

XXXII. CHILDREN WITH SPECIAL NEEDS

- A. **Code Sections: O.C.G.A. §15-11-149, §15-11-150 et seq., §20-2-130 et seq., §20-2-150 et seq., Chapters 2-7 of Title 37**
- B. **Uniform Juvenile Court Rules: 20.1, 20.2, 20.3**
- C. **Related Benchbook Chapters: XIII (Mental Health Commitment Hearings), XXVII (Mental Competency Proceedings)**
- D. **Federal Laws: American with Disabilities Act (42 U.S.C. §12101), Individuals with Disabilities Education Act (20 U.S.C. § 1400), Rehabilitation Act of 1973/Section 504 (29 U.S.C. § 790)**
- E. **Definitions**
 - 1. “Disability” - mental or emotional illness, mental retardation, or other neurologically disabling conditions which require treatment similar to that for the mentally retarded including epilepsy, cerebral palsy, and autism, or the abuse of, addiction to, or dependence upon alcohol, narcotics, or other drugs. O.C.G.A. §37-2-2(4).
 - 2. "Disability services" means services to the disabled or services which are designed to prevent or ameliorate the effect of a disability. O.C.G.A. §37-2-2(4.1).
 - 3. “Mentally Ill” - having a disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life. O.C.G.A. §37-3-1(11).
 - 4. “Mental Retardation” - a state of significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and originating in the developmental period. O.C.G.A. §37-4-2(11), 37-5-3(3), 37-6-1(3).
 - 5. “Mentally Retarded Individual” - a person whose ability to care for himself is substantially impaired by mental retardation or by a neurological dysfunction associated with mental retardation. O.C.G.A. §37-5-3(2), 37-6-1(2), 37-4-2(12).
 - 6. “Alcoholic” - a person who habitually lacks self-control as to the use of alcoholic beverages or who uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted. O.C.G.A. §37-7-1(1).

7. “Drug Dependent Individual” - a person who habitually lacks self-control as to the use of hallucinogens, or any drug, dangerous drug, narcotic drug, marijuana, or controlled substance, as defined in Article 2 or Article 3 of Chapter 13 of Title 16 or Chapter 3 of Title 26; or a person who uses such drugs to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted.
O.C.G.A. §37-7-1(8).

F. **Common Mental Disorders in Youth**¹

1. **Behavior Disorders/Emotional Disturbances:**

Many terms are used interchangeably to classify children who exhibit extreme or unacceptable chronic behavior problems. These children lag behind their age-mates in social development and are often isolated from others either because they withdraw from social contact or because they behave in an aggressive, hostile manner. Behavior disorders result from persistent negative social interactions between the child and the environment. Behavior disorders generally include conduct disorders, oppositional-defiant disorder, antisocial personality disorder, anxiety-withdrawal, immaturity, and socialized aggression. Many children with behavior disorders may have co-existing conditions such as mood disorders, anxiety, PTSD, substance abuse, ADHD, learning problems, or thought disorders which are likely to have ongoing problems without treatment.

- a. Oppositional-defiant disorder (ODD)- *A disorder of early or middle childhood that may evolve into a conduct disorder* usually diagnosed before the age of twelve. Children with oppositional defiant disorder are characterized by behavior patterns (such as frequent temper tantrums; demanding; excessive arguing with adults; active defiance and refusal to comply with adult requests/rules; deliberate attempts to annoy or upset people; blaming others for their mistakes or misbehavior; often being “touchy” or easily annoyed by others; frequent anger/resentment; mean and hateful talking when upset; and seeking revenge). *Appears to be acting like a three-year old child.
- b. Conduct disorder (CD)- A persistent pattern of behavior that involves violation of the rights of others:
 - i. Aggression to people and animals- bullies; threatens; or intimidates others; often initiates physical fights; has used a weapon that could cause serious physical harm; is physically cruel to people and animals; steals from a victim while confronting them (assault); and forces someone into sexual activity.

¹ Reprinted from TherapistFinder.net

- ii. Destruction of Property- deliberately sets fires to cause damage; and deliberately destroys other's property.
- iii. Deceitfulness, lying, or stealing- has broken into someone else's house or car; lies to obtain goods, or favors to avoid obligation; steals items without confronting victim (shoplifts, but without breaking and entering).
- iv. Serious violations of rules- often stays out at night despite parental objections; runs away from home; often truant from school.

2. Developmental Disorders:

Serious delays in the development of one or more areas of cognitive functioning.

- a. Attention-deficit/hyperactivity disorders (ADHD)- An attention-deficit disorder is a developmental disorder characterized by significant inattention, impulsiveness, and hyperactivity.
- b. Autism- a disability that impacts the normal development of the brain in the areas of social interaction, communication skills, and leisure or play activities. In some cases, aggressive and/or self-injurious behavior may be present. Other symptoms include:
 - i. Impaired ability to make friends with peers.
 - ii. Impaired ability to initiate or sustain a conversation with others.
 - iii. Repetitive or unusual use of language.
 - iv. Inflexible adherence to specific routines or rituals.
 - v. Preoccupation with parts of objects.
 - vi. Impairment of social play.

3. Dissociative disorders:

Normal consciousness or identity is split or altered; often a result of an intense psychological trauma.

- a. Post-traumatic stress disorders (PTSD)- A dissociative disorder in which symptoms develop following a psychologically distressing event that is outside the normal range of human experiences (military combat, sexual assault, natural disasters, severe auto accidents). The essential features of PTSD include increased arousal, re-experiencing of a traumatic event, and avoidance of stimuli associated with the traumatic event. *The symptoms include continued flashbacks, nightmares, and intense distress when exposed to an object or situation that is related to the traumatic event.*
- b. Multiple personality disorder- a rare dissociative disorder marked by the appearance, within one person, of two or more distinct personalities, each with its own name, history, and traits. The

alternative personalities are usually fully integrated with consistent patterns of behavior and attitudes.

4. **Mood disorders:**

- a. Bipolar disorder/manic depression- A serious mood disorder which involves extreme mood swings or highs (mania) and lows (depression); sometimes termed manic-depressive psychosis.
- b. Depression- A mood disorder involving disturbances in emotion (excessive sadness), behavior (apathy and loss of interest in usual activities), cognition (distorted thoughts of hopelessness and low self-esteem), and bodily function (fatigue, loss of appetite). Symptoms extend into many parts of an individual's life and include lack of interest in daily activities, decreased motivation, feelings of worthlessness, and sometimes-suicidal thoughts.

5. **Personality disorders:**

- a. Antisocial personality- A personality disorder characterized by a long-standing pattern of disregard for other people's rights, often crossing the line and violating those rights. This pattern of behavior has occurred since age 15 (usually only adults 18 years or older can be diagnosed with this disorder). Symptoms include:
 - i. Failure to conform to social norms- has repeatedly been in trouble with the law.
 - ii. Deceitfulness- repeatedly lies or cons others for personal gain or pleasure.
 - iii. Impulsivity- failure to plan ahead.
 - iv. Irritability and aggressiveness- repeatedly involved in physical fights or assaults.
 - v. Reckless disregard for safety of self or others.
 - vi. Consistent irresponsibility- indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
 - vii. Lack of remorse- indifferent or rationalizes having hurt, mistreated, or stolen from another.
- b. Borderline personality disorder- A highly unstable personality style characterized by intense personal relationship problems. Individuals with borderline personality often suffer from depression, anxiety, and the fear of being abandoned. Symptoms include:
 - i. Frantic efforts to avoid real or imagined abandonment.
 - ii. A pattern of unstable interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

- iii. Identity disturbance: unstable self-image.
- iv. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
- v. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
- vi. Effective instability due to a marked reactivity of mood (e.g., intense irritability, or anxiety usually lasting a few hours and rarely more than a few days).
- vii. Chronic feelings of emptiness.
- viii. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

6. **Miscellaneous Disorders:**

- a. Separation Anxiety Disorder- Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the youth is attached, as evidenced by anxiety associated with the separation from attachment figures; Nightmares with themes of separation; chronic complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation is anticipated.
- b. Schizophrenia- A psychotic disorder characterized by severe problems with a patient's thoughts, feelings, behavior, and use of words or language. Psychotic symptoms often include delusions and /or hallucinations. These delusions are often paranoid and persecutory in nature. Hallucinations are usually auditory and may include hearing voices speaking in the third person, as well as to each other, commenting on the patient's actions. Schizophrenia *does not mean* "split personality." Instead, the patient experiences a "split" or loss of contact with reality.

G. Mental Health Diagnoses and Corresponding Medications

PSYCHOTHERAPEUTIC DRUGS

Antidepressants Medications:

- 1. Tricyclics and Tetracyclics- These are considered to be the classic antidepressant drugs; they are also effective for other disorders, including: *anxiety disorders, post-traumatic stress disorder (PTSD)*, obsessive compulsive disorder, eating disorders, and others.

Some of the generic names follow (trade names in parenthesis):

amitriptyline (Elavil, Endep, Enden, Tryptizol)
 amitriptyline + (perphenazine, Etrafon, Triavil)

amoxapine (Asendin)
clomipramine (Anafranil)
desipramine (Norpramine, Pertofrane)
dothiepin (Prothiaden)
doxepin (Adapin, Sinequan)
imipramine (Tofranil, Janimine)
lofepramine
maprotiline (Ludiomil)
nortriptyline (Pamelor, Ventyl, Aventyl)
protriptyline hydro-chloride (Vivactil)
trimipramine (Surmontil)

2. Monoamine Oxidase Inhibitors (MAOI's)- These drugs are equal in efficacy of other antidepressant drugs, but are currently used less frequently because of the interactions with other medications. They are used as an alternative for patients who do not respond to the tricyclics and tetracyclics. In addition to depression, *MAOI's are used to treat bipolar disorder, posttraumatic disorder (PTSD), and other disorders.*

brofaromine
chlorgyline
isocarboxazid (Marplan)
moclobemide (Aurorix)
pargyline (Eutonyl)
phenelzine (Nardil)
selegeline (Eldepryl)
tranylcypromine (Parnate)

3. Serotonin-specific Reuptake Inhibitors (SSRI's)- *These drugs are the most widely used antidepressant drugs.* They are effective for many disorders, including: bipolar I disorder, panic disorder, borderline personality disorder, eating disorders, and others.

citalopram
fluoxetine (Prozac-most widely prescribed antidepressant because it has fewer side effects)
fluvoxamine (Luvox)
paroxetine (Paxil)
sertraline (Zoloft)
serzone

4. Miscellaneous antidepressants-

bupropion (Wellbutrin)
dextroamphetamine (Dexedrine)
liothyronine (Cytomel)

L-tryptophan
lithium (Eskalith, Lithane, Cibalith-S, Lithobid, Lithonate, Lithotabs-these work in conjunction with antidepressants)
methylphenidate (Ritalin)
nefazodone
pemoline (Cylert)
pindolol (Visken)
thyroxine (Levoxine, Levothroid, Synthroid-these work in conjunction with antidepressants)
trazadone (Desyrel)
venlafaxine (Effexor)

Antianxiety Medications (Anxiolytics):

The medicines in this group, formerly called the “minor tranquilizers,” are primarily used in the treatment of anxiety; they are also used for other disorders, such as *depression, bipolar I disorder, and substance withdrawal.*

Alprazolam (Xanax)
Atenolol (Tenormin)
buspirone (BuSpar)
chlordiazepoxide (Librium, Libritabs, Lipoxide)
clonazepam (Klonopin)
clonidine (Catapres)
clorazepate (Tranxene)
diazepam (Valium, Valrelease, Zetran)
estazolam (ProSom)
ethyl alcohol (Alcohol, Ethanol)
flunitrazepam (Rohypnol)
flurazepam (Dalmane)
halazepam (Paxipam)
hydroxyzine hydro-chloride (Atarax)
hydroxyzine pamoate (Vistaril)
lorazepam (Ativan, Alzapam)
benactyzine (Deprol)
metoprolol (Lopressor)
naldolol (Corgard)
oxazepam (Serax)
prazepam (Centrax)
propranolol (Inderal)
quazepam (Doral)
temazepam (Restoril)
triazolam (Halcion)
zolpidem (Ambien)

Antipsychotic Medications:

These drugs, formerly known as the “major tranquilizers,” are used in the treatment of patients who are severely agitated and violent. They are used for a variety of disorders, including: *schizophrenia, manic episodes, and major depressive disorders with psychotic features.*

Dopamine-blockers

acetophenazine (Tindal)
butaperazine
carphenazine
chlorpromazine (Thorazine)
chlorprothixene (Taractan)
droperidol (Inapsine)
flupenthixol
fluphenazine (Prolixin, Permitil)
haloperidol (Haldol)
loxapine (loxitane)
mesoridazine (Serentil)
molindone (Moban, Lidone)
perphenazine (Trilafon)
pimozide (Orap)
piperacetazine
prochlorperazine (Compazine)
promazine (Sparine)
remoxipride
risperidone (Risperdal)
thioridazine (Mellaril)
thiothixene (Navane)
trifluoperazine (Stelazine)
triflupromazine (Vesprin)
zuchopenthixol

Other antipsychotic drugs

carbamazepine (Tegretol)
chlormethiazile
clozapine (Clozaril)
fluspirilene
lithium (Eskalith)
raclopride
respirine (Serpasil)
sulpiride
valproate (Depakene)

Antimanic Medications:

These drugs are used primarily for mood stabilization.

diltiazem (Cardizem)
nifedipine (Adalat, Procardia)
nimodipine (Nimotop)
verapamil (Calan, Isoptin)
lithium carbonate (Cibalith-S, Camcolt, Priadel, Liskonum)

Medications used for Attention Deficit Disorder/Hyperactivity (ADHD):

amphetamine (Benzedrine)
clonidine hydro-chloride (Catapres)
desipramine hydro-chloride (Norpramin, Pertofrane)
dextroamphetamine (Dexedrine)
imipramine hydro-chloride (Tofranil, Janimine)
methylphenidate (Ritalin)
pemoline (Cylert)

H. Questions a Judge Can Ask to Determine Whether a Child Before the Court Has Special Needs²

1. Has the child been attending school regularly?
2. Did the child receive special education and related services while in school?

Special Education Services Include:

Individualized academic instruction
Anger management and conflict resolution skills training
Work readiness skills or work experience
Independent living skills training

Related Services Include:

Speech-language pathology and audiology
Physical and Occupational Therapy
Recreation, including therapeutic recreation
Psychological Services
Social Work Services
Counseling, including rehabilitation counseling
Orientation and mobility Services
Medical Services for diagnostic and evaluation purposes
Early identification and assessment

3. Is there an Individualized Education Program in place for the child? If so, is it being followed? Should it be reviewed?
4. Is the child currently being prescribed medication? If so, then what is it and what is it being prescribed for? When was the child's last medical exam and is the medication being monitored? What are the consequences of no medication?

I. Reasonable Accommodations³

A Court can make certain reasonable accommodations to help a child with a disability successfully accomplish a court appearance.

When deciding what accommodations are necessary, a judge should consider the following:

1. The characteristics of the disability
2. How the disability impacts typical functioning for the child
3. Whether the delinquent behavior relates to the presence of the disability or to side effects of the medication

² Snyder Consultations; Marlene Snyder, Ph.D.

³ Snyder Consultations; Marlene Snyder, Ph.D.

4. Whether the child can be appropriately served in school, in court, in the community, or in a correctional setting

Suggested accommodations:

1. Prepare the child for meetings and hearings by explaining the purpose of such and the role of each person involved
2. Integrate behavior strategies in the school IEP, and other settings such as employment and social activities
3. Where appropriate, consider restorative justice and family group conferencing
4. Avoid lectures
5. Avoid power struggles
6. Resist personalizing the child's negative behaviors
7. Call a recess when you see anger/frustration in the child escalating
8. Inquire of the child, parent, child's attorney, child's teachers, and other professionals as to the need for reasonable accommodations and specific recommendations for accommodations necessary for the child.

J. American Bar Association Standards of Practice for Lawyers Who Represent Children in Abuse and Neglect Cases

1. Developmentally Appropriate

"Developmentally appropriate" means that the child's attorney should ensure the child's ability to provide client-based directions by structuring all communications to account for the individual child's age, level of education, cultural context, and degree of language acquisition. *See Definitions, A-3.*

Commentary:

The lawyer has an obligation to explain clearly, precisely, and in terms the client can understand the meaning and consequences of action. See David A. Binder & Susan C. Price, *Legal Interviewing and Counseling: A Client-Centered Approach* (1977). A child client may not understand the legal terminology and for a variety of reasons may choose a particular course of action without fully appreciating the implications. With a child the potential for not understanding may be even greater. Therefore, the child's attorney has additional obligations based on the child's age, level of education, and degree of language acquisition. There is also the possibility that because of a particular child's developmental limitations, the lawyer may not completely understand the child's responses. Therefore, the child's attorney must learn how to ask developmentally appropriate questions and how to interpret the child's responses. See Anne Graffam Walker, *Handbook on Questioning Children: A Linguistic Perspective* (ABA Center on Children and the Law 1994). The child's attorney may work with social workers or other professionals to assess a child's developmental abilities and to facilitate communication.

2. Client Under Disability

The child's attorney should determine whether the child is "under a disability" pursuant to the Model Rules of Professional Conduct or the Model Code of Professional Responsibility with respect to each issue in which the child is called upon to direct the representation. *See General Authority and Duties, B-3.*

Commentary:

These Standards do not accept the idea that children of certain ages are "impaired," "disabled," "incompetent," or lack capacity to determine their position in litigation. Further, these Standards reject the concept that any disability must be globally determined. Rather, disability is contextual, incremental, and may be intermittent. The child's ability to contribute to a determination of his or her position is functional, depending upon the particular position and the circumstances prevailing at the time the position must be determined. Therefore, a child may be able to determine some positions in the case but not others. Similarly, a child may be able to direct the lawyer with respect to a particular issue at one time but not at another. This Standard relies on empirical knowledge about competencies with respect to both adults and children. See, e.g., Allen E. Buchanan & Dan W. Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* 217 (1989).

3. Child With Special Needs

Consistent with the child's wishes, the child's attorney should assure that a child with special needs receives appropriate services to address the physical, mental, or developmental disabilities. These services may include, but should not be limited to:

1. Special education and related services;
2. Supplemental security income (SSI) to help support needed services;
3. Therapeutic foster or group home care; and
4. Residential/in-patient and out-patient psychiatric treatment.

See Actions To Be Taken, C-5.

Commentary:

There are many services available from extra-judicial, as well as judicial, sources for children with special needs. The child's attorney should be familiar with these other services and how to assure their availability for the client. See generally, Thomas A. Jacobs, *Children & the Law: Rights & Obligations* (1995); *Legal Rights of Children* (2d ed. Donald T. Kramer, ed., 1994).

4. Client Explanation

The child's attorney should explain to the client, in a developmentally appropriate manner, what is expected to happen before, during and after each hearing. *See Hearings, D-2.*

5. Questioning A Child

The child's attorney should seek to ensure that questions to the child are phrased in a syntactically and linguistically appropriate manner. *See Hearings, D-8.*

Commentary:

The phrasing of questions should take into consideration the law and research regarding children's testimony, memory, and suggestibility. See generally, Karen Saywitz, *supra* D -7; Child Victims, Child Witnesses: Understanding and Improving Testimony (Gail S. Goodman & Bette L. Bottoms, eds. 1993); Ann Haralambie, 2 Handling Child Custody, Abuse, and Adoption Cases 24.09 24.22 (2nd ed. 1993); Myers, *supra* D-6, at Vol. 1, ch 2; Ellen Matthews & Karen Saywitz, Child Victim Witness Manual, 12/1 C.J.E.R.J. 40 (1992). The information a child gives in interviews and during testimony is often misleading because the adults have not understood how to ask children developmentally appropriate questions and how to interpret their answers properly. See Walker, *supra*, A-3 Commentary. The child's attorney must become skilled at recognizing the child's developmental limitations. It may be appropriate to present expert testimony on the issue and even to have an expert present during a young child's testimony to point out any developmentally inappropriate phrasing.

K. Types of Dispositions⁴

1. Mediation

- a. Connect consequences with actions (needs to be done immediately)
- b. Have the victim, in a non-confrontational setting, state how the offender's actions hurt them
- c. Dispense fair and logical consequences

2. Types of Restitution

- a. Societal – community service work
- b. Self – drug treatment, counseling, educational programs, recreational opportunities, require child to learn about disability, teach coping skills

3. Probation

- a. Intensive with verbal and written instructions along with appointments
- b. Collect as much information as possible (including school reports)
- c. Establish sincere rapport with child
- d. Suspend judgment (perceived blame will provoke negative behavior)

⁴ Snyder Consultations; Marlene Snyder, Ph.D.

L. Juvenile Court Code

1. Mental Health Commitment Hearings

If the juvenile court has evidence that a child under its jurisdiction is mentally ill, the court can order that the child be evaluated. See **Benchbook chapter XIII**. O.C.G.A. §15-11-149.

2. Determination of Disability

The juvenile court judge shall determine whether a child has been determined to be handicapped as defined in 20 U.S.C. §1401(a)(1) and 1401(a)(15). If there is an Individualized Education Program (IEP) as defined in 20 U.S.C. §1401 (a)(20), it shall be made a part of the dispositional hearing record. O.C.G.A. §15-11-149(b).

3. Mental Competency Hearings

The juvenile court on its own motion or on the motion of a party can order the evaluation of the child's mental condition if there is reason to believe that the child may not be mentally competent. During the evaluation, time limits for adjudication and disposition are tolled. See Benchbook chapter XXVII. O.C.G.A. §15-11-150 et seq.

4. Exclusive Jurisdiction of the Juvenile Court

The juvenile court has exclusive original jurisdiction over any proceedings brought by a local board of education pursuant to Code Section 20-2-766.1. O.C.G.A. §15-11-28.

5. Contempt Powers of Juvenile Court

The court may also use its contempt and other powers specified in Code Section 15-11-5 to enforce any order entered pursuant to Code Section 20-2-766.1. O.C.G.A. §20-2-766.1.

M. Quality Basic Education Act

1. Generally (O.C.G.A. §20-2-130 et seq.)

a. Free Public Education. Admission to public instructional programs shall be free to all eligible children who enroll in such programs within the local school system in which they reside. O.C.G.A. §20-2-133(a).

1. Exception - A local school system is authorized to charge nonresident student tuition or fees, however, a child placed by DJJ or by DHR in a DJJ or DHR facility for more than 60 continuous days, a child who is a patient in a facility licensed to deliver intermediate care for the mentally retarded for more than 60 continuous days, and a child who is in the physical custody of DJJ or DHR pursuant to a court order

granting temporary or permanent custody shall not be charged tuition or fees. O.C.G.A. §20-2-133(a).

- b. Appropriate Education. Georgia law requires that special education students be eligible for enrollment in appropriate education programs through age 21 or until they receive high school or special education diplomas or the equivalent. However, these students must have been enrolled during the preceding school year and had an approved *Individualized Education Program (IEP)* which indicated that a successive year of enrollment was needed. The State Board of Education shall have the authority to determine the eligibility of students for enrollment, unless otherwise provided by law. O.C.G.A. §20-2-150(a).
- c. Grade Placement Decisions. The State Board of Education is required by Georgia law to adopt instruments, procedures, and policies necessary to assess the first grade readiness of children enrolled in Georgia's public school kindergarten programs. Georgia law further requires that the Department of Education develop guidelines for utilization of the instruments in grade placement decisions and provide such guidelines to local school systems. The guidelines shall include information pertinent to consideration of the placement of students who have been identified as being disabled. O.C.G.A. §20-2-151(b)(2).
- d. Children in DJJ and DHR Facilities are Eligible for Education in Local School District. Any child placed by DJJ or DHR in a DJJ or DHR facility or in a facility for mental health care for more than 60 continuous days shall be treated as eligible for enrollment in the educational programs of that local unit of administration of the school district, provided that the child meets the age eligibility requirements. The local unit of administration of the school district in which these facilities are located is responsible for the provision of all educational programs, *including special education and related services*, free of charge to these children as long as the children remain in such facilities. However, placement in such a facility by the parent or by another local unit of administration shall not create such responsibility. O.C.G.A. §20-2-133(b)(1).
- e. Children in Youth Development Centers are NOT Eligible for Education in Local School District. No child in a youth development center, regardless of his or her custody status, shall be eligible for enrollment in the educational programs of the local unit of administration of the school district in which that youth development center is located. No child in the custody of the Department of Corrections or DJJ and confined in a facility as a result of a sentence imposed by a court shall be eligible for enrollment in the educational programs of the local unit of administration of the school district where such child or youth is being held. O.C.G.A. §20-2-133 (b)(2).

- f. Educational Records. When the custodian of any child notifies a local unit of administration that the child may become eligible for enrollment in the educational programs of a local unit of administration, the custodian of the records of that child shall transfer the educational records and *Individualized Education Programs (IEP's)* and all education related evaluations, assessments, social histories, and observations to the appropriate local unit of administration. The custodian of the records has the obligation to transfer these records and the local unit of administration has the right to receive, review, and utilize these records. O.C.G.A. §20-2-133 (b)(4).
- g. DJJ & DHR Educational and Medical Records. Upon the request of a local unit of administration responsible for providing educational services to a child, DJJ and DHR shall furnish to them all medical and educational records in the possession of DJJ and DHR pertaining to any such child, except where consent of a parent or legal guardian is required in order to authorize the release of any of such records, in which event the DJJ and DHR shall obtain such consent from the parent or guardian prior to such release. O.C.G.A. §20-2-133 (b)(4).

2. Education Programs (O.C.G.A. §20-2-150 et seq.)

- a. Special Education Programs. All children who are eligible for a general and career education program under Code Section 20-2-151 and who have special educational needs are also eligible for special education services under Georgia law.
 - 1. Eligibility Generally. Children from birth through four years of age, whose disabling condition is so severe as to necessitate early education intervention, may be eligible for special education services through programs operated by state schools for the handicapped, the psychoeducational program, or through programs financed with local or federal funds or with funds specifically appropriated by the General Assembly for this purpose. The state board shall adopt the criteria used to determine eligibility of students for state funded special education programs. O.C.G.A. §20-2-152(a).
 - 2. Eligibility Defined. Eligible children are defined as those who have emotional, physical, communicative, or intellectual deviations, or a combination thereof, to the degree that there is interference with school achievements or adjustments or prevention of full academic attainment and who require modifications or alterations in their educational programs. O.C.G.A. §20-2-152(a).
 - 3. Special Education Classifications. Special education shall include children who are classified as intellectually gifted, mentally disabled, behavior disordered, specific learning disabled, orthopedically disabled, other health impaired, hearing impaired, speech-language disordered,

visually impaired, severely emotionally disturbed, and deaf-blind and who have any other areas of special needs which may be identified. The State Board of Education shall adopt classification criteria for each area of special education to be served on a statewide basis as well as maximum class sizes by classification of special education. O.C.G.A. §20-2-152(a).

4. Obligation to Provide Special Education Programs. Local school systems shall provide special education programs for all eligible students with special needs who are residents of their local school systems by establishing and maintaining such educational facilities and employing such professional workers as are needed by these students. If this is not possible, the local school system shall contract with other local school systems, regional educational service agencies, or other qualified public or private institutions for such services. O.C.G.A. §20-2-152(b).

5. Funding. The State Board of Education shall provide funding that has been approved by the General Assembly for special education programs for students with disabling conditions which are either of such low incidence or of such severity that it is unfeasible or impractical to provide needed educational services through programs offered by local school systems. O.C.G.A. §20-2-152(c)(1).

For purposes of funding, the following are authorized special education categories under O.C.G.A. §20-2-152(d):

- Category I: self-contained specific learning disabled and self-contained speech-language disordered;
- Category II: mildly mentally disabled;
- Category III: behavior disordered, moderately mentally disabled, severely mentally disabled, resourced specific learning disabled, resourced speech-language disordered, self-contained hearing impaired and deaf, self-contained orthopedically disabled, and self-contained other health impaired;
- Category IV: deaf-blind, profoundly mentally disabled, visually impaired and blind, resourced hearing impaired and deaf, resourced orthopedically disabled, and resourced other health impaired;
- Category V: those special education students classified as being in Categories I through IV, as defined in this subsection whose Individualized Educational Programs specify specially designed instruction or supplementary aids or services in alternative placements, in the least restrictive environment, including the regular classroom and who

receive such services from personnel such as paraprofessionals, interpreters, job coaches, and other assistive personnel; and

- Category VI: intellectually gifted.
- b. Early Intervention Programs for Students K-5. The State Board of Education shall create and each local board of education shall provide an early intervention program to serve students in kindergarten through grade five. The early intervention program shall be designed with the intent of helping the student to perform at expectations and exit the program in the shortest possible time. Students shall be moved into this program, provided assistance, and moved out of this program upon reaching grade level performance. It is not the intent of the General Assembly that students be assigned to this program on a continuing or permanent basis. O.C.G.A. §20-2-153(a) and (d).
1. Eligibility Defined. The early intervention program shall serve students who are at risk of not reaching or maintaining academic grade level, including but not limited to students who are identified through the first grade readiness assessment and students with identified academic performance below grade levels defined by the Office of Education for any criterion-referenced assessment administered for grades one through five.
 2. Identifying Students. Local school systems shall devise a process for the identification of such students at the beginning of each school year and also during the school year as a continuous process of early identification and monitoring. School systems may use indicators such as but not limited to the student's scores on previous assessments, the student's classroom performance in the same or previous years, and other reliable indicators to identify such students. A student shall be assigned to the early intervention program as soon as is practicable after the student is identified as at risk or after the results of the first-grade readiness assessment or the criterion-referenced assessment are known. O.C.G.A. §20-2-153(b).
 3. Notice Provision. The school shall provide timely notice and an opportunity for a conference with the student and his or her parents or guardians to discuss the student's academic performance and the role of the early intervention program. O.C.G.A. §20-2-153(b).
 4. Delivery of Early Intervention Services. The State Board of Education shall describe by rules and regulations such additional services, resources, support, or strategies as may be provided by the local school system. The specifications for delivery of early intervention services shall be the responsibility of local boards of

education except that the program rules and regulations adopted by the State Board of Education shall be followed in designing the program delivery models. Delivery models may include, but are not limited to, class augmentation, pull-out or self-contained classes, and the Reading Recovery Program delivered by certified personnel. O.C.G.A. §20-2-153(c).

Remedial Education Program. All children who are eligible for a general and career education program under Code Section 20-2-151 and who are also eligible under the criteria specified in this Code section shall be provided remedial education program services needed to address their respective reading, mathematics, or writing deficiencies. This program will be administered in accordance with policies adopted by the State Board of Education. O.C.G.A. §20-2-154(a).

1. Eligibility. Students in grades nine through twelve may be eligible for remedial services if they meet two or more of the following criteria:
 - a. The student has been through the formal student support team process and has documented evidence to support the placement in remedial education;
 - b. The student has been retained in the grade;
 - c. The student is receiving services under Part A of Chapter 1 of Title 1 of the Elementary and Secondary Education Act of 1965, as amended by the Improving America's Schools Act of 1994 (Public Law 103-382);
 - d. The student has been recommended by the teacher who has documented any of the following student information:
 - (i) Low performance in the reading series system;
 - (ii) Low performance in the mathematics series; or
 - (iii) The student is unable to verbally express ideas and cannot write or dictate a meaningful sentence; or
 - e. Current test information in the student file indicates the student has a score at or below the twenty-fifth percentile; and
2. Eligible students are those in grades nine through twelve who are receiving services under the special education program as authorized by Code Section 20-2-152 and whose Individualized Education Programs (IEP's) specify that they meet the eligibility requirements specified in paragraph (1) of this subsection. In addition, their special education program must be one that is not designed to address their respective reading, mathematics, or writing deficiencies.

O.C.G.A. §20-2-154(a).

N. Treatment and Habilitation for Mental Illness

1. Adequate Mental Health Services

- a. State Policy. The State of Georgia recognizes its responsibility for its citizens who are mentally ill to meet their needs through a coordinated system of community facilities, programs, and services. It is the policy of this state to provide adequate mental health, mental retardation, substance abuse, and other disability services to all its citizens. It is the purpose of this chapter to enable and encourage the development of comprehensive, preventive, early detection, rehabilitative, and treatment disability services. O.C.G.A. §37-2-1(a)(b)(c).

2. Least Restrictive Alternative Placement

- a. State Policy. It is the policy of the state that the least restrictive alternative placement be secured for every patient at every stage of his medical treatment and care. It shall be the duty of the facility to assist the patient in securing placement in noninstitutional community facilities and programs. O.C.G.A. §37-3-161, 37-4-121.
- b. "Least Restrictive Alternative" Defined. Also known as "least restrictive environment" or "least restrictive appropriate habilitation" which is the least restrictive available alternative, environment, or appropriate habilitation, as applicable, within the limits of state funds specifically appropriated therefor. O.C.G.A. §37-4-2(10), 37-3-1(10), 37-7-1(15).

3. Examination of Minor Children. A parent or guardian of a minor child may apply to the DHR to have the child examined by the comprehensive evaluation team. If a majority of the comprehensive evaluation team concludes that the child is mentally retarded and in need of appropriate care, training, education, or specialized services other than that which he is then receiving, the team may recommend an individualized program plan for the child and the department may provide such services in accordance with such plan. The parent or guardian of a minor child admitted to a facility pursuant to subsection (a) of this Code section may request such child's discharge in writing at any time after admission. O.C.G.A. §37-4-20(a)(b).

O. Attorney General Opinions

1. Substantially Impaired Hearing Children

Local school systems in Georgia are legally obligated to provide a special education program for children whose hearing is substantially impaired. However, they are not necessarily confined to their own geographic boundaries in

so doing, but may furnish such special education services through a contract with a cooperative educational service agency. 1977 Op. Att'y Gen. No. 77-35.

2. Free Education

School-age children placed in facilities by DHR or the Department of Children and Youth Services for more than 60 continuous days must be provided with a free education by the local school system in which the facility is located. The exceptions are children in youth detention centers, those confined pursuant to a court order, or those unable to leave the facility. 1996 Op. Att'y Gen. No. 96-23; 1980 Op. Att'y Gen. No. 80-152 (constitutional guarantee of free public education extends to a child whose parents reside in Georgia); 1978 Op. Att'y Gen. No. 78-51 (a child in the legal custody of DHR is entitled to a free public education); 1981 Op. Att'y Gen. No. 81-80 (children who are in the legal custody of nonresident parents are not entitled to a free public education).

3. Special Education Services for Private School or Non-School Children

There is no statutory impediment to the providing of psychological services to private school or non-school children, provided that they are "eligible" (i.e., by reason of age and residence) to participate in a school system's general school or pre-school program. However, the degree to which such private school or non-school children are to be permitted to receive psychological is a matter of policy which addresses itself to the discretion of the state and local boards of education. 1976 Op. Att'y Gen. No. 76-118.

4. Authority of Juvenile Courts to Compel Services for Handicapped Children

There is no authority under federal or state law that authorizes a juvenile court to compel a local school system or a state agency to provide for or fund specialized services for handicapped children. The court could instead retain jurisdiction over the child thereby continuing to supervise that child's treatment at the expense of the county or parents or guardians. 1989 Op. Att'y Gen. No. U89-6.

5. DHR's Obligation Under the Education for all Handicapped Children Act

The State Board of Education and DHR entered into two agreements and in doing so adopted regulations and procedures in the Act that require procedural protections. These protections include the requirement of parental or surrogate parental consent to educational evaluation and placement as well as that parents be notified they are entitled to participate in the development of the child's IEP. 1981 Op. Att'y Gen. No. 81-7.

6. Appropriate Accommodations

State Board of Education rules allow local school systems to provide appropriate accommodations in the administration of tests to students with disabilities who are being educated pursuant to an IEP. In addition, the State Board is authorized to exempt students with disabilities from the graduation assessments. 1997 Op. Att'y Gen. No. 97-15.

7. Proper Hearing Procedures in Connection with Educational Placement for Handicapped Children

Impartial due process guarantees provided by state and federal law also pertain to controversies relating to the placement of children in special education programs due to their being handicapped. These guarantees include the right to a hearing by the state or local educational agency as well as the right to appeal to the State educational agency. Therefore, Georgia's procedure of having a hearing before a regional hearing officer (and not before a state or local educational agency) and only allowing appeal directly to the court (and not to the State Board of Education) is unauthorized by law. 1979 Op. Att'y Gen. No. 79-1.

P. Georgia Judicial Decisions

1. Affirmative Defense

The Court held that E.J.P. was not entitled to present the affirmative defense of delusional compulsion during a transfer hearing in juvenile court. The Court stated that the affirmative defense goes to the merits of the case and is, therefore, irrelevant during the transfer hearing. The relevant consideration is whether E.J.P. requires treatment now or in the future, and whether such treatment is available through the superior court or exclusively through the juvenile court. The Court affirmed the juvenile court holding that it thoroughly considered such needs prior to determining that transfer was in the best interests of E.J.P. and the community. In the Interest of E.J.P., 236 Ga. App. 221 (1999).

2. Transfer Hearings

- a. In order for a delinquency case to be transferred for criminal prosecution, the juvenile court must determine that there are "reasonable grounds to believe that the child is not committable to an institution for the mentally retarded or mentally ill" and such a determination must be supported by competent evidence. O.C.G.A. §15-11-30.2(a)(3). The Court held that the underlying delinquent act and subsequent escapes of S.P. were not sufficient probative evidence to support the court's conclusion that S.P. is not committable. The Court vacated the judgment of the juvenile court and remanded for a new hearing on the matter. In the Interest of S.P., 189 Ga. App. 829 (1989).
- b. J.L.B. had been in mental health treatment for three years for substance abuse and among other things, oppositional defiant disorder. While in treatment, there was no apparent improvement and J.L.B. refused to take her medication when prescribed. In addition, the juvenile justice representative informed the judge that J.L.B. could not be recommended for placement at a long-term treatment center based on her psychological profile and the severity of her offenses. Accordingly, the Appellate Court held that the juvenile court did not abuse its discretion and that there was sufficient evidence to support the juvenile court's determination that J.L.B. would be better served if her case

was transferred to superior court. The Court of Appeals further stated that “if the evidence shows the child is not amenable to treatment, the child’s interest in treatment in the juvenile system is minimized because of the treatment’s potential ineffectiveness, and, because of that ineffectiveness, the community has an interest in treating the child as an adult.” In the Interest of J.L.B., 240 Ga. App. 655 (1999).

- c. The juvenile court granted the state’s motion to transfer the case of K.J.T. to superior court. K.J.T. appeals arguing that the court abused its discretion in granting the motion because the state failed to show reasonable grounds to believe that he was not committable to an institution of the mentally ill. The juvenile court made its decision after hearing from two probation officers that had contact with K.J.T. and stated they never witnessed any behavior that would indicate K.J.T. suffered from a mental disorder. The Court also heard from the clinical psychologists who evaluated K.J.T. and reported that K.J.T. exhibited psychotic symptoms such as hearing voices and shaking uncontrollably. They recommended K.J.T. be transferred to an inpatient psychiatric setting where he could be evaluated for psychotropic medication treatment or where it could be discovered that K.J.T. was faking these symptoms for external gain. The Court of Appeals vacated the judgment of the juvenile court and remanded it for a new hearing. The Appellate Court held that the court erred in concluding that the required showing had been made before transferring K.J.T. since the probation officers had not had contact with K.J.T. for two years, and therefore could not attest to his current mental condition. In addition, the psychologists who did have knowledge of K.J.T.’s current mental state reported that inpatient treatment would be necessary to determine whether K.J.T. was legitimately suffering from a mental illness or was faking it. In the Interest of K.J.T., 246 Ga. App. 660 (2000).

3. Special Education Considerations in Child Custody Cases

The Supreme Court of Georgia held that the lower court was authorized to make the finding that it would be detrimental to the welfare of the children to suddenly remove them from their special education classes mid-year and force them to change schools. The court further held that the trial court was authorized to make such a finding from the evidentiary facts regarding the special needs of the children. Foster v. Foster, 241 Ga. 470 (1978).

Q. Medicaid Waivers (Mental Retardation Waivers)

1. General

Medicaid Waivers are agreements between the states and the federal government to use Medicaid dollars in the community rather than in institutional settings. Georgia has two mental retardation Medicaid Waivers: the Mental Retardation Medicaid Waiver and the Community Habilitation and Support Services Waiver. The differences between the two are administrative, with both providing

essentially the same services, including: workshops, supported employment, support to families when consumers live at home, out of home services, 24 hour services, respite services, and services that provide medical equipment and supplies.

2. Benefits

One advantage is that when Medicaid Waiver funding is used the federal government will match state funding. The current match ratio is 40% state and 60% federal. Two thirds of all community mental retardation service dollars are Medicaid Waiver dollars and almost all 24 hour residential services are provided under on of the two Medicaid Waiver programs. A mental retardation waiver provides funding for a child's permanent placement in a residential program that does not expire based on a child's age.

3. Eligibility Criteria

- a. The child must have a *mental retardation diagnosis* **and** be designated as being "*most in need*" of services. If a child receives a Medicaid Waiver, that child does not "age out", the Waiver provides that child with lifetime services.
- b. If there is not a mental retardation diagnosis, the child can still qualify for a Medicaid Waiver if the child is diagnosed with a *developmental disability* such as autism or cerebral palsy. The key is that the child must be diagnosed with a *condition similar* to mental retardation and *in need of similar services* to those with a mental retardation diagnosis.
- c. Supplemental Security Income (SSI) eligibility (in some cases individuals with limited income, but who do not receive SSI may be eligible).
- d. Documentation that the person is at risk for an Immediate Care Facility (either a nursing home or a mental retardation hospital) if the services are not provided.
- e. Priority is given to a child based on their circumstances. Consideration is given to factors such as whether a child's primary care giver is deceased, the child is homeless, etc.

4. Access to Services

- a. All mental retardation services are accessed through one of the DHR-Mental Health, Mental Retardation, and Substance Abuse Regional Boards. These Regional Boards are the entities that authorize Medicaid services for individuals. When a juvenile is identified by the juvenile court as needing services, the court should contact their Regional Board regarding an evaluation to confirm the need and eligibility for such services, as well as information regarding the availability of services in the region.

- b. Once a request is made on behalf of a child for a Medicaid Waiver, it is sent to a Regional Board who places it under consideration. It takes approximately two weeks to receive an initial response from the Regional Board.
- c. The Regional Board will then conduct a screening and assessment of the child applicant. It takes approximately another two weeks to get the results of these tests. An individual must receive some type of service within two weeks of being found eligible for and in need of mental retardation services.

***** See Resources Section at the end of this Chapter for Regional Board contacts and Regional Board locator map.***

R. Community Service Boards (CSB) (O.C.G.A. §37-2-5 et seq.)

1. Generally

Georgia is divided into thirteen regions each with a Regional Board, and within each region are CSB's. The Regional Boards receive funding through DHR and contract with service providers for necessary services. The Regional Boards for the most part contract with CSB's who provide therapeutic and wrap-around services, among others. However, Regional Boards will also contract with private providers for such services if they are not available through community services.

2. Days of Active Client Enrollment

The Regional Boards are charged with the responsibility of controlling inpatient hospitalization services in state facilities for juveniles. In order to do this effectively, each region is allotted a set number of 'days of active client enrollment'. There is no cost to the CSB's for using the allotted 'days of active client enrollment'. However, there is a cost to the CSB's should the region exceed their allotted days.

3. Financial Impact

When a region exceeds their allotted 'days of active client enrollment' they are required to pay back to the state the cost of the over utilization. The Regional Board will determine which CSB exceeded the allotted days and require that CSB to pay the hospital costs out of its community services funds. Because over utilization can have a deep impact on community service funds, it is extremely important for the juvenile courts to work closely with their CSB liaisons to ensure that community services are used whenever possible and that inpatient hospitalization is only used as a last resort. A juvenile court should only use inpatient hospitalization in emergency situations that cannot be handled within the community such as patient stabilization and medication adjustment.

S. Resources

1. Georgia Department of Human Resources, Division of Mental Health, Mental Retardation, and Substance Abuse

Dr. Karen Bailey-Smith
Juvenile Forensic Coordinator
2 Peachtree St., Room 23-420
Atlanta, GA 30303
Tel: (404) 463-6353
Fax: (404) 657-4349

2. Georgia Department of Education

Melanie Davis Stockwell
Director, Division of Legal Services
2054 Twin Towers East
205 Butler Street
Atlanta, GA 30334-5030
Tel: (404) 656-4689
Fax: (404) 656-8376
Internet: www.doe.k12.ga.us

3. Georgia Department of Human Resources, Division of Family and Children Services

Dianne Sacks
Manager, Treatment Services Unit
Multi-Agency Team for Children (MATCH)
2 Peachtree Street, Room 18-422
Atlanta, GA 30303-3180
Tel: (404) 657-3578
Fax: (404) 657-4482

4. The Georgia Advocacy Office (protection and advocacy for individuals with disabilities and mental illness)

Angela Lavori
Attorney
100 Crescent Centre Parkway
Suite 520
Tucker, GA 30084
Tel: (404) 885-1234
1-800-537-2329
Fax: (770) 414-2948
Internet: www.thegao.org

5. Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)

Local Contacts:

Cherokee County - Woodstock (770) 381-8687
North Atlanta - Atlanta (770) 381-8687
Gwinnett County - Lawrenceville (770) 381-8687
Dekalb County – Stone Mountain (770) 381-8687
Bartow County – Cartersville (770) 382-8687
Fayette County - Peachtree City (770) 486-7320
Cobb County – Marietta (770) 973-7520
Middle Georgia – Macon (912) 741-2246
Chatham County - Savannah (912) 925-6728

National Contact:

8181 Professional Place, Suite 201
Landover, MD 20785
Tel: (800) 233-4050
301-306-7070
Fax: 301-306-7090

6. National Alliance for the Mentally Ill (NAMI)

Local Contact:

NAMI – Georgia
Pat Strode
Director of Family Education (Family to Family Program)
3125 Presidential Parkway, Suite 335
Atlanta, GA 30340
Tel: (770) 234-0855/ 1-800-728-1052
Fax: (770) 234-0237
Email: NAMI-GA@nami.org

National Contact:

Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
Tel: 800-950-6264 or (703) 524-7600
Fax: (703) 524-9094
Internet: www.nami.org

7. Georgia Mental Health Consumer Network

Tel: (404) 687-9487

8. Mental Health Association of Georgia

Tel: (404) 527-7175

9. Georgia Parent Support Network (offers support and information for parents of children and adolescents with mental illness)

Tel: (404) 758-4500

10. Learning Disabilities Association of Georgia

Tel: (678) 461-4471

11. Parents Educating Parents & Professionals (PEPP)

Tel: (770) 577-7771

1-800-322-7065 (in Georgia only)

Fax: (770) 577-7774

Internet: www.peppac.org

12. Parent Advocacy Coalition for Educational Rights (PACER Center)

4826 Chicago Avenue South
Minneapolis, MN 55417-1098

Tel: (612) 827-2966

Fax: (612) 827-3065

Email: mnpacer@edu.gte.net

Internet: www.pacer.org

13. Bazelon Center for Mental Health Law

1101 15th Street, N.W.

Suite 1212

Washington, D.C. 20005-5002

Tel: (202) 467-5730

Fax: (202) 223-0409

Internet: www.bazelon.org

14. TherapistFinder.net (locate psychiatrists, psychologists, therapists, counselors, social workers, etc., and access glossary of mental health terms)

Internet: www.therapistfinder.net

15. Regional Board Contacts and Locator Map

Please see attached list.

16. Community Service Boards by Region

Please see attached list.