STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, November 15, 2017

CF OPERATING PROCEDURE
NO. 155-10 / 175-40

Family Safety
Mental Health/Substance Abuse

SERVICES FOR CHILDREN WITH MENTAL HEALTH AND ANY CO-OCCURRING SUBSTANCE ABUSE OR DEVELOPMENTAL DISABILTY TREATMENT NEEDS IN OUT-OF-HOME CARE PLACEMENTS

This operating procedure provides guidance for the integration of mental health, substance abuse, and developmental disabilities services for children in out-of-home care. The integration includes proper assessment, referral, and provision of community-based as well as residential behavioral health services, including psychotropic medications, to support the safety, permanency and well-being of children served by the Department of Children and Families (Department) in out-of-home care.

(Signed original copy on file)

MIKE CARROLL
Secretary

SUMMARY OF REVISED, DELETED, OR ADDED MATERIAL

Chapter 4 of this operating procedure has been superseded by Chapter 5 of CFOP 170-11.

This operating procedure supersedes CFOP 155-10 dated September 13, 2010 and CFOP 175-40 dated September 13, 2010.
OPR: Office of Child Welfare
DISTRIBUTION: OSGC; ASGO; PDFS; PDMH; Region Family Safety staff; Region Mental Health/Substance Abuse staff.

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Chapter 1

GENERAL

1-1. Purpose. This operating procedure defines the Department's responsibility to provide children in out-of-home care with timely screening and assessment for mental health and substance abuse or co-occurring mental health and substance abuse and developmental disability needs; and, to provide these children with timely, effective treatment services and supports at levels appropriate to address the severity of their conditions.

1-2. Scope. This operating procedure applies in all cases where the Department or its contracted service provider requests or provides mental health, substance abuse, and developmental disabilities screening, examination, and treatment, including psychotropic medications, for any child in out-of-home care by the Department or its contracted service provider. This operating procedure also applies to children placed outside the state of Florida under the jurisdiction of a Florida state court and to children placed in Florida and under the jurisdiction of a court from another state. This operating procedure also applies to children placed in out-of-home care that are also served by the Department of Juvenile Justice (DJJ) and have been placed in a DJJ detention center or a DJJ residential commitment program.

1-3. Authority. Relevant statutory provisions relating to medical screening, examination and treatment of children are as follows:

a. Section 39.407, Florida Statutes (F.S.).

b. Sections 394.455(9) and 394.459(3)(a), F.S. as referenced in s. 39.407, F.S.

c. Section 39.304, F.S.

d. Sections 743.064 and 743.0645, F.S.

e. Chapter 65C-35, Florida Administrative Code (F.A.C.).

1-4. Guiding Principles. The following principles will direct the planning and delivery of mental health, substance abuse and developmental disability services for children in out-of-home care.

a. Children placed in out-of-home care by the Department or its contracted service provider will be promptly screened for mental health, substance abuse, or co-occurring mental health and substance abuse and developmental disability treatment needs.

b. If the preliminary screening indicates a possible need for services, a referral for further assessment will be made.

c. Mental health and/or co-occurring mental health, substance abuse and/or developmental disability needs identified through a Comprehensive Behavioral Health Assessment (CBHA) or other mental health, substance abuse or developmental disabilities assessments must be considered when developing the family's dependency case plan.

d. Dependency case plans will be individualized according to the needs of the child and will emphasize the strengths of the child and the family.

e. The child, family, and where appropriate other individuals important to the child and family will be involved in developing the dependency case plan, unless there is reason for non-involvement

based on the child's needs; or efforts to secure involvement are unsuccessful; or other statutory requirements conflict with involvement.

f. The dependency case plan will include a description of the mental health and any co-occurring substance abuse and developmental disability service needs being addressed and a description of the services to be provided.

g. As the child's or youth's treatment needs change, the dependency case plan must be amended with the court's approval.

h. The mental health, any co-occurring substance abuse, and developmental disability services that will be provided must be consistent with the family's dependency case plan.

i. As appropriate, needs and stated goals for independent living skills and future personal or adulthood plans will be identified in the dependency case plan, and needed supports and services will be provided accordingly.

j. For all children who are also served by the DJJ, Children's Medical Services Medical Foster Care and/or the Agency for Persons with Disabilities (APD), child specific planning and service delivery will be coordinated between the agency(ies) and the Department and their contracted providers.

k. The Lead Agency should ensure transition planning in advance of youth leaving out-of-home care that includes identification of providers and source of payment for treatment.

l. Children and families who are receiving any behavioral health services should be provided ongoing information on the diagnosed behavioral health disorder, effective treatment options, and managing life with the condition.

m. Dependency case managers (DCMs) will know or have training on child and adolescent development, neuro-developmental effects of prenatal substance exposure, common mental health disorders, and the impact of trauma in the child welfare population, and effective treatment options for these mental health disorders.

1-5. Point of Contact.

a. Designation. Each Lead Agency will establish a Point of Contact (POC) to serve as the central point of contact for DCM in referring children for CBHAs, other behavioral health assessments as needed and mental health services, including psychotropic medications.

b. Roles and Responsibilities. For children in out-of-home care, the POC provides consultation to DCMs in accessing screening for mental health and any co-occurring substance abuse or developmental disorders; professional assessments; and timely, quality treatment at levels appropriate to the severity of children's conditions. The Point Of Contact will:

(1) Serve as a consultant to Community-Based Care Lead Agency staff in making timely, appropriate, and effective referrals to mental health, substance abuse, co-occurring substance abuse, and developmental disability services in the community.

(2) Assist Community-Based Care Lead Agency staff in obtaining clinical case consultations for especially complex cases.

(3) Provide monthly reports to the Circuit's Community-Based Care Lead Agency and Substance Abuse and Mental Health Program Offices (SAMH), or designee, when appropriate, on the number, demographics, timeliness, and status of CBHAs and resulting provision and availability of

mental health, substance abuse, or co-occurring mental health and substance abuse and developmental disability related services.

(4) Through sample analysis of all providers' progress reports or other methods as necessary, assess service quality, outcomes, and relevance to children's permanency goals, and report these findings, including a clear indication of departures from acceptable results, to the circuit SAMH and Community-Based Care Lead Agency offices.

(5) Manage the process of referring children for suitability assessments and continued stay reviews.

1-6. The Child Resource Record. A child's resource record (CRR) is required to be developed for every child entering out-of-home care according to Rule 65C-30.011(4), F.A.C. This document is vital to the proper health care, both physicial and behavioral, and safety of the child, and must be maintained throughout the time a child is served in out-of-home care. It must be maintained by the caregiver in the home the child is living in and must be provided to the child's physicians at each medical, behavioral health or physicial health, appointment. The DCM is responsible for the initial development, monitoring, updating, and transporting of the CRR. The DCM shall review confidentiality requirements with the child's caregiver, who shall be provided with the CRR. The caregiver is responsible for maintaining confidentiality of the CRR documents. For children in Medical Foster Care (MFC), the CRR will be maintained under its own tab in the MFC child's record where the child resides.

a. Since some of the information necessary in the CRR is not available immediately upon initial removal, the documents required in the CRR shall be placed in the record as soon as available. The CRR shall include, at a minimum the following critical health care information:

(1) Medical, substance abuse, developmental, dental, psychological, psychiatric, and behavioral history;

(2) Copies of documentation regarding all ongoing medical, dental, psychological, psychiatric, substance abuse, developmental, and behavioral services, including child health check-ups provided through Medicaid, as well as all prescribed medications;

(3) For children prescribed a psychotropic medication, a copy of the physician's Medical Report (CF-FSP 5339, available in DCF Forms);

(4) Copy of the general consent for treatment (CF-FSP 4006, available in DCF Forms);

(5) Parental express and informed consent for treatment or court order;

(6) Copy of the Medicaid card;

(7) Copy of the Shelter Order; and,

(8) The names and phone numbers of parents, legal guardians and staff to be contacted in emergencies.

b. The CRR shall be provided to the initial out-of-home caregiver within 72 hours of placement and shall accompany the child during any change of placement. If the CRR does not accompany the child at the time of a placement change, it shall be provided to the out-of-home caregiver within 72 hours of placement. For children in Medical Foster Care (MFC), the CRR shall be removed from the child's MFC in-home record in order to accompany the child at the time of a placement change.

c. The CRR shall accompany the child to medical and therapist visits.

d. The Department or its contracted service provider shall develop a method for recording required information after any psychiatric hospitalization or stay in a residential treatment program and ensure that the current and accurate information is entered into the CRR.

e. Where the Department or contracted service provider has originals of documents required to be included in the CRR, the original documents shall be placed in the child's case file and the copies shall be kept in the CRR.

f. Where medical information is not available and accessible, written documentation of the efforts made to obtain the information shall be placed in the case file.

g. Child's Resource Record in Licensed Placements.

(1) The CRR shall be physically located with the caregiver. The child's licensed caregiver shall ensure that the CRR is updated after every health care, psychological, psychiatric, behavioral, substance abuse, developmental, and educational service or assessment provided to the child.

(2) The DCM shall ensure that medical and court-related documentation are kept current at each visit. If additional information is needed in the CRR the DCM and the licensed caregiver shall work together to ensure that the CRR is promptly updated.

h. Child's Resource Record in Relative and Non-Relative Placements.

(1) The DCM shall ensure the upkeep of the CRR in relative and non-relative placements. The CRR shall be physically located with the relative or non-relative.

(2) The DCM shall assist the relative or non-relative to update the CRR after every health care, psychological, psychiatric, behavioral, substance abuse, developmental, and educational service or assessment provided to the child.

(3) The DCM shall ensure that medical and court-related documentation are kept current at each visit. If additional information is needed in the CRR, the DCM shall provide copies of needed documents to the relative/ non-relative for updating of the CRR.

1-7. Behavioral Health Services.

a. Behavioral health services shall be provided to children in out-of-home care without delay once the need for such services is identified in a CBHA or other behavioral health evaluation. These services may include, but are not limited to, parent training, individual, family and group therapy, behavior analysis and support, and the provision of psychotropic medications as ordered by the child's prescribing physician. Less invasive treatment interventions should be considered before prescribing psychotropic medication.

b. The child's DCM will ensure that all behavioral health services that are identified in behavioral health assessments or prescribed by a medical or mental health professional have been integrated into the families dependency case plan and are referred for within seven (7) business days of being identified. If all behavioral health services that are identified in behavioral health assessments or prescribed by a medical or mental health professional are not included in the family's dependency case plan the reasons will be documented in the child's case file.

c. The Department and contracted service providers that provide behavioral health services shall comply with the requirements of s. 39.407(3), F.S., and the Florida Rules of Juvenile Procedure

8.355, and Chapter 65C-35, F.A.C. whenever a child is considered for administration of psychotropic medications.

d. The Department and contracted service providers that provide behavioral health services shall comply with the requirements of s. 39.407(6), F.S., and the Florida Rules of Juvenile Procedure 8.350 whenever a child is considered for admission to a residential treatment center.

e. All behavioral health decision making should be guided by the principle that it is important to comprehensively address all the concerns in a child's life – family, legal, health, education, and social/emotional issues – as well as to provide behavioral supports and parent training, so that a child's behavioral and mental health issues can be addressed in the least restrictive setting and in a comprehensive treatment plan.

f. The administration of any medication solely for the purposes of chemical restraint is strictly prohibited.

1-8. Consent for Medical Treatment. The type of consent required for medical treatment can be either for "ordinary and necessary medical and dental care", "extraordinary medical care and treatment" or "emergency medical care or treatment".

a. General consent for medical treatment ("Consent for Treatment and Release Information," form CF-FSP 4006, available in DCF Forms), if provided by the child's parent or legal guardian, allows ordinary and necessary medical and dental care to be provided by the Department. This type of treatment includes immunizations, tuberculin testing, and well child care. If the parent of the child has provided general consent then the Department may consent to any general physical or behavioral health medical treatments included in this category. While behavioral health treatments do not require express and informed consent, the risks, benefits, length of treatment, and expected outcomes of suggested therapies should be discussed with the child's parent or legal guardian and the child, consistent with best practice.

b. Specific consent is required prior to the provision of any extraordinary medical care or treatment for any child in out-of-home care. This consent can either be provided to the physician prescribing the treatment by the child's parent or legal guardian through the express and informed consent process as defined in s. 394.455(9), F.S., and Chapter 65C-35, F.A.C., and described in s. 394.459(3)(a), F.S., or by a court order from the child's dependency judge.

(1) This level of consent is required because this type of medical treatment is not considered routine medical. This includes surgery, anesthesia, administration of psychotropic medications, and any other procedures not considered routine and ordinary by objective professional standards for medical care of children.

(2) The administration of any medication defined as a psychotropic medication is considered an extraordinary procedure for which either express and informed consent of the parent or legal guardian, or a court order, is required by law. While a medical treatment using a medication defined as a psychotropic medication may not be considered a behavioral/psychiatric treatment, it is considered not routine and therefore requires either the express and informed consent of the child's parent or legal guardian or a court order to authorize the treatment.

(3) If after a parent provides express and informed consent for any extraordinary medical care, including psychotropic medications, the parent's rights are terminated and appeals are exhausted, a court order must be requested to continue to provide the extraordinary medical care.

Chapter 2

COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENTS

2-1. Purpose. All children entering out-of-home care ages birth through 17 years who are Medicaid eligible are to be provided a CBHA. These Medicaid funded assessments are used to provide specific information about mental health and related needs. The needs identified through the CBHA and the recommendations for services are to be included in the family's case plan.

2-2. Scope. This applies to children in out-of-home placements as defined in Appendix A of this operating procedure.

2-3. Reference. Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook. Medicaid Handbooks can be down loaded at: www.mymedicaid-florida.com, then click on Public Information for Providers, then click on Provider Support, then Handbooks.

2-4. Assessment Goals. As described in the Medicaid Handbook, the goals of the CBHA are to:

a. Provide assessment of areas where no other information exists;

b. Update pertinent information not considered current;

c. Integrate and interpret all existing and new assessment information;

d. Provide functional information, including strengths and needs, that will aid in the development of long term and short term intervention strategies to enable the child to live in the most inclusive, least restrictive environment;

e. Provide specific information and recommendations to accomplish family preservation, re-unification, and permanency planning;

f. Provide data to support a child specific staffing which may include information to assist in making the most appropriate placement, when out-of-home care or residential mental health treatment is necessary;

g. Provide the basis for developing an effective, individualized, strength-based service plan; and,

h. Provide detailed information on each of the CBHA components as specified in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

2-5. Process and Timelines.

a. The Department is authorized to have the CBHA performed without authorization from the court and without consent from a parent or legal custodian, per s. 39.407(1), F.S. Within seven (7) calendar days after the child is placed in shelter care, the child protective investigator (CPI) or the DCM will request that the Point of Contact refer the child for a Comprehensive Behavioral Health Assessment by submitting a completed Comprehensive Behavioral Health Assessment Referral (CF-MH 1053, available in DCF Forms), and a completed Authorization for Comprehensive Behavioral Health Assessment (CF-MH 1066, available in DCF Forms). Referral guidelines for CBHA may be found in Medicaid's Community Mental Health Services Coverage and Limitations Handbook.

b. Within one (1) business day of receipt of a completed request, the POC will forward the "Authorization for Comprehensive Behavioral Health Assessment" form to an approved provider and

will input the referral data into a local CBHA automated tracking system authorized by the Lead Agency for this purpose.

c. The POC will request that the CBHA provider complete the summary page of the appropriate Child and Adolescent Needs and Strengths (CANS) assessment tool to serve as the front page of the completed report.

d. As required in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook, within 24 calendar days of receipt of the authorization, the CBHA provider will complete the assessment and send the report of findings to the POC. The development of the CBHA shall include information provided by the child's parents and current caregiver whenever possible.

e. Within one (1) business day of receipt of the CBHA report, the POC will review the report for quality and completeness and, if acceptable, will forward the report to the Lead Agency for distribution to the DCM or other designated staff. If the report is not complete or does not meet the Medicaid Handbook standards, the POC will return the report to the provider for revision.

f. The DCM will review the assessment report for any recommendations for behavioral health services and will make appropriate referrals for such services, asking the POC and/or other designated Lead Agency staff for consultation if needed. The DCM will also ensure that Children's Legal Services (CLS) receives a copy of the assessment at this time.

g. At any point during the assessment process, if the child is determined to have an urgent need for immediate behavioral health treatment, the dependency case manager will seek appropriate services for the child in the community. A score of 3 in "Risk Behaviors" or "Problem Presentation" areas of the CANS would indicate a high level of urgency for mental health services and will result in a referral for services to address the issue identified in the CANS.

h. The DCM will use the results and recommendations of the CBHA in developing the dependency case plan, including addressing the child's and family's mental health service needs. If the case plan is developed prior to the completion of the CBHA, the use of the assessment in developing, accessing, and referring for behavioral health services will be documented in the child's case file. If the services recommended in the CBHA are not included in the child's current case plan, the recommendations in the CBHA shall be used to revise the current case plan if necessary. The revised dependency case plan must be filed with and approved by the court.

i. When a child is experiencing serious emotional disturbance in out-of-home care, the CBHA may be used to re-assess the child's behavioral health service needs as established in the Medicaid Handbook.

2-6. Forms. The following forms are referenced in this chapter, and are available in DCF Forms:

a. Comprehensive Behavioral Health Assessment Referral (CF-MH 1053).

b. Authorization for Comprehensive Behavioral Health Assessment (CF-MH 1066).

Chapter 3

PSYCHOTROPIC MEDICATIONS

3-1. Purpose. The purpose of this chapter is to delineate the requirements for the administration and monitoring of psychotropic medications to children placed in out-of-home care by the Department, including the requirement of express and informed consent by parents or legal guardians and the alternative of court authorization for providing these medications.

3-2. Scope. This chapter applies to all children in out-of-home placements as defined in Appendix A of this operating procedure.

3-3. References. Ss. 39.407(3)(a)1., 394.455(9), 394.459(3)(a), F.S.; Rule 65C-30.011 and Chapter 65C-35, F.A.C.; and DCF General Counsel's Legal Opinion 09-01.

3-4. Psychotropic Medication Documentation Required Forms.

a. Prescribing Physicians Signed Medical Report. A prescribing physician's signed Medical Report is required to be provided for all children in out-of-home care who are prescribed a psychotropic medication for any medical reason. The contents of the Medical Report are set forth in s. 39.407 (3)(c)(1)-(5), F.S., and the use of this Medical Report are required by Chapter 65C-35, F.A.C. The Medical Report, when properly completed and signed by the prescribing physician, shall serve as the signed Medical Report as required by statute; and when signed by the parent or legal guardian, shall serve as documentation of express and informed consent.

(1) If a court order is required to obtain authorization to administer psychotropic medication, for any medical procedure, the prescribing physician must complete and sign the Medical Report form (CF-FSP 5339, available in DCF Forms).

(2) This form includes all requirements set forth in s. 39.407(3)(c)(1)-(5), F.S., and Chapter 65C-35, F.A.C. The physician may submit the Medical Report in a format prepared by their own office as long as the substitute Medical Report format addresses all information required in s. 39.407(3)(c)(1)-(5), F.S. Please note that if a court order is needed to administer the medications prescribed, some judges may ask for additional information. The information required to be provided, and the section of the Medical Report (CF-FSP 5339) as referenced, includes;

(a) Child's name date of birth, height, weight, gender (section 1);

(b) The information that the physician received, including consultations; assessments, evaluations, and other records of behavioral health and school based services received by the child, indications of the presence of brain injury, and other health conditions considered (section 2); and a statement that the information was reviewed and considered in the decision making process (section 9);

(c) The medication(s) being prescribed, the dosage range, starting date, expected length of time the child will be taking the medication, and possible side effects to monitor (section 3);

(d) The diagnoses for which the medication is being prescribed, the symptoms and behaviors it is to address, and expected results (section 3);

(e) Other recommendations for behavioral health services to be used as adjuncts to psychotropic medications as required by s. 39.407(3)(g), F.S. (section 4);

(f) A statement concerning how information about the medication has been provided to the parent or caregiver and child, and whether it has been discussed (section 6); and,

(g) Supplemental information, including whether if other treatment options are available; whether such options have been tried prior to prescribing any psychotropic medications and if so, their outcome; or, if other treatment options are available but not tried, why they were not tried (section 7).

(3) When a child changes prescribing physicians for any reason, the receiving physician must provide an updated Medical Report to the child's DCM within three (3) business days of taking over the child's treatment. If the receiving physician has been provided express and informed consent by the child's parent or legal guardian, the Medical Report will be filed with the court at the next judicial review. If parental/legal guardian express and informed consent has not been obtained by the receiving physician, the DCM will provide the new Medical Report to CLS (see paragraph 3-4a(6) below) which must file for a new court order.

(4) A new Medical Report will be provided by the prescribing physician when there is any change to the information in the original Medical Report concerning the medication prescribed. This includes the actual medication, dosage, the prescribing physician and administration instructions. This does not include when a brand named medication is replaced by a generic.

(5) Psychotropic medications may be administered without a court order or parental express and informed consent when the child's prescribing practitioner certifies, in section 5 (Certification of Significant Harm) of the Medical Report, that delay in providing the prescribed psychotropic medication would more likely than not cause significant harm to the child.

(6) The DCM shall ensure the documentation of the parental express and informed consent in section 8 (Informed Consent by Parent or Guardian) of the Medical Report and shall make the appropriate documentation in Florida Safe Families Network (FSFN).

(7) According to local agreement with CLS, the DCM may document actions to assist in ensuring the parent or legal guardian participation in the express and informed consent process by completing the Psychotropic Medication Informed Consent Facilitation (form CF-FSP 5228, available in DCF Forms).

(8) The DCM must submit the Medical Report to CLS within two (2) business days of receiving the Medical Report from the prescribing practitioner. The Psychotropic Medication Informed Consent Facilitation may also be submitted.

(9) The Medical Report will be provided to the child's caregiver to provide guidance for the medication plan for the child and will be maintained in the CRR.

b. Psychiatric Evaluation Referral.

(1) The Psychiatric Evaluation Referral (form CF-FSP 5341, available in DCF Forms) should be completed by the dependency case manager or child protective investigator, for all referrals for medical evaluation. The form will provide at a minimum the following information:

(a) Child's name, date of birth, height, weight, gender;

(b) Contact information of the DCM, the DCM's supervisor, caregiver, any current behavioral health therapist, guardian ad litem (GAL), school, and parents or legal guardians if parental rights have not been terminated;

(c) The documents that the DCM is providing the physician; including a list and, where available, copies of all known prior behavioral health evaluations, such as the current CBHA, school, psychiatric, psychological, and physical health evaluations, any medical information on conditions that may indicate the presence of brain injury (for example, blows to the head, fetal alcohol syndrome, loss of consciousness, head scars, fever above 104 degrees);

(d) Symptoms narrative which describes any behavioral or medical symptoms that have resulted in the current referral for an evaluation; and,

(e) Listing of all medications, including over-the-counter medications; other treatment services and supports the child is currently receiving; and the medication history of the child concerning any previously prescribed psychotropic medication.

(2) The Psychiatric Evaluation Referral (CF-FSP 5341) should be provided to the physician prior to the child's evaluation unless the child is in a crisis stabilization unit, residential treatment facility, or hospital, in which case the referral may be filled out after the child receives medication based on information received from the hospital/statewide inpatient psychiatric program (SIPP).

(3) Form CF-FSP 5341, when used, must also be provided to the CLS attorney and parents; and GAL or attorney ad litem if appointed.

(4) If medications are prescribed, upon the doctor's completion of the Medical Report this Referral form must be attached to the Medical Report and both faxed to CLS. If CLS identifies any legal issues with the Medical Report, CLS will notify the DCM in order to quickly remedy the problem. CLS may also attempt to contact the physician directly.

3-5. Parental or Legal Guardian Involvement. The Department or its contracted service provider is required 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 must take steps to include the parent in the child's consultation with the physician who prescribes the child psychotropic medication.

a. The DCM or CPI shall ensure that the following efforts are made to obtain express and informed consent from the child's parent or legal guardian and shall document such efforts in FSFN.

(1) Invite the parent or legal guardian to the doctor's appointment, if not prohibited by a court order, and offer the parent transportation to the appointment, if necessary.

(2) 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; and provide specific information for how and when to contact the physician.

(3) Facilitate transportation arrangements to the appointment and/or telephone calls between the parent or legal guardian and the prescribing physician.

b. If there are any changes in medication, including dosage or dosage range, that go beyond the existing authorization, the DCM or CPI will be responsible for either facilitating discussions between the prescribing physician and the parent or legal guardian in order to obtain a new express and informed consent, or pursuing a new court authorization if parental rights have been terminated. A prescribing physician's decision to change a medication from a brand name to a generic equivalent medication will not require additional consent or court authorization. The DCM or CPI shall inform CLS

and all parties of any changes in medication and shall provide CLS with a copy of the amended Medical Report.

c. If the parent or legal guardian attends the appointment, and/or speaks with the physician who prescribes the psychotropic medication, and the parent or legal guardian declines or refuses to give consent to provision of the medication, the parent's decision must be recorded in section 8 of the Medical Report.

d. If the child's parent or legal guardian has an opportunity to speak with the physician and have reasonable questions addressed, or if the parent or legal guardian has such opportunity by telephone, and if the conversation is reasonably documented by the DCM in FSFN, the subsequent express consent of that parent shall be deemed "informed." No motion for authorization of psychotropic medication will be necessary when the parent has provided express and informed consent.

e. In no case shall the DCM, the DCM's supervisor, or the foster parent provide consent to provide psychotropic medications to children in out-of-home care unless specifically authorized by the court.

f. If the parent or legal guardian is unable to attend the medical appointment, the DCM shall attend and provide information to the parent. The information provided during the appointment and provided the child's parent shall be summarized in FSFN. This information to be provided and understood shall include:

(1) A copy of the Medical Report;

(2) The method of administrating the medication;

(3) An explanation of the nature and purpose of the treatment;

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

(5) Drug-interaction precautions;

(6) Possible side effects of stopping the medication;

(7) Alternative treatment options;

(8) How the treatment will be monitored; and,

(9) The physician's plan to reduce and/or eliminate ongoing administration of the medication.

g. When the court has authorized the provision of psychotropic medications, the DCM or CPI 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 physician 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.

3-6. Caregiver Involvement. The child's caregiver must make every effort to attend medical appointments and obtain the information about medications, possible side effects, etc. Caregivers do not have the authority to provide express and informed consent for psychotropic medications. However, their knowledge of the child and monitoring of the medications prescribed for the child is

critical to support child safety and well-being, and to their ability to provide important information during the decision making process.

a. If the caregiver is unable to attend, the child's appointment must be rescheduled to allow attendance. If the appointment cannot be rescheduled, the DCM or CPI shall attend the appointment and convey the information to the caregiver. The information provided during the appointment and provided the child's caregiver shall be summarized in FSFN. This information to be provided and understood shall include:

(1) A copy of the Medical Report;

(2) The method of administrating the medication;

(3) An explanation of the nature and purpose of the treatment;

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

(5) Drug-interaction precautions;

(6) Possible side effects of stopping the medication;

(7) Alternative treatment options;

(8) How the treatment will be monitored; and,

(9) The physician's plan to reduce and/or eliminate ongoing administration of the medication.

b. If the caregiver has questions concerning the medication, the dependency case manager must encourage the caregiver to contact the prescribing physician for guidance.

c. In all cases the caregiver will be provided a copy of the Medical Report for children who are prescribed psychotropic medications. The Medical Report will be maintained in the child's resource record.

d. Licensed caregivers must fulfill the health and medication requirements under licensing and other rule sections specifically in Chapter 65C-13, F.A.C.

e. The caregiver shall monitor the child and report to the prescribing physician and the DCM any behavior or other incident that could indicate an adverse side effect.

3-7. Child Involvement in Treatment Planning. The prescribing physician must discuss the proposed course of treatment with the child, in developmentally appropriate language the child can understand. The physician must explain the risks and benefits of the prescribed medication to the child.

a. The physician will discuss the medication proposed, the reason for the medication, and the signs or symptoms to report to caregivers. Information discussed with the child shall include:

(1) Alternative treatment options;

(2) The method of administrating the medication;

(3) An explanation of the nature and purpose of the treatment;

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

(5) Drug-interaction precautions;

(6) Possible side effects of stopping the medication;

(7) How the treatment will be monitored; and,

(8) The physician's plan to reduce and/or eliminate ongoing administration of the medication.

b. The prescribing physician 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.

c. It is the physician's responsibility to inform the child as clearly as possible and as fully as is appropriate considering the child's developmental level and ability to understand . However, the child's failure to understand or assent 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 express and informed consent by a parent or legal guardian or a court order. Children are more likely to be successful in treatment if they fully understand and participate in treatment decisions.

d. If a child of sufficient age, understanding, and maturity declines to assent to the psychotropic medication, and after considering the child's position, the prescribing physician chooses to revise the recommended treatment to agreement with the child's position, the prescribing physician must document this concurrence in section 7 (Supplemental Information) of the Medical Report and no further action by the Department is required.

e. If a child of sufficient age, understanding, and maturity declines to assent to the psychotropic medication, and the prescribing physician does not change their medication recommendation, the DCM or CPI will request that CLS request an attorney ad litem be appointed for the child.

f. Whenever the child requests the discontinuation of the psychotropic medication, and the prescribing physician refuses to order the discontinuation, the DCM or CPI will request that CLS request an attorney ad litem be appointed for the child. CLS will notice all parties and file a motion with the court presenting the child's concerns, the physician's recommendation, and any other relevant information, pursuant to s. 39.407(3)(d)1., F.S.

g. In a situation in which there have been repeated medication side effect complaints from the child and these complaints are not being addressed by the prescribing physician after the DCM or CPI has confirmed that the prescribing physician has been notified of the complaints, the DCM or CPI shall notify CLS regardless. This notification will be made if the child has assented to the medication or not. CLS will notice all parties and file a motion with the court presenting the child's concerns, the physician's recommendation, and any other relevant information,

3-8. Continuation of Medical Care and Treatment When a Child Changes Placement. The child's physicial and behavioral health medical care and treatment must not be disrupted by change of placement. To the extent possible, the person making the placement, either the DCM or in some cases the CPI, shall arrange for transportation in order to continue the child with his or her existing treating physicians for any ongoing medical care. If this is not possible, then the person making the placement shall secure a copy of the child's medical records from the treating physician within three (3) business days of the change to a new provider.

a. The person making the placement is responsible for the following tasks relating to ongoing medical care and treatment:

(1) Discuss with the caregiver all known health care facts regarding the child;

(2) Review with the caregiver all health care and Medicaid information contained in the CRR; and,

(3) Obtain any prescription medication currently taken by the child. To continue medication as directed, the person making the placement shall obtain the medication in labeled medication bottles, inventory the medications provided, and transport the medications to the child's caregiver. The inventory shall include, at a minimum:

(a) The name of the child for whom the medication is prescribed;

(b) The condition and purpose for which the medication is prescribed for this child;

(c) The prescribing physician'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 and frequency of administration, and if the dosages vary at different times;

(h) Any identified side effects;

(i) The physician's plan to reduce and/or eliminate ongoing administration of the medication; and,

(j) A space for the caregiver to sign and date the medication inventory to indicate receipt of the child's medication.

b. If the child is taking unlabeled medications or prescription information is insufficient, the person making the placement shall contact the prescribing physician or pharmacist, if available, to ensure the proper identification and labeling of the medication or to arrange for a medical evaluation in order that treatment not be interrupted.

c. If a child uses medically assistive devices, the person making the placement shall ensure that these devices are taken with the child to the out-of-home placement. The person making the

placement shall also ensure that the caregiver receives the appropriate information and instruction concerning the use of the devices from the child's health care provider.

3-9. Taking a Child into Custody Who is Taking Psychotropic Medication. Children who are brought into custody may already be taking prescription medication. The child's medical well-being may depend on continuing to take such medication properly, particularly when the medication is psychotropic.

a. When a CPI takes a child into custody he or she must determine whether the child is taking psychotropic medications. If so, the CPI must ascertain the purpose of the medication, the name and phone number of the prescribing physician, the dosage, instructions regarding administration (e.g., timing, whether to administer with food), and any other information.

(1) The CPI must seek written authorization from the parent or legal guardian to continue administration of currently prescribed psychotropic medications. This authorization is good for the first 28 calendar days the child is in shelter. The Emergency Intake (form CF-FSP 5314, available in DCF Forms) may be used to document this authorization.

(2) The medication must be removed with the child. If the medication is in its original container, and clearly marked as a prescription for the child in question, and current, the medication may continue to be provided to the child. The CPI must notify or cause to be notified the parent or legal guardian that the medication is being provided.

(3) If the medication is not in the original container, clearly marked and current, a physician or pharmacist must confirm, by examining the pills, that the medication is the child's prescription and that the prescription is current. "Current" means the child is or should be taking the medication at the time the child is taken into custody, according to the prescription information.

(4) If there is a pre-existing prescription and the other conditions regarding the medication's container, labeling, and current date above are met, the psychotropic medication must be provided to the child as prescribed, but only until the emergency shelter hearing is held as required by s. 39.407(3)(b)1., F.S.

(5) The CPI may determine that the medication does not meet the conditions of being "in the original container, clearly marked, and current."

(6) In cases where the medication is not in the original container, clearly marked, and current; or there are several medications in the bottle provided by the parent; or a physician or pharmacist is unable to confirm the identity of any provided medications and that they belong to the child and are from a current prescription; the investigator will:

(a) Check with the prescribing physician or the dispensing pharmacist, if possible, or another physician at the child health check-up (within 72 hours), to determine if the child is currently prescribed a psychotropic medication.

(b) Obtain a new prescription, with the dosage and other information, and provide to the child as directed. This information must be entered in FSFN and can be used to request the court's authorization to continue the medication in the shelter order.

(7) The medication shall not be administered until such confirmation is obtained.

(8) The information on the container or as verified by the physician or pharmacist will be documented in FSFN.

(9) If the parent does not authorize, but the other conditions above are met, the psychotropic medication may nevertheless be provided to the child as prescribed , but only until the shelter hearing as required by s. 39.407(3)(b)1., F.S.

(10) When the medication is continued without parental authorization, the Department must inform the parent in writing that the medication is being provided.

(11) The CPI must document in FSFN the reason parental authorization was not initially obtained and the physician's confirmation regarding the medication and why it is necessary for the child's well-being.

(12) Unless there is a pre-existing prescription or parental express and informed consent, medication can be continued without a court order only until the date of the shelter hearing.

b. To continue administering the medication beyond the date of the shelter hearing, the CPI or DCM must have a determination from a physician licensed under Chapters 458 or 459, F.S., that the child should continue the psychotropic medication. This determination must be transmitted in writing to CLS.

c. If the DCM or CPI is unable to contact the prescribing physician prior to the shelter hearing, the information on the medication bottle may be used by the court as evidence of the intent of the prescribing physician to continue the medication until medical advice can be obtained by the DCM.

d. In the absence of parental authorization, when a physician determines the child should continue psychotropic medication, CLS must file a motion requesting that continuation of the medication be determined at the shelter hearing. The motion must indicate the physician's reasons for wanting to continue the medication and provide to the court any other available information relevant to the request.

e. Authorization in a 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, whichever occurs first.

f. Within 28 calendar days, or no later than the arraignment hearing on the petition for dependency, whichever occurs first, the child must be evaluated by a physician to determine whether it is appropriate to continue the medication.

g. All actions taken by the CPI will be entered in FSFN within three (3) business days of receipt of the parental authorization or court order approving the medication.

h. The parent or legal guardian authorization to continue a psychotropic medication that was obtained at the point of the child's removal is separate from the general "Consent for Treatment and Release of Medical Information" (CF-FSP 4006, available in DCF Forms). The general consent allows ordinary and necessary physical and behavioral health medical and dental care, to include immunizations, tuberculin testing and well child care. The administration of psychotropic medication is considered an extraordinary procedure for which express and informed consent of the parent of a court order is required by law.

3-10. Authority to Provide Psychotropic Medications to Children in Out-of-Home Care Placements.

a. Parents or legal guardians retain the right to consent to or decline the administration of psychotropic medications for children taken into state care until such time as their parental rights, or court ordered guardianship or custodial rights, have been terminated.

b. If the parents' or guardians' legal rights have been terminated; their identity or location is unknown; or they decline to approve administration of psychotropic medication, or withdraw consent, and any party to the case believes that administration of the medication is in the best interest of the child, then authorization to treat with psychotropic medication must be pursued through a court order. CLS must file a motion in court that will allow the court to "hear" the request and upon consideration of the facts, circumstances, and law, authorize the provision of the medication. Court authorization must occur before the psychotropic medication is administered to the child except in the circumstances described in paragraph 3-13 of this operating procedure.

c. In no case may the DCM, CPI, the child's caregiver, representatives from DJJ, 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.

d. The Department or its contracted service provider must 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 must take steps as required by Rule 65C-35.003(4), F.A.C., to include the parent in the child's consultation with the child's prescribing physician.

e. Placement Change. If a child on psychotropic medication is removed from an out-of-home care placement and placed in another out-of-home placement, the DCM or CPI must obtain the CRR and any prescription medication currently taken by the child.

(1) The DCM or CPI shall obtain the medication in labeled medication bottles, inventory the medications provided, and transport the medications to the child's new caregiver.

(2) The DCM shall ensure the new caregiver has sufficient information about the medication to ensure that the medication is continued as directed by the prescribing physician. The information provided shall include, at a minimum:

(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 this child;

(c) The prescribing physician'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 and frequency of administration, and if the dosages vary at different times;

(h) Any identified side effects;

(i) The physician's plan to reduce and/or eliminate ongoing administration of the medication; and,

(j) A space for the caregiver to sign and date the medication inventory to indicate receipt of the child's medication.

(3) If the child is taking unlabeled medications or prescription information is insufficient, the DCM or CPI shall contact the prescribing physician, if available, and dispensing pharmacist to ensure the proper identification and labeling of the medication by examining the pills (if unlabeled) or to arrange for a medical evaluation in order that treatment not be interrupted.

f. Changes in Medication. The DCM or CPI will be 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 DCM shall inform CLS of any changes in medication, and shall provide CLS a copy of the amended Medical Report.

g. Changes in Physician. The DCM or CPI will be responsible for ensuring a new Medical Report form is obtained, which will include securing a new parental express and informed consent, if there is a change in prescribing physician. If the new physician makes changes to medication beyond existing authorization, this may also mean seeking a new court order. The DCM shall inform CLS of any changes in physician, and shall provide CLS a copy of the amended the Medical Report.

h. Medication Reviews. The DCM or other designee will attend medication reviews as requested by the prescribing physician and/or agency. Whenever feasible, the child's caregiver and parent will also attend.

i. Request to Discontinue Medication. Whenever the child, the child's parent (if parental rights have not been terminated) or the legal guardian requests the discontinuation of the psychotropic medication, and the prescribing physician refuses to order the discontinuation, the DCM or CPI should advise CLS of this request. CLS must file a motion with the court presenting the parent's, child's or legal guardian's concerns, the physician's recommendation, and any other relevant information, pursuant to s. 39.407(3)(d)1., F.S.

j. Judicial Reviews.

(1) Whenever a child in out-of-home care is receiving psychotropic medications, whether pursuant to express 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 concerning the child which have been generated since the previous court hearing, including the Medical Report.

(2) When court authorization is needed to provide psychotropic medication, the DCM or CPI shall provide CLS a written report that documents efforts made to enable the prescribing physician to obtain express and informed consent from the child's parent or legal guardian. The Psychotropic Medication Informed Consent Facilitation (form CF-FSP 5228, available in DCF Forms) may be used. If another form is used the report must include:

(a) Dates and time the DCM or CPI attempted to contact the parent or legal guardian by phone or other means upon learning of the recommendation for psychotropic medication by the prescribing physician.

(b) Dates, times, and methods used to attempt to contact the parent or legal guardian and provide them with specific information for how and when to contact the physician.

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

k. Child with DJJ Involvement. When a child in out-of-home care is also served by DJJ and placed in a DJJ detention center or residential commitment program, prior to providing psychotropic

medications the DJJ provider must contract DCM and request either assistance in obtaining parental express and informed consent or a court order from the child's dependency judge.

3-11. Parent or Legal Guardian Declines to Consent to or Withdraws Consent for the Provision of Psychotropic Medication. If the parent or legal guardian declines to authorize the provision of psychotropic medication, or withdraws consent that was previously provided, the parent or legal guardian's decision, and any reason provided therefore, must be recorded in the Medical Report. If the prescribing physician determines that the parent or legal guardian cannot provide express and informed consent, the basis for that determination must be recorded in the Medical Report. In any case the DCM shall consult with the prescribing physician within one (1) business day of being notified that the parent or legal guardian will not provide express and informed consent or is found by the prescribing physician to lack the ability to provide express and informed consent.

a. If, after considering the parent or legal guardian's position, the prescribing physician chooses to revise the recommended treatment, the prescribing physician must document this concurrence in section 7 (Supplemental Information) of the Medical Report and no further action by the Department is required.

b. If, after considering the parent's concerns and objections, the prescribing physician determines that the benefits of the medication outweigh the risks of taking the medication, the prescribing physician will provide that justification in the Medical Report and provide the Medical Report to the DCM. The DCM shall provide CLS with the physician's Medical Report which must contain the information necessary to inform the court that psychotropic medication has been recommended but not authorized; the reasons the parent or legal guardian did not authorize the provision of the medication, and the prescribing physician's position regarding the need to administer the medication. CLS shall file a motion to authorize medication within two (2) business days of receipt of the Medical Report from the DCM. Court authorization must occur before the psychotropic medication is administered to the child.

3-12. Parent or Legal Guardian Rights Terminated or Parent or Legal Guardian Refuses to Participate or Parent or Legal Guardian Location or Identity Unknown. Whenever the parent or legal guardian rights have been terminated or the parent or legal guardian's location or identity is unknown or cannot reasonably be ascertained, the Department must seek court approval for the administration of psychotropic medication.

a. The DCM or CPI must obtain from the prescribing physician the completed Medical Report.

b. Within three (3) business days of receiving the Medical Report from the prescribing physician, the DCM or CPI must submit the Medical Report and other documentation to CLS, with a request for court authorization to administer the prescribed medication.

c. CLS must file a motion in court that will allow the court to "hear" the request and upon consideration of the facts, circumstances, and law, authorize the provision of the medication. Court authorization must occur before the psychotropic medication is administered to the child.

3-13. Emergency Administration of Psychotropic Medication. Psychotropic medications may be administered without a court order or parental express and informed consent when the child is admitted to any hospital, Crisis Stabilization Unit (CSU), or SIPP.

a. Within three (3) business days after the medication is initiated, a motion for court authorization must be filed by CLS.

b. To ensure CLS has sufficient information for the motion, the DCM or CPI must obtain the Medical Report signed by a prescribing physician in the facility, and provide this to CLS, within two (2) business days after the medication is initiated.

c. The DCM or CPI shall follow the procedures outlined in this operating procedure to assist the physician to obtain the express and informed consent of the child's parent.

d. Psychotropic medications may also be administered without a court order or parental express and informed consent when the child's prescribing physician certifies, in section 5 (Certification of Significant Harm) of the Medical Report, that delay in providing the prescribed psychotropic medication would more likely than not cause significant harm to the child.

(1) In this situation, the Medical Report must provide the specific reasons why the child may experience significant harm and the nature and extent of the potential harm.

(2) Within three (3) business days after administration of the medication begins or resumes, the DCM must obtain parental authorization or CLS must file a motion requesting court authorization.

(3) Copies of the Medical Report shall be provided by CLS or the DCM to the court, the child's GAL, and all other parties within three (3) business days after the Department begins providing the medication to the child.

(4) CLS shall submit a motion to the court within three (3) business days of initiation of the medication and shall schedule the motion to be heard at the next regularly scheduled court hearing, or within 30 calendar days after the date of the prescription, whichever occurs sooner.

(5) If any party files a written objection to the Department's motion, CLS shall request a hearing within seven (7) calendar days.

3-14. Medication Administration and Monitoring. The responsibility for administering authorized psychotropic medication primarily lies with the child's caregiver. Monitoring is a shared responsibility.

a. Psychotropic medications will be administered by the child's caregivers or other appropriate persons as directed (e.g., school official) and allowed under normalcy provisions. 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 on the following:

(1) The method of administering the medication;

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

(3) Drug-interaction precautions;

(4) Possible side effects of stopping the medication; and,

(5) How medication administration will be supervised by the caregiver.

b. The child's caregiver must keep current medical records of a child in out-of-home care. The records must include:

(1) Medical appointments for the child in out-of-home care;

(2) Medical appointment follow-up reports provided to the child's caregiver;

(3) Any immunization records obtained while in the care of the child's caregiver;

(4) A record of all prescribed medications administered to the child in out-of-home care; and,

(5) Caregivers must keep a current medication log on a form provided by the Department or its contracted service provider. MFC parents shall maintain the MFC Medication Logs as required by the MFC program instead, for MFC children. The medication log record must include all medications administered to the child in out-of-home care and must include:

(a) The name of the child in out-of-home care;

(b) The brand or generic name of the medication, including the prescribed dosage and prescribed dosage administration schedule;

(c) Times and dates of administration or monitored self-administration of the medication; and,

(d) The name or initials of the caregiver administering the medication or monitoring the self-administration.

c. The caregiver must give completed medication logs or a copy of the MFC Medication Logs for MFC children to the DCM at the end of each month. This must include logs of all medication administered to the child at school or in settings other than the caregiver's home.

d. The caregiver must keep all psychotropic medications properly stored and must:

(1) Ensure the psychotropic medication log specifies the prescribing physician's order for the administration of the psychotropic medication; and,

(2) Ensure the psychotropic medication is kept in locked storage and stored as prescribed. Psychotropic medication requiring refrigeration must be kept under refrigeration in a locked box.

e. The child's caregiver may not discontinue, change, or otherwise alter the prescribed administration of a psychotropic medication for a child in out-of-home care without direction from the prescribing physician.

f. The caregiver may not use alternative medications intended to alter or affect mood or behavior, such as herbals or homeopathic remedies, without direction and supervision of the prescribing physician of the child in out-of-home care.

g. The DCM or other designee will attend medication reviews as requested by the prescribing physician and/or agency. The child and their caregiver should also attend all medication reviews. If the child's caregiver cannot attend the DCM will ensure the child's attendance.

h. The caregiver administering the psychotropic medication must have received training (see paragraph j below) on medication management, to include the reporting of serious adverse reactions to medications, and will record the administration of these medications when given.

i. The DCM or CPI is responsible for implementing the medication plan developed by the prescribing physician and for ensuring that the child's caregiver is following the protocol for administration of the medication. The DCM or CPI will arrange for any additional medical evaluations and laboratory tests required, and report the results to CLS and the prescribing physician.

j. The DCM or CPI shall ensure that the child's caregiver is provided information about proper medication management and documentation techniques, including the possible side effects, risks, contraindications of the medication, and drug interaction precautions; how to monitor for the side effects and report any problems, such as serious adverse effects of the medication, to the prescribing physician.

k. The Department or its contracted service providers will develop locally approved medication log format for documenting the administration of psychotropic medications.

l. The Lead Agency or its contracted service provider must provide medication management training to caregivers or ensure that it has been provided. In unusual situations, the DCM or CPI who has received psychotropic medication training may also administer these medications and will be responsible for documenting the administration of the medication and the circumstances that resulted in them administrating the medication.

m. The monitoring of the use of psychotropic medication by children should be a joint responsibility among the physician, caregiver, and DCM or CPI, and the DCM or CPI supervisor. Any person with information that calls into question the child's health and safety shall immediately bring that information to the attention of the prescribing physician and CPI's or DCM's immediate supervisor, and emergency services arranged as appropriate to protect the child's safety and well-being. This information shall be provided to CLS, the court, reported through the incident reporting system, and provided to all parties within three (3) business days of the reported concerns.

n. The DCM or CPI, the supervisor, and the caregiver have joint responsibility to assure the physician's monitoring plan as documented in section 3 (Diagnosed Conditions, Symptoms, Behaviors), and elsewhere in the Medical Report, is implemented.

o. DCM supervisors and CPI supervisors shall provide ongoing review and oversight of children prescribed psychotropic medications.

p. The DCM must review the child's psychotropic medication plan with the supervisor, or other agency designee, when any of the following circumstances become known:

(1) A child under six years of age has been prescribed a psychotropic medication;

(2) More than three psychotropic medications are administered to a child in out-of-home care; or,

(3) ***More than one psychotropic medication*** is being administered from one of the following classifications of psychotropic medication:

(a) Stimulants;

(b) Mood stabilizers;

(c) Anti-depressants;

(d) Anti-anxiety; or,

(e) Anti-psychotics.

q. After the review required in paragraph p above, when advised by their supervisor, the DCM or CPI supervisor will:

(1) Consult with the prescribing physician to obtain additional information; or,

(2) Request a second opinion regarding a child on psychotropic medication; or,

(3) Consult with the MedConsult Line as described in paragraph 3-20 of this operating procedure.

r. The DCM or CPI will assure that the diagnosed condition of the child in out-of-home care and the effects of the administration of psychotropic medication are routinely reviewed and monitored by the prescribing physician.

s. The DCM or CPI will report to the prescribing physician when the condition of the child in out-of-home care is not improving or is deteriorating.

t. The DCM or CPI will request and receive updated health information on the child in out-of-home care and effects of the prescribed psychotropic medication therapy from the caregiver during the required 30 day contact with the substitute caregiver.

u. The DCM or CPI will receive and review each month the medication log of the child in out-of-home care and file a copy in the medical section of the CRR.

v. The DCM or CPI will document the review and actions taken subsequent to the review required in paragraph q above and all consultation notes in FSFN case notes.

3-15. Request for Second Opinion. A second opinion by another physician may be sought under certain circumstances, or may be ordered by the court.

a. The DCM or CPI may seek a second medical opinion at any time after consultation with a supervisor as to the need for a second opinion.

b. When any party files a motion requesting that the court order a second medical opinion, the court may require the Department or its contracted service provider to obtain a second opinion within a reasonable timeframe as established by the court. Within one (1) business day of the court's order, the DCM or CPI will make an appointment for the second opinion. The appointed time of the second opinion will depend on availability of the physician from whom the second opinion is requested.

c. The DCM or CPI must obtain the second opinion within 21 calendar days of receipt of the court order. If the second opinion is not obtained within the required timeframes, the reasons for the delay must be reported to the court and all parties.

3-16. Supervisor Reviews for Child Protective Investigations.

a. Existing policy requires supervisors to review CPI activities at various stages of an investigation. This includes review within 72 hours of the initial child safety assessment, monthly review as long as the investigation remains open, and review upon submission for closure. During the review, the supervisor must assess documentation regarding consultation with CLS as appropriate, and referral for behavioral health assessment as needed.

b. The Regional Quality Management Model requires that supervisors conduct three qualitative discussions with each CPI every month, documenting that the discussion occurred and the basic

content of the discussion in FSFN case notes. This review includes a discussion of psychotropic medications and documentation of Informed Consent and/or a court order authorizing this treatment.

3-17. Supervisor Reviews for Dependency Case Management.

a. At a minimum, existing policy requires DCM supervisors review all open cases in their units on a quarterly basis.

b. The Regional Quality Management Model requires that supervisors facilitate a qualitative discussion with the DCM to assure needed safe guards and services are in place and casework activity is moving the child toward an appropriate safe and permanent living arrangement. For mental health well-being, the supervisor must discuss the following questions with the DCM.

(1) Have you observed or been made aware of any behavioral or physical indicators that the child is not thriving or is in a potentially dangerous living arrangement? Is the child receiving physical, mental and dental health services as needed? Is the child enrolled in Medicaid or another health insurance program?

(2) Did the child receive a Child Health Check-Up (medical diagnostic screening previously known as an Early Periodic Screening, Diagnosis, and Treatment [EPSDT]) and is the child receiving the required follow up? Does the record reflect we have up-to-date medical information and has that information been shared with the caregivers?

(3) Are there any substance abuse, developmental or mental health issues? Is the child on psychotropic medications, and if so, are they appropriately documented in FSFN? Is the Informed Consent current and/or is the court order authorizing treatments maintained in the record?

(4) Was a child specific multi-disciplinary staffing held to address the child's developmental, emotional, behavioral, educational and health care status? Are the prescribed services being delivered; if so, are they effective?

3-18. Training.

a. The caregiver administering the psychotropic medication as well as the DCM must receive training from the Lead Agency or a contracted provider on medication management and administration.

b. The Department and its contracted service providers shall develop a standardized curriculum that will be used to train staff and foster parents on medication administration and management. This training will include a three part training approach that includes:

(1) A one hour foundational web-based tutorial,

(2) A more in-depth three hour training, and,

(3) Ongoing review of medication management techniques.

3-19. Florida Safe Families Network (FSFN) Documentation. Screens are available in the Department's automated system for child welfare case information, FSFN, for the proper documentation of all behavioral and physical health information.

a. There are four tabs in FSFN that must be used by DCMs or CPIs to enter all behavioral and physical health information in FSFN.

(1) FSFN Medical Profile. The first tab is the Medical Profile which requires details about the child's Primary Health Care Provider(s) such as name, address, phone number, etc. Note that other health care status information is also entered here, including any known health problems, allergies, immunization status, the child's Medicaid number, etc.

(2) FSFN Medications. On the Medications tab, all prescribed medications must be entered into the system and are summarized here, even if they have since been discontinued. Information to be entered includes name of medication, whether it is prescribed for psychotropic purposes, quantities and dosages, precautions, warnings, and additional instructions. For each psychotropic medication the date that express and informed parental consent or a court order was obtained must also be entered. Note that all medications that are defined as a psychotropic medication, regardless of the medical use, will be considered a psychotropic medication for documentation purposes in FSFN.

(3) FSFN Mental Health Profile. The Mental Health Profile tab is used to record the date of the most recent CBHA evaluation and details about the referral; information about any Axis I or Axis II diagnoses that have been made must also be entered. Document one or more diagnoses made by a health care provider that describes the child's mental/behavioral health condition, as well as caregiver information provided at time of intake (i.e. Emotionally Disturbed, Learning Disability, Physically Disabled, Drug or Alcohol Abuse, etc.).

(4) FSFN Medical History. The Medical History tab is used to document all health-related services provided to the child, particularly initial Child Health Checkup and all subsequent visits with health care providers, including dates, provider information, procedures, diagnoses, and treatment information. Descriptions of treatments should be provided (physical treatment or other types such as counseling or other mental health therapies) as well as other information such as whether or not the visit was for monitoring of medication effect, symptom relief progress, if X-rays were taken, etc.

b. All details about prescribed psychotropic medications, and other updates, including all actions taken by the purposes, will be entered in FSFN by the purposes in a timely, accurate manner to ensure complete documentation of a child's health history and current status.

(1) The information on medications prescribed will be entered in FSFN within three (3) business days of beginning the medication, based on information provided to the DCM or CPI by the prescribing physician responsible for the child's treatment.

(2) Any absence of parental express and informed consent or court order shall be explained, along with the deadline for securing the necessary post-administration court authorization. Updates, including changes in dosage or physician prescribed cessation of the medication, shall also be recorded within three (3) business days.

(3) All behavioral health actions taken by the DCM, CPI, and CLS will be entered in FSFN within three (3) business days of the action. This includes the information contained in the Medical Report (CF-FSP 5339), as well as receipt of the parental authorization or court order approving the medication.

(4) Critical data elements relating specifically to psychotropic medication include but are not limited to:

(a) Medication name, dosage prescribed, and number of refills;

(b) Prescribing physician or other authorized health care provider;

(c) Whether the medication is being used as a psychotropic medication;

(d) All medications defined as psychotropic medications regardless of whether it is prescribed for a medical or mental health reason, will have the drop down box "is Medication for Psychotropic Reasons" checked;

(e) Whether express and informed consent was provided, and the date provided;

(f) Whether a court order was required, and the date of any court order;

(g) Why the medication was prescribed, and the target symptoms or condition to be addressed;

(h) All Axis I and Axis II diagnoses for behavioral health disorders that have been given, if applicable;

(i) Date medication was prescribed and date stopped;

(j) Occurrence of and date of the initial Child Health Checkup;

(k) Occurrence of and date of the most recent CBHA; and,

(l) Other comments about important information, such as instructions for administering the medication, other behavioral health treatments provided the child, or potentially harmful side effects or precautions that caregivers need to be aware of.

(5) The Axis I and II drop down boxes on the Mental Health Profile tab must be utilized for all diagnoses for prescribed psychotropic medications. Axis I defines which mental health diagnosis the prescribing physician is treating. The drop down box will allow identification of all diagnoses given. Axis II defines which personality or developmental disability diagnosis the prescribing physician is treating.

(6) All other diagnoses provided should be placed in the text box provided on the Medical History tab. These diagnoses include Axis III General Medical Conditions; Axis IV Psychosocial and Environmental Problems; and Axis V Global Assessment of Functioning.

c. No Empty Fields in FSFN. While the FSFN system does not force users to complete every data field, every field pertaining to psychotropic medications must be completed. No field pertaining to psychotropic medication should ever be left empty, even if the system does not force the user to complete it. Therefore, if the child welfare professional entering the data in FSFN does not have the information needed to complete a field, then s/he must get the information.

3-20. Use of the MedConsult Line Program.

a. The MedConsult Line is a statewide contract to provide 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). Use of this service is voluntary for all requesting parties.

b. The MedConsult Line service is available to any prescribing physician, CPI, DCM, parent (unless parental rights have been terminated), foster parent, youth, relative/non-relative caregiver, GAL, judge, parent of a child enrolled in the BNET or the BNET Liaison who is working with a child in out-of-home care or enrolled in BNET. The MedConsult line is not a second medical opinion.

3-21. Prohibition on Participating in Clinical Trials. At no time shall a child in the custody of the Department be allowed to participate in a clinical trial that is designed to develop new psychotropic medications or evaluate the suitability of providing medications previously approved for adults to children. This paragraph does not preclude research that evaluates the consequences of administration of psychotropic medications to children in state care.

3-22. Forms. The following forms are referenced in this chapter, and are available in DCF Forms:

a. Medical Report for Prescribing Psychotropic Medication to a Child in Out-of-Home Care (CF-FSP 5339).

b. Psychotropic Medication Informed Consent Facilitation (CF-FSP 5228).

c. Psychiatric Evaluation Referral (CF-FSP 5341).

d. Emergency Intake (CF-FSP 5314).

Chapter 4

RESIDENTIAL MENTAL HEALTH TREATMENT

(superseded by CFOP 170-11, Chapter 5)

Definition of Terms

“Assent” when used in this Operating Procedure means 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.

“Authorization for Psychotropic Medication Treatment.”

(1) A person who has the power to authorize medical treatment, which includes providing express and informed consent for a child to receive psychotropic medication, as provided by law includes a birth parent if their parental rights remain intact or adoptive parent or a legal guardian.

(2) If a child does not have a birth parent whose parental rights are intact, or adoptive parent or a legal guardian, whose identity or location is known, authorization to treat with psychotropic medication must be pursued through a court order.

“Behavioral Health Assessment” includes both Comprehensive Behavioral Health Assessments as defined by the Medicaid Community Mental Health Services Coverage and Limitations Handbook and all other assessments performed by mental health professionals.

“Behavioral Health Network (BNET)” is the statewide network of Providers of Behavioral Health Services who serve non-Medicaid eligible children with mental or substance-related disorders who are determined eligible for the Title XXI part of the KidCare Program.

“Caregiver” means, for purpose of this Operating Procedure, 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.

“Chemical Restraint” means the use of medication as a restraint to control behavior or restrict freedom of movement that is not an accepted treatment for the person’s medical or physical condition.

“Child & Adolescent Needs and Strengths (CANS)” is an assessment tool developed to assist in determining the need and level of intensity and duration of mental health services.

“Children’s Legal Services (CLS)” means a statewide law firm focusing on children’s issues within the Department of Children and Families.

“Child Protective Investigator (CPI)” means an authorized agent in a professional position within the Department or designated sheriff’s office with the authority and responsibility of investigating reports of child abuse, neglect, or abandonment received by the Florida Abuse Hotline as defined in s. 39.01(62), F.S.

“Child Specific Multidisciplinary Team (CSMDT) sometimes referred to as a multidisciplinary team” is a group of people who have child specific information and come together to plan and coordinate mental health and related services to meet the needs of the child in the most appropriate, least restrictive setting in the community. Members of the team should include: the child, unless clinically contraindicated; the child’s parent or legal guardian and other caregiver, such as the foster parent; the dependency case manager; the child’s therapist and/or behavior analyst; a representative from the school district and/or the child’s Individual Education Plan (IEP) surrogate and others who may have information or services to offer for the child’s service plan.

“Comprehensive Behavioral Health Assessment (CBHA)” as further defined in the Medicaid Community Behavioral Health Services Coverage and Limitations Handbook, section 2, means an in-depth, detailed assessment of the child’s emotional, social, behavioral, and developmental functioning within the home, school, community, and clinical setting including direct observation of the child in those settings.

“Department” means the Department of Children and Family Services.

“Dependency Case Manager (DCM)” means the individual who is accountable for service delivery regarding safety, permanency, and well-being for a caseload of children in out-of-home care.

“Dependency Case Plan” means “case plan” as defined in s. 39.01(11), F.S., which refers to the services plan jointly developed between the family and dependency case worker delineating specific interventions aimed at addressing the contributing factors and underlying conditions that lead to child maltreatment.

“Designee” is a person, contractual provider or other agency or entity named by the Department to perform duties assigned by the Department.

“Emergency Medical Care or Treatment” means care or treatment for injury or acute illness, disease or condition, delay of which, within a reasonable degree of medical certainty, would endanger the health or physical well-being of the patient.

“Express and Informed Consent” means, for the purposes of this operating procedure, 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 but is not limited to the following information, provided and explained in plain language by the prescribing physician 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.

“Extraordinary Medical Care and Treatment” means care or treatment of a child that is outside of the routine medical and dental care included in the definition of “Ordinary Medical Care and Treatment.” This includes surgery, anesthesia, administration of psychotropic medications, and any other procedures not considered routine and ordinary by objective professional standards for medical care for children.

“Florida Safe Families Network (FSFN)” is the State Automated Child Welfare Information System (SACWIS) for the state of Florida. FSFN is the electronic system of record for each case. It contains information regarding a particular child and his or her family.

“Guardian ad Litem (GAL)” is defined in s. 39.820(1), F.S., to include the following: a certified guardian ad litem program, duly certified volunteer, staff attorney, contract attorney, or certified pro bono attorney working on behalf of a guardian ad litem or the program; staff members of a guardian ad litem program office; a court-appointed attorney; or a responsible adult who is appointed by the court to represent the best interests of a child in a proceeding as provided for by law, including, but not limited to, Chapter 39, F.S., who is a party to any judicial proceeding as a representative of the child, and who serves until discharged by the court.

“Independent Review” means an assessment by a Qualified Evaluator that includes a personal examination and assessment of the child in residential treatment. The assessment includes evaluation of the child’s progress toward achieving the goals and objectives of the treatment plan, which must be submitted to the court.

“Lead Agency” means the not-for-profit or governmental community-based care provider responsible for the provision of support and services for eligible children and their families who have been abused, abandoned, or neglected.

“Least Restrictive” means treatment and conditions of treatment that, separately and in combination, is no more intrusive or restrictive of freedom than reasonably necessary to achieve a substantial therapeutic benefit or to protect the child or others from physical injury.

“Legal Guardian” means a permanent guardian as described in s. 39.6221, F.S., or a "guardian" as defined in s. 744.102, F.S., or a relative with a court order of temporary custody under Chapter 751, F.S. Dependency case managers and Guardians ad Litem do not meet the definition of guardian.

“Licensed Health Care Professional” means a physician licensed under Chapter 458, F.S., an osteopathic physician licensed under Chapter 459, F.S., a nurse licensed under Chapter 464, F.S., a physician assistant certified under Chapters 458 or 459, F.S., or a dentist licensed under Chapter 466, F.S.

“Medical Foster Care (MFC)” is a coordinated effort between the Florida Medicaid Program in the Agency for Health Care Administration, Children's Medical Services in the Department of Health, and the Child Welfare and Community Based Care Program in the Department of Children and Families. Medical Foster Care delivers family-based care for medically complex and medically fragile children who are in shelter care or foster care who cannot safely receive care in their own homes. Medical Foster Care is a cost-effective alternative to long term hospitalization, private duty nursing, or skilled nursing facility placement.

“Medical Report” means a report prepared by the prescribing physician that includes information required by s. 39.407(3)(c), F.S. The form for the Medical Report is “Medical Report” (form CF-FSP 5339, available in DCF Forms), which is hereby incorporated by reference and is available by contacting the Family Safety Program Office at 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700, or at http://www.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx.

“Mental Health Case Manager (also known as a targeted case manager or TCM)” refers to the person assigned to assist the child in gaining access to and coordinate the needed mental health and related services, including co-occurring substance abuse treatment services, and to work with the child, the Department, and the child’s natural support system to develop and implement the service plan. For purposes of this operating procedure, the term “mental health case manager” is used regardless of whether case management is funded under Medicaid or another funding source.

“Ordinary Medical Care and Treatment” means ordinary and necessary medical and dental examinations and treatments. Included in this definition are blood testing, preventive care including ordinary immunizations, tuberculin testing, and well-child care. This does not include surgery, general anesthesia, provision of psychotropic medications, any invasive procedures or other extraordinary medical care and treatment as defined in this operating procedure. (s. 743.0645(1)(b), F.S.)

“Out-of-Home Care” means the placement of a child, arranged and supervised by the Department or its agent, outside the home of the child’s custodial parent or legal guardian. This includes placement in licensed shelter, foster home, group home, Residential Treatment Center (including SIPP funded centers), and non-licensed relative/non-relative settings.

“Out-of-Home Services” is the array of services provided to children and their families or caregivers for children who reside in placements other than their home.

“Person Who Has The Power To Consent As Otherwise Provided By Law” includes a biological or adoptive parent, as long as their parental rights are still intact, or legal guardian, or any other person specifically granted the power of consent by court order.

“Point of Contact (POC) also known in some areas as the Single Point of Access or SPOA” means the person or entity designated by the Circuit’s SAMH Program Office or the Lead Agency as the central point of contact within a specific geographical area for assisting the dependency case managers in accessing mental health services for children in out-of-home settings, including the Child Welfare Prepaid Mental Health Plan where available.

“Prescribing Physician” is a physician licensed under Chapters 458 or 459, F.S.

“Psychotropic Medication” as used in this policy means, any chemical substance prescribed with the intent to treat: psychiatric disorders, and those substances, which though prescribed with the intent to treat other medical conditions, have the effect of altering brain chemistry or involve any if the medications in the categories listed below. The medications include, without limitation, the following major categories:

(a) Antipsychotics;
(b) Antidepressants;
(c) Sedative Hypnotics;
(d) Lithium;
(e) Stimulants;
(f) Non-stimulant Attention Deficit Hyperactivity Disorder medications;
(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” means a psychiatrist or a psychologist licensed in Florida who has at least three (3) years experience in the diagnosis and treatment of serious emotional disturbances in children and who has no actual or perceived conflict of interest with any inpatient facility or residential treatment center. A Qualified Evaluator is appointed by Agency for Health Care Administration (AHCA) to determine children’s suitability for residential treatment, per s. 39.407, F.S.

“Qualified Medical Practitioner” means a physician licensed under Chapters 458 or 459, F.S., or an advanced registered nurse practitioner licensed under Chapter 464, F.S.

“Residential Treatment Center” means a 24 hour residential program which provides mental health services to emotionally disturbed children or adolescents as defined in s. 394.492(5) or (6), F.S., that is licensed by the AHCA.

“Resource Record” means 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 Chapters 65C-30.001(24) and 65C-30.011(4)-(6), F.A.C.

“Serious Adverse Event” means any undesirable experience associated with the use of a medical product in a patient. The event is serious and should be reported to the Food and Drug Administration's (FDA) MedWatch program when the use of the medications outcome for the patient is: Death, Life-Threatening, Hospitalization (initial or prolonged), Disability, Congenital Anomaly, or Requires Intervention to Prevent Permanent Impairment or Damage.
http://www.fda.gov/safety/MedWatch/default.htm

“Service Plan” is the document developed with the child, the family, and treatment and service program representatives, which addresses the child’s individualized mental health treatment and related service needs, including co-occurring substance abuse needs if indicated, with a goal of maintaining the child in the most inclusive and least restrictive environment possible.

“Statewide Inpatient Psychiatric Program (SIPP)” means those residential mental health treatment programs contracted with the Agency for Health Care Administration (AHCA) to participate in the Institution for Mental Disease (IMD) waiver.

“Suitability Assessment” for residential treatment means a determination by a Qualified Evaluator, who has conducted a personal examination and assessment of the child, that the child meets the criteria for placement in a residential treatment center, pursuant to s. 39.407(6)(c), F.S.

“Therapeutic Group Home” means a 24 hour residential program licensed by AHCA under 65E-9, F.A.C. providing community-based mental health treatment and extensive mental health support services in a homelike setting to no more than 12 children who meet the criteria in s. 394.492(5) or (6), F.S. Unlike the Residential Group Home provider who is licensed to provide Behavioral Health Overlay Services (BHOS) whose primary mission is to provide a living environment, the primary mission of the therapeutic group home is to provide treatment of children and youth with serious emotional disturbances.

“Treatment Plan” is a structured, goal-orientated schedule of services developed jointly by the recipient and the child’s treatment team. The child’s treatment team should consist of individuals with experience and competencies in providing mental health, substance abuse, co-occurring mental health and substance abuse, and developmental disabilities services. The plan must contain written treatment-related goals and measurable objectives.