

The Role of the School Psychologist in the Identification of Emotional Disability (ED)

Guidance and Technical Assistance for School Psychologists
In Assessment, Identification, Service Provision and Progress
Monitoring of Students with ED



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Maryland State Department of Education
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James H. DeGraffenreidt, Jr.
President, State Board of Education

Bernard J. Sadusky
Interim State Superintendent of Schools

Marcella E. Franczkowski
Assistant State Superintendent
Division of Special Education/Early Intervention Services
Maryland State Department of Education

Martin O'Malley
Governor

For more information about the contents of this document, please call the Maryland State Department of Education, Division of Special Education/Early Intervention Services, Family Services and Interagency Branch, 410-767-0858.

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Contributors

Mr. Brian Bartels

Director, Psychological Services
Montgomery County Public Schools

Ms. Brianna DeLauder

School Psychologist
Charles County Public Schools

Dr. Sally Dorman

Specialist, Psychological Services
Maryland State Department of Education

Dr. William Flook

Supervisor-Office of Psychological Services
Baltimore County Public Schools

Ms. Marcella Franczkowski

Former Branch Chief, Early Childhood
Intervention and Education Branch
Division of Special Education/Early
Intervention Services
Maryland State Department of Education

Dr. Vira Froehlinger

Consultant
Family Services and Interagency Branch
Division of Special Education/Early
Intervention Services
Maryland State Department of Education

Ms. Ann Geddes

Family Advocate
The Maryland Coalition of Families for
Children's Mental Health

Ms. Melissa Gordon

Family Support Services Consultant
Family Services and Interagency Branch
Division of Special Education/Early
Intervention Services
Maryland State Department of Education

Ms. Alice Harris

Branch Chief, Family Services and
Interagency Branch
Division of Special Education/Early
Intervention Services
Maryland State Department of Education

Dr. Carol Ann Heath

Former Assistant State Superintendent
Division of Special Education/Early
Intervention Services
Maryland State Department of Education

Dr. Margaret Kidder

Coordinator, Psychological Services
Baltimore County Public Schools

Ms. Susan Lorow

Supervising School Psychologist
Washington County Public Schools

Ms. Anita Mandis

Section Chief, Complaint Investigation
and Due Process Branch
Division of Special Education/Early
Intervention Services
Maryland State Department of Education

Ms. Leslie Seid Margolis

Managing Attorney, Education Unit
Maryland Disability Law Center

Ms. Pamela McCoy

School Psychologist
Office of Psychological Services
Prince George's County Public Schools

Dr. Michael McGrew

School Psychologist
Carroll County Public Schools

Ms. Kalisha Miller

Former Section Chief, Student
Achievement and Professional
Development Branch
Division of Special Education/Early
Intervention Services
Maryland State Department of Education

Dr. Rivka Olley

Supervisor Psychological Services
Baltimore City Public Schools

Dr. Joan Ledvina Parr

School Psychologist
Baltimore County Public Schools

Ms. Pamela Pencola

Former Director of Special Education
Frederick County Public Schools

Ms. Donna Riley

Branch Chief, Special Education
Administration Policy Branch
Division of Special Education/
Early Intervention Services
Maryland State Department of Education

Ms. Erin Runkel

School Psychologist
Somerset County Public Schools

Ms. Karla Saval

Interagency Specialist
Family Services and Interagency Branch
Division of Special Education/Early
Intervention Services
Maryland State Department of Education

Mr. Nickolas Silvestri

Resource School Psychologist
Office of Psychological Services
Anne Arundel County Schools

Ms. Alia Thomas

Special Educator
Special Education Taskforce
Howard County Public Schools

Mr. Dave Verdi

Psychologist
Baltimore City Public Schools

Dr. James M. Walsh

Former Director of Special Education
Howard County Public Schools

Dr. Mark Weist

Former Professor of Psychiatry
Psychiatry Department
University of Maryland

Executive Summary

Current data from the *2010 Special Education Census Report* indicate that 7,600 children and youth in Maryland were identified as having Emotional Disability (ED), comprising 7.34 percent of all students with disabilities receiving special education services in Maryland (Maryland State Department of Education, March 2011). In Maryland, students with ED traditionally have the highest dropout rate of all students, and are the most likely of all groups of students with disabilities to receive their education in a setting outside of their community school, in segregation from their nondisabled peers (Maryland State Department of Education, March 2010).

These students have the highest rates of suspension and expulsion of all students with disabilities and the poorest outcomes in terms of academic achievement and secondary transition to higher education and employment. There is a large difference between the 24 Maryland jurisdictions (from a high of 18 percent to a low of 1.4 percent) of students identified with Emotional Disability (Maryland State Department of Education, March, 2010). Additionally, a disproportionate number of Maryland students with ED are African-American (60 percent) and male (75 percent).

In the fall of 2009, the Maryland State Department of Education, in collaboration with representatives of the Maryland School Psychologists' Association, the Maryland Coalition of Families for Children's Mental Health, and the Maryland Disability Law Center, identified the need to examine the identification practices within local school systems when parents or school personnel suspect the presence of ED in children and youth. An interdisciplinary workgroup, including directors of student services, directors of special education, school psychologists, parents, and advocates met throughout the 2009-2010 school year to analyze data, examine current practices within Maryland and other states, review literature, and identify themes for this technical assistance paper.

The primary goals of this document are to:

- Describe appropriate identification practices when parents or school personnel suspect the presence of ED in children and youth;
- Foster improved consensus among school-based clinicians on effective practices;
- Establish a uniform standard for assessment, identification, and service delivery;
- Improve compliance with identification procedures;
- Promote consistency in current practice; and
- Address the role of the school psychologist in the provision of IEP services and supports to improve outcomes for this special education subgroup.

This document includes a comprehensive discussion of each of the following issues:

1. The role of the school psychologist in the disability determination process for students with ED:
 - Early intervention within general education
 - School psychologist's role with the initial IEP team process
 - Elements of the school psychologist's assessment for the IEP team
2. Eligibility criteria:
 - ED as a condition
 - ED as a set of 3 limiting criteria
 - ED characteristics
 - Schizophrenia
 - Social Maladjustment
3. Assessment procedures
4. Service delivery pathways for youth with Emotional Disability:
 - General education
 - Special education
 - Developing IEP goals and objectives

This document provides needed guidance and technical assistance for school psychologists in assessment, identification, service provision, and progress monitoring of students with ED. For families, youth, advocates, administrators, and school personnel, the information set forth in this document will facilitate understanding of the school psychologist's role throughout each of these processes. Each of the aforementioned partner agencies has both an interest and an investment in improving educational outcomes for this population of students. The technical assistance around identification of ED accurately reflects the current evidence-based practices and highlights our State's progressive efforts to ensure timely assessment, diagnosis, and services for children with mental health needs.

The guidance in this document is intended to clarify the terminology and criteria as stated in the current definition and requirements set forth within the Individuals with Disabilities Education Act (IDEA) and the Code of Maryland Regulations (COMAR).

The workgroup hopes that this document is used as a resource to accurately identify students with ED and equip IEP teams with recommendations on the full continuum of special education services, allowing service in inclusive and supportive community settings.

Introduction

Maryland's data for students with ED indicate that these youth experience the poorest outcomes of students in all disability groups. Throughout history, the definition, terminology, and criteria used to identify ED have changed, influencing educational practice, access to services, and policy for students with mental health needs (Heath, 2008). Current data from the 2010 Special Education Census Report indicate that 7,600 children and youth in Maryland were identified as having ED, comprising 7.34 percent of all students with disabilities receiving special education services in Maryland (Maryland State Department of Education, March, 2011).

These students traditionally have the highest dropout rate of all students and are the most likely of all groups of students with disabilities to receive their education in a setting outside of their community school, segregated from their nondisabled peers. These students also have the highest rate of suspension of students with disabilities and the poorest outcomes in terms of post-school transition to higher education and employment. The data between jurisdictions across the State on the number of students identified as having ED are alarmingly disparate. Several jurisdictions cite data that are extremely skewed toward the over-identification of youth with ED (with a high of 18 percent), while other jurisdictions consistently appear to under-identify youth with ED (with a low of 1.4 percent), indicating the need for uniform identification procedures across the State (Heath, 2008).

An overview of data and outcomes for students with Emotional Disability brings several troubling issues to light. Maryland's educational data suggest that students that are identified with ED are:

- Male;
- Over the age of 13;
- Disproportionately African American;
- Not achieving on a level that is commensurate with their cognitive abilities;
- Suspended and expelled at extremely high rates;
- Not consistently included in the general education setting; and
- Have significantly lower rates for attendance and graduation.

(Heath, 2008).

Improving outcomes for children with ED depends not only on improving their school and learning opportunities, but also on promoting effective collaboration across other critical areas of support, including families, social services, health, mental health, and juvenile justice (Heath, 2008). Although bringing about such collaboration poses a major challenge (due to different system priorities, agendas, structures, and ways of operating); the results of collaboration for children with ED and their families include:

- Greater school retention, and
- Improved educational, emotional, and behavioral development.

(Heath, 2008).

Historically, in Maryland, disproportionate numbers of African American male students have been identified as students with ED. Despite efforts at both the State and local levels, African American students—particularly males—continue to be identified with ED at disproportionate rates in comparison to other racial, ethnic and gender groups. Once identified with ED, African American students are educated in more restrictive settings and they are also suspended at disproportionate rates in comparison to students in other racial and ethnic groups (Heath, 2008).

In the spring of 2008, the Maryland State Department of Education (MSDE) hosted three forums on the topic of children in special education with ED. The forums were designed to discuss the unique challenges related to serving this population of students, to raise awareness, to assess stakeholder needs and to solicit stakeholder feedback. More than 350 public and private school system personnel, providers, family members and students attended the forums (Maryland State Department of Education, 2010, p. 9).

As an outgrowth of the forums, the Steering Committee on Students with Emotional Disability in Educational Settings was established as a partnership of the MSDE, the Department of Health and Mental Hygiene (DHMH), Maryland Coalition of Families for Children’s Mental Health (MCF) and University of Maryland Center for School Mental Health (CSMH). The Steering Committee was formed to develop a set of clear strategies to address critical issues identified through the forums that would improve the outcomes for students with ED receiving special education (Maryland State Department of Education, 2010, p. 9).



Over a period of 18 months, the Steering Committee met to synthesize feedback from the forums and develop recommendations. Through the Steering Committee process, five critical issues emerged: Discipline/Behavior Management, Appropriate Identification, Stigma, Development of Individualized Education Programs (IEPs), and Transition (Maryland State Department of Education, 2010, p. 7).

The need for the appropriate identification of ED became a major focus of the group, with the following recommendations:

- **Create guidelines for screening and appropriate identification of students with ED**
- **Provide annual training and technical assistance on identification guidelines**

(Maryland State Department of Education, 2010, p.8).

After significant research, discussion, and analysis, it was clear that there is a significant need for collaboration around training and technical assistance for the appropriate identification of ED and strategies that will support systemic change; to enhance current practices for educating students with emotional, behavioral or other mental health issues; and to establish a standard for best practice with this unique population of students.

In the fall of 2009, the MSDE, in collaboration with representatives of the Maryland School Psychologists' Association (MSPA), MCF, and the Maryland Disability Law Center (MDLC), identified the need to examine identification practices within local school systems when parents or school personnel suspect the presence of ED in children and youth, in an effort to address the aforementioned recommendations to develop screening guidelines and provide enhanced technical assistance on identification practices. The *Role of the Psychological Services for Students with ED workgroup is an interdisciplinary committee* including Directors of Student Services, Directors of Special Education, school psychologists, parents, and advocates. The workgroup, an outgrowth of the ED Steering Committee, was convened and met throughout the 2009-2010 school year to analyze data, examine current practices within Maryland and other states, review literature, and revise the MSPA's technical assistance manual regarding the identification of ED.

The workgroup took immediate action to address the needs of this group of students with the aim of intervening early and effectively to prevent the need for special education due to ED. At the same time, it was recognized that administrators, educators, counselors, social workers, and school psychologists serving on a student's IEP team must also be knowledgeable about the impact of their individual beliefs about disability, race and culture upon student performance and behavior. All staff must work effectively with students and families of all cultures and races.

In 1988, the MSPA published *Seriously Emotionally Disturbed: Guidelines for Determining Eligibility* in an attempt to clarify the definition of this special educational disability category, which would be both practical and useful for school psychologists in Maryland. To a great extent, that document accomplished its purpose, providing concrete guidance on this difficult subject. Since that time, however, additional questions and controversy have arisen regarding

the ways in which the ED definition was being interpreted and implemented in Maryland schools. Based on stakeholder response to the 1988 document, MSPA produced a revised document entitled “Members’ Advisory: Best Practice for SED Definition” (Maryland School Psychologists’ Association, 1994). The 1994 MSPA document has been used, with permission, by this workgroup as the framework for the section pertaining to the definition of ED.

Currently, ED is one of the 14 disabling conditions specified in federal and State regulations under which a student may require the provision of special education and related services in accordance with the Individuals with Disabilities Education Act (IDEA). It is a concept which has no meaning outside the field of education (for definition, see COMAR citation on pg 20). The IDEA eligibility categories for children and youth with a disability are not meaningful diagnostic entities, comparable to the “disease model” doctors refer to in the *International Classification of Diseases-Tenth Revision (ICD-10)* or the “mental disorders” psychologists and psychiatrists refer to in the *Diagnostic and Statistical Manual of Mental Disorders IV- Text Revision (DSM IV-TR; American Psychiatric Association, 2000)*.

The Steering Committee on Emotional Disturbance in Educational Settings also explored the implications that the term “Emotional Disturbance” has on children and families. The Steering Committee learned that the term “Emotional Disturbance” makes a difference in how children perceive themselves and how others in the school setting perceive them, indicating that the label is both demeaning and stigmatizing. IEP teams have also felt the stigma of “Emotional Disturbance,” frequently opting to use other special education categories such as “Other Health Impairment” for coding a child, even when the child’s primary disability is an emotional impairment.

The U.S. Department of Education permits states to use different terminology when referring to this group of students, as long as it does not change eligibility requirements or deny services to any student meeting the definition. Twenty states have already adopted different language (Maryland State Department of Education, 2010, p.15).

To determine less stigmatizing language for Maryland, the Steering Committee conducted an online survey, which received responses from a diverse group of stakeholders. Results of the survey provided the impetus for the Student Stigma Bill, jointly introduced in the Maryland House of Delegates and in the Maryland Senate during the 2010 legislative session, proposing that the term “Emotional Disturbance” be changed to “Emotional Disability (ED),” to remove stigma and accurately reflect the current practices in Maryland. The bill passed and was signed into Maryland State law by Governor Martin O’Malley on May 4, 2010 (Maryland State Department of Education, 2010, p.15). Given the passage of this legislation, the committee is now recognized as The Steering Committee on Students with Emotional Disability.

Critical Elements of this Document

This document is organized by the critical elements of the definition of ED as specified by the IDEA, the required components of a comprehensive assessment, and evidence-based strategies for effective service provision. Within each section of the document is a definition/discussion of terms for critical words, tools, and practices, followed by a discussion, with examples. Examples will provide brief illustration of critical elements within the section. Much of what follows will be familiar to those who have followed this debate over the past decade, and much of the current debate has moved beyond this material to questions of appropriate programming and service delivery for children and youth with ED.

This document includes a comprehensive discussion of each of the following issues:

1. The role of the school psychologist in the disability determination process for students with ED:
 - Early intervention within general education
 - School psychologist's role with the initial IEP team process
 - Elements of the school psychologist's assessment for the IEP team
2. Eligibility criteria:
 - ED as a condition
 - ED as a set of 3 limiting criteria
 - ED characteristics
 - Schizophrenia
 - Social Maladjustment
3. Assessment procedures
4. Service delivery pathways for youth with Emotional Disability:
 - General education
 - Special education
 - Developing IEP goals and objectives

It is important for school psychologists to collaborate with community partners to secure essential resources and wraparound services to complement existing services provided in the local school system to support students with ED. Current practice in Maryland is evolving, with a number of local school systems moving toward serving more students who are eligible for special education due to ED. To further assist local school systems in adopting a more comprehensive approach to the identification of ED, this document describes current effective practices in the identification of students with ED that require special education to progress in the general curriculum and remain in their least restrictive environment.

The Role of the School Psychologist in the Disability Determination Process for Students with ED

Early intervention within general education

School psychologists provide consultation, assessment, and intervention services to assist students, schools, and families. As delineated in greater detail in the section on “Identification of Services,” the school psychologist can play an active role in helping schools to develop, implement, and sustain a multi-tiered process for supporting all students. Participating in a student-focused consultation teaming process such as the Student Support Team (SST), the school psychologist can assist in identifying students at risk, and work with other school-based mental health providers in developing, implementing, and assessing the effectiveness of evidence-based interventions for students showing signs of difficulty with emotional or behavioral functioning.

The school psychologist should be sensitive to parent concerns and can provide appropriate information to parents regarding referral to community-based resources. When necessary, the school psychologist will assist in determining eligibility for, developing, and monitoring the implementation of 504 Plans. The school psychologist also plays a major role on the team in conducting Functional Behavioral Assessments (FBAs) and developing Behavioral Intervention Plans (BIPs) for students presenting with significant and persistent behavioral concerns. Finally, the school psychologist will assist the team in interpreting response-to-intervention (RTI) data and other information in deciding when to refer the student to the IEP team. For more information regarding Maryland’s RTI process, please refer to the MSDE document entitled *A Tiered Instructional Approach* and Appendix I.

The MSDE recommends a tiered instructional approach to support the achievement of all students (see Appendix I). *A Tiered Instructional Approach to Support Achievement of all Students- Maryland’s Response to Intervention Framework*, is an intervention process that describes a systematic school-wide multi-tiered approach. A Response to Intervention (RTI) model incorporates practices in which each tier represents an increased intensity of instructional delivery that directly corresponds with the level of a student’s needs. A system-wide RTI framework should be designed to address both academic and behavioral supports. When implemented with fidelity, the RTI framework fosters prevention of achievement and behavioral difficulties while providing interventions at increasing levels of intensity matched to the academic and behavioral needs of students.

The workgroup recommends this document as a supplemental resource when educating students with ED.



The school psychologist can play a critical role in the identification of tiered interventions for students with behavioral and emotional problems. The school psychologist has specific training and expertise that is essential to the intervention process. The extent of this involvement may vary significantly from district to district, as it is dependent on factors such as psychologist/student ratio, type of assignment, and assessment caseload. Ideally, there should be a tiered teaming process through which students' "at risk" behavior can be identified and analyzed using a problem solving framework. Within this process, staff should hypothesize underlying reasons or functions for the behavior before appropriately addressing the behavior with targeted interventions. These functions usually fall into the following broad categories: attention, escape, sensory, tangible, and control. More specifically, the function identifies what the student is trying to achieve (get/obtain or escape/avoid) by engaging in the behavior. For example, a student may engage in acting-out behavior in order to avoid completing class work.

Tier One interventions are those supports and strategies which are implemented in the general education setting, usually without the need for additional resources (see Appendix II, Tiered Interventions Menu). Classroom teachers are primarily responsible, with consultation from parents, administrators, and specialists, including the school psychologist, as needed. Tier Two and Tier Three interventions are those supports and strategies that may be implemented inside and/or outside of the general education classroom, and may be initiated by the grade level team or the Student Service Team (SST), to address more intensive needs. These interventions often require the allocation of additional resources within the school setting and may necessitate the involvement of the school administration.

In those cases where a formal Functional Behavioral Assessment (FBA) and Behavioral Intervention Plan (BIP) are needed, parent permission must be sought. However, in many instances, staff may have enough current information to develop hypotheses about the function of the student's behavior. Ideally, the psychologist should collaborate with other specialists and staff regardless of whether a formal FBA/BIP is requested or a less formal behavioral analysis and plan appears to be appropriate. For intense and persistent behavioral concerns, a formal

FBA is recommended. When disciplinary actions have been taken and a student with a disability requiring special education has been consistently removed from school, the FBA/BIP process is required [COMAR 13A.08.03.07]. Based upon the hypothesized reasons or identified functions for behaviors, interventions should then be developed, implemented, evaluated, and potentially revised after a 4-6 week period. In this effort, the school psychologist should work with other school mental health providers, as well as parents, teachers, administrators, and personnel from collaborating agencies, often as part of the tiered intervention team (example: Pupil Services Team [COMAR 13A.05.05.01]), or a related school team.

The school psychologist should provide appropriate information to parents regarding community based resources with whom they (and the school) might collaborate. If a student does not respond as expected to a behavioral intervention plan and/or a continuum of interventions provided through general education services, the school psychologist should assist the appropriate school team in deciding whether to refer the student for a formal screening due to a suspected disability, either through Section 504 or the IDEA. If, however, at any point during the tiered intervention process, a parent/guardian or staff member suspects a disability, the student should be immediately referred to the IEP team.

School psychologists can be critical to this decision-making process through their dissemination and interpretation of the MSDE ED IEP eligibility guidelines, as well as the COMAR and IDEA provisions. This is especially important for staff and parents who are not aware of the ED definition, its exclusionary factors, and the requirement that the student's emotional condition exist over a long period of time, to a marked degree, in multiple settings that adversely affect educational performance, of which academic performance is simply a part. Should an Other Health Impairment (OHI) for ADHD, or another qualifying condition, be suspected, the school psychologist should also review similar federal, State, and local eligibility criteria with staff and parents/guardians.

Individualized Education Program (IEP) team process

With respect to students with disabilities, the Code of Maryland Regulations (COMAR) defines "evaluation" as the process of reviewing: (i) Information from parents, (ii) Existing data, and (iii) Results of assessment procedures used to determine whether a student has a disability, and the nature and extent of the special education and related services that the student needs. An evaluation is a review at a meeting of the IEP team and other qualified professionals, as appropriate [COMAR 13A.05.01.03B(25)].

The IEP team is a group of individuals responsible for:

- Identifying and evaluating students with disabilities;
- Developing, reviewing, or revising an IEP for a student with a disability; and
- Determining the placement of a student with a disability in the least restrictive environment (LRE) [COMAR 13A.05.01.03B(35)].

The members of a student's IEP team include:

- The parents of the student;
- Not less than one regular education teacher of the student, if the student is or may be participating in the regular education environment;
- Not less than one special education teacher, or not less than one special education provider of the student;
- A representative of the public agency who is:
 - Qualified to provide or supervise the provision of specially designed instruction to meet the unique needs of students with disabilities, and
 - Knowledgeable about the general curriculum and about the availability of resources of the public agency;
- An individual who can interpret the instructional implications of evaluation results, who may be the regular education teacher, the special education teacher, special education service provider, or the representative of the public agency;
- Other individuals, at the discretion of the parent or public agency, who have knowledge or special expertise regarding the student, including related service personnel, as appropriate; and
- The student, if appropriate [34 CFR §300.321; COMAR 13A.05.01.07A].

Local school system and public agency IEP teams determine whether a child is a student with a disability as defined by the IDEA and the educational needs of the child. Each local school system and public agency is responsible for initiating and conducting meetings for the purposes of developing, reviewing, and revising the IEP of a student with a disability, and determining the child's educational placement. The parents of each student with a disability must be notified and afforded the opportunity to participate in all IEP team meetings conducted for their child. School personnel are to make reasonable efforts to ensure that the parents understand, and are able to participate in any group discussions relating to the educational placement of their child, including arranging for an interpreter for parents with deafness, or whose native language is not English [COMAR 13A.05.01.03B(35); COMAR 13A.05.01.07D, Maryland State Department of Education, 2008).

The initial IEP team meeting

Local school systems are to provide parents with an accessible copy of each assessment, report, data chart, draft IEP, or other document at least five (5) business days before a scheduled IEP team meeting or other multidisciplinary education team meeting [Education Article §8-405(c) (1) (i), Annotated Code of Maryland]. An assessment, report, data chart, or other document

prepared by a school psychologist or other medical professional that either team plans to discuss at the meeting may be provided to parents orally and [emphasis added] in writing prior to the meeting [Education Article §8-405(c) (1) (ii), Annotated Code of Maryland]. If school personnel are unable to provide an accessible copy of the material(s) at least five (5) business days before the scheduled meeting because of an extenuating circumstance, school personnel are to document and communicate to parents the nature of the extenuating circumstance that prevented school personnel from providing accessible copies of the material(s) [Education Article §8-405(c) (2), Annotated Code of Maryland].

In Maryland, the first IEP team meeting is to conduct a review of referral data, existing data, including prior instructional interventions, classroom-based assessments, and information from the student's parents to determine whether or not the IEP team:

- Suspects the presence of a disability that may require special education and related services; and
- Needs additional data to complete a comprehensive evaluation.

A student's parents are integral partners in the evaluation process and members of their child's IEP team. Parents are able to provide school personnel with relevant functional information about their child, including information to enhance their child's education. School personnel are expected to encourage parental participation in all IEP team meetings. The purpose of this review and determination of need for additional data is to ensure the IEP team has sufficient data to identify all of the student's special education and related services needs whether or not these needs are commonly linked to the disability category in order to determine:

- Whether the student has a particular disability has described in 34 CFR 300.8;
- The present levels of academic achievement and functional performance, and the educational need of the student; and
- Whether the student needs special education and related services [34 CFR §300.301; and 300.306].

The school psychologist's role with the initial IEP team meeting

As a member of the IEP team meeting, the school psychologist will assist in a review and analysis of RTI data (including the effectiveness of a BIP, 504 Plan, or other support plan, as appropriate) and other information that may lead the team to suspect the existence of a disability under IDEA. The school psychologist is able to help the team in understanding documents and reports in the record that address the emotional and/or behavioral functioning of the student. The school psychologist can then assist the IEP team in understanding the definition of ED as outlined in this document, and in deciding if ED is suspected in the referred student. If that is the case, the team will make an evaluation plan, with the school psychologist assisting the team in planning the assessments to be conducted. In many cases a psychological assessment will be included in the evaluation, in which case the school psychologist will explain the planned psychological assessment to the parent, to facilitate informed consent and parent participation in the assessment process.

Elements of the school psychologist's assessment for the IEP team meeting

As described in greater detail in the “Assessments Procedures,” the school psychologist conducts an assessment that includes record review, examination of RTI data, and direct and indirect data collection methods designed to determine the existence of an emotional condition. Among these methods the school psychologist should include reliable and valid instruments that enable understanding of the “base rate” (number of times per unit of time, frequency) of assessed student characteristics within an empirically based taxonomy.

Role of the school psychologist in reviewing assessments with the IEP team

All IEP team partners are to collaborate to determine whether a student has ED requiring special education and related services under the IDEA. As a member of the IEP team, the school psychologist is to determine if the student has an emotional condition defined within a diagnostic framework or empirically based taxonomy, by administering psychological assessments and interpreting findings and other relevant data. In addition, the school psychologist should explain the impact of the identified condition on the student's academic and behavioral functioning, and the relevance of the condition to the referral concerns. The school psychologist is responsible for presenting the report of their assessment findings to the team, including the parent, in clear and non-technical language. When an assessment report from another qualified mental health professional (such as a licensed psychologist or psychiatrist) is reviewed by the team, the school psychologist assists the team in understanding its utility in the decision-making process.

The disability determination process is conducted by the entire IEP team, with the assistance of the school psychologist, as appropriate. After all assessment reports and other data have been reviewed by the IEP team, it is the job of the team to decide if it has sufficient documentation of an emotional condition in the referred student. This is a necessary first step in the process of determining that a student has ED, but it is important to note that identification of the condition is not sufficient. The next step is for the team to determine if the identified condition meets one or more of the five characteristics cited in the definition of ED. The team must also determine if the condition is exhibited by the student over a long period of time and to a marked degree, and if the condition adversely impacts the student's educational performance, necessitating special education and related services.

Note that while the first step in this process (identification of the emotional condition or syndrome) must be completed by a qualified mental health professional, such as a school psychologist, all other steps are the collective responsibility of the IEP team.

Whether or not ED is determined, the school psychologist further assists in employing assessment data to develop suggested interventions and supports for the student as needed. The school psychologist assists the IEP team in developing an IEP if one is needed, or in

referring the case back to the appropriate Pupil Services Team (PST), [COMAR 13A.05.05.01] or SST for further action if the student does not need an IEP. Additional information regarding the school psychologist's role in interventions for students with disabilities is covered in the "Identification of Services and Service Delivery for Students with ED" section of this report. If the IEP team determines that the child requires special education and related services, the IEP team must meet within 30 days to develop the child's IEP [COMAR 13A.05.01.08A(1)]. As a member of the IEP team, parents have the right to request a review of their child's IEP at any time [COMAR 13A.05.01.08B(3)].

The Definition of ED: Eligibility Criteria

The purpose of this section is to provide a clarification of the current ED definition, which recognizes the problems that have arisen from the previously more rigid and exclusionary interpretation, while at the same time remaining true to the actual meaning of the original definition. It offers a more practical and inclusive reinterpretation of the current definition of ED.

MSDE COMAR 13A.05.01.03B(23): "ED" includes students who are schizophrenic but does not include students who are socially maladjusted unless it is determined that they are ED, and means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:

- (i) An inability to learn which cannot be explained by intellectual, sensory, or health factors;
- (ii) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
- (iii) Inappropriate types of behaviors or feelings under normal circumstances,
- (iv) A general pervasive mood of unhappiness or depression; or
- (v) A tendency to develop physical symptoms or fears associated with personal or school problems"

Eligibility:

The educational definition of ED consists of three major components:

- a) ED as a condition;
- b) ED as a set of three limiting criteria, all of which must be met prior to classification; and
- c) ED as a set of five characteristics, one of which must be met prior to classification.

Each component of the definition requires careful consideration before determining that a student has ED.

a) ED as a Condition

ED refers to a condition manifested by a syndrome of behaviors that are significantly different than responses or behaviors that would be expected of the student's cultural heritage or developmental level. An empirically based taxonomy of syndromes, such

as the DSM IV-TR, the ICD-9, or another empirically based taxonomy should be used as a guide to determine the existence of a condition. A taxonomic system identifies syndrome scales that describe the problems they represent but are not considered “diagnostic” labels. They include cut points for defining clinical range scores on the problem scales that can be used for judging the severity of reported problems in different settings relative to nationally representative normative samples.

The use of a taxonomic system with high reliability and validity ensures a comprehensive assessment utilizing norms that are representative, current, and appropriate for the individual being assessed in terms of age, culture, ethnicity, and gender. It is not necessary to establish the existence of a psychiatric disorder under the DSM IV-TR criteria in order to identify a student with ED.

b) ED as a Set of Three Limiting Criteria

Both COMAR and the IDEA state that the characteristics of children with ED must be exhibited “... over a long period of time and to a marked degree, that adversely affects a child’s educational performance.”

- 1) The phrase “over a long period of time” is generally accepted in practice to mean that the student has a history of affective and/or behavioral symptoms or characteristics. This phrase refers to the presence of the symptoms, not the identification of the psychopathology. It is the recommendation of this workgroup that psychologists initiate formal evaluation procedures with youth that have exhibited behavioral symptoms/characteristics for approximately six consecutive months. However, when the severity of certain symptoms or characteristics (e.g., clinical depression or psychosis) results in extreme impairment of the student, the time period may be shorter.
- 2) The phrase “to a marked degree” refers to the frequency, duration, intensity, and the settings of the symptom or characteristics, and can be interpreted, respectively, as: a) the number of times a symptom takes place within a very short time span, i.e., a day or week; b) the length of time in minutes or hours that the symptoms persist once they start; c) the strength or extremity of a behavior or affective response; and d) the symptoms occur in a variety of environments (e.g. academic, social, community, and home). At times it may be very difficult to define frequency, duration and intensity (e.g. with psychotic symptoms), therefore prominence of these characteristics may need to be evaluated from a socio-developmental perspective on an individual basis by the school psychologist.
- 3) The phrase “educational performance” should be viewed in two ways. Educational performance should be defined as both academic achievement and relevant interpersonal skills. Indicators of academic achievement include measures of the child’s progress towards meeting State academic standards at each grade level as well as measures of interpersonal and emotional functioning. Educational performance also includes enabling skills which go beyond pure academics.

These skills include the degree to which the student participates in class activities, relationships with peers and adults in the educational setting, and other interpersonal and social factors which impact academic performance even if the student's grades and test scores are acceptable. School avoidance for emotional reasons is an example of a behavior that could have an adverse educational impact.

c) ED as Characteristics

In order to be identified as being a student with ED, the child must meet all three of the limiting criteria described above, **and** at least one of the following five specific characteristics.

Characteristic #1:

“An inability to learn which cannot be explained by intellectual, sensory, or health factors”

Definition/discussion of Terms:

1. “Inability to learn” refers to a lack of academic progress that can be manifested by failure on tests, utilization of skills that are not applied at an appropriate developmental level, performance of daily work or homework at a failing level despite evidence of ability to succeed, refusal to complete work, difficulty beginning tasks, or the appearance of intellectual limitation when adequate cognitive skills have been documented.
2. “Intellectual” refers to cognitive potential including a consideration of strengths and weaknesses. Cognitive weaknesses in some areas may exist but should not be the primary cause of lack of achievement or academic progress.
3. “Sensory” refers to the activity of a sense organ, e.g., hearing, vision, touch.
4. “Health factors” refers to medical conditions and/or acute health problems such as Attention Deficit Hyperactivity Disorder (ADHD), autism, physical impairments, seizures, Traumatic Brain Injury, (TBI) or lead poisoning.

Discussion of Characteristic #1:

This characteristic is designed to insure that assessments are not only comprehensive, (i.e, cover many areas of development), but are also differential in that they distinguish between delays and/or needs in a variety of areas to rule out all other identifiable reasons for lack of school achievement. Lack of achievement can result from lack of reading or math instruction [COMAR 13A.05.01.06C (3) (a)] or from the presence of an Intellectual Disability (ID), speech/language problems, autism, other health impairment, and hearing or vision problems. It may also result from the utilization of inappropriate instructional strategies or materials. For example, presenting a first grader with fourth grade math problems could easily result in an inability to achieve but would not necessarily indicate ED.

Motivational and sociocultural factors must also be considered. A student who deliberately does not achieve academically because academic achievement is not a high priority for that student or the student who cannot complete assigned work because of family responsibilities would not be considered to be a student with ED because of this factor alone. In order to differentiate ED from other disabling conditions that would contribute to poor academic achievement, a comprehensive assessment plan should include a social/family history, review of previous school records, and standardized cognitive and academic achievement assessments. A multidisciplinary team should also carefully consider physical health, cognitive abilities, speech/language skills, social emotional functioning, attendance, and the appropriateness of the current program and effectiveness of prior evidence based interventions.

The intent of this characteristic is to eliminate the effect of potential variables other than an emotional condition may influence the student's ability to learn. Only after motivational, cognitive, social, cultural, sensory, and health factors, including Attention Deficit Hyperactivity Disorder (ADHD), have been ruled out as primary reasons for the lack of achievement, can inability to learn be presumed to result from emotional factors. However, the fact that a student has intellectual, sensory, speech/language, or health problems does not automatically disqualify the student from meeting the criterion for ED. Documentation should be provided that the inability to learn is not primarily due to these latter factors, but rather is due to the emotional factors.

Characteristic #2:

“An inability to build or maintain satisfactory interpersonal relationships with peers and teachers”

Definition/Discussion of Terms:

1. “Inability” means more than a developmental delay in social skills (“socially immature”), and clearly rules out the student who chooses socially inappropriate or self-defeating behavior when capable of appropriate, effective social behavior. The student who qualifies under this characteristic must not be capable of forming or sustaining such relationships under ordinary circumstances.
2. “Build or maintain” indicates that a student is unable to either form such relationships or maintain them; it is not necessary that the student have difficulty with both functions.
3. “Satisfactory” refers to the appropriateness and adaptiveness of the student's social behaviors in situations requiring social interaction, with respect to educational performance and functioning.
4. “Peers and teachers” indicates that the inability must be manifest in relationships with both other students and with teachers.

Discussion of Characteristic #2:

Of key importance in understanding this characteristic is the concept that the student cannot establish or sustain satisfactory interpersonal relationships at a developmentally appropriate level of social independence. Even though the student may be capable of being guided or shaped to behave in a socially effective manner under special circumstances (e.g., with close supervision, during implementation of a behavior modification program, or in a counseling group), the student may still qualify under this characteristic. It is inappropriate to attempt to impose a broad, inevitably value-laden definition of the term “satisfactory.” The degree to which the student can function effectively in a group setting, such as during cooperative large or small group instructional exercises and learning tasks, may be included in the definition objectively.

“Satisfactory interpersonal relationships” refers to the effectiveness of the child’s social functioning for accomplishing educationally important objectives. For example: *Can the student establish and maintain enough of a relationship with most teachers to learn from them?* The fact that a student cannot get along with a few teachers where there may be a “personality conflict” or “bad fit” does not automatically qualify the student under this characteristic. Likewise the fact that the student is seen as being a “loner” or as not having any friends on the playground is not sufficient. *Can the student learn with others in the group learning portions of the curriculum, such as those specified by the Maryland School Performance Program?* If the student’s emotional condition results in behavior that fundamentally interferes with or prohibits such learning, then the student may be considered as meeting this characteristic.

It is likely that a student with ED will have difficulty in both building and maintaining such relationships with others, both in and out of school. Nonetheless, some students who qualify under this category will appear to have appropriate relationships with others outside of school, but be unable to establish or sustain them in school. Others may be able to connect socially with peers and teachers, but be unable to maintain the relationships.

Conversely, some qualifying students may find it impossible to build meaningful interpersonal relationships on their own, but when a relationship is established by someone else (e.g., with a patient teacher or trusted peer tutor) the student may be able to maintain the relationship with some degree of independence. The “inability” should primarily result from the student’s emotional condition, rather than from an underlying learning problem.

Some students with learning disabilities and intellectual disabilities may be incapable of forming or maintaining satisfactory interpersonal relationships at a developmentally appropriate level, but the reasons for the student not being able to acquire and master the relevant social skills are primarily of a cognitive/information processing nature, rather than being emotionally driven.

Finally, it is also important to examine the student's experiential background to determine if sufficient developmentally appropriate social-learning experiences have been provided. A student should not be identified as ED merely due to lack of opportunity to learn school-requisite social behaviors, or due to negative characteristics of his or her learning environment, (i.e., factors that adversely affect school climate, including, but not limited to: bullying, threats to personal safety, or a lack of trust and respect amongst teachers and students).

Characteristic #3:

“Inappropriate types of behavior or feelings under normal circumstances”

Definition/Discussion of Terms:

“Inappropriate types of behavior...” refers to the excessive manifestation or expression of negative or harmful behaviors that occur persistently and interfere with the student's capacity to learn or with the learning environment so that other students' learning is disrupted. Such behaviors are deemed inappropriate as they are not expected in the school setting. Behaviors may include, but are not limited to, overreaction to environmental stimuli, obsessive or compulsive behaviors, or bizarre verbalizations. Although a student may exhibit inappropriate behaviors, if a student is able to control these behaviors when the desire to do so is expressed, it would be suggested that these inappropriate behaviors are within the control of the student.

“Inappropriate... feelings...” includes those that negatively impact the mood and awareness of a student thus interfering with the student's capacity for learning. Feelings, by definition, are not objectively observable or measurable but rather are primarily determined through inferences drawn from observable behaviors and interactions with the student. For the purposes of identifying the presences of ED, the emphasis is placed on the behavioral manifestations of those inappropriate feelings. Assessment information will support behavioral observations to document the indication of inappropriate feelings. When evaluating “inappropriate” behavior or feelings one must recognize that there are normal responses to catastrophic events that may temporarily interfere with the learning environment. These behaviors are not defined as “inappropriate.”

“Normal circumstances...” refers to the point that the “inappropriateness” of a behavior cannot be determined unless one examines the circumstances under which the behavior presents and considers what is “normal,” expected, and routine for that student in the given situation. All environmental circumstances including the student's home, community, school, and classroom setting must be considered. In addition, the term “normal circumstances” refers to “normal” behavior given the student's developmental level, cultural factors, and social/economic status. The student's behaviors should be compared to those expected for other students of similar age and similar circumstances. Behaviors that are sufficiently distinct from those of the student's peers would be considered as “not being normal.”

Discussion of Characteristic #3:

In order to evaluate a student's behavior according to this criterion, the school psychologist must first determine if the behavior meets the three limiting criteria of the ED definition. The behavior(s) and/or feelings must occur over a long period of time and to a marked degree. It must adversely affect educational performance. The behaviors and or feelings must be displayed in the classroom or other educational setting, not just evidenced during testing.

If the student's behavior and or feelings meet these limiting criteria, then the school psychologist must also assess the circumstances under which the behavior occurs. This includes not only a behavioral assessment of the antecedent and consequent environmental events surrounding the behavior, but also some assessment of the overall classroom and school environment.

The student's developmental level must be assessed as one of the circumstances under which the behavior occurs. In addition, consideration must be given for the student's racial/ethnic/cultural identity and social/economic status. This is perhaps the most difficult area to assess because though there is an extensive extant research describing education-related differences between youth of different racial/ethnic groups and socioeconomic classes (e.g., differences in academic self-esteem, teacher bias, assessment, learning styles, etc.), the current literature which delineates these differences speak to a variety of expected behaviors and reactions among various cultures (National Association of School Psychologists, 2009).

It is essential that the school psychologist, as all other mental health professionals, determine what his or her personal racial/ethnic and social/economic biases and perspectives are, and exercise professional judgment when making decisions about these criteria. If the school psychologist is unfamiliar with the cultural norms of a particular student being assessed, he or she is ethically bound to consult with another school psychologist or other appropriately trained mental health professional familiar with the student's cultural norms in order to determine what is most culturally appropriate for that student.

At times it may be unclear whether that student's behavior is inappropriate because the circumstances or environment in which the behavior occurs are also challenging. In those instances, changes in the environment may need to occur before it can be determined if the student's behavior meets these criteria. For example, the school psychologist may encourage parents to increase the amount of time the student sleeps. Teachers may be encouraged to modify their classroom management techniques, while administrators may be encouraged to alter their approach to discipline. All of these types of factors must be considered and addressed before a student's behavior is identified as meeting the ED criteria.

Examples of typical behaviors that may reflect this characteristic include extreme reactions to everyday occurrences, self-injurious behaviors, extreme behavioral manifestations of delusions, hallucinations, distorted thoughts, and extreme behavioral and emotional shifts ranging from manic (being extremely outgoing and joyful, i.e. singing, constantly laughing, etc.) to extremely withdrawn and sad (i.e. constantly crying and not communicating to others). This characteristic may refer to behaviors consistent with classifications of disorders from sources such as the DSM-IV-TR or ICD-10.

A student who experiences a significant trauma (e.g., the murder of a parent) may experience an acute emotional crisis. It is important to note, however, that this does **not** fit the criteria for certification of ED. If, after appropriate intervention, the student is still in crisis after six months, the student may be referred and evaluated to determine if he or she meets the criteria for ED.

Characteristic #4:

“A general pervasive mood of unhappiness or depression”

Definition/Discussion of Terms:

1. “General” means that this mood of unhappiness or depression is not related to a specific event or series of events, (e.g., a death in the family, divorce, etc.). This means that the unhappiness or depression is not due to an adjustment to an event or series of events.
2. “Pervasive” means that the behaviors are observable across situations and settings or occur in more than one environment. The mood of unhappiness is not related to a specific environment or set of conditions within an environment.
3. “Mood of unhappiness” means a pattern of behavior that may include feelings of sadness, tearfulness, irritable mood, exaggerated frustration over minor matters, withdrawal, helplessness, worthlessness, and/or loss of energy or fatigue.
4. “Depression” means a sustained pattern of behavior that is more than just a “mood of unhappiness.” While a DSM-IV-TR diagnosis is not required, depression is a condition that may be diagnosed from the DSM-IV-TR.

Significant changes *or impairments* usually occur in the four major areas: affective, motivational, cognitive, and physical/motor functioning.

- *Affective:* Mood changes that may include sadness; tearfulness; irritability (i.e., persistent anger, a tendency to respond to events with angry outbursts or an exaggerated sense of frustration over minor matters), social withdrawal, feelings of guilt, loneliness, dejection, and feelings of discouragement.
- *Motivational:* Changes in appetite, weight, sleep patterns, loss of interest or pleasure in activities, lack of motivation to do school work or anything that requires effort, lack of energy, tiredness, and fatigue.

- *Cognitive:* Difficulty concentrating, distractibility, hopelessness, helplessness, overwhelming feelings that things will not change, difficulty making decisions, cognitive slowing or difficulties with memory, recurrent thoughts of death or suicidal ideation, plans or attempts. May include negative self-evaluations, misinterpretation of neutral events or situations with individuals with an exaggerated response, and difficulties with memory.
- *Physical/Motor:* Changes in psychomotor activity or psychomotor agitation (e.g., inability to sit still, pacing, retardation of motor response), slowed speech, body movements, decreased volume, inflection or amount of speech.

Discussion of Characteristic #4:

It is important to note that in order to meet this characteristic, the student must demonstrate **either** a “pervasive mood of unhappiness” **or** “depression.” Both conditions are not necessary for this characteristic to be met. A “pervasive mood of unhappiness” may be a component of a student’s depressive disorder. However, a student can still be diagnosed with Depression without a “pervasive mood of unhappiness.” Depression may also be diagnosed or identified before a “pervasive mood of unhappiness” is observed.

Culture, age, developmental level, and gender all affect the expression of depression characteristics. Symptoms of depression may be expressed or described differently depending on culture, age, developmental level, and gender. (See the DSM-IV TR for more information). Characteristics of depression can also change over time. A diagnosis of depression should only be made after using appropriate tools and instruments that are reliable and valid including consultation of the DSM-IV-TR differential diagnosis of other mental health and medical disorders. Unhappiness or depression may *not* be considered ED if it includes extended bereavement (sadness that may be within normal life circumstances), or other family related issues (e.g., divorce, illness, etc.) that may be transient and expected under the circumstances. However, an intervention plan may be needed to support the student during the crisis period.



Characteristic #5:

“A tendency to develop physical symptoms or fears associated with personal or school problems”

Definition/Discussion of Terms:

1. “Tendency” implies that the student has a high likelihood to develop specific symptoms and fears.
2. “Physical symptoms” refers to some physiological condition, medically verified or not verified, reported by the individual that needs to be treated and interferes with daily functioning.
3. “Fears” means incapacitating anxiety, panic attacks or severe phobic reactions, which may be irrational given the circumstances.
4. “Associated with personal or school problems” implies that any associated physical symptom or fear is related to persons, places and/or events that are perceived stressors.

Discussion of Characteristic #5:

Before a determination of ED can be made based on this characteristic, the student’s medical history should be thoroughly reviewed with the parent or appropriate caregiver familiar with his/her regular medical care. The team must have determined that physical symptoms do not have a medical cause, as well as can be determined by the information reported by the parent or caregiver.

This characteristic implies that something within the individual’s personal or school experience is causing physiological symptoms. Fears may be manifested by incapacitating anxiety, panic attacks, and severe phobic reactions, ranging from physical symptoms (tense, restless, somatic/autonomic responses) to social anxiety (fear surrounding humiliation, rejection, and/or public performance) school avoidance, and perfectionism (Barkley & Mash, 2003). The anxiety may concern events or objects that are in the educational environment or separation from significant others.

The student may be seen as overly attached to a significant other, show excessive avoidance of unfamiliar individuals in familiar and secure settings, and/or excessive or unrealistic anxiety or worry about the future. Behaviors and feelings may be observed to include persistent and irrational fears of particular objects, activities, individuals or situations.

The student’s preoccupation with the physiological symptom(s) results in major interference with life functioning. Peer relationships, academic progress, physical health, concentration ability, and attendance may be negatively impacted by the

physiological symptom(s). Some common physiological symptoms that manifest in youth with ED include fatigue, fidgeting, headaches, nausea, numbness in hands and feet, muscle tension/aches, difficulty breathing, trembling, irritability, agitation, sweating, restlessness, and insomnia. A particular fear frequently encountered in students is school phobia. School phobia is based upon feelings of fear rather than anger, differentiating it from truancy (MSPA, 1994). Typically the student with school phobia can be found at home and is generally a good student when he attends school unlike the truant child who typically is not at home and presents problems within the school setting.

Note that the existence of an illness with a psychosomatic component does not alone document the existence of this characteristic of ED. The student's behavior must meet the limiting criteria of the definition, as previously discussed. The condition must generally be chronic rather than acute.

Schizophrenia

“ED includes schizophrenia” [COMAR 13A.05.01.03B(23) (b)]. “Schizophrenia” is a serious mental disorder, defined and described in the DSM IV-TR, in the chapter entitled *Schizophrenia and Other Psychotic Disorders*. Diagnostic criteria for these disorders are specified.

Social Maladjustment

“ED does not include a student who is socially maladjusted, unless it is determined that the student has ED.” [COMAR 13A.05.01.03B(23) (c)]

Definition/Discussion of Terms:

MSPA recommends that the term “socially maladjusted” be used to refer to students who behave in socially unacceptable ways for socially unaccepted motives within the sociocultural environment of the school (MSPA, 1994). While the IDEA and COMAR do not define the concept of “social maladjustment,” McConaughy and Ritter (in their chapter in NASP’s Best Practices in School Psychology IV) offer a helpful commentary on this issue:

“To guide best practice, school psychologists and other evaluators are encouraged to focus first on assessing the IDEA (or State) defined characteristics for ED... Once ED/EBD criteria are met, further evidence of social maladjustment is irrelevant for purposes of determining eligibility for special education or 504 accommodations. The presence of social maladjustment along with ED/EBD,

however, is an important factor to consider in planning interventions, since children with such problems often require mental health or social services in addition to educational services to meet their needs (McConaughy & Ritter, 2002, p.1315).”

The concept may be better understood through the use of a two factor model to assess social maladjustment, which indicates that while students with ED and social maladjustment may share common externalizing behaviors, the key difference between externalizing students with ED and students with social maladjustment are difficulties with affective dysregulation. Students with ED demonstrate significant affective dysregulation (or a persistent inability to control their mood state), while students with social maladjustment display limited affective dysregulation. Thus, a thorough assessment of behavior and personality traits must be conducted in order to differentiate between students with ED and those with social maladjustment (Frick, P.J., Barry, C.T., & Bodin, S.D., 2000).

MSPA recommends that the term “socially maladjusted” be used to refer to students who behave in socially unacceptable ways for socially unaccepted motives within the sociocultural environment of the school (MSPA, 1994).

Discussion of Social Maladjustment:

The definition of ED uses this term, ambiguously noting that the student is not ED if he/she is socially maladjusted, unless he/she has ED. “Social maladjustment” by itself, therefore, is something other than evidence of ED. This distinction appears to have been used in the past to exclude some students who present with challenging behavior from eligibility for special educational services. However, social maladjustment does not equal “conduct disorder” or “oppositional defiant disorder”; a maladjustment is not the same as a disorder.

Distinctions among types of disorders based on the degree to which they are more or less overtly “emotional” are clinically inappropriate and unjustified. Given their temperament, cultural upbringing, and other learning experiences, some students tend to “internalize” more when they have emotional problems, while others will tend to be more “externalizers.” The fact that a student with an emotional condition tends to “act out” his/her emotional problems rather than keeping them “inside” (in the form of depression or anxiety) does not preclude eligibility as ED. For example, a student could be diagnosed as “conduct disorder” and still qualify as ED. It is also possible that a student could have received a “conduct disorder” diagnosis, but upon comprehensive multi-disciplinary evaluation the student might be found not to meet ED defining criteria.

Social maladjustment may be better understood through the use of a two factor model, which indicates that while students with ED and social maladjustment may share common externalizing behaviors, the key difference between externalizing students with ED and students with social maladjustment are difficulties with

affective dysregulation. Students with ED demonstrate significant affective dysregulation (or a persistent inability to control their mood state), while students with social maladjustment display limited affective dysregulation. Thus, a thorough assessment of behavior and personality traits must be conducted in order to differentiate between students with ED and those with social maladjustment (Frick, P.J., Barry, C.T., & Bodin, S.D., 2000).

Social and cultural elements must be considered in determining if a student's presenting behavior is more reflective of social maladjustment instead of an actual ED. A student may have grown up in a particular social/cultural environment so experientially diverse, where the norms and values are so different from those of the school, that the child may be perceived in the school as being "maladjusted".

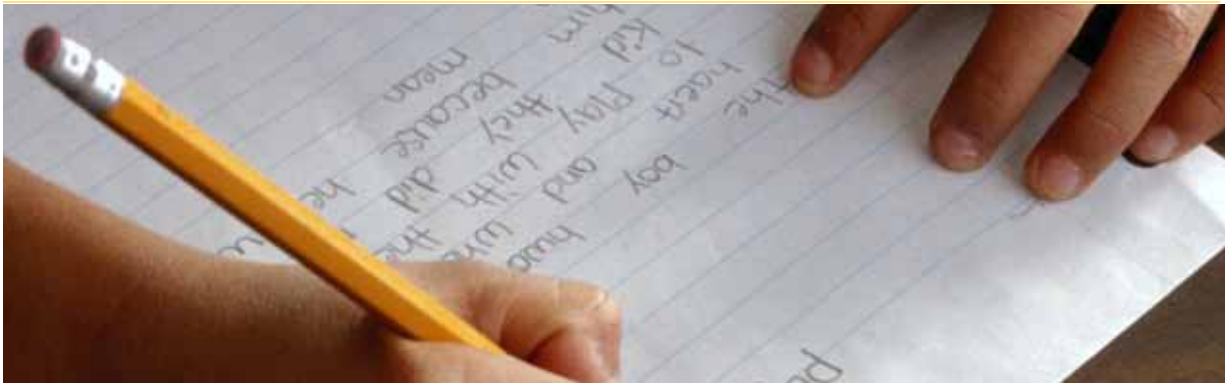
Additionally, it should be noted that school staff and clinicians are accustomed to particular sociocultural contexts through which they routinely evaluate, identify, and serve youth with ED, and these contexts are not without bias. School staff must recognize that these inherent biases impact their assessment of the child, and that they are not necessarily reflective of the child's potentially adaptive behavior in his or her home and community. However, given time, understanding, and culturally competent teaching, an emotionally intact student will be able to learn and adapt to the behavioral norms and expectations of the school. Thus, lack of exposure to requisite social and behavioral learning experiences is not sufficient grounds for identifying a student as ED.

Severely disruptive behavior should not be *automatically* be interpreted as "symptomatic" of an emotional condition. A student's inappropriate behavior may be seen as having been learned, reinforced, and sustained within a set of behavioral norms and values so different from those of the school that the student is truly maladjusted in that school setting. Furthermore, from a functional perspective, if the behavior can be understood as being goal-directed and deliberate, (resulting in identifiable power, prestige, or material gains for the student), this type of behavior may be more indicative of social maladjustment than of ED.

The IEP team should exercise great care to avoid labeling such students as disabled, when in fact they may be well adjusted within their particular social/cultural context. These students may not have been exposed to the social-learning experiences necessary for the development of school-requisite social behaviors, or they may be choosing to behave that way for social reinforcement. Given sufficient time and appropriate instruction, most students should be capable of adapting to the standards and expectations of the school, acquiring and maintaining acceptable situation-specific patterns of behavior in school without abandoning their social/cultural heritage. Students should only be considered as ED if they are incapable of such adaptation, after appropriate interventions have been attempted, and if intellectual, sensory and other health factors have been ruled out.

Assessment Procedures For Determining If a Student Meets the Criteria To Be Identified With the Condition as Defined in COMAR as ED

See COMAR 13A.05.01.03B(3); COMAR 13A.05.01.03B(23)



Assessment for ED is defined in the Individuals with Disabilities Education Act (IDEA) and the Code of Maryland Agency Regulations (COMAR). This portion of the document is intended to outline the appropriate evaluation procedures to assist in the identification of students meeting criteria pursuant to IDEA [34 CFR §§300.8(c)(4); 300.304-300.311] and COMAR [13A.05.01.03B(23); 13A.05.01.05.06].

There are many reasons that students may succeed or fail in an academic setting such as instructional methodology, motivation, ability to cope with emotional challenges, stress, cultural and language differences, and relationships with teachers or peers. To assist schools and students, school psychologists have expertise in psychology and education to help understand the needs of all students, and, in particular, those struggling academically and behaviorally.

Assessments and initial evaluations

Assessment refers to a multidimensional, integrated gathering of information regarding a student's functioning in a variety of areas: school achievement in basic skill areas and/or content areas, emotional/social/behavioral functions and relationships, medical and physical development, hearing, vision, attitudes and habits, linguistic competency, family, and other related factors. The data that supports the assessment may include formal tests such as benchmark tests, large scale assessments (such as the Maryland School Assessments), physician reports, parent reports, informal tests, or formal tests given by related service personnel such as school psychologists. School psychologists gather informal and formal data using observations, interviews, review of existing information, informal test, and formal tests (to

be discussed below). In the school setting, the choice of appropriate methods for assessment to evaluate a particular child rests with the certified personnel who will conduct that evaluation. Initial evaluations rely on previous student performance, assessment/behavioral data, and interventions that have been tried within the standard education setting. Assessment is most effective when it reflects an understanding of learning as multidimensional, integrated, and evidenced in performance over time. This is true whether it is an *initial evaluation* to determine if a child demonstrates an emotional or behavioral condition warranting special education instruction and/or related services, or a *reevaluation* to determine if a child continues to demonstrate the same needs.

Learning is a complex process regarding the development of knowledge, [academic] skills, and what students do with what they know, including their abilities, attitudes, habits and performance within and beyond the classroom. The IEP team may review information collected through the teacher, SST, and other sources with regard to interventions attempted and successful or unsuccessful strategies used. If a school utilizes a procedure known as Response to Intervention (RTI), the information collected through that process will be helpful in understanding the student's learning history. Another method of collecting data that is often available for review is a Functional Behavioral Assessment (FBA) and the Behavior Intervention Plan (BIP), which gives information on what may trigger or reinforce a behavior and what interventions have been tried previously to address behavioral issues.

Assessment should be comprehensive in nature and include a variety of sources in academic and nonacademic settings, such as the school, home, and/or community. It should assess strengths and areas of concern, intensity, pervasiveness, persistence, cognitive factors, academic functioning, and developmental and cultural and community norms and factors. The evaluative process should attempt to understand the differences between outward behaviors and internal emotional factors, which may or not be the causative factors of the behaviors of concern. The assessment techniques, evaluative procedures, and tests recommended below are not all inclusive and other venues for collecting information may be appropriate.

Assessment techniques used by professionally trained and certified school psychologists should be consistent with the guidelines of the National Association of School Psychologists. Tests used should meet the criteria set forth in *The Standards for Educational and Psychological Testing* developed jointly by the American Educational Research Association (AERA), the American Psychological Association (APA), and by the National Council on Measurement in Education (NCME). Base rates for explaining functioning need to be included and explained in terms of relevance to the child's strengths and weaknesses. School psychologists administer only tests for which they have had training and/or supervision.

Tests and other evaluative procedures and instruments used to assess a student must be selected and administered with consideration of the student's racial/ethnic and cultural background. These procedures must also be administered in the student's native language or mode of communication, unless it is not clearly feasible to do so. Under Title VI of the Civil Rights Act of 1964, in order to properly evaluate a student who may be limited in English proficiency, a public agency should assess the student's proficiency from disability needs.



An accurate assessment of the child's language proficiency should include objective assessment of reading, writing, speaking, and understanding.

Assessments completed by schools psychologists are conducted to help understand a student's academic, social, emotional, and behavioral needs so they can achieve academically. School psychologists are trained to use assessment instruments and techniques that are validated by the field of school psychology and have established validity and reliability for the student being tested considering social economic status, English proficiency, ethnicity, sensory, motor, language, behavior and other relevant factors. It is vital that school psychologists select empirically based assessment measures and when deviating from the use of such instruments make note of this and describe the rationale for use of the instrument or technique chosen; as well as factors that affect interpretation.

Any standardized tests that are administered must be validated for the specific purpose for which they are used, and be administered by trained and knowledgeable personnel in accordance with the instructions provided by the producer of the tests. If an assessor does not conduct an assessment under standard conditions, that assessor must describe the extent to which the conditions and procedures varied from standard conditions and the impact of that variance must be included in the assessment report.

Educators must demonstrate knowledge of cultural assets to create culturally reflective instruction and to form positive relationships with students and families. A philosophy of early intervention and collaboration should be developed among all school staff. School psychologists must be knowledgeable about the impact of race and culture during assessment and intervention with students, and during consultation with teachers and parents. School psychologists must have an understanding of practices that foster disproportionate identification of ED among African American students¹. It should be the goal of each local school system to eliminate disproportionate representation of students in special education on the basis of their race/

¹ African American youth are consistently over-represented in special education in Maryland, with disproportionately higher rates of identification than Caucasian students, especially with reference to the ED subgroup, despite the fact that they comprise a smaller segment of the total student population (Maryland State Department of Education, 2010). Lehr and McComas' 2006 article (as cited in Chakaborti-Ghosh, Mofield & Orellana, 2010) indicates that disproportionality is due to "institutional racism, stereotypes, cultural incompetence, racial bias, and inequitable discipline policies" (p. 165).

ethnicity and set the expectation of parity for all students in academic achievement, discipline sanctions, intervention, and special education identification and placement.

Specifically, the following is recommended to meet the criteria outlined under COMAR 13A.05.01.03B (3) and COMAR 13A.05.01.03B (23):

23 a.i. An inability to learn that cannot be explained by intellectual, sensory, or health factors. To meet these criteria:

A measure of cognitive functioning is recommended to assess reasoning, judgment, and problem-solving ability and to generally understand the student's ability to learn in an academic setting to rule out whether behavioral concerns might result from academic deficits resulting from other disabling condition(s) or a processing deficit underlying learning delays in basic academic skills.

Purpose: While reasoning, judgment, and problem solving are essential components for a student to manage his/her emotional reactivity, it is necessary to comprehensively assess and consider multiple factors to understand how a student interacts with peers and adults in a variety of situations. It is important to determine the student's intellectual, sensory, and health functioning in order to understand the student's ability to learn, to perform in social situations, and to problem solve new experiences. Once this baseline is established, it allows the examiner to understand if cognitive functioning may be the causative factor in deficits in learning and in adequate, age appropriate, behaviors and interpersonal interactions. Base rates for explaining functioning need to be included and explained in terms of relevance to the child's strengths and weaknesses.

Assessment(s) of general intelligence and cognitive functioning, in accordance with 34 CFR §300.304(c) (4), should be considered to assess reasoning, judgment, and problem-solving ability and to generally understand the student's ability to learn in an academic setting to rule out whether behavioral concerns might result from academic deficits resulting from other disabling condition(s) or a processing deficit underlying learning delays in basic academic skills.

A systematic review of medically-related information includes, but is not limited to: vision, hearing, medications, medical conditions, and a developmental history. Medical information can be gathered from the student's pediatrician, child psychiatrist, therapist, school nurse, or other medically trained providers, from school vision and hearing screenings, and parent report. Information related to lead levels, head injuries² and chronic medical conditions such as asthma, diabetes, sickle cell anemia, and other conditions should be gathered.

² If an individual experiences high lead levels or lead poisoning, an IEP team may need to consider Other Health Impairment, consistent with 34 CFR §300.8(c)(9) and COMAR 13A.05.01.03B(51). If an individual experiences a head injury, an IEP team may need to consider Traumatic Brain Injury, consistent with 34 CFR §300.8(c)(12) and COMAR 13A.05.01.03B(82).

A systematic review of academic performance includes, but is not limited to: prior and current education records, school history such as attendance and tardiness, number of schools attended, grades received, classroom interventions, State testing results, prior special education testing, if any, student support team referrals and outcomes, remedial assistance provided, individualized positive behavior programs previously implemented, informal and benchmark evaluation results, and other relevant information.

23 a. ii. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

School psychologists are encouraged to review teacher reports, parent reports, disciplinary referrals, and other school staff reports of the student's behavior. In addition, school psychologists may consider directly observing the student, conducting a student interview, and reviewing other relevant information such as that from collaborative community providers. These may include but are not limited to:

- Informal observation;
 - Formal Observation timed with peer group comparison;
 - Notation of intensity, frequency, duration of behaviors;
 - Rating Scales, self reports, Behavior Assessment System for Children (BASC-2; Reynolds & Kamphaus, 2006), Achenbach System of Empirically Based Assessment (ASEBA; Achenbach, 2009), Conners' Rating Scale-Revised (Conners, 1997), Minnesota Multiphasic Personality Inventory -2 (MMPI-2; Butcher et al., 1989) Devereaux, Millon, etc. from multiple raters;
 - Discipline record/office referrals;
 - Parent and/or teacher reports of peer/adult problems;
 - FBA-BIP as necessary;
 - Student Interview;
 - Social Skills Improvement System (SSIS);
 - Relevant projective techniques; and
 - Additional relevant tests to be determined by the school psychologist.
-

23 a. iii. Inappropriate types of behavior or feelings under normal circumstances.

Utilize assessment designed to examine covert and overt behaviors through teacher reports, parent interview, clinical interview of the student, discipline records and observations by the school psychologist and other school staff. Review and determine intensity, frequency, and duration of behaviors needed to understand if the behavior interferes to a "marked degree" with learning and if the child is unsafe to self and others. A statistical measure of the frequency, duration, and intensity of behaviors can be obtained through the use of behavior rating scales (but not necessarily limited to those scales). This may include direct observation that is timed and allows for comparison sampling with other students in the same setting. Such measures as the BOSS (Behavioral Observation of Students in Schools),

Direct Observation Form (Achenbach), or other applicable strategies may be used. Event sampling using a frequency count may help understand the pervasiveness in a variety of settings. Universal screening procedures and data management systems may be utilized, i.e., the School Wide Information System (SWIS) used by many schools implementing Positive Behavioral Interventions and Supports (PBIS), AIMSweb or other relevant, research based systems.

- Functional Behavioral Assessment (FBA) is appropriate to identify the functions underlying the student's behaviors and lead to the development of an appropriate BIP. If a plan has been in place, re-examination of the current FBA-BIP is needed. The FBA-BIP may also elucidate the environmental antecedents and consequences initiating the behavior and maintaining it. An FBA should rely on data collection and observation in the school environment. The FBA-BIP is critical at all phases of the referral, assessment, and eligibility process. Refer to Discipline of Students with Disabilities: Resources and Information on Effective Practices and Requirements Under the Individuals with Disabilities Education Act (IDEA) (MSDE, 2009) the Maryland Online IEP, or technical assistance on Functional Behavioral Assessment and Behavior Intervention Planning.

23 *a.iv.* A general, pervasive mood of unhappiness or depression.

School psychologists are encouraged to include evaluation to determine if the student shows evidence of unhappiness or depression, such as withdrawal, tearfulness, flat affect, or, conversely, anger management difficulties, irritability, or increased risk taking behaviors through multiple observations and in a variety of settings. Assessment should include reports from teachers, the student, family, peers, and other school staff. Relevant information can include the number of trips to the nurse's office, guidance office, or other supportive staff offices. Use of behavior rating scales, sociograms, and other relevant tests may include, but are not limited to:

- Observation;
- Rating Scales – BASC2, ASEBA, Conner's, Children's Depression Inventory (CDI: Kovacs, 1985), etc.;
- Parent/or teacher reports of unusual behaviors;
- Student interview;
- Parent and/or teacher reports of withdrawal;
- Parent/teacher or student report of anxiety/depression;
- FBA ;
- Beck Depression Inventory – II (BDI-II; Beck et al., 1996);
- Relevant projective assessments- Rorschach, apperception tests (e.g., Children's Apperception Test [CAT], Thematic Apperception Test [TAT], AAT, Roberts Apperception Test for Children [RATC-2; Roberts, 2005]), storytelling techniques (TEMAS), projective drawing (DAP, KFD), Sentence Completion Test, etc.; and
- Additional relevant tests determined by the school psychologist, including exploration and assessment of expressed suicidal comments/suicidal ideation (see 23 a.v. for more information).

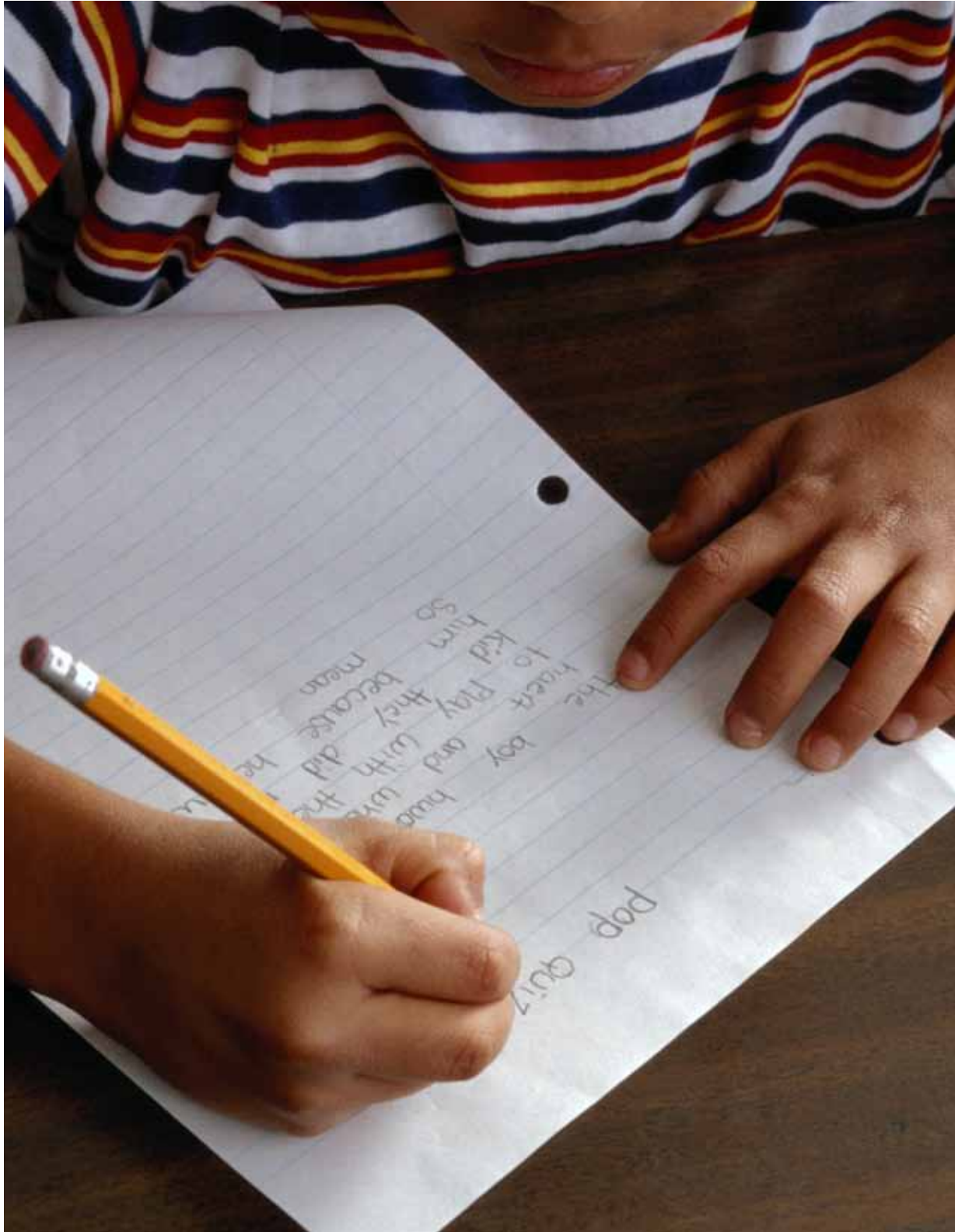
23. *a.v.* A tendency to develop physical symptoms or fears associated with personal or school problems:

School psychologists are encouraged to determine type, depth, extent and impact of physical symptoms that differentiate the child from his/her peers. This may manifest itself as anxiety, fear or reluctance to participate in classroom or school activities (i.e. chronic absenteeism, school phobia/school refusal, physical symptoms without an organic base but have a known stress related link, such as headaches, ulcers, etc.); teacher reports, the student and family report, peer reports; and other school staff reports {should be included}. Relevant information can include the number of trips to the nurse's office, guidance office, or other supportive staff offices. Use of behavior rating scales and other relevant tests and resources may include, but are not limited to:

- Observation;
- Rating Scales – BASC2, ASEBA, Conner's, etc.;
- Anxiety specific rating scales- Revised Children's Manifest Anxiety Scale: Second Edition (RCMAS-2; Reynolds & Richmond, 2008), etc.;
- Parent/or teacher reports of unusual behaviors;
- Student interview;
- Parent and/or teacher reports of withdrawal;
- Parent/teacher or student report of anxiety/depression;
- Attendance Records;
- School Nurse Logs/Records;
- Office Referrals/Discipline Records (all of this data will also be a part of the student's FBA);
- Children's Measure of Obsessive Compulsive Symptoms;
- Relevant projective assessments- Rorschach, apperception tests (CAT, TAT, AAT, RATC-2), storytelling techniques (Tell-Me-A-Story [TEMAS; Constantino et al., 1988]), projective drawing (DAP, KFD), Sentence Completion Test, etc.; and
- Additional relevant tests determined by the school psychologist.

During the process of assessment for ED, or even service provision, expressed suicidal intent may be revealed. **Any expressed suicidal intent should be explored.** Many of the risk factors associated with youth suicide are also present in students with ED. It has been demonstrated that as many as 90 percent of adolescents and children who committed suicide also suffered from a mental or emotional disorder (Conwell et al., 1996; Crowell et al, 1993, and Schaffer et al., 1996; cited in Poland & Lieberman, 2002).

While procedural guidelines and policies on suicide intervention are too extensive to cover in this document, standard protocol are included in Appendix II. Poland and Lieberman (2002), in a review of best practices in suicide intervention, indicate that it is a school's responsibility to have a policy and procedure for dealing with suicidal students. The authors emphasize that the critical first step in suicide intervention is to understand the cultural and developmental risk factors of youth suicide, which include the presence of mental or emotional disorders, substance abuse, familial suicide, biological factors, and situational factors such as access to weapons, poor coping skills, and chronic symptoms.



Identification of Services and Service Delivery for Students with ED

The reauthorization of IDEA 2004 emphasizes the importance of improving the educational results for all students and particularly those students with disabilities. Federal and State regulations require school districts to implement school-wide approaches for the provision of “...positive behavioral interventions and supports, and early intervening services to reduce the need to label children as disabled...” (USCS, Chapter 33). In this spirit, it is essential for school teams to thoroughly exhaust the services and supports available through general education in order to address the needs of students with emotional/behavioral concerns. Only then can we appropriately identify those students who have an educational disability that requires specialized instruction delivered through an IEP.

Developing IEP goals and objectives

Special education services delivered through an IEP are defined by COMAR as “specially designed instruction, at no cost to the parents, to meet the unique needs of a student with a disability” [COMAR 13A.05.01.03B(71) and (72)]. Specially designed instruction means the adaptation of content, methodology, or delivery of instruction to ensure access to the general curriculum so that the student can meet the educational standards that apply to each student in the jurisdiction. For a student with ED, specially designed instruction may need to focus on the affective aspects of learning, as well as the student’s progress through the grade-level curriculum. Once a student has been identified as having ED that requires special education and related services, it is the responsibility of the IEP team to develop an IEP to address all areas impacted by the disability. In developing the IEP, the following must be considered and documented [COMAR 13A.05.01.08]:

- Strengths of the student;
- Concerns of the parent for enhancing their child’s education;
- Results of the most recent assessments;
- Communication needs of the student;
- Need for assistive technology devices and services;
- The student’s performance on State and district assessments; and
- The academic, developmental, and functional needs of the student.

In addition, if a student’s behavior impedes the student’s learning or the learning of others, the IEP team must consider strategies, including positive behavioral interventions and supports, to address the target behaviors. These strategies may be reflected as functional goals in the IEP or as components of a behavioral intervention plan (BIP).

Present level of academic achievement and functional performance

The process of writing measurable IEP goals involves identifying and documenting the Present Level of Academic Achievement and Functional Performance, identifying annual goals and short-term instructional objectives, determining how the goals and objectives will be measured, and developing a procedure for reporting the student's progress toward meeting individual annual goals. The school psychologist collaborates with the special educator and other designated staff to document the student's needs. The IEP includes a Present Level of Academic Achievement and Functional Performance page on which the school staff documents the student's current levels of performance. Each student's identified strengths and weaknesses must be documented under the broader headings of Social/Emotional/Behavioral, Reading, Mathematics, Written Language, Communication, etc.

For each applicable area, the team must provide the following information:

- **Source:** Identify the source of the information. For students at their initial IEP or reevaluation, there will be standardized test results or other formal assessment data to be reported. For students at their annual IEP review, current observations and informal assessments aligned with the student's performance and progress on IEP goals should be utilized.
- **Level of Performance:** Specify the student's level of performance relative to age or grade, (e.g. significantly below level, moderately below level, etc.). Consider the data from private, State, local school system, and classroom based assessments as they pertain to this item.
- **Summary of Assessment Findings:** Document the assessments used and apply the information obtained to identify strengths and needs.
 - *Assessment:* Indicate the formal assessment measure or identify that informal procedures were used. Include the date the data were collected. If there were formal assessment procedures, document relevant standard scores.
 - *Other Results:* Document additional formal measures with subscales, subtests, or other relevant data. Identify the types of informal measures or procedures and include scores, results, or percentages, (e.g., behavioral point sheet data, observational data, etc.).
 - *Strengths:* Identify the student's strengths relevant to the area on which you are reporting (e.g., social/ emotional/ behavioral).
 - *Needs:* Specify the needs the student has demonstrated based on the data that has been collected. Best practices would indicate that the student's level of performance (i.e., baseline) should be indicated as well. (For example, for compliance, the student follows directions with two prompts 55 percent of the time.) The areas of specific need are translated into annual goals in the Annual Goal section of the IEP. The major areas for social/emotional/behavioral goals usually fall into the following categories: compliance, work habits, self-control, personal/interpersonal skills, and organizational skills.
- **Parental Input:** The IEP team is required to consider a parent's thoughts, observations, and concerns regarding their student's educational programming. This is documented on the PLAAFP page as well.

- **Student Strengths, Interest Areas, Significant Personal Attributes, and Personal Accomplishments:** The student's positive traits and interests should be documented and itemized on the IEP in this section.
- **How the Student's Disability Affects His/Her Involvement in the General Education Curriculum:** The IEP team documents how the disability impacts the student's involvement with and progress in the general education curriculum, as well as circumstances under which the student will be able to receive educational benefit.

Process of developing measurable IEP goals

The IDEA [34 CFR § 300.320(a) (2) (i)] and COMAR [COMAR 13A.05.01.09A(1) (b)] require that the IEP include measurable annual goals (academic and/or functional), designed to meet the student's needs resulting from the disability so that the student is able to progress in the general education curriculum. However, there may be some students who, because of their disabilities, will require alternate assessments aligned to alternate achievement standards. In either case, academic and/or functional goals are written and include short-term instructional objectives or benchmarks. Although IDEA and COMAR do not define "functional skills", the literature includes Social/Emotional/Behavioral skills within the broader category of functional skills.

IEP annual goals and short-term instructional objectives and benchmarks

Once the student's needs have been determined, those needs are used as the basis for the IEP annual goals and short-term objectives. It is recommended that school teams use the **SMART** goals process when writing IEP goals, as outlined in the *Maryland Online IEP System Process Guide*, to ensure that goals are:

- Strategic and specific;
- Measurable;
- Attainable;
- Results-based; and
- Time-bound.

Additionally, it is recommended that each goal should include six components:

- Direction (increasing a positive behavior or decreasing or extinguishing a negative behavior);
- Problem being addressed;
- The present level of functioning;
- The amount of change, by the end of the IEP year;
- The methodology needed to address the specific area of achievement; and
- The measurement to be used to determine the efficacy of the goals and objectives (standardized test, valid observational data, point sheets, etc.).



The following is a sample of a goal written with the above components: With the provision of reinforcement, the student will increase his in-seat, on-task behavior from 20 percent of the time currently to 50 percent of the time by the end of the year, measured by time sampling behavioral observations. Referencing the major areas of impact cited above, the following social/emotional/behavioral goals may apply:

- ▶ **Compliance**
 - Improve verbal communication with adults and authority figures
 - Appropriately seek support when resolving conflicts
 - Remain in designated areas
 - Follow adult directions

- ▶ **Work Habits**
 - Improve on-task behavior
 - Improve task completion

- ▶ **Self-Control**
 - Utilize coping strategies
 - Develop self-management skills to decrease impulsive behaviors
 - Develop self-management skills to decrease compulsive behaviors
 - Develop self-management skills to decrease self-injurious behaviors

- ▶ **Personal/Interpersonal Relationship**
 - Increase positive pro-social interactions
 - Improve positive peer relationships
 - Improve problem-solving skills

- ▶ **Organizational Skills**
 - Improve time management
 - Utilize graphic organizers to improve quality of written work

When creating short-term instructional objectives, consider what the student will need to be able to do to achieve the goal. The purpose of the short-term instructional objectives is to identify some intermediate steps to be taken to reach the annual goal. These steps may include a logical breakdown of the major components of the annual goal or may identify some building block skills needed for the attainment of the annual goal. Thus, the short-term instructional objectives reflect incremental, sequential steps needed to achieve the annual goal. There must be at least two short-term instructional objectives for an annual goal.

Importance of social/emotional/behavioral goals

In order to successfully meet the needs of students with ED, it is required that the IEP contain relevant social/emotional/behavioral goals. The IEP team can ensure relevance by choosing only a few behaviors to target for change at one time. The social/emotional/behavioral goals should be designed to support academic achievement and improve the student's ability to access instruction. Once the appropriate goals have been identified, the team will be able to determine the services needed. The services may be provided through instructional support, related services, and/or supplemental aids and services.

The importance of social/emotional/behavioral skills is well documented. Numerous school districts are emphasizing Social and Emotional Learning (SEL) as important for all students. Students with Emotional Disability may not be able to benefit significantly from Tier One or Tier Two interventions in a systematic *Response to Intervention (RTI)* framework. Not only do some students lack the social skills necessary for successful interpersonal growth, their impaired social skills may impact their ability to attend to and complete work within the classroom. Often, their academic frustration and poor coping skills exacerbate their lack of academic achievement. Thus, their academic growth is negatively impacted.

Additionally, the student with ED frequently has negative interactions with other students that interrupt the instructional process within the classroom, thus impacting the learning of all students. For the student with ED, social/emotional/behavioral goals are crucial in order to successfully learn and progress toward mastery of the concepts and skills outlined by the Maryland State Content Standards/State Curriculum.

Reporting progress on annual goals

Every student receives quarterly progress reports documenting progress on each of the IEP annual goals. The quarterly progress report should include a measureable benchmark toward the annual goal. If the student has not made sufficient progress during the quarter, the IEP team should identify an intervention and/or additional strategy to assist the student in making progress toward his/her annual goals. The school psychologist can support this review process by assisting the IEP team in analyzing behavioral data and revising the IEP to better meet the student's needs.

Identification and delivery of special education (IEP) services

Once appropriate IEP goals and objectives or benchmarks have been identified for the student with ED, the IEP team must determine the special education and related services necessary to achieve academic and functional progress. Best practice requires consideration of the following when programming for ED student:

- Services and service delivery must allow the student access to the least restrictive environment, while appropriately addressing the student's needs;
- The continuum of services must include access to a small, structured setting for those students whose needs require some time away from the general education environment;
- Services must provide specialized instruction to the student to address academic, behavioral, social, and functional performance, as identified in the IEP;
- The implementation of services must be positive in nature, rather than punitive, in order to foster meaningful behavioral change;
- Supplemental services in the form of staff training may be necessary in order to implement the IEP goals and objectives with fidelity;
- Since a student's social/emotional/behavioral issues may be reflected throughout the student's school environment, all staff members involved with the student should be made aware of the student's IEP and how to effectively interact with the student;
- Services must be flexible enough to address crises, as they arise; and
- The student identified with ED should be included in the IEP process, as appropriate, to better understand his/her needs and build positive relationships with the team members.

The school psychologist's expertise in learning, development, and emotional functioning enables him/her to assist in the provision of services for students with ED. The psychologist's role in service delivery may include (but is not limited to) the following:

- Consultation to school staff, parents, and other stakeholders;
- Professional development activities for school staff, parents, and other stakeholders;
- Therapeutic counseling services, as a related service on the IEP;
- Behavior Intervention Support, (i.e., crisis intervention services, as a related service on the IEP);
- Liaison between families and collaborating community providers and agencies; and
- Training and coaching for school-wide intervention services, such as PBIS.

Conclusion

The focus of the Role of the School Psychologist in the Identification of ED workgroup is to provide enhanced technical assistance (including clarification of identification criteria and assessment procedures) for the identification of ED, provide guidance on effective practices for the identification of students with ED, and to define the role of the school psychologist in the disability determination process and as a member of the IEP team.

This document describes appropriate identification practices to utilize when parents or school personnel suspect the presence of ED in children and youth, to establish a uniform standard for assessment and identification and promote consistency in current practice. The primary goals of this document are to foster improved consensus among school-based clinicians on effective practices for the identification of students with ED, to improve compliance with identification procedures, and address the role of the school psychologist in the provision of IEP services and supports to improve outcomes for this subgroup of students.

By establishing guidelines, standards and protocols for screening, we hope to inform current practice by promoting uniformity in assessment procedures and ensure the appropriate identification of ED and the timely provision of IEP services to youth in their least restrictive environment. The guidance in this document addresses concerns about subjectivity in defining the impact of ED on a child's achievement in school, as well as the significant disparity in the number of students identified with ED in jurisdictions across Maryland, including the significant over-representation of African American male youth in this disability category.

This document was developed by a diverse group of stakeholders through discussion of current practices, a review of literature on evidence-based practices in evaluation and assessment, analysis of technical assistance documents from other states, and review of relevant case law. It is our intention that this document will serve as a resource and reference tool to guide practice and inform decision making for school-based professionals and members of the IEP team.



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Appendix I:

A Sample Tiered Interventions Menu		
Tier One Interventions: Universal interventions implemented primarily by the teacher with parental assistance as needed		
Intervention	Dates	Description/Data/Outcomes
<ul style="list-style-type: none"> Increased parent contact by teacher (Email/phone/written progress) 		
<ul style="list-style-type: none"> Identify/capitalize on student strengths <i>Describe:</i> 		
<ul style="list-style-type: none"> Review parent information re: medically related conditions (e.g. asthma, diabetes, ADHD) 		
<ul style="list-style-type: none"> Modifications in teacher response to student (e.g. repeated directions, prompts) 		
<ul style="list-style-type: none"> Modification of classroom setting (e.g. seating, study carrel to enhance focus) 		
<ul style="list-style-type: none"> Analyze student's instructional level vs. grade level/curriculum expectations; modify as needed 		
<ul style="list-style-type: none"> Engage student as helper in area of interest <i>Describe:</i> 		
<ul style="list-style-type: none"> Identify/address student behavioral weaknesses <i>Describe:</i> 		
<ul style="list-style-type: none"> Teacher directed incentive program to reinforce targeted behaviors 		
<ul style="list-style-type: none"> Modifications in student schedule (e.g. Periodic breaks for stress relief or activity) 		
<ul style="list-style-type: none"> Time-out plan—as structured intervention inside or outside classroom 		
<ul style="list-style-type: none"> Use of forced (positive) choice paradigm <i>Two acceptable choices:</i> 		
<ul style="list-style-type: none"> Conflict Resolution/Mediation for peer conflicts <i>Describe:</i> 		
<ul style="list-style-type: none"> Assigned essay/teacher meeting to examine and change behavior 		
<ul style="list-style-type: none"> Teacher directed classroom management plan/ (e.g. behavior contract) <i>Attach.</i> 		
<ul style="list-style-type: none"> Suggest to parent that health/family issues might be affecting school performance 		
<ul style="list-style-type: none"> Re-arrange class groupings/student schedule to address needs. <i>Describe:</i> 		
<ul style="list-style-type: none"> Character Counts lessons 		
<ul style="list-style-type: none"> Reteach and practice classroom rules and expectations 		
<ul style="list-style-type: none"> Formal Home-School communication system between teacher and parent 		

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A Sample Tiered Interventions Menu, <i>continued</i>		
Tier Two Interventions: Targeted interventions implemented primarily by teacher/grade level team with staff assistance as needed		
Intervention	Dates	Description/Data/Outcomes
• Consultation with/ observation by school-based mental health provider with resulting plan		
• Specialist consultation to confirm instructional level match with academic expectations		
• Grade level teachers discuss potential functions of behavior and BIP across classes		
• Parent/teacher/student meeting with admin and/or support staff		
• Increase parent involvement/ reinforcement at school (e.g. lunches, monitoring)		
• Parent Reinforcement Plan for school behavior (e.g. home/school weekly rewards) <i>Describe:</i>		
• Consult with /refer to collaborating providers, (Dr., therapist, etc.) with parent permission		
• PBS Check In/ Check Out System <i>Describe:</i>		
• Emergency flash pass for counseling/ time-out <i>Criteria:</i>		
• Support from assistant/mentor/volunteer <i>Describe:</i>		
• Social Skills instruction/friendship group w/ mental health provider		
• Anger management/conflict resolution/stress management instruction as needed		
• Small group academic or study skills instruction dependent on student needs		
• Individual school counseling or referral to parent for outside counseling		
• Daily behavior report based on behavior function with pos./neg. consequences		
• A.M./lunch/after-school detention to make-up missed work or reflect on behavior		
• Peer Mediation		

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The Role of the School Psychologist in the Identification of ED

A Sample Tiered Interventions Menu, <i>continued</i>		
Tier Three Interventions: Intensive intervention implemented primarily by administrator and/or SST with outside resources as needed		
Intervention	Dates	Description/Data/Outcomes
<ul style="list-style-type: none"> SST staffing of student with teacher(s) to generate formal student support plan <i>Attach.</i> 		
<ul style="list-style-type: none"> Social worker, behavior specialist or school psychologist referral for ongoing intervention 		
<ul style="list-style-type: none"> Formal behavior contract involving specialists and support staff <i>Attach.</i> 		
<ul style="list-style-type: none"> Formal FBA and more complex BIP w/ incentives and consequences <i>Attach.</i> 		
<ul style="list-style-type: none"> Daily Administrator/ Resource room a.m./p.m. check-ins with student <i>Describe:</i> 		
<ul style="list-style-type: none"> Escort from/to bus, bathroom, classes, high-behavioral risk settings 		
<ul style="list-style-type: none"> Consultation with CASS (Community Agency School Services) 		
<ul style="list-style-type: none"> Referral to Project 103 		
<ul style="list-style-type: none"> Crisis plan developed with SST specialist <i>Describe:</i> 		
<ul style="list-style-type: none"> Home visit w/social worker/PPW to develop parent/ school alliance and home/school plan 		
<ul style="list-style-type: none"> Non-custodial family/ friend involvement to support student needs as indicated 		
<ul style="list-style-type: none"> Collaborating agency (DSS, MH Center) staffing to develop a service plan <i>Attach.</i> 		
<ul style="list-style-type: none"> Consider psychological assessment for additional information/recommendations 		
<ul style="list-style-type: none"> Temporary alternative class or program setting to stabilize behavior 		
<ul style="list-style-type: none"> Wraparound service consideration with collaborating agencies 		

Appendix II

General Suicide Intervention Strategies Suggested by Poland and Liberman (2002):

- Have a referral process system in place to handle suicidal youth.
- Inform all “gatekeepers” of warning signs of youth suicide.
- Assign a “designated reporter” who receives and acts upon all reports.
- Require the designated reporter to assess the severity of the risk.
- Collaborate with colleagues throughout the assessment, at least one of whom is an administrator and another mental health professional (e.g., counselor, school psychologist, PPW, social worker, etc.).
- Explain the limits of confidentiality to the student and his/her parent(s) (e.g., situations involving abuse of a minor, risk of harm to self, and risk of harm to others).
- Notify parent(s) that there is a duty to warn of severity of suicidal risk.
- Refer to other mental health services as needed.
- Seek the help of law enforcement or emergency services when appropriate (e.g., if the student becomes combative, flees, etc.).
- Supervise the student at all times, never leaving student alone.
- Do not send the student home unless accompanied by a responsible adult.
- Provide follow up at school for the student as needed.
- Develop a process/form for documenting interventions and assessment.

In addition, the following are several national and local resources available for additional guidance and information:

- **National Suicide Prevention Lifeline** <http://www.suicidepreventionlifeline.org/>
- **Suicide Prevention Resource Center (SPRC)** <http://www.sprc.org/>
- **SPRC prevention guide** <http://www.sprc.org/library/prevtoolkit.pdf>
- **SPRC postvention guide**
<http://www.sprc.org/library/AfteraSuicideToolkitforSchools.pdf>
- **SPRC risk and protective factors** <http://www.sprc.org/library/srisk.pdf>
- **SAMHSA** <http://www.samhsa.gov/prevention/suicide.aspx>
- **Maryland website of resources** <http://www.dhmh.maryland.gov/suicideprevention/>

The Role of the School Psychologist in the Identification of ED
Guidance and Technical Assistance for School Psychologists In Assessment,
Identification, Service Provision and Progress Monitoring of Students with ED

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Maryland State Department of Education
Division of Special Education/
Early Intervention Services
Family Services and Interagency Branch
200 West Baltimore Street, 9th Floor
Baltimore, Maryland 21201
410-767-0858

