COSAs and Psychopharmacological Interventions: Informed Consent and a Child’s Right to Self-Determination

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Abstract

Clinical and social science research indicates that minor children of substance abusers (COSAs) have an increased risk of behavioral or psychological disorders. When these disorders are identified or diagnosed by professionals, psychopharmacological interventions may often be recommended as a component of treatment. In the United States, a minor child may not legally consent to such treatment. Instead, parents (or other court-appointed persons or entities) must substitute judgment for a child. The exercise of “substituted judgment” implicates ethical and legal standards of “informed consent” and “consent-by-proxy.” Despite extensive commentary, however, the needs and interests of adults, as well as beneficiaries of the economic investment in such medications, may deny vulnerable children protection from unnecessary or ineffective interventions. The author suggests that “substituted judgment,” if undergirded in the United States by constitutional notions of due process, should require: (1) objective and compelling evidence that a parent’s exercise of substituted judgment is independent and unimpaired; (2) that consent respects the child’s right to self-determination; and (3) the child’s present and future health is enhanced by the intervention.

I. INTRODUCTION

In modern America, the tension between diagnosis and psychopharmacological1 interventions for children often arises in the midst of

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1 The term “psychopharmacological” encompasses an array of medications prescribed for children, and may include the term “psychotropic.” See Arizona Health Futures, Flashpoint: Children, Adolescents and Psychotropic Medications 4 (2006), available at http://www.slhi.org/publications/issue-briefs/pdfs/ib-2006-August/pdf. Psychotropic medications can be defined as drugs that affect the psychic function, behavior and experience of a person using them. Id. Other definitions stress the effect of psychotropic drugs on mind, emotions and behavior; or use the term “psychoactive” to refer to the “active” effects of these drugs on mental experiences and behavior. Id. The term “psychopharmacology” is also defined as the “science of drugs as they relate to mental and behavioral effects on emotional states; the use of drugs to modify psychological symptoms” and “psychotropic” is defined as “a term applied to drugs that have a special action upon the mind or psyche.” The New Lexicon Illustrated Medical Encyclopedia and Guide to Family Health 618–19 (Robert E. Rothenberg ed., 8th ed.) (1988). As noted in the text, this article is not concerned with the efficacy of these interventions. But see Mark R. Zonfrillo et al., Pediatric Psychotropic...
family dislocation through divorce, cohabitation, foster care, and child protective proceedings. Within these shape-shifting forms of family dislocation and conflict, guardians, attorneys, therapists, physicians, domestic violence advocates, foster care parents, grandparents, and a litany of other professionals, acquire distinct obligations to the well-being of a child. Because a minor child alone may not legally consent to psychopharmacological interventions, a parent must substitute his or her judgment for the child. In many of these circumstances, the exercise of authority by a parent for a child is substantially influenced by the authority and judgment of these professionals. The ethical and legal dilemma is whether parents, who operate within these complex family systems, have sufficient knowledge and independence so as to justifiably confer “active” or “passive” consent-by-proxy for such an intervention. These dilemmas are particularly problematic when
“substituted judgment” means the imposition of psychopharmacological interventions for children in an area of science and public policy fraught with emotion:

Few issues in health care generate more heat than the growing use of psychotropic medications among children and adolescents. Science, culture, politics and values collide in a fireball of beliefs, policies and practices that, like so much else in modern American life, flame out between two opposing poles: those who believe these medications can unlock the full potential of children to grow up and lead healthy, productive lives; and those who believe their increasing use represents the “medicalization” of normal behavior in children without considering the long-term biological and socio-cultural consequences.6

For professionals acting as “gatekeepers,” advocacy, in any meaningful sense, implicates a duty to respect a child’s right to self-determination while carefully assessing the capacity of an impaired parent to confer consent of any kind.7 As a threshold matter, however, professionals need to understand not just the scientific literature that suggests psychopharmacological interventions may be effective, within the vast and unique variables that exist for each child, but a renewed sensitivity to notions of loyalty and duty to a child’s “best interests.”8

ethical or legal propositions, not scientific. We can disapprove of a given value but we cannot disprove it. It can be judged (assessed as to its acceptability), but that is all. This is why the end product of the legal (“judicial”) process in the courts is called a judgment, as is the end product of an ethical analysis—it is not called a concussion. JOSEPH FLETCHER, HUMANHOOD: ESSAYS IN BIOMEDICAL ETHICS 121–22 (1979).

6 ARIZONA HEALTH FUTURES, supra note 1, at 2.


8 The term “best interests” represents a combination of statutory and case law factors that have evolved in the United States since the turn of the twentieth century. See Jennifer L. Rosato, The End of Adolescence: Let’s Get Real: Quilting a Principled Approach to Adolescent Empowerment in Health Care Decisions, 51 DEPAUL L. REV. 769, 796–97 (2002); Susan B. Hawkins, Note, Protecting the Rights and Interests of Competent Minors in Litigated Medical Treatment Disputes, 64 FORDHAM L. REV. 2075, 2076–77 (1996). All states have a list of factors courts must apply, to whatever degree is relevant to the unique circumstances of each case. Under ME. REV. STAT. ANN. tit. 19-A, §1653(3), these factors, common to most states, are as follows:

The court, in making an award of parental rights and responsibilities with respect to a child, shall apply the standard of the best interest of the child. In making decisions regarding the child’s residence and parent-child contact, the court shall consider as primary the safety and well-being of the child. In applying this standard, the court shall consider the following factors:

A. The age of the child;
Any such calculus must begin with an understanding of the family system in which a COSA resides, and thereby any unique vulnerabilities associated with parental patterns of substance abuse. Thus, Part II briefly describes the relationship between parental substance abuse and risk factors for children. The parameters of substituted judgment and informed consent for COSAs are explored in Part III. A

B. The relationship of the child with the child’s parents and any other persons who may significantly affect the child’s welfare;
C. The preference of the child, if old enough to express a meaningful preference;
D. The duration and adequacy of the child’s current living arrangements and the desirability of maintaining continuity;
E. The stability of any proposed living arrangements for the child;
F. The motivation of the parties involved and their capacities to give the child love, affection and guidance;
G. The child’s adjustment to the child’s present home, school and community;
H. The capacity of each parent to allow and encourage frequent and continuing contact between the child and the other parent, including physical access;
I. The capacity of each parent to cooperate or to learn to cooperate in childcare;
J. Methods for assisting parental cooperation and resolving disputes and each parent’s willingness to use those methods;
K. The effect on the child if one parent has sole authority over the child’s upbringing;
L. The existence of domestic abuse between the parents, in the past or currently, and how that abuse affects;
   (1) The child emotionally; and
   (2) The safety of the child;
M. The existence of any history of child abuse by a parent;
N. All other factors having a reasonable bearing on the physical and psychological well-being of the child;
O. A parent’s prior willful misuse of the protection from abuse process in chapter 101 in order to gain tactical advantage in a proceeding involving the determination of parental rights and responsibilities of a minor child. Such willful misuse may only be considered if established by clear and convincing evidence, and if it is further found by clear and convincing evidence that in the particular circumstances of the parents and child, that willful misuse tends to show that the acting parent will in the future have a lessened ability and willingness to cooperate and work with the other parent in their shared responsibilities for the child. The court shall articulate findings of fact whenever relying upon this factor as part of its determination of a child’s best interest. The voluntary dismissal of a protection from abuse petition may not, taken alone, be treated as evidence of the willful misuse of the protection from abuse process;
P. If the child is under one year of age, whether the child is being breast-fed;
Q. The existence of a parent’s conviction for a sex offense or a sexually violent offense as those terms are defined in Title 34-A, section 11203; and
R. If there is a person residing with a parent, whether that person:
   (1) Has been convicted of a crime under Title 17-A, chapter 11 or 12 or a comparable crime in another jurisdiction;
   (2) Has been adjudicated in a proceeding, in which the person was a party, under Title 22, chapter 1071 as having committed a sexual offense.
discussion follows in Part IV concerning the implications of psychopharmacological interventions in a manner that comports with a child’s due process rights, if such a right is even cognizable for a child under current American constitutional theory. In conclusion, I argue that there should exist a compelling and objective factual basis before the exercise of substituted judgment on behalf of COSAs can constitute informed consent. The underlying premise is that consent-by-proxy should require strict scrutiny of biological, psychological, social, and cultural factors unique to each child and family system.

II. COSAS AND “RISK FACTORS”

Studies correlate family dislocation with the precipitation of child maltreatment, academic failure, emotional and psychological disorders, physical and cognitive impairments, poverty, parental drug abuse, and domestic violence. Among any constellation of these factors, parental substance use frequently enhances the “accumulation of risk” for children of substance abusers (COSAs), which yields a “heightened risk for negative outcomes.” An important limitation on the use of such substance abuse data is that “predictive patterns” for COSAs may differ by parental age, race, ethnicity, marital status, education, and employment. This is true because the etiology of familial substance abuse patterns is non-linear or “multidetermined by biological, psychological, and environmental pathways.” The consequences of parental substance abuse

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9 See Cruzan v. Dir., Missouri Dep’t of Health, 497 U.S. 261, 262(1990) (stating that a competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment that must be balanced against relevant state interests and assuming, for purposes of that case, that the Constitution would grant a competent person a protected right to refuse lifesaving hydration and nutrition); Washington v. Harper, 494 U.S. 210, 210 (1990) (establishing a right to a due process hearing before an inmate can be administered psychotropic drugs).


11 NCASA, supra note 2, at 2; see also Michael D. DeBellis et al., Psychiatric Co-morbidity in Caregivers and Children Involved in Maltreatment: A Pilot Research Study with Policy Implications, 25 CHILD ABUSE & NEGLECT 923, 924 (2001).

12 NCASA, supra note 2, at 2; see also William Fals-Stewart et al., Emotional and Behavioral Problems of Children Living with Drug-abusing Fathers: Comparison with Children Living with Alcohol-Abusing and Non-Substance-Abusing Fathers, 18 J. Fam. Psychol. 319, 321 (2004).

13 Timothy J. O’Farrell & William Fals-Stewart, Treatment Models and Methods: Family Models, in ADDICTIONS: A COMPREHENSIVE GUIDEBOOK 287, 292 (Barbara S. McCrady & Elizabeth F. Epstein eds., 1999). See Jesse B. Milby et al., Psychoactive Substance Use Disorders: Drugs, in ADULT PSYCHOPATHOLOGY AND DIAGNOSIS 159, 161 (Samuel M. Turner & Michael Hersner eds., 3d ed. 1997) (“A comprehensive understanding of the etiology of substance use disorders requires recognizing the basic biological and molecular mechanisms underlying the reinforcing effects of psychoactive substances. These provide foundations for other etiological factors operating at the intrapersonal, interpersonal, and social levels and in no way diminish the importance of well-established precursors for drug abuse and variables that contribute to individual vulnerability.”).
COSAs are “thought to have unique characteristics” that demand attention because it is now “well documented that the children of untreated drug and alcohol using parents are at risk for serious educational, medical, and emotional problems and have the potential for abusing illicit drugs themselves.” The accumulation of risk factors within these family constellations renders it more likely that COSAs will be identified with, and treated for, conditions like ADHD, depression, anxiety, and conduct or behavioral disorders.

The increased rate of such diagnoses over the past decade coincides with the exponential growth of psychopharmacological medications as an outcome-intended intervention for children from pre-school to adolescence. The term “psychopharmacological” encompasses a broad range of medications that are the subject of “research and clinical experience” as applied to various “diagnostic categories.” Indeed, as revealed through a public controversy between psychiatrists, the diagnosis of pre-pubescent children with conditions like bipolar disorder and the imposition of medication have engendered considerable public discussion in the media and literature. As a threshold matter, the “informed consent process for children and adolescents needs to address the fact that most

\[\text{14} \text{ Fraser et al., supra note 7 at 869; see also Linda C. Sobell et al., Substance-Related Disorders: Alcohol, in ADULT PSYCHOPATHOLOGY AND DIAGNOSIS, supra note 13, at 182 (citing data concerning parental alcohol abuse).}
\[\text{15} \text{ Patti Juliana & Carolyn Goodman, Children of Substance Abusing Patients, in SUBSTANCE ABUSE: A COMPREHENSIVE TEXTBOOK, 665, 665 (Joyce H. Lowinson et al., 3d ed. 1997); NCASA, supra note 2, at 2. See also Richard A. Barkley et al., Does the Treatment of Attention Deficit/Hyperactivity Disorder with Stimulates Contribute to Drug Use/Abuse? A Thirteen Year Prospective Study, 111 PEDIATRICS 97, 100–01 (2003); Laurence L. Greenhill & Rebecca E. Ford, Childhood Attention-Deficit Hyperactivity Disorder: Pharmacological Treatments, in A GUIDE TO TREATMENTS THAT WORK 42, 51–52 (Peter E. Nathan & Jack M. Gorman eds., 2d ed. 2000).}
\[\text{19} \text{ See Scott Allen, Backlash on Bipolar Diagnoses in Children, BOSTON GLOBE, June 17, 2007, at A1, A8; Lawrence Diller, Misguided Standards of Care, BOSTON GLOBE, June 19, 2007, at A9.}
drugs used in pediatric psychopharmacology are not FDA-approved for use in children.” 20

The higher probability of psychopharmacological interventions for COSAs may reflect the fact that family systems with these traits have more frequent interaction with judicial, educational, medical, and mental health professionals who, with varying degrees of responsibility, encourage or support such interventions for an eclectic combination of biopsychosocial problems. 21 Another factor may be that psychoactive drugs may exert a peculiar biological property that enhances the risk factors associated with certain family systems. 22 Whatever associations may exist between a particular family constellation and psychopharmacological interventions, observers have suggested that the use of these interventions rests upon limited information as to adverse consequences and benefits. 23 For purposes of this article, however, the issue is not the efficacy of medicating children for identifiable biological or behavioral disorders. Instead, it is the process for deciding and delivering this form of intervention to minor children.

III. COSAS AND PARENTAL CONSENT-BY-PROXY

Even with attested gender differences, Locke & Newcomb have suggested that substance abuse within family systems has four theoretical perspectives. 24 First, observational learning or modeling is an important aspect of behavioral and social learning theories which assume that learning occurs “vicariously through observation and can occur without comment or reinforcement.” 25 When children are maltreated, suboptimal parenting practice is a possible explanation for the pathway between parental alcohol-and drug-related problems and polydrug

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20 Katic & Steingard, supra note 18, at 929.
22 See Milby et al., supra note 13, at 160–61 (“Drug abuse is a multifaceted biological, pharmacologic, sociopsychological phenomenon. Animals with no previous exposure to drugs readily self-administer psychoactive drugs, and their consumatory patterns are similar to human users. This phenomenon suggests that psychoactive drugs can exert their abuse and dependence properties on a human biological system with no preexisting psychopathology or addictive liability required to establish initial use and self-determination”).
23 For a critical discussion of these trade-offs, see THE ALLIANCE FOR HUMAN RESEARCH PROTECTION, BEST PHARMACEUTICALS FOR CHILDREN ACT OF 2002 passim (n.d), available at http://www.ahrp.org/cms/content/view/233/142/.
25 Id.
problems within the family of origin. Second, parentification refers to a role reversal wherein a child fills the parental role in families with drug abusing parents. If children prematurely adopt adult roles, they do not have the opportunity to progress through age-normative transitional experiences. Thirdly, the self-medicating hypothesis predicts that drug problems may be part of an individual response to emotional or psychological distress when children experience maltreatment. Finally, impaired functional theory predicts that substance abuse leads to psychosocial problems by impairing psychological function.

The question that arises from these four perspectives is whether a matrix of such vulnerabilities increases the likelihood that parental consent to psychopharmacological interventions is more readily conferred as a suboptimal parenting practice rather than an intelligent, informed, and independent exercise of judgment for another human being. The empirical research concerning competency to consent suggests that consent is structured as a series of overlapping dilemmas: autonomy versus best interests, legal versus psychological or ethical, child versus family-based, and other approaches that emphasize consent versus those that emphasize assent. Each of these dilemmas underscores a fundamental obligation to assure the psychic and physical well-being of a minor child who presumptively lacks the capacity for self-protection and self-determination. Indeed, federal and state courts in the United States have held that in the absence of a compelling state interest, “an individual has the right to be free from the administration of unwanted psychotropic medication. This right has been recognized pursuant to rights of privacy and bodily integrity.”

Only a minor child may forfeit, by age alone, the right to personally consent to an invasion of bodily integrity. Whatever the specific mixture of parental consent or professional oversight, vulnerable parents may more rapidly adopt a belief in “magic bullets” as the quest for a “scientific” explanation for their children’s behavioral and emotional struggles. Moreover, the obligation to strictly scrutinize the specific rudiments for consent is particularly important when social disadvantage may increase rates of medication. After all, parents do not self-issue scripts but accept professional recommendations that follow certain medical, educational, or societal models of “acceptable” behavior. For example, some authors suggest that the symbiotic relationship between school systems and families, as the most common means of acculturation in the United States, may increase the probability of psychopharmacological interventions:

27 See Sterling & Walco, supra note 4, at 240.
28 Komoroski, supra note 21, at 106.
29 See David Isaacs, Attention-Deficit/Hyperactivity Disorder: Are We Medicating for Social Disadvantage? (FOR), 42 J. PEDIATRICS & CHILD HEALTH 544, 545 (2006); Laurel K. Leslie et al., Racial/Ethnic Differences in the Use of Psychotropic Medication in High-Risk Children and Adolescents, 42 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1433, 1438 (2003).
Teachers complain that they are unable to teach classes with disruptive students, and suggest that medication is necessary to deter delinquency and occupational failure. Psychiatric experts warned Congress that too many educators are urging parents of problem children to treat them with prescription drugs rather than addressing the real problems at home or at school. These drugs often compound existing problems, and side effects can lead to further psychiatric misdiagnoses.\(^{30}\)

In this sense alone, an ethical and legal predicate for consent-by-proxy requires autonomy, coupled with reliance upon biological or observable phenomena that are objectively reliable within the traditional norms of scientific methodology: “parsimony,” “generality,” “consilience,” and “predictiveness.”\(^{31}\)

IV. CHILDREN AND SELF-DETERMINATION AS “A NATIONAL CONCERN”

The National Academy of Sciences found it is “a national concern that millions of children in the U.S. are being diagnosed with loosely defined psychiatric ‘disorders’ for which they are irresponsibly prescribed a variety of psychotropic drugs.”\(^{32}\) Moreover, these “powerful psychoactive drugs pose significant hazards even during short-term exposure” while their promoters acknowledge the absence of data about long-term exposure.\(^{33}\) At the present time, psychotropic drug trials do not satisfy ethical trials involving human beings who are not legally competent volunteers: namely, children.\(^{34}\)

It is quite plausible to argue that what is occurring in the United States today is a massive research study without scientifically designed outcome-based criteria for assessing the potential risks and benefits.\(^{35}\) Indeed, few longitudinal studies exist to show the behavioral, psychological, emotional, educational, or biological risks or benefits associated with medicating children from preschool through adolescence.\(^{36}\) This dark space in the scientific, legal, and ethical communities

\(^{30}\) Komoroski, supra note 21, at 99–100 (footnote omitted); see also RONALD T. BROWN & MICHAEL G. SAWYER, MEDICATIONS FOR SCHOOL AGE CHILDREN: EFFECTS ON LEARNING AND BEHAVIOR 3–9 (1998); Joseph Biederman et al., Diagnoses of Attention Deficit Hyperactivity Disorder from Parent Reports Predict Diagnoses Based on Teacher Reports, 32 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 315 (1993).

\(^{31}\) EDWARD O. WILSON, CONSILIENCE: THE UNITY OF KNOWLEDGE 216 (1998); see also John S. Carlson, Psychotropic Medication Consultation in Schools: An Ethical and Legal Dilemma for School Psychologists, 22 J. APPLIED SCH. PSYCHOL. 29, 31 (2006) (discussing the need for school-based psychologists to have competencies in evidence-based interventions that include psychopharmacological approaches).

\(^{32}\) THE ALLIANCE FOR HUMAN RESEARCH PROTECTION, supra note 23, at 3.

\(^{33}\) Id.

\(^{34}\) Id.

\(^{35}\) See Jeffrey M. Gibbs, State Regulation of Pharmaceutical Clinical Trials, 59 FOOD & DRUG L.J. 265, 271 (2004); Greenhill & Ford, supra note 15, at 25; Rubinstein, supra note 21, at 751.

\(^{36}\) See generally Gibbs, supra note 35, at 271; Katic & Steingard, supra note 18, at 929; NAS Committee, supra note 23, at 3; Chris Travell & John Visser, ‘ADHD does Bad Stuff to You’: Young
does not even begin to touch upon potential problems that may occur when COSAs reach adulthood having been prescribed a cocktail of medications without appropriate post-prescription observation or medical screening.37

Among scholars there is a technical distinction between research and treatment in the context of protocols, beneficence, and utility, but any distinction is meaningless if consent-by-proxy is “incongruent” with the needs of the child.38 Consent must be exercised by parents (or other authorities as proxies) because a child was historically presumed to lack the intelligence, maturity, or judgment to refuse or grant consent even if a child needs protection from would-be human “experimenters.”39 In this context, the dimensions of science and law have a common root when consent-by-proxy involves the invasion of a human being’s corporeal or psychic integrity: the fundamental common law principle that volenti non fit injuria (“to one who is willing, no wrong is done”).40

Underpinning this fundamental principle, however, is the obligation of professionals to respect the child’s right to self-determination.41 Self-determination is the fountainhead of informed consent as it means the right of patients “to participate fully in decisions made about them so as to ‘promote individual autonomy’ and “encourage rational decisionmaking.”42 These goals yield five elements for valid informed consent:

1. the information provided is adequate for clients to weigh the risks and benefits of the proposed action, 2. clients have been told the foreseeable risks and benefits of the proposed action, 3. clients are competent to provide consent, 4. clients give consent voluntarily and without coercive influence, and 5. clients have been told they have the right to refuse or withhold consent.43

Peoples’ and Parents’ Experiences and Perceptions of Attention Deficit Hyperactivity Disorder (ADHD), 11 EMOTIONAL & BEHAV. DIFFICULTIES 205, 205 (2006).

37 See Vitiello, supra note 17, at 986; see generally Coyle, supra note 17, at 1059.
40 LEVY, supra note 39, at 16.
41 See Jackie Tillett, Adolescents and Informed Consent-Ethical and Legal Issues, 19 J. PRENATAL & NEONATAL NURSING 112, 112 (2005); Bruce J. Winnick, Competency to Consent to Treatment: The Distinction between Assent and Objection, 28 Hous. L. Rev. 15, 16 (1991) (“Elements of informed consent include disclosure of information, competency, understanding, voluntariness, and decisionmaking”).
43 Id.
Each of these elements is necessary so as to ensure that the substitution of judgment by one human being for another implicates more than mere ritual. Indeed, the medical profession has been quite sensitive to a physician’s duty to a patient who lacks decisional capacity, particularly when the surrogate refuses what the medical profession considers a beneficial treatment. Although defining the “scope and boundaries of informed consent” has been an “arduous task,” the American Academy of Pediatrics, among other authorities, has stressed the historical importance of informed consent for children to avoid errors of the past—and the predilections of those in authority to assume altruistic motives as moral cover for unethical necessity.

Of course, there is a need to weigh risks and benefits before imposing, or refusing to impose, psychopharmacological interventions on children. In the context of medical ethics, protection of a child’s “best interests” means “minimal risk,” without necessarily limiting any intervention to the “ideal.” Any such balancing test implicates tangible and intangible costs associated with delay and other negative consequences like school suspensions or health risks. The test of societal values in the context of these kinds of trade-offs often reflects “asymmetrical paternalism” or a skepticism toward the capacity of its most vulnerable members to make choices in their best interests.

With substituted judgment, the duty of parents and professionals is that of a “classic fiduciary,” which implicates old-fashioned notions of “loyalty.” Loyalty means to refrain from exploiting a child’s vulnerability for gain as well as the avoidance of any conflicts of interest that diminish the independence of that loyalty. When the exploitation of vulnerable population limits self-determination and autonomy, then the assistance of the judicial branch of government, as arbiters of constitutional protections in American society, is often sought. If those members of society are children, the threshold question in the United States is whether the due process clause of the Fourteenth Amendment, which historically protects adults and corporations, applies with equal force to COSAs subject to psychopharmacological interventions.

45 Rubinstein, supra note 21, at 751.
47 Loretta M. Kopelman, Minimal Risk as an International Ethical Standard in Research, 29 J. MED. & PHIL. 351, 372 (2004); Loretta M. Kopelman & Timothy F. Murphy, Ethical Concerns about Federal Approval of Risky Pediatric Studies, 113 PEDIATRICS 1783, 1783 (2004) (critiquing federal limits on research and “procedural and interpretive ambiguities”).
49 Morreim, supra note 38, at 477.
50 See RHONDA WASSERMAN, PROCEDURAL DUE PROCESS: A REFERENCE GUIDE TO THE UNITED STATES CONSTITUTION 24 (2004), for a discussion of the evolution of “person,” under the Bill of Rights (“the Supreme Court has long treated corporations as persons protected by the Due Process and Equal Protection Clauses of the Fourteenth Amendment”). But see SANFORD SCANÉ, LANGUAGE
V. DUE PROCESS AND THE DIMENSIONS OF INFORMED CONSENT

As a measure of judicial restraint, federal and state courts have historically acknowledged a presumptive right of parental autonomy concerning their children’s upbringing “except in the context of neglect, abuse, or other emergencies.”\(^{51}\) When the actual or potential harm to a child is sufficiently severe (as defined by law),\(^{52}\) a child may be deemed to have fundamental right to due process under the Fourteenth Amendment to the United States Constitution. This right is defined more specifically as a “liberty interest,” which implicates government protection in the form of procedural due process, or the right to hearing that is independent of bias or pre-disposition.\(^{53}\)

Any reliance upon due process considerations as a means to protect children is, however, the source of considerable controversy.\(^{54}\) Indeed, the interjection of potential harm or benefit from a psychopharmacological intervention reveals the tension between notions of paternalism (“what is good or desirable is determined not by children themselves but by society or some subset of society”) and self-determination (the “potential right” to express “autonomous control over various facets of their lives”).\(^{55}\) For purposes of any “liberty interest” protection, a possible solution to this conundrum (or penumbra) for COSAs may be found in this test: *When the biopsychosocial assessment of parental decisionmaking yields an impaired capacity to engage in an intelligent, informed, and independent exercise of the law* 70 (2006) (the Supreme Court, however, distinguishes “citizens” from “person[hood]” as the term citizens only applies to natural persons).\(^{56}\)


\(^{52}\) The definition of “abuse” has had a long and controversial history.

At its heart, however, the policy debate involves questions of value: What are basic rights and entitlements of individual children and their families in a complex society such as ours? Which problems are best viewed as private troubles of individual citizens and which should we elevate to public social concern? How blind should policy be to questions of race, ethnicity, and disadvantage? How active a role should government play in seeking out and remedying individual dysfunction? Can policy take into account that although men primarily hold power, those with the greatest stake in the child welfare system are women and children? Child welfare policy, as all other areas of social policy, has occasioned much spirited discussion over the past decade on the proper role of government in fulfilling its historical role as *parents patriae*—the ultimate parental authority—and the balance between acting “in the best interests of the child versus family preservation.


of judgment for a minor child, and there is a compelling risk that the child’s present and future best interests are at risk from a psychopharmacological intervention, there is a right to independent review before consent-by-proxy to such an intervention may be given. This proposed test is consistent with judicial holdings related to a child’s right to procedural due process, and reasonable expectations of privacy from random, subjective acts of corporeal or psychically invasive interventions.

In *Prince v. Massachusetts*, the United States Supreme Court, in the context of a parent’s religious beliefs, wrote that “parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they make that choice for themselves.” More than three decades later, in the seminal school discipline case of *Ingraham v. Wright*, the Court concluded that “any deliberate infliction of corporal punishment on a child” creates a risk that the “intrusion on the child’s liberty will be unjustified and, therefore, unlawful. In these circumstances, the child has a strong interest in procedural safeguards that minimize the risk of wrongful punishment and provide for the resolution of undisputed questions of justification.”

Between *Prince* and *Ingraham*, the Court decided the landmark case *In re Gault*, in which the majority refused to afford juveniles all the procedural guarantees granted adults, but concluded that juvenile delinquency hearings must still afford the essentials of due process and fair treatment, which includes the right to notice of the charges, adequate time to prepare a defense, appointed or privately retained counsel, and the right to confront witnesses. In this decision, the Court posited that “neither man nor child can be allowed to stand condemned by methods which flout constitutional requests of due process of law.” This is true because “neither the Fourteenth Amendment nor the Bill of Rights is for adults alone” such that it “would be extraordinary if our Constitution did not require the procedural regularity and the exercise of care implied in the phrase ‘due process.’” As the Supreme Court aptly concluded the “condition of being a [minor] does not justify a kangaroo court.”

From the particulars of school and juvenile crime to the shifting law of a child’s right to privacy, a majority of the Supreme Court has severed the rights of minors from the traditional autonomy of parents in limited (and highly controversial) circumstances. In *Planned Parenthood of Central Missouri v. Danforth*, for example, which concerned whether minors must receive consent from parents before obtaining an abortion, a majority of the Supreme Court

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57 Id. at 170.
59 Id. at 676.
60 387 U.S. 1 (1967).
61 Id. at 13 (quoting Haley v. Ohio, 332 U.S. 596, 601 (1948)).
62 Id. at 27–28.
63 Id. at 28.
64 428 U.S. 52 (1976).
accorded minors a constitutional right to privacy by holding that “[c]onstitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights.”65 The Court recognized that the State has “somewhat broader authority to regulate the activities of children than of adults.”66 A plurality of the Court, however, declined to view parental authority as universally overcoming a constitutional right of privacy for minors qua minors.

As applied to children, a flexible concept of a meaningful opportunity for hearing at a meaningful time and in a meaningful manner is consistent with the United States Supreme Court’s rejection, over the past fifty years, of early American law that adopted the eighteenth-century English common law view that children were to be regarded as chattels of the family or wards of the government.67 There is, however, no “master theory to govern constitutional practice.”68 This tension is particularly present within the range of “agonizing” issues for parents between parental consent and “sensitive medical procedures.”69

The interests of COSAs in a meaningful right to review before parental consent need not be argued at the extremes. In a series of cases throughout the country over the past three decades, adults deemed legally incompetent to make medical decisions in their own interests were held to have a right to refuse antipsychotic drugs absent an “overwhelming state interest” that supercedes an individual’s “significant liberty interest in freedom from unwanted medication.”70 Requiring children to take psychopharmacological medications may well violate their “constitutionally protected liberty interest in privacy and bodily integrity”71 if consent-by-proxy lacks a meaningful opportunity for the essentials of due process. The test proffered in this article imposes no more than the minimal right to avoid “wrongful punishments” or “expectations of privacy” already recognized in Prince, Ingraham, Gault, and Danforth.

VI. CONCLUSION

For the reasons described above, the critical mass that has yielded such frequent psychopharmacological interventions for children makes it imperative that serious consideration be given to the means and process by which consent is taken

65 Id. at 74.
66 Id.
70 Komoroski, supra note 21, at 111.
71 Id. at 100.
The modern blend of law and science may undercut ethical assessment and intervention because American society has made “science the measure of all things. Truth means truth of science. Truth means logical truth or factual truth. Truth means math truth or data test. The truth can be a matter of degree. But that does not help ethics.” Indeed, more than three decades ago, a physician wrote that “more than a million American citizens are forced to enter mental hospital and undergo dangerous psychiatric treatments they never agreed to. Every year thousands of citizens are accused of crimes but not convicted by a court are confined in mental institutions. Abuse such as these occur because psychiatrists have state-given power to decide what is good for another person.”

Parents, of course, “play a vital role in the delivery of pharmacological and behavioral treatments.” In the new millennium, teachers, guardians ad litem, therapists, physicians, lawyers, judges, and government designees are given “power” to impose psychopharmacological interventions. Meanwhile, parents are subject to environmental, psychological, biological, cultural, or economic limitations that may foster a susceptibility to consent to medicate in the quest for an answer (or explanation) that is accepted by the community and consistent with a modern cultural narrative that validates medication as an outcome.

These outcomes for children are not merely the accidents of history. Instead, the growth of psychopharmacological interventions for children exposes a confluence of profound cultural and structural changes in America over the past thirty years: the measure of pure science as a function of stock prices; the overwhelming despair of so many parents coping with modernity; the substitution of school systems as family systems; the dislocation of parents, siblings, and extended family from each other and their communities; medical and therapeutic relationships between strangers rather than close collaboration over generations; and the absence of stigma for self-medication or self-absorption. Each combination or permutation enhances the risk that a child will be treated without recourse to duty, loyalty, or consequences—biological, social, and psychological.

In this day and age, however, a bated breath, in the absence of a true emergency, is a small price for assuring an adequate assessment of all biopsychosocial factors impacting a child. When a psychopharmacological intervention is proposed, comprehensive multidisciplinary assessments should address the mental, physical, and environmental health needs of children and parents primarily because the co-morbidity of parental substance abuse and other

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disorders enhances the severity of risk for a child. Thus, and much like institutional review boards (IRBs) that review human research studies or transplant candidates, parents, children, and professionals should have a means of requesting an independent, multidisciplinary review of psychopharmacological interventions that comports with ethical standards for clinical trials on children.

In an “ideal world,” any review panel should consist of a medical professional, attorney, and mental health professional familiar with that specific family system and the constellations of factors that yield benefits and risks. The availability of such a collaborative, multidisciplinary team to review evidence could facilitate communication between professionals and parents so as to provide comprehensive support and monitoring services related to a child’s health. This form of consilience, or unification of knowledge, means the “linking of facts and fact-based theory across disciplines to create a common groundwork of explanation.” Given contemporary preferences for evidence-based practices, as both an ethical and scientific obligation, studies are necessary to assure that a child’s right to informed consent is not abridged or abandoned in the quest for expedient psychological or behavioral controls within a cultural narrative that encourages compliant behaviors and which may ignore the unique vulnerabilities of parents and their family systems.

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76 See NCASA, supra note 2, at 9; Chronis et al., supra note 75, at 1424, 1430; Andrew Adesman, A Diagnosis of ADHD? Don’t Overlook the Probability of Comorbidity!, 20 CONTEMPORARY PEDIATRICS 91, 94 (2003).


79 WILSON, supra note 31, at 8.

80 See Andrea M. Chronis et al., Evidence-Based Psychosocial Treatments for Children and Adolescents with Attention-Deficit/Hyperactivity Disorder, 26 CLINICAL PSYCHOL. REV. 486, 487 (2006); American Academy of Pediatrics, Clinical Practice Guideline: Treatment of the School-aged Child with Attention Deficit/Hyperactivity Disorder 105 PEDIATRICS 1033, 1041 (2000), available at http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/5/1158.pdf 1033, 1041. The relationship between ethics and the role of the community has been described by Habermas, as follows:

Secondly, we see a similar development of ethics and morality. Again, as the magic and the traditional shroudings are thrown off, so ethics are increasingly rationalized. Formal principles and norms take the place of the cruder traditional moral prescriptions, proscriptions, and sanctions of the tribe, the clan, and the religious community. Moreover the principles now have to be applied universalistically, to each strictly according to the rule and without fear or favour.

MICHAEL PUSEY, JÜRGEN HABERMAS 51 (1987).