Chapter 1

GENERAL

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

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

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

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

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

c. Section 39.304, F.S.

d. Sections 743.064 and 743.0645, F.S.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1-5. Point of Contact.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) Copy of the Medicaid card;

(7) Copy of the Shelter Order; and,

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

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

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

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

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

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

g. Child's Resource Record in Licensed Placements.

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

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

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

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

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

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

1-7. Behavioral Health Services.

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

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

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

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

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

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

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

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

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

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

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

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

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