Moving Forward

Addressing Barriers to Learning

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... the Center's quarterly e-journal*

What Are Schools Planning to Do About the Increased Number of Emotional, Behavioral, and Learning Problems?

As this extraordinary school year moves along, we are being contacted by more folks asking about how we see addressing the challenges ahead for students, families, and staff in addressing emotional, behavioral, and learning problems (including reengaging disconnected students and families). Here's the gist of one we received in November:

> *Our state has approved emergency funds to support K 12 students. We have been chosen to implement this work. We are reaching out to you in the hopes that your National Center can provide us with expert consultation as we develop our efforts.*

As those who follow the Center's work know, we stress fundamental systemic changes that go beyond the prevailing and unrealistic calls for more individual and small group *services.* Our aim is to provide a blueprint to enable states, LEAs, and schools to play a greater role in providing student and learning supports systemically and in ways that enhance equity of opportunity.

From this perspective, we were invited recently by the Policy Analysis for California Education (PACE) to prepare a brief entitled: *Restructuring California Schools to Address Barriers to Learning and Teaching in the COVID 19 Context and Beyond*. See
https://edpolicyinca.org/publications/restructuring-california-schools-address-barriers-learning-and-teaching-covid-19?utm_source=PACE+All&utm_campaign=61b8aabde4-EMAIL_CAMPAIGN_2020_11_17_07_36_COPY_05&utm_medium=email&utm_term=0_9f1af6b121-61b8aabde4-522725185

In the brief, we highlight the need for and ways to systematically transform how schools address learning, behavioral, and emotional barriers interfering with effective instruction. Here is an excerpt:

Addressing Barriers to Learning and Teaching is Critical to Transitioning All Students Back to School

> The unique circumstances surrounding the transition back to physical schooling introduces challenges for all students, their families, and staff. Everyone has experienced considerable stress. Some have been ill, some have experienced economic hardship, some are grieving for a relative or friend who died. While many students are coming back to their former schools, some are entering a new school. While many are pleased to return, others are not. On top of this, there are students for whom special assistance and outreach is always indicated (e.g., those experiencing learning difficulties, homelessness, foster care; English learners; those who previously were chronically absent).
>
> Educators, families, and students are eager for school to go "back to normal," however, in order for schools to effectively transition students back and accelerate their learning, schools must address barriers to learning, some of which have been long standing and some of which have emerged during the pandemic.
> ...

Comprehensive School Improvement Policy Requires Elevating the Emphasis on Addressing Barriers to Learning

> Our analysis of school improvement policy and planning in the wake of ESSA indicate that districts and schools tend not to address – directly and comprehensively – barriers to learning and teaching. Policy and

practice planning is guided primarily by a two-component framework, namely (1) instruction and (2) governance/management. School improvement plans focus on these two components; interventions for addressing learning barriers and re-engaging disconnected students are given secondary consideration at best. This marginalization is a fundamental cause of the widely observed fragmentation and disorganization of student and learning supports. An enhanced policy framework is needed to ensure that efforts to address barriers to learning and teaching are pursued as a primary and essential component of school improvement (see Figure 2 at the previously cited URL).

We conceive the Learning Supports Component as enabling learning by (1) addressing factors that impact learning, development, and teaching and (2) reengaging students in classroom instruction. The reality is that students experience overlapping learning, behavior, and emotional problems; any system of interventions must be designed with this in mind. The intent of the expanded framework is to help districts and their schools unify all efforts to prevent and minimize the impact of barriers interfering with learning and teaching. The expanded framework requires personnel and an operational infrastructure that coalesces programs, services, initiatives, and projects that (a) provide compensatory and special assistance, and (b) promote and maintain safety, physical and mental health, school readiness, early school adjustment, and social and academic functioning. The point is to weave school and a wide range of community resources together, and to move away from approaching diverse student concerns as if they had no relationship to each other.

Strategically, given limited resources, developing a comprehensive system involves deploying, redeploying, and weaving together all available school and community resources used for student and learning supports to equitably strengthen interventions and fill critical gaps.

Our prototype for a unified, comprehensive, and equitable system to address barriers and re-engage students has two facets:

- a full continuum of integrated intervention subsystems that interweave school-community home resources
- an organized and circumscribed set of classroom and schoolwide student/learning support domains

The remainder of the brief delineates the prototype and the five elements that have been identified as essential in implementing a unified, comprehensive, and equitable system of learning supports. We conclude by noting:

> The COVID-19 pandemic and growing concerns about social justice mark a turning point for how schools, families, and communities address student and learning supports. Those adopting the prevailing MTSS framework have made a start, as have the initiatives for community schools, integrated student supports, and school-based health centers. Given the growing challenges, however, States, districts, and schools need to develop and implement a more transformative, comprehensive approach. The prototype for addressing barriers to teaching and learning highlighted in the brief is such an approach.
>
> We know from experience how hard it is to achieve the outlined policy and practice changes at a district. And given the scale of public education, the degree of transformative system change proposed here gives rise to many complications.
>
> For example, the approach calls for a major reworking of the operational and organizational infrastructure for a school, a family of schools, the district, and for school family community collaboration. It also calls for enhancing in classroom supports by retooling what ESSA labels as specialized instructional support personnel (e.g., student and learning support personnel - psychologists, counselors, social workers, nurses, Title I staff, special educators, dropout/graduation support staff, etc.). In particular, the jobs of these personnel need to be modified to include working collaboratively with regular teachers in classrooms (in person and online) for part of each day. Improving student/learning supports in classrooms requires such collaboration, which is essential to ending the myths and expectations that teachers can do it all and can do it alone.
>
> Certainly, the challenges are daunting. But maintaining the status quo is untenable, and just doing more tinkering will not meet the need.

Addressing the Pervasive and Complex Barriers that Impede Students Requires a Systemwide Approach to Comprehensively Support Whole-child Development

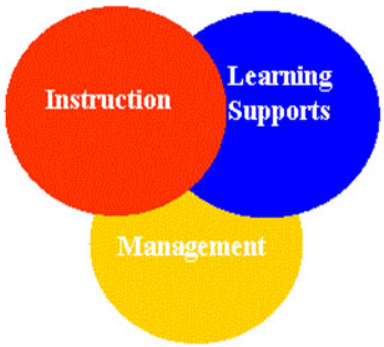
While the pandemic has introduced considerable challenges to teaching and learning, it must be remembered that students were struggling prior to COVID-19. The causes and numbers vary, but every school has students who are not doing well.

All schools devote resources to address this reality. Some strategies are designed to reach the entire student body, others are targeted interventions that address discrete problems, and a few are specialized services that can only be provided to a relatively small number of students. In some schools, principals have reported that up to 25 percent of their budget is consumed in efforts to address barriers to learning and teaching.

For a variety of reasons, schools differ with respect to the student and learning supports they have in place. Common, however, is the fragmented and disorganized way supports are developed and implemented.

The piecemeal and disjointed approach to addressing student learning, behavior, and emotional problems is long-standing concern. Rivalry for sparse resources has produced counterproductive competition among support staff and with community based professionals who link with schools. Each new initiative compounds the competition. These matters can be expected to be exacerbated as student needs increase in the wake of the pandemic and because school budgets are always tight.

For those interested in transforming how schools address barriers to learning and teaching, see the *National Initiative for Transforming Student and Learning Supports* –
http://smhp.psych.ucla.edu/newinitiative.html



Also available are several recent books detailing the work:

>*Addressing Barriers to Learning: In the Classroom and Schoolwide*

>*Improving School Improvement –*

>*Embedding Mental Health as Schools Change*

All accessible at:
http://smhp.psych.ucla.edu/improving_school_improvement.html

Analyses of current approaches to providing student and learning supports indicate limited results and redundancy in resource use. And when focus is mainly on enhancing individual and small group *services,* the tendency is to overemphasize universal screening and label more students as LD and ADHD.

We discuss these matters in the next article.

Let's Focus on Providing Support Before Screening and Labeling

This article is excerpted from *Embedding Mental Health as Schools Change* –see http://smhp.psych.ucla.edu/pdfdocs/mh20a.pdf

Strong images are associated with diagnostic labels, and people act upon these images. Sometimes the images are useful generalizations; sometimes they are harmful stereotypes. Sometimes they guide practitioners toward good ways to help; sometimes they are assigned to a person inaccurately. And sometimes they contribute to "blaming the victim" – making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place.

Inevitably, the benefits of assigning a diagnostic label are accompanied by some negative effects on the person labeled.

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal disorders. With high frequency, terms such as Attention Deficit Hyperactivity Disorder (ADHD), Depression, and Learning Disabilities (LD) are in vogue. This happens despite the fact that the problems of most youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if environmental circumstances had differed in good ways.

As schools re-open, the number of students manifesting learning, behavior, and emotional problems will be on the up-swing. Care must be exercised to avoid mislabeling the impact of COVID-19 on youngsters as a pathological condition.

Concern

Misdiagnosis

Of particular concern for schools is the widespread *misuse of the terms ADHD and LD*. This includes the problem of nonprofessional applications of these labels, and the reality of the number of misdiagnoses. At one point in time, almost 50% of those assigned a special education diagnosis were identified as having learning disabilities. This contributed to the backlash to LD seen in the last reauthorization of *Individuals with Disabilities Act* (retitled the *Individuals with Disabilities Improvement Act* but still widely referred to as IDEA). A similar concern has arisen about the number of students who manifest "garden-variety" misbehavior who are misdiagnosed as ADHD. Reports appear rather regularly that suggest a growing backlash, especially as related to the increasing use of medication to treat these youngsters. For example, reports of significant overdiagnosis have led to hearings and community forums and even legislative acts prohibiting school personnel from recommending psychotropic medications for students.

Diagnosing Behavioral, Emotional, and Learning Problems

Comprehensive formal systems used to classify problems in human functioning convey the impression that all behavioral, emotional, or learning problems are instigated by internal pathology. Some efforts to temper this notion see the pathology as a vulnerability that only becomes evident under stress. However, most differential diagnoses of children's problems still are made by focusing on identifying one or more disorders (e.g., oppositional defiant disorder, ADHD, or adjustment disorders), rather than first asking: *Is there a disorder?*

Bias toward labeling problems in terms of personal rather than social causation is bolstered by factors such as (a) attributional bias – a tendency for observers to perceive others' problems as rooted in stable personal dispositions and (b) economic and political influences – whereby society's current priorities and other extrinsic forces shape professional practice.

Overemphasis on classifying problems in terms of personal pathology skews theory, research, practice, and public policy. For instance, comprehensive classification systems do not exist for problems caused by environmental factors or for psychosocial problems (caused by the transaction of internal and environmental factors). As a result, these factors often are deemphasized in assessing cause. The irony is that so many practitioners who use prevailing diagnostic labels understand that most problems in human functioning result from the interplay of person and environment.

As we will discuss, countering nature *versus* nurture biases in thinking about problems involves approaching diagnosis guided by a broad perspective of what determines human behavior.

In the last analysis, we see only what we are ready to see.
We eliminate and ignore everything that is not part of our prejudices.
Jean-Martin Charcot

The Debate About the Role of Schools in Screening

Reasonable concern for the well-being of children and adolescents and the need to address barriers to learning and teaching has led schools to deploy resources to deal with a variety of health and psychosocial matters (e.g., bullying, depression, suicide, ADHD, LD, obesity, etc.). Over time, agenda priorities shift, and resources are redeployed.

Some of the activity is helpful; some is not; some has unintended negative consequences. And concerns arise.

Are schools colluding with practices that sensationalize and pathologically label young people's behavior?

Should schools be involved in universal, first-level screening for behavior and emotional problems?

We all have experienced the tendency to generalize from extreme and rare incidents. While one school shooting is too many, fortunately few students ever act out in this way. One suicide is too many; fortunately, few students take their own life. Some young people commit violent crimes, but the numbers are far fewer than news media convey, and the trajectory is downward.

No one is likely to argue against the value of preventing violence, suicide, and other mental heath and psychosocial concerns. In recent years, schools have had to be increasingly vigilant about potential violent incidents on campus. And the COVID-19 crisis has everyone concerned about the impact on mental health.

Even so, the debate continues over whether schools should play an institutionalized role in *screening* for mental health problems. Issues arise around:

Is such monitoring an appropriate role for schools to play? If so:

What procedures are appropriate and who should do it?
How will schools avoid doing more harm than good in the process?

Advocates for primary and secondary prevention want to predict and identify problems early. Large-scale screening programs, however, can produce many false positives, lead to premature prescription of "deep end" interventions, focus mainly on the role of factors residing in the child and thus collude with tendencies to "blame victims," and so forth. As with most such debates, those in favor emphasize benefits (e.g., "Screening lets us identify problems early, and can help prevent problems such as suicide."). Those against stress costs. For example, one state legislator is quoted as saying: "We want all of our citizens to have access to mental health services, but the idea that we are going to run everyone through some screening system with who knows what kind of values applied to them is unacceptable."

Examples of past screening include:

- *Early-age screening for behavioral, emotional, and learning disabilities*, (e.g., enhancing Early Periodic Screening, Diagnosis, and Treatment [EPSDT] and screening in preschool and kindergarten).
- *Drug testing* at school to deter substance abuse.
- *Student threat profiling to prevent school violence.*
- *Screening for suicide risk.*

In discussing these issues, concerns are raised about (a) the lack of evidence supporting the ability to predict who will and won't be violent or commit suicide, (b) what will be done to those identified as "threats" or "at risk"– including a host of due process considerations, (c) whether the procedures are antithetical to the schools education mission, and (d) the negative impact on the school environment of additional procedures that are more oriented to policing and monitoring than to creating school environments that foster caring and a sense of community.

Concerns also arise about parental consent, privacy and confidentiality protections, staff qualifications, involvement of peers, negative consequences of monitoring (especially for students who are false positive identifications), and access and availability of appropriate assistance.

The following are often heard examples of pro and con positions:

>*School staff are well-situated to keep an eye on kids who are "risky" or "at risk."*
>*Teachers can't take on another task and aren't qualified to monitor such students.*
>*Such monitoring can be done by qualified student support staff.*
>*Monitoring infringes on the rights of families and students.*
>*It's irresponsible not to monitor anyone who is "risky" or "at risk."*
>*It's inappropriate to encourage kids to "spy" on each other.*
>*Monitoring is needed so that steps can be made to help quickly.*
>*Monitoring has too many negative effects.*

Those arguing that schools should implement first-level screening programs emphasize that it is essential to monitor anyone who is at risk or a risk to others in order to intervene quickly. They believe that school staff are well-situated to do so and with good training can screen using effective safeguards for privacy and confidentiality. Moreover, they suggest that positive benefits outweigh any negative effects.

A central argument against screening students to identify threats and risks is that the practice infringes on the rights of families and students. Other arguments stress that teachers should not be distracted from teaching; teachers and other non-clinically trained school staff are seen as ill-equipped to monitor and make such identifications; students are inappropriately encouraged to play a role in screening peers; existing monitoring practices are primarily effective in following those who have already attempted suicide or have acted violently; and that monitoring others has too many negative effects (e.g., costs are seen as outweighing potential benefits).

Concern

Screening

From an article in the *New York Times* –
http://www.nytimes.com/2003/05/17/national/17DRUG.html?pagewanted=print

With respect to drug testing at school, Lloyd Johnston and colleagues at the University of Michigan reported the first major study (76,000 students nationwide) on the impact of drug testing in schools. They conclude such testing does not deter student drug use any more than doing no screening at all. Based on the study's findings, Dr. Johnston states "It's the kind of intervention that doesn't win the hearts and minds of children. I don't think it brings about any constructive changes in their attitudes about drugs or their belief in the dangers associated with using them." At the same time, he stresses" One could imagine situations where drug testing could be effective, if you impose it in a sufficiently draconian manner - that is, testing most kids and doing it frequently. We're not in a position to say that wouldn't work." Graham Boyd, director of the ACLU Drug Policy Litigation Project who argued against drug testing before the Supreme Court last year said, "In light of these findings, schools should be hard-pressed to implement or continue a policy that is intrusive and even insulting for their students." But other researchers contend that the urinalysis conducted by schools is so faulty, the supervision so lax and the opportunities for cheating so plentiful that the study may prove only that schools do a poor job of testing. Also noted is that the Michigan study does not differentiate between schools that do intensive, regular random screening and those that test only occasionally. As a result, it does not rule out the possibility that the most vigilant schools do a better job of curbing drug use.

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Comment on Trauma Screening as Schools Re-open

As plans for schools to re-open progress, discussion is increasing about the mental health needs of students. Some Departments of Education have placed a high priority on the matter – even to the point of noting that attention to mental health should come first.

At the same time, advocates around the country are calling for schools to do trauma screening.

We know that there will be an increase in students manifesting learning, behavior, and emotional problems. Teachers will be referring many more to student study teams, and they won't need a first level screening device to do so. And, as in the past, such teams will be overwhelmed and unable to process more than a small number of the referrals.

That is why we argue that schools should not add yet another first level screening survey. Rather schools need to devote their limited time and sparse resources to transforming student/learning supports into a system that better addresses barriers to learning and teaching.

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Appreciating the Full Range of Potential Barriers to Healthy Development and Learning

A transactional view of the causes of human behavior emphasizes that, for a great many students, external not internal factors often are the basis for a student's learning, behavior, and emotional problems. And when this is the case, it is the external factors that should be the primary focus of attention.

Exhibit 1 highlights an expanded set of examples of barriers to learning, development, and teaching. Besides pathological conditions that make schooling difficult, children bring a wide range of problems to school stemming from restricted opportunities associated with poverty, difficult and diverse family conditions, high rates of mobility, lack of English language skills, violent neighborhoods, problems related to substance abuse, inadequate health care, and lack of enrichment opportunities. These often are referred to as risk factors and barriers to learning and teaching.

As a result of such factors, each day at every grade level there are students who are not ready to perform and learn in the most effective manner. And students' problems are exacerbated as they internalize frustrations related to the barriers and the debilitating effects of performing poorly academically, socially, and often in both arenas.

Addressing students' learning, behavior, and emotional problems begins with a basic appreciation of both primary and secondary instigating factors and whether they can be ameliorated. Inadequate interventions allow problems to persist and fester with life-shaping consequences.

Exhibit 1

Examples of Risk-Producing Conditions that Can Become Barriers to Healthy Development and Learning

Environmental Conditions*			**Person Factors***
Neighborhood	***Family***	***School and Peers***	***Individual***
• High poverty • High rates of crime, drug use, violence, gang activity • High unemployment, abandoned/floundering businesses • Disorganized community • High mobility • Lack of positive youth development opportunities	• Domestic conflicts, abuse, distress, grief, loss • Unemployment, poverty, and homelessness • Immigrant and/or minority status • Family physical or mental health illness • Poor medical or dental care • Inadequate child care • Substance abuse	• Poor quality schools, high teacher turnover • High rates of bullying and harassment • Minimal offerings and low involvement in extracurricular activities • Frequent student- teacher conflicts • Poor school climate, negative peer models • Many disengaged students and families	• Neurodevelopmental delay • Physical illness • Mental disorders/ addictions/Disabilities • Inadequate nutrition and healthcare • Learning, behavior, & emotional problems that arise from negative environmental conditions that exacerbate existing internal factors

*A reciprocal determinist view of behavior recognizes the interplay of environment and person variables.

Needed: A Broader Classification Framework

The need to address a wider range of variables in labeling problems is clearly seen in efforts to develop multifaceted systems. The multiaxial classification system developed by the American Psychiatric Association in its recent editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) represents the dominant approach. This system does include a dimension acknowledging "psychosocial stressors." However, this dimension is used mostly to deal with the environment as a contributing factor, rather than as a primary cause.

The conceptual example illustrated in Exhibit 2 is a broad framework that offers a useful starting place for classifying behavioral, emotional, and learning problems in ways that avoid overdiagnosing internal pathology. As outlined in the exhibit, such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems caused by the environment are placed at one end of the continuum and referred to as Type I problems. At the other end are problems caused primarily by pathology within the person; these are designated as Type III problems. In the middle are problems stemming from a relatively equal contribution of environmental and person sources, labeled Type II problems.

To be more specific: In this scheme, diagnostic labels meant to identify *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category. Obviously, some problems caused by pathological conditions within a person are not manifested in severe, pervasive ways, and there are persons without such pathology whose problems do become severe and pervasive. The intent is not to ignore these individuals. As a first categorization step, however, it is essential they not be confused with those seen as having Type III problems.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of personal characteristics and failure of the environment to accommodate that individual.

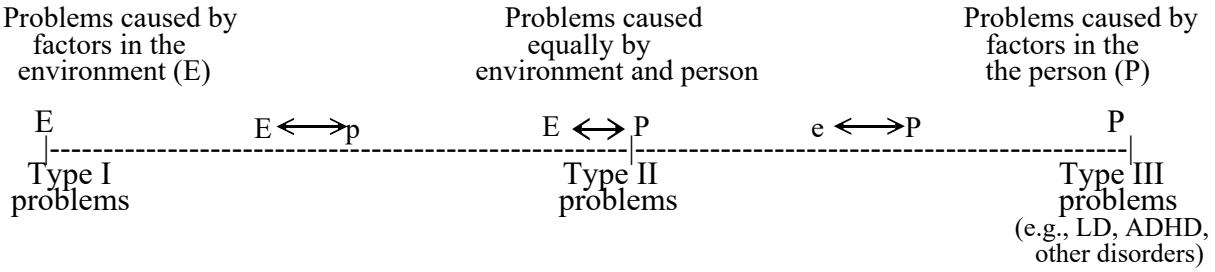
Of course, variations occur along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies.

Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating problems. Furthermore, some problems are not easily assessed or do not fall readily into a group due to data limitations and individuals who have more than one problem (i.e., comorbidity). However, the above scheme shows the value of starting with a broad model of cause. In particular, the continuum helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual. This helps combat tendencies toward blaming the victim. It also helps highlight the notion that improving the way the environment accommodates individual differences often may be a sufficient intervention strategy.

Exhibit 2

A Continuum of Problems Based on a Broad Understanding of Cause*

PRIMARY SOURCE OF CAUSE



- caused primarily by environments and systems that are deficient and/or hostile
- problems are mild to moderately severe and narrow to moderately pervasive

- caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology)
- problems are mild to moderately severe and pervasive

- caused primarily by person factors of a pathological nature
- problems are moderate to profoundly severe and moderate to broadly pervasive

*Using a transactional view, the continuum emphasizes the *primary source* of the problem and, in each case, is concerned with problems that are beyond the early stage of onset.

. . . consider the American penchant for ignoring the structural causes of problems. We prefer the simplicity and satisfaction of holding individuals responsible for whatever happens: crime, poverty, school failure, what have you. Thus, even when one high school crisis is followed by another, we concentrate on the particular people involved – their values, their character, their personal failings – rather than asking whether something about the system in which these students find themselves might also need to be addressed.

Alfie Kohn

Concluding Comments

Normality and exceptionally (or deviance) are not absolutes; both are culturally defined by particular societies at particular times for particular purposes.

Ruth Benedict

Strong images are associated with diagnostic labels, and people act upon these notions. Sometimes, the images are useful generalizations, but often they are harmful stereotypes. Sometimes, they guide practitioners toward good ways to help. But often, they contribute to blaming the victim by making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem. In all cases, diagnostic labels can profoundly shape a person's future – in good and bad ways.

A large number of young people are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters behave in ways that distress others; only a small percent have ADHD or a conduct disorder. In some schools, the majority of students have garden variety learning problems; only a few have learning disabilities. Thankfully, those suffering from true internal pathology (those referred to above as Type III problems) represent a relatively small segment of the population. Society must never stop providing the best services it can for such individuals and doing so means taking great care not to misdiagnose others whose "symptoms" may be similar but are caused to a significant degree by factors other than internal pathology (those referred to above as Type I and II problems).

As community agencies and schools struggle to find ways to finance programs for troubled and troubling youth, they continue to tap into resources that require assigning youngsters labels that convey severe pathology. Reimbursement for mental health and special education interventions is tied to such diagnoses. The situation dramatically illustrates how social policy shapes decisions about who receives assistance and the ways in which problems are addressed. It also represents a major ethical dilemma for practitioners. That dilemma is not whether to use labels, but rather how to resist the pressure to inappropriately use those labels that yield reimbursement from third party payers.

Misdiagnoses lead to policies and practices that exhaust available resources in serving a relatively small percent of those in need. That is one major reason why there are so few resources to address the barriers interfering with the education and healthy development of so many youngsters who are seen as troubled and troubling.

For these and other reasons, considerable criticism exists about some diagnostic labels, especially those applied to young children. Nevertheless, sound reasons underlie the desire to differentially label problems. One reason is that, if properly identified, some problems can be prevented; another is that proper identification can enhance correction.

However, the labeling process remains difficult. Severity has been the most common factor used to distinguish many student problems (e.g., ADHD and LD) from the many commonplace behavior, learning, and emotional problems that permeate schools. Besides severity, there has been concern about how pervasive the problem is (e.g., how far behind an individual lags in academic and social skills). Specific criteria for judging severity and pervasiveness depend on prevailing age, gender, subculture, and social status expectations. Also important is how long the problem has persisted.

Because the number of misdiagnoses has increased dramatically over the last 30 years, prior to the COVID-19 crisis greater attention was being paid in schools to differentiating commonplace student problems from personal pathology. With an increased number of learning, behavior, and emotional problems, this trend is likely to have a set-back. Practices such as *response to intervention* can be helpful. However, as underscored in subsequent chapters, how to mobilize unmotivated and disengaged students remains a core concern in any effort to rule out whether a student has a true disability/disorder (see Exhibit 3).

Exhibit 3

As they reopen: Are Schools Doing Enough to Counter Pathological Labeling?

(1) Are student support staff:

- providing general info – about the wide range of "normal" behavior and individual differences and the importance of not over-pathologizing? (e.g., distributing info and fact sheets, offering info as part of a school's inservice program)
- offering specific feedback on specific incidents and students? (e.g., using staff concerns and specific referrals as opportunities to educate them about what is and is not pathological and what should be done in each instance)
- resisting the pull of special funding? (One of the hardest things to do is avoid using the need for funds and other resources as justification interpreting a student's actions as "pathological.")
- using the least intervention needed when it becomes essential to provide students with special assistance?

(2) Is there a focus in the professional development of teachers to ensure they have the knowledge and skills to

- engage all students in learning?
- re-engage students who have become disengaged from classroom learning?
- accommodate a wider range of individual differences when teaching?
- use classroom assessments that better inform teaching?

And remember that diagnostic labels can be inaccurate and they can profoundly shape a person's future

For resources related to the above concerns, see the links in relevant Quick Finds developed by our Center a UCLA – http://smhp.psych.ucla.edu/quicksearch.htm

And for more on all this, see the links provided by our Center's Online Clearinghouse Quick Finds:

>*Assessment and Screening* – http://smhp.psych.ucla.edu/qf/p1405_01.htm

>*Stigma Reduction* – http://smhp.psych.ucla.edu/qf/stigma.htm

The Center for Mental Health in Schools operates under the auspices of the School Mental Health Project in the Dept. of Psychology, UCLA.

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