City of New York
Procedure
Administration for Children's Services

Policy and

2020/ 06

Informed Consent for Psychiatric Medication for Children in Foster Care

Approved By: David A. Hansell, Commissioner	**Date Issued:** 9/29/2020	**Number of Pages:** 23	**Number of Attachments:** 2
Related Laws: Social Services Law § 383-b; Domestic Relations Law § 111(1); Mental Hygiene Law Article 80; Mental Hygiene Law § 33.21; Education Law § 6902(3) Public Health Law Article 28; Public Health Law §§ 2305(2), 2504(1)(3)(4), 4210, 4301; General Obligations Law § 5-1551; Family Court Act § 355.4(2)	**ACS Divisions/Provider Agencies:** Office of the Commissioner; Office of the General Counsel; Child Protection; Preventive Services; Family Permanency Services; Youth and Family Justice; Family Court Legal Services; Policy, Planning and Measurement; and foster care and juvenile justice placement provider agencies	**Contact Office /Unit:** Suchet Rao, MD Medical Director of Psychiatry and Behavioral Health Suchet.Rao@acs.nyc.gov (347)986-7660	
Supporting Regulations: 18 NYCRR §§ 441.17(a)(5), 441.17(g), 441.22(d), 428.3(b)(2)(ii); 14 NYCRR §§ 587.7(a)(3)(iii), & 633.11;	**Related Policies:** • #2010/03, Guidelines for the Provision of Emergency and Inpatient Mental Health Services for Children in the Foster Care and Child Protective System • #2014/08, Medical Consents for Children in Foster Care • #2010/07, Security of Confidential, Case Specific and/or Personally Identifiable Information • ACS' Psychiatric Medication Prescribing and Monitoring Guidelines	**Bulletins & Directives:** • 08-OCFS-INF-02 The Use of Psychiatric Medications for Children and Youth in Placement; Authority to Consent to Medical Care • 08-OCFS ADM-01 Changes Associated with CONNECTIONS Build 18.9: Health, Education and Permanency Hearing Report Modules. • 05-OCFS-ADM-02, Case Management Changes Associated with CONNECTIONS Build	
Supporting Case Law:	**Supporting Standards:** ACS Foster Care Quality Assurance Standards, 2011	**Key Words:** consent, foster care, foster, care, authorization, capacity, affirmative objection, informed consent, psychiatric medication	

Related Forms:
DPS 001 – Override, Authorization, and Concurrent Review Request Form (Attachment A) FSS 010 – ACS Medication Consent (Attachment B) ACS Letter, Waivers for Psychiatric Nurse Practitioners (Attachment C)
Summary: This policy effects changes to ACS expectations regarding obtaining and documenting informed consent from parent(s) when psychiatric medications have been prescribed. The policy outlines the process by which ACS and agencies must make reasonable efforts to obtain informed parental consent, how such efforts must be documented, and how authorization from ACS' Psychiatry and Behavioral Health Unit (PBHU) may be requested when parental consent cannot be obtained or when override of a parent's affirmative objection is deemed necessary. In addition, PBHU will concurrently review prescriptions for certain medications for clinical appropriateness.
Scope: This policy applies to ACS and ACS-contracted staff at foster care agencies working with children and youth placed with ACS.

Table of Contents

I. INTRODUCTION

A. ACS is committed to obtaining informed consent to administer psychiatric medication to children and youth in foster care and supports efforts to appropriately prescribe psychiatric medication to children and youth in the care and custody or custody and guardianship of the Commissioner of the Administration for Children's Services (ACS). All medications for psychiatric conditions are considered non-routine; this policy outlines the different standards and different consent procedures for psychiatric medication versus non-psychiatric medication.[1]

B. It is ACS policy that, except in certain circumstances described in subsequent sections in this document, informed consent for psychiatric medication must always be sought first from a child's parent(s), unless parental rights have been terminated or surrendered (see Section IV of this document for more information).

1. The informed consent of the child's parent(s) must be obtained for each specific medication prescribed. See Sections II and VI for more information.

2. If informed parental consent has not been obtained for psychiatric medication(s), and ACS or the voluntary foster care agency[2] (hereafter, the agency) and prescribing clinician believe that the prescription of medication is in the child's best interest, the case planner must consult with the Family Court Legal Service (FCLS) attorney to obtain legal advice on how to proceed and discuss next steps for children in foster care in the following circumstances:

    a. Children whose parent objects due to religious beliefs;
    b. Children placed through voluntary placement agreements;
    c. Children placed after a dispositional hearing pursuant to Article 3 of the Family Court Act (i.e., children in a Close to Home placement);
    d. Children placed pursuant to a Person in Need of Supervision (PINS) case under Article 7 of the Family Court Act; and
    e. Children taken into custody by ACS while ACS investigates whether the child is destitute.

If the child is in foster care in one of the following types of placement described below in 3(a) and 3(b), and if informed parental consent has not been obtained for psychiatric medication, and ACS or the voluntary foster care agency[3] (hereafter, the agency) and prescribing clinician believes that the medication is in the child's best interest, the agency

[1] See ACS Policy 2014/08, *Medical Consents for Children in Foster Care*, issued 9/16/2014, available via this link.
[2] Voluntary Foster Care Agencies (VFCAs) are FC facilities licensed by DOH to provide limited health related services to contract and bill Medicaid managed care plans. See Article 29-I of the Public Health Law.
[3] Voluntary foster care agencies (VFCAs) are FC facilities licensed by DOH to provide limited health related services to contract and bill Medicaid managed care plans. See Article 29I.

must submit an override or authorization request to the ACS Psychiatry and Behavioral Health Unit[4] (PBHU): [5]

a. Children remanded or placed into foster care pursuant to an Article 10 petition;
b. Children removed and taken into custody prior to the filing of an Article 10 petition and
c. Children remanded or placed into foster care as a destitute child.

3. Agencies have consent authority for children in their custody for whom parental rights have been terminated or surrendered (also known as "freed children") and when guardianship of the child has been conferred to the agency.[6]

4. Psychiatric medications must not be administered to any child or youth until the appropriate consent, depending on the child's status, has been obtained.

C. Under no circumstances may psychiatric medications be prescribed or administered solely to control a child or youth's behavior, or as a form of restraint, except as permitted by 18 NYCRR 441.17 (g) (also see Section II below).

D. Children/youth may consent to their own psychiatric medication (and parental consent need not be obtained), in the following circumstances:

1. Youth 18 years of age or older must consent to their own psychiatric medication, regardless of the type of entry into foster care;

2. Children/youth who are married and/or parenting regardless of age may self-consent for medication;

3. Children/youth who are hospitalized for psychiatric treatment and are 16 years of age or older may consent to their own psychiatric medication at the prescribing clinician's discretion if they fulfill **one** of the following requirements:

a. For children under 18, a parent is not reasonably available, and the treating physician determines that the child has both the capacity to consent for him/herself and the medication is in the child's best interest; [7]
b. Requiring the consent of a parent would have a detrimental effect on the child, and the treating physician and a psychiatrist who is not an employee of the hospital agree

[4] Formerly referred to as the Psychotropic Medications Unit (PMU) in ACS Policy 2014/08, *Medical Consents for Children in Foster Care*.
[5] Agencies shall first request that PBHU consult ACS Office of General Counsel or Family Court Legal Services for children placed into foster care pursuant to an Article 10 petition for whom a parent raised a religious objection to medication.
[6] See Section VIII (B) for additional information regarding freed children and concurrent review.
[7] NYS Mental Hygiene Law § 33.21(e)(2).

that requiring parental consent would have detrimental effect, and that the child has the capacity to consent, and that medication is in his/her best interest,[8] or;

c. The child's parent/guardian refuses to provide informed, written consent, and the treating physician and a psychiatrist who is not an employee of the hospital agree that the child has the capacity to consent and that the medication is in his/her best interest.

E. Case planners and other agency staff must comply with the confidentiality protections set forth in ACS Policy and Procedure #2010/07, *Security of Confidential, Case Specific and/or Personally Identifiable Information* in correspondence related to obtaining informed consent, requesting authorization, override or review of psychiatric medications.[9]

F. Throughout this policy, case planners are directed to facilitate or otherwise make efforts to obtain and document informed consent, authorization, review or an override. In some cases, case planning responsibilities will remain with ACS. Some agencies may prefer that their clinical staff undertake the required actions. Ultimately, as with all medical requirements, each agency's medical leadership is responsible for overall compliance.

G. Throughout this policy, the term *case planner* shall refer to the assigned case planner or person with case planning responsibilities, or an appropriate agency designee, such as an agency nurse or supervisor. When case planning responsibility is shared between multiple agencies, the *child planner*[10] is responsible for complying with this policy.

II. DEFINITIONS

A. Child/Youth For the purposes of this policy, a child refers to an individual between the ages of 0-18, where a youth refers to an individual between the ages of 18-21. The policy specifically uses "child" when referring to an individual under 18 years old but uses "youth" in discussing any individual 18-21 years old. Both child and youth are used to capture individuals 0-21 years old.

B. Informed consent "Informed consent" means agreement obtained when the person(s) authorized to provide such consent has had the opportunity to discuss any questions or concerns with the prescribing clinician, and conveys an understanding of:

1. The nature of each medication: informed consent must be sought and received separately for each medication prescribed;

---

[8] NYS Mental Hygiene Law § 33.21(e)(2).

[9] See the above-referenced policy, available via this link.

[10] See the definition of case worker, which explains that case workers may be associated with a specific child, in *Case Management Changes Associated with CONNECTIONS Build 18*, 05-OCFS-ADM-02, page 20. If two foster care agencies, or a foster care agency and the Specialized Care Unit (SCU) within the division of Family Permanency Services, share planning responsibility for a child, the *child planner* is responsible for all notification and planning activities described in this policy.

2. The diagnoses and symptoms being treated;
3. How the medication(s) fits within the treatment plan;
4. The expected benefits;
5. The common and possible side effects;[11]
6. The recommended dosage or dosage range and duration of prescription;[12]
7. Alternative treatment choices, along with their risks and benefits, including the choice of no treatment;
8. The monitoring plan for complications and side effects, including lab monitoring schedule;
9. Whether or not the medication is approved by the U.S. Food and Drug Administration (FDA) for the patient's condition, age, and major risks, including any FDA Black Box warnings; and
10. How to contact the prescribing clinical provider.

C. Parent: For the purposes of this policy, a biological or adoptive mother or father whose parental rights have not been terminated or surrendered. Consent from a father may only be obtained if he is considered a "consent" father under the law,[13] even if such an individual is listed as a "father" or "respondent" on a child protective petition. For the purposes of authorizing medication, one parent's consent is sufficient. For the purposes of this policy, parent also includes an individual who has been granted legal guardianship by order of a court of competent jurisdiction.

D. Request for Authorization to Consent: A request for authorization to consent is submitted via form DPS-001 (Attachment A) by a child's agency to ACS requesting that the agency be given authority to consent on the child's behalf to the provision of prescribed psychiatric medication for a child remanded or placed into foster care pursuant to Article 10 or remanded or placed as a destitute child when the child's parent(s) cannot be located, has not responded to the case planner's reasonable efforts[14] to request consent for the medication, or is unable to provide consent due to lack of capacity to consent.

This request must be submitted to PBHU. Once authorization to consent is granted by PBHU, the agency's Executive Director or designee may consent to the prescribed medication.

E. Override request: A request for an override is submitted via form DPS-001 (Attachment A), which is sent by a child's agency to request ability to consent for a child remanded or placed into foster care pursuant to Article 10, or remanded or placed as a destitute child, who has

[11] Drugs that may be associated with serious or life-threatening risk, particularly ones that may lead to death or serious injury, may have this warning information displayed within a box in the prescribing information. This is often referred to as a "boxed" or "black box" warning. See https://www.fda.gov/drugs/prescription-drug-advertising/drug-advertising-glossary-terms#B

[12] New medications will be considered to have a "trial" of six months, after which informed consent shall be re-obtained. See Section VI (E) for additional information.

[13] As described in Domestic Relations Law § 111(1) and applicable case law, and consistent with ACS Policy 2014/08, *Medical Consents for Children in Foster Care* and any amended or successor policy.

[14] See Section VI(I) of this policy for additional information regarding reasonable efforts.

been prescribed psychiatric medication when their parent(s) affirmatively object(s) or decline(s)to provide informed, written consent for the medication. This request must be submitted to PBHU. This request should not be submitted if the parent(s) object on religious grounds, and FCLS must be consulted regarding such an objection. Once the override is granted, the agency's Executive Director or designee may consent to the prescribed medication.

F. Concurrent review: "Concurrent review" is the process by which PBHU staff will assess the clinical appropriateness of certain prescribed psychiatric medications in specific circumstances. Concurrent review requests are submitted via form DPS-001 (Attachment A). Even when a concurrent review is required by this policy, the person or entity with consenting authority retains ultimate decision-making authority.

G. Affirmative objection: Any verbal or written statement indicating that the parent is opposed to the psychiatric medication(s) proposed for their child.
   1. This does not include objection on religious grounds, for which the case planner shall request a legal consultation with the FCLS attorney assigned to the child's case (see Section VII (C) for additional information).

H. Off-label use: "Off-label" refers to the use of medications for the treatment of patient populations, including age groups, conditions or diagnoses other than those for which the FDA has approved the medication as "safe and effective."[15]

I. Pharmacological restraint: The use of a chemical agent to contain acute physical behavior by causing an immediate radical suppression of such behavior.[16] Per New York State regulations, such restraint may only be permitted on an order from a treating physician, only after other forms of intervention have been tried and proved unsuccessful, and only for as long as necessary to contain acute physical behavior and prevent physical injury to the child or others.[17]

J. Psychiatric medication: "Psychiatric medication," also commonly referred to as psychotropic, psychoactive or behavioral medication, refers to chemical substances that act primarily upon the central nervous system, where they alter brain function, resulting in temporary changes in perception, mood, consciousness and/or behavior,[18] and may be prescribed by an appropriately licensed practitioner.

K. Routine treatment: Any treatment that includes medical, dental, mental health and hospital services customarily given as part of preventative health care and/or for ordinary childhood diseases or illnesses.[19]

---

[15] See 08-OCFS-INF-02, *The Use of Psychiatric Medications for Children and Youth in Placement; Authority to Consent to Medical Care*, 2/13/08.
[16] See 18 NYCRR 441.17(a)(5).
[17] 18 NYNYNYNYCRR 441.17(g)
[18] 08-OCFS-INF-02.
[19] See 08-OCFS-INF-02 and Chapter 2, *Preventive and Ongoing Health Care* of the OCFS *Working Together* manual.

III. CONTINUITY OF PRESCRIBED PSYCHIATRIC MEDICATION DURING TRANSITIONS

A. When a child/youth who is being treated with psychiatric medication is transitioned into a new placement setting (including when the child first enters foster care), the child/youth must continue the medication regimen prescribed by their previous treating clinician until the medication plan is reviewed by a licensed clinician. If the child/youth is unable to continue seeing their previous clinician, then all medications prescribed by the former clinician, for which informed consent had previously been obtained, must be reviewed by the new clinician and renewed consent must be obtained within one (1) month of entry into the new setting.

   1. Transitions into a new placement setting include discharge from a hospital to any foster care placement, from the community to a foster care placement, or from one type of foster care placement to another.

B. If informed consent has not been obtained for a child from their parent within one (1) month of the new placement, the agency must follow the steps in Section VII to initiate a request for authorization of medication from the Director of Psychiatry and Behavioral Health or designee to continue the previous prescriptions no later than one (1) month from the child's entry into the new setting. The medication may continue to be administered as prescribed while the request for authorization is reviewed.

IV. AUTHORITY TO CONSENT FOR A CHILD IN ACS CUSTODY

A. Children/Youth Who Can Provide Consent for Their Psychiatric Medication
   1. The following children/youth can provide consent for their own psychiatric medication and parental consent is not needed:
      a. Youth 18 years of age or older;
      b. Children/youth who are parents, regardless of their age;
      c. Children/youth who are married; and
      d. Certain children/youth 16 years of age or older currently hospitalized and undergoing inpatient treatment.[20]

B. Children for Whom the Case Planning Agency has Consent Authority
   If a child has been freed for adoption by Family Court and guardianship of the child has been committed to the agency, the case planning agency may provide informed consent for psychiatric medications, provided that Sections II, V and X of this policy are followed with regard to informed consent.

C. Children Remanded or Placed with ACS as a Destitute Child

[20] See Section I (D) for specific requirements regarding children/youth aged 16 and over.

Case planners must request authorization from PBHU when a child is remanded or placed with ACS as a destitute child and has been prescribed psychiatric medication (see Section VIII, below). If a parent of a child remanded or placed into foster care as a destitute child is known, the case planner must make reasonable efforts to obtain informed consent from the parent prior to requesting authorization from PBHU.

D. Children for Whom Informed Consent for Psychiatric Medication is Required from a Parent
Case planners must make reasonable efforts [see Section VI (I) for additional information] to obtain informed consent from a parent for the following children, unless they meet the criteria in Section IV(A), above, prior to the child receiving his/her psychiatric medication:

1. Children taken into custody for child protective reasons or remanded or placed into foster care pursuant to Article 10
   a. Agencies must facilitate and seek informed consent from the parent(s) of children who have been taken into protective custody and/or have been removed from the place where they had been residing for child protective reasons, or who have been remanded or placed into foster care pursuant to Family Court Act (FCA) Article 10 and are not legally freed;

2. Children placed with ACS in Juvenile Justice placements pursuant to Article 3
   a. Parental informed consent must be obtained before dispensing any prescriptions for psychiatric medication for child remanded in detention centers pursuant to FCA Article 3 on juvenile delinquency cases prior to disposition;
      i. If the parent provided informed consent for psychiatric medication, the medication may become part of the child's ongoing mental health plan and is subsequently considered to be "routine."[21]
   b. For children who are placed in foster care after a dispositional hearing pursuant to FCA Article 3 (Close to Home placements) where parental consent cannot be obtained, the case planner must contact the FCLS attorney immediately in order to discuss the appropriateness and feasibility of obtaining a court order for the psychiatric medication. The case planner must call in a report to the Statewide Central Register (SCR), or as appropriate, request any currently assigned DCP Child Protective Specialist (CPS) to consider holding a Child Safety Conference (CSC) if a parent's failure to consent is endangering the health or safety of the child;
   c. For "crossover youth" who originally entered foster care pursuant to an Article 10 petition but are currently in a Close to Home placement, the consent of a parent shall be obtained according to the guidance for Article 10 placements (above), if the Article 10 placement order is in effect.

3. Children Placed through Voluntary Placement Agreements (VPA)
   Informed consent from parent(s) must be obtained if psychiatric medication has been prescribed for children placed pursuant to a VPA, including children placed into care voluntarily by a person(s) entrusted with care. The case planner must not seek the

[21] See FCA § 355.4.

consent of or consult the individual entrusted with care who voluntarily placed the child regarding the decision to medicate the child; only the parent(s) may give consent.

When ACS or the foster care agency requests a parent's consent for psychiatric medication for a child voluntarily placed in foster care and the parent does not grant his/her consent, and the Commissioner or his/her designee believes that the parent's lack of such consent endangers the life or health of the child, the case planner must contact the assigned FCLS attorney immediately in order to discuss the appropriateness and feasibility of obtaining a court order for the psychiatric medication. The case planner must call in a report to the SCR, or, as appropriate, request any currently assigned CPS to consider holding a CSC if the parent's lack of consent is endangering the health or safety of the child.

4. Children Placed on a Person in Need of Supervision (PINS) petition pursuant to FCA Article 7

   Informed consent from the parent(s) must be obtained if psychiatric medication has been prescribed for children placed into ACS custody pursuant to a PINS (FCA Article 7) petition.

   Only parents may consent for medical treatment for PINS placed with ACS pursuant to Article 7. If consent cannot be obtained, a court order may be sought, as appropriate.

   If a foster care agency's staff or appropriate ACS staff are concerned about a parent's declining to provide medical consent, they must consult with FCLS to determine whether to seek a court order for treatment. The case planner must call in a report to the SCR or, as appropriate, request any currently assigned CPS to consider holding a CSC if the parent's lack of consent is endangering the health or safety of the child.

   Note: See Sections VI-VIII below for additional information on how to obtain and document informed consent from the parent(s) (or authorization for an agency designee to consent for children whose parent has surrendered their rights or had their rights terminated), when it is appropriate to request an override or authorization from ACS for children in foster care (depending on the status of the child) if informed consent has not been obtained, and when to request a concurrent review after obtaining informed consent.

V. DOCUMENTING THE NEED FOR PSYCHIATRIC MEDICATION PRIOR TO SEEKING CONSENT AND DURING THE COURSE OF TREATMENT

A. Informed consent or alternative authorization or override must be obtained for all psychiatric medication or any medication prescribed to address side effects of a psychiatric medication, regardless of the prescriber. Prior to seeking consent for psychiatric medication, the prescribing clinician must comply with and document the following items:

1. Non-pharmacologic interventions such as therapy or counseling for several months must be considered;

2. Medications with less risk must be considered first, especially if the medication being considered is to be used off-label to target mood dysregulation and/or behavior. Antipsychotic medication should rarely be the first medication of choice when used off-label. Refer to ACS' *Psychiatric Medication Monitoring Guidelines*[22] for medication-specific information;

3. The prescribed medication must be either FDA-approved for the indicated use in the child's age group, or, if it is not FDA approved, an explanation must be given;[23]

4. No more than one medication should be started at any one time, unless the clinician has documented the reasons that it is clinically or medically necessary to do so;

5. Follow up appointments must be scheduled on a regular basis to monitor for symptoms and impairment, and to allow for medications to be adjusted accordingly, such that the minimum effective dose of medication is used at all times;

6. Whenever symptoms persist, despite the use of medication, the prescribing clinician has verified that the dosage of the current medication has (within the limits of tolerability) been optimized, and that the diagnosis has been re-evaluated, before an additional medication is started;

7. When significant weight gain secondary to medication is present, the prescribing clinician has considered switching to a weight-neutral alternative;

8. A second medication should not be added when the original medication is only partially effective, especially if there is another medication that, if used alone, might be sufficient. The same principle applies to any additional medication, including non-psychiatric medications, prescribed solely to address side effects;

9. For any child prescribed psychiatric medications, re-evaluation must occur regularly to ensure that there is diagnostic clarity and that target symptoms are being appropriately addressed (see Section X for additional information on prescriptions for multiple psychiatric medications); and

10. The prescribing clinician must consider the context in which the medication is being prescribed, and exercise caution, particularly with medication that requires extensive monitoring, or which could be harmful if not taken consistently. The clinician must have a plan for ongoing monitoring of the child's condition.

---

[22] Available online at this link.

[23] Such prescriptions are generally preferred to the prescription of off-label alternatives.

VI. OBTAINING AND DOCUMENTING INFORMED PARENTAL CONSENT FOR PSYCHIATRIC MEDICATION

A. Prescribing and administering psychiatric medications is considered "non-routine" treatment, for which informed consent, rather than routine medical consent, must be obtained, unless the child is placed in a Close to Home setting pursuant to Article 3 and the child's/youth's medications are part of the written mental health plan.[24]

B. Prior to seeking consent for psychiatric medications, the agency must document that the child/youth has received an initial physical examination from an appropriately licensed clinician within the past six (6) months and that appropriate laboratory tests have been conducted prior to the administration of medications.[25] The physical exam must, at a minimum, focus on the organ system(s) that may be affected by the medication.

   1. Thereafter, children/youth taking psychiatric medications must have a documented physical examination and appropriate laboratory tests every six (6) months. A pediatrician, psychiatrist, and/or certified family, pediatric, or psychiatric nurse practitioner (NP) may perform the follow-up examination and laboratory tests.

C. Trial or initial consent/authorization: The initial consent or authorization shall expire six (6) months after the date indicated on the *FSS-010 Consent for Psychiatric Medication* form or *DPS-001 Override, Authorization, and Concurrent Review Request Form*. This initial authorization is considered a "trial" authorization and must be renewed for the medication to be continued thereafter. At the time of expiration of the trial consent, the case planner must make reasonable efforts to connect the parent(s)[26] (or the consenting agency, in the case of authorization) to the prescribing psychiatrist for a meeting or phone call to discuss the following:

   1. Effectiveness of the medication;
   2. Presenting side effects of the medication;
   3. Treatment alternatives to the medication;
   4. The prescribing clinician's assessment of the benefits of continuing or discontinuing the medication; and
   5. The parents' right to withdraw consent at any time, in the case of informed parental consent.

---

[24] See 08-OCFS-INF-02: *The Use of Psychiatric Medications for Children and Youth in Placement; Authority to Consent to Medical Care*. Please note that, for children in an Article 3 (Close to Home) placement, routine mental health treatment does not include psychiatric administration of medication unless the medication is specified as part of an ongoing mental health plan or otherwise authorized by law, per FCA § 355.4.

[25] Refer to the *Psychiatric Medication Monitoring Guidelines* for additional information about the appropriate laboratory tests required to monitor psychiatric medications.

[26] See Section VI (I) for additional information on reasonable efforts.

D. After the initial consent expires, informed consent must be renewed and documented every 12 months as long as the child/youth remains in foster care and psychiatric medications continue to be prescribed.

E. The person(s) authorized to sign treatment consents have the right to have any questions or concerns addressed by the prescribing clinician before giving consent.

F. The case planner must inform the parent(s) of their right to withdraw consent at any time. If the parent(s) withdraw(s) their consent, and the prescribing clinician continues to recommend the prescribed medications, the case planner must contact PBHU immediately to discuss next steps. Parents must also be informed of their right to request a concurrent review[27] from PBHU to discuss any questions or concerns.

G. If a parent has any questions about the medication prior to or following signing the FSS – 010 ACS Medication Consent Form (Attachment B), the case planner must make reasonable efforts to facilitate a conversation, either in person or by telephone, between the prescribing clinician and the parent to discuss all details of the recommended medication, as outlined in Section II (A) above, and answer any of the parent's questions. The case planner must follow up with the parent to determine if such a conversation has taken place, and must document, in a CONNECTIONS (CNNX) progress note, whether this discussion has occurred.[28] The case planner must complete the *FSS – 010 ACS Medication Consent* form, specific to the medication, which includes obtaining the parent's signature following a review of the recommended treatment with the parent(s) to confirm that informed consent was obtained.

   1. Case planners must document in CNNX all attempts made to connect the clinician and parent, regardless of the parent's ultimate choice to consent or not. If the parent(s) confirm(s) their informed consent, the form must be kept in the medical section of the youth's foster care record.

   2. If the prescribing clinician is unable to be reached in a timely manner by the case planner or parent, the case planner shall seek support first from their agency's Medical, Clinical or Mental Health Director, or person of an equivalent title. If additional efforts to contact the clinician have been unsuccessful, the case planner should contact PBHU for guidance.

H. In addition to the information provided by the prescribing clinician, ACS has created resource sheets to address information about the medication prescribed, including what symptoms and diagnoses the medication is designed and approved to treat, and common side effects. After reviewing such resource sheets with the child's case planner, the parent or consenting person(s) must sign the consent form to indicate consent to the specific medication prescribed to the child. Consent forms for all medications prescribed shall be retained in the child's case record. The receipt of a signed form, which shall be used to document the consenting person(s) provision of informed consent for the prescribed medication, must also

[27] See Section X for more information on concurrent review.

[28] See 05-OCFS-ADM-02, *Case Management Changes Associated with CONNECTIONS Build 18.*

be documented in a progress note in CNNX, per OCFS administrative directive.[29] In addition to providing the form, case planners must make reasonable efforts to verbally review the information with the consenting person. The prescribed medication shall not be administered to the child until the parent has signed the consent form detailing the specific prescribed medication.

I. Reasonable efforts: The case planner must make reasonable efforts to seek consent from each parent and must properly document such efforts in CNNX in a timely manner in the child's progress notes. These efforts must be repeated for all subsequent renewal requests. Reasonable efforts must include the following actions at a minimum:

   1. One (1) telephone call to the last known phone number of each parent;
   2. One (1) personal visit to the current or last known address of each parent; and
   3. One (1) letter to the current or last known address of each parent, which includes contact information for the case planner or other appropriate agency staff, such as the Medical Director, and the prescribing clinician. If reasonable efforts have not been successful, refer to guidance below regarding next steps.

J. If neither parent has a court order of custody, informed consent received from either parent whose rights have not been terminated or surrendered is valid, regardless of whether the parents live together or separately from one another. If, however, one parent has been granted custody, consent may be obtained only from that parent.[30]

   1. Documented informed consent from either parent is sufficient. If the first parent contacted objects but the second parent contacted consents, the consent of the second parent prevails.

   2. The initial informed consent from a child's parent(s) for psychiatric medications must be documented with the parent signature on form FSS-010.

K. If the parent(s) declines or is/are unable to renew their informed consent after providing an initial consent, or a parent cannot be located, the case planner must follow the appropriate steps as described below (Sections VIII and IX) depending on the status of the child.

L. If informed parental consent has not been obtained for medications, a psychiatric medication authorization/override request must be submitted using form DPS-001 if a child is prescribed medications by a psychiatrist, including non-psychiatric medications prescribed to address side effects of a psychiatric medication.

---

[29] Ibid at pg 10.

[30] As outlined in the definitions section of this policy, consent from a father may only be sought if he is considered a "consent" father under the law, even if such an individual is listed as a "father" or "respondent" on a child protective petition. For the purposes of authorizing medication, one parent's consent is sufficient.

VII. WAIVERS FOR PRESCRIBING NURSE PRACTITIONERS

A. All psychiatric medications prescribed to children in foster care must be prescribed by a child and adolescent psychiatrist or pediatrician. If a foster care agency would like a nurse practitioner to be permitted to prescribe psychiatric medication to children in foster care, the agency must contact PBHU at psychiatry@acs.nyc.gov to apply for a waiver. All waivers must be granted prior the filling of any psychiatric medications.[31]

VIII. NEXT STEPS WHEN INFORMED PARENTAL CONSENT HAS NOT BEEN OBTAINED

A. The case planner must document the reasonable efforts to secure parental consent, including all dates and methods used to secure the consent, in CNNX progress notes. If the parent(s) affirmatively object(s) to a recommended psychiatric medication, the case planner must inquire about their concerns and reasons for opposing the psychiatric medication and document the conversation in CNNX. The agency is obligated to first discuss the parent's concerns and attempt to facilitate a conversation with the prescribing clinician to address the parent's questions prior to initiating any of the next steps described below.

B. If, following discussion with the prescribing clinician and case planner or agency clinical staff, a parent has outstanding concerns or questions about the proposed medication, the provider agency must request a review from PBHU.

C. In any of the following situations, if informed parental consent for a specified psychiatric medication cannot be obtained, because the parent affirmatively objects to the proposed medication, declines or is unable to provide informed, written consent for the proposed medication, or cannot be located or contacted to provide informed consent, the case planner must contacting the FCLS attorney. If no attorney is assigned to the child's case, the case planner must contact the appropriate FCLS Borough Chief.

    1. An Article 3 (juvenile justice placement);
    2. An Article 7 (PINS placement);
    3. A Voluntary Placement Agreement (by parent(s)/guardian(s) or person entrusted with care); and
    4. Any child in foster care for whom a parent/guardian expresses a religious objection to the prescribed medication.

    After discussing the case with the case planner, FCLS attorneys shall consult with PBHU regarding the anticipated impact of the medications on the child's safety and well-being and the clinical appropriateness of the proposed medications. The FCLS attorney must contact

[31] For additional information on completing and submitting a waiver for a prescribing nurse practitioner, see ACS Letter: Waivers for Psychiatric Nurse Practitioners.

the case planner to inform them of the outcome of their discussion with PBHU. If appropriate, FCLS will seek a court order for the proposed medication.

D. Children placed in foster care pursuant to Article 10

1. Parent Affirmatively Objects or Declines to Provide Informed, Written Consent

a. If a parent(s) affirmatively object(s) to the administration of the prescribed medication, or declines to provide informed, written consent for the psychiatric medication, the case planner or case planning team must request an override by submitting Form DPS-001, Override, Authorization and Concurrent Review Request Form (Attachment A), to PBHU.[32] The provider agency or relevant DCP, FPS, or DYFJ unit is responsible for promptly submitting the legal and clinical information necessary for review of the medication override request (see Section VIII, below, for details).

b. Parental consent is valid, and no authorization or override is needed if one parent affirmatively objects to the treatment but the other parent, whose rights have not been terminated or surrendered, provides informed consent.

c. If the parent(s) decline(s) to provide consent, it is still the responsibility of the agency to keep the parent(s) informed of any override being sought, the result of that process, and the results of any laboratory tests or examinations that were completed before a child is prescribed a psychiatric medication.

2. Parent Cannot be Located or Has Not Responded to Reasonable Efforts to Request Informed, Written Consent

If, following reasonable efforts (as described in Section VI (I) above) to contact the parent(s), the parent(s) cannot be located, has not responded, or is unable to provide consent due to an apparent lack of capacity to consent, the case planner must request ACS authorization prior to administering any prescribed psychiatric medications, as described below.

IX. AUTHORIZATION AND OVERRIDE REQUESTS FOR CHILDREN IN PROTECTIVE PLACEMENTS AND CHILDREN PLACED AS DESTITUTE CHILDREN

A. ACS has the legal authority to provide consent for psychiatric medication for children remanded or placed into foster care pursuant to Article 10 (i.e. in "protective placement"), a destitute child petition, or a child who has been removed from the place where he or she has been residing for child protective reasons but prior to a petition being filed (i.e. emergency removal).

[32] Override requests shall not be submitted when a parent of a child placed pursuant to an Article 10 petition objects on religious grounds. In such cases, the case planner shall request a consultation with the assigned FCLS attorney.

B. As stated above, if a child is in foster care pursuant to a protective placement and has been freed for adoption, the agency may provide consent for the proposed psychiatric medication. In such cases, agencies shall still request concurrent review of medications if the medication falls into the prescribed categories outlined in Section X below.

C. For all other children in protective placements whose parents' rights have not been terminated or surrendered and for children placed as destitute children, if informed consent has not been obtained due to the parent's affirmative objection or declining to sign the informed consent form, or because a parent cannot be located, has not responded to reasonable efforts to contact them, or is unable to consent due to apparent lack of capacity to consent, the case planner must use Form DPS-001 to submit, as appropriate, an authorization or override request for PBHU review. Requests should be submitted via email to the PBHU at psychiatry@acs.nyc.gov within two business days. Case planners shall indicate whether an authorization or override is requested where indicated on the form.

D. In addition to completing the form, the case planner must submit clinical information necessary for review of the medication authorization/override request. This must include:

   1. A clinical note from the prescribing psychiatrist that has been written within the last sixty (60) days that includes:
      a. Medication prescribed, including dosage and frequency details, or a copy of the electronic prescription if available;
      b. A DSM-5 diagnosis;
      c. Current clinical history;
      d. The target symptoms for each prescribed/recommended medication;
      e. Observation of responses to previous medication trials, and to any current medications; and
      f. A justification for the recommended dose or medication combination, if it does not comply with the principles outlined below, or the ACS *Psychiatric Medication Monitoring Guidelines*, issued in December 2017.

   2. Any additional information about the child's symptoms or treatment response to date, including from the child, the child's parent(s), foster parent, or school personnel, should also be included for review, if applicable.

E. When reviewing authorization or override requests and concurrent review submissions (see Section X below), PBHU staff will review submitted documents to see that the precautions set forth in Section V above were taken by the prescribing clinician. PBHU will return a decision within three (3) business days of receiving a completed request packet as described in Section VIII (D), above.

   1. This timeframe may be expedited on a case-by-case basis, based on clinical need as determined by PBHU staff.

F. Upon receipt of an override request, PBHU will submit the review of override requests to either the FCLS Legal Compliance Unit or OGC Legal Counsel Unit for review. Note that authorization requests do not need to be submitted for legal review. The FCLS Legal Compliance Unit attorney or OGC Legal Counsel Unit attorney will review the case for legal authority and compliance with ACS procedures.[33] PBHU must forward request forms and any other required documents to the reviewing attorney.

G. PBHU will notify the case planning agency or ACS division with a dated, emailed, letter that documents the outcome of the override/authorization request and if applicable authorizes the appropriate agency designee to provide consent for the medication as prescribed. A copy of the letter must be retained in the child's case record; PBHU will retain a copy of the letter of override or authorization. The case planner must also provide child's parent/legal guardian with a copy of the letter. The initial override or authorization, like the initial consent when obtained from a parent, must be renewed after the trial period [six (6) months]. See Section V(B) for additional information.

X. EXCEPTIONS TO NEED FOR ACS CONSENT

A. Subject Children on Trial Discharge Status
   1. ACS declines to exercise its authority to consent for medication for children who are on trial discharge status while still in foster care.
   2. Upon request and/or upon being informed that the child on trial discharge has been prescribed psychiatric medications, case planners shall make reasonable efforts to provide the parent(s) with information about the prescribed medication (see Attachment B) to facilitate the parent's informed consent prior to the administration of psychiatric medication, and arranging for a conversation with the prescribing clinician upon request. If foster care agency staff or appropriate ACS staff are concerned about the parent's declining to consent or inability to provide consent to the administration of psychiatric medication to the child, the staff must immediately consult with the FCLS attorney.

B. Children Temporarily Placed with or in the Custody of a Parent, Relative or Other Suitable Person

   ACS lacks legal authority to consent for medication for children who are temporarily placed in the custody of or released to a parent, relative, or other suitable person.

C. Children Who are Placed with an Agency Under the Auspices of a Governmental Agency Other Than ACS

   Authority to consent to the administration of psychiatric medication to children in the custody of, and placement in a facility operated by, the New York State Office of Children and Family Services (OCFS), New York State Office of Mental Health (OMH), New York State

[33] OGC and FCLS do not need to review submissions concerning children in foster care who have been freed for adoption, as outlined in Section IV(B) above, or submissions for authorization requests.

Office for People with Developmental Disabilities (OPWDD), or with their contractors rests with the appropriate oversight agency and not with ACS.[34] Children who are legally placed with ACS but are physically placed in an OCFS, OMH, or OPWDD facility, however, remain subject to the requirements herein, as well as applicable statutes and regulations.

D. Youth Over 18 in ACS' Care

Youth over the age of 18 are presumed to have the capacity to consent to medical and/or mental health treatment. ACS lacks legal authority to consent on their behalf. If the young adult's mental health treatment provider questions their capacity to consent (which could include their cognitive ability to provide informed consent), the agency shall contact the assigned FCLS attorney and the FCLS Legal Compliance Unit in order to discuss the appropriate course of action.

XI. ACS CONCURRENT REVIEW

A. Concurrent review is the process by which PBHU staff will assess the clinical appropriateness of certain prescribed psychiatric medications, as outlined below. The foster care agency's Clinical Director, or appropriate equivalent in the agency's clinical leadership structure, is responsible for identifying cases that require a concurrent review based on the guidance provided in this section. Additional details have been provided in the ACS *Psychiatric Medication Monitoring Guidelines*, issued in December 2017.[35] The case planner shall consult with his/her agency's clinical leadership or the PBHU for additional guidance or clarification. The outcome of the PBHU review will be a written recommendation sent via email to the clinical director of the child's agency, the child's case planner and to the prescribing psychiatrist. The case planner or clinical director will then relay this information to the person/agency that is the designee of the commissioner responsible for consenting. This review is similar to a second opinion.

Note: The agency with guardianship of a freed child, or a parent who has maintained their parental rights to the subject child, has the ultimately authority to consent for psychiatric medication following any concurrent review.

B. All override/authorization requests will undergo a concurrent review.

C. The agency is required to request a concurrent review from PBHU using DPS-001, *Override, Authorization and Concurrent Review Request Form* (Attachment A) in the following circumstances:

[34] See Mental Hygiene Law Article 80 and 14 NYCRR § 633.11 for information concerning medical consent for individuals who are residents of facilities operated or certified by OPWDD or OMH.
[35] Available on ACS SharePoint via this link.

1. When it has obtained consent from a child who has the authority to consent on their own behalf; or

2. When it has obtained valid consent from one of the parents still in possession of the right to consent on the child's behalf, or it has consented on behalf of a freed child in its care, and one of the following circumstances exists:

   a. A child aged six (6) or under will be prescribed a second psychiatric medication;

   b. A child between the ages of seven (7) and twelve (12) will be prescribed a third psychiatric medication;

   c. A child between the ages of thirteen (13) and seventeen (17) will be prescribed a fourth psychiatric medication;

   d. A child taking psychiatric medication has gained significant weight or has a body mass index (BMI) of thirty (30) or higher;

   e. A child of any age is prescribed a second medication in the same class as a medication the child is currently taking (for example, a second antidepressant);

   f. A child is prescribed an antipsychotic medication off-label as a first-line treatment (before being prescribed any other psychiatric medications);[36]

   g. A child of any age will be prescribed clozapine;

   h. A parent has raised outstanding concerns or questions about the proposed medication; and

   i. The child taking psychiatric medication has new significant lab abnormalities.[37] (It is the responsibility of the agency to keep in contact with the child's pediatrician in order to monitor any changes in bloodwork or other labs.[38]).

D. After obtaining informed consent from the parent in any of the situations listed above, the case planner shall inform the parent that the proposed medication requires review by ACS. Likewise, after obtaining informed consent from any child who is able to consent to their own medical treatment, the case planner shall inform the child that the proposed medication requires review by ACS.

---

[36] Refer to the Psychiatric Medication Monitoring Guidelines for additional information about off-label medications, which refers to medications prescribed for ages or uses other than those included in the medication's FDA approval.
[37] Ibid.
[38] See Section VI (A) for required examinations and labs.

E. The agency shall complete and submit the DPS-001 form to PBHU for concurrent review. The following documentation shall be submitted along with the form:
   1. A recent psychiatric evaluation by the prescribing clinician and/or a recent clinical note, which must provide clinical justification for the proposed medication;
   2. The results of a recent pediatric (physical) exam; and
   3. Recent lab (blood) work results (if clinically indicated; see ACS's *Psychiatric Medication Monitoring Guidelines* for more information).

F. PBHU will provide the case planner with a letter of recommendation, including any clinical concerns as applicable, which the case planner must share with the parent(s), or with the youth who legally consented to their own treatment. The letter of recommendation shall also be shared with the prescribing clinician.

G. If, following a discussion with the case planner and/or agency clinical staff, the parent(s) (or children/youth able to consent to their own medical treatment) still have questions, the agency shall contact PBHU to schedule a call to discuss ACS' recommendation concerning the prescribed medication, and relay the conversation to the parent(s).

H. The concurrent review process does not give ACS the authority to override the consent of any person who has the legal authority to provide it. Thus, if the child/youth who can provide informed consent, or the parent(s), prefers the proposed psychiatric medication they can consent over ACS' recommendation.

I. PBHU must document all discussions, according to PBHU's review tracking protocol, with the prescribing clinician regarding the concurrent review and/or discussions regarding the letter of recommendation with the agency's Medical Director, the case planner, and the prescribing clinician.

XII. AGENCY AND ACS QUALITY ASSURANCE REQUIREMENTS

A. Provider agencies must establish internal policies and procedures to guide their medical consent process, including how to obtain informed consent. Procedures shall describe the level or title of staff eligible to provide medical consents; the availability of medical and mental health staff to provide consultation 24 hours a day, seven days a week; and internal prospective and retrospective review of medical consents.

B. Every two (2) years, provider agencies must submit their internal psychiatric and mental health consent policies via email to the PBHU at psychiatry@acs.nyc.gov.

C. PBHU will track psychiatric prescription override, authorization, and concurrent review requests, including requests received, the PBHU decision following legal and clinical review, the date authorization or override was granted or denied, and the date when efforts to obtain informed consent must be renewed. All necessary documentation required for review will be stored in a secure electronic location. The following will be included in PBHU documentation:

1. Key decision points, including the outcome of any PBHU review, and whether the request was approved or denied;
2. Clinical justification for decision, including information on considerations that informed PBHU's recommendation or decision;
3. All parties involved, including the name of the agency that submitted a request and who performed the PBHU review;
4. Communication dates, including the date the request was initially made, the date a completed request packet, including supporting documentation, was received, and the date the final decision was communicated back to the agency.
5. Communication with clinicians, FCLS and OGC attorneys, agency Medical Directors, and others, including dates of communication and description of the nature of the communication.

D. The ACS Medical Audit Unit (MAU) will be monitoring provider agencies' compliance with this policy through the existing medical audit process. This includes, but is not limited to the following:
1. Assessment of mental health-related practice during the pre-scheduled medical audits using the existing Medical Audit Tool, which is periodically updated to reflect policy changes;
2. Follow-up on specific cases brought to the attention of the MAU during the process of case reviews related to the implementation of this policy;
3. Follow-up on referrals from the PBHU to the Medical Audit Unit; and
4. Unscheduled medical audits as deemed necessary by ACS.

XIII. SHARING MEDICATION INFORMATION WITH FOSTER PARENTS

A. In addition to sharing medication information with parents, case planners and/or agency clinical staff must share and review, in person and in writing (by providing medication-specific forms), medication information including the name, dosage, indication, and potential side effects with the foster parent. This will enable the foster parent to provide information to the prescribing physician or case planner regarding changes in the child's condition and response to the medication. The information shared must also include contact information for the prescribing clinician and the date of the next follow-up appointment.

B. While foster parents do not have the authority to consent for psychiatric medication, a copy of the medication-specific form must be given to the foster parent for informational purposes. The case planner must discuss each medication in person with the foster parent(s),

and provide instructions on how the foster parent must report any concerns about the medications and what to do if the child demonstrates symptoms or side effects after starting the medication, as well as a schedule for medication administration, and answers to any additional questions raised by the foster parent.

C. Case planners must inform foster parents that they are not to administer any medications prescribed by a child's psychiatrist until agency case planner verifies that the prescription has been authorized by someone with legal consent authority.

D. Case planners shall discuss the child's response to medications and ask about any presenting side effects or changes during each casework contact with the foster parent and parents.

XIV. REFERRALS TO THE MEDICAL AUDIT UNIT

A. PBHU will alert the MAU if, during the course of responding to requests for case reviews based on this policy, and/or a review of available data and information, the PBHU clinical staff identifies, with respect to a foster care agency, a pattern of non-compliance and/or specific situations that may be evidence of disregard for other ACS policies. Such a pattern or circumstance may be recognized as, but not limited to:
   1. Multiple cases of polypharmacy[39] with no adequate documentation of clinical justification by an appropriate clinician;
   2. Multiple cases of inadequate trials of first-line medications before prescribing second and third-line alternatives;
   3. Multiple cases of age-inappropriate use of psychiatric medications;
   4. Use of any psychiatric medication without adequate documentation of diagnosis, follow-up, and/or clinical indication;
   5. Lack of appropriate consent; or
   6. Other situations that may indicate gross non-compliance with the general principles and the goals of this Policy.

B. The PBHU will inform the MAU regarding the specifics of the case(s) reviewed and the MAU will then include the case(s) as part of its next scheduled audit. In cases in which it is deemed that children and youth are placed at high unnecessary health risks, an unscheduled audit may be performed.

[39] Concurrent use of multiple medications.