enroll in job training programs and 2-year colleges (Valdes et al., 1990). This is also true for youth without disabilities; 54 percent of all beginning postsecondary students are female (U.S. Department of Education, 1996). Women with disabilities are also less involved with vocational rehabilitation services than men; this may contribute further to women's economic disadvantage (Gragg, 1997; Menz et al., 1989). Studies have found that the rehabilitation system is more helpful for men who are under 45 years of age, White, better educated, middle class, articulate, aggressive, and motivated (Kirchner, 1987; Stone, as cited in Fine & Asch, 1988). Women who receive vocational rehabilitation services are more likely than men to have their cases closed while not earning wages (Vash, as cited in Fine & Asch, 1988), and women are more likely than men with similar skills and aptitudes to be directed toward traditionally female occupations (Packer, as cited in Fine & Asch, 1988), which often pay low wages.

Independent Community Living. Living independently, marrying, and having children are other aspects of the transition from adolescence to adulthood. Three to five years after leaving high school, almost one-third of young women with disabilities are married, compared with 15

percent of young men. Due to their marital status, young women with disabilities are more likely than young men to live apart from their parents. However, their lower rates of employment and greater social isolation limit their overall independence (Wagner, 1992).

Compliance with community norms and laws is another measure of adjustment. Three to five years after leaving secondary school, 15.8 percent of males and 4.2 percent of females with disabilities have been arrested (Valdes et al., 1990). While in school, males with disabilities are 2.4 times more likely than females to be arrested, controlling for other variables (Doren et al., 1996).

Summary

It is not clear why males are disproportionately represented in special education, although it appears that the proportion is greatest among those with learning disabilities and emotional disturbance. Maturation gaps between boys and girls may inflate referrals of boys for special education evaluation. It is also possible that although learning disabilities are equally prevalent among males and females, ADD, which can exacerbate the effects of a learning disability, is more prevalent in males than in females. As a result, males with learning disabilities may be more likely than females to be identified by their schools (Felton & Wood, 1989; Lubs et al., 1991; Lyon, 1996). Criteria for eligibility under the emotional disturbance category may also contribute to the overrepresentation of males in special education (Caseau et al., 1994). Consequently, in addition to enrolling fewer females in special education, those females identified with disabilities have a different disability distribution from males in special education.

Girls in special education receive more support services than boys, with the exception of job training. Girls with and without disabilities have better grades in secondary school than boys and are more likely to enroll in 4-year colleges. Boys with disabilities are more likely than girls to enroll in occupationally oriented vocational education in

high school and in postsecondary vocational training or 2-year college courses. In the years after high school, young men with and without disabilities are more likely to be employed than young women, work more hours, and earn higher wages. A larger percentage of young women than young men with disabilities live independently, primarily because many women marry shortly after leaving school. Three to five years after leaving high school, almost one-third of young women with disabilities are married, and 41 percent have children. This likely contributes to their reduced employment and wages.

Issues Remaining

Many questions remain about the relationship between gender and disability. Why do female special education students receive better grades than male students, despite having more severe disabilities? To what extent, if at all, are young women with disabilities discouraged from enrolling in training and rehabilitation programs that would prepare them for higher paying jobs? Are males and females treated differently in rehabilitation programs, and, if so, what is the basis for that differential treatment? To what extent do physiological differences between males and females relate to the disproportionate representation of males in special education?

Disaggregated Data on Males and Females with Disabilities

Some steps are being taken to address these issues. Researchers in special education are beginning to recognize the need for analyses that are disaggregated by gender. General and special education research shows that males and females may experience school differently and, as a result, may react differently to interventions or instructional strategies (AAUW, 1992). Consequently, data regarding the issues of gender and disability are gradually becoming available.

Sensitivity to Gender Issues in Education

Many educators are now aware of research showing differences in teacher-student interaction based on gender. Males are more often called on in class and are asked more probing questions by their teachers (Sadker & Sadker, 1994). Increased sensitivity to gender issues in schools will likely affect special education as well as general education. For example, teacher bias in overreferring male students for special education evaluation may be targeted as one aspect of a school's gender-related self-study. Likewise, schools may examine gender biases in counseling; enrolling more female students in vocational education classes may improve their employment and wages.

Issues related to gender in special education are closely tied to understanding gender issues in general education and contemporary culture. Understanding the differences between the behaviors of males and females and culturally defined gender roles is challenging. Awareness of the issues surrounding gender and special education is the first step in making necessary changes in educational practice.

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Students with Emotional Disturbance¹

PURPOSE: To characterize the population of children with emotional disturbance, present eligibility requirements for their participation in special education, discuss the placements of and services provided to these students and the results that follow for them, and describe OSEP's efforts to improve results for them.

Children and youth with emotional disturbance are a heterogeneous group of young people with a variety of strengths and needs. Much is known about the school and community factors that place young people at risk for developing emotional disturbance and about what must be done to improve school and community results for them. This knowledge has been incorporated into OSEP's *National Agenda for Achieving Better Results for Children and Youth with Serious Emotional Disturbance* (U.S. Department of Education, 1994), which has framed OSEP's recent research and development efforts.

Unfortunately, a gap exists between what is known and what is done to identify and address the strengths and needs of these young people and their families. OSEP is addressing the gap through its Research to Practice efforts, which support the exchange and effective use of research-based knowledge on how to improve results for children and youth with emotional disturbance.

The first section of this module addresses eligibility for services and the characteristics of children with emotional disturbance. The second discusses the educational environments of and services provided to these students and the results that follow for them. The final section presents an overview of what OSEP is doing to improve results for children and youth with emotional disturbance.

Eligibility and Characteristics

Children and youth with emotional disturbance frequently require and receive services from a variety of agencies that apply different eligibility criteria. These young people are also quite diverse in terms of their needs and strengths.

¹ This module reports on work conducted by the Center for Effective Collaboration and Practice, one of several research centers funded by OSEP.

The students present with a complex range of disabilities, from conduct disorder to schizophrenia. Within this statistically and diagnostically diverse population, females appear to be underrepresented, and African Americans appear to be overrepresented. The following paragraphs elaborate on service eligibility for and the characteristics of these students.

Eligibility for Services

Emotional disturbance is 1 of 12 disability categories specified under IDEA. It is defined as follows:

- “(i) 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.
- (ii) The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance” (CFR §300.7 (a) 9).

Children who meet these criteria, as determined by a multidisciplinary team, may receive services under IDEA.

Children under the age of 9 who exhibit delays in social or emotional development may receive services under the developmental delay category.

Other Federal agencies use different eligibility criteria for youth with emotional disturbance. Their definitions cover a broad array of mental health conditions, some of which may also lead to eligibility under IDEA:

- The Center for Mental Health Services' (CMHS) definition covers children under 18. This definition requires the presence of a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders, 4th ed.*), and which results in a functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities (Substance Abuse and Mental Health Services Administration, 1993).
- The Social Security Administration's (SSA) definition of eligibility for the children's Supplemental Security Income program is the presence of a mental condition that can be medically proven and that results in marked and severe functional limitations of substantial duration.

Children identified under these two definitions may be eligible for services under IDEA or under Section 504 of the Rehabilitation Act of 1973. However, eligibility is not automatic. A child must meet the requirements of the Department of Education's regulatory definition of emotional disturbance to receive services under IDEA (or must meet the requirements of other IDEA eligibility categories). Therefore, identification of a child as emotionally disturbed under the CMHS or SSA definitions does not necessarily lead to identification under IDEA.

States also define emotional disturbance and specify the criteria to be used by local school districts in the identification of children with this disability. Although they must specify criteria that are not inconsistent with the Federal

definition, States interpret that definition based on their own standards, programs, and requirements (McInerney, Kane, & Pelavin, 1992). In fact, many States have adopted their own specific terminology and criteria (Tallmadge, Gund, Munson, & Hanley, 1985; Swartz, Mosley, & Koenig-Jerz, 1987; Gonzalez, 1991). Local variation may affect the ability of Federal authorities to monitor the impact of the IDEA Amendments of 1997. According to a 1992 report, "The resulting differences in definition and eligibility criteria make it difficult to evaluate the identification rates of children with serious emotional disturbance" (McInerney et al., 1992, p. 46).

For example, students identified as having conduct disorder are eligible for services in some States, but not in others. Conduct disorder is a persistent pattern of anti-social, rulebreaking, or aggressive behavior, including defiance, fighting, bullying, disruptiveness, exploitiveness, and disturbed relations with both peers and adults (Cohen, 1994; Forness, 1992; Forness, Kavale, & Lopez, 1993). Research suggests that conduct disorder frequently co-occurs with attention deficit hyperactivity disorder (ADHD), reading disabilities, anxiety disorders, and depression (Clarizio, 1992; Hinshaw, Lahey, & Hart, 1993; McConaughy & Skiba, 1993; Zoccolillo, 1992). The literature also suggests that there are no valid theoretical or empirical grounds for differentiating between conduct disorders and other behavioral and emotional disorders and that there are no reliable or socially validated instruments for making such a distinction (Cohen, 1994; Nelson, 1992; Nelson & Rutherford, 1988; Skiba & Grizzle, 1992; Stein & Merrell, 1992).

Children with emotional disturbance may also be socially maladjusted, but to receive services under IDEA, they must satisfy additional requirements. Since IDEA excludes social maladjustment *without* emotional disturbance from the definition of emotional disturbance, some State definitions and eligibility requirements serve to exclude students with conduct disorder (Gonzalez, 1991). Alternatively, some research has found that students with conduct disorder constituted the largest percentage of students with emotional disturbance who were served in day schools

and residential schools (Forness, 1992; Forness, Kavale, King, & Kasari, 1994; Sinclair & Alexson, 1992). Children with conduct disorder were the largest diagnostic group in the National Adolescent and Child Treatment Study (Silver et al., 1992). That study was co-sponsored by the National Institute for Disability and Rehabilitative Research (OSERS/NIDRR) and the National Institute of Mental Health. Its purpose was to “describe. . . children with [emotional disturbance] and their families” (Greenbaum et al., 1998, p. 21). Students with conduct disorder were also the largest group served at the 31 sites of the CMHS’ Comprehensive Mental Health Services for Children and Their Families program (Doucette, 1997).

In general, the literature documents varying orientations to children with different patterns of behavior. While some of these students are “provided access to therapeutic services, and considered victims of their disorders . . . students who are considered antisocial or socially maladjusted are usually blamed for their aversive and maladaptive behavior patterns and exposed to control, containment, or punishment strategies” (Walker, Stieber, & O’Neill, 1990, p. 62).

Student Characteristics

Students with emotional disturbance who are eligible for services under IDEA typically exhibit mood disorders, anxiety disorders, ADHD, conduct disorders, or other psychiatric disorders (Forness et al., 1994; Mattison & Felix, 1997). Comorbidity of emotional and behavioral disorders is common (Caron & Rutter, 1991; Friedman, Kutash, & Duchnowski, 1996). In addition, the co-occurrence of emotional disturbance and other disabilities may intensify students’ behavioral problems and further compromise academic performance. Many students with emotional disturbance are at great risk for substance abuse disorders (Capaldi & Dishion, 1993; Leone, 1991; Leone, Greenberg, Trickett, & Spero, 1989) and negative encounters with the juvenile justice system (Gilliam & Scott, 1987; Leone, 1991). These problems may exacerbate the impact of emotional disturbance and of any co-occurring disabilities.

In comparison with other students, both with and without disabilities, children with emotional disturbance are more likely to be male, African American, and economically disadvantaged. They are also more likely to live with one parent, in foster care, or in another alternative living arrangement (Cullinan, Epstein, & Sabornie, 1992; Marder, 1992; Wagner, 1995). Students with emotional disturbance are particularly vulnerable to environmental changes such as transitions and to a lack of positive behavioral support during transitions. These students' presenting behavior, as well as its intensity, is episodic, subject to change over time (Strayhorn, Strain, & Walker, 1993), and may serve to direct attention away from underlying issues such as depression (McCracken, Cantwell, & Hanna, 1993; Wehby & Symons, 1996; Wehby, Symons, & Shores, 1995). These variations in behavior often result in students with emotional disturbance being blamed for disability-related behavior or subject to negative reactions from their peers and teachers (Forness, Kavale, MacMillan, Asarnow, & Duncan, 1996; Lewis, Chard, & Scott, 1994).

Identification

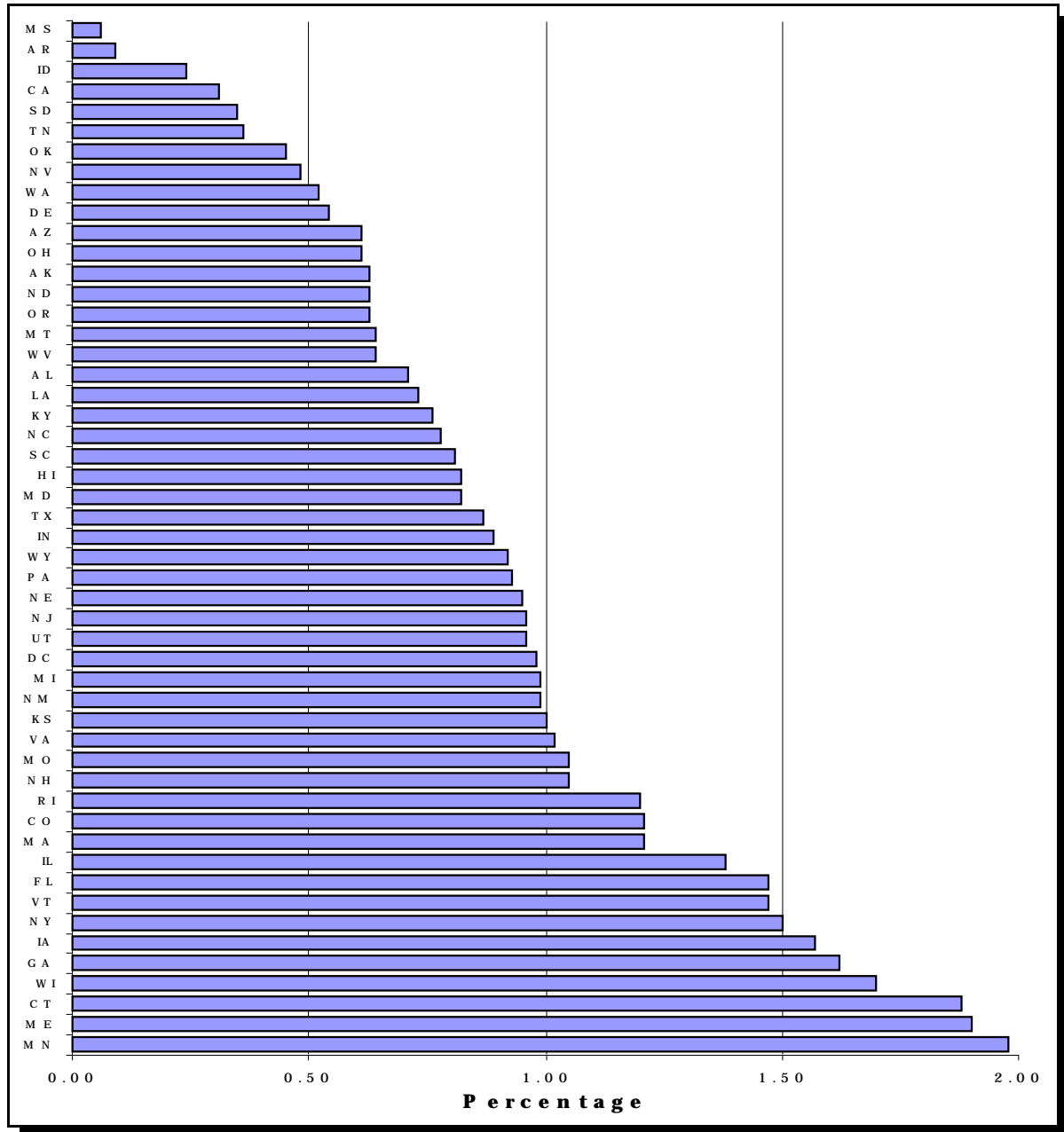
IDEA requires each State to have in effect a policy ensuring all children with disabilities the right to a free appropriate public education (FAPE) (20 U.S.C. 1412 (1)). Thus, it is the obligation of State educational agencies (SEAs) and local educational agencies (LEAs) to evaluate a child who is suspected of having a disability in order to determine his or her need for special education and related services (Davila, Williams, & MacDonald, 1991). But research suggests that the identification process, as implemented, is often reactive, subjective, limited by a local lack of culturally and linguistically appropriate assessment tools, driven by institutional needs, and constrained by parental concerns about pejorative labels (U.S. House of Representatives, 1997) and inappropriate placement, as well as by the inability of some professionals to collaborate with families or with each other (McInerney et al., 1992; Osher & Hanley, 1996; Smith, 1997).

Nationally, the identification rate for emotional disturbance has remained stable at approximately 0.9 percent since OSEP began collecting these data in 1976 (Oswald & Coutinho, 1995). This rate is significantly less than the predicted prevalence of emotional disturbance within schools. For example, the U.S. Department of Education's *Second Annual Report to Congress on the Implementation of P.L. 94-142* estimated a prevalence rate of 2 percent for students with emotional disturbance (U.S. Department of Education, 1980). Similarly, many experts believe that an identification rate of 3-6 percent would be more accurate (Eber & Nelson, 1994; Friedman et al., 1996; Grosenick & Huntze, 1980; Institute of Medicine, 1989; Kauffman, 1994; Smith, Wood, & Grimes, 1988). In fact, mental health epidemiological studies suggest even higher rates of diagnosable psychological and psychiatric impairments in youth (Costello et al., 1988; Friedman et al., 1996; McInerney et al., 1992). There is also great variation in State and local identification rates. One example is the 33-fold difference between the lowest and highest State identification rates of school-aged youth for the 1996-97 school year (see figure II-10 and table AA13, p. A-40, which presents the actual rates).

Identification rates are lower for girls and young women among students identified with emotional disturbance (U.S. Department of Education, 1994). In the National Longitudinal Transition Study (NLTS), more than three-fourths (76.4 percent) of secondary students with emotional disturbance were male, the highest proportion of males to females in any of the disability categories (Marder & Cox, 1991). Lower identification rates among females have been attributed to an assessment and identification process that is subjective (Walker & Fabre, 1988; Wehby, Symons, & Hollo, 1997), and largely driven by how schools operationalize behavioral norms and standards (Gerber & Semmel, 1984; Talbott, 1997; Walker & Severson, 1990). Some researchers and theorists have proposed that the apparent underidentification of girls and young women may also be due to the different ways in which emotional disturbance is manifested in females (Zahn-Waxler, 1993). Girls and young women are more likely to exhibit internalizing problems such as anxiety and depression that do not

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**Figure II-10
Students Ages 6-21 Identified as Having Emotional Disturbance in the 50 States
and the District of Columbia**



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

usually interfere with classroom management, while males are more likely to demonstrate the externalizing behaviors that do disrupt the classroom. Other possible explanations include the gender-specific expectations of teachers and evaluators (Caseau, Luckasson, & Kroth, 1994; Talbott & Lloyd, 1997) and a lack of gender-appropriate diagnostic criteria (Zoccolillo, 1993). Although some screening and assessment tools are available to aid in the identification of withdrawn, isolated students and others who internalize their problems, those tools are used infrequently. Teachers, the primary gatekeepers in the identification process, are more likely to identify students who exhibit externalizing behaviors (Boggiano & Barrett, 1992; Caseau et al., 1994; Gresham, MacMillan, & Bocian, 1996; Kazdin, 1990; Walker & Severson, 1990). Interestingly, a new assessment tool (Epstein & Cullinan, 1998), incorporating national norms derived from students with emotional disturbance and from their nondisabled peers, explicitly addresses the specific, multiple characteristics of emotional disturbance in the IDEA definition. The instrument also incorporates a subscale on social maladjustment, providing for distinctions between emotional disturbance with or without social maladjustment, and vice versa.

While females appear to be underrepresented among students identified with emotional disturbance, African Americans appear to be overrepresented. Research suggests that the high identification rates for African Americans may be due both to teacher expectations regarding normative behavior (Horowitz, Bility, Plichta, Leaf, & Haynes, 1998; McLaughlin & Talbert, 1992; Metz, 1994) and to a paucity of culturally sensitive and linguistically appropriate assessment instruments (Harry, 1994). Culturally competent approaches are needed to work effectively with racially and ethnically diverse students and families (Cross, Bazron, Dennis, & Isaacs, 1989; Comer, 1996; Isaacs-Shockley, Cross, Bazron, Dennis, & Benjamin, 1996). Culturally relevant and responsive techniques can increase the efficacy of both primary prevention efforts (Comer, 1996) and targeted prereferral strategies (Zins, Coyne, & Ponti, 1988).

Table II-7
Percentage of Students with Disabilities Identified as Having Emotional Disturbance (1995-96)

Age	6-7 years	8-9 years	10-11 years	12-13 years	14-15 years	16-17 years
Percentage	3.5%	5.6%	7.3%	10.2%	13.1%	13.0%

Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Although many children with emotional disturbance exhibit problems at an early age (Knitzer, 1996; Marder, 1992), students with this disability are usually identified later than those with other disabilities, despite the availability of valid and reliable screening tools. Research suggests that behavioral and emotional problems identified during adolescence can often be linked to early childhood behavioral patterns (Hinshaw et al., 1993; Walker, Colvin, & Ramsey, 1995; Walker, Shinn, O'Neil, & Ramsey, 1987; Walker et al., 1990). Early intervention appears to be both possible and cost effective (Forness et al., 1996; Hinshaw, Han, Erhardt, & Huber, 1992; Knitzer, 1996; Walker, 1995; Zigler, Taussig, & Black 1992).

Table II-7 shows the percentage of students with disabilities who were identified as having emotional disturbance in 1995-96 by age.

Educational Environments and Services

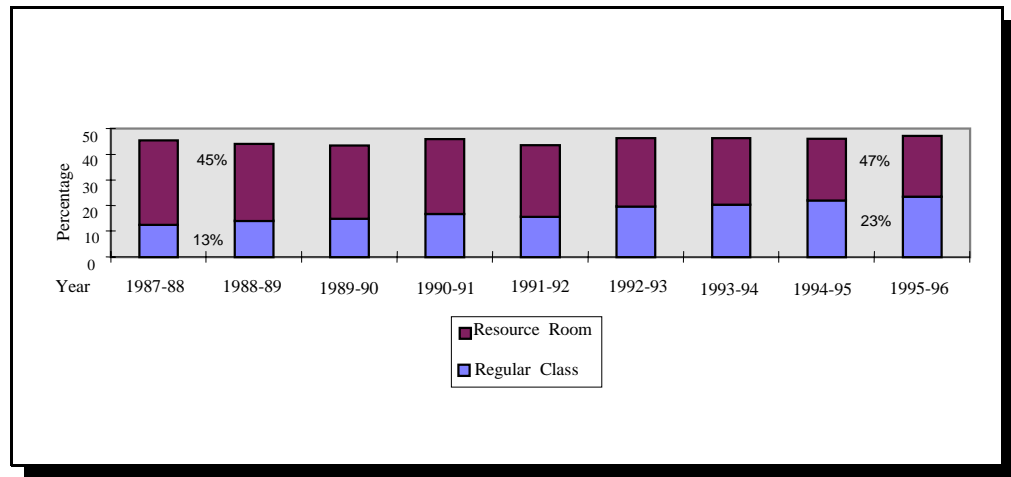
Once identified, students with emotional disturbance are served in a variety of settings, with placement rates varying by States and localities. For example, in 1994-95, 80 percent of Iowa's students with emotional disturbance and 78 percent of Vermont's were served in regular schools. In contrast, some other States served less than 20 percent of their students with emotional disturbance in such environments. In general, educational environment and service decisions are often driven by the availability of resources

(Hallenbeck, Kauffman, & Lloyd, 1995; Kauffman & Smucker, 1995).

The majority of students with emotional disturbance continue to receive most of their services in environments that separate them from students who do not have emotional disturbance. Between 1984-85 and 1994-95 the percentage of students receiving services in special classes, day schools, and residential facilities ranged from 54 percent to 57 percent. The restrictiveness of these environments contrasts with the environments of most students with disabilities. This is particularly true for students who, in the absence of appropriate school or community-based services, had to receive services in residential settings or at home. During 1995-96, 4.78 percent of students with emotional disturbance were served in residential settings, in hospitals, or at home, in contrast to 1.22 percent of all students with disabilities. The percentage of students with emotional disturbance reported to be receiving the majority of their education, special education, and related services in regular classrooms increased from 12 percent in 1984-85 to 23 percent in 1995-96. Figure II-11 displays the percentages of students with emotional disturbance served in resource rooms or regular classes from 1987-88 to 1995-96.

The diminished use of resource rooms may be significant because, although some students can succeed in regular classes, research suggests that many of these students and their teachers do not currently receive the supports that they need to succeed in regular class environments, particularly at a time of rising academic and behavioral standards (Eber & Nelson, 1994; Lewis et al., 1994). According to the NLTS, of the students with emotional disturbance who were served in regular education environments, only 11 percent had behavior management plans. In the same study, just 6 percent of the regular education teachers serving students with emotional disturbance received the support that teachers identify as being most important--a reduced teacher-student ratio (Marder, 1992; Wagner, 1995). Three key provisions in the IDEA Amendments of 1997 address these issues. The first provision is that regular educators and general education must be

Figure II-11
Percentage of Children with Emotional Disturbance Ages 6-21 Served From 1987-88 Through 1995-96 in Regular Classes and Resource Rooms



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

included in the development of individualized education programs (IEPs). The second is that IEP teams must explore the need for strategies and support systems to address any behavior that may impede the learning of a child with a disability or that of his or her peers. The third provision requires States to address the needs of in-service and preservice personnel, as they relate to the development and implementation of positive intervention strategies.

Some schools achieve high outcomes for students with emotional disturbance. During the winter of 1997-98, OSEP and the Safe and Drug Free Schools (SDFS) program in the Office of Elementary and Secondary Education collaboratively supported a research project to identify such schools and synthesize information that could help other schools replicate effective programs. The results of the study were included in a special report titled *Safe, Drug-Free Schools, and Effective Schools for ALL Students: What Works!* (Quinn, Osher, Hoffman, & Hanley, 1998). These schools have high behavioral and academic expectations and provide students and staff with the support

needed to achieve those standards. They combine schoolwide prevention efforts with early intervention for students who are at risk of developing emotional disturbance, and individualized services for students already identified with emotional disturbance. These schools also provide students with positive behavioral supports, offer ongoing training and support to staff, collaborate with families, and coordinate services (Mayer, 1995; Nelson, Crabtree, Marchand-Martella, & Martella, 1998; Quinn et al., 1998; Sugai & Horner, in press).

Unfortunately, in some other schools, the support services that students and teachers receive are often fragmented, inadequate, or inappropriate (Grosenick, George, & George, 1987; McLaughlin, Leone, Warren & Schofield, 1994; Smith & Farrell, 1993). Some schools unintentionally set the stage for or reinforce inappropriate behavior (Gunter, Denny, Jack, Shores, & Nelson, 1993; Shores, Gunter, & Jack, 1993). Staff may emphasize behavioral management and a "curriculum of control" instead of engaging students' interests and supporting their emotional needs (Knitzer et al., 1990; Zabel, 1988). Some programs frequently fail to address students' individual needs (Cessna & Skiba, 1996; Dunlap & Childs, 1996; Reiher, 1992; Neel, Alexander, & Meadows, 1997), or use strategies that are not empirically supported (Scheuermann, Webber, Partin, & Knies, 1994; Smith & Farrell, 1993). In sum, services for students with emotional disturbance often do not provide them with the supports that would enable them to succeed: tutoring, counseling, schoolwide behavior support plans, and collaboration with families and other service providers (Cheney & Osher, 1997; Eber, 1996; Marder, 1992; McLaughlin, Leone, Meisel, & Henderson, 1997; Myles & Simpson, 1992; Nelson & Colvin, 1996; Quinn, Gable, Rutherford, Nelson, & Howell, 1998; Valdes, Williamson, & Wagner, 1990; Wagner, Blackorby, & Hebbeler, 1993).

Results

Not surprisingly, many students with emotional disturbance experience poor academic results. They fail more courses, earn lower grade point averages, miss more days

of school, and are retained at grade more than students with other disabilities (Wagner, Blackorby, & Hebbeler, 1993). Fifty-five percent leave school before graduating; only 42 percent graduate (Wagner, 1995). School factors such as a lack of academic and social supports, reactive teaching styles, and frequent placement changes contribute to poor results (Kortering & Blackorby, 1992; Mayer, 1995; Munk & Repp, 1994; Osher & Hanley, 1996; Rumberger & Larson, 1994).

Gender, race, and poverty mediate service provision and results for students with emotional disturbance. (Kortering & Blackorby, 1992; Osher & Hanley, 1995; Valdes et al., 1990). Males, African Americans, and students with family income under \$12,000 are more likely to be placed in restrictive settings, less likely to receive counseling in school, less likely to graduate, and more likely to drop out of school than their female, White, and more affluent counterparts. For example, students with family incomes under \$12,000 are almost 2.5 times more likely to drop out of school than those whose families earn over \$25,000 (Osher & Osher, 1996).

Failure to address the needs of students with emotional disturbance is a portent for poor community results as well as poor academic results. Researchers conducting the NLTS found that within 3 to 5 years of leaving school, 48 percent of young women with emotional disturbance were mothers, as compared to 28 percent of young women with other disabilities. Fifty-eight percent of the students with emotional disturbance had been arrested, versus 19 percent of those with other disabilities. And 10 percent of youth with emotional disturbance were living in a correctional facility, halfway house, drug treatment center, or "on the street"--twice as many as among the students with other disabilities (Wagner, 1995; Wagner, Blackorby, Cameto, Hebbeler, & Newman, 1993).

Improving Results

In the past two decades, researchers and practitioners have developed an extensive knowledge base about chil-

dren with emotional disturbance. These intensive research efforts suggest that results for students with emotional disturbance can be improved through interventions that are sustained, flexible, positive, collaborative, culturally appropriate, and regularly evaluated. These interventions should have multiple components tailored to individual needs; they should build on the strengths of youth and their families, address academic as well as social concerns, be implemented by trained and supported practitioners, and be continually evaluated (Carpenter & Apter, 1988; Clarke et al., 1995; Eber, Nelson, & Miles, 1997; Epstein, Nelson, Polsgrove, Coutinho, Cumblad, & Quinn, 1993; Huntze, 1988; Knitzer, Steinberg, & Fleisch, 1990; McLaughlin et al., 1994; Nelson & Rutherford, 1988; Peacock Hill Working Group, 1991; Stroul & Friedman, 1996; Sugai, Bullis, & Cumblad, 1997).

OSEP continues to play an active role in developing and applying knowledge to improve results for young people with emotional disturbance. OSEP-supported research projects like the National Needs Assessment in Behavior Disorders and the NLTS have helped pinpoint problem areas in these students' development and have made significant contributions to the development of promising approaches to early intervention and school discipline (e.g., Walker et al., 1995). OSEP research investments have developed tools such as functional behavioral assessments to identify and address the needs of individual students (Horner, 1994; Umbreit & Blair, 1997; Wehby et al., 1997). OSEP has also supported demonstration projects that build on research in children's mental health (e.g., Stroul, Lourie, Goldman, & Katz-Leavy, 1992) to create flexible, results-driven, family responsive services and comprehensive education and support systems to reduce the need for restrictive out-of-home placements (Petr, 1994; Stroul & Friedman, 1996).

This knowledge base was influential in the development of *The National Agenda for Achieving Better Results for Children and Youth with Serious Emotional Disturbance* (U.S. Department of Education, 1994). To create this agenda, OSEP garnered extensive input from researchers, practitioners, and families (Smith & Coutinho, 1997) to

“focus the attention of educators, parents, advocates, and professionals from a variety of disciplines on what is needed to be done to encourage, assist, and support our nation’s schools in their efforts to improve the educational process to achieve better outcomes for children and youth with serious emotional disturbance” (Osher, Osher, & Smith, 1994). The agenda featured seven interdependent targets: expanding positive learning opportunities and results, strengthening school and community capacity, valuing and addressing diversity, collaborating with families, promoting appropriate assessment, providing ongoing skill development and support, and creative comprehensive and collaborative systems (U.S. Department of Education, 1994).

The National Agenda has served as the basis for State planning and evaluation efforts such as the Serious Emotional Disturbance Network (SEDNET, 1996). It is also the foundation of Federal interagency collaboration on issues of concern to children with emotional disturbance and their families. In a cooperative effort, the Department of Health and Human Services and the Department of Justice, OSERS, the Head Start Bureau, the Children’s Bureau, CMHS, and the Office of Juvenile Justice and Delinquency Prevention (OJJDP) co-sponsored an invitational conference entitled “Making Collaboration Work for Children, Youth, Families, Schools and Communities.” This project brought together youth and their families with researchers, practitioners, administrators, and public officials. The meeting highlighted exemplary programs and documented the extent to which all service areas work simultaneously to serve children and families. The conference also delineated what is necessary to ensure effective interagency collaboration (Bullock & Gable, 1997; U.S. Department of Education, 1996; U.S. Department of Education, 1997). In the same vein, OSEP has joined with OJJDP and CMHS to fund collaborative research and technical assistance efforts on education’s role in systems of care and in the prevention of juvenile delinquency.

OSERS has made the National Agenda the basis for targeting OSEP’s research to practice investments in the field of childhood and youth emotional disturbance. OSEP

currently funds projects that focus on prevention, positive approaches to learning, cultural competence, and assessment of children with emotional disturbance. In fiscal year 1998, the National Agenda became a Focus Area under OSEP's Model/Demonstration priority, and three new awards were granted to support comprehensive programs that implement services in conformance with the seven target areas of the Agenda.

OSEP continues to address the gap between research and practice--between what is known and what is done. The Center for Effective Collaboration and Practice, housed at the American Institutes for Research, was created to promote a national reorientation toward fostering the development and adjustment of children with or at risk of emotional disturbance. The Center engages in strategic activities intended to help family members, practitioners, administrators, researchers and policy makers collaborate effectively in the efficient production and use of knowledge to improve results for children with or at risk of emotional disturbance. In the summer of 1998, the Center teamed with the National Association of School Psychologists, in a special collaborative project jointly led by the Departments of Education and Justice and in response to President Clinton's directive, to produce *Early Warning--Timely Response: A Guide to Safe Schools*, which was disseminated to all American schools in the fall. The guide emphasized the importance of child-centered and school- and community-supported prevention and intervention approaches.

Summary

Children and youth with emotional disturbance have a variety of needs and receive services that vary by State. Nationally, these students often realize poor school and community results. Such results tend to reflect fragmented, inappropriate, inadequate, and tardy interventions that frequently fail to address the complex factors that contribute to emotional disturbance.

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Fortunately, a great deal is known about how to improve results for students with emotional disturbance. OSEP is working to promote culturally appropriate, child- and family-centered, sustained, flexible, collaborative, positive, data-based interventions with multicomponent treatments. These interventions should be built on the strengths of youth and their families, be subject to ongoing evaluation, and be tailored to students' individual needs. The accumulated knowledge base created and refined through various OSEP-sponsored projects is reflected in *The National Agenda for Achieving Better Results for Children and Youth with Serious Emotional Disturbance*. OSEP has used this agenda to target research to practice investments and as the foundation for collaboration with other Federal partners.

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