

**RECOGNIZING
MENTAL DISORDERS
AND COGNITIVE DEFICITS**

**National Seminar for Federal Defenders
Omaha, Nebraska
May 27-29, 2015**

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I. Meet your ethical and professional obligations to identify and assess each client's mental status and cognitive abilities

A. Model Rules of Professional Conduct

Rule 1.4(b): “A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.”

“Ordinarily, the information to be provided is that appropriate for a client who is a comprehending and responsible adult. However, fully informing the client according to this standard may be impracticable, for example, where the client is a child or suffers from diminished capacity.” Comment 6.

Rule 1.14, Client With Diminished Capacity: “When a client’s ability to make adequately considered decisions in connection with the representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.”

The Commentary notes that when a client suffers from diminished mental capacity, it may not be possible to maintain ordinary attorney-client relationship in all respects. Comment 1.

“Disclosure of the client’s diminished capacity could adversely affect the client’s interest. For example, raising the question of diminished capacity could, in some circumstances, lead to proceedings for involuntary commitment. . . . The lawyer’s position in such cases is an unavoidably difficult one.” Comment 8.

B. Case law

Obligation to investigate “Mental Deficiency”: “[C]ounsel has a duty to make reasonable investigations or to make a reasonable decision that makes particular investigations unnecessary.” *Strickland v. Washington*, 466 U.S. 668, 690-91(1984). Failure to investigate a mental deficiency renders counsel’s assistance ineffective where there is reason to believe the defendant suffers from some mental deficiency, *see Moore v. Johnson*, 194 F.3d 586, 616-17 (5th Cir. 1999), or where there is otherwise reason to believe mental deficiency is an important defense. *See Mauldin v. Wainwright*, 723 F.2d 799, 800 (11th Cir. 1984).

Special role of defense counsel: Because a defendant typically makes only a limited appearance before the court, defense counsel is “the sole hope” that a

mental deficiency will be brought to the attention of the court. *Bouchillon v. Collins*, 907 F.2d 589, 597 (5th Cir. 1990).

Extra solicitude required in client interactions: Particular solicitude may be required during client discussions with clients who have diminished mental states. *Shelton v. United States*, 2010 U.S. App. LEXIS 10273 (6th Cir. 2010) (Cole, dissenting)

II. Define your client's abilities and limitations

- A. **Mental illness:** Mental illness refers to a person's emotions, moods, and thought processes. Mental illness can develop at any time during life and has nothing to do with intellectual skills. It can be temporary. It can be curable. Mental illness is identified and treated by psychiatrists and psychologists.
- B. **Intellectual disability:** Intellectual disability refers to a below average ability to learn and process information. It is a developmental disorder and has its onset before the age of 18. A person with an intellectual disability has an IQ < 70-75 and delayed adaptive skills (e.g., caring for oneself, community use, social skills, self-direction, functional academics). Intellectual disability is a lifelong disability and is not curable. It is identified and treated by psychologists, educators, and vocational specialists. Mental illness and intellectual disability can co-occur in a person.

III. Recognize the probabilities

- A. **Mental illness:** There is an 11% rate of mental illness in the general adult U.S. population. In the prison population, this rate jumps to roughly 55%. The highest rate is seen in local jails, with a prevalence rate of 64%. State prisons have a 56% rate, while federal prisons have a 45% rate. *See* Bureau of Justice Statistics Special Report: Mental Health Problems of Prison and Jail Inmates, 2006, U.S. Department of Justice, Office of Justice Programs.
- B. **Intellectual disability:** There is a 3% rate of intellectual disability in the general adult U.S. population. In the prison population, this rate jumps to roughly 10%. *See* People with Intellectual Disabilities in the Criminal Justice System: Victims & Suspects, The ARC, 2009.

IV. Act on early indicators associated with mental illness and intellectual disability

- A. Mental illness:** There are many factors that are associated with mental illness. Some of these factors are family history of mental health diagnoses, a history of drug and alcohol abuse, prior hospitalizations, history of suicide attempts, homelessness, multiple incarcerations, history of psychotropic medications (see list), special education placement in behavior programs, history of foster care or other out of home placements, history of disability check, employment difficulties, history of physical, sexual, and/or emotional abuse, parent or guardian who abused alcohol, high rate of incarceration among family members.

Among the things you may observe in your interactions with your client are factors such as sad mood or rapidly changing moods, report of recent unexplained weight loss or gain, psychomotor agitation or retardation, report of sleep problems, difficulty concentrating or an inability to move from one topic to another, delusional thought, anger or irritability, loosely associated thoughts.

- B. Intellectual disability:** Some of the factors that are associated with a diagnosis of intellectual disability include special education services (life skills, comprehensive development), failure to thrive, birth trauma, premature birth, maternal use of drugs and/or alcohol during gestation, low birth weight, family history of intellectual disability, school dropout, repetition of grades, inability to keep a job, history of disability check, reliance on other people to manage money, cook, and care for medical needs.

When you are working with your client, you may notice things such as poor memory, lack of understanding of what you are saying, agreement with everything you say, repeated raising of the same questions or issues that already have been discussed, an appearance of being eager to please, an unawareness of the severity of the situation, and incorrect use of common vocabulary.

V. Gather full information to assess whether your client has a mental illness or cognitive disability

- A. Interviewing the family:** When interviewing a client's family to assess whether or not your client may have a mental illness or an intellectual disability, there are several areas that should be covered (see Family Interview). When speaking with a family member, keep in mind that if your client does in fact have a psychiatric issue, his family may not be aware of it or may be reluctant to acknowledge his limitations. Additionally, family members may suffer from some of the same limitations as your client.

- B. Interviewing your client:** When conducting an interview with your client, there are several tools that may prove useful (see Client Interview). As you interview, attend to how your client expresses himself, whether or not he is able to read and write, and how he understands what you are saying to him. Also keep in mind that many people with intellectual disability are eager to please and may give the answers they think you want to hear. They have a lifetime of covering inadequacies and hiding deficits, so be aware of this.
- C. Looking at school records:** There are often early indicators of issues in a client's school records. Don't assume that a general request for school records will get you everything you need. Special education records and school-related psychological and psychiatric records may need to be requested separately from traditional school grade records. When reviewing your client's scholastic history, look at standardized group achievement scores, grades, anecdotal notes from teachers, retentions, and "passing on extenuating circumstances." Remember that Individual Education Plans (IEPs) are written in "educationese." Much information can be gleaned from these documents, but you have to have someone who is familiar with the codes and abbreviations.
- D. Reviewing medical and disability records:** Medical records can be a rich source of information about your client. Often you will find anecdotal notes that provide valuable insight into what was happening in your client's life at the time. Check for referrals to specialists and for repeated medical visits. Hospital records often include information on mental status, family factors, and recommended services. Make sure you have someone who can read and interpret medical records.

SSI disability records also provide a wealth of data. Applications for disability include in-depth questions about daily functioning and independent living skills, and often include input from your client's caregivers. Your client may not be able to remember the issues that prompted his application for disability, but the paperwork provides strong support for his functional status at that time. All of this information can be used to help build the historical support for your client's defense.

VI. Incorporate your client's mental abilities into legal strategies

- A. Competency hearing:** At any time after the commencement of a prosecution and prior to sentencing, you may move for a hearing to determine mental competency. A client may be incompetent if suffering from "a mental disease or defect" rendering him "unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense." 18 U.S.C. §4241(a).

Weigh the costs and benefits of a finding of incompetence, which could result in long-term prison hospitalization of your client. See 18 U.S.C. §4241(d) and §4246.

For a thoughtful analysis of the distinct competency issues faced with clients who have mental retardation (as opposed to mental illness), see *United States v. Duhon*, 104 F.Supp.2d 663 (W.D. Louis. 2000) (finding defendant with m.r. to be incompetent, despite “successful” participation in a prison competency restoration group)

- B. Juvenile transfer to adult status for federal prosecution:** Mental disability and cognitive limitations impact several of the six factors which a district court considers to determine whether a transfer to adult status for federal prosecution is in the interest of justice. The six factors include (1) the age and social background of the juvenile; (2) the nature of the alleged offense; (3) the extent and nature of the juvenile’s prior delinquency record; (4) the present intellectual and psychological development and maturity of the juvenile; (5) the nature and past treatment efforts and the effect of such efforts; and (6) the availability of programs to treat the juvenile’s behavioral problems. 18 U.S.C. § 5032.
- C. Detention and bond considerations:** At a detention hearing, the court must consider both the nature and circumstances of the offense charged, 18 USC § 3142(g)(1), and the history and characteristics of your client, including mental condition, § 3142(g)(3).
- D. Waivers and suppression issues:** Consider whether your client’s cognitive differences prevented him from knowingly and intelligently understanding the police, validly consenting to search, or validly waiving his rights.

Compelling empirical data and legal analysis suggest that (1) *Miranda* warnings are essentially meaningless to people with mental retardation, and (2) current constitutional doctrines under *Miranda* does not effectively ensure the validity of confessions or waivers, by mentally retarded persons. Morgan Cloud, George B. Shepherd, Alison Nodvin Barkoff and Justin V. Shur, *Words Without Meaning: The Constitution, Confessions, and Mentally Retarded Suspects*, 69 U.Chi.L.Rev. 495 (2002).

To succeed with a claim that your client did not validly waive his rights, it is important for defense counsel to show the court that the police should have recognized the defendant’s cognitive limitations. See *United States v. Preston*, 751 F.3d 1008 (9th Cir. 2014) (*en banc*) (suppressing statement coerced from intellectually disabled suspect; officers knew early on that suspect had mental disability); *Garner v. Mitchell*, 557 F.3d 257 (6th Cir. 2009) (*en banc*) (taking into account that “even if Garner’s mental capacity, background, age, and experience did somehow prevent him from actually understanding the *Miranda*

warnings. . . the officers questioning Garner had no way to discern the misunderstanding in Garner’s mind.”)

A key concern about the voluntariness of a confession is “the intelligence, mental state, or any other factors possessed by the defendant that might make him particularly suggestible, and susceptible to having his will overborne.” *Wilson v. Lawrence County, MO*, 260 F.3d 946 (8th Cir. 2001), *see also*, *Colorado v. Connelly*, 479 U.S. 157, 165 (1986) (mental condition relevant to susceptibility to police coercion). Legal principles regarding voluntariness of confessions have particular application where the individual interrogated has unusually low intelligence. *United States v. Preston*, 751 F.3d 1008 (9th Cir. 2014) (*en banc*)

One tool that may be useful is Thomas Grisso’s *Instrument for Assessing Understanding & Appreciation of MIRANDA Rights* (1998). This test is designed to help mental health professionals assess clients’ capacities to understand and appreciate the significance of their Miranda rights. There are four components of the instrument: Comprehension of Miranda Rights; Comprehension of Miranda Rights – Recognition; Comprehension of Miranda Vocabulary; Function of Rights in Interrogation. The instrument is used to assess a defendant’s capacity to understand what they are being told when the warnings are given to them (Comprehension) as well as the defendant’s grasp of why the Miranda rights are important (Appreciation). *But see Garner v. Mitchell*, 557 F.3d 257 (6th Cir. 2009) (*en banc*) (discounting the utility of the Grisso test).

- E. Plea negotiations:** Your client’s diminished cognitive abilities may prevent him from understanding complex terms of a plea agreement. *See, e.g., United States v. Thomas*, 178 Fed. Appx. 935, 937-38 (11th Cir. 2006) (district court struck *Blakely* appeal waiver provision from plea agreement because defendant with low to borderline intellectual functioning could not understand it).
- F. Trial considerations:** Your client’s mental limitations may negate mens rea requirements or may lead to other potential trial defenses. Consider whether your client’s limited cognitive abilities help support your theory of defense, and whether you need to present expert testimony at trial about your client’s condition. *See, e.g., United States v. Sandoval-Mendoza*, 472 F.3d 645 (9th 2006) (reversing conviction where district court erroneously excluded expert testimony that defendant’s brain tumor rendered defendant unusually vulnerable to inducement; this testimony was highly relevant to defendant’s entrapment defense)

Keep in mind that you must provide pretrial notice to the court and prosecution if you intend “to introduce expert evidence relating to a mental disease or defect or any other mental condition of the defendant bearing on the issue of guilt.” Fed. R. Crim. P. 12.2(b)

G. Sentencing:

1. There are no limitations on the information the Court may consider at sentencing “concerning the background, character, and conduct of a person convicted of an offense.” 18 U.S.C. § 3661.

18 USC §3553 requires the court to consider, among other factors:

- The nature and circumstances of the offense
- The history and characteristics of the offender
- The need for sentence imposed to provide just punishment
- The need for sentence imposed to provide defendant with needed educational or vocational training. . . in the most effective manner

2. Incarceration puts a person with mental retardation at risk

Unusual susceptibility to abuse by other inmates may be grounds for a downward departure. Koon v. United States, 518 U.S. 81, 111-12 (1996); see United States v. Mena, 968 F.Supp. 115 (E.D. NY 1997) (departing downward because mentally retarded defendant would be vulnerable to attack while incarcerated)

Individuals with mental retardation may be vulnerable to exploitation by others e.g., being physically and sexually abused.” DSM-IV § 319, “Associated descriptive features and mental disorders.”

3. The U.S. Sentencing Guidelines incorporate factors that may relate to client’s mental limitations:

§ 5K2.12: Coercion or duress not amounting to a complete defense can be grounds for a departure.

§ 5K2.13: Diminished capacity departure may be appropriate where the defendant had a significantly reduced mental capacity, and her reduced mental capacity contributed substantially to the commission of the offense.

See, e.g., United States v. Cockett, 330 F.3d 706 (6th Cir. 2003) (upholding downward departure based on diminished capacity, despite a jury finding of guilt); United States v. Jones, 42 Fed. Appx. 879 (7th Cir. 2002) (remanding because district court erroneously suggested that mental retardation never provides basis for §5K2.13 departure; also noting that defendant with IQ of 54 who “is subject to being used, taken advantage of, by others” provides compelling case for departure); United States v. Tipton, 572 Fed. Appx. 743 (11th Cir. 2014) (upholding 94 month

variance based upon defendant's cognitive disorder and passive/dependent personality); *compare with United States v. Brewer*, 520 F.3d 367 (4th Cir. 2008) (finding that defendant's well-documented mental retardation resulted in diminished capacity and may have caused him to engage in the instant criminal conduct, but declining to depart downward because defendant was impulsive and a follower and therefore posed a danger to society)

Even if a defendant is not eligible for a §5K2.13 departure, his mental deficits may still remove his case from the heartland of cases and qualify for a downward departure. *See United States v. Allen*, 250 F.Supp.2d 317 (S.D. NY 2003) (granting departure in drug and gun case)

4. The United States Supreme Court recognizes that mental retardation reduces personal culpability:

“Mentally retarded persons. . . have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others. . . often act on impulse rather than pursuant to a premeditated plan, and . . . are followers rather than leaders. Their deficiencies do not warrant an exemption from criminal sanctions, but they do diminish their personal culpability.” *Atkins v. Virginia*, 122 S.Ct. 2242 (2002); *Penry v. Lynaugh*, 492 U.S. 302, 322 (1989) (O’Connor, J., concurring) (mental retardation may render a defendant less morally culpable than defendants who have no such excuse).

VII. Interact thoughtfully with your client

It is important to discuss intellectual disability and mental illness with your client before you go into the courtroom to discuss it. Even if you are merely requesting funds to hire an expert or conduct an evaluation, make sure that you have discussed this with your client too. Remember that this may be the first time your client has heard that she may show signs of mental illness or an intellectual disability.

It is easier for a client to hear that she functions in the range of intellectual disability or that she has schizophrenia than that she is intellectually disabled or a schizophrenic. Emphasize that having a psychiatric diagnosis doesn't mean that she can't function, just that she may need extra supports to be successful.

A client with a mental disability may not be able to discuss the case with you the same way as other clients. Your client may say what he thinks you want to hear. He may have difficulty describing details and facts.

You must talk with your client in a way he can understand. Do not make assumptions about what your client knows. Ask open-ended questions and have your client explain things that might otherwise be obvious. Be willing to speak slowly and use simple sentences if needed. Do not move from one topic to the next until you are certain that he understands. Use visual aids if needed. Make sure your client understands that you know the disability is not his fault and that he does not need to cover up for you.

You may need to seek special accommodations in the courtroom to ensure that your client understands the proceedings despite his limitations. For example, you may ask the court to use simple words and phrases instead of complicated legal terms. In hearings involving witness testimony, you may need to request in advance for frequent breaks to review the proceedings with your client.

VIII. Recognize your own limitations

You are in a unique position to raise questions about your client's mental status. Given the rates of mental disorders and cognitive deficits in the population we serve, it is likely that you will encounter these issues on a frequent basis.

Familiarize yourself with the DSM. Get to know the experts in your area, and seek out their expertise when you see the indicators set out in this outline and in the DSM. Psychologists assess for intellectual disability as well as mental disorders, but not all psychologists are knowledgeable in both areas. Psychiatrists deal with mental health issues from a more medical perspective.

Don't be overwhelmed by your client's deficits. Know the warning signs, ask the important questions, pay attention to your intuitions, and have working relationships with the experts in your area who can assess and help your client.

ATTACHMENTS

SAMPLE FAMILY INTERVIEW

Client: _____ Interviewer: _____

Facility: _____ Interviewee: _____

Date: _____

How are you related to my client? How long have you known him?

Do you know anything about the pregnancy? Was there prenatal care? Did his mother use drugs, alcohol, or cigarettes? Was there any illness or accident?

Was he born on time or early? How much did he weigh? How long was he in the hospital? What were his APGAR scores?

Are there any family members with special needs? Did his parents and siblings graduate from high school? What do they do now?

How old was he when he started walking _____ (8-16 months)?
Talking _____ (12-24 months)? Toilet training _____ (24-36 months)?

How was his behavior as a small child? How did he tell you what he wanted?

Tell me about his friendships when he was a child? Were his playmates older, younger, or about the same age? Did he get into frequent fights?

How did he do in school? Has he ever repeated a grade? Was he suspended or zero tolerated out of school? Did he graduate?

Was he in special education? What kind of class?

What kinds of grades did he make? What did his teachers say about him?

Has he ever had a job? How long did he keep it? How did he do there?

I am going to list some things and I want you to tell me if they are easy or hard for him to do:

looking up and/or remembering a phone number

writing a check

shopping for groceries

making change

telling time on a clock with hands

naming the days of the week

paying attention to what people are saying

reading a bus schedule

following a recipe

reading

washing clothes

SAMPLE CLIENT INTERVIEW

Client: _____ Interviewer: _____

Facility: _____ Date: _____

When and where were you born?

Do you know anything about your mother's pregnancy or about your birth?

What kind of kid were you? Did you get in trouble a lot or did you stay out of trouble?

Who did you live with when you were growing up?

Who do you live with now?

Tell me about your parents and your siblings. What do they do?

How about the rest of your family – grandparents, cousins, aunts. Are they in good health? Do they have any problems? Have they ever been in a hospital?

Where did you go to school? Did you repeat a grade?

Did you have special ed classes? What kind?

What is the highest grade you finished?

How was your behavior when you were in school? Did you get in trouble?

Do you remember learning to read and write? Was it easy or hard?

Do you like to read now? What do you read?

How is your health? Do you take medicine? Have you ever taken medicine every day?

Do you see and hear well?

Have you ever been in the hospital? Have you ever been in an accident or had a head injury?

Have you ever seen a psychologist or a psychiatrist? What did he tell you?

Have you ever had a job? What kind of job would you like to do?

Do you have a driver's license?

Do you have a group of friends? What do you like to do for fun?

How is your mood? Are you usually happy or sad? Do you get angry easily or does it take a lot to get you upset?

Tell me three things about yourself that you are proud of.

Tell me three things about yourself that you wish you could change.

I'm going to list some things and I want you to tell me if they are easy or hard for you to do:

looking up and/or remembering a phone number

writing a check

shopping for groceries

making change

telling time on a clock with hands

naming the days of the week

paying attention to what people are saying

reading a bus schedule

following a recipe

reading

washing clothes

COMMON PSYCHOTROPIC MEDICATIONS

Abilify	Fluphenazine	Seroquel
Adderall	Fluoxetine	Sertraline
Amitriptyline	Fluvoxemine	Stelazine
Anafranil	Focalin	Strattera
Aricept	Gabapentin	Symbyax
Aripiprazole	Galantamine HBR	Tegretol
Ativan	Geodon	Temazepam
Atarax	Guanfacine	Tenex
Atomoxetine	Haldon	Thiothixene
Benzotropine	Haloperidol	Thorazine
Bupropion	Keppra	Topamax
Buspar	Klonopin	Topiramate
Buspiron	Lamictal	Trazodone
Carbamazepine	Levetiracetam	Trifluoperazine HCL
Catapres	Lexapro	Trileptal
Celexa	Lithium	Valium
Chlorpromazine	Lorazepam	Valproic Acid
Citalopram	Lunesta	Venlafaxine
Clomipramine	Luvox	Vyvanse
Clonidine	Lyrica	Wellbutrin
Clonazepam	Memantine	Venlafaxine
Clozaril	Metadate	Xanax
Clozapine	Methylphenidate	Ziprasidone
Cogentin	Mirtazapine	Zoloft
Concerta	Modafinil	Zolpidem
Cymbalta	Namenda	Zyprexa
Cytomel	Navane	
Depakene	Neurontin	
Depakote	Nortriptyline	
Deplin	Olanzapine	
Desyrel	Oxcarbazepine	
Dexamethylphenidate	Paxil	
Dextroamphetamine	Paroxetine	
Diazepam	Phenobarbital	
Dilantin	Provigil	
Divalproex	Prozac	
Donepezil	Quetiapine Fumarate	
Doxepin	Razadyne ER	
Duloxetine	Remeron	
Effexor	Requip	
Elavil	Restoril	
Escitalopram	Risperdal	
Eskalith	Risperidone	
Exelon	Ritalin	

SPECIAL EDUCATION PRIMER

Public Law 94-142 (1975) seeks “...to assure that all handicapped children have available to them...a free appropriate public education.” In the United States in 2009-2010, there were 6,480,540 students between the ages of 3 and 22 receiving special education services. (National Center for Education Statistics – www.nces.ed.gov)

Disability Category	Definition	% of special ed population
Autism	Disturbance in ability to: <ul style="list-style-type: none"> ⤴ relate to people ⤴ communicate with meaning through language ⤴ respond to sensory stimuli ⤴ adapt readily to change 	6%
Deaf/Blindness	Concomitant hearing and visual impairments, the combination of which causes severe communication and other developmental and educational needs	<1%
Developmental Delay	Delay in one or more of the following areas in students ages 3 through 9: <ul style="list-style-type: none"> ⤴ cognition ⤴ socialization ⤴ adaptive functioning ⤴ communication ⤴ motor skills 	6%
Emotional Disturbance	School-related emotional problems that impact interpersonal relationships. Examples include withdrawal, depression, anxiety, low self-esteem, and somatic complaints	6%
Hearing Impairment	An impairment in hearing (not deafness), whether permanent or fluctuating, that adversely affects a child's educational performance	1%
Intellectual Disability	Significant deficits in both cognitive skills and adaptive functioning	7%
Learning Disability	Average to above average cognitive skills with severe academic and processing deficits	37%
Language or Speech Impairment	Deficits in communication skills, either in articulation or meaningful speech	22%
	More than one disability, with the combined	

Multiple Disabilities	effect creating more needs than can be met by a single program	2%
Orthopedic Impairment	A severe orthopedic impairment that adversely affects a child's educational performance (e.g., cerebral palsy)	1%
Other Health Impairment	Limited strength, vitality or alertness, with respect to the educational environment, that is due to chronic or acute health problems (e.g., diabetes, ADHD, asthma)	11%
Traumatic Brain Injury	An acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both	<1%
Visual Impairment	Impairment in vision, including blindness and partial sight, that, even with correction, adversely affects a child's educational performance	<1%

SPECIAL EDUCATION VOCABULARY

504 Plan – a plan based on the Americans with Disabilities Act which specifies that no one with a disability can be excluded from participating in federally funded programs or activities – includes “physical or mental impairment which substantially limits one or more major life activities” - the plan spells out the modifications and accommodations that are needed for students to perform at the same level as their peers

BIP – Behavior Intervention Plan – a plan developed to address specific behaviors that are not conducive to the learning environment – should be developed for all students when there are behavioral concerns

ELL/ESL – English Language Learners/English as a Second Language – those students for whom English is not the first language and who require additional support in the school setting in order to learn

FAPE – Free appropriate public education – guaranteed to every student

IEP – Individual Educational Plan – a legally binding document that is prepared by a group including the student's parent, teacher, administrator, evaluation expert, and, depending on age, the student

Inclusion – the theory of providing the special modifications and supports that are detailed in the IEP in the regular classroom setting rather than in a pull-out classroom so that all students can access their least restrictive environment

LEA – Local Educational Agency - a public board of education or other public authority legally constituted within a State for either administrative control of or direction of, or to perform service functions for, public elementary or secondary schools

LRE – Least Restrictive Environment – to the maximum extent appropriate, children with disabilities are educated with their typically developing peers

Manifestation Determination – an IEP process to determine if a student's behavior problem was or was not a manifestation of the student's disability

RTI – Response to Intervention – an educational method used to prevent academic failure through early intervention, frequent progress monitoring, and progressively intensive research-based interventions for children who continue to have difficulty

S-Team – Support Team, Student Support Team – a school-based decision making team that identifies strategies for making regular education accommodations for students who are in need of support – may or may not lead to a special education evaluation

Transition – a coordinated set of services that helps students move from school to the adult world