

MENTAL HEALTH AS A RELATED SERVICE

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Supporting students with emotional and behavioral needs in the Least Restrictive Environment

Mental Health as a Related Service, formerly known as AB3632 or AB2726 services, is identified as clinical mental health services necessary for a student to benefit from their special education program and services.

Within the educational environment these can include:

- Mental health assessments,
- Crisis intervention within the educational setting,
- Therapy (individual or group),
- Intensive day treatment,
- Case management, and/or
- Residential placement recommendations

These services can be evaluated by the Mental Health Team, which may include but not limited to:

- SELPA Administrator or designee (with appropriate PPS credential),
- SELPA Program Specialist,
- SELPA School Psychologist,
- District representative(s), as appropriate, and a
- Clinical psychologist, or
- Licensed Clinical Social Worker (LCSW), or
- Marriage, Family, and Child Counselor (MFCC), or
- Marriage and Family Therapist (MFT).

Target Population

Students must have significant needs identified through assessment in the areas of social-emotional or social-behavioral by a school psychologist. This also indicates that the students are currently served under an active and updated IEP. Students can be anywhere on the continuum of placement and services as long as they meet the criteria for mental health referral and assessment.

Pre-referral

When it is determined by the IEP team that a student's social-emotional symptoms and/or related behavioral presentation impede his/her learning or the learning of others, the team acknowledges that all appropriate

- Behavior interventions and pre-referral counseling shall be exhausted.

School based interventions can include:

- School-wide behavior supports,
- Heterogeneous counseling groups, and
- Character education.

IEP based interventions can include:

- Behavior specialist consultation/support services,
- Pragmatics or social skill instruction,
- DIS psychological counseling,
- Behavior Support Plan development/review,
- Functional Analysis Assessment, and/or
- Behavior Intervention Plan development/review.

Pre-referral counseling must exist for a minimum of 3-6 months; either through IEP related services or private care.

Many students access private psychiatric care, psychotherapy, or family counseling/therapy outside of their educational setting. When this occurs,

- It is the responsibility of the case manager and/or school psychologist to maintain request/release of information
- School psychologist involvement is necessary to identify emotional/behavioral characteristics/symptoms and how these characteristics or symptoms are negatively impacting educational performance.

The Mental Health Team shall be considered for

- cursory review of referrals,
- Appropriateness of clinical referral,
- Compliance to state and federal regulations, and
- Clinical assessments.

The team shall be comprised of

- SELPA administrator or administrative designee with appropriate PPS credentials,
- SELPA program specialist with appropriate PPS credentials,
- School psychologist, and a
- Mental health clinician from a partnering agency with which the SELPA has an interagency agreement.

The SELPA Mental Health Team will coordinate with school district personnel to provide seamless transition of caseloads, services, and coordination of clinicians.

The purpose of the SELPA Mental Health Team is to

- Insure process/protocol education,
- Referral review,
- IEP attendance,
- Collaboration and coordination with outside agency clinicians and services, and
- School site or district collaboration and support.

Initial proposal is for SELPA to lead the Mental Health team by staffing with a

- SELPA administrator or designee with appropriate PPS credentials,
- SELPA school psychologist,
- SELPA Program Specialist with appropriate PPS credentials,
- Mental health clinician, and
- District representative, as needed.

The SELPA Mental Health team will coordinate with school personnel to provide seamless transition of caseloads, services, coordination of clinicians.

Current information on existing students with mental health services must be compiled prior to transition. Information needed

- Name
- Birthdate
- Goals
- District of residence
- District of service
- School of attendance
- Type of related service
- Frequency & duration
- Treatment logs/notes
- IEP case manager

Mental health team will

- Reconcile between county Mental Health agency and district caseloads a comprehensive list of students (clients),
- Work with partnering agency providing mental health clinicians in developing client lists/caseloads based on geographical efficiency and needs,
- Grouping students by school,
- Secure a confidential space on school campuses,

- Facilitate the transition,
- Develop Prior Written Notices,
- Attend IEPs to examine appropriateness of needs, goals, services and
- Identify necessary changes in provider/location of services

As student groups are identified, Mental Health team can plot an IEP schedule. IEP teams can include

- District administrative case manager,
- District school psychologist,
- Mental health clinician,
- SELPA representative,
- Student, when appropriate and
- Parent.

The “rollout” of change of providers will be closely monitored by the mental health team during the school year and will participate as needed in subsequent IEPs.

When a student is suspected of needing mental health services an IEP team can initiate a referral of student’s social and emotional status.

District school psychologist shall validate and compile the following information:

- The pupil has recently been assessed by school personnel and a current psychoeducational evaluation report is complete,
- Written parental consent for **referral to** the school based mental health assessment team,
- IEP team documentation that the student exhibits emotional or behavioral characteristics symptoms that:
 - Are observed by qualified educational staff in educational and other settings, as appropriate,
 - Impede the pupil from benefiting from special education services,
 - Are identified significant, as indicated by their rate of occurrence and intensity,
 - Are associated with a condition that cannot be described solely as a social maladjustment,
 - Are associated with a condition that cannot be described as a temporary adjustment problem that can be resolved with less than three months of school counseling,
- Based on an IEP team decision using educational assessments, the pupil’s current functioning, including cognitive functioning, is at a level sufficient to enable the pupil to benefit from mental health services,
 - The IEP team has provided appropriate Designated Instruction Services or related services as indicated on the IEP, and
 - In cases where these services are clearly inadequate individualized education program team documented why they were determined to be inadequate.

A student who is in the process of being evaluated and may require Mental Health related services, the initial assessment team must clearly document the suspected/identified need related to mental health and recommendation for Mental Health related services.

Transfer Students/Interim Placement

The LEA administrator or designee will immediately refer the student to the Mental Health Team Coordinator for review of interim placement

Referral packet

- Student's current IEP,
- All assessment reports,
- Mental health team will assign a mental health clinician, and
- A subsequent IEP team meeting will be convened to review interim services within 30 days of transfer

Referral packet

When an IEP team has initiated a referral the District School Psychologist will submit to the Mental Health team the following documents:

- Referral checklist,
- Current IEP,
- Current assessment,
- Behavior plans (BSP or BIP),
- Supporting letter from clinical psychologist and/or school psychologist counseling,
- Parent consent to referral, and
- Consent for release or exchange of information.

Referral procedures and timelines

- Within 15 days of the referring IEP the administrative designee will contact parent and request consent/decline to assess.
- Parent will be given 15 days to respond.
- If assessment plan is not responded to by the parent within 30 days from the initial request for consent, the administrative designee will inform the district that the student cannot be assessed due to lack of parental response.

Assessment

- The mental health team (mental health clinician) will conduct assessment to determine needs and goals for Mental Health related services.

Evaluation

- Upon receipt of parental consent the Mental Health Team will conduct a clinical analysis of the history,
- Current status of the student's mental health,

- Development of a clinical and family assessment,
- Observation of the student,
- Review of records, and
- Further clinical measures, as needed.
- Sources of information:
 - Parent
 - Teacher
 - Physician
 - Psychiatrist
 - Social worker
 - Probation officer
 - School psychologist
 - School counselor
 - Administrator
 - Extended family
 - Other significant adults

Assessment report documented in a written report. Will detail

- History of mental and/or behavioral health,
- Previous interventions,
- Attendance of interventions,
- Relevant behavior noted during observation and interventions,
- Relationship of that behavior to the student's academic and social functioning,
- Developmental & medical findings, and
- Need for specialized services.

IEP Meeting for Induction of Mental Health as a Related Service

- Within 60 days of receipt of parent consent, the IEP team will reconvene.

Goal Development

- Treatment goals that focus on the reduction of symptoms as a means of improving functional impairments will be developed.
- Goals must be observable and measurable.
- Goals cannot be changed or adjusted without a formal IEP and parental consent is obtained.

Case Management and Service Provision within school district or as Mental Health as a Related Service

- Mental health clinician will provide and monitor all agreed upon mental health related services.
- IEP case management will be maintained by the school district case manager (i.e., special education teacher, SLP, school psychologist, district designee, etc.) as appropriate. Case managers will be responsible for consultation/collaboration with all program and related service providers, progress on all goals including mental health.

- When communication regarding IEP meeting development is needed the case manager will initiate and facilitate this communication.
- In the case of the addition of Mental Health as a Related Service, the Mental Health Team will provide the case manager with all appropriate contact information for the mental health clinician and SELPA representative.

Services can include but are not limited to

- Mental health assessments,
- Crisis intervention within the educational setting,
- Therapy (individual or group),
- Intensive day treatment,
- Case management, and
- Residential placement.

Assessment includes services designed to provide formal documented evaluation or analysis of the cause or nature of the patient's

- Mental,
- Emotional, and
- Behavioral disorder.

A collateral service activity is an activity provided to significant support persons in the student's life, rather than to the student.

- The definition of collateral service activities must be clear that the overall goal of collateral service activities is to help improve, maintain, and restore the student's mental health status through interaction with the significant support person. There must be a clear linkage between the collateral service activity and the student's goals as expressed in the IEP.

Crisis intervention services are limited to stabilization of the presenting emergency.

Service location

- Individual or group therapy shall determine needed space at the student's school site,
- Will discuss space requirements, and
- At minimum a private room will be available on a regular basis.

All efforts must be made to address the student's needs within the continuum of services within the LEA (including SELPA regional programs) prior to day treatment or residential nonpublic school attendance.

Students being considered for intensive day treatment or residential nonpublic school must have a review of records or re-evaluation of areas of need conducted by the clinician, with subsequent IEP meeting held.

Just as any review of LRE and services, it must be evident that outside of crisis intervention, the student's needs exceed the current supports and services. Therefore, it is vital to review student's related services, attendance, medication compliance (if applicable), educational environmental supports, and current diagnostic status (i.e., R/O evaluations).

In the event that a student's functioning stabilizes, which includes consistent goal achievement, general adaptive functioning improvement and stabilization, as well as clinical recommendation; the student will be re-evaluated for exit from service. To be eligible for exit, all services must be completed, student must have an acceptable level of stability, and student must have adequate community or school resources so that he/she can benefit from their special education program and services. Any and all changes to IEP related services shall be addressed in an IEP meeting.

Providing staff with legally compliant and student focused language will be important in translating the change from "AB3632" to "Mental Health as a Related Service". Thus, having a Mental Health Team member provide in-service workshops on the change in process, language and service providers will be needed. Education of all staff members, at all levels of employment will help promote a seamless transition.

Skill building in school psychologists may be necessary, as well. Providing training and support in the area of counseling skills (solution-focused brief, cognitive-behavioral therapy, etc.) and logistics around balancing counseling with assessments can help build capacity in the schools. Those school psychologists who desire this support can build their skills in the "Tier 1, 2" areas of support and become valuable assets in their school districts.

Considering the needs of students and responsibilities of a Mental Health Clinician, caseloads can be realized at a maximum of 23 – 28 students. Upon case assignment, duties for this position include, but are not limited to timeline compliance of mental health assessment/services/review, goal achievement/progress reporting, consultation/collaboration with teachers and special education service providers, maintaining appropriate clinical documentation, provision of therapy as determined in IEP, consultation with social services as appropriate for each student, and parent or outside clinician consultation as appropriate.

Additionally, Mental Health program monitoring and centralization of referrals is vital in maintaining quality programs and legal compliance. Thus, it appears necessary to employ a Mental Health Team Administrator. This individual's responsibilities can include, but not limited to, collaboration with partner agency (assignment of mental health clinicians, etc.) receipt and review of referrals, IEP attendance, compliance (review/maintenance), assistance in dispute resolution, SELPA reporting of date, and/or case management as appropriate (residential placement).

Recommendations for Written Reports for Mental Health as a Related Service (including Psycho-Educational & Mental Health Clinical reports)

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What Are the Components of a Good Psychoeducational/Mental Health Assessment?

- Referral question(s)
- Referral source
- Background information
- Assessment procedures
- Relevant test procedures
- Assessment results
- Interpretation of results
- Summary and recommendations

Key ingredients of the psychoeducational/mental health evaluation include, but are not limited to the following:

A. Reason for Referral (School Psychologist/Mental Health Clinician)

- State the person who made referral including referring school psychologist, school and district.
- This section of the report describes why the child is being referred for testing, what problems the child has had that warrant evaluation and the purposes of the examination. This part of the report orients the reader to the report's contents and provides a framework for evaluation findings.
- This should address how the school district believes the mental health issues effect current educational performance as well as school attendance.

B. Child History and Background Information (School Psychologist/Mental Health Clinician)

A psychoeducational/mental health evaluation is essentially a "snapshot in time." It represents an appraisal of the child's current functioning against the backdrop of the child's past. Therefore, the psychologist/clinician needs to obtain a thorough history of the child and include all relevant historical information within the report.

For children who may be in need of special education services, it is critical that the historical section of the report include all relevant **medical history**. Information to be included consists of any pre- and perinatal factors, which may have a bearing on subsequent child development; the child's acquisition of developmental milestones in accordance with a

developmental timeframe; the child's history of infection, illness and injury; and anecdotal observations regarding the child's health and preschool development.

Research has shown that various adverse pre- and perinatal factors may predispose the child to subsequent learning problems. For example, prematurity puts the child "at risk" for later problems with language and other forms of information processing. Adverse reactions to vaccines, the experience of frequent and chronic ear infections, seizure disorder, attention deficit, social and/or emotional difficulties, surgeries and strep infection, can provide important clues regarding the "risk factors" that may predispose the child to subsequent learning problems.

Historical information should also include data regarding the **child's development** of fine- and gross-motor skills; demonstration of facility in speech and language functions; ability to interact, play and socialize with peers; and the timeline for accomplishment of developmental milestones.

The historical section of the report should also contain a complete review of the child's **educational history**, beginning with preschool educational experiences and concluding with the child's present educational placement. Therefore, it is critical that the psychologist/clinician obtain a complete educational record for the child to include all report cards, anecdotal records, standardized test results, teacher and parent observations and the results of prior evaluations. Whenever possible, psychologists/clinicians should seek to obtain actual test scores and not just written summaries from previously completed evaluations.

It is also important to include in the historical section of the report **observational data** from individuals who have had an opportunity to interact with the child over time. This includes teachers, parents and other professionals who can provide important insight into the child's functioning in a variety of settings and the child's **progress (or lack of it)** over time.

For the child with a prior **history of evaluation**, particular attention should be paid to how the child has tested over time. It is not unusual for children who receive appropriate educational programs to demonstrate growth, not only on standardized academic achievement tests, but also on measures of cognitive functioning.

The historical section of the report should take the reader from the beginning of the child's life and leave the reader right at the point where the evaluation begins. This sets the stage for the occurrence of the "snapshot in time".

C. Child Behavior during Testing (School Psychologist/Mental Health Clinician)

Behavioral observations of the child under standardized test conditions are critical to the compilation of the psychoeducational/clinical evaluation report. It is not only important *how* the child tests in terms of scores, but what the child does during the *process* of the evaluation. Whether the child is attentive or inattentive, hyperactive or hypoactive, has

good or poor rapport with the examiner, has an impulsive or methodical response style or is motivated or unmotivated to complete the testing tasks, is crucial to interpreting the obtained test results.

Some children with special needs are extremely difficult to test. Their problems with attention, concentration, impulse control and limited frustration tolerance can create continual interferences during the testing process and may compromise the reliability and validity of the obtained test scores. If negative behaviors are observed during testing, these should be reported by the examiner and obtained test scores should be interpreted with extreme caution.

On the other hand, many children are extremely hardworking and motivated to do well during testing. They put forth an extraordinarily strong amount of effort, which contributes to the reliability and validity of obtained test results. These behaviors also need to be noted when they are observed.

Often test scores obscure the *process* behind the child's test-taking behavior and may obscure the truth of the child's functioning rather than reveal it. The concept of reporting qualitative data rather than just quantitative data in an evaluation is referred to as "*process assessment*." The term "process assessment" comes from the saying, "It is not whether you win or lose but how you play the game." How the child obtains test scores is just as critical, if not more critical, than the actual scores themselves. Therefore, both *qualitative* and *quantitative* information is critical to the compilation of the psychoeducational evaluation report.

D. Test Results and Analysis (School Psychologist/Mental Health Clinician)

In this section of the report, the psychologist/clinician presents all relevant information obtained during testing and analyzes and interprets test results. This is a critical section of the report, which gives the psychologist the opportunity to discuss and interpret both the quantitative and qualitative information obtained during the course of the evaluation.

If prior testing was accomplished or if the child has been receiving special education, this section of the report should include information as to whether the child is making a reasonable degree of educational progress and whether the child is benefiting from specially designed instruction and educational intervention.

E. Summary of Test Results and Recommendations for Intervention (School Psychologist/Mental Health Clinician)

The final section of the psychoeducational/clinical evaluation contains a summary of test results and the recommendations for intervention. This section should contain not only an overview of all major test findings, but also a determination of the child's eligibility for special education services and specific recommendations for the implementation of specially designed

instruction. In essence, this section of the report provides a blueprint for the writing of the child's IEP.

Anatomy of the Psychoeducational/Mental Health Evaluation

Psychoeducational evaluations generally contain measures of *aptitude* and *ability* including tests of intelligence and other cognitive functions; neuro-psychological functioning; speech and language; visual-spatial perception; visual-motor integration; achievement; attention and concentration; and career/vocational aptitude for children over the age of fourteen. On such measures of *maximum performance*, the child is asked to do his *best*.

Psychoeducational evaluations also generally contain measures of *typical performance* where the child is asked to be *honest*. Examples of tests of *typical performance* include tests of social and emotional functioning; personality questionnaires; measures of career/vocational interest for children over the age of fourteen; projective tests; and self-esteem inventories.

Psychoeducational/clinical evaluations should consist of multiple assessments of a variety of constructs and provide a snapshot of the child's strengths and needs in each area of ability and suspected disability.

A. Cognitive tests (School Psychologist)

Cognitive testing is accomplished by using standardized IQ tests. However, various intelligence tests measure different constructs and different aspects of information processing, which is why IQ test scores can differ dramatically from one test to another. Scores obtained on tests of *maximum performance*, such as IQ tests, may also be depressed by the very disorder that is adversely impacting the child's academic achievement. Therefore, it may be necessary to give a battery of cognitive or tests during the evaluation rather than only one test of IQ to obtain a valid and reliable appraisal of the child's cognitive functioning status.

B. Tests of Adaptive Behavior (School Psychologist)

When constructing a psychoeducational evaluation, the psychologist /clinician must be aware of best practice guidelines for the measurement of adaptive behavior. State and federal laws require that a measure of adaptive behavior (i.e., domestic, daily living, social and functioning academic and communication skills) must be obtained in making a diagnosis of mental retardation. It should be noted for an emotional disturbance evaluation a rule out of mental capacity is necessary for benefit of mental health support.

C. Tests of Speech & Language Functions (School Psychologist)

Typically, the speech and language clinician performs testing of speech and language functions. However, psychologists should routinely provide assessment of receptive and expressive language, word finding ability, phonological awareness, phonological memory and rapid naming for any child suspected of having disabilities.

D. Tests of Visual-Spatial Perception and Visual-Motor Integration (School Psychologist)

Many children experience problems with handwriting, fine-motor coordination and perception of the “orthographic” aspects of print-related material. Therefore, thorough testing of these domains is a necessary and important ingredient of any psychoeducational evaluation. Impairments of visual-spatial perception, fine-motor functioning and/or visual-motor integration may adversely affect the child’s ability to learn through reading and to complete tasks requiring a written response.

E. Neuropsychological Tests (School Psychologist)

Although neuropsychological testing can also be an integral part of the psychoeducational examination although many school psychologists have little to no training. Neuropsychological tests help to provide an understanding of the child’s cognitive processes that may not be evident through traditional cognitive or intelligence testing.

Using a neuropsychological model for the determination of disability forms a useful basis for linking evaluation data with best practice guidelines for intervention. The purpose of neuropsychological testing is to localize areas of deficit, which may be critically important when evaluating for the presence of certain types of disabilities and syndromes.

F. Achievement Tests (Special Education Teacher/School Psychologist, if needed)

Present levels of academic achievement are normally ascertained through a combination of curriculum-based assessment (CBA) and the use of norm referenced achievement tests. While curriculum based assessment (CBA) is necessary to determine how the child is progressing in and responding to the curriculum, standardized norm referenced achievement tests are used to determine if the child is functioning academically, commensurate with his or her cognitive capabilities.

As is true with all psychoeducational tests, different achievement tests measure different constructs. For example, for a child suspected of having a specific reading disability such as dyslexia, it is imperative that academic testing consist not only real word identification, but also of nonsense word reading. This is because dyslexic children have difficulty phonetically decoding words, which are not in their sight vocabulary. It is only by using pseudo words, or phonetically regular nonsense words, that the psychologist can adequately establish the child’s phonetic decoding capabilities.

Many academic achievement tests are *untimed*. As a result, disabled children who do relatively well when given unlimited testing time may not appear to have any difficulties by virtue of their achievement test scores. In such cases, *process assessment* is imperative in that it provides important *qualitative* data about how the child actually performed when taking the test.

A psychoeducational evaluation and the results obtained are only as good as the tests administered. There are strengths and weaknesses associated with all tests on the market and two concepts, which must be considered when picking and choosing tests, are the **reliability** and **validity** of test measures. *Reliability* refers to the ability of the test to

measure the same constructs consistently over time. If a test is unreliable, wildly disparate results may be obtained during test-retest situations. *Validity* refers to the ability of the test to accurately measure what it purports to measure. Therefore, when picking and choosing academic achievement tests, as well as any other type of test, psychologists must be aware of the reliability and validity characteristics of their test instruments.

Norm referenced academic achievement tests provide important objective data about the child's present levels of academic functioning. This data can be used to determine the child's response to prior special education intervention and can form a baseline against which to determine the effectiveness of future special education initiatives.

G. Tests of Attention and Executive Function (School Psychologist/Mental Health Clinician)

Testing of attention and executive functions becomes rather complex because there are no single test measures that effectively ascertain functioning within these domains. Therefore, the psychologist must create a battery of tests and checklists, which provide both anecdotal information and objective evidence of the child's ability to attend, concentrate, control impulsivity and engage higher-level executive functions.

Attention Deficit Hyperactivity Disorder (ADHD) is the most common childhood neurobehavioral disorder inherent in 4 to 12 percent of all school-age children. When evaluating for Attention Deficit Hyperactivity Disorder, direct information must be obtained from parents, classroom teachers and the student's caregivers regarding the core symptoms of ADHD in various settings. This includes the age of onset of symptoms, duration of symptoms and the degree of functional impairment that results from the symptoms.

Psychoeducational evaluation of a child suspected of having ADHD should also include assessment for co-existing conditions including learning and language problems, aggression, disruptive behavior, depression or anxiety. As many as a third of children diagnosed with ADHD also have one or more of these co-existing conditions. Physicians also need to be involved in the assessment of Attention Deficit Disorders. The American Academy of Pediatrics recently issued guidelines for diagnosing and evaluating students from the ages of six through twelve for ADHD, which require the child's primary care physician to obtain a history and physical examination, neurological exam, family assessment and school assessment. The primary care physician should consider ADHD as a possible diagnosis in any child presenting with the following concerns:

- Cannot sit still/hyperactive
- Lack of attention/poor concentration/doesn't seem to listen/day
- Acts without thinking/impulsive
- Behavior problems
- Academic underachievement

Family assessment for ADHD includes documentation of the specific elements by interview or the use of ADHD specific checklists to rate the child in the areas of inattention,

hyperactivity and impulsivity. Documentation should also include observations of the child in multiple settings, information regarding the age of onset of symptoms, the duration of symptoms and the degree of functional impairment.

School assessment for ADHD should include documentation of specific elements of inattention, hyperactivity and impulsivity which occur in the classroom. Use of teacher ADHD specific behavior checklists is also recommended.

Teacher narrative should also be included to provide information regarding the child's classroom behavior, learning patterns, classroom interventions which have been tried, degree of functional impairment, evidence of impact of ADHD on the child's school work, report cards and samples of school work.

The American Academy of Pediatrics relied upon research developed by the American Psychiatric Association and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) to provide their newly released practice guidelines for physicians and to offer a clinical algorithm for diagnosing and evaluating children with ADHD. Psychologists also rely on guidelines from the DSM-IV to diagnose the presence of attention deficits in school-age children.

H. Tests of Social and Emotional Status (School Psychologist)

Evaluation of a child's social and emotional status can be completed through the use of teacher and parent observation forms, direct self-reports completed by the child, **clinical personality inventories** and projective tests. A variety of standardized checklist forms are available on the market for parents and teachers to rate the child's social and emotional functioning across a variety of settings. Additional tests of social and emotional functioning may include the judicious use of clinical personality tests, which provides an assessment of the child's personality traits and a predictor of how the child's social, emotional and personality orientation functioning impacts upon the child's academic performances. This represents a useful tool for determining the impact of the child's personality orientation upon school performance.

There are also a variety of clinical personality tests, which are designed to determine the nature and degree of social/emotional problem that may adversely affect the child's performance at school and elsewhere. Typically, psychologists use a combination of data gathering instruments to form a complete picture of the child's social and emotional functioning.

When evaluating for social and emotional concerns, the **psychologist/clinicians** must determine whether social or emotional problems represent the primary obstacle interfering with the child's educational progress or the secondary symptoms, which have developed in response to the child's frustration at school.

State and Federal laws prohibit diagnosing a child with a serious emotional disturbance when the child's inability to learn can be explained by intellectual, sensory or other health factors. A student may not be determined to have a serious emotional disturbance for disciplinary reasons alone.

I. Measures of Personality Functioning (School Psychologist/Mental Health Clinician)

Understanding the child's personality orientation is critical to determining the variables that may affect the child's academic performances at school. Some children may have profound and serious learning problems but because of the nature of their personality, present as very hardworking youngsters who manage to accomplish a great deal against sizable odds. Other children may experience very mild learning impairments but as a result of temperament and personality, experience a great deal of distress about their learning. Therefore, assessment of personality functioning is a critical component of the psychoeducational examination.

J. Career and Vocational Tests (School Psychologist)

For children of fourteen years of age and older, measures of career and vocational aptitude and interest should be performed as part of the psychoeducational examination. This allows for the development of a vocational transition plan (VTP), which is a critical component of a child's IEP. In this case, designing appropriate educational interventions that will allow the student to progress toward the accomplishment of career and vocational goals becomes the focus of assessment and recommended intervention.

Observational Data Collection

An important component of the psychoeducational evaluation includes observational data regarding the child's functioning in the classroom, in structured and unstructured social situations and at home. While the psychologist should directly observe the student when possible, it is most important to obtain observational data directly from individuals who have frequent and ongoing contact with the child in a variety of settings.

A. Direct classroom observation (School Psychologist/Mental Health Clinician)

School psychologists are often required to perform direct classroom observation of the child. While there is value to observing the child in the instructional setting, there are also some difficulties inherent in this type of procedure.

The presence of an observer in the classroom changes the typical flow of classroom functioning and will often alters the behavior of those being observed. "Observer effects" not only alter teacher behavior, but also student behavior. Therefore, while direct classroom observation is an important part of evaluation, it should not be solely relied upon to generate conclusions regarding the child's functioning within the classroom setting.

B. Input from Teachers (School Psychologist/Mental Health Clinician)

Teachers who work with the student day in and day out should be contributing members of the multidisciplinary team to provide information regarding their observations of the student "in the field".

Teachers can provide a wealth of information regarding the child's day-to-day functioning within the classroom setting. Typically it is advantageous to use some form of checklist to obtain observations directly from teachers. The **Pre-Referral Checklist**, developed by Hawthorne Publishers, is an excellent tool for soliciting observational data from teachers in an organized fashion.

C. Observational Information from Parents (School Psychologist/Mental Health Clinician)

There is no one who knows the child better than his or her parents. Parents have had the opportunity to observe the child from birth until the present time. Parents are "in the trenches" with the child from one school year to the next and have the ability to observe the child's strengths and weaknesses in a variety of settings over a lifetime. Therefore, obtaining observational data directly from parents is an important and critical part of any psychoeducational evaluation.

Parents are able to provide input to the psychologist about how the child has progressed through the grades and how the child has interacted with various teachers. Parents have the opportunity to directly observe the child's ability to complete homework in an independent setting. Parents also are more likely to see the results of fatigue and frustration in the child at the end of the day.

Many disabled children hold themselves together during the school day and expend a tremendous amount of effort to meet the academic demands of school. However, those same children oftentimes come home from school exhausted, frustrated, upset and anxious when their ability to cope becomes overwhelming. Observational data from parents regarding is, therefore, critical to understanding how the child performs on a day-to-day basis and how the child returns home after the school day.

D. Observations of Allied Professionals (School Psychologist/Mental Health Clinician)

Other professionals who may be working with the child can also provide important input regarding the child's behavior and functioning in a variety of settings. Counselors, psychotherapists, occupational therapists, physical therapists, speech and language therapists, playground aides, cafeteria workers and school bus drivers can often provide important data regarding the child's functioning across a variety of settings. To the degree possible, it is often advantageous for the psychologist to obtain direct observational data from these individuals.

Interpretation of Test Results

Psychoeducational evaluation provides a wealth of information about the functioning of a child. Those psychologists, who perform their testing using a process assessment approach, look not only at the quantitative data obtained during the evaluation, but also at the qualitative data regarding the child's functioning.

Merely reporting test scores without interpreting results does not result in an accurate understanding of the child or provide a basis for specially designed instruction. Therefore,

accurate and thorough interpretation of test results is critical to the formulation of an appropriate educational program for the child.

A. Reliance on Best-Practice Guidelines (School Psychologist/Mental Health Clinician)

Psychologists must be current with the research literature regarding disabilities and other types of syndromes and difficulties, which may adversely affect the child's functioning at school. When the professional's knowledge basis is weak or faulty or when the psychologist's belief is incorrect and unsupported by research literature, inaccurate interpretation of test data and inappropriate recommendations result.

For each type of disability, syndrome and disorder, which may adversely impact a child's educational functioning, there exists a body of research literature and best practice guidelines for assessment and intervention. Psychologists need to remain current regarding the research literature so that they can provide meaningful assessment and offer recommendations for intervention based upon their expert knowledge.

B. Quantitative vs. Qualitative Data Interpretation (School Psychologist/Mental Health Clinician)

Within the interpretation of the **Test Results** section of the psychoeducational evaluation report, psychologists have the opportunity to discuss and comment upon quantitative vs. qualitative data. For example, the examiner might report that the child was able to recognize words to an average degree when reading a list of real words, but was a very slow word-by-word reader who had to read and reread material in order to correctly decode the stimulus words. Quantitative data, when accompanied by qualitative observation, provides the reader of the psychoeducational evaluation report with important information regarding the child's functioning.

C. Relating Test Findings to Standards for Special Education

When interpreting psychoeducational test results, the examiner needs to relate test findings to State and Federal Standards for Special Education. For example, does the child present with indicators of speech and language dysfunction, autism, pervasive developmental disorder, mental retardation or **emotional disturbance**? It is important in this section of the report for psychologists/clinicians to tie in evaluation data to the standards of how it impacts educational benefit.

Creating the IEP Blueprint

The psychoeducational evaluation contains a synthesis of observational data, test results, test interpretation and findings of strength and need, which are important to development of the multidisciplinary evaluation report and the construction of the child's individualized educational program (IEP).

A. Evaluation as the Kingpin

Once the evaluation has been completed, the school district needs to convene a staff meeting. This report contains a synthesis of the child's relevant medical and educational

history, a review of all prior assessments and observations, the establishment of the child's present levels of functioning, the inclusion of current information regarding the child's strengths and needs and recommendations to the multidisciplinary team for the formation of an IEP. The appropriately done psychoeducational evaluation, therefore, is the kingpin of the comprehensive evaluation report (CER).

B. Logic links from Evaluation, to Staffing to IEP

Before the child's IEP can be created, the child must be seen for a comprehensive psychoeducational evaluation and a comprehensive evaluation report must be developed. The next step, assuming that eligibility for specially designed instruction has been established, is creating the child's IEP.

The psychoeducational evaluation generally serves as a blueprint for the creation of the child's IEP. The psychologist performing the evaluation should not only provide information regarding the child's diagnosis, but should also provide recommendations for intervention.

C. Using Evaluation Data as a Baseline for Measuring Progress

Present levels of functioning within a psychoeducational evaluation represent a baseline of how the child is performing academically at the present time. Once an IEP has been constructed and specially-designed instruction provided, this data can serve as an important baseline against which to objectively measure the child's progress.

Many IEP's provide evaluation criteria, which are wholly subjective rather than objective and measurable. The child's report card grades, "teacher observations" and "teacher checklists" are insufficient to objectively track the child's progress with specially designed instruction over time. The standard for "appropriateness" of program and placement is determined by whether the child is able to make a reasonable degree of educational progress as a result of targeted intervention. One way to track that educational progress is through repeated curriculum-based measurements and a repeat of baseline tests once or twice a year. It is useful to provide baseline testing using norm referenced achievement test measures, which have alternate forms. This eliminates problems associated with practice effect for repeated test measures. When norm-referenced tests are given repeatedly, practice effect can distort the child's test scores and make the child appear to be doing much better than is actually true. Therefore, whenever possible, psychologists should use standardized academic achievement tests which have alternate test forms that can be used to eliminate problems associated with practice effect.

SUMMARY:

[Summary of report here]

A pupil's eligibility for special education under state and federal law is determined by the Individualized Education Program (IEP) Team based upon the following eligibility factor(s).

Serious Emotional Disturbance

Because of a serious emotional disturbance, a pupil exhibits one or more of the following characteristics over a long period of time and to a marked degree, which adversely affect educational performance (California Education Code, Article 3.1, Section 3030):

- An inability to learn which cannot be explained by intellectual, sensory, or health factors.
- An inability to build or maintain satisfactory interpersonal relationships with peers or teachers.
- Inappropriate types of behavior or feelings under normal circumstances exhibited in several situations.
- A general pervasive mood of unhappiness or depression.
- A tendency to develop physical symptoms or fears associated with personal or school problems.

RECOMMENDATIONS:

EXCLUSION:

In accordance with Educational Code 56320, the following was considered regarding the procedures and materials used during this evaluation to ensure compliance with state and federal regulations:

This evaluation was conducted by qualified persons. All intellectual and/or emotional functioning testing was administered by a credentialed school psychologist. Test and assessment materials and procedures used for the purposes of assessment and placement of individuals with exceptional needs were selected and administered so as not to be racially, culturally, or sexually discriminatory. The student's dominant language was considered in selecting assessment instruments. Tests have been validated for the specific purpose for which they were used. Tests and other assessment materials include those tailored to assess specific areas of educational need and not merely those that are designed to provide a single, general intelligence quotient. The assessment results that have been provided accurately reflect the student's aptitude (unless otherwise noted) and/or factors the test purports to measure and not the pupil's impaired sensory, manual, or speaking skills.

STATEMENT OF NEED FOR SPECIAL EDUCATION SERVICES

"Established no need for special education services"

The profile identified in this evaluation does not adversely affect educational performance. Therefore, the student does not appear to need special education services, at this time. The student's educational performance is determined to be primarily impacted due to one or more of the following: limited school experience, poor school attendance, environmental, cultural or economic disadvantage, vision, hearing and/or motor problems, lack of instruction in reading or math, or limited English proficiency. The student's performance can most likely be addressed through additional services in conjunction with interventions within the general program.

“Established need for special education services”

The profile identified in this evaluation does adversely affect educational performance. Therefore, the student does appear to need special education services, at this time. The student’s educational performance is determined not to be primarily impacted due to one or more of the following: limited school experience, poor school attendance, environmental, cultural or economic disadvantage, vision, hearing and/or motor problems, lack of instruction in reading or math, or limited English proficiency. The student’s performance cannot most likely be addressed through additional services in conjunction with interventions within the general program.

Larry P

Assessment(s) were selected for this evaluation due to the Larry P. Case Law ruling which does not allow the use of intelligence testing for special education placement of African-American students in the state of California.

Name

Title

Agency (School District)

Description of Mental Health Team as a Related Service

- Mental Health Team shall be considered for:
 - Cursory review of referrals,
 - Appropriateness of clinical referral,
 - Compliance to state and federal regulations, and
 - Clinical assessment.
- Mental Health Team shall be comprised of:
 - Administrative designee (Assistant Director, Coordinator)
 - Program Specialist,
 - School Psychologist,
 - Mental Health clinician from a partnering agency, and
 - Other appropriate personnel, as needed.
- Purpose of the Mental Health Team is to insure:
 - Process & protocol within education,
 - Referral review,
 - IEP attendance,
 - Collaboration & coordination with outside agency clinicians and services, and
 - School site or district collaboration and support.