Prescribing a Legislative Response: Educators, Physicians and Psychotropic Medication for Children

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The prescription of psychotropic medication to children, particularly stimulant medication to treat attention deficit disorders, has been the subject of great debate for several decades and has focused attention on the practices of both school personnel and physicians. Educators have been accused of pressuring parents to medicate students in order to facilitate classroom management. Physicians have been faulted for too readily prescribing psychotropic medication without following proper diagnostic and monitoring procedures. Recently, Congress and state legislatures have made efforts to address these perceived problems.

While there has been a dramatic increase in prescriptions to children for all psychotropic medications over the past decade, the analysis in this article will focus on the diagnosis and treatment of Attention Deficit Hyper-

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activity Disorder (ADHD). The diagnosis of ADHD and the use of stimulant medications to treat the disorder have been the subjects of a longstanding, intense debate and numerous medical studies. The debate has played out in school boards, courts, state legislatures and Congress. Largely negative media attention, focused on the over-prescription of such medication, has shaped much of the debate. The conclusions reached and recommendations made in this article are not, however, limited to cases of ADHD but may be applicable to the identification, diagnosis, and treatment of other neurobehavioral disorders in children.

Although the very existence of ADHD as a valid disorder has fueled much debate, this article adopts the view supported by the mainstream medical professional literature and assumes the validity of attention deficit disorders and the use of stimulant medication in treatment when appropriate. The medical literature acknowledges that there are problems with the diagnosis

3. AMERICAN PSYCHIATRIC ASSOCIATION, Diagnostic and Statistical Manual of Mental Disorders 85-93 (4th ed. 2000) [hereinafter, DSM-IV]. DSM-IV criteria identify three subtypes of ADHD: predominantly inattentive, predominantly hyperactive-impulsive, and combined types. This article does not differentiate between the three types and uses the term ADHD interchangeably.

4. Stimulant medications, including Ritalin, Concerta, and Adderall, are used to treat attention deficit disorders. Strattera, a non-stimulant medication, is also used to treat attention deficit disorder.

5. See infra notes 37 and 64.

6. While most legislative efforts to prohibit school personnel from recommending or requiring psychotropic medication were initiated by concerns over stimulant medication, most enacted legislation ultimately included broad definitions of psychotropic medication. See infra notes 135-36.

7. See Council on Scientific Affairs, American Medical Association, Council Report: Diagnosis and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents, 279 JAMA 1100, 1101 (1998) [hereinafter Council Report] (noting that "highly inflammatory public relations campaigns and pitched legal battles have been waged (particularly by groups such as the Church of Scientology) that seek to label the whole idea of ADHD as an illness a 'myth' and to brand the use of stimulants in children as a form of 'mind control'").

and treatment of attention deficit disorders, and many medical studies suggest that stimulant medication is both over- and under-prescribed. These concerns are important to the analysis in this article.

According to the American Academy of Pediatrics (AAP), ADHD is the most common neurobehavioral disorder of childhood and is among the most prevalent chronic health conditions affecting school-aged children. It is estimated that approximately five percent of children will suffer from the disorder during middle childhood. The American Psychiatric Association (APA) has established criteria for diagnosing ADHD. These criteria require that the child show six or more symptoms of either inattention or hyperactivity for at least six months. At least some of the symptoms must

9. NIH Conference Statement, supra note 8, at 187 (noting the issues raised by the wide variations in the use of psychostimulants across communities and physicians).

10. Id. at 186; Peter Jensen, et al., Are Stimulants Overprescribed? Treatment of ADHD in Four U.S. Communities, 38 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 797 (1999).


13. DSM-IV, supra note 3, at 85-93.

14. Id. at 92. Symptoms of inattention include:

(a) often fails to give close attention to details or makes careless mistakes in school work, work, or other activities; (b) often has difficulty sustaining attention in tasks or play activities; (c) often does not seem to listen when spoken to directly; (d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions); (e) often has difficulty organizing tasks and activities; (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework); (g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools); (h) is often easily distracted by extraneous stimuli; (i) is often forgetful in daily activities.

Id.

15. Id. Symptoms of hyperactivity include:

(a) often fidgets with hands or feet or squirms in seat; (b) often leaves seat in classroom or in other situations in which remaining seated is expected; (c) often runs about or climbs excessively in situations in which it is inappropriate; (d) often has difficulty playing or engaging in leisure activities quietly; (e) is often "on the go" or often acts as if "driven by a motor"; (f) often talks excessively;
be present before the child is seven years old. Some impairment from the symptoms must be present in two or more settings, generally home and school. There must be clear evidence of clinically significant impairment in social or academic functioning. Finally, the symptoms must not be better accounted for by another mental disorder.

The diagnosis and treatment of ADHD in children necessarily involve parents, school personnel, and medical practitioners. Teachers, who spend a great deal of time observing children, may be the first to notice symptoms of attention deficit disorder. Furthermore, under federal laws, school personnel are required to identify students with disabilities that qualify those students for special education services. ADHD diagnostic and treatment guidelines stress the importance of communication between school personnel and physicians. Such communication is important throughout diagnosis and treatment and often involves the teacher providing results of assessments and observations. Physicians are the professionals who must make a diagnosis, suggest a course of treatment, and prescribe medication if included in that course of treatment. Parents, relying upon physicians' information-sharing and recommendations, must ultimately decide upon a course of treatment.

Unfortunately, medical practitioners, school personnel, and parents do not always establish the necessary collaborative relationship when a child exhibits symptoms of ADHD. In some instances, school personnel have overstepped boundaries and have recommended, or even attempted to require, the use of psychotropic medication for students. There also have been cases where school personnel reported or threatened to report parents to child protection services when parents refused to medicate a child. Medical practitioners have been accused of misdiagnosis and of failure to provide adequate information regarding medication side effects or alternative

(g) often blurs out answers before questions have been completed; (h) often has difficulty awaiting turn; and (i) often interrupts or intrudes on others (e.g., butts into conversations or games).

Id.

16. See Section II, infra, and accompanying notes.
17. See infra notes 88-108 and accompanying text.
19. The package insert for Ritalin, the most widely prescribed stimulant medication, includes the following statement regarding the most common “adverse reactions”:

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include hypersensitivity (including skin rash, urti-
treatments. In the late 1980s and again in the early 2000s, these issues were widely publicized as the subject of litigation. Recently, these issues have emerged as subjects of legislative action.

This paper argues that state legislatures should enact legislation governing both school personnel and medical practitioners with respect to the identification, diagnosis, and treatment of children suffering from ADHD and other neurobehavioral disorders. Part I gives a brief chronology of the stimulant debate, adverse media attention, and litigation from the late 1980s to date. Part II examines the role school personnel are required to play in identifying students with ADHD. This section provides an overview of federal education laws that require school personnel to consider whether a student has an eligible disability requiring special education services. Part III reviews current medical practice guidelines for the diagnosis and treatment of ADHD, and provides a brief overview of the doctrine of informed consent. Part IV examines recent legislative attempts to address school personnel recommending or requiring psychotropic medication, and to regulate the practice of physicians prescribing psychotropic medication to children. Part V argues that state legislatures should pass legislation to guide both school personnel and medical practitioners. Legislation should require local school boards to adopt policies establishing procedures for school personnel working with students who exhibit symptoms of or who have been diagnosed with ADHD or other neurobehavioral disorders. Similarly, legislation should require medical boards or panels to establish training procedures and guidelines for medical practitioners who diagnose and treat children with ADHD and other neurobehavioral disorders.

caria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. There have been rare reports of Tourette's syndrome. Toxic psychosis has been reported.... In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

I. A CHRONOLOGY OF THE RITALIN DEBATE

The late 1980s and early 1990s saw a series of highly publicized cases filed nationwide against medical professionals and educational professionals regarding the diagnosis and treatment of children with ADHD.\textsuperscript{20} Almost all of the actions included medical malpractice and informed consent claims against physicians charged with misdiagnosis, failure to monitor, or failure to provide information regarding side effects.\textsuperscript{21} Many of the suits also included claims of coercion or misrepresentation against school districts or employees.\textsuperscript{22} A sampling of these early actions clarifies the issues that arise in the identification, diagnosis, and treatment of children with ADHD, and demonstrates how these issues involve both medical practitioners and educators.

In \textit{Lorenzo v. Yusin},\textsuperscript{23} the plaintiff claimed that her eleven-year-old son suffered permanent side effects, in the form of depression and headaches, after taking Ritalin for three months and sued both her son's physician and his school. The plaintiff alleged that the prescribing physician was negligent in three ways: in diagnosing her son with ADHD, in failing to disclose potential side effects of treating medications to her, and in raising the child's dosage level at the request of school officials.\textsuperscript{24} With respect to the school, the plaintiff alleged that her son was coerced into taking Ritalin for three months and was threatened with expulsion if he failed to do so.\textsuperscript{25} The school district argued that school personnel were simply following the physician's


\textsuperscript{21} Welke, \textit{supra} note 20, at 157-60; Andrew Blum, \textit{Lawsuits Over Ritalin Spread to Massachusetts}, NAT'L L. J., Mar. 28, 1988, at 41.


\textsuperscript{25} Welke, \textit{supra} note 20, at 162 n.165; Grange, \textit{supra} note 24.
prescription and parent's instruction when they administered Ritalin. The case was never decided on its merits.26

_Parker v. American Psychiatric Association_27 was a class action suit seeking $125 million in damages from the Gwinnett County Board of Education, the APA, and individual doctors. The lead plaintiff, LaVarne Parker, claimed that school officials threatened to expel her son if he did not take Ritalin, and that four years of taking such psychotropic medication had made him violent and suicidal.28 The suit accused the APA of fraud,29 and the doctors who prescribed the Ritalin of malpractice in the diagnosis, monitoring, and treatment of the children. The physicians also were accused of failing to inform plaintiffs of potentially serious side effects. The plaintiffs also listed Gwinnett County Board of Education and various educators who advocated the use of medication as defendants, arguing that their children's due process rights had been violated by the schools' actions. The plaintiffs accused all of the defendants of negligent misrepresentation regarding the drug.30

_Valerie J. v. Derry Cooperative School District_31 involved an Individuals with Disabilities Education Act (IDEA) claim.32 This case involved a twelve-year-old student, Casey J., who had behavioral problems from the time he entered school. Casey J. began taking Ritalin just prior to entering first grade. While the Ritalin seemed to help his concentration, his behavioral problems continued. After almost two years, his parents discontinued the medication, and were thereafter strongly opposed to medicating their son. The following school year, at the suggestion of the school psychologist, Casey J. was evaluated by a team of physicians at Children's Hospital in Boston. The team believed that Casey J.'s problems were behavioral, and included hyperactivity and attention deficit disorder. The team made sixteen recommendations, including both classroom accommodations and the trial use of the drug Cylert. The school then attempted to incorporate the use of

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26. *See* Grange, *supra* note 24. A mistrial was declared on the fourth day of trial, when the plaintiff introduced allegations of racism which the judge had ordered excluded from testimony.


29. *See id.* The fraud claim was based on the APA's definition of attention deficit hyperactivity disorder, which the plaintiffs argued is overly broad.


32. 20 U.S.C. §§ 1400-1482 (2000). *See also infra* notes 74-78 and accompanying text.
medication into Casey J.'s Individualized Education Program (IEP). The court held that the student's "right to a free appropriate public education could not be premised on the condition that he be medicated without his parents' consent." Consequently, the plaintiffs were awarded compensatory damages.

With the exception of Valerie J., none of the late 1980s suits led to either a successful verdict or a financial settlement. The suits did, however, attract widespread negative media attention regarding the use of psychotropic medication for children.

For a brief period, the media attention had a chilling effect on the use of Ritalin and other stimulant medication, particularly in cities where such cases were litigated. Researchers found a significant decrease in medication rates in the late 1980s and early 1990s in Baltimore County, where a

35. Id. at 491-492 (awarding plaintiff compensatory education for the seven and one-half months that school district had failed to provide appropriate education, in addition to monetary damages for that time period under 42 U.S.C. § 1983).
36. Daniel J. Safer, The Impact of Recent Lawsuits on Methylphenidate Sales, 33 CLINICAL PEDIATRICS 166 (1994); but see Ouellette, supra note 20, at S71 (citing an earlier case, Benskin v. Taft City Sch. Dist., No. 16,431 (Kern City, Cal., filed June 30, 1980), that settled out of court for $250,000).
37. Valerie J., 771 F. Supp. at 484 (noting that "[t]his case is different from most cases under the Act [IDEA] in that the parents of Casey J. went public and his case garnered national attention as articles were published in People Magazine and the J.'s appeared on Nightline and the Geraldo Rivera television show."); Grange, supra note 24; Cowart, supra note 28, at 2521; Divoky, supra note 20, at 603-05; Carol Angel, Lawsuits Mount Over Drugs Given Children, L.A. DAILY J., June 10, 1988, at 5. See also Welke, supra note 20, at 125 n.1 (noting numerous articles addressing negative media attention).
38. Safer, supra note 36, at 166.

The eight metropolitan areas that experienced anti-Ritalin lawsuits in 1987-1988 had an average decline of 37% in estimated methylphenidate [Ritalin] sales from 1986-1987 to 1990, whereas during that same period, the nonlitigation cities in nearby states had virtually no change in medication usage.... In the nation as a whole, estimated sales of methylphenidate declined an average of 13% over the period from 1986 through 1990.

threatened lawsuit had been highly publicized.\footnote{Ritalin Action Not Filed, NAT'L. L. J., June 13, 1988, at 6. The Baltimore County school district was publicly threatened with a lawsuit over educators' alleged role in proposing treatment for possibly hyperactive children. The threatened suit was dropped after the school district issued a memo warning staff not to suggest that Ritalin be used to treat hyperactive children. \textit{Id.}} Their report concluded that "strong circumstantial evidence" suggested that the county's 1989 and 1991 declines in medical stimulant initiation were a reflection of parent, educator, and medical professional trepidation over the threatened lawsuit and the intense media blitz surrounding it.\footnote{Safer & Krager, supra note 39.}

While Ritalin use may have declined in the late 1980s and early 1990s, prescriptions for Ritalin and other psychotropic medications for children again climbed during the mid-1990s.\footnote{Zito, supra note 2, at 18 (noting that most of the growth in psychotropic medication prevalence in their study took place after 1991); Jerry L. Rushton & J. Timothy Whitmire, Pediatric Stimulant and Selective Serotonin Reuptake Inhibitor Prescription Trends: 1992 to 1998, 155 ARCHIVES OF PEDIATRIC & ADOLESCENT MED. 560 (2001); Daniel J. Safer, Julie M. Zito, & Eric M. Fine, Increased Methylphenidate Usage for Attention Deficit Disorder in the 1990s, 98 PEDIATRICS 1084 (1996).} A recent study, including over 900,000 youths and nine classes of medication, found that between 1987 and 1996 the proportion of children under the age of twenty treated with psychotropic drugs in three large healthcare systems doubled and, in some cases, even tripled.\footnote{Zito, supra note 2, at 17.} While prescriptions for all psychotropic medications included in the study increased over the decade, stimulant medications and antidepressants were the most highly prescribed medications.\footnote{Id. at 22. Antidepressants, which include Prozac, Paxil, Zoloft, and Luvox, are used to treat depressive disorders. Recently, the FDA has warned of increased suicidal behavior in patients, particularly children and adolescents, being treated with antidepressants. Ctr. for Drug Evaluation and Research, U.S. Food and Drug Admin., Suicidality in Children and Adolescents Being Treated With Antidepressant Medications, FDA PUB. HEALTH ADVISORY, Oct. 15, 2004, available at http://www.fda.gov/cder/drug/antidepressants/SSRIPHA200410.htm.} Comparing rates of treatment between 1987 and 1997, researchers found that there was a significant increase in the overall rate of treatment of childhood ADHD, rising from approximately 493,000 treated children in 1987 to 2,158,000 treated children in 1997.\footnote{Mark Olfson, et al., National Trends in the Treatment of Attention Deficit Hyperactivity Disorder, 160 AM. J. PSYCHIATRY 1071, at 1073–74 (2003). Researchers found increases in treatment rates in nearly every demographic group studied. Large numbers of older children, children from lower-income families, children without health insurance, and, to a lesser extent, children from racial and ethnic minority groups were brought into treatment. Children treated for ADHD tended to receive fewer visits but...}
The medical literature identifies several factors that may have contributed to the increased medication rates in the 1990s. In 1991, the U.S. Department of Education recognized ADHD as a disability that made students eligible for special education services. This, in addition to the development of easily administered instruments to be used by parents and teachers for assessing behavioral problems, may have increased recognition of ADHD. In the early 1990s, the negative publicity formerly associated with the Ritalin lawsuits ceased and stimulant medication developed a more positive image through advocacy campaigns of groups such as Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD). Patients began to receive longer courses of treatment, and broader diagnostic criteria introduced in 1994 most likely led to more children being diagnosed with ADHD. By the end of the 1990s, pharmaceutical companies also had started direct marketing of medication. Finally, changes in the healthcare system created financial incentives that favored medication over counseling and other types of therapy.

Notably, the medical literature does not identify school personnel promoting medication as a factor contributing to increased medication rates. In 2000, however, high profile litigation once again focused negative media attention on educators' role in promoting Ritalin use. Two New York
cases, in which schools attempted to require parents to place their children on medication, received widespread attention, focusing on schools' role in promoting and even mandating medication. In both of these cases, school personnel reported parents to the state's child protective services agency when the parents refused to continue medicating their children.

In the Carroll case, parents were charged with educational neglect when they decided to remove their son from medication because he was suffering negative side effects. In court, the law guardian supported the school district's position that the family should be required to address the child's condition. Ultimately, the Carrolls consented to an adjournment in contemplation of dismissal, which directed the parents to comply with the doctor's treatment regimen, including a prescription for Ritalin, or find some medically approved alternative.

In the Weathers case, school officials filed a complaint with the state's Department of Child Protective Services alleging medical and educational


53. In addition to new publicity about Ritalin in schools, there was also publicity about three class action lawsuits filed in Texas, California, and New Jersey in 2000. These suits were filed against the manufacturer of Ritalin, Ciba/Novartis, the American Psychiatric Association (APA) and Children and Adults with Attention Deficit Disorder (CHADD). The suits charged the drug manufacturer with conspiring with the APA and CHADD to invent and promote the ADD/ADHD diagnosis in order to promote Ritalin sales. Vess v. Ciba-Geigy Corp., No. 00-CV-1839, 2001 WL 290333 (S.D. Cal. 2001), aff'd in part, rev'd in part, and remanded 317 F.3d 1097 (9th Cir., 2003); Dawson v. Ciba-Geigy Corp., 145 F.Supp.2d 565 (D.N.J. 2001); Hernandez v. Ciba-Geigy Corp., 200 F.R.D. 285 (S.D. Tex. 2001). These cases did not name school personnel or individual physicians as defendants and are, therefore, ancillary to this article beyond the extent to which they attracted media attention and helped to further shape public opinion about stimulant medication. See also Davis v. Francis Howell School Dist., 138 F.3d 754 (8th Cir. 1998) and DeBord v. Bd. of Educ. of the Ferguson-Florissant Sch. Dist., 126 F.3d 1102 (8th Cir. 1997) (both holding that school districts did not discriminate against students by refusing to administer Ritalin in a dosage above that which was recommended in the PDR). These cases did not receive widespread media attention. For an academic review of these cases, see Ann Chiumino, Class Action Suits Prompt Governmental Action to Examine Ritalin Use and Regulation, 13 Loy. Consumer L. Rev. 380, 392 (2001); Rex R. Schultze, Reading, Writing and Ritalin: The Responsibility of Public School Districts To Administer Medications to Students, 32 Creighton L. Rev. 793 (1999).

54. Caher, supra note 52, at 2.

55. Id.
neglect when parents took their son off psychotropic medication.\textsuperscript{56} Due to adverse side effects, the parents discontinued their son’s medications,\textsuperscript{57} despite the school’s and the psychiatrist’s insistence that they try alternative prescriptions. Shortly after medication was discontinued, the student was constructively dismissed from the school.\textsuperscript{58} The school district initially agreed to provide homebound instruction, but stopped such instruction soon after its implementation because it did not deem “psychiatric reasons” for absence from school to be “medical reasons.” The school then filed a report with Child Protective Services and the Weathers were charged with neglect for failing to give their son “the necessary medication” and not hospitalizing him as advised by the psychiatrist. The Weathers avoided having their son removed from custody when they produced an independent psychiatrist’s evaluation stating that their son did not require hospitalization.\textsuperscript{59}

Patricia Weathers filed suit in federal court in September 2002. She claims that the principal, school district, and school psychologist were negligent, and that they violated her son’s constitutional rights by coercing his parents to medicate him and banning him from school unless he was medicated.\textsuperscript{60} The suit also charges two doctors and the school psychologist with medical malpractice for misdiagnosis without proper examination. Finally, all defendants are accused of medicating the plaintiff’s son without his or his mother’s informed consent.

Ritalin litigation and the media attention that it has received have shaped public opinion about the use of stimulant medication, and, at times, may also have influenced the professional judgments of medical practitioners.\textsuperscript{61}

\textsuperscript{56} Weathers Complaint, supra note 52; Behavioral Drugs in Schools: Questions and Concerns: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Education and the Workforce, 106th Cong. 4-6 (2000). [hereinafter Hearings on Behavioral Drugs in Schools] (statement of Patricia Weathers); see also Amy L. Komoroski, Stimulant Drug Therapy for Hyperactive Children: Adjudicating Disputes Between Parents and Educators, 11 B.U. PUB. INT. L.J. 97, 102 (2001).

\textsuperscript{57} The child was originally taking Ritalin, and eventually had switched to a combination of Dexedrine and Paxil. Weathers Complaint, supra note 52.

\textsuperscript{58} Id. The school principal informed the Weathers that “[w]e [the school and the staff, including teachers and social workers] have nothing more to offer Michael,” and that “a different placement was probably the best solution for Michael.” Michael now receives homebound instruction. Id.

\textsuperscript{59} Hearings on Behavioral Drugs in Schools, supra note 56, at 5.

\textsuperscript{60} Weathers Complaint, supra note 52.

\textsuperscript{61} Safer & Krager, supra note 39, at 1007 (suggesting that increased physician concern was a contributing factor to the decline in stimulant treatment in the late 1980s); Cowart, supra note 28, at 2521 (noting that the wave of adverse publicity has raised concern that public opinion may affect medical practice).
educators, and even courts. While many of the suits named both medical practitioners and school personnel, the media's coverage over the past few years has increasingly focused on schools. This criticism has shaped both the public's perception that school personnel promote psychotropic medication and the course pursued by legislators in attempting to address the perceived over-prescription problem. While some state legislatures have considered laws governing physicians who diagnose and treat children with ADHD and other neurobehavioral disorders, most of the legislation has been aimed at school personnel.

II. FEDERAL SPECIAL EDUCATION LAWS

Critics of psychotropic medication for children portray school personnel as promoters of medication as a means of behavioral control or as a classroom management tool. While the cases and anecdotal accounts suggest

62. Safer & Krager, supra note 39, at 1007 (noting school personnel’s apprehension about potential liability and adverse publicity as a contributing factor to the decline in stimulant treatment in the late 1980s).


65. Infra notes 132-50 and accompanying text.

66. Infra notes 161-70 and accompanying text.

67. Craig S. Lerner, “Accommodations” for the Learning Disabled: A Level Playing Field or Affirmative Action for Elites?, 57 VAND. L. Rev. 1043, at 1069 (2004) (noting the “incentives of overworked teachers to diagnose troublesome students as ADD/ADHD, and thereby medicate them into some preferred condition”); Komoroski, supra note 56, at 99-100 (examining the “aggressive promotion of Ritalin by educational institutions”); Powers, supra note 18, at 148 (noting that “schools may encourage the prescription of Ritalin to create an easier environment for teachers who do not want to take the extra time to address the borderline children who need extra help,” and asserting that the “ultimate pressure for the use of Ritalin comes from school administrators”);
that such advocacy has occurred in some instances, there is no data with respect to how often it occurs. Furthermore, the criticism of school personnel does not address the federal requirement that school personnel identify students with special education needs in order to fulfill their obligation to provide necessary special educational services.

The Individuals with Disabilities Education Act (IDEA)\(^\text{68}\) and Section 504 of the Rehabilitation Act (Section 504)\(^\text{69}\) both apply to the education of disabled students. In complying with their obligations under these laws, educators must determine whether students have qualifying disabilities. Although the Individuals with Disabilities Education Improvement Act of 2004 now mandates that state educational agencies develop policies prohibiting school personnel from requiring medication as a condition to attending school or receiving an evaluation or services under the Act,\(^\text{70}\) school personnel must still become involved in some preliminary diagnostic activity in determining whether a student has a qualifying disability.\(^\text{71}\) In fact, the U.S. Department of Education has published a resource document for teachers, addressing the identification and treatment of ADHD.\(^\text{72}\) This document includes a section on “Legal Requirements for Identification of and Educational Services for Children with ADHD.”\(^\text{73}\)

IDEA provides funding to state education agencies to support special education and related services to children with disabilities.\(^\text{74}\) A student with

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70. See infra notes 147-50 and accompanying text.


73. Id. at 5. This article cites to the information contained in RESOURCE FOR SCHOOL AND HOME, as this is information published by a federal agency and intended to provide guidance to school personnel.

74. 20 U.S.C. § 1404(3)(A) (2000). A “child with a disability” is defined as a child: (i) with mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emo-
ADHD may qualify under IDEA under the category of "Other Health Impairment," if the disability results in:

limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli that results in limited alertness with respect to the educational environment, that is due to chronic or acute health problems such as ... attention deficit disorder or attention deficit hyperactivity disorder ... and [a]dversely affects a child’s educational performance.\textsuperscript{75}

Under IDEA, each school district must conduct a full and individual evaluation for each child being considered for special education and related services.\textsuperscript{76} A team of school professionals and the child’s parents will use the evaluation results to determine whether the child qualifies as a "child with a disability under IDEA."\textsuperscript{77} While a medical practitioner’s diagnosis of ADHD may be an important evaluation result, the diagnosis does not necessarily qualify that child as eligible for special education and related services under IDEA.\textsuperscript{78}

Although a child may not qualify for services under IDEA, he or she may meet the requirements of Section 504, which requires a free appropriate education for all children who have an impairment that substantially limits one or more major life activities.\textsuperscript{79} If a child’s ADHD adversely affects his or her learning, which is a major life activity, the student may qualify for services under Section 504.\textsuperscript{80} To be considered eligible under Section 504, an evaluation must show that the student’s disability interferes with the learning process and that the disability requires special education or related services.

To determine if the student has a qualifying disability requiring special education or related services under either IDEA or Section 504, the school district, in cooperation with parents, must conduct an evaluation. This evaluation can include three components: behavioral, educational, and medical.\textsuperscript{81} The behavioral evaluation can make use of standard questionnaires, and should collect information about the child’s ADHD symptoms from several different sources, which may include the child’s parents,

\textsuperscript{75} 34 C.F.R. § 300.7(c)(9) (2004).
\textsuperscript{76} 20 U.S.C. § 1414 (2000)
\textsuperscript{78} RESOURCE FOR SCHOOL AND HOME, supra note 72, at 5.
\textsuperscript{79} Id.
\textsuperscript{80} 34 C.F.R. § 104.3(j) (2004)
\textsuperscript{81} RESOURCE FOR SCHOOL AND HOME, supra note 72, at 6.
teachers, and medical practitioners. The educational evaluation involves classroom observations, a review of the child’s productivity, and a review of the child’s academic record, to assess the extent to which the child’s ADHD impairs his or her performance at school. IDEA does not require that the school conduct a medical evaluation to determine whether a child has ADHD. If, however, the school believes that such an evaluation is necessary to determine whether the student meets the eligibility criteria under IDEA, the school must ensure that a medical evaluation is conducted at no cost to the parents.

Given that school personnel are required to engage in some form of preliminary diagnostic activity in order to “identify” students with disabilities, the line between “identification” and “diagnosis” can blur. Likewise, while school personnel can recommend a medical evaluation to determine whether a student suffers from ADHD or some other neurobehavioral disorder, educators must make sure that they do not appear to be recommending consultation with a medical practitioner for the purpose of obtaining a specific diagnosis or receiving any particular prescribed treatment. While many instances of overstepping reported in anecdotal accounts may have been well-intentioned efforts to assist parents and students, it is clear that school personnel need stronger guidelines to ensure that they do not cross appropriate boundaries or create the perception that they are recommending or attempting to require medical treatment.

III. MEDICAL PRACTICE

While it is certainly inappropriate for school personnel to make medical recommendations or requirements, medical practitioners are ultimately responsible for any over-prescription of psychotropic medication for children. Even if a teacher attempts to diagnose a neurobehavioral disorder and recommend a course of treatment, the medical practitioner is responsible for

82. Id. at 6-7.
83. Id. at 7-8.
84. Id. at 8-9.
85. See, e.g., Valerie J. v. Derry Coop. Sch. Dist., 771 F. Supp. 483, 489 (D.N.H. 1991) (noting that school district authorities “acted with the patience of Job”); id. at 485 (noting that the physician at Children’s Hospital in Boston was “quite impressed when school members appeared [at a meeting at the hospital] showing concern for Casey J. as this was unusual for school members to come to Boston”).
86. Angel, supra note 37 (quoting plaintiff’s attorney in Parker who admitted that he did not view schools as the true “culprits,” but rather doctors and psychologists).
conducting a thorough evaluation and making any diagnosis. In addition, only a medical practitioner can prescribe medication to the child.87

A. Diagnosis and Treatment of ADHD

The American Academy of Pediatrics (AAP) has issued two clinical practice guidelines88 addressing the diagnosis and treatment of ADHD.89 These guidelines make clear that diagnosis and treatment of ADHD necessarily involve medical professionals,90 parents, and school personnel. Researchers have found, however, that these guidelines are not widely followed.

87. Welke, supra note 20, at 158-59 (observing that "[i]t is clear that, if a physician renders a diagnosis of ADH primarily on the basis or claims of an exasperated teacher who remarks that something needs to be done with a particular child, then he has clearly breached accepted medical diagnostic criteria and is liable for malpractice").

88. Practice guidelines are a means of professional self-regulation and set out standards of conduct for members of the professional group. While these guidelines are not legally binding, courts may consider such guidelines in defining appropriate standards of care. For a discussion of the evolution and legal status of professional guidelines, see Angela Campbell and Kathleen Cranley Glass, The Legal Status of Clinical and Ethics Policies, Codes, and Guidelines in Medical Practice and Research, 46 McGill L.J. 473 (2001).

89. AAP Diagnostic Guideline, supra note 11; American Academy of Pediatrics, Comm. on Quality Improvement, Subcomm. on Attention-Deficit/Hyperactivity Disorder, Clinical Practice Guideline: Treatment of the School-Aged Child With Attention-Deficit/Hyperactivity Disorder, 108 Pediatrics 1033 (2001) [hereinafter AAP Treatment Guideline]. The American Academy of Child and Adolescent Psychiatry (AACAP) has also issued practice parameters that include considerable overlap with the AAP clinical practice guidelines. See American Academy of Child and Adolescent Psychiatry, Practice Parameter for the Use of Stimulant Medications in the Treatment of Children, Adolescents, and Adults, 41 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 26S (2002); American Academy of Child and Adolescent Psychiatry, Practice Parameters for the Assessment and Treatment of Children, Adolescents, and Adults with Attention-Deficit/Hyperactivity Disorder, 36 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 85S (1997).

90. This section will focus on the involvement of primary care physicians and pediatricians, as a majority of children with ADHD are diagnosed and treated by their primary care clinicians. See Wolraich, supra note 71, at 23-3 – 23-4.
1. AAP Diagnostic Guideline

The AAP guideline addressing diagnosis and evaluation of ADHD notes that common presentations of ADHD in clinical practice include “referral from school for academic underachievement and failure, disruptive classroom behavior, inattentiveness, problems with social relationships, parental concerns regarding similar phenomena, poor self-esteem, or problems with establishing or maintaining social relationships.”91 The physician must have input both from parents and from the school professionals working with the child because symptoms may not be apparent in the clinical setting and because the diagnostic criteria for ADHD require that the symptoms should be present in two or more settings (i.e., home and school).92 The evaluation and diagnosis of ADHD usually requires several steps and more than one visit.93

The diagnostic guideline includes six recommendations. The clinician should initiate an evaluation for ADHD if a six- to twelve-year-old child exhibits inattention, hyperactivity, impulsivity, academic underachievement, or behavior problems.94 The diagnosis of ADHD requires that a child meet DSM-IV criteria.95 ADHD assessment “requires evidence directly obtained from parents or caregivers regarding the core symptoms of ADHD in various settings, the age of onset, duration of symptoms, and degree of functional impairment”;96 and “evidence directly obtained from the classroom teacher (or other school professional) regarding the core symptoms of ADHD, the duration of symptoms, the degree of functional impairment, and coexisting conditions.”97 The child’s evaluation “should include assessment for coexisting conditions.”98 Finally, “other diagnostic tests are not routinely indicated to establish the diagnosis of ADHD.”99

Under the fourth recommendation requiring evidence provided by school personnel, the guideline suggests that the classroom teacher, who typically has more information about the child’s behavior than other school personnel, should provide the report. If the teacher cannot provide the report, the guideline suggests that a school counselor or principal can help to coordinate

91. AAP Diagnostic Guideline, supra note 11, at 1160.
92. Id. at 1162 (stating “[t]he diagnosis comes from a synthesis of information obtained from parents; school reports; mental health care professionals, if they have been involved; and an interview/examination of the child.”).
93. Id. at 1159.
94. Id. at 1160 (Recommendation 1).
95. Id. at 1160 (Recommendation 2).
96. Id. at 1163 (Recommendation 3).
97. Id. at 1165 (Recommendation 4).
98. Id. at 1166 (Recommendation 5).
99. Id. at 1167 (Recommendation 6).
such reporting and to provide the required information.\textsuperscript{100} The guideline also addresses teachers’ use of certain questionnaires and rating scales that assess behavioral conditions.\textsuperscript{101}

2. AAP Treatment Guideline

The AAP guideline addressing treatment of children with ADHD recognizes that clinicians’ “[o]ngoing communication with parents, teachers, and other school-based professionals is necessary to monitor the progress and effectiveness of specific interventions.”\textsuperscript{102} The treatment guideline includes five recommendations. First, “clinicians should establish a long-term management program that recognizes ADHD as a chronic condition.”\textsuperscript{103} This recommendation stresses the need to establish a partnership among the clinician, parents, teachers, and the child as well as the importance of monitoring care over time. It also stresses the importance of providing information about the condition and observes that “[t]horough family understanding of the problem is essential before discussing treatment options and side effects.”\textsuperscript{104}

Second, the treating clinician, parents, and the child, in collaboration with school personnel, “should specify appropriate target outcomes to guide management.”\textsuperscript{105} Third, “the clinician should recommend stimulant medication and/or behavior therapy as appropriate.”\textsuperscript{106} Fourth, “when the selected management plan has not met target outcomes, clinicians should evaluate the original diagnosis, use of all appropriate treatments, adherence to the treatment plan, and presence of coexisting conditions.”\textsuperscript{107} This recommendation emphasizes the importance of monitoring and evaluating treatment plans through information gathered from parents, the child, and school personnel.

\textsuperscript{100} Id. at 1165.

\textsuperscript{101} Id. at 1166. For a detailed overview of scales used to assess ADHD, see Brent R. Collett, Jeneva L. Ohan, and Kathleen Myers, Ten-Year Review of Rating Scales. V: Scales Assessing Attention-Deficit/Hyperactivity Disorder, 42 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1015 (2003).

\textsuperscript{102} AAP Treatment Guideline, supra note 89, at 1034.

\textsuperscript{103} Id. at 1036. (Recommendation 1).

\textsuperscript{104} Id.

\textsuperscript{105} Id. at 1036 (Recommendation 2).

\textsuperscript{106} Id. at 1037, 1039-40 (Recommendation 3). Behavior therapy in this context is usually implemented by training parents and teachers in specific techniques of improving behavior, and should be differentiated from psychological interventions directed to the child. Schools may provide behavior therapy with teachers within the context of an individual education plan (IEP) or under a Section 504 plan, which might include preferential seating and a decreased assignment and homework load.

\textsuperscript{107} Id. at 1040 (Recommendation 4).
Finally, "the clinician should periodically provide a systematic follow-up for the child with ADHD. Monitoring should be directed to target outcomes and adverse effects by obtaining specific information from parents, teachers, and the child."  

3. Actual Practice

Studies have found that the recommendations included in the AAP guidelines are not generally followed. Many physicians have never received medical training with respect to the diagnosis of ADHD and may, therefore, need more specific details than are provided by the AAP guidelines. Due to the structure of many pediatric practices and limitations imposed by some health insurance groups, many physicians are unable to spend adequate time diagnosing children who may suffer from ADHD or to have follow-up visits with adequate frequency. Physicians often do not communicate with school personnel regarding diagnosis or monitoring of treatment, but rely instead on input from parents. Finally, physicians fail to provide

108. Id. at 1041 (Recommendation 5) (recommending that once the child is stable, the child should make an office visit every 3 to 6 months, and that the clinician should continue to receive information from parents, the child, and school personnel throughout treatment).

109. Kimberly Hoagwood et al., Treatment Services for Children with ADHD: A National Perspective, 39 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 198, 205 (2000) (observing that "[a]lthough at least 2 professional associations have written guidelines or parameters for practice with these children (AACAP and American Academy of Pediatrics), and thorough evidence-based reviews have been completed (McMaster University, 1998), these guidelines are not yet influencing care as delivered in real-world practices"); see also Campbell and Glass, supra note 88, at 478-80 (discussing how guidelines come to be adopted as a “professional norm” and observing that generally there is “widespread enthusiasm for guidelines, but only a minimal impact on actual clinical practices”).


111. Id. at 134.

112. Id. at 134-135; Wolraich, supra note 71, at 23-6 – 23-7.

113. Wolraich, supra note 71, at 23-8 – 23-9; See also Olfon, National Trends 2003, supra note 45, at 1073-75 (noting decrease in psychotherapy visits by children with ADHD).

114. Leslie, supra note 110, at 134 (suggesting that physicians are unsure of the manner and timing for requesting evaluations from schools and fear that such requests may overwhelm school personnel); Wolraich, supra note 71, at 23-5; NIH Conference Statement, supra note 8, at 186.
parents with adequate information regarding the disorder itself, possible side effects of medication, and alternative treatments.115

4. Informed Consent

Almost all of the Ritalin cases included claims of failure to obtain informed consent.116 While states’ informed consent laws vary, standards of disclosure are generally measured by either professional standards or patient-oriented standards.117 Under professional standards, the physician is required to disclose what a reasonable medical practitioner would disclose under the same or similar circumstance. The patient-oriented standard requires the physician to disclose all information that a reasonable person in the patient’s circumstances would find material to making a decision regarding treatment. States are split fairly evenly with respect to which standard they follow,118 and courts often overlook the line between the two standards.119

Courts and legislatures addressing informed consent generally require that adequate disclosure include: information about the nature and purpose of the proposed treatment, the risks and benefits of the proposed treatment, and facts about available alternative treatments.120 In addition, the physician should be sure that the patient understands the information disclosed and provides voluntary consent.121

Some states only require informed consent for surgical or invasive procedures,122 while other states have enacted informed consent legislation for specific procedures.123 A few states have established disclosure panels that

115. Leslie, supra note 110, at 135.
116. Welke, supra note 20, at 157, 159 and accompanying text; see also Weathers Complaint, supra note 52. The law of informed consent has largely developed through state case law, although many state legislatures also have enacted laws governing informed consent. These laws vary from state to state, and this article will only provide a general outline of this doctrine. See Ketchup v. Howard, 543 S.E.2d 371, at 381 (Ga.Ct. App. 2000) (providing a state-by-state overview of informed consent laws).
118. Id. at 48.
119. Id. at 51.
120. Id. at 53.
121. Id. at 65-70 (noting that understanding and voluntariness are two of the most vaguely defined concepts in informed consent law).
122. Id. at 54.
123. See, e.g., 40 PA. STAT. ANN. § 1303.504 (West Supp. 2004) (requiring informed consent prior to conducting the following procedures: surgery, including the related administration of anesthesia; administering radiation or chemotherapy; administering a
specify which treatments and procedures require informed consent and that prescribe the necessary disclosures.¹²⁴ States also vary with respect to the physician's duty to disclose alternatives, with some cases and statutes failing to address the issue at all and other states enacting special statutes mandating disclosure of alternatives to certain procedures, such as breast cancer treatments.¹²⁵ Unfortunately, informed consent laws often serve to guide juries in litigation rather than offering guidance for physicians in working with their patients.¹²⁶

IV. GOVERNMENT REGULATION

A. School Personnel

The earliest efforts to address psychotropic medication in the schools came in the form of State Board of Education resolutions in Colorado¹²⁷ and Texas.¹²⁸ While these resolutions lacked any legally binding effect, they represent the first steps taken towards state regulation. In November 1999, the Colorado State Board of Education passed a resolution encouraging school personnel "to use proven academic and/or classroom management blood transfusion; inserting a surgical device or appliance; or administering an experimental medication, using an experimental device, or using an approved medication or device in an experimental manner.)

¹²⁴. BERG ET AL., supra note 117, at 58; See, e.g., TEX. CIV. PRAC. & REM. § 74.102 (Vernon Supp. 2004-2005).
¹²⁵. BERG ET AL., supra note 117, at 60. See, e.g., CAL. HEALTH & SAFETY CODE § 109275(b)-(c)(1) (West 1996).
¹²⁶. BERG ET AL., supra note 117, at 53, 130.
¹²⁷. Colo. State Bd. of Educ., Resolution: Promoting the Use of Academic Solutions to Resolve Problems with Behavior, Attention, and Learning (Nov. 11, 1999), available at http://www.cde.state.co.us/cdeboard/download/res_Behavior.pdf [hereinafter Colorado Resolution]. See Michael Janofsky, Colorado Fuels U.S. Debate Over Use of Behavioral Drugs, N.Y. TIMES, Nov. 25, 1999, at A1. The Colorado resolution was passed largely in response to the Columbine high school shootings. Proponents of the resolution were motivated by evidence linking the use of psychotropic medication and school violence. While one of the teenage shooters at Columbine had been taking an antidepressant, there is no indication that a teacher recommended the use of the medication. The resolution's sponsor also cited anecdotal reports of school personnel pressuring parents to medicate their children. Id.
solutions to resolve behavior, attention and learning difficulties” and encouraging “greater communication and education among parents, educators, and medical professionals about the effects of psychotropic drugs on student achievement and our ability to provide a safe and civil learning environment.” The Colorado resolution sparked both local and national debate, and the Texas State Board of Education passed a similar resolution the following year.

In 2001, Connecticut and Minnesota passed the first laws addressing schools’ involvement in psychotropic drug issues, and other states have followed. Unlike the school board resolutions, the state laws do not pass judgment upon the validity of psychiatric diagnoses or presume to identify preferred courses of treatment. While the state laws vary, the legislation generally falls into three categories: legislation prohibiting school personnel from recommending the use of psychotropic drugs; legislation prohibiting

129. *Colorado Resolution*, supra note 127.


134. *Colorado Resolution*, supra note 127; *Texas Resolution*, supra note 128. While both resolutions correctly observed that only medical personnel can recommend the use of prescription medication, both also cited “documented incidents of highly negative consequences in which psychiatric prescription drugs have been utilized for what are essentially problems of discipline which may be related to lack of academic success.”

135. COLO. REV. STAT. § 22-32-109(1)(ee) (2004) (requiring school boards to adopt a policy prohibiting school personnel from recommending or requiring the use of a psychotropic drug by any student; permitting school personnel to suggest consultation with an appropriate health care professional); CONN. GEN. STAT. ANN. § 10-212b (West Supp. 2004) (defining psychotropic drugs broadly to include prescription medications for behavioral and social-emotional concerns, including, but not limited to, stimulants and antidepressants; requiring school boards to adopt policies prohibiting any school personnel from recommending the use of psychotropic drugs for any child; permitting school health personnel to recommend medical evaluation of a child; permitting school personnel to consult with medical practitioner with parent’s consent); OR. REV. STAT. § 339.873
school personnel from requiring the use of psychotropic drugs as a condition of continued enrollment;\textsuperscript{136} and legislation stating that a parent or guardian’s refusal to medicate a child with psychotropic drugs does not constitute neglect.\textsuperscript{137} In many states that have not yet enacted such legislation, similar bills are pending.\textsuperscript{138}

\textsuperscript{136} COLO. REV. STAT. § 22-32-109(1)(ee) (2004) (requiring school boards to adopt a policy prohibiting school personnel from recommending or requiring the use of a psychotropic drug by any student); 105 ILL. COMP. STAT. § 5/10-20.35 (West Supp. 2004) (defining psychotropic medication broadly to include medication used for antipsychotic, antidepressant, antianxiety, behavioral modification or behavioral management purposes; requiring school boards to adopt a policy prohibiting any disciplinary action based on a parent’s refusal to administer psychotropic medication to the student; requiring training of school personnel on the identification and treatment of ADHD, the application of non-aversive behavioral interventions in school, and the use of psychotropic medication for children; permitting school medical staff, IEP team, or specified trained specialists to recommend medical evaluation of the student and to consult with such practitioner with parent’s written consent.); MINN. STAT. ANN. § 121A.41(10) (West Supp. 2004) (prohibiting school from requiring parent of suspended student to provide sympathomimetic [stimulant] medication as a condition of readmission); TEX. EDUC. CODE ANN. § 38.016 (Vernon Supp. 2004-2005) (prohibiting school personnel from using parent’s refusal to consent to administration of psychotropic medication to a student or to a psychiatric evaluation or examination of the student as grounds, by itself, for prohibiting the child from attending a class or participating in a school-related activity).

\textsuperscript{137} CONN. GEN. STAT. ANN. § 17a-131a (West Supp. 2004) (stating that parent’s refusal to administer or consent to the administration of psychotropic drugs to children shall not, in and of itself, constitute grounds for the state to take child into custody unless such refusal causes the child to be neglected or abused as defined by statute); MINN. STAT. ANN. §§ 260A.01(b), 260C.163(11)(b) (West 2005) (stating that parent’s refusal to
Congress also has turned its focus to school personnel recommending the use of psychotropic medication for children. Shortly after the Colorado School Board of Education approved its resolution encouraging the use of classroom management solutions to resolve behavior, attention, and learning difficulties, a similar resolution was introduced in Congress. Informational hearings on children's use of behavioral drugs were held in May 2000, September 2000, and September 2002. In May 2003, the

provide child with sympathomimetic [stimulant] medications does not constitute educational neglect; TEX. EDUC. CODE ANN. § 26.0091 (Vernon Supp. 2004-2005) (prohibiting school personnel from using or threatening to use parent's refusal to administer or to consent to the administration of a psychotropic drug to child, or to consent to any other psychiatric or psychological testing or treatment of child, as the sole basis for making a report of neglect of the child unless the employee has cause to believe that the refusal presents a substantial risk of death, disfigurement, or bodily injury to the child, or has resulted in an observable and material impairment to the growth, development, or functioning of the child); TEX. FAM. CODE ANN. § 261.111 (Vernon Supp. 2004-2005) (stating that parent’s refusal to administer or to consent to the administration of a psychotropic drug to child, or to consent to any other psychiatric or psychological testing or treatment of child, does not by itself constitute neglect of the child unless the refusal presents a substantial risk of death, disfigurement, or bodily injury to the child, or has resulted in an observable and material impairment to the growth, development, or functioning of the child). For a discussion of medical and educational neglect, see Komoroski, supra note 56, at 113-20.


139. Prior to 2000, Congress held two informational hearings on the use of psychotropic medications in schools. See 1970 Hearings, supra note 1; Oversight of the Dep’t of Educ. and the Nat’l Inst. of Mental Health: Current Approaches to Attention Deficit/Hyperactivity Disorders: Hearing Before the Subcomm. on Human Resources and Intergovernmental Relations of the H. Comm. on Gov’t Reform and Oversight, 104th Cong. (1996).

140. H.R. Res. 459, 106th Cong. (2000) (recognizing state and local control of public education) The resolution called for Congress to conduct hearings, recommend studies, support state and local education agency efforts, encourage school personnel to use proven academic and classroom management solutions for problems of behavior, attention, and learning difficulties, and urge greater communication between and education of parents, educators, and medical professionals. Id.

House of Representatives passed the Child Medication Safety Act (CMSA), requiring states receiving funds administered by the U.S. Department of Education to establish policies and procedures that prohibit school personnel from requiring a child to obtain a prescription for substances covered by section 202(c) of the Controlled Substances Act as a condition of attendance or receipt of school services. The legislation was referred to the Senate, where it was not reported out of committee.

In 2004, Congress reauthorized and amended IDEA through enactment of the Individuals with Disabilities Education Improvement Act. Under the reauthorized Act, state education agencies must require schools receiving funds under IDEA to prohibit school personnel from mandating the use of medication covered by the Controlled Substances Act as a prerequisite for attendance or receipt of services. The statute specifically clarifies that this prohibition should not be construed so broadly as to prohibit school personnel from communicating with parents regarding a student’s academic performance, behavior, or the need for an evaluation to determine eligibility for special education services. The House Committee Report explains the rationale for this section:

The Committee has been made aware of incidents where local educational agency officials have required parents to place children on psychotropic medication in order to attend school or receive services. The Committee feels that school officials should not presume to know what medication a child needs, or if the child even needs medication. Only medical doctors have the ability to determine if a prescription for a psychotropic drug is...
appropriate for a child. However, the Committee wants to stress the importance of open and effective communication between the parent and school officials (including teachers) regarding the needs of the child as a whole.\textsuperscript{150}

While few question that school personnel should not recommend or require the use of psychotropic medication,\textsuperscript{151} there is some debate over whether or not legislation prohibiting such action is necessary. Although there are some well-publicized cases of such coercion, proponents of legislation largely rely on anecdotal accounts of such pressure.\textsuperscript{152} They argue that parents feel intimidated and therefore perceive undue pressure when these recommendations come from school personnel.\textsuperscript{153} While some proponents agree that coercion may be rare, they argue that if it is happening in any instance, the legislation is justified and necessary.\textsuperscript{154}

Many educators and health care professionals oppose legislation on the basis that it is not necessary. In their view, it is clear that schools should not

\begin{enumerate}
\item\textsuperscript{151} See, e.g., Protecting Children: The Use of Medication in Our Nation’s Schools and H.R. 1170, Child Medication Safety Act of 2003: Hearing Before the H. Subcomm. On Educ. Reform of the Comm. on Educ. and the Workforce, 108th Cong. 12 (2003) (statement of Dr. Lance Clawson, private psychiatrist, Cabin John, Md.) (“[M]y sense is that it is not the purview of educators to recommend medication. They know that.”); id. at 24 (statement of Rep. Chris Van Hollen, Member, H. Comm. Educ. and Workforce) (“I think from the testimony on all sides, it is clear that no one thinks that teachers should be prescribing Ritalin or saying that we should require kids as a condition to going to school to take Ritalin”).
\item\textsuperscript{153} Carrie Budoff, House Approves Bill on Child Behavior: Measure Would Ban School Officials from Suggesting Drugs, HARTFORD COURANT, May 23, 2001, at A6 (noting the argument that since teachers are held in such high esteem, parents tend to listen to their recommendations even though they are not qualified to be recommending medication); John Sanko, It Was a Quick Fix, Take a Pill: School Personnel Urge Behavior-Control Drugs, Senate Hearing Is Told, ROCKY MOUNTAIN NEWS, Mar. 14, 2002, at A20 (“noting parents feel very intimidated when they walk into a school setting where teachers and others tell them their children should be put on behavioral drugs”).
\item\textsuperscript{154} Budoff, \textit{supra} note 153 (reporting that although Connecticut’s Office of Protection and Advocacy for Persons with Disabilities received only a “handful” of complaints about the issue over the preceding 18 months, the executive director of that office thought that was certainly enough to warrant legislative action on the issue).
be recommending medication and such recommendations do not occur.\textsuperscript{155} Opponents worry that legislation could have a chilling effect on communication between parents and teachers.\textsuperscript{156} Finally, there are those who claim that even if schools do make medication recommendations, it is the parent and physician who make the ultimate decision, and the physician who writes the prescription.\textsuperscript{157}

\section*{B. Medical Profession}

While the AAP guidelines seek to establish standards for the diagnosis and treatment of ADHD,\textsuperscript{158} including communication with parents and schools, the guidelines have not yet been widely adopted and an array of problems persists.\textsuperscript{159} Many times, physicians do not spend adequate time evaluating and monitoring patients. Parents do not receive adequate information. Teachers and school personnel are not consulted during the diagnostic process or once treatment begins. Primary care physicians fail to provide the follow up treatment necessary after prescribing stimulant medication. Studies also have found that treatment of children with presumably similar needs varies widely, and researchers have suggested that physicians require greater training.\textsuperscript{160}

Responding to these concerns, Indiana has enacted legislation aimed at physicians' practices in prescribing psychotropic medication for children,\textsuperscript{161}

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\begin{itemize}
\item 155. Julien, \textit{supra} note 152 (noting that "[a] wide range of educators say that the underlying premise of [the] proposed legislation is accurate – that [it is] not the job of school officials to diagnose or order treatment options. But they also say that educators already understand their role and that a new law is not necessary").
\item 156. Individuals with Disabilities Education Improvement Act of 2004, Pub. L. No. 108-446, § 612, 118 Stat. 2647, 2691 attempts to address this concern by affirmatively stating that the Act does not prohibit communications regarding academic performance, behavior, or the need for an evaluation or services. See H. REP. No. 108-77, at 99 (2003).
\item 157. Julien, \textit{supra} note 152 (discussing a pediatric neurologist who agrees that some teachers may be too aggressive but believes legislation governing school personnel is unnecessary because the decision ultimately lies with the doctor and the parent).
\item 158. \textit{See supra} notes 88-108 and accompanying text.
\item 159. \textit{See supra} notes 109-15 and accompanying text.
\item 160. Kimberly Hoagwood, et al., \textit{Treatment Services for Children With ADHD – A National Perspective}, in \textit{ATTENTION DEFICIT HYPERACTIVITY DISORDER: STATE OF THE SCIENCE, BEST PRACTICES} 22-16 (Peter S. Jensen and James R. Cooper, eds., 2002) ("Residency programs and continuing education training for general practice physicians who are likely to see increasing number of children with this condition are necessary to ensure that knowledge about best practices and the limits of expertise (i.e., when referral is appropriate) is disseminated widely.").
\end{itemize}
\end{flushright}
and several state legislatures have considered bills on the subject. Indiana requires medical practitioners to follow the most recent AAP or AACAP guidelines for diagnosing and evaluating a child with ADHD symptoms before prescribing stimulant medication.\(^{162}\) Other states have considered, but not passed, bills addressing physician education in the use of psychotropic medication for children\(^{163}\) and the establishment of guidelines by state boards of medicine.\(^{164}\) These proposed laws have varied in their approaches. Some require the state board of medical examiners to adopt training procedures\(^{165}\) or to establish guidelines and procedures to be followed before prescribing psychotropic medication to children.\(^{166}\) Others require specific training for physicians who prescribe such medications.\(^{167}\)

While moving in the right direction, neither the Indiana law nor the bills introduced in other states include provisions regarding both training and procedural guidelines. Additionally, in some instances, the legislators assert medical judgments that are beyond the scope of their expertise. For example, the Indiana law specifies which guidelines medical practitioners must follow rather than delegating that determination to a medical board or panel. The Arkansas bill included language similar to the Colorado and Texas school board resolutions regarding "negative consequences" and questioning the validity of the disorder.\(^{168}\)

In addition to training and guidelines, some states have considered bills addressing the prescription of psychotropic medication to children and informed consent.\(^{169}\) The California Senate considered such legislation in 2002.\(^{170}\) The bill would have required a physician to obtain a signed consent form before prescribing, dispensing, or furnishing a Schedule II psychotro-

\(^{162}\) Id.

\(^{163}\) See, e.g., H.B. 1870, 83rd Gen. Assem. (Ark. 2001) (requiring doctors who prescribe psychotropic drugs to have training in child psychology and development and training in the use and effects of psychotropic drugs on children); H.B. 3630, 71st Leg. Assem. (Or. 2001) (requiring Board of Medical Examiners to adopt training procedures for physicians who prescribe and dispense psychotropic medication to children).

\(^{164}\) See e.g., S.B. 26, 2001 Reg. Sess. (Ala. 2001) (requiring a certain evaluation and management procedure for physicians treating children with psychotropic medication; authorizing the State Board of Medical Examiners to establish and enforce procedures to be followed by physicians prior to prescribing psychotropic medication to children).

\(^{165}\) H.B. 3630, 71st Leg. Assem. (Or. 2001).


\(^{168}\) Id.; see supra notes 122-23 and accompanying text.


Prescribing a Legislative Response

A psychotropic drug primarily used to treat ADHD to a child. The bill would have required a physician to inform a child's parent or guardian of their right to accept or reject the use of the psychotropic drug. It also would have required a physician to provide specified information, including reasonable alternative treatments and probable side effects, so that the parent or guardian could make an informed decision. The signed consent form would have included information prepared by the State Department of Health concerning effects of the psychotropic drug. Any violation of these requirements would have constituted unprofessional conduct on the part of the physician or surgeon.

Medical groups, including the California Psychiatric Association, the California Medical Association, and the American Academy of Pediatrics, opposed the bill. They asserted that the bill was unnecessary because physicians are already required to obtain informed consent. In their view, additional requirements would unduly burden physicians and have a detrimental effect on the physician's ability to communicate with parents. Physicians also suggested that the legislation would have a chilling effect on the prescription of such medication.

The California Senate Health and Human Services Committee analysis of the bill questioned whether the bill was necessary, given both current informed consent requirements and existing mandates that doctors prescribing Schedule II drugs comply with additional requirements. The analysis also notes that proponents of the bill did not provide evidence of widespread problems of doctors failing to obtain informed consent. Ultimately, the bill died in committee.

V. SUGGESTED LEGISLATIVE RESPONSE

State legislatures have clearly recognized a need to address the diagnosis and treatment of ADHD and other neurobehavioral disorders in children, and specifically the use of psychotropic medication in that course of treatment.


172. See Cobbs v. Grant, 502 P.2d 1 (Cal. 1972) (setting forth California's legal requirements for informed consent, which require the physician to discuss risks, complications and expected benefits of treatment, including likelihood of success, and alternatives to treatment, including risks and benefits thereof).

173. Staff Analysis, supra note 171, at 18.

174. Id. at 19, but cf. sources cited supra notes 141 and 152 (one could argue that just as anecdotal evidence has been used to support passage of legislation governing the actions of school personnel, anecdotal evidence and claims made in suits can be used to support legislation governing the actions of medical practitioners).
Although federal law will now require state educational agencies to prohibit school personnel from requiring medication as a condition of attendance or eligibility for special education services,\(^{175}\) it is not clear what form such prohibitions must take.\(^{176}\) The federal law only addresses one of the issues that have arisen in schools. States, therefore, need to take a more comprehensive view of the problem and enact multi-faceted legislation governing both school personnel and medical practitioners.

Given that some school personnel have recommended or attempted to require medication, such legislation is warranted to protect the rights of students and parents. Additionally, such legislation is necessary to help school personnel draw clear lines when identifying students with special education needs and when communicating with parents about behavioral issues. Likewise, there is a need for legislation governing physicians who diagnose neurobehavioral disorders and prescribe psychotropic medication for children. Within the medical community itself, there is concern regarding both under-prescription and over-prescription of medication due to a lack of training and guidelines,\(^{177}\) and parents have asserted that they have not been properly informed about treatment options or side effects.\(^{178}\)

A. School Legislation

State legislation with respect to school personnel should broadly define psychotropic medication to include any prescription medications intended to have an altering effect on behavior or emotions, including but not limited to stimulant medication, antidepressants, and anti-anxiety medication.\(^{179}\) The legislation should address all three areas noted in Part IV of this article:\(^{180}\) schools recommending psychotropic medication, schools attempting to


\(^{176}\) See, e.g., Memorandum from James A. Kadamus, Deputy Comm’r, Office for Elementary, Middle, Secondary and Continuing Educ., N.Y. Dep’t. of Educ. to Dist. Superintendents of Sch., Superintendents of Public Sch., Charter Sch., Dir. of Special Educ., and Chairpersons of Comm. on Special Educ. (Aug. 15, 2002), available at http://www.emsc.nysed.gov/deputy/Documents/ritalin.html (advising all schools in New York that school personnel could not require parents to administer Ritalin or psychotropic medication as a condition of enrolling their child in school). It is not clear if this memo would be sufficient to meet the federal requirement.

\(^{177}\) See supra note 10 and accompanying text.

\(^{178}\) See supra notes 115-16 and accompanying text.


\(^{180}\) See supra notes 135-37 and accompanying text.
require psychotropic medication, and schools reporting parents under neglect statutes for failure to administer psychotropic medication.

State statutes should require local school boards to adopt and implement policies prohibiting school personnel from recommending the use of psychotropic medication or suggesting any diagnosis of neurobehavioral disorders.\textsuperscript{181} Such policies should establish procedures for non-health school personnel—i.e., teachers—to communicate their concerns about a child’s behavioral problems or suspected health-related academic difficulties to school health personnel. The policies should create a procedure for communication with the parent or guardian, which might require that school health personnel initiate such contact.\textsuperscript{182} School personnel should take a team approach in communicating and meeting with parents, and in recommending that a student receive a medical evaluation. Additionally, the policies should encourage school personnel to offer their observations to assist the medical practitioner in the evaluation of the child. School policies should set forth procedures for obtaining the proper consent from parents in such cases. Finally, the policies should require regular training for school personnel in both appropriate administrative steps they might take when they suspect a child suffers from a neurobehavioral disorder and in academic and classroom management strategies in teaching children who may suffer from such disorders.\textsuperscript{183}

In addition to enumerating items that should be included in school board policies, state legislation should include a section clarifying what the legislation does not limit. In this way, legislatures can attempt to draw clear lines for school personnel. The legislation should clarify that it seeks to preserve open lines of communication between parents and school personnel regarding students’ academic performance and behavior in school by providing guidelines for how such communication can be handled most effectively and professionally. The legislation should make clear that it does not prohibit school personnel from recommending an evaluation by a medical practitioner, as long as personnel follow appropriate school board policies. Finally, the statute should affirmatively state that it does not alter the school district’s

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\item \textsuperscript{183} 105 Ill. Comp. Stat. § 5/10-20.35 (West Supp. 2004) requires training at least once every 2 years on “current best practices regarding the identification and treatment of attention deficit disorder and attention deficit hyperactivity disorder, the application of non-aversive behavioral interventions in the school environment, and the use of psychotropic or psychostimulant medication for school-age children.” \textit{Id}. The statute seems to go beyond what should be required of teachers in terms of knowledge regarding diagnosis and treatment of ADHD, and may increase teachers’ confusion regarding their appropriate role.
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obligation to identify and evaluate students who may qualify for special education and related services under IDEA or Section 504.184

States also should enact legislation explicitly stating that school personnel cannot require parents to place their children on psychotropic medication or to submit to a medical evaluation as a condition of attendance. Although federal law will now require state education agencies to prohibit schools from requiring psychotropic medication, this prohibition should be codified in state law as part of a comprehensive approach to the issue. The language of the Texas statute provides a model for legislation in this area.185

Legislation also should state affirmatively that a parent's refusal to place a child on psychotropic medication recommended or prescribed by a medical practitioner cannot be the sole basis for making a child neglect report to the state child protective services agency, and that such action on the part of a parent does not in and of itself constitute neglect. As part of the state's comprehensive approach to psychotropic medication prescriptions for children, the law should cover school personnel as well as all other individuals.186

B. Medical Practitioner Legislation

Just as states should enact legislation governing school personnel recommending or requiring psychotropic medication for children, state legislatures should also enact legislation governing medical practitioners. Similar to legislation requiring school boards to adopt certain policies, state law should require state medical boards or panels to adopt and implement policies regarding training of physicians who prescribe psychotropic medication as well as guidelines and procedures for diagnosis and treatment.

Legislation should address training required for physicians who will diagnose and treat children with ADHD and other neurobehavioral disorders. This training should include all facets involved in the diagnosis and treatment of neurobehavioral disorders, including the prescription of psychotropic medication as well as alternative treatments. Legislation also

186. Texas addresses the issue of neglect in two separate statutes. TEX. EDUC. CODE ANN. § 26.0091 (Vernon Supp. 2004-2005) (prohibiting school personnel from using or threatening to use a parent's refusal to administer a psychotropic drug to a child or to consent to psychiatric testing or treatment as the sole basis for making a neglect report); TEX. FAM. CODE ANN. § 261.111 (Vernon Supp. 2004-2005) (stating generally that the refusal to administer a psychotropic drug to a child or to consent to psychiatric testing or treatment does not by itself constitute neglect).
should require guidelines, including informed consent requirements, for medical practitioners who prescribe psychotropic medication to children. Such guidelines should foster cooperation among medical practitioners, parents, and educators in the diagnosis and treatment of children with neurobehavioral disorders. Although it is clear that the AAP and AACAP diagnostic and treatment guidelines would serve as excellent models for ADHD patients, state legislatures should defer to medical experts to identify and define the required training programs and treatment guidelines.

Guidelines regarding informed consent should ensure that adequate disclosure includes certain basic elements, such as information about the nature and purpose of the proposed treatment, the risks and benefits of the proposed treatment, and facts about available alternative treatments. While informed consent must be required when psychotropic medication is prescribed to children, enacting informed consent legislation cannot be the sole, or even primary, approach to the problem. As the reaction of the medical community in California makes clear, the medical profession is not receptive to additional requirements in this area. Rather than solely focusing on new requirements that will ultimately be enforced in the courts, all involved would be best served by legislation aimed at providing guidelines and training and at fostering the cooperation of medical practitioners with parents and school personnel.

CONCLUSION

State legislatures have appropriately begun to address the identification, diagnosis, and treatment of children with ADHD and other neurobehavioral disorders. While there are many children who are properly diagnosed, and who benefit from treatment including psychotropic medication, there are also children who are not receiving proper care. Legislative action is long overdue, as debate surrounding neurobehavioral disorders in children and the use of psychotropic medication to treat them has continued for over thirty years. This debate has played out in courts, school boards, state legislatures, and Congress. The popular media has influenced much of the debate, and has sharpened the focus on school personnel attempting to recommend or require medication for students. Because of this focus, most

187. See Staff Analysis, supra note 171 and accompanying text. See also BERG ET AL., supra note 117, at 161 (observing that the medical profession views informed consent as “a pernicious, alien doctrine imposed by a hostile legal system. More stringent legal rules are not the answer, since they will only evoke increased resistance from physicians, who after all still remain largely in control of both the content and tone of doctor-patient interactions”).
state action to date has been aimed at educators. While school personnel do require stronger guidelines, state legislatures should take a more comprehensive view of the diagnostic and treatment process. Because this process necessarily involves medical practitioners, school personnel, and parents, states should enact laws that will foster cooperation between all involved.

School personnel are required under federal laws to identify children who may qualify for special education services, and state legislatures must draw clear lines between identification and diagnosis, and must require policies prohibiting school personnel from recommending or attempting to require a course of treatment. Legislation should affirmatively state that schools cannot require that a child be medicated as a condition of enrollment, and that a parent’s failure to medicate with psychotropic medication cannot, in and of itself, constitute neglect. Legislation must be carefully crafted to preserve open communication between educators and parents, and, with parental consent, between educators and medical practitioners.

Only physicians can make a medical diagnosis and prescribe a course of treatment. State laws, therefore, should mandate that physicians who diagnose and treat children with ADHD and other neurobehavioral disorders receive specified training and follow diagnostic and treatment guidelines, including informed consent requirements. The legislature should delegate the identification or development of the specific training requirements and diagnostic and treatment guidelines to a state medical board or panel.

Enacting such legislation will not resolve all of the controversy regarding the use of psychotropic medication for children. It will, however, go far in improving the process of diagnosing and treating children with ADHD and other neurobehavioral disorders by simply drawing boundaries for school personnel and requiring that physicians obtain training and follow guidelines. Equally important, this legislation will foster much more information sharing and collaboration among educators, medical practitioners and parents, and ultimately benefit children requiring diagnosis and treatment.