THE USE OF PSYCHOTROPIC MEDICATION IN MICHIGAN FOSTER CARE

I. INTRODUCTION

Every year in the United States over 800,000 children spend some amount of time in foster care.[1] Recently, there have been nationwide allegations that certain medications are being used in foster care to manage disruptive behavior rather than to treat genuine disorders.[2] Children are largely defenseless, as they have little say regarding what medication they are given.[3] The problem is further exacerbated by the fact that these medications are poorly understood and poorly tracked.[4]

To protect foster care children from being overmedicated and misdiagnosed, additional legislation is needed that provides more stringent and sweeping oversight, and places an emphasis on coupling medical with psychotherapeutic treatments. Additionally, biological parents, whose parental rights have not been terminated, should have a more active role in treatment decisions.

II. BACKGROUND

Psychotropic medications serve a distinct function and carry with them certain risks.[5] The information below provides a brief overview of the purpose, prevalence, efficacy, and risks associated with these drugs,

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1. HEALTHY FOSTER CARE AM., *Facts and Figures*, AM. ACAD. PEDIATRICS, http://www.aap.org/fostercare/facts_figures.html (last visited Apr. 2, 2011).

2. Charles G. Childress, *The Rights of Children Regarding Medical Treatment*, GP SOLO 44, 46, (Apr./May 2008), *available at* http://www.americanbar.org/newsletter/publications/gp_solo_magazine_home/gp_solo_magazine_index/medicaltreatment.html. Some authority, however, does exist, suggesting that youth in state custody suffer from mental disorders at far higher rates than the general youth population. For example, a recent study found that between fifty and seventy-five percent of *incarcerated* youths have a diagnosable mental disorder and that twenty percent have had a "serious emotional disturbance." David R. Katner, *The Mental Health Paradigm and the Macarther Study: Emerging Issues Challenging the Competence of Juveniles in Delinquency Systems*, 32 AM. J. L. & MED. 503, 510 (2006) (focusing on the relationship between juvenile mental illness and competency).

3. Childress, *supra* note 2, at 45. This article cites a 1979 Supreme Court case in which the Court opined that children "'simply are not able to make sound judgments concerning many decisions, including their need of medical care or treatment.'" *Id.* (quoting Parham v. JR, 442 U.S. 584, 603 (1979)).

4. *Id.* Katner, *supra* note 2, at n.350.

5. *Mental Health Medications*, NAT'L INS. MENTAL HEALTH, http://www.nimh.nih.gov/health/publications/mental-health-medications/nimh-mental-health-medications.pdf (last visited Sept. 28, 2010).

followed by an overview of how psychotropic medications are regulated and tracked in the United States.

A. Purpose & Prevalence

1. Purpose

Psychotropic medication is used to treat mental disorders.[6] These medications are meant to alleviate many debilitating symptoms associated with an array of conditions, but do not provide any permanent cures.[7] Of these disorders, children are most commonly treated for depression and attention deficit/hyperactivity disorder (ADHD).[8] Antidepressants are used, unsurprisingly, to treat depression, which is done by manipulating chemicals in the brain in an attempt to modify mood and emotion.[9] ADHD has become widely recognized by the public at large, and is normally treated using stimulants such as Ritalin,[10] Adderall, or Dexedrine.[11]

2. Prevalence

The use of psychotropic medication on children is an issue not isolated to foster care. The rate of children being prescribed psychotropic medication in the United States has almost tripled in the past decade, with children in the United States being prescribed psychotropic medications two to three times more often than in other developed countries.[12] Between 1995 and 1999, the prescription of antidepressants alone increased by 580% among children under the age of six.[13]

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6. *Id.*

7. *Id.*

8. U.S. PUB. HEALTH SERV., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *available at* http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c3.pdf.

9. *Id.* at 147. The most common antidepressants are selective serotonin reuptake inhibitors (SSRIs). *Id.* at 156. The most familiar SSRIs are drugs such as Prozac, Paxil, and Zoloft. *See* NAT'L INS. MENTAL HEALTH, *supra* note 5, at 4. Other antidepressants manipulate norepinephrine (SNRIs) and dopamine in the brain. Common SNRIs include Cymbalta and Effexor. *See* NAT'L INS. MENTAL HEALTH, *supra* note 5, at 4.

10. A report in 2000 found that roughly 6,000,000 children in the United States were taking Ritalin. *Psychotropic Drug Use in Schools*, HOUSE FISCAL AGENCY, http://www.legislature.mi.gov/documents/2001-2002/billanalysis/House/htm/2001-HLA-5083-A.htm (last visited Apr. 2, 2011). This meant that one out of every eight children was taking Ritalin during the study period. *Id.*

11. NAT'L INS. MENTAL HEALTH, *supra* note 5, at 12.

12. LAUREL K. LESLIE, ET AL., MULTI-STATE STUDY ON PSYCHOTROPIC MEDICATION OVERSIGHT IN FOSTER CARE, TUFTS CLINICAL & TRANSLATIONAL SCI. INST. 1 (2010), *available at* http://160.109.101.132/icrhps/prodserv/docs/Executive_Report_09-07-

While general rates of psychotropic medication use are staggering, children in foster care are far more often prescribed these medications than any other child population.[14] In 1999, there were roughly 547,000 children reported to be in foster care.[15] Modest estimates suggest that approximately 13.5% of youth in foster care receive psychotropic medication.[16] Some states have reported higher rates, such as Texas, which found in 2004 that 34.7% of foster children in the state were on one or more psychotropic medications.[17] Shockingly, other states have

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10_348.pdf [hereinafter TUFTS]; Dennis D. Embry, *Prevention Policy and Health-Care Reform to Reduce Psychotropic Use in Pediatrics*, PAXIS INST., http://www.paxis.org/content/news/articles/Prevention%20Policy%20and%20Health.pdf (last visited Mar. 31, 2011). Revisions in the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is used to identify disorder information, also exacerbated the issue. *See* Mark Olfson et al., *National Trends in the Use of Psychotropic Medication by Children*, 41:5 J. AM. ACAD. CHILD ADOLESCENCE PSYCHIATRY, 518 (2002), *available at* http://psychrights.org/research/Digest/CriticalThinkRxCites/olfson.pdf. The DSM-IV requires two fewer symptoms than the DSM-III-R to meet the criteria for an ADHD diagnosis. *Id.*

13. Jacqueline A. Sparks & Barry L. Duncan, *The Ethics and Science of Medicating Children*, 6 ETHICAL HUM. PSYCHOL. & PSYCHIATRY 25 (2004), *available at* http://psychrights.org/research/digest/ADHD/MedicatingKids.pdf. Youth between the ages of seven and twelve also saw a 151% increase in antidepressant use. *Id.* at 25.

14. *Id.*

15. Christine M. Dine, *Protecting Those Who Cannot Protect Themselves: State Liability for Violation of Foster Children's Right to Safety*, 38 CAL. W. L. REV. 507, 509 (2002). This figure represents a 35% increase since a decade prior in 1990. *Id.* Other sources have put the number closer to 581,000 children in foster care in 1999. *See Foster Care Facts*, EVAN B. DONALDSON ADOPTION INST., http://www.adoptioninstitute.org/research/fostercare/php (last visited Mar. 31, 2011).

16. Michael W. Naylor et al., *Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations*, 86 CHILD WELFARE, 176, 176 (2007), *available at* http://www.psych.uic.edu/ijr/pdf/mnaylor/PsychotropicMedicationsWards.pdf. The authors were citing a study isolated to three counties in the Los Angeles area. *See* Bonnie T. Zima et al., *Psychotropic Medication Use Among Children in Foster Care: Relationship to Severe Psychiatric Disorders*, 89 AM. J. PUB. HEALTH, 1732, 1732-35 (1999), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1508994/pdf/amjph00011-0118.pdf. Another study notes that psychotropic medication is more prevalent in group foster care homes than therapeutic foster care, indicating that the level of care provided predicts the use of psychotropic medication. *See* Naylor, *supra* at 176.

17. David Sessions, *Psychotropic Drug Abuse in Foster Care Costs Government Billions*, HOW CHILD PROTECTION SERVICES BUYS AND SELLS OUR CHILDREN: A SITE TO TEACH PARENTS HOW TO PROTECT THEMSELVES AND THEIR CHILDREN FROM BEING ABUSED BY CHILD PROTECTION SERVICES (Jan. 9, 2011), http://protectingourchildrenfrombeingsold.wordpress.com/2011/01/09/psychotropic-drug-abuse-in-foster-care-costs-government-billions-2/.

reported that "more than 60% of foster children are prescribed mood-altering drugs."[18]

These figures can partially be attributed to the fact that children in foster care are often more susceptible to mental illness and emotional and behavioral problems.[19] However, as discussed below, there are many factors, in addition to a foster child's mental state, that may contribute to their misdiagnosis. Whether or not justified, the heightened rate of medication among foster children is alarming.

B. Efficacy and Side-Effects

Given the rates at which psychotropic medications are used, it is pertinent to examine just how effective these medications are and the risks associated with them.

1. Efficacy

The American Psychological Association's Working Group on Psychotropic Medications for Children and Adolescents (the "Group") reported that more research is necessary to "examine the efficacy and safety of psychotropic medication—and other treatments—for specific disorders in children."[20] The Group acknowledged that "[c]learly the use of medication far exceeds any data."[21] The commonly cited Zito study found the "dramatic increases 'remarkable in light of the limited knowledge base that underlies psychotropic medication use in very young children.'"[22]

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18. CITIZENS' COMM'N ON HUMAN RIGHTS, *Facts About Foster Care Children Abused with Psychotropic Drugs*, *available at* http://www.cchr.org/sites/default/files/downloads/facts_about_foster_care_children.pdf.

19. Naylor et al., *supra* note 16, at 176. This is also an issue when considering the efficacy of these drugs, as the Code of Federal Regulations prohibits using children who are in state care from research "involving greater than minimal risk." *Id.* at 178. As a result, most data regarding psychotropic medications is taken from adult psychiatric research or from children with mental illness not in state care. *Id.* This means that many of the unique problems faced by foster children, such as experience with abuse, neglect, as well as placement disruptions, are neglected. *Id.* Therefore, any findings made may not be readily generalizable to the foster child population. *Id.*

20. Laurie Meyers, *Medicate or Not?*, 37 AM. PSYCHOL. ASS'N, 24 (2006), *available at* http://www.apa.org/monitor/nov06/medicate.aspx.

21. *Id.* (internal punctuation omitted).

22. *Id.* at 26 (quoting Julie Magno Zito et al., *Trends in the Prescribing of Psychotropic Medications to Preschoolers*, 283, J. AM. MED. ASS'N, 1028 (2000)).

Although many studies have shown that ADHD stimulants are successful in curbing inattention, impulsiveness, and hyperactivity,[23] many of these studies have been criticized for how medical efficacy is measured.[24] As one particular study identified, findings are lacking when they 1) neglect client-rated measures of improvement,[25] 2) use inert rather than active placebos,[26] 3) are too short,[27] and 4) are funded by a company strongly affiliated with the authors of that study.[28]

2. Side Effects

Studies that *have* adequately researched the safety and efficacy of certain psychotropic medications are still limited in that they focus less on long-term and more on short-term effects.[29] The known effects, both short-term and long-term, of antidepressant and ADHD medication are distinct, potentially serious, and deserve individual exploration.

Antidepressants can cause a variety of short-term side effects.[30] The most common antidepressant medications are SSRIs and SNRIs, which may cause headaches, nausea, sleeplessness or drowsiness, agitation, and a reduced sex drive.[31] Tricyclic antidepressants, which may be more effective for some patients, have more serious side-effects; including

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23. OR. ST. UNIV. COLL. OF PHARMACY, OR. DEPT. OF HUMAN SERVS. *Psychotropic Medication Management in Children and Adolescents*, 76-82 (2008), *available at* http://pharmacy.oregonstate.edu/drug_policy/pages/dur_board/reviews/articles/dur_review_2008_09_05_pedpsychreview.pdf.

24. *See* Sparks & Duncan, *supra* note 13, at 28.

25. *Id.* at 30. The authors argue that there is a difference between how clients and clinicians measure improvements. Often, clients find improvements even when the actual client experiences no self-reported improvement. *Id.*

26. *Id.* at 28. The authors argue that supposed double blind studies are effectually "unblinded" when inert placebos are used because participants taking the inert placebos do not experience any of the side effects (weight change, nausea, dry mouth, etc.) that participants experience when actually using the drug. Therefore, people who experience no side-effects are more likely, along with the clinician, to suspect that they were given a placebo. *Id.* at 28.

27. *Id.* at 29. The authors argue that longer study periods need to be conducted, and that in some studies "longer-term evaluation was avoided, as in nearly all drug studies, because of fear that the effects would wash out." *Id.*

28. The author references the Emslie study whose authors were either paid consultants or employees of Eli Lilly and Company, a pharmaceutical company. *Id.* at 29-30. This is the same company that paid out $62,000,000 from a settlement with thirty-two states and the District of Columbia following allegations that the company suppressed harmful side-effects of particular drugs and advertised those drugs illegally. *See* Sessions, *supra* note 17.

29. U.S. PUB. HEALTH SERV., *supra* note 8, at 140.

30. NAT'L INS. MENTAL HEALTH, *supra* note 5, at 4-6.

31. *Id.*

bladder problems, constipation, blurred vision, drowsiness, dry mouth, and a reduced sex drive.[32]

Most notably, the FDA recently found that antidepressants lead to a greater percentage of adolescents thinking about or attempting suicide.[33] In 2005, the FDA applied a "black box" warning label to all antidepressant medications, which is the most severe warning the FDA adopts.[34] This label warns of the "increased risk of suicidal thinking or attempts" by youth who take antidepressants.[35] The label also cautions that "patients of all ages taking antidepressants should be watched closely, especially during the first few weeks of treatment."[36]

ADHD medications share many similar side-effects with antidepressants, but also carry unique risks. According to the National Institute of Mental Health, the side effects of ADHD medications include a decrease in appetite, sleeping problems, stomachaches, headaches, and, less commonly, the development of tics and changes in personality.[37] The FDA in 2007 required all ADHD manufacturers to develop "Patient Medication Guides" that inform patients of certain serious risks associated with ADHD medications.[38] Specifically, the FDA found that:

> ADHD patients with heart conditions had a slightly higher risk of strokes, heart attacks, and sudden death when taking the medications. The review also found a slightly higher risk (about 1 in 1,000) for medication-related psychiatric problems, *such as*

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32. *Id.* Tricyclic antidepressants also come with risks relating to overdose. *See* Jase Donaldson, *Tricyclic Antidepressant Drugs – Information Sheet*, INSIGHT J., http://www.anxiety-and-depression-solutions.com/articles/conventional/pharmaceutical/tricyclic.php (last visited Mar. 31, 2011). Overdoses that do not result in death include symptoms such as "lethargy, seizures, muscle twitching, agitation, and jerking movements." *Id.* Overdoses can also lead to heart problems, possible coma, and extremely low blood pressure. *Id.*

33. NAT'L INS. MENTAL HEALTH, *supra* note 5, at 6. Specifically, the FDA in 2004 found that among 4,400 youth, four percent thought about or attempted suicide, while two percent of youth receiving placebos thought about or attempted suicide. *Id.* Although there was no increase in the number of suicides actually committed, the FDA nevertheless extended the warning to include anyone age twenty-four or younger. *Id. See also* U.S. FOOD AND DRUG ADMIN., *Understanding Antidepressant Medication*, (Jan. 9, 2009), http://www.fda.gov/forconsumers/consumerupdates/ucm095980.htm.

34. NAT'L INS. MENTAL HEALTH, *supra* note 5, at 6.

35. *Id.*

36. *Id.*

37. *Id.* at 12-13. Tics are "sudden, repetitive movements or sounds . . . [that] may or may not be noticeable. *Id.* at 12. The National Institute of Mental Health posits that many of these side effects can be managed by lowering dosage levels. *Id.* Finally, changes in personality are most popularly characterized as seeming emotionless or "flat." *Id.*

38. *Id.* at 13.

hearing voices, having hallucinations, becoming suspicious for no reason, or becoming manic. This happened to patients who had no history of psychiatric problems.[39]

C. Regulation and Reform

Given the prevalence of psychotropic medications in the United States, the serious potential side-effects they carry, and the disproportionate number of foster care children receiving these drugs, one might assume that they are closely regulated and carefully tracked. Such an assumption would be erroneous. As discussed below, psychotropic medications receive little oversight regarding administration and consent procedures. Many states have been prompted, by various motivations, to reform how they administer and track psychotropic medications. This section ends with a look at Michigan's reform efforts in accordance with a consent decree.

1. Tracking Psychotropic Medication: The Tufts Study

In 2010, the Tufts Clinical and Translational Science Institute completed their "Multi-State Study on Psychotropic Medication Oversight in Foster Care."[40] Their findings are startling. Despite the dramatic proliferation of psychotropic medications in the Unites States, only twenty-six states have written policies or guidelines regarding their use.[41] In regards to tracking, approximately twenty-seven percent of states do not track the use of psychotropic medication.[42]

Another concern is that only twenty-five of the participating states used a "red flag" system that prompted further investigation or action upon a peculiar practice taking place.[43] Of the forty-eight participating states, giving a dosage exceeding current maximum recommendations only triggered red flags in fourteen states; not documenting a discussion

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39. *Id.* (emphasis added). The FDA also recommends a health and family history exam before using ADHD medication. *Id.* This may be problematic for children that are in foster care, as their parents may not be present to provide potentially critical information.

40. TUFTS, *supra* note 12.

41. *Id.* at 5. Three to four states did not participate in various parts of the study (one section includes a forty-eight state analysis while another includes only forty-seven states). *Id.* Of the twenty-six states that did have a written policy or guidelines established, over half reported that their motivation to do so was, at least in part, because of a lawsuit or some other negative event, such as media coverage. *Id.*

42. *Id.* at 6.

43. *Id.* at 7.

of the risks and benefits of the drug triggered red flags in only ten states; and the most common red flag—giving young children psychotropic medication—was still only be triggered in twenty-two states.[44]

2. Consenting to Psychotropic Medication in the United States

A recent study sent questionnaires to all fifty states regarding their consent procedures for administering medication to children after parental rights had been terminated.[45] Only twenty-nine states returned completed questionnaires.[46] Michigan did not.[47] Of those states that did respond, eight states required consent from the child's parent or legal guardian, seven states allowed for case workers to provide consent, six states required a court order, and the remainder of states had various other practices.[48]

In addition to these consent requirements, eleven states also incorporated mental health and psychiatric consultation into the consent process.[49] Eleven states have also established programs that monitor psychotropic medication use by children in state custody.[50] Only three states have actually established databases that monitor psychotropic medication usage by children in state care.[51] These databases track who has consented to a particular medication being administered, and allow

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44. *Id.* (providing a complete list of red flag events).

45. Naylor et al., *supra* note 16, at 180. Notably, the study did not request information regarding consent requirements when parental rights had not been terminated. *Id.*

46. *Id.* at 182. Five of these twenty-nine states completed the interviews and questionnaires using information on the state's website (five states). *Id.*

47. Naylor et al., *supra* note 16.

48. *Id.*

49. Naylor et al., *supra* note 16, at 182. In Illinois, for example, the University of Illinois at Chicago is contracted to review all psychotropic medication request. *Id.* These reviews are carried out by "board certified child and adolescent psychiatrists for youth in state care." *Id.* Tennessee requires a psychiatrist from the Department of Children's Services to approve any psychotropic medication requests for children under five years of age. *Id.* at 182-83. If the child is between the ages of six and ten, then a nurse and psychiatrist must approve before the medication can be administered. *Id.* at 183. Additional consultation support is provided by three separate universities when necessary. *Id.*

50. *Id.* at 184. In Florida, for example, each social service report for every review hearing includes an update of the child's current medical and behavioral conditions. Naylor, *supra* note 16, at 184. These reports include all relevant medical records, including the "child's psychotropic medication management." *Id.* The courts in Florida can also order a second opinion regarding the use of psychotropic medication, or order additional consultations. *Id.*

51. *Id.* at 184-85.

for review of "prescribing patterns by placement, discipline, region, or individual clinician."[52]

3. Michigan Regulation

In Michigan, the authority to consent to the medical care of minors and public wards appears in various Michigan statutes, in both broad and specific contexts. Generally, the juvenile code empowers the court to enter orders of disposition regarding the health care needs of a minor under its jurisdiction;[53] the mental health code provides guidelines for the hospitalization of "emotionally disturbed minors;"[54] the public health code involves consent to care related to minors who are substance abusers;[55] and the Youth Rehabilitation Services Act describes the authority and responsibilities given to a youth agency caring for public wards.[56]

The medical treatment of court wards appears to be governed by what is popularly referred to as the Child Care Licensing Act ("the Act").[57] The Act differentiates between routine, nonsurgical medical care and emergency medical and surgical treatment.[58] The Act provides 1) that the court, a child placing agency, or DHS "may consent to routine, nonsurgical medical care, or emergency medical and surgical treatment of a minor child placed in out-of-home care[,] . . ."[59] 2) a child care organization shall also be vested with authority to consent to emergency medical and surgical treatment for children placed in its care; however, 3) whoever places the child (the court, child placing agency, or DHS) has the discretion to *also* authorize the child care organization to consent to routine, nonsurgical medical care for the child.[60] Finally, 4) if a child is placed in a child caring institution, the court, a child placing agency, or DHS must grant it the authority to consent to routine, nonsurgical medical care.[61]

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52. *Id.* Connecticut, Illinois, and Tennessee are the only three states that have established this type of database. *Id.* Child welfare agencies that do not have their own database often work with their state Medicaid programs to oversee psychotropic medication use by children. *Id.*

53. MICH. COMP. LAWS ANN. § 712A.18(f) (West 2011).

54. MICH. COMP. LAWS ANN. § 330.1498a (West 1984).

55. MICH. COMP. LAWS ANN. §§ 333.6123-6131 (West 1987).

56. MICH. COMP. LAWS ANN. § 803.304 (West 1974).

57. MICH. COMP. LAWS ANN. § 722.124(a)(1) (West 1974).

58. *Id.*

59. *Id.*

60. *Id.*

61. *Id.*

The Child Care Licensing Act's definition of "child care organization" includes foster homes.[62] Therefore, a foster home must be given the authority to consent to emergency medical and surgical treatment, and may, at the discretion of whoever places the child (the court, child placing agency, or DHS), be given the authority to consent to routine, nonsurgical medical care.[63] The only circumstance when court involvement may be necessary is when the department responsible for placing the child has not authorized the foster care provider to consent to routine, nonsurgical medical care.[64] In this situation, however, a court order is still unnecessary if the child placing agency or DHS consents to the treatment, as all three entities share this authority under the Act.[65]

III. ANALYSIS

A. Michigan Reform Efforts and Progress

In 2006, the organization Children's Rights brought a class action suit against the State of Michigan on behalf of roughly 19,000 children who were relying on the State's child welfare system.[66] Attempts to settle failed twice before former Governor Jennifer Granholm signed a settlement agreement, which was approved by the court as an enforceable Consent Decree on October 24, 2008.[67]

The Consent Decree explicitly addressed the use of psychotropic medication on foster children.[68] Under its provisions, DHS was required to review its "policies and procedures surrounding the use of

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62. MICH. COMP. LAWS ANN. § 722.111(1)(a) (West 2011).

63. MICH. COMP. LAWS ANN. § 722.124(a)(1) (West 1974). For a child care organization or child caring institution to have consenting authority of any kind, the department placing the child must "execute a written instrument vesting that organization [or institution] with [such] authority . . . ." at the time the child is placed. *Id.* However, if a parent voluntarily places their child in a child care organization, the parent or guardian retains the power to consent to routine, nonsurgical medical care. MICH. COMP. LAWS ANN. § 722.124a(2).

64. MICH. COMP. LAWS ANN. § 722.124a(1).

65. *Id.*

66. *See* Dwayne B. v. Granholm, No. 06 -13548, 2007 WL 1140920 (E.D. Mich. Apr. 17, 2007). The settlement agreement is available at http://www.michigan.gov/documents/dhs/DHS-LegalPolicy-ChildWelfareReform-Settlement_243876_7.pdf [hereinafter "Settlement"]. *See also Michigan Reforms Stall and Too Many Children Remain Stranded in Foster Care; Stable Leadership Needed Immediately,* CHILDREN'S RIGHTS (Mar. 9, 2010), http://www.childrensrights.org/news-events/press/michigan-reforms-stall-and-too-many-children-remain-stranded-in-foster-care-stable-leadership-needed-immediately/.

67. *See* Settlement, *supra* note, at 666.

68. *Id.* at 54.

psychotropic drugs."[69] In addition, DHS needed to set up procedures to document the approval and uses of psychotropic medication, and to review this documentation continually.[70]

DHS has failed to fulfill many of its obligations under the consent decree.[71] A monitoring report issued December 7, 2010 found that DHS has failed to accomplish both of the aforementioned requirements, which were supposed to be completed by January 2009.[72] The monitoring report provided that:

> DHS had issued a Foster Care Policy Bulletin clarifying the consent needed for a child to be prescribed any psychotropic medication, but was still in the process of developing its processes for reviewing prescription, consent and utilization data. DHS is also responsible for undertaking a review of the policies and procedures surrounding the use of psychotropic medications, in close consultation with the monitoring team, which did not occur by the end of Period Three.[73]

As of the most recent monitoring report covering Period Four, which was issued on July 18, 2011, these obligations still have not been met.[74] In fact, DHS has taken a step backward in that the most recent report found that DHS has not yet completed its commitment to ensuring that psychotropic medication is not used "as a method of discipline or control for any child."[75]

The inability of DHS to satisfy these settlement commitments does not bode well for the state of Michigan in the national context. By June

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69. *Id.*

70. *Id.*

71. *See generally* PUBLIC CATALYST, PROGRESS OF THE MICHIGAN DEPARTMENT OF HUMAN SERVICES: PERIOD THREE MONITORING REPORT FOR DWAYNE B. V. GRANHOLM, *available at* http://www.childrensrights.org/wp-content/uploads//2010/12/2010-12-07_mi_monitoring_report_period_3_final.pdf [hereinafter "Monitoring Report"].

72. *Id.* at 68.

73. *Id.* at 70.

74. PUBLIC CATALYST, PROGRESS OF THE MICHIGAN DEPARTMENT OF HUMAN SERVICES: PERIOD FOUR MONITORING REPORT FOR DWAYNE B. V. GRANHOLM, 24 (July 18, 2011), *available at* http://www.michigan.gov/documents/dhs/Sec-5881_MI-Dwayne-B-V-Granholm-Period-4-Report_360703_7.pdf.

75. *Id.* at 24. With the election of Governor Rick Snyder came a modified settlement agreement, which is available at http://www.michiganchildwelfaretraining.com/LinkClick.aspx?fileticket=wMDstGGDxaU%3D&tabid=110. This agreement does not seem to significantly modify any of the DHS commitments regarding psychotropic medications, other than establishing new deadlines for compliance. *Id.*

2012, all states must submit a report to the Federal Department of Health and Human Services' Administration for Children and Families including a "'comprehensive description of procedures and protocols planned or in place to ensure the safe and appropriate use of psychotropic medications[.]'"[76]

Despite these failures, progress is slowly being made, and the consent decree, if ever fully realized, will improve the plight of foster care children. However, the future well-being of these children depends not just on having a set of procedures and guidelines in place, but on ensuring that these protocols are drafted in recognition of the unique circumstances facing foster children.

B. The Unique Nature of Foster Care and the Need for Greater Oversight

Foster children face unique challenges that require additional oversight when psychotropic medication is involved. There are many characteristics unique to foster children that pose potential pitfalls that may expose them to more of the risks of psychotropic medications and less of their benefits. For instance, the Illinois Department of Children and Family Services has recognized the many problems facing foster children in need of medication or counseling, which is worth providing in detail:

> [C]hildren in foster care are treated in multiple settings including psychiatric hospitals, residential treatment centers, juvenile detention facilities, outpatient clinics, and therapeutic day schools. Communication between providers in each of the settings is often quite poor resulting in fragmented psychiatric care. Additionally, the dependable, ongoing therapeutic and caregiving relationships these children desperately need are hampered by the high turnover among child welfare caseworkers and childcare providers. Furthermore, unlike mentally ill children from intact families, often no consistent interested party is available to coordinate treatment planning and clinical care,

76. John Kelly, *Obama Administration Concerned About Psych Meds and Foster Youths*, YOUTH TODAY, (Nov. 29, 2011), http://youthtoday.org/view_article.cfm?article_id=5131.

provide informed consent for treatment, or to provide longitudinal oversight of a foster child's treatment.[77]

1. Increased Parental Involvement Helps Across the Board

If parental rights have not been terminated, the decision whether or not to medicate a child should remain with the natural parents and deference should be given to their decisions.[78] Doing so would remove the problems associated with not having a consistent interested party to oversee the child's care. The right of parents to parent has been articulated by the United States Supreme Court when it opined that "[t]he fundamental liberty interest of natural parents in the care, custody, and management of their child does not evaporate simply because they have not been model parents or *have lost temporary custody of their child to the State.*"[79]

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77. ILL. DEP'T. CHILD. & FAMILY SERVS., GUIDELINES FOR THE UTILIZATION OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN IN FOSTER CARE, *available at* http://www.psych.uic.edu/csp/physicians/Medication%20Guidelines.pdf. Although there are reports that suggest that some psychotropic medications are not being overprescribed, it has been reported that:

> [S]ome of the increase in use may reflect inappropriate diagnosis and treatment. In one study, the rate of stimulant treatment was twice the rate of parent-reported ADHD, based on a standardized psychiatric interview . . . . While many children who do meet the full criteria for ADHD are not being treated, the majority of children and adolescents who are receiving stimulants did not fully meet the criteria . . . . A diagnosis of ADHD requires the presence of impairing ADHD symptoms in *multiple* settings for at least 6 months. Although fidgeting and not paying attention are normal, common childhood behaviors, DSM-IV criteria reserve a diagnosis of ADHD for children in whom such frequent behavior produces persistent and pervasive dysfunction. An adequate diagnostic evaluation requires histories to be taken from multiple sources (parents, child, teachers), a medical evaluation of general and neurological health, a full cognitive assessment including school history, use of parent and teacher rating scales, and all necessary adjunct evaluation (such as assessment of speech, language). These evaluations take time and require multiple clinical skills. Regrettably, there is a dearth of appropriately trained professionals.

U.S. PUB. HEALTH SERV., *supra* note 8, at 149.

78. The obvious problem with this recommendation is that the children are often in custody because of abuse or neglect by their parents; therefore, the parents may be the least qualified to make a decision regarding the child's best interest involving medication. However, if the parent works closely with DHS and ultimately is planning for reunification with their child, then the parent may still be the best choice for being the final decision maker regarding medical treatment.

79. Santosky v. Kramer, 455 U.S. 745, 753 (1982) (holding that the standard for terminating parental rights is clear and convincing evidence, rather than a fair preponderance of the evidence) (emphasis added).

Recent controversies in Michigan have, however unfairly, characterized our administrative and judicial systems as promoting anything but the "fundamental liberty interests" of parents, as illustrated by the highly publicized Godboldo controversy.[80] In 2011, Detroit resident, Maryanne Godboldo, refused to give her daughter an antipsychotic drug that DHS insisted she should be taking.[81] Maryanne's refusal resulted in Child Protective Services (CPS) sending police officers to remove Maryanne's child from her custody under the authority of an insufficient, contradictory court order.[82] The confrontation between Maryanne and the police escalated into a "shootout" in which Maryanne barricaded herself and her daughter inside their home.[83]

2. Parental Representation in Michigan

Michigan law does not require parental approval—even when parental rights have not been terminated—for child to receive psychotropic medication if the child is in foster care, unless the court itself orders the prescription of the medication.[84] Although Michigan case law provides that "[o]nce the family court determines that the child comes within its jurisdiction, it can enter dispositional orders that govern all matters of care for the child[,]"[85] notice requirements to parents whose rights have not been terminated still exist.[86] Absent a court order; however, a foster parent can consent to the use of psychotropic medication without the biological parents' consent under Michigan's current laws.[87]

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80. *Godboldo Testifies In Court About Daughter's Medical Treatment*, CBS DETROIT.COM, (Aug. 6, 2011 12:21 A.M.) http://detroit.cbslocal.com/2011/08/06/godboldo-testifies-in-court-about-daughters-medical-treatment/.

81. *Id.*

82. *Charges Dropped Against Detroit Standoff Mom*, CBS DETROIT.COM, (Aug. 29, 2011, 9:48 PM), http://detroit.cbslocal.com/2011/08/29/charges-dropped-against-detroit-standoff-mom/.

83. *See Detroit Judge Upholds Decision In Standoff Mom's Case*, CBS DETROIT.COM, (Dec. 12, 2011 2:38PM), http://detroit.cbslocal.com/2011/12/12/detroit-judge-upholds-decision-standoff-moms-case/ (explaining how the case ended).

84. *See* MICH. COMP. LAWS ANN. § 333.6123 (7) (West 1987).

85. *In re* AMB, 640 N.W.2d 262, 281 (Mich Ct. App. 2001).

86. *See* MICH. CT. R. 3.921(b)(1)(d).

87. STATE OF MICHIGAN: DHS, FOSTER CARE – DELEGATION OF PARENTAL CONSENT: CHILDRENS FOSTER CARE MANUAL, (2010), *available at* http://www.mfia.state.mi.us/olmweb/ex/fom/722-11.pdf. DHS created a "Childrens Foster Care Manual" in 2010 that requires the consent of a parent or legal guardian for

Given the authority relinquished by parents who have lost temporary custody of their children, it is vital that the public has confidence in the courts and state agencies to provide the best medical care possible to these children. Michigan, like many states, does little to foster such confidence. Of the roughly 8,000 children removed from their parents every year in Michigan, at least half are taken away because of "poverty-related neglect."[88] These impoverished parents are often inadequately represented.[89] A report issued by the Michigan State Court Administrative Office in 2009 found, among other things, that:

> "[H]allway exchanges of information are accepted as a substitute for private office interviews[,]" . . . courts frequently gave parents substitute counsel who had little knowledge of the case and no relationship with the parents[,] . . . parents' attorneys did not advocate for clients outside the courts during the months or weeks between court hearings.[90]

Although these practices are unfortunately all too common in juvenile and family courts across the nation, especially in densely-populated cities, few could argue that such representation is ideal when so much is at stake. Despite the fact that research has shown that quality representation for parents yields shorter stays for children in state custody, thus lowering annual costs for the state,[91] the system will not likely change anytime soon.

Aside from saving money and expediting reunification, increased parental involvement should provide greater oversight as to the efficacy

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the administration of psychotropic medication to temporary court wards. This is a step in the right direction, but is not explicitly required by Michigan law. *Id.*

88. Vivek S. Sankaran, *A Hidden Crisis: The Need to Strengthen Representation of Parents in Child Protective Proceedings*, 89 MICH. B.J. 36, 36 (2010).

89. *Id.*

90. *Id.* at 38. The report also found that most attorneys did not receive compensation for "out of court work." *Id.* The author rightfully recognizes how such a practice discourages adequate advocacy. *Id.*

91. *Id.* at 38. The authors also acknowledge that "[b]y [attorneys] challenging unreliable information and producing independent evidence . . . [they] ensure that courts rely only on the most accurate information available before rendering life-altering decisions." *Id.* at 37. A law office in New York reported that children represented by the Center for Family Representation spent eight-and-one-half fewer months in state custody than when not represented by the Center. *Id.* at 38. Another initiative in Washington "created a parents' representation pilot project that enhanced legal representation to parents by lowering caseloads, increasing compensation, and providing support services such as experts to the lawyers." *Id.* The three year project resulted in a 50% increase in reunification and a 45% decrease in parental terminations. *Id.*

of the medication and the severity of any side effects experienced by the child.

A provision of Michigan's mental health code also, albeit indirectly, supports parental involvement.[92] It provides that the recipient of psychotropic medication must first be given an explanation of the "specific risks and the most common adverse effects that have been associated with that drug . . .[and be provided] with a written summary of the most common adverse effects associated with that drug."[93] For these risks to be fully considered and appreciated, a parent should always be the person providing consent. A parent, more than anyone, has a vested interest in the well-being of their child. Unlike case workers, parents have not been desensitized to the laundry list of side-effects associated with many of these drugs. Additionally, foster parents who take care of multiple children might pay less attention to the risks a medication poses to a particular child if they gave previous children similar medications.

Increasing parental involvement and improving the quality of their representation will ultimately benefit Michigan financially by getting children out of the system sooner, while also ensuring that children are not subjected to unnecessary medications.

C. Legislation Emphasizing Psychotherapeutic Treatment

There is evidence that using psychotherapy serves the best interests of both the child and the state.[94] A report by the American Psychological Association found that a combination of behavioral and pharmacological treatment yields better short-term results than either approach alone, and reduces the dosage of medication necessary.[95] This means fewer side effects for the child, and less money spent by the state on medication.[96] A long term study conducted by the National Institute of Mental Health similarly found that the most effective treatment involved combining both medication and counseling.[97] Such "multisystematic therapy"

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92. MICH. COMP. LAWS ANN. § 330.1719(a)-(b) (West 2011).

93. *Id.* Interestingly, prior to its amendment in 1996, this provision also provided a punishment for violating these requirements, making an offender "guilty of a misdemeanor punishable by a fine of $100.00 or imprisonment for 90 days, or both." *Id.* No such punishment exists anymore. *Id.* It could be argued that reinstating this provision, and even strengthening it, would better serve the interests of children in foster care.

94. *See* Laurie Meyers, *Psychologists and Psychotropic Medication*, 37 AM. PSYCHOL. ASS'N 46, (2006), *available at* http://www.apa.org/monitor/jun06/psychotropic.aspx.

95. *Id.*

96. *Id.*

97. Naylor et al., *supra* note 16, at 1.

(MST) has been shown to decrease recidivism rates among juvenile offenders.[98] One study found a 22% recidivism rate among juvenile offenders subjected to MST, compared to a 71% recidivism rate among juveniles exposed only to psychotherapy.[99] The study noted that juveniles under an MST program "exhibited less aggression with peers and more family cohesion."[100]

Aside from these benefits, additional issues arise when children return home to their parents, who cannot afford the medication their children relied upon during state care.[101] Of all children in the country who spend time in foster care, approximately 59% return to their birth parents.[102] As of March, 2010, there were 16,857 children in Michigan DHS custody.[103] This begs the question; what happens to the thousands of children each year who may have been overly dependent on medication? There simply is a portion of American families that cannot afford private medical insurance but nevertheless do not qualify for public assistance.[104] There have even been instances when parents willfully give up custody of their child to the state just so the child can receive mental health care.[105]

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98. Katner, *supra* note 2, at 577 (citing Lisa M. Dennis & Thomas L. Hafemeister, *Detained Juvenile Offenders with Substance Abuse Treatment Needs: An Examination of Associated Legal Issues*, 1 J. HEALTH & BIOMEDICAL L. 49, 63-64 (2004)).

99. *Id.*

100. *Id.*

101. Katner, *supra* note 2.

102. *Foster Care Facts*, *supra* note 15. Aside from the 59% of children reunited with their birth parents, 16% are adopted, 10% end up living with relatives, 7% are emancipated, and 3% enter into a guardianship. *Id.*

103. MONITORING REPORT, *supra* note 71, at 29.

104. Katner, *supra* note 2, at 547. The authors cite a particular commentator who contributed this:

> [T]here is no audible debate about the federal government's responsibility for the plight of the indigent mentally ill. By excluding from Medicaid reimbursement the majority of mentally ill individuals who need long-term psychiatric care in a hospital, yet permitting payment for "treatment" received elsewhere, the federal government has contributed to the provision of substandard care, as well as to the failure to provide the mentally ill with any care at all. Since many of the most severely mentally ill are also extremely poor, forcing private insurance to cover psychiatric illnesses does nothing to assist those who cannot afford insurance in the first place.

Id. at 548. (citing Joanmarie I. Davoli, *No Room at the Inn: How the Federal Medicaid Program Created Inequities in Psychiatric Hospital Access for the Indigent Mentally Ill*, 29 AM. J.L. & MED. 159, 162 (2003)).

105. *Id.* at 547.

IV. CONCLUSION

Michigan needs new, clear legislation that safeguards children—foster children in particular—from the dangers and potential abuse associated with the prescription of psychotropic medications. Due to the how often these drugs are prescribed and the serious health risks posed, greater oversight is necessary. Although Michigan is making improvements, foster children will be better protected when parental involvement is increased and medication serves as a supplement to psychotherapeutic treatments. The obstacles faced by the foster child population are simply too multifaceted and complex to be solved by a single pill.

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