PROCEDURES FOR CONFIRMING

Emotional Disturbance & Mental Retardation

January 2003 Edition
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Introduction

The Office for Civil Rights in the US Department of Education has identified the issue of the over-representation of African American students in the categories of emotional disturbance and mental retardation as a significant barrier to their right to equal educational opportunity. In Montgomery County Public Schools (MCPS) one attempt to ensure equal educational opportunity to such students was the creation of an Advocacy Review Committee (ARC), which reviewed the records of African-American special education students identified as having emotional disturbance or mental retardation and made recommendations for best practice diagnostic procedures. At the recommendation of members of the ARC, the Montgomery County School Psychologists Association (MCSPA) created a subcommittee to develop best practice procedures for confirming Emotional Disturbance and/or Mental Retardation.

These procedures are an outgrowth of the work done by the MCSPA. They reflect the MCPS goal of the promoting student achievement and keeping students in the general education classes to the greatest extent possible. They are intended to provide practical assistance to school personnel attempting to improve their early intervention problem solving process and special education diagnostic decision-making processes and procedures, with the expectation that this will eliminate the disproportionate representation of African American students in special education programs.

“Emotional Disturbance,” is defined in the Individuals with Disabilities Education Act (IDEA) and the Code of Maryland Regulations (COMAR) as follows:

A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance:

- an inability to learn that cannot be explained by intellectual, sensory, or health factors
- an inability to build or maintain satisfactory interpersonal relationships with peers and teachers
- inappropriate types of behavior or feelings under normal circumstances
- a general pervasive mood of unhappiness or depression
- a tendency to develop physical symptoms or fears associated with personal or school problems

The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an Emotional Disturbance.

“Mental Retardation,” is defined in the Individuals with Disabilities Education Act (IDEA), the Code of Maryland Regulations (COMAR), the Diagnostic & Statistical Manual-Fourth Edition (DSM-IV), and by the American Association of Mental Retardation (AAMR) as follows:

- the age of onset comes before the age of 18
- the person demonstrates significantly sub-average intellectual functioning demonstrated by comprehensive measures of Verbal and Non-Verbal Reasoning competencies at or below standard scores of 70±5 or two or more standard deviations below the mean based on individual test manual requirements in multiple measures of verbal and non-verbal reasoning
- significantly sub-average adaptive skill functioning in at least two of the following areas: communication, health & safety, self-care, functional academics, home living, leisure, social skills, work, and community use
- the above described deficits adversely affect the child’s educational performance

The definitions of Emotional Disturbance and Mental Retardation generally remain static, as they are legal dictates. However, many leaders in assessment research agree that diagnosing Emotional Disturbance, Mental Retardation, and the subsequent need for special education is one of the most difficult tasks given to the Individualized Education Program (IEP) team. Working in a collaborative and interdisciplinary mode, the IEP team must consider a number of possible factors that may account for the academic or behavioral difficulties, such as environmental and cultural factors, as well as weigh issues of duration, severity, and pervasiveness of problem manifestations. Except when the severity of certain symptoms (e.g., depression) threatens to result in extreme impairment, the team must be convinced that appropriate interventions have been tried in the general education setting and found lacking before making a final eligibility decision. In extreme cases, professional judgment should take precedence over normal procedures. The determination of Mental Retardation is particularly challenging when the diagnosis has not been made prior to age five or upon school entrance. However, in instances when the condition is reported, it is usually the more severe cases where overrepresentation of minority students has not been an issue to date. In addition, in view of the complexity of the diagnosis of mild Mental Retardation, it is incumbent upon the diagnostician to consider the limitations of cognitive and adaptive assessment tools.

The IEP team must always use assessment information collected across multiple settings and from multiple sources to verify that the student has been rated within the highest level of significance on a variety of valid and reliable measures. The IEP team must also determine that the student needs interventions that cannot be accomplished solely through general education programming. If early interventions have produced minimal positive effects on the student's behavior or school performance, then such resistance to change could be evidence of the need for special education services.
The following must be considered:

- **Severity**: The behaviors of concern must significantly affect school performance as reflected by academic achievement, acquisition of social skills, and interpersonal relationships within the school setting.
- **Effect on School Functioning**: The behaviors of concern must relate specifically to school functioning.
- **Resistance to Intervention**: The behaviors of concern must continue (or in situations of an emotional break, would be projected to continue) despite the appropriate, individualized application of intervention strategies provided within the general education classroom.

When the assignment of a disability code and eligibility for special education are under consideration by an IEP team, a two-pronged test must be answered:

1) Is there a disability?
2) Does the student require special education and related services?

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### Early Intervention

When a classroom teacher notices that a student is not keeping up academically, behaviorally, and/or socially, despite trying the typical age- and grade-appropriate interventions, he/she should consult with staff (e.g., special educator, counselor, ESOL staff, psychologist, and others, as appropriate) to gain further instructional suggestions. This consultation may occur formally, through Educational Management Team/Collaborative Action Process (EMT/CAP), or informally, prior to an EMT/CAP referral, as appropriate.

Once a child is referred to EMT/CAP, the team should begin to complete the **Student Information Summary (SIS)** to determine if other issues may be contributing to the child’s lack of learning. This form may be completed through multiple EMT/CAP meetings and on an ongoing basis. The EMT/CAP committee should develop an appropriate intervention plan that addresses the child’s academic, behavioral, and/or social deficits. As the SIS is completed, other issues may arise that necessitate further action or decisions. The EMT/CAP committee should re-convene to address these factors, modify intervention plans, and implement additional strategies where appropriate.

Teams should routinely investigate the possibility of instructional mismatch when students are referred. If the concern raised is behavioral in nature, the school team, in consultation with staff members who have expertise in behavior management (e.g., a special education teacher, guidance counselor, or school psychologist) should conduct a Functional Behavioral Assessment (FBA) and develop a written behavioral intervention plan for the student based on the FBA. If the concern is academic in nature, the school team, in consultation with staff members who have expertise in instructional strategies (e.g., reading specialists or special educators) should conduct informal assessments to determine the child’s specific skill deficits and develop a written intervention plan for the student based on the assessments. All intervention plans should be implemented for a **minimum period** of four consecutive weeks. The school team should re-convene to consider the effectiveness of the plan, make adjustments to the intervention(s) as needed, and implement the updated plan for a reasonable period of time.

The prescribed interventions should be consistently employed and documented. Documentation should include graphs and/or charts so that any changes are clearly noted. Anecdotal records should be collected over a period of time. Consideration of these factors should be central to educational planning for students. If pertinent or critical data is missing or unavailable, then the EMT/CAP committee must obtain that information, or document why that data is unattainable. If the documentation does not reflect a significant improvement in the problem area and all SIS factors have been considered, the student may be referred to an IEP team for consideration of eligibility for special education.

If the student displays behavior that is endangering his/her life or the safety of others, or the student experiences significant emotional disruption or trauma that is expected to have lasting impact, the early intervention period may be **abbreviated**.

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### Student Information Summary

There are many factors unrelated to the possible presence of Emotional Disturbance or Mental Retardation that may result in a student failing to make appropriate educational progress. To identify Emotional Disturbance and/or Mental Retardation, the school-related problems must not be primarily attributed to visual, hearing, or motor impairments, environmental disadvantages, learning problems, cultural differences, economic disadvantages, language differences, frequent or extended absences from school or moves from one school to another. The behaviors of concern must not be due to transient or situational variables, cultural or linguistic differences, or
primarily the result of other disabling conditions. It is important for a school team to review all such factors before determining the need for formal evaluations. For example:

- Students who have experienced interrupted learning by having changed schools multiple times, by being absent frequently, or by having moved in or out of the country, lack curricular stability. This leads to instructional gaps and meager performance on academic tasks, which in turn may lead to behavioral difficulties.

- Students who are learning English as a second language require approximately one to three years of exposure to English in order to acquire basic interpersonal communication skills. It may take an additional five to eight years for cognitive/academic language competencies to develop. It is these latter skills that are required in school for learning. As such, second-language learners often lag behind their native English-speaking peers in academic development, even after having exited ESOL services, and may experience frustration/behavioral difficulties.

- Some children struggle within the academic setting because of physical and/or medical conditions that get in the way of skill acquisition. Therefore, school staff should encourage the child’s family to consult with the pediatrician on these matters. School staff should check visual and auditory acuity to determine whether or not these skills are currently within normal limits (or being corrected and/or accommodated) before questioning Emotional Disturbance or Mental Retardation.

- Children who have experienced emotional issues/traumatic events, including those who have suffered abuse/neglect, frequently do not perform to their potential. These children should be allowed time to heal, and educational supports should be tailored to meet their needs. Often, these traumatic events are both acute and transient as opposed to the long-standing nature of an Emotional Disturbance and/or Mental Retardation.

- Students who have experienced head injuries that are not congenital, degenerative, or related to birth trauma may demonstrate learning and/or behavior problems that mimic characteristics of Emotional Disturbance and/or Mental Retardation.

- Students with Pervasive Developmental Disorder (PDD) and/or Autism exhibit delays in communication, social interaction, and behavior that can be misconstrued as Mental Retardation and/or Emotional Disturbance. Should evidence of PDD/Autism be present, school staff should rule in/out this educational disability as part of any Emotional Disturbance or Mental Retardation decision-making process.

It is critical to note that the presence of a factor identified on the SIS does not, in and of itself, eliminate the need to examine the possibility of Emotional Disturbance and/or Mental Retardation. However, it is important that the identified factor(s) not be the primary condition(s) producing the behaviors of concern.

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**Referral Process to Special Education**

**Screening**

IEP team must meet to review existing data, including:

- Evaluations and information provided by the parents, including MCPS Form 336-22: Parent Questionnaire, which includes a summary of demographic, developmental, educational, and medical history obtained from a parent or primary caretaker;

- Current classroom-based assessments and observations including MCPS Form 336-21;

- Pre-referral interventions and strategies, including documentation of consultation provided by a certified staff member with expertise in behavior management resulting in an intervention plan implemented for a minimum of four weeks within the past twelve months;

- MCPS Form 272-2a or b: Teacher Referral/Report;

- School Nurse health appraisal. As part of this appraisal process, the IEP team should confirm that the student's vision and hearing are within normal limits. Testing should have occurred within a year of the Screening and should be re-done if these results are absent or over a year old. **No individualized standardized testing should occur until this determination is made;**
• **Student Screening Profile Worksheet** (MCPS Form 336-23) and, in cases where significant emotional and/or behavioral issues are present, the **Emotional Disturbance Student Screening Profile Worksheet--Supplemental** (Appendix B). Common terms and descriptors to aid staff in completing this worksheet are found in Appendix C;

• Review and consider information in **Student Information Summary** (Appendix A).

Once the IEP team has reviewed the existing data, team members need to determine if there is substantial evidence to suspect an Emotional Disturbance or Mental Retardation. If one of these disabilities is suspected, then the examiners should:

• Recommend appropriate assessments;

• Obtain written parental permission to conduct assessments, using MCPS Form 336-31: **Authorization for Assessments**;

• Obtain written parental permission to consult with other professionals/agencies involved with the student, using MCPS Form 336-32: **Authorization for Release of Confidential Information**, when appropriate.

**Assessment Procedures**

IEP team decisions should be based on data sources that are sufficient, valid, and as free from bias as possible. This data should be made available in a format that will be understood by the meeting participants. Educational, psychological and medical jargon should be minimized, although detailed technical information, where necessary, can be provided as needed or summarized in the written record. Examiners may include, but not be limited to, school psychologists, special educators, speech/language pathologists, and occupational/physical therapists. The examiners should:

• Complete assessments in all areas of suspected disability;

• Complete all assessment and data gathering activities necessary to come to a data-driven diagnostic conclusion in which the examiner has reasonable confidence;

• Consider all available data sources recorded in the multidisciplinary EMT/CAP forms;

• Make every effort to obtain pertinent or critical data that is missing or unavailable prior to finalizing a conclusion. If data is not available, the final conclusion should be deferred until such time as the examiner has reasonable confidence that there is sufficient information to make a decision;

• Confer with professional colleagues in regard to low incidence disabilities when rigorous data-gathering on the part of the examiners and other staff yield an unusual or ambiguous information composite;

• Make their diagnostic conclusions on the basis of applicable **IDEA, COMAR, and DSM-IV** criteria;

• Prepare a signed written report that will be available to the evaluation IEP team.

**Disability-Specific Procedures**

**EMOTIONAL DISTURBANCE**

| **Definition** | “Emotional Disturbance,” is defined in the **Individuals with Disabilities Education Act (IDEA)** and the **Code of Maryland Regulations (COMAR)** as follows:

A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance:

• an inability to learn that cannot be explained by intellectual, sensory, or health factors

• an inability to build or maintain satisfactory interpersonal relationships with peers and teachers

• inappropriate types of behavior or feelings under normal circumstances

• a general pervasive mood of unhappiness or depression

• a tendency to develop physical symptoms or fears associated with personal or school problems

The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an Emotional Disturbance. |
### Evaluation Components

1. The school psychologist addresses factors such as pervasive mood disturbance, emotionally-based physical symptomatology, reality orientation, fearfulness, behavior, feelings, and interpersonal relationships, while the special educator addresses factors related to academic achievement. Other assessors may address domains unique to their professional disciplines when deemed appropriate by the Screening IEP team.

2. The school psychologist completes the *Parent Questionnaire Supplement (Appendix D)* to document the history of any emotional dysfunction as well as additional information provided by the parents. This form will be sent to Psychological Services with other raw data following the completion of the psychological report.

3. School psychologist and/or an observer with expertise in behavior management must make three direct observations of the student in at least two different settings, both of which may be school settings. The purpose of the observations is to determine whether the student evidences problem behavior at a significantly different rate, intensity or duration than a substantial majority of typical school peers.

4. Anecdotal records collected by school staff (e.g., teachers, administrators, counselors, etc.) over a period of time should be examined to document the presence of presenting problems for a period of time six months or longer.

5. The school psychologist makes a professional judgment as to whether an emotional condition exists that could adversely affect the student’s educational performance.

### Evaluation IEP Meeting

**Emotional Disturbance Multidisciplinary Evaluation Form Part I**

The school psychologist shares his/her findings with the IEP team regarding the presence of an Emotional Disturbance and relevance to an educational disability by examining each of the sections on the *Emotional Disturbance Multidisciplinary Evaluation Form Part I* (Appendix E).

**Section A: Previously Identified Educational Disability/Disabilities** - This section provides a brief review of conditions that might co-exist with ED or aid in critically evaluating a student's behavior now under consideration for ED. Only educational disabilities currently identified are noted.

**Section B: Assessed Intellectual and Academic Ability Levels** - This section should include the most recent cognitive and academic assessments. This should be an individually administered full-scale norm-referenced measure with appropriate reliability, validity, and standardization characteristics. Dates and major standard scores should be listed. The psychologist should state the reason if no measure of cognitive ability was given.

**Section C: Techniques Employed** - This section documents the instruments used and the dates of actual contact (direct and indirect) with student. The basic data on the student's behavioral and social/emotional status is gathered through a variety of techniques.

**Section D: Characteristics** - *(See Appendix F)*. This section indicates the school psychologist’s determination of whether the student has a condition (a set of related responses that may be affective and/or behavioral in nature, a syndrome or pattern) exhibiting one or more of the characteristics of the disability over a long period of time (approximately 6 consecutive months) or, in some cases, will be anticipated to last 6 or more months and to a marked degree (frequency, duration, intensity, pervasiveness; across two or more educational setting/environments), and would be expected to adversely affect a student's educational performance (the degree of interference with educational functioning and/or interpersonal skills related to effective functioning in an educational environment).

The school psychologist certifies that s/he found evidence that the student EXHIBITS or DOES NOT EXHIBIT the characteristics of an emotional condition through his/her signature *(School Psychologist’s Signature)*. If the school psychologist certifies the presence of an emotional condition, the IEP team discusses adverse educational impact in the *Emotional Disturbance Evaluation Form*, Part II. If the school psychologist does not certify the presence of an emotional condition, the case is referred either to the EMT/CAP committee for further interventions, or to an IEP team for consideration of a disability other than Emotional Disturbance.
Section A: Adverse Educational Impact - Evidence of adverse impact on educational performance may include, but not be limited to, present and past grades, achievement test scores, interpersonal relationships with peers and adults in the educational setting, curriculum-based measures, retention/promotion decisions, degree of engagement in learning and functioning in the classroom. The behaviors must be (or be expected to be) long standing, and occur regularly and often enough to consistently interfere with the student’s own learning process to a marked degree. All of the data are evaluated in terms of the student’s age, cultural background, curriculum offerings, educational setting, instructional environment, social and family stressors, and medical/developmental history. It should be noted that students sometimes have emotional issues and/or troubling behaviors that are not related to one another. In order to confirm the presence of Emotional Disturbance, the emotional issues should be clearly identifiable as the causative factors for the specific school-related troubling behaviors. A student's depression, for example, may account for low energy levels and lack of interest in exerting energy for learning or interacting but might not be related to assaultive behavior. If, for example, assaultive behavior is the major concern, though socially inappropriate, such behavior should not be labeled as emotionally disturbed for educational purposes. Such relationships between the emotional condition and the behaviors will need to be determined by the school psychologist. The school psychologist and IEP team must then determine whether the behaviors, which are attributable to emotional causes, are of such a magnitude to be of concern within the educational setting by addressing the following questions. A student must meet all of the following criteria in order for the IEP team to confirm adverse educational impact. The behaviors/characteristics must be long standing (observed over a long period of time) and occur regularly and often enough to consistently interfere to a marked degree with the student’s own learning process or they may result from an acute emotional condition, such as a psychotic break or post-traumatic stress syndrome.

**Question 1:** Is there evidence that, despite having received supportive general education assistance, the student still exhibits a behavioral-emotional disorder consistent with the definition? It is imperative that when school staff have been aware of troubling behaviors for a period of time, meetings have been held and strategies specifically targeting the troubling behaviors have been tried and evaluated. The specificity of the strategies should be at the level of an applied behavioral assessment process. If the strategies, which are available in general education school programming have not been successful, then it would be judged that the troubling behaviors are at such a level to consider more specialized strategies appropriate to the emotional issues of the particular student. Documentation could include a listing of intervention strategies attempted, behavioral implementation plans, behavioral contracts, description of staff contacts, current grades, serious incident reports, degree of engaged learning and functioning in the classroom.

**Question 2:** Is there evidence that the student's own learning process is significantly disrupted because of an emotional condition? Disruption in the student's learning process could include time on task, availability of the student for delivery of instruction, classroom performance, classroom participation, appropriate social functioning, degree of engaged learning, curriculum based measures, academic engagement and other relevant observations, current grades, serious incident reports.

**Question 3:** Is there evidence that the emotional condition is not primarily the result of physical, sensory, or intellectual deficit, lack of appropriate instruction or management of behavior, culture or social maladjustment? This section would include documentation of intact physical, sensory and intellectual functioning (e.g., medical reports, psychological reports, educational reports), evidence of appropriate instructional and/or behavior management (e.g., contracts, Functional Behavioral Analyses, attendance reports, curriculum based assessments, etc.), attention to cultural factors, or social maladjustment (e.g., parent/family reports and questionnaires, community data, identifiable peer associations, etc.).

**Question 4:** Is there evidence that the patterns of behavior occur in more than one setting or class? If the student has been in the school for a period of time, it will be important to document a description of the specific behaviors in the classroom or other school environment and their general magnitude and frequency of occurrence. Examples might include several teacher reports or referrals, or documented observations by administrators or other school staff. Additional information might include parent/family and/or community reports. It is important, however, that the behaviors be specifically disruptive to school functioning.

**Note:** Only when all of these questions are answered in the affirmative, may the student be designated as emotionally disturbed.

**Section B: Team Decision** - This section should reflect whether or not the student meets the criteria for Emotional Disturbance found in the 1997 Amendments to IDEA and in COMAR. If the IEP team agrees that the student meets the criteria for Emotional Disturbance, the IEP team should now determine whether the student
MENTAL RETARDATION

**Definition ~**

Mental Retardation has been defined by *IDEA, COMAR, DSM-IV*, and AAMR as follows:

- The age of onset comes before the age of 18.
- The person demonstrates significantly sub-average intellectual functioning demonstrated by comprehensive measures of verbal and nonverbal reasoning competencies at or below standard scores of 70±5 or two or more standard deviations below the mean based on individual test manual requirements in multiple measures of verbal and non-verbal reasoning.
- Significantly sub-average adaptive skill functioning in at least two of the following areas: communication, health and safety, self-care, functional academics, home living, leisure, social skills, work, and community use.
- The above described deficits adversely affect the child’s educational performance.

“General intellectual functioning is defined as an intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., *Wechsler Intelligence Scales for Children-III, Stanford-Binet, Kaufman Assessment Battery for Children*). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately two standard deviations below the mean). It should be noted that there is a measurement error of approximately five points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75).

Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairment in adaptive functioning. The choice of testing instruments and interpretation of results should take into account factors that may limit test performance (e.g., the individual's sociocultural background, native language, and associated communicative, motor, and sensory handicaps). When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, the average to obtain a full-scale IQ score can be misleading.” (*Diagnostic and Statistical Manual of the American Psychiatric Association-Fourth Edition*, 1994, pp. 39-40)

**Evaluation Components ~**

1. The school psychologist addresses factors such as levels of cognitive and adaptive skills functioning across settings and age of onset, while the special educator addresses factors related to academic achievement. Other assessors may address domains unique to their professional disciplines, when deemed appropriate by the Screening IEP team. Examiners consult with parents, teachers, and other specialists, as appropriate.

2. The school psychologist uses a measure to document cognitive functioning across measured domains. If subtests/tests that are not normed for the particular student or informal diagnostic techniques are used, these should be noted in the school psychologist’s report and on the Mental Retardation Multidisciplinary Evaluation Form (Appendix G). An adaptive measure should be administered to at least two informants (i.e. parent and teacher) across at least two domains (i.e. social skills and self-care skills). The following additional tools may also help to illuminate the child’s profile: behavioral observations in the classroom over time, functional behavioral analysis, rating scales and checklists (to address the presence of any autistic symptoms, attentional issues, or social/emotional issues).

3. Evaluators should attempt to use standardized measures to document academic achievement (e.g., reading, writing, and math; academic readiness skills; etc.) and rate of progress.

4. The school psychologist makes a professional judgment as to whether the student meets the criteria for Mental Retardation.
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<td><strong>The school psychologist shares his/her written findings with the IEP team regarding the presence of Mental Retardation and relevance to an educational disability by examining each of the sections on the Mental Retardation Multidisciplinary Evaluation Form (Appendix G).</strong></td>
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**Section A: Previously Identified Educational Disability** - This section provides a brief review of conditions that might co-exist with Mental Retardation or aid in critically evaluating a student's behavior now under consideration for Mental Retardation. Only educational disabilities currently identified are noted.

**Section B: Assessment Data** - This section should include the most recent cognitive assessment, adaptive abilities, and academic abilities, as well as any relevant supplemental data.

**Section C: Characteristics of Mental Retardation** - In this section, the school psychologist focuses on the specific conditions for determining Mental Retardation eligibility. The school psychologist addresses the following information: age of onset before age 18, significantly sub-average intellectual functioning, and significantly sub-average adaptive skills functioning in two areas not excluded by any documented factors.

**Section D: Previously diagnosed medical and/or psychiatric conditions which support/refute a diagnosis of Mental Retardation when available** - This section includes information such as Down’s Syndrome or other genetic anomalies, as well as any other condition that supports the diagnosis of Mental Retardation.

**Section E: Confirmation** - In this section, the school psychologist officially confirms or rules-out the presence of Mental Retardation, based on the information documented in previous sections. The school psychologist with the IEP team must also determine the presence/absence of adverse educational impact. Evidence of adverse impact on educational performance may include, but not be limited to, present and past grades, achievement test scores, interpersonal relationships with peers and adults across multiple settings, curriculum-based measures, retention/promotion decisions, degree of engagement in learning and functioning in the classroom. The behaviors must be (or be expected to be) long standing, and occur regularly and often enough to consistently interfere with the student’s own learning process to a marked degree. **All of the data are evaluated in terms of the student’s age, cultural background, curriculum offerings, educational setting, instructional environment, social and family stressors, and medical/developmental history.** The school psychologist confirms the presence of Mental Retardation through his/her signature (Signature of the MCPS School Psychologist).

**NOTE:** If the school psychologist does not certify the presence of Mental Retardation the case is referred either to the EMT/CAP committee for further interventions, or to an IEP team for consideration of a disability other than Mental Retardation.
Re-evaluation Procedures

EMOTIONAL DISTURBANCE

Children already identified with Emotional Disturbance:

1. Re-evaluation planning meeting should include the psychologist (or a consult with the psychologist prior to the meeting).

2. At the re-evaluation planning meeting, the IEP team should have current data (including record review, teacher reports, progress reports on goals, and other appropriate supplemental information) to develop appropriate diagnostic questions related to progress, code, and/or placement. Given the dynamic nature of Emotional Disturbance, the IEP team must always question the continued existence of the disability and the appropriateness of the program. The IEP team should decide what additional data should be gathered (and by whom) to answer those questions at the re-evaluation meeting. The IEP team must consider current and relevant classroom performance in addition to available standardized testing data.

3. The school psychologist must gather current data, including direct contact with the student, to determine the continued existence of the emotional condition. Data should include progress made over time in mainstream environments.

4. The IEP team must complete all assessments, develop written reports, and hold a re-evaluation IEP team meeting within 90 calendar days.

5. Both pages of the Emotional Disturbance Multidisciplinary Evaluation Form must be completed at the re-evaluation IEP team meeting to re-confirm or remove the Emotional Disturbance code.

Children identified with another disability, but the IEP team suspects Emotional Disturbance

1. If emotional and/or behavioral issues are suggested at the re-evaluation planning meeting, the school IEP team should schedule a periodic review, complete a Functional Behavior Assessment, analyze the data, and develop an appropriate intervention plan. The school psychologist should be involved in this and all subsequent meetings. If it has not already been completed, the IEP team should complete the Student Information Summary (Appendix A) to guide later decision-making.

2. At a subsequent periodic review, the IEP team should discuss progress on the intervention plan following a minimum four-week implementation period. The team should make appropriate adjustments to the plan and implement the updated plan for a reasonable amount of time.

3. If the information documents resistance to the intervention(s), then screening data should be collected/updated and presented at a re-evaluation planning meeting to determine the need for further assessments. If the student displays behavior that is endangering his/her life or the safety of others, or the student experiences significant emotional disruption or trauma that is expected to have lasting impact, the invention period may be abbreviated.

4. If further assessments are needed and the questions raised include the suspicion of an Emotional Disturbance, then the IEP team must complete all assessments and hold a re-evaluation IEP team meeting within 90 calendar days.

5. Both pages of the Emotional Disturbance Multidisciplinary Evaluation Report must be completed at the re-evaluation IEP team meeting to confirm or rule out the Emotional Disturbance code.

MENTAL RETARDATION

Children already identified with Mental Retardation:

1. Re-evaluation planning meeting should include the psychologist (or a consult with the school psychologist prior to the meeting).

2. The IEP team must determine whether or not there is a well established, consistent, and valid cognitive/adaptive profile. If there have been at least two prior assessments with cognitive and adaptive scores within the range of mental retardation, then the IEP team may determine that formal, standardized cognitive assessments are not necessary. Current adaptive and/or non-standardized measures with scores or outcomes within the range of mental retardation may be sufficient to document progress and needs. Adaptive measures should be completed across two environments with two different raters. There should also be commensurate academic performance as measured by curriculum-based
and/or norm-referenced assessments. All SIS factors should be taken into account. If the above criteria have not been met, comprehensive, comprehensive multidisciplinary assessments (including a full psychological evaluation) are warranted.

3. The IEP team must complete all assessments, develop written reports, and hold a re-evaluation IEP team meeting within 90 calendar days.

4. The Mental Retardation Multidisciplinary Evaluation Form should be completed at the re-evaluation IEP team meeting to re-confirm or remove the Mental Retardation code. If no new data was deemed necessary to re-confirm eligibility, the Mental Retardation Multidisciplinary Evaluation Form should be completed at the re-evaluation planning meeting.

Children identified with another disability, but the IEP team suspects Mental Retardation:

1. If concurrent cognitive and adaptive limitations are present, the school IEP team should develop an appropriate intervention plan to address these limitations. Special education supports should be adjusted as necessary and implemented. If it has not already been completed, the IEP team should also complete the SIS form to guide later decision-making.

2. The IEP team should meet to discuss progress on the intervention plan and, if limited progress is made, the screening information should be gathered/updated and presented at a subsequent re-evaluation planning IEP team meeting to determine the need for further assessments.

3. If further assessments are needed and the questions raised include the suspicion of Mental Retardation, then the IEP team must complete all assessments and hold a re-evaluation IEP team meeting within 90 calendar days.

4. The Mental Retardation Multidisciplinary Evaluation Form should be completed at the re-evaluation meeting to re-confirm or remove the Mental Retardation code. If no new data was deemed necessary to re-confirm eligibility, the Mental Retardation Multidisciplinary Evaluation Form should be completed at the re-evaluation planning meeting.

CONCLUSION

The task of identifying a student with Emotional Disturbance and Mental Retardation under IDEA presents unique challenges to school teams. Best practice procedures have been changed over time and reflect adjustments in the philosophy of educating children, practice of assessment, and issues of diversity. The purpose of these Procedures is to enlarge the scope of how we look at children and facilitate collaborative problem solving, on both an individual school and systemic level. It is hoped that the attention paid to early intervention, as well as other mitigating factors, will enable school teams to conduct thorough and well-reasoned analyses of students’ strengths and needs which will result in success for every student while minimizing misidentification of any student.
Office of Student and Community Services
MONTGOMERY COUNTY PUBLIC SCHOOLS
Rockville, Maryland 20850

STUDENT INFORMATION SUMMARY

DIRECTIONS: Complete this summary, over time, at the EMT/CAP committee level.

Student Name: ____________________________________________  Student ID#: __________________

Dates of Completion: _______________________________________

A. Educational History

1) List student's educational history, noting gaps of time in which student was not enrolled in a school program and the nature of these gaps. Attach additional information if necessary.

<table>
<thead>
<tr>
<th>Dates</th>
<th>School</th>
<th>Location</th>
<th>Grade</th>
<th>Programs/Supports</th>
</tr>
</thead>
<tbody>
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2) List student's attendance pattern. See past report cards.

<table>
<thead>
<tr>
<th>Grade</th>
<th>K</th>
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<th>5</th>
<th>6</th>
<th>7</th>
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<th>10</th>
<th>11</th>
<th>12</th>
<th>OTHER</th>
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<tbody>
<tr>
<td>DAYS ABSENT</td>
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Grades Repeated ____________________________

B. Language/ Cultural Background

1. What is the student's primary language? _______________________

2. Has the student been enrolled in ESOL? Never Enrolled _____ Yes: Entry Level _____ Exit Level _____ Start Date _____ Exit Date _____

3. How many years has the student received instruction in English? _______

4. When was the student first exposed to English in his/her environment? _______

List any other significant differences in cultural background and limitations in opportunities that may be impacting student's ability to learn.

____________________________________________________________________

____________________________________________________________________

C. Significant Medical Issues/History

1) List the dates and results of most recent vision and hearing screenings. If screenings are more than two years old, update and document below. If screenings were failed, document actions taken to address the issues.

<table>
<thead>
<tr>
<th>Date(s)</th>
<th>Results</th>
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</table>

2) If significant vision/hearing issues are present, have the offices of Vision and/or Deaf/Hard of Hearing Services been consulted? Yes _____ No ____ If no, follow official MCPS referral procedures. Document follow-up interventions on the chart below.

<table>
<thead>
<tr>
<th>Date(s)</th>
<th>Results</th>
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</table>
3) Does the student have any physical and/or medical disabilities that significantly impact communication and/or classroom performance?
Yes _____ No ______ If yes, please describe the disability and its impact on communication and/or classroom performance.

4) If significant issues are present, has the appropriate MCPS office been consulted (e.g., InterAct team, Office of Programs for Students with Physical Disabilities)? Yes_____ No_____ If no, follow official MCPS referral procedures. Document follow-up interventions on the chart below.

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<th>Date(s)</th>
<th>Results</th>
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5) Briefly describe prenatal, birth, and early developmental histories.


D. Social-Emotional Issues/Significant Emotional Traumas
List significant emotional issues/traumatic events that have occurred and dates of occurrence.

<table>
<thead>
<tr>
<th>Date(s)</th>
<th>Event(s) &amp; Intervention(s)</th>
</tr>
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E. Head Injury
Has the child experienced any open or closed head injury that is not congenital, degenerative, or related to birth trauma? Yes____ No____
If yes, please list rehabilitation plans/hospitalizations/progress.

<table>
<thead>
<tr>
<th>Dates of Stay</th>
<th>Interventions, Progress, &amp; Recommendations</th>
</tr>
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<tbody>
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F. Atypical Development
Has atypical behavior and/or development been observed across more than one major developmental domain? Domains include Social Interaction (e.g., marked impairment in reciprocal verbal/nonverbal interaction), Communication (e.g., significant delay or lack of development of receptive/expressive language), and Behavior (e.g., restricted, repetitive and stereotyped patterns of behavior, interests, and activities). Yes___ No____ If yes, please describe observed behaviors.
G. Summary

- Once the **Student Information Summary** has been completed, the EMT/CAP committee should discuss this information and determine what **next steps** are appropriate to aid the student’s academic progress. Next steps may include continued supports within the general education program and/or referral for Special Education Screening.
- Document the decisions made by the committee **AND** the data that lead to those decisions.
- **Use additional summary pages as necessary.**

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<th>Decision:</th>
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**Person(s) Responsible:**

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**Person(s) Responsible:**

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**Date(s) Due:**

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**Date(s) Due:**

**Person(s) Responsible:**
APPENDIX B
Emotional Disturbance Student Screening Profile Worksheet
**PART I: SCREENING DATA**

Directions: Enter S for Strength and C for Concern under the columns on Externalizing, Internalizing, and Additional Factors.

<table>
<thead>
<tr>
<th>DATA SOURCE</th>
<th>DATE</th>
<th>EXTERNALIZING FACTORS</th>
<th>INTERNALIZING FACTORS</th>
<th>ADDITIONAL FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Aggression: Peers</td>
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<td>(Physical, Verbal)</td>
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<td>Aggression: Adults</td>
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<td></td>
<td></td>
<td>(Physical, Verbal)</td>
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<td></td>
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<td>Aggression: Self</td>
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<td>Opposition</td>
<td>Social Reciprocity/</td>
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<td></td>
<td>Empathy</td>
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<td></td>
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<td>Unhappiness</td>
<td>Anxiety</td>
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<td></td>
<td></td>
<td>Illogical Thoughts</td>
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<td></td>
<td></td>
<td>Withdrawal: Peers</td>
<td>Withdrawal: Adults</td>
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<tr>
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<td></td>
<td>(Physical, Verbal)</td>
<td>(Physical, Verbal)</td>
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<td></td>
<td></td>
<td>Insight into Problems</td>
<td>Suicidal Ideation</td>
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<td></td>
<td></td>
<td>Variability of Mood</td>
<td>Physical Complaints</td>
<td></td>
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<td>Social Skills</td>
<td>Leadership</td>
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<td>Motivation</td>
<td>Motivation</td>
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<td></td>
<td></td>
<td>Self-Esteem</td>
<td>Substance Abuse</td>
<td></td>
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<tr>
<td>Teacher Referral Report</td>
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<tr>
<td>Educational History</td>
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<tr>
<td>Parent Questionnaire</td>
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<tr>
<td>Classroom Observation</td>
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<tr>
<td>Functional Behavior Assessment</td>
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<td>Other</td>
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**PART II: COMMENTS**

Enter comments, as appropriate, under the columns for Externalizing, Internalizing, Additional Factors

Revised 1/03
APPENDIX C

COMMON TERMS - EMOTIONAL DISTURBANCE
STUDENT SCREENING PROFILE WORKSHEET
The following common terms with descriptors may be used as a guide to assist the IEP team when screening for the educational disability of ED and completing the form, Student Screening Profile Worksheet--Emotional Disturbance Addendum (see Appendix A):

**Externalizing Factors:**

**Aggression** is an intentional hostile action against a person or object. Aggression can be either verbal abuse or physical violation of space. Verbal abuse includes teasing, taunting, threatening, humiliating or extortion. Physical attack includes intimidation, assault and battery with or without a weapon. Aggression can also include the violation of physical space with the clear intent to harm another person or thing. Aggression to self means any self-injurious behavior or self-mutilation.

**Oppositional behavior** is defiance or resistance toward authority figure(s) and/or established norms or rules. These behaviors persistently violate school rules and procedures, and may be non-compliant, argumentative, passive-aggressive, or disruptive. Essentially, the major characteristic is the provocative resistance to people in authority.

**Social Reciprocity/Empathy** refers to the misuse of social skills. In the maladaptive instance, the student may not seek comfort or encouragement that is available from other people including friends, family, peers, or community groups. The student’s social skills are used to meet the immediate needs of the individual irrespective of the negative impact it has on others. They may display social callousness and may not take responsibility for behavior including the failure to exhibit remorse, caring, or compassion. They also routinely tend to disregard general societal rules. This category does not refer to autistic spectrum syndromes or profound mental retardation.

**Internalizing Factors**

**Unhappiness** is a despondent mood that is subjective in description, self-critical, pessimistic, lethargic, melancholy, gloomy and dejected. Crying episodes and seething anger may be experienced.

**Anxiety** is an affective component (mood) with both a psychological and physical basis. Generally, it involves an unpleasant emotional state accompanied by physiological arousal and the cognitive elements of apprehension, guilt, and a sense of impending disaster. It is distinguished from fear, an emotional reaction to a specific or identified object. Anxiety can be generalized or specific. Anxiety may manifest itself in the form of nail biting, hair pulling or twirling, scratching, fidgeting, nervous tics, picking at skins or clothing, etc.

**Illogical Thoughts or Statements** are irrational expressions that may be verbal or nonverbal that appears to have no basis in reality. It may involve bizarre comments or preoccupation with morbid and violent themes. Feelings or perceptions of impaired body image may accompany illogical thinking.

**Withdrawal** is physical or emotional isolation or avoidance of social contact with peers. Withdrawal is frequently observed when there has been an altering in behavioral response. For example, in contrast to previous interactions, a student limits his/her contact with peers or adults. Withdrawal is frequently considered symptomatic when there has been tangible change in the student's behavior.

**Insight to Problem** is the ability or art of communicating an awareness of the presenting problem(s) or a willingness to seek and respond to peer or authority and guidance.

**Suicidal Statement/Gesture** reflects clear and/or ambiguous statements or behaviors suggesting a desire to kill oneself.

**ADDITIONAL FACTORS**

**Variability of Moods** is a sudden, abrupt change in mood. Mood can shift from one place on a continuum to the next without appropriate sequence or response to stimuli. Moods can sometimes be extreme, e.g., euphoria, irritability, sullenness, agitation, sulkiness, hostility, suspiciousness, explosive temper, sadness, and crying.
Social Skills refers to the manifestation of social competency behaviors that do or do not meet social expectations based on universal developmental principles of physical maturation, cognitive development, or psychosocial progression. In the maladaptive instance, in spite of the best intentions of the student, social skills are not available to facilitate more successful interaction. Maladaptive behaviors could include poor judgment, inappropriate attire for age, regressive behavior such as thumb sucking, self-defeating behavior, inappropriate comments, lack of ability to perceive social cues, etc.

Physical Complaints are the expression of physical problems or discomforts that are psychologically based. For example, although medical or physical causes have been ruled out, the student may complain of headaches, stomach problems, and other symptoms.

Leadership is the demonstrated ability to organize an individual or group toward a goal. It involves a willingness to help or support others through some code of belief or moral reasoning. Frequently, there is evidence of a willingness to help or support others through common courtesy, e.g. assisting peers in conflict, deferring to others, etc.

Motivation is an internal or external arousal or condition that appears by inference to initiate, activate, or maintain a student's goal-directed behavior. Motivation involves factors that arouse, maintain, and channel behavior toward task completion. For example, a younger student might be motivated by external conditions through tangible reinforcement, whereas an older student might be developing a sense of internal arousal (motivation) through intrinsic rewards such as a sense of accomplishment when completing tasks.

Self-Esteem or self-efficacy involves a student’s belief about whether he/she can successfully engage in and execute a specific behavior such as task completion, mastery of task, etc. Self-esteem can be communicated verbally or non-verbally through expressions or behaviors that indicate how a person feels regarding his/her own self-worth. There can be a distinct difference between the real self and ideal self. The real self is the self one actually is, while the ideal self is the self one would like to be. Self-esteem is the judgment people make about their own worth.

Substance Abuse involves a documented history of use of illegal substances, such as intoxicants or controlled substances. Documentation may include proof from parents, hospitalization for substance abuse, or court records.
APPENDIX D
PARENT QUESTIONNAIRE SUPPLEMENT
Confidential

For school psychologist’s use only

Note: This is additional information to be considered at the discretion of the professional examiner when Emotional Disturbance is suspected. Information may generate hypotheses to be tested in the context of other data and professional consideration.

Student Name: ___________________________  Student ID#: ___________  Date: ___________

Date of Birth: _______________  School: ___________________________  Grade: _______________

Informant: ___________________________________________________________________________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
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</table>

1. Have there been any changes in family structure or relationships, such as divorce or a death in your family?
   Comments

2. Has your child experienced significant or upsetting changes in school?
   Comments

3. Has there been a significant change in residence or the economic status of your family?
   Comments

4. Have any members of your family had psychological or psychiatric problems or received mental health services?
   Comments

5. Has your child experienced significant losses, such as death of a loved one, break-up of peer, romantic relationship or loss of pet?
   Comments

6. Has your child or members of your family experienced any medical traumas, hospitalizations, or serious illnesses?
   Comments
7. Is there any evidence of alcohol or drug use/abuse by your child or members of your family?  
Comments

8. Has your child experienced any traumatic episodes, such as a suicide attempt, sexual or physical abuse, violence, or serious accident?  
Comments

9. Has your child or members of the family ever had trouble with the law or been involved in the juvenile justice system or social service agencies?  
Comments

10. Describe your child’s peer relationships within the home and in the community.

11. Please feel free to include any other information that you think is important in understanding this child.

Form completed by: ____________________________________________

Name                   Title

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APPENDIX E

EMOTIONAL DISTURBANCE
Multidisciplinary Evaluation Form -Parts I & II
DIRECTIONS: Attach this supplement to the evaluation IEP team meeting form when an Emotional Disturbance is suspected.

Student Name: ___________________________ 
Student ID#: ________________ Date: ________________

A. Previously Identified Educational Disability

Directions: Check as many as are confirmed.

- 01 Mental retardation
- 02 Hard of Hearing
- 03 Deaf
- 04 Speech-Language Impairment
- 05 Visual Impairment
- 06 Emotional Disturbance
- 07 Orthopedic Impairment
- 08 Other Health Impairment
- 09 Specific Learning Disability
- 10 Multiple Disabilities
- 12 Deaf/Blindness
- 13 Traumatic Brain Injury
- 14 Autism
- 15 Developmental Delay

B. Assessed Intellectual and Academic Ability Levels

Directions: Include dates, names of tests and standard scores. If no data is entered, state the reason for its absence.

Cognitive Data: _______________________________________________________________________________________________________
Achievement Data: ______________________________________________________________________________________________________
Other: _______________________________________________________________________________________________________________

C. Techniques Employed

Directions: Provide dates.

Record Review: ___________________________ Staff Consultations: ___________________________
Observation(s): ___________________________ Parent Interview(s): ___________________________
Behavioral Checklist(s): ____________________ Student Interview: ___________________________
Psychodiagnostics: _________________________
Functional Behavioral Assessment (s): ___________________________

D. Characteristics

Directions: As a prerequisite to finding that a student has an Emotional Disturbance under IDEA, the school psychologist must find evidence that an emotional condition exists that exhibits one or more of the following characteristics over a long period of time and to a marked degree.

1. An inability to learn that cannot be explained by intellectual, sensory or other health factors. 
   Yes ___ No ___
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers. 
   Yes ___ No ___
3. Inappropriate types of behavior or feelings under normal circumstances. 
   Yes ___ No ___
4. A general pervasive mood of unhappiness or depression. 
   Yes ___ No ___
5. A tendency to develop physical symptoms or fears associated with personal or school problems. 
   Yes ___ No ___

I certify that I have found evidence that the student EXHIBITS/DOS NOT EXHIBIT an emotional condition based on the characteristics I have checked above AND that all affirmative characteristics reflect an emotional condition that is not solely the result of social maladjustment.

_________________________________________________________________________          ________________
School Psychologist's Signature        Date

If the school psychologist 

certifies the presence of an emotional condition, the IEP team should discuss whether or not there is adverse educational impact directly related to the emotional condition.

If the school psychologist does not certify the presence of an emotional condition, the case is referred either to the EMT/CAP committee for further interventions, or to an IEP team for consideration of a disability other than Emotional Disturbance.
EMOTIONAL DISTURBANCE
Multidisciplinary Evaluation Form
Part II

Student Name: ______________________________  Student ID#: _______________  Date: _______________

A. Adverse Educational impact:

A student must meet all of the criteria, which are a direct manifestation of the emotional condition, in order for the IEP team to confirm adverse educational impact. The behaviors must be long standing (observed over a long period of time) and occur regularly and often enough to interfere to a marked degree with the student’s own learning process or they may result from an acute emotional condition, such as a psychotic break or post-traumatic stress syndrome.

1. Is there evidence that, despite having received supportive regular education assistance, the student still exhibits behaviors that are directly related to the emotional condition documented by the psychologist in his/her report?  Yes ___ No ___
   Documentation: ___ behavior intervention plan/contract  ___ staff contacts  ___ instructional modifications  ___ serious incident reports  ___ other: _________________________

2. Is there evidence that the student’s own learning process is significantly disrupted because of an emotional condition?  Yes ___ No ___
   Documentation: ___ classroom participation  ___ availability for instruction  ___ appropriate social functioning  ___ current grades  ___ degree of engaged learning  ___ curriculum based measures  ___ serious incident reports  ___ other: _________________________

3. Is there evidence that the emotional condition is not primarily the result of physical, sensory, or intellectual deficit, lack of appropriate instruction or management of behavior, culture or social maladjustment?  Yes ___ No ___
   Documentation: ___ curriculum based measures  ___ parent/family reports and questionnaires  ___ identifiable peer relationships  ___ other: _________________________

4. Is there evidence that the patterns of behavior occur in more than one setting/class?  Yes ___ No ___
   Documentation: ___ teacher reports  ___ office referrals  ___ serious incident reports  ___ report cards  ___ observations  ___ other: _________________________

B. Team Decision:

___ The student meets criteria for Emotional Disturbance found in the 1997 Amendments to IDEA and in COMAR 13A.01.05.01. The IEP team should now determine whether or not the student needs special education and related services.

___ The student does not meet criteria for Emotional Disturbance found in the 1997 Amendments to IDEA and in COMAR 13A.01.05.01. The student should be referred to the EMT/CAP committee for additional interventions or to an IEP team for consideration of a disability other than Emotional Disturbance.

C. Signatures of IEP Team Members:  The team decision reflects my opinion.

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<tr>
<th>Name</th>
<th>Title</th>
<th>Yes</th>
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Dissenting team members must attach a separate statement explaining their conclusions. When there is a dissenting opinion, the case should be referred to the Director of the Department of Special Education for review.
APPENDIX F
CHARACTERISTICS OF EMOTIONAL DISTURBANCE: SAMPLE BEHAVIORS
CHARACTERISTICS OF EMOTIONAL DISTURBANCE: SAMPLE BEHAVIORS

1. An inability to learn that cannot be explained by intellectual, sensory or other health factors
   - disorganized thinking or reasoning
   - incoherent or markedly loose associations
   - hallucinations or delusions that interfere with learning
   - disturbed or unclear awareness of reality, such as not being able to distinguish reality from fantasy
   - very inconsistent behavior pattern in the classroom
   - highly resistant to interventions.

2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
   - significant interpersonal difficulties occurring across multiple settings and with a variety of individuals
   - has no friends at home, at school or in the community
   - may build relationships but cannot maintain them
   - excessively shy, intense and constricted in relationships
   - extremely withdrawn or fearful of teachers and peers
   - unable to interact in organized games or activities
   - excessively and routinely aggressive (verbal and/or physical) with teachers and peers. Note: rule out situation-specific reactions.

3. Inappropriate types of behaviors or feelings under normal circumstances.
   - bizarre or psychotic behavior, such as hallucinations, delusions, preoccupations, compulsions, severe mood swings
   - lack of appropriate fear reactions
   - flat, blunted affect or distorted, excessive affect
   - self mutilation and/or suicidal ideation or behaviors
   - unexplained euphoria or manic behaviors, such as excessive overactivity
   - unexplained rage reactions or violent temper tantrums
   - odd or inappropriate laughing or crying
   - extreme, unprovoked aggression, such as physical attacks upon others or property for unjustified reasons
   - unusual and unprovoked sexual verbalizations or behaviors, such as public masturbation or attempts to fondle others.

4. A general pervasive mood of unhappiness or depression.
   - feelings of worthlessness, hopelessness, self-reproach or inappropriate guilt
   - blunted affect or lack of emotional responsiveness; sadness pervades face/body
   - an irrational increase in anxiety, fearfulness or apprehension
   - prolonged periods of crying
   - recurrent thoughts of death, death wishes, or suicidal ideation or behaviors
   - poor appetite or significant weight loss when not dieting or significant weight gain
   - insomnia or hypersomnia
   - self-destructive ideas or behavior, such as destroying property or schoolwork.

5. A tendency to develop physical symptoms or fears associated with personal or school problems.
   - symptoms of physical disorder without conscious control and with no demonstrable organic etiology
   - incapacitating feelings of anxiety or panic
   - severe phobic reactions
   - persistent and irrational fears of particular objects, activities, individuals or situations; intense fears or irrational thoughts related to separation from parent(s).
APPENDIX G
MENTAL RETARDATION
Multidisciplinary Evaluation Form
OFFICE OF STUDENT AND COMMUNITY SERVICES  
Department of Special Education  
MONTGOMERY COUNTY PUBLIC SCHOOLS  
Rockville, Maryland 20850

MENTAL RETARDATION  Multidisciplinary Evaluation Form  
CONFIDENTIAL

Attach this supplement to the IEP team meeting notes when Mental Retardation is suspected.

Student Name: ___________________________________________________  
Student ID#: ______________________  
Date: ___________________________

A. Previously Identified Educational Disability (Check as many as are confirmed.)

01 Mental retardation  
02 Hard of Hearing  
03 Deaf  
04 Speech/Language Impairment  
05 Visual Impairment  
06 Emotional Disturbance  
07 Orthopedic Impairment  
08 Other Health Impairment  
09 Specific Learning Disability  
10 Multiple Disabilities  
12 Deaf/Blindness  
13 Traumatic Brain Injury  
14 Autism  
15 Developmental Delay

B. Assessment Data

Intellectual Ability Levels (Test Name & Scores) ____________________________________________________________

(Date) ______________________________________________________________________________________________

Adaptive Ability Levels (Test Name & Scores) ______________________________________________________________

(Date) ______________________________________________________________________________________________

Achievement Levels (Test Name & Scores) _________________________________________________________________

(Date) ______________________________________________________________________________________________

Additional formal and/or non-traditional data used to compare rate of learning to chronological age.

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

C. Characteristics of Mental Retardation

The psychologist must certify that the student demonstrates the following: (all criteria MUST be met for Mental Retardation to be confirmed)

- Is the age of onset before age 18?  
  Yes_____ No_____ 

  Does the student exhibit significantly sub-average intellectual functioning, demonstrated by comprehensive measures of Verbal and Non-Verbal Reasoning competencies at or below standard scores of 70 ±5 (including the Standard Error of Measurement)? Other formal/informal measures may be used to clarify strengths/weaknesses in ability level. Additionally, the psychologist should support/refute the validity of test data when necessary.  
  Yes_____ No_____ 

  NOTE: If a discrepancy between verbal and nonverbal scores is statistically significant (.05 level), according to the test manual of instrument utilized, a composite score cannot be considered as a valid measure of a student's intellectual potential or justification for a diagnosis of Mental Retardation. In the event of such a discrepancy, the higher score should be considered as the best measure of the student's intellectual potential.

- Are the scores on the assessment instrument(s) two or more standard deviations below the mean based on individual test manual requirements in multiple measures of verbal and non-verbal reasoning, including the use of adaptations when necessary due to severe physical disability, speech, hearing, or vision impairment?  
  Yes_____ No_____ 

  Does the student exhibit significantly sub-average adaptive functioning in areas not excluded by documented vision, hearing, medical, or physical disability, or cultural or religious factors? Two or more informants, who know the student well, including at least one who knows the student outside the school community, must confirm significant delays in the same two or more areas on standardized instruments.  
  Yes_____ No_____ 

Circle all Adaptive areas that rated as significantly sub-average by one or more raters.

<table>
<thead>
<tr>
<th>COMMUNICATION</th>
<th>SELF-CARE</th>
<th>HOME LIVING</th>
<th>SOCIAL SKILLS</th>
<th>COMMUNITY USE</th>
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<tr>
<td>HEALTH &amp; SAFETY</td>
<td>FUNCTIONAL ACADEMICS</td>
<td>LEISURE</td>
<td>WORK</td>
<td>OTHER/SPECIFY</td>
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Please note any special circumstances that may compromise the validity of accurate adaptive skill measurement (e.g., physical limitations). ____________________________________________________________

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

32
D. Previously diagnosed medical and/or psychiatric conditions which support/refute the diagnosis of Mental Retardation.

Please list, including date of diagnosis & evaluating examiner.

<table>
<thead>
<tr>
<th>Date/Examiner</th>
<th>Diagnosis</th>
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E. Confirmation

- The school psychologist states that the student exhibits significantly sub-average intellectual functioning, concurrent with deficits in adaptive behavior, and that these deficits manifested themselves during the developmental period (per COMAR)?
  
  Yes____ No____

- The school psychologist states that these deficits adversely affect the child’s educational performance (per COMAR)?
  
  Yes____ No____

_____________________________________________________  (Signature of MCPS School Psychologist)

If the answer to either question is “No,” the special education process stops here if no other educational disability is suspected. If another educational disability is suspected the student is referred back to the IEP team for further intervention and/additional assessments.

F. Conclusions of the IEP Team

- Are Special Education Services warranted? Yes_____ No_____

- Areas in which goals are required.

G. Signatures of IEP Team Members: The team decision reflects my opinion.

<table>
<thead>
<tr>
<th>NAME</th>
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<th>YES</th>
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Note: Dissenting team members must attach a separate statement presenting his/her conclusions. When there is a dissenting opinion, the statement should be referred to the Director of Special Education for review.
Frequently Asked Questions

Emotional Disturbance-related questions

1. Many children with emotional disturbance have had trauma. Are you looking to exclude only the effects of recent trauma as an exclusionary factor? How do you distinguish between an acute situation that can be an “exception” to the longstanding nature part of the definition versus a “crisis” that does not constitute an Emotional Disturbance? The definition of Emotional Disturbance includes “acute emotional condition”. Is this in the legal definition? What constitutes “acute”?
   ANSWER: An acute situation (versus a chronic condition) typically relates to the presence of a stressor that has recently arisen, may be short-lived, may be situational, and would reasonably be expected to be ameliorated once the stressor was removed. This likely constitutes a “crisis.” An “exception” to the longstanding nature part of the definition, that is also referred to in the manual as an “acute emotional condition,” would be an emotional condition that could be reasonably expected to persist beyond a six month time period.

2. How does “an inability to maintain interpersonal relationships” differ from a social maladjustment?
   ANSWER: A socially maladjusted youngster may exhibit satisfactory interpersonal relationships, while also displaying behavior that deviates from the social norm.

3. Is ED only to be used for endogenous or biochemical conditions such as schizophrenia or bipolar illness? Where does environmental factors fit in?
   ANSWER: There are many conditions for which we can find no particular biological or neurological foundation. That would not preclude a student being identified as ED. Environmental factors may or may not be critical in terms of etiology.

4. Once a team suspects an emotional impairment, is that the point when the disciplinary guidelines go into effect?
   ANSWER: Yes.

5. Is there a difference in diagnosing of ED between elementary, middle, and high school levels?
   ANSWER: No.

6. Scenario: When a student in an abusive home, with behavioral and emotional problems at school has been repeatedly referred to the EMT/CAP for ED suspicion, does the background information act as an exclusionary factor for diagnosis of ED?
   ANSWER: It depends on the case. Just because a student is abused does not automatically mean that he/she will have ED. We must look objectively at the condition as it presents itself. The question really is can this student control his behavior within the school setting? Can he keep his negative behavioral and emotional response-style from manifesting itself? What are his perceptions and defense mechanisms? How objectively can he assess a stressful situation? Is there a resultant emotional condition in school related to the abusive home situation? The school’s program of intervention would be critical to answering these questions because it would address response to intervention.

7. How should private/parochial referrals be handled when Emotional Disturbance is suspected?
   ANSWER: All private/parochial schools are expected to provide documentation of prereferral interventions as otherwise described in this manual. This will require ongoing consultation between MCPS and the private/parochial sector.

8. What should be done with evaluations where an outside provider has identified an emotional condition?
   ANSWER: A clinically determined diagnosis of an emotional condition does not by itself constitute an educational disability. An MCPS psychologist must evaluate the data regarding its accuracy and relevance to educational decision-making.

Mental Retardation-related questions

1. Does a student with significantly subaverage cognitive and adaptive scores and low average or better achievement scores meet the Mental Retardation criteria?
   ANSWER: The definition says nothing specifically about achievement scores. However the educational achievement of truly mentally retarded individuals is typically quite weak. If the achievement scores are stronger, then there may be reason to question the validity of the cognitive, adaptive, and/or achievement scores.

2. Can a co-occurring diagnosis of speech/language impairment exist with MR in addition to PPD/Autism?
   ANSWER: Typically no, but there may be a rare exception to this rule. If all scores are consistent, it is reasonable to assume that language impairments are a function of the Mental Retardation. There may be cases, however, where a speech/language disorder may co-occur with Mental Retardation if the speech/language skills are impaired above and beyond what would be expected.
given the child’s cognitive impairments. Autism is a disorder that includes speech/language impairments as part of its subset of symptoms. A student might require therapeutic interventions, as related services, without needing a specific educational code. In other words, rarely should we see a 14/04 coding.

3. **Why did you change the MR criterion from 69 and below to scores in 70 to 75? Can the state challenge the 70-75 cutoff range for MR so that it is more consistent with the norms established by the test makers?**
   
   **ANSWER:** The change in criteria was made by AAMR and *DSM-IV* as early as 1992. Using the cutoff of 70-75 remains consistent with established test norms and takes into account the standard error of measurement. MSDE could ‘challenge’ or rule-on the cut-off, if they chose to do so. Please refer to the AAMR website for details: [http://www.aamr.org](http://www.aamr.org).

4. **Would psychosis be an exclusionary criterion for MR?**
   
   **ANSWER:** They are not necessarily mutually exclusive conditions and can co-exist. One must look at prior levels of functioning in order to help make this determination.

5. **If substitute teachers are teaching a class, is it all right to do extra observations instead of the *Vineland Classroom Edition*?**
   
   **ANSWER:** No. Observations and standardized adaptive measures are not interchangeable. Adaptive information must be gathered from at least two or more informants who know the student well including at least one who knows the student outside the school community. Good professional judgment is expected in choosing these informants.

**Other questions**

1. **When the rater doesn’t know the child for the required amount of time, does the committee suggest that we always have the teacher complete the scale?**
   
   **ANSWER:** If the rater has not known the child for the requisite amount of time, then it is important for the psychologist to secure a rater who meets the instrument’s requirements.

2. **Do parents sign the MR and/or ED Evaluation Forms? Can parents write dissenting opinions to the decisions made by the team?**
   
   **ANSWER:** Parents are members of the IEP team and can sign the form, if they wish. Whether or not they sign the form does not affect their due process rights.

3. **Are ESOL students excluded from the process?**
   
   **ANSWER:** No. Language or cultural issues do not, in and of themselves, preclude a finding of Mental Retardation or Emotional Disturbance.
APPENDIX I
CHECKLIST FOR EMOTIONAL DISTURBANCE/MENTAL RETARDATION
Checklist for Emotional Disturbance/Mental Retardation

Issue: Student presenting behavioral and/or academic concerns.

EMT/CAP Level

- Establish status of vision and hearing.
- Establish Student Information Summary (SIS) form as a ‘working document’ to be completed as the child is being discussed and planned for; documentation can be managed by the case manager or counselor.
- Consultations (on-going) with behavior management specialists including school psychologists.
- FBA and Behavior Intervention Plan (BIP) of at least four consecutive weeks within the past 12 months (documentations of reviews and analysis for effective outcomes). The four-week-period is considered the bare minimum, as this process should be instructive for further planning and adjustments.
- Anecdotal Records and data collection should be ongoing.

Note: Continue EMT/CAP problem solving process until team has enough evidence to suspect a disabling condition under IDEA & COMAR.

Decision by EMT/CAP: Suspicions of ED or MR.

IEP Level:

Preparation for Screening

- Parent Questionnaire 336-22
- Summary of classroom-based assessments (e.g., FBA, CBA, etc.) & interventions implemented (e.g., BIP, instructional modifications, etc.)
- Observations
- Teacher Referrals
- Educational History
- FBA/BIP
- School Nurse Health Appraisal
- Student Screening Profile Worksheet and the ED Supplemental Profile (Appendix B)
- Student Information Summary (SIS) [Appendix A]

Required Evaluation Components

- Authorization for Assessment
- Authorization for Release of Confidential Information (if appropriate)
- Review of anecdotal records
- Parent Questionnaire Supplement (if Emotional Disturbance is suspected) completed by the school psychologist or designee.
- Three direct observations in two different settings (by psychologist and/or designee). Note: Some of the observations may have occurred as part of the screening; for ED only.

Evaluation IEP Team Meeting

Emotional Disturbance –

- Part I: Complete Emotional Disturbance Multidisciplinary Evaluation Form (Appendix E).
- Psychologist confirms an emotional condition that could adversely affect the student’s educational performance; move to Part II.
Psychologist does not confirm an emotional condition that could adversely affect the student’s educational performance; refer case back to EMT/CAP or for IEP team consideration of a disability other than Emotional Disturbance.

Part II: Team answers questions one through four. All four questions must be answered YES to confirm Emotional Disturbance.

Issues from the SIS form accounted for.

Conclusion: team needs for special education and related services (if any).

Signature of team members.

Special education services are not warranted, then refer case back to EMT/CAP or for IEP team consideration of a disability other than Emotional Disturbance.

Mental Retardation -

Cognitive scores are 70 ± 5 or lower.

Adaptive skills in at least two domains are significantly subaverage across two raters.

Age of onset before age 18

Or, in extenuating circumstances, scores on the assessment instrument(s) two or more SD below the mean or a severe discrepancy between rate of learning and CA.

Issues documented on the SIS accounted for.

Signature of school psychologist.

Conclusion: Team identifies areas in which goals are required

Signatures of team members.

Special education services are not warranted, then refer case back to EMT/CAP or for IEP consideration of a disability other than Mental Retardation.

Dissenting Opinions:

NO

YES. Dissenting opinions should be referred to the Director of Special Education for review.
Process Snapshot 1:
Consult

Problem or Issue is Raised → Informal Staff/Peer Consultation

Issue Resolved?

Yes, Resolved!

No, Go to EMT/CAP Problem Solving

Process Snapshot 2:
Consider

EMT/CAP Problem Solving Begins

Begin consideration of SIS factors.
Assumes increased data gathering, recording, and analysis by staff.

- Language/Cultural Issues
- Educational History
- Medical History
- Transient Social/Emotional Factors

(Continued)
Process Snapshot 2 (Continuation)

Consider

**EMT/CAP Problem Solving Begins/Continues**
Structured Interventions/Consultations Across Time including FBAs

- **Issue Resolved?**
  - Yes, Resolved!
  - No, unresolved but no disability suspected: Continue EMT/CAP
  - No, unresolved, but disability suspected: Go to Screening IEP team meeting

Process Snapshot 3:

Consider

**IEP Screening Begins**
Organize and consider all available case data including SIS factors and strategies employed by knowledgeable personnel.

- **Disability suspected?**
  - Yes, complete recommended assessments
  - No, refer to EMT/CAP for continued data gathering and analysis
**Process Snapshot 4: Consider**

**Testing/Evaluation**
- Gather sufficient information to make diagnostic conclusion supported by the data and with active consideration of all data, including SIS factors.
- Standards reflect accepted professional and legal interpretations and are operationally defined.

![](image)

**Process Snapshot 5: Confirm**

**Concluding Decisions**
Standards are operationally defined

![](image)

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APPENDIX K
RESOURCES
RESOURCES

Information addressing over-representation of African-American students in Special Education

http://www.ideapractices.org/resources/detail.php?id=22070


http://www.nabse.org/nabsecec.htm

http://www.law.harvard.edu/civil rights

Information addressing specific disabilities


Dissociative Disorders – http://www.sidran.org


PTSD - http://www.dartmouth.edu/dms/ptsd/


TEACCH – http://www.unc.edu/dents/teacch

Fetal Alcohol Syndrome – http://www.achr.com/fas/


Additional resources – http://www.schoolpsychology.net/p_01.html

Additional supporting data, including updated full size copies of the forms herein can be accessed on the Montgomery County Public Schools Department of Student and Community Services web site: http://www.mcps.k12.md.us/departments/psychservices/decisions/