NOTES

STIMULANT DRUG THERAPY FOR HYPERACTIVE CHILDREN: ADJUDICATING DISPUTES BETWEEN PARENTS AND EDUCATORS

I. INTRODUCTION

This note examines the use of Ritalin and other stimulant drug therapy to treat Attention Deficit Disorder ("ADD") and Attention Deficit Hyperactivity Disorder ("ADHD") in juveniles in the United States. It summarizes the current use of Ritalin and other stimulant drugs in the United States and analyzes the aggressive promotion of Ritalin and other stimulant drugs by educational institutions. This note explores judicial authority to intervene in intra-family decisions regarding the mental health and education of a child pursuant to a state's police power and the doctrine of *parens patriae*. It examines the traditional role of parents, including a constitutional analysis of parental sovereignty, and parents' rights to make decisions on behalf of their children. This note also reviews the right of an individual to refuse unwanted medical treatment, and the role of parents in making this decision on their children's behalf. It then explores the general exceptions to personal and parental autonomy in making medical treatment decisions. Finally, this note advocates alternative forums for the resolution of disputes between parents and the state regarding the propriety of administering Ritalin to correct behavioral problems and assist children with learning disabilities.

II. RITALIN USE IN THE UNITED STATES OF AMERICA

Approximately four to ten percent of all school age children in America suffer from ADHD. ADHD is often manifested by restlessness, distractibility, impulsiveness, excessive motor activity and shortened attention span.[1] The stress of having a

---

[1] *See* James C. O'Leary, Note, *An Analysis of the Legal Issues Surrounding Forced use of Ritalin: Protecting a Child's Right to "Just Say No,"* 27 NEW ENG. L. REV. 1173 (1993). The exact numbers of children who suffer from this disorder, as well as the exact symptoms characteristic of the disorder, are the subject of some disagreement. *See* AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 50 (3d ed. rev. 1987) ("DSM"); AMERICAN MEDICAL ASSOCIATION ENCYCLOPEDIA OF MEDICINE 552 (Charles B.

hyperactive child in the classroom can frustrate educators, resulting in a classification of the child as "learning disabled."[2] In such cases, schools and parents quickly focus on ways to conform the child's behavior to the structured atmosphere of the classroom.[3]

One of the most effective ways of treating a hyperactive child is stimulant drug therapy because it is inexpensive and its effects are immediate.[4] Ritalin, the brand name for methylphenadine hydrochloride, is the most common drug prescribed to treat ADHD.[5] Common side effects of stimulant drugs, like Ritalin, are sleeplessness, nervousness and loss of appetite.[6] Some commonly used stimulants are highly addictive, kill brain cells, cause symptoms of Tourettes Syndrome and hallucinations, disrupt growth hormone production and can lead to depression.[7] The long-term effects of stimulant drugs on a child's brain and development have not yet been determined.[8]

Clayman ed., 1989); Victor W. Henderson, *Stimulant Drug Treatment of the Attention Deficit Disorder*, 65 S. CAL. L. REV. 397 (1991).

[2] O'Leary, *supra* note 1, at 1174.

[3] *See* Peter R. Breggin, M.D., *Vital Information About Ritalin, Attention Deficit Hyperactivity Disorder and the Politics Behind the ADHD/Ritalin Movement* (summarized from Peter R. Breggin, M.D., *Talking Back to Ritalin*, (Common Courage Press 1998)), *available at* <http://www.geocities.com/HotSprings/8568/talking_back_to_ritalin.html>.

[4] *See* Therese Powers, Note, *Race for Perfection: Children's Rights and Enhancement Drugs,* 13 CLEV. ST. UNIV. J.L. & HEALTH 141, 144 (1998-99).

[5] *See* O'Leary, *supra* note 1, at 1175. The Drug Enforcement Agency considers Ritalin a class II drug, in the same class as cocaine, methamphetamine, and methadone. It is not uncommon, however, to find 25% or more of the children on Ritalin in American classrooms. Guy Clavel, *Ritalin Gets a Second Look as U.S. Use Climbs Dramatically*, AGENCE FRANCE PRESSE, Oct. 9, 2000, (quoting the group Parents Against Ritalin). The United States uses 90% of the world's supply of Ritalin. Judy Holland, *Experts Say Kids Are Over-Medicated, Drugs Like Ritalin Overused, Abused*, SAN FRANCISCO EXAMINER, Sept. 30, 2000, at A1. ADHD was only classified by the American Psychiatric Association as a mental illness in 1980. Fred A. Baughman Jr., M.D., *ADD / ADHD, Attention Deficit Disorder, and Ritalin: Immunize Your Child Against Attention Deficit Disorder (ADD)* <http://www.geocities.com/HotSprings/8568/Baughman_MD_Immunize_against_ADD.html> (visited Oct. 18, 2000).

[6] *See* Powers, *supra* note, 4 at 144.

[7] *See* Breggin, *supra* note 3; Holland, *supra* note 5, at A1.

[8] *See* Powers, *supra* note 4, at 144. The potential for dangerous side effects of stimulant drugs in children was illustrated in 1990 in the case of Commonwealth v. Matthews, 548 N.E.2d 843 (Mass. 1990). Fifteen-year-old Matthews was convicted as an adult for murdering his friend with a baseball bat. His lawyer argued that the alteration of brain chemistry caused by Ritalin exacerbated Matthews' mental illness, causing an obsession with killing another student. This has become known as the "Ritalin defense" and illustrates an "extreme, but valid, concern re-

misdiagnosis of ADHD and excessive dispensation of stimulant drugs to children [9] The case was a class action lawsuit filed against a school board, alleging violation of students' constitutional rights to be free from Ritalin and misrepresentation of Ritalin's potential side effects.[10] The plaintiffs claimed that the school board coerced students to take Ritalin.[11] The plaintiffs further alleged fraud and misrepresentation by the American Psychiatric Association for its excessively broad definition of hyperactivity. Purportedly, this definition caused children to be misdiagnosed with ADD and ADHD.[12]

The use of stimulant drugs to treat children has reached such extensive proportions that users of Ritalin in California, Texas and New Jersey filed three separate class action lawsuits in the year 2000. The Texas case names Ritalin's manufacturer, Novartis, the American Psychiatric Association and Children and Adults with ADHD as defendants.[13] The defendants are accused of conspiring, colluding and collaborating to promote the diagnoses of ADD and ADHD.[14] The plaintiffs contend that the influence of pharmaceutical companies over public and private health organizations is responsible for the growing number of "mental illnesses" and the resulting increased use of psychotropic drugs.[15] The New Jersey and California cases, filed in early October 2000, name Novartis and the American Psychiatric Association as defendants, alleging a conspiracy to create a market for Ritalin by targeting millions of children and misdiagnosing them with ADD and ADHD in an effort to expand the market for Ritalin.[16]

III. THE AGGRESSIVE PROMOTION OF RITALIN BY EDUCATIONAL INSTITUTIONS

While parents may choose to treat their children with Ritalin "to avoid the stigmatization of having their child in remedial classes, . . . [t]he ultimate pressure for the use of [R]italin comes from school administrators."[17] Teachers complain that they are unable to teach classes with disruptive students, and suggest that medication is necessary to deter delinquency and occupational failure.[18] Psychiatric ex-

---

[9] This case was unreported. *See* Andrew Blum, *Legal Attack on Ritalin Expands*, NAT'L L.J. Nov. 23, 1987, at 16; O'Leary, *supra* note 1, at 1179 .

[10] *See* Blum, *supra* note 9, at 8.

[11] *Id.*

[12] *Id.*

[13] *See* Kelly Patricia O'Meara, *Writing May be on the Wall for Ritalin,* INSIGHT ON THE NEWS, October 16, 2000, at 16.

[14] *See* Ken Hausman, *Parents Accuse APA, Novartis of Conspiracy Over Ritalin Sales*, PSYCHIATRIC NEWS, Aug. 4, 2000.

[15] O'Meara, *supra* note 13, at 16.

[16] *Id.*

[17] Powers, *supra* note 4, at 147-48.

[18] *See* Patricia Weathers, Congressional Testimony, *Behavioral Drugs in Schools* (Sept. 29, 2000) 2000 WL 23833280; Commonwealth v. Matthews, 548 N.E.2d 843 (Mass. 1990). Additionally, "[s]chools depend on the federal money provided for compliance with programs that address special education legislation and, there-

perts warned Congress that too many educators are urging parents of problem children to treat them with prescription drugs rather than addressing their real problems at home or school.[19] These drugs often compound existing problems, and side effects can lead to further psychiatric misdiagnoses.[20] School officials increasingly pressure parents to give hyperactive children stimulant drugs such as Ritalin, Concerta, Metadate, Dexedrine and Adderall.[21] Parents who resist treating their children with Ritalin have faced the expulsion of their children from school, and recently, courts have mandated medication for disruptive children.[22] Parents increasingly are at risk of judicial findings of educational or medical neglect in family court proceedings if they fail to give their children psychotropic drugs prescribed or suggested by psychiatrists.[23]

Forcing children to take medication such as Ritalin for the sole purpose of controlling disruptive behavior in school, violates their constitutionally protected liberty interest in privacy and bodily integrity, as well as their right to an education pursuant to federal law.[24] Most cases involving forced medication are decided in the context of child neglect, thereby removing parental choice to medicate, even though foregoing treatment may be in their child's best interests.[25] Situations like those experienced by Casey Jesson, Michael Weathers and Kyle Carroll exemplify the types of cases being litigated on this issue.

A. The Jesson Family

Valerie J. v. Derry Cooperative School District is one of the earliest reported cases of parents contesting the right of educators to induce forced medication.[26] After an administrative hearing pursuant to the Individuals with Disabilities Education Act (IDEA), the United States District Court for the District of New Hamp-

---

fore, may give borderline children Ritalin when in fact the child has problems which would be more effectively addressed through other means." Powers, *supra* note, 4, at 149. It is also suspected that school systems are identifying a high percentage of children with ADD/ADHD to get more federal funding. Holland, *supra* note 5, at A1.

[19] Holland, *supra* note 5, at A1.

[20] Weathers, *supra* note 18; Commonwealth v. Matthews, 548 N.E.2d 843 (Mass. 1990).

[21] Holland, *supra* note 5, at A1.

[22] Karen Thomas, *Parents Pressured to Put Kids on Drugs: Court, Schools Force Ritalin Use*, USA TODAY, Aug. 8, 2000, at 1D; John Caher, *Issue Puts Parents, Courts on Collision Course*, N.Y. L.J., Aug. 17, 2000, at 1.

[23] *See, e.g.*, Valerie J. v. Derry Coop. Sch. Dist., 771 F. Supp. 483 (D.N.H. 1991); Weathers, *supra* note 18; Caher, *supra* note 22 at 1.

[24] *See* O'Leary, *supra* note 1, at 1175; U.S. CONST. amend. XIV, § 1.

[25] *See* Valerie J. v. Derry Coop. Sch. Dist., 771 F. Supp. 483 (D.N.H. 1991); Weathers, *supra* note 18; Caher, *supra* note 22, at 2.

[26] 771 F. Supp. 483 (D.N.H. 1991).

shire heard the case on appeal.[27] The plaintiffs alleged that the school district denied the plaintiff's son, Casey, a free appropriate public education, as required by the IDEA, by conditioning his education on his treatment with Ritalin.[28]

The plaintiffs became aware of Casey's hyperactivity in the summer of 1985 and brought him to a pediatrician who prescribed Ritalin, which was to be administered daily by Casey's school nurse.[29] While on Ritalin, Casey continued to struggle in school and began exhibiting behavioral problems at home, including lying, stealing and arguing with family members.[30] Casey's parents noticed that while Casey was less hyperactive while on Ritalin, he also "seemed spacy or drugged and lethargic," with a diminished attention span.[31] All of Casey's neurological examinations throughout this time were normal, although his test scores continued to decline.[32]

An evaluation in 1987 by the Children's Hospital in Boston, Massachusetts indicated that Casey exhibited symptoms of ADD. Accordingly, the hospital issued sixteen recommendations including cooperative learning, structured education and the use of a trial drug, Cyclert.[33] Casey's parents were strongly opposed to the use of Ritalin or any other medication because of their negative side effects.[34] The Derry School District incorporated some of the Children's Hospital's recommendations in its proposed Independent Education Plan (IEP), including medicating Casey with either Cyclert or Ritalin *upon a pediatrician's prescription and parental consent.*[35] In 1988, the Derry school superintendent informed the Jessons that Casey would be suspended for the remainder of the school year if they refused to accept an IEP that included mandated medication.[36]

Although the hearing examiner found that the school district's grounds for suspension were violative of Casey's Due Process Rights, he found that the IEP itself, including its compulsory medication provision, was appropriate.[37] Subsequently, the Jessons appealed the hearing examiner's decision to the United States District Court for the District of New Hampshire.[38] At trial, two experts testified that Ritalin's side effects may cause impairment, as evidenced by Casey's behavior.[39] The district court found that the school district's failure to "implement[] some sort of compromise [with the parents] with respect to the IEP," unreasonable and held that "Casey J.'s right to a free appropriate public education could not be premised on

---

[27] *Id.*
[28] *Id.* at 484.
[29] *Id.*
[30] *Id.*
[31] *Valerie J.*, 771 F. Supp. at 485.
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] *Id.* at 486.
[36] *Valerie J.*, 771 F. Supp. at 486.
[37] *Id.*
[38] *Id.* at 484.
[39] *Id.* at 487.

the condition that he be medicated without his parents' consent."[40]

B. *The Weathers Family*

When Michael Weathers was in first grade, his teachers told his mother that Michael's "learning development was not normal, [and] that he would not be able to learn unless he was put on medication."[41] The school pressured Michael's mother to put him on Ritalin.[42] His teacher filled out a checklist and a pediatrician used it to diagnose Michael with ADHD and prescribe Ritalin.[43] Whereas Michael's teacher was pleased with Ritalin's effects on his classroom behavior, Michael became very withdrawn and stopped socializing with the other children.[44] His condition worsened, and he soon began exhibiting bizarre behavior, resulting in a diagnosis of "Social Anxiety Disorder" two years later.[45] Michael was then placed on an anti-depressant in addition to Ritalin.[46] The combination of these drugs caused Michael to hallucinate and hear a voice "telling him to do bad things."[47] His mother promptly took Michael off the medications, despite the school's and the psychiatrist's insistence that she try alternative prescriptions.[48] When Mrs. Weathers presented research to the principal tending to show that Michael's problems were a product of his daily medications, Michael was dismissed from school.[49]

Consequently, Michael's school reported the Weathers to Child Protective Services.[50] The Weathers were charged with medical neglect for failing to give Michael "the necessary medication" and not hospitalizing him, as advised by a psychiatrist.[51] Michael's mother would have lost custody, had she not obtained an independent psychological evaluation stating that Michael did not require hospitalization.[52]

C. *The Carroll Family*

In the case of the Carroll family, a family court in Albany, New York ordered the parents of a seven year old boy, Kyle, to resume his Ritalin treatment.[53] During the three years that Kyle was taking Ritalin, his personality changed and he became a

---

[40] *Id.* at 490.
[41] Weathers, *supra* note 18.
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] *Id.*
[46] *See* Weathers, *supra* note 18.
[47] *Id.* (internal quotation marks omitted).
[48] *Id.*
[49] *Id.*
[50] *Id.*
[51] Weathers, *supra* note 18.
[52] *Id.*
[53] *See* Thomas, *supra* note 22, at 1D.

"sickly, staring insomniac."[54] In Kyle's case, his "parents were pressured – if not outright ordered – by a judge to give their child the controversial stimulant [Ritalin] after the school district petitioned the court."[55] The Carroll case raises issues regarding privacy rights, judicial authority and parental sovereignty.[56]

The case involved no fact-finding hearing, no testimony and no written decision was issued.[57] The Carrolls, faced with the threat of having Kyle removed from their care, agreed to continue giving him Ritalin until a court-approved medical doctor decided otherwise.[58] The judge's interference with a decision traditionally relegated to the family has been criticized by scholars, the American Psychiatric Association and the National Coalition for Child Protective Reform.[59] On March 20, 2000, the Clinton Administration, concerned with the widespread use of Ritalin by children under six years of age, launched a five-year, six million dollar study of the effects of Ritalin on children.[60]

How should these types of cases be resolved? First, this Note will illustrate how cases like Casey Jesson, Michael Weathers and Kyle Carroll are distinct from traditional cases involving compulsory medication. Most compulsory medication cases involve (a) an individual who poses a danger to himself or others, (b) mentally ill patients who have been involuntarily committed or (c) mentally ill prison inmates. This Note argues that if it is necessary to classify forced Ritalin treatment as medical-care decision making, courts should afford children the same protection that they provide to adult incompetent patients. In the alternative, if the cases must be decided in the neglect context, educational neglect is a more appropriate forum in which to address these cases. Since cases are generally brought by school officials and implicate the educational needs and abilities of children, educational neglect is the correct theory for relief.

IV. PARENTAL SOVEREIGNTY AND THE INTEGRITY OF THE FAMILY UNIT

A. Judicial Respect for Parental Decisions

"The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents . . . is now established beyond debate as an enduring American tradition."[61] The rights to bear and raise children are "essential, basic civil rights of

---

[54] *Justice as a Drug*, BUFFALO NEWS, Editorial Page, Sept. 18, 2000, at 4B.
[55] Caher, *supra* note 22, at 1.
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Justice as a Drug*, *supra* note 54, at 4B.
[60] *Id.*
[61] Troxel v. Granville, 530 U.S. 57, 66 (2000) (finding a Washington statute allowing *any person* to petition the court for child visitation rights violative of a

man, and rights far more precious . . . than property rights."[62] The United States Supreme Court has utilized the Due Process Clause of the Fourteenth Amendment, the Equal Protection Clause of the Fourteenth Amendment and the Ninth Amendment to protect the integrity of the American family.[63] The law presumes that "parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions" and that "natural bonds of affection lead parents to act in the best interests of their children."[64]

Troxel v. Granville, decided in the Supreme Court's 2000 term, confirmed that "the interest of parents in the care, custody and control of their children is perhaps the oldest of the fundamental liberty interests recognized by [the Supreme] Court."[65] The Court analyzed *Troxel* under the Due Process Clause of the Fourteenth Amendment.[66] As early as 1923 in *Meyer v. Nebraska*, the Supreme Court held that parents have the right to "establish a home and bring up children" and "control the education of their own."[67] The Court reaffirmed this holding in *Pierce v. Society of Sisters*, recognizing the "liberty [interest] of parents and guardians to direct the upbringing and education of children under their control."[68] Almost two decades later, the Supreme Court declared "[i]t is cardinal . . . that the custody, care and nurture of the child reside first in the parents . . . ."[69] As the *Troxel* court noted:

> [S]o long as a parent adequately cares for his or her children (*i.e.* is fit), there will normally be no reason for the State to inject itself into the private realm of the family to further question the ability of that parent to make the best decisions

---

mother's constitutional right to direct the upbringing of her children) (internal citation omitted).

[62] Stanley v. Illinois, 405 U.S. 645, 621 (1972) (holding Illinois statute excluding an unwed father from the definition of "parent," and denying him a hearing regarding parental fitness upon the death of the child's mother unconstitutional under Due Process rights) (internal quotation marks and citations omitted).

[63] *Id.* (internal citations omitted).

[64] Parham v. J.R., 442 U.S. 584, 602 (1979) (finding Georgia statute admitting a child to state mental health facilities upon a parent's request to meet minimum Due Process requirements).

[65] *Troxel*, 530 U.S. at 65.

[66] *Id.*

[67] 262 U.S. 390, 399, 401 (1923) (holding that the Fourteenth Amendment protects the plaintiff's right to teach foreign languages and the right of parents to engage plaintiff to teach their children).

[68] 268 U.S. 510, 534-35 (1925) (holding the right of parents to send their children to private or parochial schools to be a protected liberty interest under the Fourteenth Amendment).

[69] Prince v. Massachusetts, 321 U.S. 158, 166 (1944) (holding that a child's guardian was not denied equal protection by child labor law that excluded the child from handing out religious pamphlets on a public street).

concerning the rearing of that parent's children.[70]

It is firmly established in American law that a parent's constitutional right to control the care and custody of his or her children, "includes making major decisions on their behalf," and "only a compelling state interest can limit [a parent's right]."[71]

B. Judicial Authority to Intervene in Parental Decisions

Only in certain, limited situations may the state intervene in medical care decision-making for the general population, through either its police powers or the doctrine of *parens patriae.*

1. Police Power of the States

Police powers are reserved to the states by the Tenth Amendment and may be used to protect the "health, safety, welfare and morals" of its citizens.[72] Pursuant to this power, the Supreme Court has sanctioned – and the states have practiced – the use of chemical and physical restraints on patients posing an immediate threat to himself or others.[73] However, the use of physical and chemical restraints for purposes of administrative or institutional expedience or economic efficiency has been uniformly rejected.[74] Medicating children to obtain passivity is unlikely to be sanctioned as a proper use of state police power.[75]

2. Doctrine of *Parens Patriae*

The doctrine of *parens patriae* defines the authority of the judiciary over moral and social issues, allowing a court to intervene when a child or incompetent adult's

---

[70] *Troxel*, 530 U.S. at 68-69.

[71] Jennifer L. Rosato, *Using Bioethics Discourse to Determine When Parents Should Make Health Care Decisions for Their Children: Is Deference Justified?*, 73 TEMP. L. REV. 1, 6-7 (2000).

[72] U.S. CONST. amend. X.

[73] *See* Washington v. Harper, 494 U.S. 210 (1990); Youngberg v. Romeo, 457 U.S. 307 (1982).

[74] *See* Mills v. Rogers, 457 U.S. 291 (1982); Davis v. Hubbard, 506 F. Supp. 915, 926 (N.D. Ohio 1980) (holding that the use of drugs for convenience or punishment is counter-therapeutic); Rennie v. Klein, 476 F. Supp. 1294, 1299 (D.N.J. 1979) (rejecting use of "drugs as a form of control and as a substitute for treatment"), *modified*, 653 F.2d 836 (3d Cir. 1981), *vacated and remanded*, 458 U.S. 1119 (1982); Rogers v. Commissioner of Dep't of Mental Health, 458 N.E.2d 308, 320-21 (Mass. 1983) (holding drugs used to attain passivity and obedience in patients an abuse of administrative power); O'Leary, *supra*, note 1, at 1202.

[75] *See generally* O'Leary *supra* note 1, at 1202-04.

"best interests" are threatened.[76] Courts generally intervene under this doctrine when parents refuse to provide consent to their child's medical treatment.[77] The Supreme Court has noted that individual states have authority over children's activities that is "broader than over like actions of adults."[78] Courts must remember that "the public has a paramount interest in the virtue and knowledge of its members, and that, of strict right, the business of education belongs to it."[79]

A parent's right to control decisions regarding their children "is a natural, but not an unalienable one."[80] If parents are shown to be "unequal to the task of education, or unworthy of it," their rights may be "superseded by the *parens patriae*, or common guardian of the community[.]"[81] *Parens patriae* is understood to grant the state power to invalidate a parent's decision or restrict parental control to ensure that the "best interests of the child" are met.[82]

Where medication is forced on an adult incompetent patient, the state must show the person would consent to the treatment had she been capable of making the decision herself.[83] Generally the state acts as guardian for one who is a "ward of the state, with nobody to speak on her behalf."[84] With hyperactive children, state guardianship is usually "unnecessary given that a parent will usually be available to fill this role."[85] The protection offered by the state in these cases is "redundant, and may in effect act only as an encumbrance to the will of both parents and student."[86]

C. *The Right to Refuse Medical Treatment*

In the absence of a compelling state interest, an individual has the right to be free from the administration of unwanted psychotropic medication.[87] This right has been recognized pursuant to the rights of privacy and bodily integrity.[88]

The same principles governing a guardian's right to refuse medical treatment for an incompetent patient support the right of a patient to refuse treatment for his or

---

[76] *See generally* U.S. v. Johnson, 28 F.3d 151, 159 (1999).
[77] *See* Newmark v. William/DCPS, 588 A.2d 1108, 1116 (Del. 1990).
[78] *Prince*, 321 U.S. at 168.
[79] *Ex parte* Crouse, 4 Whart. 9, 11 (Pa. 1839).
[80] *Id.*
[81] *Id.*
[82] Bowen v. American Hosp. Ass'n., 476 U.S. 610, 627-28 (1986); *see also* Schall v. Martin, 467 U.S. 253, 265 (1984); *In re* Gault, 387 U.S. 1, 16-17 (1967).
[83] *See* O'Leary, *supra* note 1, at 1205 n.91.
[84] *Id.* at 1205.
[85] *Id.*
[86] *Id.*
[87] *See* U.S. v. Santonio, No. 2:00-CR-90C, 2001 U.S. Dist. LEXIS 5892 (C.D. Utah May 4, 2001).
[88] *See* Washington v. Harper, 494 U.S. 210 (1990); Rogers v. Okin, 634 F.2d 650 (1st Cir. 1980); In re Guardianship of Roe, 421 N.E.2d 40 (1981).

her self.[89] An individual's constitutionally protected right to refuse medical treatment stems from the right to privacy first articulated in *Griswold v. Connecticut*.[90] The *Griswold* court interpreted the right to privacy to include the right to control one's body— a right to personal autonomy.[91] Absent a legitimate state interest in the patient's treatment, and with no less intrusive methods available, the right to privacy bars unwanted medical treatment.[92]

Parental consent is generally required before a doctor may legally treat a minor.[93] This requirement reflects the notion that an "identity of interests between parent and child" exists and the rights of the parents are coextensive with those of the child.[94] Courts assume parents will consult with the clinician and make treatment decisions based upon the child's best interests.[95] Therefore, "[p]arents are permitted to make most decisions for their wards, and society gives them considerable

---

[89] *See* Robert M. Veatch, *Limits of Guardian Treatment Refusal: A Reasonableness Standard*, 9 AM. J. L. & MED. 427, 429 (1984).

[90] 381 U.S. 479, 483 (1965) (holding that the right of privacy derives from penumbras in the Bill of Rights).

[91] *See* Veatch, *supra* note 89, at 429 n.12-13 (citing Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) ("[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body"); Whalen v. Roe, 429 U.S. 589, 599-600 (1977) (expanding the right of privacy to include an "an interest in independence in making certain kinds of important decisions")).

[92] *See* Washington v. Harper, 494 U.S. 210 (1990) (holding that forced medication for inmates did not violate Due Process rights because of extensive procedural safeguards); Winston v. Lee, 470 U.S. 753 (1985) (holding that evidence of forced surgery to remove bullet from respondent's chest for use as evidence violated his Fourth Amendment right to be secure in his person); Youngberg v. Romeo, 457 U.S. 307 (1982) (holding that mentally retarded individual had a liberty interest under the Fourteenth Amendment, requiring the state to provide training to ensure his safety and freedom from undue restraint); Vitek v. Jones, 445 U.S. 480 (1980) (holding that involuntary transfer of prisoner to state mental hospital without notice and adversary hearing violated prisoner's Due Process rights).

[93] A "mature minor" exception to parental consent has developed in recent years. The U.S. Supreme Court has recognized it in at least two contexts. *See* Kelli Schmidt, *"Who are You to Say What My Best Interest is?" Minors' Due Process Rights When Admitted by Parents for Inpatient Mental Health Treatment*, 71 WASH. L. REV. 1187, 1189 (1996) (citing Belotti v. Baird, 443 U.S. 622 (1979) (abortion); Carey v. Population Services Int'l, 431 U.S. 678 (1977) (contraception)). This exception applies when a court deems a parent unfit or unable to provide consent and the child is capable of making an independent decision regarding certain types of medical treatment. *See* Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 712 (1993).

[94] Schmidt, *supra* note 93, at 1189.

[95] *See* Redding, *supra* note 93, at 696.

discretion to make unpopular choices."[96] In *Parham v. J.R.*, the Supreme Court noted that parents may not always act in their child's best interest.[97] However, the Court held that "[s]imply because the decision of a parent is not agreeable to a child or because it involves risks does not automatically transfer the power to make that decision from the parents to some agency or officer of the state."[98] Additionally, the *Parham* court indicated that if parents act in good faith regarding medical care and treatment decisions for their children, "[n]either state nor federal courts are equipped to review such parental decisions."[99]

1. General Exceptions to Personal/Parental Autonomy in Making Medical Treatment Decisions

Correctional and educational institutions also use "best interest" rationales "for the drugging of their populations."[100] State police power is intended to protect the health, safety and welfare of its citizens.[101] States also utilize the *parens patriae* doctrine to protect the mentally incompetent, with a similar rationale for the treatment of children.[102] Proponents of forced medication for children with ADD and ADHD look to a number of exceptions to the right to autonomy in making medical treatment decisions, in order to support forced medication for children in the classroom.

a. Patient Presents a Danger to Herself or Others

Courts may intervene in mental health matters pursuant to state laws, such as New York's Kendra's Law.[103] Kendra's Law is named after Kendra Webdale, who died after a man with an extensive psychiatric history pushed her in front of a moving subway car.[104] The New York Legislature found that "some mentally ill persons, because of their illness, have great difficulty taking responsibility for their

---

[96] Veatch, *supra* note 89, at 446; *see also* O'Leary, *supra* note 1, at 1181 nn. 71, 74; Kathleen Knepper, *Withholding Medical Treatment from Infants: When is it Child Neglect?*, 33 U. OF LOUISVILLE J. OF FAM. L. 1, 35 (1994) ("The child's parents or legal guardians are presumed to have the right to exercise the treatment decision on the child's behalf.").

[97] 442 U.S. 584, 603 (1979).

[98] *Id.*

[99] *Id.* at 603-04.

[100] O'Leary, *supra* note 1, at 1181.

[101] *See* Rogers v. Okin, 634 F.2d 650, 654 (1st Cir. 1980).

[102] *Id.* at 654, 657.

[103] N.Y. MENTAL HYG. LAW § 9.60 (Consol. 2000). Although the laws vary from state to state, the New York law is indicative of typical protections afforded mentally ill adults.

[104] *In re* Urcuyo, 185 Misc. 2d 836, 838 n.1 (N.Y. Sup. Ct. 2000).

own care, and often [voluntarily] reject the outpatient treatment offered to them."[105] To address this problem, courts have given the state power to intervene on the patient's behalf.[106] When the legislature enacted Kendra's Law, it carefully set out extensive criteria that the petitioner must demonstrate in order to warrant court intrusion into mental health care decisions for an individual.[107] Accordingly, courts may order "assisted outpatient treatment," which may include mandated medication.[108] "[T]he petitioner must prove at a hearing, by clear and convincing evidence, that the patient meets each of the criteria enumerated in [the statute]."[109] If the petitioner meets his burden of proof, the patient's physician must testify to the proposed plan and the reasoning behind each treatment element.[110] Further, if medication is recommended, the physician must testify regarding "the types or classes of medication recommended, the beneficial and detrimental physical and mental effects of such medication, and whether such medication should be self-administered or administered by an authorized professional."[111] Additionally, the physician must testify, and the court must find by clear and convincing evidence, "that assisted outpatient treatment is the least restrictive alternative for the patient" pursuant to Kendra's Law.[112]

---

[105] L. 1999, ch. 408, § 1, reproduced in 34A McKinney's MENTAL HYG. LAWS, §§ 1.01-41.36 (McKinney 2000).

[106] *See Urcuyo*, 185 Misc. 2d at 838.

[107] *Id.* at 838-39.

[108] N.Y. MENTAL HYG. LAW §9.60 (a)(1).

[109] *Urcuyo*, 185 Misc. 2d at 838. N.Y. MENTAL HYG. LAW § 9.60(c) sets out the criteria as follows:

(1) the patient is 18 years of age or older; and
(2) the patient is suffering from a mental illness; and
(3) the patient is unlikely to survive safely in the community without supervision, based on a clinical determination; and
(4) the patient has a history of lack of compliance with treatment for mental illness that has:
    (i) at least twice within the last 36 months been a significant factor in necessitating hospitalization . . . or
    (ii) resulted in one or more acts of serious violent behavior toward self or others . . . and
(5) the patient is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment pursuant to the treatment plan; and
(6) in view of the patient's treatment history and current behavior, the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others . . . and
(7) it is likely that the patient will benefit from assisted outpatient treatment.

[110] *See Urcuyo*, 185 Misc. 2d at 838.

[111] *Id.* (quoting N.Y. MENTAL HYG. LAW § 9.60 (i)(2)).

[112] *Id.* at 845.

Although Kendra's Law does not apply to children,[113] it illustrates the degree of care provided to situations involving mandated medication for adults.[114] The objective criteria allow temperate application to cases involving a mentally ill patient who presents a danger to herself or others.[115] Requiring the physician to testify to the proposed medication insures that the court learns about possible detrimental side effects of medication, and that the least restrictive treatment plan is imposed.[116]

In the Ritalin cases, most of the children do not pose a serious risk to themselves or others, nor do they have an extensive history of mental illness or hospitalization.[117] In fact, many children are dangerous only after suffering adverse side effects from their stimulant therapy.[118] However, enacting or applying a statutory scheme like Kendra's Law to cases involving hyperactive children would afford the families much more protection than current law. Additionally, it would assure that an intelligent, informed decision is made as to the desirability or necessity of mandated medication for children.

b. Institutionalized Mentally Ill Patients

The federal courts first addressed this issue in *Rogers v. Okin*.[119] In *Rogers* the court delineated the circumstances under which state officials may forcibly administer antipsychotic drugs to involuntarily institutionalized mental health patients without violating their Fourteenth Amendment rights.[120] The court found that a constitutionally protected liberty interest exists regarding a patient's decision to submit to the administration of antipsychotic drugs.[121] However, two sets of circumstances can defeat this liberty interest in freedom from unwanted medication.[122] Pursuant to the police power, states have a valid interest in "protecting persons from physical harm at the hands of the mentally ill."[123] The state's interest therefore provides justification for forcible administration of drugs to the mentally ill regardless of their legal competence.[124] This theory applies only in emergency situations presenting a "substantial likelihood" that the patient may physically harm himself or others.[125] Second, the state may intervene under its *parens patriae* power to forcibly administer drugs to patients incapable of making competent deci-

---

[113] N.Y. MENTAL HYG. LAW § 9.60(c)(1).
[114] *See Urcuyo*, 185 Misc. 2d at 837-42.
[115] *Id.*
[116] *See* N.Y. MENTAL HYG. LAW § 9.60(h)(4).
[117] *See, e.g.*, Valerie J., 771 F. Supp. 483; Weathers, *supra* note 18; Caher, *supra* note 22 at 1.
[118] *See* Commonwealth v. Matthews, 548 N.E.2d 843 (Mass. 1990).
[119] 634 F.2d 650 (1st Cir. 1980).
[120] *Id.*
[121] *Id.* at 653.
[122] *Id.* at 654.
[123] *Id.* at 657.
[124] Rogers v. Okin, 634 F.2d 650, 654 (1st Cir. 1980).
[125] *Id.*

sions.[126] Under Massachusetts law, as applied in *Rogers v. Orkin*, the state must presume that all involuntarily committed patients are competent to assert his or her liberty interest.[127] Under either theory of interference, the court opined that advances in antipsychotic drugs offer a greater possibility of improved behavior from forced treatment.[128]

The United States Supreme Court granted certiorari in *Rogers v. Orkin*, and discussed the cogency of the First Circuit's opinion. However, due to an intervening Massachusetts state court ruling, the Court found it unnecessary to articulate the substantive bounds of the constitutional issues.[129] The Court recognized that state law may afford greater protections than the federal Constitution, and therefore it remanded *Rogers* for further proceedings, consistent with state law.[130] In *In re Guardianship of Roe*, the Supreme Judicial Court of Massachusetts addressed whether a non-institutionalized but mentally incompetent person has a right to refuse treatment with antipsychotic drugs.[131] The court based its decision on the common law of Massachusetts and the federal Constitution.[132] The *Roe* court held that only an "overwhelming state interest" can supersede an individual's significant liberty interest in freedom from unwanted medication.[133] Further, the court held that a person's liberty interest is not forfeited by a finding of incompetence, since a parent or interested party can substitute her judgment for which "[no] medical expertise is required."[134]

If courts employed the "substituted judgment" standard articulated in *Roe*, a parent would be appointed guardian to make decisions for his or her child.[135] Parents are in the best position to determine the best interests of their child.[136]

c. Inmates and Institutional Safety

Similar considerations of institutional safety are often discussed in the context of inmates who are restrained by physical or medical means. *Washington v. Harper* emphasized the need for order and safety in state penitentiaries.[137] In *Harper*, the Supreme Court enunciated the protections afforded to a prisoner pursuant to the Due Process Clause of the Fourteenth Amendment.[138] Following a robbery con-

---

[126] *Id.* at 657.
[127] *Id* at 658.
[128] *Id.* at 657.
[129] Okin v. Rogers, 451 U.S. 906 (1981), *vacated sub nom,* Mills v. Rogers, 457 U.S. 291 (1982).
[130] *Mills*, 457 U.S. at 306.
[131] 421 N.E.2d 40 (1981).
[132] *Id.*
[133] *Id.* at 51.
[134] *Id.* at 51-52.
[135] *See supra* notes 76-77 and accompanying text.
[136] *Id.*
[137] 494 U.S. 210 (1990).
[138] *Id.*

viction, defendant Harper was incarcerated at the Washington State Penitentiary from 1976 to 1980. While temporarily on parole, Harper consented to the administration of psychotropic drugs to treat his mental illness.[139] When Harper was transferred to the Special Offender Center (SOC), a state institute for felons with serious mental illnesses, staff psychiatrists diagnosed him with a manic-depressive disorder and forced him to take medication against his will, pursuant to SOC policy.[140] Under this policy, a psychiatrist may only subject an inmate to involuntary medication if he "(1) suffers from a mental disorder and (2) is gravely disabled or poses a likelihood of serious harm to himself, others, or their property." [141] The SOC policy entitled the inmate to an administrative hearing before disinterested parties, and periodic review of his treatment.[142]

The Court recognized that Harper "possessed a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment," but determined that "the extent of a prisoner's rights . . . must be defined in the context of the inmate's confinement."[143] The Court opined that "[t]here are few cases in which the State's interest in combating the danger posed by a person to both himself and others is greater than in a prison environment, which, by definition, is made up of persons with . . . proclivity for antisocial criminal, and often violent, conduct."[144] The Court held that the administrative proceeding satisfied procedural due process requirements and negated the need for a judicial hearing.[145] The Court determined that the state's regulation was an "accommodation between an inmate's liberty interest in avoiding the forced administration of antipsychotic drugs and the State's interests in providing appropriate medical treatment to reduce the danger that an inmate suffering from a serious mental disorder represents to himself or others," and that it complied with all procedural and substantive due process requirements.[146]

In *New Jersey v. T.L.O.*, regarding the rights of students to be free from unreasonable searches and seizures in an educational institution, the Supreme Court noted:

> Although this Court may take notice of the difficulty of maintaining discipline in the public schools today . . . it goes almost without saying that "[t]he prisoner and the schoolchild stand in wholly different circumstances, separated by the harsh facts of criminal conviction and incarceration." We are not yet ready to hold that the schools and the prisons need be equated for purposes of the Fourth

---

[139] *Id.* at 213.
[140] *Id.* at 213-16.
[141] *Id.* at 215 (internal citations omitted).
[142] *Harper*, 494 U.S. at 215.
[143] *Id.* at 221-22.
[144] *Id.* at 225 (internal citations omitted).
[145] *Id.* at 231.
[146] *Id.* at 236.

Amendment.[147]

It is beyond question that a hyperactive six-year-old child is not dangerous in the same sense that a mentally ill prisoner or mental patient may be. As illustrated previously, courts and legislators emphasize that immoderate behavioral controls, such as forced medication, be used primarily for purposes of health and safety, and never as a means of maintaining order or administrative convenience.[148] Applying this reasoning to the Ritalin cases, courts must decide whether the behavior of a child has become so extreme as to establish a threat of violence or danger to themselves or others such that immoderate behavioral controls would be warranted. In the majority of cases, it is apparent that the child's capacity and potential for violence is not nearly as imminent as the threat posed by a violent inmate or an involuntarily committed mental patient.[149]

A hyperactive child "presents an entirely different situation from that of an adult with an established pattern of violent behavior."[150] The actual threat of danger or violence from a hyperactive child is insignificant in comparison to a violent adult.[151]

> The fact that a hyperactive child may resort to a physical solution [to remedy their problems in school] may make them bullies, but it should not put them in the same class as the violently insane. Annoying they may be, but "it is clear that the threat of harm to self or others does *not* include the mere potential for throwing pen caps or erasers."[152]

This "strongly suggests the illegality and impropriety of state mandated drugging of hyperactive children," under the police power.[153] While the state's police power may justify forced use of Ritalin in exceptional cases, it does not grant the state pervasive authority to require chemical restraint of hyperactive children.[154]

d. Neglect

Abuse and neglect proceedings are essentially intra-family processes in civil or family court. The state will intrude into the life of a child under its *parens patriae*

---

[147] 469 U.S. 325, 338-39 (1985) (quoting Ingraham v. Wright, 430 U.S. 651, 669 (1977)).
[148] O'Leary, *supra* note 1, at 1192.
[149] *Id.* at 1203.
[150] *Id.* at 1203-04.
[151] *Id.* at 1204.
[152] *Id.* (quoting Plaintiff's Trial Memorandum at 26, Valerie J. v. Derry Coop. Sch. Dist., 771 F. Supp. 483 (D.N.H. 1991)).
[153] *Id.* at 1192.
[154] O'Leary, *supra* note 1, at 1204.

power, to protect children whose "best interests" are endangered.[155] States usually define "child neglect" by a statutory enumeration of specific harms.[156] Cases are initiated by reporting statutes, which mandate that specified individuals, namely teachers, doctors and social workers, report suspected abuse or neglect.[157] If a court finds a child to be suffering from one of these enumerated harms, it makes a finding of neglect, and intervenes to fashion a remedy.[158] A finding of abuse or neglect does not require the removal of the child from his home, but it is a common solution.[159]

"Current reform in child neglect law generally follows three interrelated principles in factoring a child's best interests into child neglect statutes."[160] First, acts or omissions warranting state intervention should be defined narrowly, preventing judges from making subjective determinations.[161] Second, consistent with the notion of parental sovereignty, the state should only interfere when there is a serious threat of harm to the child.[162] Finally, courts should only interfere where it is more beneficial than detrimental to the child.[163]

1. Medical Neglect

Most cases in which parents refuse medical treatment for their children are treated as ordinary medical neglect cases.[164] While a parent has a fundamental right to raise his or her child,[165] he or she also has an affirmative duty to provide adequate medical care to the child.[166] "What constitutes adequate medical care, however, cannot be judged in a vacuum free from external influences, but, rather, each case must be decided on its own particular facts."[167] A medically neglected child is defined by the New York Family Court Act as "a child less than eighteen years of age whose physical . . . condition has been impaired . . . as a result of the failure of his parent . . . to exercise a minimum degree of care in supplying the

---

[155] *Id.* at 1205; *see also* Ex Parte Crouse, 4 Whart. (Pa.) 9 (1839); Prince v. Massachusetts, 321 U.S. 158 (1944); In the Matter of Lori M., 496 N.Y.S.2d 940 (Fam. Ct. 1985); N.Y. FAM. CT. ACT § 1011 (Consol. 1998).

[156] *See* N.Y. FAM. CT. ACT § 1012(f) (Consol. 1998).

[157] *See* N.Y. SOC. SERV. L. § 413 (Consol. 2001).

[158] *See* N.Y. FAM. CT. ACT § 1051-59 (Consol. 1998).

[159] *See* N.Y. FAM. CT. ACT § 1055(b)(1) (Consol. 1998).

[160] Eric W. Johnson, *Educational Neglect as a Proper Harm to Warrant a Child Neglect Finding:* In re B.B., 76 IOWA L. REV. 167, 181 (1990).

[161] *Id.*

[162] *Id.* at 181-82.

[163] *Id.* at 182.

[164] *See* Valerie J., 771 F. Supp. 483; Weathers, *supra* note 18; *but see* Caher, *supra* note 22, at 1 (employing theory of educational neglect in Ritalin case).

[165] *See* Quilloin v. Walcott, 434 U.S. 246, 255 (1978).

[166] *See* N.Y. FAM. CT. ACT § 1012(f)(i)(A) (Consol. 1998).

[167] *In re* Hofbauer, 393 N.E.2d 1009, 1013 (N.Y. 1979).

child with adequate . . . medical . . . care, though financially able to do so."[168] "[T]he statute may be interpreted to include psychiatric medical care where it is necessary to prevent the impairment of the child's emotional condition."[169] And while a court "may intervene to ensure that a child's health or welfare is not being seriously jeopardized by a parent's fault or omission," the court should afford great deference to a parent's choice in medical treatment.[170]

While courts have allowed parents to refuse medical treatment for their children in certain significant situations, "inconsistencies within states and between states in factually similar cases have made it difficult to predict when and to what extent courts will intervene."[171] The only situation in which courts across the board seem willing to intervene is where the child's life is in immediate jeopardy.[172] For example, in *State v. Perricone*, the New Jersey Supreme Court ordered a blood transfusion for a critically ill child over the religious objection of the parents.[173] "[T]he preservation of life is a goal of the highest priority, and courts do and should override parental objections, allowing the state to intervene to save a child's life with appropriate medical care."[174]

The United States Supreme Court seems to be in accord with the New Jersey Supreme Court regarding intervention in life-or-death situations.[175] In *Jehovah's Witnesses v. King County Hospital*, the Supreme Court affirmed a lower court decision, without opinion, allowing child blood transfusions incident to surgery, over the religious objections of the parents.[176] Though most medical neglect cases are not so clear cut, they generally fall into three categories: (1) the physical health of the child is impaired, but his or her life is not in immediate jeopardy, (2) the child suffers from emotional difficulties due to a correctable physical deformity, and (3) the child suffers from mental illness or behavioral disorder.[177]

In the first category of cases, where the child's physical health is jeopardized but not immediately life-threatening, courts give a great amount of deference to the de-

---

[168] N.Y. FAM. CT. ACT § 1012(f)(i)(A).

[169] *In re* Felicia D., 693 N.Y.S.2d 41, 42 (N.Y. App. Div. 1999).

[170] *Hofbauer*, 393 N.E.2d at 1013 (citing Wisconsin v. Yoder, 406 U.S. 205, 233-34 (1972)); *see also* Prince v. Massachusetts, 321 U.S. 158, 166-67 (1944); Matter of Vasko, 263 N.Y.S. 552, 555 (N.Y. App. Div. 1933).

[171] Elizabeth J. Sher, Note, *Choosing for Children: Adjudicating Medical Care Disputes Between Parents and the State*, 58 N.Y.U. L. REV. 157, 159 (1983) (internal citations omitted).

[172] *See id.* at 162.

[173] 181 A.2d 751 (N.J. 1962).

[174] Sher, *supra* note 171, at 162.

[175] *See* Jehovah's Witnesses v. King County Hospital, 390 U.S. 598 (1968) (per curiam) (affirming lower court decision authorizing child blood transfusions over parental objections); Perricone, 181 A.2d 751 (N.J. 1962).

[176] 278 F. Supp. 488 (W.D. Wash. 1967), *aff'd per curiam*, 390 U.S. 598 (1968).

[177] *See In re* Philip B., 156 Cal. Rptr. 48 (Cal. Ct. App. 1979), *cert. denied sub nom.*, Bathmar v. Warren B., 445 U.S. 949 (1980); *In re* Seiferth, 127 N.E.2d 820 (N.Y. 1955); Sher, *supra* note 171, at 194-200.

cision of the parents.[178] In *In re Philip B.*, a California appellate court refused to order corrective surgery for a child's congenital heart defect even though it may have improved the child's quality of life, and possibly lengthened his life expectancy.[179] The court articulated four factors to consider in making treatment decisions: (1) the evaluation of treatment by medical staff; (2) the risks involved in the treatment; (3) the harm the child is likely to suffer or presently suffering; and (4) the child's preference.[180]

In *Matter of Hofbauer*, the child suffered from Hodgkin's disease, which is typically fatal if not treated.[181] In lieu of the radiation treatment and chemotherapy that the child's physicians recommended, the parents elected for nutritional therapy for their child.[182] Deferring to the parents' decision, the New York Court of Appeals determined that the parents were entitled to choose their child's course of treatment, provided that two requirements were met: (1) the parents sought licensed medical assistance when an ordinarily prudent and loving parent would have done so; and (2) the course of treatment had "not been totally rejected by all responsible medical authority."[183] The *Hofbauer* court affirmed the ruling of the lower court, finding that the parents' actions did not constitute neglect.[184]

In cases where a physical deformity has contributed to impairing the child's mental health, the results have been less consistent. In *In re Seiferth*, a father objected to relatively routine surgery to correct his son's cleft palate and harelip.[185] The treatment was refused based on the family's belief in spiritual healing and opposition to surgery.[186] Although the child was deemed legally incompetent as a minor, the New York Court of Appeals refused to disturb the decision of the family, finding the father's choice sufficiently reasonable to accord deference.[187] It is significant to note that in the *Seiferth* case, there was scant evidence regarding the detrimental effects of the cleft palate and harelip on the child.[188]

In a factually similar case, *In re Sampson*, a fifteen-year-old boy had a serious facial deformity due to neurofibromatosis.[189] The boy suffered emotionally and did

---

[178] Newmark v. Williams, 588 A.2d 1108 (Del. 1991).
[179] *In re Philip B.*, 156 Cal. Rptr. at 52.
[180] *Id.* at 51.
[181] *Hofbauer*, 393 N.E.2d at 1011.
[182] *Id.*
[183] *Id.* at 1014
[184] *Id.* at 1015; *but see* Custody of a Minor, 379 N.E.2d 1053 (Mass. 1978) (holding that the state's duty to enforce the child's best interests outweighed the family's rights of privacy and autonomy in requiring chemotherapy treatment for child's acute lymphcytic leukemia).
[185] 127 N.E.2d 820 (N.Y. 1955).
[186] *Id.*
[187] *Id.*
[188] *Id.* at 822.
[189] 317 N.Y.S.2d 641 (N.Y. Fam. Ct. 1970), *aff'd* 323 N.Y.S. 2d 253 (N.Y. App. Div. 1971), *aff'd* 278 N.E. 2d 918 (N.Y. 1972).

not attend school because of the deformity.[190] At fifteen years of age, the child remained virtually illiterate.[191] Although surgery would improve his appearance, it offered no physical health-related benefits and involved significant risks.[192] The mother, a Jehovah's witness, refused to authorize the surgery on grounds that blood transfusions were entailed, a procedure that offended her religious beliefs.[193] Nevertheless, the court deferred to the judgment of the surgeons, found the boy to be "neglected" and ordered the mother to authorize the surgery and any necessary blood transfusions.[194]

The third category of cases, where the child's alleged impairment is not physical, but emotional or behavioral in nature, poses the greatest challenge to courts adjudicating health care disputes between parents and the state.[195] Courts must weigh many factors to decide whether or not to interfere with a parental decision regarding mental health care.[196] Among the factors that should considered are: (1) consensus or disagreement regarding diagnosis and proposed treatment; (2) the extent to which the proposed treatment will help the child; (3) if the child's treatment was terminated by his parents, the positive as well as the detrimental effects of such treatment on the child; (4) the child's ability to function on a normal level with and without treatment; (5) alternatives to the proposed treatment; and (6) the danger a child may pose to herself or the community. Since assessing the problem in these cases is quite complex, and the elements extremely subjective, determining a solution is particularly difficult, as "the degree of government intrusion varies when the state is seeking court permission to facilitate diagnosis and evaluation on the one hand, and court-ordered treatment on the other."[197]

In many medical neglect cases, particularly those involving mental health related questions, courts face a quagmire.

> Although the parents' conduct arguably satisfies the broad statutory language defining neglect, it does not satisfy the normative definition of neglect that underlies these statutes. The prototypical parent in these denial-of-treatment cases is a parent who denies treatment to the child in good faith, in order to adhere to the dictates of the parent's or child's religion, or to reduce the child's suffering. This image stands in contrast to the prototypical "neglectful" parent, whose omissions violate the social consensus of good parenting and thus warrant state intervention under the traditional neglect statutes.[198]

---

[190] *Id.* at 644.
[191] *Id.*
[192] *Id.* at 645.
[193] *Id.* at 645-46.
[194] *In re Sampson*, 317 N.Y.S.2d at 641.
[195] Sher, *supra* note 171, at 197.
[196] *Id.*
[197] Sher, *supra* note 171, at 198.
[198] Rosato, *supra* note 71, at 26.

This situation presents a dilemma for family court judges, because a finding of neglect is necessary to mandate treatment. However, frequently the judge does not believe that the parents are "neglectful" as the term is generally understood.[199] In the *Matter of Christine M.* the child's father refused to authorize an immunization during an outbreak of measles which, the physician surmised, placed Christine in danger of contracting the disease.[200] Although Christine was deemed a "neglected" child, the court limited the term to its "legal definition . . . and in no way suggested that the [father] failed in his parental duty to his daughter in any other respect."[201]

In cases where a treatment "might have benefits for an incompetent patient but the treatment is not necessary to preserve the life of the patient," guardians should be allowed to refuse treatment if reasonable people could disagree about the benefits of the treatment as well as its risks.[202] Frequently, the child's physician, educators or child welfare personnel assume that a child's parents should not be allowed to make treatment decisions.[203]

Commentators advance the argument that courts are equipped to adjudicate mental health disputes between states and parents of hyperactive children, because courts "have generally been held competent to adjudicate mental illness questions . . . with regard to civil commitment and insanity . . . ."[204] As discussed previously, however, children and their parents are not afforded the same procedural safeguards given adult incompetent patients.[205]

2. Educational Neglect

The educational neglect framework may be a more appropriate context than medical neglect for adjudicating disputes between educational institutions and parents of hyperactive children. In cases pertaining to ADD or ADHD and treatment with Ritalin, the disagreement arises in the educational context, as to whether a parent's refusal to medicate their child deprives the child of a meaningful education.[206] Against this backdrop, the court will focus on the educational needs of the child, and not the treatment of behavioral or emotional disorders, or mental health and impairment.

Approximately one half of all states allow educational neglect as a ground for finding parental child neglect.[207] This is an exercise of the states' *parens patriae* power, as the lack of a proper education "can pose an insurmountable obstacle to

---

[199] Sher, *supra* note 171, at 202.
[200] 595 N.Y.S.2d 606, 607 (N.Y. Fam. Ct. 1992).
[201] *Id.* at 618.
[202] Veatch, *supra* note 89, at 451.
[203] Knepper, *supra* note 96, at 35-36.
[204] Sher, *supra* note 171, at 200.
[205] *See* N.Y. MENTAL HYG. LAW § 9.60 (Consol. 2000).
[206] Unless the child poses a danger to herself or others in the classroom, in which case, "medical" neglect may be a more conducive forum, in the context of mental health. *See* N.Y. MENTAL HYG. LAW § 9.60 (A)(1).
[207] Johnson, *supra* note 160, at 168 n.6.

the child's future."[208] Common educational neglect cases involve parents who do not send their children to school at all, or fail to deter truancy.[209] *In re Devone* is a typical case in which a moderately retarded child was deemed to be educationally neglected based on his parents' decision to provide home schooling.[210] The court found that home schooling denied the child of the right to attend special education classes which were critical to his welfare and development.[211]

In *Wisconsin v. Yoder*, the United States Supreme Court recognized an exception to a state's requisite education laws.[212] The *Yoder* court found that Wisconsin's compulsory education laws unduly burdened the Free Exercise Clause of the First Amendment by forcing Amish parents to send their children to school beyond the eighth grade, over their objections on religious grounds.[213] While recognizing that states may impose reasonable regulations regarding education, the *Yoder* court affirmed that a state must balance its interest in universal education against the parents' rights to direct the education of their children.[214]

One commentator advocates for a "liberal parentalism" approach to determining a child's educational rights.[215] This theory promotes deference "to parents' educational choices unless they are plainly unreasonable," since "custodial parents are more likely than the state or its agents faithfully to discover and pursue the child's welfare, defined by reference to some reasonable view of the good life and of the child's interests in living such a life."[216] This approach supports the view that "the majority ought not substitute its educational judgment for that of the child's custodial parents merely because it disagrees with their reasonable conception of the child's emotional good."[217] Only in instances where a parent's educational decisions are "plainly unreasonable" should states interfere.[218]

In the cases of the Jesson, Weathers and Carroll families, the parents were motivated by the best interests of their children in their pursuit of alternative treatment plans. Although these parents initially agreed to stimulant drug therapy to treat their hyperactive children,[219] it was only after the children began exhibiting unfavorable side effects and declining emotional health that they sought alternative

---

[208] *Id.* at 179.
[209] *See In re* Devone, 336 S.E.2d 389 (N.C. App. 1987); *In re* B.B., 440 N.W.2d 594 (Iowa 1989).
[210] *See In re Devone*, 336 S.E.2d at 390-91.
[211] *Id.*
[212] 406 U.S. 205, 234 (1972).
[213] *Id.* at 214.
[214] *Id.* at 214-15.
[215] Stephen G. Gilles, *Liberal Parentalism and Children's Educational Rights*, 26 CAP. U.L. REV. 9 (1997).
[216] *Id.*
[217] *Id.* at 10.
[218] *Id.*
[219] *See Valerie J.*, 771 F. Supp. at 483; Weathers, *supra* note 18; Thomas, *supra* note 22, at 1D; *Justice as a Drug*, *supra* note 54, at 4B; Caher, *supra* note 22, at 2.

treatments.[220] The parents' desire to cease the administration of psychotropic drugs to their children was not unreasonable in light of the circumstances under which the decisions were made.

V. CONCLUSION

From the beginning of time, little boys have been impulsive, hyperactive and distractible. Until recently, these behaviors have not been perceived by educators as constituting a "behavioral disorder" warranting such extreme action as compulsory medication. The modern trend to medicate children for administrative convenience in schools is alarming. An exorbitant amount of children in the United States have been diagnosed with ADD and ADHD, often from checklists provided to teachers by the school district, with little or no contact with the medical personnel who prescribe drugs to treat this behavioral problem.[221] The amount of contact children have with educators is scant compared to the time children spend with their parents. In light of this extensive contact, parents are in a better position to determine the needs of their children.

The decision whether to medicate children with behavioral problems in school is a very difficult one. The treatment may affect their health as well as their educational opportunities. While educators focus on their own immediate concerns – the ability to teach classes effectively, without disruption – parents are more likely to focus on the long-term needs and best interests of their children. While parents may agree to medicate with stimulant drugs, often to avoid placement of their children in remedial classes, educators are too rash in advocating medication to address children's problems. Rather, educators should explore other means of resolving a child's behavioral problems. Stimulant drugs often substitute existing problems with new ones, as demonstrated in the cases of the Jesson, Weathers and Carroll families.

A school district's allegation that parents are neglecting their child when refusing medication to correct a behavioral problem is inappropriate and astonishing. Parents' rights to direct the upbringing of their child have long been afforded constitutional protection under the Equal Protection and Due Process clauses of the Fourteenth and Ninth Amendments. A parent is deemed to "possess what a child lacks in maturity, experience and capacity for judgment," and accordingly, has always been entrusted to make important decisions on the child's behalf.[222] Amongst these decisions is the right to accept or refuse medical treatment.

Only in extraordinary circumstances may a state intervene and remove the decision making power from the parents. A state may act under its police powers to protect the health, safety, welfare or morals of its citizenry, and mandate medication only if the patient poses a danger to himself or others.[223] This power has been

---

[220] *Id.*

[221] *See* Weathers, *supra* note 18.

[222] *Parham v. J.R.*, 442 U.S. at 602.

[223] *See* Washington v. Harper, 494 U.S. 210 (1990); Youngberg v. Romeo, 457 U.S. 307 (1982).

exercised by the states in cases of dangerous mentally ill persons, as well as dangerous inmates.[224] The rationale for institutional safety in prisons and mental hospitals, to control disruptive behavior, has often been utilized by schools.[225] However, courts have uniformly rejected the use of medication for purely administrative or economic convenience, and hence, the schools' arguments must fail on these grounds.[226] Deciding forced medication for ADD/ADHD children under the protection of statutes designed for adjudication of forced medication for adults would afford much greater protection to children and their parents than they are currently afforded in neglect proceedings.

Under its *parens patriae* power, states may intervene to protect incompetent citizens, both adults and children.[227] It is established that a state my use this power to override a parent's decisions if those decisions threaten the child's "best interests."[228] However, in cases implicating an individual's right to refuse medical treatment, and the parent's right to refuse stimulant drugs on behalf of their child, "medical" neglect, under which most of there cases are brought, is an inappropriate forum.

Individuals have a constitutionally protected liberty interest in being free from unwanted medical treatment.[229] Unless there is a legitimate state interest in the treatment, and no less intrusive means available, the individual's right to refuse treatment is absolute.[230] Parental consent is required before any medical treatment may be administered to a child.[231] The parents' and child's interests are viewed as co-extensive, and courts presume that parents will make medical decisions that comport with their child's best interests.[232]

In cases of mentally incompetent adults, the state may step in to appoint a guardian, who may allow or refuse treatment on behalf of the incompetent individual, because there is no one to look out for their "best interests." This is not the case with legally incompetent minors. They have built-in guardians - their parents.

Most of the cases in which parents refuse the administration of Ritalin to their

---

[224] *Id.*

[225] *See* O'Leary, *supra* note 1, at 1180.

[226] *See* Mills v. Rogers, 457 U.S. 291 (1982); Davis v. Hubbard, 506 F. Supp. 915, 926 (N.D. Ohio 1980) (holding that the use of drugs for convenience or punishment is counter-therapeutic); Rennie v. Klein, 476 F. Supp. 1294, 1299 (D.N.J. 1979) (rejecting use of "drugs as a form of control and as a substitute for treatment"), *modified*, 653 F.2d 836 (3d Cir. 1981), *vacated and remanded*, 458 U.S. 1119 (1982); Rogers v. Commissioner of Dep't of Mental Health, 458 N.E.2d 308, 320-21 (Mass. 1983) (holding drugs used to attain passivity and obedience in patients an abuse of administrative power).

[227] *See Johnson*, 28 F.3d at 159.

[228] *See Ex parte Crouse*, 4 Whart. at 11.

[229] *See* U.S. v. Santonio, No. 2:00-CR-90C, 2001 U.S. Dist. LEXIS 5892 (C.D. Utah May 4, 2001).

[230] *See id.*

[231] *See* Redding, *supra* note 93, at 697.

[232] *See id.*

children are treated as "medical neglect" cases.[233] The only uniform principle discernible in "medical neglect" cases is that courts will, and should intervene when a child's life is at stake.[234] Although it is generally accepted that parents have an affirmative duty to provide adequate medical care for their child, courts have been extremely deferential to parents' decisions when a child's life is not immediately endangered. In cases where a physical deformity has led to the emotional impairment of a child, courts' reactions have been less predictable. When a child's impairment is not physical, but emotional or behavioral in nature, the court's job becomes more difficult, and thus these types of cases are inappropriate for adjudication in the "medical neglect" context. In fact, there are very few reported cases in which judges have decided mental health question regarding children in this context. Often, parents have made a "good faith" decision to refuse medication for their child. They are often concerned about adverse side effects, and lack of knowledge regarding the long-term effects of drugs on their children. Contrary to the beliefs of educators, they have in fact made a well-informed decision, and are not "neglectful" as the term is generally understood.

Although the Ritalin cases are not generally brought in this context, "educational" neglect is a more appropriate forum for adjudicating disputes between parents and schools. The question in these cases is essentially whether a parent is depriving a child of a meaningful education by refusing stimulant drug therapy. This situation is analogous to typical educational neglect cases, where the court looks to see if the alternative schooling provided to the child by a parent reaches an acceptable level of education.

Amy L. Komoroski

---

[233] *See* Valerie J. v. Derry Coop. Sch. Dist., 771 F. Supp. 483 (D.N.H.1991); Weathers, *supra* note 18; *but see* Caher, *supra* note 22 at 1 (employing educational neglect theory in Ritalin case).

[234] *See* Jehovah's Witnesses v. King County Hospital, 278 F. Supp. 488 (W.D. Wash. 1967), *aff'd per curiam*, 390 U.S. 598 (1968); Perricone, 181 A.2d 751 (N.J. 1962).