THE ROLES OF THE CHILD'S ATTORNEY AD LITEM AND GUARDIAN AD LITEM AND THE CHILD'S PERSPECTIVE IN PSYCHOTROPIC MEDICATION HEARINGS

PRESENTATION BY CLINICAL LAW PROFESSOR
BERNARD P. PERLMUTTER
UNIVERSITY OF MIAMI SCHOOL OF LAW
CHILDREN & YOUTH LAW CLINIC
TO GABRIEL MYERS WORKGROUP
AUGUST 5, 2009

I. Introduction

The Children & Youth Law Clinic ("Clinic") is an in-house legal clinic staffed by faculty and students of the University of Miami School of Law. In 2006, the Clinic presented comments in the Florida Supreme Court in a proceeding before the Court on a petition by the Florida Bar Juvenile Court Rules Committee to adopt Rule 8.355 of the Florida Rules of Juvenile Procedure, entitled Administration of Psychotropic Medication to a Child in Shelter Care or in Foster Care When Parental Consent Has Not Been Obtained. The rule was intended to provide procedures to implement §39.407(3), Fla. Stat., which was created by Chapter 2005-65, Section 2, Laws of Florida. Section 39.407(3) requires court authorization for the administration of psychotropic medications to children in shelter or foster care when parental consent cannot be obtained. The rule set forth procedures governing a motion by the Department of Children & Families and a court order for administration of psychotropic medication as required

by §39.407(3)(c). It also created procedures for emergency situations such as when a delay in authorization could cause significant harm or when the child has been placed in a psychiatric facility on an emergency basis.

The Children & Youth Law Clinic's main critique of proposed Rule 8.355 was that it needed to be amended to mandate the appointment of a guardian *ad litem* and an attorney *ad litem* to represent the child in proceedings under the rule. Our comments contended that requiring such representation is necessary to ensure that the court's decision to authorize the administration of psychotropic medications is informed by accurate and up-to-date information about the health status and needs of the child. Further, we argued that without representation, it may be impossible for a child to meaningfully voice objections to the prescribed treatment and to participate in a hearing as provided in the statute.

Our comments were informed by the scholarship of our University of Miami Law School colleague Professor Bruce Winick, who pioneered the approach of therapeutic jurisprudence and has written extensively about the therapeutic dimensions of legal rules and procedures. In particular, he has written about the therapeutic aspects of inpatient and outpatient civil commitment hearings and psychotropic medication hearings, and how they

can be reshaped to diminish their anti-therapeutic effects and increase their therapeutic potential.[1]

Because of our interest in safeguarding the due process, therapeutic and health rights and needs of foster children who may be administered psychotropic medications, the Clinic contended that requiring such representation assures that the court is provided with accurate medical information that it needs in order to render an informed decision on the medical necessity, safety and appropriateness of psychotropic drugs. Providing representation also affords the child the opportunity to voice objections to the prescribed treatment, and makes it less likely that the child will perceive the psychotropic medication process as coercive and more likely that the child will comply with any treatment prescribed by a physician and ordered by the court.

Although the Florida Supreme Court agreed that it was important for children in these proceedings to have counsel or a guardian *ad litem* and to

---

[1]*See, e.g.,* Bruce J. Winick, CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL (2005); Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES 37 (1999); Bruce J. Winick, *Coercion and Mental Health Treatment*, 74 DENVER U.L. REV. 1145 (1997); and Bruce J. Winick, *Therapeutic Jurisprudence and the Role of Counsel in Litigation*, in PRACTICING THERAPEUTIC JURISPRUDENCE: LAW AS A HELPING PROFESSION (Dennis P. Stolle, David B. Wexler & Bruce J. Winick eds. 2000).

be afforded the opportunity for meaningful age-appropriate participation in the process, the Court declined to insert a requirement for such representation into Rule 8.355. The Court reasoned that the statute imposed detailed requirements upon the Department of Children and Families sufficient to ensure that the court's ruling on the motion for court authorization to administer the medications would be based upon the most complete medical information that is available. The Court also held that imposing the mandatory appointment of GALs in these proceedings to be unnecessary as under Chapter 39 the majority of children in the care and custody of DCF should already have representation in the form of a GAL.

The tragic death of Gabriel Myers, and the testimony previously presented to this distinguished Workgroup, suggest that the Court's assumptions were not correct. The time is right for Florida to revisit this issue and to require the appointment of attorneys and GALs for all children in the Department's custody in psychotropic medication hearings.

II. Background

In June 2002, after a year-long investigation into the use of prescribed psychotropic drugs by foster children in the DCF foster care program, the Florida Statewide Advocacy Council ("SAC") issued an *Orange Item Report*

finding that foster care children's medical records were "seriously deficient." The review of over 1,000 foster care records by the statewide council members uncovered serious systemic problems including: records were incomplete; information was not easy to locate; frequently information about multiple children was commingled in a single file; information about unrelated foster care children was found in some case files; files were poorly organized.[2]

The review also found, *inter alia,* that medical records were incomplete and/or portions missing; in files where there was medical information it was spread throughout the files; it was often impossible to determine what medications were prescribed, if any, including the dosage and time to be administered, for each child; only a very few records had any type of documentation that medication was administered; "medical passports" were missing from numerous files; and those files where passports could be located did not contain current information.[3]

---

[2]*See* Orange Item Report *at* http://www.floridasac.org/sacweb/documents/orange_item.doc.

[3]Florida law defines the "medical passport" as "a written health history of a child in shelter status or foster care, which is used to document health care. The medical passport is to be kept with the child's caregiver (in the child's resource record) and updated at each health care provider visit." Rule 65C-12.00(18), Fla. Admin. Code. Additionally, DCF must abide by federal statutory requirements to compile, update, and provide to each foster

In July 2003, the SAC issued a *Red Item Report: Psychotropic Drug Use in Foster Care*, finding serious problems in the widespread, unsupervised administration of psychotropic medications by DCF to foster children. The council's review of 1,180 DCF case files revealed that over half—652 children—were on one or more psychotropic medications. Many of the children were infants and toddlers enrolled in preschool, "a disturbing discovery since many of these drugs have not been approved for use in

---

care parent or caregiver the child's full medical and educational records. *See* 42 U.S.C. § 675(1) (C).

However, as documented by the *Orange Item Report*, and as shown in reports and data presented to the Gabriel Myers Workgroup, DCF has failed to abide by these medical record-keeping requirements, which has resulted in judicial action to compel DCF to comply with federal and state law. *See, e.g.,* Megan O'Matz, *Judge Warns of Risks to Kids: DCF Ordered to Provide Health Records on Foster Children,* South Florida Sun-Sentinel, Aug. 17, 2001, at 1B; Carol Marbin Miller, *Many Kids in Foster Care Don't See Doctor,* The Miami Herald, Sept. 4, 2001, at 1A.

Because inadequate medical record-keeping is a widespread problem in many state foster care systems, typically due to the fact that children placed in foster care experience multiple changes in foster homes and frequently reenter the system after being returned to their families, the American Academy of Pediatrics has adopted a policy recommending that "[c]hild welfare agencies and health care providers...develop and implement systems to ensure the efficient transfer of physical and mental health information among professionals who treat children in foster care." American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care, *Policy Statement: Health Care of Young Children in Foster Care*, 109 PEDIATRICS 536-541 (Mar. 2002), *available at* http://aappolicy.aappublications.org/cgi/content/full/pediatrics;109/3/536. The AAP policy also recommends use of medical passports by foster parents, "designed to facilitate the transfer of essential information among physical and mental health professionals." *Id.*

young children by the Federal Food and Drug Administration," and "there is very little data on the possible long-term consequences of using these drugs at such an early age." The SAC report also noted that "diagnosing mental illness in children at such a young age is extremely difficult as these children are unable to describe their symptoms adequately, if at all."[4]

The review further found that many of the children's records "lacked adequate or accurate information, or omitted details on how consent was obtained and what information was provided to children, parents or guardians." The SAC also learned "that many of these drugs are prescribed by the child's primary care physician and in some cases by more than one physician instead of a psychiatrist who specializes in treating children." The report described the many serious side effects that could result, including

> decreased blood flow to the brain, cardiac arrhythmias, disruption of growth hormone leading to suppression of growth in the body and brain of a child, weight loss, permanent neurological tics, dystonia, addiction and abuse, including withdrawal reactions, psychosis, depression, insomnia, agitation and social withdrawal, suicidal tendencies, possible atrophy in the brain, worsening of the very symptoms the drugs are supposed to improve, and decreased ability to learn, tardive dyskinesia and malignant neuroleptic syndrome.

---

[4] *See* Red Item Report *at* http://www.floridasac.org/sacweb/documents/red_psychotropic.doc.

A 2004 report by DCF found that 13% of all children in state custody were receiving at least one psychotropic medication.[5] Of this group, 8% were being treated with three or more medications concurrently. The DCF findings also indicated that 3.5% of the children in state custody *age five and under* received at least one psychotropic medication. Additionally, 25% of children living in a foster care setting were being treated with psychotropic medications, a rate *five times higher* than the general population of Medicaid eligible children. After summarizing these findings, a 2005 Senate Staff Analysis concluded: "Despite initiatives by the department to identify children in its care who are on psychotropic medications and to determine the appropriateness of this treatment, *limited information exists*."[6]

These reports and widespread concerns among children's advocates about children in DCF custody taking psychotropic drugs,[7] which the MIAMI

---

[5]*See Ensuring Appropriate and Informed Use of Psychotropic Medications With Children in Department Custody,* Department of Children & Families PowerPoint Presentation to Florida Senate Children & Families Committee (Jan. 11, 2005).

[6]*See* CS/CS/SB 1090, Senate Staff Analysis and Economic Impact Statement (Mental Health Care Services for Minors and Incapacitated Persons) (Apr. 14, 2005), at 2-3 (emphasis added).

[7]*See, e.g.,* FINAL REPORT OF THE FLORIDA BAR COMMISSION ON THE LEGAL NEEDS OF CHILDREN (June 2002)("Legislation is needed to provide procedures to ensure that psychotropic drugs are administered only to children in the foster care and the juvenile justice system [sic] when medically necessary. In some cases, psychotropic medications may be essential to treatment. However, based upon published reports, such

HERALD and other newspapers reported on beginning in 2001,[8] prompted the passage in 2005 of § 39.407(3). The legislation requires that the department seek the express and informed consent of the child's parents before administering the drugs. Without such consent, DCF is obligated to get approval from a judge after filing a motion seeking the court's authorization

---

medications have been used as a method of controlling behavior among children who simply needed mental health counseling or services. This occurs notwithstanding the fact that this medication has not been specifically approved for use by children." *Id.* at B.10).

[8]*See, e.g.*, Carol Marbin Miller, *Advocates Criticize Medicating Foster Kids; Treatment Raises Claims of Misuse*, Miami Herald, Apr. 12, 2001, at 1A; Editorial, *Adult Drugs for Kids*, Miami Herald, Apr. 13, 2001, at 8B; Carol Marbin Miller, *Foster Kids Describe Drugs' Effects; Prescribed Psychiatric Medications Made 'Everything a Blur' For One Girl*, Miami Herald, Apr. 23, 2001, at 1A; Carol Marbin Miller, *Groups to Investigate Drugs for Kids*, Miami Herald, June 22, 2001, at 5B; Carol Marbin Miller, *Bill to Regulate Psychiatric-Drug Use on Foster Kids Pushed*, Jan. 13, 2002, at 2B; Carol Marbin Miller, *Law May Curb Drug Therapy of Foster Kids*, Miami Herald, Mar. 18, 2002, at 3B; Carol Marbin Miller, *Mind-Altering Drugs Given to Some Babies in DCF's Care*, Sept. 12, 2003, at 1A; Kathleen Chapman, *Hundreds of Foster Care Kids on Mind Drugs*, Palm Beach Post, Sept. 12, 2003 at 1A; Editorial, *Throwing Drugs at a Problem*, St. Petersburg Times, Sept. 22, 2003, at 6A; Carol Marbin Miller, *State to Probe Drugs For Kids*, Miami Herald, Nov. 20, 2003, at 7B; Kathleen Chapman, *DCF to Investigate Mind Drugs Given to Foster Children*, Palm Beach Post, Nov. 20, 2003, at 1A; Editorial, *Minding the Children*, Nov. 26, 2003, St. Petersburg Times, at 14A; Kathleen Chapman, *DCF Sets Up Hotline for Children's Prescriptions*, Palm Beach Post, Jan. 16, 2004, at 9A; Carol Marbin Miller, *1 in 4 Foster Kids on Risky Mind Medication*, Miami Herald, Jan. 15, 2005, at 1A; Editorial, *Prescriptions for Tragedy*, St. Petersburg Times, Feb. 1, 2005, at 8A; Kathleen Chapman, *Mental Health Drugs for Kids Alarm Officials*, Palm Beach Post, Feb. 25, 2005, at 1A; Carol Marbin Miller, *Foster Children: New Law Curbs Drugging of Kids*, Miami Herald, May 5, 2005, at A1.

to initially provide or continue to provide psychotropic medication to a child in its legal custody.[9]

Sections 39.407(3) (c) & (d), Fla. Stat., in effect, place the judge in a limited *in loco parentis* role, by requiring the court to give careful review of a prescribing physician's signed medical report which contains the following information, before it may authorize DCF (*i.e.*, before the court gives express and informed consent) to provide psychotropic medication to a child in department custody:

> 1. The name of the child, the name and range of the dosage of the psychotropic medication, and that there is a need to prescribe psychotropic medication to the child based upon a diagnosed condition for which such medication is being prescribed.
>
> 2. A statement indicating that the physician has reviewed all medical information concerning the child which has been provided.
>
> 3. A statement indicating that the psychotropic medication, at its prescribed dosage, is appropriate for treating the child's diagnosed medical condition, as well as the behaviors and symptoms the medication, at its prescribed dosage, is expected to address.
>
> 4. An explanation of the nature and purpose of the treatment; the recognized side effects, risks, and contraindications of the medication; drug-interaction precautions; the possible effects of stopping the medication; and how the treatment will be monitored, followed by a

[9] §39.407(3) (c), Fla. Stat.

> statement indicating that this explanation was provided to the child if age appropriate and to the child's caregiver.
>
> 5. Documentation addressing whether the psychotropic medication will replace or supplement any other currently prescribed medications or treatments; the length of time the child is expected to be taking the medication; and any additional medical, mental health, behavioral, counseling, or other services that the prescribing physician recommends.[10]

Section 39.407(3) (d), Fla. Stat., requires DCF to notify all parties[11] of the proposed administration of psychotropic medication in writing within 48 hours after the motion is filed.[12] Only when a party "objects" to the department's motion, within two working days after being notified of the department's motion, is the court obligated to hold a hearing to decide whether or not to authorize the department to initially provide or to continue providing psychotropic medication.[13] At the hearing, the court may admit into evidence the medical report, but the statute does not obligate the

---

[10]§39.407(3) (c) (1)-(5), Fla. Stat.

[11]Florida law defines "party" in Chapter 39 dependency proceedings as "the parent or parents of the child, the petitioner, the department, the guardian ad litem or representative of the guardian ad litem when the program has been appointed, and *the child.*" §39.01(51), Fla. Stat. (emphasis added). *See also* Rule 8.210(a) Fla.R.Juv.P. (defining "party" or "parties" in dependency and termination of parental rights proceedings to include the child).

[12]§39.407(3) (d) 1., Fla. Stat.

[13]*Id.* Rule 8.355(b) (1), Fla.R.Juv.P., thus contains a hearing bypass provision: "If no party timely files an objection to the department's motion, the court may enter its order authorizing the proposed administration of the psychotropic medication *without a hearing.*" *Id.* (emphasis added).

prescribing physician to attend the hearing or testify unless the court "specifically orders such attendance or testimony, or a party subpoenas the physician to attend the hearing or provide testimony."[14] The court has considerable latitude to consider additional evidence or testimony before it may order DCF to provide or continue to provide psychotropic medication to the child:

> At any hearing held under this paragraph, the court shall further inquire of the department as to whether additional medical, mental health, behavioral, counseling, or other services are being provided to the child by the department which the prescribing physician considers to be necessary or beneficial in treating the child's medical condition and which the physician recommends or expects to provide to the child in concert with the medication. The court may order additional medical consultation, including consultation with the MedConsult line at the University of Florida, if available, or require the department to obtain a second opinion within a reasonable timeframe as established by the court, not to exceed 21 calendar days, after such order based upon consideration of the best interests of the child. The department must make a referral for an appointment for a second opinion with a physician within 1 working day.[15]

III. The Need for Guardian *ad Litem* and Attorney *ad Litem* Representation in Rule 8.355 Hearings

Three interests are promoted by mandating the appointment of a guardian *ad litem* and an attorney *ad litem* for a child in these proceedings: (1) the court will have access to more accurate and up-to-date medical

[14] §39.407(3) (d) 1., Fla. Stat.

information necessary to be able to render an informed decision on the necessity, safety and appropriateness of administering psychotropic medication; (2) the child will benefit therapeutically and medically from being heard through a guardian *ad litem* and an attorney *ad litem* in these hearings; and (3) the rule will be in conformity with the enabling legislation and other rules of juvenile procedure, which contain requirements and expectations that the child will be represented by an appointed guardian *ad litem* and/or attorney *ad litem* at judicial review hearings and in other hearings involving the child's medical needs.

a. Providing Children with GALs and Attorneys Assures that the Court Will Have More Accurate and Up to Date Health Information about the Child When Rendering the Decision to Authorize DCF to Administer Psychotropic Medication

Because §39.407(3), Fla. Stat., requires the court to conduct a far-reaching factual inquiry into the necessity, safety and appropriateness of administering psychotropic medication to a child in DCF custody, the court cannot and should not rely exclusively on medical information provided by the department. The inherent unreliability and systemic inaccuracies found in the review of foster children's medical records by the two Florida Statewide Advocacy Council reports issued in 2002 and 2003, in DCF's own

[15] §39.407(3) (d) 1., Fla. Stat.

self-study in 2004, and the more recent data provided to the Gabriel Myers Workgroup, suggest that any information provided by DCF to the court and that the court relies on in determining whether to authorize psychotropic medication, must be carefully scrutinized to ascertain that it is accurate and up to date. Moreover, as the *Red Item Report* noted, because the medications' use by children has not been generally approved by the FDA for safety or efficacy, the court needs to be especially vigilant and to monitor for signs and symptoms of adverse side effects. Only by providing a mechanism for outside review of this information by an independent guardian *ad litem* and a trained attorney *ad litem*, can the fact-finding process be considered one that is reliable and trustworthy and that promotes the best interests and healthy development of children who will be administered psychotropic medications.

Recognizing the serious nature of the parents' decision to consent to psychotropic medicines,[16] the American Academy of Child and Adolescent

---

[16]The AACAP's policy on prescribing psychoactive medications for children and adolescents states: "Prescribing psychoactive medications for children and adolescents requires the judgement of a physician, such as a child and adolescent psychiatrist, with training and qualifications in the use of these medications in this age group. Certainly any consideration of such medication in a child or infant below the age of five should be very carefully evaluated by a clinician with special training and experience with this very young age group." American Academy of Child and Adolescent Psychiatry, *Policy Statement: Prescribing Psychoactive Medications for*

Psychiatry ("AACAP") recommends that families ask the following questions *before* their child or adolescent starts taking psychiatric medications:

1. What is the name of the medication? Is it known by other names?
2. What is known about its helpfulness with other children who have a similar condition to my child?
3. How will the medication help my child? How long before I see improvement? When will it work?
4. What are the side effects which commonly occur with this medication?
5. What are the rare or serious side effects, if any, which can occur?
6. Is this medication addictive? Can it be abused?

Children and Adolescents (Revised and approved by the Council on Sept. 20, 2001), *available at* http://www.aacap.org/publications/policy/ps41.htm.

Additionally, the AACAP Policy Statement observes that the prescribing of multiple medications for children, a practice which DCF has documented for a significant percentage of the children in its custody, should be "judiciously" used only in "clearly justifiable circumstances": "Anecdotally the prescribing of multiple psychotropic medications ('combined treatment'- 'polypharmacy') in the pediatric population seems on the increase. Little data exist to support advantageous efficacy for drug combinations, used primarily to treat co-morbid conditions. The current clinical 'state-of-the-art' supports judicious use of combined medications, keeping such use to clearly justifiable circumstances. Medication management requires the informed consent of the parents or legal guardians and must address benefits vs. risks, side effects and the potential for drug interactions." *Id.*

7. What is the recommended dosage? How often will the medication be taken?

8. Are there any laboratory tests (e.g. heart tests, blood test, etc.) which need to be done before my child begins taking the medication? Will any tests need to be done while my child is taking the medication?

9. Will a child and adolescent psychiatrist be monitoring my child's response to medication and make dosage changes if necessary? How often will progress be checked and by whom?

10. Are there any other medications or foods which my child should avoid while taking the medication?

11. Are there interactions between this medication and other medications (prescription and/or over-the-counter) my child is taking?

12. Are there any activities that my child should avoid while taking the medication? Are any precautions recommended for other activities?

13. How long will my child need to take this medication? How will the decision be made to stop this medication?

14. What do I do if a problem develops (e.g. if my child becomes ill, doses are missed, or side effects develop)?

15. What is the cost of the medication (generic vs. brand name)?

16. Does my child's school nurse need to be informed about this medication?[17]

These recommended questions for parents are, in effect, ones which the court, in its limited *in loco parentis* role under §39.407(3), Fla. Stat., must also ask *before* it authorizes the administration of psychotropic

[17]American Academy of Child and Adolescent Psychiatry, *Psychiatric Medicines for Children and Adolescents, Part III: Questions to Ask, available at* http://www.aacap.org/publications/factsfam/medquest.htm.

medications to a child. However, because the juvenile court judge lacks the "intimacy of daily association"[18] with the child that the child's natural parents enjoy, the court *must*, of necessity, rely on information provided by DCF. Because of the inherent unreliability of that information, the court should also appoint a guardian *ad litem* and an attorney *ad litem* to assist it before rendering a decision to authorize psychotropic medication. Having the assistance of a GAL and an attorney *ad litem* for the child will ensure that the decision to authorize administration of psychotropic medication is better informed by accurate and up-to-date information about the health status and needs of the child.[19]

---

[18]*Smith v. Org. of Foster Families for Equality and Reform*, 431 U.S. 816, 844 (1977) (noting that "[t]he importance of the familial relationship, to the individuals involved and to the society, stems from the emotional attachments that derive from the intimacy of daily association....").

[19]Notwithstanding the confidential nature of health records, both the GAL and the attorney *ad litem* should be able to gain access to record information related to the child's health and mental history and current health needs. *See* §39.822(3)(b), Fla. Stat. (authorizing the guardian *ad litem* to inspect and copy "any records related to the best interests of the child," including not limited to, medical and mental health records; *cf. S.C. v. GAL*, 845 So.2d 953 (Fla. 4th DCA 2003)(minor was entitled to notice and opportunity to be heard before her guardian *ad litem* was given access to records of psychologist and as matter of first impression, mature minor has right to assert psychotherapist/patient privilege); *E.C. v. GAL*, 867 So.2d 1193 (Fla. 4th DCA 2004)(same).

See also Kathi Grasso, *Children and Psychotropic Drugs: What's an Attorney to Do?*, 16 A.B.A. CHILD L. PRAC. 49 (1997)(the attorney should review records pertaining to the client's history in foster care, medical (including nursing notes), mental health, educational, group homes, and

Providing the child with access to a guardian *ad litem* and an attorney *ad litem*, each of whom can assist the court in asking critically important questions about the child's basic health needs, also promotes the administration of justice for these children and enhances their overall well-being. As noted by the New York State Permanent Judicial Commission on Justice for Children, in concluding a child health initiative composed of judges, lawyers, physicians, social workers and other professionals to address the health needs of children in foster care:

> By asking [questions about the child's basic medical needs], we can create a climate that spotlights the critical connection between foster children's healthy development and their prospects for a permanent home. Hopefully, the inquiry will ensure that needed services are provided. Where questions expose the inadequacy of resources available to meet the needs, we hope that judicial leadership can help spur new initiatives to ensure the healthy development of every foster child.[20]

---

residential treatment in representing a child treated with psychotropic medications; the attorney should also speak with the medical, mental health, and other professionals involved in the child's care); American Bar Association, Standards of Practice for Lawyers Who Represent Children in Abuse and Neglect Cases (Approved by the A.B.A. House of Delegates, Feb. 5, 1996)(Standard C-2)(the attorney should conduct thorough, continuing and independent investigations and discovery of the child's social services, psychiatric, psychological, drug and alcohol, medical, law enforcement, school, and other records relevant to the case).

[20]New York State Permanent Judicial Commission on Justice for Children, *Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates, and Child Welfare Professionals*, Foreword by Chair Judith S. Kaye, Chief Judge of the State of New York (no date available). *See also* Karen Aileen Howze, Esq., HEALTH FOR TEENS IN CARE: A JUDGE'S

b. Providing Children with GALs and Attorneys Assures that Children Will Have a Meaningful Opportunity to Voice Their Objection to the Proposed Administration of Psychotropic Medication and Will be More Likely to Comply With Any Treatment Ordered by the Court

Because §39.407(3)(d)1., Fla. Stat., and Rule 8.355(a)(3), Fla.R.Juv.P., allow any party, including the child, to object to the proposed administration of these medications, but mandate that the party file its objection within two working days of being notified of the department's motion, without an appointed GAL and legal counsel, the child will not be able to meaningfully voice an objection to the proposed action. In practical terms, an adolescent, and certainly a very young child, cannot file an objection and meaningfully participate in the hearing unless given access to a GAL and a lawyer. The absence of any provision in the rule requiring an appointed representative for the child in this hearing not only deprives the child of important due process safeguards; it also deprives the child of dignitary and participatory interests that are critical to the child's perception of the basic fairness of the hearing process. As the Florida Supreme Court observed in *M.W. v. Davis,* 756 So.2d 90, 107 (Fla. 2001):

GUIDE, American Bar Association Center on Children and the Law (2002) at 41-55 (offering checklist for judges, attorneys and agency personnel for use in hearings on the health needs of adolescents subject to court supervision).

> Indeed, the issue presented by this case extends beyond the legal question of what process is due; rather, this case also presents the question of whether the child believes that he or she is being listened to and that his or her opinion is respected and counts. *See generally* Gary B. Melton, et al., *No Place to Go: The Civil Commitment of Minors* 146-47 (1998) (stating that children obtain psychological benefit from procedural protections prior to being placed in psychiatric treatment facilities).

Empirical studies of how litigants experience judicial and administrative hearings have led to the development of a literature on the psychology of procedural justice.[21] Research on the psychology of procedural justice suggests that people are more satisfied with and comply more readily with the outcome of legal proceedings when they perceive those proceedings to be fair and have an opportunity to participate in them. The process or dignitary value of a hearing is important to litigants. People who feel that they have been treated fairly at a hearing—dealt with in good faith and with respect and dignity—experience greater litigant satisfaction than those who feel treated unfairly, with disrespect, and in bad faith. People highly value "voice," the ability to tell their story, and "validation,"

---

[21] *See, e.g.*, E. ALLEN LIND & TOM R. TYLER, THE SOCIAL PSYCHOLOGY OF PROCEDURAL JUSTICE (1988); TOM R. TYLER, WHY PEOPLE OBEY THE LAW (1990); E. Allen Lind, *et al.*, *Voice, Control, and Procedural Justice: Instrumental and Noninstrumental Concerns in Fairness Judgements*, 59 J. PERSONALITY & SOC. PSYCHOL. 952 (1990); John Thibaut & Laurens Walker, *A Theory of Procedure*, 66 CALIF. L. REV. 541 (1978).

the feeling that what they had to say was taken seriously by the judge or other decision-maker. Even when the result of the hearing is adverse, people treated fairly, in good faith and with respect are more satisfied with the result and comply more readily with the outcome of the hearing. Moreover, they perceive the result as less coercive than when these conditions are violated and even feel that they have voluntarily chosen the course that is judicially imposed. Such feelings of voluntariness rather than coercion tend to produce more effective behavior on their part. For many litigants, these process values are more important than winning.[22]

Social psychologist Tom Tyler, applying these principles to the civil commitment hearing, has argued that increasing the individual's sense of participation, dignity, and trust during the commitment proceedings is likely to increase his or her acceptance of the outcome of the hearing, lead to a greater willingness to accept hospitalization and treatment, and enhance treatment efficacy.[23] Psychotropic medication hearings that appear to

---

[22]*See generally* Bruce J. Winick & Ginger Lerner-Wren, *Do Juveniles Facing Commitment Have a Right to Counsel?: A Therapeutic Jurisprudence Brief*, 71 U. CIN. L. REV. 115, 121-23 (2002); *see also* Jan C. Costello, *Why Have Hearings for Kids If You're Not Going to Listen? A Therapeutic Jurisprudence Approach to Mental Disability Proceedings for Minors*, 71 U. CIN. L. REV. 19 (2002).

[23]*See* Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings,* 46 S.M.U. L.

children, particularly adolescents, who are subject to them to be a sham violate their need to be treated with "respect, politeness, and dignity," and to feel that "their rights as citizens are acknowledged."[24] Hearings that deny them the practical ability to voice their objection to a proposed administration of psychotropic medication, due to the lack of access to counsel and GAL representation, may be thus perceived by them as phony rituals violating their sense of participation, dignity, and equal citizenship. Indeed, such hearings may actually produce feelings of worthlessness and loss of dignity, exacerbating the child's mental illness or behavioral problems, and perhaps even fostering a form of learned helplessness that can further diminish performance, motivation, and mood in ways that can be anti- therapeutic.[25]

The procedures in Rule 8.355 are likely to be perceived by the children subjected to them as phony rituals, unless these children have the practical ability to lodge objections to the proposed treatment through a guardian *ad litem* and an attorney *ad litem*, and if they object, to have a hearing on the proposed treatment in a manner similar to the procedures set

---

REV. 433 (1992); Bruce J. Winick, *Coercion and Mental Health Treatment*, 74 DENVER U. L.REV. 1145, 1155-67 (1997).

[24]Tyler, *supra* note 23, at 440.

forth in Rule 8.350(a) (6), (8), (9) & (11), Fla.R.Juv.P. Otherwise, they are likely to perceive the hearing as a judicially imposed coercive measure, and without the ability to meaningfully voice their objections, will be less compliant with the treatment ordered by the court.

Providing legal counsel and a guardian *ad litem* for the child effectuates rather than compromises the child's participatory interests in the hearing process. As Professor Winick observes, in taking measure of the benefits of affording counsel to a child in a civil commitment hearing:

> [t]he attorney can contribute to the juvenile's sense that he or she was treated fairly and to his or her ability to accept the outcome of the proceeding, even if adverse, and to comply with the court's decision in ways that can better achieve the goals of hospitalization. Without this, the juvenile is more likely to experience the hospital admission that may be ordered as coercive, with potentially devastating consequences for his or her ability to gain the benefits that such hospitalization may offer.[26]

c. Providing Children With GALs and Attorneys Conforms the Rule to the Intent of the Enabling Statute

Although §39.407(3)(f)1., Fla. Stat., contemplates representation in review hearings by a guardian *ad litem*, attorney, or attorney *ad litem*, Rule

---

[25]Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, 1 PSYCHOL. PUB. POL'Y & L. 6, 14-23 (1995).

8.355 is completely silent as to appointment of a guardian or attorney. Despite the fact that the statute recognizes the right of a child to be represented by a guardian or attorney, and the guardian's or attorney's role in advocating for more frequent review by the court of the child's psychotropic medication status, the rule omits any mention of or mechanism for such appointment to be exercised by the court; it also fails to make any reference to Rule 8.215 or Rule 8.217, Fla.R.Juv.P., which provide for the appointment of a guardian *ad litem* or an attorney *ad litem* at any stage of a dependency proceeding. As such Rule 8.355 does not conform to §39.407(3), Fla. Stat., and is not consistent with other rules of juvenile procedure requiring the appointment of counsel and guardians *ad litem* for children in hearings concerning medical or psychiatric treatment.

By contrast, in other contexts involving the adjudication of comparable medical interests of children, the juvenile rules require, consistent with statutory enactments, that the child have appointed lay and/or legal representatives in the hearings. For example, Rule 8.350(a)(3), Fla.R.Juv.P., explicitly provides for the appointment of a guardian *ad litem* for a child in a residential treatment hearing, in conformity with §39.407(6),

---

[26]*See* Bruce J. Winick & Ginger Lerner-Wren, *Do Juveniles Facing Commitment Have a Right to Counsel?: A Therapeutic Jurisprudence Brief*, 71 U. CIN. L. REV. at 125.

Fla. Stat., and the appointment of an attorney *ad litem* for the child, pursuant to Rule 8.350(a) (6), Fla.R.Juv.P., when the guardian reports to the court that the child objects to placement in such a facility.

Similarly, Rule 8.815, Fla.R.Juv.P., governing hearings on petitions for judicial waiver of parental notice of termination of pregnancy, contains an explicit requirement, pursuant to §390.01114(4) (a), Fla. Stat., for a minor to be notified of the right to court-appointed counsel and the provision to the minor of counsel upon her request at no cost in any judicial bypass hearings.[27]

Furthermore, although Rule 8.355(a) (3), Fla.R.Juv.P., states that any party objecting to the administration of psychotropic medication must file its objection within two working days of the DCF motion for court authorization of psychotropic medication, as observed above, *no* child (the party most likely to "object" to this proposed action by DCF) can realistically be expected to file such an objection, without access to counsel or a GAL.[28] Particularly for an infant or toddler subjected to psychotropic

---

[27]*See generally* Jan C. Costello, *Making Kids Take Their Medicine: The Privacy and Due Process Rights of the De Facto Competent Minor*, 31 LOY. L.A. L. REV. 907, 912-918 (1998) (comparing adolescent decisionmaking in the psychotropic medication and abortion contexts).

[28]As the Florida Supreme Court noted in *In Re T.W.,* 551 So.2d 1186, 1196 (Fla. 1989): "A minor, completely untrained in the law, needs legal advice to help her understand how to prepare her case, what papers to file,

medication, the absence of a requirement of a GAL or lawyer to protect the child's health care and due process rights makes the prospect of an objection being filed utterly meaningless. Given the potential harm to a very young child who is subjected to psychotropic medication, the absence of meaningful judicial oversight, without the right to be represented in a hearing by counsel and a guardian *ad litem* before the drugs are administered, carries potentially devastating and irreversible medical consequences.[29]

IV. Conclusion

For the foregoing reasons, the Children & Youth Law Clinic respectfully asks that the Gabriel Myers Workgroup recommend that Rule 8.355, Fla.R.Juv.P., which governs the procedures for juvenile court hearings on the administration of psychotropic medication for children in state custody when parental consent has not been obtained, be amended to

---

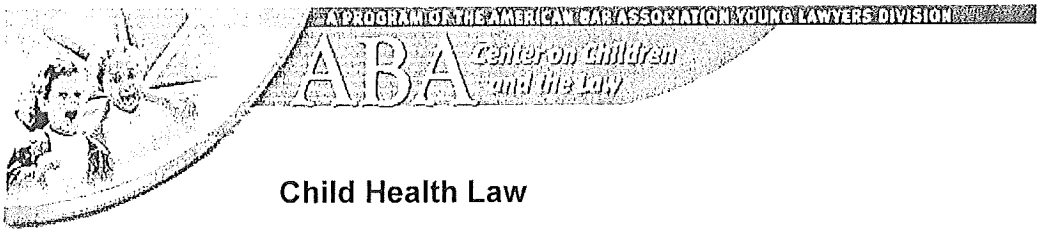
and how to appeal if necessary. Requiring an indigent minor to handle her case all alone is to risk deterring many minors from pursuing their rights because they are unable to understand how to navigate the complicated court system on their own or because they are too intimidated by the seeming complexity to try."

[29] *See Washington v. Harper*, 494 U.S. 210, 213-214 (1990) (describing adverse side effects of psychotropic medication); BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT 70-76 (1997) (same).

provide these children the opportunity to be heard by the court through both an appointed attorney *ad litem* and a guardian *ad litem*.

Respectfully submitted,

Bernard P. Perlmutter
Associate Clinical Professor
University of Miami School of Law
Children & Youth Law Clinic
1311 Miller Dr., Suite F305
Coral Gables, FL 33124
(305) 284-3123 Phone
(305) 284-4384 Fax
bperlmut@law.miami.edu



Child Health Law

This article is one of a series supported through the Partners in Programming Planning for Adolescent Health Project (PIPPAH), an interdisciplinary initiative to promote adolscent health issues. This project is funded by the U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health. Grant No: MCU-11A301-01-0.

Children and Psychotropic Drugs: What's An Attorney To Do? [1]

by Kathi Grasso

[W]e're prescribing for patients when we don't know the person. There are too many kids on too many drugs, and many of the kids have been given medication as a substitute for engagement and exploration of personal issues.

Glen Pearson, M.D., Psychiatrist and President of the American Society for Adolescent Psychiatry (ASAP)[2]

An Advocate's Dilemma

I once represented an eight-year-old girl who was placed in a residential treatment facility and prescribed multiple medications in varied combinations. Over her short lifetime, the laundry list of drugs she was prescribed included: Lithium, Prozac, Ritalin, Haldol, Mellaril and several others. She was ultimately diagnosed with bipolar disorder with a history of post traumatic stress disorder and sexual abuse. Her parents had little contact with her, the caseworker, or staff at the treatment facility.

As her attorney, I questioned the effectiveness and safety of the numerous drugs she was prescribed. I voiced concern about who was consenting to and monitoring their prescription. I sought a court order for a second medical opinion. I argued for alternative interventions, such as placement in a therapeutic foster home, so that she might come to know the nurturance of her parents. Upon my request, a Court Appointed Special Advocate (CASA) was assigned to monitor her medical care and special education services.

During the year I represented this child, I struggled with her case. A second independent,

expert opinion supported continued use of medication to control her behavior. I was unable to get her placement changed to a less restrictive alternative as her behavior continued to deteriorate. I recently learned that she is still institutionalized and exhibits self-injurious behavior. Could I have done anything differently?

As many of you are aware, accessing appropriate health, mental health, and educational services can make a real difference in the successful implementation of permanency plans. The right services can prepare children for adoptive placements or family reunification. They can also help prevent institutional placements and placement disruptions.

No Magic Bullet

Drugs prescribed to children in the foster care and juvenile justice systems are not always harmless. The UCLA Center for Mental Health in Schools reports most psychotropic drugs prescribed to children have not been well documented. In fact, the FDA has not approved the use of many psychotropic medications to treat children. Also lacking is information on the severity of the drugs' side effects and their long-term effects on children's development. According to the UCLA Center for Mental Health in Schools:

> Medical researchers warn that it is a mistake to think about medication as if it worked as a magic bullet. They say many people tend to think that, once administered, a drug speeds directly to its target and cures the problem. Medication is imagined to disappear upon entering the body and to reappear magically at its goal where is performs its work and again disappears. This belief fosters a tendency to ignore such facts as (1) *drugs can cause damage as they go through the body,* and (2) *drugs don't necessarily stop having effects as soon they have done the work they are intended to do.* [3]

Because there are many unknowns and potential risks surrounding children's use of psychotropic medications, individuals prescribing psychotropic drugs should fully explain the need for the medication, the benefits and risks, and treatment alternatives.

Know Your Client's Health History

As an attorney representing a child, you should know if your client is taking any medications. All medications, including over-the-counter medications, can alter behavior and have adverse side effects.[4] You should not only ask the assigned caseworker about the child's general health and medication use, but also anyone who might be involved with the child, including: relatives, teachers and school counselors, pediatricians and other medical personnel, and mental health practitioners.

It might appear unnecessary to have information on medication when the child does not seem to have any health problems; however medical records are essential to help explain any future disruptive behaviors of the child that could detrimentally impact on school and foster care placements. These behaviors could potentially be traced to medication use.

If your client is prescribed medication, ask the child's pediatrician or other medical professional the reasons for the prescription. Be sure to ask the following questions:

- What is the child's diagnosis?
- Are there alternatives to medication?
- What is the expertise of the medical professional prescribing the medication and monitoring its administration?

The American Academy of Child and Adolescent Psychiatry recommends families ask the following questions about psychotropic drugs for children and adolescents. These questions are useful for attorneys and individuals responsible for consenting to the prescription of drugs. They include:

- What is the name of the medication? Is it known by other names?
- What is known about its helpfulness with other children who have a similar condition to [the] child?
- How will the medication help [the] child? How long before [we] see improvement?
- What are the side effects which commonly occur with this medication?
- What are the rare or serious side effects which commonly occur with this medication?
- Is this medication addictive? Can it be abused?
- What is the recommended dosage? How often will the medication be taken?
- Are there any laboratory tests (e.g., heart tests, blood tests, etc.) which need to be done before [the]child begins taking the medication? Will any tests need to be done while [the] child is taking the medication?
- Will a child and adolescent psychiatrist be monitoring [the] child's response to medication and make dosage changes if necessary? How often will progress be checked and by whom?
- Are there any other medications or foods which [the] child should avoid while taking the medication?
- Are there any activities that [the] child should avoid while taking the medication? Are any precautions recommended for other activities?
- How long will [the] child need to take this medication? How will the decision be made to stop this medication?
- What should [be done] if a problem develops (e.g., if [the] child becomes ill, doses are missed, or side effects develop)?
- What is the cost of the medication (generic vs. brand name)?
- Does [the] child's school nurse need to be informed about [the] medication?[5]

These questions emphasize how seriously prescribing psychotropic medicine to a child should be taken. As advocates, we should not just accept on face value that our clients need to be on medications. There may be circumstances when medication is warranted, but in some cases it is not.

Who is consenting to the prescription of medication?

The person responsible for consenting to a child's receipt of medication should be a *responsible, caring, and knowledgeable* adult. This does not always include parents who may not be actively involved with their children, or the assigned agency caseworker who may not have the time to fully explore whether a child needs to be on medication. When deciding who should have authority to consent to medical care, the advocate should ask the following questions:

- Are either of the child's parents interested in making medical decisions affecting their child? Are they interested in learning about the drugs that will be or are being prescribed to their children? Parents are the preferred decision-maker if the permanency plan is reunification and if they are genuinely interested in their child's well-being.
- Does the assigned caseworker have the time, knowledge, and commitment to make or recommend medical decisions to authorized agency personnel responsible for making medical decisions for children in state care? If the worker does not have all three, the agency is not the appropriate "medical guardian."
- If parents and governmental agencies are inappropriate medical decision-makers, who should make health care decisions for the child? The child's lawyers should ask the court to appoint a guardian authorized to consent to the prescription of medication. Candidates include the child's foster parent, godparent, relatives, CASA or other individual who would have the knowledge to make thoughtful decisions on the child's behalf.

A court order granting an individual or agency limited guardianship to consent to the child receiving medical care (usually defined as "ordinary and necessary") is insufficient. If

psychotropic medications are to be prescribed, the court should specify that a person or agency has authority to consent to the prescription of psychotropic drugs.

The Child's Voice in Medical Decision-Making

Older clients should be asked if they wish to be on medication. Older clients should be included in discussions and informed about the drugs they are prescribed. Including them in decision-making will help ensure that drugs, if appropriate, are taken as directed, and that reports of adverse effects are documented immediately and accurately.

Advocates should consult their state laws on the issue of minors' authority to consent to medical care. Your client may have the legal authority to consent to his or her medical treatment. In most cases, a parent or guardian consents to a child's medical care. However, depending on state statute and case law, minors over a certain age or legal status may have the authority to consent to certain medical care (e.g., reproductive health services; care for pregnancy; drug and alcohol abuse counseling; and some mental health treatment).[6] Note that in some states, such as California, a minor is not authorized to consent to psychotropic drugs without a parent or guardian's consent.[7]

Preparing the Case

What if your "gut" sense is telling you your client's behavior may be the result of prescription medicines? What if your client is experiencing negative side effects? What can you do for your client?

Know your client's medical history. You need to know what your client was like before being medicated. In the cases of older children, you need to find out how your client feels about taking medication. Always review records held by hospitals, child protective service agencies, and other groups that contain infomration about the child's drug history. Dr. Diana Calvert, a pharmacologist in Oklahoma recommends taking the following steps when reviewing these records:

1. Review the child's admission history.
2. Review the medical section and write down how many times the child was given a medication.
3. Review the nurse's notes. Usually the nurse is the one who has been involved with the child and is more likely to note any behavioral characteristics that led to adminstration of the drug.
4. Look for how many times the child was started on a new drug and check the dates against the nurse's notes. Usually a behavioral incident can be matched to administration of a new drug.[8]

Find out as much about the prescribed drugs as you can, including their side effects and whether they have been clinically tested on children. You need to be able to question the experts, both off and on the witness stand.

You can find information about drugs in the most recent version of the *Physician's Desk Reference(PDR)* [9] and the *Essential Guide to Prescription Drugs.*[10] These resources offer some surprising information about commonly-prescribed drugs for children and youth.[11] For example, the 1996 *PDR Supplement A* has information on Ritalin, including:

Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established. Sufficient data on safety and efficacy of long-term use of Ritalin in children are not yet available. Although a causal link relationship has not been established, suppression of growth (i.e., weight gain, and/or height) has been reported with the long-term use of stimulants in children. Therefore, patients requiring long-term therapy should be carefully monitored. Clinical experience suggests that in phychotic (sic) children, administration of Ritalin may exacerbate symptoms of behavior disturbance and thought

disorder.[12]

Bring the *PDR* to court with you for cross-examination purposes.

You can also call the pharmaceutical company that produces the drug and ask for the package insert. This insert details information about the drug (e.g., recommended dosage, side effects).

Review copies of all records relevant to your client. The records to review include: foster care, medical (plus nursing notes), mental health, educational, group homes, and residential treatment records. Look for information on whether and what medication is prescribed, the client's behavior before and after receiving medication, any evidence of adverse side effects, consent forms, and evidence of drug monitoring (e.g., blood tests).

Speak with the medical, mental health, and other professionals involved in your client's medical care. Find out about the qualifications of the psychiatrist who is prescribing your client's medication. Ask this individual if and how often the child is being monitored for a drug's adverse side effects.

Get a second and third expert opinion on medical or mental health diagnosis and the prescription of drugs. If necessary, get a court order for a second opinion outside the institution where the child lives, and outside the court system. Advocate for the state to pay the costs for the additional opinion. A second and third opinion are in the child's best interest.

To get the names of health professionals sensitive to your client's needs, you might want to contact your state's local protection and advocacy (P&A) organization. These organizations work to protect the rights of individuals with mental, physical and developmental disabilities. Their staffs are usually familiar with mental health professionals in the community. Contact The National Association of Protection and Advocacy Systems (NAPAS) (Phone: 202-408-9514) for information on local programs in your jurisdiction.

Research the law in your jurisdiction. Find out if state statutes and agency regulations govern the administration of psychotropic or other medication. Examine their legislative history. Not many states have laws specifically addressing the issue, but some do. For instance, a Massachusetts regulation requires that a child welfare agency seek judicial approval before the agency consents to the administration of psychotropic medications to a child in their custody, even if the child's biological parents consent.[13]

Similarly, in Oregon, a relatively comprehensive statute requires the Children's Services Division to develop rules governing the use of psychotropic drugs by children in its foster care system. The statute mandates that the rules allow for detailed notice to parents, their legal representatives, and the child's legal representative or CASA of the administration of psychotropic medications to children. If any of these individuals object "to the use of or the prescribed dosage of the psychotropic medication," they may petition the court for a hearing. The court has the authority to order "an independent evaluation of the need for or the prescribed dosage of the medication." It can order that "the administration of the medication be discontinued or the prescribed dosage be modified upon a showing that either the prescribed medication or the dosage, are inappropriate."[14]

Remember to look outside the code governing juvenile or family court proceedings. Examine state statutes governing mental health services, including involuntary commitment to mental health facilities. Review "right to refuse" drug statutes and case law as they relate to adults.

Be creative. You may be able to make legal arguments on behalf of children and youth that have been made on behalf of adults. The United States Supreme Court has asserted that "the forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty" as protected by the Due Process Clause of the Fourteenth Amendment. *Washington v. Harper,* 494 U.S. 221-222, 229, 110 S. Ct. 1028, 108 L.Ed.2d 178, 198, 203; (1990); *Riggins v. Nevada*, 504 U.S. 127, 134, 112 S. Ct. 1810, 118 L.Ed.2d 479, 488 (1992).

File the necessary pleadings to get the issue before the court. An advocate in Massachusetts was successful in getting a temporary guardian appointed to consent independent of the Department of Social Services (DSS) after filing a petition with an attached memorandum of

law. At the time of the petition's filing, her client 's medication (Mellaril) had caused A significant side effects, including . . . uncontrollable tremors, nausea, and tics." And, the DSS had not obtained the court's approval to consent to the continued administration of the drug.[15]

Prepare for trial just like you would any other case. Thoroughly interview your expert witnesses. Prepare to cross examine the opposing side's experts. Organize pertinent records for submission to the court. Consider having the court hear from your client. Develop your legal arguments.

In addition to addressing consent issues in its written order, ask the court to direct the agency to submit regular progress reports on the prescription of psychotropic drugs to the child. If necessary, request that the case be scheduled for periodic court reviews. The child's receipt of medication cannot be forgotten at the end of a hearing. Progress reports and court reviews can help ensure that it is not.

Conclusion

Those of us who represent children committed to state care must be vigilant about our clients' health care needs and treatment. We must educate ourselves on relevant law and health care options so that we are better able to challenge potentially harmful treatment. For many children, accessing appropriate health care, including mental health services, is crucial to achieving permanency in their lives.

This article is not intended to provide an in depth legal analysis of all relevant issues. I would like to learn how you have addressed children's psychotropic medication use, and other issues relevant to health care decision making for children in state care. The author can be reached at the ABA Center on Children and the Law at kgrasso@staff.abanet.org or (202) 663-1730.

Notes

1. Points of view or opinions in this document are those of the author and do not represent the official position or policies of the United States Department of Health and Human Services and its subsidiary divisions.
2. Glen Pearson, *Revisiting Medication for Kids*, Students and Psychotropic Medications: The School's Role (UCLA, Department of Psychology, School Mental Health Project 1997), 38.
3. Id. at 6.
4. Telephone Interview with Dr. Dianna Calvert, Pharmocologist, Wagoner, OK (April 4, 1997).
5. Id. at 14.
6. For a discussion and comprehensive overview of consent statutes, refer to Abigail English et al., *State Minor Consent Statutes: A Summary* (Center for Continuing Education in Adolescent Health/National Center For Youth Law 1995).
7. See Cal. Fam. Code ' 6924.
8. Dr. Diana Calvert, *supra* note 4.
9. Supplements to the *PDR* are published two times per year. The *PDR* itself is published once a year by Medical Economics Company of Montvale, NJ.
10. James J. Rybacki & James W. Long, The Essential Guide to Prescription Drugs (Harper Perennial 1997).
11. UCLA Center for Mental Health in Schools, *Students and Psychotropic Medication: The School's Role* (1997) (lists references and internet resources relating to psychotropic medication and its use by children and youth).
12. Physicians' Desk Reference: Supplement A, A95.
13. 110 C.M.R. 11.14(4)(a).

14. 34 Ore. Rev. Stat. 418.517.
15. Pleading of E. Alexandra Golden, Attorney at Law, West Newton, Massachusetts.

return to top