DRAFT

DRAFT

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES

CF OPERATING PROCEDURE
NO. 155-10
175-40

TALLAHASSEE, March X X, 2010

Family Safety
Mental Health

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

1. Purpose. This operating procedure provides guidance for the full 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 in out-of-home care.

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 placed and supervised, 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 another state court. The portions of this operating procedure that assign certain tasks to Substance Abuse/Mental Health program offices or designee apply only to Escambia, Santa Rosa, Walton, Okaloosa, Manatee, Polk, Hardee, Highlands, and Broward Counties.

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.

George Sheldon
Secretary

SUMMARY OF REVISED, DELETED, OR ADDED MATERIAL

This document supersedes CFOP 155-10 dated August 7, 2008, CFOP 175-40 dated January 15, 1997 and CFOP 175-98 dated June 22, 2009. This document combines information found in these CFOPs, updating that information and adding information and guidance on Psychotropic Medications.

CONTENTS

Chapter 1

General

1-1. Context. These procedures carry out 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 with timely, and effective treatment services and supports at levels appropriate to address the severity of their conditions.

1-2. 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 and substance abuse and developmental disabilities 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 child'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 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 adjusted accordingly.

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

i. The dependency case manager must ensure that progress identified in the plan is being made, must detect risk situations and emerging needs or problems, and must take steps to address them.

j. 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.

k. For all children who are also served by the Department of Juvenile Justice or the Agency for Persons with Disabilities, child specific planning and service delivery will be coordinated between the agency(ies) and the Department of Children and Families.

l. A dependency case plan is not a substitute for the active engagement of the dependency case manager in comprehensively monitoring the behavioral health needs of the child.

1-3. Department and/or Lead Agency Joint Responsibilities:

a. Facilitate initial and ongoing training and technical assistance on this operating procedure for all levels of Department and Lead Agency staff and contracted providers of the Lead Agency functions.

b. Monitor to ensure that children in out-of-home care are referred for a Comprehensive Behavioral Health Assessment (CBHA) and, if the assessment is not completed within 24 calendar days of referral to the provider, ensure the reasons are documented in the child's case file.

c. Monitor the number and timeliness of referrals for Comprehensive Behavioral Health Assessments and their incorporation into the case plan process.

d. Ensure that all children entering out-of-home care, who are not Medicaid eligible when placed in out-of-home care, are qualified for Medicaid, when possible, by working with the child's caregiver and the economic services office (that is, the ACCESS Florida program unit – specifically Child in Care staff) in the area in which the child is placed.

e. Ensure the integration of mental health, substance abuse, co-occurring mental health and substance abuse, and developmental disabilities service planning into the child's dependency case planning process.

f. Monitor the dependency case managers' participation in visiting children in residential treatment centers and in active, timely and appropriate discharge planning where relevant.

g. In conjunction with the Region/Circuit Substance Abuse and Mental Health (SAMH) and Agency for Persons with Disabilities Program Offices, develop strategies to maximize the effective use of funding sources, including those of Medicaid, Mental Health, Community Based Care, and support services within the community to meet the mental health, substance abuse, co-occurring substance abuse and developmental disability needs of children in out-of-home care.

h. Work closely with the Circuit Substance Abuse and Mental Health (SAMH) and Agency for Persons with Disabilities Program Offices to identify and resolve any local implementation problems, when required.

i. Monitor implementation of this operating procedure throughout the Lead Agency and Circuit.

1-4. Point of Contact.

a. Designation. Each Circuit SAMH Program Office or Lead Agency will designate a Point of Contact (POC) to serve as the central point of contact for dependency case managers (DCM) in referring children for comprehensive behavioral health assessments and mental health services, including psychotropic medications. This service must be provided to all lead agency dependency case managers, in support of the dependency case manager's assigned responsibilities. In some areas it is provided by the Child Welfare Prepaid Mental Health Program (CWPHMP) and in others through the Children's Mental Health Program within the Substance Abuse and Mental Health program office.

b. Role. For children in out-of-home care, the Point of Contact provides consultation to dependency case managers 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 primary role of the Point of Contact is to serve as a resource to the dependency case manager in ensuring that children are assessed as to their need for mental health, developmental disabilities and/or substance abuse services and provided with individualized treatment and integrated services in support of their permanency goals.

c. Responsibilities. 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, and/or co-occurring substance abuse 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 SAMH Program Offices, or designee, when appropriate, on the number, demographics, timeliness, and status of Comprehensive Behavioral Health Assessments 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.

1-5 The Child Resource Record. A child's resource record is required to be deveoloped for every child entering out-of-home care by 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 through out the time a child is served in out-of-home care. It must be maintained in the home the child is living in and will be provided to the child's physicians at each medical, behavioral health or physicial health appointment. The dependency case manager is responsible for the initial development, monitoring, updating and transporting of the child's resource record. The dependency case manager shall review confidentiality requirements with the child's caregiver, who shall be provided with the child's resource record. The caregiver is responsible for maintaining confidentiality of the child's resource record documents.

a. Since some of the information necessary in the child's resource record is not available immediately upon initial removal, the documents required in the child's resource record shall be placed in the record as available. The child's resource record 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 on-going 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) will be in the resource record;

4. Copy of the general consent for treatment (CF-FSP 4006);

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

6. Copy of the Medicaid card;

7. Copy of the Shelter Order;

8. The names and phone numbers of staff to be contacted in emergencies.

b. The child's resource record 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 child's resource record 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.

c. The child's resource record shall accompany the child to medical and therapist visits.

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

e. 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.

f. Child's Resource Records in Licensed Placements.

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

2. The dependency case manager shall ensure that medical and court-related documentation are kept current at each visit that is made at least every thirty days. If additional information is needed in the child's resource record the dependency case manager and the licensed caregiver shall work together to ensure that the child's resource record is promptly updated.

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

1. The dependency case manager shall ensure the upkeep of the child's resource record in relative and non-relative placements. The child's resource record shall be physically located with the relative or non-relative.

2 The dependency case manager shall assist the relative or non-relative to update the child's resource record after every health care, psychological, psychiatric, behavioral, substance abuse, developmental and educational service or assessment provided to the child.

3. The dependency case manager shall ensure that medical and court-related documentation are kept current at each visit. If additional information is needed in the child's

resource record, the Services Worker shall provide copies of needed documents to the relative/ non-relative for updating of the child's resource record.

1-6. 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 Comprehensive Behavioral Health Assessment (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. The treating physician must consider less invasive treatment interventions before prescribing psychotropic medication.

b. The child's dependency case manager 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 child's dependency case plan and are provided to the child in a timely manner. 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 child's dependency case plan the reasons will be documented in the child's case record.

c. The department and contracted service providers who provide behavioral health services shall comply with the requirements of Section 39.407(3), F.S., and the Florida Rules of Juvenile Procedure 8.355 whenever a child is considered for administration of psychotropic medications.

d. The department and contracted service providers who provide behavioral health services shall comply with the requirements of Section 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.

1-7 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" CF-FSP 4006), 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.

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, this process is defined in s. 394.455 (9), F.S. and described in s. 394.459(3) (a), 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, sterilization, 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 express and informed consent of the parent 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.

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 Comprehensive Behavioral Health Assessment (CBHA). These Medicaid-funded assessments are used to provide specific information about mental health and related needs, including treatment of co-occurring needs, and to identify services to accomplish permanency planning. The needs identified through the CBHA and the recommendations for services are to be included in the child's case plan.

2-2. Scope. This section 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.

2-4. Assessment Goals. As described in the Medicaid Handbook, the goals of the Comprehensive Behavioral Health Assessment 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, or re-entry 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 Comprehensive Behavioral Health Assessment 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 Comprehensive Behavioral Health Assessment performed without authorization from the court and without consent from a parent or legal custodian, per ss. 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 dependency case manager (DCM) will forward a completed CF-MH 1053, PDF 10/2005 -Comprehensive Behavioral Health Assessment Referral (Attachment A to this chapter), may be found on DCF Forms at http://dnp1.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx

and a complete CF-MH 1066, PDF 10/2005 Authorization for Comprehensive Behavioral Health Assessment (Attachment B) may be found on DCF Forms at http://dnp1.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx, to request that the Point of Contact refer the child for a Comprehensive Behavioral Health Assessment. Referral guidelines for Comprehensive Behavioral Health Assessment may be found in Medicaid's Community Mental Health Services Coverage and Limitations Handbook incorporated by reference in Rule 59G-4.050.

b. Within one (1) business day of receipt of a complete request, the Point of Contact will forward an "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 Point of Contact will request that the Comprehensive Behavioral Health Assessment provider complete the summary page of the appropriate Child and Adolescent Needs and Strengths 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 Comprehensive Behavioral Health Assessment (CBHA) provider will complete the assessment and send the report of findings to the Point of Contact. The development of the CBHA shall include information provided by the child's parents and current care giver when ever possible.

e. Within one (1) business day of receipt of the Comprehensive Behavioral Health Assessment report, the Point of Contact will review the report for quality and completeness and, if acceptable, will forward the report to the Lead Agency for distribution to the dependency case manager or other designated staff. If the report is not complete or does not meet the Medicaid Handbook standards, the Point of Contact will return the report to the provider for revision.

f. The dependency case manager will review the assessment report for any recommendations for behavioral health services and will make appropriate referrals for such services, asking the Point of Contact and/or other designated Lead Agency staff for consultation if needed. The dependency case manager will also ensure that Children's Legal Services 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 Child and Adolescent Needs and Strengths Assessment (CANS) would indicate a high level of urgency for mental health services).

h. The dependency case manager will use the results and recommendations of the Comprehensive Behavioral Health Assessment 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 Comprehensive Behavioral Health Assessment, 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.

Comprehensive Behavioral Health Assessment Referral

Please complete this form and forward it to the Single Point of Access along **with the Authorization for Comprehensive Behavioral Health Assessment form.**

Child's Name: _____ Sex: _____ D.O.B. _____ Race: _____

SSN #: _____

Name of Caregiver: _____ Phone #: _____

Address of Caregiver: _____

School Child Attends: _____

Reason for Shelter: (Abuse, Neglect, Abandonment) _____

_____

Name of Parents: _____ Phone/Cell/Pager #: _____

Name(s) of siblings: 1._____ Location: _____

2._____ Location: _____

3. _____ Location: _____

Preliminary Goal: (Reunification, adoption, expedited termination of parental rights) _____

_____

What services and with whom are services currently provided to the child/family: _____

_____

_____

Prior reports to DCF (date, findings, indications) _____

_____

Has there been any identified mental illness in child/family? :_____

_____

_____

Has there been any identified alcohol or other drug use with the child/family?: _____

_____

_____

Please provide the Following Department Information:

CW/CBC Counselor/Investigator: _____ County: _____ Phone #: _____

CW/CBC Supervisor: _____ Phone Number: _____

CW/CBC Contact Person: _____ Phone Number: _____

CF-MH 1053, PDF 10/2005

AUTHORIZATION FOR COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT

This is to certify that

Child's Name _____ Date _____

Medicaid Number _____

has been screened and determined to be in need of a Comprehensive Behavioral Health Assessment as outlined in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook. The comprehensive behavioral health assessment will be provided by

_____(provider)

_____ _____
Circuit Substance Abuse and Mental Health Representative Date

AND

_____ _____
Child Welfare Prepaid Mental Health Plan Vendor or designee Date

OR

_____ _____
Juvenile Justice Representative Date

AUTHORIZATION FOR COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT FOR CHILD IN SHELTER

This is to certify that

Child's Name _____ Date of Referral_____

Medicaid Number _____ Shelter Name _____

Shelter Address _____

has been screened and determined to be in need of a Comprehensive Behavioral Health Assessment as outlined in the Florida Medicaid Community Behavioral Health Coverage and Limitations handbook. The behavioral health comprehensive assessment will be provided by

_____(provider)

_____ _____
Circuit Community Based Care Lead Agency Representative Date
to be placed in recipients (child's) medical record

CF-MH 1066, PDF 10/2005

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 section applies to all children in out-of-home placements as defined in Appendix 1 of this operating procedure.

3-3. References**.** S. 39.407(3) (a) 1, 394.455(9), 394.459(3) (a), 65C-30.011, 65C-35., Legal Opinion 09-01.

3- 4 Psychotropic Medication Documentation Required Forms

a. Prescribing Physicians Signed Medical Report. A prescribing physicians 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.. 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, serve as documentation of the parent's 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 attachment A to this chapter and found on http://www.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx).

(2) This form includes all requirements set forth in s. 39.407 (3)(c)(1)-(5), F.S. The physician may submit the Medical Report in a format prepared by their own office as long as the Medical Report substited addresses all information required in s. 39.407 (3)(c)(1)-(5), F.S. is included. Pease 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 provide includes;

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

(b) The information that the physician received from consultations from other professionals, and the referring dependency case manager or child protective investigator, including tests reviewed and other records of behavioral health and school based services received by the child, as well as a statement that the prescribing physician has reviewed the information provided, including information on indications of the presence of brain injury, and considered it in their decision making process (section 2);

(c) the Medication 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 (section 3);

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

(f) A statement concerning how ~~drug~~ information about the medication has been provided to the parent of caregiver (section 6)

g) Supplemental information, such as if other treatment 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, must be provided (section 7) and shall be included in the Medical Report.

h) When a child changes prescribing physicians for any reason, the receiving physician must provide an updated Medical Report to the child's dependency case manager within three (3) 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 given to the receiving physician, the dependency case manager will provide the new Medical Report to CLS who must file for a new court order.

i) A new Medical Report will be provided by the prescribing physician when the information in the original Medical Report concerning the medication prescribed changes. 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

(3) 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.

(4) The dependency case manager 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 in FSFN.

(5) The dependency case manager may document their actions to assist in ensuring the parent or legal guardians participation in the express and informed consent process by completing the Psychotropic Medication Informed Consent Facilitation Form (CF-FSP 5279 March 2009 attachment B to this chapter found on http://www.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx).

(6) Within two (2) working days of receiving the Medical Report from the prescribing practitioner, the dependency case manager must submit The Medical Report and may also submit the Psychotropic Medication Informed Consent Facilitation Form to CLS .

(7) 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 child's resource record.

b. Psychiatric Evaluation Referral Form

(1) Psychiatric Evaluation Referral Form (CF-FSP 5341 Attachment C to this CFOP and found on http://www.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx) should be completed by the dependency case manager or child protective investigator, for all referrals for medical

evaluation that may result in psychotropic medications being prescribed. The form will provide at a minim the following information:

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

(b) Contact information of the dependency case manager, the dependency case managers supervisor, caregiver, any current behavioral health therapist, guardian ad litem, school, and parents if parental rights have not been terminated;

(c) The documents that the dependency case manager is providing the physician including, all known prior behavioral health evaluations, such as the current CBHA, school, psychiatric, psychological, and physical health evaluations, to include 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).

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

(e) Listing of all medications, including over-the-counter medications, and 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 Form (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) This form, when used, must also be provided to the CLS attorney, parents, guardian ad litem or attorney ad litem if one has been 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 there are any problems with the request for medication, CLS will notify the dependency case manager 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 by statute 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 dependency case manager or child protective investigator shall ensure that the following efforts are made in furtherance of obtaining 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 and to 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 specific information for how and when to contact the physician shall be provided.

(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 dependency case manager or child protective investigator will be responsible for facilitating discussions between the prescribing physician and the parent or legal guardian or pursuing a new court authorization. A prescribing physician's decision to prescribe a generic medication will not require additional consent or court authorization. The dependency case manager or child protective investigator shall inform Children's Legal Services and all parties of any changes in medication and shall provide Children's Legal Services 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 child 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 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 after the appointment by telephone, and if the conversation is reasonably documented by the dependency case manager 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 dependency case manager, the dependency case manager's supervisor, or the foster parent provide consent to provide psychotropic medications to children in out-of-home care.

f. If the parent or legal guardian is unable to attend the medical appointment, the dependency case manager shall attend and provide information to the parent, which 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 dependency case manager or child protective investigator 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 information to be provided 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 dependency case manager or child protective investigator shall attend the appointment and convey the information to the caregiver, which 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;

(7) How the treatment will be monitored; and

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

b. This information must include possible side effects and the proper method of administering the medication based on the information provided by the prescribing physician.

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

d. The caregiver has a parallel responsibility to understand and comply with the treatment being provided to meet the child's needs, particularly when psychotropic medication is involved.

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

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

g. The caregiver shall monitor the child and report to the prescribing physician and the dependence case manager any behavior or other incident that could indicate as 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. 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, the dependency case manager or child protective investigator will request that Children's Legal Services request an attorney ad litem be appointed for the child.

e. Whenever the child requests the discontinuation of the psychotropic medication, and the prescribing physician refuses to order the discontinuation, the dependency case manager or child protective investigator will request that Children's Legal Services request an attorney ad litem be appointed for the child. Children's Legal Services will notice all parties and file a motion with the court presenting the child's concerns, the physician's recommendation, and any other relevant information, pursuant to Section 39.407(3) (d) 1, F.S.

3-8. Continuation of Medical Care and Treatment.when a child changes placement The child's medical care and treatment must not be disrupted by change of placement. To the extent possible, the person making the placement, either the dependency case manager or in some cases the child protective investigator, shall arrange for transportation in order to continue the child with his or her existing treating physicians for any on-going 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 working days of the change to a new provider. The person making the placement is responsible for the following tasks relating to on-going medical care and treatment:

a. Discuss with the caregiver all known health care facts regarding the child;

b. Review with the caregiver all health care and Medicaid information contained in the child'sresource record;

c. 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:

(1) The child for whom the medication is prescribed;

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

(3) The prescribing physician's name and contact information;

(4) The pharmacy from which the prescription was obtained and the contact information;

(5) The prescription number

(6) The drug name and dosage;

(7) The times and frequency of administration, and if the dosages vary at different times;

(8) Any identified side effects;

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

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

d. If the child is taking unlabeled medications or prescription information is insufficient, the person making the placement shall contact the prescribing physician, 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; and

e. 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.

a. When a child protective investigator takes a child into custody they must determine whether the child is taking psychotropic medications. If so, the child protective investigator 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 child protective investigator 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 Attachment D) 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 protective investigator must notify or cause to be notified the parent of legal guardian that the medication is being provided.

(3) If the medication in not in the original container, clearly marked and current, a physician or pharmacist must confirm 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 Section 39.407(3)(b)1., F.S.

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

(6). In cases where there are several medications in the bottle provided by the parent, a physician or pharmacist is unable to confirm the identity of any provided medications and that they belong to the child and have a current prescription, the investigator will check with the prescribing physician, 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, and obtain the dosage and other information and new prescription. This information must be entered into 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 child protective investigator 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 child protective investigator or dependency case manager must have a determination from a physician

licensed under chapter 458 or chapter 459, Florida Statutes, that the child should continue the psychotropic medication. This determination must be transmitted in writing to CLS.

c. If the dependency case manager or the child protective investigator 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 dependency case manager.

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 to 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 child protective investigator will be entered into 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 Information" (CF-FSP 4006). The general consent allows ordinary and necessary 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 withdraws consent and any party 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. Children's Legal Services 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 3-13.

c. In no case may the dependency case manager, child protective investigator, the child's caregiver, representatives from the Department of Juvenile justice, 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 practitioner 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 65C-35.003 (4) to include the parent in the child's consultation with the child's prescribing practitioner.

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 dependency case manager or child protective investigator must obtain the child's Resource Record and any prescription medication currently taken by the child.

(1) The dependency case manager or child protective investigator shall obtain the medication in labeled medication bottles, inventory the medications provided, and transport the medications to the child's new caregiver.

(2) The dependency case manager 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 practitioner's name and contact information;

(d) The pharmacy from which the prescription was obtained and the contact information;

(e) The prescription number;

(f) The drug name and dosage;

(g) The times 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.

(k) If the child is taking unlabeled medications or prescription information is insufficient, the dependency case manager or child protective investigator shall contact the prescribing physician, 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. Changes in Medication. The dependency case manager or child protective investigator will be responsible for securing a new parental express and informed consent or court order if there are any changes in medication, or prescribing physician including dosage or dosage range, that go beyond the existing authorization. The dependency case manager shall inform CLS of any changes in medication, and shall provide CLS a copy of the amended the Medical Report.

d. Medication Reviews. The dependency case manager or other designee will attend medication reviews as requested by the prescribing practitioner and/or agency. Whenever feasible, the child's caregiver and parent, will also attend

e. 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 dependency case manager or child protective investigator 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.

f. Judicial Reviews. 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 .

g. When court authorization is needed to provide psychotropic medication, the dependency case manager or child protective investigator shall provide Children's Legal Services 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. This report must include:

(1) Dates and time the dependency case manager or child protective investigator 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.

(2) 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.

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

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 Medial 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 dependency case manager 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) 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 benifets 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 dependency case manager. The dependency case manager shall provide Children's Legal Services 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. Children's Legal Services shall file a motion to authorize medication within two (2) business day of receipt the Medical Report for the Dependency Case manager.

c.. Whenever the parental rights of the parent have been terminated, the parent's location or identity is unknown or cannot reasonably be ascertained, or the parent refuses to consider the request to provide express and informed consent, the dependency case manager must obtain the completed Medical Report from the prescribing physician.

d. When the parent declines to provide express and informed consent, or withdraws consent that was previously provided, the Department must seek court approval for the administration of psychotropic medication. The following steps must be taken:

(1) The dependency case manager must obtain a completed Medical Report from the prescribing physician.

(2) Within three (3) business days of receiving the Medical Report from the prescribing physician, the dependency case manager must submit the supporting documentation to Children's Legal Services, with a request for legal action to obtain a court order authorizing the administration of the prescribed medication.

(3) Children's Legal Services 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.

3-12. Parent or Legal Guardian Rights Terminated or Parent or Legal Guardian Location or Identify Unknown

a. 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.

b. The dependency case manager or child protective investigator must obtain from the prescribing physician the completed Medical Report.

c. Within three (3) business day of receiving the Medical Report from the prescribing physician, the dependency case manager or child protective investigator must submit the Medical Report and other documentation to Children's Legal Services, with a request for court authorization to administer the prescribed medication.

d. Children's Legal Services 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 Psychiatric Residential Treatment Center.

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 dependency case manager or child protective investigator must obtain the Medical Report signed by a prescribing

physician in the facility, and provide this to CLS, within two (2) working days after the medication is initiated.

c. The dependency case manager or child protective investigator 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 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 dependency case manager must obtain parental authorization or CLS must file a motion requesting court authorization.

(3) Copies of the Medical Report shall be provided to the court, the child's guardian ad litem, and all other parties within three (3) working 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.

a. Psychotropic medications will be administrated only by the child's caregivers. Children who are age and developmentally appropriate must be given the choice to self administer medication under the supervision of the caregiver or school personnel. Children assessed as appropriate to self administer medication must be educated 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.

(5) Caregivers must keep a current medication log on a form provided by the Department of its contracted service provider 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.

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

c. The caregiver must give completed Medication logs to the dependency case manager 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 specifies the prescribing physicians 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 dependency case manager or other designee will attend medication reviews as requested by the prescribing physician and/or agency. The child's caregiver should also attend all medication reviews.

h. The caregiver administering the psychotropic medication must have received training 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 dependency case manager or child protective investigator is responsible for implementing the medication plan developed by the prescribing physician. The dependency

case manager or child protective investigator will arrange for any additional medical evaluations and laboratory tests required, and report the results to Children's Legal Services and the prescribing physician.

j. The dependency case manager or the child protective investigator 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, serious adverse effects of the medication to the prescribing physician.

k. The department or its contracted service providers will develop a locally approved medication logs for documenting the administration of psychotropic medications.

l. The Lead Agency must provide medication management training to caregivers or ensure that it has been provided. In unusual situations, the dependency case manager or child protective investigator who has received psychotropic medication training may also administer these medications.

m. The monitoring of the use of psychotropic medication by children should be a joint responsibility between the physician, caregiver and dependency case manager or child protective investigator, and the supervisor of the dependency case worker or child protective investigator. 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 child protective investigator's or dependency case manager's immediate supervisor, and emergency services arranged as appropriate to protect the child's safety and wellbeing. This information shall be provided to Children's Legal Services, the court, reported through the incident reporting system and provided to all parties within three (3) business days of the reported concerns.

n. The dependency case manager or child protective investigator, 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. Dependency case manager supervisors and child protective investigator supervisors shall provide on going review and oversight of children prescribed psychiatric medications.

p. The dependency case worker must review the child's psychotropic medication with their supervisor, or other agency designee, when any of the following circumstances become known to the caseworker:

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.

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.

e). Anti-psychotics.

q. After the review required in subsection (p.) of this section, when advised by their supervisor:

1. Consult with the prescribing physician to obtain additional information; or

2. Request a second opinion regarding a child or psychotropic medication.

r. 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. Report to the prescribing physician when the condition of the child in out-of-home care is not improving or is deteriorating. Request and receive updated health information of the child in out-of-home care and effects of the prescribed psychotropic medication therapy from the substitute caregiver during the required 30 day contact with the substitute caregiver.

w. 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 child's resource record.

x. Document the review and actions taken subsequent to the review required in subsection q of this section, and all consultation notes in FSFN case notes.

3-15 Requests for Second Opinion.

a. The child protective investigator or dependency case manager 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 child protective investigator or the dependency case worker 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 child protective investigator or dependency case manager must obtain the second opinion within twenty-one (21) calendar days or 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 Child Protective Investigations

a. Existing policy requires supervisors review child protective investigative 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 file review, the supervisor must assess documentation

regarding consultation with Children's Legal Services 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 child protective investigator every month, documenting that the discussion occurred and the basic content of the discussion in Florida Safe Families Network (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 Case Management

a. At a minimum, existing policy requires case management 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 case manager 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 case manager.

(1) Have you observed 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 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 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 dependency case manager 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 fosters parents on medication administration and management.

(1) This training will include a three part training approach that includes:

(a) a one hour foundational web-based tutorial,

(b). a more in-depth three hour training, and

(c) On going 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, Florida Safety Families Network (FSFN) for the proper documentation of all behavioral and physical health purposes. There is a FSFN User's Guide that has been developed and placed on the Center for the Advancement of Child Welfare Practice Web Portal for detailed guidance in documenting psychotropic medications prescribed for child in out-of-home care in FSFN. (http://centerforchildwelfare.fmhi.usf.edu/Pages/Default.aspx)

a. There are four Tabs in FSFN that must be used by Dependency case managers and child protective investigators to enter all behavioral and physical health information into FSFN.

(1). FSFN Medical Profile. The first tab is the Medical Profile tab 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 in FSFN purposes.

(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, updates, including all actions taken by the dependency case manager or child protective investigator, will be entered into FSFN by the dependency case manager or child protective investigator in a timely, accurate manner including complete documentation of a child's health history and current status.

(1) The information on medications prescribed will be entered into FSFN within three (3) business days of beginning the medication, based on information provided to the dependency case manager or child protective investigator 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 dependence case manager, child protective investigator and children's legal services will be entered into 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 provide;

(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;

(1) The Axis I & II drop down boxes on the Mental Health Profile tab must be unitized for all diagnosis for prescribed psychotropic medications.
(2) Axis I defines which mental health diagnosis the prescribing physician is treating. Drop down box will allow identification of all diagnosis given,
(3) Axis II defines which personality or developmental disability diagnosis the prescribing physician is treating.
(4) All other diagnosis provided, Axis III, IV, V, should be place in the text box provided on the Medical History Tab.
    (a) Axis III General Medical Conditions;
    (b) Axis IV Psychosocial and Environmental Problems;
    (c) Axis V Global Assessment of Functioning

(i) Date medication was prescribed and date stopped;

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

(k) Comprehensive Behavioral Health Assessment;

(l) Other comments about important information, such as;

(m)

a. Any instructions for administering the medication,
b. Any other behavioral health treatments provided the child,
c. Any potentially harmful side effects or precautions that caregivers need to be aware of.

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 who is entering the data into 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[1] 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 , child protective investigator, dependency case worker, parent (unless parental rights have been terminated), foster parent, minor, relative/non-relative caregiver, Guardian ad Litem (GAL), judge, parent of a child enrolled in the Behavioral Health Network (BNET) or the BNET Liaison who is working with a child in out-of-home care or enrolled in BNET.

.

[1] Currently, with the University of Florida, College of Medicine, Department of Psychiatry.

Prescribing Psychotropic Medication
Children in Out-of-Home Care
MEDICAL REPORT

Child's Name:_____
Evaluating Physician Name:_____
Aress:_____
_____
Date/Time of Office Visit:_____
Phone #_____Fax #_____
Please Indicate if you are a:
☐ Child Psychiatrist ☐ General Psychiatrist
☐ Pediatrician ☐ Other _____
Board Certified? ☐ Yes ☐ No

OPTION FOR PHYSICIAN

YOU MAY SUBSTITUTE A MEDICAL REPORT PREPARED BY YOUR OFFICE AS LONG AS THE MEDICAL REPORT SUBSTITUTED ADDRESSES ALL ELEMENTS IN THIS REPORT. PLEASE NOTE THAT IF A COURT ORDER IS NEEDED TO ADMINISTER THIS MEDICATION, SOME JUDGES MAY ASK FOR ADDITIONAL INFORMATION.

Dear Physician:

The attached Medical Report has been developed to guide the treatment of children in the custody of the Florida Department of Children and Families who are prescribed a psychotropic medication. These children are not residing with their parent or legal guardian.

- Prior to prescribing a psychotropic medication, s. 39.407, F.S. requires the prescribing physician to attempt to obtain express and informed consent from the child's parent or legal guardian. This is required even when the medication is prescribed for medical reasons unrelated to behavioral healthcare.

- In the absence of the parent's express and informed consent or in emergency situations, the completed and signed Medical Report will be submitted to the court and admitted into evidence at a hearing. The information in the report will be used in lieu of a court appearance by the physician. Therefore, it is critical that all information contained in the report be complete and thorough.

- In no case may the dependency case manager, child protective investigator, or the child's foster parents provide express and informed consent for a child to be prescribed a psychotropic medication.

Florida Statute 39.407 requires physicians who prescribe psychotropic medications to children in foster care complete a Medical Report that includes the following information:

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

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

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

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

Thank you for your work with children in the foster care system.

An electronic version of this form can be downloaded from http://www.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx

DRAFT

Child's Name:_____ Child's Date of Birth: _____

Medical Report for

Children in Out-of-Home Care

(to be completed by the physician)

SECTION 1: CHILD'S INFORMATION

Child's Name: _____ Child's Date of Birth: _____

Child's Height: _____ Weight:_____Gender: _____

SECTION 2: INFORMATION RECEIVED BY PHYSICIAN. Briefly list any persons consulted, tests performed, or documents reviewed in conjunction with this child's evaluation. The dependency case manager is responsible for providing all pertinent medical information known to the Department concerning the child.

Documents Provided: (check all that apply)

- ☐ Comprehensive Behavioral Health Assessment; (date of latest CBHA)
- ☐ Previous psychological evaluation.
- ☐ Current Health Physical; (date of the current physical)
- ☐ Referral Information including all medications currently prescribed, health status, health services and therapy currently receiving.
- ☐ Current school records, including assessments (e.g., Functional Behavioral Assessments, etc)
- ☐ Other:

_____

Persons Consulted(Name, title/relationship to child, date of consultation)

_____

_____

Does the child's medical history includes 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):

☐ Yes ☐ No ☐ Further assessment needed (see Section 4)

Other health conditions were considered (list)

_____

Comments:

_____

_____

Child's Name: _____ Child's Date of Birth: _____

SECTION 3: DIAGNOSED CONDITIONS, SYMPTOMS, BEHAVIORS. **Details should be provided for each separate diagnosis.** Duplicate this page as necessary for additional diagnosis/medications. List all diagnosed conditions, symptoms, and behaviors that support the need for the requested medications, including current medications that will be continued, for a complete profile. Please provide the Axis diagnosis(es) if known. Duplicate this page as necessary for additional diagnoses/medications.

Diagnosis #_____: ☐ ADHD/ADD ☐ Oppositional Defiant Disorder ☐ Adjustment Disorder
☐ Post Traumatic Stress Disorder ☐ Bipolar Disorder ☐ Depression
☐ Reactive Attachment Disorder ☐ Mood Disorder ☐ Other (specify) _____

Medication recommended: _____

Starting dose: _____ Dosage Range: _____

Expected length of medication treatment / Plan to reduce or eliminate the medication (Titration Plan):

Side effects for caregiver to monitor: _____

Target Symptoms/Behaviors Medication Will Address and Expected Results: _____

This Medication is NEW ☐

This Medication is for ☐ Medical Condition ☐ Behavioral Health Condition

Concerns regarding medication:

Diagnosis #_____: ☐ ADHD/ADD ☐ Oppositional Defiant Disorder ☐ Adjustment Disorder
☐ Post Traumatic Stress Disorder ☐ Bipolar Disorder ☐ Depression
☐ Reactive Attachment Disorder ☐ Mood Disorder ☐ Other (specify) _____

Medication recommended: _____

Starting dose: _____ Dosage Range: _____

Expected length of medication treatment / Plan to reduce or eliminate the medication (Titration Plan):

Side effects for caregiver to monitor: _____

Target Symptoms/Behaviors Medication Will Address and Expected Results: _____

This Medication is NEW ☐

This Medication is for ☐ Medical Condition ☐ Behavioral Health Condition

Comments regarding the medication: _____

Concerns regarding medication:

Child's Name: _____ Child's Date of Birth: _____

Child's Name:_____ Child's Date of Birth: _____

SECTION 4: RECOMMENDED SERVICES, OTHER TREATMENTS. *To include any psycho-social services, medical or psychiatric follow-ups, or treatments the child should receive in conjunction with this medication profile including a recommended schedule.*

Medication Monitoring Plan and Follow-up: Next Appointment:_____

Treatment monitoring frequency recommended:

☐ Weekly ☐ monthly ☐ 2months ☐ 3months ☐ 4 months ☐ 6 months ☐ annually

Follow-up visit frequency recommended:

☐ Weekly ☐ monthly ☐ 2months ☐ 3months ☐ 4 months ☐ 6 months ☐ annually

Lab monitoring:

☐ CBC ☐ with differential ☐ without differential frequency _____

☐ Comprehensive metabolic panel frequency_____

☐ Basic metabolic panel frequency_____

☐ Urinalysis frequency_____

☐ Urine Toxicology Screen frequency_____

☐ Pregnancy test ☐ Urine ☐ Blood

☐ TSH frequency_____

☐ Lipid profile (HDL, LDL, Chol, Trig) frequency_____

☐ Lithium level ☐ Depakote/Depakene level ☐ Tegretol level

☐ Other laboratory tests not noted above _____

_____

Other Tests / Therapies / Services

☐ Electrocardiogram (ECG) ☐ Neurological exam/assessment

☐ Other (specify) _____

☐ Therapy recommended: _____

_____

_____

☐ Psycho-social services recommended:_____

_____

DRAFT

Child's Name:_____ Child's Date of Birth: _____

SECTION 5: CERTIFICATION OF SIGNIFICANT HARM: *This section is to be completed when it is likely that any delay in taking the prescribed medication would cause significant harm to the child.*

I, the physician, have reviewed all medical information concerning this child provided to me by DCF/CBC and/or the child's caregivers, and certify that a delay in providing the prescribed psychotropic is likely to cause significant harm to the child as noted below:

☐ **I find that it is likely that any delay in taking this medication would cause significant harm to this child.** I recognize that this finding statutorily *pre-authorizes* the Department to provide the proposed medication profile to the child immediately and prior to obtaining a court order. Delay in taking the psychotropic medication(s) will more likely than not harm the child for one or more of the following clinical conditions:

Please provide detailed explanation of the nature and extent of harm the child will likely experience:

_____

_____

_____

☐ **This child is currently in a hospital, crisis stabilization unit, or psychiatric residential treatment center.** I recognize that this finding statutorily *pre-authorizes* the Department to provide the proposed medication profile to the child immediately and prior to obtaining a court order. A court order must then be sought within 3 business days.

SECTION 6: DRUG INFORMATION *Section 39.407(3)(c)4., Florida Statutes (2009) requires that Medical Report include information covering the recognized side effects, risks, contraindications, drug-interaction precautions, and possible effects of stopping medication for each medication. This information must be attached to this Medical Report. Medical Reports without such information attached cannot be filed with the court.*

Please attach the appropriate information for all psychotropic medications listed in section 3 of this report.

☐ I have provided a copy of the attached medical information to the child and to the child's caregiver.

☐ I have also *discussed* this information with the child and with the child's caregiver.

DRAFT

Child's Name _____ Date: _____

SECTION 7: SUPPLEMENTAL INFORMATION. *Please describe below information on other treatment options. In addition please attach any supplemental information that might explain or support this Medical Report.*

1. Are there other treatment options available in lieu of administering psychotropic medications? ☐ Yes ☐ No

   If yes, what are those alternatives?

   _____

   _____

   _____

2. Have these alternatives been tried? ☐ Yes ☐ No

   If yes, what was the response to the alternative treatments?

   _____

   _____

3. If the alternative treatments were not tried, explain why:

   _____

   _____

4. Other supplemental information:

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

DRAFT

Child's Name _____ Date: _____

SECTION 8: INFORMED CONSENT BY PARENT OR GUARDIAN *To be completed by parent or guardian in consultation with the physician.*

By signing this section I am certifying that I am a parent or guardian of the above-named child, and that the physician has explained to me each of the following (initial each):

____ the reason for treatment;

____ the proposed treatment;

____ the purpose of the treatment to be provided;

____ the common risks, benefits, and side effects of the treatment;

____ what results are expected;

____ the specific dosage range for the medication;

____ alternative treatment options and the risks and benefits thereof;

____ the approximate length of care;

____ the potential effects of stopping treatment;

____ how treatment will be monitored.

Further, by signing this section I am certifying the following (initial each):

____ The physician has fully answered all of my questions about this Medical Report.

____ I understand that I am not required to consent to this Medical Report. The Department may, after consultation with the prescribing physician, seek court authorization to provide the psychotropic medication to the child.

____ I understand that any consent given for treatment in this Medical Report may be revoked orally or in writing before or during the treatment period by a person who is legally authorized to make health care decisions on behalf of the child, and the Department will then be required to obtain a court order to continue the child on the medication.

SIGN HERE IF YOU CONSENT TO THE TREATMENT:

_____
Signature of parent or guardian CONSENTING

_____
Date

SIGN HERE IF YOU DO NOT CONSENT:

_____
Signature of parent or guardian NOT CONSENTING

_____
Date

_____
Print Name

_____
Relationship to Child

DRAFT

Child's Name _____ Date: _____

SECTION 9: SIGNATURE OF PHYSICIAN

By signing this document, I am certifying that I have reviewed all medical information concerning the child which has been provided, and I am certifying that the psychotropic medication, at its prescribed dosage, is medically necessary for treating the child's diagnosed medical condition, as well as the behaviors and symptoms the medication, and its prescribed dosage, is expected to address.

☐ **I have discussed with the child's parent/legal guardian** the reason for treatment; the proposed treatment; the purpose of the treatment to be provided; the common risks, benefits, and side effects of the treatment; the specific dosage range for the medication; alternative treatment modalities; the approximate length of care; the potential effects of stopping treatment; how treatment will be monitored.

☐ by phone ☐ in person

☐ **I have discussed with the child** the reason for treatment; the proposed treatment; the purpose of the treatment to be provided; the common risks, benefits, and side effects of the treatment; the specific dosage range for the medication; alternative treatment modalities; the approximate length of care; the potential effects of stopping treatment; how treatment will be monitored.

☐ Child assents ☐ Child does not assent ☐ Child is not age/developmentally appropriate

Comments, especially reason for nonassent: _____

_____

☐ I have not discussed this treatment with the parent/legal guardian and have not obtained express and informed consent for administration of this medication.

_____
Signature of prescribing physician

_____
Date

_____
Print Name

License: _____

Telephone Number: _____

Emergency Contact Telephone Number: _____

PSYCHOTROPIC MEDICATION INFORMED CONSENT FACILITATION FORM

This Form must be completed by the Case Manager for all cases where a child in out-of-home care is seeing a physician for the purposes of assessing a need for a prescription of psychotropic medication for any reason. This completed form must be submitted to CLS with the CLS Psychotropic Medication Packet immediately upon completion.

I _____ (Print Case Manager Name) certify that I have taken the following steps necessary to facilitate the inclusion of a parent or guardian, whose parental/guardian rights are intact, in the child's consultation with the prescribing practitioner:

Section 1:

☐ I successfully contacted the following parent or guardian advising them of an appointment with a physician regarding the prescription of psychotropic medication to their child in out-of-home care. *If parent or guardian is unable to be contacted, skip to Section 3.*

Name of parent or guardian contacted: _____ Date of contact: _____

AND

☐ I provided the parent or guardian with the following information regarding the appointment with the physician:

☐ Phone Conference Information: Name of physician _____

Phone Number _____

Date/Time to Call _____

OR

☐ Face-to-Face Meeting Information: Name of physician _____

Address _____

Date/Time _____

☐ Transportation Information *(Describe efforts made to assist parent/guardian with transportation to appointment with physician)*:

_____

AND

Section 2:

☐ Parent agreed to attend the face-to-face meeting with the physician or to call the physician.

OR

☐ Parent refused to attend the face-to-face meeting with the physician or to call the physician.

Section 3:

☐ The parent or guardian of the child is unknown and, as a result, informed consent will not be obtained.

OR

☐ I was unsuccessful in my attempts to advise a parent or guardian of an appointment with a physician regarding the prescription of psychotropic medication to their child in out-of-home care. I took ALL of the following steps to attempt to contact the parent or guardian:

☐ I sent written information concerning the need of the parent/guardian to provide express and informed consent for the prescription of psychotropic medication to their child to the last known address of the parent or guardian on the following occasion:

1. _____

AND

☐ I called the parent or guardian at the last know telephone/cell number and left messages when possible to ensure parental awareness of the need to provide express and informed consent for the prescription of psychotropic medication (s) on the following occasions:

1. _____
2. _____
3. _____
4. _____

Signature of Case Manager: _____ Date: _____

PSYCHIATRIC EVALUATION REFERRAL FORM

Evaluating Physician's Name: _____

Evaluation Address: _____

Date/Time of Scheduled Eval: _____

Case Manager Instructions: This Referral must be completed for all psychiatric evaluation requests. This Referral must be provided to the physician prior to the child's evaluation (unless the child is hospitalized or in SIPP, in which case the Referral may be filled out after the child receives medication based on information received from the hospital/SIPP). This form must also be provided to the CLS attorney, parents, guardian *ad litem* or attorney *ad litem* if one has been appointed.

If medications are prescribed, upon the doctor's completion of the Medical Treatment Plan, this Referral must be attached to the Medical Treatment Plan and both faxed to: CLS If there are any problems with the request for medication, CLS will notify the case manager and the CBC in order to quickly remedy the problem. CLS may also attempt to contact the physician directly.

SECTION 1: CHILD'S INFORMATION

Child's Name: _____ DOB: _____

Child's Height: _____ Child's Weight: _____ Gender: _____

Case No.: _____ Assigned Attorney: _____ Judge: _____

SECTION 2: CONTACT INFORMATION

Case Manager: _____ Phone: _____ Email: _____

Case Manager Supervisor: _____ Phone: _____ Email: _____

Contracted Agency: _____ Phone: _____ Email: _____

Caregiver (if not confidential): _____ Phone: _____ Email: _____

Therapist name: _____ Phone: _____ Email: _____

Primary care phys. name: _____ Phone: _____ Email: _____

Treating psychiatrist name: _____ Phone: _____ Email: _____

GAL name (if assigned): _____ Phone: _____ Email: _____

School name: _____ Phone: _____ Email: _____

Mother (if not terminated): _____ Phone: _____ Email: _____

Father (if not terminated): _____ Phone: _____ Email: _____

SECTION 3: AVAILABLE DOCUMENTS, PRIOR REPORTS. Please list all known prior evaluations or reports on the child. Include dates. Ex: psychiatric, psychological, mental health assessment, CPT, forensic interviews, etc. Please ATTACH any evaluation that specifically requested this evaluation.

Child's Name: _____ Date:_____

SECTION 4: CHILD HISTORY, BACKGROUND

Please check all that apply to this child.

☐ history of substance abuse

☐ history of non-compliance with medications

☐ history of psychiatric hospitalization/residential treatment center

☐ currently placed in psychiatric hospital/residential treatment center

☐ history of violence or threats of violence (to self or others)

☐ depression

☐ social or developmental delays

☐ other_____

☐ Specific suicidal statements or actions

☐ Traumatic experiences

☐ prior psychiatric diagnoses

☐ current non-psychiatric medical condition

☐ recent change in mood or behavior

☐ family mental health history

☐ family history of substance abuse

☐ family history of domestic violence

☐ academic or social difficulties

Symptoms began within last _____ (number) ☐ days, ☐ weeks, ☐ months, ☐ years; or ☐ lifelong.

Who has reported the symptoms? ☐ the child, ☐ placement, ☐ school, ☐ physician, ☐ parent,

☐ case manger, ☐other(please list)_____

History of abuse: ☐ abandonment, ☐ neglect, ☐ physical, ☐ sexual, ☐ emotional.

SECTION 5: SYMPTOMS NARRATIVE

Please describe any behaviors or symptoms of the child that have led to the request for this evaluation. In addition, include explanation of any factors checked in Section 4.

Child's Name: _____ Date: _____

SECTION 6: PSYCHOTROPIC MEDICATION and SERVICES HISTORY

List below or attach a list of all known medications that the child has taken or *is taking* at the time this referral is being made. Also list below or attach all psycho-social services (including therapy, CBHAs, and any school services) the child has received. Repeat page as necessary.

MEDICATION NAME	DOSAGE	START DATE	END DATE (REASON)	PRESCRIBING PRACTITIONER & CONTACT NUMBER	Reason for Medication

SERVICE/THERAPY	START DATE	END DATE	FREQUENCY	PROVIDER'S NAME & PHONE NUMBER (if known)

EMERGENCY INTAKE

Date and Time:_____ County:_____

Child's Name:_____ Date of Birth:_____

Child's Physician Contact Information:

Physician's Name	Physician's Phone Number
Physician's Address	

Are siblings also in foster care? ☐ Yes ☐ No

If yes, siblings' names and ages:_____

Parents'/Caregivers' Names:_____

Reasons for Removal:

☐ Suspected Physical Abuse ☐ Suspected Neglect ☐ Father Incarcerated ☐ Mother Incarcerated

☐ Suspected Sexual Abuse ☐ Other (specify):_____

Any known allergies: ☐ Yes ☐ No

If yes, list allergies:_____

Any know physical or emotional problems: ☐ Yes ☐ No If yes, list problems:

Any special dietary needs/formulas: ☐ Yes ☐ No If yes, list needs:

I _____(Print name of parent or legal guardian) certify that my child _____(print child's full name) is currently prescribed and taking the listed medications and by my signature I am giving authorization to the Department of Children and Families to continue to provide the listed medications and continue any listed behavioral health services.

Signature of Parent: _____ Date: _____

Medications	Reason for taking medication	Dosage	Length of Time on Medication	Giving to Shelter/ Foster Parent
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Medical Equipment/Information Accompanying Child: ☐ Eyeglasses ☐ Medication ☐ Medical Equipment ☐ Immunization Records ☐ Newborn Discharge Summary

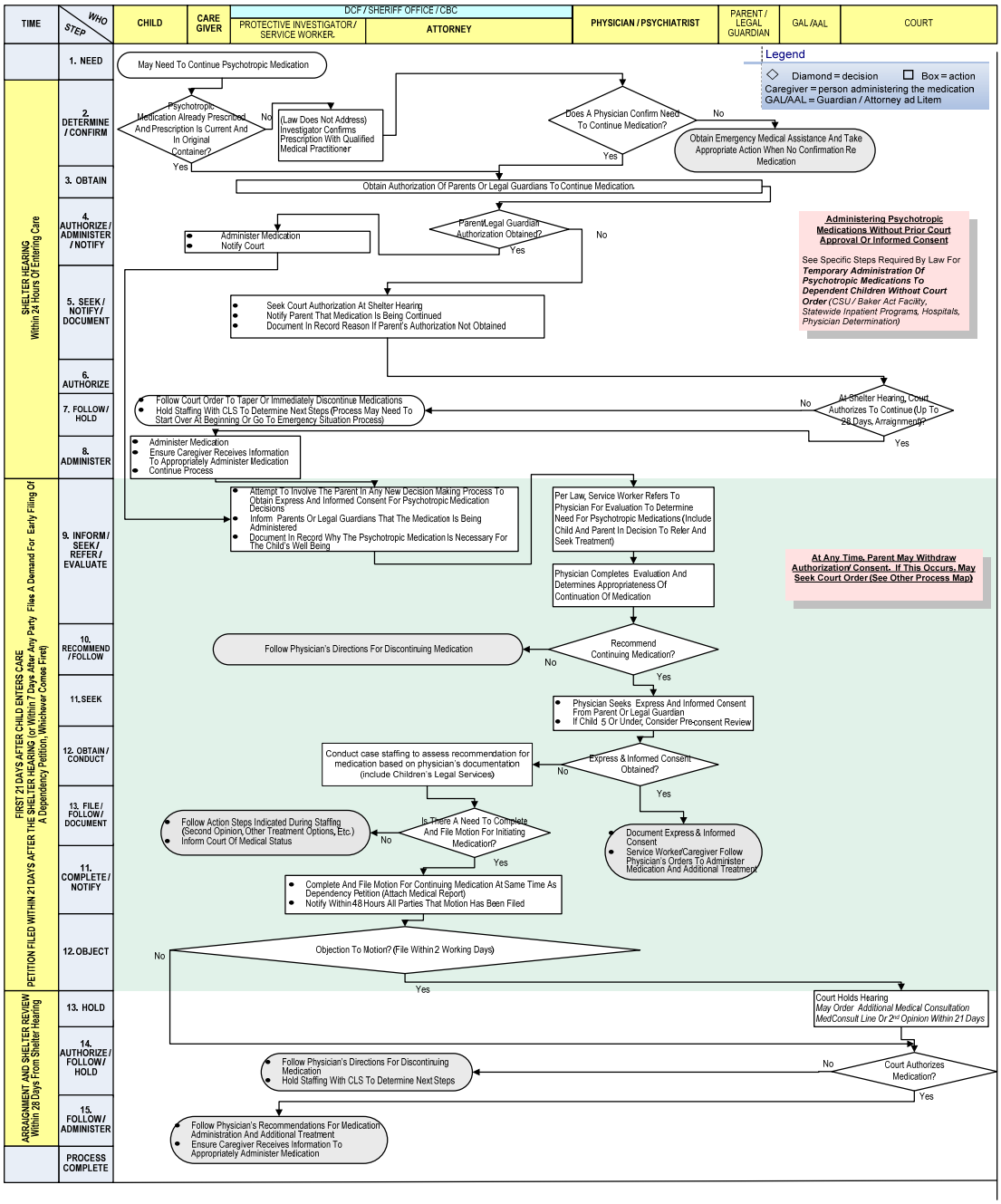
Where is the child being taken: ☐ Temporary shelter ☐ Relative of family ☐ Temporary foster home
☐ Friend of family ☐ Other (specify):_____

Contact Name:_____ Phone Number:_____

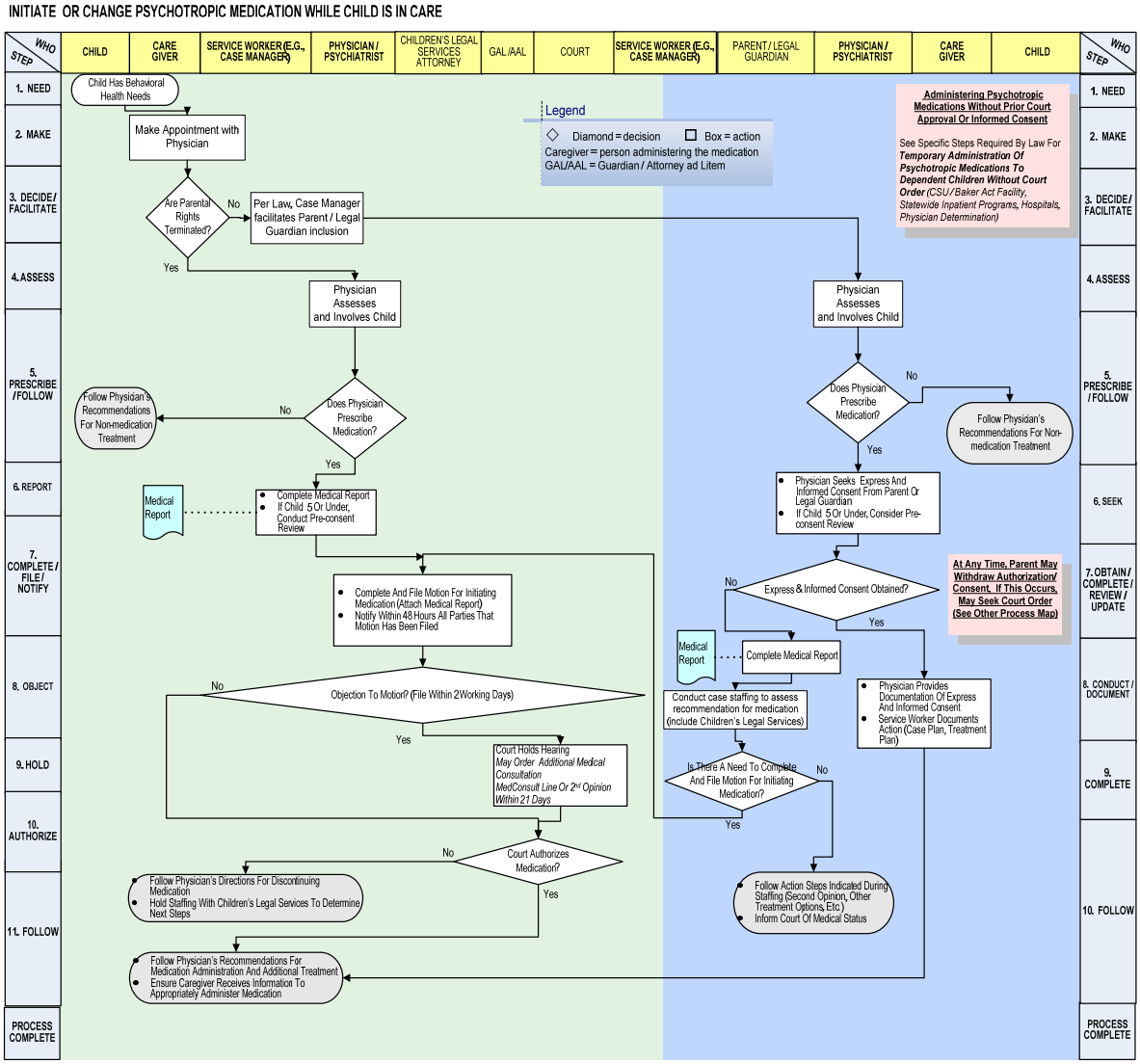
Address:_____

Notes:
Name/Title of person completing form:_____ Phone #:_____

Process Flow for Psychotropic Medication: Continue At Removal and During First 28 Days



Process Flow for Psychotropic Medication: Initiate or Change While Child Is In Care



Chapter 4

RESIDENTIAL MENTAL HEALTH TREATMENT

4-1. Purpose. This chapter provides the process for assessing and, if needed, placing children that are in out-of-home care into residential treatment centers, including therapeutic group homes. The process is consistent with Section 39.407, F.S., which provides the statutory requirements for such placements. Such placements must be carefully planned and should be considered only when a child has not been responsive to mental health treatment in the community and less restrictive treatment interventions are not currently appropriate or available. Residential treatment shall not be used for emergency placements; children or youth experiencing an acute psychiatric crisis should be referred to the local Baker Act receiving facility for emergency screening and stabilization.

4-2. Reference. Section 39.407, F.S., Rule 8.350, Florida Rules for Juvenile Procedures.

4-3. Threshold Criteria.

a. Before a child can be referred for a suitability assessment, the dependency case manager will review the child's current condition with the child's mental health case manager in relation to specific threshold criteria (see CF-MH 1054, Appendix A may be found on DCF Forms at http://dnp1.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx). The purpose of this internal review is to determine if the Department believes the child has an emotional disturbance severe enough to require the intensity and restrictiveness of treatment in a residential treatment center.

b. Resources that should be sought in reviewing the child's current condition are:

(1) Current evaluations or assessments;
(2) Reports from the family, the child, foster family, school, and the child's current placement;
(3) The results of recent case staffing(s);
(4) Staff observations of the child; and,
(5) Reports from mental health treatment, substance abuse and/or co-occurring mental health and substance abuse providers who worked with the child in the community or in less restrictive residential treatment settings, such as Specialized Therapeutic Foster Care, to determine what previous interventions were attempted, what interventions worked, did not work, and why

c. Each child being considered for referral for a suitability assessment must meet one or more of the Children's Functional Assessment Rating Scale (CFARS) problem severity ratings in Section B of Appendix H, and one or more of the following situations, as described in Section A of Appendix H:

(1) Treatment was implemented according to a comprehensive service plan developed by a multidisciplinary team, but was ineffective.
(2) Placement in a Specialized Therapeutic Foster Home program or other community-based therapeutic setting was ineffective.
(3) The child's condition is so severe and the situation is so urgent that treatment can not be safely attempted in the community.

4-4. Suitability Assessment. If it is determined that the child meets the threshold criteria:

a. The dependency case manager will prepare the referral packet (Appendices A, B and D), including all required attachments, obtain the signatures of the immediate supervisor and next level supervisor, and forward the packet and all attachments to the Point of Contact. The dependency case manager will simultaneously notify the Children's Legal Services that a suitability assessment has been requested so that Children's Legal Services can file notice with the court and all parties, including the child's guardian ad litem and, if appointed, attorney. The dependency case manager shall provide the child's guardian ad litem and, if appointed, attorney the opportunity to meet with the child before the

child's appointment with the Qualified Evaluator, and shall provide the opportunity for the child's guardian ad litem and, if appointed, attorney to discuss the child's suitability for placement in a residential treatment setting with the qualified evaluator prior to the written assessment.

b. The Point of Contact will review the referral packet to ensure that it is complete. Within two (2) working days, the Point of Contact will fax the cover letter (Appendix B to this operating procedure), the Threshold Criteria form (Appendix A to this operating procedure) and the three-page Referral for Mental Health Services form (Appendix C may be found on DCF Forms at http://dnp1.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx) to the Agency for Health Care Administration's (AHCA) contracted provider. Any additional attachments that the Point of Contact receives in support of the referral should not be faxed at this time, but will be furnished to the Qualified Evaluator or AHCA provider as per 5-4.d.(3), below.

c. Within two working days of receiving the referral from the Point of Contact, AHCA's contracted provider is required by contract to:

(1) Designate a Qualified Evaluator;

(2) Schedule the child's appointment with the Qualified Evaluator; and,

(3) Notify the Point of Contact of the name, address, and phone number of the selected Qualified Evaluator and the date and time of the appointment at least three working days before the appointment.

d. Immediately upon notification from AHCA's contracted provider, the Point of Contact will:

(1) Notify the dependency case manager of the appointment;

(2) Confirm that the dependency case manager, or the child's foster parent or another adult who knows the child well, will transport and accompany the child during the appointment; and,

(3) At least one working day before the appointment, ensure that the completed packet, including all required attachments, is delivered to the office of the Qualified Evaluator.

e. The Qualified Evaluator, after completing the evaluation and suitability assessment, will submit the assessment report and any supporting information to AHCA's contracted provider for approval. This report must include written findings that the child has been provided with a clinically appropriate explanation of the nature and purpose of the recommended treatment.

f. After approving the report, AHCA's contracted provider will send the assessment report to the Point of Contact, who will forward the report to the dependency case manager, the dependency case manager's supervisor, and to the Circuit Substance Abuse and Mental Health (SAMH) Office. The report will be forwarded within 14 working days of receipt of the referral.

g. The Point of Contact or, as appropriate under local protocol, the dependency case manager will provide a copy of the suitability assessment report to the CLS attorney who will provide it to the court and all parties, including the guardian ad litem and attorney ad litem, if assigned.

h. If, at any point during the suitability assessment process, the child appears to have an urgent need for immediate mental health services, the dependency case manager will access appropriate mental health services in the community, including emergency services as necessary. The dependency case manager may request assistance as needed from the Point of Contact.

4-5. Actions Following Suitability Determination.

a. If the Qualified Evaluator determines the child does not require placement in a residential treatment center, the Point of Contact will offer to assist in developing a plan for necessary treatment and support services for the child in the community.

b. If the Qualified Evaluator determines the child does need treatment in a residential treatment center and the decision is made to place the child into a residential treatment center or under contract with AHCA as a SIPP, the dependency case manager will:

-

(1) Immediately notify Children's Legal Services (CLS).

(2) Meet with mental health placement and services staff according to local protocol to identify less restrictive placement options, services and supports for the child as an alternative to residential treatment in the event the court orders that the child be placed in a less restrictive placement. These staff should include the Point of Contact, and in certain areas as established in the Scope of this operating procedure (paragraph 2.) the circuit SAMH Program Office.

c. Upon notification from the child's dependency case manager, the CLS attorney will file a motion for placement of the child with the court and notify the child's guardian ad litem and attorney, when assigned, and all other parties. This motion shall include a statement as to why the child is suitable for this placement, why less restrictive alternatives are not appropriate, and the written findings of the Qualified Evaluator. This motion shall also state whether all parties, including the child, are in agreement with the decision. CLS shall ensure the court sets the matter for a status hearing within 48 hours, excluding weekends and holidays, and shall provide timely notice of the date, time and place of the hearing to all parties and participants, except that the child's attorney or guardian ad litem shall notify the child of the date, time and place of the hearing. If, at the status hearing, any party disagrees with the recommended placement, then the matter shall be heard by the court within 10 working days.

d. If the Qualified Evaluator's written assessment indicates that the child requires immediate placement in a residential treatment center or hospital and that such placement cannot wait for a court hearing, then the child may be placed, pending a hearing.

e. Upon the filing of the motion for placement, the Department will provide timely notice of the date, time, and place of the status hearing to all parties and participants.

f. If the motion for placement of the child into residential treatment is approved by the court during the status hearing, the dependency case manager, the Point of Contact and, according to local protocol, the Circuit SAMH Office or other mental health placement and services staff, will coordinate the placement of the child.

g. If the child, or any other party, disagrees with the placement of the child into residential treatment, a placement hearing will be requested. The dependency case manager will assist Children's Legal Services staff in preparing for the placement hearing.

h. If the court approves the motion for placement of the child into residential treatment and if resources are immediately available for placing the child in a residential treatment center:

(1) According to local protocol, the Lead Agency will consult with all mental health placement and services staff appropriate to the level of residential treatment recommended by the suitability assessment. If the recommendation is for a Statewide Inpatient Psychiatric Program or SIPP placement, then Children's Mental Health staff from the SAMH Program Office in the circuit of the lead agency must be involved. If the recommendation is not for SIPP, then coordinating staff should include, in the areas as established in the Scope of this operating procedure (paragraph 2.), the circuit SAMH Program Office. The selection of the residential treatment center must be designed to meet the child's identified treatment needs and follow the approval and placement process required for the placement selected.

(a) If SIPP is selected, submit a complete referral package to the SIPP that includes, at a minimum: Appendix A, Threshold Criteria: Appendix C, Referral for Mental Health Services with all attachments: Appendix D, Statement of Medical Stability; and the suitability assessment of the Qualified Evaluator.

(b) Follow-up with the SIPP provider to ensure that prior authorization is being requested from AHCA's contracted provider of SIPP utilization management.

(c) Upon notification from the SIPP that the child has been authorized for admission, notify the Point of Contact, the dependency case manager and AHCA's contracted provider for independent evaluations of the child's admission, the date of admission, and the name, address and phone number of the facility.

(d) If authorization is denied, reconsideration may be requested per the process outlined in AHCA's "Utilization Management Procedures for Statewide Inpatient Psychiatric Program" manual.

(2) Upon notification from the Circuit SAMH Program Office that the child will be placed in the SIPP/residential treatment center, the dependency case manager will:

(a) Immediately notify the Children's Legal Services attorney who will in turn notify the guardian ad litem, the attorney ad litem, if assigned, and the court of the child's placement in the residential treatment center.

(b) Provide the facility with a copy of the court order that currently authorizes administration of psychotropic medications.

(c) Provide the facility with the appropriate legal consent to treatment and a copy of the court order approving placement of the child, if available.

(d) Prepare the child for the placement, including describing the facility and its program and explaining the nature and purpose of the treatment.

(e) Ensure that the child has suitable clothing and arrange in advance with the residential treatment center for the child to bring allowable personal possessions.

(f) Inform the child's parents of the child's status and the SIPP placement arrangements.

(g) Give the child and the residential treatment center the name and phone number of the dependency case manager and supervisor, including an after-hours contact for urgent situations, and the phone number of the child's foster parents, parents and/or other relatives that the child has permission to contact unless contraindicated, as well as the guardian ad litem and child's attorney, if one has been appointed.

(h) Monitor the child's safety, care, and treatment while in the residential treatment center by maintaining regular contact with the child and the child's treatment team, including monthly visits with the child.

(i) In coordination with the residential treatment center, facilitate regular contacts between the child and the significant people in the child's life.

(j) Work closely with the facility and relevant resources in the community toward a timely and appropriate discharge plan.

(k) Follow through to ensure appropriate treatment and support services are provided to the child and family upon discharge.

i. If the court denies the motion to place the child into a residential treatment facility or orders the placement of the child in a less restrictive setting during a 90-day review hearing, the dependency case manager will consult with the Point of Contact and the Circuit SAMH Program Office to coordinate the referral and placement of the child into the least restrictive setting that is best suited to meet the child's needs.

j. If the child cannot be placed immediately in a residential treatment center, the Point of Contact in consultation with the dependency case manager and the local mental health placement and services staff (which may include the circuit SAMH Program Office and/or the Child Welfare Prepaid Mental Health Plan) will:

(1) Ensure that a targeted case manager is designated to develop, implement, and monitor a service plan for the child that is integrated into the child's case plan.

(2) Enter the child's name onto the area's waitlist for the purpose of providing needed services.

(3) Monitor, through the mental health data system, to ensure the child is receiving the needed mental health services.

4-6. Discharge Planning.

a. Before a child is admitted to a residential treatment center, the dependency case manager will coordinate the development of an initial discharge plan that at a minimum identifies:

(1) The individual or family or program that the Lead Agency anticipates will be providing a home for the child following discharge. Because this may not be firmly established at the time of admission to the facility or may be subject to future court approval, contingency plans should also be discussed with the child and included in the initial discharge plan.

(2) Services that will be offered to the child's identified future caregiver during the placement and following discharge. These services should be designed to prepare the caregiver to work effectively with the child and ensure stability in the discharge environment.

(3) Potential step-down treatment programs in the community that may be explored, depending on the intensity of the child's needs for continued structured treatment at the time of discharge. Such programs might include a therapeutic foster home, Specialized Therapeutic Foster Care at Level 1 or 2, or a specially recruited foster home that has been trained through the Lead Agencies' Behavior Analyst Services personnel, if available.

b. While the child is in the facility, the child's designated case manager and/or the dependency case manager will communicate regularly with the child, the child's family/caregiver, the facility's treatment team and the Lead Agency placement unit to plan for the child's discharge. The discharge plan will be finalized at least 30 days prior to the child's projected discharge date.

c. As soon as the child's future caregiver is identified, the dependency case manager will work with the facility to facilitate phone calls, visits, and home visits with the caregiver and to address any issues identified by the child, the caregiver, or facility staff to ensure a successful discharge.

4-7. Reviews and Reports.

a. Section 39.407(6), F.S., requires certain reports and reviews for children in the Department's custody who are placed into residential treatment centers or hospitals. It is imperative that Circuits track compliance with these requirements and ensure timely receipt and distribution, including requirements for filing reports with the court. Each Circuit will develop its own operating procedures for ensuring compliance.

b. The following reports and reviews are required for placements made under Section 39.407(5), F.S., to hospitals licensed under Chapter 395, F.S., or residential treatment centers, including therapeutic group homes, licensed under Chapter 65E-9, F.A.C

(1) 10-Day Report. Subsection 39.407(6) (e), F.S, requires that:

(a) Within 10 days after the admission of a child to a residential treatment program, the director of the residential treatment program or the director's designee must ensure that an individualized plan of treatment has been prepared by the program and has been explained to the child, to the Department, and to the guardian ad litem, and submitted to the Point of Contact and dependency case manager.

(b) The child must be involved in the preparation of the plan to the maximum feasible extent consistent with his or her ability to understand and participate, and the guardian ad litem and the child's foster parents must be involved to the maximum extent consistent with the child's treatment needs.

(c) The plan must include a preliminary plan for residential treatment and aftercare upon completion of residential treatment. The plan must include specific behavioral and emotional goals against which the success of the residential treatment may be measured.

(d) A copy of the plan must be provided to the child, to the guardian ad litem, the CLS attorney and to the child's dependency case manager.

(2) 30-Day Report. Subsection 39.407(6)(f), F.S, requires that:

(a) Within 30 days after admission, the residential treatment program must review the appropriateness and suitability of the child's placement in the program. The residential treatment program must determine whether the child is receiving benefit towards the treatment goals and whether the child could be treated in a less restrictive treatment program.

(b) The residential treatment program shall prepare a written report of its findings and submit the report to the guardian ad litem, the Department, and to the dependency case manager.

(c) The Department must submit the report to the court through the CLS attorney. The report must include a discharge plan for the child.

(d) The residential treatment program must continue to evaluate the child's treatment progress every 30 days thereafter and must include its findings in a written report submitted to the Department and the dependency case manager.

(e) The Department, through the CLS attorney, must submit, at the beginning of each month, to the court having jurisdiction over the child, a written report regarding the child's progress towards achieving the goals specified in the individualized plan of treatment as required in s. 39.407(6)(g)1., F.S.

(3) 90 Day Reviews.

(a) The Agency for Health Care's (AHCA) contracted provider will direct one of its registered Qualified Evaluators to conduct the 90-day independent reviews, for children in Department custody in facilities licensed under Chapter 395, F.S. and 65E-9, F.A.C.

(b) The Circuit will provide ongoing notification to AHCA's contracted provider of all children in Department custody placed in these facilities to ensure that the reviews are scheduled timely. the 90Day Review for Suitability of Service: Residential Treatment (Appendix D to this operating procedure may be found on DCF Forms at http://dnp1.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx) will be used to authorize access to the child by the Qualified Evaluator for these reviews.

(c) Subsection 39.407(6) (g) and (h), F.S., requires that:

1. The court must conduct a hearing to review the status of the child's residential treatment plan no later than three months after the child's admission to the residential treatment program.

2. An independent review of the child's progress towards achieving the goals and objectives of the treatment plan must be completed by a Qualified Evaluator and submitted to the court before its three-month review.

3. For any child in residential treatment at the time a judicial review is held pursuant to s. 39.701, the child's continued placement in residential treatment must be a subject of the judicial review. If at any time the court determines that the child is not suitable for continued residential treatment, the court shall order the Department to place the child in the least restrictive setting that is best suited to meet his or her needs.

4. After the initial 3-month review, the court must conduct a review of the child's residential treatment plan every 90 days.

c. Florida Supreme Court Rule 8.350 requires the court to review the status of the child's residential treatment plan no later than three (3) months after admission to the residential treatment facility and every three (3) months thereafter, until the child is placed in a less restrictive setting. The dependency case manager will provide a copy of the child's 90-day review, completed by the Qualified Evaluator, to the child's guardian ad litem and the Children's Legal Services attorney so they can provide the court , and all other parties, with a copy at least 72 hours prior to the child's review hearing.

4-8. Visitation.

a. Within three working days of placement in a residential treatment center, the dependency case manager will contact the child, by phone or in person, and the facility's treatment staff to assure the program is meeting the child's needs.

b. The dependency case manager will visit the child at least every 30 days while the child is in the placement to monitor the child's condition and progress and will document the visits through Florida Safe Families Network (FSFN). During the visit, the dependency case manager will ensure that services are being provided that address all domains of a child's life and document that in the case

record.

c. If the child is placed out of Circuit, the Lead Agency will formally request the receiving Circuit to visit the child at least every 30 days, document the visits through FSFN, and provide the home Circuit with regular written updates on the child's adjustment and condition.

4-9. Out-of-State Placements Prohibited. It is the policy of the Department that the Circuit will not approve or participate in funding out-of-state placements for mental health treatment of children. The only exception that may be considered must meet the following conditions:

a. The Lead Agency reunification plan is for the child to join a family who lives in the other state.

b. The home study is complete and approved.

c. Funding is for a transitional period not to exceed three months.

d. The Circuit Administrator has provided prior written approval of the placement.

e. A copy of the Circuit Administrator's approval letter is sent to the Chief of Children's Mental Health in the SAMH Central Office.

Threshold Criteria

Each child being considered for referral for a suitability assessment must meet one or more of the conditions described in Sections A and one or more of the CFARS problem severity ratings in Section B. The CFARS ratings in Subsection B-1 should be provided also, but they should be considered only as supplementary risk factors or functional impairments related to the child's serious emotional disturbance as described in Section B. This form will be completed by the Community Based Care Lead Agency Service Worker with assistance from the child's mental health case manager.

A. Attempts to treat child in the community: **(check all that apply)**

- ❑ A comprehensive service plan developed by a multidisciplinary team was implemented. A case manager coordinated the provision of the services, and the services were not successful in treating the child's condition; and/or
- ❑ The child was placed in a Specialized Therapeutic Foster Home program or other community-based therapeutic setting for treatment and the placement was not successful in treating the child's condition; and/or
- ❑ The child's condition is so severe and the situation so urgent that treatment can not be safely attempted in the community.

B. Serious emotional disturbance: **Insert the number ratings from the most recent CFARS and attach the CFARS two-page summary sheets.** A rating of 7 or above on one or more of the following areas generally indicates a child with a serious emotional disturbance.

____ **DEPRESSION** (unipolar, dysthymia, bipolar)

____ **ANXIETY** (panic attacks, obsessive-compulsive disorders)

____ **THOUGHT PROCESS** (schizophrenia, psychotic disorders, hallucinations)

____ **TRAUMATIC STRESS** (intrusive thoughts, hyper-vigilance)

____ **DANGER TO SELF** (recent suicidal gestures or attempts, head-banging)

B-1: Supplementary information: <u>Insert the number ratings</u> from the most recent CFARS and <u>attach</u>.

____ DANGER TO OTHERS
____ COGNITIVE PERFORMANCE
____ HYPERACTIVITY
____ MEDICAL/PHYSICAL
____ SUBSTANCE USE
____ INTERPERSONAL RELATIONSHIPS
____ BEHAVIOR IN "HOME" SETTING
____ ADL FUNCTIONING
____ SOCIO-LEGAL
____ WORK OR SCHOOL
____ SECURITY MANAGEMENT NEEDS

CF-MH 1054, PDF 10/2005

Referral for Suitability Assessment – Sample Letter

DATE:

TO: (Agency for Health Care Administration contracted provider)

FROM: (Single Point of Access), Circuit _____

Attached is a referral on behalf of (child's name) _____ to determine if:

1. This child has an emotional disturbance serious enough to require residential mental health treatment,
2. The child is reasonably likely to benefit from the residential treatment, and,
3. All available treatment options less restrictive than residential treatment have been considered and a less restrictive alternative that would offer comparable benefits to the child is unavailable.

I have reviewed the attached referral information for completeness and am requesting that you provide me with the name, phone number and mailing and street address of the Qualified Evaluator you have selected to perform the assessment. Upon receiving that information, I will immediately send to the Qualified Evaluator the entire referral packet, including attachments, for review before the suitability assessment appointment.

Please ask the Qualified Evaluator to call _____, the child's Community Based Care Lead Agency Child Welfare Service Worker, at (____) ____-_____ to schedule the appointment, to give directions to the Evaluator's office, and to confirm transportation arrangements to the appointment.

Please provide a copy of your findings and any additional supporting information to me at the following address:_____

_____

_____

I will then share the report with the Community Based Care Lead Agency Child Welfare Service Worker who will inform the guardian ad litem and the court. If you have any questions about the referral, please call me at (____) ____-_____.

REFERRAL FOR MENTAL HEALTH SERVICES

☐ **COMMUNITY MENTAL HEALTH SERVICES** ☐ **MENTAL HEALTH CASE MANAGEMENT** ☐ **RESIDENTIAL MENTAL HEALTH SERVICES**

Formatted: Bulleted + Level: 1 + Aligned at: 0" + Tab after: 0" + Indent at: 0.25"

Child information:

Name:	Date of birth: / /
Social Security #:	Gender: ☐ Male ☐ Female
Medicaid ID #:	Race/ethnicity:
Current school:	Current grade:
Legal Status (as reported in FSN):	

Parent or legal guardian information: (This is the biological or adoptive parent or relative or other adult appointed by the court as legal guardian, not the DCF staff, foster parent, or shelter):

Name of parent or legal guardian:	Mailing address: Street address:
Daytime phone:	Directions:
Evening phone:	

Child's *current* living arrangement: Complete this section if child is *not* living with the parent or legal guardian.

Name of current caregiver:	Daytime phone: Evening phone:
Type of setting: ☐ Shelter ☐ Foster home ☐ Group home ☐ Therapeutic foster home ☐ Therapeutic group home ☐ Residential treatment center ☐ Acute hospital ☐ Crisis unit ☐ Psychiatric hospital ☐ Detention ☐ Other (specify) _____	Mailing address: Street address: Directions:

Community Based Care Lead Agency Child Welfare Service Worker: Complete this section if child has a Community Based Care Lead Agency Service Worker; if not, place "N/A" next to "name."

Name:	Mailing address:
Phone #:	
Pager or cell phone #:	E-mail address:
Supervisor name:	Supervisor phone #:

Summary of permanency or transition plan goals for the child:

CF-MH 1055, Jan 2004

Guardian Ad Litem: Complete this section if child has a Guardian Ad Litem; if not, place "N/A" next to "name."

Name:	Mailing address:
Phone #:	
Pager or cell phone #:	E-mail address:

Juvenile Probation Officer: Complete this section if child has a Juvenile Probation Officer; if not, place "N/A" next to "name."

Name:	Mailing address:
Phone #:	
Pager or cell phone #:	E-mail address:

Child's mental health information:

Current prescribed medications			Current DSM-IV diagnosis:
Drug name	Dosage & frequency	Dates used	Axis I.
			Axis II.
			Axis III.
			Axis IV.
			Avis V. (GAF):
Prescribing practitioner name & phone #:			Diagnosing professional's name & phone #:

Reason for referral for treatment: In your own words, describe the child's need for mental health services. Please describe specific behaviors the child is exhibiting.

Desired treatment outcomes: In your own words, describe the results you want for the child from receiving mental health treatment.

Summary of discharge plan: (include specific caregiver and living arrangements):

Required documents attached: Check all the documents that are attached. If not available, please explain why.

- ☐ Threshold criteria (Appendix A to CFOP 155-10)
- ☐ Comprehensive Behavioral Health Assessment
- ☐ Most recent CFARS (completed by the mental health professional working with the child)
- ☐ Previous mental health treatment (types of services/facilities, dates of admission & discharge, outcomes)
- ☐ Shelter petition, shelter order, or foster care order
- ☐ Pre-Disposition Summary
- ☐ Case plan
- ☐ Individual Educational Plan and/or 504 Plan
- ☐ Multidisciplinary service plan, including outcomes
- ☐ Summary of foster care placement(s) (List child's foster care placement(s), reasons moved, and dates.)
- ☐ Summary of Juvenile Justice involvement (List delinquency charges, dispositions, and dates.)
- ☐ Department consent for treatment
- ☐ Parent or legal guardian consent for psychotropic medication or court order
- ☐ Statement of Medical Stability (Appendix F to CFOP 155-10) – for referrals to SIPPs
- ☐ Other – attached (please describe): _____

Additional comments or information regarding this child's referral:

Return the completed form and attachments to:

Complete the following section only for children being referred for a <u>suitability assessment</u> for possible treatment in a residential treatment center/hospital or therapeutic group home:

We, the undersigned, believe that _____, a child in the custody of the Department of Children and Families, has a severe emotional disturbance and may need residential treatment, pursuant to Section 39.407, Florida Statutes.

Community Based Care Lead Agency Child Welfare Service Worker
_____ Date: _____/_____/____

Community Based Care Lead Agency Supervisor:_____ Date: _____/_____/____

Next level supervisor:_____ Date: _____/_____/____

I certify the referral form and packet for suitability assessment are complete:

_____ Date:_____/_____/____
Single Point of Access

Copy to:

CF-MH 1055, Jan 2004

STATEMENT OF MEDICAL STABILITY

Child's Name: _____ Date of Birth: _____

Social Security #: _____

I, _____, have examined the above child and have determined that he or she is currently in good physical health with no acute or chronic conditions requiring extensive medical treatment, and the need for medical care, other than routine, is not anticipated.

_____ _____
Health Care Provider's Signature Date

PLEASE ATTACH A COPY OF THE PHYSICAL EXAM THAT HAS BEEN DONE WITHIN THE LAST 30 DAYS

CF-MH 1056, Jun 2002

REFERRAL FOR A 90-DAY REVIEW FOR SUITABILITY OF SERVICE: RESIDENTIAL TREATMENT

DIRECTIONS:
This review is required for children placed in a 395 or a 65E-9 licensed facility that are in the custody of the Department of Children and Families (DCF). The time frame for completion of the suitability assessment is 70-75 days after admission and every 90 days thereafter. Each child in the custody of the Department placed in this type of facility is subject to a judicial review of treatment pursuant to F.S., 39.407. The authorization section within this document serves as a release from the Department to allow the designated Qualified Evaluator access to the child for a face-to-face interview and to the child's clinical record for a record review.

Please complete this form and fax it to the attention of the QEN Coordinator at First Health Services of Florida: 800-639-8982.

Referring Circuit: _____ Today's Date: _____

SINGLE POINT OF ACCESS

NAME:	
ADDRESS 1:	
ADDRESS 2:	
CITY/STATE/ZIP:	
PHONE:	**FAX:**

CHILD'S NAME	SSN	MEDICAID #	DOB

FACILITY WHERE THE CHILD IS PLACED

NAME:	
ADDRESS 1:	
ADDRESS 2:	
CITY/STATE/ZIP:	
PHONE:	**FAX:**

SIPP REFERRED? ☐ Yes ☐ No **DATE OF SAMHIT:**_____

LAST REVIEW DATE:_____

(include Agency Logo if applicable at top of page

AUTHORIZATION OF SUITABILITY ASSESSMENT BY A QUALIFIED EVALUATOR

Re: _____ SSN: _____ DOB: _____

Pursuant to Section 39.407(6)(g)2., Florida Statutes, Dr. _____, a Qualified Evaluator contracted by First Health, Inc., is authorized to have access to the child, to members of the child's treatment team and to the child's clinical records for the purpose of producing a report to the Department of Children & Families. The Qualified Evaluator is a Florida-licensed psychiatrist or psychologist with at least three years' experience in the diagnosis and treatment of serious emotional disturbances in children and adolescents. The Department will submit to the dependency court the Qualified Evaluator's report, which will summarize the child's progress toward achieving the goals and objectives of the individualized treatment plan that is on file with the court.

Authorization beginning date: ___/___/___ (valid for 90 days)

If there are any questions about this authorization, please contact me at (____) ____-_____.

Thank you for your cooperation.

Sincerely,

_____
(name)

_____
(title)

Point of Contact

Agency Name Here

Circuit _____

Appendix 1. Definition of Terms

"Assent" when used in this Chapter 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 chapter, 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" 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 Section 39.01(62), F.S.

"Child Specific Multidisciplinary Team" (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 surrogate and others who may have information or services to offer for the child's service plan.

“Comprehensive Behavioral Health Assessment”, 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, and community, including direct observation of the child in those settings.

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

“Dependency Case Manager” 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 Section 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, sterilization, 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” 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, are 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 Section 39.6221, F.S., or a "guardian" as defined in Section 744.102, F.S., or a relative with a court order of temporary custody under Section 751, F.S. Dependency case managers and Guardian Ad Litems do not meet the definition of guardian.

“Licensed health care professional” means a physician licensed under Chapter 458, an osteopathic physician licensed under Chapter 459, a nurse licensed under Chapter 464, a physician assistant certified under Chapter 458 or Chapter 459, or a dentist licensed under Chapter 466.

“Medical Report” means a report prepared by the prescribing physician that includes information required by Section 39.407(3)(c), F.S . The form for the Medical Report is “Medical Report” (form CF-FSP 5339 dated September 2009), 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) 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. (Sec. 743.0645(1) (b), F.S.)

“Out-of-Home Care” means the placement of a child, arranged and supervised by the Department of Children and Families 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 are placed outside of their homes.

“Person who has the power to consent as otherwise provided by law” includes a natural 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) is also known in some areas as the Single Point of Access or SPOA, and means the person or entity designated by the Circuit’s Substance Abuse and Mental Health 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 Chapter 458 or 459, Florida Statutes.

“Psychotropic Medication” 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 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 a person who meets this definition and 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 Chapter 458 or 459, Florida Statutes, or an advanced registered nurse practitioner licensed under Chapter 464, Florida Statutes.

“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 Agency for Health Care Administration.

“ 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 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” or “SIPP” means those residential mental health treatment programs selected through a request for proposal and contracted by 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 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 and Behavioral Health Overlay Services (BHOS) provider 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 consists of individuals with experience and competencies in providing mental health, substance abuse, co-occuring mental health and substance abuse, and developmental disabilities services. The plan must contain written treatment-related goals andmeasurable objectives.