

HYPERACTIVE CHILDREN AND THE USE OF PSYCHOACTIVE DRUGS: TREATMENT OR COERCIVE BEHAVIOR MANAGEMENT?

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Given the recent passage of Public Law 94-142,¹ requiring state school systems to adopt a program to identify, locate, and evaluate all handicapped children within the system in order to qualify for federal assistance in the education of the handicapped, it seems inevitable that many children previously thought to be merely troublesome will now be labeled emotionally handicapped.

This problem will be evident in children referred for treatment of hyperactivity (HA). One study showed that teachers in Des Moines, Iowa, perceived 53% of the boys and 30% of the girls to have problems with hyperactivity.² If all were treated with drugs, the total would be around 15 million children. Though accurate figures are impossible to obtain, some estimates go as high as 1½ million, with the average estimate around 500,000 children now being treated for HA.³

This article will examine the statutory and constitutional constraints on those who treat HA children, and will suggest guidelines for safeguarding such children.

In conjunction with the passage of Public Law 94-142, Congress included specific procedural safeguards that the local school districts must follow before classifying a child as handicapped.⁴ These call for parental consent, a hearing upon request, and a right to appeal a decision to federal court, regardless of the amount in controversy. Congress was obviously aware of the potential dangers involved in such an attempt at classification. This article will show that the state of the art of diagnosing and treating emotional problems in school children is, in the words of one commentator, "a mess".⁵ Given the seductive attraction of an easy excuse for bad behavior and easy treatment with psychoactive drugs, the chance is real that the practice will

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¹ 20 U.S.C.A. §§ 1401-1461 (West 1974).

² P. SCHRAG & D. DIVOKY, *THE MYTH OF THE HYPERACTIVE CHILD* 36 (1975 ed.) [hereinafter cited as SCHRAG & DIVOKY].

³ *Id.* at 35.

⁴ 20 U.S.C.A. § 1415 (West 1974).

⁵ Freeman, *Minimal Brain Dysfunction, Hyperactivity and Learning Disorders Epidemic or Episode?*, in BOSCO & ROBIN, *THE HYPERACTIVE CHILD AND STIMULANT DRUGS* 5 (1976 ed.) [hereinafter cited as Freeman].

continue, without concern for the negative side effects nor for the potential for masking serious social problems.

I. HYPERACTIVITY — SYNDROME OR EXCUSE FOR BAD BEHAVIOR?

In a recent manual designed for use by physicians, the following definition was offered for HA: "It is the persistent pattern of excessive activity in situations requiring motor inhibition. Persistent means consistently, year after year. Excessive means extreme (i.e., the most restless — 3 to 5%)."⁶ It is both interesting and revealing that the term "excessive" is a subjective impression with a certain percentage of a population being so described. The unsatisfactory nature of this definition becomes apparent upon examining the results of a Berkeley study⁷ on normal patterns of behavior in children. The study showed that significant numbers of normal children "were unusually active, had a short attention span," and had tantrums at given times. Dr. Mark A. Stewart suggests that behavioral characteristics are relevant only if they can be shown to cluster together in a child suspected of HA. Dr. Stewart does not feel this linkage has been conclusively established.⁸ He points out that there has been no definitive study for explaining the fact that HA is manifested in varying degrees depending on the social and physical environment, and that the HA child often is no trouble at all when alone. He further suggests that the answer from such a study may require a more skeptical approach to a purely physiological explanation for HA.⁹

At one time in the search for causes of HA, brain damage was suspected, the result of defective embryo development or trouble during birth. However, recent studies show that more than 95% of diagnosed HA children have no evidence of any injury to the brain.¹⁰ Those seeking a neurological explanation now suggest that a "minimal dysfunction associated with a selective lag in the maturation of the central nervous system" is the cause;¹¹ thus the coining of the expression "MBD" (minimal brain damage).

With the lack of any demonstrable physical cause for HA, one wonders how amphetamines ever came into widespread use as a treat-

⁶ D. SAFER & R. ALLEN, *HYPERACTIVE CHILDREN* 7 (1976 ed.) [hereinafter cited as SAFER & ALLEN].

⁷ McFarlane, *A Developmental Study of the Behavior Problems of Normal Children Between 21 Months and 14 Years*, 2 U. CAL. PUBLICATIONS IN CHILD DEVELOPMENT (1954).

⁸ Stewart, *Is Hyperactivity Abnormal*, in BOSCO & ROBIN, *THE HYPERACTIVE CHILD AND STIMULANT DRUGS* 32 (1976 ed.).

⁹ *Id.* at 34.

¹⁰ SAFER & ALLEN, *supra* note 6, at 6.

¹¹ *Id.*

ment. In 1937, Charles Bradley observed the effect of benzedrine on children with behavioral disorders. He suggested that a paradoxical calming effect occurred in children as opposed to adults.¹² However, in 1973 Lester Grinspoon and Susan B. Singer argued for a non-paradoxical explanation of amphetamine action.¹³ Between 35 and 60% of HA children respond to amphetamines and are perceived as less active and more attentive, leading to an assumption that amphetamines calm rather than stimulate children. In reinterpreting Laufer's study,¹⁴ Grinspoon and Singer examined the hypothesis of a lack of pathway arousal, technically known as "brain stem reticular formation functions". The investigators point out the role of the brain stem in maintaining alertness and regulating incoming stimuli that reach the cortex. This hypothesis, if it is correct with respect to amphetamine action, would account for both increased ability to disregard diverse stimuli and enhanced sustained attention without relying on the "paradoxical" explanation. This conclusion has recently been substantiated in a 1977 study by Russell A. Barkley,¹⁵ although the Interagency Collaborative Group in Hyperkinesis (another name for HA), after examining the hypothesis of underarousal, concluded: "The neuropathologic basis of hyperactivity is simply unknown."¹⁶

The use of amphetamines did not become widespread until the late 1960s. It is perhaps not coincidental that a new drug, Ritalin, became available about the same time. The manufacturer of Ritalin (Ciba) encouraged salesmen to become "more effective pushers" and complimented them on their ingenuity in promoting the drug,¹⁷ suggesting some foundation for the charge that the drug industry is largely responsible for expanding the practice of treating HA children with amphetamines.¹⁸ P.T.A. visits by company-paid doctors to discuss problems of HA with slides or other visual aids purporting to show the remarkable improvement obtained with drug treatment were common until 1972, when the U.S. Food and Drug Administration (FDA) finally

¹² Bradley, *The Behavior of Children Receiving Benzedrine*, 94 AM. J. PSYCH. 577 (1937).

¹³ Grinspoon & Singer, *Amphetamines in the Treatment of Hyperactive Children*, 43 HARV. EDUC. REV. 535 (1973) [hereinafter cited as Grinspoon & Singer].

¹⁴ Laufer, *Hyperkinetic Impulse Disorder in Children's Behavior Problems*, 19 PSYCHOSOMATIC MEDICINE 38 (1957).

¹⁵ Barkley, *A Review of Stimulant Drug Research with Hyperactive Children*, 18 J. CHILD PSYCH. AND PSYCH. 137 (1977). He states that stimulant drugs "energize the central nervous system and increase ability to concentrate without responding impulsively."

¹⁶ 1975 JOINT HEARINGS ON THE COMMITTEE ON LABOR AND PUBLIC WELFARE, FIRST REPORT OF THE PRELIMINARY FINDINGS AND RECOMMENDATIONS OF THE INTERAGENCY COLLABORATIVE GROUP IN HYPERKINESIS IN HYPERACTIVE CHILDREN 271 (1976).

¹⁷ Grinspoon & Singer, *supra* note 13, at 517.

¹⁸ For more information on the role of the drug industry in promoting stimulant drugs for treatment of HA, see SCHRAG & DIVOKY, *supra* note 2, at chs. 2 & 3.

labeled the drug dangerous and outlawed its promotion. However, there are indications that the seed planted is growing very well. One commentator called the trend toward labeling children HA an epidemic;¹⁹ another, the invention of a disease.²⁰

The seductive nature of the case favoring the use of drugs is obvious. Instead of blaming bad behavior on parents, or institutions, or simply the child's nature, we now have an easy organic scapegoat: problem children have chemical imbalances that we can treat with drugs. Indeed drug treatment advocates analogize using drugs for treatment of HA children to giving insulin to diabetics. They claim that no reward or discipline can help the child until the drug realigns the chemical imbalance.²¹

A description of a typical case study will perhaps illustrate the problem. Bill is six and in first grade. His teacher sends his mother a note saying, "Bill is hyperactive. Please have him see a physician." Bill is taken to a physician who inquires about Bill's normal behavior. Frequently Bill's school is contacted. If the doctor is very careful, he may even get a written work-up on the child from the teacher and a copy of Bill's file to date. Infrequently an electroencephalogram (EEG) is taken. Fifty percent of suspected HA children show abnormal brain activity, whereas only 15-20% of nonhyperactive children show such abnormalities.²² On this basis the drug is tried in a normal dosage and, if improvement is shown, the diagnosis is confirmed. If no reaction is manifest, the dosage will often be increased. In any case, Bill now has a label that will be very hard to lose. In fairness, it may be conceded that many professionals take far more care in prescribing psychoactive drugs for children than the scenario indicates. It is nonetheless common.²³

It should be obvious that the only "hard" measure of determining whether a child is a proper candidate for drug treatment is to try it. Indeed one psychiatrist contacted felt that this was the preferred diagnostic measure.²⁴ Is this wrong?

A recent unpublished study by Dr. R. Rapoport for the National Institute of Mental Health involved the administering of amphetamines and placebos to fourteen normal boys, ages six to twelve, using

¹⁹ Freeman, *supra* note 5, at 1.

²⁰ SCHRAG & DIVOKY, *supra* note 2, at 31.

²¹ Interview with Dr. David Wood, psychiatrist, Salt Lake County Mental Health Center, Salt Lake City, Utah (Aug. 10, 1978).

²² SAFER & ALLEN, *supra* note 6, at 18-19. This finding may appear to conflict with the statement that more than 95% of HA children show no brain damage. EEGs do not, however, diagnose brain damage, but only indicate abnormal brain activity.

²³ Grinspoon & Singer, *supra* note 13, at 544.

²⁴ Interview with Dr. David Wood, *supra* note 21.

the double-blind cross-over method wherein neither the examiner nor the subjects knew the purpose of the study, and in which the control group is switched with the test group part way through the experiment. On the basis of this work, Dr. Rapoport concluded that the "effects of stimulant drugs are not specific to a particular diagnostic group, and that the response of children with MBD to stimulants is neither paradoxical nor diagnostic."²⁵ In lay terms, normal children respond to stimulant drugs the same way children diagnosed HA do. This method of diagnosis is thus both over-inclusive and under-inclusive since (a) many normal children will be diagnosed as HA by giving them the drug, and (b) many truly HA children will not be properly diagnosed because only half the suspected HA children respond to amphetamines.

Should we then conclude that using the drug may benefit the learning ability of 50% of all school children? Two studies show that the value of amphetamines in promoting learning is doubtful. Rachel Gittelman-Klein studied three groups: one given Ritalin; the second, Ritalin along with behavior modification; and the third, a placebo with behavior modification. The results indicated a universal reduction in reported deviance. On three separate ratings of the degree of HA (by objective standards, by teachers, and by parents), the evaluations were about the same, except that teachers overall slightly favored the group given Ritalin with behavior modification.²⁶

A subsequent study casts further doubt on the ability of drugs to enhance the opportunity for HA children to learn. Dr. Gabrielle Weiss²⁷ undertook a five-year study of two groups. One group took Ritalin, a stimulant; the second took chlorpromazine, a sedative, or no drug at all. Dr. Weiss found "no significant differences between the two pairs of matched groups on measures of reading, language, or arithmetic."²⁸ She was surprised by the result, since other studies had documented improvement in cognitive skills.²⁹ This lack of a showing

²⁵ R. Rapoport, reported in the PHYSICIAN'S NEWSLETTER, July 1978. The drug involved was dextedrine, one group being given the drug and the other a placebo.

²⁶ Gittelman-Klein, *Relative Efficacy of Methylphenidate and Behavior Modification in Hyperkinetic Children: An Interim Report*, 4 J. OF ABNORMAL CHILD PSYCH. 101 (1976) [hereinafter cited as Gittelman-Klein].

²⁷ Weiss, *Effect of Long-Term Treatment of Hyperactive Children with Methylphenidate*, 112 CAN. MED. A.J. (1975).

²⁸ *Id.* at 163.

²⁹ *Id.* at 163-64. In explaining the result, Dr. Weiss noted:

The findings of this study were surprising. All of us had in general been impressed by the efficacy of stimulant drugs for HA children, . . .

Our failure to demonstrate a better five-year outcome in adolescence in the children who had received methylphenidate for 3-5 years than in children treated with chlor-

of greater learning progress calls into question the justification for treating suspected HA children with drugs. Grinspoon and Singer, calling HA little more than a convenient label for excusing social problems as a disease, wrote that the use of drugs "does little more than provide a relatively easy and economical way of making the classroom situation more tolerable and manageable for the teacher."³⁰

This is crucial to an examination of side effects of the use of drugs. In the name of treatment, with parents and teachers believing drugs to be crucial for a child's education, it is easy to dismiss side effects as minor; but if drugs are merely a means of controlling unwanted deviant behavior, the significance of the side effects looms larger.

Common short-term side effects are headaches, moodiness, stomach aches, and talkativeness. Moodiness is generally expressed as a tendency to cry. Insomnia can occur when more than one or two Ritalin or dexedrine pills are given per day (the normal dosage is three capsules per day). Hallucinatory episodes are also reported. Another common side effect, though generally temporary, is appetite suppression.³¹

Long-term effects have not been well researched; but growth suppression, weight loss, and possible liver damage have been mentioned,³² although growth suppression is questioned in recent studies.³³ In general, it can be said that the long-term effects are unknown. This is not reassuring, since long-term negative effects from extended use of amphetamines by adults became known only recently. One commentator feels this lag in knowledge constitutes a serious risk to children.³⁴

The question of how much risk and short-term discomfort we are willing to subject children to can be answered only in terms of our perception of whether this is indeed a treatment of a serious physical impediment to learning, or just a popular method of improving behavior. That question is inextricably connected to the question of whether or not there are alternatives to drug treatment.

promazine or not treated at all is difficult to explain, because methylphenidate has proved itself efficacious in several short-term drug studies and in clinical practice. . . .

Perhaps our findings can be summarized by suggesting that we initially expected too much from any one drug or from any one method of treatment of HA children. . . . There is no doubt that stimulant drugs are effective drugs for many HA children, but as the sole method of management their value is limited.

³⁰ Grinspoon & Singer, *supra* note 13, at 547.

³¹ SAFER & ALLEN, *supra* note 6, at 57-58.

³² *Id.* at 58; interview with Dr. David Wood, *supra* note 21.

³³ Greenhill & McNutt, *Hormone and Growth Responses in Hyperkinetic Children on Stimulant Medication*, 13 *PSYCHOPHARMACOLOGY BULL.* 33, 36 (1977).

³⁴ See Freeman, *supra* note 5, at 19-20.

Freeman³⁵ lists the alternatives: special education techniques to minimize distractions; perceptual or perceptual-motor training; diet; early intervention and screening; drugs other than amphetamines; behavior modification; parent counseling; and psychotherapy. An examination of these methods is beyond the scope of this article. However, a recent study found no quantifiable difference between the effectiveness of behavior modification techniques and that of drugs.³⁶ It is possible that further research will show that both are equally ineffective; but it would seem that the somewhat less objectionable behavior modification should be tried more extensively. Few of those interviewed in the course of this research perceived a potential for invasion into protected areas of autonomy and privacy posed by behavior modification, while they rather frequently condemned the widespread use of drugs on that basis.³⁷

Another alternative, examined closely during this author's research, is found in the growing body of literature on diet, with a particular emphasis on the work of Dr. Ben Feingold who looked into the relationship of food additives to HA.³⁸ A 1975 government publication indicates that work is proceeding in this area but that few conclusions have yet been reached.³⁹

Based on the lack of a clear-cut means of diagnosis, the side effects of drug treatment, and the lack of conclusive evidence that drug treatment furthers the education of a child, the need for safeguards against indiscriminate classification and treatment comes into focus — safeguards to constrain schools and, indirectly, parents and teachers.

II. STATUTORY RESTRAINTS

Recent statutory enactments, such as Public Law 94-142, radically alter the rights of HA children and their parents. For example, although the right of handicapped children to an education has been recognized in Utah since 1969,⁴⁰ and in the District of Columbia since 1972,⁴¹ it was not until Public Law 94-142 passed in 1975 that this right was established as national policy.⁴² Though education of the handi-

³⁵ *Id.* at 16-17.

³⁶ Gittelman-Klein, *supra* note 26, at 361.

³⁷ For a complete discussion of the problem of coerciveness and behavioral modification, see Jones, *Coercive Behavior Control*, 29 *STAN. L. REV.* 93 (1976) [hereinafter cited as Jones].

³⁸ See B. FEINGOLD, *WHY YOUR CHILD IS HYPERACTIVE* (1975), and Feingold, *Behavioral Disturbances Linked to the Ingestion of Food Additives*, 49 *DEL. MED. J.* 89 (1977).

³⁹ See *FIRST REPORT*, *supra* note 16, at 122.

⁴⁰ Wolf v. Legislature of the State of Utah, Civ. No. 182646 (Utah D.C. 1969), cited in Jones, *supra* note 37, n.77 at 105.

⁴¹ Mills v. Board of Education of the District of Columbia, 348 F. Supp. 866, 880-81 (D.D.C. 1972).

⁴² See 20 U.S.C.A. § 1401 (West 1974).

capped is laudable, it is doubtful that the art of locating and diagnosing HA children is well tuned enough to protect their rights.

As previously mentioned, the new federal statute requires the identification, location, and evaluation of all handicapped children. The law defines handicapped to include the "seriously emotionally disturbed . . . or children with specific learning disabilities . . ." This is interpreted to include hyperactive children. The affirmative duty creates the potential for significant violation of the rights of the children, the most basic problem being the inability of the schools accurately to delineate what is a handicap and what is merely a slight deviance in behavior. The schools are forced to adopt arbitrary cut-offs, based largely on subjective impressions of teachers. One commentator presents studies showing the tendency of teachers to be over-inclusive in their diagnosis of behavioral disorders.⁴³

An example of the implementation of the safeguards is provided by studying the procedures employed by the Salt Lake City School District.

In attempting to comply with Public Law 94-142, the Salt Lake City schools have adopted the following procedure. After a teacher perceives a child as handicapped, written parental consent is sought before any testing. The form merely provides a blank space for listing reasons for the suggested further evaluation; it provides no assurance that the parents will be told or made to understand the consequences of the testing.⁴⁴ The form further fails to inform parents of the right to a hearing or to an independent evaluation.⁴⁵ If the parents do consent, diagnosis by an evaluation-placement team begins. The Utah State Board of Education regulations⁴⁷ suggest five categories of participants: (1) a representative of the school board trained in providing or supervising special education, such as a special education teacher, the principal, or a psychologist; (2) the teacher or teachers of the child; (3) the parents; (4) the child; (5) anyone else the school board or the parents want.⁴⁶ After the evaluation, the parents are given written notification of the agency's decision, again using a general form that does not highlight the rights of the parents to a due process hearing or to appellate review.⁴⁸ The form also fails to explain place-

⁴³ *Id.* § 1415.

⁴⁴ Jones, *supra* note 37, at 106-07.

⁴⁵ See Appendix 1.

⁴⁶ 20 U.S.C.A. § 1415(b)(1)(D) (West 1974).

⁴⁷ UTAH STATE BOARD OF EDUCATION, RULES AND REGULATIONS FOR PROGRAMS FOR THE HANDICAPPED, Salt Lake City, Utah (Aug. 19, 1977).

⁴⁸ *Id.*

⁴⁹ See Appendix 2.

ment or treatment alternatives available. To require consent no doubt is a step in the right direction, but as yet it is inadequate.

Under the current system, a parent could bypass all the preceding safeguards, refuse to participate in the evaluation, and simply consent to the classification and treatment. Recognizing the possibility that parents may have their own reasons to want the treatment, the agency proposing the placement program should be required to document the parents' participation and to demonstrate that the parents are aware of and concerned about the consequences before the agency is allowed to accept the parents' consent. Absent such a showing, a hearing to examine the interests of the child should be mandatory, with independent counsel to represent the child.

The next step in the procedure of classification is a hearing upon the request of the parents. According to school officials, this hearing could also be held if the parents refuse consent and the board wished to press the issue.⁴⁹ The hearing officer may not be affiliated with the school board of the child's district, but is generally a school official from within the state. This procedure complies with the federal statute.⁵¹ (Only once has a hearing regarding HA children been held in Utah; the parents conceded the issue and consented before a decision was reached.⁵²)

There appear to be a number of problems with the hearings. First is the question of the identity of the hearing examiner. A likelihood of bias in favor of the school board seems clear. The rules should require the appointment of someone from state government who is not affiliated with the schools but who has a background of dealing with juveniles.

Second is the difficulty of rebutting an adverse diagnosis. Public Law 94-142 and the state regulations do not address the issue of burden of proof. The imprecise nature of the diagnosis for HA and the lack of expertise of most parents suggest that it is greater wisdom to place that burden on the schools.

Third the child's right to have his/her interest protected by independent counsel is not explicit. In many cases, the parent is totally unable to consider and protect the child's interest due to the parent's own dislike for the behavior. In other circumstances, the parent is substantially responsible for the conditions that cause the problem. In either situation, independent counsel for the child is imperative.

⁴⁹ Interview with Joseph Nelson, Department of Pupil Services, Salt Lake City Schools (Aug. 11, 1978).

⁵¹ See 20 U.S.C.A. § 1451(b)(2) (West 1974).

⁵² Interview with Joseph Nelson, *supra* note 50.

Fourth is the fact that parents can now waive the right to a hearing for their child by mere inaction rather than by express waiver. The potential for harm to the child requires an explicit waiver based on valid, informed consent.

The problems of over-diagnosis and stigma to normal children remain significant, since diagnosis is highly inexact. Many have argued that this problem can be overcome by relying on the professional judgment of physicians.⁵³ However, absent good diagnostic techniques that clearly identify only those in need of treatment, this trust seems misplaced.

In response to the problem of excessive use of drugs on persons who are institutionalized, Congress in 1975 passed Public Law 94-103.⁵⁴ Section 111 outlines the rights of the developmentally disabled. Among other things, the federal and state governments are required to see that no program receives money unless it has a "prohibition on the excessive use of chemical restraints on [developmentally disabled] persons and the use of such restraints as punishment or as a substitute for a habilitation program or in quantities that interfere with services, treatment or habilitation of such persons."⁵⁵ Developmental disability is defined in 42 U.S.C.A. § 6001(7) as:

a disability of a person which is attributable to any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of mentally retarded persons or requires treatment and services similar to those required for such persons; originates before such person attains age eighteen; has continued or can be expected to continue indefinitely; and constitutes a substantial handicap to such person's ability to function normally in society.

Inasmuch as recent work with adults suggests that HA may not be outgrown, it is entirely possible that HA individuals will be included in this protected class.⁵⁶ It can be argued that the drugs do not constitute treatment for HA, but are rather merely control measures for the convenience of others. Public Law 94-103 could force a withdrawal of federal funds from an HA drug program and provide a basis for showing that public policy does not favor such treatment. Such an application of Public Law 94-103 would, of course, also be of help in a subsequent tort action.

⁵³ Jones, *supra* note 37, at 109.

⁵⁴ Codified at 42 U.S.C.A. §§ 6001-6081 (West 1975).

⁵⁵ *Id.* § 6010.

⁵⁶ Interview with Dr. David Wood, *supra* note 21.

More stringent controls on the administration of drugs might be implemented by convincing school boards of their statutory duty to see that their programs are aimed primarily at habilitation, and by encouraging them to use their power to ensure that the best diagnosis possible is rendered by all concerned, including the doctor. School boards may initially feel no responsibility for policing physicians, but one commentator established a theoretical basis for holding the school board liable.⁵⁷ One case has been filed pursuing the theory.⁵⁸

In *Mills v. Board of Education of the District of Columbia*,⁵⁹ decided prior to the adoption of Public Law 94-142 with its mandatory procedural guidelines, the court adopted guidelines for implementing educational opportunities for handicapped children. Therein the judge spelled out the information to be given the parents before special placement:

Such notice shall:

- (a) describe the proposed action in detail;
- (b) clearly state the specific and complete reasons for the proposed action, including the specification of any tests or reports upon which such action is proposed;
- (c) describe any alternative educational opportunities available on a permanent or temporary basis;
- (d) inform the parent or guardian of the right to object to the proposed action at a hearing before the hearing officer;
- (e) inform the parent or guardian that the child is eligible to be referred to a federally or locally funded diagnostic center for an independent medical, psychological and educational evaluation and shall specify the name, address and telephone number of an appropriate diagnostic center;
- (f) inform the parent or guardian of the right to be represented at the hearing by legal counsel, to examine the child's school records before the hearing, including any tests or reports upon which the proposed action may be based, and to present evidence and cross-examine any witnesses at the hearing.⁶⁰

Though quite complete, even these guidelines are inadequate, especially where parents can waive their rights by inaction.

An article cited earlier⁶¹ recommends six points of information to be

⁵⁷ Jones, *supra* note 37, at 119-25.

⁵⁸ *Benskin v. Taft City School District*, Civ. No. 136785 (Sup. Ct. Kern County, Calif., filed Sept. 8, 1975). As of August 1978, this case was still in discovery.

⁵⁹ 348 F. Supp. 866 (D.D.C. 1972).

⁶⁰ *Id.* at 880-882.

⁶¹ Jones, *supra* note 37, at 115.

given to parents before consent can be considered valid and informed. Combined with the list in *Mills*, they serve as a model:

1. The form requesting the consent of the parents before evaluation should include:
 - (a) the preliminary diagnosis and any tests or reports on which the preliminary diagnosis is based;
 - (b) a complete description of the contemplated evaluation;
 - (c) explicit information that the parent may refuse to consent;
 - (d) information on the possible effect the testing will have on the child's placement in school programs;
 - (e) the parents' right to a hearing before testing; and
 - (f) notice that the parents have a right to request an independent evaluation, and informing the parents in their own language how such an assessment can be obtained.
2. The form outlining the diagnosis after evaluation should include:
 - (a) the diagnosis and a specification of any tests or reports upon which such diagnosis is based;
 - (b) a complete description of the contemplated treatment procedures;
 - (c) the risks involved along with current information on the problem of stigmatization for a child labeled handicapped;
 - (d) the prospects of success;
 - (e) alternative methods of treatment;
 - (f) the prognosis if the procedures recommended are not implemented;
 - (g) the right to an independent assessment along with current information on how to obtain such an assessment;
 - (h) the right to examine the records and tests performed on the child;
 - (i) the right to a hearing where parents and child can be represented by counsel, offer evidence, and cross-examine other witnesses and how to obtain such counsel, if the parents are indigent;
 - (j) the right to appeal to federal court if they disagree with the decision at the hearing.
3. The burden of showing the need for special treatment should be placed on the school board, with a requirement that a hearing be held where the child is afforded free, independent representation, should the parents either refuse consent or fail to act upon the request.

One large gap remains in protecting the rights of HA children where a parent seeks out treatment and the school is not directly involved. It appears that control would be possible only if constitutional restraints are found, protecting the child's freedom in his/her thoughts.

III. CONSTITUTIONAL CONSTRAINTS

The most obvious basis to restrict state action in programs aimed at handicapped children generally and HA children specifically would be to establish education as a fundamental interest, and thereby force school boards and others to demonstrate the value of their programs.⁶²

*San Antonio v. Rodriguez*⁶³ appeared to seriously undercut such an analysis. In that case, the United States Supreme Court specifically refused to analyze education as such a fundamental interest. However, in light of subsequent cases, it can be argued that *Rodriguez* speaks merely to financing education.

In 1974 the United States Supreme Court in *Lau v. Nichols*,⁶⁴ held that § 601 of the Civil Rights Act of 1964 was violated when children from Chinatown in San Francisco were not afforded a bilingual education. The Court said that this deprived the children of any education at all. Though the Court specifically refused to reach the constitutional issue, its language suggests that it might do so in the future. A number of lower courts have seized on this opening and declared there is a right of handicapped children to obtain a meaningful education.⁶⁵ For example, *Frederick L. v. Thomas*,⁶⁶ cites *Weisenberger v. Weisenfeld*,⁶⁷ and applies the Supreme Court's standard to require that schools show a legislative purpose that is reasonably advanced by the proposed treatment. For HA children this would mean that the administering of drugs must afford a greater opportunity to learn. Further, there is a discernible trend toward strictly scrutinizing treatment and education of the handicapped — either as a quasi-fundamental interest or as a protection for a person put into a suspect class.⁶⁸

A second basis to restrict the programs is found in the mental privacy argument developed by Professor Michael Shapiro.⁶⁹ The argument asserts that the right to be free in one's thoughts is protected

⁶² See Wells, *Drug Control of School Children and the Child's Right to Choose*, 43 S. CAL. L. REV. 585 (1973).

⁶³ 411 U.S. 1 (1973).

⁶⁴ 414 U.S. 563 (1975).

⁶⁵ See *Frederick L. v. Thomas*, 408 F. Supp. 832 (E.D. Pa. 1976) (denial of motion to dismiss), 419 F. Supp. 960 (E.D. Pa. 1976), *aff'd*, 557 F.2d 373 (3d Cir. 1977); *Fialowski v. Shapp*, 405 F. Supp. 946 (E.D. Pa. 1975); *Interest of G.H.*, 218 N.W.2d 441 (N.D. 1974); *Burgdorf & Burgdorf, A History of Unequal Treatment*, 15 SANTA CLARA LAW. 855 (1975); *Haggerty & Sacks, Education of the Handicapped*, 50 TEMPLE L. Q. 961 (1977).

⁶⁶ 408 F. Supp. 832 (E.D. Pa. 1976) (denial of motion to dismiss), 419 F. Supp. 960 (E.D. Pa. 1976), *aff'd*, 557 F.2d 373 (3d Cir. 1977).

⁶⁷ 420 U.S. 636 (1975).

⁶⁸ See note 65, *supra*.

⁶⁹ Shapiro, *Legislating the Control of Behavior Control*, 48 S. CAL. L. REV. 237, 261 (1974).

by the First Amendment. In terms of the HA child, it is important to provide safeguards to ensure that relatively harmless deviant behavior, of unknown value to the child's future development and growth, is distinguished from behavior that may deprive the HA child of an education. The latter is a valid concern for state involvement.

The mentational privacy argument was adopted in *Kaimowitz v. Department of Mental Health*,⁷⁰ a decision that presents potential ramifications in the treatment of HA children. The case involved proposed psychosurgery on an inmate of a mental institution. The court ruled that the inmate could not validly consent to the procedure and flatly prohibited it. The surgery was experimental and of questionable value. The court looked at competency, knowledge of risk, and voluntariness in deciding whether or not the consent of the inmate's parents could suffice. In examining the element of competency, the court remarked that consent from parents was ineffective for psychosurgery when it involves involuntarily detained mental patients. The court indicated that the high risks involved and the lack of known benefits from the procedure precluded parental consent from being sufficient.

Applying the rationale of *Kaimowitz* to drug treatment of HA children, a court could hold that a parent is not capable of giving valid consent. Although not so clearly experimental as psychosurgery, drug treatment of HA children does present known side effects with a lack of demonstrable improvement in the education of the child. Further, parents may want to curb hyperactive behavior for their own personal motives rather than to benefit the child. Finally, the voluntariness required by *Kaimowitz* is arguably lacking in treating HA children with drugs. In a setting similar to prison, a child is required to attend school. The consent of the parents could be seen as coerced, in view of the pressure to treat the problem that a school often exerts on parents.

This analysis could provide the basis for a court not only to impose more restrictive guidelines on the schools before treatment, but also to hold that parental consent was invalid. It might also give the child a cause of action against the prescribing physician or against the parents where immunity does not prevent it.

IV. CONCLUSION

The following summarizes the problem which our society currently faces in the treatment of HA children:

⁷⁰ No. 73-19434-AW (Cir. Ct. Wayne County, Mich., July 10, 1973), excerpted in 42 U.S.L.W. 2063 (1973).

The race is between technology and ideology. If the technology is recognized for what it is — as a means of controlling and managing people — the political issues will be apparent If, on the other hand, the proponents — scientists, doctors, school administrators, the police, the drug companies, and the federal government — continue successfully to present these technologies and ideas as therapeutic measures to "treat" individual children, then there will not even be a fight. . . . "Science" in that sense abolishes the Constitution — informally, gradually, subtly — and scientism becomes the instrument by which the individual is subsumed to the requirements and impositions of an orderly system. The country has not yet reached the critical point from which there is no return, but it is close.⁷¹

The diagnosis of HA children is inexact and treatment of these children with drugs is of questionable value. On the basis of trends developing in case law and the tension between Public Law 94-142⁷² dictating treatment and Public Law 94-103⁷³ calling for controls on the use of drugs in treating the developmentally disabled, it is urged that the procedures leading to diagnosis and treatment be subject to strict scrutiny, placing a burden on schools and physicians to demonstrate that the planned program of treatment is reasonably likely to benefit the child's education, not just the school's disciplinary environment, and that the plan represents the least onerous intrusion into the child's mental processes.

⁷¹ SCHRAG & DIVOKY, *supra* note 2, at 228.

⁷² 20 U.S.C.A. §§ 1401-1461 (West 1974).

⁷³ 42 U.S.C.A. §§ 6001-6081 (West 1975).

APPENDIX 1

ASSESSMENT APPROVAL FORM

At the request of _____ [Name] _____ [Title] _____ the school resource staff is seeking your permission to carry out a more detailed educational-adaptive-psychological assessment of _____ than is provided by the classroom teacher. The reasons for this request are:

Before we may perform this assessment, we must have written consent from you. You have the right to refuse permission for this assessment. You also have the right to request and to review all of your child's school records. Following the assessment you will be informed of the results. Further, your child's educational program will not be changed without your written consent.

If you have any questions, contact _____ Phone _____. Please return this form as soon as possible. Thank you for your cooperation.

Sincerely,

[Pupil's Name] _____

____ Yes, I do authorize the assessment and understand that the results are kept confidential.

____ No, I do not authorize the assessment you have requested.

Parent's comments: _____

Date

Signature of parent or guardian

APPENDIX 2

PLACEMENT APPROVAL FORM—SELF-CONTAINED CLASSES

The purpose of this conference is to discuss with you the assessment results and your child's school placement for the year _____. Educational options available in the Salt Lake City Schools are the following:

- Regular Class _____ Educable Mentally Handicapped _____
- Resource Program _____ Trainable Mentally Handicapped _____
- Emotionally Handicapped _____ Severely Multiple Handicapped _____

Based on available data, we recommend the placement checked above.

Reasons for this placement are: _____

You may either approve of the above placement or reject it. If you do not feel that this recommendation is appropriate, you may request a conference with school personnel to obtain additional facts. You may have an independent assessment completed on your child. You also have the right to due process. You have the right to review and to amend the information collected in determining your child's placement. The information collected in developing your child's program will be available only to the staff implementing the program. The records will not be released under any other circumstances without your written consent.

Participants:

____ I approve of the above placement.

____ I do not approve of this placement.

Parent's comments: _____

Parent's signature

Date