Policy: Psychotropic Medication for Children in Out of Home Care

ChildNet Number: CN 003.052
Original Approved Date: August 23, 2004
Policy Revised Date(s): September 8, 2005, May 20, 2010
Policy Sunset Date:
COA Standard(s): HR 3.07, RPM 3.01, 3.02, 3.05

Statement of Policy:
Safe and effective use of psychotropic medications is vital to the health and well-being of children in the care and custody of ChildNet. ChildNet believes that both Child Advocates and ChildNet administrators must always know what medications children in our care are receiving and continuously work to ensure the appropriateness of their use. Such use always requires either the express and informed consent of the child's parent or legal guardian, or the alternative of court authorization, to administer these medications to the child.

Board Chair's Signature: _____ **Date:** 11-15-10

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Please see appendix on page 18 with required timelines for reporting and documentation

Definitions:

Assent – a process by which a provider of medical services helps the patient achieve a developmentally appropriate awareness of the nature of his or her condition; informs the patient of what can be expected with tests and treatment; makes a clinical assessment of the patient's understanding of the situation and the factors influencing how he or she is responding; and solicits an expression of the patient's willingness to accept the proposed care.

Behavioral Health Assessment – includes both the Comprehensive Behavioral Health Assessment (CBHA) as defined by the Medicaid Community Behavioral Health Services Coverage and Limitations Handbook and all other assessments performed by mental health professionals.

Caregiver- a person who is approved in writing by the Department as responsible for providing for the child's daily needs, or any other person legally responsible for the child's welfare in a residential setting.

Case Manager/Child Advocate- a child welfare professional who is responsible for ongoing safety management and service provision of children who, through assessment by a child protective investigator, have been determined to be unsafe.

Case Plan- the dependency case plan as defined in Section 39.011(11), F.S., which refers to the services plan jointly developed between the family and dependency case manager, delineating specific interventions aimed at addressing the contributing factors and underlying conditions that led to child maltreatment.

Children's Legal Services – a statewide law firm focusing on children's issues within the Department of Children and Families. In Broward County, this service is provided by the Office of the Attorney General, Children's Services.

Child Protective Investigator (CPI)- a child welfare professional who is responsible for investigating alleged child maltreatment and conducting assessments regarding the safety of children.

Community-based Care Lead Agency- the non-for-profit or governmental community-based care provider responsible for the provision of support and services for eligible children who have been abused, abandoned or neglected and their families through a contract with the State.

Current Prescription- a medication that is prescribed to the child and that the child is being administered or directed to be administered at the time the child is taken into custody.

Department- the Department of Children and Families.

Express and Informed Consent – Refers to voluntary written consent from a competent person who has received full, accurate, and sufficient information and explanation about a child's medical condition, medication and treatment to enable the person to make a knowledgeable decision without being subjected to any deceit or coercion. Express and informed consent for the administration of psychotropic medication may only be given by a parent whose rights have not been terminated, or a legal guardian of the child. Sufficient explanation includes the following information, provided and explained in plain language by the prescribing practitioner to the consent giver: the medication, reason for prescribing it, and its purpose or intended results; side effects, risks and contraindications, including effects of stopping the medication; method for administering the medication and dosage range when applicable; potential drug interactions; alternative treatments; and the behavioral health or other services used to complement the use of medication when applicable.

Florida Safe Families Network (FSFN)- the Department's comprehensive, statewide automated data base that supports child welfare practice. FSFN holds the state's official case file for all children and families served. FSFN is the Comprehensive Child Welfare Information System (CCWIS) for the State of Florida.

Lead Agency- the non-for profit or governmental community-based care provider responsible for the provision of support and service for eligible children who have been abused, abandoned or neglected and their families.

Legal Guardian- a permanent guardian as described in Section 39.6221, F.S., or a "guardian" as defined in Section 744.102, F.S. or relative with a court order of temporary custody under Chapter 751, F.S. Case managers and Guardians ad Litem do not meet the definition of legal guardian.

MedConsult Line – DCF contracted statewide service that provides medical consultation by a Board Certified Child and Adolescent Psychiatrist on psychotropic medication treatment decisions for children in out-of-home care or enrolled in the Behavioral Health Network (BNET).1-866-453-2266

Medical Report – a report prepared by the prescribing physician that includes information required by Section 39.407(3) (c), F.S. The form for the medical report is "Medical Report" (form CF-FSP 5339 dated January 2010).

Out of Home Care – the placement of a child, arranged and supervised by the Department of Children and Families or the designated Community Based Care Lead Agency, outside of the home of the child's parent or legal guardian. This includes placement in licensed (i.e.: shelter, foster home, group home, specialized therapeutic foster care, residential treatment center) and non-licensed (relative/non-relative) settings.

Pre-Consent Review- a review by a child psychiatrist of a proposed medication regimen to determine whether or not the proposed prescribed medication and dosage are consistent with accepted medical practice given the diagnosis of the physical condition of the child. A pre-consent review is not a second opinion.

Prescribing Practitioner – a physician licensed under Chapter 458 or 459, F.S. or an advanced registered nurse practitioner licensed under 464 F.S.

Psychotropic Medications - any medication prescribed with the primary intent to stabilize or improve mood, mental status, behavioral symptomology or mental illness.

A. Antipsychotics
B. Antidepressants
C. Sedative Hypnotics
D. Lithium
E. Stimulants
F. Non-Stimulant Attention Deficit Hyperactivity Disorder medication
G. Anti-Dementia medications and cognition enhancers
H. Anticonvulsants and alpha-2 agonists; and
I. Any other medication used to stabilize or improve mood, mental status, behavior, or mental illness

Qualified Evaluator (QE) - a professional who is required by state law to be either a licensed psychologist or psychiatrist and have no financial or business relationship with a SIPP or TCH facility.

Residential treatment center – a 24-hour residential program which provides mental health services to emotionally disturbed children or adolescents as defined in Section

394.492(5) or (6), F.S. that is licensed by the Agency for Health Care Administration. *For the purposes of this policy and procedure*, therapeutic group homes are not considered a residential treatment center.

Resource Record- the child's standardized record that contains copies of all available and accessible medical and psychological information (including behavioral health information) pertaining to the child as described in subsections 65C- 300.001(21) and 65C.30.011(4), F.A.C.

Statewide Inpatient Psychiatric Program (SIPP) – those residential mental health treatment programs selected and contracted by the Agency for Health Care Administration. SIPP facilities provide intensive psychiatric services to children in a locked residential setting and are designed to service those high-risk youth that fail to benefit from acute psychiatric inpatient or traditional outpatient treatment settings. Dependent children may not be referred or admitted without an independent evaluation by a qualified evaluator in accordance with Chapter 39.407, F.S., which concurs with the findings of medical necessity for this level of care.

Procedure:

A. Express and Informed Consent

Parents or legal guardians retain the right to provide express and informed consent to or decline the administration of psychotropic medication for children taken into state care until such time as their parental rights, or court ordered guardianship rights, have been terminated. Prior to the provision of psychotropic medication, ChildNet must have either written express or informed consent of the parent or legal guardian or a court order to administer the psychotropic medication to the child.

B. Taking a Child Into Custody

1. When a Child Protective Investigator (CPI) takes a child into custody he or she must ascertain whether the child is taking psychotropic medications. If so, the CPI must determine the purpose of the medication, the name and number of the prescribing practitioner, the dosage, instructions regarding administration (e.g. timing, whether to administer with food) and any other relevant information.
2. The CPI must seek written authorization from the parent or legal guardian to continue administration of currently prescribed psychotropic medications. The authorization shall be documented on the "Emergency Intake" form, CF-FSP 5314, May 2010. This authorization is good for the **first 60 calendar days** the child is in shelter status.
3. In order for medication to be administered to a child, the medication must be a current prescription, in the original container and clearly marked. If the medication is not in the original container, is not clearly marked, or is not the child's current prescription, the child shall not be continued on the medication unless the

prescribing practitioner or the dispensing pharmacy confirms the child is currently on the prescribed medication and provides a new prescription to be filled or refilled.

4. If the CPI is informed that the child is currently taking prescribed psychotropic medication, however, the original container is unavailable or the label on the container provided is indiscernible, the child must be evaluated by a practitioner at the initial health screening to determine if the medication is needed and provide instruction on proper dosing.
5. If the parental authorization is not obtained and the CPI receives a medical opinion that the child needs to continue taking the medication, the medical opinion must be in writing and provided to Children's Legal Services.
6. Children's Legal Services must file a motion requesting that continuation of the medication be determined at the shelter hearing. The motion must indicate the prescribing practitioner's reason for wanting to continue the medication and provide the court with any other available information relevant to the request.
7. Authorization in the shelter order to continue the medication shall be valid only until the arraignment hearing on the petition for dependency or for **28 calendar days** following the date of removal, or no later than the arraignment hearing on the petition for dependency, whichever occurs first. The child must be evaluated by a practitioner to determine whether it is appropriate to continue the medication.
8. The CPI shall document in FSFN all actions in regards to the provision of the medication within **(3) business days** of receipt of the parent or legal guardian authorization or court order approving the medication.

C. Authority to Provide Psychotropic Medications to Children in Out-of-Home Care

1. Parent or Legal Guardian Express and Informed Consent – the Child Advocate/DCM is to assist the prescribing physician in obtaining express and informed consent from the child's parent or legal guardian, unless parental rights have been terminated and they must take steps to include them in the child's consultation with the treating physician.
2. In no case may the child protective investigator (CPI), Child Advocate/DCM, child's caregiver or staff from Residential Treatment Centers provide express and informed consent for a child in out-of-home care to be prescribed a psychotropic medication.
3. If the parents' or guardians' rights have been terminated, their identify or location is unknown, they decline to approve administration of psychotropic medication, or withdraw consent to the administration of psychotropic medication and any part to the dependency action believes that administration of the medication is in the best interest of the child and medically necessary, the authorization to treat with psychotropic medication shall be pursued as follows:
    a. The Child Advocate /DCM shall consult with the prescribing practitioner within **one (1) business day** of being notified that the parent :

i. Is unavailable;

ii. Withdraws consent;

iii. Declines to consent, or

iv. Is found by the prescribing practitioner to lack the ability to provide express and informed consent.

b. If the prescribing practitioner determined that the medication is medically necessary for the child despite the lack of authorization, the Child Advocate /DCM must obtain a completed Medical Report, incorporated by reference in Rule 65C-35.001, F.A.C., from the prescribing practitioner. If the parent or legal guardian withdraws consent that was previously provided or declines to consent to the administration of psychotropic medication, the parent or legal guardian's decision, and any reason provided therefore, must be recorded by the prescribing practitioner in the Medical Report. If the prescribing practitioner determines that the parent or legal guardian cannot provide express and informed consent, the basis for that determination must be recorded by the prescribing practitioner in the Medical Report.

c. Within **three (3) business** days of receiving the Medical Report from the prescribing practitioner, the Child Advocate /DCM must submit the Medical Report and any supporting documentation to Children's Legal Services, with a request for legal action or obtain a court order authorizing the administration of the prescribed medication.

d. Children's Legal Services must file a motion seeking court authorization for the provision of the psychotropic medication. Except as provided in Section 39.407(3)(e), F.S., court authorization must occur before the psychotropic medication is administered to the child.

e. Psychotropic medication may be administered in advance of a court order or parental authorization in accordance with Sections 39.407(3)(b)1, and 39.407(3)(e), F.S., court authorization must occur before the psychotropic medication is administered to the child.

f. If at any time, the child's parental rights, or legal guardianship rights, are terminated, the parental consent is no longer valid and the Child Advocate/DCM must follow the procedure to obtain a court order for the psychotropic medications.

D. Medication Monitoring and Administration

1. The monitoring of the use of psychotropic medication provided to children will be the joint responsibility of the prescribing practitioner, the caregiver, the Child Advocate/DCM and Child Advocate/DCM supervisor. Child Advocate DCM supervisors shall provide ongoing review and oversight of children prescribed psychotropic medication.

2. The caregiver and Child Advocate/DCM are responsible for implementing the medication plan developed by the prescribing practitioner. The Child Advocate/DCM shall ensure any additional medical evaluations and laboratory tests required are completed as per the prescribing practitioner. The CPI or Child Advocate/DCM shall add all information to the child's Resource Record and report the results of evaluations and tests to Children's Legal Services, all parties and the prescribing practitioner. When medication is initially prescribed, the CA/DCM will request that the prescribing clinician provides education about the medications prescribed, including: medication name, dose, reason for use, how to administer, desired effects and potential side effects.
3. Psychotropic medication will be administered only by the child's caregivers. Children who are age and developmentally appropriate must be given the choice to self-administer medication under the supervision of the caregiver or school personnel. Children assessed as appropriate to self-administer medication must be educated by the practitioner or caregiver on the following:
    a. The method of administering the medication;
    b. The recognized side effects, risks and contraindications of the medication;
    c. Drug-interaction precautions;
    d. Possible side effects of stopping the medication; and,
    e. How medication administration will be supervised by the caregiver.
4. Any person with information that questions the child's health and safety, including the signs or symptoms of side effects or adverse reactions to the medication, shall as soon as possible bring that information to the attention of the prescribing practitioner, Child Advocate/DCM or Child Advocate//DCM's supervisor. Emergency services shall be arranged to protect the child's safety and well-being. The child's Child Advocate/DCM shall provide this information to Children's Legal Services. Children's Legal Services shall notify the court and parties within **three (3) business days** of the reported concern.
5. The case manager or designee who has received training on psychotropic medications in accordance with Rule 65C-35.014, F.A.C., shall attend medication reviews.
6. All details about prescribed psychotropic medications, updates (including changes in dosage or practitioner prescribed cessation of the medication) and all actions taken by the CPI or case manager will be entered into the Florida Safe Families Network (FSFN) by the CPI or case manager within **three (3) business days** of the action.
7. Whenever a child in out-of-home care is receiving psychotropic medications pursuant to expressed and informed consent by the parent or legal guardian or as authorized by an order of the court, the Department shall fully inform the court of the child's medical and behavioral status at each subsequent Judicial review

hearing and shall furnish copies of all pertinent medical records contained in the child's Resource Record that have been generated since the previous court hearing, including the Medical Report, incorporate by reference in Rule 65C-35.001,F.A.C.

8. If a child on psychotropic medication is moved from an out-of-home placement and placed into another out-of-home placement the Child Advocate/DCM must obtain the child's Resource Record and any prescription psychotropic medication currently taken by the child.
9. The Child Advocate/DCM shall explain to the current and previous caregivers the importance of communication regarding the child's medication monitoring and administration and recommend that they exchange contact information.
10. The Child Advocate/DCM shall obtain the medication in original labeled medication bottles, inventory the medication provided, and transport the medications to the child's new caregivers.
11. To ensure that the medication is continued as directed by the prescribing practitioner, the Child Advocate/ DCM shall provide the caregiver with the following information:
    a. The full name of the child for whom the medication is prescribed;
    b. The condition and purpose for which the medication is prescribed for the child;
    c. The prescribing practitioner's name and contact information;
    d. The pharmacy from which the prescription was obtained and the contact information;
    e. The prescription number;
    f. The drug name and dosage;
    g. The times, frequency and method or administration, and if the dosages vary at difference times;
    h. Any identified side effects, risks and contraindications (including possible side effects of stopping the medication);
    i. Any other specific instructions regarding the medication;
    j. The practitioner's plan to reduce and/or eliminate ongoing administration of the medication; and,
    k. The dates and time of any follow-up appointments, including appointments for laboratory testing.
12. If the child is moved from an out-of-home placement and is placed in another out-of-home placement and the medication is in an unlabeled container or prescription information is insufficient, the Child Advocate/ DCM shall contact the prescribing practitioner, if available, and dispensing pharmacist to ensure the proper

identification and labeling of the mediation by examining the pills (if unlabeled) or to arrange for a medical evaluation in order that treatment not be interrupted.

13. Each time a child receives a new prescription, or has a prescription re-authorized, that prescription must be entered into CCWIS with a new prescription or re-authorized prescription begin date. This is required even if the new prescription or re-authorization is to continue a current medication without any changes. It is not necessary to enter this information into CCWIS each time a medication is refilled, only when a new prescription is required in order for the child to continue receiving the medication. The prescription "end date" must be entered into CCWIS when either the child stops taking the medication or the prescription expires (including refills), whichever comes first.

E. Parent or Legal Guardian Involvement

1. The Child Advocate/ DCM is to make the following efforts to assist the prescribing physician in obtaining express and informed parental consent:
   a. Attempt to invite the parent or legal guardian to the doctor's appointment and facilitate the parent's attendance at the appointment. Facilitate arrangements for transportation to the appointment, if needed. These attempts are to include, at a minimum, telephone call(s) to the last known phone number, or home visit, or letter to the last known address.
   b. Facilitate telephone or tele-medicine participation between the prescribing practitioner and the parent or legal guardian when unable to attend in person.
2. If the parent or legal guardian cannot physically attend, the Child Advocate/DCM shall:
   a. Attempt to contact the parent or legal guardian by phone as soon as feasibly possible upon learning of the recommendation for psychotropic medication by the prescribing physician, if they were not present at the appointment. If contact is made, provide the parent with specific information for how and when to contact the physician.
   b. Provide a copy of the Medical Report, incorporated by reference in Rule 65C-35.001, F.A.C., to the child's parent or legal guardian, which includes the prescribing practitioner's contact information.
3. When the court has authorized the provision of psychotropic medication, the Child Advocate/ DCM must continue to try to involve the parent or legal guardian in the child's ongoing medical treatment planning and shall continue to facilitate the parent or legal guardian's communication with the prescribing practitioner so that the parent or legal guardian has the opportunity to consider whether to authorize the provision of any new medications or dosages, unless the parent or legal guardian's rights have been terminated.

4. Phone calls and written communication to the parent or legal guardian concerning the prescription of the psychotropic medications are to be documented in the CCWIS within **2 business days** of the communication.

F. Caregiver Involvement

1. The caregiver's schedule must be taken into consideration when scheduling appointments. The caregiver must make every effort to attend medical appointments and obtain the information about the medications, possible side effects and provide information about the child to the prescriber as requested. Caregivers do not have the authority to provide expressed and informed consent for psychotropic medication. However, nothing in this rule prohibits caregivers from expressing their concerns regarding prescribing psychotropic medications.
2. If a caregiver is unable to attend the appointment and it cannot be re-scheduled, then the Child Advocate/DCM or his or her designee who has received training on psychotropic medications in accordance with Rule 65C-35.014, F.A.C., shall attend the appointment. The designee must also be familiar with the child.
    a. The Child Advocate/ DCM shall provide to the designee, in writing, the child's medical and mental health history, behaviors, concerns and effects of the current psychotropic medications on the child.
    b. The Child Advocate/DCM shall provide a copy of the Medical Report, incorporated by reference in Rule 65C-35.001, F.A.C., to the caregiver and review the report with the caregiver to ensure the caregiver's understanding of the report.
3. The caregiver shall monitor the child and report to the prescribing practitioner and the Child Advocate/DCM any behaviors or other incident that could indicate an adverse reaction or side effect. The caregiver must seek emergency medical care for the child if the presence of an adverse reaction or side effect to the medication is affecting the child's health or safety.

G. Child Involvement in Treatment Planning

1. The prescribing practitioner must discuss the proposed course of treatment with the child, in developmentally appropriate language the child can understand. The practitioner must explain the risks and benefits for the prescribed medication to the child. The practitioner will discuss the following:
    a) The medication proposed;
    b) The reason for the medication;
    c) The signs or symptoms to report to caregivers;
    d) Alternative treatment options;
    e) The method of administering the medication;
    f) An explanation of the nature and purpose of the treatment;

g) The recognized side effects, risks and contraindications of the medication;

h) Drug-interaction precautions;

i) Possible side effects of stopping the medication;

j) How treatment will be monitored; and

k) The practitioner's plan to reduce and/or eliminate ongoing administration of the medication.

2. The prescribing practitioner must ascertain the child's position with regard to the medication and consider whether to revise the recommendation based on the child's input. The child's position must be noted in the Medical Report, incorporated by reference in Rule 65C-35.001, F.A.C. The Child Advocate/ DCM shall provide the child with a copy of the Medical Report if the child is of sufficient maturity and intellectual capacity to understand the report.

   a) It is the practitioner's responsibility to inform the child as clearly as possible and as fully as appropriate. However, the child's failure to understand or assent to treatment is not, by itself, sufficient to prevent the administration of a prescribed medication. Likewise, the child's assent to the treatment is not a substitute for expressed and informed consent by a parent or legal guardian or a court order

   b) Pursuant to Section 39.01305, F.S. the Child Advocate/ DCM shall request that Children's Leal Services file a motion for the appointment of an attorney for the child when the child declines to assent or the prescribing practitioner determined the child is not developmentally able to provide assent.

3. Whenever, the child requests the discontinuation of the psychotropic medication, and the prescribing practitioner refuses to order the discontinuation, the Child Advocate/DCM shall request that Children's Legal Services request an attorney to be appointed for the child. Children's Legal Services will notice all parties and file a motion with the court, presenting the child's concerns, the practitioner's recommendation, and any other relevant information.

H. Requests for Second Opinions and Pre-Consent Reviews

1. Second Opinions

   a) The Child Advocate/ DCM may seek a second medical opinion at any time after consultation with a supervisor.

   a) When any party files a motion requesting that the court order a second medical option, the court may order the Child Advocate/CMO DCM obtain a second opinion within a reasonable timeframe as established by the court. Within **one (1) business day** of the court's order the Child Advocate/DCM will make a referral for an appointment for the second opinion. The Child Advocate/DCM must obtain the second opinion within **twenty-one (21) calendar days** of receipt of a court order for such.

2. **Pre-Consent Review**. The Child Advocate/DCM shall seek a pre-consent review when:
   a) A practitioner proposes prescribing psychotropic medication or changing the dosage of prescribed psychotropic medication outside the dosage parameters documented in the Medical report; and,
   b) The child is age birth through 10 years; and,
   c) The child is prescribed two (2) or more psychotropic medications.
3. The result of the pre-consent review or a second opinion is to be provided to the parent/legal guardian or to the court for consideration in their decision to provide express and informed consent.

4. Pre-Consent Review Procedures
   a) Within **one (1) working day**, it is the Child Advocate's/ DCM's responsibility to notify ChildNet's Director of Service Coordination or designee if the treating physician recommends two (2) or more psychotropic medication for a child in out-of-home care under the age of ten (10).
   b) The Child Advocate/DCM will provide the recommending physician with the Medical Report form to complete. Once the form is completed the Service Coordination designee will upload the form to: the MedConsult web link: https://dcf.psychiatry.ufl.edu.
   c) Except under the emergency circumstances allowed in s. 39.407, F.S., no psychotropic medications will be administered to children under the age of ten (10) until pre-consent review and all other requirements have been met.
   d) Upon notification by the Child Advocate/DCM, the Director of Service Coordination or designee is to track the date and time the pre-consent review form was submitted to the consultant Child Psychiatrist for review. Upon receipt of the completed pre-consent review from ChildNet's selected consultant Child Psychiatrist, the Director of Service Coordination or designee will document the date and time received, along with the recommendation.
   e) Within **three (3) days**, the Child Advocate/DCM is to document the pre-consent review and recommendations in the CCWIS and provide (by fax or secured email) the completed review to the prescribing physician and request that the prescribing physician complete the Medical Report for Psychotropic Medication, at that time.
   f) Within **one (1) business day**, the Child Advocate/ DCM is to deliver the completed pre-consent review, along with the completed Medical Report for Psychotropic Medication, to the parent/legal guardian if they are providing consent or to the CLS attorney to file with the court, if a court order is being requested.

g) If the prescribing physician determines changes are necessary in the psychotropic medication, and the changes are outside the parameters for which a court order or express and informed consent has been given, a new pre-consent review process must be conducted, if the child is still under the age of ten (10). This must occur regardless of the results of any prior pre-consent review for the child for that particular medication.

I. Medical Reports

1. The Child Advocate/DCM, Child Advocate/ DCM Supervisor, or ChildNet/ DCM Assistant Director/Director is required to attend initial psychiatric evaluation appointments for all children in out-of-home care. The Child Advocate/ DCM is to encourage the parent and caregiver to attend the initial psychiatric evaluation appointment, so that they can provide information about the child's behavior and functioning directly to the prescribing physician, as well. On-going psychiatric medication management appointments must be attended either by the child's caregiver, or if the caregiver cannot attend, the Child Advocate/ DCM, Child Advocate/ DCM Supervisor, or ChildNet/ DCM Assistant Director/Director. If medication changes are being considered and/or the child is demonstrating significant behavioral/emotional impairments, the Child Advocate/ DCM is to consult with their supervisor to determine if the Child Advocate/ DCM should attend additional psychiatric appointments.
2. When the parent and caregiver are able to attend the medical appointment and the parent provides express and informed consent for the child to be administered psychotropic medications, the prescribing practitioner must complete Section 5: Parental Consent of the Medical Report Form. The parent must sign this section of the form attesting to his or her consent.
    a. If the parent or caregiver is unable to attend the medical appointment, the prescribing practitioner must complete and sign the Medical Report form, incorporated by reference in Rule 65C-35.001, F.A.C.
    b. For changes in medication (including dosage or dosage range) that go beyond the existing authorization the Child Advocate/DCM is responsible for securing new parental express and informed consent or court order.
    c. Children's Legal Services shall notice all parties to the case of the parent's consent to the administration of psychotropic medication and file the consent and documentation of prescribed medication with the court.
    d. The Child Advocate/ DCM shall provide CLS the parent's consent, as well as documentation noting the medications prescribed to the child, within **three (3) business days** of receipt of the parental consent and documentation. In addition, the Child Advocate/CMO DCM shall notify CLS of any changes in medication or changes in physician. For changes in physician the Child Advocate/CMO DCM will be responsible for providing the treating physician with the Medical Report Form prior to, or at the time of the psychiatric

appointment (only exceptions are for situations where the child is placed in a hospital, crisis stabilization unit, or psychiatric residential treatment center/Statewide Inpatient Psychiatric Program). The Child Advocate/DCM is to ensure that the Medical Report Form is completed thoroughly and accurately by the prescribing health professional. CLS shall notice all parties to the case of the parent's consent to the administration

e. The Child Advocate/ DCM is to document the completion of the above forms in the CCWIS. Within **three (3) business days** of receiving the completed Medical Report from the prescribing physician, the Child Advocate/DCM is to submit this form, along with a legal request for court authorization for psychotropic medication, to the Children's Legal Services attorney assigned for the child. In the legal request, the Child Advocate/ DCM is to include a report that explains all efforts made to assist the physician in obtaining express and informed consent from the parent or legal guardian. The Child Advocate/ DCM is to request a timely court hearing. If the Child Advocate/ DCM is not provided with a court date by Children's Legal Services within **two (2) business days** of the legal request, the Child Advocate/ DCM is to contact CLS to inquire as to the status of the court date. If a court date is still not provided at that time, the Child Advocate/ DCM is to notify ChildNet's Program Manager for assistance.

3. When court authorization is needed to provide psychotropic medication, the Child Advocate/ DCM must documents efforts made to enable the prescribing practitioner to obtain express and informed consent from the child's parent or legal guardian on the Medical Report form. Efforts to enable the prescribing practitioner.

   a. Dates and times the Child Advocate/ DCM attempted to contact the parent or legal guardian by phone or other means upon learning of the recommendation for psychotropic medication by the prescribing practitioner;

   b. Dates, times and methods the Child Advocate/ DCM used to attempt to contact the parent or legal guardian and provide them with specific information for how and when to contact the practitioner; and,

   c. Efforts to facilitate transportation arrangements to the appointment and/or telephone calls between the parent or legal guardian and the prescribing practitioner.

4. The Medical Report form must be uploaded in FSFN within **three (3) business days** of receipt of the completed document.

Exceptions – Psychotropic medications may be administered in advance of a court order or parental express and informed consent when the child is admitted to the hospital, Crisis Stabilization Unit (CSU), or a Psychiatric Residential Treatment Center/Statewide Inpatient Psychiatric Program (SIPP). However, then the following must occur:

1. Within **three (3) business days** after the medication is initiated, a motion for court authorization must be filed or written express and informed consent must be obtained from the parent or legal guardian.
2. To ensure that Children's Legal Services has sufficient information for the motion, the Child Advocate/ DCM is to provide the prescribing physician with the Medical Report form within the same business day of being informed that the medication has been initiated. The Child Advocate/ DCM is to visit the child at the facility and request the fully and accurately completed Medical Report from the prescribing physician for the facility, and provide this to Children's Legal Services within **two (2) business days** after the medication is initiated.
3. Psychotropic medications may also be administered in advance of a court order or express and informed parental consent when the child's prescribing physician certifies, on the Medical Report Form, that delay in providing the prescribed psychotropic medication would more likely than not cause significant harm to the child.
4. In this situation, the Medical Report Form must provide the specific reasons why the child may experience significant harm and the nature and extent of the potential harm.
5. Within **three (3) business days** after the administration of the medication begins or resumes, the Child Advocate/ DCM is to obtain written express and informed parental consent or a motion must be filed requesting court authorization.
6. Copies of the Medical Report Form are to be provided to the court, the child's Guardian Ad Litem, and all other legally entitled parties within **three (3) working days** after the medication is initiated.

J. Changes in Medication – the Child Advocate/ DCM is responsible for securing a new parental express and informed consent or court order if there are any changes in medication, including dosage or dosage range, that go beyond the existing authorization. The Child Advocate/ DCM is to inform Children's Legal Services of any changes in medication outside of what is specified in the existing authorization and provide the CLS attorney with a copy of the amended Medical Report Form.

K. Request to Discontinue Medication – Whenever the child, the child's parent (if parental rights have not been terminated) or the caregiver requests the discontinuation of the psychotropic mediation, and the prescribing physician refuses to order the discontinuation, the Child Advocate/DCM is to advise the CLS attorney of this request. CLS may file a motion with the court presenting the concern, the physician's recommendation, and any other relevant information, pursuant to s 39.407(3)(d)1, F.S.

L. Psychotropic Medication Administration – Psychotropic Medications for children in out of home care are to be administered by designated caregivers only.

1. All foster parents are to receive training on psychotropic medication and medication management on an annual basis.
2. All Out-of-Home caregivers are to record the administration of these medications when given, on a ChildNet approved Medication Log. This record is to include who received the medication, what medication(s) was administered, and when and by whom the medication(s) was administered.
3. ChildNet is to ensure that licensed caregivers receive medication management training annually and that required medication documentation forms are completed.
4. ChildNet's Behavioral Health Care and/or Nurse Coordinator are available to provide assistance related to medication issues or concerns and shall contact the member's Medicaid Managed Medical Assistance Plan (MMAP) and/or as needed to resolve any encountered barriers.

M. Supervisory Reviews

1. Child Advocate/ DCM Supervisors are to monitor their staff to oversee that the data is entered into the CCWIS in a timely manner, as required, and that all data is accurate.
2. Legally appropriate express and informed consent for all psychotropic medication is to be monitored by the Child Advocate/ DCM Supervisor and confirmed on a quarterly basis or more frequently as needed.
3. Qualitative supervisor reviews with Child Advocates/ DCMs are to include, but not limited to, discussion regarding the following: any observed behavioral or physical indicators that the child is not thriving or is in a potentially dangerous situation; needed physical or mental health services; if updated medical information has been shared with caregivers and treating healthcare professionals; any developmental or mental health issues; if the child is on psychotropic medications and, if so, are the appropriately documented in the CCWIS; are informed consents current and legally sufficient; child specific multi-disciplinary staffings held to address the child's developmental, emotional, behavior, education, and health care and status of recommended services.

N. Management Tools and Administrative Oversight

1. ChildNet's CQI Department provides the Director of Service Coordination, a licensed mental health professional, with a report including the CCWIS data related to psychotropic medication for children in out-of-home care.
2. The Director of Service Coordination is available for consultation if there are concerns regarding a child's prescribed psychotropic medication. The Director of Service Coordination is to take appropriate action, which may include consultation with ChildNet's selected independent Psychiatrist or MedConsult Line review. Action(s) taken and outcome will be reported back to the individual issuing the concern by The Director of Service Coordination.

a) The Director of Service Coordination is to work collaboratively with therapeutic programs whose professional staff prescribes psychotropic medication for foster care children toward the goal of doing so safely and appropriately. This collaboration will include review of the programs' policies and procedures for the prescription, administration and monitoring of psychotropic medications to ensure that they meet current legal and quality industry standards.

b) The Director of Service Coordination or subcontracted designee is to develop and oversee implementation of an annual schedule of training sessions for ChildNet and contracted program staff devoted to increasing their understanding of psychotropic medications and their appropriate and safe use. Training is to include statutory requirements for express and informed consent for children prescribed psychotropic medications, monitoring of "Black Box" medication warnings, signs and symptoms to be monitored for adverse reactions, responsibilities in the monitoring process, and the components of this policy and procedure.

c). The Network Development Department, Director of Service Coordination, or designee, is to review the credentials of all prescribing physicians who prescribe psychotropic medications and provide psychiatric services to children under ChildNet's supervision and in out-of-home care. Through this process, the applicable license is to be verified including that the license is clear and active at the current time.

President's Signature: _____ **Date:** 5/2/18

APPENDIX

TIMELINE TO COMPLY WITH DOCUMENTATION OR RECORD INFORMATION

Documenting in SACWIS	
2 business days	The CPI must document in CCWIS the reason that parental authorization was not initially obtained and why the medication is necessary for child's well-being.
2 business days	All phone calls and written communication to the parent or legal guardian concerning the prescription of the psychotropic medications are to be documented in the CCWIS within **2 business days** of the communication
3 business days	If the parent provides written express and informed consent on the Medical Report form, the Child Advocate/ DCM is to document this in the CCWIS within **3 business days**,
2 business days	The Director of Service Coordination or designee is to document and track the medical consultation and the recommendations made. The Child Advocate/ DCM is to document the medical consultation in the CCWIS within **2 business days**
3 business days	Changes in medication or physician: the Child Advocate/ DCM is to document the completion of these forms in the CCWIS. Within **three (3) business days** of receiving the completed Medical Report from the prescribing physician.
3 business days	Information regarding all prescribed psychotropic medications must be entered in CCWIS by Child Advocate/ DCM or CPI for a new child coming into care.
3 business days	Any absence of express and informed parental consent or court order is to be explained along with changes in dosage or physician and recorded in CCWIS by the Child Advocate/ DCM
3 days	The Child Advocate/DCM is to document the pre-consent review and recommendations in the CCWIS and provide (by fax or secured email) the completed review to the prescribing physician and request that the prescribing physician complete the Medical Report for Psychotropic Medication
Reporting to the Court/CLS	
2 business days	If the Child Advocate/ DCM is not provided with a court date by Children's Legal Services within **two (2) business** days of the legal request the Child Advocate/ DCM is to contact CLS to inquire as to the status of the court date.
3 business days	Within **three (3) business days** of receiving the Medical Report from the prescribing physician, the Child Advocate DCM is to submit the Medical Report and any supporting documentation to Children's Legal Services
3 working days	Copies of the Medical Report form are to be provided to the court, the Child's Guardian Ad Litem and all other legally entitled parties
3 business days	Obtaining court authorization for administration of psychotropic medication the Child Advocate/ DCM must submit a written report and the legal request for the court order to CLS, within three (3) business days of receiving a complete Medical Report from the prescribing physician.

3 business days	Within **three (3) business days** after the medication is initiated, a motion for court authorization must be filed or written express and informed consent must be obtained from the parent or legal guardian.
3 business days	Within **three (3) business days** after the administration of the medication begins or resumes, the Child Advocate/ DCM is to obtain written express and informed parental consent or a motion must be filed requesting court authorization
21 days	ChildNet/CMO seeks court authorization to continue, a motion for such continued authorization is to be filed at the same time as the dependency petition, within **21 days** of after the shelter hearing
21 calendar days	Child Advocate/ DCM must obtain the second opinion within twenty-one **(21) calendar days** of receipt of a court order for such
28 days	Authorization granted at the shelter hearing may extend only until the arraignment hearing on the petition for adjudication of dependency or 28 days following the date of removal, whichever occurs sooner
Medical Report/Physician/Health and Safety	
2 business days	The Child Advocate/ DCM is to visit the child at the facility and request the fully and accurately completed Medical Report from the prescribing physician for the facility, and provide this to Children's Legal Services within **two (2) business days** after the medication is initiated.
3 business days	The Child Advocate/ DCM is to immediately bring any information that calls into question the child's health and safety to the attention of the prescribing physician and ChildNet Child Advocate/ DCM Supervisor, and emergency services are to be arranged, as appropriate