# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 261 w/CS Relating to Dependent Children/Psychotropic Meds.
**SPONSOR(S):** Ryan
**TIED BILLS:** **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 | | | |
| 4) Human Services Appropriations (Sub) | | | |
| 5) Appropriations | | | |

## SUMMARY ANALYSIS


The purpose of the Committee Substitute for HB 261 (CS) 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). The CS amends s. 39.407, F.S., to provide a framework for the court order and review. The CS requires a prescribing physician to provide the court with an affidavit or medical report that specific 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.

The CS adopts a definition of child resource record as "a standardized folder which 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 receive medical treatment."

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

Although DCF believes the CS will require additional resources, DCF is currently unable to estimate these costs.

The effective date of the CS is July 1, 2003.

# 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, Department of Children and Families (DCF) caseworkers 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. 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 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 FY 01-02, 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)
- 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 the 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 decisionmaking, 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—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 certain medical care and treatment, but cannot authorize "surgery, general anesthesia, provision of psychotropic medications or other extraordinary procedures" without a court order.

C. EFFECT OF PROPOSED CHANGES:

CS for HB 261 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 CS requires a prescribing physician to provide the court with an affidavit or medical report regarding the medication's appropriateness for the child. The CS adopts a definition of child resource record as "a standardized folder which contains copies of the basic legal, demographic and know medical information pertaining to a specific child, as well as any documents necessary for the child to receive medical treatment."

The CS requires that the department 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 could be detrimental to the child, until review by the court within 60 days of the date of the prescription

- 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 the department in s. 39.407 (3) (a), F.S., provides an exception to the limitations on administering psychotropic medications to children.

CS for HB 261 requires that a petition for authority to dispense or continue psychotropic medication to a child in out-of-home placement or legal custody of the department must have attached a signed medical report or an affidavit 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.
- Whether the medication will replace or supplement other medication and treatment and any additional services the physician believes should supplement the medication.
- Requires the department to carry the burden of compliance with and proof of these provisions.

CS for HB 261 requires the signed medical report or affidavit is permissible as evidence at a hearing to initiate or continue medication, and that the physician is not required to be present unless the court specially orders. It allows the court to order dispensing of the medications if the child resource record, medical report or affidavit, and other evidence are in accord with the requirements of the section. The CS requires the court to inquire of the department as to the provision of the other services requested by the treating physician. The CS 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.

CS for HB 261 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.

The CS 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 correct cross references.

**Section 2.** Amends s. 39.01(14), F.S., to provide a definition of "Child Resource Record" and corrects a cross reference."

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

**Section 4.** Amends s. 39.302(1), F.S., relating to protective investigations of child abuse in institutions to correct 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 5.** Provides that the effective date of the act is 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 CS will require expenditure of additional litigation expenses to pay for medical testimony on behalf of DCF. DCF cannot provide a fiscal impact.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   None.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

DCF is granted the 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 uniform forms to be used in requesting court authorization for the use of psychotropic medications.

C. DRAFTING ISSUES OR OTHER COMMENTS:

This CS 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.

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

## IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES