Moving Forward

Addressing Barriers to Learning

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... the Center's quarterly e-journal

Countering LD and ADHD False Positive Diagnoses: Another Pandemic Challenge

Strong images are associated with diagnostic labels. Sometimes the images are useful generalizations; sometimes they are harmful stereotypes. Sometimes they guide practitioners toward good ways to help; sometimes they contribute to "blaming the victim" – making young people the focus of intervention rather than improving system deficiencies that are causing the problems in the first place. In all cases, diagnostic labels can profoundly shape a person's future and influence what is and isn't done to ensure equity of opportunity at school.

COVID 19 disruptions have exacerbated students' learning, behavior, and emotional problems. As a result, it is likely that, in addition to being seen as anxious, stressed, depressed, and lagging behind academically, more students will end up being diagnosed as having a learning disability (LD) or attention deficit/hyperactivity disorder (ADHD).

LD and ADHD are the two most commonly diagnosed learning and behavior problems. Informed researchers, practitioners, and policy makers in the U.S. and in other countries long have cautioned about widespread misapplications of the terms. They stress that the problems manifested at school by most youngsters tend not to be rooted primarily in personal pathology. Misdiagnosing such students has significant repercussions for them, for schools, and for society

Our intent here is to highlight the challenge for schools by (1) underscoring the problem, (2) suggesting an alternative way of categorizing learning and behavior problems, and (3) exploring how schools can stem the tide of false positive diagnoses.

The Problem

Many children and adults are diagnosed as LD or ADHD by primary-care physicians

It is estimated that about 5% of school-aged children are diagnosed as having a learning disability, with core symptoms designated as underachievement of basic academic skills, especially reading, and deficits in processing abilities. About 5% of school-aged children also are diagnosed as ADHD, with core symptoms being not paying attention when it is asked for, being highly active, and acting impulsively. Reported prevalence differs among states (e.g., ranging from 5 to 15% of school aged children).

By the early 2000s, learning disabilities had become the largest group in special education in the U.S. (about 50% of those with IEPs). It was widely recognized that many were inappropriately diagnosed in order to provide them with additional services. The growing numbers became an excessive drain on already overburdened special education budgets and contributed to the backlash to LD seen in the reauthorization of the *Individuals with Disabilities Act*.

A similar concern has arisen related to ADHD. After the 1997 reauthorization of IDEA allowed students diagnosed as having ADHD to receive special education services, the rates of ADHD diagnosis increased an average of 3% a year. For IEP purposes, these students are grouped under the "other health impairments" category and are the largest group in that category. Students labeled as ADHD also may be diagnosed with other problems such as LD; thus, some are served under the LD designation.

There is concern that youngsters who manifest common learning problems or "garden-variety" misbehavior or are simply immature may be misdiagnosed as LD or ADHD. For example, in 2010, a study by Elder estimated that nearly 1 million children in the U.S. were misdiagnosed as ADHD because they were the youngest and most immature in their kindergarten class.

Because of the significant differences in reported prevalence of LD and ADHD across the U.S. and around the world, concern has been raised that, in some places, there is substantial overdiagnosis. The degree to which this is the case is compounded by parents and teachers seeking such diagnoses and older students and adults feigning these disorders to obtain special accommodations in the classroom and in academic testing situations. Concerns about ADHD misdiagnosis are compounded because of the frequency with which the diagnosis leads to prescribing medication.

Differential diagnosis clearly is difficult and where LD and ADHD rates have increased markedly there usually is a backlash suggesting significant false positive diagnoses. In discussing problems of diagnosing mental disorders in general, Hyman (2010) focuses in on ADHD and concludes:

> "The conceptualization of ADHD as a category discontinuous from normalcy is not only implausible, but also inhibits the kind of research that would improve the ... utility of the diagnosis and perhaps its validity. ... Arbitrary symptom counts do not provide effective tools for family doctors and other primary care practitioners, who evaluate the majority of children for ADHD, to make a diagnosis against the moving developmental target of brain maturation."

As noted, a backlash happened with LD in the U.S. in the early 2000s; it is happening currently with ADHD and LD in the United Kingdom. Questions inevitably arise such as:

> *How often are false positive diagnoses arrived at inappropriately because of personal-professional, social-cultural, and economic interests and biases?*
>
> *What is the impact on research, practice, policy, and training of skewing differential diagnosis in ways that maximize false positive and minimize false negative diagnoses?*
>
> *Can school interventions play a significant role in preventing and identifying misdiagnoses*?

Differentiating Causes Rather than Labeling "Symptoms"

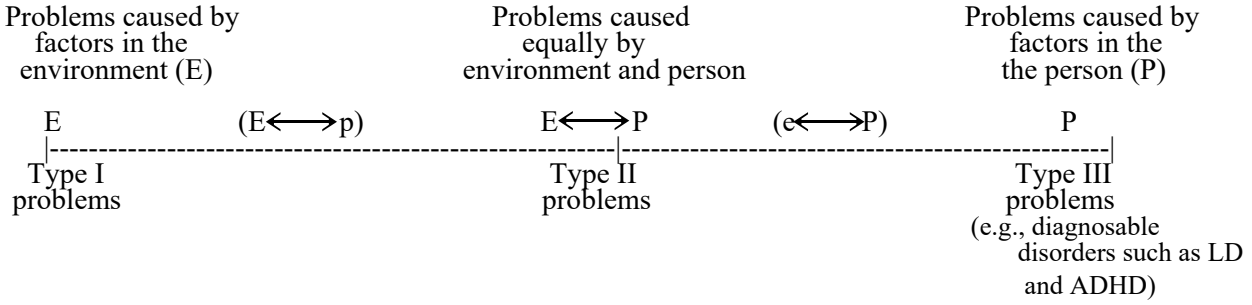
What often is not well understood by the general public is that the prevailing classification schemes used in special education and psychiatry focus mainly on "symptoms" and the labels assigned imply personal disorders and disabilities. The matter is compounded by subtyping efforts that focus only on differentiating within the diagnosed group.

All this ignores the reality that learning and behaviors *problems* often begin with environmental factors. Understanding the initial causes of students' learning and behavior problems is best done from the perspective of a transactional paradigm (i.e., reciprocal determinism) and dimensional labeling. A transactional perspective ensures full consideration of ecological viewpoints, while not losing site of the individual's contribution to a given problem. The following Exhibit illustrates the point.

Exhibit 1

A Continuum of Problems Based on a Transactional 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.

Adapted from the work of Adelman & Taylor and published in various resources.

As illustrated, when a learning, behavior, and/or emotional problem arises, a transactional paradigm considers whether the *primary* instigating factors leading to the problem stem from conditions in (a) the environment, (b) factors within a person, or (c) a specific set of transactions. For example, some neighborhood, home, and school environments seem to produce vulnerabilities to learning and behavior problems for many students. In contrast, subtle central nervous system disorders that produce learning *disabilities* and attention deficit/hyperactivity *disorders* are much less common.

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 environments. Such conditions should be considered first in hypothesizing what *initially* caused the individual's learning, behavioral, and emotional problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

The continuum offers a perspective that can help counter premature conclusions that a problem is caused by deficiencies or pathology within the individual

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 person characteristics and failure of the environment to accommodate that individual.

There are, of course, variations 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 among learning and behavior problems in general and at different periods in an individual's development. The reality is that problems vary in severity, pervasiveness, and chronicity; some problems are not easily or reliably assessed; many are not differentiated readily or validly because problems can have more than one cause and/or manifestation.

Given all this, the continuum outlined in the Exhibit illustrates the potential value of starting with a broad model of cause and can play a role in countering tendencies of classification schemes to reify prevailing diagnostic criteria. In particular, it provides a perspective that can counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual and thus can help combat blaming the victim. It also helps highlight the notion that improving the way the environment accommodates individual differences often may be a sufficient strategy for correcting and preventing many learning, behavior, and emotional problems.

Schools Can Stem the Tide of Misdiagnoses

As a way to help reduce false positive diagnoses, schools have adopted the idea of requiring a procedure called *Response to Intervention* (RTI) before considering a formal diagnosis for special education eligibility. Effective use of RTI is expected be a counter measure to premature diagnoses of LD and ADHD.

Response to Intervention (RTI): An Aid in Countering Misdiagnoses

To support the RTI movement, the U.S. Department of Education funded a technical assistance center, the National Center on Response to Intervention, involving the American Institutes for Research and researchers from Vanderbilt University and the University of Kansas (http://www.rti4success.org/). The center defines and frames response to intervention as follows:

> "The purpose of RTI is to provide all students with the best opportunities to succeed in school, identify students with learning or behavioral problems, and ensure that they receive appropriate instruction and related supports." This purpose is translated into a definition that states "response to intervention integrates assessment and intervention within a multi-level prevention system to maximize student achievement and to reduce behavior problems. With RTI, schools identify students at risk for poor learning outcomes, monitor student progress, provide evidence-based interventions and adjust the intensity and nature of those interventions depending on a student's responsiveness, and identify students with learning disabilities or other disabilities."
>
> A RTI center guidebook describes four essential components of response to intervention as (1) a school-wide, multi-level instructional and behavioral system for preventing school failure, (2) screening, (3) progress monitoring, and (4) data-based decision making for instruction, movement within the multi-level system, and disability identification (in accordance with state law). The guidebook also states response to intervention is "a framework for providing comprehensive support to students and is not an instructional practice" and that "RTI is a prevention oriented approach to linking assessment and instruction that can inform educators' decisions about how best to teach their students.

Concerns have been raised about RTI

The approach formulated by the RTI center is meant to be broad-based and preventative*, but it is too limited* in how it frames what needs to go on in a classroom and schoolwide to enable learning, engage students, and keep them engaged. From a special education perspective, there is fear that the process will inappropriately delay identification of students with true LD and ADHD. As an intervention initiative, the concern is that the approach will be pursued simplistically. In many places, RTI is viewed primarily as a matter of providing more and better instruction. This is too limited in nature and scope to address the wide range of factors interfering with the learning of many students. Instructional strategies always need to be conceived as one part of a comprehensive system of classroom and school-wide learning supports. Viable school improvement requires that initiatives such as RTI help in differentiating Type I, II, and III problems not only by responding early after onset, but also by preventing many from occurring in the first place.

For RTI to be highly effective, significant changes are needed with respect to how administrators, teachers, student support staff, and other key stakeholders transform those schools where a significant proportion of students lack enthusiasm about attendance and about engaging in the day's lesson plans. This is especially the case in schools where many students have become disengaged from classroom instruction, are behaving in disruptive ways, and are dropping out. To facilitate the success of such students, staff must enable them to (1) get around interfering barriers and (2) (re)engage in classroom instruction. Properly designed, RTI strategies can help with all this if they are embedded into the larger agenda for transforming classroom and schoolwide approaches in ways that ensure equity of opportunity for all students to succeed at a given school. Applied in a sequential and hierarchical manner RTI can aid in differentiating Type I, II, and III problems and, thus, can help counter misdiagnoses.

Most schools, of course, are not seeking to increase the special education population; some already find it hard to meet IDEA mandates. And yet, schools are not mobilizing to counter the dilemmas arising from the numbers of students inappropriately diagnosed as LD and ADHD.

This is the time for schools to enable student/learning support staff to work with teachers to

- engage all students in learning
- reengage students who have become disengaged from classroom learning
- accommodate a wider range of individual differences when teaching
- use in-classroom responses to intervention (RtI) to better inform teaching and special assistance

Professional development can include

- 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)
- feedback on specific incidents and students (e.g., using staff concerns and specific referrals as opportunities to educate about what is and is not pathological and what should be done in each instance)
- an emphasis on avoiding interpreting a student's actions as "pathological" in order to justify using funding targeted for labelled students.

Concluding Comments

Obviously some students have significant problems that require referral for special assistance and even special education identification and services. However, care must be exercised to avoid mislabeling and overpathologizing such problems, especially given the impact of COVID-19 on learning, behavior, and emotional states.

The problems in making a valid diagnoses of ADHD and LD will continue as long as they are based on clinical assessment of behavioral *symptoms*. The symptom criteria relied on are common behaviors found among children in many cultures and vary significantly with development. The instability of symptom patterns and the many problems related to reliability and validity of current assessment procedures are well recognized. Also well discussed are the inequities and biases related to race, ethnicity, and primary language.

The thinking of those who study learning, behavioral, and emotional problems has long been dominated by models stressing person pathology. This is evident in discussions of cause, diagnosis, and intervention strategies. Because so much discussion focuses on person pathology, diagnostic systems have not been developed in ways that adequately account for psychosocial problems. As a result, comprehensive formal systems currently used to classify problems in human functioning convey the impression that all learning, behavioral, or emotional problems are instigated by internal pathology.

Most differential diagnoses of children's problems are made by focusing on identifying one or more disorders (e.g., learning disabilities, attention-deficit/hyperactivity disorder, oppositional defiant disorder, adjustment disorders), rather than first asking: *Is there a disorder?*

Overemphasis on classifying problems in terms of personal pathology skews theory, research, practice, and public policy. One example is seen in the fact that comprehensive classification systems do not exist for environmentally caused problems or for psychosocial problems (caused by the transaction of internal and environmental factors).

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.

Given all this, is it any wonder that diagnoses of LD and ADHD are controversial?

Our center at UCLA stresses that major breakthroughs in countering students' learning, behavior, and emotional problems can be achieved only when school improvement policy, planning, implementation, and accountability *comprehensively* address barriers to learning and teaching and re-engage disconnected students. One major facet of this involves redesigning and transforming a wide range of regular classroom strategies to enable learning. Specifically, we place RTI in the context of the classroom and delineate it as a sequential and hierarchical approach for all students. At the same time, we emphasize that classroom efforts to enhance equity of opportunity must be embedded within a comprehensive schoolwide system of student and learning supports. See

>*Improving School Improvement*

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

>*Embedding Mental Health as Schools Change*

all 3 can be accessed at http://smhp.psych.ucla.edu/improving_school_improvement.html

What happened at school today?

They said I'm too active so they put me in the slow class!

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For more on what schools can do to meet the challenges ahead by more effectively addressing students' learning, behavior, and emotional problems, see the sample of some of the free recent resources listed at the end of this issue.

About Using the Relief Funds to Begin Transforming Student/Learning Supports

Another challenge for schools at this time is to use some of the relief funds to do more than address the service needs of a few more individuals. Schools have struggled long and hard to provide necessary services to students. The reality is that they have only been able to serve a small proportion. So, it is not surprising that many are using temporary relief funds to enhance access to services and availability (e.g., by hiring a few more student support staff). While well-intentioned, enhancing *services* does little to address long-term deficiencies with respect to how schools address the many students manifesting learning, behavior, and emotional problems .

Moreover, we caution that focusing mainly on service provision has negative consequences for reworking student and learning supports to better meet a whole child agenda. For example, the overemphasis on "services" and billing Medicaid narrows and limits the roles and functions of many district and school student support staff; it increases counterproductive competition between school and community providers; it leads to excessive screening for mental health problems at the expense of improving classroom and schoolwide special assistance and accommodations; it slows development of comprehensive community schools and other forms of school-community collaboration.

In the process, it further limits and *marginalizes* student and learning supports in school improvement policy and practice. And it certainly undermines efforts to (1) *unify* student and learning supports at schools and then (2) develop them into *a comprehensive and equitable system* that integrates a wide range of community resources.

The opportunity at this time is to use part of the relief funds to begin the process of building a *unified, comprehensive, and equitable system of learning supports* to better address barriers to learning and teaching and reengage disconnected students (and families). Such system building will enable schools to enhance their role in addressing the learning, behavior, and emotional problems of and increase equity of opportunity for a great many more students in the coming years.

At a time when schools are confronted with a wide range of factors interfering with success at school, the need is to build a system that brings together not only essential health services, but develops a systematic and equitable approach to supporting students, families, and school staff at school each day. This includes *six domains of student/learning supports* (preK-12):

- enhancing supports *in classrooms*
- supporting transitions
- increasing home connections to the school
- increasing community involvement and collaborative engagement
- responding to, and where feasible, preventing crises

and, of course,

- facilitating student and family access to effective services and special assistance *as needed*. (If the other domains are well-addressed and the school's role in promoting social and emotional development is well-enhanced, the number needing referral for specialized help can be significantly reduced.)

The Exhibit on the next page outlines some steps schools can take immediately to begin reworking student/learning supports.

For a detailed discussion of a unified, comprehensive, and equitable system of student and learning supports and about the six domains, see

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

both can be accessed from our Center's website. Go to:
http://smhp.psych.ucla.edu/improving_school_improvement.html

Some Next Steps in Improving a School's Student/Learning Supports

(1) Establish a Learning Supports Leadership Team
(See *What is a learning supports leadership team?* http://smhp.psych.ucla.edu/pdfdocs/Report/resource_oriented_teams.pdf)

(2) Have the team

(a) map existing resources for addressing barriers to learning and teaching and renegaging disconnected students (see *Mapping & Analyzing Learning Supports* http://smhp.psych.ucla.edu/summit2002/tool%20mapping%20current%20status.pdf and *An Aid for Initial Listing of Current Resources Used at a School for Addressing Barriers Learning and Teaching* http://smhp.psych.ucla.edu/pdfdocs/listingresources.pdf)

(b) analyze what's working, what needs strengthening, and critical gaps

(c) develop a set of prioritized recommendations for moving toward a unified, comprehensive, and equitable system of student/learning supports

(d) present the recommendations for approval.

(3) After a set of proposed improvements are approved, establish a workgroup to develop a strategic action plan that details the who, what, and when of the steps forward.

(4) Assign the Learning Supports Leadership Team to guide implementation of the strategic plan.

For more aids in moving forward, see the *System Change Toolkit* http://smhp.psych.ucla.edu/summit2002/resourceaids.htm

Also see the recent Center reports:

>2021-22: *Addressing Learning, Behavior, and Emotional Problems Through Better Use of Student and Learning Support Staff* http://smhp.psych.ucla.edu/pdfdocs/supports.pdf

>*Evolving Community Schools and Transforming Student/Learning Supports* http://smhp.psych.ucla.edu/pdfdocs/evolvecomm.pdf

Finally, for those moving forward to develop a unified, comprehensive, and equitable system of learning supports, we offer free distance coaching and technical assistance http://smhp.psych.ucla.edu/pdfdocs/coach.pdf

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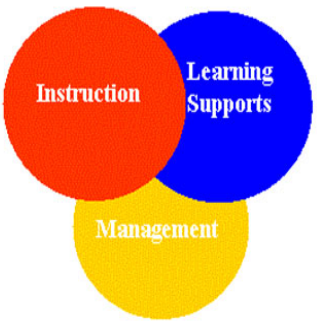

For information about the

National Initiative for Transforming Student and Learning Supports
go to http://smhp.psych.ucla.edu/newinitiative.html

Equity of opportunity is fundamental to enabling civil rights; transforming student and learning supports is fundamental to promoting whole child development, advancing social justice, and enhancing learning and a positive school climate.

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Some Recent Resource Aids from the Center

We provide a variety of resources to aid with school improvement. See, for example:

Books

These include prototypes for reframing student and learning supports (to unify and weave together available resources and rework operational infrastructure) at schools and districts. See

>*Improving School Improvement*

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

>*Embedding Mental Health as Schools Change*

all 3 can be accessed at http://smhp.psych.ucla.edu/improving_school_improvement.html

Recent Center Reports

2021-22: Addressing Learning, Behavior, and Emotional Problems Through Better Use of Student and Learning Support Staff
http://smhp.psych.ucla.edu/pdfdocs/supports.pdf

Enhancing Student/Learning Supports in Classrooms
http://smhp.psych.ucla.edu/pdfdocs/classroomredes.pdf

New Directions for School Improvement Policy
http://smhp.psych.ucla.edu/pdfdocs/policynd.pdf

Evolving Community Schools and Transforming Student/Learning Supports
http://smhp.psych.ucla.edu/pdfdocs/evolvecomm.pdf

About Connecting Students with the Right Forms of Mental Health Assistance
http://smhp.psych.ucla.edu/pdfdocs/connect.pdf

Implementation Science and Complex School Changes
http://smhp.psych.ucla.edu/pdfdocs/implemreport.pdf

Also see policy brief done for the Policy Analysis for California Education (PACE):

Restructuring California Schools to Address Barriers to Learning and Teaching in the COVID 19 Context and Beyond (The content, of course, is applicable to other states.)
https://edpolicyinca.org/publications/restructuring-california-schools-address-barriers-learning-and-teaching-covid-19

Community of practice *School Practitioner* http://smhp.psych.ucla.edu/practitioner.htm

This resource regularly shares information, ideas, resources, lessons learned, etc. about supporting students/families/community. The last few editions explored the following topics:

>*About increasing school attendance*
>*About alternative schools*
>*About the impact of the shortage of substitute teachers*
>*At this stage in the pandemic: How Are Adolescents Coping?*
>*How are schools currently addressing the many COVID-related problems arising for students?*
>*About addressing the impact of lost instructional time*
>*About making teams and work groups effective*

All also contain links to relevant resources from many sources.

Monthly ENEWS http://smhp.psych.ucla.edu/enews.htm

This resource provides many links to online resources and discussion topics and comments and sharing from the field. Specific topics covered recently:

>*Minimizing Stress Reactions & Preventing "Burnout"*
>*WELCOMING -- it seems more important than ever this school year*
>*About Supports for Transitions*
>*About students who are having problems adjusting to school*
>*A few cautions about screening and identifying students at this time*
>*How are Schools Enhancing Student Engagement? (in person, in quarantine, online....?)*

Quarterly ejournal - http://smhp.psych.ucla.edu/news.htm

Articles in the last two editions:

>*Outreaching to and reengaging disconnected students*
>*Improving differentiated instruction*
>*Broadly embedding social emotional learning and development*
>*Reorganizing student/learning supports*
>*Promoting staff well-being*
>*Schools and Mental Health: A Position Statement*
>*About Promoting Mental Health*
>*Everyone's Talking About Students' Mental Health: Schools Need to Avoid Five Potential Pitfalls*

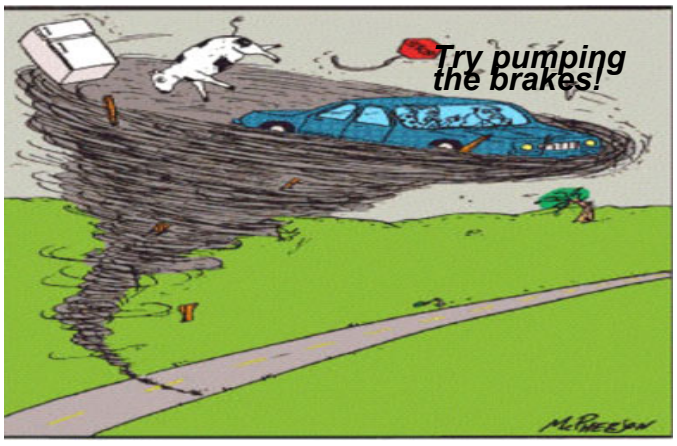
Commentaries and Calls to Action http://smhp.psych.ucla.edu/newinit3.html

Here are a few recent ones:

>*Open Letter to Chief School Officers, District Superintendents, School Board Members,Principals, and All Other Education Leaders* http://smhp.psych.ucla.edu/7-8-2021.pdf
>*2021-22: Addressing Learning, Behavior, and Emotional Problems Through Better Use of Student and Learning Support Staff* http://smhp.psych.ucla.edu/pdfdocs/supports.pdf
>*What's Being Done to Improve Efforts to Address Learning, Behavior, and Emotional Problems?* http://smhp.psych.ucla.edu/pdfdocs/8-26-21.pdf
>*Concerned about Mental Health in Schools? Then Focus on Improving How Schools Control and Socialize Students . . . see Misbehavior, Social Control, and Student Engagement* http://smhp.psych.ucla.edu/pdfdocs/misbeh.pdf
>*Schools and Mental Health: A Position Statement* http://smhp.psych.ucla.edu/pdfdocs/9-21-21.pdf
>*What Can Schools Do to Counter Unnecessary Referrals for Special Services and Over-Pathological Labeling of Students?* http://smhp.psych.ucla.edu/pdfdocs/9-23-21.pdf

A host of other free resources to aid in the transformation process are available on the Center's website http://smhp.psych.ucla.edu/ - for example, the *System Change Toolkit* http://smhp.psych.ucla.edu/summit2002/resourceaids.htm

And we offer free technical assistance and coaching if you need it - see http://smhp.psych.ucla.edu/pdfdocs/coach.pdf



We don't have email addresses for all who we hope will be interested, so please share this with your colleagues.

And as always, we ask that you share with us whatever you think others might find relevant. Send to Ltaylor@ucla.edu

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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Howard Adelman, Co-Director
Linda Taylor, Co-Director
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. . . and a host of students