Beyond Placement in the Least Restrictive Environment: The Concept of Least Intervention Needed and the Need for a Continuum of Community-School Programs/Services

When professionals attempt to ameliorate problems, standards for good practice call on them to prescribe as much but no more intervention than is necessary. This is essential because interventions can be costly -- financially and in terms of potential negative consequences.

Of course, the ability to provide what is necessary depends on the availability of a full array of appropriate and accessible interventions. However, even if one has the good fortune to be able to prescribe from a full array of interventions, good practice requires using an intervention only when it is necessary and the benefits significantly outweigh the costs. (Obviously, dilemmas arise regarding costs and benefits for and according to whom.)

Least Intervention Needed

The desire to meet needs in ways that ensure that benefits outweigh costs (financial and otherwise) makes the concept of *least intervention needed* a fundamental intervention concern. The concept of using the least intervention needed (and the related notion of placement in the least restrictive environment) find support in "the principle of normalization"-- which is associated with antilabelling, mainstreaming, and deinstitutionalization policies[1].

First and foremost, least intervention needed emphasizes the intent to do what is *needed.* At the same time, the adjective "least" reflects the recognition that any intervention

- is an interference into the affairs of others (can be intrusive, disruptive, restrictive)
- consumes resources
- may produce serious negative outcomes.

Thus, translated into an intervention guideline, the concept can be stated as follows: *In ensuring that needs for assistance are met, do not interfere with an individual's opportunity for a normal range of experiences more than is absolutely necessary.*

For example, if an individual with emotional problems can be helped effectively at a community agency, this is seen as a better option than placing the person in a mental hospital. For special education populations, when a student with learning or behavior problems can be worked with effectively in a regular classroom, placement in a special education class is inappropriate. The concept of least intervention needed is reflected in laws that protect individuals from removal from the "mainstream" without good cause and due process. Such legislation and associated regulations reflect concern that disruptive or restrictive interventions can produce negative effects, such as poor self-concept and social alienation; in turn, these effects may narrow immediate and future options and choices, thereby minimizing life opportunities.

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[1] On deinstitutionalization and the principle of normalization, see N.E. Bank-Mikkelsen (1976). Administrative normalizing. *S.A.-Nyt, 14*, 3–6 and W. Wolfensberger (1972). *The principle of normalization in human services*. Toronto: National Institute on Mental Retardation.

The special education example illustrates the difficulty in applying the principle of least intervention needed. Because of legislation and related regulations in the United States, the concept of least intervention needed quickly became embroiled with demands that (a) schools ensure availability and access to a continuum of alternative placements for students with disabilities and (b) students be placed in the least restrictive environment (LRE). By consensus, the least restrictive placement was described as keeping people in normal situations and using special assistance only to the degree necessary. Thus, placement in a special class is seen as somewhat more restrictive than keeping the individual in a regular class. Full-day placement in a special class is viewed as even more restrictive, and assignment to a special school or institution is even a more restrictive placement (see below). Similar degrees of restrictiveness are assignied in categorizing differences in residential arrangements and vocationally-oriented training programs.

Example: Continuum of Placements for Schooling Conceived as Ranging from Least to Most Restrictive

Least restrictive

- •regular class—ongoing teacher education and support to increase range of individual differences accommodated (prevention and mainstreaming)
- •regular class— consultation for teacher provided as needed (prereferral interventions and mainstreaming)
- •regular class—resources added—such as materials, aides, tutors, specialist help on a regular basis
- •special class—partial day (specialist or resource room)
- •special class—entire day
- •special school—public or private

Most restrictive

- •special institutions—residential homes, hospital programs

Obviously, there are interpretative and administrative problems related to such a one dimensional approach to a complex concept such as providing the least intervention needed. A setting designated as least restrictive may lead to extreme future restrictions with respect to an individual's life opportunities if the setting cannot meet the individual's needs. (Note: The assumption often has been made that the least restrictive environment is also the most effective.)

A particular concern in applying the least restrictive environment guideline arises because administrative factors such as financial support and program availability play significant roles in intervention decisions. At times, for example, placements are approached as an administrative rather than a treatment arrangement. When this occurs, individuals are shifted from one setting to another without significant attention to whether the new setting can provide appropriate assistance. Often placement in a setting (regular or special) works administratively; however, if the setting is not capable of meeting individuals' special needs, clearly it is not good practice. In the past, such poor practice often undermined mainstreaming efforts and will certainly plague inclusion initiatives. Obviously, the emphasis on providing *least intervention* has not ensured that *needs* are met. That is why the first and foremost emphasis must be on ensuring needs can be addressed and in ways that produce benefits that outweigh costs.

Once one escapes from the debate over *where* a youngster should be taught, the concern shifts to four fundamental factors that must be considered in meeting students' learning, behavioral, and emotional needs and doing so with the least intervention:

- Is there a full array of programs and services designed to address factors interfering with learning and teaching? (See Figure 1.)
- Is there an appropriate curriculum (including a focus on areas of strength and weakness -- including prerequisites that may not have been learned, underlying factors that may be interfering with learning, and enrichment opportunities)?
- Do staff have the ability to personalize instruction/structure teaching in ways that account for the range of individual differences and disabilities in the classroom (accounting for differences in *both* motivation and capability and implementing special practices when necessary)?
- Does the student-staff ratio ensures the necessary time required for personalizing instruction, implementing special practices, and providing enrichment?

Needed: A Comprehensive, Multifaceted, Integrated Continuum of Programs/Services

As suggested above, for learning in the classroom and home to be effective for some individuals, there must be a full array of programs and services designed to address factors that interfere with learning and teaching. From this persepctive, the concept of *least intervention needed* calls for (1) ensuring availability and access to *a comprehensive, integrated continuum of community and school programs/services*, and (2) only using specialized interventions when they are needed -- and only to the degree they are needed and appropriate.

Figures 2-4 outline the nature and scope of the type of continuum that is essential in designated geographic areas (e.g., local catchment areas) for addressing barriers to student learning. The framework for such a continuum emerges from analyses of social, economic, political, and cultural factors associated with the problems of youth and from reviews of promising practices (including peer and self-help strategies). It encompasses a holistic and developmental emphasis. Such an approach requires a significant range of multifaceted programs focused on individuals, families, and environments. Implied is the importance of using the least restrictive and nonintrusive forms of intervention required to address problems and accommodate diversity. With respect to concerns about integrating activity, the continuum of community and school interventions underscores that interprogram connections are essential on a daily basis and over time. That is, the continuum must include *systems* of *prevention*, *systems* of *early intervention* to address problems as soon after onset as feasible, and *systems of care* for those with chronic and severe problems. And each of these systems must be connected seamlessly.

The point is: When the focus is on the concept of *least intervention needed* (rather than LRE) and the concept is approached first from the perspective of need, the primary concern is not about placement, but about a necessary continuum of multifaceted and integrated programs and services for preventing and correcting problems effectively. Moreover, the focus is not just on the individual, but on improving environments so that they do a better job with respect to accounting for individual differences and disabilities. And when the continuum is conceived in terms of integrated *systems* of *prevention* and *early intervention*, as well as *systems of care*, many problems that now require special education can be prevented, thereby ensuring enhanced attention to persons with special needs.

Figure 1. A model for an enabling component at a school site.

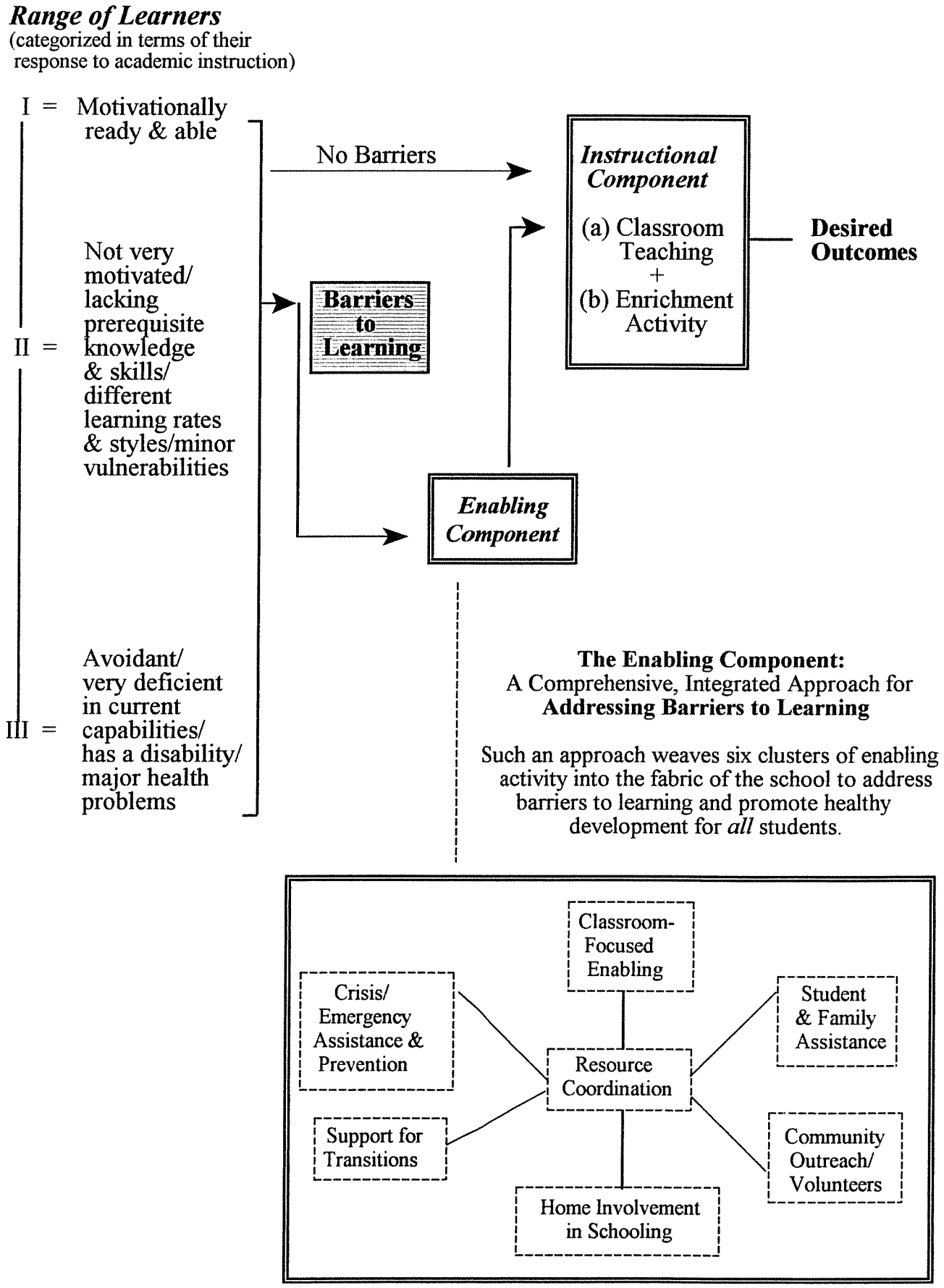


Figure: Addressing barriers to student learning: A continuum of five fundamental areas for analyzing policy and practice.

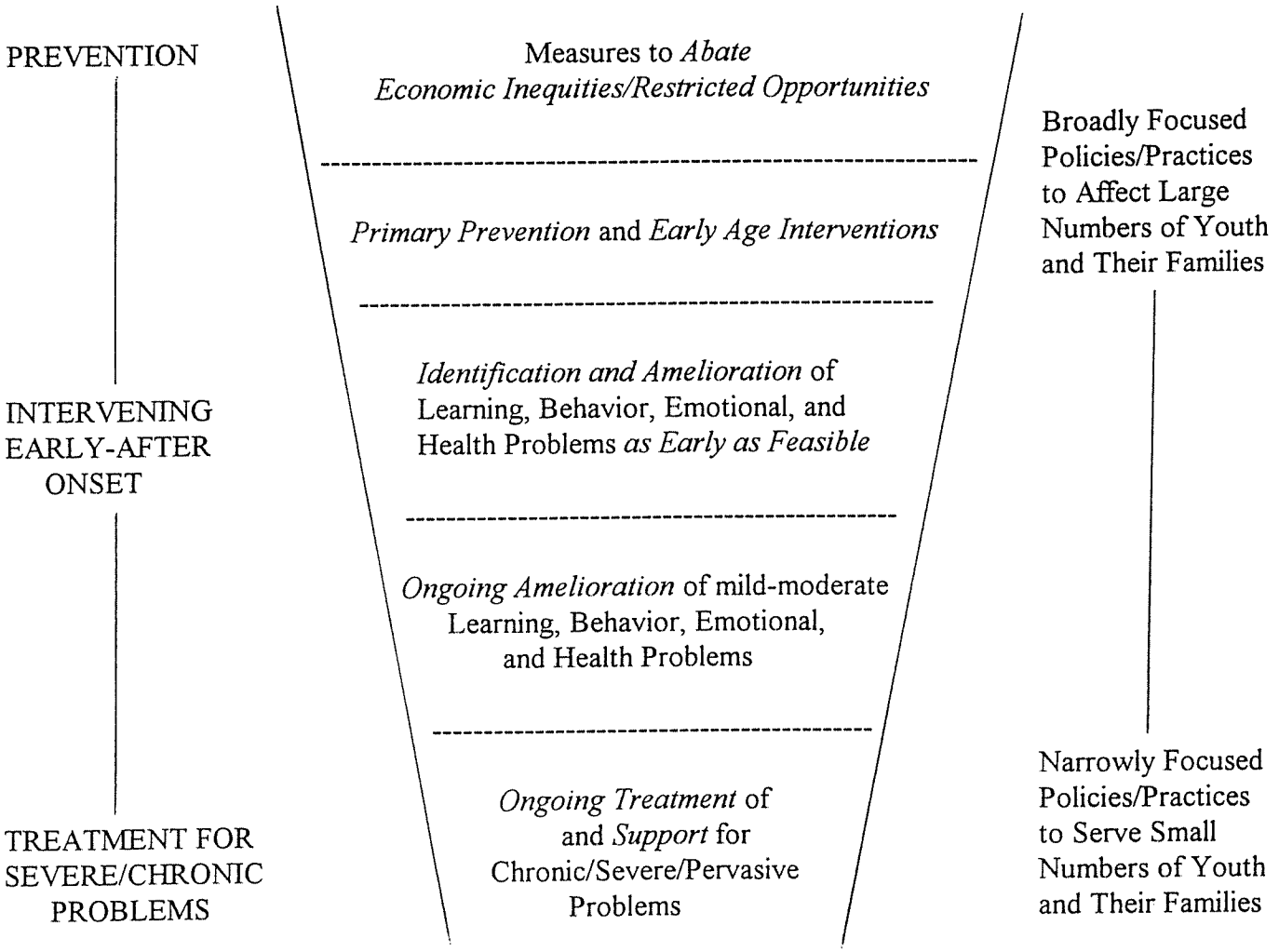


Figure 3. From Primary Prevention to Treatment of Serious Problems: A Continuum of Community-School Programs

Intervention Continuum	*Examples of Focus and Types of Intervention* (Programs and services aimed at system changes and individual needs)
Primary prevention	1. *Public health protection, promotion, and maintenance to foster opportunities, positive development, and wellness* • economic enhancement of those living in poverty (e.g., work/welfare programs) • safety (e.g., instruction, regulations, lead abatement programs) • physical and mental health (incl. healthy start initiatives, immunizations, dental care, substance abuse prevention, violence prevention, health/mental health education, sex education and family planning, recreation, social services to access basic living resources, and so forth)
Early-after-onset intervention	2. *Preschool-age support and assistance to enhance health and psychosocial development* • systems' enhancement through multidisciplinary team work, consultation, and staff development • education and social support for parents of preschoolers • quality day care • quality early education • appropriate screening and amelioration of physical and mental health and psychosocial problems
	3. *Early-schooling targeted interventions* • orientations, welcoming and transition support into school and community life for students and their families (especially immigrants) • support and guidance to ameliorate school adjustment problems • personalized instruction in the primary grades • additional support to address specific learning problems • parent involvement in problem solving • comprehensive and accessible psychosocial and physical and mental health programs (incl. a focus on community and home violence and other problems identified through community needs assessment)
	4. *Improvement and augmentation of ongoing regular support* • enhance systems through multidisciplinary team work, consultation, and staff development • preparation and support for school and life transitions • teaching "basics" of support and remediation to regular teachers (incl. use of available resource personnel, peer and volunteer support) • parent involvement in problem solving • resource support for parents-in-need (incl. assistance in finding work, legal aid, ESL and citizenship classes, and so forth) • comprehensive and accessible psychosocial and physical and mental health interventions (incl. health and physical education, recreation, violence reduction programs, and so forth) • Academic guidance and assistance • Emergency and crisis prevention and response mechanisms
	5. *Other interventions prior to referral for intensive, ongoing targeted treatments* • enhance systems through multidisciplinary team work, consultation, and staff development • short-term specialized interventions (including resource teacher instruction and family mobilization; programs for suicide prevention, pregnant minors, substance abusers, gang members, and other potential dropouts)
Treatment for severe/chronic problems	6. *Intensive treatments* • referral, triage, placement guidance and assistance, case management, and resource coordination • family preservation programs and services • special education and rehabilitation • dropout recovery and follow-up support • services for severe-chronic psychosocial/mental/physical health problems

Figure 4. Interconnected systems for meeting the needs of all students

Aims:

To provide a CONTINUUM OF SCHOOL AND COMMUNITY PROGRAMS & SERVICES

To ensure use of the LEAST INTERVENTION NEEDED

School Resources
(facilities, stakeholders, programs, services)

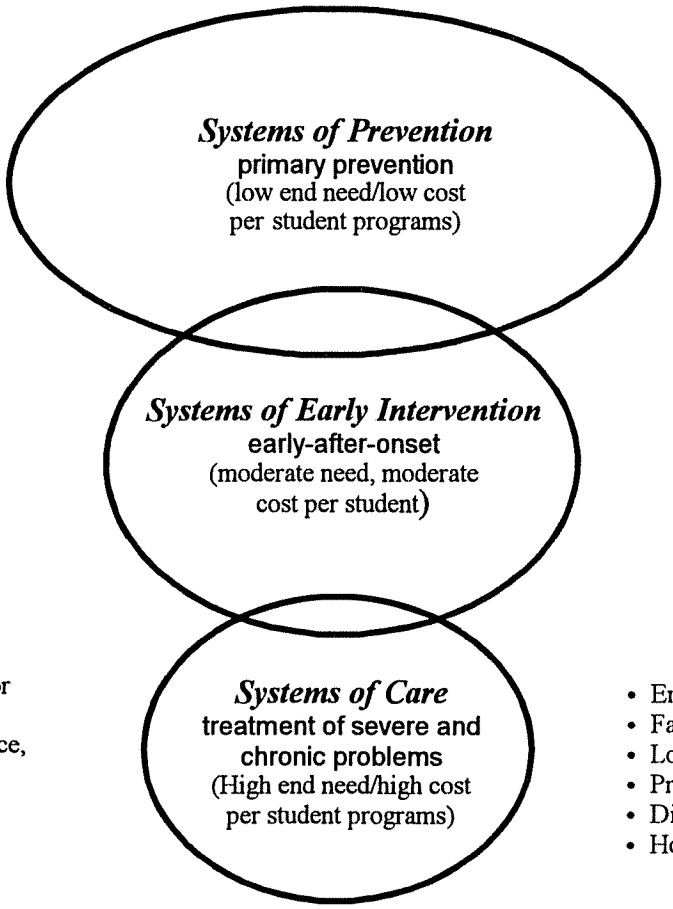
Examples:

- General health education
- Drug and alcohol education
- Support for transitions
- Conflict resolution
- Parent involvement

Community Resources
(facilities, stakeholders, programs, services)

Examples:

- Public health & safety programs
- Prenatal care
- Immunizations
- Recreation & enrichment
- Child abuse education



- Pregnancy prevention
- Violence prevention
- Dropout prevention
- Learning/behavior accommodations
- Work programs

- Early identification to treat health problems
- Monitoring health problems
- Short-term counseling
- Foster placement/group homes
- Family support
- Shelter, food, clothing
- Job programs

- Special education for learning disabilities, emotional disturbance, and other health impairments

- Emergency/crisis treatment
- Family preservation
- Long-term therapy
- Probation/incarceration
- Disabilities programs
- Hospitalization

Systemic collaboration* is essential to establish interprogram connections on a daily basis and over time to ensure seamless intervention within each system and among *systems* of *prevention, systems* of *early intervention*, and *systems of care*.

*Such collaboration involves horizontal and vertical restructuring of programs and services
(a) between jurisdictions, school and community agencies, public and private sectors; among schools; among community agencies;
(b) with jurisdictions, school districts, and community agencies (e.g., among departments, divisions, units, schools, clusters or schools)

The above material is extrapolated from the following references:

H.S. Adelman (1996). *Restructuring education support services: Toward the concept of an enabling component.* Kent, OH: American School Health Association.

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Center for Mental Health in Schools (1996). *Policies and practices for addressing barriers to student learning: Current status and new directions.* Los Angeles, CA: Author. Available by contacting the Center at the Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563.

ABOUT THE CENTER FOR MENTAL HEALTH IN SCHOOLS at UCLA

The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA. The Center is one of two national centers funded by the U.S. Department of Health and Human Services (Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health). For an overview of resources available from the Center, write c/o Dept. of Psychology, UCLA, Box 951563, Los Angeles, CA 90095-1563 or call (310) 825-3634 or use the internet to scan the website http://smhp.psych.ucla.edu