

THE CRISIS OF OVER-MEDICATING CHILDREN IN FOSTER CARE: LEGAL REFORM RECOMMENDATIONS FOR NEW YORK[†]

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INTRODUCTION

In April 2009, seven-year-old Gabriel Meyers was home sick from school.¹ In the middle of the day, he was called to the kitchen for lunch.² The meal was soup, but young Gabriel was a picky eater with a short temper.³ He refused the food and dumped his bowl in the trash.⁴ In response, his twenty-three-year-old foster brother sent the boy to his room.⁵ Further upset, Gabriel kicked his toys around, yelled, and threatened to kill himself.⁶ He locked himself in the bathroom; his foster brother grew nervous and then desperate as he struggled with the locked door.⁷ Local police responded quickly to the brother's 911 call and found Gabriel dead.⁸ He had hanged himself with the shower curtain.⁹

Gabriel suffered from physical and sexual abuse, neglect, and frequent transfer between foster homes.¹⁰ Doctors ordered cocktails of powerful

[†] This Note addresses the crisis of over-medicating children in foster care by examining the parameters of the issue (Part I), reviewing current policy from various jurisdictions at both federal and state levels (Part II) and then offering recommendations as to what can be done (Part III). New York is selected as the focus jurisdiction because of the Author's familiarity with the context and because New York has not yet responded as other states have with proposed and enacted reforms. Despite this focus, the policy models discussed herein may also be helpful as guidelines for other states.

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¹ 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>.

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ Sessions, *supra* note 1.

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

psychotropic medications, including antipsychotics and antidepressants that the Food and Drug Administration (the "FDA") had only deemed safe for use in adults.¹¹ Several of his medications carried labels explicitly warning that use in children would lead to increased risk of suicide.¹²

Unfortunately, Gabriel's tragic death is not an isolated incident. Across the country, tens of thousands of children in foster care are prescribed dangerous psychotropic medication,¹³ drugs that are "capable of affecting the mind, emotions, and behavior."¹⁴ The word "psychotropic" comes from the Greek words for "mind" and "turn"; a drug in this category is one that is literally meant to turn one's mind.¹⁵ Despite the facts that psychotropic medications were meant exclusively for adults in extreme situations¹⁶ and that the FDA has not approved the vast majority of these drugs as safe for children,¹⁷ prescriptions written for children have risen at an alarming rate; the sharpest increase is among children in foster care.¹⁸

The crisis caused by the over-medication of children in foster care is attended by several multifaceted issues. With the hope of making some progress toward relief for the affected children, this Note will perform a three-step analysis. Part I will discuss the parameters of this issue and explain why the high medication rates are not innocuous, but rather indicate a real problem. This Part also explores the lack of meaningful informed consent, flaws in medical education, and unlawful kickback schemes as possible causative factors behind the crisis.

Part II will provide information on current federal and state policy to elucidate the current parameters and to demonstrate the relative viability of alternative regulatory methods. State policies from Florida, Texas, Georgia, and California are discussed in turn, followed by a comparative analysis between Florida and Georgia policy, which are meant to further guide policy development in New York and other states considering reform.

Part III of this Note offers recommendations for policy development and implementation. This Part begins by reviewing current policy in New York State and New York City, and it then moves on to an analysis of the policy and proposals for reform. On the pivotal issue of consent, children in foster care often lack a

¹¹ *Id.*

¹² *Id.*

¹³ *Landmark Report on Psychotropic Medication and Foster Care Calls for National Resources*, TUFTS CLINICAL AND TRANSLATIONAL SCIENCE INSTITUTE (Sept. 14, 2010), <http://www.tuftsctsi.org/About-Us/News/Archive/Landmark-Report-on-Psychotropic-Medication-Oversight-in-Foster-Care.aspx>.

¹⁴ *Definition of Psychotropic Medication*, MEDICINENET (Feb. 17, 2004), <http://www.medterms.com/script/main/art.asp?articlekey=30808>.

¹⁵ *Id.*

¹⁶ *Detailed History of Mental Health*, MINNESOTA PSYCHIATRIC SOCIETY, <http://www.mnpsychsoc.org/history%20appendix.pdf> (last accessed Nov. 11, 2011).

¹⁷ Sessions, *supra* note 1.

¹⁸ TUFTS CLINICAL, *supra* note 13.

stable, committed parent to act on their behalf.¹⁹ The best solution appears to be a “care team,” whose members could all be included in the consent process, thereby increasing the type of oversight necessary to shield children from excessive psychotropic medication. This team would consist of the child’s biological parents, foster parents, either a caseworker or the supervising social services director, the attorney for the child, and a volunteer advocate.

Furthermore, unlike New York attorneys and physicians in most other states, most New York physicians currently have no continuing medical education requirements.²⁰ Part III will address this issue by proposing Continuing Medical Education or medical training requirements, which place an emphasis on trying non-pharmaceutical methods first and then using the lowest possible quantity and dosage of a drug.

Regarding the issue of oversight, Part III discusses several possible options. In addition to oversight by the care team introduced in the consent subsection, an independent clinical review board could be made available to review “extreme” prescriptions, a concept discussed further below. A one-doctor approach is also emphasized and increased documentation is encouraged. Additionally, Part III proposes and recommends the continuation of New York’s aggressive prosecution of illegal kickbacks.

Finally, this Part will address the topic of children’s participation in clinical drug trials. Various state approaches are considered and this Note concludes that the best course of action for New York would be to prevent children from becoming subjects in clinical trials of psychotropic medication, but continue to allow them to participate in other clinical trials of emerging medications.

I. ANATOMY OF A CRISIS

A. Profuse Medication as Over-Medication

Rates of prescription to children in foster care are extremely high.²¹ According to a recent multistate study, one out of every twenty-five children across the country is on at least one of these medications; for children in foster care, that rate may be as high as more than one out of every two.²² The drastic increase of psychotropic medication prescription among children in foster care indicates a severe problem. In addition the real risk of suicide,²³ the medications can also cause death by cardiac arrest.²⁴ The drugs also expose these vulnerable children to

¹⁹ *Become a Foster Parent: Overview*, NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES, <http://www.ocfs.state.ny.us/main/fostercare/overview.asp> (last visited July 2, 2012).

²⁰ *State CME Requirements*, MEDSCAPE EDUCATION, http://www.medscape.org/public/state_requirements (last visited Nov. 12, 2012).

²¹ TUFTS CLINICAL, *supra* note 13.

²² *Id.*

²³ Sessions, *supra* note 1.

²⁴ *Psychotropic Drugs and Children*, THE CENTER FOR HEALTH AND HEALTH CARE IN SCHOOLS:

seizures, pancreatitis,²⁵ diabetes, and neuromuscular disability, vomiting, acid reflux, diarrhea, agitation, nervousness, insomnia, bedwetting, vivid nightmares, and severe weight loss or gain.²⁶ Paradoxically, some psychotropic drugs can inflict paranoia and hallucinations.²⁷ Certain side effects, such as involuntary spasms of facial muscles, can be permanent.²⁸

Psychotropic medication may actually exacerbate a child's suffering by stifling his cries for help.²⁹ If a child cannot express his anxiety because his medications have deadened his emotions, even an attentive adult may overlook the problems and therefore fail to respond appropriately.³⁰

Although children in foster care are struggling, they need genuine care, which does not necessarily require mind-altering drugs.³¹ To determine the cause of the over-medication problem, one might point to the fact that virtually all children in foster care have been abused or neglected.³² Although it is likely that the average child in foster care suffers from considerably more emotional trauma than a child not in foster care, it does not follow that the appropriate response is from psychopharmacology, the science "of drug-induced changes in mood, thinking, and behavior."³³ A pharmaceutical response is rational where the underlying illness is biological,³⁴ but talk therapy and social support are far more appropriate where the underlying maladies result from a volatile home life, because then treatment matches the real problem.³⁵ It is certainly possible, and indeed probable, that some children in foster care do suffer from biological abnormalities that require medication for abatement. It is, however, virtually impossible that the benefits of medication outweigh the harm for more than half of all such children, especially in light of recent research indicating that the etiology of childhood mental illness is

THE SCHOOL OF PUBLIC HEALTH & HEALTH SERVICES, THE GEORGE WASHINGTON UNIVERSITY (2007), www.healthinschools.org/~media/Files/psychotropic07.ashx.

²⁵ Inflammation of the pancreas; severe cases can be deadly. *Pancreatitis*, MAYO CLINIC (Jan. 15, 2011), <http://www.mayoclinic.com/health/pancreatitis/DS00371>.

²⁶ JoAnne Solchany, *Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges*, AMERICAN BAR ASSOCIATION CENTER ON CHILDREN AND THE LAW, 13, 21 (2011), http://www.americanbar.org/content/dam/aba/administrative/child_law/PsychMed.authcheckdam.pdf.

²⁷ *The Side Effects of Common Psychiatric Drugs*, THE CITIZENS COMMISSION ON HUMAN RIGHTS INTERNATIONAL (2008), http://www.cchr.org/sites/default/files/The_Side_Effects_of_Common_Psychiatric_Drugs.pdf.

²⁸ *Tardive Dyskinesia Introduction & Overview*, TARDIVE DYSKINESIA, www.tardivedyskinesia.com (last visited Mar. 11, 2012) (describing these spasms, also known as "tardive dyskinesia").

²⁹ Robert T. Garrett, *Drug Fraud Alleged in Foster Care: Strayhorn Believes Kids are Getting Unnecessary Psychiatric Medication*, THE DALLAS MORNING NEWS (Nov. 12, 2004), <http://www.ahrp.org/infomail/04/11/13.php>.

³⁰ *Id.*

³¹ *Id.*

³² *Id.* (including a discussion of this counter-argument, now largely rejected).

³³ *Id.* See also "Psychopharmacology," *Science Reference*, SCIENCE DAILY, <http://www.science.daily.com/articles/p/psychopharmacology.htm> (last visited Nov. 12, 2012).

³⁴ Garrett, *supra* note 29.

³⁵ *Id.*

usually less biological than adult-onset illness.³⁶ The neurological imbalances that typically call for psychopharmacology have been found to affect a minute portion of the general population;³⁷ the majority of children in foster care undoubtedly do not have the type of physical ailment that requires drugs with potentially fatal effects.³⁸ Although scientists have yet to create a simple test to determine etiology,³⁹ most patients are first treated without drugs to see if their symptoms might be amenable to a less dangerous course of treatment.⁴⁰ A child's status as a ward of the state should not be grounds for depriving him of this essential process.⁴¹

Many experts in this field would admit that these drugs are not medically necessary for most of the children for whom they are prescribed, but are rather used as an easy way to subdue upset children.⁴² Like all other children, those in foster care can be unruly and disruptive; however, a child should actually be considered *unhealthy* if abuse, neglect, and removal from home do not affect him.⁴³ "The state takes a child that is upset, crying, yelling and screaming because they've just been taken from their families and, with all those symptoms, prescribes them medication[.] . . . They think that if the child is unruly, it's easier to deal with them by medicating them than by counseling."⁴⁴ The ease of prescription cannot justify the damage inflicted.⁴⁵ In the words of Tony Appel, a neurologist quoted by the *Dallas Morning News*, "[by administering these medications,] [w]e're taking away their future. We're taking away their ability to relate to people; trust, love caring, ability to put yourself in the other person's shoes and see how they see you. We take all that away from these children. We blunt their emotion."⁴⁶ And in severe

³⁶ Robert M. Post, *Transduction of Psychosocial Stress into the Neurobiology of Recurrent Affective Disorder*, 149 AM. J. PSYCHIATRY 999 (1992).

³⁷ See *id.*

³⁸ Robert E. Roberts, C. Clifford Attkisson, & Abram Rosenblatt, *Prevalence of Psychopathology Among Children and Adolescents*, 155 AM. J. PSYCHIATRY 715 (1998).

³⁹ Causation, or why a given patient contracts and suffers from a given illness.

⁴⁰ Garrett, *supra* note 29.

⁴¹ *Id.*

⁴² *Id.* See also Peter Breggin, *The Psychiatric Drugging of America's Foster Children*, HUFFINGTON POST (Dec. 22, 2011, 03:22 PM ET), http://www.huffingtonpost.com/dr-peter-breggin/foster-children_b_1149805.html; Thomas S. Szasz, *Chemical Straitjackets for Children*, 50 IDEAS ON LIBERTY 38-39 (2000), available at <http://www.szasz.com/iol5.html>; Aletha Solter, *The Drugging of Children: A National Disgrace*, SANTA BARBARA NEWS-PRESS (Feb. 8, 1998), available at <http://www.awareparenting.com/ritalin.htm>; April Hunt, *Georgia Foster Kids Medicated at High Rates: Review of Kids' Psych Drugs Urged*, THE ATLANTA JOURNAL-CONSTITUTION, (Feb. 23, 2011), <http://www.ajc.com/news/news/local/georgia-foster-kids-medicated-at-high-rates/nQqqp/> (quoting Richard Wexler, head of the National Coalition for Child Protection and Reform) ("Medications dispersed often aren't to help the child with their problems but to make the child more docile for the caregivers.").

⁴³ Garrett, *supra* note 29.

⁴⁴ Emily Ramshaw, *Texas Foster Kids' Doctors Have Ties to Drug Firms*, THE DALLAS MORNING NEWS (Aug. 18, 2008), <http://tmap.wordpress.com/2008/08/17/texas-foster-kids-doctors-have-ties-to-drug-firms> (quoting Brett Ferguson, an attorney who represents children in foster care).

⁴⁵ Garrett, *supra* note 29.

⁴⁶ *Id.*

cases, prescribing these medications may inflict suicidal ideation and effectively kill them.⁴⁷

In several documented case studies, children in foster care simply needed social support responsive to their needs, not powerful drugs. In one poignant example, a little boy named Cole was only three years old when his mother began leaving him home alone with his infant brother so that she could use illicit drugs.⁴⁸ Between ages three and seven, Cole was also subjected to physical and sexual abuse.⁴⁹ He and his brother were removed from their mother's care when a neighbor found Cole "disheveled and barely dressed," searching for food in a garbage can.⁵⁰ Cole's father, who had been searching for his son for years, took him in and cared for him.⁵¹ Meanwhile, his mother was arrested, convicted, and sentenced to eight years in prison.⁵² From the prison phone, she called her young boy and told him that he would ultimately return to her permanently and that he would be spending time with her behind bars.⁵³

Traumatized, seven-year-old Cole soon began to avoid sleeping because he was afraid of nightmares.⁵⁴ He also stated that he was scared of "voices."⁵⁵ Without his father, Cole likely would have been labeled schizophrenic and placed on antipsychotic drugs.⁵⁶ Instead, Cole's father and social service workers assured him that he could stay in the home he loved and additionally gave him a safe space where he could talk about his fears.⁵⁷ "Within a week, Cole's symptoms vanished."⁵⁸ Even when *the* hallmark of psychosis is present, appropriate social support can be all that a child needs.⁵⁹

B. Causation

If we accept as a basic premise of this Note that high medication rates reflect over-prescription, the next step is to explore the possible explanations behind the phenomenon. Specifically, three primary factors are examined as possible sources of causation: lack of meaningful informed consent, inadequate medical education, and kickbacks.⁶⁰ Each is discussed in turn below.

⁴⁷ Sessions, *supra* note 1.

⁴⁸ Solchany, *supra* note 26, at 8.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Id.*

⁵⁴ Solchany, *supra* note 26, at 8.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ See, e.g., Gardiner Harris, *Crackdown on Doctors Who Take Kickbacks*, N.Y. TIMES (Mar. 3, 2009), <http://www.nytimes.com/2009/03/04/health/policy/04doctors.html>.

1. Lack of Meaningful Informed Consent

For those children fortunate enough to avoid foster care, their parents and guardians are responsible for their medical care. On the other hand, for most children in the foster system, a stable and devoted adult is almost always absent.⁶¹ In all states, someone must still consent to placing a child on psychotropic medication, but there is no individual clearly qualified to fill this role.⁶² There are five possible candidates. First, a biological parent may be competent and is often the most concerned, yet she has usually had her child taken away by the state.⁶³ Second, other relatives may be competent and concerned, but alternatively might be neither, and they almost always lack legal status over the child.⁶⁴ Third, the presiding family court judge typically has legal authority to provide or withhold authorization for medication, but often lacks both expertise in this area and in-depth knowledge of the child.⁶⁵ Accordingly, the judge will usually just defer to the judgment of the prescribing physician, who is often the only expert on the case.⁶⁶ Fourth, the foster parents may be competent and devoted or may not be, and they are too often only a transient presence in the child's life.⁶⁷ In some unfortunate cases, foster parents may be motivated by the increased financial stipend that accompanies the placement of the child on psychotropic medication.⁶⁸ The fifth and final candidate is the social services agency charged with temporary custody of the child.⁶⁹ The agency may or may not have an employee available with the capacity to learn enough about the child in question to make a good decision as to whether psychotropic medication is in his best interest.⁷⁰

Since none of the candidates are in a strong position to safeguard the child against unnecessary drugs for the various reasons mentioned above, one of the factors leading to over-prescription may be this lack of meaningful informed

⁶¹ *Become a Foster Parent: Overview*, *supra* note 19.

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ See William M. Brooks, *The Tail Still Wags the Dog: The Pervasive and Inappropriate Influence by the Psychiatric Profession on the Civil Commitment Process*, 86 N.D. L. REV. 259, 284-287 (discussing excessive judicial deference to psychiatric experts in the context of civil commitment procedure).

⁶⁶ *Id.*

⁶⁷ *Become a Foster Parent: Overview*, *supra* note 19.

⁶⁸ Psychotropic medication usually elevates the child's classification from "normal" or "basic" to "special," a change accompanied by a significant increase in financial compensation. See *Notification of Foster Care Level of Care and Room and Board Payment*, NEW YORK STATE OFFICE OF CHILDREN & FAMILY SERVICES, http://www.ocfs.state.ny.us/main/Forms/Foster_Care/OCFS-LDSS-7018%20Notification%20of%20Foster%20Care%20Level%20of%20Care%20and%20Room%20and%20Board%20Payment.pdf (last accessed Mar. 9, 2012).

⁶⁹ *Become a Foster Parent: Overview*, *supra* note 19.

⁷⁰ *The Long Road Home: A Study of Children Stranded in New York City Foster Care*, CHILDREN'S RIGHTS, 119-20 (2009), http://www.childrensrights.org/wp-content/uploads/2009/11/2009-11-02_long_road_home_full_report_final.pdf.

consent.⁷¹ Consent is considered important in New York—a fact evidenced by the laws mandating it—and must be considered important for all children, regardless of whether or not they are in foster care.⁷² Children in foster care often lack the care given to children in stable homes; accordingly, they should receive extra protection to ensure that their needs are met.⁷³

Legally, notwithstanding certain limited emergency provisions, a parent or guardian must provide informed consent before a minor may begin treatment through psychotropic medication.⁷⁴ Pursuant to New York Mental Hygiene Law Section 33.21, the consent of a parent or guardian or the authorization of a court is legally mandatory.⁷⁵ There are only two exceptions to this rule, and they become applicable when the given situation falls into one of two categories: (1) the minor is already residing in a hospital *and* the situation is one of emergency,⁷⁶ or (2) the minor is over the age of sixteen and is in one of the following three situations.⁷⁷

The first situation occurs in instances in which the minor has no reasonably available parent or guardian, the minor has capacity, and the medication is determined to be in the minor's best interests.⁷⁸ This is often a paradox because if the medication is thoroughly necessary, the capacity of the minor is likely to be less than full.⁷⁹ The second situation is found when the minor would be detrimentally affected if the consent of his parent or guardian were required and both the treating physician and a second physician—whose specialty is psychiatry and who is not an employee of the hospital—have determined that the minor would be detrimentally impacted, the minor is capable, and the medication is in the minor's best interest.⁸⁰ In the third situation, the parent or guardian has refused consent but is given notice where the treating physician and the second physician—not an employee of the hospital but one specializing in psychiatry—have determined that the minor is capable and that the medication is in his best interest.⁸¹ Any one of these extraordinary circumstances must be meticulously documented in the minor's clinical record.⁸²

The purpose of laying out the text of this law is to demonstrate its unequivocal intent to safeguard minors who lack parental consent. Consent is legally required and may only be circumvented in truly exceptional circumstances:

⁷¹ Ramshaw, *supra* note 44.

⁷² N.Y. MENTAL HYG. LAW § 33.21.

⁷³ *The Long Road Home*, *supra* note 70.

⁷⁴ N.Y. MENTAL HYG. LAW § 33.21.

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ See Fred K. Berger & David Zieve, *Heath Guide: Psychosis*, N.Y. TIMES, Mar. 7, 2012, <http://health.nytimes.com/health/guides/disease/psychosis/overview.html>.

⁸⁰ N.Y. MENTAL HYG. LAW § 33.21.

⁸¹ *Id.*

⁸² *Id.*

when the minor's health and safety are jeopardized and multiple physicians are carefully monitoring the situation.⁸³ Note the conjunctive language of the law: "consent is mandatory, and exceptions are allowed only where a *and b and c and d and e . . .* are met."⁸⁴ In short, consent is highly valued in New York.

For minors in foster care, however, meaningful parental consent is often lacking.⁸⁵ In many cases, if a child had a competent and devoted parent, then that child probably would not have become a ward of the state.⁸⁶ Even so, Mental Hygiene Law Section 33.21 leaves these children without any real protection from gratuitous psychotropic medication.⁸⁷ Notably, the law does not address the problem of what to do when a child lacks an involved and competent parent who can decide whether or not to approve the prescription of psychotropic medication.⁸⁸ Various jurisdictions have instituted measures designed to combat this problem. The relative merits of each approach and the possible implications for legal reform in New York are discussed *infra* in Part IV.

2. Inadequate Medical Education

Too often, over-medication is discussed in the passive voice: drugs "are being over-prescribed."⁸⁹ The absent subject is the physician. Attorneys, judges, legislators, caseworkers, and others are working hard to change the system but are largely ignoring the professionals at the heart of the matter.⁹⁰ A person with psychotropic prescription privileges is highly educated, experienced, and licensed by a state board.⁹¹ Yet clinicians are often improperly trained to medicate first,

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Become a Foster Parent: Overview*, *supra* note 19.

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ Benedict Carey, *Drugs Used for Psychosis Go to Youths in Foster Care*, N.Y. TIMES, Nov. 21, 2011, at A13, available at <http://www.nytimes.com/2011/11/21/health/research/study-finds-foster-children-often-given-antipsychosis-drugs.html?scp=1&sq=foster%20care%20medication&st=cse>; Marc Caputo, *Gov. Charlie Crist Urged to Stop 'Chemical Restraint' of Foster Kids*, MIAMI HERALD, posted on CITIZENS COMMISSION ON HUMAN RIGHTS OF FLORIDA (July 23, 2009), <http://www.cchrflorida.org/blog/42>; Robyn Murray, *Bill Would Monitor Medication Prescriptions for Foster Kids*, KVNO NEWS: OMAHA'S PUBLIC RADIO NEWSROOM (Feb. 6, 2012), <http://www.kvnonews.com/2012/02/bill-would-monitor-medication-prescriptions-for-foster-kids/>.

⁹⁰ Mark Abdelmalek, et al., *New Study Shows U.S. Government Fails to Oversee Treatment of Foster Children with Mind-Altering Drugs*, ABC WORLD NEWS WITH DIANE SAWYER (Nov. 30, 2011), <http://abcnews.go.com/US/story?id=15058380#.T1pshTEgfwg> (reporting on a national Government Accountability Office ("GAO") publication produced after years of intensive research).

⁹¹ *Practice Management for Early Career Psychiatrists: A Reference Guide*, AM. PSYCHIATRIC ASS'N: OFFICE OF HEALTHCARE SYS. AND FIN., 136 (2003), available at http://www.google.com/url?sa=t&rc=t&ret=j&q=&esrc=s&source=web&cd=4&ved=0CFAQFjAD&url=http%3A%2F%2Fjcremyartinezmd.com%2Fuserfiles%2F1410818%2Ffile%2FPractice%2520Management.pdf&ei=HzquUOOWk5K49gSGjICwDg&usq=AFQjCNGZbvPjiVCdIjTU10r_DQRNF4upoQ&sig2=N1gv5augF9-sCFmxA0qB8Q (last accessed Nov. 22, 2012).

and only then begin to think about other forms of treatment.⁹² According to Barry D. Berger, Ph.D., “[t]oo many psychiatrists have stopped listening to their patients and have become obsessed with finding the right drug augmentation strategy.”⁹³

This treatment approach results in pervasive over-medication and it can be extreme: there are doctors who prescribe dangerous psychotropic medication to one-year-old infants.⁹⁴ For a two-year-old child with “severe” tantrums, one doctor felt that he had “no choice” in prescribing five different psychotropic medications.⁹⁵ The toddler “[w]hen upset, he screamed, threw objects, even hit his head on the wall or floor—not uncommon for toddlers, but frightening.”⁹⁶ Overwhelmed, his mother turned to a psychiatrist who agreed to provide the array of powerful drugs as a means of establishing peace in the home.⁹⁷ Soon, however, she began to worry about her sedated little boy. She rescued him and vowed, “I will never, ever let my children be put on these drugs again. I didn’t realize what I was doing.”⁹⁸

Experts cited by *The New York Times* agreed that there was “no valid medical reason” for the young boy to be taking the psychotropic drugs.⁹⁹ The young, overwhelmed mother may have exercised poor judgment in initially consenting to the prescriptions, but why did the licensed psychiatrist issue them in the first place? Moreover, what happens to children in foster care who face a similar scenario but lack a dedicated parent to step in and protect them? To address these issues, improvements in medical training need to be implemented.

3. Kickbacks

A kickback is a payment or service exchanged for a favor, and it is usually illegal.¹⁰⁰ For purposes of this Note, a kickback is a payment from a drug company to a psychiatrist in exchange for advertising and prescribing the company’s product: psychotropic medication.¹⁰¹ The scheme is typically against the law because it sets up a dangerous system of incentives, in which the doctor is

⁹² Susan Stern, *Treatment Resistance? Try Psychotherapy*, 4 CURRENT PSYCHIATRY 100 (2005); Barry D. Berger, *Prescribe First, Ask Questions Later?*, THE JOURNAL OF FAMILY PRACTICE (May 2005), <http://www.jfponline.com/pages.asp?aid=988>. See also JUDITH WARNER, WE’VE GOT ISSUES: CHILDREN AND PARENTS IN THE AGE OF MEDICATION (Penguin Books 2010).

⁹³ Berger, *supra* note 92.

⁹⁴ *Antipsychotic Drug Use Spiraling in Kids, Research Says*, CBC NEWS (July 2, 2009), <http://www.cbc.ca/news/health/story/2009/07/02/health-drugs.html>.

⁹⁵ Duff Wilson, *Child’s Ordeal Shows Risks of Psychosis Drugs for Young*, N.Y. TIMES, Sept. 1, 2010, <http://www.nytimes.com/2010/09/02/business/02kids.html?pagewanted=all>.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Comparison of the Anti-Kickback Statute and Stark Law*, U.S. DEPT. OF HEALTH AND HUMAN SERVICES: OFFICE OF INSPECTOR GENERAL, <http://oig.hhs.gov/compliance/provider-compliance-training/files/starkandakscharthandout508.pdf> (last accessed Mar. 11, 2012).

¹⁰¹ Harris, *supra* note 60.

encouraged to serve the interests of his financial benefactor instead of his patient.¹⁰² For example, a prescribing clinician may be offered a large sum of money to give a talk on a new drug to his peers; that physician may be more motivated to promote the drug than to cautiously consider whether it would truly serve the best interests of each young patient who comes before him.¹⁰³

Since Medicaid or similar government funds pay for most of the psychotropic prescriptions for children in foster care, these kickbacks violate the federal anti-kickback statute.¹⁰⁴ This law states in relevant part:

Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind — (A) in return for . . . arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program . . . shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.¹⁰⁵

Those responsible for knowingly and willfully offering and paying the remuneration are also guilty of a felony punishable by up to \$25,000 in fines and five years' imprisonment.¹⁰⁶ Not only are kickbacks illegal, but they can be felonious and punishable by years in prison.¹⁰⁷

Despite the unlawful nature of these payments, kickbacks are still pervasive in the medical field.¹⁰⁸ In 2009, the U.S. Department of Health and Human Services spearheaded a campaign against several prominent pharmaceutical companies.¹⁰⁹ In January of that year, pharmacy giant Eli Lilly acknowledged that it faced federal criminal charges for illegally marketing the antipsychotic “Zyprexa” and announced that it would settle by paying a record fine of \$1.4 billion.¹¹⁰ Shortly thereafter, the record was broken when Pfizer announced its expected payment of \$2.3 billion for settlement of charges that the company illegally marketed the painkiller “Bextra.”¹¹¹ The magnitude of these cases demonstrates the severity of the kickback problem in the medical field.

Although large pharmaceutical companies may be the prime culprit, they could not have acted alone. According to Michael J. Sullivan, the United States Attorney for Massachusetts, “[t]he strategy of looking at the companies alone was

¹⁰² *Special Fraud Alerts*, U.S. DEPT. OF HEALTH AND HUMAN SERVICES: OFFICE OF INSPECTOR GENERAL, HHS (Dec. 19, 1994), <http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html>.

¹⁰³ Harris, *supra* note 60.

¹⁰⁴ 42 U.S.C. § 1320a-7b(b).

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ Harris, *supra* note 60.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

not completely successful in terms of our objective to deter health care fraud, [s]o it's fair to say that the government is looking at evidence of criminal wrongdoing even by doctors."¹¹² As noted in the federal statute,¹¹³ individual physicians can face exclusion from Medicare and Medicaid funding, license suspension or revocation, fines, and even substantial imprisonment upon conviction.¹¹⁴ Accordingly, although prominent kickback prosecutions have focused on large pharmaceutical companies,¹¹⁵ individual physicians are not immune.¹¹⁶

Justice for kickback perpetrators should provide a considerable measure of relief to children who are at the mercy of their prescribing physicians.¹¹⁷ Innocent physicians should not be disturbed in their noble and vital work, but the legal push against offenders is a laudable movement that should continue with zeal.¹¹⁸

Kickbacks, along with problems in meaningful informed consent and medical training, are sources of harm that need to be addressed. For the reasons discussed above, they are causative or at least contributory factors in the excessive medication of children in foster care. The next Part will explore the steps taken by the federal government and several states toward combating these detrimental influences.

II. CURRENT POLICY

In several jurisdictions, laws and regulations have been enacted specifically to combat the over-medication of children in foster care. Congress passed a law that applies to all states,¹¹⁹ and certain states have gone a step further by passing their own legislation on this topic.¹²⁰ Federal and selected state laws are discussed in this Part, and particular attention is paid to provisions that either apply directly to New York or could have instructive value for reform development in New York. Again, effective reforms are appropriately tailored to context, but some models may prove helpful for other states as well.

¹¹² *Id.*

¹¹³ 42 U.S.C. § 1320a-7b(b).

¹¹⁴ Harris, *supra* note 60; 42 U.S.C. § 1320a-7b(b). Reduction of penalties may be available through plea bargaining or other negotiations with prosecutors. *See, e.g.*, Josh Margolin, *Feds Sue Essex Doctor in UMDNJ Scheme*, NJ.COM (Apr. 17, 2008), <http://www.nj.com/news/index.ssf/2008/04/umdnj.html>.

¹¹⁵ Harris, *supra* note 60.

¹¹⁶ 42 U.S.C. § 1320a-7b(b).

¹¹⁷ Harris, *supra* note 60.

¹¹⁸ *Id.*

¹¹⁹ 42 U.S.C.A. § 622 (West 2011).

¹²⁰ The exact number of states with specific policies of the use of psychotropic medication in children in foster care is unclear due to the very current nature of this topic and because of the vagueness of state provisions sometimes pointed to as sources of law on this subject. State policies are being developed as this Note is written, and some states apply general laws for specific use here.

A. Federal Law

A federal statute, 42 U.S.C. Section 622, governs each state's responsibility in planning for child welfare service provision.¹²¹ As one of the conditions for maintaining federal funding eligibility under this law, each state must:

Develop . . . a plan for the ongoing oversight and coordination of health care services for any child in a foster care placement, which shall ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs, and shall include an outline of . . . (v) the oversight of prescription medicines.¹²²

A recent amendment, H.R. 2883, now requires that these plans include “protocols for the appropriate use and monitoring of psychotropic medication.”¹²³ The development of this plan is to be conducted by the state in collaboration with the state's child welfare agency.¹²⁴

The plan for oversight of medication must therefore stand as at least one component of a larger plan that guarantees “a coordinated strategy” designed to meet “the health care needs of children in foster care,”¹²⁵ but the law does not address the specifics of exactly what that plan should include. All details of psychotropic medication regulation are left to the individual state's discretion.¹²⁶ Therefore, it is important that New York, like all other states, develop a strategy for implementation of laws that both meet the federal requirements and the needs of New Yorkers, particularly New York children in foster care. Courts have since clarified certain points of this law, including what circumstances may give rise to a private right of action,¹²⁷ but they have not squarely addressed the issue of what a plan needs to look like in order to satisfy the federal requirement.

There are states that have begun to answer the fundamental questions of how to meet the gaps in the federal law and how to fulfill the federal requirements while addressing the real needs of local children. The legal innovations and reforms of four exemplary states are discussed in detail, *infra*, in subsection C of this Part.

¹²¹ 42 U.S.C.A. § 622 (West 2011).

¹²² 42 U.S.C.A. § 622(15)(a) (West 2011).

¹²³ H.R. 2883, 112th Cong. § 101 (2011).

¹²⁴ 42 U.S.C.A. § 622 (West 2011).

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ *Alger v. County of Albany*, 489 F.Supp.2d 155 (N.D.N.Y. 2006) (holding that the Adoption Assistance and Child Welfare Act did not create a private right to sue for abuse, neglect, or maltreatment suffered in foster care); *Forbes v. Giuliani*, 929 F.Supp. 662, 126 F.3d 372 (S.D.N.Y. 1996) (holding that the Multiethnic Placement Act did create a private cause of action for children injured by state noncompliance with the statutory requirements).

B. National Guidelines

At the national level, the American Bar Association's JoAnne Solchany has produced a set of guidelines for implementation of Section 622.¹²⁸ This publication is helpful in that it includes substantial background information. Solchany begins with an acknowledgement of the severe hardships that weigh upon children in foster care: "[r]egardless of what led to their involvement in the child welfare system, all face separation, broken relationships, and confusion. Increasing their vulnerabilities are risk factors such as poverty, neighborhood violence, exposure to parental mental illness, racial discrimination, lack of food, and homelessness."¹²⁹ The author continues with descriptions of common mental illnesses and medications as well as several compelling case studies.¹³⁰

For physicians, Solchany provides best-practice models for prescription, such as "[b]efore starting pharmacotherapy, a medical history is obtained, and a medical evaluation is considered when appropriate," and "[t]he prescriber develops a plan to monitor the patient, short and long term."¹³¹ Recommendations of planning, monitoring, and caution may be helpful to some physicians, but the prescribing physician who thinks himself negligent in planning and monitoring will be hard to find.¹³²

C. State Law

Several states have attempted to combat the problem of over-medicating children in foster care by enacting specially targeted legal reforms. As examples, developments in Florida, Texas, Georgia, and California are discussed in this Part. The pros and cons of the various approaches are analyzed in Part III, followed by the implications for legal reform in New York.

1. Florida

Florida was Gabriel Myers' home until the young boy tragically took his own life in 2009.¹³³ In the wake of this heartbreak, the state commissioned a panel to investigate Gabriel's case as well as to oversee children in foster care more generally.¹³⁴ The panel found that "every level of the Florida system had missed 'warning signs'" that Gabriel was in danger.¹³⁵ The panel also found that at least thirteen percent of children in the Florida system of foster care were on

¹²⁸ Solchany, *supra* note 26.

¹²⁹ *Id.* at 3.

¹³⁰ *Id.* at 4-11, including a case study of Cole, discussed *supra* in Part I.

¹³¹ *Id.* at 22.

¹³² See Anthony Youn, *Seriously? Doctors Say They're Underpaid*, CNN (May 1, 2012, 10:55 AM), <http://thechart.blogs.cnn.com/2012/05/01/seriously-doctors-say-theyre-underpaid>.

¹³³ Sessions, *supra* note 1.

¹³⁴ *Id.*

¹³⁵ *Id.*

psychotropic medications, and in sixteen percent of those cases, informed consent had not been obtained by a parent or guardian.¹³⁶

In response to these travesties, Florida tried to set up new laws that would protect the children in its care. As of 2010, no child in Florida foster care may participate in a clinical drug trial.¹³⁷ Lawmakers also advocated for legislation that would have required the appointment of a volunteer *guardian ad litem* (“GAL”)¹³⁸ to any child in foster care prescribed a psychotropic medication.¹³⁹ Pursuant to this proposed measure, express and informed consent and assent¹⁴⁰ would have been required from the child or his parent or legal guardian, and the minimum age at which a child could be medicated would have been raised from six to eleven in most cases.¹⁴¹ Unfortunately, the bill did not receive adequate support and was never passed into law¹⁴²—a “major failure” according to the secretary for the State Department of Children and Families.¹⁴³

Nonetheless, the state did pass administrative regulations in 2010 that obligate the welfare agency to assist the physician in obtaining consent from the child’s biological parent prior to initiating a course of psychotropic medication.¹⁴⁴ These efforts must be documented.¹⁴⁵

On the issue of consent, Florida regulations provide that parents retain the right to refuse or consent to psychotropic medication for their children unless and until their parental rights are legally terminated or if a judicial override is obtained after a formal hearing.¹⁴⁶ This is one possible approach that states may take regarding consent.

¹³⁶ *Id.*

¹³⁷ Pareesha Narang, *Florida Bans Foster Children from Clinical Drug Trials*, CHILD WELFARE TODAY (Aug. 6, 2010), http://www.youthtoday.org/view_blog.cfm?blog_id=385.

¹³⁸ A *guardian ad litem* is someone “appointed by the court to advocate for a child . . . [t]he GAL becomes familiar with the child and the child’s case and makes recommendations to the court to help ensure a safe, caring, stable, and permanent environment.” *Volunteers Needed*, THE FLORIDA GUARDIAN AD LITEM PROGRAM, http://www.google.com/url?sa=t&rot=j&q=&esrc=s&source=web&cd=7&ved=0CF4QFjAG&url=http%3A%2F%2Fguardianadlitem.org%2Fdocuments%2FGALLay_volbrochure.pdf&ei=MLuuUOXWGMrJ0AHWq4HgCw&usg=AFQjCNGqokclgtkkqiR6CSCgp2kt5So2uQ&sig2=sDvh-hzgGXTD_Bnhaiwxgd (last accessed Nov. 22, 2012).

¹³⁹ S.B. 2718, 2010 Leg., Reg. Sess. (Fla. 2010).

¹⁴⁰ “Consent” is agreement that is necessary as a prerequisite to psychopharmacologic treatment; “assent” refers to agreement by someone incapable of giving valid consent, such as a minor, and is typically meant to engage children in treatment. See Michelle Boucher, *Ethical Implications Regarding Minors and the Therapeutic Relationship: The Appropriate Age of Consent*, FAMILY CLINIC, <http://www.yourfamilyclinic.com/pro/ageconsent.html> (last accessed Dec. 7, 2011).

¹⁴¹ S. 2718 (Fla. 2010).

¹⁴² Deborah Circelli, *Florida Tightening Psych Drug Rules*, DAYTONA BEACH NEWS JOURNAL (May 14, 2010), <http://www.psychsearch.net/florida-tightening-psych-drug-rules/>.

¹⁴³ *Id.*

¹⁴⁴ FLA. ADMIN. CODE ANN. 65C-35.007 (2010).

¹⁴⁵ *Id.*

¹⁴⁶ FLA. STAT. § 39.407 (2010).

2. Texas

In Texas, as in New York, reform efforts have resulted in a workgroup and treatment recommendations, although no new legal changes have been enacted.¹⁴⁷ The Texas Health and Human Services Commission (“HHSC”) and the Department of Family and Protective Services (“DFPS”) convened an Advisory Committee on Psychotropic Medications and authored a report with best practice models pertaining to safe medication of children in foster care.¹⁴⁸ Specifically, the group called for a statewide system of clinical supervision.¹⁴⁹ In 2005, these agencies collaborated with the Department of State Health Services (“DHS”) to publish *Psychotropic Medication Utilization Parameters for Foster Children*.¹⁵⁰ By the following year, researchers concluded that this publication had produced both a reduction in overall use of psychoactive drugs in children in foster care and a reduction in polypharmacy—the use of multiple drugs, typically concurrently—in these children.¹⁵¹ The work group updated its publication in 2007 and 2010.¹⁵²

The most recent version includes several general principles that should guide prescription: as a safeguard against prescription simply to make a child more docile or manageable, a Diagnostic and Statistical Manual (“DSM”) diagnosis should be a prerequisite to prescription; medical history and progress should be carefully documented; and informed consent should be a top priority.¹⁵³ Consent should not be considered “informed” if it was not preceded by a discussion of the “diagnosis, expected benefits and risks of treatment, including common side effects, . . . laboratory findings, and uncommon but potentially severe adverse events, [a]lternative treatments, the risks associated with no treatment, and the overall potential benefit to risk ratio of treatment.”¹⁵⁴ Physicians should strive to use the minimum quantity of medication possible and, especially for young children—*e.g.*, under six years of age—several months of non-psychopharmacological treatment should be tried before resorting to medication.¹⁵⁵

Additionally, the publication includes specific medication charts that provide guidelines for prescription and dosage.¹⁵⁶ Addressing most common psychotropic medicines, these charts present helpful information including the recommended

¹⁴⁷ *Update on the Use of Psychotropic Medications in Texas Foster Children: Fiscal Years 2002-2010*, TEXAS HEALTH AND HUMAN SERVICES COMMISSION (Feb. 9, 2011), http://www.hhsc.state.tx.us/medicaid/OCC/psychoactive_medications.html#_blank.

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ *Psychotropic Medication Utilization Parameters for Foster Children*, FAMILY & PROTECTIVE SERVICES (Dec. 2010), www.dfps.state.tx.us/documents/about/pdf/TxFosterCareParameters-December2010.pdf.

¹⁵⁴ *Id.* at 4.

¹⁵⁵ *Id.* at 4-6.

¹⁵⁶ *Id.* at 12-18.

initial dosage, the target dose or range, the literature-based maximum dosage, the FDA approved maximum dosage for children and adolescents, a model dosage schedule, patient monitoring parameters, black box warnings, and additional warnings and precautions.¹⁵⁷

Research suggests that these charts have led to concrete improvements toward reducing unnecessary psychotropic medication in foster care children.¹⁵⁸ As discussed in Part III, *infra*, the model of clear prescription guidelines for physicians is a great idea and is one of several that New York can and should borrow from Texas.

3. Georgia

In January 2011, attorney Karen Worthington published a report for the Georgia Supreme Court that reviewed available research and set forth the following recommendations: the state should “collect and disseminate accurate information, develop guidelines for the administration of psychotropic medication, develop a clear consent process, engage experts and obtain independent reviews, provide comprehensive, individualized mental health treatment, create quality assurance mechanisms, [and] raise awareness about psychotropic drugs and youth in foster care.”¹⁵⁹ Significantly, Ms. Worthington specifically addressed the issue of consent.¹⁶⁰ She noted that a child’s placement in foster care typically means that he lacks the guidance and care of a stable parent or guardian who would normally retain the right to refuse or consent to his psychotropic medication.¹⁶¹

One possible way of tightening regulation is to codify whether the right to consent or refuse psychotropic medication is a matter of ordinary or extraordinary medical care because this line often demarcates zones of control by the state and biological parents respectively.¹⁶² In Georgia, as in many other states, the state welfare agency gains control over a child’s “ordinary medical care” when that child comes into their care, but parents retain control over extraordinary medical services unless and until their parent rights are formally terminated.¹⁶³ Ms. Worthington’s report does not articulate a preference as to either option, but does recommend the development of a clear process so that all parties may understand who holds the right to consent.¹⁶⁴

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ Karen Worthington, *Psychotropic Meds for Georgia Youth in Foster Care: Who Decides?*, GEORGIA SUPREME COURT COMMITTEE ON JUSTICE FOR CHILDREN (Jan. 2011), [http://w2.georgiacourts.org/cj4c/files/Psych_meds_paper%20\(2\).pdf](http://w2.georgiacourts.org/cj4c/files/Psych_meds_paper%20(2).pdf).

¹⁶⁰ *Id.* at 20-23.

¹⁶¹ *Id.* at 21.

¹⁶² *Id.* (explaining that biological parents retain decision-making authority in “ordinary” circumstances, but that the state assumes this power when “extraordinary” medical care is deemed required).

¹⁶³ *Id.*; see, e.g., Ga. Code § 15-11-13 (2010).

¹⁶⁴ Worthington, *supra* note 159, at 35.

As Ms. Worthington made her submission to the Supreme Court of Georgia, Georgia's House of Representatives developed House Bill 23 as a proposal for the codification of psychopharmacology reform.¹⁶⁵ Although the law never passed, it called for utilization parameters based on peer-reviewed research, and would have specifically required extensive record-keeping as well as at least semiannual reviews of each child's medication by an independent clinical team.¹⁶⁶

Regarding consent, this law would have mandated the development of processes to include the child, his foster parent, and his legal guardian in making any decision about medicating the child.¹⁶⁷ If the child is at least fourteen years old, his written informed consent and that of his legal guardian would have been necessary as a prerequisite to medication.¹⁶⁸ For any child under fourteen, documentation of his assent or refusal would have been required.¹⁶⁹ Provisions of the bill also mandated the development of a process for situations in which the various stakeholders disagree as to whether the child should be medicated, although more specific guidance is lacking:

The regulations shall include . . . [p]rovisions addressing informed consent and notifications related to the administration of psychotropic medications that include, but are not limited to . . . [a]n independent, fair process for resolving differences of opinions among prescribing providers, the child's legal guardian, the independent clinical review team, and the child or the child's attorney or *guardian ad litem*, if either are so appointed.¹⁷⁰

4. California

Pursuant to a memorandum issued by the President Judge of Juvenile Court and the Supervising Judge of Dependency Court, a child in foster care does not have a meaningful right to refuse psychotropic medication; "it is the policy of the court that the refusal constitutes a treatment issue and should be dealt with by the treating physician and caregiver."¹⁷¹ Although the physician must explain the medication to the child and must specifically describe the possible side effects, it is the parent, legal guardian, or court that must consent to or authorize pharmaceutical treatment.¹⁷²

In emergency situations, this consent or authorization is not required, but "emergency" is meant to be interpreted narrowly: an emergency occurs

¹⁶⁵ H.B. 23, 151st Gen. Assem., Reg. Sess. (Ga. 2011).

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ Memorandum from Michael Nash, Juvenile Court Presiding Judge & Margaret Henry, Dependency Court Supervising Judge to Physicians Treating Children under Juvenile Court Jurisdiction, et al. (Dec. 8, 2005) (relevant memorandum page attached *infra* as "Appendix A").

¹⁷² *Id.*

- (a) when a physician finds that the child requires psychotropic medication
- (b) due to a mental disorder (c) where the purpose of the medication is to
 - (i) protect the life of the child or others, (ii) prevent serious harm to the child or others, or (iii) to treat current or imminent substantial suffering, and (d) it is impractical to obtain consent.¹⁷³

Although a parent or legal guardian's consent or a court's authorization is necessary, the parent or guardian is only given two days to refuse and so the parental consent provision may in some circumstances be more comparable to a notice requirement.¹⁷⁴ Further corroborating this point is the fact that the parent or guardian is told in the course of the consent request that his refusal may be overcome by a court's authorization.¹⁷⁵ Form letters for consent requests are provided by the state.¹⁷⁶

5. Comparative Analysis: Florida and Georgia

The enacted and proposed systems in Florida and Georgia illustrate legal potential as well as possible roadblocks in this area of the law. Florida requires its child welfare agency to document efforts toward securing the biological parent's consent, and a parent's refusal may only be overcome by a termination of parental rights or a judicial override after a hearing.¹⁷⁷ Georgia's proposed law would have required the consent of the legal guardian and thus functionally would have followed Florida's inclusion of the biological parent unless rights are terminated.¹⁷⁸ Additionally, Georgia's proposal would have set the age of minor consent at fourteen, granting a real say to the person who has the most at stake, and it would have mandated semiannual reviews of each child's medication by an independent clinic team.¹⁷⁹ However, the law was vague in calling for a "fair process" to resolve conflicting opinions among the prescribing physician, the legal guardian, the child or his GAL, and the clinical team.¹⁸⁰ Florida is right to place a clear judicial safeguard on its system and Georgia was on the right track to include the child and the protective oversight of the review team. Florida did try to mandate a GAL for each child, but failed to pass the measure.¹⁸¹ The failed legislation in Georgia, if successful, would have gone a long way toward demonstrating the viability of this standard.

¹⁷³ *Id.*

¹⁷⁴ *Id.*

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ FLA. ADMIN. CODE ANN r. 65C-35.007 (2010).

¹⁷⁸ H.B. 23, 151st Gen. Assem., Reg. Sess. (Ga. 2011).

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ S.B. 2718, 2010 Leg., Reg. Sess. (Fla. 2010).

III: ANALYSIS AND RECOMMENDATIONS FOR NEW YORK

The various approaches discussed in Part II, *supra*, each hold lessons for legislative reform in New York. In this Part, the contours of current New York policy are explored and then specific recommendations are set forth. The New York policy discussion is divided into subsections on New York State and New York City. Reform recommendations focus on issues in consent, medical education, oversight, kickbacks, and clinical drug trials.

A. Current New York Policy

1. New York State

Currently, New York lacks a codified system of regulations for the use of psychotropic medication on children in foster care. Guidelines have been issued by the New York State Office of Children and Family Services (OCFS) on the “Use of Psychiatric Medications for Children and Youth in Placement [and] Authority to Consent to Medical Care.”¹⁸² According to this informational letter, psychotropic medication should not be administered to a child in foster care without input from a strong array of professionals and stakeholders: “The decision to treat a child with psychiatric medications should be made in consultation with the parent or guardian and a team that should include the caseworker, caregivers, health care coordinator, agency staff with oversight responsibilities, pediatricians, and psychiatrist.”¹⁸³

The letter includes a section on consent that specifically requires “authorized consent” for “any medical care.”¹⁸⁴ For a child in a protective placement—due to removal from the home on grounds of abuse and/or neglect, the local commissioner or authorized agency must submit a written request of consent to the parents or legal guardian.¹⁸⁵ If consent is refused, however, the local commissioner has the authority to override and give valid consent.¹⁸⁶ The commissioner may even override while the parental consent request is pending.¹⁸⁷ A time limit is not specified therein and a parent’s complete failure to answer seems to be considered a tacit refusal that may be overridden.¹⁸⁸

New York further clarifies the issue of who may consent: Social Services Law Section 383-b gives the commissioner the authority to consent to medical

¹⁸² Informational Letter to Commissioners of Social Services, Executive Directors of Voluntary Authorized Agencies, & OCFS Facility Directors on the Use of Psychiatric Medications for Children and Youth in Placement and the Authority to Consent to Medical Care (Feb. 13 2008), http://www.ocfs.state.ny.us/main/policies/external/OCFS_2008/INFs/08-OCFS-INF-02%20The%20Use%20of%20Psychiatric%20Medications%20for%20Children%20and%20Youth%20in%20Placement%20-%20Authority%20to%20Consent%20to%20Medical%20Care.pdf.

¹⁸³ *Id.* at 5.

¹⁸⁴ *Id.* at 6.

¹⁸⁵ *Id.* at 7.

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

¹⁸⁸ *See id.*

services,¹⁸⁹ and the state Office of Children and Family Services stated in its letter that the medical services outlined in Section 383-b should be interpreted broadly to include emergency and non-routine care.¹⁹⁰ This interpretation is necessary in empowering the commissioner because psychotropic medications are not considered routine care in New York.¹⁹¹ The OCFS guidelines also speak briefly to parameters of prescription and supervision.¹⁹² Physicians are encouraged to “start low and go slow,’ *i.e.*, begin with low dosages and increase slowly” and to follow other seemingly obvious guidelines like making “individualize[d] medication decisions for each child” and “consider[ing] the balance between benefits and risk.”¹⁹³

2. New York City

In New York City, the Administration for Children’s Services (ACS) has issued guidelines similar to those of the State. Again, physicians are encouraged to “start low and go slow” and are even encouraged to try non-medicinal options first.¹⁹⁴ According to an ACS “Quality Assurance” document, the prescribing psychiatrist must document his “reasons for prescribing the medication; name and dosage of medication and the date prescribed; previous non-pharmacological interventions; and expected results of the medication and potential side effects.”¹⁹⁵

Informed consent may be given by a parent or guardian whose rights have not been terminated and the agency must make reasonable efforts to obtain this consent.¹⁹⁶ Where the parent or guardian does not consent but does not affirmatively refuse, the case-planning agency may consent to medication for most children removed from the home due to abuse and/or neglect.¹⁹⁷ In case of a parent or guardian’s affirmative refusal, Children’s Services must conduct a comprehensive legal and medical review.¹⁹⁸

Laudably, ACS addresses psychotropic medication in its training and support of foster parents.¹⁹⁹ In-service trainings include education on “common

¹⁸⁹ N.Y. SOC. SERV. LAW § 383-b (McKinney 2012).

¹⁹⁰ Informational Letter, *supra* note 182.

¹⁹¹ *Id.*

¹⁹² *Id.*

¹⁹³ *Id.*

¹⁹⁴ *Preliminary Psychotropic Medication Practice Guidelines for Children in Foster Care*, NEW YORK CITY ADMINISTRATION FOR CHILDREN’S SERVICES.

¹⁹⁵ Ronald E. Richter, *Preventive Services Quality Assurance Standards and Indicators*, NEW YORK CITY ADMINISTRATION FOR CHILDREN’S SERVICES (Sept 2011).

¹⁹⁶ *Preliminary Psychotropic Medication Practice Guidelines*, *supra* note 194; *see also* John B. Mattingly, New York City Administration for Children’s Services Commissioner, to Provider Agency Staff & Children’s Services Staff, “Guidelines for the Provision of Emergency and Inpatient Mental Health Services for Children in the Foster Care and Child Protective System,” May 28, 2010, *revised* Nov. 3, 2010.

¹⁹⁷ *Preliminary Psychotropic Medication Practice Guidelines*, *supra* note 194.

¹⁹⁸ *Id.*

¹⁹⁹ *Foster Care Standards Part II: Recruitment, Training and Certification of Foster and Adoptive*

psychotropic medications used with children, and risks/side effects associated with such medication,” and caretakers and foster parents are to be advised where applicable of all prescribed “psychotropic medications and how they are used within a mental health treatment plan.”²⁰⁰

ACS also has some changes and improvements planned: for example, a Psychotropic Medication Committee is currently being formed to provide further guidance in this area,²⁰¹ which should be a welcome advancement. On the other hand, one planned modification could be problematic: currently, only a child or adolescent psychiatrist can prescribe psychotropic medication for children in foster care and then must review the prescription each month, but ACS is considering approving waivers to this requirement.²⁰² This is an area that needs more oversight, not less.²⁰³ A weakening of the current safeguard could lead to infliction of more harm upon these vulnerable children.²⁰⁴

B. Proposals for Legal Reform

1. Consent

New York Social Services should not retain the right to consent automatically even where parents or legal guardians have refused.²⁰⁵ Still, the question of who should take control here goes directly to the heart of the over-medication of children in foster care. If children had a constantly present parent or guardian who could reliably protect their well-being, they probably would not be in foster care.²⁰⁶ Biological parents may not be fully capable of providing meaningful informed consent; foster parents are often a fleeting presence and may sometimes be overcome by the substantial financial gain of allowing the child to be placed on psychiatric medication;²⁰⁷ social service professionals typically cannot form relationships with each child sufficient to form a basis for this type of decision; and judges often simply defer to the prescribing physician’s medical opinion, which usually stands as the only expert opinion on the record.²⁰⁸

Parents, NEW YORK CITY ADMINISTRATION FOR CHILDREN’S SERVICES (last accessed Dec. 14, 2011).

²⁰⁰ *Id.*

²⁰¹ *Id.*

²⁰² *Id.*

²⁰³ TUFTS CLINICAL, *supra* note 13.

²⁰⁴ *Id.*

²⁰⁵ Informational Letter, *supra* note 182.

²⁰⁶ *Become a Foster Parent: Overview*, *supra* note 19.

²⁰⁷ Psychotropic medication usually elevates the child’s classification from “normal” or “basic” to “special,” a change accompanied by a significant increase in financial compensation. See *Notification of Foster Care Level of Care and Room and Board Payment*, *supra* note 68. This note is by no means meant to implicate the motives of most foster parents, whom the author deeply respects, but is merely meant to highlight a harsh financial reality.

²⁰⁸ Brooks, *supra* note 65.

Florida's proposal of a volunteer GAL for each child facing psychopharmacologic treatment²⁰⁹ is admirable. Fully embracing the proposal is Michael Piraino, the CEO of Court Appointed Special Advocates (CASA) for Children, a non-profit organization dedicated to matching individual volunteer advocates with children in foster care.²¹⁰ New York has an active CASA group that could and should match dedicated volunteers with each child in foster care for whom psychotropic medications are being considered.²¹¹ As one former foster care child has said, "Children . . . just need somebody who's going to be there for them, who's going to be on their side."²¹²

Since there is often no single figure capable of providing meaningful informed consent, this Note proposes the following standards as policy to be implemented for children in New York foster care:

- i. Notice of possible psychotropic medication administration must be provided to (1) the child's biological parents, (2) foster parents, (3) caseworker or the supervising social services director, (4) the attorney for the child, and (5) the volunteer advocate. Each may contribute to legal informed consent, which may only be constituted through the assent of at least three of the above five.²¹³
- ii. Upon refusal by any of the above five, a Family Court judge shall hear arguments presented by the disagreeing parties and shall be guided by a legal presumption in favor of refusal, only surmountable by a showing of clear and convincing evidence that the medication in question is in the child's best interests and is superior to all alternative treatment options.²¹⁴
- iii. Upon a child's fourteenth birthday, he or she shall have the right to refuse psychotropic medication and will have the same opportunity for a hearing as any other refusing party would so have.²¹⁵

²⁰⁹ S.B. 2718, 2010 Leg., Reg. Sess. (Fla. 2010).

²¹⁰ Michael Piraino, *Drugged into Submission?*, COURT APPOINTED SPECIAL ADVOCATES FOR CHILDREN (2011), http://www.casaforchildren.org/site/c.mtJSJ7MPIsE/b.7792419/k.62A9/Message_from_the_CEO.htm.

²¹¹ CASA ADVOCATES FOR CHILDREN OF NEW YORK STATE, <http://www.casany.org> (last visited Mar. 8, 2012).

²¹² Susanna Rustin, *What Kind of Family Matters?*, THE GUARDIAN (Jan. 28, 2011), <http://www.guardian.co.uk/commentisfree/2011/jan/29/the-conversation-family-fostering-adoption>.

²¹³ Florida requires consent by biological parents, subject to judicial override, until termination of parental rights. See FLA. STAT. § 39.407 (2010). Proposed Georgia law would have required a consent process that includes biological and foster parents, and the child; the child's consent would be required upon his fourteenth birthday. See H.B. 23, 151st Gen. Assem., Reg. Sess. (Ga. 2011). California ostensibly requires consent by either by the biological parent or legal guardian, but effectively only requires court approval. Nash, *supra* note 171. Florida's work stands out as the cutting edge of *guardian ad litem* inclusion. See THE FLORIDA GUARDIAN AD LITEM PROGRAM, *supra* note 138.

²¹⁴ "Best interests of the child" is the standard that controls abuse and neglect proceedings in New York, as in all states. See *Determining the Best Interests of the Child: Summary of State Laws*, U.S. DEPT. OF HEALTH AND HUMAN SERVICES ADMINISTRATION FOR CHILDREN AND FAMILIES (2010), http://www.childwelfare.gov/systemwide/laws_policies/statutes/best_interest.cfm (last visited Mar. 11, 2012).

²¹⁵ Proposed Georgia law would have required the child's consent upon his fourteenth birthday. See H.B. 23, 151st Gen. Assem., Reg. Sess. (Ga. 2011).

By design, these barriers between drugs and children would drastically reduce rates of psychotropic medication of children in foster care. As a result, children will have the physical and mental capacity to react to their placement in foster care and will do so; they will be sad, angry, and frustrated, but that will help caregivers and advocates know what is wrong and allow them the opportunity to address the real issues.²¹⁶ When a “check engine” light comes on, your car is not fixed if you simply cover the bright yellow warning sign. Comparably, children are not healed when their symptoms of abuse are simply masked by sedatives and other drugs.²¹⁷

The measures proposed here might increase challenges for caregivers, but are vital to the well-being of the children—emotional expression conveys social cues that request responses.²¹⁸ For some patients, medication treats underlying biological imbalances and grants that which would otherwise be unreachable: healthy functioning in daily life.²¹⁹ Yet for too many others, powerful psychotropic medication only compounds the many problems heaped upon the vulnerable children in New York’s system of foster care.²²⁰

2. Medical Education, Guidance

All attorneys admitted to the bar in New York are required to complete annual continuing legal education requirements.²²¹ Most states require physicians to obtain continuing medical education credits, but New York is one of the six that do not.²²² For continued licensing, New York psychiatrists should be required to fulfill credits in medicating children. The course should counsel against medicating first, but should also match the legal presumption in favor of refusal—proposed *supra*²²³—by teaching a practice model of seeking alternative treatment methods first. The dangers of using powerful psychotropic medication in children, including risks of cardiac arrest, suicide, seizure, pancreatitis, diabetes, and neuromuscular disability,²²⁴ should be addressed. For aspiring psychiatrists, a comparable course should be required as a prerequisite to New York State licensing.

²¹⁶ Berger, *supra* note 92.

²¹⁷ *Id.*; see also Garrett, *supra* note 29.

²¹⁸ Erving Goffman, *Response Cries*, 54 LANGUAGE 787 (1978).

²¹⁹ Ramshaw, *supra* note 44.

²²⁰ *Id.*; see also *The Long Road Home*, *supra* note 70.

²²¹ *Continuing Legal Education*, NEW YORK STATE UNIFIED COURT SYSTEM, <http://www.nycourts.gov/attorneys/cle> (last visited Mar. 8, 2012).

²²² *State CME Requirements*, *supra* note 20.

²²³ *Supra*, Part III.B.i.

²²⁴ *Psychotropic Drugs and Children*, THE CENTER FOR HEALTH AND HEALTH CARE IN SCHOOLS, THE SCHOOL OF PUBLIC HEALTH & HEALTH SERVICES, GEORGE WASHINGTON UNIVERSITY (2007), www.healthinschools.org/~media/Files/psychotropic07.ashx.

The Texas charts²²⁵ could serve as a helpful resource for jurisdictions across the country. Funding for research and development is unnecessary since the Texas charts themselves should be distributed to New York physicians.

3. Oversight

A single physician should maintain continuous supervision over each child's care. Furthermore, a care team should be organized for each child who may need psychotropic medication, and the team should consist of: (1) the physician, (2) the child's biological parents, (3) the foster parents, (4) the caseworker or the supervising social services director, (5) the attorney for the child, and (6) the volunteer advocate. Meetings or regular correspondence should be used as necessary to address medication and related issues. The child should be directly included to the extent that his or her maturity so permits and should be presumptively included by the age of fourteen.

More stringent documentation is required to ensure continuity and quality in care. Without records subject to oversight, medical histories get lost and children suffer.²²⁶ Specifically, physicians should be required to carefully document all prescription and to submit any proposed extreme situation—such as prescription of more than three psychotropic medications and/or prescription of more than one psychiatric medication from the same class—to an independent review board.²²⁷

4. Kickbacks

Kickbacks are the one area in which significant reform seems unnecessary in New York State and New York City. The work is not over, but the current aggressive approach²²⁸ should be maintained. A switch in emphasis from large-scale prosecution of corporations to smaller prosecutions of individuals may not be required or even desirable, although physicians should be held accountable for their actions. Instruction regarding relevant law could be continued.

5. Clinical drug trials

Florida's swift reaction after Gabriel's death was undoubtedly well-intentioned, but it may have missed the mark.²²⁹ In contrast to Florida, the FDA has blocked efforts at a total ban on participation in clinical drug trials by children in foster care, citing the possibility that children could benefit significantly from

²²⁵ *Supra* notes 147 and 153.

²²⁶ Worthington, *supra* note 159.

²²⁷ Christopher Bellonci. *Medication Monitoring Guidelines*, BRIAN A. PROTECTION FROM HARM SETTLEMENT, PSYCHOTROPIC MEDICATIONS WORKGROUP (2006), http://www.hunter.cuny.edu/soc/work/nrcfcpp/downloads/teleconferences/Medication_Monitoring_Guidelines.doc, (classifying these situations as indicators of need for independent review), *as cited in* Informational Letter, *supra* note 182.

²²⁸ *Supra* Part I.

²²⁹ Narang, *supra* note 137; *see also* Circelli, *supra* note 142.

these trials.²³⁰ The appropriate course of action for New York may be to ban participation by children in foster care in clinical psychopharmacological, but not all, medicinal trials. As discussed above, in contrast to many other childhood illnesses for which medication is appropriate and necessary, mental illness in children is often due to psychological and social stressors and so should be treated with special care.²³¹ The history of prescribing psychotropic medication to children without clinical safeguards has proved dangerous, destructive, and sometimes deadly,²³² and it should not be repeated.

CONCLUSION

New York needs to rescue its children in foster care from unnecessary and dangerous prescriptions of psychotropic medication. Using legal reforms from other states as demonstrations of those which do and those which do not ameliorate the problem, New York can form and implement its own model of law.

On the pivotal issue of consent, New York should protect its children against lack of meaningful consent by including a care team of all legitimately dedicated parties. Upon reasonable maturity, presumptively attained by age fourteen, the child himself should be included in this process, which most directly affects his own life.

Medical education, guidance, and oversight should all be expanded and improved to ensure that the individuals best qualified to make medical decisions are in fact well qualified to make decisions regarding the use of psychotropic medication in children.

Aggressive prosecution of kickback offenses should be maintained. Law enforcement does and should continue to reflect the need for physicians, in making prescription decisions, to focus exclusively on the health and well-being of their patients. Finally, for safety reasons already reflected in the law of other states, children should be legally shielded from clinical trials of psychotropic medications.

We remove children from their homes because we find their parents or other caregivers to be abusive and/or neglectful. Yet, we fail to rise above this level if we stand idly by as these children's lives are further destroyed by needless drugs. Through thoughtful legal reform, perhaps there is hope for a brighter future.

²³⁰ *Id.*

²³¹ Post, *supra* note 36.

²³² Sessions, *supra* note 1.