I. Introduction

We are three child advocacy organizations, a law professor and a forensic psychiatrist working in the juvenile justice system committed to furthering the rights of children to be heard in dependency court proceedings through legal counsel and lay guardians ad litem. We submit these comments because we believe that Rule 8.355, Fla.R.Juv.P., which governs hearings on the administration of psychotropic medication for children in state custody when parental consent has not been obtained, must be amended to provide the child an opportunity to be heard by the court through both an appointed attorney ad litem and a guardian ad litem.

On November 17, 2005, based on out-of-cycle proposals by the Florida Bar Juvenile Court Rules Committee, this Court adopted amendments to the Florida Rules of Juvenile Procedure intended to conform
the rules to recent legislation. In Re Amendments to the Florida Rules of Juvenile Procedure, 915 So.2d 592 (Fla. Nov. 17, 2005). The Court amended several rules and adopted new Rule 8.355 (“Administration of Psychotropic Medication to a Child in Shelter Care or in Foster Care When Parental Consent Has Not Been Obtained”), which was drafted by the Juvenile Court Rules Committee to conform to newly enacted Fla. Stat. § 39.407(3), Laws of Florida, Ch. 2005-65, § 2.1 Because the Court did not publish the amendments for comment prior to their adoption through the fast-track process, it subsequently invited comments from interested persons on this and other rules. In Re Amendments to the Rules of Juvenile Procedure, Case No. SC 05-1303, THE FLORIDA BAR NEWS (Dec. 15, 2005).

II. Interests of Commentators

The Children & Youth Law Clinic (“Clinic”) is an in-house legal clinic staffed by faculty and students of the University of Miami School of Law. The Clinic represented the petitioner before this Court in M.W. v. Davis & DCF, 756 So.2d 90 (Fla. 2000), which resulted in the Court’s adoption of Florida Rule of Juvenile Procedure 8.350, a rule that establishes due process protections, including pre-commitment hearings and the right to

1The undersigned is a member of the Juvenile Court Rules Committee, but was not able to attend the June 23, 2005, Committee meeting when the rule was presented and approved by a vote of 25-0-2.
counsel, for children in state custody involuntarily committed to psychiatric facilities by the Department of Children & Families (“DCF” or department). *Amendment to the Rules of Juvenile Procedure, Fla. R. Juv. P. 8.350, 842 So.2d 763 (Fla. 2003).*

Florida’s Children First (“FCF”) is a statewide nonprofit advocacy organization established to advance children’s rights consistent with their medical, educational, and social needs. FCF was created to address the serious unmet legal needs of children who require legal representation in the various legal forums that affect their lives. Its goal is to achieve significant improvements in all systems affecting children’s lives, with a special emphasis on the child welfare system. Litigation, legislative and policy advocacy, executive branch monitoring, training and technical assistance to lawyers representing children, public awareness, and the education of law students are all tools in FCF’s advocacy arsenal.

Jacksonville Area Legal Aid, Inc. (“JALA”) has for more than a quarter of a century represented the area’s poor and vulnerable citizens, including children. JALA has developed a Mental Health Advocacy Project (“Project”) to meet the legal needs of the mentally ill in the Jacksonville community. The Project provides legal advocacy for the most vulnerable members of the community, mentally disabled children and adults. In
addition to providing attorney *ad litem* representation of individual children in dependency proceedings, and Rule 8.350 hearings, JALA also accepts children's education cases, public benefits matters, and appointments as guardian *ad litem* in delinquency cases.

Professor Bruce J. Winick is Professor of Law and Professor of Psychiatry and Behavioral Sciences at the University of Miami, where he has taught since 1974, and is a scholar in the area of mental health law and law and psychology. Professor Winick has pioneered the approach of therapeutic jurisprudence and written extensively about the therapeutic dimensions of legal rules and procedures. In particular, he has written about the therapeutic aspects of inpatient and outpatient civil commitment hearings and psychotropic medication hearings, and how they can be reshaped to diminish their anti-therapeutic effects and increase their therapeutic potential.²

Dr. Lester P. Hartswick is a Forensic Psychiatric Fellow at the University of Miami School of Medicine and Jackson Memorial Hospital. The Forensic Fellowship Program is a 12-month program accredited by the American Board of Psychiatry and Neurology in Forensic Psychiatry. The program is divided into four basic rotations including a rotation with the Children and Youth Law Clinic, designed to teach the skills necessary to address forensic psychiatric issues related to children and families in child custody, parental rights, child abuse, civil commitment, and psychotropic medication proceedings, and to communicate that expertise to the various child protective and juvenile justice agencies and the courts. Dr. Hartswick is supervised by University of Miami Medical and Law School faculty.

Because of our interest in safeguarding the due process, therapeutic and health rights and needs of foster children who may be administered psychotropic medications, we believe that the rule should require the appointment of a guardian ad litem and an attorney ad litem to protect the child and the child’s interests in these hearings. Requiring such representation assures that the court is provided with accurate medical information that it needs in order to render an informed decision on the medical necessity, safety and appropriateness of psychotropic drugs, affords the child the opportunity to voice objections to the prescribed treatment, and
makes it less likely that the child will perceive the psychotropic medication process as coercive and more likely that the child will comply with any treatment prescribed by a physician and ordered by the court.

III. Background

In June 2002, after a year-long investigation into the use of prescribed psychotropic drugs by foster children in the DCF foster care program, the Florida Statewide Advocacy Council (“SAC”) issued an Orange Item Report finding that foster care children’s medical records were “seriously deficient.” The review of over 1,000 foster care records by the statewide council members uncovered serious systemic problems including: records were incomplete; information was not easy to locate; frequently information about multiple children was commingled in a single file; information about unrelated foster care children was found in some case files; files were poorly organized.3

The review also found, inter alia, that medical records were incomplete and/or portions missing; in files where there was medical information it was spread throughout the files; it was often impossible to determine what medications were prescribed, if any, including the dosage

and time to be administered, for each child; only a very few records had any type of documentation that medication was administered; “medical passports” were missing from numerous files; and those files where passports could be located did not contain current information.⁴

⁴Florida law defines the “medical passport” as “a written health history of a child in shelter status or foster care, which is used to document health care. The medical passport is to be kept with the child’s caregiver (in the child’s resource record) and updated at each health care provider visit.” Rule 65C-12.00(18), Fla. Admin. Code. Additionally, DCF must abide by federal statutory requirements to compile, update, and provide to each foster care parent or caregiver the child’s full medical and educational records. See 42 U.S.C. § 675(1) (C).

However, as documented by the Orange Item Report, DCF has failed to abide by these medical record-keeping requirements, which has resulted in judicial action to compel DCF to comply with federal and state law. See Megan O’Matz, Judge Warns of Risks to Kids: DCF Ordered to Provide Health Records on Foster Children, South Florida Sun-Sentinel, Aug. 17, 2001, at 1B; Carol Marbin Miller, Many Kids in Foster Care Don’t See Doctor, The Miami Herald, Sept. 4, 2001, at 1A.

Because inadequate medical record-keeping is a widespread problem in many state foster care systems, typically due to the fact that children placed in foster care experience multiple changes in foster homes and frequently reenter the system after being returned to their families, the American Academy of Pediatrics has adopted a policy recommending that “[c]hild welfare agencies and health care providers...develop and implement systems to ensure the efficient transfer of physical and mental health information among professionals who treat children in foster care.” American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care, Policy Statement: Health Care of Young Children in Foster Care, 109 PEDIATRICS 536-541 (Mar. 2002), available at http://aappolicy.aapublications.org/cgi/content/full/pediatrics;109/3/536. The AAP policy also recommends use of medical passports by foster parents, “designed to facilitate the transfer of essential information among physical and mental health professionals.” Id.
In July 2003, the SAC issued a *Red Item Report: Psychotropic Drug Use in Foster Care*, finding serious problems in the widespread, unsupervised administration of psychotropic medications by DCF to foster children. The council’s review of 1,180 DCF case files revealed that over half—652 children—were on one or more psychotropic medications. Many of the children were infants and toddlers enrolled in preschool, “a disturbing discovery since many of these drugs have not been approved for use in young children by the Federal Food and Drug Administration,” and “there is very little data on the possible long-term consequences of using these drugs at such an early age.” The SAC report also noted that “diagnosing mental illness in children at such a young age is extremely difficult as these children are unable to describe their symptoms adequately, if at all.”

The review further found that many of the children’s records “lacked adequate or accurate information, or omitted details on how consent was obtained and what information was provided to children, parents or guardians.” The SAC also learned “that many of these drugs are prescribed by the child’s primary care physician and in some cases by more than one

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physician instead of a psychiatrist who specializes in treating children.” The report described the many serious side effects that could result, including decreased blood flow to the brain, cardiac arrhythmias, disruption of growth hormone leading to suppression of growth in the body and brain of a child, weight loss, permanent neurological tics, dystonia, addiction and abuse, including withdrawal reactions, psychosis, depression, insomnia, agitation and social withdrawal, suicidal tendencies, possible atrophy in the brain, worsening of the very symptoms the drugs are supposed to improve, and decreased ability to learn, tardive dyskinesia and malignant neuroleptic syndrome.

A 2004 report by DCF found that 13% of all children in state custody were receiving at least one psychotropic medication. Of this group, 8% were being treated with three or more medications concurrently. The DCF findings also indicated that 3.5% of the children in state custody age five and under received at least one psychotropic medication. Additionally, 25% of children living in a foster care setting were being treated with psychotropic medications, a rate five times higher than the general population of Medicaid eligible children. After summarizing these findings, a 2005 Senate Staff Analysis concluded: “Despite initiatives by the department to identify

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6See Ensuring Appropriate and Informed Use of Psychotropic Medications With Children in Department Custody, Department of Children & Families PowerPoint Presentation to Florida Senate Children & Families Committee (Jan. 11, 2005).
children in its care who are on psychotropic medications and to determine
the appropriateness of this treatment, *limited information exists.*”

These reports and widespread concerns among children’s advocates
about children in DCF custody taking psychotropic drugs,⁸ which the MIAMI
HERALD and other newspapers reported on beginning in 2001,⁹ prompted the

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⁷See CS/CS/SB 1090, Senate Staff Analysis and Economic Impact
Statement (Mental Health Care Services for Minors and Incapacitated

⁸See, e.g., FINAL REPORT OF THE FLORIDA BAR COMMISSION ON THE
LEGAL NEEDS OF CHILDREN (June 2002) (“Legislation is needed to provide
procedures to ensure that psychotropic drugs are administered only to
children in the foster care and the juvenile justice system [sic] when
medically necessary. In some cases, psychotropic medications may be
essential to treatment. However, based upon published reports, such
medications have been used as a method of controlling behavior among
children who simply needed mental health counseling or services. This
occurs notwithstanding the fact that this medication has not been specifically
approved for use by children.” *Id.* at B.10).

⁹See, e.g., Carol Marbin Miller, *Advocates Criticize Medicating
Foster Kids; Treatment Raises Claims of Misuse*, Miami Herald, Apr. 12,
2001, at 1A; Editorial, *Adult Drugs for Kids*, Miami Herald, Apr. 13, 2001,
at 8B; Carol Marbin Miller, *Foster Kids Describe Drugs’ Effects; Prescribed Psychiatric Medications Made ‘Everything a Blur’ For One Girl*,
Miami Herald, Apr. 23, 2001, at 1A; Carol Marbin Miller, *Groups to
Investigate Drugs for Kids*, Miami Herald, June 22, 2001, at 5B; Carol
Marbin Miller, *Bill to Regulate Psychiatric-Drug Use on Foster Kids
Therapy of Foster Kids*, Miami Herald, Mar. 18, 2002, at 3B; Carol Marbin
Miller, *Mind-Altering Drugs Given to Some Babies in DCF’s Care*, Sept. 12,
2003, at 1A; Kathleen Chapman, *Hundreds of Foster Care Kids on Mind
Drugs*, Palm Beach Post, Sept. 12, 2003 at 1A; Editorial, *Throwing Drugs at
a Problem*, St. Petersburg Times, Sept. 22, 2003, at 6A; Carol Marbin
Miller, *State to Probe Drugs For Kids*, Miami Herald, Nov. 20, 2003, at 7B;
Kathleen Chapman, *DCF to Investigate Mind Drugs Given to Foster*
passage in 2005 of § 39.407(3), Laws of Florida, Ch. 2005-65, § 2. The legislation requires that the department seek the express and informed consent of the child’s parents before administering the drugs. Without such consent, DCF is obligated to get approval from a judge after filing a motion seeking the court’s authorization to initially provide or continue to provide psychotropic medication to a child in its legal custody.\(^\text{10}\)

Sections 39.407(3) (c) & (d), Fla. Stat. (2005), in effect, place the judge in a limited \textit{in loco parentis} role, by requiring the court to give careful review of a prescribing physician’s signed medical report which contains the following information, before it may authorize DCF (\textit{i.e.}, before the court gives express and informed consent) to provide psychotropic medication to a child in department custody:

1. The name of the child, the name and range of the dosage of the psychotropic medication, and that there is a need to prescribe psychotropic medication to the child based upon a

diagnosed condition for which such medication is being prescribed.

2. A statement indicating that the physician has reviewed all medical information concerning the child which has been provided.

3. A statement indicating that the psychotropic medication, at its prescribed dosage, is appropriate for treating the child's diagnosed medical condition, as well as the behaviors and symptoms the medication, at its prescribed dosage, is expected to address.

4. An explanation of the nature and purpose of the treatment; the recognized side effects, risks, and contraindications of the medication; drug-interaction precautions; the possible effects of stopping the medication; and how the treatment will be monitored, followed by a statement indicating that this explanation was provided to the child if age appropriate and to the child's caregiver.

5. Documentation addressing whether the psychotropic medication will replace or supplement any other currently prescribed medications or treatments; the length of time the child is expected to be taking the medication; and any additional medical, mental health, behavioral, counseling, or other services that the prescribing physician recommends.\(^\text{11}\)

Section 39.407(3) (d), Fla. Stat. (2005), requires DCF to notify all parties\(^\text{12}\) of the proposed administration of psychotropic medication in

\(^{11}\)Section 39.407(3) (c) (1)-(5), Fla. Stat. (2005).

\(^{12}\)Florida law defines “party” in Chapter 39 dependency proceedings as “the parent or parents of the child, the petitioner, the department, the guardian ad litem or representative of the guardian ad litem when the program has been appointed, and the child.” §39.01(51), Fla. Stat. (2005) (emphasis added). See also Rule 8.210(a) Fla.R.Juv.P. (defining “party” or
writing within 48 hours after the motion is filed. Only when a party “objects” to the department’s motion, within two working days after being notified of the department’s motion, is the court obligated to hold a hearing to decide whether or not to authorize the department to initially provide or to continue providing psychotropic medication. At the hearing, the court may admit into evidence the medical report, but the statute does not obligate the prescribing physician to attend the hearing or testify unless the court “specifically orders such attendance or testimony, or a party subpoenas the physician to attend the hearing or provide testimony.” The court has considerable latitude to consider additional evidence or testimony before it may order DCF to provide or continue to provide psychotropic medication to the child:

At any hearing held under this paragraph, the court shall further inquire of the department as to whether additional medical, mental health, behavioral, counseling, or other services are being provided to the child by the department which the prescribing physician considers to be necessary or beneficial in treating the child’s medical condition and which the physician

\[\text{\textsuperscript{13} \S39.407(3) (d) 1., Fla. Stat. (2005).} \]
\[\text{\textsuperscript{14} Id. Rule 8.355(b) (1), Fla.R.Juv.P., thus contains a hearing bypass provision: “If no party timely files an objection to the department’s motion, the court may enter its order authorizing the proposed administration of the psychotropic medication without a hearing.” Id. (emphasis added).} \]
\[\text{\textsuperscript{15} \S39.407(3) (d) 1., Fla. Stat. (2005).} \]
recommends or expects to provide to the child in concert with the medication. The court may order additional medical consultation, including consultation with the MedConsult line at the University of Florida, if available, or require the department to obtain a second opinion within a reasonable timeframe as established by the court, not to exceed 21 calendar days, after such order based upon consideration of the best interests of the child. The department must make a referral for an appointment for a second opinion with a physician within 1 working day.  

IV. The Need for Guardian ad Litem and Attorney ad Litem Representation in Rule 8.355 Hearings

Three interests are promoted by amending Rule 8.355, Fla.R.Juv.P., to require the appointment of a guardian ad litem and an attorney ad litem for a child in these proceedings: (1) the court will have access to more accurate and up to date medical information necessary to be able to render an informed decision on the necessity, safety and appropriateness of administering psychotropic medication; (2) the child will benefit therapeutically and medically from being heard through a guardian ad litem and an attorney ad litem in these hearings; and (3) the rule will be in conformity with the enabling legislation and other rules of juvenile procedure, which contain requirements and expectations that the child will be represented by an appointed guardian ad litem and/or attorney ad litem at

\[\text{§39.407(3) (d) 1., Fla. Stat. (2005).}\]
judicial review hearings and in other hearings involving the child’s medical needs.

A. Providing Children with GALs and Attorneys Assures that the Court Will Have More Accurate and Up to Date Health Information about the Child When Rendering the Decision to Authorize DCF to Administer Psychotropic Medication

Because §39.407(3), Fla. Stat. (2005), requires the court to conduct a far-reaching factual inquiry into the necessity, safety and appropriateness of administering psychotropic medication to a child in DCF custody, the court cannot and should not rely exclusively on medical information provided by the department. The inherent unreliability and systemic inaccuracies found in the review of foster children’s medical records by the two Florida Statewide Advocacy Council reports issued in 2002 and 2003, and in DCF’s own self-study in 2004, suggest that any information provided by DCF to the court and that the court relies on in determining whether to authorize psychotropic medication, must be carefully scrutinized to ascertain that it is accurate and up to date. Moreover, as the Red Item Report noted, because the medications’ use by children has not been generally approved by the FDA for safety or efficacy, the court needs to be especially vigilant and to monitor for signs and symptoms of adverse side effects. Only by providing a mechanism for outside review of this information by an independent
guardian *ad litem* and a trained attorney *ad litem*, can the fact-finding process be considered one that is reliable and trustworthy and that promotes the best interests and healthy development of children who will be administered psychotropic medications.

Recognizing the serious nature of the parents’ decision to consent to psychotropic medicines, the American Academy of Child and Adolescent Psychiatry (“AACAP”) recommends that families ask the following

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The AACAP’s policy on prescribing psychoactive medications for children and adolescents states: “Prescribing psychoactive medications for children and adolescents requires the judgement of a physician, such as a child and adolescent psychiatrist, with training and qualifications in the use of these medications in this age group. Certainly any consideration of such medication in a child or infant below the age of five should be very carefully evaluated by a clinician with special training and experience with this very young age group.” American Academy of Child and Adolescent Psychiatry, *Policy Statement: Prescribing Psychoactive Medications for Children and Adolescents* (Revised and approved by the Council on Sept. 20, 2001), available at [http://www.aacap.org/publications/policy/ps41.htm](http://www.aacap.org/publications/policy/ps41.htm).

Additionally, the AACAP Policy Statement observes that the prescribing of multiple medications for children, a practice which DCF has documented for a significant percentage of the children in its custody, should be “judiciously” used only in “clearly justifiable circumstances”: “Anecdotally the prescribing of multiple psychotropic medications (‘combined treatment’- ‘polypharmacy’) in the pediatric population seems on the increase. Little data exist to support advantageous efficacy for drug combinations, used primarily to treat co-morbid conditions. The current clinical ‘state-of-the-art’ supports judicious use of combined medications, keeping such use to clearly justifiable circumstances. Medication management requires the informed consent of the parents or legal guardians and must address benefits vs. risks, side effects and the potential for drug interactions.” *Id.*
questions *before* their child or adolescent starts taking psychiatric medications:

1. What is the name of the medication? Is it known by other names?

2. What is known about its helpfulness with other children who have a similar condition to my child?

3. How will the medication help my child? How long before I see improvement? When will it work?

4. What are the side effects which commonly occur with this medication?

5. What are the rare or serious side effects, if any, which can occur?

6. Is this medication addictive? Can it be abused?

7. What is the recommended dosage? How often will the medication be taken?

8. Are there any laboratory tests (e.g. heart tests, blood test, etc.) which need to be done before my child begins taking the medication? Will any tests need to be done while my child is taking the medication?

9. Will a child and adolescent psychiatrist be monitoring my child's response to medication and make dosage changes if necessary? How often will progress be checked and by whom?

10. Are there any other medications or foods which my child should avoid while taking the medication?

11. Are there interactions between this medication and other medications (prescription and/or over-the-counter) my child is taking?
12. Are there any activities that my child should avoid while taking the medication? Are any precautions recommended for other activities?

13. How long will my child need to take this medication? How will the decision be made to stop this medication?

14. What do I do if a problem develops (e.g. if my child becomes ill, doses are missed, or side effects develop)?

15. What is the cost of the medication (generic vs. brand name)?

16. Does my child's school nurse need to be informed about this medication?18

These recommended questions for parents are, in effect, ones which the court, in its limited in loco parentis role under §39.407(3), Fla. Stat. (2005), must also ask before it authorizes the administration of psychotropic medications to a child. However, because the juvenile court judge lacks the “intimacy of daily association”19 with the child that the child’s natural parents enjoy, the court must, of necessity, rely on information provided by the department. Because of the inherent unreliability of that information, the court should also appoint a guardian ad litem and an attorney ad litem to assist it before rendering a decision to authorize psychotropic medication. Having the assistance of a GAL and an attorney ad litem for the child will

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ensure that the decision to authorize administration of psychotropic medication is better informed by accurate and up to date information about the health status and needs of the child.\(^{20}\)

Providing the child with access to a guardian *ad litem* and an attorney *ad litem*, each of whom can assist the court in asking critically important questions about the child’s basic health needs, also promotes the

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\(^{20}\)Notwithstanding the confidential nature of health records, both the GAL and the attorney *ad litem* should be able to gain access to record information related to the child’s health and mental history and current health needs. *See* §39.822(3)(b), Fla. Stat. (2005)(authorizing the guardian *ad litem* to inspect and copy “any records related to the best interests of the child,” including not limited to, medical and mental health records; *cf. S.C. v. GAL*, 845 So.2d 953 (Fla. 4\(^{th}\) DCA 2003)(minor was entitled to notice and opportunity to be heard before her guardian *ad litem* was given access to records of psychologist and as matter of first impression, mature minor has right to assert psychotherapist/patient privilege); *E.C. v. GAL*, 867 So.2d 1193 (Fla. 4\(^{th}\) DCA 2004)(same).

*See also* Kathi Grasso, *Children and Psychotropic Drugs: What’s an Attorney to Do?*, 16 A.B.A. CHILD L. PRAC. 49 (1997)(the attorney should review records pertaining to the client’s history in foster care, medical (including nursing notes), mental health, educational, group homes, and residential treatment in representing a child treated with psychotropic medications; the attorney should also speak with the medical, mental health, and other professionals involved in the child’s care); American Bar Association, *Standards of Practice for Lawyers Who Represent Children in Abuse and Neglect Cases* (Approved by the A.B.A. House of Delegates, Feb. 5, 1996)(Standard C-2)(the attorney should conduct thorough, continuing and independent investigations and discovery of the child’s social services, psychiatric, psychological, drug and alcohol, medical, law enforcement, school, and other records relevant to the case).
administration of justice for these children and enhances their overall well-being. As noted by the New York State Permanent Judicial Commission on Justice for Children, in concluding a child health initiative composed of judges, lawyers, physicians, social workers and other professionals to address the health needs of children in foster care:

By asking [questions about the child’s basic medical needs], we can create a climate that spotlights the critical connection between foster children’s healthy development and their prospects for a permanent home. Hopefully, the inquiry will ensure that needed services are provided. Where questions expose the inadequacy of resources available to meet the needs, we hope that judicial leadership can help spur new initiatives to ensure the healthy development of every foster child. 21

B. Providing Children with GALs and Attorneys Assures that Children Will Have a Meaningful Opportunity to Voice Their Objection to the Proposed Administration of Psychotropic Medication and Will be More Likely to Comply With Any Treatment Ordered by the Court

Because §39.407(3) (d) 1., Fla. Stat. (2005), and Rule 8.355(a) (3), Fla.R.Juv.P., allow any party, including the child, to object to the proposed administration of these medications, but mandate that the party file its

objection within two working days of being notified of the department’s motion, without an appointed GAL and legal counsel, the child will not be able to meaningfully voice an objection to the proposed action. In practical terms, an adolescent, and certainly a very young child, cannot file an objection and meaningfully participate in the hearing unless given access to a GAL and a lawyer. The absence of any provision in the rule requiring an appointed representative for the child in this hearing not only deprives the child of important due process safeguards; it also deprives the child of dignitary and participatory interests that are critical to the child’s perception of the basic fairness of the hearing process. As this Court observed in *M.W. v. Davis*, 756 So.2d 90, 107 (Fla. 2001):

> Indeed, the issue presented by this case extends beyond the legal question of what process is due; rather, this case also presents the question of whether the child believes that he or she is being listened to and that his or her opinion is respected and counts. *See generally* Gary B. Melton, et al., *No Place to Go: The Civil Commitment of Minors* 146-47 (1998) (stating that children obtain psychological benefit from procedural protections prior to being placed in psychiatric treatment facilities).

Empirical studies of how litigants experience judicial and administrative hearings have led to the development of a literature on the

41-55 (offering checklist for judges, attorneys and agency personnel for use in hearings on the health needs of adolescents subject to court supervision).
psychology of procedural justice. Research on the psychology of procedural justice suggests that people are more satisfied with and comply more readily with the outcome of legal proceedings when they perceive those proceedings to be fair and have an opportunity to participate in them. The process or dignitary value of a hearing is important to litigants. People who feel that they have been treated fairly at a hearing—dealt with in good faith and with respect and dignity—experience greater litigant satisfaction than those who feel treated unfairly, with disrespect, and in bad faith. People highly value “voice,” the ability to tell their story, and “validation,” the feeling that what they had to say was taken seriously by the judge or other decision-maker. Even when the result of the hearing is adverse, people treated fairly, in good faith and with respect are more satisfied with the result and comply more readily with the outcome of the hearing. Moreover, they perceive the result as less coercive than when these conditions are violated and even feel that they have voluntarily chosen the course that is judicially imposed. Such feelings of voluntariness rather than coercion tend

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to produce more effective behavior on their part. For many litigants, these process values are more important than winning.\textsuperscript{23}

Social psychologist Tom Tyler, applying these principles to the civil commitment hearing, has argued that increasing the individual’s sense of participation, dignity, and trust during the commitment proceedings is likely to increase his or her acceptance of the outcome of the hearing, lead to a greater willingness to accept hospitalization and treatment, and enhance treatment efficacy.\textsuperscript{24} Psychotropic medication hearings that appear to children, particularly adolescents, who are subject to them to be a sham violate their need to be treated with “respect, politeness, and dignity,” and to feel that “their rights as citizens are acknowledged.”\textsuperscript{25} Hearings that deny them the practical ability to voice their objection to a proposed administration of psychotropic medication, due to the lack of access to counsel and GAL representation, may be thus perceived by them as phony


\textsuperscript{25}Tyler, supra note 24, at 440.
rituals violating their sense of participation, dignity, and equal citizenship. Indeed, such hearings may actually produce feelings of worthlessness and loss of dignity, exacerbating the child’s mental illness or behavioral problems, and perhaps even fostering a form of learned helplessness that can further diminish performance, motivation, and mood in ways that can be anti-therapeutic.  

The procedures proposed by Rule 8.355 are likely to be perceived by the children subjected to them as phony rituals, unless these children have the practical ability to lodge objections to the proposed treatment through a guardian *ad litem* and an attorney *ad litem*, and if they object, to have a hearing on the proposed treatment in a manner similar to the procedures set forth in Rule 8.350(a) (6), (8), (9) & (11), Fla.R.Juv.P. Otherwise, they are likely to perceive the hearing as a judicially imposed coercive measure, and without the ability to meaningfully voice their objections, will be less compliant with the treatment ordered by the court.

Providing legal counsel and a guardian *ad litem* for the child effectuates rather than compromises the child’s participatory interests in the

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hearing process. As Professor Winick observes, in taking measure of the benefits of affording counsel to a child in a civil commitment hearing:

[t]he attorney can contribute to the juvenile’s sense that he or she was treated fairly and to his or her ability to accept the outcome of the proceeding, even if adverse, and to comply with the court’s decision in ways that can better achieve the goals of hospitalization. Without this, the juvenile is more likely to experience the hospital admission that may be ordered as coercive, with potentially devastating consequences for his or her ability to gain the benefits that such hospitalization may offer.27

C. Providing Children With GALs and Attorneys Conforms the Rule to the Intent of the Enabling Statute

Although §39.407(3)(f)1., Fla. Stat. (2005), contemplates representation in review hearings by a guardian ad litem, attorney, or attorney ad litem, Rule 8.355 is completely silent as to appointment of a guardian or attorney. Despite the fact that the statute recognizes the right of a child to be represented by a guardian or attorney, and the guardian’s or attorney’s role in advocating for more frequent review by the court of the child’s psychotropic medication status, the rule omits any mention of or mechanism for such appointment to be exercised by the court; it also fails to make any reference to Rule 8.215 or Rule 8.217, Fla.R.Juv.P., which provide

27See Bruce J. Winick & Ginger Lerner-Wren, Do Juveniles Facing Commitment Have a Right to Counsel?: A Therapeutic Jurisprudence Brief, 71 U. Cin. L. Rev. at 125.
for the appointment of a guardian *ad litem* or an attorney *ad litem* at any stage of a dependency proceeding. As such Rule 8.355 does not conform to §39.407(3), Fla. Stat. (2005), and is not consistent with other rules of juvenile procedure requiring the appointment of counsel and guardians *ad litem* for children in hearings concerning medical or psychiatric treatment.

By contrast, in other contexts involving the adjudication of comparable medical interests of children, the juvenile rules require, consistent with statutory enactments, that the child have appointed lay and/or legal representatives in the hearings. For example, Rule 8.350(a) (3), Fla.R.Juv.P., explicitly provides for the appointment of a guardian *ad litem* for a child in a residential treatment hearing, in conformity with §39.407(6), Fla. Stat. (2005), and the appointment of an attorney *ad litem* for the child, pursuant to Rule 8.350(a) (6), Fla.R.Juv.P., when the guardian reports to the court that the child objects to placement in such a facility.

Similarly, Rule 8.815, Fla.R.Juv.P., governing hearings on petitions for judicial waiver of parental notice of termination of pregnancy, contains an explicit requirement, pursuant to §390.01114(4) (a), Fla. Stat. (2005), for a minor to be notified of the right to court-appointed counsel and the
provision to the minor of counsel upon her request at no cost in any judicial bypass hearings.\(^{28}\)

Furthermore, although Rule 8.355(a) (3), Fla.R.Juv.P., states that any party objecting to the administration of psychotropic medication must file its objection within two working days of the DCF motion for court authorization of psychotropic medication, as observed above, no child (the party most likely to “object” to this proposed action by DCF) can realistically be expected to file such an objection, without access to counsel or a GAL.\(^{29}\) Particularly for an infant or toddler subjected to psychotropic medication, the absence of a requirement of a GAL or lawyer to protect the child’s health care and due process rights makes the prospect of an objection being filed utterly meaningless. Given the potential harm to a very young child who is subjected to psychotropic medication, the absence of meaningful judicial oversight, without the right to be represented in a


\(^{29}\)As this Court noted in In Re T.W., 551 So.2d 1186, 1196 (Fla. 1989): “A minor, completely untrained in the law, needs legal advice to help her understand how to prepare her case, what papers to file, and how to appeal if necessary. Requiring an indigent minor to handle her case all alone is to risk deterring many minors from pursuing their rights because they are unable to understand how to navigate the complicated court system on their own or because they are too intimidated by the seeming complexity to try.”
hearing by counsel and a guardian _ad litem_ before the drugs are administered, carries potentially devastating and irreversible medical consequences.\(^{30}\)

V. Conclusion

For the foregoing reasons, we respectfully request that Rule 8.355, Fla.R.Juv.P., which governs the procedures for juvenile court hearings on the administration of psychotropic medication for children in state custody when parental consent has not been obtained, be amended to provide these children the opportunity to be heard by the court through both an appointed attorney _ad litem_ and a guardian _ad litem_.

Respectfully submitted,

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CERTIFICATE OF FONT COMPLIANCE

I HEREBY CERTIFY that the foregoing is prepared in 14 point Times New Roman font, in compliance with Fla. R. App. P. 9.210(a) (2).

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing was sent this 23rd day of January, 2006, by U.S. Mail to the following: Alan Abramowitz, Esq., Committee Chair, Florida Bar Juvenile Court Rules Committee, 210 N. Palmetto Avenue, Suite 440, Daytona Beach, FL 32114-3269.

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BERNARD P. PERLMUTTER