

An Evidence-Based Approach to Reducing Disproportionality in Special Education and Discipline Referrals

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The District of Columbia Public Schools (DCPS) has been nationally recognized as a leader in education reform (Chandler, 2015). Our goal as a school district is to ensure that every DCPS school provides a world-class education that prepares all students, regardless of background or circumstance, for success in college, career, and life (DCPS, n.d.). We have invested substantially in creating schools where students can receive high-quality instruction, feel safe, and are satisfied with their school experience. Yet we still have some work to do. We must ensure that students of various racial and ethnic subgroups have the same access to the general education curriculum as do students from the majority culture because disproportionality is empirically linked to gaps in achievement (Hosp & Reschly, 2004). *Disproportionality* is defined as either the overrepresentation or underrepresentation of a particular population or demographic group in special or gifted education programs relative to the presence of this group in the overall student population (National Association for Bilingual Education, 2002).

DCPS shifted the way we support students' academic and functional performance in 2011. Before school year 2011–2012, related service providers (RSPs) at DCPS identified their roles in the school setting as advocates and liaisons, especially as it relates to academic functioning. However, students had clinical needs that were not being met and the signs and symptoms of their diagnoses were preventing students and their peers from accessing the curriculum. In addition, a growing bank of data began to show that children and youths were more likely to benefit from clinical services provided in school as opposed to services provided in the

community. According to Catron, Harris, and Weiss (1998), for example, students are seven times more likely to follow through with clinical services provided in the school than with services provided in the community. Based on both observation and data, DCPS's School Mental Health Team fostered a paradigm shift wherein RSPs were encouraged to meet students' holistic needs as opposed to focusing solely on academic achievement. We developed a screening protocol and expanded our response to intervention (RTI) model to include socioemotional and behavioral needs. The goal of these efforts was to link students to a menu of intervention options that were directly related to their needs.

RTI

Reducing disproportionality as it relates to discipline referrals and special education eligibility determination is incumbent on the creation and consistent implementation of fair, unbiased school policy. School policy is informed not only by local and school leadership, but also by the federal government. The Individuals with Disabilities Education Act of 1990 (P.L. 105–17), one such federal law, requires local education agencies to use the RTI educational framework. RTI is designed around a multitiered approach to the early identification and provision of supports to students when they are struggling academically or behaviorally in the general education school setting (Hosp, n.d.). Several of the characteristics of an RTI model can be useful for monitoring and addressing issues of disproportionality, including intentional focus on data-based decision making in educational planning. Although educators have always collected data to make

decisions about individuals or classrooms, schools that commit to the use of RTI have become more sophisticated in monitoring trends in broad and more granular ways that enable better matching of needs to appropriate supports. A good RTI system requires the use of a defined universal screening procedure with reliable measures that can be used to make decisions about individual performance. It eliminates some of the guesswork in understanding why students are struggling academically, socially, or emotionally; and requires a cadre of interventions available to meet each student's unique needs.

EBIs

DCPS began a focused effort to provide more socioemotional supports to students who presented with a need. We ensured that our workforce was highly qualified to ensure that workers could implement structured, evidence-based treatments (EBTs) and practices. We piloted EBTs for several years and assessed their impact. Some of the piloted EBTs were subsequently introduced to schools districtwide. We have introduced a minimum of one EBT each year since we began our efforts and continue to scale up to meet the diverse needs of our students. Our use of evidence-based interventions (EBIs) over the years includes trauma-focused interventions across both elementary and secondary levels to help our students effectively address the difficulties they face in day-to-day interactions with their environments.

The following are EBIs currently being implemented in DCPS:

- **Cannabis Youth Treatment:** A school-based intervention to address cannabis use disorders. Treatment uses motivational enhancement therapy and cognitive-behavioral therapy principles in sessions with adolescents between the ages of 12 and 18.
- **Child-Centered Play Therapy:** An evidence-informed, early intervention approach to help young children self-regulate emotions, develop improved executive functioning skills, and increase emotional literacy using play.
- **Cognitive-Behavioral Intervention for Trauma in Schools:** A school-based intervention for addressing specific incidents of trauma exposure. It is designed for students between grades 5 and 9.

- **Cognitive-Behavioral Therapy:** A problem-focused intervention that seeks to teach children who manifest socioemotional challenges and maladaptive behaviors to become their own therapist.
- **Grief and Trauma Intervention:** An intervention designed for children ages seven to 12 who are exhibiting posttraumatic stress.
- **Structured Psychotherapy for Adolescents Responding to Chronic Stress:** An intervention targeting chronically traumatized adolescents experiencing chronic stress and problems in functioning.
- **Theater Troupe/Peer Education Project:** An evidence-based prevention and peer education intervention that increases knowledge of social norms; modifies attitudes, beliefs, and intentions through the examination of consequences; and promotes the development of communication and peer refusal skills related to alcohol use, marijuana use, domestic violence, and other student-specific topics.

A COMPREHENSIVE PLAN: PUTTING IT ALL TOGETHER

DCPS has developed a comprehensive plan for early identification and screening of students with social, emotional, and behavioral concerns using reliable measures to ensure that they participate in interventions that accurately match their needs. This screening process parallels the existing RTI process for academic concerns.

Students who are identified as “at risk” based on Early Warning Indicator data are referred to the RTI team and proceed through the socioemotional behavior screening process. This process begins with the school psychologist conducting screening using the Strengths and Difficulties Questionnaire (Goodman, 2001) for students ages three to 17, or the Global Appraisal of Individual Needs (Dennis, Feeny, Stevens, & Bedoya, 2007) for students 18 years of age and older and students with reported concerns related to substance abuse or antisocial behavior. If trauma is reported in the original referral or becomes known to school staff, the Child PTSD Symptom Scale (Foa, Johnson, Feeny, & Treadwell, 2001) and the Trauma History Questionnaire (Hooper, Stockton, Krupnick, & Green, 2011) are also administered. (For more information about the aforementioned scales, please refer to the [Appendix](#).) RTI

teams, which include school psychologists, clinical social workers, teachers, and all other relevant stakeholders, then make recommendations and develop intervention plans and referrals based on screening results and other relevant data. Use of this screening data allows RTI teams to develop interventions tailored to meet student educational and behavioral needs in a proactive and coordinated manner. This enables schools to identify barriers to learning earlier and ensures full access to academic offerings. In addition, this level of screening ensures that students are being provided appropriate intervention given their identified, not perceived, need.

The combination of an effective, data-driven RTI process; early screening plan; and menu of evidence-based, trauma-focused interventions serve as the keys to reducing disproportionality in discipline referrals and special education. When these processes are carried out, data show that students are able to progress in their area of need because the interventions are specific and targeted.

Progress has not come without challenges. Some barriers to these processes have included varying levels of awareness about the connection between mental health and academic achievement, competing priorities for school mental health staff, and an emergent universal prevention plan. All of these challenges can lead to reactive responses to students who act out the pain of performance and psychological challenges. Through commitment to this practice, expected outcomes include a proportionate representation of students in gifted and specialized instruction programs.

The DCPS School Mental Health Team continues to develop processes to meet the challenge of reducing disproportionality, with focus on disciplinary practice, specialized instruction, and improving overall mental health. The availability of comprehensive school mental health supports is essential for addressing barriers to school engagement and optimal academic performance. **CS**

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APPENDIX: Overview of Progress Monitoring Tools Used to Measure Significance in District of Columbia Public Schools

The Child PTSD Symptom Scale (CPSS) is a 17-item measure divided into two sections: symptoms and functioning. Scores greater than or equal to 15 suggest the presence of clinically significant post-traumatic stress disorder signs and symptoms. Students who reported that they had experienced a trauma on

the Trauma History Questionnaire and endorsed a CPSS score of 14 or higher were considered appropriate candidates for trauma-specific interventions such as Structured Psychotherapy for Adolescents Responding to Chronic Stress, Cognitive–Behavioral Intervention for Trauma in Schools, and Grief and Trauma Intervention.

The Global Appraisal of Individual Needs–Short Screener (GAIN–SS) was the primary progress monitoring tool for middle and high school students. It was also the progress-screening and monitoring instrument used with Cannabis Youth Treatment. GAIN–SS is a self-report instrument that serves as a periodic measure of behavioral health over time. GAIN–SS has 23 scored items divided into four subscreeners: Internalizing Disorder, Externalizing Disorder, Substance Disorder, and Crime/Violence. Students report when they last experienced an identified problem. Scores in the moderate range (1–2) or high range (3+) on the four subscreeners are used to identify the specific kinds of behavioral health services that students need.

The Strength and Difficulties Questionnaire (SDQ) was the primary tool used by DCPS social workers to measure indicators of behavioral progress for students in grades preK–5. It is a brief behavioral screening questionnaire that queries parents and teachers about the socioemotional functioning of children ages three to 16 years. Older children can also self-report their symptomology.

Each version of the SDQ asks 25 questions related to students’ strengths and areas of growth. The questions are divided between five scales:

1. Emotional Symptoms
2. Conduct Problems
3. Hyperactivity/Inattention
4. Prosocial Behavior
5. Peer Relationship Problems

For each of the five scales, the score can range from 0 to 10 depending on how the questions were answered. Scores are classified as normal, borderline, and abnormal. Scores on the higher end of the “abnormal” range are considered clinically significant.

Extended versions of the SDQ include an impact supplement that asks whether the respondent thinks the student has a specific problem, especially as it relates to chronicity, distress, social impairment, and burden to others. These additional data provide useful information to related

service providers for treatment planning and determining necessity for further assessment.

The Trauma History Questionnaire (THQ) is a 24-item self-report measure that examines experiences with potentially traumatic events such as crime, general disaster, and sexual and physical assault. Students answer “yes” or “no” to each question. THQ is used in conjunction with CPSS to determine whether there is a need for intervention.

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