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Sedating Forgotten Children: How Unnecessary Psychotropic Medication Endangers Foster Children's Rights and Health

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SEDATING FORGOTTEN CHILDREN: HOW UNNECESSARY PSYCHOTROPIC MEDICATION ENDANGERS FOSTER CHILDREN'S RIGHTS AND HEALTH

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Abstract: State foster care systems are forcing many foster children to take high dosages of dangerous, mind-altering psychotropic medications. State actors have little medical background for each child and have limited time to diagnose disorders, thereby creating potential constitutional and human rights violations. States are only supposed to administer psychotropic medication to a child when necessary and in the child's best interest. Many children in foster care, however, are heavily medicated despite the difficulties of proving necessity. Those difficulties are due to a combination of diagnosis practice, the foster child's background, and the poor condition of state foster care systems. In light of these limitations and the potential for using medication solely to curb bad behavior, such high prescription rates are unjustified. Many states lack in-depth tracking and oversight measures and fail to recognize this problem, thereby allowing abuse to continue and potentially preventing foster children from seeking justice.

INTRODUCTION

Between February and March 2009, seven-year-old Gabriel Myers had multiple therapists, foster home placements, and after-school programs.[1] He lost many of the privileges he typically had at his original

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[1] *Report of Gabriel Myers Work Group*, FLA. DEPARTMENT CHILD. & FAMILIES, 1, 3–4 (Nov. 19, 2009), http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/GabrielMyersWorkGroupReport082009Final.pdf [hereinafter *GM Work Group*]. Gabriel entered the foster care system on June 29, 2008, after being the subject of an abuse report, and subsequently, his mother's arrest. *Id.* at 3. In the ten months preceding his death and before he moved into the Margate foster home, Gabriel "was initially sheltered in a licensed foster home, then, after a positive home study, placed with relatives. When that placement broke down, he was returned to the licensed home in which he was initially placed." *Id.* Unfortunately, his third placement fell apart, too, and the foster care system placed him in a foster home in Margate, Florida, where he lived when he died. *Id.* One therapist documented that "it is clear that this child is overwhelmed with change and possibly re-experiencing trauma." *Id.* During the ten months in which Gabriel was in foster care, an older foster child sexually abused him and an adult relative in Ohio exposed him to pornography. *Report of Gabriel Myers Work Group on Child-on-Child Sexual Abuse*, FLA. DEPARTMENT CHILD. & FAMILIES, 1 (May 14,

home and faced changes in the visitation arrangements he had with his biological mother.[2] During this time, Gabriel acted out on numerous occasions and had other behavioral problems; as a result, doctors put him on multiple psychotropic medications covered by Medicaid.[3] He took Lexapro, an antidepressant, and Vyvanse, a medication for attention deficit hyperactivity disorder (ADHD).[4] Then, a doctor—having been warned by the FDA for over-prescribing to children—prescribed Gabriel Symbyax, a medication not recommended for use in children.[5] Symbyax, a powerful anti-depressant, contains an FDA-required black label warning in its packaging because of its potential to cause suicidal thoughts in teenagers and children.[6] Medicaid paid for Gabriel's Symbyax prescription, despite not qualifying for reimbursement.[7] By April 2009, the Florida Department of Children & Families had Gabriel on multiple psychotropic medications, even though his medical records lacked the necessary parental consent form.[8]

On April 16, 2009, less than one month after receiving the Symbyax prescription, Gabriel stayed home sick from school while his caretaker's adult son—Miguel Gould, an unlicensed caregiver—watched over him.[9] During lunch, Gabriel dumped his soup into the trash and then, as Miguel sent him to his room, claimed he wanted to kill himself.[10] In his room, Gabriel threw his toys and told Miguel that he was

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2010), http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/Gabriel%20Myers%20-COC%20Report%20May%2014%202010.pdf. Following those incidences, other children accused Gabriel of inappropriately touching them at school. *Id.* at 4. Thus, Gabriel missed significant time in school and his aunt and uncle requested that he be removed from their care. *Id.* The Gabriel Myers Work Group noted that while Gabriel was in Florida care "[n]o one followed up with Ohio authorities concerning Gabriel's medical and welfare history, and, specifically, his claims of sexual abuse were not investigated in a timely manner." *Id.* at 5. In addition, Gabriel's treating psychiatrist knew no information regarding a prior history of sexual abuse. *Id.* at 4.

[2] *Report of Gabriel Myers Work Group*, *supra* note 1, at 3–4.

[3] *Id.*; David Sessions, *Psychotropic Drug Abuse in Foster Care Costs Government Billions*, Politics Daily (June 17, 2010), http://www.politicsdaily.com/2010/06/17/psychotropic-drug-abuse-in-foster-care-costs-government-billions.

[4] *GM Work Group*, *supra* note 1, at 3–4; Sessions, *supra* note 3.

[5] Sessions, *supra* note 3.

[6] *Id.*

[7] *Id.* Due to the fact that Symbyax failed to meet the criteria for Medicaid reimbursement, it is illegal for Medicaid to pay for a prescription of Symbyax to a child. *Id.*

[8] *Report of Gabriel Myers Work Group*, *supra* note 1, at 3, 5.

[9] *Gabriel Myers Timeline*, Fla. Department Child. & Families, 25 (Nov. 19, 2009), http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/GM_timeline.pdf; *Report of Gabriel Myers Work Group*, *supra* note 1, at 1, 6; Sessions, *supra* note 3.

[10] *Gabriel Myers Timeline*, *supra* note 9, at 25.

going to commit suicide.[11] Gabriel locked himself in the bathroom and Miguel spent "five or ten minutes" opening the door.[12] By the time Miguel gained entry, Gabriel was unresponsive and, when first responders arrived, it was too late.[13] Gabriel had hung himself using the bathroom's extendable shower cord, taking his own life less than three months after his seventh birthday.[14]

Psychotropic medications are "drugs that affect the psychic function, behavior and experience of a person using them."[15] Generally, psychotropic medications are divided into six classes: stimulants, antidepressants, depressants, antipsychotics, mood stabilizers, and anxyiolitics (antianxiety).[16] These medications, however, carry significant side effects.[17] Their risks range from constipation, restlessness, and fatigue,

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[11] *Id.*

[12] *Id.* at 25–26. Daver Gould, Miguel Gould's mother and Gabriel's foster mother, told police officers that "'she received a call from Miguel Gould at about 1300 hours and said she could hear Gabriel over the phone shouting that he was not coming out of the bathroom.'" *Id.* at 26. Miguel was able to get the door open by using a screwdriver to pick the lock. *Id.*

[13] *Id.* at 25–26.

[14] *See id.* at 13, 26.

[15] Roger A. Hughes et al., *Flashpoint: Children, Adolescents and Psychotropic Medications*, Ariz. Health Futures, 4 (Aug. 2006), http://www.slhi.org/publications/issue_briefs/pdfs/ib-2006-August.pdf. Many definitions of psychotropic medications "stress the effect of psychotropic drugs on mind, emotions and behavior; or use the term 'psychoactive' to refer to the 'active' effects of these drugs on mental experiences and behavior." *Id.* at 4.

[16]Angela Olivia Burton, *"They Use it Like Candy": How the Prescription of Psychotropic Drugs to State-Involved Children Violates International Law*, 35 Brook. J. Int'l L. 453, 466 (2010); Hughes et al., *supra* note 15, at 4. Stimulant medications include medications that treat ADHD, such as Adderall (amphetamine) and Ritalin (methylphenidate). Hughes et al., *supra* note 15, at 4. Examples of antidepressant and antianxiety medications include Anafranil (clomipramine), Prozac (fluoxetine), and Zoloft (sertraline), as well as the Lexapro and Symbyax administered to Gabriel Myers. *Id.*; Sessions, *supra* note 3. Antidepressants are also used on children for a variety of conditions, including ADHD, depression, anxiety disorders, uncontrollable agitation, post-traumatic stress disorder, bulimia, bedwetting, obsessive-compulsive disorder (OCD), and aggressive behavior. Burton, *supra*, at 466 n.54; Hughes et al., *supra* note 15, at 4. Antipsychotics, such as Thorazine (chlorpromazine), are not only used for psychoses—such as schizophrenia, mania, and psychotic depression—but are also used in children to treat severe ADHD, depression, conduct problems, and aggressive behavior. Burton, *supra*, at 466 n.53; Hughes et al., *supra* note 15, at 4. Mood stabilizing medications such as Depakote (divalproex sodium) and Lithobid (lithium carbonate) can be used to treat bipolar disorders, aggressive behaviors, and "labile mood with tantrums or rages." Burton, *supra*, at 467 n.56; Hughes et al., *supra* note 15, at 4. Finally, anti-anxiety medications are used in children to treat seizures, panic attacks, and anxiety or behavior disorders. Burton, *supra*, at 466 n.55.

[17] *See* Hughes et al., *supra* note 15, at 22–28. Psychotropic medications are commonly used in children to treat anxiety, depression, ADHD, OCD, eating disorders, bipolar disorder, psychosis, autism, aggressive behavior, sleep problems, and bedwetting. *Facts for Families: Psychiatric Medication for Children and Adolescents: Part 1—How Medications Are Used*, Am. Acad.

to more serious complications such as impaired motor skills, convulsions, liver damage, and suicidal thoughts.[18] Some can even cause tardive dyskenisia—a neurological disorder producing "involuntary and grotesque movements of the face, mouth, tongue, jaw and extremities and which is irreversible in its most severe form"—chronic irreversible neurological impairments, and death.[19]

There are few studies analyzing the potential long-term effects of psychotropic medications on children or their mental development.[20] The limits of medical science require physicians to diagnose disorders warranting psychotropic medication through symptoms rather than testing directly for diseases.[21] Physicians, psychiatrists, and other practices are not regulated by the FDA and their prescriptions may be "off-label," meaning that they can prescribe higher dosages or medication not approved for children.[22] According to a 2006 report, the FDA approved only thirty-one percent of psychotropic medications for children, but children took approximately forty-five percent of their psy-

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Child & Adolescent Psychiatry 1, 2 (July 2004), http://www.aacap.org/galleries/FactsForFamilies/21_psychiatric_medication_for_children_and_adolescents_part_one.pdf.

[18] Burton, *supra* note 16, at 467; Kathleen Knepper, *The Importance of Establishing Competence in Cases Involving the Involuntary Administration of Psychotropic Medication*, 20 Law & Psychol. Rev. 97, 124–25 (1996); *see also* Sessions, *supra* note 3.

[19] Trudi Kirk & Donald N. Bersoff, *How Many Procedural Safeguards Does It Take to Get a Psychiatrist to Leave the Lightbulb Unchanged? A Due Process Analysis of the MacArthur Treatment Competence Study*, 2 Psychol. Pub. Pol'y & L. 45, 59 (1996); Knepper, *supra* note 18, at 125.

[20] *See Need to Know on PBS: The Watch List: The Medication of Foster Children* (PBS television broadcast Jan. 7, 2011), *available at* http://www.pbs.org/wnet/need-to-know/health/video-the-watch-list-the-medication-of-foster-children/6232 [hereinafter *PBS*].

[21] *See id.*; *see also* Bob Jacobs, *Legal Strategies to Challenge Chemical Restraint of Children in Foster Care: A Resource for Child Advocates in Florida*, Advocacy Center for Persons with Disabilities, Inc., 7, http://www.guardianadlitem.org/documents/LegalStrategiestoChallengeChemicalRestraintofChildreninFosterCare.pdf (last visited Feb. 2, 2012).

[22] Michael W. Naylor et al., *Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations*, 86 Child Welfare 175, at 177–78 (2007); *PBS*, *supra* note 20; *Psychotropic Medication Utilization Parameters for Foster Children*, Tex. Department Fam. & Protective Services, 3 (Dec., 2010), http://www.dfps.state.tx.us/documents/about/pdf/TxFosterCareParameters-December2010.pdf. In fact, the FDA does not limit the manner in which physicians, psychiatrists, and other kinds of practitioners prescribe FDA approved medication. *Psychotropic Medication Utilization Parameters for Foster Children*, *supra*, at 3. Though these "off-label" uses are not approved in children, "it may represent the standard of care." Naylor et al., *supra*, at 177–78. Physicians are expected to "utilize the available evidence, expert opinion, their own clinical experience, and exercise their clinical judgment in prescribing what is best for each individual patient." *Psychotropic Medication Utilization Parameters for Foster Children*, *supra*, at 3.

chotropic medications off-label.[23] Due to the known side effects, unknown developmental risks, and mind altering impact, best practices dictate that children should only take psychotropic medication when absolutely necessary and as a last resort.[24]

Though the state in some instances properly administers psychotropic medication to foster children in need, overcrowded care facilities, high caregiver turnover, and inadequate administration increases the risk of over-medication.[25] Additionally, practitioners and caseworkers have discretionary power—deciding what is within the best interest of the child—to administer mind-altering medication through Medicaid.[26] Due to this discretionary authority, psychotropic medication is often seen as a way to chemically restrain hyperactive or difficult children and not a last resort.[27] Every person has the basic human and constitutional right to be free from the dangers of unnecessary, mind-

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[23] Naylor et al., *supra* note 22, at 178. In addition, medications like clonidine and divalproex can be used to treat some specific medical illnesses for children under the age of eighteen but not for treating psychiatric disorders. *Id.*

[24] *See* Burton, *supra* note 16, at 467 ("Best practices dictate that psychotropic drugs should be used only as a last resort, and never as the sole approach to addressing children's mental health needs."); Naylor et al., *supra* note 22, at 178; Jacqueline A. Sparks & Barry L. Duncan, *The Ethics and Science of Medicating Children*, 6 ETHICAL HUM. PSYCHOL. & PSYCHIATRY 25, 36 (2004) ("[W]e consider the practice of prescribing drugs to youths as clearly the last resort, and in many cases, unethical, until other options have been discussed."); *see also* Sell v. United States, 539 U.S. 166, 181 (2003) ("The court must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results."); M. Lynn Crismon & Tami Argo, *The Use of Psychotropic Medication for Children in Foster Care*, 88 CHILD WELFARE 71, 73 (2009) ("Principles of evidence-based medicine recommend that clinicians should utilize treatments with research-proven evidence for their patients before using unproven treatments."); *Psychotropic Medication Utilization Parameters for Foster Children*, *supra* note 22, at 3 ("The role of non-pharmacological intervention should be considered before beginning a psychotropic medication, except in urgent situations . . . .").

[25] *See* Sandra Stukes Chipungu & Tricia B. Bent-Goodley, *Meeting the Challenges of Contemporary Foster Care*, 14 FUTURE CHILD. 75, 75 (2004) (discussing the status and inadequacies of state foster care systems); *Report of Gabriel Myers Work Group*, *supra* note 1, at 7 (describing medication practices for the Florida Department of Children & Families); PBS, *supra* note 20 (reporting on psychotropic medication prescriptions of foster children). Inadequate administrative measures include poor finances, improper training of caregivers, inconsistent monitoring, and neglected medical records. *See* Chipungu & Bent-Goodley, *supra*, at 75; *Report of Gabriel Myers Work Group*, *supra* note 1, at 7; PBS, *supra* note 20.

[26] Maggie Brandow, Note, *A Spoonful of Sugar Won't Help This Medicine Go Down: Psychotropic Drugs for Abused and Neglected Children*, 72 S. CAL. L. REV. 1151, 1161 (1999); *see* PBS, *supra* note 20 (discussing the administration of psychotropic medication to foster children).

[27] *See* PBS, *supra* note 20.

altering medication.[28] These children, however, do not have the means to protect their right to avoid unnecessary medication, or alternatively, someone interested in securing that right for them.[29]

This Note argues that the government needs to develop a national database of medical records, track prescriptions, and adopt stricter administration regulations for psychotropic medications to protect the rights of foster children. Part I explores the idea of informed consent and analyzes the difference between a parent's right to choose when to medicate a child and a state's decision to do so. Part II illustrates why states cannot consistently act in a child's best interest and should only administer psychotropic medication when indisputably necessary. Part III addresses why state actors may choose psychotropic medication for reasons other than the best interest of the child. Part IV discusses how the lack of oversight measures, mixed with wide discretion and qualified immunity, allows this abuse to continue and may work to keep these problems out of court. Finally, Part V analyzes what has and needs to be done on a state and federal level to ensure the safety of foster children.

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[28] *See Sell*, 539 U.S. at 179–81; Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278 (1990); Vitek v. Jones, 445 U.S. 480, 493–94 (1980); Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 74 (1976); Burton, *supra* note 16, at 490–96 (addressing the human rights violations caused by the overmedication of foster children); Brandow, *supra* note 26, at 1169–73 (discussing children's constitutional rights involving psychotropic medication). An individual's right to refuse unwanted medical treatment comes from the general right to privacy established in *Griswold v. Connecticut*. *See* 381 U.S. 479, 485–86 (1965) (establishing the right to privacy regarding contraceptive use); James C. O'Leary, Note, *An Analysis of the Legal Issues Surrounding the Forced Use of Ritalin: Protecting a Child's Right to "Just Say No,"* 27 New Eng. L. Rev. 1173, 1181 (1993). Children also have the rights to privacy and protection from unwanted medical treatment because "[c]onstitutional rights do not mature and come into being magically only when one attains the state-defined age of majority." *Danforth*, 428 U.S. at 74.

[29] *See* Laurel K. Leslie et al., Tufts Clinical & Translational Sci. Inst., Multi-State Study on Psychotropic Medication Oversight in Foster Care 2 (Sept., 2010), *available at* http://www.tuftsctsi.org (under the "About Us" menu, select "Announcements"; then follow the "Landmark Report on Psychotropic Medication and Foster Care Calls for National Resources" hyperlink; then follow the "study report is available here" hyperlink); *Report of Gabriel Myers Work Group*, *supra* note 1, at 9 (addressing the failure of Florida foster care workers to properly protect Gabriel Myers's rights). The state may put foster children into medical testing experiments without consent if the medication involved in the testing is considered beneficial to the child. *See* Sheryl L. Buske, *Foster Children and Pediatric Clinical Trials: Access Without Protection Is Not Enough*, 14 Va. J. Soc. Pol'y & L. 253, 278–80 (2007) (discussing the law regarding foster child placement in medical testing experiments).

I. The Basis for Providing Informed Consent for a Child

Each patient must give informed consent before undergoing medical treatment.[30] For those under the age of majority, parents or guardians have the right to provide informed consent on their behalf.[31] When a child is in foster care, however, the state does not have a similar right and the child's right to autonomy may sometimes trump state interests.[32]

A. *The Requirement of Informed Consent*

Courts have generally held that informed consent is required for any medical treatment.[33] This is based on the natural and constitutional right of bodily self-determination—the belief that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ."[34] Under the doctrine of informed consent, "physicians have a duty to make adequate disclosures to patients regarding proposed medical treatment so that patients can make knowledgeable choices."[35]

There are two competing methods to determine whether a physician's disclosure is adequate for a patient to give informed consent.[36] First, the reasonable physician standard requires a physician to disclose any information that a reasonable physician would provide to the patient.[37] States, however, have generally adopted the second approach,

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[30] Washington v. Glucksberg, 521 U.S. 702, 724 (1997).

[31] *See* Doriane Lambelet Coleman, *The Legal Ethics of Pediatric Research*, 57 Duke L.J. 517, 545–48 (2007).

[32] *See* Knepper, *supra* note 18, at 106–07; Stephen A. Talmadge, *Who Should Determine What Is Best for Children in State Custody Who Object to Psychotropic Medication?*, 15 Annals Health L. 183, 194–95 (2006).

[33] *Glucksberg*, 521 U.S. at 724–25 (quoting Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 277 (1990)) ("After reviewing a long line of relevant state cases, we conclude that 'the common law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment'").

[34] Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914); *see also* Cruzan, 497 U.S. at 269.

[35] Richard A. Heinemann, *Pushing the Limits of Informed Consent:* Johnson v. Kokemoor *and Physician-Specific Disclosure*, 1997 Wis. L. Rev. 1079, 1082. The purposes of informed consent are: "(1) to promote individual autonomy; (2) to protect the patient subject's status as a human being worthy of respect; (3) to avoid fraud and duress; (4) to encourage self-scrutiny by the physician/researcher; (5) to promote rational decision making; and (6) to involve the public in important questions about health care policy and research." Talmadge, *supra* note 32, at 189.

[36] Armand Arabian, *Informed Consent: From the Ambivalence of* Arato *to the Thunder of* Thor, 10 Issues L. & Med. 261, 262–63 (1994).

[37] *Id.* at 263.

that of the reasonable patient, where a physician must "disclose whatever information a reasonable *patient* would find material . . . ."[38] The disclosure must include "information relating risks, benefits, and available alternatives, including no treatment . . . ."[39] Accordingly, the American Medical Association (AMA) defines informed consent as "more than simply getting a patient to sign a written consent form. It is a process of communication between a patient and physician that results in the patient's authorization or agreement to undergo a specific medical intervention."[40]

For a patient to give informed consent, the patient must fulfill three elements: possession of knowledge about the modes of treatment, voluntary consent, and competency to determine what is in his or her best interest.[41] Competency or capacity is "the basic capacity to arrive at a decision by assimilating information through a reasonable process of thinking."[42] When one is incompetent to give informed consent, that person's guardian must receive the same information and opportunity to weigh the risks and benefits.[43] The guardian is generally held to the best interest standard, and therefore chooses an option that is in the incompetent person's best interest of health and person.[44]

The general view in the United States is that children cannot meet the elements required to adequately give informed consent to medical treatment.[45] Therefore, the child's parent—absent evidence of abuse

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[38] *Id.*

[39] *Id.*

[40] *Informed Consent*, Am. Med. Ass'n, 1 (Mar. 17, 2011), http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/informed-consent.shtml. The AMA says that physicians should discuss with the patient: 1) his or her diagnosis, if it is known; 2) the medication's nature and purpose; 3) the medication's risks and benefits; 4) available alternatives to the medication, regardless of costs or its insurance coverage; 5) the risks and benefits of alternative treatments or procedures; and 6) the potential risks and benefits of not receiving the medication or treatment. *Id.*

[41] Brandow, *supra* note 26, at 1163.

[42] *Id.* at 1164. Someone who is mentally ill or incompetent to consent to or refuse psychiatric hospitalization is not necessarily incompetent to refuse or give informed consent to psychotropic medication. Talmadge, *supra* note 32, at 188–90.

[43] Talmadge, *supra* note 32, at 191.

[44] *Id.* The guardian may also base his or her decision on the "substituted judgment" standard, which requires the guardian to make the choice that is most in line with what the incompetent person would choose if he or she had the capacity to make the decision. *See id.* at 204; Brandow, *supra* note 26, at 1159.

[45] *See* Coleman, *supra* note 31, at 546–47; Susan D. Hawkins, Note, *Protecting the Rights and Interests of Competent Minors in Litigated Medical Treatment Disputes*, 64 Fordham L. Rev. 2075, 2075 (1996). This view remains intact despite several studies showing that adolescents have sufficient capacity to competently make medical decisions and the Supreme Court recognizing the right of a minor to have an abortion without state or parental con-

or neglect—is given authority.[46] When a child is in state custody, however, the state retains the right to choose a treatment.[47] Thus, the state can medicate children in foster care according to their best interest, regardless of their competency and proximity to the age of majority or the availability of alternative treatments.[48]

B. *Parental Rights and Abilities to Provide Informed Consent*

A parent's right to decide what is best for a child relies on two principles: personal rights and the belief that parents are most suited to provide for a child's best interest.[49] Accordingly, parents are usually considered the sole authority for their children and receive deference in considerations of medical treatment, regardless of the child's competency.[50]

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sent. *See* Coleman, *supra* note 31, at 547 n.118; Talmadge, *supra* note 32, at 189–92; Hawkins, *supra*, at 2077, 2095–96; *see also* Bellotti v. Baird, 443 U.S. 622, 651 (1979) (invalidating a statute requiring unmarried women under the age of eighteen to get parental consent, or at minimum, inform parents of any intentions prior to obtaining judicial approval); Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 74 (1976) (finding that a state cannot create a provision "requiring consent of a parent or person *in loco parentis* as a condition for abortion of an unmarried minor during the first 12 weeks of her pregnancy"). In fact, various studies have "found that choices made by fourteen-year-olds did not differ significantly from those of adults in terms of comprehension, understanding of alternatives, rational reasoning, and decision making processes when responding to medical and psychological treatment hypotheticals." Talmadge, *supra* note 32, at 191. Although the competency of minors in making their own medical decisions is a significant issue, this Note focuses on all foster children, regardless of whether they have the intellectual capacity and competency to fully comprehend the potential risks and dangers of the psychotropic medication they may be forced to take.

[46] Coleman, *supra* note 31, at 548–49; *see also* Commonwealth v. Nixon, 761 A.2d 1151, 1152–53 (Pa. 2000) (refusing to adopt a "mature minor doctrine" when a sixteen year-old daughter refused medical care because the doctrine would absolve parents' rights and responsibilities to care for their children).

[47] Talmadge, *supra* note 32, at 183.

[48] *See* Coleman, *supra* note 31, at 546–47; Talmadge, *supra* note 32, at 189–92; Hawkins, *supra* note 45, at 2075; *see, e.g.*, *Nixon*, 761 A.2d at 1152–53.

[49] *See* Coleman, *supra* note 31, at 545–48 (discussing the boundaries of parental authority); Elizabeth S. Scott & Robert E. Scott, *Parents as Fiduciaries*, 81 VA. L. REV. 2401, 2401 (1995) (analyzing the parent-child relationship); Joyce Koo Dalrymple, Note, *Seeking Asylum Alone: Using the Best Interests of the Child Principle to Protect Unaccompanied Minors*, 26 B.C. THIRD WORLD L.J. 131, 143–44 (2006) ("There is a presumption that absent a finding of abuse or neglect, parents act in the best interests of their children.").

[50] *See* Coleman, *supra* note 31, at 545–48; Scott & Scott, *supra* note 49, at 2401.

1. Parents' Constitutional Rights to Provide Informed Consent for Children

The decision to medicate a child involves the rights of both the child and the parent.[51] A parent's right is based on the "constitutional doctrine of parental autonomy."[52] The Supreme Court has continually recognized that an individual's freedom to determine family matters is a constitutionally protected right under the Fourteenth Amendment.[53] "[P]arents are entitled to raise their children as they see fit" and can make most of a child's decisions when the child is a minor.[54] Thus, parents receive deference in determining the course of medical treatment for children in the same manner as personal medical treatment choices for competent individuals.[55] Therefore, parents may ignore side effects and safer alternative treatments and choose psychotropic medication for their children as long as the choice is "recommended by their physician and . . . has not been totally rejected by all responsible medical authority."[56]

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[51] *See Danforth*, 428 U.S. at 74; Coleman, *supra* note 31, at 545–48.

[52] Coleman, *supra* note 31, at 545; *see also* Troxel v. Granville, 530 U.S. 57, 65 (2000) ("[T]he interest of parents in the care, custody, and control of their children . . . is perhaps the oldest of the fundamental liberty interests recognized by this Court."); Santosky v. Kramer, 455 U.S. 745, 753 (1981) (discussing "the fundamental liberty interest of natural parents in the care, custody, and management of their child"); Talmadge, *supra* note 32, at 183 ("Parents normally have the right to direct the education and upbringing of their children as well as to decide whether and when their minor children will get medical treatment.").

[53] *Troxel*, 530 U.S. at 65; *Santosky*, 455 U.S. at 753. The courts tend to "defer to parental choice in medical treatment cases out of respect for parental authority . . . ." Talmadge, *supra* note 32, at 183.

[54] Coleman, *supra* note 31, at 546. Due to this doctrine, parents are also given the right to make a variety of day-to-day decisions for their children, including "where their children go to school, with whom they associate, what treatment they receive in the event they become ill or injured, and in general the values according to which they are raised." *Id.* at 548 (citations omitted); *see also Troxel*, 530 U.S. at 78 (Souter, J., concurring); Parham v. J.R., 442 U.S. 584, 604 (1979); Wisconsin v. Yoder, 406 U.S. 205, 233 (1972) (discussing "the rights of parents to direct the religious upbringing of their children").

[55] *See Santosky*, 455 U.S. at 753; Saratoga Cnty. Dep't of Soc. Servs. v. Hofbauer, 393 N.E.2d 1009, 1013–14 (N.Y. 1979) (holding that a parent has wide deference in choosing the kind of medical care for a child); Bottoms v. Bottoms, 457 S.E.2d 102, 104 (Va. 1995) (quoting Malpass v. Morgan, 192 S.E.2d. 794, 799 (Va. 1972)) ("a parent's rights 'are to be respected if at all consonant with the best interests of the child'"). Courts, however, have given less deference to the decisions of divorced or separated parents with joint physical and legal custody of a child. *See, e.g.*, Hardin v. Hardin, 711 S.W.2d 863, 865 (Ky. Ct. App. 1986) (authorizing trial courts to make their own determination of what is best for a child when two parents cannot agree); *see also* Coleman, *supra* note 31, at 548 n.126.

[56] *Hofbauer*, 393 N.E.2d at 1014.

2. Societal Interest in Allowing Parents to Provide Informed Consent

Although parental autonomy is based on the Fourteenth Amendment, a parent's right is also based on the best interest of his or her child.[57] Parents retain the right to act in their child's best interest because of their inherent instinct to do so and their ability to make rational decisions.[58] Furthermore, parents placing their children on psychotropic medication are usually most familiar with the child's behavior and needs, and therefore can monitor potential side effects.[59] Thus, even if the child objects to treatment, parental decisions outweigh the child's decision.[60] The parent's action in the child's best interest ensures protection of the child's health and safety.[61]

Parental deference, however, is not absolute.[62] Courts may rebut the presumption of deference in favor of a child's autonomy if evidence shows that the parent puts the child at risk of harm or violates state

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[57] Coleman, *supra* note 31, at 545–48; Scott & Scott, *supra* note 49, at 2432–37 (discussing the biological bonds and societal norms that influence parental decision rights); Brandow, *supra* note 26, at 1159 (discussing how states base parental autonomy on "trusting parents to act in the best interest of their children").

[58] *Troxel*, 530 U.S. at 69; *Parham*, 442 U.S. at 603 ("Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments."); Coleman, *supra* note 31, at 546–48 ("[T]he law formally presumes that whatever the parent's decision, it is in the child's best interests."); Brandow, *supra* note 26, at 1159–61 (discussing the belief that children "lack the mental competence and maturity possessed by adults" to properly give informed consent to medical treatment); Hawkins, *supra* note 45, at 2081. It is worth noting that "[t]his is a dangerous assumption, because even in the most ideal situation of a 'loving, intact, two-parent family,' there are conflicts of interest between parents and child which could prevent the parents from choosing in the child's best interests." Brandow, *supra* note 26, at 1159–60. Furthermore, a parent may be unable to accurately act in the child's best interest "because of their own dysfunctional upbringing, lack of education, or even mental illness." *Id.* at 1160.

[59] *See* Prince v. Massachusetts, 321 U.S. 158, 166 (1944) ("It is cardinal with us that the custody, care, and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder."); Hawkins, *supra* note 45, at 2081; *Report of Gabriel Myers Work Group*, *supra* note 1, at 4 (stating that part of the failure to recognize Gabriel Myers's problems was that no single individual took full responsibility to monitor him and meet his needs).

[60] *See* Talmadge, *supra* note 32, at 183. In addition, another theory for allowing parents to give consent for their children is that parents may frequently choose the same option as the child would if given the opportunity. Brandow, *supra* note 26, at 1159–60.

[61] Brandow, *supra* note 26, at 1159–60.

[62] Coleman, *supra* note 31, at 548; Talmadge, *supra* note 32, at 183 ("Courts tend to defer to parental choice in medical treatment cases out of respect for parental authority, but a court may not always view the best interests of the child in the same way that child's parents view his or her interests.").

child protection laws through abuse or neglect.[63] States, therefore, may restrict a parent's control over his or her child based on its compelling interest to protect children from harm.[64]

C. *States Have Limited Parens Patriae Powers When Choosing a Course of Medical Treatment for a Child*

The state's authority to determine the medical treatment for a child in its custody is based on its limited parens patriae powers.[65] Those parens patriae powers give the state the authority and duty to protect those who lack the mental capacity to act in their own best interest.[66] With regard to foster children, these powers are based on: "(1) the presumption that children lack the mental competence and maturity possessed by adults, (2) the fact that the child's parents are unfit, unwilling, or unable to care for the child, and (3) the requirement that the *parens patriae* power be exercised only to further the best interests of the child."[67] Whereas parental interests outweigh a child's right to personal autonomy, children in state custody do not necessarily have their interests outweighed by the state.[68] State decisions of medical treatment made without prior consent from the child or parent likely infringes an

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[63] Coleman, *supra* note 31, at 548–49 nn.126–27. Among other things, these laws mainly pertain to "physical abuse, emotional abuse, and neglect." *Id.* at 549.

[64] *See* Stanley v. Illinois, 405 U.S. 645, 651–52 (1972); *Prince*, 321 U.S. at 170 ("Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children . . . ."); *see also* Coleman, *supra* note 31, at 549 ("Federal constitutional law generally embraces these boundaries on the ground that states have a compelling interest in protecting children from harm and risk that is intentionally inflicted by their parents.").

[65] Brandow, *supra* note 26, at 1161.

[66] *Id.* The doctrine is "grounded in the actual or assumed incapacity of the individual to engage in rational decision making in his or her own best interest." Bruce J. Winick, *The MacArthur Treatment Competence Study: Legal and Therapeutic Implications*, 2 PSYCHOL. PUB. POL'Y & L. 137, 145 (1996).

[67] Brandow, *supra* note 26, at 1161. "[E]ven though a parent has lost the care and custody of his or her children due to neglect, he or she still retains his or her constitutional right (i.e., liberty interest) to the management of important medical decisions for those children." *In re* Martin F., 820 N.Y.S.2d 759, 772 (Fam. Ct. 2006) (recognizing that a foster child's biological mother's explicit objection to the state administering psychotropic medication to her child deserves protection, as long as there was no court order).

[68] *See* Talmadge, *supra* note 32, at 195 ("Although the circuit courts seem to be divided, it appears that applicable precedent exists for asserting a right to refuse psychotropic medication on the basis of liberty interest and constitutional privacy grounds."); *see also* Brandow, *supra* note 26, at 1161–63 (arguing for limited state parens patriae power); O'Leary, *supra* note 28, at 1201; *supra* notes 25–29 and accompanying text.

individual's constitutional and common law rights to privacy and autonomy.[69]

II. State Administration of Psychotropic Medication to Foster Children, Necessity, and Protecting the Child's Best Interest

States must make a firm showing of necessity when medicating wards with psychotropic medication because the potential for mind-altering side effects constitutes an intrusive treatment regimen.[70] The lack of funding for and collaboration between caseworkers and caregivers sometimes creates a risk of misdiagnosis, and therefore, may impede that showing of necessity.[71]

A. *Administering Psychotropic Medication Without Consent Is a Severe Infringement on Constitutional Rights*

The Supreme Court has consistently held that the right to privacy and bodily integrity grants individuals the freedom from being forced to take psychotropic medication.[72] The state cannot infringe this right without a legitimate interest for treatment that cannot be achieved by less intrusive means.[73] Medication may curtail individual liberties and free will more than most bodily restraints or other treatments because it alters the mind and has the potential for long-term side effects.[74]

The Supreme Court's jurisprudence on the use of psychotropic medication in adults emphasizes the constitutional right to be free

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[69] *See* Knepper, *supra* note 18, at 106–07; Talmadge, *supra* note 32, at 194–95; *supra* notes 25–29 and accompanying text.

[70] *See* Sell v. United States, 539 U.S. 166, 181 (2003); Riggins v. Nevada, 504 U.S. 127, 133–35 (1992); Washington v. Harper, 494 U.S. 211, 229 (1990); Talmadge, *supra* note 32, at 183–84, 194–95. In reference to the forced administration of psychotropic medication, the court in *Rodgers v. Okin*, stated "[t]he First Amendment protects the communication of ideas. That protected right of communication presupposes a capacity to produce ideas. As a practical matter, therefore, the power to produce ideas is fundamental to our cherished right to communicate and is entitled to comparable constitutional protection." 478 F. Supp. 1342, 1367 (D. Mass. 1979), *vacated sub nom.*, 457 U.S. 291.

[71] *See* Burton, *supra* note 16, at 457; Naylor et al., *supra* note 22, at 175–78; PBS, *supra* note 20.

[72] *See* O'Leary, *supra* note 28, at 1201; *see also* Mills v. Rogers, 457 U.S. 291, 299 (1982); Stanley v. Georgia, 394 U.S. 557, 565 (1969) ("Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds.").

[73] *See Sell*, 539 U.S. at 181; O'Leary, *supra* note 28, at 1201.

[74] *See* Talmadge, *supra* note 32, at 184; *see also* Nancy K. Rhoden, *The Right to Refuse Psychotropic Drugs*, 15 Harv. C.R.-C.L. L. Rev. 363, 373 (1980) (discussing the idea that forced administration may violate an individual's First Amendment freedom to thought).

from forced administration.[75] In *Washington v. Harper*, the Court prohibited medicating a mentally ill inmate unless the state's interest outweighed the "substantial interference" imposed on his constitutional rights to liberty.[76] In *Riggins v. Nevada*, the Court held unconstitutional the forced administration of anti-psychotic medication to a defendant as a "particularly severe" interference with his Fourteenth Amendment personal liberty rights.[77] The state actions, however, could have been justified if treatment was medically appropriate and done for safety, but only after "considering less intrusive alternatives . . . ."[78]

The Supreme Court determined this level of appropriateness in *Sell v. United States*, holding that it must be "*necessary* to further [the state's] interests" when safer or less intrusive treatments "are unlikely to achieve substantially the same results."[79] The Court has recognized the right to be free from forced administration of psychotropic medication for incompetent adults, and would likely extend this same right to children if given the opportunity.[80] Therefore, states must likely meet a de facto higher standard of necessity when choosing psychotropic medication because the potential for mind-altering side effects creates an intrusive treatment regimen.[81]

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[75] *See Sell*, 539 U.S. at 181–82; *Riggins*, 504 U.S. at 133–35; *Harper*, 494 U.S. at 229–30; *Mills*, 457 U.S. at 299; *see also* Talmadge, *supra* note 32, at 184, 194–95; Brandow, *supra* note 26, at 1176 (discussing the Supreme Court's concerns regarding psychotropic medication). Furthermore, states may adopt broader and more extensive liberty interests under the Due Process Clause than those protected by the Constitution. *See Mills*, 457 U.S. at 300.

[76] 494 U.S. at 229; *see also Riggins*, 504 U.S. at 133–35.

[77] 504 U.S. at 134, 138.

[78] *Id.* at 135; *see Sell*, 539 U.S. at 179.

[79] 539 U.S. at 181.

[80] *See* Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 74 (1976) ("Minors, as well as adults, are protected by the Constitution and possess constitutional rights."); Talmadge, *supra* note 32, at 194–95 ("Although the circuit courts seem to be divided, it appears that applicable precedent exists for asserting a right to refuse psychotropic medication on the basis of a liberty interest and constitutional privacy grounds."); Brandow, *supra* note 26, at 1176 ("The law should protect the privacy and bodily integrity of minors by taking into account the Supreme Court's concern regarding forced treatment with psychotropic medications."); *see also Sell*, 539 U.S. at 181; *Riggins*, 504 U.S. at 133–35; *Harper*, 494 U.S. at 229; *Mills*, 457 U.S. at 299.

[81] *See Sell*, 539 U.S. at 181; *Riggins*, 504 U.S. at 133–35; *Harper*, 494 U.S. at 229; Talmadge, *supra* note 32, at 183–84, 194–95. In reference to the forced administration of psychotropic medication, the court in *Rodgers v. Okin* stated, "The First Amendment protects the communication of ideas. That protected right of communication presupposes a capacity to produce ideas. As a practical matter, therefore, the power to produce ideas is fundamental to our cherished right to communicate and is entitled to comparable constitutional protection." 478 F. Supp. at 1367.

B. *States Are Ill-Equipped to Consistently Act in the Best Interest of All Children in Foster Care*

State foster care systems may not always act in a child's best interest because they are constricted by finite resources, high turnover rates, limited training, and poor working conditions.[82] Generally, a child's caseworker and foster parents are in charge of ensuring compliance with his or her best interest, though such duties and responsibilities are not formally delineated.[83] As the "face of foster care," caseworkers make major decisions involving the child's care, including whether to consent to psychotropic medication.[84] There are two major types of foster parents: unrelated foster parents and kin caregivers.[85] Kin caregivers are relatives of the child and account for less than one-third of foster parents nationwide.[86] All foster parents are responsible for monitoring their children but, because they cannot make medical decisions, caseworkers regularly do not inform them about mental health assessments or ask for any feedback.[87] States vest this power in caseworkers because they

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[82] Joseph Goldstein, *Medical Care for the Child at Risk: On State Supervention of Parental Autonomy*, *in* CHILD, PARENT, AND STATE: LAW AND POLICY READER 460, 462–63 (S. Randall Humm et al. eds., 1994); Chipungu & Bent-Goodley, *supra* note 25, at 83; Brandow, *supra* note 26, at 1162–63.

[83] *See* Naylor et al., *supra* note 22, at 181–83; Anne S. Robertson, *Including Parents, Foster Parents and Parenting Caregivers in the Assessments and Interventions of Young Children Placed in the Foster Care System*, 28 CHILD. & YOUTH SERV. REV. 180, 183–87 (2006). *See generally* Sandra Bass et al., *Children, Families, and Foster Care: Analysis and Recommendations*, 14 FUTURE CHILD. 5 (2004) (discussing the roles of foster parents and caseworkers).

[84] Bass et al., *supra* note 83, at 18–19, 23–24; *see* Naylor et al., *supra* note 22, at 182. Once a course of treatment is approved by the prescribing physician or psychiatrist, it is common for states to require informed consent through the child's parent or caseworker. Naylor et al., *supra* note 22, at 182. Nevertheless, in jurisdictions that require parental consent, if the state fails to locate the parent or finds the parent unsuitable to provide informed consent, then the caseworker may provide consent. *See id.*; Brandow, *supra* note 26, at 1161. In a 2007 study of thirty-seven states, only six require a court order prior to the administration of psychotropic medication and, in some of those states, the order is only necessary if the parent cannot be located. Naylor et al., *supra* note 22, at 181–82.

[85] *See* Bass et al., *supra* note 83, at 16–18.

[86] *See id.* at 17. Even though children placed with kin caregivers tend to have greater stability in placements compared to children placed with unrelated foster parents, kin caregivers tend to be older and have a higher chance of being single, of limited education, and poor health. *Id.* In addition, due to akin caregiver's ties to the child's birth parents, he or she is more likely to allow unsupervised visits by the child's parents. *Id.* In some cases, these unsupervised visitations may increase the probability of the child facing repeated abuse. *Id.*

[87] *See Hearing on the Utilization of Psychotropic Medication for Children in Foster Care: Hearing Before the Subcomm. on Income Security and Family Support of the H. Comm. on Ways & Means*, 110th Cong. 4 (2008) (testimony of Laurel K. Leslie, of the American Academy of Pediat-

cannot provide caregivers with the sufficient resources and training needed to handle each child's constantly changing needs or demands.[88]

Therefore, foster parents and caseworkers do not properly collaborate to monitor the effects of psychotropic medication on foster children.[89] Because caseworkers usually only spend a limited period of time with a child, the state is simply "too crude an instrument to become an adequate substitute for parents."[90] Compounding the crude treatment is the foster child's complex life experience that may result in behavior nearly identical to that of many psychiatric disorders.[91] Due to the lack of funding and collaboration with caseworkers, caregivers are unlikely to distinguish trauma-induced behavior from a psychiatric condition and therefore create a risk of misdiagnosis.[92]

1. Difficulties in Recruiting and Retaining Trained and Qualified Social Workers

States cannot recruit and retain social workers to match the growing need of the foster care system; thus, protection from misdiagnosis and the side-effects of psychotropic medication is lacking.[93] The foster

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rics), *available at* http://www.aap.org/advocacy/washing/Testimonies-Statements-Petitions/05-08-08-Leslie-Psychotropics-Meds-Testimony.pdf; Bass et al., *supra* note 83, at 16–18.

[88] Goldstein, *supra* note 82, at 463; Chipungu & Bent-Goodley, *supra* note 25, at 83; Brandow, *supra* note 26, at 1162.

[89] *See* Goldstein, *supra* note 82, at 463; Chipungu & Bent-Goodley, *supra* note 25, at 86; Brandow, *supra* note 26, at 1162–63.

[90] Goldstein, *supra* note 82, at 462–63; *see* Chipungu & Bent-Goodley, *supra* note 25, at 83; Brandow, *supra* note 26, at 1162.

[91] *See* Burton, *supra* note 16, at 457; Naylor et al., *supra* note 22, at 176 ("With few exceptions, youth in foster care have been physically or sexually abused, neglected, or both."); Brandow, *supra* note 26, at 1163. Additionally, a child's history of physical and emotional abuse, neglect, and repeated displacements in living arrangements may affect his or her clinical presentation. Naylor et al., *supra* note 22, at 178. For example, the symptoms associated with bipolar disorder and trauma are so similar that it may take between two and three years to determine whether the symptoms are associated with one or the other. *See* PBS, *supra* note 20. Unfortunately, due to inaccurate medical records and constant changes in placement of foster children, practitioners tend to medicate without being able to ensure whether a child's symptoms are the result of trauma or a bipolar disorder. *See id.*

[92] *See* Burton, *supra* note 16, at 457–58; Naylor et al., *supra* note 22, at 176; PBS, *supra* note 20.

[93] Chipungu & Bent-Goodley, *supra* note 25, at 77, 83, 86; Talmadge, *supra* note 32, at 202, 211. The inability to hire and retain staff is not limited solely to caseworkers. *See* Bass et al., *supra* note 83, at 8. In a 1999 study of thirteen states conducted by the Urban Institute, nearly half of the states' child welfare agencies had a change in leadership within three years. *Id.* (citing Karin Malm et al., *Running to Keep in Place: The Continuing Evolution of Our Nation's Child Welfare System*, Urban Institute (Oct. 2001), http://www.urban.org/uploadedPDF/310358_occa54.pdf).

care system grew dramatically in the 1980s and 1990s.[94] This is due in part to the increase in birth rates, maternal incarceration, and parental substance abuse.[95] Child welfare agencies, however, are unable to attract and retain the staff needed to handle these caseloads because of poor working conditions, heavy demands, and low salaries, among other reasons.[96] Therefore, the state cannot provide the consistent and long-term monitoring necessary for children taking psychotropic medication.[97]

Also, most caseworkers are under-qualified or lack the training necessary to handle children with developmental needs or disabilities.[98] These staffing difficulties inhibit a state's ability to increase education standards for social workers.[99] For example, more than eighty-five percent of all child welfare agencies do not require social workers

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[94] Chipungu & Bent-Goodley, *supra* note 25, at 77. In 1985, the number of children in foster care was reportedly less than 300,000 children; by the year 2000, however, there were nearly 570,000 children in foster care at any given time. *Id.* In 2001, more than 800,000 children went through the foster care system, with approximately 542,000 in care at any given time. *See* Bass et al., *supra* note 83, at 6; Chipungu & Bent-Goodley, *supra* note 25, at 77.

[95] Chipungu & Bent-Goodley, *supra* note 25, at 77.

[96] *See* Bass et al., *supra* note 83, at 24; Chipungu & Bent-Goodley, *supra* note 25, at 77, 83; Brandow, *supra* note 26, at 1162. As a result of these conditions, ninety percent of state welfare agencies reported that they had difficulty recruiting and retaining caseworkers. Chipungu & Bent-Goodley, *supra* note 25, at 83. Public demand for shorter foster care stays has put greater pressure on social workers to provide data on measuring and documenting the process leading to reunification with parents or adoption. Bass et al., *supra* note 83, at 24; Chipungu & Bent-Goodley, *supra* note 25, at 83. In addition, the U.S. General Accountability Office reported that seventy percent of frontline caseworkers have either been threatened by violence or have been a victim of violence during the course of their employment. *See* U.S. Gen. Accounting Office, GAO-03-357, HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff 13 (2003). For example, one state's peer exit interviews found that ninety percent of its child protective services employees experienced verbal threats, thirty percent were physically attacked, and thirteen percent were threatened with a weapon. *See id.* The administrative demands, risks, and low salaries make it more difficult for child welfare agencies to hire skilled social workers in the areas where children are the most vulnerable. *See* Chipungu & Bent-Goodley, *supra* note 25, at 83.

[97] *See* Chipungu & Bent-Goodley, *supra* note 25, at 77–79, 83; Talmadge, *supra* note 32, at 202, 211; Brandow, *supra* note 26, at 1162. The recommended caseload for each caseworker is between twelve and eighteen cases each. Bass et al., *supra* note 83, at 23. Depending on the agency, however, caseworkers are responsible for anywhere between ten to more than one hundred cases each. *Id.* The increased policy demand for reunification and adoption requires social workers to spend more "time meeting paperwork requirements rather than providing counseling, support, and encouragement . . . ." Chipungu & Bent-Goodley, *supra* note 25, at 83.

[98] *See* Robertson, *supra* note 83, at 188.

[99] *See* Bass et al., *supra* note 83, at 24. Most social welfare agencies do not require degrees despite evidence showing that caseworkers with degrees have lower turnover rates and higher job performance scores. *Id.*

to have a bachelor's or master's degree in social work.[100] As a result, "only one-third of child welfare workers are trained social workers."[101] Even if all social workers had these degrees, it is unclear if their education would train them to handle children with developmental disabilities or behavioral problems.[102] As of 1993, fewer than half of all accredited graduate schools of social work offered courses in "development of infants and toddlers with disabilities, parent-professional collaboration, and community resources."[103] This general lack of experience and training means that caseworkers may agree to place a child on psychotropic medication without being fully aware of the potential risks.[104]

2. Difficulties in Recruiting, Retaining, and Training Suitable Foster Parents

States are unable to recruit and retain the caliber of foster parent needed to consistently monitor children and ensure that psychotropic

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[100] *See id.*

[101] Chipungu & Bent-Goodley, *supra* note 25, at 83.

[102] *See* Robertson, *supra* note 83, at 188.

[103] *See* D. Michael Malone et al., *Social Work Early Intervention for Young Children with Developmental Disabilities*, 25 HEALTH & SOC. WORK 169, 176 (2000)). The survey respondents also indicated no interest in creating such a program where one did not already exist. *Id.* These programs are lacking because of strict course requirements and the belief that training in these areas would develop in employment. Robertson, *supra* note 83, at 188. The belief that these skills will be obtained while in practice dangerously assumes that practitioners already know best practices, despite limited training and high caseloads. *Id.*

[104] Bass et al. *supra* note 83, at 23; Chipungu & Bent-Goodley, *supra* note 25, at 83; Robertston, *supra* note 83, at 188; Brandow, *supra* note 26, at 1162; PBS, *supra* note 20. *See generally* Tally Moses, *The "Other" Effects of Psychotropic Medication: Social Workers' Perspectives on the Psychosocial Effects of Medication Treatment on Adolescent Clients*, 25 CHILD & ADOLESCENT SOC. WORK J. 205 (2008) (exploring results of a national survey of experienced social workers on their perspective about the psychosocial effects of psychotropic medication treatment). The Moses study suggests that the majority of social workers feels that harmful psychosocial effects of medication are outweighed by its beneficial effects. Moses, *supra*, at 205, 214. The findings further suggest that social workers only look at the global positives and negatives and do not think about the specific harmful psychosocial effects of the medication, such as its impact on self-confidence, normalization, self-efficacy, social rejection, and dependency. *Id.* at 218–19. For example, despite multiple studies finding that some psychotropic medication users have problems "making sense of the personal transformation associated with medication," ninety-three percent of social workers disagreed with the statement "'*Taking medication has made my client confused about who he/she really is.*'" *Id.* at 219. Due to weak correlations between answers regarding the beneficial and harmful side effects of the medications, some social workers, the study suggests, may not become aware of certain side effects unless they take the time to ask children specific questions regarding their experiences on the medication. *See id.* at 218–19.

medications are being administered appropriately.[105] Unstable living arrangements and multiple placements undermine a child's ability to develop socially, emotionally, and physically.[106] Seventy-five percent of foster children have at least one disruption in their foster home placement and one-fifth have three or more changes.[107] Being a foster parent is arguably one to the most demanding positions one can assume.[108] Not only must foster parents provide for the child's basic needs, but they also must respond to "emotional and behavioral needs appropriately; arrange and transport children to medical appointments, mental health counseling sessions, and court hearings; advocate on behalf of foster children with schools; and arrange visits with birth parents and caseworkers."[109]

Historically, foster parents received limited compensation and had to use their own funds to subsidize some of the child's care.[110] The low compensation ideally prevented self-interested people from becoming foster parents.[111] In modern times, however, societal changes decreased the number of homemakers and increased financial strains, thereby negatively affecting the number of willing and qualified foster parents.[112]

The general lack of caseworkers has had a trickledown effect on their ability to properly train, inform, or assist foster parents.[113] Conse-

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[105] *See* Chipungu & Bent-Goodley, *supra* note 25, at 83; *Report of Gabriel Myers Work Group*, *supra* note 1, at 7.

[106] *See* Racusin et al., *Psychosocial Treatment of Children in Foster Care: A Review*, 41 Community Mental Health J. 199, 207 (2005) ("Separation from caretakers produces emotional insecurity which adversely effects [*sic*] emotional growth and behavior in later childhood . . . ."); Robertson, *supra* note 83, at 182 (stating that this is the opinion of "[v]irtually everyone involved in the care and education of vulnerable children").

[107] Robertson, *supra* note 83, at 182, 187. Approximately fifteen percent of children in foster care for less than one year experience more than two placements. *See* Bass et al., *supra* note 83, at 7. Each year a child is in foster care, the likelihood of a placement disruption occurring that year increases. *Id.*

[108] *See* Chipungu & Bent-Goodley, *supra* note 25, at 83.

[109] *Id.*

[110] *Id.* at 85.

[111] Teresa Toguchi Swartz, *Mothering for the State: Foster Parenting and the Challenges of Government-Contracted Carework*, 18 Gender & Soc'y 567, 568 (2004). It is not uncommon for child welfare agencies and caseworkers to question the motives of foster parents that call about not receiving their stipend checks or request reimbursements of costs that are covered by Medicaid. *See id.* at 582.

[112] *See* Chipungu & Bent-Goodley, *supra* note 25, at 83–84; Swartz, *supra* note 111, at 571–72.

[113] Chipungu & Bent-Goodley, *supra* note 25, at 83–86. More than two-thirds of foster parents claim that they were not properly prepared. *Id.* at 86. Compared to unrelated foster parents, kin caregivers are less likely to receive case management services or financial

quently, many foster parents quit within the first year because of dissatisfaction with the experience.[114] Foster parent disruption causes emotional insecurity in many foster children, hinders development, produces detachment disorders, and prevents them from building relationships with adults and caregivers.[115]

When foster children are frequently moved, their caregivers may be unaware of their history or how to deal with their trauma, and may misinterpret self-defeating or uncontrollable behavior.[116] As a result, a foster parent may seek psychiatric medication from a caseworker when the child only needs a stable living environment.[117] For these children, any additional placement changes hinder the monitoring of gradual side-effects and positive results of psychotropic medication.[118]

3. Incomplete and Inaccurate Medical, Educational, and Family Records

Foster children risk misdiagnosis because unstable environments and independently-operated child welfare agencies allow for incomplete medical records and permit diagnoses based solely on apparent behavior.[119] Foster children do not enter a single foster care system but

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assistance. *See* Bass et al., *supra* note 83, at 17. For kin to receive federal reimbursements, "states must license kin under the same standards as nonrelative foster families, and kin must be caring for children from income-eligible households." *Id.* Additionally, states have broad discretion in determining whether kin receive any foster payments at all. *Id.* For example, in Oregon and California, kin caregivers can only receive foster care payments if the foster children are eligible to receive federal reimbursements. *Id.*

[114] Chipungu & Bent-Goodley, *supra* note 25, at 86. Some foster parents complain about their experience with social workers, including the inadequate training prior to placement, no reinforcement of training once a child is placed, failure to inform foster parents about unique child needs, failure to return phone calls, rigorous demands, distrust, and social workers not involving the foster parents in decision-making. *See id.* at 84, 86.

[115] Racusin et al., *supra* note 106, at 207; Robertson, *supra* note 83, at 182; *see* PBS, *supra* note 20.

[116] *See, e.g.*, *Report of Gabriel Myers Work Group*, *supra* note 1, at 9; PBS, *supra* note 20.

[117] *See* Burton, *supra* note 16, at 494–95; Racusin, *supra* note 106, at 207; *see also* PBS, *supra* note 20.

[118] *See* Bass et al. *supra* note 83, at 7; Robertston, *supra* note 83, at 182; Brandow, *supra* note 26, at 1162; PBS, *supra* note 20. These behavioral patterns also contribute to the frustration of foster parents that may result in further displacement for the child. *See* Chipungu & Bent-Goodley, *supra* note 25, at 83–86; Brandow, *supra* note 26, at 1162.

[119] *See* Robertson, *supra* note 83, at 184 (discussing how diagnostic mistakes of infants and young children are made when parents and caregivers are not involved); *Forgotten Children: A Case for Action for Children and Youth with Disability in Foster Care*, CHILD. RTS., 7 (2006), http://www.childrensrights.org/wp-content/uploads/2008/06/forgotten_children_children_with_disabilities_in_foster_care_2006.pdf ("These challenges are further exacerbated by a

rather multiple intersecting systems.[120] The systems are meant to "create a safety net for children" through intersecting and interacting to ensure that the child's needs are met.[121]

Children commonly enter the foster care systems with either incomplete medical records or no records at all.[122] Even though psychotropic drugs are only to be prescribed as a "last resort," doctors often issue prescriptions without seeing full medical records.[123] Foster care agencies, however, generally fail to share with one another information pertaining to the foster children under their control.[124] Therefore, there is no guarantee that each agency knows the same information about a child's medical, family, temperamental, or scholastic history.[125] This problem worsens when placements span multiple states because each state's system can vary in organization, responsibility, records, funding, and assessment practices.[126]

Even though parental rights to give informed consent for children make medicating children an easy task, the state administers psychotropic medication at a much higher rate than parents.[127] In fact, foster

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general lack of information-sharing, collaboration and communication . . . .") [hereinafter *Forgotten Children*]; *see, e.g.*, *Report of Gabriel Myers Work Group*, *supra* note 1, at 5 ("There was inadequate, incomplete, repetitive, and at times inaccurate documentation in Gabriel's case files.").

[120] Bass et al., *supra* note 83, at 7. These systems include "[s]tate and local child welfare agencies, courts, private service providers, and public agencies that administer other government programs (such as public assistance or welfare, mental health counseling, substance abuse treatment), and Medicaid . . . ." *Id.* This also places an additional burden on foster parents, as they find it difficult to juggle all the paperwork requirements of each system. *See id.*

[121] *See id.*

[122] *2008 Fact Sheet: Improving Health Care of Children in Foster Care: An Ongoing Collaboration*, WASH. ST. DEPARTMENT SOC. & HEALTH SERVICES, 2 (2008), http://hrsa.dshs.wa.gov/news/Fact/FS008011FosterCarehealthimprovements.pdf ("Incomplete or inaccessible medical records represent one of the biggest challenges in quick, effective care for foster children."); *see* PBS, *supra* note 20.

[123] *See* Sparks & Duncan, *supra* note 24, at 36; PBS, *supra* note 20.

[124] *See* Laurel K. Leslie et al., *States' Perspectives on Medication Use for Emotional and Behavioral Problems Among Children in Foster Care*, NAT'L RESOURCE CENTER FOR PERMANENCY & FAM. CONNECTIONS (Feb. 2010), http://www.nrcpfc.org/teleconferences/2-10-10/L%20Leslie%20medication%20powerpoint.ppt (discussing how child welfare agencies typically do not work together); *see also Report of Gabriel Myers Work Group*, *supra* note 1, at 4 (discussing the failures of agencies to properly communicate Gabriel's history).

[125] *See* Leslie et al., *supra* note 124, at 12; *see, e.g.*, *Report of Gabriel Myers Work Group*, *supra* note 1, at 5.

[126] *See* Bass et al., *supra* note 83, at 7 (discussing variations in state welfare agencies); *see, e.g.*, *Report of Gabriel Myers Work Group*, *supra* note 1, at 5 (analyzing the failures in communication between Florida and Ohio authorities regarding Gabriel's sexual abuse).

[127] Brandow, *supra* note 26, at 1158–59, 1161; Leslie et al., *supra* note 124.

children receive psychotropic medication at a rate over ten times that of children living with parents.[128] This statistic indicates that states are abusing their parens patriae powers and violating foster children's natural and constitutional rights by subjecting them to mind-altering medication.[129]

III. Acting in The Foster Child's Best Interest When Administering Psychotropic Medication

Though exceeding the parens patriae powers, states sometimes administer psychotropic medication to children even when inappropriate if they burden caregivers or are not otherwise easily restrained.[130] This solution incentivizes caseworkers to medicate children as a means to quickly manage their caseloads, while foster parents benefit from the medication's low cost and ability to restrain children.[131]

A. *Using Psychotropic Medication as a Chemical Restraint*

Although most caregivers generally want to work in the child's best interest, some caregivers use psychotropic medication as a chemical restraint.[132] Medication used as chemical restraints are administered "for the sole purpose of sedating and immobilizing the child."[133] Although medical professionals may use this practice on severely deranged and dangerous adult mental patients and criminals, chemically restraining children is condemned by the American Association of Adolescent Psychiatry, the Child Welfare League, Amnesty International, the Interna-

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[128] *See* Leslie et al., *supra* note 29, at 1; Mary Ellen Foti et al., *Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide From a 16-State Study*, Medicaid Med. Dirs. Learning Network & Rutgers Center Educ. & Res. on Mental Health Therapeutics, 14 (June 2010), http://rci.rutgers.edu/~cseap/MMDLNAPKIDS/Antipsychotic_Use_in_Medicaid_Children_Report_and_Resource_Guide_Final.pdf (analyzing psychotropic medication use in the Medicaid system); PBS, *supra* note 20 (discussing how foster children are nine times more likely to be on antipsychotic medication than other children on Medicaid); Sessions, *supra* note 3.

[129] *See* Burton, *supra* note 16, at 493; Talmadge, *supra* note 32, at 184; Brandow, *supra* note 26, at 1162, 1169.

[130] *See* Brandow, *supra* note 26, at 1162.

[131] *See* Burton, *supra* note 16, at 494–95; Brandow, *supra* note 26, at 1162.

[132] *See* Burton, *supra* note 16, at 494–95; Brandow, *supra* note 26, at 1162; *see also Report of Gabriel Myers Work Group*, *supra* note 1, at 7. An investigation by the *Atlanta Journal-Constitution* into companies running foster homes in Georgia uncovered the fact that several of them repeatedly used psychotropic medication as a chemical restraint. Sessions, *supra* note 3. Even though these agencies had already received multiple citations, none received a fine greater than $500. *See id.*

[133] Burton, *supra* note 16, at 492.

tional Narcotics Control Board (INCB), and the 1971 United Nations Convention on Psychotropic Substances.[134]

Due to the burdens facing the foster care system, chemically restraining children provides a quick fix to many of these problems.[135] For example, states may be overly willing to medicate problematic children to prevent losing caregivers to burdensome working conditions.[136] As a result, states may medicate children who are either challenging or traumatized only because they burden caregivers.[137]

B. Medicaid Reimbursements Make Psychotropic Medication the Most Cost-Effective Form of Treatment

Because most forms of psychotropic medication are covered by Medicaid, they are the most attractive treatment to foster parents, administering physicians, and caseworkers.[138] Medicaid is a federally and state-funded health care program that provides services and prescrip-

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[134] *See* Sell v. United States, 539 U.S. 166, 179, 181, 186 (2003); Mills v. Rogers, 457 U.S. 291, 299, 306 (1982); Burton, *supra* note 16, at 454, 492–93; Talmadge, *supra* note 32, at 193. In a 2000 report, the INCB expressed concern that high rates of psychotropic medication use among U.S. children indicates that it is intended to suppress and control child behavior that adults find to be "problematic." *See* Burton, *supra* note 16, at 456 & n.10 (citing Int'l Narcotics Control Bd., Report of the International Narcotics Control Board for 2000, ¶¶ 1–49, 161–65 (2000), *available at* http://www.incb.org/incb/annual_report_2000.html).

[135] Leslie et al., *supra* note 29, at 20; Burton, *supra* note 16, at 494–95; Brandow, *supra* note 26, at 1174. "Despite the fact that there is virtually no research to support the use of psychotropics on children for such conditions as acute aggression, state-involved children are sometimes given these powerful, brain-altering chemicals simply for being aggressive, unruly, or otherwise problematic." Burton, *supra* note 16, at 493 (internal quotation marks omitted). For example, a physician-led review of the medical records of children within the Texas foster care system found little support for the aggressive use of psychotropic medication and questioned whether its use merely ensured that children acted in compliance with the expectations of foster parents, "not only to make them more submissive during care, but, more nefariously, to get more money and public benefits." *Id.* at 494–95.

[136] *See* Chipungu & Bent-Goodley, *supra* note 25, at 83; Brandow, *supra* note 26, at 1162. Due to the burdens and restraints of foster home placements, constant therapy and gradual adjustment can become impossible, and caregivers may view medicating disturbed children as the only way for these homes to function properly. *See* Chipungu & Bent-Goodley, *supra* note 25, at 83; Brandow, *supra* note 26, at 1162; *Report of Gabriel Myers Work Group*, *supra* note 1, at 3.

[137] *See* Burton, *supra* note 16, at 494–95; Brandow, *supra* note 26, at 1175. Prescribing physicians may be general practitioners with limited training in psychiatry. *See* Brandow, *supra* note 26, at 1175. Furthermore, instead of acting in the best interest of the child, practitioners may by motivated by the interest of the caregiver in promoting the ability to control a child. *See id.*

[138] *See* Leslie et al., *supra* note 29, at 16, 20; Burton, *supra* note 16, at 494–95; Brandow, *supra* note 26, at 1162; PBS, *supra* note 20.

tion reimbursements to low-income individuals, including children in the foster care system.[139] Although Medicaid reimbursement ensures that foster children receive expensive but necessary treatment, it also incentivizes overburdened caregivers to choose psychotropic medication.[140]

Caseworkers may choose psychotropic medication as a means of relaxing the financial burden on foster parents because the medication's cost does not come out of the caregiver's limited stipend.[141] In addition, Medicaid allows overburdened caseworkers to choose psychotropic medication as a quick fix for out of control children, rather than lengthy and comprehensive treatment programs.[142] These perverse incentives mean that a foster child's best interest may not be taken into account when caregivers administer medication.[143]

IV. Minimal Data, Tracking, and Oversight Measures May Prevent Foster Children from Seeking Relief

Despite the danger of psychotropic medication, not all states track when and why they are prescribed.[144] When states fail to keep adequate records, chemically abused children may struggle to find evidence sufficient for use in court to prove that caseworkers infringed their constitutional and personal rights.[145]

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[139] *See* PBS, *supra* note 20.

[140] *See* Leslie et al., *supra* note 28, at 20; *see also* PBS, *supra* note 20. As a result, in 2008 alone, Medicaid spend over $288.6 million on psychotropic medication for foster children. *See* PBS, *supra* note 20.

[141] *See* Burton, *supra* note 16, at 494–95; Chipungu & Bent-Goodley, *supra* note 25, at 85.

[142] *See* Leslie et al., *supra* note 29, at 20. Due to society's desire to push for fast solutions to these problems,

> The reimbursement structure of our health care system offers incentives for brief medication visits instead of comprehensive, collaborative, and interdisciplinary mental health treatment approaches. Despite research that suggests comprehensive treatment approaches are more effective in treating many mental health problems commonly seen in youth, the reimbursement structure of our health care system tends to impede this treatment strategy.

Id.

[143] *Id.*; Burton, *supra* note 16, at 494–95; Brandow, *supra* note 26, at 1162.

[144] *See* Leslie et al., *supra* note 29, at 6–8, 16; PBS, *supra* note 20.

[145] *See* Wilder v. City of New York, 568 F. Supp. 1132, 1137 (E.D.N.Y. 1983); PBS, *supra* note 20; *see also* Starkey v. Miller, No. 06-cv-00659-LTB, 2007 WL 4522702, at *14–15 (D. Colo. Oct. 17, 2007), *aff'd sub nom.* Starkey *ex rel.* A.B. v. Boulder Cnty. Soc. Servs., 569 F.3d 1244 (10th Cir. 2009).

A. *Limited National Data, Tracking, and Oversight Measures*

Even though psychotropic medications endanger health and violate rights of foster children, not every state adequately tracks when and why they are prescribed.[146] Consent to the use of psychotropic medication is left solely in the hands of each child's individual caseworker, regardless of his or her ability to make an informed determination.[147] Foster children remain over-medicated in part because not everyone in the child welfare community recognizes the problem.[148]

One reason for this failure is that almost all analyses are state- and county-specific, and not national.[149] Without statistical analyses or significant media attention, states may not realize that compartmentalized data systems pose a problem.[150] States, therefore, may be unable to conduct the research necessary to discover a system's inadequacies and hold irresponsible state actors accountable.[151]

Others may justify overmedication as a result of too many children entering the foster care system with severe histories of maltreatment,

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[146] *See* LESLIE ET AL., *supra* note 29, at 6–8, 16 (reviewing statistics regarding state policies in overseeing psychotropic medication administration in foster children); PBS, *supra* note 20; *see also supra* notes 73–93, 133–138 and accompanying text (discussing the potential for misdiagnosis and human rights violations that may occur from unnecessarily administering psychotropic medication to a non-consenting individual). In 2008, the Foster Connections to Success and Increasing Adoptions Act required states to develop oversight measures for health and mental health services for foster children. Pub. L. No. 110-351, § 205, 122 stat. 3949, 3961 (2008) (codified as amended at 42 U.S.C. § 622(b)(15) (2006)); *see* Leslie et al., *supra* note 124. Nevertheless, according to a 2010 study of forty-seven states and the District of Columbia, only approximately 54% had developed a written policy or a guideline regarding the use of psychotropic medication in foster children. LESLIE ET AL., *supra* note 29, at 1, 5. Of the remaining states, 27% stated that they were in the process of developing a program and 19% said they had no plan in place. *Id.*

[147] *See* Chipungu & Bent-Goodley, *supra* note 25, at 86; Robertson, *supra* note 83, at 188; Brandow, *supra* note 26, at 1162; Leslie et al., *supra* note 124; PBS, *supra* note 20.

[148] *See* Leslie et al., *supra* note 124 ("Identifying the problem—that is the stage we are at—not every one agrees that it is a problem.") (internal quotation marks omitted).

[149] *See* LESLIE ET AL., *supra* note 29, at 6; Leslie et al., *supra* note 124; PBS, *supra* note 20 (stating that there is no national data on the issue but it has become a growing concern). *See generally* CAROLE KEETON STRAYHORN, OFFICE OF THE COMPTROLLER OF PUB. ACCOUNTS, TEXAS HEALTH CARE CLAIMS STUDY (2006), *available at* http://www.window.state.tx.us/specialrpt/hcc2006/96-787healthcareclaims06.pdf (analyzing the inadequacies of the Texas foster care system); *Report of Gabriel Myers Work Group*, *supra* note 1 (reviewing the problem in the Florida foster care system).

[150] *See* LESLIE ET AL., *supra* note 29, at 6; PBS, *supra* note 20; *see, e.g.*, STRAYHORN, *supra* note 149, at 141–47 (findings on the inadequacies of the Texas foster care system); *Report of Gabriel Myers Work Group*, *supra* note 1, at 9–13 (putting together a review group after the death of Gabriel Myers in 2009).

[151] *See* Burton, *supra* note 16, at 494–95; Leslie et al., *supra* note 124; PBS, *supra* note 20.

neglect, sexual abuse, and broken families.[152] Without a proper tracking system and oversight measures, however, this justification remains a hypothesis and the risk of improper diagnosis and abusive prescription remains a threat to foster children.[153] Even if this hypothesis proves correct, the principal rule of medical ethics is "first do no harm" and not "first do something."[154] Without ensuring the absolute necessity of medications and then balancing the risks, physicians must first implement other less intrusive courses of treatment.[155] Doing so shields children from the harms of psychotropic medication and protects their right to be free from forced administration.[156]

B. *The Nature of Psychotropic Disorder Diagnoses, Limited Tracking and Oversight Measures, and Qualified Immunity*

In states with limited tracking or oversight, chemically-abused children may have no right to constitutional claims under 42 U.S.C. § 1983 due to the nature of the prescription process and qualified immunity.[157] State actors that administer and monitor psychotropic medi-

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[152] *See* Chipungu & Bent-Goodley, *supra* note 25, at 77, 79, 84; *Forgotten Children*, *supra* note 119, at 5 (discussing the likelihood of foster children suffering from issues such as birth defects and maltreatment); *see also* Leslie et al., *supra* note 124.

[153] *See* Chipungu & Bent-Goodley, *supra* note 25, at 77, 79, 84; *Forgotten Children*, *supra* note 119, at 5; *see also* Leslie et al., *supra* note 124.

[154] *See* Sparks & Duncan, *supra* note 24, at 36; PBS, *supra* note 20; *supra* note 80 and accompanying text; *see also* Chipungu & Bent-Goodley, *supra* note 25, at 79; *Forgotten Children*, *supra* note 1119, at 5.

[155] *See* Sparks & Duncan, *supra* note 24, at 36; PBS, *supra* note 20.

[156] *See* Sparks & Duncan, *supra* note 24, at 36; Talmadge, *supra* note 32, at 183–84; PBS, *supra* note 20.

[157] *See* 42 U.S.C. § 1983 (2006); Youngberg v. Romeo, 457 U.S. 307, 323–24 (1982); Henry A. v. Willden, No. 2:10-cv-00528-RCJ-PAL, 2010 WL 4362809, at *7 (D. Nev. Oct. 26, 2010) (finding the Nevada foster care system to be immune from suit due to the agent's discretionary powers and because it is not clearly established that foster children have "a constitutional right to . . . monitory of, administration, and use of psychotropic drugs"); Smith v. Rainey, 747 F. Supp. 2d 1327, 1343–44 (M.D. Fla. 2010) (rejecting plaintiffs claim on the grounds of sovereign immunity and that the claim lacked "factual or legal support"); *Starkey*, 2007 WL 4522702, at *15–16 (granting defendant's motion for summary judgment with respect to plaintiff's claim that defendant had ulterior motives when prescribing psychotropic medication because the claim presented "no evidence other than the bare allegation itself"); *Wilder*, 568 F. Supp. at 1137 (The city's decision to place plaintiff on psychotropic medication was "presumptively correct, that presumption may be rebutted . . . . [by] a fully developed factual record establishing the actual level of treatment . . . ."); *see also* Geller v. Staten Island Dev. Ctr., No. 84-CV-354, 1991 WL 99054, at *18–19 (N.D.N.Y. June 5, 1991) (entitling defendant to qualified immunity from suit as long as the defendant's practices of administering the psychotropic medications were "in conformity with acceptable professional standards existing at the time"). According to 42 U.S.C.

cations—namely consenting caseworkers and recommending practitioners—are not liable if they act within their discretionary authority.[158] Courts presume discretionary decisions are valid unless there is "a fully developed factual record establishing the actual treatment" that departed from professional standards.[159]

This burden is substantial.[160] Diagnosing physicians have wide discretion when making a recommendation and may avoid liability as long as the child's behavior reflects the symptoms of the disorder.[161] Likewise, when physicians recommend psychotropic medication, the caseworkers act within their authority when following that advice.[162] For example, to rebut a qualified immunity defense, the Eleventh Circuit requires proof of deliberate indifference on behalf of the government actor.[163] To prove deliberate indifference, the claimant must show: "1)

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§ 1983, an individual is allowed to seek a civil remedy against the government if an individual acting under the state's authority violated one of the individual's constitutional or federally secured rights. *See* 42 U.S.C. § 1983; Karen W. Yiu, Note, *Foster Parents as State Actors in Section 1983 Actions: What* Rayburn v. Hogue *Missed*, 7 U. CAL. DAVIS J. JUV. L. & POL'Y 117, 117 (2003) (citing 42 U.S.C. § 1983). If a state does not have a system that monitors psychotropic medications in foster children, it likely cannot be sued under § 1983 because there is arguably no clearly established constitutional right to the monitoring of the administration of psychotropic medication to children in state custody. *See Henry A.*, 2010 WL 4362809, at *7. While § 1983 provides plaintiffs with a means for suing the government, a governmental actor may have qualified immunity against such claims. *See* Harlow v. Fitzgerald, 457 U.S. 800, 818–19 (1982). Under the rule of qualified immunity, a government official is not subject to liability if his or her actions were within the scope of discretionary authority, as long as he or she has not violated a "clearly established statutory or constitutional right[] of which a reasonable person would have known." *Id.* at 818.

[158] *See Youngberg*, 457 U.S. at 323–24; Camp v. Gregory, 67 F.3d 1286, 1298 (7th Cir. 1995); *supra* note 158 and accompanying text. According to the Supreme Court in *Youngberg v. Romeo*, "liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment." 457 U.S. at 323. Furthermore, a practitioner who administers psychotropic medication to a child may also be entitled to qualified immunity. *See Geller*, 1991 WL 99054, at *18 (discussing the prescribing doctor's entitlement to qualified immunity).

[159] *Wilder*, 568 F. Supp. at 1137; *see Youngberg*, 457 U.S. at 323–24.

[160] *See Wilder*, 568 F. Supp. at 1137; PBS, *supra* note 20 (discussing the leeway practitioners have in administering psychotropic medication to foster children and stating that medical records for foster children are most often incomplete and inadequate); *see also Starkey*, 2007 WL 4522702, at *13–15.

[161] *See Youngberg*, 457 U.S. at 323–24; *Feller*, 1991 WL 99054, at *17–18; *Wilder* 568 F. Supp. at 1137; PBS, *supra* note 20 (discussing the practice of medicating foster children with psychotropic medication, even with limited medical records, if their behavior coincides with a disorder associated with the medication).

[162] Leslie et al., *supra* note 124 (discussing how caseworkers are unqualified to question the recommending physician's judgment).

[163] *See* McElligott v. Foley, 182 F.3d 1248, 1255 (11th Cir. 1999). The Eleventh Circuit joined the Second Circuit in expanding this requirement to "minor[s] in state custody."

subjective knowledge of a risk of serious harm; 2) disregard of that risk; 3) by conduct that is more than mere negligence."[164] Evidence of deliberate indifference, however, may not exist in states without strict oversight and tracking measures, thereby potentially preventing chemically abused children from nullifying qualified immunity.[165]

V. State and Federal Government Solutions

There are six general criteria that, if implemented, would successfully protect foster children from overmedication.[166] In practice, a comprehensive and collaborative national database would meet these six criteria, thereby protecting foster children's safety and constitutional rights through dismissal of irresponsible caseworkers and practitioners.[167]

A. *What States Need to Do to Address Over-Medicated Foster Children*

Though some states have implemented oversight mechanisms or improved healthcare quality to prevent foster children from unjustifiably receiving psychotropic medication, more reform is necessary.[168] Due to the differences between foster care systems, no single policy is perfect for all state systems.[169] A successful system, however, should fulfill six general criteria: it should (1) promote recognition of problems, (2) maximize medical data tracking and collection, (3) promote communication and collaboration between the foster organizations and

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Taylor *ex rel* Walker v. Ledbetter, 818 F.2d 791, 795 (11th Cir. 1987); *see also* S.M. v. Feaver, 2004 WL 213198, at *3 (S.D. Fla. Jan. 22, 2004).

[164] *Feaver*, 2004 WL 213198, at *3 (citing *McElligott*, 182 F.3d at 1255).

[165] *See Youngberg*, 457 U.S. at 323–24; *Starkey*, 2007 WL 4522702, at *13–15; *Wilder*, 568 F. Supp. at 1137; PBS, *supra* note 20 (discussing the motivations against the best interest of the child involved in the overuse of psychotropic medication in foster children and the need for tracking measures). This is more troubling considering the fact that, in a 2010 study of forty-eight states measuring what factors states would want to use in an oversight system that flags concerning trends in medication, only ten states (21.3%) would look for "no documentation of discussion of risks and benefits of medication," and only fourteen states (29.8%) would look for prescribed dosages of medication that are not consistent with recommendations. *See* Leslie et al., *supra* note 29, at 7.

[166] *See* Leslie et al., *supra* note 29, at 9–10, 12–13, 15; Leslie et al., *supra* note 124.

[167] *See* Leslie et al., *supra* note 29, at 9–10, 12–13, 15; Foti et al., *supra* note 128, at 38; Leslie et al., *supra* note 124; *supra* notes 73–82, 134–138 and accompanying text.

[168] *See* Leslie et al., *supra* note 29, at 5 (reporting that approximately fifty-four percent of states in 2010 had a policy in place on psychotropic medication use in foster children); Leslie et al., *supra* note 124 (reporting forty-nine percent of states with a policy in place on psychotropic medication use in foster children).

[169] *See* Leslie et al., *supra* note 29, at 1 (discussing policies of various states aimed at solving the problem); Foti et al., *supra* note 128, at 38 ("There was no single essential approach—each State crafted interventions based on its specific environment.").

stakeholders, (4) create systems of oversight and secondary review of consent, (5) train and educate employees on overmedication, and (6) gather input from foster parents, biological parents, and children.[170]

The first criterion in a successful system is to make government actors recognize the problem of overmedication.[171] One efficient way to achieve this goal is to collect data and then promote the findings.[172] Some states have already done this, using means such as gathering all available local and national data, pooling data with agencies in other states, and commissioning independent reports.[173] States then need to review this data and implement measures limiting the chances of improper psychotropic medication prescription.[174]

To maximize medical data tracking—the second proposed criterion—states should require practitioners to fill out in-depth reports, justifying recommendations of psychotropic medication and noting the risks, benefits, and alternatives explained to the caseworker.[175] This data would give a basis for states to hold practitioners accountable for inadequate records.[176] Another potential oversight measure is to better ensure that recipients only take medication prescribed for a legitimate purpose.[177] Some states have traditionally accomplished this by initially screening for health issues within three days after a child enters foster care, more thoroughly screening after thirty to sixty days, and requiring annual screenings thereafter.[178] This further oversight, however, should come from an impartial psychiatrist that reviews all prescription decisions or an attorney appointed for the child to represent his or her interests.[179]

States should also collaborate with other organizations, thereby fulfilling the third criterion of sharing a common vision of how to ad-

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[170] *See* LESLIE ET AL., *supra* note 29, at 9–10, 12–13, 15; Leslie et al., *supra* 124.

[171] *See* LESLIE ET AL., *supra* note 29, at 9; Leslie et al., *supra* note 124.

[172] *See* LESLIE ET AL., *supra* note 29, at 9; Leslie et al., *supra* note 124.

[173] *See* LESLIE ET AL., *supra* note 29, at 9. *See, e.g.*, STRAYHORN, *supra* note 149, at 10 (report by the Texas Comptroller of Public Accounts); *Report of Gabriel Myers Work Group*, *supra* note 1, at 7–8 (report commissioned by the Florida Department of Children & Families).

[174] *See* LESLIE ET AL., *supra* note 29, at 9–19; Leslie et al., *supra* note 124.

[175] *See* LESLIE ET AL., *supra* note 29, at 12; Leslie et al., *supra* note 124; Sessions, *supra* note 3.

[176] *See* Leslie et al., *supra* note 124; Sessions, *supra* note 3 (questioning the state of Georgia for not properly holding practitioners accountable).

[177] *See* LESLIE ET AL., *supra* note 29, at 12.

[178] *See id.*; Naylor et al., *supra* note 22, at 183; Leslie et al., *supra* note 124; *see also* PBS, *supra* note 20 (discussing motivations that impact psychiatrists' decisions to medicate over therapy).

[179] *See* LESLIE ET AL., *supra* note 29, at 12, 20; Naylor et al., *supra* note 22, at 183; Leslie et al., *supra* note 124; *see also* PBS, *supra* note 20.

dress overmedication and effectively communicating the risks.[180] This would also help provide up-to-date guidelines on acceptable practices, allowing caseworkers and foster parents to recognize when medicating a child is unnecessary.[181] To stop stifling normal behavior, states should educate foster parents about behavioral patterns common to foster children undergoing placement changes.[182]

Furthermore, some states have already implemented the fourth criterion—secondary oversight mechanisms—by setting guidelines based on recommendations of the Academy of Child and Adolescent Psychiatry, the American Academy of Psychiatry, the Child Welfare League of America, or a state-recommended evaluation conducted by an appointed agency.[183] Practitioners should follow a chosen guideline and seek departmental review when psychotropic medication is prescribed outside of the recommendations.[184] States should then use this information to form a database of foster children's medical records and psychotropic prescriptions—categorized by child, recommending practitioner, and consenting caseworker—by merging the data from Medicaid and child welfare agencies.[185] Therefore, states will quickly spot out-

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[180] *See* LESLIE ET AL., *supra* note 29, at 9; Leslie et al., *supra* note 124 (discussing the problem of child welfare agencies not working together); *Report of Gabriel Myers Work Group*, *supra* note 1, at 4–5, 9, 31 (stating that failures of child welfare agencies to properly communicate with one another had an impact on Gabriel's death). To address this issue, some states have created a child-serving advisory group, placed public individuals in charge of care, developed standards of practice, provided education and training, and provided coaching and mentor programs wherein retired child welfare workers mentor new ones. LESLIE ET AL., *supra* note 29, at 9–10.

[181] *See* LESLIE ET AL., *supra* note 29, at 11.

[182] *See* Chipungu & Bent-Goodley, *supra* note 25, at 86–87; Racusin et al., *supra* note 106, at 207–09.

[183] *See* LESLIE ET AL., *supra* note 29, at 12 (providing the California Evidence-Based Clearinghouse as an example of a state's recommended evaluation tool).

[184] *See id.*; Julie M. Zito et al., *Psychotropic Medication Patterns Among Youth in Foster Care*, 121 PEDIATRICS e157, e162 (2008); *see also* PBS, *supra* note 20. The Texas Department of State Health Services created a board, composed of a research pharmacist, a physician, a mental health administrator, a child psychologist, six child and adolescent psychiatrists, and an adult psychiatrist to write a system of practice guidelines for the administration of psychotropic medication in foster children. Zito et al., *supra*, at e162. The board determined that the state should require a departmental review "if antipsychotic agents and antidepressants were prescribed for youth under age 4 years, stimulants under age 3 years, if ≥2 drugs from the same class were prescribed concomitantly, and if ≥5 different classes of psychotropic medication were prescribed concomitantly." *Id.* Although these guidelines are provided, they are not the law and psychiatrists can recommend psychotropic medication to children despite their existence. PBS, *supra* note 20.

[185] *See* LESLIE ET AL., *supra* note 29, at 6; PBS, *supra* note 20.

liers and hold accountable irresponsible caseworkers and practitioners.[186]

To promote the fifth criterion of training and educating employees, states should involve foster parents in decisions on psychotropic medication administration.[187] This increases familiarity with medications and potential side effects, thereby allowing for closer monitoring.[188] This is a means of training foster parents while gathering their input and promoting collaboration.[189]

Finally, to implement the sixth criterion of preserving the rights of the biological parents and the child, states should find ways to involve them in the decision-making process.[190] Even if parents are incapable of raising their child, they still have the constitutional right to parental autonomy and may have the child's best interest at heart.[191] Additionally, involving them in the decision-making process may alleviate concerns regarding later reunification because it may educate parents about their child's health, behavioral problems, and medication.[192]

Furthermore, involving children in their own medical decisions may not only help protect their rights but also may increase the effectiveness of care.[193] This would improve relationships with caregivers, promote understanding of disorders and treatments, and may increase children's commitment to improving themselves.[194] When strict guidelines prevent misdiagnosis and cause the termination of irresponsible caseworkers and practitioners, children will be less susceptible to co-

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[186] *See* Leslie et al., *supra* note 29, at 6; PBS, *supra* note 20.

[187] *See* Leslie et al., *supra* note 29, at 5, 15; Chipungu & Bent-Goodley, *supra* note 25, at 86–87; PBS, *supra* note 20.

[188] *See* Leslie et al., *supra* note 29, at 5, 15; Chipungu & Bent-Goodley, *supra* note 25, at 86–87; PBS, *supra* note 20.

[189] *See* Leslie et al., *supra* note 29, at 5, 15; Chipungu & Bent-Goodley, *supra* note 25, at 86–87; Leslie et al., *supra* note 124; PBS, *supra* note 20.

[190] *See* Leslie et al., *supra* note 29, at 15.

[191] *See* Santosky v. Kramer, 455 U.S. 745, 753 (1981); Scott & Scott, *supra* note 49, at 2431–32; *supra* notes 52–57 and accompanying text. This should not apply to parents who intentionally abuse or neglect children, but may apply to parents lacking in fitness only because the community cannot help support their children through community services. *See* Chipungu & Bent-Goodley, *supra* note 25, at 80; Brandow, *supra* note 26, at 1158–61.

[192] *See* Leslie et al., *supra* note 29, at 15.

[193] *See* Brandow, *supra* note 26, at 1176.

[194] *See id.* at 1177 ("Children who participate in decisionmaking adjust better to treatment, are more committed to treatment, show greater compliance with treatment, and prematurely terminate treatment less frequently."). This should apply to all children, especially older children. Talmadge, *supra* note 32, at 191–92; Brandow, *supra* note 26, at 1173–78.

erced consent.[195] In those situations where a medication's necessity is unclear, parents and the child may provide valuable feedback.[196] Finally, a child's involvement in the decision-making process may create a better treatment experience and ensure preservation of rights.[197]

B. *States Cannot Protect the Rights and Safety of Foster Children Without Implementing National Policies and a National Database*

The overmedication issue needs prioritization on a national level because it is arguably the only way for the government to prevent state actors from violating foster children's constitutional rights.[198] Because the majority of states lack either Medicaid databases, child welfare databases, or a combination of both with which to track psychotropic medication use, foster children crossing between states may not have complete and accurate information in their files.[199] Even a cautious practitioner or caseworker may never know if he or she has the necessary information to ensure an accurate determination.[200] Therefore, states must collectively protect children's rights and mental safety by ensuring the complete certainty of medical records.[201] This requires the aid of the federal government through a national database of foster children's medical records and case information, thereby preventing misdiagnosis and protecting the children's best interests.[202]

A national database would force states to create measures that preserve children's rights, punish state actors that violate these rights, and promote cross-border communication methods.[203] A federal governmental advisory body may implement this database, review and pro-

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[195] *See* LESLIE ET AL., *supra* note 29, at 12, 15; Brandow, *supra* note 26, at 1177; Leslie et al., *supra* note 124; PBS, *supra* note 20.

[196] *See* LESLIE ET AL., *supra* note 29, at 15; Brandow, *supra* note 26, at 1176–77.

[197] *See* Brandow, *supra* note 26, at 1176–78.

[198] *See* LESLIE ET AL., *supra* note 29, at 19; Talmadge, *supra* note 32, at 190–92; Leslie et al., *supra* note 124.

[199] *See* LESLIE ET AL., *supra* note 29, at 6; Foti et al., *supra* note 128, at 38; *see, e.g.*, *Report of Gabriel Myers Work Group*, *supra* note 1, at 3–5 (discussing the failure to communicate vital information regarding sexual abuse once Gabriel was moved from Ohio to Florida).

[200] *See* LESLIE ET AL., *supra* note 29, at 6; Foti et al., *supra* note 128, at 38; *see, e.g.*, *Report of Gabriel Myers Work Group*, *supra* note 1, at 3–5.

[201] *See* LESLIE ET AL., *supra* note 29, at 6, 16; Leslie et al., *supra* note 124 (stating a solution to the problem is "[g]ather[ing] data of medication use—national and state specific"); *see, e.g.*, *Report of Gabriel Myers Work Group*, *supra* note 1, at 3–5.

[202] *See* LESLIE ET AL., *supra* note 29, at 16, 19; Foti et al., *supra* note 128, at 38; Leslie et al., *supra* note 124; *see, e.g.*, *Report of Gabriel Myers Work Group*, *supra* note 1, at 4–5.

[203] *See* LESLIE ET AL., *supra* note 29, at 19; Foti et al., *supra* note 128, at 38; *supra* notes 73–82, 134–138 and accompanying text; *see, e.g.*, *Report of Gabriel Myers Work Group*, *supra* note 1, at 3–5.

mote the best oversight and treatment practices, quantify the impact on a child's well-being, and protect rights and liberties.[204] Furthermore, this comprehensive and collaborative national database would meet all six criteria for a successful foster care system, thereby protecting foster children's safety and constitutional rights and dismissing irresponsible caseworkers and practitioners.[205]

Conclusion

Over-prescription of psychotropic medication turns many foster children into victims of chemical abuse and infringes their constitutional and natural rights. Even though psychotropic medication should only be used as a last resort, caseworkers and practitioners have wide discretionary power in determining what medication is in a child's best interest. This discretionary authority can become dangerous when the actors lack the evidence or the ability to make a proper judgment. When states fail to provide measures to ensure that discretion is not abused, they miss the problem, cannot hold irresponsible actors accountable, cause harm to foster children, and potentially prevent children from bringing claims for relief. Although some states have implemented oversight, all states should follow suit and the federal government should regulate state collaboration to protect the health, safety, welfare, and rights of foster children.

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[204] *See* Leslie et al., *supra* note 29, at 19; Talmadge, *supra* note 32, at 190–92; Brandow, *supra* note 26, at 1176.

[205] *See* Leslie et al., *supra* note 29, at 9–10, 12–13, 15; Foti et al., *supra* note 128, at 38; Brandow, *supra* note 26, at 1176; Leslie et al., *supra* note 124; *supra* notes 73–82, 134–138 and accompanying text.