Supporting Materials: A Staff Compilation of Relevant Statutory, Statistical, and Case Materials

COMPILED BY STAFF

The following materials were compiled by the Journal Staff to supplement the presentations at our *2004 Symposium on Children's Rights*. They consist of tables, charts, and short summaries of recent developments in child, family, dependency, and juvenile law

CALIFORNIA STATUTORY MEASURES ON JUVENILE LAW & POLICY LEGISLATIVE ACTION DURING 2003-04 LEGISLATIVE SESSION

Poverty

AB 231 (Chapter 743, Statutes 2003) amended Sections 11155 and 18901.6 of, and added Sections 18901.9 and 18901.10 to, the Welfare and Institutions Code.

AB 231 reforms the Food Stamp Program in an attempt to increase participation and improve the health and nutrition of low-income families. It allows the Department of Social Services to ease the vehicle exemption that it had previously used to determine the eligibility of possible food stamp recipients. Originally, a family that owned a decent car would not be eligible for food stamps; under this reform, this is no longer the case.

AB 739 (Chapter 387, Statutes 2003) amended Section 706.030 of the Code of Civil Procedure, and amended Sections 4200, 4201, 4204, 5235, 5237, 5240, 5247, 5253, and 17309 of, and added Sections 17311, 17311.5, and 17311.7 to, the Family Code.

AB 739 creates the Child Support Payment Trust Fund, which will be administered by the Department of Child Support Services. It establishes a structure and and distributing millions of dollars of child support payments. This makes the child support payment process more efficient and increases the collections and timely payments to families.

Nutrition

SB 677 (Chapter 415, Statutes 2003) amended Section 49431 of, and added Section 49431.5 to, the Education Code.

SB 677 creates the California Childhood Obesity Prevention Act. This Act prohibits the sale of carbonated

beverages on elementary school campuses starting on July 1, 2004. Permissible beverages for sale on elementary and middle school campuses include: water, milk, fruit juices, and fruit-based drinks that contain at least fifty percent juice and no added sweeteners. The Act is intended to provide healthy options for children during school hours thereby combating childhood obesity.

Health and Safety

AB 24 (Chapter 422, Statutes 2003) amended Sections 1102.18 and 1940.7.5 of the Civil Code, and added Section 115929 to the Health and Safety Code.

When producing pamphlets concerning home swimming pool and spa safety, AB 24 encourages private entities to consult with the Epidemiology and Prevention for Injury Control Branch of the Department of Health Services (DHS). This statute requires DHS to review and approve the brochure concerning child drowning hazards and safety and preventive measures for home pools and spas and to post it on the DHS website in a format that can be easily downloaded or published.

AB 1697 (Chapter 524, Statutes 2003) amended, repealed, and added Section 27360 of the Vehicle Code.

AB 1697 requires all children who are less than six years old or who weigh less than 60 pounds to be secured in a child passenger restraint system located in the rear seat, except under specific circumstances. This requirement is effective on January 1, 2005. These requirements are based on recommendations by the National Highway Traffic Safety Administration.

Child Care

AB 305 (Chapter 430, Statutes 2003) amended Section 65915 of the Government Code.

AB 305 creates an incentive for developers to include childcare facilities in new housing developments. It requires a city or county to give an additional density bonus, concession, or incentive to a housing developer when that developer includes a childcare facility in a housing development. It also includes provisions to ensure that children from low and moderate-income families have access to spaces at these childcare facilities. Cities and counties are allowed to waive this law if there is adequate childcare already provided in the area.

AB 1683 (Chapter 403, Statutes 2003) added Sections 1596.817 and 1596.8595 to the Health and Safety Code.

AB 1683 is intended to educate parents about the safety of their children's childcare facility. It requires every licensed child day care facility to immediately post a copy of a licensing report that documents a citation or a complaint investigation for the facility. It also requires the report and other verifying documents to remain posted for thirty days. The added scrutiny creates an incentive for day care facilities to avoid receiving citations and to better protect children in their care.

Education

SB 892 (Chapter 909, Statutes 2003) added Section 35292.5 to the Education Code.

SB 892 requires every public and private school to have restroom facilities that are kept open during school hours. They are to be maintained and cleaned regularly, kept fully operational, and stocked with soap and paper supplies at all times. Any school district that operates a public school that is in violation of this section, as determined by the State

Allocation Board, is ineligible for state deferred maintenance funds.

Child Protection

AB 353 (Chapter 28, Statutes of 2003) amended Section 361.5 of the Welfare and Institutions Code

AB 353 expands the definition of a "sibling" to include any relationship by through a common legal parent. This modified the old definition, which restricted the term "sibling" to biological relationships. This allows courts to consider a parent's sexual abuse of one child (biological or foster) as a legal ground for denying reunification services with respect to the parent's other children.

Juvenile Justice

AB 945 (Chapter 332, Statutes of 2003) added Section 207.6 to the Welfare and Institutions Code.

AB 945 provides that, in order for a minor to be held in a jail or in any other secure facility designed to detain adults, the court must find that the minor poses a danger to the staff of a juvenile facility or other minors in society or in a juvenile facility in which the minor is being detained.

Other Legislative Bills Passed during 2003-04 Session

Foster Care and Adoption Related Bills

AB 408 (Chapter 813, Statutes of 2003) amended Sections 349, 366, 366.1, 366.21, 366.22, 366.26,366.3, 391, 10609.4, 16206, 16500.1, and 16501.1 of, and added Section 362.05 to, the Welfare and Institutions Code.

AB 408 encourages foster children to achieve a sense of permanency by reducing their reliance on foster care systems and encouraging them to establish relationships with other individuals.

AB 458 (Chapter 331, Statutes of 2003) amended Sections 1522.41, 1529.2, and 1563 of the Health and Safety Code, and amended Sections 16001.9 and 16003 of, and added Section 16013 to, the Welfare and Institutions Code.

AB 458 prevents discrimination and harassment among foster children within the foster care system. Forms of discrimination prohibited include: actual or perceived race, ethnicity, ancestry, national origin, color, religion, sex, sexual orientation, gender identity, mental or physical disability, or HIV status.

AB 490 (Chapter 862, Statutes of 2003) amended Sections 48645.5, 48850, 48859, 49061, 49069.5, 49076, and 56055 of, and added Sections 48853 and 48853.5 to, the Education Code, and amended Sections 361, 366.27, 726, 727.2, 4570, 16000, and 16501.1 of the Welfare and Institutions Code.

AB 490 requires children in foster homes and institutions to have access to local educational programs and ensures that all homeless and foster care children have the opportunity to engage in education programs.

AB 1151 (Chapter 847, Statutes of 2003) amended Section 911.4 of, and added Section 6252.6 to the Government Code, Section 1527.6 of the Health and Safety Code, and added Sections 16000.1 and 16501.15 to the Welfare and Institutions Code.

AB 1151 enacted the Duty to Foster Children Reaffirmation Act, which declares the state's duty to care for and protect children in the foster care system.

SB 182 (Chapter 251, Statutes of 2003) amended Sections 7620, 7630, 7662, 7669, 8614, 8714, 8714.5, 8715, and 8814.5 of, and amended and renumbered Section 8714.7 of, the Family Code, and added Section 1516.5 to the Probate Code.

SB 182 permits a child's legal guardian to adopt the child once the child has been in the guardian's custody for at least two years provided that the court finds that it is in the child's best interest.

SB 591 (Chapter 812, Statutes of 2003) amended Sections 358, 358.1, 361.3, 16002, and 16501.1 of, and added Sections 16010.4, 16010.5, 16010.6, and 16503.5 to, the Welfare and Institutions Code.

SB 591 authorized Child Protective Services to provide foster parents with personal information relating to their foster child's case.

Health Care Related Bills

AB 1286 (Chapter 591, Statutes of 2003) repealed and added Sections 1373.65, 1373.95, and 1373.96 of the Health and Safety Code, and amended Section 10133.56 of the Insurance Code.

AB 1286 requires that "continuity of care" laws apply to the care of a newborn between birth and 36 months. "Continuity of care" laws allow the insured parent to continue to see for the child's care a health care provider who is no longer contracting with the insuring entity.

SB 2 (Chapter 673 Statutes of 2003) amended Section 6254 of the Government Code, added Article 3.11 (commencing with Section 1357.20) to Chapter 2.2 of Division 2 of the Health and Safety Code, added Section 12693.55 to, and added Chapter 8.1 (commencing with Section 10760) to Part 2 of Division 2 of, the Insurance Code, added Part 8.7 (commencing with Section 2120) to Division 2 of the Labor Code, to amend Section 131 of, and added Section 976.7 to, the Unemployment Insurance Code, and to amend Section 14124.91 of, and added Sections 14105.981, 14124.915, and 14124.916 to, the Welfare and Institutions Code.

SB 2 enacts the Health Insurance Act of 2003, which provides health care coverage to certain individuals and their dependants who do not receive job-based health care coverage.

<u>SB 24</u> (Chapter 895, Statutes of 2003) added Sections 14148.03, 14148.04, and 14148.05 to the Welfare and Institutions Code.

SB 24 creates the Prenatal Gateway and the Newborn Hospital Gateway to simplify enrollment of pregnant women and certain newborn infants into Medi-Cal.

INTERNATIONALLY ADOPTED CHILDREN

Introduction

With adoption becoming increasingly popular in the United States, Americans have turned to foreign countries to adopt children. Statistics display the popularity of international adoption.[1] An increasing trend towards international adoption means new issues: 1) the citizenship status of adopted children, 2) new adoption regulations and 3) the ethics of international adoption.

Recent Legislation and the Immigration Status of Internationally Adopted Children

On February 27, 2001, the Child Citizenship Act of 2000 became effective.[2] One of the issues of adoption is the status of internationally adopted children. These children do not have automatic United States citizenship because they were born outside of the United States. The Act allows the adopted children to automatically gain U.S. citizenship. The Act requires that at least one parent be a US citizen either by birth or naturalization, the prospective child be under the age of 18, and that the adoption is final.

US Department of State

The Office of Children's Issues in the Bureau of Consular Affairs also provides additional information regarding regulations for adoption in specific countries. Additionally, the State Department can provide general information about US visa requirements for international adoption, make inquiries of the US Consular section abroad

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[1] *See generally* http://www.i-a-a.org/iaa_legislative_updates.htm (displaying information regarding international adoption rates) (last visited July 18, 2004).

[2] 8 U.S.C. § 1431 (2000).

regarding the status of a specific adoption case, clarify documentation or other requirements, and insure that US citizens are not discriminated against by foreign authorities or courts. However, the State Department cannot locate a child or children available for adoption, become directly involved in the adoption in another country, act as an attorney, represent adoptive parents in court, or order that an adoption take place or that a visa be issued.

Ethics – Adopt a Child, Adopt a Culture

Race, identity, and culture are important components of the adoption process. When parents adopt from another country, they become an interracial family Formerly in international adoptions, the emphasis was on getting the children to assimilate into American society without taking into account the racial and cultural identities of the children.

However, experts now say that acknowledgment of the different race and ethnicity of adoptive children is growing these days. Parents are encouraged to expose their adoptive children to their ethnic culture by joining cultural centers and by allowing their children to meet other children from their birth country. Those that adopt internationally generally see the multicultural aspect as an enriching positive addition to the whole family.

UNITED STATES V. AMERICAN LIBRARY ASS'N, INC.
539 U.S. 194 (2003)

Congress enacted the Children's Internet Protection Act[3](CIPA), to address the problems associated with the availability of Internet pornography in public libraries. Appellee library associations and others challenged the constitutionality of the filtering provisions within CIPA. The United States District Court for the Eastern District of Pennsylvania held that the filtering provisions were invalid because they compelled public libraries to violate patrons' First Amendment rights. Appellant United States appealed to the United States Supreme Court, which reversed.

Chief Justice Rehnquist, joined by Justice O'Connor, Justice Scalia, and Justice Thomas concluded that CIPA is constitutional because the use of filtering software does not violate First Amendment rights and is a valid exercise of Congress' spending power. To reach this conclusion, the majority looked at whether the conditions attached to spending would further policy objectives. The government here was not denying a benefit, but was instead requiring that public be funds be spent to help libraries fulfill their traditional role of obtaining material of requisite and appropriate quality for educational and informational purposes. Since public libraries have traditionally excluded pornographic material from their book and periodical collections, Congress could reasonably impose a similar limitation on its Internet assistance programs.

The substantial government interest at stake is the protection of young library users from material that is inappropriate for minors. Given this interest, and the failure to show a burden on adult access, CIPA is not unconstitutional on its face.

Justice Stevens dissented, arguing that filtering should be up to the local libraries discretion rather than

[3] Children's Internet Protection Act of 2000, Pub. L. No. 106-554, § 1(a)(4), 114 Stat. 2763 (as amended 20 U.S.C. § 9101 et seq. (Supp. 2003).

congressionally mandated. Stevens was also concerned that it would give parents a false sense of security, because these filters were incapable of blocking all pornography.

MARRIAGE FOR MINORS

In the United States a minor cannot vote or purchase alcoholic beverages. However, with the exception of a few states, minors are permitted to marry. Many states authorize juvenile marriages between the age group of 16-18 with parental consent. About half of the states authorize marriage for those under 16 with parental consent and judicial approval. A handful of states authorize marriage between minors if there is a pregnancy exception. Often times parental and/or judicial consent is required, though not across the board. A number of states also have age discrepancies between females and males, with male age always higher than the female age. Three states have adopted statutes that make the standard marriage age below the age of minority.

Figure 1: Comparison of State Marriage Statutes

<u>Must be 18</u>

Arkansas	Massachusetts
California	New Hampshire

<u>16-18 with Parental Consent</u>

Hawaii	Kentucky	Rhode Island	Tennessee
Illinois	Michigan	South Carolina	Wisconsin
Iowa*	Montana	South Dakota	

* Or if either party falsely represents their age

<u>Under 18 with Parental Consent</u>

Kansas	Massachusetts	Oregon

Under 16 with Parental Consent and Judicial Approval

(16-18 with Parental Consent)

Arizona*	Maine	Pennsylvania	Wyoming
Colorado	Nevada	Utah	
Connecticut	New Jersey	Vermont***	
Idaho**	New York	West Virginia	

* Requires premarital counseling

** Must have physician testify that the minor is sufficiently developed, mentally and physically

*** Must be at least 14

Pregnancy Exceptions

Florida: 16-18 with parental consent, or pregnant minors can marry without judicial consent

Georgia: 16-18 with parental consent, or pregnant minors or minors with children can marry regardless of age

Louisiana: under 16 with parental consent and judicial approval, or waiver of parental consent may be granted when the female is pregnant or will be 16 within two months of the waiver

Marlyand: 16-18 with parental consent, or under 16 with parental consent if pregnant

New Mexico: 16-18 with parental consent or under 16 with judicial approval

North Carolina: under 16 with judicial approval if pregnant (or father-to-be)

Oklahoma: 16-18 with parental consent, or uner 16 if female is pregnant or has child and has parental consent, or under 16 in settlement suits for seduction and paternity

Virginia: 16-18 with parental consent, or under 16 with parentsl consent if pregnant

Female and Male Age Discrepancies

Delaware: male must be 18; female must be 16 (if under 18, must have parental consent)

Minnesota: male must be 18; female must be 16

Mississippi: male must be 17; female must be 15 (but judge can waive minimum age requirement)

Ohio: male must be 18; female must be 16 (if under 18, must have parental consent)

Other Age Restrictions

Indiana: 17 with parental consent

Nebraska: 17

Texas: 14-18 with parental consent

INFORMATION ON STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

The United States of America has recognized a right for all children to have at least basic access to health care. In August of 1997, Congress created the State Children's health insurance Program (SCHIP) to expand health insurance coverage for low-income, uninsured children. SCHIP was designed to combat the growing problem of uninsured children, especially those whose families earned too much money to qualify for Medicaid, but not enough money to purchase private health insurance. SCHIP helps provide health insurance to children in families with an income at or below the federal poverty level or whose family has an income that is 50% higher than their state's Medicaid eligibility threshold. Over 37 million children in the United States are eligible for either Medicaid or SCHIP.[4]

SCHIP offers states the choice of three options when choosing to expand coverage. The states can either : 1) use SCHP funds to increase Medicaid eligibility to children who previously did not qualify for the program, 2) implement a new children's health insurance program that is entirely separate from Medicaid, or 3) have some combination of both Medicaid and a separate, state program.[5] SCHIP allows states great flexibility in setting income eligibility level and in implementing their programs.[6] However, just as with state Medicaid programs, every state must submit a SCHIP plan to the Centers for Medicare and Medicaid Services (CMS), and it must be approved within 90 days.[7] This plan can be modified as necessary, based on changes in the state's needs and economic situation.[8] Since 1999, all states, U.S. territories

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[4] U.S. Department of Health and Human Services, Centers of Medicare and Medicaid Services, *Welcome to the State Children's Health Insurance Program*, *at* www.cms.hhs.gov/schip/about-SCHIP.asp (last visited July 18, 2004).
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] *Id.*

and the District of Columbia had approved SCHIP plans in place.[9]

The amount of federal funds available under SCHIP varies each year, and is limited both nationally and on a state-specific basis.[10] Federal funding available for FY 1998 was $4,295,000,000 and increases to $5,000,000,000 by FY 2007.[11] State allotments are determined in accordance with a statutory formula. During the first three years of administering the SCHIP program, states receive allotments based on the number of low-income, uninsured children in the state.[12] After that, the allocation formula is changed to focus on the number of low income-children residing in the state, regardless of their health insurance status.[13] In order to qualify for these federal funds, a state must contribute matching funds.[14] Higher-income states must contribute a higher amount than low-income states.[15]

The chart provided shows the Medicaid/SCHIP enrollment of five states through the age of 18 up to the year 2002.[16] The chart shows that Medicaid and SCHIP programs have really begun to provide health insurance to low-income children who might not otherwise have health insurance. Since each state has its own SCHIP program, the levels of SCHIP enrollment vary between each state with some states having high enrollment, 70% or higher enrollment of the children eligible in the program and some states having enrollment as low as 35% of eligible children.[17]

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[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] American Academy of Pediatrics, *Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment Characteristics of Medicaid-enrolled and Uninsured Children,* State Reports *2002* (Oct. 2003), *available at* http://www.aap.org.
[17] *Id.*

Why are not all eligible children enrolled in Medicare/SCHIP programs?[18] The answer is a mixture of parental misunderstanding of the Medicare/SCHIP programs and lack of funding to encourage growth of the programs. About 88% of all low-income parents of uninsured children have heard of their state's Medicaid/SCHIP programs, and only 24% of them inquired about the program and even fewer parents actually applied for coverage for their child.[19] The most common reasons for not inquiring or applying to the health program were administrative hassles, not believing that their child was eligible or feeling that they did not know enough or understand enough about the health programs.[20] The states know of these reasons and so many states have started to explain the health programs to low-income families through commercials, and information given out at neighborhood hospitals and free clinics.[21] If parents have true understanding the Medicaid/SCHIP program, then uninsured children are one step closer to having health insurance.

The second program is a lack of funding for the Medicaid/SCHIP programs.[22] The federal government is supposed to supply at least half of the money to states to pay for these programs, but with the recent budget woes of the federal government, the same amount of money is not available to fund these programs.[23] At the same time, the state governments are also low on funds and are finding it difficult to fill in the gaps created by the lack of funding by the federal government.[24] California, a state hard hit by budget restraints,

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[18] Genevieve Kenney & Jennifer Haley, *Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP?*, Series B, No. B-35 (May 2001), *available at* http://www.urban.org/Content/Research/NewFederalism/NSA/Overview/NSAOverview.htm

[19] *Id.*

[20] *Id.*

[21] *Id.*

[22] *Id.*

[23] U.S. Department of Health and Human Services, Centers of Medicare and Medicaid Services, *Welcome to the State Children's Health Insurance Program*, *at* http://www.cms.hhs.gov/schip/about-SCHIP.asp (last visited July 17, 2004).

[24] *Id.*

is suggesting a cap on enrollment in the Health Families program, its SCHIP program.[25] This cap would provide services to a specific number of children in order to maintain the health insurance to at least some children who need the insurance and are currently enrolled.[26] Currently, this proposed cap has not been passed by the California legislature and Healthy Families is still enrolling new children.[27] However, the proposed cap is evidence that even though there is an increased need and desire to provide healthcare and health insurance to more uninsured children, there is a lack of funds available to attain this goal. There is serious doubt that California is the only state considering narrowing its SCHIP program to save funds in this time of fiscal crisis.

The Medicaid/SCHIP programs provide health insurance to uninsured children in order to afford them the change to have at least basic healthcare.[28] These individualized state programs are doing a good job of enrolling children and providing health services to those children who need services the most. However, the lack of understanding that low-income parents have about the programs and the current lack of funding threatens the growth and future of these commendable state programs.

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[25] California Healthy Families*, Proposed cap on enrollment in Healthy Families Program, available at* http://www.healthyfamilies.ca.gov/English/about_cap/html (last visited July 17, 2004).
[26] *Id.*
[27] *Id.*
[28] U.S. Department of Health and Human Services, Centers of Medicare and Medicaid Services, *Welcome to the State Children's Health Insurance Program*, *at* http://www.cms.hhs.gov/schip/about-SCHIP.asp (last visited July 17, 2004).

ANTIDEPRESSANTS IN CHILDREN AND INFORMED CONSENT

Introduction

Parents and physicians generally rely on regulatory agencies, experts, and peer-reviewed scientific literature to help them make treatment decisions for children. When these sources disagree, and when relevant data from clinical trials is unavailable, there is a question as to whether informed consent can be given. This is currently the case with the class of antidepressant drugs known as selective serotonin reuptake inhibitors (SSRI's). In this handout, we present some aspects of this complex issue.

Background

SSRI's are antidepressants that were introduced in the United States in 1988.[29] Early clinical trials indicated that the SSRI's had far fewer dangerous side effects than other classes of antidepressants, and they were widely accepted as an important discovery.[30] However soon after their introduction, reports describing SSRI-induced violence against self and others began to appear.[31] Since that time, there have been many reports describing these side effects in children diagnosed with depression and treated with SSRI's.[32]

SSRI prescriptions for children have increased greatly in recent years despite a lack of safety and efficacy data and a

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[29] James M. Ferguson, M.D., *SSRI Antidepressant Medications: Adverse Effects and Tolerability*, 3 Primary Care Companion, J. CLINICAL PSYCHIATRY 22 (2001).
[30] *Id.*
[31] Peter R. Breggin, *Suicidiality, violence and mania caused by selective serotonin reuptake inhibitors (SSRIs): A review and analysis*, 16 INT'L J. RISK & SAFETY IN MED. 31 (2003/2004).
[32] *Id.* at 10-12.

lack of clear guidelines for use.[33] They have become viewed as safe and effective for children and are widely prescribed for a variety of psychiatric illnesses by family physicians and pediatricians,[34] even though only one SSRI, Prozac (fluoxetine), has been approved for use in children.[35]

Recent Developments

On June 10, 2003, the Medicines and Healthcare products Regulatory Agency (MHRA), Britain's equivalent to the Food and Drug Administration (FDA) in the United States, issued a press release stating that the SSRI Seroxat (marketed as Paxil in the U.S.) must not be used for treatment of children.[36] Subsequent to this warning, the MHRA's Committee on Safety of Medicines (CSM) reviewed data from a number of clinical trials conducted by the manufacturers of SSRI's.[37] The CSM concluded that for six of the seven SSRI's investigated, the risks of suicide and suicidal ideation outweigh any benefits in children with depression, and stated that SSRI use is contraindicated in this population.[38]

The FDA responded by issuing its own warnings and requesting unreleased clinical data from SSRI manufacturers.[39] The FDA is using 20 trials to evaluate the SSRI's but has not identified which trials; data for 11 SSRI trials has not been published.[40] The FDA held a hearing on

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[33] *Pediatrician and Family Physician Prescription of Selective Serotonin Reuptake Inhibitors*, 105 PEDIATRICS 6, e82 (Jun. 2000).
[34] *Id*.
[35] FDA Pub. Health Advisory (Oct. 27, 2003) *at* http://www.fda.gov/cder/drug/advisory/mdd.htm.
[36] Alison Langley, Press Officer, Committee for Safety in Medicine, Press Release *available at* http://www.mhra.gov.uk/news/2003.htm#ssri.
[37] Letter from Professor Gordon Duff, Chairman, Committee on Safety of Medicines (Dec. 10, 2004), *available at* http://www.mhra.gov.uk/news/2003.htm#ssri (last visited July 17, 2004).
[38] *Id*.
[39] FDA Pub. Health Advisory (Oct. 27, 2003), *available at* www.fda.gov/cder/drug/advisory/mdd.htm.
[40] Shankar Vedantum, *Antidepressant Makers Withhold Data on Children*, WASH. POST, Jan. 29, 2004, at A01

February 2, 2004, to discuss how to analyze the data, whether to require labeling changes, and whether to issue further warnings.[41] There was testimony also requesting the release of the clinical data held by the drug companies so that physicians and families can make informed treatment choices, but the FDA chose not to address this issue.[42]

Raul Silva, the editor of the Journal of Child and Adolescent Psychopharmacology recently noted that: "Physicians who treat children and adolescents with medications are often using them for off-label indications, as for many years pharmaceutical companies were hesitant to conduct studies on pediatric age groups."[43] Doctor Silva also commented that: "[W]ithout access to the details of… studies, clinicians are left in an awkward position when addressing the concerns of patients and their families."[44]

Informed Consent

The Restatement (Third) of Torts states that a drug manufacturer is not liable in tort for failing to directly warn patients, as their duty to warn extends only to physicians.[45] This is usually called the "learned intermediary" rule, and relieves the drug manufacturer of any duty if they have given the physician the necessary information needed to make informed choices about patient safety.[46] There are a couple of exceptions to this rule, but this principle is generally accepted,

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[41] Department of Health and Human Services, Food and Drug Administration, *Center for Drug Evaluation and Research, Psychopharmacologic Drugs Advisory Committee with the Pediatric Subcommittee of the Anti-Infective Drugs Advisory Committee*, *at* http://www.fda.gov/ohrms/dockets/ac/04/transcripts/4006T1.pdf (last visited July 17, 2004).
[42] *Id*.
[43] Raul Silva M.D., *Psychopharmacology* News, 13 J. CHILD & ADOLESCENT PSYCHOPHARMACOLOGY 409 (2003).
[44] *Id*.
[45] RESTATEMENT (THIRD) OF TORTS § 6 (1998).
[46] *Id.*

and dominates in California.[47] In fulfilling this duty, a doctor must generally tell the patient information about dangers in treatment options that he or she might expect with the treatment or use of a medication.[48] This includes disclosing treatment choices and the risks associated with those choices.[49] Without a complete understanding of risks, the doctor is unable to realize this duty.

When there is a lack of medical information available to doctors and pediatricians, the concept of a "learned intermediary" falls apart, and patient safety is compromised. This is the current dilemma with SSRIs. The lack of adequate information in the U.S. about the adverse effects of these drugs on children may place their health and safety at risk. When the physician cannot describe or explain all possible side effects and risks, the patient or parent consents without being completely informed. This puts children in harms way, as the child relies on the parent, who believes the doctor, who depends on the drug company and the FDA. If there is a breakdown of communication at any point in this chain, it is the child who ultimately suffers.

In the case of the SSRI's, trade secret laws protect drug manufacturers.[50] How should the conflict between Federal trade secret law and the duty to disclose under torts law be resolved? This is a difficult legal and ethical question.

There is considerable controversy about how the unpublished data should be analyzed and what it might mean. At the FDA hearing, the FDA itself acknowledged that,

> Some within the Agency have examined the data and concluded that the data, as currently submitted, do permit definitive analyses and that these analyses support the conclusion that this class of drugs is

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[47] *See, e.g., Brown v. Superior Court*, 751 P2d 470, 478-79 (Cal. 1988).
[48] *Canterbury v. Spence*, 464 F.2d 772, 782 (1972).
[49] *Id.*
[50] *See* Gordon U. Sanford, III, 19 MISS. C.L. L. REV. 177, 206 (1998); *see also* Uniform Trade Secrets Act § 1, official comment, 14 U.L.A. 439 (1990) (negative information can be trade secret under Act).

> associated with a risk of suicidal behavior in pediatric patients.[51]

At the same hearing, Lawrence Greenhill MD, Chair of the Pediatric Psychopharmacology Initiative Committee of the American Academy of Child and Adolescent Psychiatry (AACAP), noted that "…one of the greatest roadblocks to understanding the safety and efficacy of trials is the lack of public access and its disclosure of these data sets due to laws that treat some of the data as proprietary trade secrets."[52] Further, eight family members of children who committed suicide while taking an SSRI stated directly that they were told that the drug involved was safe and that they were not informed of any risk of suicidal ideation or suicide.[53] The FDA plans to conduct its own analysis of the data, but has not addressed the need to make the data available.

Conclusion

The FDA should consider requiring pharmaceutical companies to make public all clinical data related to the use of SSRI's in children. In doing so, it should consider the following:

- The SSRI's are widely prescribed off-label by primary care providers for use in children with depression.
- The only SSRI that has been shown to have efficacy in children with depression is fluoxetine, though, others are prescribed.
- Data from clinical trials suggests that all SSRI's may pose a risk of suicide and suicidal ideation in children

[51] Department of Health and Human Services, Food and Drug Administration*, Center for Drug Evaluation and Research, Psychopharmacologic Drugs Advisory Committee with the Pediatric Subcommittee of the Anti-Infective Drugs Advisory Committee* 24, *at* http://www.fda.gov/ohrms/dockets/ac/04/transcripts/4006T1.pdf (last visited July 17, 2004).
[52] *Id* at 152.
[53] *Id.* at 85, 88, 92, 98-99, 123, 129, 131, 149.

with depression. Some of this data has not been released by the pharmaceutical companies that conducted the trials.

- Experts and regulatory agencies disagree on how to interpret the trial data being withheld by pharmaceutical companies.
- Physicians and families of depressed children may not be able to make fully informed treatment decisions without access to the clinical data.
- Physicians and parents should pay close attention to the FDA's expert interpretation of the clinical data, but they must be the ones to weigh the potential risks and benefits of these drugs when making treatment decisions for individual children.

SECOND PARENT ADOPTION INFORMATION

Introduction

As our nation tackles the questions of same-sex marriage state by state, an incidental issue of adoption rights still remains unresolved. Although a significant number of states allow for adoption by same-sex couples, often in same-sex adoptions, only one parent may be the child's legal parent. This poses serious problems in the event that the non-legal parent becomes ill, disabled, or dies. The child may not receive any government benefits for the condition of the non-legal parent. Furthermore, if the legal parent dies, the non-legal parent would not necessarily get automatic custody.[54]

Interesting Cases

In re: Adoption of R.B.F. and R.C.F.[55]

This is a consolidated appeal where two pairs of same-sex partners petitioned to adopt the child of the legal parent. The lower courts in both cases denied the adoption, citing a statute that required the legal parent to relinquish her/his own rights before another could adopt the child. The Supreme Court of Pennsylvania vacated the trial courts orders denying each of the petitioners the right to adopt. The court found that there was room in the statute that gave the courts discretion to permit adoptions in the best interests of children when not all the statutory requirements had been met. The court remanded the case so that the parties could provide "good cause" for why the above requirement should not bar the adoption.

A dissenting judge in the intermediate Superior Court decision affirming the court's orders argued that children

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[54] Joan Biskupic, *Same-sex Couples Redefining Family Law in USA*, USA TODAY, Feb. 17, 2003, *at* http://www.usatoday.com/news/nation/2003-02-17-cover-samesex_x.htm.
[55] *In re: Adoption of R.B.F. and R.C.F.,* 803 A.2d 1195 (Pa. 2002).

would not have the same benefits of adoption if the legal parent has to terminate his own rights. These benefits include:

1. The legal protection of the children's existing familial bonds.
2. The right to financial support from two parents.
3. The right to inherit from two parents.
4. The right to obtain other available dependent benefits, such as health care insurance and Social Security benefits, from either parent.[56]

Lofton v. Sec'y of the Dep't of Children & Family Servs. [57]

With the exception of the minors, the appellants here were licensed foster parents in Florida. Lofton, Skaken, and Smith are foster parents who were denied the right to adopt their foster children because Florida law prohibits adoption by homosexual persons. Houghton was also denied the right to adopt child because of his sexual orientation, although he is the legal guardian of the child and the parent has relinquished all rights. The US Court of Appeals for the 11th Circuit affirmed the District Court for the Southern District of Florida's ruling that the Florida Statute §63.042(3) does not violate the appellants' constitutional rights. The court rejected a "fundamental right to family integrity" argument that foster families had a right to family integrity:

> There is no precedent for appellants' novel proposition that long-term foster care arrangements and guardianships are entitled to constitutional protection akin to that accorded to natural and adoptive families. Moreover, we decline appellants' invitation to recognize a new fundamental right to family integrity for groups of individuals who have formed deeply loving and interdependent relationships.[58]

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[56] *Id*.
[57] *Lofton v. Sec'y of the Dep't of Children & Family Servs* 358 F.3d 804 (11th Cir. 2004).
[58] *Id*. at 827.

The US Supreme Court denied certiorari in 2002. However, in February 2004, the ACLU petitioned the Court of Appeals for the 11th Circuit to reconsider its ruling.

CONSTITUTIONAL RIGHTS OF THE FOSTER FAMILY: A GLIMPSE INTO U.S. COURT OF APPEALS FOR THE 9TH CIRCUIT CASE LAW

Foster children stand in a unique position—both natural and foster parents and the government all have legal interests in them. Where so many actors compete for influence, one wonders what protections are afforded to the foster family unit. Two recent 9th Circuit cases show that foster parents and children have lesser constitutional protections than do natural families, and are subject to greater state influence.

Since the foster parent's interest in their foster child is not exclusive, the constitutional rights of foster parents are put to stricter scrutiny than are those of natural parents.[59] In the *Backlund*[60] case Pamela, a foster child, had been living with the Backlund's for about three years when the Washington State Department of Social and Health Services received a complaint. The Department investigated the allegations of physical abuse, and found the Backlund's used corporal punishment on her in accordance with their religious beliefs. They refused to refrain from exercising this practice, and the child was removed from their care.[61] The Backlund's then sued the state to recover her. The district court granted summary judgment against them. The appellate court affirmed, finding that parents in general do not have a "clearly established right to unlimited exercise of religious beliefs on their children."[62] Moreover, "foster parents do not enjoy the same constitutional protections that natural parents do."[63]

Foster parent rights are thus held inherently inferior to the rights of natural parents, as foster parents must present a greater showing of a constitutional right in able to be afforded its protections. Absent such a showing, the interests of the

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[59] *Backlund v. Barnhart*, 778 F.2d 1387 (1985).
[60] *Id.*
[61] *Id.* at 1387.
[62] *Id.* at 1389.
[63] *Id.*

state outweigh those of the foster parents. While most will be pleased wit the outcome of the *Backlund* case, it begs some serious questions: where does the state interest end, and which constitutional rights are strong enough to survive this standard? The issue of state intrusion becomes more complicated where the child is claiming an interest against the state.

A claimed foster family constitutional right may not necessarily be any stronger because it is brought on behalf of the child.[64] In *Gibson*,[65] the Merced County Department planned for Susan, the Gibson's foster child, to be reunified with her biological mother. After about four years however, Mrs. Gibson refused to continue working toward reunification. The Department then secured an order to remove Susan. After a psychiatric evaluation at Stanford, the Department concluded Susan should be returned and reunification abandoned.[66] The Gibson's sued the Department on behalf of themselves and Susan, claiming the traumatic removal violated their "constitutionally protected liberty interest" in maintaining their foster relationship.[67] The district court granted summary judgment against them, finding no such liberty interest existed in the Gibson's or Susan.[68] The appellate court affirmed, holding that a foster family is a creature of contract created by the state, and the state does not give it an integrity interest.[69]

The court's declaration that the foster child's interests where not violated by removal seems unsatisfactory, given that psychiatric evaluation revealed that she should be returned to her foster parents and reunification plans cancelled. While there is apparently some interest in preserving a foster family where such is the best for the child, it is not strong enough for the court to find it constitutionally protected.

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[64] *Gibson v. Merced County Dep't of Human Res.*, 799 F.2d 582 (1986).
[65] *Id.*
[66] *Id.* at 587.
[67] *Id.* at 583.
[68] *Id.* at 585.

In Search of Quality Education for Foster Children

Current Educational Concerns about Children in the Foster System

The educational challenges that foster children face, as compared to their peers, are undeniable: higher rates of grade retention, lower standardized test scores, higher absenteeism and tardiness, and higher truancy and dropout rates. Compounding these problems are administrative obstacles, which include difficulties in obtaining complete health and academic records and securing parental consent as children are shuffled from school to school. The overall effect is that the educational goals of these youth are systematically discouraged as they struggle to advance in their academic careers. According to the California Youth Connection, 70 percent of foster youth plan to attend college, but 46 percent do not even complete high school.[70] Of those who do complete high school, only 10 percent go on to college.[71] Both poor academic performance and lack of continuing education contribute to higher than average rates of homelessness, criminality, drug abuse, and unemployment among foster care "graduates."[72]

Tackling the Education Challenges of Foster Youth

ePassport

Technology has teamed up with the child welfare system to create a smart card called a Foster Youth ePassport to solve the problem of incomplete and missing health and

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[69] *Id.* at 586.
[70] Steve Christian, *Educating Children in Foster Care*, National Conference of State Legislatures, *at* http://www.ncsl.org/programs/cyf/CPIeducate.htm (last visited Mar. 11, 2004).
[71] *Id*.
[72] *Id*.

academic records that often plague foster youth enrolling in the educational system. The encrypted, password-protected card carries immunization, drug allergy, school admissions activity, and other information in a secure, portable, Internet-based system that is accessible 24 hours a day, seven days a week.[73] To operate the card, school and healthcare providers need an Operator Card to access the database, easy-to-learn ePassport software, and a card reader that attaches to a personal computer and costs as little as $25. ePassport is designed to complement existing state databases of the health and education records of foster youth.[74] The Community College Foundation, a California organization that specializes in foster youth training and education programs has conducted pilot programs in Antelope Valley and Amador County, issuing about 500 cards so far. In the future, the foundation plans to introduce the card to schools, doctors' offices, human service providers, and juvenile court facilities.[75]

The Stanford Foster Care College Project

To children in the foster system, college is often disregarded as an option because they do not think they are smart enough or are not informed of the resources available to pursue higher education. It is these misconceptions that Stanford University senior Johnny Madrid hopes to banish with his Stanford Foster Care College Project (SFCCP). As one of ten foster youth enrolled at the university of 6,700 undergraduates, Madrid overcame significant obstacles to make it to college.[76] In 2003, Madrid founded this organization to bring higher education within the reach of all foster youth. SFCCP will focus on a broad policy level and is currently conducting research on the education obstacles that foster youth face and which policies are best in response to

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[73] Julee Newberger, *A Passport to Better Health, Better Grades*, Connect For Kids: Guidance for Grown-ups, (July 11, 2003), *available at* http://www.connectforkids.org.
[74] *Id*.
[75] *Id*.
[76] Kristen Bell, *Project Hopes to Improve Foster Children's Education*, The Stanford Daily, *at* http://daily.stanford.edu (Nov. 18, 2003).

these problems.[77] Once the research is completed, SFCCP will implement its findings through an outreach effort aimed at increasing awareness of foster youth educational problems among college and university administrators, state legislators, and social workers.[78]

Linkage to Education

Linkage to Education is a non-profit organization that provides assistance to foster and incarcerated youths exiting institutional custody and care into college in the Sacramento, California area. The program focuses on promoting higher educational goals among these youth by filling in the financial and support gaps that often prevent these students from attaining advanced degrees. Linkage provides diagnostic assessment to students and aids their enrollment in community colleges and vocational training programs. Once the students are in school, Linkage also helps provide on-campus support, including supplying textbooks, help with tuition waivers, and general guidance and workshops.

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[77] *Id*.
[78] *Id*.