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THE CHILD MEDICATION SAFETY ACT: SPECIAL TREATMENT FOR THE PARENTS OF CHILDREN WITH ADHD?

I. INTRODUCTION

Casey is a seven year-old with Attention Deficit Hyperactivity Disorder (ADHD).¹ For the past year, he has taken Ritalin² to curb his hyperactivity at school and help him function in a mainstream classroom.³ However, the Ritalin has also subjected Casey to negative side effects, and his reading scores have become so low that they are off the charts.⁴ For these reasons, Casey's parents have decided to stop giving him Ritalin.⁵ In an attempt to effectively treat his ADHD, Casey underwent a series of tests and examinations at the hospital.⁶ The hospital's recommendations were taken into consideration when Casey's school developed an Individualized Educational Program (IEP) for him.⁷ Because the hospital recommended drug therapy, the IEP included a provision that Casey should be placed on Ritalin, with parental consent.⁸ Yet because of Casey's past experiences with Ritalin, his parents refused to consent to the

1. This story is based on the facts in *Valerie J. v. Derry Coop. Sch. Dist.*, 771 F. Supp. 483 (D.N.H. 1991). Throughout this Note, the term "ADHD" is used for Attention Deficit Hyperactivity Disorder. In this Note, the term also applies to students who have been diagnosed with ADD (Attention Deficit Disorder) or other related disorders that can be treated with Ritalin.

2. Throughout this Note, "Ritalin" (the brand name for Methylphenidate Hydrochloride) is used to refer to a variety of psychotropic drugs that are used to treat disorders such as ADHD. This is because Ritalin is one of the most frequently prescribed drugs for ADHD. See *infra* note 23 and accompanying text.

3. *Valerie J.*, 771 F. Supp. at 485.

4. *Id.* Casey's parents have noticed drastic changes in his behavior: he steals and lies, and he is aggressive and destructive. *Id.* at 484–85.

5. *Id.* at 484–85.

6. *Id.* Casey underwent neurological tests in 1985 and again on September 4, 1987. *Id.* During the 1987 tests, conducted at Children's Hospital in Boston, a report from September 10th stated that "Casey J. had characteristics of attention deficit disorder, but no neurological basis for his behavior." *Id.* In total, the doctors at Children's Hospital made sixteen recommendations about courses of treatment for Casey. *Id.* These recommendations varied as some recommended cooperative learning, structured education, and the use of medications (either Ritalin or Cylert, an experimental drug that was known to have side effects that affected the liver). *Id.* at 485.

7. *Id.* An Individualized Educational Program (IEP) is a procedural element provided under the Individuals with Disabilities Education Act (IDEA). 20 U.S.C. §§ 1400–1487 (2000); 20 U.S.C. § 1436 (2000). For a more detailed discussion of IEPs, see *infra* notes 37–56 and accompanying text.

8. *Valerie J.*, 771 F. Supp. at 485. In Casey's case, the IEP included a provision for the use of either Ritalin or Cylert if a pediatrician prescribed it, and if the parents agreed to it. *Id.*

IEP.⁹ Soon after, the school suspended Casey, saying it had “no choice”: he was simply too difficult to control.¹⁰

Ms. A is a Kindergarten teacher.¹¹ Each year in her classroom of thirty students, as many as seven of them have Attention Deficit Disorder (ADD) or ADHD. When she writes on the board, these young students squirm in their seats, making it hard for the rest of the students to pay attention. Some of these students have been prescribed Ritalin by their family doctors or other licensed physicians, and Ms. A recognizes that the medications provide a “sense of calm” that is welcomed by both the teacher and the student himself. Sam is a child in Ms. A’s class who has been having a difficult time concentrating. Ms. A suspects Sam may have ADHD, and if so, may benefit from taking Ritalin. She wants to tell Sam’s parents about this, but is wary of doing so. Ms. A knows that last year, another teacher at her school was accused of coercing a child into taking Ritalin when he had the school’s psychologist give informative pamphlets to the parents of a child he suspected might also benefit from such therapy. Since then, Ms. A’s principal has told all the teachers that they “shouldn’t mention anything” about ADHD to parents, because the school doesn’t want to be sued or risk losing federal funding.

As ADHD diagnosis and Ritalin use become omnipresent in our society, the tensions described in the above hypotheticals are frequently played out in America’s public schools. These tensions raise interesting legal questions because, as is often the case when children are involved, the suffering child has little or no say in what happens.¹² Instead, two well-intentioned parties—parents and educators—who have different perspectives on the effectiveness and appropriateness of using Ritalin to treat ADHD, are entitled to make a decision on the child’s behalf.¹³ In worst-case scenarios reported around the country, children have been “forced” to take Ritalin as a condition of attending school.¹⁴ In response, several states have drafted legislation aimed at preventing such occurrences.¹⁵ The issue has been addressed at the federal level as well: in

9. *Id.* at 486.

10. *Id.*

11. The following hypothetical story is compiled from surveys and interviews conducted with elementary school teachers in Boulder, Colorado, and a telephone interview with Libby Nealis, Director of Public Policy for the National Association of School Psychologists (Feb. 4, 2005) [hereinafter Nealis Interview].

12. See 20 U.S.C. § 1414(d)(B)(vii) (2000). Only in some cases will a child be included in the formation of his own IEP. *Id.* When appropriate, the child should be a member of the IEP team. *Id.*

13. See generally *infra* Parts II.C.1 and II.C.2.

14. See *infra* note 119.

15. See *infra* note 127.

2003, the federal Child Medication Safety Act (CMSA) was introduced in Congress,¹⁶ which was incorporated into the full scale reauthorization of the Individuals with Disabilities Education Act (IDEA) in December 2004.¹⁷

This Note will consider the merits of the CMSA in light of the legal rights and competing interests of parents, children, and educators. First, this Note will explain the history of students with disabilities' (which includes children with ADHD¹⁸) right to a public education, and how the framework of IDEA¹⁹ provides extensive procedural remedies that are designed to give parents meaningful participation in the IEP process. Next, this Note will examine the case law that defines the boundaries of parental rights and decision-making powers on behalf of their children in both the medical and educational contexts, and will discuss the legislation that responds to parental concerns about schools forcing Ritalin on their children. After analyzing the merits of such legislation, and considering it in light of established common law doctrines, this Note proposes that legislation such as the CMSA is unnecessary because it has the potential to allow parents of children with ADHD to subvert IDEA's traditional avenues of administrative redress available to parents wishing to challenge IEPs. The legislation creates opportunities for challenge that are unavailable to parents of children with other disabilities. This Note will also conclude that the CMSA and other proposed legislation attempt to legitimize a sensationalized crisis, and prevent public school personnel from focusing on the important parts of their jobs, and acting in the best interests of children.

II. HISTORY

A. *The Increased Use of Ritalin to Treat ADHD in School-Aged Children*

ADHD is a neurological disorder characterized by behavioral patterns displaying persistent overactivity and an inability to focus on a single task.²⁰ It is particularly common in school-aged children, and is four to

16. See *infra* note 130 and accompanying text.

17. 20 U.S.C.A. § 1412(25) (2004). IDEA is the federal statute governing the education of children with disabilities. For a more detailed explanation of IDEA, see *infra* notes 42–46 and accompanying text. IDEA 2004 includes a new provision, which prohibits educators from “requiring a child to obtain a prescription for [Ritalin] as a condition of attending school. . . .” 20 U.S.C.A. § 1412(25)(A).

18. See *infra* note 46.

19. 20 U.S.C §§ 1400–1487 (2000).

20. James C. O’Leary, Note, *An Analysis of the Legal Issues Surrounding the Forced Use of*

five times more likely to occur in boys than girls.²¹ Because of the immediacy of results and relative inexpense, many children diagnosed with ADHD are treated with drug therapy.²² For the large majority of American children whose ADHD is treated with medication, only two controlled substances are widely utilized: methylphenidate (commonly known as Ritalin) and amphetamine (primarily Adderall and Dexedrine).²³ In 2000, approximately five million children in the United States took Ritalin,²⁴ compared to approximately 900,000 children in 1990.²⁵ This represents a 550% increase in the use of Ritalin in a ten-year period.²⁶ Approximately 90% of the world's Ritalin is consumed in the United States.²⁷

The cognitive effect of Ritalin on a person with ADHD is a slowing of brain functions.²⁸ The noticeable consequence of this effect is that it keeps normally hyperactive children relatively still, and reduces their distracting behaviors.²⁹ However, Ritalin is also known to dull emotions, or produce symptoms of depression or anger.³⁰ For these reasons, many argue that there are more appropriate ways to treat ADHD than with drug therapy.³¹

Ritalin: Protecting a Child's Right to "Just Say No," NEW ENG. L. REV. 1173, 1177 (1993). For a more general discussion of the background of Ritalin use and ADHD, see *id.* at 1177–80.

21. AMERICAN MEDICAL ASSOCIATION, ENCYCLOPEDIA OF MEDICINE 552 (Charles B. Clayman ed., 1989).

22. O'Leary, *supra* note 20, at 1175.

23. *DEA Congressional Testimony Before the House Comm. on Education and the Workforce: Subcomm. on Early Childhood, Youth and Families*, 106th Cong. (2000) (statement of Terrance Woodworth, Deputy Director, Office of Diversion Control), available at <http://www.usdoj.gov/dea/pubs/cngrtest/ct051600.htm>.

24. Eben Carle, *ADHD For Sale*, PSYCHOL. TODAY, May–June 2000, at 17.

25. *Id.*

26. *Id.*

27. Nancy Gibbs, *The Age of Ritalin*, TIME, Nov. 30, 1998, at 89. Other ADHD and Ritalin-related issues (including the possibilities of over-diagnosis of ADHD, over-prescription of Ritalin, and abuse of Ritalin and sale of it on the street) are beyond the scope of this Note.

28. Alan D. Demmitt et al., *Children with Attention Deficit Hyperactivity Disorder; Ritalin and the Law; Recommendations for Practice*, 171 EDUC. LAW. REP. 415 (2003). While Ritalin is a stimulant that will speed up brain function in a normal brain, it has the opposite effect on an individual with ADHD or ADD; the reason for this is unknown in the medical community. PETER SCHRAG & DIANE DIVOKY, THE MYTH OF THE HYPERACTIVE CHILD 78 (1975).

29. RUSSELL A. BARKLEY, HYPERACTIVE CHILDREN: A HANDBOOK FOR DIAGNOSIS AND TREATMENT 7 (1981); BARBARA FISH, STIMULANT DRUG TREATMENT OF HYPERACTIVE CHILDREN, THE HYPERACTIVE CHILD 109, 111 (Dennis P. Cantwell ed., 1975).

30. BARKLEY, *supra* note 29, at 197; see also Valerie J. v. Derry Coop. Sch. Dist., 771 F. Supp. 483, 484–85 (D.N.H. 1991).

31. Among the most vocal proponents of this position are parents who have organized themselves into activist groups, one of the most popular of which is Able Child: Parents for Label & Drug Free Education (www.ablechild.org). See *infra* note 112 and accompanying text. Other proponents of this position are The Center for Cognitive Liberty and Ethics and the National Alliance for the Mentally Ill. See *Making Choices for Children*, www.cognitiveliberty.org/makingchoices/

B. Statutory History of Protecting the Right to a Public Education for Students with Disabilities

1. Landmark Cases and the Education of the Handicapped Act

In 1970, Congress passed the Education of the Handicapped Act (EHA)³² as a response to two landmark cases in which handicapped children³³ and their parents alleged that the children were not being given fair access to public education.³⁴ In the first of these cases, *Pennsylvania Ass'n of Retarded Children v. Commonwealth*,³⁵ the district court approved a consent decree enjoining Pennsylvania from excluding retarded individuals from access to a public education.³⁶ In its decision, the court recognized the importance of providing each retarded child with an education that would address his or her individual needs and learning capacities.³⁷ In the second case, *Mills v. Board of Education*,³⁸ the district court similarly recognized the necessity of preventing children with behavioral problems from being categorically excluded from public schools.³⁹

about.htm (last visited Jan. 31, 2006); House Passes Child Medication Safety Act, www.namisc.org/News/2003/Spring/ChildMedicationSafetyAct.htm (last visited Jan. 31, 2006). This was also the position put forth by the parents of Casey J. in *Valerie J.*, 771 F. Supp. at 485.

32. 20 U.S.C. §§ 1400–1485 (1988 & Supp. II 1990) (current version at 20 U.S.C.A. §§ 1400–1487 (2004)). The EHA was amended in 1975 to include procedural safeguards, and renamed the Education for All Handicapped Children Act (EAHCA). LAURA F. ROTHSTEIN, *SPECIAL EDUCATION LAW* 21 (3d ed. 2000). The original 1990 enactment of IDEA is effectively identical to the EAHCA, its most significant change being the replacement of the term “handicapped child” with the currently preferred “child with a disability.” *Id.*

33. Although the phrase “children with disabilities” is the term currently preferred by the disabilities rights movement, the phrase “handicapped children” was used historically and will be used in this Note when referring to a past event. I will use the phrase “children with disabilities” when discussing current issues.

34. ROTHSTEIN, *supra* note 32, at 12–21.

35. 343 F. Supp. 279 (E.D. Pa. 1972).

36. *Id.* at 301–02. This class action suit was brought in response to four Pennsylvania statutes that, among other things, relieved public schools from the obligation to educate a child who was “uneducable” as determined by a public school psychologist, and stated that a school can provide an “indefinite postponement of admission” to any child who has not reached a “mental age” of five years. *Id.* at 282 (citing Pennsylvania statutes). The court held argued that the state, having undertaken the education of some children, should not be permitted to deny education to retarded children. *Id.* at 302–03.

37. *Id.* When the EHA was passed, this concept was molded into the IEP program. See ROTHSTEIN, *supra* note 32, at 39.

38. 348 F. Supp. 866 (D.D.C. 1972).

39. *Id.* at 876. The court, ruling on grounds of equal protection and due process, held that the Board of Education has an obligation to provide a child with whatever specialized instruction will benefit him. *Id.* at 874. It further noted that financial constraints were not legitimate excuses for categorically denying education to handicapped children. *Id.* at 876.

The need for a uniform approach to the education of the handicapped, as evidenced by these cases, was a primary consideration in developing and passing the EHA.⁴⁰ This landmark legislation provided that every child, regardless of handicap or disability, is entitled to a “free appropriate public education,” or FAPE, as it is commonly known.⁴¹

2. *A Floor, Not a Ceiling: IDEA and the IEP*

In 1990, the EHA was renamed the Individuals with Disabilities Education Act (IDEA).⁴² IDEA was recently amended and reauthorized in December of 2004.⁴³ As the “most comprehensive federal statute safeguarding the rights of children with disabilities,”⁴⁴ IDEA, along with ensuing case law, has further articulated the concept that children between the ages of three and twenty-one deserve a FAPE.⁴⁵ Children suffering

40. STEVEN S. GOLDBERG, *SPECIAL EDUCATION LAW: A GUIDE FOR PARENTS, ADVOCATES, AND EDUCATORS* 19 (1982). The EHA was “an ambitious federal effort to promote the education of handicapped children, and was passed in response to Congress’ perception that a majority of handicapped children . . . ‘were either totally excluded from school of [were] sitting idly in regular classrooms awaiting the time when they were old enough to “drop out.”’” *Valerie J.*, 771 F. Supp. at 488 (internal citations omitted).

41. 20 U.S.C. § 1412 (2000). § 1412(a)(1)(A) reads: “[Each state must provide a] free appropriate public education . . . to all children with disabilities residing in the State between the ages of 3 and 21, inclusive, including children who have been suspended or expelled from school.” The pertinent code section reads:

The term “free appropriate public education” means special education and related services that—

(A) have been provided at public expense, under public supervision and direction, and without charge;

(B) meet the standards of the State educational agency;

(C) include an appropriate preschool, elementary, or secondary school education in the State involved; and

(D) are provided in conformity with the individualized education program required under section 1414(d) of this title.

Id. § 1401(8). Generally, courts have held that a FAPE is more of a floor than a ceiling. *See infra* notes 47–51 and accompanying text.

42. *See supra* note 32 and accompanying text. The 1990 passage of IDEA was essentially a name change, replacing the word “handicap” with “disability” in the title and throughout all sections of the Act. ROTHSTEIN, *supra* note 32 at 21. IDEA was amended in 1997. *Id.*

43. Press Release, President Bush Signs Special Education Reform Bill; House Republicans Hail Bipartisan Achievement (Dec. 3, 2004) (on file with author), available at 2004 WLNR 17578734; *see also* 20 U.S.C.A. §§ 1400–1487 (2004).

44. Demmitt, *supra* note 28, at 417.

45. 20 U.S.C. § 1412. Many federal courts have further articulated the boundaries of a FAPE. A FAPE requires a “demonstrable improvement in the educational and personal skills identified as special needs—as a consequence of implementing the proposed IEP.” *Town of Burlington v. Dep’t of Educ.*, 736 F.2d 773, 788 (1st Cir. 1984) (“Burlington II”). An IEP-determined placement is sufficient if it is “reasonably calculated” to give a child a more-than-trivial educational benefit. *Gregory K. v.*

from ADHD are recognized as “other health impaired,” which entitles them to the protections of IDEA.⁴⁶ In *Hendrick Hudson Board of Education v. Rowley*,⁴⁷ the Supreme Court articulated the substantive requirement of a FAPE. It emphasized that the IDEA was intended to provide students with the opportunity for an education through an Individualized Education Program (IEP), which is designed to give the student an “educational benefit.”⁴⁸ The IEP is the hallmark of IDEA, and the way in which every disabled student is insured a FAPE.⁴⁹ According to the *Rowley* Court, a student has received an “educational benefit” even

Longview Sch. Dist., 811 F.2d 1307–1314 (9th Cir. 1987). A FAPE does not, however, require an IEP to meet all of a disabled child’s needs. *Lenn v. Portland Sch. Comm.*, 998 F.2d 1083, 1086 (1st Cir. 1993) (“[T]he benefit conferred need not reach the highest attainable level. . . .”); *Colin K. v. Schmidt*, 536 F. Supp. 1375, 1386 (D.R.I. 1982), *aff’d*, 715 F.2d 1 (1st Cir. 1983). Nor does a FAPE mandate a particular educational outcome or use of a particular method of education. *See, e.g.*, *Hendrick Hudson Bd. of Educ. v. Rowley*, 458 U.S. 176, 188–89 (1982). These decisions have been made in an effort to weigh the goal of providing children with an “appropriate education” with the realistic and practical aspects of funding for public schools and the expense of providing specialized services. *T.B. v. Warwick Sch. Dept.*, No. CIV.A.01-122T, 2003 WL 22069432, at *4 (D.R.I. June 6, 2003) (citing *Colin K.*, 536 F. Supp. at 1386).

46. *See* 34 C.F.R. § 300.7(c)(9) (2005). ADHD is not specifically addressed in IDEA, but is considered an “Other Health Impairment”, meaning that the child has

limited strength, vitality or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that—(i) Is due to chronic or acute health problems such as . . . attention deficit disorder or attention deficit hyperactivity disorder; and . . . (ii) [a]dversely affects a child’s educational performance.

Id.

47. 458 U.S. at 188–89. In this case, the parents of a deaf girl challenged the school board’s determination that their daughter, Amy, who had exceptional lip-reading skills, was not eligible to have a full time sign language interpreter to assist her in her regular classes. *Id.* at 184–85. The determination was based on the fact that Amy was “advancing easily from grade to grade,” and performing at an above adequate level without the help of an interpreter. *Id.* at 210.

48. *Id.* at 188–89, 201. An IEP must be “reasonably calculated to enable the child to receive educational benefits.” *Id.* at 207. An “Education benefit” is said to be conferred when the child has been given “access to specialized instruction and related services” that is designed for the purpose of providing such a benefit. *Id.* at 200–01.

49. 20 U.S.C. § 1401(8)(D) (2000). Essentially, an IEP is a “written statement for each child with a disability” that includes: statements about a child’s current “levels of educational performance,” *id.* § 1414(d)(1)(A)(i), a statement of “measurable annual goals” relating to meeting needs associated with the child’s disability, *id.* § 1414(d)(1)(A)(ii), and the special education resources and services necessary for these goals to be met, *id.* § 1414(d)(1)(A)(iii). An IEP team is generally comprised of the child’s parents, at least one of the child’s “regular education” teachers, at least one “special education” teacher, “a representative of the local educational agency,” and someone who can “interpret the instructional implications of evaluation results.” *Id.* § 1414(d)(1)(B). When appropriate, “other individuals who have knowledge or special expertise regarding the child” and the child himself can and should be members of the team. *Id.* § 1414(d)(1)(B). For a complete definition of an IEP and the procedures involved in implementing one, see generally *id.* § 1414(d).

when the student's performance is unremarkable.⁵⁰ This sentiment has been echoed in other cases defining the outer limits of a FAPE.⁵¹

Due process is important both substantively and procedurally in IDEA. The guarantee of a FAPE insures substantive due process, and the extensive procedural regulations satisfy procedural due process by allowing parents "meaningful opportunity to participate" in IEP formulation.⁵² IDEA also provides an entire rubric of administrative procedural safeguards, the cornerstone of which is an "impartial due process hearing."⁵³ Prior to an administrative hearing, a child's IEP can be implemented only if parents agree to its terms.⁵⁴ However, if a hearing officer determines that a proposed IEP was reasonably calculated to give

50. *Rowley*, 458 U.S. at 198–200; *see also* *Cone v. Randolph County Sch.*, 302 F. Supp. 2d 500, 509 (4th Cir. 1990) ("The relatively modest 'reasonably calculated' standard of *Rowley* does not require a school district to maximize a handicapped child's potential. . ."). In 1991 the Eleventh Circuit re-visited the issue of what constitutes an "educational benefit" in *JSK v. Hendry County Sch. Bd.*, 941 F.2d 1563 (11th Cir. 1991). In that case, the parents of an autistic child challenged a lower court's determination that the public school's proposed IEP conferred an educational benefit on their son. *Id.* at 1564–65. The appellate court affirmed the district court's decision holding that "when measuring whether a handicapped child has received educational benefits from an IEP and related instructions and services, courts must only determine whether the child has received the basic floor of opportunity." *Id.* at 1572–73. The majority qualified this statement by noting that this "basic floor of opportunity" must include more than de minimus benefits. *Id.* at 1573; *but see* *Ridgewood Bd. of Educ. v. N.E.*, 172 F.3d 238, 247 (3d Cir. 1999) (holding that an educational benefit "must be gauged in relation to a child's potential").

51. *T.B. v. Warwick Sch. Dept.*, No. CIV.A.01-122T, 2003 WL 22069432, at *4 (D.R.I., June 6, 2003) ("Courts have struggled to flesh out [the] rather cryptic definition [of a FAPE] and to strike a proper balance between, on the one hand, the goal of providing . . . an 'appropriate' education; and, on the other hand, the practical difficulties in determining what is 'appropriate' given the considerable expense involved."); *see, e.g.*, *Cedar Rapids Cmty. Sch. Dist. v. Garret F.*, 526 U.S. 66, 78–79 (1999); *Daniel R.R. v. State Bd. Of Educ.*, 874 F.2d 1036, 1048 (5th Cir. 1989); *Roland M. v. Concord Sch. Comm.*, 910 F.2d 983 (1st Cir. 1990). *But see* *Oberti v. Bd. of Educ. of Borough of Clementon Sch. Dist.*, 789 F. Supp. 1322, 1328 (D.N.J. 1992) (remarking that while states need not provide every possible supplementary service or aid for a disabled student, "there will be a floor beneath which such provisions will be deemed inadequate. . . . [T]he Act does not permit states to make mere token gestures to accommodate handicapped students.") (quoting *Daniel R.R.*, 874 F.2d, at 1046). In *Cypress-Fairbanks Indep. Sch. Dist. v. Michael F.*, 118 F.3d 245, 253 (1997), the Fifth Circuit went so far as to develop a four-pronged test in an attempt to more rigidly define the substantive guarantee of a FAPE. The elements of this test demand: (1) that the program be "individualized on the basis of the student's assessment and performance; (2) the program [be] administered in the least restrictive environment; (3) the services [be] provided in a coordinated and collaborative manner by the key 'stakeholders'; and (4) [that] positive academic and non-academic benefits are demonstrated." *Id.* at 253.

52. *See generally* 20 U.S.C. § 1415 (2000); *Warwick Sch.*, 2003 WL 22069432, at *5.

53. 20 U.S.C. § 1415(f). These procedural safeguards are the "heart" of IDEA, and the IEP is "among the most significant of [the] procedural protections." RUTH COLKER ET AL., *THE LAW OF DISABILITY DISCRIMINATION* 289 (4th ed. 2003).

54. *Warwick*, 2003 WL 22069432, at *5 (citing 34 C.F.R. § 300.505(a)(1)(ii) (2005)).

the child an educational benefit, it can be implemented over a parent's objections.⁵⁵

One of the main goals of IDEA is to create an IEP that allows the child to be educated in the least restrictive environment possible.⁵⁶ This preference presumes placement in a mainstream (as opposed to special education) classroom that provides maximum contact with non-disabled students.⁵⁷ Unless the opponents of a proposed IEP can prove that the drawbacks of placement in a mainstream classroom outweigh the benefits, the child will remain in a mainstream classroom.⁵⁸

The use of Ritalin to treat ADHD arises when drug therapy is a recommended element of an IEP.⁵⁹ When compared to other successful treatment options for ADHD, Ritalin is popular because it is cheap and because it provides a relatively simple method to keep students in mainstream classrooms.⁶⁰ Because an IEP can be implemented over a parent's objections,⁶¹ a child could be made to take Ritalin if his parents choose to keep him in public school.⁶²

55. *Cf.* *Hendrick Hudson Bd. of Educ. v. Rowley*, 458 U.S. 176, 177 (1982).

56. 20 U.S.C. § 1412(a)(5):

To the maximum extent appropriate, children with disabilities . . . [shall be] educated with children who are not disabled, and special classes . . . [shall occur] only when the nature or severity of the disability of a child is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

57. *See, e.g., Daniel R.R.*, 874 F.2d at 1049; *Oberti v. Bd. of Educ.*, 995 F.2d 1204, 1204 (3d Cir. 1993) (determining that the mainstreaming preference is appropriate when a "disabled child can be educated satisfactorily in a regular classroom with supplementary aids and services.") (internal citations omitted). *See also* 34 C.F.R. § 300.50 (2005) (interpreting IDEA's least restrictive environment provision, 20 U.S.C. § 1412(5)(B)). "[H]andicapped children [should not be] removed from regular educational environments unless 'education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.'" *Hunt on Behalf of Hunt v. Bartman*, 873 F. Supp. 229, 246-47 (discussing Department of Education regulation 34 C.F.R. § 300.550 interpreting IDEA least restrictive environment requirements 20 U.S.C. § 1412(5)(B)). For a general discussion on the merits of placing children with disabilities in an environment with non-disabled students, see Kathryn E. Crossley, Note, *Inclusion: A New Addition to Remedy a History of Inadequate Conditions and Terms*, 4 WASH. U. J.L. & POL'Y 239 (2000).

58. *Hartmann v. Loudoun County Bd. of Educ.*, 118 F.3d 996, 1001 (4th Cir. 1997) (citing *DeBries by DeBlaay v. Fairfax County Sch. Bd.*, 882 F.2d 876, 879 (1989)).

59. *Valerie J. v. Derry Coop. Sch. Dist.*, 771 F. Supp. 483, 485-86 (D.N.H. 1991).

60. *Cf. id.* at 485-86. In *Casey J.'s* case, his parents wanted to continue his participation in a small special education classroom setting. *Id.* The school board determined that *Casey J.* could be in mainstream classrooms with the assistance of Ritalin. *Id.*

61. *See supra* note 55 and accompanying text.

62. *See generally Valerie J.*, 771 F. Supp. at 483. Obviously, if parents choose to send the child to a private school, they can choose one that adheres to the particular educational methodology or teaching strategy they prefer.

C. Competing Interests: Legal Foundations and Rights

Legal doctrine tells us that the family is a private realm that the law and the state may not unnecessarily invade.⁶³ However, it is imperative to consider the well-defined legal boundaries of this private realm.⁶⁴ There *are* limits on the extent to which parents can make decisions for their children both in the contexts of education and medical treatment.⁶⁵ Because the ultimate goal must be to protect the best interests of a child, the state has the responsibility to intervene when it can be more effective than parents in meeting this goal.⁶⁶

1. *A Tough Pill to Swallow: Limits on the Parental Right to Make Medical Decisions for Their Children.*

Whereas competent adults have the legal ability to make decisions about their own medical treatment, children are legal incompetents and do not have this right.⁶⁷ Generally, parents are given the decision-making power in this context.⁶⁸ Just as an adult has a recognized right to make an unpopular medical decision for herself,⁶⁹ a parent can make a similarly unpopular decision on behalf of her child.⁷⁰ There are however limits on this power, which stem from the notion that parents may not always act in their child's best interest.⁷¹ Most typically, this issue arises in the context

63. See generally *Parham v. J.R.*, 442 U.S. 584, 602 (1977) ("Our jurisprudence historically has reflected Western civilization concepts of the family as a unit with broad parental authority over minor children. Our cases have consistently followed that course. . . ."); *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Pierce v. Soc'y of Sisters*, 268 U.S. 510 (1925).

64. See generally *infra* notes 71–86, 91–98 and accompanying text.

65. See generally *infra* notes 71–86, 91–98 and accompanying text.

66. See generally *infra* notes 71–86, 91–98 and accompanying text.

67. LESLIE J. HARRIS & LEE E. TIETELBAUM, *CHILDREN, PARENTS, AND THE LAW: PUBLIC AND PRIVATE AUTHORITY IN THE HOME, SCHOOLS, AND JUVENILE COURTS* 231 (2002).

68. *Parham*, 442 U.S. at 602 ("The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions; natural bonds of affection lead parents to act in the best interests of their children.").

69. See, e.g., *Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 279 (1990); *Tune v. Walter Reed Army Med. Hosp.*, 602 F. Supp. 1452, 1455 (D.D.C. 1985); *In re Estate of Brooks*, 205 N.E.2d 435, 441–42 (Ill. 1965); *In re Winthrop Univ. Hosp.*, 490 N.Y.S.2d 996 (Sup. Ct. Nassau Co. 1985).

70. *Parham v. J.R.*, 442 U.S. 584, 589 (1979) (concerning parents who unilaterally sought to admit their children to a state mental institution). The *Parham* Court held that the state could intervene in a situation such as this one. *Id.* at 603. When a parent's decision is simply unfavorable, however, her interest cannot be transferred to the state. *Id.* A more common case is when parents refuse to provide medical treatment to their children. See, e.g., *Walker v. Superior Court*, 763 P.2d 852 (Cal. 1988); *State v. McKown*, 475 N.W.2d 63 (Minn. 1991).

71. *Parham*, 442 U.S. at 603 ("[A] state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized."); *In re Phillip*

of parents refusing (as opposed to advocating) medical treatment for their minor children.⁷² Though this is most common in situations where the child's condition is physically life threatening,⁷³ it also holds true in cases where the child's physical health is not in jeopardy.⁷⁴

When a parent's refusal to treat his child amounts to medical neglect, the state can intervene under the doctrine of *parens patriae*.⁷⁵ This determination can be made in the context of a child's mental or physical health.⁷⁶

Cases involving mental patients in state institutions are often cited for the proposition that parents (as a proxy for their children) should be able to

B., 156 Cal. Rptr. 48, 51 (Cal. App. 1979) ("The underlying consideration is the child's welfare and whether his best interests will be served by the medical treatment."). See also *Wisconsin v. Yoder*, 406 U.S. 205, 230 (1972); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944).

72. HARRIS & TIETELBAUM, *supra* note 67, at 244.

73. See, e.g., *In re Rena*, 705 N.E.2d 1155 (Mass. App. Ct. 1999) (allowing court-authorized treatment when it is in the child's best interest, even when parents refuse to consent); *In re Cabrera*, 552 A.2d 1114 (Pa. Super. Ct. 1989) (holding that parents can't refuse treatment for a deadly illness for their child, even when treatment is inconsistent with their religious practice).

74. See generally *Phillip B.*, 156 Cal. Rptr. 48. In this case, the parents refused to consent to heart surgery that would prevent their child, who suffered from a congenital heart disease, from suffering lung damage and forcing him to lead a "bed-to-chair" existence. *Id.* at 50. In *Phillip B.*, the court outlined a test to be used when determining whether the state may "insist upon medical treatment rejected by the parents." *Id.* at 51. These factors include: the likelihood the child will suffer harm without treatment and the seriousness of the harm suffered; medical professional's evaluation and opinion of the treatment; any risks involved with the treatment; and if possible, the child's own wishes. *Id.* Although the *Phillip B.* court ultimately held that the state could not override the parents' decision, in a later proceeding involving the same family, custody was taken away from Phillip's parents as a result of medical neglect stemming from the heart surgery at issue in this case. *Guardianship of Phillip B.*, 188 Cal. Rptr. 781, 790 (Cal. App. 1979); see also *In re Sampson*, 278 N.E.2d 918 (N.Y. 1972) (holding that the state could trump a parents decision not to allow surgery to be performed on a child in order to fix his non-life threatening facial deformity). For a discussion regarding parental rights (or lack thereof) in refuse medical treatment on behalf of their children in non-life threatening situations, see Shireen Arani, Case Comment, *State Intervention in Cases of Obesity-Related Medical Neglect*, 82 B.U. L. REV. 875, 885-87 (2002) (explaining that the state can intervene in order to improve a child's quality of life). There is one known instance in which state authorities charged parents with medical neglect because they refused to medicate him with Ritalin. *Attention Deficit/Hyperactivity Disorder: Are We Overmedicating our Children?: Hearing before the House Comm. on Gov't. Reform*, 107th Cong. 24-27 (2002) (statement of Patricia Whethers, President of Able Child); Nealis Interview, *supra* note 11. Although the case was ultimately dropped, it demonstrates the fact that the Ritalin issue may be looked at in terms of medical neglect, most likely under the "quality of life" standard.

75. *In re Phillip B.*, 156 Cal. Rep. at 51. Under this doctrine, the state has duty to protect children because the state is said to be the "guardian of society's basic values." *Id.*

76. The factors in this determination include: the extent to which there is consensus regarding the prescribed treatment; the extent to which this treatment can help the child; the possible detrimental effects of following the parents' determination; the child's ability to function normally with or without the treatment; and finally, the danger the child may pose to himself or the community. Elizabeth J. Sher, *Choosing for Children: Adjudicating Medical Care Disputes Between Parents and the State*, 58 N.Y.U. L. REV. 157, 197 (1983).

refuse psychotropic medications.⁷⁷ In *Rogers v. Okin*,⁷⁸ the First Circuit held that mental patients have an “intuitively obvious” right to be “left free by the state to decide for himself whether to submit to the serious and potentially harmful medical treatment that is represented by the administration of antipsychotic drugs.”⁷⁹ Similarly, in *Youngberg v. Romeo* the Supreme Court held that involuntarily committed mental patients have a right to be free from physical restraints.⁸⁰ Both of these holdings, however, are subject to important caveats: that individual liberty can be outweighed by institutional concerns for safety and “the demands for organized society.”⁸¹ As long as the decision is made with the exercise of professional medical judgment, mental health facilities can assert their *parens patriae* power to restrain a patient.⁸²

These caveats become crucial when the argument is placed in the context of public schools. Because the Ritalin issue involves public schools—not mental institutions—cases concerning a school’s right to limit individual authority are significant, and worthy of analysis. In *Tinker v. Des Moines Independent Community School District*,⁸³ students and their parents challenged a school policy that infringed on their freedom of speech.⁸⁴ In that case, the Supreme Court held that First Amendment rights must yield to school order.⁸⁵ More recently, this rule was upheld in *Bethel School District No. 403 v. Fraser*, in which a student was suspended for his speech at a high school assembly that included vulgar language and a

77. See, e.g., Amy L. Komoroski, *Stimulant Drug Therapy for Hyperactive Children: Adjudicating Disputes between Parents and Educators*, 11 B.U. PUB. INT. L.J. 97, 110–12 (2001); O’Leary, *supra* note 20, at 1182–88. The parent’s group Able Child has a link to the O’Leary article on its website, showing their endorsement of this proposition. Able Child, Reading for Parents, <http://www.ablechild.org/documents%20and%20reports.htm> (last visited Feb. 2, 2006).

78. 634 F.2d 650 (1st Cir. 1980).

79. *Id.* at 653. This “intuitively obvious” right most likely stems from the penumbral right to privacy and bodily integrity. O’Leary, *supra* note 20, at 1183–84.

80. 457 U.S. 307 (1982). An involuntarily committed mentally retarded individual brought this civil rights suit, by way of his parent, alleging that his substantive due process rights had been breached when he was physically restrained for prolonged periods of time. *Id.* at 309. The Court held that individuals, even when involuntarily committed due to mental retardation, have a due process right to safe conditions of confinement and freedom from bodily restraints. *Id.* at 319–20.

81. *Rogers*, 634 F.2d at 654–56; *Youngberg*, 457 U.S. at 319–20.

82. *U.S. v. Brandon*, 158 F.3d 947, 952 (1998) (citing *Youngberg*, 457 U.S. at 307).

83. 393 U.S. 503, 504 (1969).

84. In this case, students protested the Vietnam War by wearing black armbands to school. *Id.* at 504. The school soon adopted a policy that students wearing these armbands would be suspended if they did not remove the bands when asked. *Id.* In remanding the case for a decision consistent with its opinion, the Court noted that First Amendment rights must fall when conduct “materially disrupts classwork or involves substantial disorder or invasion of the rights of others. . . .” *Id.* at 513.

85. *Id.* at 507–09.

“graphic, and explicit sexual metaphor.”⁸⁶ Though refusing medication is not a First Amendment right, these cases delineate how extensively a school may be able to limit an individual’s autonomy in order to limit disruptions or other conduct that would undermine the “basic educational mission” of the school.⁸⁷

2. *Parental Limits on Controlling Their Child’s Education: Educators as Experts*

The right of a parent to direct the upbringing of her children and choose a course of education for them was first articulated in *Meyer v. Nebraska*⁸⁸ and later reinforced in *Pierce v. Society of Sisters*.⁸⁹ This parental right has since been referred to as “perhaps the oldest of the fundamental liberty interests recognized by [the Supreme] Court.”⁹⁰ But this right is not absolute.⁹¹ It has been undeniably tempered by state regulation of compulsory education.⁹² Courts have generally taken the

86. 478 U.S. 675, 678 (1986). In its opinion, the Court held that the School District was acting within its authority in deciding to suspend the student, and that the First Amendment does not “prevent the school officials from determining that [a student’s conduct] would undermine the school’s basic educational mission.” *Id.* at 685.

87. *Id.* Furthermore, First Amendment rights are often thought to be those most worthy of protection. Ritalin use in schools is not an infringement of First Amendment liberties, but rather a possible privacy infringement that is not always subject to the same level of scrutiny.

88. 262 U.S. 390 (1923). This case struck down a Nebraska state law that prohibited any language other than English from being taught in schools to children younger than eighth grade. *Id.* at 403. It was challenged by a teacher who was convicted of teaching German to a ten-year old boy. *Id.* at 396. The Court held that the law was a violation of individual liberty interests, which included the right of parents to direct the upbringing of their children. *Id.* at 402–03. This liberty interest, the Court noted, cannot be interfered with “under the guise of protecting the public interest.” *Id.* at 399–400.

89. 268 U.S. 510, 534–35 (1925). In this case, the Court struck down the Compulsory Education Act of 1922, which required that every child attend a public school. *Id.* at 530. In doing so, it determined that the Act was a violation of a parent’s Fourteenth Amendment liberty right to direct the upbringing and education of their children, a right that was previously articulated in *Meyer*, 262 U.S. at 390. *Pierce*, 268 U.S. at 534–35.

90. *Troxel v. Granville*, 530 U.S. 57, 65 (2000).

91. See *infra* notes 92–102 and accompanying text.

92. This power is derived from the states’ Tenth Amendment police power, which the state can use to insure the “health, safety, welfare, and morals” of its citizens. U.S. Const. amend. X. See generally *Bangor Baptist Church v. Maine*, 549 F. Supp. 1208, 1220–22 (D. Me., 1982) (holding that, while Maine’s compulsory education laws did impose a burden on the plaintiff’s fundamentalist Christian religious practices, they were not unduly burdensome, and did not violate the establishment clause). See also *Wisconsin v. Yoder*, 406 U.S. 205, 213 (1972) (“There is no doubt as to the power of a State, having a high responsibility for education of its citizens, to impose reasonable regulations for the control and duration of basic education.” (citing *Pierce*, 268 U.S. at 534 (1925)); *Meyer*, 262 U.S. at 402 (1923) (“The power of the state to compel attendance at some school and to make reasonable regulations for all schools. . . is not questioned.”)).

position that it is the state's responsibility to monitor the content of curriculum as well as the teaching method used to educate children.⁹³

In essence, *Pierce* and *Meyer* stand for the proposition that parents may choose to educate their children in any number of ways, be it through parochial school, secular private school, public school, home school, or any educational institution that complies with compulsory education laws.⁹⁴ Yet, if a parent chooses to educate his child in the public school system, his parental liberty interests do not extend so far as to allow him to influence the school's curriculum or teaching method.⁹⁵ As it relates to IDEA and a parent's input in an IEP, this doctrine of limited parental input means that parents cannot demand that a particular teaching method be used.⁹⁶ As long as the method implemented by the school is "reasonably calculated" to provide an "appropriate" education, a child's substantive rights have been protected and parents cannot demand an alternative.⁹⁷

Several cases have solidified this rule in conjunction with IEPs.⁹⁸ In *T.B. v. Warwick School Department*, the court held that the school's proposed IEP, advocating one method of educating autistic children, was acceptable even though the parents advocated another educational method.⁹⁹ In *Cone v. Randolph County Schools*,¹⁰⁰ the court similarly held

93. Philip T.K. Daniel, *Education for Students with Special Needs: The Judicially Defined Role of Parents in the Process*, 29 J.L. & EDUC. 1, 4 (2000) ("The federal judiciary has determined that the state has a compelling interest in ensuring that children are adequately educated and that, in education generally, the rights of parents challenging such an interest are relatively *de minimis*.").

94. See generally *Pierce*, 268 U.S. 510.

95. *Brown v. Hot, Sexy and Safer Prods., Inc.*, 68 F.3d 525, 533–34 (1995). The particular facts of this case demonstrate the remarkable amount of leeway and discretion schools have in designing their curriculum, and the methods they use to teach that curriculum. *Id.* at 529–30. In the instant case, students and their parents took issue with a mandatory "AIDS awareness" program that was sexually explicit in nature, had minor students participate by licking condoms and putting them over the heads of other students, made multiple references to orgasms and genitals, and used profane and lewd language to describe body parts and excretory functions. *Id.* at 529. The First Circuit held that a state can not prevent parents from choosing a specific educational program for their child (such as parochial or other private schooling), but when the parents have chosen to have their child educated within the public schools, they do not have a fundamental liberty interest to dictate the curriculum. *Id.* at 533.

96. See *infra* notes 97–102 and accompanying text.

97. See generally *Hedrick Hudson Bd. of Ed. v. Rowley*, 458 U.S. 176 (1982). Administrative review insures substantial procedural due process as well. *Id.* § 1415.

98. See, e.g., *Burilovich v. Bd. of Educ. of the Lincoln Consolidated Sch.*, 208 F.3d 560, 566 (6th Cir. 2000); *Cone v. Randolph County Sch.*, 302 F. Supp. 2d 500 (M.D.N.C. 2004); *T.B. v. Warwick Sch. Dep't.*, No. CIV. A. 01-122T, 2003 WL 22069432 (D.R.I. June 6, 2003).

99. 2003 WL 22069432, at *18. In this case the parents advocated a program called Discrete Trial Training (DTT) for their autistic son. *Id.* at *1. This program was only available at a private school, and the parents wanted the state to pay for the services its schools were not offering. *Id.* at *2. The state successfully argued that its school that offered the Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH program), would provide the child with an appropriate education because there were similarities between the methods. *Id.* at *18–20.

that both substantive and procedural due process requirements had been satisfied in an IEP. The IEP proposed that a child be transferred from an out-of-state private school (for which the State of North Carolina was paying) to an in-state school that used a different teaching method.¹⁰¹ Although the parents disagreed with the recommendation and challenged it in an administrative hearing, the court ultimately held that the new IEP was “reasonably calculated” to meet the child’s needs, and that the court should be “reluctant indeed to second-guess the judgment of education professionals.”¹⁰²

The legal doctrine on which these cases stand was first developed in *Burilovich v. Board of Education of the Lincoln Consolidated Schools*,¹⁰³ in which the court approved of the weight given to opinions of educational agencies in administrative IEP hearings. It noted that in determinations in which an educator’s expertise is relevant (such as deciding on an appropriate method of educating a disabled student), the educator’s decisions carry more weight than the parents’.¹⁰⁴ Accordingly, when parents and educators disagree about the contents of an IEP, the recommendations of educators, as experts in the areas of education policy and practice, are regularly given deference.¹⁰⁵

One of the earliest reported cases in which parents challenged a school’s right to medicate a child without parental consent was *Valerie J.*

100. 302 F. Supp. 2d at 509, 512.

101. *Id.* at 504–05. In this case, a North Carolina child diagnosed with Fragile X Syndrome was being treated at the Benedictine School for Exceptional Children in Maryland pursuant to his North Carolina 2000 IEP because it was determined that there was no appropriate placement in North Carolina. *Id.* at 504. In 2001, an appropriate facility in North Carolina was identified, and the school district encouraged the child to be transferred there. *Id.* at 504–05. His parents contested this change in the IEP on the basis that the two facilities used different teaching methods. *Id.* The court upheld the 2001 IEP, dictating that Elliott would attend the North Carolina facility on the basis that the determination was “reasonably calculated” to allow Elliott to receive educational benefits. *Id.* at 512.

102. *Id.* at 509 (citing *Tice v. Botetourt County Sch. Bd.*, 908 F.2d 1200, 1207 (4th Cir. 1990)).

103. 208 F.3d at 566. This case also involves an autistic child, and a disagreement between the child’s parents and educators over the teaching method that should be used help treat and educate him. *Id.* at 563. The parents argued that the DTT method should be used because the child performed best when being taught according to that program. *Id.* The school, however, felt that the programs it used were sufficient to bestow upon the child the educational benefit to which he was entitled. *Id.* at 564. At an administrative hearing conducted by a state hearing officer, the officer agreed that the school had developed an IEP that was reasonably calculated to give the child an educational benefit. *Id.* at 564. In affirming the lower court’s ruling in favor of the school district, the Sixth Circuit stated that that courts should not “substitute their own notions of sound educational policy for those of the school authorities which they review.” *Id.* at 572. Because the hearing officer was an educational expert, and the officer’s findings were reasonable based on the evidence, the court should not overturn them. *Id.*

104. *Id.* at 572.

105. *Id.*

v. *Derry Cooperative School District*.¹⁰⁶ In that case, the IEP recommended medication, the parents disapproved, and the school subsequently suspended the child.¹⁰⁷ The court held that this was a violation of the parents' procedural due process rights afforded under IDEA.¹⁰⁸ Although over ten years have passed since *Valerie J.*, only a few courts have since considered child medication without parental consent. However, the child medication issue is frequently addressed in administrative hearings before the Department of Education.¹⁰⁹

3. *Popular Response and Action—Pushing the Limits of Parental Rights*

In the past seven years,¹¹⁰ the issue of forced medication of hyperactive children as a precondition of public school attendance has made its way from the largely unpublicized world of administrative hearings to the forefront of a thriving and sensationalized social debate.¹¹¹ Across the country, parents, frustrated with two seemingly hopeless options of medicating their child or having him expelled from school, have found a voice through a grassroots support community.¹¹² Able Child: Parents for

106. 771 F. Supp 483, 484 (D.N.H. 1991). In this case, the District Court overturned the administrative hearing officer's determination that the school could medicate the child without his parent's consent. *Id.* at 489.

107. *Id.* at 484–87.

108. *Id.* at 490. It is important to note that this case was primarily decided on procedural violations of IDEA, and not on the issue of recommending Ritalin. *Id.* The court maintained that the physician's recommendations that Ritalin be included in the IEP were reasonable, but that it was unreasonable for the school to "[insist] that the parents consent to medication as a necessary component of the IEP." *Id.* at 489. *Valerie J.* remains, however, one of the only cases on record in which parents have challenged the content of an IEP in the context of Ritalin use and ADHD. Interview with Libby Nealis, *supra* note 11. Recently, Patricia Weathers, founder of Able Child, is one of the few to have actually filed suite. See also testimony of Patricia Weathers, *infra* note 121, at 26 (testifying that she filed a lawsuit in federal court against her son's school district regarding the school's coercing her into drugging her son).

109. Nealis Interview, *supra* note 11. There have really only been one or two known cases in which parents have been coerced into medicating their children. *Id.* In those extreme cases, the schools were "way out of bounds" and any procedural problems were resolved at much lower levels. *Id.*

110. The first legislative resolution relating to this issue was passed in 1999 by the Colorado State Board of Education. *Bills and Resolutions*, http://www.fightforkids.com/bills_resolutions.htm (last visited Feb. 6, 2005) [hereinafter Table of State Legislation] ("In 1999, the Colorado State Board of Education passed a precedent-setting Resolution [asking] school personnel to use academic rather than drug solutions to resolve problems with behavior, attention and learning."). For a copy of the Resolution, see *Colorado School Board Passes Resolution About Ritalin*, EDUCATION REPORTER, No. 167, Dec. 1999, available at <http://www.eagleforum.org/educate/1999/dec99/ritalin.html>.

111. See *infra* notes 112–28 and accompanying text.

112. See generally Parents for Label and Drug Free Education, <http://www.ablechild.org> (last visited Mar. 3, 2005). This site, one of the most prominent, was started by two mothers as a reaction to their families' experiences. The History of Able Child, <http://www.ablechild.org/history.htm> (last

Label and Drug Free Education is one of the most prominent of these organizations.¹¹³ Although it does not claim any religious affiliation and its members are not by-and-large members of the Church of Scientology, Able Child receives a significant portion of its funding from that Church.¹¹⁴ As part of its doctrine, the Church of Scientology holds a disbelief in psychiatry and in treating mental disorders with pharmaceuticals.¹¹⁵ Able Child has developed a website to give parents a venue for sharing their personal stories,¹¹⁶ informing them about legal issues and legislation,¹¹⁷ urging letter-writing campaigns and petitions,¹¹⁸ and even providing a list where parents can add their name and hometown and state who pressured or coerced them into drugging their children.¹¹⁹ The members of Able Child and other such organizations have announced their message loudly and clearly, and have gained national attention.¹²⁰ In

visited Mar. 3, 2005).

One of AbleChilds [sic] goals is to educate the educators [because] they have been exposed to only one-side of this issue, many being taught that . . . medicating children is a solid answer for behavioral or attentional [sic] problems. [They think] these medications are mild substances, completely unaware of the very real risks and dangers that these drugs can have on a child. This is part of the problem. As an organization we are there to open their eyes to the reality of the situation. - Ms. Patricia Weathers

About Us, <http://www.ablechild.org/about%20us.htm> (last visited on Mar. 3, 2005). For a list of other organizations sharing the goals of Able Child, see Recommended links, <http://www.ablechild.org/links/htm> (last visited Mar. 3, 2005).

113. According to the member list on their website, [ablechild.org](http://www.ablechild.org) has almost 300 registered members from almost all states and several foreign countries. The Able Child Member List, <http://www.ablechild.org/memberlist.asp> (last visited Mar. 3, 2005).

114. Nealis Interview, *supra* note 11.

115. *Id.* The Church of Scientology's most recent foray in the spotlight came from one of its most prominent members, actor Tom Cruise, who famously declared on the *Today Show* that fellow actor Brooke Shields was "misinform[ed]" about taking medication to treat postpartum depression, and that "[t]here is no such thing as a chemical imbalance in a body." Richard Leiby, *A Couch Tom Cruise Won't Jump On: Actor Lambastes Psychiatry on 'Today'*, WASH. POST, June 25, 2005, at C-01. Cruise also advocated his religion's position that drugs like Ritalin and Adderall are "street drugs" that should not be used to treat children with ADD and ADHD. *Id.*

116. Parents Speak Out Against Schools Coercing Them to Place Children on Psychiatric Drugs, <http://ablechild.org/voices.htm> (last visited Feb. 6, 2006).

117. Child Labeling & Drugging Bills & Resolutions Passed, <http://www.ablechild.org/slegislation.htm> (last visited Feb. 6, 2006); *Federal Legislation*, <http://www.ablechild.org/flegislation.htm> (last visited Feb. 6, 2006).

118. Petition for Children's Rights Against Stigma and Psychiatric Drug Abuse, <http://petitiononline.com/forkids/petition.html> (last visited Feb. 6, 2006).

119. The Following Parents Attest to the Fact that They Have Been Pressured and/or Coerced by School Personnel to Place Their Children on Psychotropic Drugs, <http://www.ablechild.org/data/thelist.asp> (last visited Mar. 3, 2005).

120. According to their website, members of Able Child: Parents for Label and Drug Free Education have appeared on the *Today Show*, CNN, the CBS Evening News, Good Morning America and other national television programs. *About Us*, <http://www.ablechild.org/about%20us.htm> (last visited Mar. 3, 2005).

2002, the founder of Able Child testified before the House Committee on Government Reform regarding her family's experiences when school officials coerced her into medicating her son with Ritalin.¹²¹

D. State Legislation

In 1999, the Colorado State Board of Education passed a resolution that, for the first time, addressed the increased use of Ritalin in schools and called for alternative methods of treating ADD and ADHD.¹²² This original resolution focused in large part on the detrimental side-effects of Ritalin and its tendency to increase suicidal or violent behavior.¹²³ The resolution was in part a reaction to the then-recent events at Columbine High School, where Eric Harris and his friend Dylan Klebold led a shooting spree, killing twelve of their classmates before taking their own

121. Ms. Patricia Whethers, President and Co-Founder of Able Child, testified on September 26, 2002 that:

[T]he school principal. . . said that unless I agreed to put [my son] on medication, she would find a way to transfer him to a Special Education Center. I felt intimidated, scared, and unsure of what to do as a result of the school's coercive tactics. At no time was I offered any alternatives. . . . The schools [sic.] one and only solution was to have my child drugged. . . . The drug cocktail [prescribed by the school psychologist] made his behavior more and more out of character [, and f]earing what the drugs had done to him, I stopped them. [T]he school threw [my son] out [and f]or a final blow, they proceeded to call child protective services on my husband and I [sic.], charging us with medical neglect. . . . As a mother, I should have been given all this information [about controversies surrounding ADHD diagnosis and treatment]. . . . I would never have subjected my son to being labeled with a mental disorder. . . I would not have allowed my son to be administered drugs. . . . Its for this reason that I am asking this committee to. . . enact legal safeguards. . . .

Attention Deficit/ Hyperactivity Disorder: Are We Overmedicating our Children?: Hearing before the House Comm. on Government Reform, 107th Cong. 24, 26–27 (2002) (prepared statement of Patricia Whethers, President of Able Child).

122. Resolution Against Psychotropic Medications, *supra* note 110 (“Be it resolved that. . . Mind-altering psychotropic drugs . . . shall not be dispensed to children for [ADHD]. . . . Tutoring, vision testing, phonics. . . and other remedies known to be effective and harmless shall be recommended to parents as their options.”). *Id.*

123. *Id.* (“Whereas. . . [s]ome patients have been reported to have an increase in suicidal thoughts and/or violent behavior. . .”). See also John J. Lumpkin, Associated Press, *Suicide Warning Will Accompany ADHD Medicine: The Maker of Straterra, Used to Treat Attention Deficit Hyperactivity Disorder, Said the Drug's Label Will Carry a Warning About Suicidal Thoughts in Children Who Take It*, MIAMI HERALD, Sept. 30, 2005, at A.

lives.¹²⁴ It was later discovered that Harris had been taking antidepressants that had side effects similar to those of Ritalin.¹²⁵

More recently, Colorado passed a law requiring each school board “to adopt a policy to prohibit school personnel from recommending or requiring the use of a psychotropic drug for any student.”¹²⁶ In total, three states have passed similar legislation that is consistent with the agenda set forth by parent organizations such as Able Child.¹²⁷ Most other states are in various stages of passing such legislation.¹²⁸

E. Federal Legislation: Preserving Communication Between Parents and Educators

As a response to the legislation enacted or pending in several states and the testimony given during the House Committee on Government Reform,¹²⁹ federal legislation commonly known as the Child Medication Safety Act (CMSA) was introduced to Congress in 2003.¹³⁰ This bill

124. Resolution Against Psychotropic medications, *supra* note 110 (“Whereas . . . Eric Harris began [taking Luvox and] began planning the massacre one year prior to the April 20, 1999 Columbine shooting—indicating that his destructive mania emerged shortly after he began taking Luvox, and [his] an autopsy found a “therapeutic level” of Luvox in [his] bloodstream.”). See also Lynn Bartels & Carla Crowder, *Fatal Friendship: How Two Suburban Boys Traded Baseball and Bowling for Murder and Madness*, DENV. ROCKY MTN. NEWS, Aug. 22, 1999, at Special Pullout Section.

125. *Id.*

126. H.B. 1172, 64th Gen. Assem., 1st Reg. Sess. (Colo. 2003).

127. Currently there are three states that have laws directly prohibiting school personnel from recommending psychotropic drugs for children: Colorado, Virginia, and Connecticut. COLO. REV. STAT. § 22-32-109(1)(ee) (2005) (“Each board of education shall . . . adopt a policy to prohibit school personnel from recommending or requiring the use of a psychotropic drug for any student. School personnel shall not test or require a test for a child’s behavior without prior written permission from the parents. . . .”); VA. CODE ANN. § 22.1-274.3 (2003) (requiring the Board of Education to “develop and implement policies prohibiting school personnel from recommending the use of psychotropic medications for any student”) (“An act concerning recommendations for and refusals of the use of psychotropic drugs by children . . . prohibiting any school personnel from recommending the use of psychotropic drugs for any child. The refusal of a parent or other person having control of a child to administer or consent to the administration of any psychotropic drug to such child shall not, in and of itself, constitute grounds for the Department of Children and Families to take such child into custody.”). 2001 Conn. Acts 01-124 (Reg. Sess.). A list of U.S. legislative bills and resolutions that have been introduced or passed against coercive psychiatric labeling and drugging of children, see Table of State Legislation, *supra* note 110.

128. *Id.*

129. 149 CONG. REC. H1753 (daily ed. Mar. 12, 2003) (statement of Rep. Burns) (“Last year [in] the House Committee on Government Reform. . . [we heard shocking testimony] that some school officials have taken it upon themselves to decide that a child needs to be placed on psychotropic drugs. . . . [the legislation I have introduced] will address a significant problem facing children and their parents.”).

130. H.R. 1170, 108th Cong. (2003). It was introduced on March 11, 2003, by Representative Max Burns (R-GA). *Id.* The original language of the bill stated its purpose as “protect[ing] children and their parents from being coerced into administering psychotropic medication in order to attend

required states,¹³¹ as a condition of receiving federal funding,¹³² to develop policies that would prohibit schools and school personnel from requiring a child¹³³ to obtain a prescription for Ritalin¹³⁴ as a condition of attending school or receiving services.¹³⁵

The CMSA was referred to the Committee on Education and the Workforce, which specifically addressed the concern that the harsh punishment for violating the law¹³⁶ would scare teachers away from discussing drug therapy with parents as one possible option for treating ADHD.¹³⁷ After being amended to reflect these concerns, the bill was re-introduced.¹³⁸ Floor debates showed overwhelming support of the legislation,¹³⁹ and it was eventually passed in the house 425 votes to

school, and for other purposes. . . ." *Id.*

131. *Id.* at section 3 ("(2) STATE.—The term 'State' means each of the 50 states, the District of Columbia, and the Commonwealth of Puerto Rico.")

132. *Id.* at section 2 ("As a condition of receiving funds under any program or activity administered by the Secretary of Education.")

133. *Id.* at section 3 ("(1) CHILD.—The term 'child' means any person within the age limits for which the State provides free public education.")

134. *Id.* at section 2. The bill encompasses any controlled substances in schedule II under section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)). *Id.*

135. *Id.* at section 2.

136. See Libby Nealis, *The Child Medication Safety Act*, NASP COMMUNIQUE, VOL. 33, NO. #1, Sept. 2004, adapted version available at www.nasponline.org/advocacy/SPAN/span_sept04_childmed.html.

137. *Comm. on Educ. and the Workforce: Markup of H.R. 1170, The Child Medication Safety Act of 2003*, 108th Cong. 1–2 (2003) (statement by Rep. Max Burns) ("We've also made an important clarification to ensure that parents and teachers are able to have an open dialogue about any academic or behavior related needs of the child. This legislation is intended only to prevent school personnel from requiring children to be medicated.")

138. Child Medication Safety Act of 2003, H.R. 1170, 108th Cong. (2003). The amended construction reads as follows:

Sec. 2. Required Policies and Procedures: (a) In General.—As a condition of receiving funds under any program or activity administered by the Secretary of Education, not later than 1 year after the date of the enactment of this Act, each State shall develop and implement policies and procedures prohibiting school personnel from requiring a child to obtain a prescription for substances covered by section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)) as a condition of attending school or receiving services [for a description of "services" see 20 USC 1412(a)(3)]. (b) *Rule of Construction.*—Nothing in subsection (a) shall be construed to create a Federal prohibition against teachers and other school personnel consulting or sharing classroom-based observations with parents or guardians regarding a student's academic performance or behavior in the classroom or school, or regarding the need for evaluation for special education or related services under 612(a)(3) of the Individuals with Disabilities Education Act (20 U.S.C. 1412(a)(3)).

Id. (emphasis added); 149 CONG. REC. H4382, H4383 (daily ed. May 21, 2003) (statement of Rep. Woosley) ("[N]o one wants a school to force parents to medicate their children. . . [b]ut neither do we want teachers. . . to be afraid to talk to parents about children's behavior or to suggest that a child should be evaluated by a medical health practitioner.")

139. 149 CONG. REC. at H4383 (statement of Rep. Burns) ("This bill is not antischool [sic], antiteacher [sic], or antimedication [sic]. This bill is pro-children and pro-parent.") *Id.* (statement of

one.¹⁴⁰ The sole member of the House to vote against the bill was Congresswoman Susan Davis of California, a former school board member.¹⁴¹ While she appreciated the changes in favor of open communication, she continued to voice concern about the impact of the legislation on well-intentioned teachers. She opined that the legislation was frivolous, and a “solution without a problem” in that no empirical evidence regarding the frequency with which this problem occurs had been presented.¹⁴² Most significantly, she explained, IDEA’s IEP procedure already provides due process safeguards for parents who disagree with school recommendations, making the CMSA a quick way for some parents to circumvent this established procedure.¹⁴³

Once passed to the Senate for review, the bill was referred to the Senate Committee on Health, Education, Labor, and Pensions.¹⁴⁴ Senator Edward Kennedy, a member of this committee, was a vocal opponent of this legislation and “single-handedly” kept it from being approved in the

Rep. Wilson) (“Only medical personnel [not educators] have the ability to determine if a prescription for a controlled substance is appropriate for a child.”). *Id.* at H4383-84 (statement of Rep. Kennedy) (expressing support of the bill with the added language when stating, “[T]eachers have a window into what is going on in that child’s life, and they are best equipped to be able to talk to those parents and be able to consult with those parents about what those children might need,” and citing stigma of mental illness as reason to support the bill). *Id.* at H4384 (statement of Rep. Murphy) (speaking as a medical professional on the necessity of this bill in preventing schools from coercing medical personnel and parents). *Id.* at H4385 (statement of Rep. Norwood) (citing the common-sensical approach to support of H.R. 1170). *Id.* (statement of Rep. Davis (IL) (addressing possible abuse of Ritalin and overuse of drug therapy as reasons to support the bill). *Id.* at H4386 (statement of Rep. Hastert) (explaining an extreme outcome of charging parents with medical neglect for resisting school coercion).

140. 149 CONG. REC. at H4398. The vote was taken by electronic device: there were 425 yays, one nay, and eight who abstained from voting. *Id.*

141. 149 CONG. REC. at H4385 (statement of Rep. Davis).

Are there bad apples in the world of education who may have put inappropriate pressure on a parent to seek a pharmaceutical solution to a behavior problem? Well, yes, there possibly are. . . I think we discredit the tens of thousands of wonderful teachers in our country when we legislate based on th[e] false assumption [that all teachers do this].

Id.

142. *Id.* (“I believe that legislation should be based on the documented existence of a problem, not on hearsay and innuendo; and I believe that all of the wonderful, caring teachers in our country should be celebrated. . . not tarnished by the stated assumption of this measure.”).

143. *Id.* (“[T]he parent has clear due process rights to seek an evaluation through the special education process. . . . If the parent is dissatisfied with those results, an appeal to a due process hearing officer is available.”).

144. S. 1390, 108th Cong. (2003). The Bill’s original sponsors was Senators Ensign (R-NV) and Senator Alexander (R-TN) was the original cosponsor. Later sponsors included Allard (R-CO) on July 24, 2003, Hagel (R-NE) on July 31, 2003 and Graham (R-SC) on Sept. 4, 2003. Thomas S.1390, available at <http://thomas.loc.gov/cgi-bin/bdquery/Z?d108:SN01390:@@Pe> (last visited Feb. 22, 2006).

Senate.¹⁴⁵ Although there is relatively little opposition from other members of the Senate, Senator Kennedy's position is strongly supported by professional mental health organizations including the American Psychiatric Association¹⁴⁶ and the National Association of School Psychologists (NASP).¹⁴⁷

In November 2004 Congress recommended a large-scale reauthorization of IDEA, including several modifications to the 1997 version.¹⁴⁸ In December of 2004, President George W. Bush signed the new IDEA into law.¹⁴⁹ Included in this reauthorization were several provisions designed to give parents a larger role in decisions affecting the education of their disabled children.¹⁵⁰ One such provision is modeled on the CMSA.¹⁵¹ Because of this inclusion in IDEA, the CMSA as an independent bill is no longer before Congress.¹⁵² The most significant difference between the last proposed independent CMSA and the version

145. Jessica E. Vascellaro, *Kennedy ties up drug bill*, BOSTON GLOBE, July 2, 2004, (reporting that Sen. Kennedy opposes the bill, and contended that the issue required more study), available at http://www.boston.com/news/nation/articles/2004/07/02/kennedy_ties_up_drug_bill/; see also Edward M. Kennedy, Editorial, *The Child Medication Safety Act*, BOSTON GLOBE, July 7, 2004 (responding to the previous article by stating that his opposition stems from the fact that the bill does too little, and may have the "unintended effect of discouraging schools from identifying and informing parents about the classroom difficulties faced by children with mental health or learning issues").

146. APA Online, Public Policy Office, Letter on Child Medication Safety Act of 2003 (May 14, 2003), <http://www.apa.org/ppo/issues/cmsa1170.html> ("In our view, enactment of this legislation is likely to cause harm . . . given the bill's strict enforcement mechanism, . . . school personnel could be expected to be fearful of the risks of speaking openly with families about a student's emotional well-being and/or behavior, or recommending a mental health evaluation.").

147. Nealis, *supra* note 136 (voicing concern that HR 1170 would create a "gag rule" on school personnel which is particularly dangerous to children who have mental health problems legitimately requiring treatment because "[c]hildren spend the majority of their awake hours in school; school personnel therefore are often the first to observe behaviors . . . that suggest the presence of [such problems]").

148. Government Press Release, *supra* note 43.

149. *Id.*

150. *Id.*

151. 20 U.S.C.A. § 1412(25) (2004).

PROHIBITION ON MANDATORY MEDICATION-

(A) IN GENERAL- The State educational agency shall prohibit State and local educational agency personnel from requiring a child to obtain a prescription for a substance covered by the Controlled Substances Act (21 U.S.C. 801 *et seq.*) as a condition of attending school, receiving an evaluation under subsection (a) or (c) of [section 614], or receiving services under this chapter.

(B) RULE OF CONSTRUCTION- Nothing in subparagraph (A) shall be construed to create a Federal prohibition against teachers and other school personnel consulting or sharing classroom-based observations with parents or guardians regarding a student's academic and functional performance, or behavior in the classroom or school, or regarding the need for evaluation for special education or related services under paragraph (3).

Id.

152. Nealis Interview, *supra* note 11.

incorporated into IDEA 2004 is that the new IDEA provision does not make federal funding contingent on states adopting policies consistent with the idea of the legislation.¹⁵³

153. *Id.*; see also S. 1390, 108th Cong. (2003) (“As a condition of receiving funds . . . each state shall develop and implement policies and procedures prohibiting school personnel from requiring a child to obtain a prescription [for Ritalin].”). Although this is a positive change, and NASP is satisfied that the wording incorporated in IDEA 2004 essentially codifies the already understood policy that school officials must not coerce children into taking Ritalin, they warn that the schism between parents and school officials in detecting and treating mental health issues in children are far from over. Nealis Interview, *supra* note 11. More recently, a movement has started that is working to “ban mental health screenings in schools” with the same players (namely Able Child) arguing that this process will soon become mandatory and will result in even more children being forced to take Ritalin. *Id.* On January 4, 2005 the “Parental Consent Act of 2005” was introduced in the House as a preemptive strike against mandatory screening. H.R. 181, 109th Cong. § 2 (2005). The bill was prompted by the following “Findings:”

Section 2—(9) There has been a precipitous increase in the prescription rates of psychiatric drugs in children:

(A) A 300-percent increase in psychotropic drug use in 2 to 4 year old children from 1991 to 1995. . .

(B) A 300-percent increase in psychotropic drug use in children from 1987 to 1996. . .

(C) More money was spent on psychiatric drugs for children than on antibiotics or asthma medication in 2003. . .

Section 2—(13) Parents are already being coerced to put their children on psychiatric medications and some children are dying because of it. . . Across the country [people like Patricia Weathers have been] threatened with child abuse charges for refusing or taking their children off of psychiatric medications.

Section 2—(14) The United States Supreme Court in *Pierce versus Society of Sisters* (268 U.S. 510 (1925)) held that parents have a right to direct the education and upbringing of their children.

Section 2—(15) Universal or mandatory mental health screening violates the right of parents to direct and control the upbringing of their children.

Id.

Based on these findings, the following has been proposed:

Section 3—(a) UNIVERSAL OR MANDATORY MENTAL HEALTH SCREENING PROGRAM—No Federal funds may be used to establish or implement any universal or mandatory mental health screening program.

(c) DEFINITION—For purposes of this Act, the term “universal or mandatory mental health screening program”[includes] . . .

(B) any student mental health screening program that allows mental health screening of individuals under 18 years of age without the express, written, voluntary, informed consent of the parent or legal guardian of the individual involved.

Id. The most recent action involving the Parental Consent Act was referral to the House Subcommittee on Education Reform on Feb. 9, 2005. *Bill Summary and Status*, ¶ 23, <http://thomas.loc.gov/cgi-bin/bdquerytr/Z?d109:HR00181:@@X> (last visited Feb. 6, 2006).

While the notion of mental health screenings in schools is beyond the scope of this Note, it is significant in demonstrating the power of the “Parent’s Rights” movement and the continuation of legislation that stigmatizes mental illness, and the role schools play in diagnosing it. Furthermore, existing law requires parental consent before a child undergoes mental health screening. Nealis Interview, *supra* note 11.

III. ANALYSIS

As evidenced above, there is, at the very least, a perception that schools routinely force children to take psychotropic medications. It is also clear that the Child Medication and Safety Act would be an effective way to prevent school officials from coercing students into taking Ritalin. Therefore the legislation also raises legitimate legal concerns.

A. Support of the Child Medication Safety Act

Parents, shocked by the idea that schools can forcefully medicate their children, have done an admirable job of championing their cause, and have gained national attention in doing so.¹⁵⁴ Not only does the CMSA appeal to the public's moral sympathies, but proponents do have some legal grounding for their position.¹⁵⁵ Courts have long recognized that parents have some degree of choice in how to educate their children,¹⁵⁶ and in deciding how they wish to treat their children's medical problems.¹⁵⁷ This relatively small but vocal group of parents has cleverly capitalized on the larger social debate concerning overuse and abuse of Ritalin, and captured the public's—and the legislature's—attention.¹⁵⁸ Yet in doing so, they have blinded Congress into ignoring long-standing legal traditions that firmly limit the influence parents can have in the public school system.¹⁵⁹

As a piece of legislation, the Child Medication Safety Act is appropriately broad and narrow in its focus. Although Ritalin is the most commonly prescribed drug, the Act includes all medications covered by § 202(c) of the Controlled Substances Act.¹⁶⁰ This insures that schools cannot create a loophole by recommending a “Ritalin Substitute.”¹⁶¹ More significant is the second paragraph of the bill, regarding intended

154. *See supra* note 113.

155. *See supra* notes 67–70, 88–90 and accompanying text.

156. *See supra* notes 88–90 and accompanying text.

157. *See supra* notes 77–70 and accompanying text.

158. *See supra* notes 129 and 123 and accompanying text. In 2001 the House Committee on the Judiciary requested an investigation and report on the issues of “Diversion and Abuse” of Ritalin in schools. *See generally* GAO, REPORT TO CONGRESSIONAL REQUESTERS: ATTENTION DISORDER DRUGS: FEW INCIDENTS OF DIVERSION AND ABUSE IDENTIFIED BY SCHOOLS (2001).

159. *See supra* note 91–95 and accompanying text.

160. *See supra* note 134 and accompanying text; *see also* Comm. on Educ. and the Workforce, *supra* note 137, at 2 (“We have learned that there are some replacement drugs for Ritalin and Adderall that are not in Schedule II [where the chemical formulation for Ritalin is included], but are instead listed in other Schedules. Therefore all five schedules of the Controlled Substances Act are incorporated. . . .”); *see also* 21 U.S.C. 812(c) (2000) (The Controlled Substances Act).

161. Comm. on Educ. and the Workforce, *supra* note 137.

construction. It indicates that nothing in the bill prohibits school personnel from talking to parents about “classroom based observations.”¹⁶² This concept was explicitly added to the bill after members of the Committee on Education and the Workforce voiced concern that it was otherwise too restrictive.¹⁶³ The amended bill recognizes that school personnel have a unique perspective and ability to identify symptoms of ADHD in a way parents may not.¹⁶⁴ At least on paper, the CMSA evinces a legitimate intent to end a disturbing problem, all the while maintaining communication between parents and school officials.

B. Fears of the Child Medication Safety Act

Although their position might seem facially “anti-child” or “anti-parent,” the opponents of the Child Medication Safety Act voice well-founded concerns that, in actuality, promote the best interests of children. Even with language explicitly preserving a school’s right to communicate with parents, Congresswoman Susan Davis worries that the bill stigmatizes all public school teachers based on what is essentially the bad experience of a handful of families, with a small number of (likely well-intentioned) school officials.¹⁶⁵

The National Association of School Psychologists (NASP) agrees with Congresswoman Davis’ concerns. According to their statistics, there is only one known case in which a school threatened expulsion if a child did not take Ritalin.¹⁶⁶ NASP maintains that “parents *feel* they have been

162. H.R. 1170 at Section 2(b)

“Nothing in subsection (a) shall be construed to create a Federal prohibition against teachers and other school personnel consulting or sharing classroom-based observations with parents or guardians regarding a student’s academic performance or behavior in the classroom or school, or regarding the need for evaluation for special education or related services. . . .”

Id.

163. 149 CONG. REC. 4382, H4383 (daily ed. May 21, 2003) (statement of Rep. Burns) (“This is an important change that was brought to my attention by . . . Mr. Kennedy. . . Mrs. Davis, and . . . Ms. Woosley”). This was also a concern voiced by the National Association of School Psychologists. *See supra* note 147.

164. 149 CONG. REC. at H4383 (statement of Rep. Burns) (“[The bill] is not intended to stifle appropriate dialogue between parents and teachers. Teachers spend so much time with the students and observe a wide variety of situations and parents often ask their child’s teachers to share their observations . . . We certainly do not want to infringe on these important conversations. . . .”).

165. *See supra* note 141; *see also* 149 CONG. REC. at H4383 (Statement of Rep. Woosley) (“I asked the Marin County superintendent of public schools what she thought of [the CMSA, and she thought] that it was a bill that would affect the many to solve the possible problem of just a few. . . .”).

166. Nealis Interview, *supra* note 11. The only reported case of actual coercion was that of the son of Patricia Whethers, founder of Able Child. *Id.* In that case, the principal of the school was immediately and appropriately disciplined. *Id.* “It was an extreme case, where the school went way out of bounds.” *Id.*

coerced” when, in actuality, they are being informed of their options.¹⁶⁷ They feel that schools are in the best position to detect possible ADHD, and parents have a right to as much information as possible about their children’s potential behavior disorders.¹⁶⁸ Unfortunately, the publicizing of “sensationalized accounts” has encouraged parents to cry coercion, which has in turn forced schools to keep quiet.¹⁶⁹

The net effect is one that concerns the psychiatric community. Many worry that the effective “gag order” will decrease mental illness detection in children.¹⁷⁰ Although CMSA supporters claim that opponents are puppets acting for large pharmaceutical corporations,¹⁷¹ it is unseemly to suggest that is the motivation of parties who have longstanding traditions of concern for children and the mentally ill.¹⁷²

Yet another criticism of the bill is that it is duplicative, and thus, unnecessary.¹⁷³ Typically, the use of Ritalin is suggested as a component of an IEP.¹⁷⁴ As explained above, IEPs carry with them mechanisms designed to protect both procedural¹⁷⁵ and substantive¹⁷⁶ due process

167. *Id.* This was the case with Sheila Matthews, the other co-founder of Able Child. When her son’s teachers noticed that he was having some behavioral problems in the classroom, school personnel gave her pamphlets about ADHD and treatment options (including Ritalin). *Id.* She claims this was coercion. *Id.*

168. *Id.*

169. *Id.* Practically speaking, there are several “layers of interpretation” between the intent effected by congress and the outcome seen in schools. *Id.* The severe threat of losing federal funding if not in compliance with the bill, combined with the tendency of parents to wrongfully accuse schools of coercive tactics has resulted in school policies to “err on the safe side” and “not say anything at all”—even though the legislation specifically protects this kind of communication. *Id.*

170. Vascellaro, *supra* note 145 (citing Dr. Harold Koplewicz, Director of the NYU Child Study Center, who noted that more than eighty percent of mental health problems in children go undetected, and this Act would undermine the important role of teachers in attempting to detect these problems.); Nealis, *supra* note 136; APA, *supra* note 146 ([T]here remains “A large percentage of unidentified and untreated children with mental health-related needs. Enactment of this legislation would set back further efforts to address these children’s needs, while increasing the stigma and discrimination experienced by children with mental disorders.”).

171. Vascellaro, *supra* note 145.

172. Nealis, *supra* note 136.

173. 149 CONG. REC. at H4385 (statement of Rep. Davis) (“The parent has clear due process rights to seek an evaluation [and if dissatisfied still,] an appeal to a due process hearing officer is available.”).

174. *See, e.g.,* Valerie J. v. Derry Coop. Sch. Dist. 771 F. Supp. 483 (D.N.H. 1991). The use of Ritalin was an IEP component that had been suggested by teachers and echoed by medical professionals upon evaluation of Casey. *Id.*

175. T.B. v. Warwick Sch. Dept., No. CIV.A.01-122T, 2003 WL 22069432, at *9 (D.R.I., June 6, 2003) (“[P]rocedural violations are grounds for rejecting an IEP only if there is ‘some rational basis to believe that [the] procedural inadequacies compromised the pupil’s right to an appropriate education, seriously hampered the parent’s opportunity to participate in the formulation process, or caused a deprivation of educational benefits.’”).

176. *See supra* notes 52 and 97 and accompanying text.

rights. Furthermore, parents have a limited right to challenge a school's chosen teaching strategies and methodologies because of the recognized presumptions that schools, as educational experts, have unique insight that allows them to make appropriate determinations.¹⁷⁷

C. IDEA 2004: 20 U.S.C. § 1412(25)

The 2004 reauthorization of IDEA contains a provision developed from the ideology of the CMSA. Though the gist of the legislation is the same in that it explicitly prohibits school personnel from requiring students take Ritalin, several of the procedural aspects have been altered. Most notably, the requirement that states adopt policies and procedures consistent with the legislation as a requirement of receiving federal funding has been dropped.¹⁷⁸ The intended effect of this omission, similar to the "Rules of Construction" language adopted in §1412(25) of IDEA 2004, is to keep lines of communication between parents and schools open without the fear of severe punishment if parents misperceive such a conversation.¹⁷⁹

IV. PROPOSAL

The essential problem is that teachers and school psychologists have become the target of parental frustration with a system lacking the resources necessary to give children opportunities to maximize their protected right to an educational benefit. It is socially injurious to use legislation such as the CMSA¹⁸⁰ to label teachers as uncaring¹⁸¹ for simply trying to maximize their ability to educate masses of children in an appallingly under-funded public education system.¹⁸²

Buried in the seemingly innocent language of the CMSA is a weapon with the power to effectively undermine the entire rubric of procedural and substantive due process established in IDEA. IDEA has always given

177. See *supra* notes 92–102 and accompanying text.

178. See *supra* note 153.

179. Nealis Interview, *supra* note 11.

180. For the remainder of this Note, the term "CMSA" will refer to the enacted version codified in IDEA 2004 as §1412(25).

181. See *supra* note 141.

182. National Education Association Special Education and the Individuals with Disabilities Education Act, <http://www.nea.org/specialed> (last visited Feb. 6, 2006). Currently, the average per student expenditure for public schools is roughly \$7500. The average cost of education for a special education student is almost \$17,000. *Id.* Yet in 2004 the federal government provided public schools with just twenty percent of the necessary additional funding (after promising to pay forty percent in IDEA). *Id.* This has created a \$10.6 billion dollar "shortfall" requiring local school districts to pick up the slack. *Id.*

parents the right to challenge proposed IEPs in a neutral administrative hearing.¹⁸³ Circumventing this fundamental IDEA procedure undermines the use of the administrative hearing procedure for parents challenging IEPs outside of the ADHD context.¹⁸⁴ More significantly, it provides special treatment that is unavailable to families of children with other disabilities, by categorically declaring that parents' preferences will be honored. CMSA proponents argue that, because Ritalin is a chemical treatment, the appropriate legal analysis is wholly dissimilar from cases regarding education methodology disputes. This is an inaccurate representation of the conflict. It is undeniable that psychotropic medications *are* a simple and effective treatment option.¹⁸⁵ These children should not be denied this therapy simply because their parents do not recognize that it is a legitimate option, or are fearful of the stigma attached.¹⁸⁶

Although the Child Medication Safety Act attempts to remedy this problem by specifically preserving a school's role in expressing concern for students, in reality it does nothing more than lend legitimacy to a sensationalized crisis.¹⁸⁷ In doing so, it neglects the reality that there are only a handful of cases nationwide in which coercion is a reality.¹⁸⁸ It further ignores the fact that the behavior exhibited by schools in those extreme cases is already condemned.¹⁸⁹ The enacted CMSA is superfluous legislation that explicitly reiterates procedures and restrictions firmly entrenched in IDEA. Its only effect is to exacerbate the infrequent problem of coerced medication while perpetuating the notion that schools are routinely forcing Ritalin on children, all the while stigmatizing a legitimate mental health concern and an effective course of treatment.

The advent of legislative proposals to "ban mandatory mental health screening"¹⁹⁰—a process that as of now does not exist in schools—

183. See *supra* notes 51–53 and accompanying text.

184. See, e.g., *Hendrick Hudson Bd. of Educ. v. Rowley*, 458 U.S. 176 (1982); *Burilovich v. Bd. of Educ. of the Lincoln Consolidated Sch.*, 208 F.3d 560 (6th Cir. 2000); *Cone v. Randolph County Sch.*, 302 F. Supp. 2d 500 (M.D.N.C. 2004); *T.B. v. Warwick Sch. Dep't* 2003 WL 22069432 (D.R.I. June 6, 2003).

185. See *supra* note 22; *Valerie J. v. Derry Coop. School Dist.*, 771 F. Supp. 483 (D.N.H. 1991) (Parents wanted child to remain in a special education classroom, while school expressed a preference for mainstreaming with use of Ritalin.). This demonstrates that the fundamental classification of Ritalin use as a "teaching method" because the alternatives considered are clearly options that would be classified as such.

186. Nealis Interview, *supra* note 11.

187. *Id.*

188. *Id.*

189. *Id.*

190. H.R. 181 109th Cong. § 3 (2005), *supra* note 153.

demonstrates the power of the parents' rights movement and its continuing crusade to prevent schools from performing their important function in detecting mental health issues in children, and working to educate them in the best way possible. As such, it is imperative that the message of the parent's rights movement be tempered by a close inspection of the law, which clearly limits parental rights to make decisions that may not be in the best interest of their children.

V. CONCLUSION

From a legal perspective, legislation such as the Child Medication Safety Act exploits the notion that parents have the right to raise and educate their children as they choose. The CMSA ignores longstanding legal doctrine that explicitly limits this right, and allows the state to exercise its police powers to ensure the well-being of its children.¹⁹¹ Although the most problematic elements of the Child Medication Safety Act were left out of IDEA 2004,¹⁹² similar issues are now being raised in the context of anti-mandatory mental health screening legislation.¹⁹³ Such legislation undermines the complex and delicate balance of power between parents and educators that is contemplated under IDEA's longstanding framework,¹⁹⁴ wipes out its notions of procedural and substantive due process,¹⁹⁵ unfairly characterizes teachers as uncaring,¹⁹⁶ and stigmatizes mental illness.¹⁹⁷ Such legislation is therefore harmful to America's school children, and must be carefully scrutinized for consistency with recognized legal doctrine, rather than hastily passed as a result of a sensationalized crisis.

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191. *See supra* notes 65–71 and accompanying text.

192. *See supra* notes 130, 151. When comparing §1412(25) to the original proposed CMAS, there are two clear changes that stand out: (1), the inclusion of the “rules of construction” which purports to protect communication between parents and educators, and (2), the exclusion of the provision mandating states adapt policies and procedures consistent with the legislation as a condition of receiving federal funding. Without these two of its sharpest teeth, the CMSA is relatively benign.

193. *See supra* note 153.

194. *See supra* notes 143 and 184 and accompanying text.

195. *See supra* notes 52–53 and accompanying text.

196. *See supra* notes 141, 181 and accompanying text.

197. *See supra* notes 186 and accompanying text.

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