

Chapter 3

PSYCHOTROPIC MEDICATIONS

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

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

3-3. References. Sections [39.407\(3\)\(a\)1](#), [394.455\(9\)](#), and [394.459\(3\)\(a\)](#), Florida Statutes (F.S.); Rule 65C-30.011 and Chapter [65C-35](#), Florida Administrative Code (F.A.C.); and DCF General Counsel's Legal Opinion 09-01.

3-4. Psychotropic Medication Documentation Required Forms.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) The child welfare professional may document actions to assist in ensuring the parent's or legal guardian's participation in the express and informed consent process by completing the Psychotropic Medication Informed Consent Facilitation (form CF-FSP [5228](#), available in DCF Forms).

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

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

b. Psychiatric Evaluation Referral.

(1) The Psychiatric Evaluation Referral (form CF-FSP [5341](#), available in DCF Forms) should be completed by the child welfare professional for all referrals for medical evaluation. The form will provide at a minimum the following information:

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

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

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

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

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

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

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

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

3-5. Parental or Legal Guardian Involvement. The Department or its contracted service provider is required to assist the prescribing physician or psychiatric nurse 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 or psychiatric nurse who prescribes the child psychotropic medication.

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

(1) Invite the parent or legal guardian to the doctor's appointment, if not prohibited by a court order, and offer the parent(s) transportation, if needed, or arrange and facilitate telephone calls for 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 or psychiatric nurse and provide specific information for how and when to contact the physician or psychiatric nurse (e.g., letter via postal service, email, text, etc.).

b. If there are any changes in medication, including dosage or dosage range, that go beyond the existing authorization, the child welfare professional will be responsible for either facilitating

discussions between the prescribing physician or psychiatric nurse and the parent or legal guardian in order to obtain a new express and informed consent, or pursuing a new court authorization if parental rights have been terminated. A prescribing physician's or psychiatric nurse's decision to change a medication from a brand name to a generic equivalent medication will not require additional consent or court authorization. The child welfare professional I shall inform CLS and all parties of any changes in medication and shall provide CLS with a copy of the amended Medical Report.

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

d. If the child's parent or legal guardian has an opportunity to speak with the physician or psychiatric nurse and have reasonable questions addressed, or if the parent or legal guardian has such opportunity by telephone or video conferencing if available, and if the conversation is reasonably documented by the child welfare professional 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 child welfare professional or the caregiver provide consent to provide psychotropic medications to children in out-of-home care, unless specifically authorized by the court.

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

- (1) A copy of the Medical Report;
- (2) The method of administering 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 or psychiatric nurse's plan to reduce and/or eliminate ongoing administration of the medication.

g. When the court has authorized the provision of psychotropic medications, the child welfare professional 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 or psychiatric nurse so that the parent or legal guardian has the opportunity to consider whether to authorize the provision of any new medications or dosages, unless the parent or legal guardian's rights have been terminated.

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

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

- (1) A copy of the Medical Report;
- (2) The method of administering 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 or psychiatric nurse's plan to reduce and/or eliminate ongoing administration of the medication.

b. If the caregiver has questions concerning the medication, the child welfare professional must encourage the caregiver to contact the prescribing physician or psychiatric nurse for guidance.

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

d. Licensed caregivers must fulfill the health and medication requirements under licensing and other rule sections specifically in Chapter [65C-45](#), F.A.C.

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

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

a. The physician or psychiatric nurse 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 administering 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 or psychiatric nurse's plan to reduce and/or eliminate ongoing administration of the medication.

b. The prescribing physician or psychiatric nurse 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 or psychiatric nurse's responsibility to inform the child as clearly as possible and as fully as is appropriate considering the child's developmental level and ability to understand. However, the child's failure to understand or assent is not, by itself, sufficient to prevent the administration of a prescribed medication. Likewise, the child's assent to the treatment is not a substitute for express and informed consent by a parent or legal guardian or a court order. Children are more likely to be successful in treatment if they fully understand and participate in treatment decisions.

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

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

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

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

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

a. The child welfare professional with primary assignment is responsible for the following tasks relating to ongoing medical care and treatment:

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

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

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

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

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

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

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

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

c. If a child uses medically assistive devices, the child welfare professional with primary assignment or the assigned person making the placement shall ensure that these devices are taken with the child to the out-of-home placement. The child welfare professional with primary assignment shall also ensure that the caregiver receives the appropriate information and instruction concerning the use of the devices from the child's health care provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) The CPI must document in FSFN the reason parental authorization was not initially obtained and the physician's or psychiatric nurse'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 welfare professional must have a determination from a physician licensed under Chapters [458](#) or [459](#), F.S., or a psychiatric nurse licensed under Chapters [464](#), F.S., that the child should continue the psychotropic medication. This determination must be transmitted in writing to CLS.

c. If the child welfare professional is unable to contact the prescribing physician or psychiatric nurse 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 or psychiatric nurse to continue the medication until medical advice can be obtained by the child welfare professional.

d. In the absence of parental authorization, when a physician or psychiatric nurse determines the child should continue psychotropic medication, CLS must file a motion requesting that continuation of the medication be determined at the shelter hearing. The motion must indicate the physician's or psychiatric nurse'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 or psychiatric nurse to determine whether it is appropriate to continue the medication.

g. All actions taken by the child welfare professional will be entered in FSFN within three business days of receipt of the parental authorization or court order approving the medication.

h. The parent or legal guardian authorization to continue a psychotropic medication that was obtained at the point of the child's removal is separate from the general "Consent for Treatment and Release of Medical Information" (CF-FSP [4006](#), available in DCF Forms). The general consent allows ordinary and necessary physical and behavioral health medical and dental care, to include

immunizations, tuberculin testing and well childcare. The administration of psychotropic medication is considered an extraordinary procedure for which express and informed consent of the parent or a court order is required by law.

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

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

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

c. In no case may the child welfare professional, the child's caregiver, representatives from DJJ, or staff from residential treatment centers provide express and informed consent for a child in out-of-home care to be prescribed a psychotropic medication.

d. The Department or its contracted service provider must assist the prescribing physician or psychiatric nurse in obtaining express and informed consent from the child's parent or legal guardian unless parental rights have been terminated, and must take steps as required by Rule [65C-35.003\(4\)](#), F.A.C., to include the parent in the child's consultation with the child's prescribing physician or psychiatric nurse.

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 child welfare professional must obtain the child resource record (CRR) and any prescription medication currently taken by the child.

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

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

- (a) The full name of the child for whom the medication is prescribed;
- (b) The condition and purpose for which the medication is prescribed for this child;
- (c) The prescribing physician's or psychiatric nurse'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 or psychiatric nurse's plan to reduce and/or eliminate ongoing administration of the medication; and,

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

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

f. Changes in Medication. The child welfare professional will be responsible for securing a new parental express and informed consent or court order if there are any changes in medication (including dosage or dosage range) that go beyond the existing authorization. The child welfare professional shall inform CLS of any changes in medication and shall provide CLS a copy of the amended Medical Report.

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

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

i. Request to Discontinue Medication. Whenever the child, the child's parent (if parental rights have not been terminated) or the legal guardian requests the discontinuation of the psychotropic medication, and the prescribing physician or psychiatric nurse refuses to order the discontinuation, the child welfare professional 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 or psychiatric nurse's recommendation, and any other relevant information, pursuant to s. [39.407\(3\)\(d\)1.](#), F.S.

j. Judicial Reviews.

(1) Whenever a child in out-of-home care is receiving psychotropic medications, whether pursuant to express and informed consent by the parent or legal guardian, or as authorized by an order of the court, the Department shall fully inform the court of the child's medical and behavioral status at each subsequent judicial review hearing, and shall furnish copies of all pertinent medical records concerning the child which have been generated since the previous court hearing, including the Medical Report.

(2) When court authorization is needed to provide psychotropic medication, the child welfare professional shall provide CLS a written report that documents efforts made to enable the prescribing physician or psychiatric nurse to obtain express and informed consent from the child's

parent or legal guardian. The Psychotropic Medication Informed Consent Facilitation (form CF-FSP [5228](#), available in DCF Forms) may be used. If another form is used the report must include:

(a) Dates and time the child welfare professional 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 or psychiatric nurse.

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

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

k. Child with DJJ Involvement. When a child in out-of-home care is also served by DJJ and placed in a DJJ detention center or residential commitment program, prior to providing psychotropic medications the DJJ provider must contact the child welfare professional and request either assistance in obtaining parental express and informed consent or a court order from the child's dependency judge.

3-11. Parent or Legal Guardian Declines to Consent to or Withdraws Consent for the Provision of Psychotropic Medication. If the parent or legal guardian declines to authorize the provision of psychotropic medication, or withdraws consent that was previously provided, the parent or legal guardian's decision, and any reason provided therefore, must be recorded in the Medical Report. If the prescribing physician or psychiatric nurse 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 child welfare professional shall consult with the prescribing physician or psychiatric nurse within one 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 or psychiatric nurse to lack the ability to provide express and informed consent.

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

b. If, after considering the parent's concerns and objections, the prescribing physician or psychiatric nurse determines that the benefits of the medication outweigh the risks of taking the medication, the prescribing physician or psychiatric nurse will provide that justification in the Medical Report and provide the Medical Report to the child welfare professional. The child welfare professional shall provide CLS with the Psychotropic Medication 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 or psychiatric nurse's position regarding the need to administer the medication. CLS shall file a motion to authorize medication within two business days of receipt of the Medical Report from the child welfare professional. Court authorization must occur before the psychotropic medication is administered to the child.

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

a. The child welfare professional must obtain from the prescribing physician or psychiatric nurse the completed Medical Report.

b. Within three business days of receiving the Medical Report from the prescribing physician, the child welfare professional must submit the Medical Report and other documentation to CLS, with a request for court authorization to administer the prescribed medication.

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

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

a. Within three 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 child welfare professional must obtain the Medical Report signed by a prescribing physician or psychiatric nurse in the facility, and provide this to CLS, within two business days after the medication is initiated.

c. The child welfare professional shall follow the procedures outlined in this operating procedure to assist the physician or psychiatric nurse 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 or psychiatric nurse certifies, in section 5 (Certification of Significant Harm) of the Medical Report, that delay in providing the prescribed psychotropic medication would more likely than not cause significant harm to the child.

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

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

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

(4) CLS shall submit a motion to the court within three 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 calendar days.

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

a. Psychotropic medications will be administered by the child's caregivers or other appropriate persons as directed (e.g., school official) and allowed under normalcy provisions. Children who are age and developmentally appropriate must be given the choice to self-administer medication under the supervision of the caregiver or school personnel. Children assessed as appropriate to self-administer medication must be educated on the following:

- (1) The method of administering the medication;
- (2) The recognized side effects, risks and contraindications of the medication;
- (3) Drug-interaction precautions;
- (4) Possible side effects of stopping the medication; and,
- (5) How medication administration will be supervised by the caregiver.

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

- (1) Medical appointments for the child in out-of-home care;
- (2) Medical appointment follow-up reports provided to the child's caregiver;
- (3) Any immunization records obtained while in the care of the child's caregiver;
- (4) A record of all prescribed medications administered to the child in out-of-home care;

and,

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

- (a) The name of the child in out-of-home care;
- (b) The brand or generic name of the medication, including the prescribed dosage and prescribed dosage administration schedule;
- (c) Times and dates of administration or monitored self-administration of the medication; and,
- (d) The name or initials of the caregiver administering the medication or monitoring the self-administration.

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

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

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

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

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

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 or psychiatric nurse of the child in out-of-home care.

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

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

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

j. The child welfare professional 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; and how to monitor for the side effects and report any problems, such as serious adverse effects of the medication, to the prescribing physician or psychiatric nurse.

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

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

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

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

o. Child welfare professional supervisors shall provide ongoing review and oversight of children prescribed psychotropic medications.

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

(1) A child between the ages of 0-17 years of age has been prescribed a psychotropic medication;

(2) Two or more psychotropic medications are administered to a child in out-of-home care; or,

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

(a) Stimulants;

(b) Mood stabilizers;

(c) Anti-depressants;

(d) Anti-anxiety; or,

(e) Anti-psychotics.

q. After the review required in paragraph p above, when advised by their supervisor, the child welfare professional supervisor will:

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

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

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

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

s. The child welfare professional will report to the prescribing physician or psychiatric nurse when the condition of the child in out-of-home care is not improving or is deteriorating.

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

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

v. The child welfare professional will document the review and actions taken subsequent to the review required in paragraph q above and all consultation notes in FSFN case notes.

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

a. The child welfare professional 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 business day of the court's order, the child welfare professional will make an appointment for the second opinion. The appointed time of the second opinion will depend on availability of the physician or psychiatric nurse from whom the second opinion is requested.

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

3-16. Supervisor Reviews for Child Protective Investigations.

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

b. The Regional Quality Management Model requires that supervisors conduct three qualitative discussions with each CPI every month, documenting that the discussion occurred and the basic content of the discussion in FSFN case notes. This review includes a discussion of psychotropic medications and documentation of Informed Consent and/or a court order authorizing this treatment.

3-17. Supervisor Reviews for Dependency Case Management.

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

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

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

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

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

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

3-18. Training.

a. The caregiver administering the psychotropic medication as well as the child welfare professional must receive training from the community-based care lead agency or a contracted provider on medication management and administration.

b. The Department and its contracted service providers shall develop a standardized curriculum that will be used to train staff and foster parents on medication administration and management. This training will include an e-learning tutorial that consists of components identified in Rule [65C-35.014](#), F.A.C. The associated link for the training can be located at http://centervideo.forest.usf.edu/psychmedselearning/story_html5.html.

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

a. There are four tabs in FSFN that must be used by child welfare professionals to enter all behavioral and physical health information in FSFN.

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

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

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

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

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

(1) The information on medications prescribed will be entered in FSFN within three business days of beginning the medication, based on information provided to the child welfare professional by the prescribing physician or psychiatric nurse 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 or psychiatric nurse prescribed cessation of the medication, shall also be recorded within three business days.

(3) All behavioral health actions taken by the child welfare professional, and CLS will be entered in FSFN within three 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, psychiatric nurse, or other authorized health care provider;

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

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

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

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

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

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

(i) Date medication was prescribed and date stopped;

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

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

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

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

all diagnoses given. Axis II defines which personality or developmental disability diagnosis the prescribing physician or psychiatric nurse is treating.

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

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

3-20. Use of the MedConsult Line Program.

a. The MedConsult Line is a statewide contract to provide medical consultation by a board-certified child and adolescent psychiatrist on psychotropic medication treatment decisions for children in out-of-home care or enrolled in the Behavioral Health Network (BNET). Use of this service is voluntary for all requesting parties.

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

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

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

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

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

c. Psychiatric Evaluation Referral (CF-FSP [5341](#)).

d. Emergency Intake (CF-FSP [5314](#)).