Gabriel Myers Workgroup
June 18, 2009
Ft. Lauderdale, Florida
Meeting Summary/Minutes

Present: Jim Sewell, Chairman
Bill Janes
Anne Wells
Robin Rosenberg
Rajiv Tandon
Judge John Frusciante, Workgroup Advisor

CALL TO ORDER

The meeting was called to order at 9:22 a.m. Chairman Sewell welcomed the attendees and reminded them of the Secretary's charge to the workgroup, which is to examine three primary issues: (1) the instant case involving Gabriel Myers; (2) the use of psychotropic medication in the foster care system; and (3) child-on-child sexual abuse. He advised that it is the intent of the workgroup to concentrate on the first two issues and have a report prepared prior to the next meeting of the Task Force on Fostering Success, which is scheduled for late August. Child-on-child sexual abuse will be addressed separately.

Chairman Sewell introduced Ron Moffett, Southeast Region Program Director for the Department of Children and Families, who welcomed attendees on behalf of Regional Director Jack Moss and the Southeast Region team and community.

WORKGROUP INTRODUCTIONS

At Chairman Sewell's request, the workgroup members introduced themselves to the audience.

UPDATE ON DATA VALIDATION PROJECT/QUALITY ASSURANCE

David Daniels, Department of Children and Families, Family Safety Program Office, provided a presentation on the Special Quality Assurance Review and an update on the data validation project.

Mr. Daniels advised that Secretary Sheldon ordered a special quality assurance review of all children, beginning with the cohort of five and under, in out-of-home care who are prescribed psychotropic medications. The review team consisted of representatives from Children's Legal Services, Department of Children and Families' Quality Assurance, and community based care Quality Assurance. The team reviewed 112 cases in this first cohort in a three-day period. The purpose of the review was to assess compliance with s. 39.407, Florida Statutes; 65C-28.016, Florida Administrative Code; and DCF Operating Procedure 175-98, and determine the validity and reliability of the data contained in Florida Safe Families Network (FSFN). The Department's central office produced a tool for the review team to use when reviewing the files,

along with a set of guidelines for use in completing the tool. A web-based process for collecting the data was also developed.

Mr. Daniels advised that the key findings of the review included:

- 67 percent of the 112 children reviewed had a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD);
- parental rights were terminated in 41 of the cases (37 percent);
- 78 (70 percent) of the cases had no documentation to support that the case manager coordinated with the prescribing practitioner to obtain a psychiatric evaluation for the child;
- the case manager did not fax the pre-consent treatment plan to the contracted consultant psychiatrist within one business day as required by operating procedure in 110 cases (98 percent);
- a review and consultation between the prescribing practitioner and the contracted consultant psychiatrist did not occur in 109 cases (97 percent) as required by operating procedure;
- the prescribing practitioner did not complete the pre-consent Psychotherapeutic Medication Treatment Plan Review (as required by operating procedure) and the Psychotherapeutic Treatment Plan form (as required by Florida Administrative Code) in 83 cases (74 percent), and in 22 cases (20 percent) the date of the office visit was not the same as the practitioner's signature date;
- informed consent or a court order was absent in 50 cases (45 percent);
- supervisory discussions with case managers regarding the child's health care and behavioral health care were not documented in 80 cases (71 percent); and
- data in FSFN were not accurate in 82 cases (73 percent).

Mr. Daniels also shared and explained charts and graphs contained in his PowerPoint presentation that were developed relating to the review findings.

He closed his presentation with an outline of actions underway from a quality assurance standpoint. Those actions are:

- Cases identified without informed consent or court orders are referred to Children's Legal Services attorneys who are notifying the court that the Department is seeking a valid informed consent or a court order.
- On June 10 the special quality assurance review was extended to the next cohort of children ages 6-7 who are prescribed psychotropic medications. This review includes 281 children and will be completed on June 23.
- Quality assurance teams will begin to review cases of children ages 8-9 who are on psychotropic medications on July 24.
- For all children 0-17, the child's case will be reviewed by quality assurance staff and action taken where deficiencies are noted.
- A validation review will be conducted after the quality assurance process is complete to ensure compliance has been achieved.

Questions/Comments/Discussion:

Colonel Janes noted concern with the high percentage rates and asked for comment from meeting attendees if some of the deficiencies noted in the key findings, especially with regard to the pre-consent process, were a result of the responsible party not being aware of the requirements.

Neiko Shea, Director of Service Coordination for ChildNet, Inc., noted that some children with seizure disorder are prescribed a medication specifically for seizure disorder that can also be prescribed for mental health disorder. She added that there has been some inconsistency in terms of requirements and she feels that, in the past, there has not been an expectation for the pre-consent review in those instances. She also noted that if a child came into care on medication, she did not believe most case managers would perceive that the pre-consent process was necessary.

Dr. Bhagirathy Sahasranamanm, Medical Director for Henderson Mental Health Center, added that perhaps there is some confusion surrounding age 5 when referencing the 0-5 age group. She thinks the general understanding is that you don't need the pre-consent consultation if the child has turned 5. She also noted that physicians other than child psychiatrists are prescribing medication.

Mr. Daniels advised that information on the type of prescribing practitioner and information on if a child came into care on medication are being collected in the next phases of the review.

Gihan Omar, Psychologist and Supervisor at Citrus Health Network, suggested that a possible reason for the high percentage rate with regard to lack of documentation could be due to the documentation being in the medical record but not in the case manager's files. This could be due to something as simple as a fax not transmitting.

Perry Borman, Department of Children and Families Circuit Administrator for Palm Beach County, pointed out that the turnover of dependency case managers in Palm Beach County for the last fiscal year has been significantly higher than 50 percent. He noted that when you have a revolving front door and training and the tools to support that training are not incorporated into a new dependency case manager or case management training, you are always going to be three steps behind.

Michelle Montero, Director of Clinical Services for Our Kids of Miami and Monroe, noted that there will be cases where other physicians are prescribing. In those cases, a psychiatric assessment is not submitted.

Mr. Daniels asked that the workgroup also keep in mind that some of the medications were prescribed for non-psychiatric reasons.

Colonel Janes expressed concern with the lack of documentation of supervisory discussions with case managers regarding health care and behavioral health care and asked what might be contributing to the very high percentage. He also expressed concern over the inaccurate data in FSFN and asked what might be contributing factors.

Christine Butler with ChildNet responded that, in part in FSFN, as it relates to medication as a whole, clarification is needed, in so far as what terms mean and what is the expectation for standardization so there is meaningful data that can be measured equally.

Chairman Sewell inquired if within one business day of the child's appointment with the prescribing practitioner is a reasonable period of time for the case manager to fax the completed Psychotropic Medication Treatment Plan to the contracted consultant psychiatrist.

Dr. Sahasranamanm responded that this time frame can present difficulty for various reasons including that the smaller agencies that have contracted consulting psychiatrists probably have them coming once or twice a month or for a few hours, the prescribing practitioner may be waiting for additional information and doing further assessment before making a decision to prescribe the medication, and other general communication related issues.

Dr. Sewell suggested that perhaps clarification is needed on if the clock starts on the one day requirement on the day the prescribing practitioner first sees the child or on the day assessment is completed and medication is prescribed.

Judge Frusciante added that his understanding is that the material the doctor needs to be evaluating should be in his/her hands prior to seeing the child for assessment, which does not always occur. He added that he does not know in practice how many doctors are seeing a child one day and waiting to look at some record in the future before prescribing medication.

UPDATE ON BROWARD AGENCIES PERFORMANCE IMPROVEMENT PLAN

Kim Welles, Department of Children and Families Southeast Region Family Safety Program Manager, provided a PowerPoint presentation and discussed some of the highlights of the Broward Community Action Plan developed as a result of the death of Gabriel Myers.

She noted that the last time the workgroup met in Ft. Lauderdale, she had advised that the Broward agencies had decided as a community to develop a local community action plan demonstrating their collaboration and commitment to working on issues within their own community.

Ms. Welles began her presentation by saying that the tragic death of Gabriel Myers highlighted for the Broward County child welfare community the need to improve practice and communication. Their goal is to strengthen the safety net for children in out-of-home care who have mental health or behavioral needs requiring treatment that includes psychotropic medication. She added that the Community Action Plan will remain a dynamic document driven by practice and communication needs.

She noted that each agency developed short term and long term goals, and began with ChildNet's part of the plan. ChildNet's short term goal is to ensure all children on psychotropic medications have the proper court order or consent; all information in FSFN is current and accurate; and all child advocates and foster parents are trained on psychotropic medications and informed consent.

The long term goal is to work in concert with community mental health providers, Guardian Ad Litem, the judiciary, officers of the court, foster parents and other residential providers to improve the mental health safety net for children.

Ms. Welles continued that the first Identified Area/Issue under the plan is to ensure understanding of the use of psychotropic medications for children. She added that ChildNet has scheduled seven trainings regarding psychotropic medication, symptoms, behaviors, informed consent, and ensuring safe and effective use of such medication. This training will be extended to community members, child placing agencies, Guardian Ad Litem, Office of the Attorney General, and Broward County Sheriff's Office. She also noted that once the Department of Children and Families updates the psychotropic medications booklet, it will be distributed to relative caregivers.

The second Identified Area/Issue is to ensure the ChildNet policies and procedures regarding psychotropic medications are current and accurate and staff is trained in the application and provide sufficient oversight to ensure adherence. Ms. Welles advised that ChildNet had appropriate policies in place that were updated when the 2005 legislative change was implemented. They are currently drafting updates, which cannot be finalized until the revised state requirements and documents are available.

Questions/Comments/Discussion

Colonel Janes advised caution in developing psychotropic medication training and suggested that consideration be given statewide to what a case manager needs to know about psychotropic medication, what a judge needs to know, what the players in the system need to know, etc.

Ms. Shea responded that some of the training will involve an overview of psychotropic medication just so there is an understanding of the general types of medications, why they are used, and black box warnings. The training will also cover informed consent, and there will be in-service training with ChildNet case workers so they are up to date on the most current requirements.

Ms. Welles continued with the presentation noting that communication has been a consistent theme and that there are inherent challenges in the communication field. Every agency is trying to focus on how to communicate more efficiently and effectively. Ms. Welles advised that the Broward community has talked about setting up better team approaches so there is a shared responsibility.

Ms. Welles advised that one action ChildNet will take is to coordinate a process for conducting a multi-disciplinary staffing for every child prescribed a psychotropic medication.

The next Identified Area/Issue in the ChildNet plan is to ensure the parent and/or court is provided with information for all psychotropic medications as well as non-psychotropic medications prescribed for psychiatric issues. ChildNet plans to modify its psychotropic medication policy and ensure staff attends Children's Legal Services training regarding informed consent.

The next Identified Area/Issue is to improve communication regarding children prescribed psychotropic medication. Some actions being taken include developing a form for stakeholders to document their concerns regarding medication. A single point of access will be used to facilitate resolution. The ChildNet contract specialists will continue to work with all the community providers to look at expectations for their training. Staff rosters will be updated and provided to all system of care partners. ChildNet will create a fact sheet for the Child Resource Record to enable stakeholders to be aware of all treatment professionals working with the child.

Ms. Welles continued that the next Identified Area/Issue indicates that ChildNet will ensure the accuracy of FSFN data related to psychotropic medication. ChildNet will provide their site directors and assistant site directors with a weekly report of children on psychotropic medication. The site directors will also select a sample of 10 children from the list and will conduct a validation review.

The next Identified Area/Issue of the plan involves ensuring that child and adolescent psychiatrists, to whom ChildNet regularly refers children for outpatient psychiatric treatment, are advised of Florida Statutes, Administrative Code, ChildNet policies and procedures, and the overall court process as it relates to psychotropic medication and informed consent. Ms. Welles continued that ChildNet will provide an additional segment of the ChildNet/Office of the Attorney General Roundtable directed to physicians providing outpatient psychiatric treatment to children in out-of-home care.

Ms. Welles continued that the next Identified Area/Issue is to enhance awareness of Florida Statutes related to shelter hearings. ChildNet legal staff will partner with Children's Legal Services and the Department of Children and Families to modify the current shelter order to be reflective of the criteria of 39.407(3)(b)3, F.S., including the FSFN shelter order. Requirements of the modified order and FSFN will be incorporated and trained.

The final Identified Area/Issue is that ChildNet will ensure foster parents receive a cross section of training annually so their knowledge base remains current. ChildNet will require an additional 4 hours of training over the mandated 8.

Following a brief break, the workgroup reconvened and moved to the next agenda item before returning to the Community Action Plan presentation.

MY EXPERIENCE AS A CHILD IN THE FOSTER CARE SYSTEM

Two former foster care youth were invited to share their stories and experience in the foster care system with the workgroup members.

Mez Pierre is a member of the Florida Youth Shine team and was the first former foster care youth to speak. Mez was five years old when he entered the foster care system. He advised that during his time in foster care, he was referred to as one of the worst children and was prescribed medication for bipolar disorder and other behavior issues. He added that he was prescribed a

particular medication that resulted in hospitalization due to medical issues caused by the medication. He added that he was never taken off the medication while in foster care.

Mez said that when he entered the foster care system, he was hurt and confused and went from placement to placement. He ended up in a homeless shelter at 18 years old. He continued that, in spite of negative events that occurred during his life, he now stands as an advocate for youth in the system and has lobbied with the Governor in Washington. He added that what he needed wasn't medication. What it took for him was one person to acknowledge him. He is now 22 years old and in college. He has a team of people who push him and believe in him, and he said that care, love, and nurture changed his life. Mez encouraged meeting attendees to work together as a team to ensure a successful future for foster care youth.

Kimberly Foster was the second former foster youth to address the workgroup. Kimberly is a 25 year old mother, student, and advocate. She was in the foster care system from ages 8-18, most of which was spent in long term locked facilities, mental health facilities, because she was displaying behaviors that were considered inappropriate for regular foster homes.

Kimberly shared that the message she got from foster care was that if you go into the system because your parents did something wrong, the system then punishes you for how you react to what happened to you. She felt like she was given medication for behaviors that were normal given her circumstances. She was never off medication during her time in foster care. At 18, Kimberly signed herself out of her placement against medical advice. She became pregnant and took herself off medication due to possible harm to her unborn fetus. Since that time she has not displayed any type of suicidal ideation, self mutilation, hallucinations, homicidal ideations, or disorientation, nor has she returned to the prescribed medication.

Chairman Sewell thanked Mez and Kimberly for sharing with the workgroup and asked Ms. Welles to continue with the presentation of the Community Action Plans.

UPDATE ON BROWARD AGENCIES PERFORMANCE IMPROVEMENT PLAN

Ms. Welles asked Ellyn Okrent, Chief Operating Office of Kids in Distress to present her agency's action plan.

The short term goal established for Kids In Distress is to understand areas of concern that may have prevented the child death in Circuit 17. The long term goal is to improve the system of care for children in foster care in Circuit 17.

The first Identified Area/Issue involves working to improve communication with child welfare system of care partners by sharing information regarding the care and well-being of children placed in Kids in Distress foster homes. Ms. Okrent indicated that Kids in Distress has and will continue to work in partnership with the lead agency, the Department of Children and Families, and the other providers in the community and will strive to improve communication. In their role as the licensing agency, Kids in Distress will continue to inform ChildNet child advocates of all information regarding children in their care. They will include communication in Model Approach to Partnerships in Parenting (MAPP) classes and teach foster parents to write in their

progress notes and Child Resource Records and to inform staff of issues relating to the children in their care. She added that Kids in Distress will continue to provide immediate response within 24 hours to ChildNet child advocates, which includes, but is not limited to, incident reports.

The second Identified Area/Issue involves providing all foster parents with backup babysitter/caregiver training and providing training specifically for backup babysitters/caregivers.

The third Identified Area/Issue directs that foster parents will make Kids in Distress aware of any changes in household composition or frequent visitors. Ms. Okrent noted that Kids in Distress will continually train, re-train, and conduct in-home visits to address this issue.

The final Identified Area/Issue requires that Kids in Distress licensing staff must have current knowledge of licensing standards according to Chapter 65C-13, FAC. Ms. Okrent advised that licensing staff will be trained and re-trained and will attend ChildNet and Department of Children and Families' trainings on an ongoing basis.

The next section of the Community Action Plan involved Broward Sheriff's Office. The short term goal is that, under the lead of the Margate Police Department, a thorough child institutional death investigation of Gabriel Myers will be completed. The long term goal is a complete joint child death institutional investigation related to Gabriel Myers with outcome findings and recommendations provided to applicable parties at the conclusion of the investigation.

Ms. Welles indicated Margate Police Department considers this an open investigation. It is anticipated that results will be received from the medical examiner in mid July or August.

The Identified Area/Issue directs that Broward Sheriff's Office will investigate all allegations of abuse or neglect that occur in a licensed foster home or residential placement and share the results with other pertinent partners in the system of care. Broward Sheriff's Office will continue to complete investigations of alleged maltreatment in foster homes and residential placements, and, prior to closure, will participate in a multidisciplinary staffing to discuss the investigative findings, recommendations, corrective and any other action as warranted.

The Chrysalis Action Plan was presented next. The short term goal for Chrysalis is to develop a mechanism for tracking communications between multiple agencies working on the same case. The long term goal is to improve service coordination and information sharing between agencies serving the same client. The Identified Area/Issue is to improve communication with other agencies serving the same foster care client. Ms. Welles indicated that the Chrysalis internal development team is developing a formalized system to track communication.

Compass Health Systems' Action Plan includes a short term goal of strengthening their relationship with all their community agencies and a long term goal of continually working with community agencies to improve communication among all levels of providers. The Identified Area/Issue is an understanding of the procedural paperwork and length of time to obtain medication approval for ChildNet cases. Ms. Welles advised that Compass will provide an

education opportunity for their treating clinicians on ChildNet's policies and procedures as they relate to the Florida Statutes and Florida Administrative Code.

Patti Walker, Circuit Director and Southeast Regional Director for the Guardian Ad Litem Program, was introduced to present the Guardian Ad Litem Action Plan. Ms. Walker stated that she takes ownership of the fact that the Guardian Ad Litem Program can do a better job of being part of the checks and balances system, and, to that end, took an intense look internally at what the program does regarding children with severe behavioral issues and children on psychotropic medications.

The short term goal of the program is to implement procedures to ensure that all program children on psychotropic medication are identified for purposes of conducting quarterly internal staffings. The long term goal is to continue to work in partnership with ChildNet to improve case specific communication between the agencies.

Ms. Walker continued that the first Identified Area/Issue was poor communication between front line staff and the Guardian Ad Litem Program regarding crucial case changes (placement changes, medication changes, and involuntary commitments under the Baker Act). The program will meet with ChildNet to develop a protocol to identify and share information on high risk children in care. That protocol has not yet been developed, but is being discussed.

The next Identified Area/Issue was the need for expedient identification of children with severe mental/behavioral health needs that are on psychotropic medications. Ms. Walker added that the program will work diligently to conduct complete file reviews to have internal staffings on all identified children. A monitoring log has also been created for each child who is prescribed medications and will be kept in the child's file.

The next Identified Area/Issue is the need for comprehensive training for staff and volunteers regarding psychotropic medications. Training will be scheduled on a semi-annual basis.

The final Identified Area/Issue is a more in-depth review of all children who are receiving psychotropic medications. Ms. Walker advised that one of the first steps was to include psychotropic medication information as part of their new court report format beginning July 1. In tandem with this report is an advocacy framework review, which is a thorough review of all cases. It is done minimally twice a year.

<u>Questions/Comments/Discussion</u>

Ms. Rosenberg asked if all the foster children in the area on psychotropic medications currently have a Guardian Ad Litem, and, if not, will they at some time in the future.

Ms. Walker responded that the majority of the children currently have a Guardian Ad Litem and that it is a priority to ensure that all children on psychotropic medications have a Guardian Ad Litem in the future.

Ms. Rosenberg suggested that the new court report format developed by the Guardian Ad Litem Program should include information on the child's view or perspective.

Colonel Janes asked if there were any communication issues the workgroup should be sensitive to statewide.

Ms. Walker suggested that it is important to ensure that the community based care agency and the Guardian Ad Litem Program are communicating.

Emilio Benitez, ChildNet, suggested that all partners work on developing non-adversarial relationships.

The next action plan was for the Office of the Attorney General. The short term goal for the Office of the Attorney General is to ensure that all children in care receiving psychotropic medications have a current court order or informed parental consent. The long term goal is to work effectively with other Broward County child welfare community providers to ensure thorough assessment of children exhibiting mental health/behavioral issues is completed and appropriate services provided.

The first Identified Area/Issue is to ensure face-to-face meetings with ChildNet child advocates are held before every hearing and a checklist regarding medication is completed and made part of the case tracking along with full review of the Judicial Review and Social Summary Report (JRSSR) prior to filing. Hampton Peterson, Bureau Chief, Office of the Attorney General, advised that he has reinforced to his staff the importance of questioning the assigned child advocate in detail regarding medication and mental health issues of children in care. He is also copied on every incident report, and anytime he sees a mental health issue being addressed, he forwards the incident report directly to the attorney for follow up with the child advocate.

The second Identified Area/Issue is informed consent documents do not meet legal requirements. The action is that the Bureau Chief will review the Affidavit for Medication and Informed Consent document with ChildNet Legal and create legally sufficient, easily understood documents for medical professionals and parents.

Ms. Welles presented the Southeast Region action plan and advised that the short term goal is to provide the requested support to child welfare community partners represented in the plan so they will be able to successfully achieve improvements in their processes and services to children with mental health/behavioral issues. The long term goal is to work effectively with other Broward County child welfare community providers to ensure thorough assessment of children exhibiting mental health/behavioral issues is completed and appropriate services provided.

The first Identified Area/Issue is that children are currently assessed for involuntary commitment using the same statutory guidelines as those used for adults. The second is improvements are needed in the manner in which Circuit 17 ensures the needs of children with mental health/behavioral needs are met.

BEST PRACTICES FOR MENTAL HEALTH IN CHILD WELFARE: PHARMACOTHERAPY PRACTICES AND GUIDELINES

Chairman Sewell introduced Dr. Chris Bellonci, Medical Director and Senior Clinical Consultant, Walker Home and School, to discuss best practices.

Dr. Bellonci provided a PowerPoint presentation outlining 9 principles.

Principle 1: In establishing informed consent, information must be given to the child, youth, family, caseworker/state-assigned decision maker about treatment options (both medication and non-medication treatment options), the risks/side effects and benefits of the medication, the targeted symptoms, and the course of the treatment.

Dr. Bellonci indicated that this principle gets at the notion of informed consent and evidence based practice. The Institutes of Medicine definition of evidence based practice includes discussion about the clinical experience of the prescriber as well as the values and beliefs of the individual who is going to be taking the medication. He advised that states need to be aware that, just because it is a doctor prescribing medication, it does not mean he/she can disengage from the conversation around whether or not it is still in the best interest of the child to take that medication. There are a number of means of addressing psychiatric conditions besides just the medication, and it is really important to ensure all the options are being explored.

He continued that the role of the prescriber is to provide the information necessary for the person who has consent giving authority and responsibility to make informed choices.

Questions/Comments/Discussion

Colonel Janes asked if the guidelines change at all when the court/judge is the decision maker.

Dr. Bellonci responded that he feels the person who is in the best position to make the decision is the person closest to the consultation with the prescriber. The challenge, when the state has judges giving approval for psychotropic medications for children in the child welfare system, is the judge is so many steps removed from the individual consultation. He does not believe that a form can be developed that is a sufficient communication mechanism to convey the complexity of what happens in a psychiatric consultation that many levels removed. He added that, if you are making a decision that this is so complicated that you want a judge making this determination, then the challenge is how you get the judge the information to make that decision in an informed way.

He continued that in California, each county has its own form and its own approach. San Francisco County has a child psychiatrist who consults to the court. He added that he does not really know a way around ultimately having some kind of child psychiatric expertise embedded in the child welfare system.

Ms. Rosenberg asked Dr. Bellonci what he would suggest as a best practice as an alternative to making the judge the ultimate decision maker.

Dr. Bellonci responded with examples from Illinois and Tennessee. Illinois has a contract for a medical team based at the University of Illinois in Chicago to do reviews for all requests for psychiatric medications for children in child welfare. They have a 24-hour turnaround time and a form they feel has been sufficient to put forth the information that the team uses. If they have questions, they call the provider.

Tennessee has a system of regional health unit nurses. They have the same protocol where you should default first to the parent or guardian, and then to the regional health unit nurse if parental rights have been terminated or if the parent/guardian cannot be located.

Christine Butler, ChildNet, asked about the resolution process when the prescribing physician does not concur with the recommendation of the reviewing individual.

Dr. Bellonci responded that ultimately, the state, the regional health care nurse, or the University of Illinois would be the final arbiter of whether or not that child is prescribed that medication. He added that Tennessee has also developed a consultative relationship with four medical schools throughout the state where they can get a consultation from top to bottom about psychiatric medication and the whole treatment course. He continued that he thinks it is essential to embed consultative capacity into the system.

Dr. Bellonci continued with Principle 2: The child welfare agency must document the medications the child or youth is taking, and the response to the medications, risks/side effects and benefits and the time frames for the expected response. This documentation will follow the child or youth throughout his or her stay in care.

The rationale for this principle is that continuity of care is a critical concern for children in the child welfare system. Having documentation that can follow the child is consistent with the medical home model which is also being supported by the federal government as a best practice.

<u>Questions/Comments/Discussion</u>

Colonel Janes asked where the child welfare agency must document.

Dr. Bellonci responded that he has seen the inefficiency and perhaps the lack of ability of most state SACWIS systems to be able to do this. Tennessee ultimately came to the decision that an entirely new system was needed for tracking medications.

Dr. Bellonci moved to Principle 3. The prescriber should have ongoing communication with the child and caregiver to monitor treatment response and side effects on a continuing basis and discuss with the child adherence to medications and any medication changes in the context of an engaged collaborative, therapeutic relationship. He added that an engaged collaborative, therapeutic relationship is the key, and it is a challenge in the way that the service array is constructed for children in the child welfare system. Appropriate monitoring is essential

knowing that there are some data to indicate that antidepressants are associated with suicidal ideation.

Questions/Comments/Discussion

Colonel Janes asked with what frequency the state should monitor when medication has a black box warning.

Dr. Bellonci responded that his thought is at a minimum monthly in the initiation and if the child becomes stable on the medication and you move into maintenance phase of treatment, at the outset 3 months. This is all medication, not antidepressants specifically.

Dr. Bellonci moved to Principle 4. Recognized clinical rating scales or other measures should be used to quantify the response of the child's target symptoms to treatment and the progress made toward treatment goals. In the initial phase of treatment, visits should take place on at least a monthly basis, or more frequently if the child's condition is unstable or worsening.

Dr. Bellonci continued that whenever possible, rating scales can also inform diagnoses, treatment recommendations and whether treatments are working, and allow data to be collected from the multiple informants. It is suggested that the rating scale be completed by as many people as possible. Minimally teachers should fill them out.

Principle 5: Caseworkers will know or have training on child and adolescent development; neuro-developmental effects of prenatal substance exposure; common mental health disorders in the child welfare population; and effective treatment options for these mental health disorders.

Dr. Bellonci added that, again, the caseworker is the person who is most closely in the role of loco parentis when the child is in state care. So, for that individual, even if they are not having the medication consent authority, to not have sufficient knowledge to be able to engage in a dialogue as they are bringing the child to the mental health provider is a missed opportunity.

Dr. Bellonci continued that children in foster care have significant and often co-occurring developmental, behavioral, and mental health problems. Estimates of mental health problems range from 23 percent to 80 percent.

Dr. Bellonci continued that you don't have to be an expert in mental health treatment and you don't have to know all the evidence based practice literature. What you need to be able to do is ask reasonable questions.

Principle 6: Youth and families should be provided ongoing information on the diagnosed mental health disorder, effective treatment options, and managing life with the condition including what to expect in the future; how severe the condition is; can the youth not take medication in the future; what can be done instead of medication; and how to access help in the future.

Dr. Bellonci added that the role of the prescriber is as a consultant to the child/youth, parents, caretakers and child welfare staff. Ultimately, the child and their caretakers are responsible for implementing treatment and effecting change in their lives. The prescriber's role is to act as a catalyst towards that growth.

Principle 7: The agency should ensure transition planning in advance of youth leaving care that includes identification of providers and source of payment for treatment. He added that if you really believe the child has a major mental illness that is going to continue into adulthood, then it is part of the state's responsibility to ensure a seamless transition into adult services, including a means for them to pay for the prescriptions they are being given.

Dr. Bellonci continued that he believes if you give people adequate information to make informed choices, most of the time they are going to do right by themselves. If the youth has been given adequate information and believes and understands what the mental health condition is, there is a much greater likelihood that he/she will follow through with mental health treatment during the transition out of care either by age, or going back to birth family, or going into an adoptive setting.

Principle 8: The child welfare agency should encourage, support, and monitor the mental health needs and access to psychotropic medications and other mental health services for birth families.

Dr. Bellonci noted that depressed parents were found to be 3.45 times more likely to initiate physical abuse than non-depressed counterparts. He also noted 40 percent of parents who abused children and 56 percent who were neglectful were substance abusers compared to 16 percent of non-abusive and 17 percent of parents who were not neglectful. He said that parents with mental illness, particularly depression and multi generational issues of trauma and substance abuse, are almost endemic in our population. When working towards reunification, if we are not addressing the parental mental health and substance abuse issues, we are unlikely to be successful with the goal of reunification.

Principle 9: The agency should periodically conduct reviews of patterns of psychotropic medication use within its caseload, on an aggregate and provider specific basis, and take necessary action in response to findings of such reviews. Dr. Bellonci stated that there is a new study coming out on the current prescribing rates of various states involving children in the child welfare system. The big concern is the exponential increase in the use of atypical antipsychotics. He added that although there is wide variability in the prescribing rates of psychotropic medications for children in the child welfare system, there does appear to be a significantly higher rate of psychotropic medication use for children in state custody. He stated that in order to ensure that the use of psychotropic medication is both safe and appropriate, states should monitor the use of these medications and be required to report the data to a national database.

<u>Questions/Comments/Discussion</u>

Ms. Rosenberg commented that one of the concerns raised to her is the lack of a requirement in Florida that adverse effects being experienced by a child who has been taking medication be reported. She asked if that issue has been addressed in any of the best practice discussions.

Dr. Bellonci responded that he feels it is the responsibility of the prescriber to know whether or not that child is having side effects.

Ms. Rosenberg asked what the obligation is of the prescribing physician to make the further report about the effects.

Dr. Bellonci responded that it is a strictly voluntary process. There is a post marketing adverse effect process for reporting to the FDA. In truth, these medications are being brought to market with very little study on children.

UPDATE ON LEGAL ISSUES/PROCESS FLOW CHART FOR CHILDREN IN THE DEPARTMENT'S CARE WHO ARE PRESCRIBED PSYCHOTROPIC MEDICATION

Esther Jacobo, State Director of Litigation for Children's Legal Services and Regional Director for the Southeast and Southern Regions for Children's Legal Services, was introduced to present to the workgroup.

Ms. Jacobo introduced the people who helped develop the presentation and the proposed protocol. Those people were Robert Latham, Guardian Ad Litem Program Attorney in the Eleventh Judicial Circuit; Jani Singer, Managing Attorney for the Southern Region that comprises Miami-Dade and Monroe County; Jeffrey Gillan, State Director of Appeals; and Honorable Nushin Sayfie, Eleventh Judicial Circuit Judge.

Ms. Jacobo began by discussing CFOP 175-98. It is the only operating procedure that the Department of Children and Families has that discusses psychotropic medication of children, and it only addresses children ages 0-5. She advised that this operating procedure is being redrafted and written into a much more comprehensive document which will be part of the larger mental health operating procedure that will address all children on psychotropic medication. She added that many of the issues discussed throughout the day will be included in that operating procedure.

Ms. Jacobo directed the workgroup's attention to a folder in the packet of information she provided and, in particular, to the legal opinion contained therein. She advised that it is the last legal opinion written for the Department; it was written May 17, 2001. Also contained in the folder was a "cheat sheet" legal opinion that is going out the field so that case managers, lawyers, and all the people in the field understand what the law is in a nutshell.

Ms. Jacobo directed the workgroup to another folder in the packet containing a 2009 Children's Legal Services training PowerPoint presentation. The purpose of this training is to improve the ability of case managers and Children's Legal Services attorneys to work together to ensure authorization for the administration of psychotropic medication.

Ms. Jacobo continued through the presentation to the psychotropic medication protocol contained in the informational packets. She advised that the development of the protocol began prior to the death of Gabriel Myers. In February 2008, Judge Sayfie was sitting on the

dependency bench and was very uncomfortable with regard to the issues she was being asked to rule upon with regard to children on psychotropic medications. This resulted in a workgroup being put together to address all these issues. The protocol being presented was developed by that workgroup. Ms. Jacobo asked Judge Sayfie to provide further information to the meeting attendees.

Judge Sayfie advised that she was new on the bench in November 2007. She had been a public defender for about 14 years and was well versed with the issues of mental illness of the people in the criminal justice system. She said, however, the information she was being provided did not make her feel comfortable making the decisions she was being asked to make on medication. She added that some of the affidavits she looked at were 6 or 7 days old, but typically, weeks and sometimes months old. One of the affidavits was three months old. The doctors would often attach literature regarding the prescribed medication to the affidavits. The literature would indicate the medication was not appropriate for a child under 12. On one occasion, she had a psychotropic medication motion in front of her for a child that she knew well. The motion indicated the child was diagnosed with bipolar disorder and needed medication. Judge Sayfie called the child's therapist and realized the therapist had never spoken to the psychiatrist. The psychiatrist had seen the child on a particularly bad day after court, spent about 30 minutes with her, and really didn't talk to her foster parent or anyone who was a regular part of her life to know that what she was presenting at that particular time was not her norm. She really didn't need the medication; she needed an extra session with the therapist.

Judge Sayfie said that as a judge, she never wanted to be a decision maker on medication because that is not her area of expertise. She said she noticed that doctors attending the workgroup meetings also seemed reluctant to be the decision maker.

Judge Sayfie advised that the workgroup that began meeting as a result of her frustration and concern revamped the form being used and created new forms that were user friendly for judges, lawyer, and the doctors.

<u>Questions/Comments/Discussion</u>

Colonel Janes commented that Dr. Bellonci suggested that judges are too far removed from the prescribing practitioner in terms of informed consent.

Judge Sayfie responded that she did not disagree; however, that currently is the state of the law. She added that that was part of the reason why the workgroup invited doctors to participate in its meetings and that more interaction is needed. She continued that another problem is that case managers are not as well educated on the issue as they need to be. Judge Sayfie said she would feel more comfortable as a judge if she could speak directly or at least know that the guardian, the case manager, or someone involved in the case had spoken directly to the doctor. She noted that in the course of the meetings, workgroup members learned that the doctors that were typically diagnosing the children and prescribing medication were not in contact with any of the people they needed to be in contact with to make a full decision.

Colonel Janes asked Judge Sayfie if she thought there might be judges who would not want to have that decision moved to a medical review group of some sort before it gets to them, or would they be receptive to the informed consent going elsewhere.

Judge Sayfie responded that she could not speak for all judges, but from her point of view, judges should not be making decisions about medication.

Colonel Janes asked Judge Sayfie for her reaction to sitting on the bench knowing that the informed consent should be given before the medication and yet there are children who have been on medication for weeks before they get to her because the court process is too slow.

Judge Sayfie responded that that was one of the reasons the workgroup began and part of what they have been successful in doing in Miami is streamlining the process.

Dr. Tandon commented that in thinking about the system, there seems to be a fear of sorts that everyone has of doing the wrong thing or being responsible for something bad that might happen. He asked Judge Sayfie if, as a judge, having the following three pieces of information would be helpful: (1) what happened in the physician's assessment of the child and what are the recommendations; (2) knowledge that the information being provided has also gone to a second source for review and assessment of the reasonableness and appropriateness of the proposed treatment; and (3) input of the Guardian Ad Litem or other interested parties.

Judge Sayfie responded that a standard process that could occur quickly and efficiently and include a second opinion would be good. She continued that part of the problem is dealing with a system that is completely overburdened and a lack of continuity in medical care due partly to placement instability of the children.

Ms. Jacobo continued with her presentation and reminded the workgroup that informed consent and court authorization are two different things. Informed consent means that if the parental rights are intact and the child is in dependency, the Department is to facilitate the parent attending a medical appointment with the child and having a face-to-face interaction with the physician. When this type of informed consent happens, the court does not get involved at all. She continued that what has been discovered is that in many cases where the court was not involved, many of the consents were not really informed consents. The parents were just signing forms at the case manager's request.

Ms. Jacobo advised that one of the things the workgroup has done in the protocol they have developed is create a Medical Report for Children on Psychotropic Medication for the case manager to give to Children's Legal Services for review. This report includes the documented informed consent. A Psychotropic Medication Informed Consent Facilitation Form and an Evaluation Referral Form for Psychotropic Medications were also developed.

Ms. Jacobo continued that when a court order on a motion for psychotropic medication is required, the process is that, once the information has been reviewed by Children's Legal Services and determined legally appropriate, it is put on the judge's calendar. She added that Guardians are appointed to those cases, and they call the medical consult line for the

consultation. The motion goes before the judge regardless of the outcome of the medical consultation.

Ms. Jacobo covered the information the judge would have before them under the protocol for use in evaluating whether the order on the motion for psychotropic medication should be granted.

Questions/Comments/Discussion

Judge Frusciante expressed concern that the referral form seems to be duplicating the things that should be part of medical passport or Child Resource Record that should be traveling with the child. He also expressed concern that this process added to the already heavy case manager workload.

Ms. Jacobo responded that they found during workgroup meetings that this was not always occurring. Many times the Child Resource Record was not available at medical appointments.

Judge Sayfie added that another important piece on the referral form is the names and phone numbers of all the people in the child's life, so at the very least the doctor can consult with the therapist, foster parent, or the guardian prior to making the diagnosis.

Chairman Sewell commented that obviously this is being created to fill a void, and the question becomes if we are concerned about the burden we put on case workers, is there a way to take information they have already and get that information first to the doctor and then to the judge.

Ms. Jacobo asked the workgroup to please understand that they had full case management at the table formulating this protocol and the forms, and that if there had been a way not to overload the case manager and get the same information, it would have been done.

Ms. Jacobo moved to an explanation of the Medical Report for Children on Psychotropic Medication, which originally was called the Medical Treatment Plan. She continued that the Children and Families Operating Procedure talks about a medical treatment plan, but the statute specifically requires a medical report.

Ms. Jacobo continued with an explanation of the Psychotropic Medication Informed Consent Form, which was developed following the Gabriel Myers tragedy. She added that the law directs that the case manager must facilitate a meeting with the doctor and the parent so they can give informed consent. This form provides verification that a conversation took place with the doctor. She stated that it is also acceptable under the law to have a phone conversation with the doctor and it is does not necessarily have to be at the evaluation, although that is preferable. So, even if the parent is unable to accompany the child to the appointment, they can still have a conversation with the doctor and ask questions. The informed consent form can then be signed by the parent after that conversation. As a part of the motion for psychotropic medication, the judge has to be advised if informed consent has been obtained, and, if not, what efforts were made to attempt to secure informed consent. This form provides that documentation.

Questions/Comments/Discussion

Ms. Rosenberg encouraged Ms. Jacobo and the Miami workgroup to consider adding the child's input somewhere in the process.

Ms. Jacobo added that she would suggest that when the child objects to the medication that he/she should be appointed an attorney so the objections can be filed with the court.

Judge Sayfie added that, when children are made part of the process and they come to court regularly, they have some sort of faith in the people that are taking care of them. She said she felt like judges in all jurisdictions should be encouraged to give children an opportunity to come to court. The protocol in Miami is that every child is required to come to court within the first 3 months.

Ms. Jacobo closed her presentation and asked for the workgroup's input on the protocol and if the legal opinion and forms could be sent to the field for review.

Chairman Sewell advised that it would be premature to do so pending the results of the workgroup and that further discussion was needed.

ADJOURNMENT

The next meeting is scheduled for July 6 in Tallahassee.

The meeting adjourned at 4:30 p.m.