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Who Should Determine What Is Best for Children in State Custody Who Object to Psychotropic Medication?

Stephen A. Talmadge, Ph.D., J.D.

I. INTRODUCTION

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. The Supreme Court suggested that the Due Process Clause defends the traditional right to refuse unwanted medical treatment. However, in disagreements over the medical treatment of a minor, only the minor's parents and the state have standing to go to court. 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. Does the state have the child's best interests at heart? It stretches credulity to think that caseworkers for children in the state's custody have the time to know and understand each child's best interests.

The effectiveness of psychotropic drugs in the treatment of mental illness...
has been demonstrated beyond question. However, anti-psychotic medications arguably limit a person's liberty more than bodily restraints and may affect control over a person's mind as well as body. The results of administering these drugs can be more profound than the use of physical restraints. The Supreme Court has recognized that the drugs psychiatric patients receive are “mind altering.” Therefore, the choice to make use of this treatment must be carefully balanced against any possible side effects.

Research has shown that fourteen- and fifteen-year-old adolescents are competent to give consent. Allowing adolescents in state custody to make their own informed decisions about accepting psychotropic medication best serves their legal interests. Furthermore, recognizing and respecting the child's right to self-determination guarantees due process (liberty).

Part II of this article discusses psychotropic medications and their side effects, with a focus on anti-psychotic medication, while Part III reviews informed consent. Part IV discusses competence, comparing the decisional ability of adolescents with that of adults. Part V discusses decisions to medicate and Part VI reviews children, the legal concept of the family, and children's rights. The article concludes with a suggestion to allow those adolescents in state custody to make their own decisions about psychotropic medications.

II. PSYCHOTROPIC MEDICATION

The use of drugs with well-substantiated effectiveness in psychiatric disorders has grown extensively since the mid-1950s. Drugs used in the management of psychiatric disorders are usually referred to as

7 See Brief for the American Psychiatric Association et al. as Amici Curiae Supporting Petitioner, Perry v. Louisiana, 498 U.S. 38 (1990) (No 89-5120), 1990 WL 10013108 (stating that the American Psychiatric Association has explained in detail in prior briefs that psychotropic medication is a very effective form of treatment when properly used).


9 Id. at 1264.


11. Floyd, supra note 8, at 1249.

12 See Brief for American Psychological Association as Amici Curiae Supporting Appellees, Hartigan v. Zbaraz, 484 U.S. 171 (1987) (No. 85-673), 1987 WL 880965 (stating “[t]hus, it is now generally accepted that by midadolescence (14-15) the great majority of adolescents do not differ from adults in their capacities to understand and reason about medical and psychological treatment alternatives, or in their abilities to comprehend and consider risks and benefits regarding treatment alternatives ”).

13 See generally BENJAMIN JAMES SADOCK & VIRGINIA ALCOTT SADOCK, KAPLAN & SADOCK’S SYNOPSIS OF PSYCHIATRY BEHAVIORAL SCIENCES/CLINICAL PSYCHIATRY (9th ed. 2003).
"psychotropic." The dictionary defines psychotropic as "of a drug: acting on the mind." "Psychotropic medication is widely accepted within the psychiatric community as an extraordinarily effective treatment for both acute and chronic psychoses, particularly schizophrenia." Over 1500 compounds classified primarily as psychotropic agents have been described. Psychotropic medications have been divided into three major categories: mood-stabilizers (including anti-depressants), anti-anxiety sedatives, and anti-psychotics (neuroleptic). Some of the more common mood stabilizers are: Prozac, Zoloft, Paxil, Elavil, Pamelor, Tofranil, Sinequinn, Nardil, Parnate, Remeron, and Buspar. Prominent anti-anxiety agents include: Xanax, Librium, Klonopin, Tranzene, Valium, Ativan, and Serax. Some of the more common anti-psychotic medications are: Navane, Haldol, and Lithium.

Approximately three million Americans were prescribed anti-psychotic drugs in 1986. According to the National Ambulatory Medical Care Surveys, from 1985 to 1994, the number of office visits during which psychotropic medication was prescribed grew from 32.73 million to 45.64 million, with the proportion of such visits rising from 5.1% to 6.5%. As of 2003, an estimated 11% of American children had a mental health impairment that caused important functional deficits. According to the U.S. Department of Justice, the number of psychotropic drugs prescribed to students has climbed from three million in 1992 to more than eighteen

19. See TARASCON POCKET PHARMACOPOEIA (Deluxe Lab-coat Pocket Ed. 2002).
20. Id.
21. Id.
22. Id.
million in 2000.\textsuperscript{26} As of September 30, 2005, there were 14,853 children receiving mental health services via the Child and Family Services Department in Florida.\textsuperscript{27} According to the \textit{Sun-Sentinel} in Fort Lauderdale, “[m]ore than one of every 10 children, or 5,100 kids, in the [Florida] state welfare system are on medications meant to treat depression, schizophrenia and other mental disorders.”\textsuperscript{28}

\textbf{A. Anti-Psychotic Medication\textsuperscript{29}}

This paper focuses on anti-psychotic medication because it “has been the mainstay of treatment for inpatients and has also advanced the public policy of deinstitutionalizing patients whenever possible.”\textsuperscript{30} These medications are primarily used to treat thought disorders.\textsuperscript{31} While anti-psychotics have proven effective in the treatment of schizophrenia, they are infamous for a wide range of undesirable side effects, including neurological, cardiovascular, and endocrinological abnormalities.\textsuperscript{32} Chlorpromazine, the first anti-psychotic drug, appeared in the early 1950s under the trade name Thorazine,\textsuperscript{33} which was marketed as electroconvulsive therapy in a bottle.\textsuperscript{34} Some psychiatrists described it as a “chemical lobotomy,”\textsuperscript{35} while the Supreme Court stated that these drugs are mind-altering.\textsuperscript{36}

Anti-psychotic medication alters the chemical balance in an individual’s brain, leading to changes in one’s cognitive processes that are intended to be beneficial.\textsuperscript{37} Although it is unknown exactly how this medication works, some medical professionals believe that the drugs change levels of dopamine that are available in the brain.\textsuperscript{38} By influencing chemical transmissions in the brain, the drugs sedate the schizophrenic and suppress
psychotic symptoms. The drugs have a propensity to shorten confinement stays and allow patients to function in the community.  

B. Side Effects

Psychotropic medications, in particular anti-psychotics, often produce side effects that range from short-term and merely discomforting to permanent and life-threatening. Many side effects fall within the category of extrapyramidal symptoms, which are neurological side-effects of anti-psychotics. Among the temporary and reversible extrapyramidal effects are dystonic reactions, akathisia, and Parkinsonism. Reactions include muscle spasms, especially in the eyes, neck, face and arms; irregular flexing, writhing, or grimacing movements; or protrusion of the tongue. Parkinsonism produces a mask-like face, drooling, muscle rigidity, a shuffling gait, and tremors. The most damaging extrapyramidal symptom, and the one that has generated the most scrutiny and controversy, is tardive dyskinesia, a syndrome associated with the long-term use of anti-psychotic drugs. It is a sometimes-permanent neurological disorder characterized by involuntary muscular movements.

Although all medications have side effects, it has been concluded that these psychotropic medications, particularly anti-psychotic medications, are hazardous. One court said, “[t]hey deaden the patient’s ability to think and their forced administration is an affront to basic concepts of human dignity.”

C. Administration

Psychotropic medications can be administered either voluntarily or involuntarily. The level of incompetence required for involuntary psychiatric hospitalization is based on the dangerousness of the patient.

41. See Harper, 494 U.S. at 229; see also generally Baldessarini, supra note 14.
42. See Harper, 494 U.S. at 230; see also generally Baldessarini, supra note 14.
44. See Baldessarini, supra note 14, at 500-02.
46. Id.
47. See Borger, supra note 40, at 1113-14; see also Brooks, supra note 43.
Most current statutes regarding the civil commitment of adults not only require that the individual suffer from mental illness, but also that the infirmity renders a danger to himself or others. This level of competence is not the same as what is required for forced administration of psychotropic medications. An individual can be considered incompetent in refusing psychiatric hospitalization but sufficiently competent to refuse psychotropic medications. In 1986, a New York court found:

[Neither the fact that appellants are mentally ill nor that they have been involuntarily committed, without more, constitutes a sufficient basis to conclude that they lack the mental capacity to comprehend the consequences of their decision to refuse medication that poses a significant risk to their physical well-being. Indeed, it is well accepted that mental illness often strikes only limited areas of functioning, leaving other areas unimpaired, and consequently, that many mentally ill persons retain the capacity to function in a competent manner . . .]

Although an individual’s mental illness and involuntary commitment both raise questions about his or her capacity to make a rational and knowledgeable treatment decision, they do not alone demonstrate incapacity. By extension, they do not necessarily justify the forced administration of psychotropic medications to the individual.

The psychiatric treatment of adults and children is governed in all states by legislative acts. These statutes, which establish guidelines for both voluntary admission and involuntary psychiatric examination, generally appear alongside other mental health legislation. Some states break the rules down into adult and juvenile subdivisions, while others divide their acts on the basis of mental illness or drug/alcohol commitment procedures. Each jurisdiction’s laws typically provide for short-term


52. Floyd, supra note 8, at 1258.

53. Knepper, supra note 50, at 98.


55. See, e.g., § 394.451.

56. See, e.g., §§ 394.490-.4995 (West 2002).

57. See, e.g., MISS. CODE ANN. §§ 41-4-1 to -23 (West 2005).

58. See, e.g., §§ 41-4-1 to -23.
emergency admission with procedures for accomplishing an evaluation.59

III. INFORMED CONSENT

Informed consent is defined as "[a] patient’s knowing choice about a medical treatment or procedure, made after a physician or other healthcare provider discloses whatever information a reasonably prudent provider in the medical community would give to a patient regarding the risks involved in the proposed treatment or procedure."60 Informed consent is generally required for medical treatment.61 The objectives of the informed consent principle, inter alia, have been defined in the following way: (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.62

Courts first discussed informed consent in 1957.63 This doctrine posits that physicians have a duty to make sufficient disclosures to patients about planned medical treatment so that patients can make well-informed choices.64 A number of states have moved toward a patient-oriented approach instead of a physician-driven method.65 This technique regulates medical practitioners by requiring them to probe the informational necessities of the “reasonable patient,” rather than simply relying entirely on existing medical practice to come to a decision about what comprises material disclosure.66

A substantial amount of judicial examination of informed consent has involved minors and medically performed abortions. The United States District Court for the Eastern District of Pennsylvania, while holding that parts of a Pennsylvania statute requiring parents to be informed about

64. Id. at 1082.
abortions performed on underage girls was unconstitutional, upheld the statute’s definition of informed consent: 67

“Informed consent” means a written statement, voluntarily entered into by the person upon whom . . . whereby she specifically consents thereto. Such consent shall be deemed to be an informed consent only if it affirmatively appears . . . that she has been advised (i) that there may be detrimental physical and psychological effects which are not foreseeable, (ii) of possible alternatives . . . and (iii) of the medical procedures to be used. Such statement . . . shall be . . . in readily understandable terms in so far as practicable. 68

The definition articulated here is a good reflection of what is meant by informed consent.

Even when a person is incompetent to give informed consent for voluntary psychiatric hospitalization, that does not mean she is incompetent to refuse medication. 69 However, if a mentally ill person has given informed consent, it may not be clear. The mere fact that a person has signed a form does not mean that actual consent has been obtained. The Supreme Court thus has warned of “[t]he risk . . . that some persons who come into . . . mental health facilities will apparently be willing to sign forms authorizing admission and treatment, but will be incompetent to give the ‘express and informed consent’ . . . .” 70

IV. COMPETENCE

Mental illness and legal incompetence are not coterminous; therefore, it does not necessarily follow that all mentally ill people are legally incompetent. 71 “Incompetence,” contrasted with “legal incompetence,” may have different meanings in general custom, everyday language, the medical profession, and in other scientific fields. 72 Basically, competence refers to the ability to come to a decision by assimilating information

68. Id. at 583 (Green, Dist. J., dissenting) (quoting 35 PA. STAT. §§ 6601–6604 (repealed 1982)).
69. See S. REP. NO. 96-712, at 81 (1980), as reprinted in 1980 U.S.C.C.A.N. 3372, 3448 (“While a judicial commitment authorizes one’s physical detention, it does not automatically follow that the state may force a competent individual to undergo any and all forms of treatment. A patient still retains separate rights to privacy.”).
71. Nachtigall v. Class, 48 F.3d 1076, 1081 (8th Cir. 1995).
through a reasonable process of thinking. Only if an individual's ability to make independent decisions is severely limited is she considered incompetent to make a treatment decision. The incompetent individual differs from a competent person because she is unable to put together and logically present her own viewpoint about the planned treatment.

If an individual is incompetent, the doctrine of informed consent posits that the person given the authority to make the treatment decision for the incompetent individual should have the opportunity to assess the choices available and the risks of each choice. The two different standards that may be used in complying with informed consent for an incompetent individual are the application of the "best interests" standard and the substituted judgment standard, discussed below. The former reflects the idea that the treatment decision that is to be made on an incompetent patient's behalf should advance the individual's best interests. This standard requires that decisions about the administration of medication should be made in the patient's best interests, as opposed to independent interests that parents or others may have. Unfortunately, the legal decision-maker is left with little direction regarding how a child's interests are to be determined under this test.

Lois Weithorn and Susan Campbell 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. At least one court paid attention to Weithorn's

76. Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir. 1972) ("True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.").
78. Otto et al., supra note 75, at 181.
80. Lois A. Weithorn & Susan B. Campbell, The Competency of Children and
research and expertise when it proclaimed, "a court should not dismiss outright the value of a twelve-year-old’s opinion." Child psychologists Thomas Grisso and Linda Vierling suggest that by age fifteen, children possess psychological abilities that are important to the decision-making process and are no less competent than adults to give consent. The fifteen-year-old adolescents included in their study were able to concentrate, delay responses while contemplating results, think about more than one treatment choice, and use inductive and deductive reasoning. A Florida court cited the research studies of both Weithorn and Campbell and of Grisso and Vierling when it recognized the decision-making abilities of minors and the intent of the Florida legislature. Overall, "[a] sizeable and convincing body of research shows that children possess far more competence than has previously been recognized."

V. RIGHT TO REFUSE

In our society people have the right to make treatment decisions that may lead to harm. "[E]ven truly irrational choices are not sufficient to establish a patient’s incompetence and to justify overriding them." Furthermore, "[a] competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment." For example, a California appellate court held that all competent patients, whether terminally ill or not, have the right to refuse any and all medical treatment regardless of their motives for doing so. In another case, an appellate court in Florida upheld the request of a seventy-three-year-old paralyzed and terminally ill patient to remove his respirator. The court reasoned that the constitutional right to privacy protects the sanctity of individual choice and self-determination, including a competent patient’s decision to refuse

82 Grisso & Vierling, supra note 73, at 423.
83 See id. at 418.
85 FLA. STAT. ANN. § 394.4784 (West 2005).
86 RICHARD E. REDDING, DUE PROCESS PROTECTIONS FOR JUVENILES IN CIVIL COMMITMENT PROCEEDINGS 18 (Elissa C. Lichtenstein et al. eds., 1991) (cited in Maggie Brandow, A Spoonful of Sugar Won't Help This Medicine Go Down: Psychotropic Drugs for Abused and Neglected Children, 72 S. CAL. L. REV. 1151, 1163 (1999)).
Children in State Custody and Psychotropic Medication

This protection extends to the mentally ill by allowing them to refuse invasive treatment, even when the state may think such measures are in their best interest.

The legal basis for forced administration of psychotropic drugs is rooted in the police and parens patriae powers of the state. The parens patriae authority implicates best interests treatment decisions, in which the state has an interest in protecting the welfare of a mentally ill patient. In contrast, the police power relates to the state’s responsibility to protect others from the potentially troublesome, violent acts of a mentally ill patient. Thus, under parens patriae and police powers, the administration of psychotropic medication can be justified on the basis that the effects are more beneficial than harmful, or that the use of the drug is necessary for the protection of others.

The Supreme Court held in Mills v. Rogers that involuntarily committed mental patients had a constitutional right to refuse anti-psychotic drugs, except where the state’s police power or parens patriae interests outweighed the patient’s rights. The Court also held that a state may grant greater liberty interests than the Constitution requires and that state law may determine mental patients’ rights, permitting fewer medications to be administered involuntarily in states that recognize a greater liberty interest than that which is federally guaranteed. The Mills case found that committed patients had a liberty interest in refusing drugs and that this interest could be superseded only when outweighed by the state’s interests. Further, the Court held that judicial determination of substituted judgment was required before the administration of drugs, even

92. Id. at 162.
93. See, e.g., Olmstead v. United States, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) (arguing that the right to be left alone is most comprehensive and most valued by civilized society).
94. "A doctrine by which a government has standing to prosecute a lawsuit on behalf of a citizen, esp. on behalf of someone who is under a legal disability to prosecute the suit." BLACK’S LAW DICTIONARY 511 (8th ed. 2004).
95. Knepper, supra note 50, at 106.
96. The Tenth Amendment is considered to be the source of state police power and provides that “the powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.” U.S. CONST. amend. X; see also In re Doe, 104 A.D.2d 200, 200 (N.Y. App. Div. 1984) (“The court under its parens patriae authority is empowered to protect the person and property of an individual who is not capable of making decisions in his own best interests”).
97. U.S. CONST. amend. X.
100. Id. at 300 (discussing minimum protection of rights).
101. Id. at 303-04 (comparing federal and state protection of liberty rights).
to incompetent persons.102

VI. DECISIONS TO MEDICATE

The majority of judicial decisions examining forced medication have involved the competence to stand trial and also within the context of incarceration. The patients in these decisions have generally been found to be competent to make treatment decisions. In addition, committed patients normally may only be forcibly medicated during potentially dangerous emergencies.103 The state has relied upon its power as parens patriae to justify involuntary medication. Yet, this power to contradict a person’s wishes must be significantly limited, as it conflicts directly with individual autonomy. Even without these limits, one can interpret the state’s role as “parent” to mean that the state can intervene more extensively to prevent self-harm than to avert harm to others. There are no cases directly addressing the issue of whether a child has a liberty interest that allows her to refuse psychotropic medication.

Cases involving refusal of psychotropic medication have been decided using either a legal or medical model.104 The former gives priority to the patient’s constitutional rights, while the latter presumes that the treatment decision is primarily a medical matter.105 The majority of courts have deferred to medical decision-makers when there is a conflict between a patient’s right to decline anti-psychotic medication and a state’s insistence that the patient be administered the medication.106 In considering both the procedural and substantive rights to refuse psychotropic medications and the state’s authority to override the patient’s decision, one must determine which model will be applied to the decision regarding whether refusal of the medication is acceptable.

The Supreme Court has avoided clarifying whether competent or incompetent patients enjoy a substantive right to refuse the administration of psychotropic drugs. Although it suggested that the mentally ill enjoy constitutional and common law rights like other patients, the Court limited these rights to procedural protections against obvious abuse. However, it also failed to make a clear-cut finding regarding the competence of a mental patient to make a treatment decision on his or her own behalf.107 The

102. Id.
105. Id. at 108.
107. Knepper, supra note 50, at 98.
procedural protections concern the minimum constitutional standard required for determining that the individual's liberty interest is actually outweighed in a particular case. The substantive issues that the Court did not address include the meaning of the protected constitutional interest and the identification of conditions under which opposing state interests might be more important than the patient's interest. As one commentator expressed, "[t]he lack of doctrinal direction has been exacerbated by the Supreme Court's reluctance to decide many of the fundamental constitutional dilemmas presented by an institutionalized individual's decision to refuse anti-psychotic medications."

Although the Supreme Court has evaded the issue, other courts have held that there is a constitutional privacy right to refuse psychotropic medication. In *Davis v. Hubbard*, a federal district court held that the common law history of individual independence in medical decisions required a finding that the right to privacy permits rejecting treatment in civil commitment contexts. In *Bee v. Greaves*, the Tenth Circuit also found a privacy right to refuse treatment based on individual bodily autonomy, citing *Whalen v. Roe*, in which the Supreme Court held that the right to privacy encompasses independence in making definite kinds of significant decisions.

Recently, the Ninth Circuit indicated the Supreme Court's preference in letting medical professionals decide medication issues rather than the courts. In a 2003 case, the Supreme Court found that "there are often strong reasons for a court to determine whether forced administration of drugs can be justified on... alternative grounds before turning to the trial competence question." and discussed other, non-judicially-mandated ways to require involuntary administration of psychotropic medication. 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.

110. *Id.* at 43.
One of the first cases that applied deference to medical decision-making was *Vitek v. Jones*.\(^{117}\) Nebraska sought to remove an injunction that prohibited it from transferring Jones, a mentally ill state prisoner, to a mental hospital.\(^{118}\) Jones had been convicted of robbery and sentenced to a term of three to nine years in state prison.\(^{119}\) He was transferred to the penitentiary hospital in January 1975.\(^{120}\) Two days after his transfer, Jones was placed in solitary confinement, during which he set his mattress on fire, thus burning himself severely and resulting in treatment at the burn unit of a private hospital.\(^{121}\) Upon his release, it was determined that he was suffering from a mental illness or defect and could not receive proper treatment in the prison.\(^{122}\) He was transferred to a state mental hospital under the jurisdiction of the Department of Public Institutions.\(^{123}\) Jones argued that he was receiving treatment against his will and that he was continuing to suffer from the stigmatizing consequences of the initial determination of mental illness.\(^{124}\) The Supreme Court affirmed the order of the district court, which had initially found that inmates have a liberty interest in refusing to be transferred to a mental hospital unless afflicted by a mental disease that cannot be sufficiently treated in prison.\(^{125}\) The district court held that in order to afford sufficient protection to this liberty interest, the state was required to observe minimum procedures before transferring a prisoner to a mental hospital.\(^{126}\) The district court further found that the state had satisfied the independent decision-maker element.\(^{127}\) In doing so, the state had also avoided unnecessary intrusion into either medical or correctional judgments by providing that the independent decision-maker conducting the transfer need not come from outside the prison or hospital administration.\(^{128}\) The transfer of Jones to a mental hospital was thus a medical decision, not a judicial one.

In another case, John Rennie brought a class action suit against a hospital

\(^{118}\) *Id.* at 486.
\(^{119}\) *Id.* at 484.
\(^{120}\) *Id.*
\(^{121}\) *Id.*
\(^{122}\) *Id.*
\(^{123}\) *Vitek*, 445 U.S. at 484.
\(^{124}\) *Id.* at 486.
\(^{125}\) *Id.* at 488.
\(^{126}\) *Id.* at 494-95.
\(^{127}\) *Id.* at 494-96.
\(^{128}\) *Id.*
claiming that he had a constitutional right to refuse anti-psychotic drugs.\textsuperscript{129} The federal district court in \textit{Rennie v. Klein} deferred to the independent medical decision-maker, thus recognizing the right of a person who has been civilly committed to refuse psychotropic medication.\textsuperscript{130} The district court, recognizing a constitutional right to refuse treatment, denied Rennie's injunction.\textsuperscript{131} It reasoned that in the absence of an emergency, due process required an assessment of: (1) the patient's capacity to decide; (2) the patient's physical threat to others; (3) the existence of any less restrictive treatment; and (4) the risk of permanent side effects.\textsuperscript{132} Although the Third Circuit affirmed the district court's analysis and stated that Rennie had a constitutional right to refuse medications, it left the decision whether to medicate involuntarily committed patients up to medical professionals.\textsuperscript{133} The appellate court indicated that the appropriate test is whether a physician's decision was such a substantial departure from accepted professional standards as to show that he did not actually base the decision on those accepted standards.\textsuperscript{134}

In \textit{United States v. Charters}, a patient contended that medication without consent or a judicial determination of incompetence was a violation of constitutionally protected liberty interests.\textsuperscript{135} The Fourth Circuit ruled that anti-psychotic medications could be given without the consent of an involuntarily committed psychiatric defendant who had previously been declared incompetent to stand trial so long as suitable medical professionals had decided to medicate him in a non-arbitrary fashion.\textsuperscript{136} The court stated that, in this case, there was no violation of constitutional rights and that the defendant's interests were adequately protected by the exercise of the professional judgment of medical personnel at the time the decision to medicate him was made.\textsuperscript{137}

Following the \textit{Charters} and \textit{Rennie} holdings, the Supreme Court ruled in \textit{Washington v. Harper} that a medical decision can override a treatment refusal when a psychiatric patient refused medication.\textsuperscript{138} In 1976, Walter

\textsuperscript{129} Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983) ("Rennie IV").
\textsuperscript{131} Rennie I, 462 F. Supp. at 1142.
\textsuperscript{132} Id. at 1145-46; see also Rennie III, 653 F.2d at 839.
\textsuperscript{133} Rennie IV, 720 F.2d at 273-74.
\textsuperscript{134} Id.
\textsuperscript{135} United States v. Charters, 863 F.2d 302, 304 (4th Cir. 1988).
\textsuperscript{136} Id. at 313.
\textsuperscript{137} Id.

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Harper was sentenced to prison for robbery and was incarcerated at the Washington State Penitentiary until 1980. For the majority of that time, he was housed in the prison's mental health unit and he initially consented to treatment, including the administration of anti-psychotic drugs. However, in November 1982 he refused to continue taking the prescribed medications, prompting a request to administer anti-psychotic medication over his objection. The Supreme Court affirmed the administration order, finding that it was proper to consider the medical basis upon which the decision was made and that due process was satisfied by managerial and professional judgment reviews. The Court allowed forced medication with only an internal, institutionally-based due process appraisal, examining three significant factors: (1) a rational connection between the prison regulation and a legitimate government interest, (2) impact of the accommodation of the asserted right, and (3) the existence of ready alternatives. The Court held that Washington state policy, which allowed prison authorities to administer medication to inmates against their will, was constitutional because the procedures did not deprive the prisoner of the right to refuse treatment without adequate due process.

B. Legal Decision-Making Cases

There have been cases where courts have held that involuntary administration of anti-psychotic medication was unconstitutional. Under a rights-driven model, a 1986 case in Massachusetts affected the manner of operation of health facilities for the mentally challenged. Mental patients filed a civil rights action against the physicians under 42 U.S.C. § 1983, asserting that the policies of forced medication and involuntary seclusion in

Loxitane, Mellaril, and Navane).

139. Id.
140. Id.
141. Id.
142. Id. at 215.
143. Id. at 222-23.
144. Harper, 494 U.S. at 231.
145. Id. at 224-25.
146. Id. at 215. Washington State policy 600.30 was developed in partial response to the Court's decision in Vitek v. Jones, 445 U.S. 480 (1980). Under Special Offender Center Policy 600.300, involuntary administration of anti-psychotic medication is limited to those inmates assigned to that facility: (1) who are suffering from a mental disorder and (2) who are either gravely disabled or present a likelihood of serious harm to themselves or others as a result of that mental disorder, and (3) for whom the medication has been prescribed or approved by a psychiatrist.
non-emergency circumstances violated their constitutional rights.\textsuperscript{149} The Rogers \textit{v. Okin} case, popularly known as the Boston State case,\textsuperscript{150} addressed liberty and First Amendment rights and held that a patient must be judicially certified as incompetent in order to be involuntarily medicated.\textsuperscript{151} The court held that committed patients are generally competent to make treatment decisions, including psychotropic medication, except in an emergency.\textsuperscript{152} 

In \textit{Riggins \textit{v. Nevada}}, the Supreme Court held that the daily administration of 450 milligrams of the anti-psychotic drug Mellariil during the trial of Riggins, an accused murderer, created an improperly high danger that his constitutional trial rights were being violated.\textsuperscript{153} After being taken into custody on a homicide charge, Riggins reported hearing voices in his head and having trouble sleeping.\textsuperscript{154} A psychiatrist prescribed an anti-psychotic drug, with which the defendant had been successfully treated in the past, and an antiepileptic drug.\textsuperscript{155} Riggins argued that sustained administration of these drugs infringed upon his freedom and that the drugs' effect on his demeanor and mental state during trial would deny him due process rights.\textsuperscript{156} Riggins also claimed that, because he would offer an insanity defense at trial, he had a right to show jurors his "true mental state."\textsuperscript{157} In response, the state noted that Nevada law prohibits the trial of incompetent persons and argued that the trial court therefore had authority to compel Riggins to take medication required to ensure his competence.\textsuperscript{158} The U.S. Supreme Court found that the Nevada Supreme Court erred by not acknowledging Riggins' liberty interest in freedom from unwanted anti-psychotic drugs, stating, "[t]his error may well have impaired the constitutionally protected trial rights Riggins invokes."\textsuperscript{159} In his concurring opinion, Justice Kennedy expressed the view that the due process clause prohibited involuntary administration of anti-psychotic medicines and wrote

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\textsuperscript{149} Okin, 478 F. Supp. at 1352.
\textsuperscript{150} Gutheil \& Appelbaum, \textit{The patient always pays: Reflections on the Boston State case and the right to rot}, 5 MAN \& MED. 3, 3 (1980).
\textsuperscript{151} Okin, 478 F. Supp. at 1364; Gutheil \& Appelbaum, \textit{supra} note 150, at 4.
\textsuperscript{152} Okin, 478 F. Supp. at 1364; Gutheil \& Appelbaum, \textit{supra} note 150, at 4.
\textsuperscript{154} Id. at 129.
\textsuperscript{155} Id.
\textsuperscript{156} Id. at 130.
\textsuperscript{157} Id.
\textsuperscript{158} Id. at 130; see also \textit{NEV. REV. STAT.} \textsection 178.400 (2005) (stating in pertinent part: "A person may not be tried or adjudged to punishment for a public offense while he is incompetent.").
\textsuperscript{159} Riggins, 504 U.S. at 137.
\end{flushleft}
that the understanding about the properties of these drugs is limited.\textsuperscript{160}

In \textit{Rivers v. Katz}, a major New York decision consolidating three individual complaints,\textsuperscript{161} the Court of Appeals of New York held that the state constitution\textsuperscript{162} permitted individuals a right to refuse treatment that could only be overridden after a hearing determining that the patient was dangerous or incompetent.\textsuperscript{163} In this case, the use of anti-psychotics (Prolixin Hydrochloride, Prolixin Decanoate, Mellaril, Navane, and Lithium) was ordered pursuant to administrative review.\textsuperscript{164} New York did not dispute the right of competent adults to refuse anti-psychotic medication, but instead argued that an involuntarily committed mental patient is presumably incompetent in exercising this right because impaired judgment had led to commitment and an inability to make decisions regarding treatment and care.\textsuperscript{165}

The U.S. Supreme Court has held that if a patient is not dangerous, courts, not medical professionals, must determine whether involuntary administration of psychotropic medication is authorized.\textsuperscript{166} The details surrounding the case of Charles Sell, a former dentist with a long history of mental illness,\textsuperscript{167} are unfortunate:

In September 1982, after telling doctors that the gold he used for fillings had been contaminated by Communists, Sell was hospitalized, treated with anti-psychotic medication, and subsequently discharged... In June 1984, Sell called the police to say that a leopard was outside his office boarding a bus, and he then asked the police to shoot him... In May 1997, the Government charged Sell with submitting fictitious insurance claims for payment... A grand jury later produced a superseding indictment charging Sell and his wife with 56 counts of mail fraud, 6 counts of Medicaid fraud, and 1 count of money laundering.\textsuperscript{168}

The Supreme Court vacated the district court's decision because it failed to find Sell dangerous,\textsuperscript{169} thus holding that if a patient is not dangerous, courts must determine whether involuntary administration of psychotropic

\textsuperscript{160} Id. at 138-39.
\textsuperscript{161} See Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986) (important because of its clarity and unanimity).
\textsuperscript{162} N.Y. CONST. art. I, § 6.
\textsuperscript{163} See Rivers, 495 N.E.2d at 343-44.
\textsuperscript{164} Id. at 339-40 (citing N.Y. CLS Mental Hyg. Law § 9.27).
\textsuperscript{165} Id. at 341.
\textsuperscript{166} See Sell v. United States, 539 U.S. 166, 179 (2003).
\textsuperscript{167} Id. at 169.
\textsuperscript{168} Id. at 169-70.
\textsuperscript{169} See id. at 186.
The Court reasoned:

[t]he medical experts may find it easier to provide an informed opinion about whether, given the risk of side effects, particular drugs are medically appropriate and necessary to control a patient's potentially dangerous behavior (or to avoid serious harm to the patient himself) than to try to balance harms and benefits related to the more quintessentially legal questions of trial fairness and competence.

VII. CHILDREN

In the United States, minors are generally considered legally incompetent and thus cannot consent to or refuse most forms of medical treatment. Only a child's parents and the state have standing to go to court in a typical dispute over the administration of medical treatment to a minor. "The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions." Minors characteristically depend on their families and "the wishes of the minor receive little or no deference if the case is litigated in court." However, because unlimited parental discretion creates a real danger of unfair action and exploitation, particularly among poorer families, courts intervene at different levels to give some amount of due process to youngsters.

The recognition of children's rights under the law did not begin until the 1960s, when the Supreme Court recognized that the Constitution provides clear authority for the protection of children's rights. However, Supreme Court decisions throughout the twentieth century have usually granted constitutional protection to the rights of parents to rear and educate their children...
children. Parental rights in the context of decision-making usually include the right of parents to make the vital choice of whether and when minor children will receive medical treatment. "It is not disputed that a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment and that the state's involvement in the commitment decision constitutes state action under the Fourteenth Amendment."181

A. Best Interests

The interests of parents and children are viewed as co-extensive and courts presume that parents will make medical decisions that comport with their child's best interests.182 A state may use its parens patriae power to override parental decisions if they threaten the child's best interests.183 Courts often look to the best interests of the child in making decisions about treatment,184 by which the state acts "in loco parentis."

However, in many cases, a court may not view the best interests of the child in the same way as the parents. In In re C. A., an Illinois appellate court ruled that where the consent or desire of the infant was indeterminable, the juvenile court properly applied the "best interests" of the minor standard.185 Because of her premature birth, cocaine withdrawal symptoms, and the inability of her nineteen-year-old parents to care for her, the Illinois Department of Children and Family Services (DCFS) filed a petition for adjudication of wardship in the juvenile division of Cook County Circuit Court.186

A New York court in In re Cicero held that parental rights were not absolute and that the court was empowered to intervene when the child's well-being demanded judicial intervention.187 Because the child in the case had a realistic possibility to live a functional, fulfilling life through surgery, the court refused to allow parental inaction to defeat that chance.188

179. See, e.g., Ginsberg v. New York, 390 U.S. 629, 639 (1968) ("[C]onstitutional interpretation has consistently recognized that the parents' claim to authority in their own household to direct the rearing of their children is basic in the structure of our society.").
180. See Feigenbaum, supra note 2.
183. Ex parte Crouse, 4 Whart. 9, 11 (Pa. 1839).
186. Id. at 598.
188. Id. at 701.
Another court in New York held almost identically against a parent, in spite of the mother’s religious opposition to the planned medical treatment. The court found that if the child did not have the proposed medical treatment “his chances for a normal, useful life [were] virtually nil.” The child’s mother, a Jehovah’s Witness, had denied consent for a blood transfusion that would have been necessary to safely perform a surgery to correct facial deformities.

What seems particularly important in the court’s determination is the realistic existence of alternatives for treatment other than the one refused by the parent. In October 1977, Joseph Hofbauer, then a seven-year-old child, was diagnosed with Hodgkin’s disease. The attending physician recommended that Joseph’s treatment include radiation treatments and possibly chemotherapy, the conventional modes of treatment. Joseph’s parents, however, rejected this advice and instead embarked on a course of nutritional, or metabolic, therapy, including injections given by another physician. The Court of Appeals of New York in In re Hofbauer dismissed the allegations of child neglect against the parents because their decision about the care had not been rejected in the medical field and was based on the advice of a skilled physician.

Although the earlier case of Painter v. Bannister has been overruled on other points of law, the decision by the Supreme Court of Iowa remains valid where it did find that it was in the child’s best interest to be removed from the stable atmosphere of the grandparents against the warnings of an eminent child psychologist and send him to an uncertain future in the home of his father, who had a “Bohemian approach to finances and life in general.”

Thus, while courts certainly ratify parental decision-making in some medical treatment cases out of deference for parental authority and religious beliefs, the right of parents to refuse consent for treatment for their children is far from absolute. When courts take precedence over parental opposition to treatment, however, they usually do so because mandating treatment is in the best interests of the child, not because of any deference to the child’s desires.
B. Substituted Judgment

The substituted judgment standard requires the decision-maker "to ascertain the incompetent person's actual interests and preferences" and to attempt to make the decision that a particular incompetent person would make if he or she were competent.\textsuperscript{198} Substituted judgment does not apply to children because they have never been "competent," but instead, their parents' judgment is substituted.\textsuperscript{199} Parents are not always allowed to substitute their judgment if the child has a chance to lead a normal life once given the disputed treatment and if no alternative treatment is proposed. A Florida court purported to employ the substituted judgment approach in allowing the withdrawal of life-support systems from a ten-month-old child, but recognized that the doctrine was difficult to apply to children.\textsuperscript{200} In Massachusetts, after the parents of a minor child diagnosed with leukemia refused to continue the child's chemotherapy treatment, the child's physician sought the child's commitment to the legal custody of the Department of Public Welfare ("DPW") for the limited purpose of providing necessary medical care.\textsuperscript{201} The superior court, finding that there was a substantial chance for a cure and a normal life for the child if he underwent treatment, ordered the child committed to the legal custody of the DPW.\textsuperscript{202} On appeal, the Supreme Judicial Court of Massachusetts affirmed,\textsuperscript{203} recognizing that while there exists a "private realm of family life which the state cannot enter," we think that family autonomy is not absolute, and may be limited where, as here, 'it appears that parental decisions will jeopardize the health or safety of (their) child.'\textsuperscript{204}

The substituted judgment standard has been criticized when used in cases where there is no reliable evidence concerning the patient's viewpoint about the proposed treatment.\textsuperscript{205} At least one court would not allow substituted judgment when there was a lack of evidence regarding what the adult patient would do. In January 1983, Nancy Cruzan lost control of her car as she traveled down a road in Missouri.\textsuperscript{206} The car overturned and a state

\textsuperscript{201.} Custody of a Minor, 379 N.E.2d 1053, 1055 (Mass. 1978).
\textsuperscript{202.} Id. at 1056.
\textsuperscript{203.} Id.
\textsuperscript{204.} Id. (citations omitted).
\textsuperscript{206.} Cruzan v. Harmon, 760 S.W.2d 408, 410-11 (Mo. 1988).
trooper discovered her lying face down in a ditch, without detectable respiratory or cardiac function. An attending neurosurgeon diagnosed Ms. Cruzan as having sustained probable cerebral contusions compounded by anoxia. She remained in a coma for approximately three weeks and then progressed to an unconscious state in which she was able to orally ingest some nutrition.

Ms. Cruzan's parents, who had been appointed as her co-guardians, asked employees of the state hospital to terminate the artificial nutrition and hydration procedures. The employees refused to honor the request without court approval. The parents then filed a declaratory judgment in a Missouri trial court seeking a judicial authorization for the termination of care. The trial court entered an order directing that the parents' request be carried out, partially because during a somewhat serious conversation with her housemate, Ms. Cruzan said that if sick or injured, she would not wish to continue her life unless she could live "at least halfway normally." The Supreme Court of Missouri reversed, reasoning that the woman's conversation with her housemate was unreliable for the purpose of determining her intent and thus insufficient to support the parents' claim to exercise substituted judgment on the woman's behalf.

On certiorari, the U.S. Supreme Court affirmed, holding that a state was not required to repose a right of substituted judgment as to such decision with close family members of the patient and that it could choose to defer to only the patient's wishes. The Court stated, "But we do not think the Due Process Clause requires the State to repose judgment on these matters with anyone but the patient herself.

Because there is no evidence that a child has ever been competent, "substituted judgment" is probably not applicable when deciding the issue of whether to administer medication over a child's objection. The best interests doctrine is more appropriate to children's use of psychotropic medication.
C. Rights

In 1967, juveniles were given due process rights after Gerald Gault, a fifteen-year-old, was committed as a juvenile delinquent for an unknown term potentially spanning the entire period of his minority. Gault was taken into custody by the sheriff for making an obscene telephone call. Neither he nor his parents were given procedural rights because he was a delinquent minor. The Supreme Court held that the boy was denied due process of law because juvenile delinquency proceedings, which may lead to commitment in a state institution, must measure up to the constitutional standards of due process and fair treatment. The Supreme Court indicated that children might need greater protection because of their psychological immaturity and cited sociological studies for the proposition that "the appearance as well as the actuality of fairness, impartiality and orderliness - in short, the essentials of due process - may be a more impressive and more therapeutic attitude so far as the juvenile is concerned."

In another federal case, J.L. v. Parham, two adolescent boys, J. R. and J. L., brought suit to obtain their release from more than five years of confinement in a Georgia mental hospital pursuant to Georgia's mental health laws. The laws provided for the voluntary admission of minor children to mental hospitals by parents or guardians. Even though one of the boys died while appeal was pending, the Supreme Court decided the class action case. Under the Georgia statute, the superintendent of a mental hospital was authorized to admit any child upon application by a parent or guardian. The court concluded that Georgia's medical fact-finding processes were reasonable and consistent with constitutional.

217. See generally In re Gault, 387 U.S. 1 (1967).
218. Id. at 4
219. Id. at 5.
220. Id. at 27-28, 30-31.
221. Id.
222. Id. at 26
223. J.L. v. Parham, 412 F. Supp. 112, 114 (D.C. Ga. 1976) (citing the Georgia law in effect at the time of the case, GA. CODE. ANN. §§ 88-503.1(a), (b) (1933). "The superintendent of any facility may receive for observation and diagnosis ... any individual under 18 years of age for whom such application is made by his parent or guardian ... If found to show evidence of mental illness and to be suitable for treatment, such person may be given care and treatment at such facility and such person may be detained by such facility for such period and under such conditions as may be authorized by law.").
226. Id. at 590-91.
guarantees\textsuperscript{227} after expressing concern about the risk of error intrinsic in a parent's decision to have a child institutionalized for mental health care.\textsuperscript{228} However, the court did not require a judicial determination and was satisfied that some kind of inquiry by a "neutral fact-finder" was sufficient.\textsuperscript{229} That inquiry had to carefully probe the child's background using all available sources.\textsuperscript{230} Of course, the review had to also include an interview with the child. It was necessary that the decision-maker have the authority to refuse admission for any child who did not satisfy the medical standards for admission and that the child's continuing need for commitment be periodically reviewed by an independent process as a necessary check against arbitrariness in the initial admission decision.\textsuperscript{231}

\textbf{D. Treatment Decisions}

Children are considered unable to make independent decisions regarding medical treatment.\textsuperscript{232} If children are not allowed to make the decision to refuse psychotropic medications, someone must make that decision for them. In Florida, the law requires children to have at least one adult representative, usually a guardian ad litem, to protect them and represent their interests in court.\textsuperscript{233}

In the past three decades, a noticeable trend toward greater recognition of children's rights by federal and state courts has emerged.\textsuperscript{234} The Supreme Court stated, "[a] child, merely on account of his minority, is not beyond the protection of the Constitution."\textsuperscript{235} Justice Marshall, dissenting, wrote:

\begin{quote}
[O]ur cases have exhibited particular sensitivity to minors' claims to
\end{quote}

\begin{footnotes}
\textsuperscript{227} \textit{Id.} at 620.
\textsuperscript{228} \textit{Id.} at 606.
\textsuperscript{229} \textit{Id.} at 619-20.
\textsuperscript{230} \textit{Id.} at 613-14.
\textsuperscript{231} \textit{Parham}, 442 U.S. at 615.
\textsuperscript{232} \textit{Maggie Brandow}, \textit{A Spoonful of Sugar Won't Help This Medicine Go Down: Psychotropic Drugs for Abused and Neglected Children}, 72 S. CAL. L. REV. 1151, 1152 (1999).
\textsuperscript{234} \textit{See} Planned Parenthood v. Danforth, 428 U.S. 52, 74 (1976) ("Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights."). \textit{See also} Troxel v. Granville, 530 U.S. 57, 88-89 (2000) (Stevens, J., dissenting).
\end{footnotes}
constitutional protection against deprivations of liberty by the State. Because loss of liberty is no less a deprivation for a child than for an adult . . . we have held that a minor’s right with respect to many of these claims is virtually coextensive with an adult’s. 236

The Court has extended to minors the fundamental rights of privacy and bodily integrity in the context of contraception 237 and abortion. 238 The emotionally charged and time-sensitive nature of the abortion decision can be compared to the decision about administration of psychotropic drugs. Both implicate fundamental constitutional interests and also both affect familial relations. The tension between the preservation of the right of parents to raise their own children while simultaneously upholding constitutional protections exists in both scenarios. If a minor has the right to choose to undergo an invasive procedure like an abortion, then certainly she should have the right to refuse or accept other forms of medical treatment on her own behalf. 239 As such, the Supreme Court has struck down state statutes that require a mature pregnant minor to obtain parental consent before having an abortion. 240

In the example of Florida, the state legislature’s intent is “[t]o provide for the care, safety, and protection of children in an environment that fosters healthy social, emotional, intellectual, and physical development; to ensure secure and safe custody; and to promote the health and well-being of all children under the state’s care.” 241 The Supreme Court of Florida stated, “reasonable workloads are essential to the proper functioning of dependency courts in performing multiple important reviews and hearings required of them by law and necessary for the best interests of the children.” 242

But is the state really able to have the best interests of children in their custody in mind? Not always. According to Mark Hollis reporting for the Sun-Sentinel in Fort Lauderdale, Florida:

[m]ore than one of every 10 children, or 5,100 kids, in the state welfare system are on medications meant to treat depression, schizophrenia and other mental disorders. The drug use is highest, [DCF Secretary] Regier

238. See Bellotti, 443 U.S. at 651; Planned Parenthood, 428 U.S. at 74.
239. See Hawkins, supra note 176, at 2092.
240. Bellotti, 443 U.S. at 647-48 (finding that a Massachusetts statute requiring a mature, unemancipated minor to obtain parental consent or judicial approval after notification of her parents unconstitutionally burdened the minor’s right to seek an abortion).
said, among those 13 and older. Of that age group, more than 2,700 children, or roughly one in every four, are on the drugs.\textsuperscript{243}

The prevalence of foster program abuse has been well recognized, from children who are moved through one foster home after another, to children who receive substandard medical care, or no medical care at all.\textsuperscript{244} Child protection workers carry larger caseloads than recommended and perform law enforcement tasks, making the prospect of superior performance increasingly unreasonable.\textsuperscript{245} Caseloads have grown beyond the workers’ ability to provide minimal care for their constituents.\textsuperscript{246} Although the National Child Welfare League recommends only fifteen cases per foster care worker,\textsuperscript{247} many systems are so over-burdened that caseworkers are required to handle caseloads four times more than what they should have.\textsuperscript{248} According to Professor Richard Wexler, “[m]ost people assume that removing children from their parents means removing them from danger and placing them in safety. Often it is the other way around.”\textsuperscript{249} Although foster children suffer disproportionately from serious emotional, medical, and psychological disabilities, they usually receive woefully insufficient care and frequently no therapeutic intercession of any kind.\textsuperscript{250}

Mental disorders afflict 7.5 million children in the U.S., with about half of these children suffering from conditions causing serious disability.\textsuperscript{251}

\begin{itemize}
\item \textsuperscript{243} Hollis, \textit{supra} note 28.
\item \textsuperscript{244} Laura A. Harper, \textit{The State’s Duty to Children in Foster Care - Bearing the Burden of Protecting Children}, 51 DRAKE L. REV. 793, 797 (2003).
\item \textsuperscript{245} Janet Weinstein, \textit{And Never the Twain Shall Meet: The Best Interests of Children and the Adversary System}, 52 U. MIAMI L. REV. 79, 119-21 (1997).
\item \textsuperscript{246} Roger J.R. Levesque, \textit{The Failures of Foster Care Reform: Revolutionizing the Most Radical Blueprint}, 6 MD. J. CONTEMP. LEGAL ISSUES 1, 10 (1994-95).
\item \textsuperscript{247} ADMIN. FOR CHILDREN \& FAMILIES, U.S. DEP’T OF HEALTH \& HUMAN SERVS., \textit{CHILD MALTREATMENT ANNUAL REPORTS: REPORTS FROM THE STATES TO THE NATIONAL CHILD ABUSE AND NEGLECT DATA SYSTEMS – NATIONAL STATISTICS ON CHILD ABUSE AND NEGLECT} 7 (2000).
\item \textsuperscript{251} NAT’L ALLIANCE FOR THE MENTALLY ILL. FAMILIES ON THE BRINK: THE IMPACT OF IGNORING CHILDREN WITH SERIOUS MENTAL ILLNESS (July 1999), available at http://www.nami.org/Template.cfm?Section=Child_and_Adolescent_Action_Center&template=/ContentManagement/ContentDisplay.cfm&ContentID=22196 (last visited Apr. 21,
When combined with the fact that the natural bonds of affection are absent when the state acts as parent, these disabled children have an increased likelihood of experiencing deprivations of due process. Aptly put in *Parham v. J. R.*, "[f]or a child without natural parents, we must acknowledge the risk of being ‘lost in the shuffle.’"

VIII. SUMMARY

There is little doubt that psychotropic drugs, particularly anti-psychotics, have troublesome side effects. Adults have a constitutional right to prevent involuntary administration of such drugs in several contexts, including incompetence to stand trial, prison transfers, and civil commitment. It is not clear whether children can refuse psychotropic medication against their biological parents’ wishes because parents usually make decisions for their minor children. However, this is not always the case. At least one of the justices of the Supreme Court has indicated that children have constitutional guarantees similar to adults.

Even if it is the case that biological parents may have their minor children’s best interests in mind, the assumption that state case workers, acting as parents for children in custody, also have their best interests in mind is probably inaccurate. If knowing a child’s best interests involves knowing the child, it would not be possible for a state case worker to know each child. There were 11,439 children in Florida’s Children and Permanency Program as of October 31, 2005. Since it is known that

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253. *See* Hutchinson *ex rel. Baker v. Spink*, 126 F.3d 895, 900-01 (7th Cir. 1997) (finding that claim that child suffered a deprivation of substantive due process in violation of 42 U.S.C. § 1983 was not frivolous or malicious where the County officials placed him in the foster home and negligently supervised that home).
259. *See, e.g., Parham v. J.R.*, 442 U.S. 584, 624 (1979) (Stewart, J., concurring) ("To be sure, the presumption that a parent is acting in the best interests of his child must be a rebuttable one, since certainly not all parents are actuated by the unselfish motive the law presumes.").
260. *See, e.g., Hollis, supra* note 28 ("[m]ore than one of every 10 children, or 5,100 kids, in the [Florida] state welfare system are on medications meant to treat depression, schizophrenia and other mental disorders.").
261. Health and Human Services: The Florida Department of Children & Families,
children at age fifteen are just as capable to make decisions as adults,\textsuperscript{262} it would be wise to allow those in state custody to make their own decisions about the administration of psychotropic medication. This would not be the first time that a decision made in the best interest of the child by a biological parental may be different than a decision for the child made by a state social worker, or that the child in state custody should be entitled to a legal hearing before medical procedures are undertaken. In discussing the rights of children whose best interests are determined by state guardians, Justice Brennan implied that juveniles in state custody should be entitled to a judicial hearing before their psychiatric treatment begins.\textsuperscript{263} He also stated, \textquotedblleft[t]he social worker-child relationship is not deserving of the special protection and deference accorded to the parent-child relationship and state officials acting \textit{in loco parentis} cannot be equated with parents.\textsuperscript{264}