3525.1329 EMOTIONAL OR BEHAVIORAL DISORDERS.

Subpart 1. **Definition.** "Emotional or behavioral disorders" means an established pattern of one or more of the following emotional or behavioral responses:

A. withdrawal or anxiety, depression, problems with mood, or feelings of self-worth;

B. disordered thought processes with unusual behavior patterns and atypical communication styles; or

C. aggression, hyperactivity, or impulsivity.

The established pattern of emotional or behavioral responses must adversely affect educational or developmental performance, including intrapersonal, academic, vocational, or social skills; be significantly different from appropriate age, cultural, or ethnic norms; and be more than temporary, expected responses to stressful events in the environment. The emotional or behavioral responses must be consistently exhibited in at least three different settings, two of which must be educational settings, and one other setting in either the home, child care, or community. The responses must not be primarily the result of intellectual, sensory, or acute or chronic physical health conditions.

Subp. 2. [Repealed, 26 SR 657]

Subp. 2a. **Criteria.** A pupil is eligible and in need of special education and related services for an emotional or behavioral disorder when the pupil meets the criteria in items A to C.

A. A pupil must demonstrate an established pattern of emotional or behavioral responses that is described in at least one of the following subitems and which represents a significant difference from peers:

(1) withdrawn or anxious behaviors, pervasive unhappiness, depression, or severe problems with mood or feelings of self-worth defined by behaviors, for example: isolating self from peers; displaying intense fears or school refusal; overly perfectionistic; failing to express emotion; displaying a pervasive sad disposition; developing physical symptoms related to worry or stress; or changes in eating or sleeping patterns;

(2) disordered thought processes manifested by unusual behavior patterns, atypical communication styles, or distorted interpersonal relationships, for example: reality distortion beyond normal developmental fantasy and play or talk; inappropriate laughter, crying, sounds, or language; self-mutilation, developmentally inappropriate sexual acting out, or developmentally inappropriate self-stimulation; rigid, ritualistic patterning; perseveration or obsession with specific objects; overly affectionate behavior towards unfamiliar persons; or hallucinating or delusions of grandeur; or

(3) aggressive, hyperactive, or impulsive behaviors that are developmentally inappropriate, for example: physically or verbally abusive behaviors; impulsive or violent, destructive, or intimidating behaviors; or behaviors that are threatening to others or excessively antagonistic.

The pattern must not be the result of cultural factors, and must be based on evaluation data which may include a diagnosis of mental disorder by a licensed mental health professional.

B. The pupil's pattern of emotional or behavioral responses adversely affects educational performance and results in:

(1) an inability to demonstrate satisfactory social competence that is significantly different from appropriate age, cultural, or ethnic norms; or

(2) a pattern of unsatisfactory educational progress that is not primarily a result of intellectual, sensory, physical health, cultural, or linguistic factors; illegal chemical use; autism spectrum disorders under part 3525.1325; or inconsistent educational programming.

C. The combined results of prior documented interventions and the evaluation data for the pupil must establish significant impairments in one or more of the following areas: intrapersonal, academic, vocational, or social skills. The data must document that the impairment:

(1) severely interferes with the pupil's or other students' educational performance;

(2) is consistently exhibited by occurrences in at least three different settings: two educational settings, one of which is the classroom, and one other setting in either the home, child care, or community; or for children not yet enrolled in kindergarten, the emotional or behavioral responses must be consistently exhibited in at least one setting in the home, child care, or community; and

(3) has been occurring throughout a minimum of six months, or results from the well-documented, sudden onset of a serious mental health disorder diagnosed by a licensed mental health professional.

Subp. 3. **Evaluation.**

A. The evaluation findings in subpart 2a must be supported by current or existing data from:

(1) clinically significant scores on standardized, nationally normed behavior rating scales;

(2) individually administered, standardized, nationally normed tests of intellectual ability and academic achievement;

(3) three systematic observations in the classroom or other learning environment;

(4) record review;

(5) interviews with parent, pupil, and teacher;

(6) health history review procedures;

(7) a mental health screening; and

(8) functional behavioral assessment.

The evaluation may include data from vocational skills measures; personality measures; self-report scales; adaptive behavior rating scales; communication measures; diagnostic assessment and mental health evaluation reviews; environmental, socio-cultural, and ethnic information reviews; gross and fine motor and sensory motor measures; or chemical health assessments.

B. Children not yet enrolled in kindergarten are eligible for special education and related services if they meet the criteria listed in subpart 2a, items A, B, and C, subitems (2) and (3). The evaluation process must show developmentally significant impairments in self-care, social relations, or social or emotional growth, and must include data from each of the following areas: two or more systematic observations, including one in the home; a case history, including medical, cultural, and developmental information; information on the pupil's cognitive ability, social skills, and communication abilities; standardized and informal interviews, including teacher, parent, caregiver, and child care provider; and standardized adaptive behavior scales.

Statutory Authority: *MS s 120.17; L 1999 c 123 s 19,20*

History: *16 SR 1543; 17 SR 3361; 26 SR 657*

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Frequently Asked Questions about EBD Eligibility Criteria Minn. R. 3525.1329

1. Why does the rule use Emotional OR Behavioral Disorders instead of Emotional AND Behavior Disorders?

A proposed version of the EBD criteria used the word “AND” between emotional and behavioral disorders in the rule’s title. There was significant public comment recommending use of the term OR rather than AND so that the term was not perceived to be more restrictive. The criteria elements operationalize the identification of both emotional and behavioral responses comprising the presence of a disorder in this category. The title of the rule simply informs the public of the rule’s general subject matter and has no bearing on criteria or eligibility.

The term "emotional or behavioral disorders" was adopted by a broad coalition of professional and advocacy organizations as preferred terminology because it is more inclusive, referring to students who manifest emotional or behavioral disorders or both (Kaufman, 2001). The CFL accepted this recommendation.

2. What is meant by "settings” as used in the rule? [Minn. R. 3525, Subp. 2 C (2)]

Setting, as used in the rule, refers to the location in which emotional or behavioral responses are observed or measured. Eligibility determinations for EBD require that these responses be exhibited across settings: two educational settings and either the home or community setting. One of the educational settings must be the classroom but home and community settings are not more specifically defined. Examples of other educational settings include the playground, hallway, lunchroom and bus except for early childhood. Examples of home or community settings include the child’s home, neighborhood, public places, and events.

A student’s behavior frequently varies across settings. These differences may be due to different situational demands and expectations, differences among informants (parents, teachers, child, others) and problems with assessment methods. IEP teams should carefully control for "source" and "instrument" differences as a way to identify whether differences are due to settings or actual differences in the student's emotional or behavioral responses.

3. How do you determine that the disability “ is not primarily the result of intellectual factors?” [Minn. R. 3525.1329, Subp. 2a (B) (2)]

A comprehensive evaluation is necessary to determine the appropriate disability as well as to provide information for developing an appropriate IEP. Sattler (2001) describes an assessment as a detailed evaluation of a child's strengths and weaknesses in several areas, such as cognitive, academic, language and social functioning. This research compares with IDEA’s regulations which require the “…technically sound instruments that may assess the relative contributions of cognitive behavioral factors, in addition to physical or developmental factors” in evaluation (34 CFR 300.532). A multi-method multi-source process is recommended. This includes measures of intelligence. The rule out for EBD eligibility refers to the possibility of

intellectual factors (DCD, broad differences in abilities, limitations, learning disabilities, low intelligence, etc.) as primary explanations for the emotional or behavioral responses that are observed. Many students who are referred for special education evaluation with a suspected emotional or behavioral disorder are co-morbid with other disorders. Some of these disorders meet other disability criteria and some do not. These are factors the IEP team needs to evaluate. School psychologists, as IEP team members, have the training and experience to glean a great deal of information out of ability testing with students as well as ways to obtain and use this information. A wealth of information can be derived from ability evaluations including indications of expressive and receptive language, social comprehension, attention and impulsive behavioral responses, subclinical LD, and others.

Normed and standardized brief measures may be a useful in evaluating the presence and role of intellectual factors, however Sattler (2001) does not recommend these brief measures as a substitute for a comprehensive measure for identifying the intellectual abilities of children and adolescents. Therefore, the IEP team will need to use careful professional judgment in making determinations about the use of any brief measures in meeting the requirements of this part of the rule.

4. How do you determine whether the emotional or behavioral responses are related primarily to cultural factors? [Minn. R. 3525.1329, subp. 2a (B) (2)]

As a part of the comprehensive evaluation for special education and EBD eligibility, the IEP team must rule out, as primary reasons for the child's emotional or behavioral responses, exclusionary or qualifying factors. These include establishing the adverse effect on educational performance in one of the following areas: (1) an inability to demonstrate satisfactory social competence that is significantly different from appropriate age, **cultural**, **or ethnic norms; OR** (2) a pattern of unsatisfactory educational progress that is not **primarily** the result of intellectual, sensory, physical health, **cultural, or ethnic norms; or linguistic factors**; illegal chemical use; autism spectrum disorders, or inconsistent educational programming. According to the Minnesota Department of Children, Families and Learning's *Reducing Bias Manual,* the current general practice suggests the possible use of a Socio-cultural Checklist, the Home and Family Interview as well as other assessment procedures to address cultural factors. Comparisons between home and school emotional or behavioral norms may help reduce bias due to cultural factors. General evaluation procedures include using a standardized instrument that measures a broad-based syndrome or dimension.

5. How do you define, "…interferes with other student's educational performance?" [Minn. R. 3525. 1329 Subp. 2a (C) (1)]

This is determined based on the professional judgment of the IEP team. There are many possible data sources and methods such as rating scales, teacher reports, observations, interviews and record reviews. The rule does not specify a criterion for this so IEP teams will make a decision based on professional judgment and data.

6. What is meant by, "…consistently exhibited"….? [Minn. R. 3525.1329 Subp. 2a (C) (2)]

"Consistently exhibited" means that the emotional or behavioral responses are observed and documentable across settings and in multiple instances. This could refer to a specific response or category of responses. For example, a student who is observed not interacting with peers is

observed doing this in classroom settings, playground, on the bus, home and during community activities.

7. What about students who are using “illegal chemicals" [Minn. R. 3525.1329 Subp. 2a (B) (2)]

In the context of a comprehensive evaluation, the EBD eligibility criteria requires that the IEP team rule out “illegal chemical use” as a factor “primarily” causing the unsatisfactory educational progress. The literature indicates that there is a high rate of co-morbidity, i.e., mental health issues and chemical abuse or dependence existing together. In some instances, educational progress is negatively affected by an otherwise typical student’s engagement with chemicals. When the IEP team can determine that there is NO disability prior to or co-existing with the illegal chemical use, then this would be exclusionary.

More common scenarios might reveal students who had or currently have a disability and are abusing or dependent upon chemicals. It is often difficult to differentiate and determine causality but when suspected, the IEP team should make that judgment.

Students may meet eligibility for EBD and be abusing or dependent upon chemicals. Co-morbidity is not exclusionary, therefore students may have both an emotional or behavioral disorder as well as a chemical abuse or dependency condition. The questions about how to handle these situations are about service and treatment, rather than initial eligibility.

In addition, it should be noted that while most standards refer to "illegal chemical use," the IEP Team should also consider the possible effects of legally obtained chemicals or drugs. For example, common side effects of many legally obtained weight control and body building supplements may include: irritability, increased aggression, and reduced concentration and focus.

8. How do you screen for chemical issues?

A detailed and comprehensive developmental history may assist the IEP team in identifying indicators of a disability that preceded the known onset of a chemical abuse or dependence condition.

The Substance Abuse Subtle Screening Inventory (SASSI) may be useful in screening for those students who have Substance Dependence. The test developers caution that this instrument is NOT useful for screening for substance abuse although it may indicate the need to do further screening and assessment in this area (Miller, 1995) User's Guide
SASSI-3, pp 61).

9. What is meant by “…ruling out Autism Spectrum Disorders”? [Minn. R. 3525.1329 Subp. 2a (B) (2)]

This “rule out” provision for EBD eligibility means that if the IEP team determines that a student has an Autism Spectrum Disorder, then the student would be reported under that disability category, not EBD.

10. What does “social competence” mean? [Minn. R. 3525.1329 Subp. 2a (B) (1)]

Social competence is a broad concept that encompasses an array of social behavior and social skills expected by children as a part of normal development. According to Melloy, Davis, Wehby, Murry, & Leiber (1998), social competence relies on a set of social behaviors defined as individual, discrete, observable acts that make up social skills.

11. What qualifies as mental health screening? [Minn. R. 3525.1329 Subp. 3 (A) (7)]

A mental health screening, in the context of the EBD Criteria, refers to an analysis of school-based evaluation information for the purposes of referring a student for further evaluation of mental health needs among students evaluated for EBD eligibility. This is important especially in cases where the student may need a related service to benefit from special education instruction. A mental health screening is not a specific instrument or tool, nor is it as extensive as a formal mental health assessment done for purposes of establishing a mental health diagnosis (as outlined in DSM-IV, ICD 10). Definitions of mental health that appear in other parts of health or human service sections of Minnesota or Federal law do not apply to this rule. The mental health screening information is gathered from existing data such as the behavior rating scales, social developmental history, interviews and observations.

Information gathered during an evaluation for EBD may suggest a possible mental health need for which further evaluation is indicated and the student's family may choose to seek further assessment from an appropriately licensed mental health professional or contact other agencies for coordinating interagency services. If information about a co-existing mental health is confirmed the IEP team should consider school-based related services to meet that child's need and help the child to benefit from their special education services. Whether the IEP team needs to procure the assessment, or instead recommend that the family obtain one, hinges on whether the IEP team needs the assessment to provide special education and related services to the student.

12. What does “current and existing data” mean? [Minn. R. 3525.1329 Subp. 3 (A)]

Current and existing data refers to evaluation information that is contained in a student’s file that is valid and relevant to the comprehensive evaluation. A record review may yield a great deal of information that meets the purpose of an initial evaluation. For example, a student may have been previously evaluated by school professionals or outside professionals with a record containing a valid and reliable individually administered intellectual assessment. If it is deemed current and valid, the IEP team may use this data as a part of the eligibility evaluation.

13. How do you handle the differences among parent, teacher, and self-report of student’s emotional or behavioral responses?

Research demonstrates differences are common among raters using standardized rating scales. The following differences are noted. Agreements among teachers, parents and even between mothers and fathers have been low. Differences between raters do not necessarily make one or the other invalid. Inter-rater agreement is somewhat higher for disruptive behaviors and somewhat lower for internalizing problems. Some hypotheses for these differences include: (1) the bias of one parent in viewing the student's problems, (2) the settings in which the student is

viewed are different, and (3) one parent or teacher is less familiar with the student's behavior (Huberty, 1998). These known differences should be analyzed in the context of the individual student being evaluated and the relevance of this particular data type too the referral. For example, when differences emerge, the IEP team might compare these data to other data methods and sources collected during the evaluation process.

Some key points to remember: differences among raters are explainable; other educational settings outside of the classroom and community can include PE, choir, recess, lunch, etc.; and different raters can include coaches, ministers, other family members, etc.

14. What does clinically significant mean? [Minn. R. 3525.1329 Subp. 3 (A) (1)]

Test developers generally define the term “clinically significant” for application to their instruments. For the BASC, clinical composite scores of T = 70 or above and adaptive composite scores of 30 or below are considered clinically significant.

Composite scores are useful as indices of the overall level or extent of psychopathology or adaptation and its impact on the individual (not useful for differential diagnosis)(See BASC, pp 51).

15. What is a Functional Behavioral Assessment (FBA) and how extensive does it have to be? [Minn. R. 3525.1329 Subp. 3 (8)]

Minnesota Rule 3525.0200, Subpart 3a. defines a functional behavioral assessment (FBA) as follows:

> Functional behavior assessment means a process for gathering information to maximize the efficiency of behavioral supports. An FBA includes a description of problem behaviors and the identification of events, times and situations that predict the occurrence and nonoccurrence of the behavior. An FBA also identifies the antecedents, consequences, and reinforcers that maintain the behavior, the possible functions of the behavior, and possible positive alternative behaviors. An FBA includes a variety of data collection methods and sources that facilitate the development of hypotheses and summary statements regarding behavioral patterns.

There is no requirement addressing the length of a FBA. In the process of developing its evaluation plan, the IEP Team uses professional judgment in determining the adequacy of the FBA plan to meet the presenting problems and individual needs of the student being evaluated.

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