HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 261 w/CS Dependent Children/Psychotropic Meds.
SPONSOR(S): Ryan
TIED BILLS: None **IDEN./SIM. BILLS:** SB 112

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Children's Services (Sub)	7 Y, 0 N	Walsh	Liem
2) Future of Florida's Families	15 Y, 0 N w/CS	Walsh	Liem
3) Judiciary	10 Y, 1 N w/CS	Jaroslav	Havlicak
4) Human Services Appropriations (Sub)	6 Y, 0 N	Ekholm	Ekholm
5) Appropriations			

SUMMARY ANALYSIS

The purpose of this bill is to regulate the use of psychotropic drugs among children in state foster care. It addresses concerns that foster children have been given potentially harmful psychotropic drugs, not because they suffered mental illness, but to sedate them and mute difficult behaviors.

Current law requires a court order before administration of psychotropic medication to children in the legal custody of the Department of Children and Family Services (DCF). This bill provides a framework for obtaining and reviewing such an order. This bill requires a prescribing physician to provide the court with a medical report specifying that particular conditions regarding the medication's appropriateness for the child are met, including: need for the medication; review of the child resource record (a medical history); explanation of the treatment and medication to the child and caregivers; and, consideration of alternatives.

Additionally, this bill adopts a definition of child resource record as ". . . a standardized folder that contains copies of the basic legal, demographic and known medical information pertaining to a specific child, as well as any documents necessary for the child to be provided medical treatment."

This bill further provides for periodic court review of the child's progress under treatment; provides conditions for the court to suspend the treatment; and, finally, allows exceptions under which a physician may administer psychotropic medication to a child in DCF custody without a court order.

DCF estimates that this bill will require some limited amount of additional resources; however, there is no appropriation contained in the bill. This bill does not appear to have a fiscal impact on local governments.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[]	N/A[x]
2. Lower taxes?	Yes[]	No[]	N/A[x]
3. Expand individual freedom?	Yes[]	No[]	N/A[x]
4. Increase personal responsibility?	Yes[]	No[]	N/A[x]
5. Empower families?	Yes[]	No[]	N/A[x]

For any principle that received a "no" above, please explain:

B. EFFECT OF PROPOSED CHANGES:

General Background

Emotional and mental disorders are disproportionately frequent among children who have been abused or neglected. Those same children frequently end up in the foster care system because of that abuse or neglect. Until recently, caseworkers in the Department of Children and Families (DCF) routinely provided consent for the use of drugs such as Ritalin for attention-deficit hyperactivity disorder (ADHD), and for the use of more powerful anti-psychotic drugs such as Risperdal that may have serious side effects.

A series of stories published throughout 2001 by the *Miami Herald* documented the concerns of children's advocates that thousands of foster children were being given potentially harmful psychiatric drugs to mute difficult behaviors and sedate troubled children.[1] Some of the children developed serious side effects, such as shaking, lethargy, drooling, and weight gain.

Often there is no clear information available at judicial review for courts to monitor psychotropic medication of foster care children. One Broward County dependency judge, John A. Frusciante, became so concerned by the lack of medical records for foster children that he ordered DCF to complete medical records for all of the hundreds of children in his division or face a contempt sanction.

In response to these concerns, DCF created a blue-ribbon task force in May 2001 to study the issue and design a model of mental healthcare that might render some drug use unnecessary. DCF is now in the process of revising the state's administrative code and operating procedures to address the concerns raised by the group.

Children in Foster Care are at High Risk of Mental Illness

According to a 2000 report by Dr. John Landsverk of Children's Hospital, San Diego, to the Surgeon General's Conference on Children's Mental Health, studies of mental health needs specific to the foster care system have firmly established that children in foster care are a high-risk population for socio-emotional, behavioral, and psychiatric problems warranting mental health treatments.

Half of children aged zero to seventeen in foster care have adaptive functioning scores in the "problematic" range. Among children ages zero to six, 50-65 percent are in the "problematic" range in terms of developmental status. Among two- to seventeen-year olds, 50-60 percent exhibit behavior

[1] *See, e.g.*, Carol Marbin Miller, "Report Decried Giving Drugs to Kids: Consultant Studied Florida Centers for Foster Care," MIAMI HERALD, May 11, 2001, 1A.

problems. Finally, among six- to seventeen-year olds, roughly 40 percent meet the criteria for any diagnosis with moderate impairment.

Children in foster care use mental health services up to fifteen times more than other children in the Medicaid system. Foster children with behavioral problems are most likely to be seen. Data also show that children with a history of sexual abuse are three times more likely to receive mental health services, while children with a history of neglect are only half as likely to receive treatment. African-American and Hispanic children are least likely to receive services, and they need to display more pathology to be referred for mental health services. Developmental services are accessed significantly less than would be expected based on the high rate of developmental problems observed.

Use of Mental Health Services by Children in Foster Care in Florida

According to the department, on February 28, 2003, there were 14,440 children in foster care. This number includes non-relative foster homes, group homes, institutions, independent living and runaway children. In Fiscal Year 2001-2002, 6,744 dependent and delinquent children in the physical custody of DCF were served by the mental health system. Those children received one or more of the following types of services:

- Case management: 2,041
- Community Support Services: 1,853
- Emergency Stabilization: 325
- Outpatient: 5,096
- Residential Care: 1,427

Despite the large mental health service utilization in the child welfare system, the use of evidence-based treatments is low.

The Appropriate Use of Psychotropic Medication for Children is a National Concern

Concerns about inappropriate diagnoses—by either over- or under-diagnosis—of children's mental health problems, and about the availability of evidence-based, scientifically proven, treatments and services, have sparked a national debate.

Children with emotional, behavioral, and mental disorders that could be treated with medications may not be treated, or may be treated improperly, because their physicians do not know which products might be most effective or what dosage to administer. Clinicians, families, researchers and advocates are concerned about the unknown, long-term effects of medication on children’s development.

“Off Label” Use and Questions of Drug Safety and Efficacy for Children

There are only a small number of psychotropic drugs approved by the Federal Drug Administration (FDA) specifically for the treatment of pediatric psychiatric disorders. These include drugs for:

- Obsessive-compulsive disorder (Zoloft, Luvox and Anafranil);
- ADHD (Ritalin, Cylert and Amphetamines such as Adderall and Dexedrine);
- Tourette's Disorder (Haldol, Orap);
- Mania (Lithium such as Cibalith-S, Eskalith and Lithobid);
- Enuresis (Imipramine);
- Psychoneurosis (Sinequan); and,
- “Various behavior problems” (Haldol and Thorazine).

Published pediatric studies demonstrate the effectiveness of these medications for some disorders and for some children. For example, on the basis of hundreds of randomized controlled trials, stimulants such as Ritalin have been shown to be highly effective for 75 to 90 percent of children with ADHD.

According to Dr. F. Daniel Armstrong, of the University of Miami's Mailman Center for Child Development, new drug therapies are helping children combat even serious mental illnesses, such as schizophrenia and depression. Troubled children have been able to make dramatic turnarounds and do things they never could before—go to school, be with friends and get along with their family.

However, according to the Surgeon General's Conference on Children's Mental Health, three-fourths of all medications used by children are prescribed "off label," in that they have not been approved by the FDA for use by children. Risperdal and Prozac, for example, are not approved for use under age 18. Ritalin is not approved for children under age 6. The report states that more research is needed to ensure proper pediatric labeling of medications, indicating how they can be safely and effectively used with children.

Recommendations for Use of Psychotropic Medication to Treat Children's Mental Health Needs

Professionals strongly recommend that when medication is used with children, it should be part of a comprehensive, individualized treatment plan that is monitored closely and regularly by child-trained professionals, recognized under state licensing and certification requirements. For example, according to the American Academy of Pediatrics, use of medication should not be considered the complete treatment program for children with ADHD and should be prescribed only after thorough evaluation.

The American Academy of Child and Adolescent Psychiatry suggests that medications are appropriate when there are clear target symptoms, and that parents should be involved in decision making, and be provided with complete information about side effects, benefits, and alternatives.

Unclear Legal Authority for Use of Psychotropic Medication for Children in Foster Care

DCF believes that it lacks clear authority under current law to consent to extraordinary medical treatment, including not only the administration of psychotropic medications, but also general anesthesia or surgery. In defining "legal custody," s. 39.01(33), F.S., vests the custodian of a child—who, in the case of a foster child is DCF—with the right and duty to provide that child with ordinary medical, dental, psychiatric, and psychological care. Section 39.407(13), F.S., provides that DCF can consent to "medical treatment" for a dependent child when that child is committed to DCF's custody. Section 743.0645, F.S., however, provides that DCF may, without a court order, consent to some forms of medical care and treatment, but that it may not authorize "surgery, general anesthesia, provision of psychotropic medications or other extraordinary procedures" without a court order.

Proposed Changes

This bill amends s. 39.407, F.S., to provide a framework by which a court may order the dispensing of psychotropic medication to a child who is in the legal custody of DCF. The bill requires a prescribing physician to provide the court with medical report regarding the medication's appropriateness for the child. The bill adopts a definition of child resource record as " . . . a standardized folder that contains copies of the basic legal, demographic, and known medical information pertaining to a specific child, as well as any documents necessary for the child to be provided medical treatment."

The bill requires that DCF obtain a court order to administer psychotropic medications to children in out-of-home placement or legal custody of the department, except:

- When the child is already taking the medication when removed from the home, until reviewed by the court within 60 days of the child's removal;

- When the physician indicates in writing that delay in dispensing medication would, more likely than not cause significant harm to the child, until review by the court at the next scheduled hearing or within 30 days of the date of the prescription, whichever is sooner; or,
- In an acute care setting.

As a cross reference, s. 743.0645 (1) (b), F.S., is amended to specify that this authority granted to DCF in s. 39.407 (3) (a), F.S., provides an exception to the limitations on administering psychotropic medications to children.

This bill requires that a petition for authority to dispense or continue psychotropic medication to a child in the legal custody of DCF must have attached a signed medical report from the prescribing physician that indicates:

- The need for the medication and a plan of treatment addressing treatment alternatives;
- That the prescribed dosage of the medication is appropriate for the treatment of the child's condition;
- That the treatment and medication has been explained to the child and caregivers; and,
- Whether the medication will replace or supplement other medication and treatment and any additional services the physician believes should supplement the medication.

The bill requires the signed medical report is permissible as evidence at a hearing to initiate or continue medication, that the physician is not required to be present unless the court specially orders, and that DCF bears the burden of proof to show that psychotropic medication is necessary. The bill allows the court to order dispensing of the medications if the child resource record, medical report, and other evidence are in accord with the requirements of the section. The bill requires the court to inquire of DCF as to the provision of the other services requested by the treating physician. The bill allows the court to require further medical consultation, including a second opinion, and when second opinions are obtained regarding the discontinuation of psychotropic medications, the opinion must be obtained from a licensed psychiatrist whenever available or, when not available, by a licensed physician.

This bill requires the court to review the child resource record and the status of the child's progress on psychotropic medication at least every six months or more frequently on its own motion or good cause shown by any party.

It allows the court to order the department to demonstrate compliance or provide a medical opinion regarding the safety and appropriateness of the medication, if the court determines requirements for continued medication are not being met.

Finally, the bill directs the department to adopt rules to assure children receive timely access to clinically appropriate psychotropic medications. These rules are to address, at a minimum, a uniform process for obtaining court authorization, including the adoption of uniform forms to be used in requesting court authorization for the use of psychotropic medications

C. SECTION DIRECTORY:

Section 1. Amends s. 39.0015(3)(b), F.S., relating to definitions for school district child abuse prevention training, to conform cross references.

Section 2. Amends s. 39.01, F.S., to provide a definition of "Child Resource Record" and conforms a cross reference.

Section 3. Amends s. 39.205, F.S. relating to penalties for false reporting of child abuse, neglect or abandonment to conform cross references.

Section 4. Amends s. 39.302(1), F.S., relating to protective investigations of child abuse in institutions to conform cross references.

Section 5. Amends s. 39.407, F.S., relating to medical, psychiatric, and psychological examination and treatment of a child; creating a new subsection (3) providing for psychotropic medication, providing for periodic court review of the child's progress under such treatment, providing conditions for the court to suspend the treatment; authorizing the court to require further medical consultation, including second opinions; correcting cross references; and renumbering subsequent subsections.

Section 6. Amends s. 39.828, F.S., relating to appointment of guardian advocates, to conform cross references.

Section 7. Amends s. 419.001, F.S., relating to site selection of community residential homes, to conform cross references.

Section 8. Amends s. 743.0645, F.S., relating to who may consent to the medical care or treatment of a minor, to provide that the procedures elsewhere this bill prevail with respect to children in DCF custody.

Section 9. Provides an effective date of July 1, 2003.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The Department of Children and Families (DCF) reports that this bill could require expenditures of additional litigation expenses to pay for medical testimony on behalf of DCF. The department has estimated this impact at $165,600 based on the following assumptions: In May 2001, department data reflected that 690 children in licensed substitute care and emergency shelter care were receiving the drug Risperdal. If approximately 50% of those children were in hearings each requiring expert testimony of 3 hours by a physician at $160 per hour, the cost would be $165,600.

   No appropriation of funds is contained in the bill.

   At the April 15, 2003, Human Services Appropriations Subcommittee meeting, department representatives testified that they believed that the department could handle the fiscal impact of the bill within existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

It is unclear who would pay for any court-ordered second medical opinions, which this bill allows in all cases and requires in order to compel discontinuation of treatment if contrary to the opinion of the prescribing physician.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, does not appear to reduce the authority that counties or municipalities have to raise revenue in the aggregate, and does not appear to reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

This bill grants DCF authority to adopt rules to assure children receive timely access to clinically appropriate psychotropic medications. These rules are to address at a minimum, a uniform process for obtaining court authorization, including the adoption of standard forms to be used in requesting court authorization for the use of psychotropic medications.

C. DRAFTING ISSUES OR OTHER COMMENTS:

This bill does not provide a definition of the “acute care setting” in which health care providers are allowed to dispense psychotropic medication without a court order. Indeed, although the term “acute care” is occasionally used throughout the Florida Statutes, it is never defined.

This bill defines “child resource record” but does not make clear who generates this document, or how.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 14, 2003, the House Subcommittee on Children’s Services recommended this bill favorably with one amendment. This amendment substitutes the term “Child Resource Record” for “medical Passport,” and conforms cross-references.

On March 25, 2003, the House Committee on The Future of Florida’s Families incorporated the Subcommittee’s recommended amendment into a committee substitute. The Committee than reported the bill favorably with this committee substitute.

On April 9, 2003, the House Committee on Judiciary adopted one amendment to this bill. The amendment allows for dispensation of psychotropic medication prior to a court order only if the prescribing physician’s medical report certifies that failure to do would, more likely than not, cause significant harm to the child, and requires DCF to seek such an order at the next scheduled hearing required under chapter 39, F.S., or within 30 days, whichever is sooner. The Committee then reported this bill favorably with a committee substitute.