

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL: SB 1808

INTRODUCER: Senator Storms and others

SUBJECT: Psychotropic Medication

DATE: February 7, 2012 REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Farmer	CF	Favorable
2.	Davlanges	Stovall	HR	Pre-meeting
3.			BC	
4.				
5.				
6.				

I. Summary:

The bill makes a number of changes to current law relating to psychotropic medication and children in out-of-home placements, including:

- Providing that every child placed in out-of-home care be provided a comprehensive behavioral health assessment;
- Providing for legislative findings and intent;
- Providing definitions for terms used in a newly created section of law;
- Providing for the appointment of a guardian ad litem (GAL) for every child who is being prescribed a psychotropic medication and providing duties and responsibilities of the GAL;
- Prescribing procedures for obtaining express and informed consent and assent;
- Requiring the development of a mental health treatment plan for children in out-of-home care who need mental health services;
- Providing procedures to be followed for the administration of psychotropic medication to a child in out-of-home care when parental consent has not been obtained and for the administration of psychotropic medication to a child in out-of-home care before court authorization has been obtained;
- Requiring a court finding of a compelling government interest before administering psychotropic medication to certain children; and
- Prohibiting a child in the custody of the Department of Children and Family Services (DCF or department) from participating in clinical trials involving psychotropic medication.

This bill amends sections 39.407 and 743.0645 and creates section 39.4071, of the Florida Statutes.

II. Present Situation:

Psychotropic Medications¹

Psychotropic medications are one of many treatment interventions that may be used to address mental health problems. Medication may be recommended and prescribed for children with mental, behavioral, or emotional symptoms when the potential benefits of treatment outweigh the risks. This is particularly true when the problems experienced by the child are so severe that there would be serious negative consequences for the child if the child is left untreated and when other treatment interventions have not been effective. However, public concern is growing over reports that very young children are being prescribed psychotropic medications, which is not generally the first option of treatment for a child, that some children are on multiple medications, and that these medications are sometimes used inappropriately to control a child's behavior.

Major categories of psychotropic medications include stimulants, antidepressants, anti-anxiety agents, anti-psychotics, and mood stabilizers. However, effective treatment with psychotropic medication depends on the appropriate diagnosis of the problem. These medications may be used to treat a variety of symptoms, which include:

- **Stimulant medications** that are frequently used to treat Attention Deficit Hyperactivity Disorder (ADHD), the most common behavioral disorder of childhood;
- **Anti-depressants and anti-anxiety medications** which follow the stimulant medications in prevalence among children and adolescents. These medications are commonly used for depression, anxiety, and obsessive compulsive disorders;
- **Anti-psychotic medications**, which are used to treat children with schizophrenia, bipolar disorders, autism, and severe conduct disorders; and
- **Mood stabilizing medications**, which are used to treat bipolar disorders.

Some of the concerns regarding the use of psychotropic medications with children stem from the limited information that is available regarding the efficacy and the potential side effects of these drugs with children. Most clinical trials for these drugs were conducted on an adult population. The same results are not always obtained when these drugs are used with children, and the side effects for children are frequently different than those experienced by adults. The Food and Drug Administration has expressed concern regarding the use of antidepressants in children and established an advisory committee to further study and evaluate the use of such medications.

Use of Psychotropic Medications by Children: Background

Many children in the United States receive psychotropic medications, and this number has increased over time. The use of multiple psychotropic medications has also been reported to have

¹ 1 The information in this portion of this bill analysis is from the analysis for CS/CS/SB 1090 by the Senate Committee on Health and Human Services Appropriations (April 14, 2005). Retrieved January 21, 2012, from <http://www.flsenate.gov/data/session/2005/Senate/bills/analysis/pdf/2005s1090.ha.pdf>.

increased among children. The efficacy and short-and long-term safety knowledge base for pediatric psychopharmacology has increased in recent years but remains limited.²

An issue that has increasingly received national attention over the past decade has been the concern for the overuse of psychotropic medications among our nation's youth in general, with a potentially disproportionate increase among children in foster care.³ Among community-based populations, children in foster care tend to receive psychotropic medication as much as, or more than, disabled youth and three to four times the rate among children with Medicaid coverage based on family income.⁴ Children in foster care and disabled youth have the greatest likelihood of receiving complex, poorly evidenced, high cost medication regimens.⁵

The few research studies available show rates of psychotropic medication use ranging from 13-50 percent among children in foster care, compared with approximately 4 percent in youth in the general population.⁶ A 2006 report prepared by the Government Accountability Office found that 15 states identified the overuse of psychotropic medications as one of the leading issues facing their child welfare systems.⁷ In her testimony to Congress, Dr. Laurel Leslie, on behalf of the American Academy of Pediatrics, stated:

It is difficult to know from these preliminary analyses or the multitude of reports that are emerging in the media whether the use of these medications by children in foster care is appropriate, although at the very least the use of combinations of three or more medications remains controversial. Clearly, medication can be helpful to some children, but with the increasing use of these medications among children in general, there comes the added responsibility to ensure that children have access to an array of treatment strategies, from medication to community-based services that may augment or replace the need for medications in many circumstances. Furthermore, the failure to coordinate and provide continuity in services and the absence of clear guidelines and accountability to ensure that treatment decisions are in the child's best interest, create a greater risk that medications will be prescribed to control children's behaviors in the absence of individualized service plans that might offer the best chance for success.⁸

² Alfree M. Breland-Nobel et al., *Use of Psychotropic Medications by Youths in Therapeutic Foster Care and Group Homes*, PSYCHIATRIC SERVICES, Vol. 55, No. 6., 706 (June 2004), Retrieved January 21, 2012, from <http://ps.psychiatryonline.org/cgi/reprint/55/6/706>.

³ Laurel K. Leslie, MD MPH FAAP, Am. Acad. of Pediatrics, *Hearing on the Utilization of Psychotropic Medication for Children in Foster Care*, 6 (May 8, 2008). Retrieved January 21, 2012, from <http://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Documents/HearingontheUtilizationofPsychotropicMedicationforChildreninFosterCare.pdf>.

⁴ Julie M. Zito, PhD, Professor of Pharmacy and Psychiatry, U. of Maryland, *Prescription Psychotropic Drug Use Among Children in Foster Care*, 2-3 (May 8, 2008). Retrieved January 21, 2012, from <http://www.hunter.cuny.edu/socwork/nrcfcpp/teleconferences/2-10-10/Zito%20Medication%20handout.doc>.

⁵ *Id.* at 2.

⁶ Leslie, *supra* note 3, at 6.

⁷ *Id.* (citing U.S. Government Accountability Office, *Child Welfare: Improving Social Service Program, Training, and Technical Assistance Information Would Help Address Long-standing Service-Level and Workforce Challenges*, Report GAO-07-75 (Oct. 2006). Retrieved January 21, 2012, from <http://www.gao.gov/new.items/d0775.pdf>.

⁸ Leslie, *supra* note 3, at 7.

Use of Psychotropic Medications by Children: Florida

In Florida, prescribing psychotropic medications for children in out-of-home placements has been an issue for at least a decade. The Statewide Advocacy Council (SAC)⁹ conducted an investigation in 2001 of the use of psychotropic drugs in foster children, with an emphasis on children under the age of 5.¹⁰ When an internal investigation by the department was conducted, it concluded that the use of psychotropic drugs in children in the department's care was not a problem. However, information received from the Agency for Health Care Administration (AHCA) revealed that more than 9,500 children in Florida on Medicaid had received psychotropic drugs in the year 2000.

The SAC published its final report to the Governor in 2003, which found that out of the 1,180 children reviewed, 652 were on one or more psychotropic medications, and that the average age of the children on medication was 12. The final recommendation of the SAC was: "Until there is more information regarding the safety and efficiency of these drugs, Florida's foster care children should be monitored closely. The information in this report should be immediately incorporated into an agenda in order to preserve and protect the health, safety, welfare and rights of children in foster care."¹¹

In 2004, the DCF studied the use of psychotropic medications with children in care over a specified period of time. The department determined that 13 percent of all children in state custody were receiving at least one psychotropic medication. Of this group, 8 percent were being treated with three or more medications concurrently. Findings also indicated that 3.5 percent of the children in state custody age 5 and under received at least one psychotropic medication. An additional finding was that 25 percent of the children living in a foster care setting were being treated with psychotropic medications, a rate five times higher than the general population of Medicaid eligible children. Despite initiatives by DCF to identify children in its care who were on psychotropic medications and to determine the appropriateness of this treatment, limited information existed.¹²

In 2005, the Florida Legislature enacted Senate Bill 1090,¹³ which provided a comprehensive statutory framework relating to the use of psychotropic medications with children who are in out-of-home placements. As of June 2011, 1.50 percent of children in care ages 0-5, 19.57 percent of children in care ages 6-12 and 29.61 percent of children in care ages 13-17 are receiving

⁹ Statewide and local advocacy councils began in 1972 as a consumer protection mechanism for people receiving services from state agencies in Florida. The councils were codified in 1975. The councils investigate complaints about abuse and deprivations of human and constitutional rights; monitor and investigate reports of abuse; monitor programs and facilities that are operated, funded, or contracted by state agencies; review research projects involving human subjects; and generally advocate for the welfare of individuals who are in the care and custody of state agencies in the social service area or private vendors under contract to the state. Senate Staff Analysis and Economic Impact Statement, CS/CS/SB 2718, April 14, 2010.

¹⁰ Senate Staff Analysis and Economic Impact Statement, CS/CS/SB 2718, April 14, 2010.

¹¹ Florida Statewide Advocacy Council, Red Item Report: Psychotropic Drug Use in Foster Care, 4, 23 (July 2003) . Senate Staff Analysis and Economic Impact Statement, CS/CS/SB 2718, April 14, 2010.

¹² Senate Staff Analysis and Economic Impact Statement, CS/CS/SB 1090, supra note 1.

¹³ Chapter 2005-65, L.O.F.

psychotropic medication. The total number of children in care receiving psychotropic medication is 13.34 percent. This appears to reflect little, if any, change since the 2004 estimates.¹⁴

Gabriel Myers

Seven-year old Gabriel Myers was adjudicated dependent on September 2, 2008, following the arrest of his mother and the filing of the abuse report that brought him into the care of DCF on June 29, 2008. During the following 10 months, Gabriel was initially sheltered in a licensed foster home until being placed with relatives. When the relative placement failed, he was returned to the licensed home where he was initially placed. When that placement also failed, he was sent to the licensed home in which he resided until he died. This particular home had previously served as a respite for Gabriel, and he was familiar with the surroundings.¹⁵

In February and March 2009, Gabriel experienced a number of significant life events, including changes in foster homes, therapists, and after-school programs. He lost privileges at home and visitation time with his mother, all of which more than likely contributed to his mental status at the time of his death.¹⁶

While in care, he received numerous mental health and behavioral assessments and underwent regular treatment from a psychiatrist and two therapists, one of whom documented that “it is clear that this child is overwhelmed with change and possibly re-experiencing trauma.”¹⁷ Gabriel demonstrated a number of incidents of destructive behavior and conduct problems and was treated with counseling and several psychotropic medications. On April 16, 2009, Gabriel Myers hanged himself in the residence of his foster parents.¹⁸

A review of Gabriel’s medical records by the Broward County Medical Examiner’s office indicates that Gabriel was prescribed Vyvanse and Symbax by Dr. Sohail Punjwani, M.D.¹⁹

A report issued by DCF on May 20, 2009, stated that the Child Resource Record for Gabriel that contained medical information, including medications, was secured by law enforcement. A timeline of medications that were prescribed to Gabriel, based on the information obtained from the documentation available for review, is provided below:

¹⁴ Department of Children and Family Services, DCF Quick Facts. December 2011. Retrieved January 22, 2012, from <http://www.dcf.state.fl.us/newsroom/docs/quickfacts.pdf>.

¹⁵ Department of Children and Family Services., Report of the Gabriel Myers Work Group, 3 (Nov. 19. 2009), Retrieved January 21, 2012, from <http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/GabrielMyersWorkGroupReport082009Final.pdf>.

¹⁶ *Id.* at 3-4.

¹⁷ *Id.* at 3.

¹⁸ *Id.*

¹⁹ Broward County Medical Examiner, Autopsy No. 09-0557 (Apr. 17, 2009). Retrieved January 21, 2012, from http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/GM_ME_Report.pdf. Dr. Punjwani was the psychiatrist treating Gabriel at the time of his death. A warning letter from the United States Food and Drug Administration stated that Dr. Punjwani overmedicated children who were enrolled in clinical trials for undisclosed drugs and that her “failure to conduct the requisite safety measures contributed to the unnecessary exposure of pediatric subjects to significant overdoses, which jeopardized the subjects’ right, safety, and welfare.” U.S. Food and Drug Admin., Warning Letter (Feb. 4, 2010). Retrieved January 21, 2012, from <http://www.fda.gov/ICECI/EnforcementActions/WarningLetters/ucm202862.htm>.

- June 29, 2008, Adderall;
- July 31, 2008, Adderall discontinued;
- August 21, 2008, Dr. Punjwani noted medication was not indicated at that time;
- December 09, 2008, Vyvanse²⁰ for ADHD prescribed;
- February 03, 2009, Vyvanse continued and Lexapro prescribed;
- March 18, 2009, Vyvanse continued, Lexapro discontinued, Symbyax²¹ prescribed.²²

Gabriel Myers Work Group²³

The Gabriel Myers Work Group was appointed in April 2009 to analyze and make recommendations relating to Gabriel Myers and the use of psychotropic medication for children in out-of-home care. The work group identified 147 findings in 10 areas, resulting in 90 recommendations for action.²⁴

The work group determined that a detailed framework of safeguards for Florida's foster children exists and is articulated in statute, administrative rule, and operating procedures. The core failures in the system, however, stem from lack of compliance with this framework and with failures in communication, advocacy, supervision, monitoring, and oversight.

Of the 90 recommendations contained in the final report (with the exception of five that are related to funding requests), there were 10 recommendations directed to the Legislature:

- The Legislature should amend the requirement for a pre-consent consultation for all children in out-of-home care under age six. The consultation should be expanded to include all children age 11 and younger who are prescribed two or more psychotropic medications.
- The Legislature should review current statutes to ensure that procedural safeguards employed for the use of psychotropic medications are applied to all medications that alter brain function, regardless of the purpose of the prescription, to ensure they are adequate.
- The Legislature should amend s. 39.407, F.S., to change the term "medical report" to "medical treatment plan" so that interventions focus on treatment and the holistic needs of the child.

²⁰ Vyvanse is lisdexamfetamine, an amphetamine used for treating attention deficit hyperactivity disorder (ADHD) in certain patients. It is used as a part of a total treatment program that may include psychological, educational, and social therapy. *Lisdexamfetamine*. Retrieved January 21, 2012, from <http://www.drugs.com/cdi/lisdexamfetamine.html>.

²¹ Symbyax contains a combination of fluoxetine and olanzapine. Fluoxetine is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Olanzapine is an antipsychotic medication. Symbyax is used to treat depression caused by bipolar disorder (manic depression). Symbyax is also used to treat depression after at least two other medications have been tried without successful treatment of symptoms. It is not known if Symbyax is safe and works in children under 18 years of age. *Symbyax*. Retrieved January 21, 2012, from <http://www.drugs.com/symbyax.html>.

²² Department of Children and Family Services., Issue Summary Update, 4 (May 20, 2009). Retrieved January 21, 2012, from <http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/FinalMyers.pdf>.

²³ The information in this portion of this bill analysis is from the Report of the Gabriel Myers Work Group by the Department of Children and Family Services., supra note 14.

²⁴ In August 2009, a Miami Herald article reporting on the Gabriel Myers Work Group stated that one of the work group's findings was that "[t]he state has failed to implement recommendations from prior task forces that studied the deaths of foster children or the use of psychotropic drugs. Indeed, DCF has failed to even assign "responsibility" or "accountability" for implementing such reports." Carol Marbin Miller, Child-welfare panel: Drugs misused on foster kids, MIAMI HERALD, Aug. 13, 2009, at A-7.

- The Legislature should authorize DCF to develop a single medical treatment plan form with standardized information that can be utilized in all judicial circuits across the state.
- The Legislature should ensure that statutes and department policies, procedures, and practices recognize that children should be fully involved and allowed to participate in court hearings and treatment decisions. As part of this, prescribers should be required to confer with and seek assent from each child and to document the child's position. The department should be required to inform the Court of the child's position.
- The Legislature should review Florida statutes to ensure requirements are practical and clearly defined for:
 - Prescribing psychotropic medications;
 - Obtaining informed consent;
 - Obtaining the child's assent;
 - Requiring a parent, case worker, or other adult responsible for the child's care to attend each medical appointment with the child;
 - Administering and monitoring psychotropic medications;
 - Discontinuing, when appropriate, psychotropic medications. To include a formal plan for discontinuation;
 - Notifying involved parties; and
 - Reporting adverse incidents.
- The Legislature should require all prescribing physicians to report adverse consequences of psychotropic medications; all adverse effects should become a record in the medical file of a child in the care of the state.
- The Legislature should allow Advanced Registered Nurse Practitioners and Physician Assistants to provide information to parents and legal guardians in order to obtain express and informed consent for treatment.
- The Legislature should preclude any participation by children in state care in clinical trials relating to the development of new psychotropic medications.
- In any legislation arising from this report, the Legislature should utilize these guiding principles articulated by the work group as the statement of legislative intent and expected standards of care for children in the care of the state.

III. Effect of Proposed Changes:

This bill addresses many of the recommendations raised by the department's Gabriel Myers Work Group, as well as additional issues that were raised by others. The bill makes a number of changes related to the provision of psychotropic medication to children who are in an out-of-home placement. Specifically, the bill creates s. 39.4071, F.S., which is titled "Use of psychotropic medication for children in out-of-home placement."

The bill provides legislative findings and intent that, due to multiple risk factors, children in out-of-home care are more likely to have behavioral and emotional disorders, receive mental health services, and be provided psychotropic medications at higher rates than other children. The bill states that it is the intent of the Legislature that children in out-of-home care who need psychotropic medications receive them as part of a comprehensive treatment plan monitored by a court-appointed guardian ad litem (GAL).

The bill creates definitions for the following terms:

- “Behavior analysis” means “services rendered by a provider who is certified by the Behavior Analysis Certification Board in accordance with chapter 393.”
- “Obtaining assent” means “a process by which a provider of medical services helps a child achieve a developmentally appropriate awareness of the nature of his or her condition, informs the child of what can be expected through tests and treatment, makes a clinical assessment of the child’s understanding of the situation and the factors influencing how he or she is responding, and solicits an expression of the child’s willingness to adhere to the proposed care. The mere absence of an objection by the child may not be construed as assent.”
- “Comprehensive behavior health assessment” means “an in-depth and detailed assessment of the child’s emotional, social, behavioral, and developmental functioning within the family home, school, and community. A comprehensive behavioral health assessment must include direct observation of the child in the home, school, and community, as well as in the clinical setting, and must adhere to the requirements contained in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.”
- “Express and informed consent” means “a process by which a provider of medical services obtains voluntary consent from a parent whose rights have not been terminated or a legal guardian of the child who has received full, accurate, and sufficient information and an explanation about the child’s medical condition, medication, and treatment to enable the parent or guardian to make a knowledgeable decision without any element of fraud, deceit, duress, or other form of coercion.”
- “Mental health treatment plan” means “a plan which lists the particular mental health needs of the child and the services that will be provided to address those needs.” If the plan includes prescribing psychotropic medication to a child in out-of-home placement, the plan must also include certain specified information.
- “Psychotropic medication” means “a prescription medication that is used for the treatment of mental disorders and includes, without limitation, hypnotics, antipsychotics, antidepressants, antianxiety agents, sedatives, stimulants, and mood stabilizers.”²⁵

The bill provides for the appointment of a GAL at the earliest possible time to represent the best interest of a child in DCF custody who is prescribed a psychotropic medication. The bill provides duties and responsibilities of the GAL and requires the department and its community-based care lead agencies to notify the GAL within 24 hours after any change in the status of the child.

When DCF believes that a child in its custody may need psychiatric treatment, an evaluation must be conducted by a physician licensed under chs. 458 or 459, F.S. If, at the time of removal from his or her home, a child is already being provided prescribed medication, the prescribing physician shall try to obtain express and informed consent of the parent or legal guardian and assent of the child. The bill provides that the prescribing physician must consider the capacity of the child to make an independent decision based on his or her age, maturity, and psychological and emotional state when determining whether or not it is appropriate to obtain assent from the child. The bill provides different instructions for the physician in obtaining assent, depending on

²⁵ The Florida Rules of Criminal Procedure provide a slightly different definition of psychotropic medication. Specifically, rule 3.215 provides that psychotropic medication is “any drug or compound affecting the mind, behavior, intellectual functions, perception, moods, or emotion and includes anti-psychotic, anti-depressant, anti-manic, and anti-anxiety drugs.”

the age of the child. Whether the child assents or refuses to give assent, the physician must document it and place it in the child's mental health treatment plan.

The physician must also attempt to get express and informed consent for the administration of psychotropic medication from the child's parent or legal guardian. Consent may only be given by a parent whose rights have not been terminated or a legal guardian who has received full, accurate, and sufficient information about the child's medical condition, medication, and treatment. A copy of the parent's or legal guardian's consent (or lack thereof) must be documented and placed in the child's mental health treatment plan. The bill requires that when assent or informed consent is obtained, a copy of the assent or consent documents must be placed in the child's mental health treatment plan and filed with the court. Oral assent or informed consent must be documented by the prescribing physician.

Consent may become invalid under certain circumstances and if that happens, DCF must immediately notify all parties and try to obtain consent from the other parent or another legal guardian. If DCF cannot obtain valid consent, then the department must file a motion for administration of psychotropic medication. The child must continue on his or her medication until the court rules on the motion.

The bill provides procedures to be followed by the department and the court in cases where a child is in an out-of-home placement and may need a psychotropic medication, but parental consent has not been obtained. In any case where consent is invalid, the department must file a motion with the court within 3 working days to authorize the administration of the psychotropic medication before the administration of the medication.

The motion must include:

- A written report by DCF describing the efforts made to obtain express and informed consent, and describing other treatments attempted, considered, and recommended for the child; and
- The prescribing physician's completed and signed mental health treatment plan.

The department must notify all parties within 48 hours of filing the motion with the court. An objection to the motion must be made within 2 working days after a party is notified of the motion. If an objection is not filed and the motion is legally sufficient, the court may enter an order without a hearing. If an objection is timely filed, the court shall hold a hearing as soon as possible. The court must find a compelling governmental interest that the proposed psychotropic medication is in the child's best interest when issuing its order. The bill provides certain factors for a court to consider when determining if the medication is in the child's best interest. The bill also outlines procedures to be followed when administering psychotropic medication before a court order has been obtained, including cases when a child receives a one-time dose of medication. Specifically:

- If a child is removed from his or her home and taken into custody, the department may continue to administer a current prescription of psychotropic medication until the shelter hearing, where the department must request court authorization for the continued administration of the medication.

- If it approves, the court may only authorize continued use of the medication until the arraignment hearing on the petition for adjudication. If DCF believes that it needs to continue the medication beyond the time authorized by the court, the department must file a motion at the same time that it files the dependency petition.
- The department must administer the medication to the child immediately if the prescribing physician certifies that a delay in providing the medication would cause significant harm. The bill provides certain requirements if the department immediately administers the medication to the child.
- The department may authorize, in advance of a court order, the administration of psychotropic medication to a child in its custody in a hospital, crisis stabilization unit or receiving facility, therapeutic group home, or in a statewide inpatient psychiatric program. Upon administering the medication, the department must file a motion to seek court authorization for the continued administration of the medication within 3 working days.
- If a child receives a one-time dose of a psychotropic medication during a crisis, the department must immediately notify all parties and the court of the emergency use.

The bill provides procedures for discontinuing or altering the provision of psychotropic medication to a child and requires the department to ensure destruction of unused medication that is no longer being taken by a child.

The bill requires that any child who needs mental health services must have a mental health treatment plan. This plan must include:

- The name of the child, a statement indicating that there is a need to prescribe psychotropic medication to the child based upon a diagnosed condition for which there is an evidence base for the medication that is being prescribed, a statement indicating the compelling governmental interest in prescribing the psychotropic medication, and the name and range of the dosage of the psychotropic medication.
- A statement indicating that the physician has reviewed all medical information concerning the child which has been provided by the department or community-based care lead agency and briefly listing all such information received.
- A medication profile, including all medications the child is prescribed or will be prescribed, any previously prescribed medications where known, and whether those medications are being added, continued, or discontinued upon implementation of the mental health treatment plan.
- A statement indicating that the psychotropic medication, at its prescribed dosage, is appropriate for treating the child's diagnosed medical condition, as well as the behaviors and symptoms that the medication, at its prescribed dosage, is expected to address.
- An explanation of the nature and purpose of the treatment; the recognized side effects, risks, and contraindications of the medication, including procedures for reporting adverse effects; drug-interaction precautions; the possible effects of stopping or not initiating the medication; and how the treatment will be monitored, followed by a statement indicating that this explanation was provided to the child if developmentally appropriate and to the child's caregiver.
- Documentation addressing whether the psychotropic medication will replace or supplement any other currently prescribed medications or treatments; the length of time the child is

expected to be taking the medication; a plan for the discontinuation of any medication when medically appropriate; and any additional medical, mental health, behavioral, counseling, or other services that the prescribing physician recommends as part of a comprehensive treatment plan.

- A document describing those observable behaviors warranting psychotropic treatment, the means for obtaining reliable frequency data on these same observable behaviors, and the reporting of this data with sufficient frequency to support medication decisions.

The bill provides that no child under 11 years of age may be prescribed psychotropic medication absent a finding of a compelling governmental interest.²⁶ The current age requirement for pre-consent review is any child 6 years old or younger. It is unclear whether the court must find a compelling governmental interest in order for psychotropic medication to be prescribed to a child under the age of 11 if the parent or legal guardian has given consent.

Before psychotropic medication is authorized, a review of the administration must be obtained from a child psychiatrist licensed under chs. 458 or 459, F.S. It is unclear if a child is already being seen by a psychiatrist if that child would need to get a second opinion under this provision, or if the child's current psychiatrist could review the administration.

The department may authorize, in advance of a court order, the administration of psychotropic medications to a child from birth through 10 years of age in its custody in the following levels of residential care:

- Hospital;
- Crisis stabilization unit or receiving facility;
- Therapeutic group home; or
- Statewide inpatient psychiatric program.

If the child is in one of these levels of residential care, the compelling governmental interest requirement is satisfied. The department must still file a motion with the court to seek authorization or continued administration of the medication. If the department authorizes a one-time dose of psychotropic medication during a crisis, the department must immediately notify all parties and the court.

The bill prohibits a child in the custody of the department from participating in clinical trials relating to the development of new psychotropic medications. The bill also provides for additional information relating to psychotropic medication to be added to judicial review hearings.

Finally, the bill provides rulemaking authority to the department to ensure that children receive timely access to mental health services, including, but not limited to, clinically appropriate psychotropic medications.

²⁶ A compelling governmental interest is a very high burden and is often reserved for situations where a fundamental right is involved. See *A.W. v. Dep't of Children and Families*, 969 So. 2d 496, 504 (Fla. 1st DCA 2007) (citing *North Fla. Women's Health and Counseling Services, Inc. v. State*, 866 So. 2d 612, 625 n. 16 (Fla. 2003)).

The bill deletes provisions in s. 39.407, F.S., relating to the provisions of psychotropic medications to children in out-of-home care (similar provisions were included in the newly created s. 39.4071, F.S.). Additionally, the bill amends s. 39.407, F.S., to require that every child placed in out-of-home care receive a comprehensive behavioral health assessment, specify who is eligible for the assessment, and require that the assessment be provided to the physician involved in developing the mental health treatment plan for any child in need of mental health services.

The bill amends s. 743.0645, F.S., to conform to other changes made by the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Physicians prescribing psychotropic medicine to foster care children will have to increase the amount of time spent with each child in order to complete the additional examination and medical documentation requirements in this bill.

This bill creates a potential liability for guardian volunteers who fail to provide medical records, behavioral observations, or other requirements necessary for the prescription of psychotropic medications to children. This could subject the GAL and the GAL program to claims resulting from children who are injured as a result of such failure.

C. Government Sector Impact:

At the time of this analysis, there were no available analyses from state agencies or other entities. However, an analysis from the department for an identical bill from the 2010 Legislative Session stated the fiscal impact of the bill on DCF was anticipated to be

covered within existing resources. The fiscal impact would have resulted from the increase in the number of pre-consent authorizations. Specifically:

This cost is based on \$160 per authorization, at an average of 3 pre-consent reviews (as medications change) per child for 917 children aged 10 and under and who are on psychotropic medication: $\$480 \times 917 = \$440,160$. An additional \$4,000 to establish an online submission capacity for pre-consent reviews is added into this recommendation for a total of \$444,160.²⁷

The Guardian ad Litem Program also anticipated no additional costs as a result of the 2010 bill.²⁸

VI. Technical Deficiencies:

The bill's language describes court proceedings in terms that are not consistent with existing law or procedure, including requiring the court to treat certain behavior of the child as a "motion" and that the court must schedule a hearing on that "motion." These provisions must be rewritten to conform to existing court practices and procedures. In addition, there is no "motion" for a final judgment of termination of parental rights (lines 543-545). The correct language should simply be "along with a copy of the final judgment of termination of parental rights."

The bill protects children's rights in that an absence of assent by the child is deemed a timely objection to the medication proposal, thereby automatically triggering a court hearing on the matter. However, this provision is inserted only into the language for seeking administration of medication in the first instance; it is not repeated in the provisions for continuation of medications already being administered.

Lines 424-431 state that the GAL is the "representative of" the child. This may cause unnecessary confusion as several entities may represent a child, including the child himself or herself, a parent or guardian, or an attorney or attorney ad litem. Perhaps these lines could be rewritten to conform to the role of the GAL as the representative of the child's best interests.

On line 497, the bill provides that consent forms for parents and older children must be written at a sixth- to eighth-grade reading level. The portion regarding consent forms for parents may need to be included in paragraph (b) instead (starting at line 503), which deals specifically with obtaining express and informed consent from a child's parent or legal guardian. Currently, it is in the paragraph relating to obtaining assent from the child.

Given the definition of "parental consent" in this bill, it might be inappropriate to authorize the department to obtain parental consent (lines 525-528). By definition, this can only be obtained by the child's physician or staff.

²⁷ Department of Children and Family Services, Staff Analysis and Economic Impact HB 1567 (SB 2718), (Mar. 5, 2010) (on file with the Senate Committee on Children, Families and Elder Affairs).

²⁸ E-mail from Nathan Ray, Guardian ad Litem Program, to professional staff of the Senate Committee on Children, Families and Elder Affairs (Apr. 8, 2010) (on file with the Senate Committee on Children, Families, and Elder Affairs).

It is unclear to what “revokes assent” refers in line 537. “Assent” in this bill is otherwise mentioned only when referring to assuring the cooperation of the child before prescribing psychotropic medication. Perhaps this should be changed to “consent” to maintain consistency with the remainder of the bill’s language.

VII. Related Issues:

Lines 374-380 require that the mental health treatment plan include the appointment of a GAL. This should be rewritten to simply require that whenever the department seeks to medicate or continue medication for mental health treatment of a child in foster care, the court shall appoint the GAL and the GAL shall immediately accept that appointment. Allowing the Legislature to direct the contents of the child’s actual treatment plan may constitute an invasion of the child’s privacy.

“No other parent or legal guardian gives informed consent” in lines 542-543 could be construed in two ways. It could be that another parent or legal guardian is available and does not give consent to treatment with psychotropic medications, or it could mean that no other parent or legal guardian could be found to ask for consent. If another parent or legal guardian is found, is deemed competent, and declines further treatment of the child with psychotropic medications, that decision must be respected like any other healthcare decision a parent makes for a child, unless the lack of intervention can be proven to result in the child suffering or potentially suffering unnecessarily. Similar reasoning applies to the language in lines 546-549, 558-567, and 703-706.

The child’s act of refusing medication (lines 712-716) cannot be treated as a motion in court. Although the concept makes sense, there must be a process in place for filing a written motion. Therefore, the caregiver must be required to notify the case manager or the GAL, who would be required to file and serve a written motion on all parties. They would then set the motion for a hearing no later than 7 days after service to all parties. Additionally, “repeated” refusal should be defined to avoid confusion on the part of the child’s caregiver.

In lines 785-816, the bill provides that no child under 11 years of age may be prescribed psychotropic medication absent a finding of a compelling governmental interest. The current age requirement for pre-consent review is any child 6 years old or younger. It is unclear whether the court must find a compelling governmental interest in order for psychotropic medication to be prescribed to a child under the age of 11 if the parent or legal guardian has given consent.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes: (Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.
