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COMMENT

A NEW WAR ON DRUGS: FIGHTING STATE-SPONSORED OVERMEDICATION OF CALIFORNIA'S FOSTER YOUTH

JESSIE CONRADI*

INTRODUCTION

DeAngelo was first removed from his mother when he was three years old after she attempted suicide in front of him.¹ After the removal, he lived with his grandparents in San Francisco, where he grew up, but still saw his mother during limited and supervised visits.² At age eight, at his mother's direction, DeAngelo told his Child Protective Services worker that his grandparents were abusing him so his mother could reassume custody.³ The guilt from this lie caused DeAngelo to act out in school, and he was soon placed into a mental institution for an evaluation.⁴

After this evaluation, DeAngelo was given Depakote and Klonopin for sleep and Attention Deficit Hyperactivity Disorder (“ADHD”)—but

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¹ Elaine Korry, *California Moves to Stop Misuse of Psychiatric Meds in Foster Care*, NPR (Sept. 2, 2015), http://www.npr.org/sections/health-shots/2015/09/02/436350334/california-moves-to-stop-misuse-of-psychiatric-meds-in-foster-care?utm_campaign=storyshare&utm_source=facebook.com&utm_medium=social, archived at <http://archive.is/ZpLUK>.

² *Psychotropic Medication and Mental Health Services for Foster Youth: Seeking Solutions for a Broken System: Hearing Before the S. Standing Comm. on Health & S. Standing Comm. on Human Servs.*, 114th Cong., Sess. 1 (2015) [hereinafter *Hearing*] (statement of DeAngelo Cortijo), <http://www.digitaldemocracy.org/hearing/480?startTime=43&vid=SP1YjU0sIdc>, archived at <http://archive.is/tdKmS>.

³ *Id.*

⁴ *Id.*

no other behavioral health services were provided.⁵ The drugs were psychotropic substitutes for “the things any eight year-old needs to sleep.”⁶

DeAngelo’s trauma at the hands of family members and the system continued: he was sexually abused by a family friend; moved between various group homes; not provided mental health treatment; and finally, at age twelve, entered the juvenile justice system as he continued to act out.⁷

Throughout these transitions, DeAngelo was prescribed several drugs, including antipsychotics, antidepressants, and stimulants.⁸ He was told that taking them was his only chance of being normal.⁹ Despite years of treatment using psychotropic medication, DeAngelo experienced the most profound improvement in his mental health after completing equine therapy as a part of the Vision Quest program in Arizona.¹⁰ As he was nearing his eighteenth birthday, he also participated in arts-based programs where he performed poetry written about his mother,¹¹ and wrote plays using metaphors to process challenges that he had faced.¹²

DeAngelo is only one of thousands of children who are treated with psychotropic medication – instead of much needed mental health services – in an attempt to resolve behavioral issues that often stem from their difficult circumstances. His story is one of miscommunication between his providers and the system’s desire to treat the symptoms of behavior instead of the underlying causes. While the suffering he encountered during his time in the foster care system was by no means trivial, he was spared some of the harsher realities that affect other overmedicated youth in the foster care system.

In June of 2008, six-year old Gabriel was brought into the Florida Dependency System after experiencing neglect, trauma, and sexual abuse.¹³ He was diagnosed with ADHD and Impulse Control Disorder

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ Korry, *supra* note 1.

⁹ *Id.*

¹⁰ *Hearing, supra* note 2.

¹¹ Robert Gomez Hernandez, *The Beat Within: “For You” by DeAngelo Cortijo*, VIMEO (July 26, 2013), <https://vimeo.com/65914769>, archived at <http://archive.is/UW0NC>.

¹² DeAngelo depicts himself as ice, and his mother as a meteor, “She seems dull to the fact that she melts a part of me every time she comes around. I mean I love my mom but she’s slowly killing me.” DeAngelo, *The Heavens and Beyond*, EACH ONE REACH ONE (2009), <https://sites.google.com/site/eachonereachoneoro/eoro-youth/youth-plays/juvenile-justice-center/the-heavens-and-beyond-2009>, archived at <http://archive.is/Kc3Ck>.

¹³ See Fla. Dep’t of Children & Families, Gabriel Meyers 4, 24, <http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/GMPresentation.pdf> (last visited Jan. 20, 2016)[hereinafter *Gabriel*].

and prescribed multiple medications.¹⁴ His medication changed several times during his year in foster care and he continued to act out through tantrums and sexually inappropriate behavior.¹⁵ In June 2009, nine months after entering the dependency system, Gabriel hanged himself in the bathroom of his foster home after being sent to his room after a tantrum.¹⁶

The U.S Food and Drug Administration (FDA) had not approved the medications Gabriel was prescribed for use by children.¹⁷ The Florida Department of Children and Family found that there was “insufficient communication/coordination between the professionals involved with Gabriel.”¹⁸ Also, the case manager had not obtained parental consent or a court order for Gabriel’s psychotropic medication prescription as was statutorily required.¹⁹

Gabriel’s story is an example of a tragic worst-case scenario, while DeAngelo’s story is typical of what many foster children experience because of the tendency of caretakers in the foster system to try to medicate problems as a “quick fix” for behavioral issues. Both children were unheard, minimally represented, and left without care by the very system that was designed to protect them from abuse and neglect. In particular, both cases demonstrate the perils of prescribing adult psychotropic medications to children absent the provision of mental health services.

The overmedication of foster care youth has been on the rise statistically and has also been drawing increased media attention.²⁰ Tragic stories like Gabriel’s bring mismanagement of psychotropic medication to the forefront. Additionally, class action lawsuits in Tennessee,²¹ Nevada,²² and Massachusetts²³ have sought to hold the state accountable for its neglect of foster youth. In February 2015, the *San Francisco Chroni-*

¹⁴ *Id.* at 16.

¹⁵ *Id.* at 26.

¹⁶ *Id.* at 56.

¹⁷ Michelle L. Mello, Note, *Psychotropic Medication and Foster Care Children: A Prescription for State Oversight*, 85 S. CAL. L. REV. 395, 396 (2012).

¹⁸ *Gabriel*, supra note 13, at 64.

¹⁹ *Id.* at 65.

²⁰ Among other articles, Karen de Sá’s five part series, *Drugging Our Kids*, from the SAN JOSE MERCURY NEWS (discussed *infra*) brought the plight of foster youth to the forefront in California. Her article was recognized with several journalistic awards, in large part because the article exposed California’s dramatic overprescribing of foster youth. See Meiling Bedard, “*Drugging Our Kids*” Wins Another Journalism Award, THE CHRONICLE OF SOCIAL CHANGE (June 30, 2015), <https://chronicleofsocialchange.org/news-2/drugging-our-kids-wins-another-journalism-award/10637>.

²¹ Kimber E. Strawbridge, Article, *The Children Are Crying: The Need for Change in Florida’s Management of Psychotropic Medication to Foster Children*, 15 U.C. DAVIS J. JUV. L. & POL’Y 247, 282-83 (2011).

²² Jessalyn Schwartz, Article, *Overprescribed and Underserved: Psychotropic Medication and Foster Care in the U.S.*, NW. UNIV. L. J. : EXTRA LEGAL 6-7 (Fall 2013).

cle published an editorial using strong language to highlight the need for reform, calling it an “outrage that has been documented for many years.”²⁴

Further, in the 2015 legislative session, California was on the brink of passing legislation to address these pressing issues. Senate Bill 253 (SB 253), described below, was one in a package of four bills designed to provide oversight for the prescription of psychotropic medications.²⁵ However, high priced lobbying on the part of California organizations representing psychiatrists, doctors, and group homes prevented SB 253 from getting past the appropriations committee, and the bill died before making it to the governor’s desk.²⁶

California desperately needs to amend the law pertaining to the administration of psychotropic medication to foster youth. State policy affecting foster youth impacts many lives, as California is home to fifteen percent of foster youth in the United States.²⁷ While California began offering such protections, a comprehensive amendment to California’s law should address consent, case review for troublesome cases, monitoring, and a standard of review that matches the current standard used when prescribing involuntary medication to adults. Anything less than this falls short of the state’s duty to act, under the state’s *parens patriae* power, as the foster youth’s parent.

This Comment will discuss the current problem with overmedication of foster care youth, specifically in California. Part I outlines the immediate problems facing foster youth in the California dependency system who have been prescribed psychotropic medication and examines the federal and state laws that have attempted to address the issue. Part II explains what federal law requires and several states’ interpretations, specifically focusing on the definition of “oversight” and “monitoring.”

²³ Martine Powers, *Lawsuit Faults Mass. on Foster Care System*, BOSTON GLOBE (Jan. 21, 2013), <http://www.bostonglobe.com/metro/2013/01/21/class-action-case-against-mass-child-welfare-system-start-trial-tuesday/yr6NaoTi6mIuCeNLfHXcyL/story.html>.

²⁴ Editorial, *California Must Stop Overuse of Psychiatric Drugs for Foster Kids*, S.F. CHRON., Feb. 2, 2015, <http://www.sfchronicle.com/opinion/editorials/article/California-must-stop-overuse-of-psychiatric-drugs-6057629.php>.

²⁵ *Calif. Bills Targeting Foster Kids’ Medication Could Be National Model*, CAL. HEALTHLINE (Sept. 3, 2015), http://www.californiahealthline.org/articles/2015/9/3/calif-bills-targeting-foster-kids-medication-could-be-national-model#.VenqLIQDF_8.facebook.

²⁶ Karen de Sá, *California Assembly to Vote on Diminished Bill Package to Curb Psychotropic Drug Use on Foster Children*, SAN JOSE MERCURY NEWS (Sept. 6, 2015, 4:54 PM), http://www.mercurynews.com/california/ci_28769540/california-assembly-vote-diminished-bill-package-curb-psychotropic.

²⁷ Caroline Danielson & Helen Lee, *Foster Care in California: Achievements and Challenges*, PUB. POL’Y INST. OF CA 1, 8, http://www.ppic.org/content/pubs/report/R_510CDR.pdf (last visited Nov. 13, 2015).

Part III proposes an amendment to California's law that addresses consent, case review, monitoring, and an adequate standard of review.

I. THE CURRENT STATE OF AFFAIRS IN CALIFORNIA

A. THE PROBLEM OF OVER PRESCRIBING

California's foster care system includes about 60,000 children.²⁸ In California's foster care system, almost one in four youth are prescribed psychotropic medication – about 3.5 times the national rate.²⁹ Therefore, psychotropic medication policy affects a large number of foster youth and is out of proportion with youth not in foster care.

The children in foster care are often especially vulnerable because of previous abuse or neglect and the continued instability inherent in the foster care system. More than sixty percent of youth that have been in foster care longer than two years have moved at least twice,³⁰ which makes adhering to a schedule, attending regular doctor appointments, and making other behavioral adjustments more difficult. The doctors who are treating and prescribing medications for them often do not have the children's medical or drug history.³¹ Further, children in foster care often stay on psychotropic medication longer than children out of care.³²

Many children in foster care may also have a higher incidence of experiencing trauma due to the circumstances that brought them into foster care; however, medications are often prescribed to change the youth's behavior without treating the underlying mental health deficiency.³³ On the other hand, some argue that the use of medications has contributed to the deinstitutionalization of many foster care youth.³⁴ Some children that were previously required to stay in group homes or juvenile hall may be able to return home or to another foster family with the assistance of psychotropic medication.³⁵ However, "therapy is often a secondary recommendation after prescribing a quick-fix medication to control" the youth's behavior.³⁶

²⁸ Karen de Sá, *Drugging Our Kids*, SAN JOSE MERCURY NEWS (Aug. 24, 2014), <http://web-special.mercurynews.com/druggedkids/?page=PT1>.

²⁹ *Id.*

³⁰ *Id.*

³¹ *Id.*

³² William Grimm, *Caring for our Kids: Are we Overmedicating Children in Foster Care?* PSYCHDRUGS ACTION CAMPAIGN (May 29, 2014), <http://childpsychdrugsafety.org/caring-for-our-kids-are-we-overmedicating-children-in-foster-care/>.

³³ de Sá, *supra* note 27.

³⁴ *Id.*

³⁵ *Id.*

³⁶ Strawbridge, *supra* note 20.

1. *Psychotropic Medication Defined*

Psychotropic medication is defined by the California Rules of Court as “those medications prescribed to affect the central nervous system to treat psychiatric disorders or illnesses. They may include . . . antidepressants, mood stabilizers, antipsychotic medications . . . and psychostimulants.”³⁷ These medications are typically used to treat mental health conditions such as depression, anxiety, ADHD, bipolar disorder, psychosis, and obsessive-compulsive disorder.³⁸

Psychotropic medications often have serious short- and long-term side effects, including rapid-onset obesity, diabetes, and extreme lethargy.³⁹ Some of the medications can impact brain development and can even increase the risk of suicide.⁴⁰ The FDA has approved only limited uses and diagnoses for which psychotropic medications can be prescribed.⁴¹ There is no research on the effectiveness of these medications on foster care youth.⁴²

2. *A Vulnerable Population*

Twelve percent of youth in California’s foster care system who were prescribed a psychotropic medication were prescribed two, three, or four psychotropic medications at once.⁴³ Combinations of medications increase the risk of known and unknown side effects, as there is little scientific evidence regarding such combinations.⁴⁴ The concurrent use of psychotropic medication can amplify each drug’s toxicity and side effects, including risk of death.⁴⁵ The overlapping prescriptions often occur when a child is prescribed psychotropic medication during a psychiatric emergency and then retains the high-dosage prescription due to inadequate psychiatric follow-up.⁴⁶ As the behavioral symptoms change, doctors often prescribe additional medications to modify behavior or to adjust for side effects.⁴⁷

³⁷ CAL. R. CT. 5.640(a).

³⁸ Mello, *supra* note 17, at 399??400.

³⁹ de Sá, *supra* note 27.

⁴⁰ *Id.*

⁴¹ Grimm, *supra* note 31.

⁴² Karen de Sá, *Drugging Our Kids, Part IV: Finding Yolanda*, SAN JOSE MERCURY NEWS (Dec. 21, 2014), <http://webspecial.mercurynews.com/druggedkids/?page=PT4>.

⁴³ de Sá, *supra* note 27.

⁴⁴ PROTECTION & ADVOCACY, INC., PSYCHIATRIC POLYPHARMACY: A WORD OF CAUTION, 21 (June 2004), <http://www.disabilityrightsca.org/pubs/702001.pdf>.

⁴⁵ *Id.* at 22.

⁴⁶ de Sá, *supra* note 27.

⁴⁷ *Id.*

The overreliance on psychotropic medications is particularly acute in group homes, where the most vulnerable and troubled foster care youth are often placed. In California foster care group homes, almost half of the youth are on psychotropic medication.⁴⁸ This increased rate of psychotropic medication in group homes may be attributed to lack of staff training, a high youth-to-staff ratio, minimal useful therapeutic interventions, and a perception that “medications are effective in treating behaviors and that non-pharmacological interventions may be less effective or too time-consuming to be part of standard care.”⁴⁹ When youth in group homes do not take their medications, they often face punishment or removal of privileges.⁵⁰

Youth in the foster care system are particularly vulnerable to being inappropriately medicated using psychotropic drugs. Because youth in foster care have a higher incidence of experiencing trauma, they are also at a higher risk of “‘mental health problems, difficulties with social relationships and behavior, physical illness, and poor school performance.’ Unfortunately, such traumatic stress symptoms are often identical to the symptoms that indicate other mental health conditions, which may lead to misdiagnosis and inappropriate treatments.”⁵¹ In foster or group homes, psychotropic medications are used more frequently due to their effect in decreasing some of the child’s troublesome behaviors.⁵² Even though a child’s problematic behavior might be symptoms of a rebellious phase or normal childhood development,⁵³ “it’s just cheaper and easier to drug kids than to take care of them in the most therapeutically appropriate way.”⁵⁴ Instead of the foster care system employing resources to ascertain or address these children’s problems with age-appropriate techniques, the children are drugged. The current guidelines regarding use of psychotropic medications in children are inadequate to protect these children from overmedication, even when well-intentioned. Something greater is needed to promote a paradigm shift away from depen-

⁴⁸ de Sá, *supra* note 27.

⁴⁹ Grimm, *supra* note 31.

⁵⁰ de Sá, *supra* note 27.

⁵¹ Donald H. Stone, *The Dangers of Psychotropic Medication for Mentally Ill Children: Where is the Child’s Voice in Consenting to Medication? An Empirical Study*, 23 TEMP. POL. & CIV. RTS. L. REV. 121, 144 (2013) (citing U.S. Gov’t Accountability Office, GAO-13-15, Children’s Mental Health: Concerns Remain About Appropriate Services for Children in Medicaid and Foster Care I (2012)).

⁵² *Id.* at 140.

⁵³ Maggie Brandow, Note, *A Spoonful of Sugar Won’t Help This Medicine Go Down: Psychotropic Drugs for Abused and Neglected Children*, 72 S. CAL. L. REV. 1151, 1160 (1999).

⁵⁴ Jonathan Walters, *Are We Overmedicating Foster Care Children?*, GOVERNING MAG. (Oct. 8, 2013), <http://www.governing.com/topics/health-human-services/col-overmedicating-foster-care-children-human-services.html>.

dence on medications. This shift should be facilitated through a change in state or federal law.

B. CURRENT LAW ON PSYCHOTROPIC MEDICATION

1. Federal Law

Two federal laws govern the use of psychotropic medications for children. They provide general guidelines that set a framework for states to adopt their own statutes. Congress addressed the growing need for support of foster youth in two different acts: The Fostering Connections to Success and Increasing Adoptions Act of 2008 (“FCS”) and the Child and Family Services Improvement and Innovation Act of 2011 (“CFS”).

The Fostering Connections to Success and Increasing Adoptions Act of 2008 amended the Social Security Act to include the first federal statutory reference to the mental health of foster care children.⁵⁵ The FCS urges the states to develop a coordinated plan for the ongoing oversight of the mental health needs of the foster care child.⁵⁶ This oversight is to include consultation with a pediatrician as well as experts in health care and child welfare.⁵⁷ This section also specifically states that oversight shall be provided for prescription medication.⁵⁸ However, “oversight” is not defined and is therefore left to the states to interpret.

The Child and Family Services Improvement and Innovation Act (2011) also amended the Social Security Act. It adds language to the Social Security Act that requires protocols for the “appropriate use and monitoring of psychotropic medications” administered to foster care youth.⁵⁹ It also calls for mental health care that is “child-specific, comprehensive, appropriate, and consistent.”⁶⁰ However, this “monitoring” was not further elaborated upon by CFS, leaving it in the hands of the states to determine how to apply it.

Federal law only provides general guidance, on the premise that each state has different factors that will affect the foster care system within the state, and which will require guidelines that are specifically tailored to those factors. State laws governing medication for youth in

⁵⁵ Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351, 122 Stat. 3949 (codified as amended in scattered sections of 42 U.S.C.); 42 U.S.C.A § 1305 Note (West 2011).

⁵⁶ 42 U.S.C.A § 622(b)(15)(A).

⁵⁷ *Id.*

⁵⁸ 42 U.S.C.A. § (b)(15)(A)(v).

⁵⁹ Child and Family Services Improvement and Innovation Act of 2011, Pub. L. No. 112-34, 125 Stat. 369 (codified as amended in scattered sections of 42 U.S.C.); 42 U.S.C.A § 1320a-9(a)(7)(B) (West 2011).

⁶⁰ 42 U.S.C.A § 1320a-9(a)(7)(B).

foster care may differ depending on characteristics, such as whether the state is urban or rural, whether child-welfare services are delivered through the county or the state, and whether practitioners are available.⁶¹ Despite state differences, the Administration for Children and Families, a federal agency, suggested that state policies should include provisions for treatment screening, informed consent, information sharing, medication monitoring at the patient and agency level, and availability of mental health consultation by a Board Certified Child Psychiatrist.⁶²

2. *California Law*

In California, the requirement for oversight is addressed in the rules for the Dependency System, contained in the Welfare and Institutions Code. Unless otherwise specified, the court is held to a preponderance of the evidence standard for all findings, including those pertaining to the administration of medication.⁶³ Preponderance of the evidence is typically a civil standard, meaning the existence of a fact is more probable than its nonexistence,⁶⁴ or more than fifty percent probable.

When the state removes a child from parental custody, the child is appointed an attorney.⁶⁵ The attorney is “charged in general with the representation of the child’s interest.”⁶⁶ However, there are no specific provisions requiring the attorney to represent the youth’s mental health interests or calling for the attorney to contact the youth’s doctor or psychiatrist.⁶⁷

For youth in California’s foster system, only a juvenile court judicial officer (most commonly a judge) can authorize the administration of psychotropic medications, but the process to secure that authorization has dire gaps and weaknesses. The law states that “only a juvenile court judicial officer shall have authority to make orders regarding the administration of psychotropic medications. . . .”⁶⁸ The court makes its decision based on the physician’s request, the basis for that request, the child’s diagnosis and behavior, and the effects of the medication, both those intended and the side effects.⁶⁹ To provide the court with this information,

⁶¹ ADMIN. ON CHILDREN, YOUTH AND FAMILIES, U.S. DEP’T OF HEALTH AND HUMAN SERVS.: INFORMATION MEMORANDUM ACYF-CB-IM-12-03, 13 (2012), <https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf>.

⁶² *Id.*

⁶³ CAL. EVID. CODE § 115 (West 2016).

⁶⁴ *Lillian F. v. Sup. Ct.*, 160 Cal. App. 3d, 314, 320 (Ct. App. 1984).

⁶⁵ CAL. WELF. & INST. CODE § 317(e) (West 2016).

⁶⁶ *Id.* § 317(e)(1).

⁶⁷ *Id.* § 317.

⁶⁸ *Id.* § 369.5(a).

⁶⁹ *Id.*

the Judicial Council has adopted forms and rules of court for implementation.⁷⁰ The only exception to this procedure is for emergency administration of medication, which is covered in a different statute.⁷¹

In 2007, the California Judicial Council established the forms for oversight of psychotropic medication for youth in foster care:⁷²

- JV-219: Information About Psychotropic Medication Forms,
- JV-220: Application Regarding Psychotropic Medication,
- JV-220(A): Prescribing Physician's Statement,
- JV-221: Proof of Notice: Application Regarding Psychotropic Medication,
- JV-222: Opposition to Application Regarding Psychotropic Medication, and
- JV-223: Order Regarding Application for Psychotropic Medication.

To fulfill notice requirements, the JV-220, JV-220(A), and JV-222 forms must be provided to the parents, caregiver, Court Appointed Special Advocate (CASA), Indian Tribe (if applicable), and all parties' attorneys.⁷³

Any time a foster youth needs a new psychotropic medication prescription, or every six months for foster youth already on psychotropic medication, the JV-220 must be filled out by the prescribing physician and the youth's social worker and then submitted to the court for review.⁷⁴ The JV-220 and JV-220(A) forms are mandatory and require the information specified by California Welfare & Institutions Code Section 369.5.⁷⁵ The three-page JV-220(A) form requests the physician write the youth's diagnosis and symptoms, the last face-to-face contact with the youth, other individuals from whom information about the youth was obtained, treatment that the youth is receiving besides medication, and the list of medications and their potential side effects.⁷⁶ This form allows for multiple medications to be listed, as well as "as needed" medications.⁷⁷

⁷⁰ *Id.*

⁷¹ CAL. R. CT. 5.640(g).

⁷² NAT'L CONF. OF STATE LEG., NCSL CHILD WELFARE LEGISLATION UPDATE, OVERSIGHT AND MANAGEMENT OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN AND YOUTH IN FOSTER CARE (2013).

⁷³ CAL. R. CT. 5.640(g).

⁷⁴ JUDICIAL COUNCIL OF CALIFORNIA, APPLICATION REGARDING PSYCHOTROPIC MEDICATION (2008), <http://www.courts.ca.gov/documents/jv220.pdf>.

⁷⁵ CAL. R. CT. 5.640(c)(1).

⁷⁶ CAL. R. CT. 5.640(c)(6)(A)(G).

⁷⁷ JUDICIAL COUNCIL OF CALIFORNIA, APPLICATION REGARDING PSYCHOTROPIC MEDICATION (2008), <http://www.courts.ca.gov/documents/jv220.pdf>.

If anyone opposes the administration of medication for any reason, they can submit the JV-222 form to the court and parties required to receive notice.⁷⁸ This form requests basic information about the individual opposing the application and a statement stating why the application is opposed.⁷⁹ It must be submitted within four court days after the JV-220 service of notice.⁸⁰ The court must then conduct a hearing prior to completing the order.⁸¹

Neither the form nor the California code has any restrictions on the number, doses, or combination of psychotropic medication that the youth can be prescribed and required to take.⁸² The prescribing physician is not required to see the youth with any regularity or ever again.⁸³ The youth need not be enrolled in any other type of treatment.⁸⁴ The prescribing physician is not required to consult with anyone else in the youth's support network.⁸⁵ The only check on the JV-220 process is the ability for a party to oppose the request through a JV-222 or the denial or modification of the request by the court. The use of this court oversight has not led to a decrease in the administration of psychotropic medication to foster youth.⁸⁶

If there is no opposition, the judge considers all of the submitted forms and then makes an order, JV-223, granting the request, granting the request with modifications, or denying the request.⁸⁷ This is the entirety of the oversight process for a youth to be prescribed and receive psychotropic medications.

While a minor twelve years of age or older can refuse medication, most youth will not refuse medication because they trust the doctors that are prescribing for them. Other youth may not refuse medication for fear of punishment from caregivers.⁸⁸ As the court is taking on the role of the

⁷⁸ CAL. R. CT. 5.640(c)(8).

⁷⁹ JUDICIAL COUNCIL OF CALIFORNIA, OPPOSITION TO APPLICATION REGARDING PSYCHOTROPIC MEDICATION (2014), <http://www.courts.ca.gov/documents/jv222.pdf>.

⁸⁰ CAL. R. CT. 5.640(c)(8).

⁸¹ CAL. WELF. & INST. CODE § 317(c).

⁸² Whitney Richey Rubenstein, *Raising Red Flags: A Look at State Policies for Prescribing Psychotropic Meds for Foster Children*, NAT'L CTR. FOR YOUTH L., <https://web.archive.org/web/20151108064448/http://youthlaw.org/publication/raising-red-flags-a-look-at-state-policies-for-prescribing-psychotropic-meds-for-foster-children/>.

⁸³ An examination of the California Rules of court reveals no additional requirements beyond those included in the rule. *See* CAL. R. CT. 5.640.

⁸⁴ *Id.*

⁸⁵ CAL. R. CT. 5.640.

⁸⁶ Karen de Sá, *Drugging Our Kids*, SAN JOSE MERCURY NEWS (Aug. 24, 2014), <http://web-special.mercurynews.com/druggedkids/?page=PT1>.

⁸⁷ CAL. R. CT. 5.640(d); JUDICIAL COUNCIL OF CALIFORNIA, ORDER REGARDING APPLICATION FOR PSYCHOTROPIC MEDICATION (2008), <http://www.courts.ca.gov/documents/jv223.pdf>.

⁸⁸ de Sá, *supra* note 85.

child's parent, it is also responsible to consent on the child's behalf and should conduct a thorough investigation into the medication as would a concerned parent. Other states have enacted legislation to facilitate this investigation.

3. *Other State Regimes*

The American Academy of Children and Adult Psychiatry (AACAP) developed a three-part guideline to evaluate the existing laws regarding the prescription and administration of psychotropic medication to youth in foster care.⁸⁹ First, many states have established the use of "red flags" in psychotropic treatment.⁹⁰ Red flags are circumstances that automatically trigger review or heightened scrutiny.⁹¹ Generally, red flags include the age of the minor, the dosage of the medication, or the combination of medications.⁹² Second, several states address informed consent in their legislation through procedures that permit the child's caregiver, parent, social services agency, or the court to consent to psychotropic medication.⁹³ Third, some states require ongoing monitoring of the youth and their treatment as it relates to the psychotropic medication, including medical screenings and regular psychiatry appointments.⁹⁴ Not addressed in AACAP's guidelines, but vital to a law's success, is the standard of review by which the court will be reviewing the evidence.

4. *Standard of Evidence for Adults Receiving Involuntary Medications*

Children are not afforded the same protections as adults when it comes to their ability to avoid psychotropic medication in an institutional setting. For adults in the penal or civil commitment system, the freedom from bodily intrusion through psychotropic medication is protected by California's Constitutional right to privacy.⁹⁵ The Lanterman-Petris-Short Act (LPS) went into effect in 1972 as a further protection of this right.⁹⁶ LPS was passed to better protect the rights of civilly committed

⁸⁹ Rubenstein, *supra* note 81.

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *In re Qawi*, 81 P.3d 224 (Cal. 2004) (quoting *Conservatorship of Wendland*, 28 P.3d 151, 15860 (2001)).

⁹⁶ CAL. WELF. & INST. CODE § 5000.

persons.⁹⁷ Under this Act, a civilly committed individual has the right to refuse psychotropic medication unless one of the following conditions is met: (1) the person is determined to be incompetent regarding decisions involving their treatment; (2) the medication is required in an emergency situation; or (3) the person was committed under section 5300 and there is a particularized showing that the patient is a demonstrated danger and has recently been dangerous.⁹⁸ LPS has been a model for mental health and medication regulations in other areas of law.

In 1986, the California Court of Appeal for the First District reiterated the importance of protecting incarcerated adults from bodily invasion of privacy through forced medication.⁹⁹ In *Keyhea*, a prisoner brought a taxpayer suit against the state after being forcibly medicated without a judicial determination of competency.¹⁰⁰ The Court of Appeal recognized the prisoner's right to privacy as derived from a non-prisoner's right as protected under the LPS.¹⁰¹ Under LPS, conservatees have a right to a judicial determination of competency prior to being forcibly medicated with psychotropic medications against their will.¹⁰² The court concluded that the prisoner was entitled to the same rights regarding judicial determination of their competency to refuse medication that are afforded to non-prisoners under LPS.¹⁰³ The court noted, "mental health professionals and prison administrators may find this requirement cumbersome, but this is a price of life in a free society. Forced drugging is one of the earmarks of the gulag. It should be permitted in state institutions only after adherence to stringent substantive and procedural safeguards."¹⁰⁴

After *Keyhea*, California enacted Penal Code Section 2602, which adds protections for adults in the prison system, including a clear and convincing standard of evidence required for involuntary administration of medication.¹⁰⁵ Section 2602 requires that a prisoner who does not consent to receiving psychotropic medication can only be medicated if cer-

⁹⁷ CAL. WELF. & INST. CODE § 5001 ("construed to support. . .[an] end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, and to eliminate legal disabilities.")

⁹⁸ *Qawi*, 81 P.3d at 23436.

⁹⁹ *See Keyhea v. Rushen*, 178 Cal. App. 3d 526 (Ct. App. 1986) ("state prisoners presently have a statutory right to refuse long-term treatment with psychotropic drugs absent a judicial determination that they are incompetent to do so.")

¹⁰⁰ *Id.*

¹⁰¹ *See id.* at 534.

¹⁰² *Keyhea*, 178 Cal. App. 3d at 536; CAL. WELF. & INST. CODE §§ 5325, 5327.

¹⁰³ *Keyhea*, 178 Cal. App. 3d at 542; CAL. WELF. & INST. CODE §§ 5325, 5327.

¹⁰⁴ *Keyhea*, 178 Cal. App. 3d at 542.

¹⁰⁵ CAL. PENAL CODE § 2602 (West 2016).

tain conditions are met.¹⁰⁶ These conditions include: (1) prisoner has a demonstrably and factually-based diagnosed mental disorder that renders him gravely disabled;¹⁰⁷ (2) the psychiatrist has evaluated the risks and benefits of medicating the prisoner after consulting the prisoner's medical and psychiatric history;¹⁰⁸ (3) the prisoner is entitled to counsel and a hearing;¹⁰⁹ and (4) the judge makes a finding based on "clear and convincing" evidence that the above listed are true.¹¹⁰

Children in the foster care system, while not civilly committed or incarcerated, have limited rights due to their status as children and wards of the state. Unlike prisoners or committed adults, children do not even have the legal right to consent to psychotropic medication; they may only assent.¹¹¹

However, like prisoners and civilly committed adults, children are entitled to most of the due process protections of the Fourteenth Amendment. "It is not disputed that the 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."¹¹² Similarly, the state approving medication for a child who is in foster care constitutes state action and implicates serious protected liberty interests for the child.

C. PREVIOUS LEGISLATIVE EFFORTS: SENATE BILL 253

The California legislature has seen recent activity designed to address the gaps in the current legal framework governing the provision of psychotropic medication to foster youth. In the 2015 legislative session, Senator Monning (D-Carmel) introduced Senate Bill 253 (SB 253) as part of a package of four bills meant to curb the overmedication of foster youth.¹¹³ Since presently a juvenile officer is required to approve the JV-220, SB 253 was aimed at modifying the required bases for a court's

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* § 2602 (c)(1)-(2), (c)(7)(A).

¹⁰⁸ *Id.* § 2602 (c)(4).

¹⁰⁹ *Id.* § 2602(c)(6)-(7).

¹¹⁰ *Id.* § 2602(c)(8).

¹¹¹ AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, A GUIDE FOR COMMUNITY CHILD SERVING AGENCIES ON PSYCHOTROPIC MEDICATIONS FOR CHILDREN AND ADOLESCENTS, 9 (2012), http://www.aacap.org/app_themes/aacap/docs/press/guide_for_community_child_serving_agencies_on_psychotropic_medications_for_children_and_adolescents_2012.pdf.

¹¹² *Parham v. J.R.*, 442 U.S. 584, 600 (1979).

¹¹³ *Calif. Bills Targeting Foster Kids' Medication Could Be National Model*, CAL. HEALTHLINE (Sept. 3, 2015), http://www.californiahealthline.org/articles/2015/9/3/calif-bills-targeting-foster-kids-medication-could-be-national-model#.VenQLIQDF_8.facebook.

findings prior to the prescription of psychotropic medication.¹¹⁴ SB 253 would have required that the doctor, prior to prescribing the medication, meet with the foster youth, complete a comprehensive medical examination that included the child's trauma and medication history, and speak to other medical providers working with the youth.¹¹⁵ Further, the doctor would be required to confirm that there are no less invasive treatment options, that the medicine and dosage are appropriate, that all appropriate labs and testing are completed, and that the risks do not outweigh the benefits.¹¹⁶

The court also would have been required to request a second medical opinion from "an appropriately qualified health care professional" if any of the following conditions exist: (1) the child is under the age of five; (2) the child is receiving more than three psychotropic medications; or (3) the child is concurrently prescribed two or more antipsychotic medications.¹¹⁷

Most of the language in the proposed amendment to the statute comes from the practice parameters and recommendations outlined by AACAP. The Practice Guide on the Use of Psychotropic Medication in Children and Adolescents states, "[b]ecause a medication intervention in a child is a significant medical event, it is prudent to *complete a medical evaluation* to ensure that the child has no medical problem accounting for the psychiatric presentation and is healthy enough to participate in a medication trial with minimal risk."¹¹⁸ Further, the prescriber is advised to "communicate with other professionals involved with the child to obtain collateral history."¹¹⁹

In the Practice Parameter for the Assessment and Management of Youth Involved with the Child Welfare System, prescribing physicians are informed that they "should recognize that maltreatment and trauma can be complex and chronic, leading to a confusing clinical presentation that might be difficult to differentiate from other mental health conditions."¹²⁰

¹¹⁴ Juveniles: Psychotropic Medication, S.B. 253, 2015-2016 Sess. (Cal. 2015), http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB253#content_anchor.

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ John Walkup et al., *Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents*, 48 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 961, 964 (2009) (emphasis added), [http://www.jaacap.com/article/S0890-8567\(09\)60156-8/pdf](http://www.jaacap.com/article/S0890-8567(09)60156-8/pdf).

¹¹⁹ *Id.*

¹²⁰ Terry Lee et al., *Practice Parameter for the Assessment and Management of Youth Involved with the Child Welfare System*, 54 J. AM. ACAD. ADOLESCENT & CHILD PSYCHIATRY 502, 511 (2015), [http://www.jaacap.com/article/S0890-8567\(15\)00148-3/pdf](http://www.jaacap.com/article/S0890-8567(15)00148-3/pdf).

However, the California Medical Association, the California Psychiatric Association, the California Academy of Adolescent and Child Psychiatry, and the California Alliance of Child and Family Services, representing group homes, all opposed the bill and called for a “no” vote even after SB 253 had unanimously passed the senate.¹²¹ Combined, these groups spent more than \$1.4 million dollars lobbying against the bill between January 1 and June 1, 2015.¹²² Those opposed to the bill stated that SB 253 would have had the unintended consequence of harming foster youth through restricting their access to medically appropriate medications.¹²³ However, SB 253 would not have prevented any medications from being prescribed – it only would have provided additional oversight.

While the three other bills in the package do address some of the issues that give rise to overmedication, SB 253 was the “linchpin” of the package, because “the courts are the gatekeepers.”¹²⁴ The other bills require the state to provide more practitioner training and data on the number of youth that are on psychotropic medication,¹²⁵ establish a system for public health nurses to oversee youth in foster care that are prescribed psychotropic medication,¹²⁶ and provide additional oversight to foster youth on psychotropic medication who are residing in group homes.¹²⁷ Without oversight by the courts through an amendment to California Welfare & Institutions Code Section 369.5, the efforts through public health nurses and group homes will not provide the needed substantive change.

¹²¹ Karen de Sá, *California Assembly to Vote on Diminished Bill Package to Curb Psychotropic Drug Use on Foster Children*, SAN JOSE MERCURY NEWS (Sept. 6, 2015, 4:54 PM), http://www.mercurynews.com/california/ci_28769540/california-assembly-vote-diminished-bill-package-curb-psychotropic.

¹²² *Id.*

¹²³ Randall Hagar, Letter to the Editor, *Better Mental Health Plan for Foster Kids*, OROVILLE MERCURY REG.: SEPT. 10 READERS’ LETTERS (Sept. 10, 2015), <http://www.oroVILLEmr.com/general-news/20150909/sept-10-readers-letters>.

¹²⁴ de Sá, *Diminished Bill Package*, *supra* note 120.

¹²⁵ Foster Care: Psychotropic Medication, S.B. 238, 205 (Cal. 2015), https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB238.

¹²⁶ Child-Welfare Services: Public Health Nursing, S.B. 319, 2015. (Cal. 2015), http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB319.

¹²⁷ Juveniles, S.B. 484, 2015. (Cal. 2015), http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB484.

II. OVERSIGHT & MONITORING

A. A STATE COMPARISON

Since the federal statutes do not define oversight and monitoring, other state statutes provide the best examples of the various ways to implement a framework that accomplishes the federal goals. Currently, twenty-six states have a written policy or guideline regarding the administration of psychotropic medication to foster youth, thirteen states are in the process of developing policy, and only nine states have no policy in place.¹²⁸

Three of the states that have established the most comprehensive oversight and monitoring of psychotropic medications are Illinois, Texas, and Nevada. Both Illinois and Texas have procedures in their legislation that require case review in the presence of enumerated red flags. Nevada's law requires assignment of psychiatric rights of the child.¹²⁹

1. *Texas Law*

In Texas, House Bill (HB 915) "ensures that the use of psychotropic medications by foster youth is appropriate, necessary, and monitored."¹³⁰ The bill addresses consent, requiring consent by the youth or the individual authorized to consent on behalf of the youth.¹³¹ Additionally the youth or an authorized individual receives:

. . . verbally or in writing information that describes the specific condition to be treated, the beneficial effects on that condition expected from the medication, the probable health and mental health consequences of not consenting to the medication, the probable clinically significant side effects and risks associated with the medication, and the generally accepted alternative medications and non-pharmacological interventions to the medication, if any, and the reasons the physician recommends the proposed course of treatment.¹³²

¹²⁸ Tufts CTSI, *Multi-State Study on Psychotropic Medication Oversight in Foster Care*, (Sept. 2010).

¹²⁹ Whitney Richey Rubenstein, *Raising Red Flags: A Look at State Policies for Prescribing Psychotropic Meds for Foster Children*, NAT'L CTR. FOR YOUTH L., <https://web.archive.org/web/20151108064448/http://youthlaw.org/publication/raising-red-flags-a-look-at-state-policies-for-prescribing-psychotropic-meds-for-foster-children/>.

¹³⁰ B. Analysis for H.B. 915, S. Research Center-83R14889 MCK-F. (Tex. 2013), <http://www.legis.state.tx.us/tlodocs/83R/analysis/html/HB00915E.HTM>.

¹³¹ TEX. FAM. CODE ANN. § 266.004 (West 2015).

¹³² *Id.* § 266.0042(2).

This signed authorization must stay in the youth's file and with their medical records.¹³³ The individual who is authorized to consent must also receive training on consent and relevant medical care¹³⁴ and accompany the minor to medical appointments.¹³⁵

To satisfy the federal requirement for monitoring, Texas requires that the individual who is authorized to consent for the child ensures that the child has an office visit with the prescribing physician at least every ninety days.¹³⁶ During these visits, the physician should be monitoring the side effects of the current medications, evaluating whether the medication is helping the child progress toward his treatment goals, as well as determining whether the continued use of the medication is necessary.¹³⁷ Follow-ups also provide an opportunity for the physician to reevaluate high-dosage prescriptions that may have been implemented for a psychiatric emergency. Further monitoring occurs during each review and permanency hearing. The state provides summaries for each youth on psychotropic medication that contains information about their medical treatment, including non-pharmacological interventions that have been utilized, and recent office visits with the treating physician.¹³⁸

Texas' statute, by defining and assigning consent, adds a safeguard on the prescription of psychotropic medication. For each child that is prescribed psychotropic medication, a trained individual must be educated about the medication and sign off on its administration. Additionally, the office visit requirement serves as scaffolding to ensure the medication is still a working part of the youth's treatment goals. The prescribing physician has an opportunity to place eyes on the child and the child can communicate directly about the impact and side effects of the medication.

2. *Nevada Law*

In 2011, Nevada passed a law that requires court appointment of a person legally responsible for the psychiatric care of the foster care youth.¹³⁹ This individual's responsibilities include maintaining up-to-date information on the youth's medical history as well as providing

¹³³ B. Analysis for H.B. 915, S. Research Center-83R14889 MCK-F. (Tex. 2013), <http://www.legis.state.tx.us/tlodocs/83R/analysis/html/HB00915E.HTM>.

¹³⁴ FAM. CODE ANN. §§ 266.004(h).

¹³⁵ *Id.* § 266.004(j).

¹³⁶ *Id.* § 263.306(a)(10)(B).

¹³⁷ *Id.* § 263.306(a)(11).

¹³⁸ *Id.* § 263.306(a)(10)(A).

¹³⁹ NAT'L CONF. OF STATE LEG., NCSL CHILD WELFARE LEGISLATION UPDATE, OVERSIGHT AND MANAGEMENT OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN AND YOUTH IN FOSTER CARE (2013).

written consent to the administration of psychotropic medications.¹⁴⁰ By statute, that person must consider the “purpose, benefits, risks, alternatives, side effects, and complications of each psychotropic medication.”¹⁴¹

Similar to the Texas law, the Nevada law’s psychiatric rights holder provides intentional and educated support and consent regarding psychiatric care. In all cases, but especially for those where children may be too young or underdeveloped to consent to medication, the court’s appointment of a psychiatric rights holder empowers a normally vulnerable population.

3. *Illinois Law*

The Illinois law pertaining to psychotropic medications for foster youth is one of the most comprehensive in the nation. It requires publication of the guidelines for utilization psychotropic medication on the Illinois Department of Children and Family Services’ website.¹⁴² The law explicitly prohibits use of psychotropic medication for punishment, convenience of the staff, or as a substitute for adequate programming for foster care youth.¹⁴³ Illinois law also prohibits as needed (or “PRN”) medications for treatment of psychiatric illnesses and behavioral problems.¹⁴⁴

To address the federal requirement for oversight, the Illinois law has a list of nine “triggers” that could lead to case review by an oversight team.¹⁴⁵ Some triggers include: prescription of four or more psychotropic medications; prescription of psychotropic medication to a foster care child under the age of four; frequent changes in psychotropic medications without clear rationale; and the request of the Division of Child and Family Services (DCFS) guardian.¹⁴⁶

The Illinois statute also includes guidelines for group homes, temporary placements, and foster homes.¹⁴⁷ It contains specific standards for consent as well as penalties for violations of the statute.¹⁴⁸ The specificity and clarity in this statute prevents different standards regarding medication between group and foster home placements. As with the Nevada

¹⁴⁰ NEV. REV. STAT. § 432B.4687 (West 2015).

¹⁴¹ *Id.* § 432B.4687(1)(a).

¹⁴² 20 ILL. COMP. STAT. 535/5(f) (West 2015).

¹⁴³ *Id.* 535/5(e).

¹⁴⁴ ILL. ADMIN. CODE tit. 89, § 325.30 (West 2012).

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

and Texas statutes, explicit instructions regarding consent mitigate the chances that a youth will be required to take psychotropic medication against their will or the will of their family/caretakers. It reduces ambiguity about who is responsible for the psychiatric care of a foster care youth.

In Illinois' guidelines, legislation also calls for collaboration between medical providers. This communication enhances the "continuity of care" and "facilitate[s] the monitoring of the outcome of the medication trial."¹⁴⁹

B. HOW CALIFORNIA MEASURES UP

Compared to the robust oversight and monitoring provisions of the model state laws described above, California's current law contains serious deficiencies that leave youth in the foster system at risk of over- or inappropriate medication. As described above, California code requires approval by a judicial officer prior to the administration of psychotropic medication, but the information that an officer receives is inadequate to ensure that the youth's interest is fully protected.

When a youth enters the foster care system, by California law, the juvenile court takes jurisdiction and is granted *parens patriae* power over the child.¹⁵⁰ This power is derived from the fact that the youth's parents are unfit, unwilling, or unable to care for them.¹⁵¹ *Parens patriae* power can be exercised "only to further the best interests of the child."¹⁵²

As part of this *parens patriae* power, only a judicial officer is required to sign off on psychotropic medications for foster care youth.¹⁵³ The judicial officer is not required to have any training in consent, psychotropic medications, or mental health treatment.¹⁵⁴ The only information about the medication that the prescribing physician is required to attach to the JV-220 is its name, dosage, the condition that it will be treating, and its potential side effects.¹⁵⁵ Far from providing comprehensive data, the prescribing physicians generally attach generic printouts about the medication that do not address the risks pertaining to the specific child.

¹⁴⁹ *Id.*

¹⁵⁰ 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, 1160 (1999).

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ CAL. WELF. & INST. CODE § 369.5(a) (West 2015).

¹⁵⁴ CAL. R. CT. 5.640.

¹⁵⁵ CAL. R. CT. 5.640(c)(6)(A) (G); JUDICIAL COUNCIL OF CALIFORNIA, APPLICATION REGARDING PSYCHOTROPIC MEDICATION (2008), <http://www.courts.ca.gov/documents/jv220.pdf>.

Additionally, the judicial officer does not necessarily have a relationship with the child or their caregivers.¹⁵⁶ After the dependency court obtains jurisdiction over a child, a review hearing is only required on a biannual basis.¹⁵⁷ The social worker submits a report to the judge that includes information on the youth's mental health and current medication, but the judicial officer has no obligation to personally interact with the youth or their support network.¹⁵⁸ Outside of a JV-222 Opposition form or communication with the social worker, there is no meaningful way for adults in the foster care youth's life to provide input regarding the youth's behavior and treatment responses.

The approval of psychiatric medication ends up being a "rubber-stamp" of the physician's request due to the judicial officer's lack of information. The judicial officer is therefore poorly positioned to make any decision regarding psychotropic medication except as a last resort. While SB 253 would have addressed many of these shortcomings, it did not pass and consequently California's foster youth are left without this protection.

III. RECOMMENDATION

For an amendment to California's Welfare & Institutions Code to effectively provide oversight and monitoring of psychotropic medication prescriptions to youth in foster care, it must require more than simple approval by a judicial officer under a standard of preponderance of the evidence. Additional oversight not only protects foster youth, but increases the state's accountability and establishes consistent standards among the counties. As demonstrated by the laws in Texas, Nevada, and Illinois, an effective state policy requires informed consent, red flag "triggers" for case review, and monitoring of foster youth on psychotropic medications.

Further, the standard of review is critical since the court is reviewing the request for medication. For adults in the prison or civil commitment system to be prescribed involuntary medication, the court must make findings that it is necessary by a standard of clear and convincing evidence. At the very least, foster youth should have this higher standard to protect them from overmedication and further abuses.

¹⁵⁶ See generally Brandow, *A Spoonful of Sugar Won't Help This Medicine Go Down: Psychotropic Drugs for Abused and Neglected Children*, 72 S. CAL. L. REV. at 1162.

¹⁵⁷ CAL. WELF. & INST. CODE § 366(a)(1).

¹⁵⁸ See generally Brandow, *supra* note 155.

A. RATIONALE FOR RECOMMENDED REVISIONS TO STATE LAW

There are four main reasons why a state law is appropriate to address the crisis of overmedication: uniformity among counties; the power of a state law; the ongoing risk to foster youth; and the role of the court as the foster youth's parent. First, for youth in foster care who may experience repeated changes prior to and while in foster care, uniformity is crucial. Foster children often have frequent placement changes,¹⁵⁹ and due to variances in county guidelines, their treatment can be interrupted upon moving. A state law allows foster children to move if necessary without this interruption. The children in each county should be entitled to the same standard of care regarding their medical health. For De-Angelo, while some of the placement changes may have been unavoidable, a more comprehensive state law would have mandated that he receive continuing medical care throughout his time in foster care. Consistency in his medication may have enabled his doctors to determine which medications were helping him, or if the medications were helping at all.

In addition to uniformity, a state law has greater force than a policy or guideline. The state has an obligation to ensure that all children within its care are protected. It is responsible for the care of these neglected and abused children as they are a vulnerable population, and there are serious risks to the mismanagement of psychotropic medications. Counties can presently create different policies if justified but many foster youth move between counties, resulting in a change or deprivation of services. Further, neighboring counties are not required to uphold bordering counties' standards. A state law sets a base of protection that is unchanging.

As detailed above, without the needed oversight, California's large foster care population is currently being prescribed psychotropic medication at a much higher rate than children not in foster care.¹⁶⁰ There are no guidelines for how much mental treatment youth should receive in addition to psychotropic medication, and the prescribing physician is under no legal obligation to follow up with the child after they begin taking their medication. The procedure for consent is not outlined explicitly, nor is there required training for the individual responsible for consenting. In the short-term, children are suffering from side effects and being treated as nuisances in need of control instead of as traumatized individuals in need of treatment. In the long-term, foster youth are more likely to end

¹⁵⁹ Donald H. Stone, *The Dangers of Psychotropic Medication for Mentally Ill Children: Where is the Child's Voice in Consenting to Medication? An Empirical Study*, 23 TEMP. POL. & CIV. RTS. L. REV. 121, 144 (2013).

¹⁶⁰ *Id.*

up homeless, incarcerated, or suffering from chronic health problems due to a failure to treat their underlying mental health needs.¹⁶¹

Finally, the state, in its *parens patriae* role, should be held responsible for the children in its care. This duty extends not only to the foster youth, but also to society as a whole, which ultimately pays the cost of caring for foster children. A parent who negligently or recklessly managed a child's medication over a long period of time may be subject to intervention by child welfare services or even criminal charges. The state, unlike a parent, cannot maintain close contact with each minor in its care,¹⁶² but nevertheless has an obligation to ensure that the child's mental health needs are met. A law detailing this obligation supports the state in its role by specifying the inquiries that it should make prior to approving an order for psychotropic medication.

B. PROPOSED LAW

To satisfy the federal government's requirement for oversight and monitoring, and to consider the child's best interest, an amendment to California's law should include strong provisions with strict requirements for three areas: consent, red flags for case review, and requirements for follow up and monitoring.

1. Consent

For consent, Texas's law stands as a guide. If a child is removed from his or her home, a court-appointed adult must consent in writing to any prescription for any psychotropic medication.¹⁶³ The court may appoint the child's foster parent, the social worker, or the agency as a whole as the responsible adult.¹⁶⁴ When foster care youth enter the foster care system, they may or may not have immediate psychiatric needs. If they do, California's law should require the immediate identification of an adult who will be responsible for consenting to their psychiatric care. The individual empowered to consent should receive training on informed consent and the medication application procedure.¹⁶⁵ This man-

¹⁶¹ *Youth Homelessness in California: A Quick Overview*, CALIFORNIA HOMELESS YOUTH PROJECT, <http://cahomelessyouth.library.ca.gov/docs/pdf/a-quickoverview-of-hy-inca.pdf> (last visited April 17, 2016).

¹⁶² Brandow, *A Spoonful of Sugar Won't Help This Medicine Go Down: Psychotropic Drugs for Abused and Neglected Children*, 72 S. CAL. L. REV. at 1162.

¹⁶³ TEX. FAM. CODE ANN. § 266.004(b) (West 2015).

¹⁶⁴ *Id.* § 266.004(b)(1) (2).

¹⁶⁵ *Id.* § 266.04(h), (h-1), (h-2).

ner of appointment is similar to how an educational rights holder is currently appointed in California.

California should adopt this procedure for consent because it places power to consent for medication onto an individual who interacts with the child rather than the court. In California, a minor twelve or older can refuse treatment by means of psychotropic medication.¹⁶⁶ However, refusal serves more as a last-ditch protection for the youth than as a procedural safeguard that is required for every prescription. To facilitate informed consent, the AACAP encourages both the child and the caregiver to be “meaningful participants” in the conversation with the prescriber to facilitate the consent process.¹⁶⁷ In DeAngelo’s case, had there been an adult responsible for consenting to his psychotropic medications, this adult would have been able to provide up-to-date medical information to the prescribing doctors to inform their diagnoses. After consultation with DeAngelo, they might have made different decisions about psychotropic medications. The adult could have informed the doctor about DeAngelo’s trauma or placement history, which likely impacted his behavior. The adult could have affirmatively advocated for a non-pharmaceutical treatment to address specific challenges.

2. Case Review

For red flags, California should, at a minimum, have automatic case review in the following circumstances: when any psychotropic medication is prescribed to a foster child under a certain age; when a child is prescribed two or more psychotropic medications for the same condition; when there are frequent changes to a child’s psychotropic medication; when there is an emergency situation involving psychotropic medication; and at the request of the foster home caretaker. In addition to these, California may consider discretionary case review for: certain dosage levels; medications with a black box label (suicide risk as a side effect); and other factors such as the child’s age, diagnosis, or placement changes. Most of these triggers are included in Illinois state law. SB 253 would have included several of these provisions.¹⁶⁸

Further, California should require that information about all of the psychotropic medication be placed in a public forum, such as on the

¹⁶⁶ Brandow, *supra* note 160, at 1154.

¹⁶⁷ Stone, *The Dangers of Psychotropic Medication for Mentally Ill Children: Where is the Child’s Voice in Consenting to Medication? An Empirical Study*, 23 TEMP. POL. & CIV. RTS. L. REV. at 149.

¹⁶⁸ Juveniles: Psychotropic Medication, S.B. 253, 2015-16 Sess. (Cal. 2015), http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB253#content_anchor.

state's website.¹⁶⁹ Upon submission of JV-220, the parent should be directed to this information. Publication of psychotropic medication data, side effects, and warnings promote transparency and education. Those individuals who may not have received the JV-220 request can still look up the state's guidelines regarding psychotropic medications. Additionally, an individual who is included in the JV-220's notice requirement can have access to more information about the medication or policy than may have been provided in the three-page court document.

With case review, the county or state should establish a team to conduct the review. In other states, this team has multi-disciplinary professionals from several facets of childcare and child psychiatry.¹⁷⁰ A team like this should meet regularly or be on call to review the children's cases or to meet with the children if necessary. Their assessment should be conducted independently of the child welfare agency, though they may collaborate in coming to a solution if changes are required. This independent assessment allows for objectivity in a setting where emotions may affect the judgment or requests of the support team involved in the foster child's care. Further, review by a neutral third-party prevents instances of overmedication urged by caregivers as a means of sedating a youth in their care.

Both DeAngelo and Gabriel's cases would have required—and likely benefitted from—case review. For Gabriel, case review would have been required due to his age. For DeAngelo, case review would have been required due to the combination of medications he was receiving. This additional attention to youth with troublesome mental health conditions provides another access point for professional assessment, collaboration, and intervention.

3. *Monitoring*

All children who are prescribed psychotropic medication should also have more frequent and in-depth monitoring due to the risks inherent in the medication. Upon entry into the dependency system, each youth should have a medical screening that includes evaluation of the child's psychiatric needs.¹⁷¹ If the child requires or is already taking psychotropic medication upon entry into the child welfare system, the court

¹⁶⁹ See 20 ILL. COMP. STAT. ANN. 535/5(f) (West 2011).

¹⁷⁰ Texas Department of Family and Protective Services, *Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care*, 9 (Sept. 2013), http://www.dfps.state.tx.us/Child_Protection/Medical_Services/documents/pdf/TxFosterCareParameters.pdf.

¹⁷¹ Stone, *The Dangers of Psychotropic Medication for Mentally Ill Children: Where is the Child's Voice in Consenting to Medication? An Empirical Study*, 23 TEMP. POL. & CIV. RTS. L. REV at 149.

should determine who is responsible for the child's psychiatric care at the detention hearing.

Once the child is prescribed medication, there should be a requirement for ongoing treatment.¹⁷² California should adopt Texas's policy, which requires that a child in the dependency system who is on psychotropic medication should see their prescribing psychiatrist at least every ninety days.¹⁷³ Maintaining contact with a psychiatrist is one piece of treatment that is vital to recovery from mental health conditions. In a growing body of smaller studies, treatment that includes a stable home environment, caring adults, and focus on the full effect of maltreatment has shown to be an effective alternative to psychotropic treatment.¹⁷⁴ To encourage the integration of such treatment, at each hearing, the psychiatrist or child welfare agency should be required to inform the court of non-pharmacological options to treatment.¹⁷⁵

For effective monitoring, collaboration between the youth's providers is essential. As found in the guidelines in Illinois, California law should require psychiatrists that prescribe for dependent youth to communicate with the youth's other providers and document these contacts.¹⁷⁶ Correspondence between the child's providers decreases the likelihood that multiple medications are prescribed unintentionally. For a youth like Gabriel, correspondence and collaboration between his prescribing physicians, parents, and caregivers would likely have resulted in a comprehensive treatment plan that spanned each facet of his life. Instead, his treatment was fragmented and each adult in Gabriel's life dealt with his problem behavior in a different way.

Children in the child welfare system often have mental health needs due to the trauma they experienced that led to state intervention.¹⁷⁷ However, they generally aren't getting "consistent, appropriate mental health care of any kind."¹⁷⁸ There is no decisive test to determine whether mental illness is the cause of a youth's behavior problems,¹⁷⁹ so non-pharmacological treatment is vital to a child's success with or without prescription medication.

¹⁷² Jonathan Walters, *Are We Overmedicating Foster Care Children?* GOVERNING MAG. (Oct. 8, 2013), <http://www.governing.com/topics/health-human-services/col-overmedicating-foster-care-children-human-services.html>.

¹⁷³ See TEX. FAM. CODE ANN. § 266.306(a)(13)(B) (West 2015).

¹⁷⁴ Karen De Sá, *Drugging Our Kids, Part IV: Finding Yolanda*, SAN JOSE MERCURY NEWS (Dec. 21, 2014), <http://webspecial.mercurynews.com/druggedkids/?page=PT4>.

¹⁷⁵ See FAM. CODE ANN. § 266.0042(2)(A) (E).

¹⁷⁶ ILL. ADMIN. CODE tit. 89, § 325.30 (West 2012).

¹⁷⁷ Walters, *supra* note 170.

¹⁷⁸ *Id.*

¹⁷⁹ Ashley A. Norton, Note, *The Captive Mind: Antipsychotics as Chemical Restraint in Juvenile Detention*, 29 J. CONTEMP. HEALTH L. & POL'Y 152, 169 (2012).

All provisions of the proposed law mean little if the state only need show that the child “more likely than not” meets each of these criteria. The risk of severe side-effects alone warrants a clear finding of need in order for the new amendment to offer any viable protection for foster youth.

C. STANDARD OF REVIEW

While the interest in the child’s well-being is specified by state law, there is no consistent interested party to provide informed consent or ask the questions a typical parent asks. Therefore, the court should be held to a higher standard of evidence to ensure that the child is not being medicated unnecessarily. The AACAP guidelines underscore this need,

Unlike mentally ill children from intact families, these children often have no consistent interested party to provide informed consent for their treatment, to coordinate treatment planning and clinical care, or to provide longitudinal oversight of their treatment. The state has a duty to perform this protective role for children in state custody.¹⁸⁰

Further, as medication is a bodily intrusion that, if unwarranted, is a gross violation of the youth’s right to privacy, a finding of clear and convincing evidence is fitting for the State’s *parens patriae* responsibility to the youth.

In an early challenge to involuntary mental health treatment for adults, the First District Court of Appeal determined that clear and convincing evidence was required to support an order that a patient lacked capacity to consent to convulsive treatment.¹⁸¹ Because of the “intrusive” and “possibly hazardous” nature of convulsive therapy, the court noted additional safeguards had justifiably been put in place for treatment of involuntarily committed patients.¹⁸² The court balanced the concerns of the state and the patient to determine which standard of proof should be required for these invasive treatments.¹⁸³

The court underscored the way convulsive treatment impacts “the right to be free in the exercise of one’s own thoughts. . . .”¹⁸⁴ Because of the effect on this personal and integral right, the practice of involuntarily treating someone can only be sustained through a showing that there is a

¹⁸⁰ AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, A GUIDE FOR COMMUNITY CHILD SERVING AGENCIES ON PSYCHOTROPIC MEDICATIONS FOR CHILDREN AND ADOLESCENTS, 18 (2012), http://www.aacap.org/app_themes/aacap/docs/press/guide_for_community_child_serving_agencies_on_psychotropic_medications_for_children_and_adolescents_2012.pdf.

¹⁸¹ Lillian F. v. Super. Ct., 160 Cal. App. 3d 314, 324 (Ct. App. 1984).

¹⁸² *Id.* at 317.

¹⁸³ *Id.* at 321.

¹⁸⁴ *Id.* at 321 (citing *Aden v. Younger*, 57 Cal. App. 3d 662, 67980 (1976)).

compelling state interest and that the least drastic means have been used to employ those interests.¹⁸⁵ Accordingly, the court determined that “preponderance of the evidence” was inappropriate because society’s interest in preventing erroneous determination of the power to consent was greater than interest in an erroneous money award in a civil suit.¹⁸⁶ Further, as the proceeding in that case was not a criminal one, the “clear and convincing” standard was appropriate.¹⁸⁷ “The clear and convincing evidence test is consistent with the balancing of these interests and the proper allocation of the risk of error.”¹⁸⁸

Children are at least entitled to the liberty interest protections of prisoners. Society’s interest in whether children are receiving the appropriate standard of care prior to being medicated with serious psychotropic medication is more substantial than its interest in resolution of a civil suit for monetary damages. A preponderance of the evidence standard does not safeguard the rights of foster youth, who may be left without a single, consistent advocate to ask the questions required to ensure they receive adequate protection from overmedication.

Even though it satisfies the preponderance of the evidence standard, a reasonable parent asks more than whether the medication is more likely than not to produce the desired effect. A reasonable parent asks: what other treatment options have we tried? Is this the only way? Will my child suffer from the side effects? Does my child want to take this medication? In applying a clear and convincing standard, the court is more likely to ask questions that are within its duty as the child’s parent.

This amendment permits medication as a part of a comprehensive treatment plan, not as a first resort for behavior control. A law that includes consent, red flags, and monitoring, evaluated at a standard of review of clear and convincing evidence comes as close as California can to providing foster youth with the benefit of a parent’s oversight and monitoring.

CONCLUSION

California’s current regulatory regime has weaknesses that affect the state’s most vulnerable children, and it needs to be brought into step with the best practices that are working effectively today to protect children in other states. Presently, the law only calls for court approval by a standard of preponderance of the evidence. This falls dangerously short of the

¹⁸⁵ *Id.* at 321.

¹⁸⁶ *Id.* at 32223.

¹⁸⁷ *Id.* at 323.

¹⁸⁸ *Id.*

holistic, comprehensive, collaborative approach that other states have implemented and that is recommended by the AACAP. For children like DeAngelo and Gabriel, the lack of oversight of prescribed psychotropic medications led to unnecessary harm. The state removed them from their homes to prevent abuse and neglect, but only furthered their trauma through well-intentioned pharmacological intervention. Further, the state neglected their mental health needs by failing to implement a collaborative treatment plan.

To protect children that come into the foster care system with psychiatric needs, California needs to have a comprehensive, youth-centered approach to mental health treatment. At a minimum, California legislation should include oversight, as required by the federal law that addresses consent, case review, and monitoring for youth in foster care at a standard of clear and convincing evidence. While key stakeholders continue to take strides to address legislative gaps in services,¹⁸⁹ foster youth remain vulnerable to overtreatment in the meantime. The state takes responsibility for foster youth as soon as it deems the child's parents incapable of doing so, and this should include concern for children's psychiatric needs. With legislative oversight, California can end the crisis of overmedication that currently exists in our foster care system.

¹⁸⁹ As of this Comment's publication, Senate Bill 1174 is making its way through the legislative hearing process. SB 1174 would provide greater authority for the California Medical Board to penalize doctors who regularly overprescribe psychotropic medication to minors without medical justification. See Karen de Sá, *Drugging Our Kids: Foster care bill targets excessive prescribing of psychiatric drugs*, DAILY DEMOCRAT (April 11, 2016, 7:28PM), <http://www.dailydemocrat.com/general-news/20160411/drugging-our-kids-foster-care-bill-targets-excessive-prescribing-of-psychiatric-drugs>. Additionally, implementation of Senate Bill 238 (mentioned *infra* page 17) begins July 2016. Under new guidelines, doctors will be required to state their rationale for prescription medication, indicate whether the child agrees with the treatment, conduct all appropriate labs and explain how the medication is expected to improve the child's symptoms. The changes do not require case review or ongoing monitoring of the child's treatment. See Karen de Sá, *California courts step up oversight of psychotropic medication use in foster care*, SAN JOSE MERCURY NEWS (April 15, 2016, 4:59PM), http://www.mercurynews.com/breaking-news/ci_29772962/california-courts-step-up-oversight-psychotropic-medication-use; see *infra* p. 17 and note 125.

