



Administrative Policies and Procedures: 20.24

Subject:	Informed Consent
Authority:	TCA 29-26-118, TCA 37-5-105(3), 37-5-106, TCA 37-1-140, TCA 37-1-128, TCA 33-8-202, TCA 37-10-301 through 307, TCA 63-6-220, TCA 63-6-222-223, TCA 63-6-229, TCA 68-10-104(c), TCA 68-11-1802, TCA 68-34-107, <i>Cardwell v. Bechtol</i> (724 S.W. 2d 739), <i>Brian A. v. Bredesen</i> , and Tennessee Attorney General Opinion No. 04-127.
Standards:	ACA: 4-JCF-4C-44, 4-JCF-4C-48; DCS Practice Model Standards: 7-100 A, 7-114 A, 7-120 C, 7-208 B, 8-304, 8-306; COA: PA-CR 1.04, PA-CR 1.07, PA-CR 2.01-2.03, PA-RPM 3.02.
Application:	All Department of Children's Services Employees

Policy Statement:

In order for children in custody to receive appropriate health services, DCS shall facilitate the informed consent process by involving the parent/guardian/older youth or by providing the consent as appropriate.

Purpose:

Informed consent is based on the fundamental principle that every person has the right to control his/her own bodily integrity. The individual has a right to receive sufficient information to enable the individual to make an informed decision about whether to consent to or refuse the tests or treatments.

Procedures:

A. Introduction to informed consent

1. Every individual has the right to receive information regarding prescribed tests or treatments, including risks and benefits of taking the tests or treatments and risks/benefits of not taking the tests or treatments.
2. The healthcare provider should provide a verbal and/or written explanation about the prescribed treatment or test, explained in a way the patient fully understands, which generally includes the following:
 - a) Diagnosis for which the treatment/medication is prescribed;
 - b) Nature of the medication, treatment, test, or procedure;
 - c) Name of the medication, including both generic and brand names;
 - d) Dosage and frequency of medication;
 - e) Expected benefits;
 - f) Possible risks and side effects;
 - g) Availability of alternatives; and

	<p>h) Prognosis without proposed intervention.</p> <p>3. Informed consent is the consent to treatment given after the individual, legal custodian, and/or legal guardian has received sufficient information about the risks and benefits of taking and not taking a prescribed or recommended treatment.</p> <p>4. In deciding whether or not to consent to treatment, youth, parents, or DCS staff/representatives should ask questions as appropriate or needed, and may seek assistance from the DCS regional nurse or psychologist. Furthermore, DCS staff/representatives should seek guidance from supervisory staff or local DCS attorney if they have further questions.</p> <p>5. Depending upon the setting and the healthcare provider, the individual or their guardian may be asked to sign a form documenting their consent to or refusal of treatment. Should the consent be provided verbally, DCS will require a written copy of the consent documentation from the healthcare provider.</p>
<p>B. Engaging families in informed consent</p>	<p>1. Parents should be engaged in the informed consent process unless their rights are terminated.</p> <p>2. In addition to the parent(s), the child's DCS Caregiver (FSW, resource parent, or private provider staff) should also participate in healthcare appointments.</p> <p>3. At the Initial Child and Family Team Meeting, (see DCS Policy 31.7, Building, Preparing and Maintaining Child and Family Teams) parents should be informed of the right and responsibility to make healthcare decisions about their child, as well as the expectation that they will participate in these decisions.</p> <p>4. The parent(s) shall be informed at the Initial Child and Family Team Meeting that if they are unavailable to consent to necessary healthcare treatment for their child, then DCS will do so under its authority as the legal custodian. The parent(s) shall also be informed that DCS honors their role as the parent and will make every effort to involve them in decisions about their child.</p> <p>5. Upon a child's entry into custody, the parent(s) will be asked to sign DCS form CS-0206, Authorization for Routine Health Services for Minors. This form verifies that DCS is the legal custodial of the named child and as such is authorized to consent to ordinary and /or necessary medical care. It also allows the parent to permit such care.</p> <p>6. If a parent is not available to make the decision of whether to consent to treatment, the child's parent should be informed as soon as possible about the healthcare given and the need for any follow-up care. Notification of parents should be handled as follows:</p> <p>a) <u>DCS Resource Home</u>: If the resource parent signs the consent for healthcare, the resource parent will notify the DCS Family Service Worker (FSW) as soon as possible. The FSW will then notify the child's parent(s).</p> <p>b) <u>Private Provider, DCS Youth Development Center</u>: If the private provider caseworker or private provider resource parent or DCS YDC staff provides consent for healthcare, they shall contact the child's parent(s) and the FSW.</p>

	<p>7. Initial Child and Family Team meetings and Permanency Plan staffings will include a discussion of the possibility of mental health evaluations and psychotropic medications. FSWs will advise parents that their attendance at appointments and involvement in their child’s care, including informed consent, is expected and welcomed. The statute regarding youth 16 years and older making their own consent decisions about mental healthcare will be reviewed at these meetings, if applicable (refer to Section H “Consent for Psychotropic Medication”).</p> <p>8. There may be special circumstances in which it may not be in the best interest of the child or youth for parent(s) to be involved in healthcare decisions about their child. In these cases, the FSW should contact the regional DCS attorney assigned to the case.</p>
<p>C. Age requirements for minor’s consent or refusal</p>	<p>1. Parental consent is generally required for the healthcare treatment of a minor child. However, there are instances according to Tennessee law when the minor’s decision can be accepted if the healthcare provider chooses to do so.</p> <p>2. Guidelines for a healthcare provider to determine a minor child’s maturity and capacity to make healthcare decisions (consent or refusal) are:</p> <ul style="list-style-type: none"> a) Ages 0 – 7, no capacity b) Ages 7-13, presumed to not have capacity, but the presumption can be rebutted, c) Ages 14 and older, presumed to have capacity, but the presumption can be rebutted. <p>3. Certain types of healthcare and treatment do not require specific age for a provider to treat minors without consent or knowledge of parent or guardian.</p> <ul style="list-style-type: none"> a) treatment of juvenile drug abusers b) prenatal care c) contraceptive supplies d) examination, diagnosis, and treatment if delay of care for consent would result in serious threat to the life of the minor or serious worsening of the medical condition <p>4. Beginning at age 16, minors in Tennessee with serious emotional disturbance (SED) or mental illness have the same rights as adults to make decisions about mental health treatment.</p>
<p>D. Consent for routine medical care</p>	<p>1. When the need for routine medical care arises, the parent should be contacted to decide whether to provide informed consent unless parental rights have been terminated.</p> <p>2. If the child’s parent(s) is unavailable to provide consent, the FSW¹, the resource parent, the private provider caseworker, and the designated Youth</p>

¹ This includes the FSW’s supervisor(s) or Regional Administrator’s designee(s).

	<p>Development Center staff (Superintendent or designee) are authorized by DCS to give consent for routine medical care.</p> <ol style="list-style-type: none"> 3. Case aides and Transportation Officers may not provide consent for any type of healthcare for children in custody. 4. If someone other than the parent provides consent, refer to Section B “Engaging Families in Informed Consent” for parent notification process. 5. If the parent or child refuses to give consent for routine medical care, refer to Section K “Refusal.”
<p>E. Consent for emergency healthcare treatment</p>	<ol style="list-style-type: none"> 1. When the need for emergency healthcare treatment arises, the parent should be contacted to decide whether to provide informed consent unless parental rights have been terminated. 2. If parents are not immediately available, the FSW, the resource parent, the private provider caseworker and the designated Youth Development Center staff (Superintendent or designee) may all give consent at the time emergency healthcare is needed. 3. If someone other than the parent provides consent, refer to Section B “Engaging Families in Informed Consent” for parent notification process.
<p>F. Consent for surgical procedures and/or anesthesia</p>	<ol style="list-style-type: none"> 1. When the need for surgical procedures and/or anesthesia arises, the parent(s) should be engaged in all perioperative decisions and appointments. The parent(s) will make the decision of whether to provide informed consent for the surgery and/or anesthesia unless parental rights have been terminated. 2. The FSW, the private provider caseworker or the designated Youth Development Center staff will arrange for the parent(s) to attend all perioperative appointments with the treating healthcare provider. The parent(s) will make the decision regarding the surgical procedure and/or anesthesia. 3. If the parent(s) refuses to give consent for the surgical procedure and/or anesthesia, refer to Section K “Refusal.” 4. If the child’s parent(s) is not available to participate in perioperative appointments and determine consent, the DCS Regional Nurse should be notified of all perioperative appointments and will make the consent decision regarding the surgical procedure and/or anesthesia. 5. If someone other than the parent provides consent, refer to Section B “Engaging Families in Informed Consent” for parent notification process (rule applies if child is under 15 years old).
<p>G. Consent for routine mental health</p>	<ol style="list-style-type: none"> 1. When the need for routine mental health treatment arises, the parent(s) should be contacted to decide whether to provide informed consent unless

<p>treatment</p>	<p>parental rights have been terminated or the youth is 16 years of age or older.</p> <ol style="list-style-type: none"> 2. If the child is younger than 16 years of age and the child’s parent(s) is unavailable to provide consent, the FSW², resource parent, private provider caseworker and designated Youth Development Center staff (Superintendent or designee) are authorized by DCS to sign consent for outpatient and inpatient mental health treatment (excluding psychotropic medication—refer to Section H “Consent for Psychotropic Medication”). 3. If someone other than the parent provides consent, refer to Section B “Engaging Families in Informed Consent” for parent notification process. 4. Older children have special rights with regard to mental health services³. Youths 16 years and older may provide their own consents for mental health treatment. When these youths give consent, additional consent from the parent, legal guardian or legal custodian is not needed. However, some mental health providers, at their discretion, may choose not to treat 16-year-old youths without parental involvement. In these cases, if the 16-year-old youth does not want his/her parent(s) involved, then another mental health treatment provider should be sought. 5. If the parent(s) or child refuses to give consent for routine mental healthcare, refer to Section K “Refusal.”
<p>H. Consent for psychotropic medication</p>	<ol style="list-style-type: none"> 1. When the need for psychotropic medication arises, the parent(s) should be engaged in all medication decisions and appointments for the child, unless parental rights have been terminated or the youth is 16 years of age or older. 2. <u>Under Age 16 Years:</u> For children less than 16 years of age, the parent(s) will be notified of psychiatric appointments by direct contact, phone, or mail. Parents are requested to participate in person or be available by phone for consultation at the time of the appointment whenever possible. The contact with the parent(s) should be made by one of the following staff: the FSW⁴, private provider caseworker, or designated Youth Development Center staff. The staff person coordinating parental involvement will relay this information to the prescribing provider. <u>Age 16 Years or Older:</u> Youth 16 years of age or older have the right to determine parental involvement in psychiatric appointments and medication decisions. The following staff should discuss this option with the youth: the FSW⁵, private provider caseworker, or designated Youth Development Center staff. The staff person discussing this with the youth will relay the youth’s decision regarding parental involvement to the prescribing provider. 3. When a psychotropic medication is prescribed, the prescribing healthcare provider should discuss information about the medication (refer to Section A “Introduction to Informed Consent”). If the parent(s) or youth age 16 years or older agrees with the prescribed medication, DCS form, CS-0627, Informed

² This includes the FSW’s supervisor(s) or Regional Administrator’s designee(s).

³ See Legal Reference Document for additional information.

⁴ This includes the FSW’s supervisor(s) or Regional Administrator’s designee(s).

⁵ This includes the FSW’s supervisor(s) or Regional Administrator’s designee(s).

Consent for Psychotropic Medication will be completed and signed. The parent will provide verbal consent if he/she is not physically present for the appointment. Refer to Section J "Verbal Consent" for information on documentation of verbal consent. If the parent is not present for the appointment or available by phone, the consent document will be forwarded to the DCS Regional Nurse for informed consent responsibility. The prescribing healthcare provider will be provided with contact information for the DCS Regional Nurse should he/she wish to discuss the recommendation verbally. The DCS Regional Nurse will review the medication recommendations. Should the DCS Regional Nurse consent to treatment, he/she will sign and fax the consent to the appropriate party so the child can begin the medication.

4. If the child is in an acute or sub-acute psychiatric setting and the parent cannot be located within 4 hours or less if late in the business day, or the child requires urgent consent outside of regular DCS business hours including weekends and holidays, the provider can contact the DCS Regional Nurse.
5. Once the DCS Regional Nurse has signed the consent, he/she will notify the FSW, who will then notify the parent (if appropriate) of the medication and encourage parent participation in future appointments. In the case of a youth age 16 years or older, the parent will be notified of the medication only with authorization of the youth.
6. If the parent has been unable to participate in the mental health appointment but has been notified about healthcare decisions and has questions, the DCS Regional Nurse will answer questions to the best of their ability. The DCS Regional Nurse will work with staff to facilitate communication between the parent and the prescribing provider and encourage participation of the parent in future appointments.
7. If the parent or youth age 16 years or older refuses to consent to the psychotropic medication recommendations, refer to section K "Refusal".
8. Informed consent is given for a specific child to take a specific psychotropic medication(s). If a medication is stopped for more than 14 days, a new consent is required. The DCS Regional Nurse and the parent, if appropriate (refer to Section H-6 above), should be notified of all changes with medication (e.g., dosage changes, discontinuations) regardless if a new consent is required.
9. DCS form **CS-0627, Informed Consent for Psychotropic Medication** will travel with the child. If a child's placement is changed, the consent forms for current medications will accompany the child to the new care provider. However, the new prescribing provider may also request consent (verbally or in writing) for his or her own proper informed consent documentation.
10. Some medications, such as anti-seizure drugs, can be used for medical or psychiatric conditions. When prescribed for a medical condition, these medications do not require written informed consent. Only medications prescribed for a mental health diagnosis or used as a psychotropic medication require this informed consent.

	<p>11. If a child/youth enters custody on psychotropic medication, the parent or youth age 16 years and older should provide consent to continue the medication by signing DCS form CS-0627, Informed Consent for Psychotropic Medication. If a parent refuses to consent to continuation of the medication, the DCS Regional Nurse will provide consent until the child is further evaluated.</p> <p>12. If a child remains on the same medication for a year, renewal consent should be obtained.</p>
<p>I. Emergency administration of psychotropic medication</p>	<p>If an emergency administration of a psychotropic medication is deemed necessary for the protection of a child in state custody, the medication should be administered per physician order. Consent is not needed prior to the emergency administration, but the FSW, parent, and DCS Regional Nurse are to be notified at the earliest possible opportunity (within 24 hours). Refer to DCS policy 20.18, Psychotropic Medication.</p>
<p>J. Verbal consent</p>	<p>When it is not possible to obtain written documentation of the informed consent, the healthcare provider will document on the consent form that the consent was given verbally and note by whom (e.g., parent, DCS Regional Nurse). Ideally a second person should witness the verbal consent, whenever possible, and document the witness of the verbal consent on the consent form. A copy of the verbal consent documentation must be obtained from the healthcare provider and kept in the child’s DCS case file.</p>
<p>K. Refusal</p>	<ol style="list-style-type: none"> 1. The following persons can refuse treatment or medication: parent, legal guardian, and minors in some instances (refer to Section C “Age Requirement for Minor’s Consent or Refusal”). 2. Any person refusing treatment should be appropriately informed regarding the impact of such refusal. 3. Any youth refusing recommended healthcare services should sign DCS form CS-0093, Release from Medical Responsibility. If the youth refuses to sign, the FSW, private provider caseworker, or designated Youth Development Center staff shall complete the form and note the youth refused to sign. 4. In cases of refusal, DCS will consult with the prescribing healthcare provider to determine if: <ol style="list-style-type: none"> a) The treatment or medication is medically necessary, b) If the child may be harmed if he/she does not receive the treatment or medication, and c) If there are any less invasive alternative treatments or medications available. d) If the minor child is the one refusing, the prescribing healthcare provider must also determine if the minor child is mature enough to make an informed decision. If the provider determines that the minor child is not mature enough to make an informed decision, then parental

	<p>consent should be obtained.</p> <p>5. If after consulting with the provider, DCS determines that the treatment is necessary to protect the child from harm and having the treatment is in the best interest of the child, then the FSW will consult with the regional DCS attorney regarding the need for judicial intervention.</p>
<p>L. Documentation</p>	<ol style="list-style-type: none"> 1. Efforts to involve the parent(s) in informed consent decisions about the healthcare of their child will be documented in TFACTS by the FSW. 2. Documentation includes the parent’s actual involvement or reasons why the parent could not or should not be involved. If private provider staff coordinates parental involvement, the private provider will notify the FSW, who will then document the coordination in TFACTS. 3. If the parent cannot be located, the FSW will document reasonable efforts taken to notify them. 4. In situations when parental consent is not available, efforts to notify the child’s parent about the healthcare given and the need for any follow-up care will be documented in TFACTS by the FSW. 5. Youth 16 years of age or older have the right to determine parental involvement in psychiatric appointments and medication decisions. The staff person discussing this with the youth will relay the youth’s decision regarding parental involvement to the prescribing provider and document the decision in TFACTS. If private provider staff holds this conversation with the youth, the private provider will notify the FSW, who will then document the youth’s decision regarding parental involvement in TFACTS. 6. Any case of healthcare service refusal will be documented in TFACTS. Documentation should include information regarding steps taken to inform person refusing about the impact of the refusal, consultation with the treating healthcare provider, and consultation with the regional DCS attorney (if applicable). Additionally, youth refusing healthcare services should complete DCS form CS-0093, Release from Medical Responsibility.
<p>M. Categorical exclusions and extraordinary medical care</p>	<ol style="list-style-type: none"> 1. Consent for certain medical procedures is never given by DCS, due to the limitation of DCS’ consenting authority to ordinary medical care and the existence of a specific statutory scheme that governs consent for certain procedures. 2. As a general rule, DCS does not provide consent for medical treatment or procedures that are not medically necessary. However, those decisions will be made on case-by-case basis considering what is in the best interest of the child. 3. DCS does not provide consent for the following procedures: <ol style="list-style-type: none"> a) Removal of Life Support (refer to DCS policy 20.57, End of Life Decisions for Children in Custody/Guardianship) b) Do Not Resuscitate Orders (refer to DCS policy 20.57, End of Life Decisions for Children in Custody/Guardianship)

	<ul style="list-style-type: none"> c) Organ Donation (refer to DCS policy 20.29, Death of a Child/Youth in Department of Children's Services Custody/Guardianship) d) Medical Research and Clinical Trials e) Abortion (refer to DCS policy 20.9, Court Advocate Program) <p>4. In addition to the above categorical exclusions, determination of whether other medical procedures are considered extraordinary medical care and thus, outside DCS authority to consent, will be made on a case-by-case basis.</p> <p>5. If the prescribing or consulting healthcare provider deems a procedure or medical treatment to be extraordinary medical care, DCS will request a hearing by the juvenile court when the child's parent(s) is unavailable, refuses to give consent, or if the parental rights have been terminated.</p>
--	--

Forms:	<p>CS-0093, Release From Medical Responsibility</p> <p>CS-0627, Informed Consent for Psychotropic Medication</p> <p>CS-0206, Authorization for Routine Health Services for Minors</p> <p>CS-0629, Psychotropic Medication Evaluation</p>
---------------	--

Collateral documents:	None
------------------------------	------

Glossary:	
Private Provider Case Worker	A staff person of a DCS private provider agency providing services for DCS state custody children and youth. This person works directly with the children and youth in custody.
Case Aide	An individual who was solely hired to assist FSW's in their routine job performances.
Parent(s)	Refers to biological parent, adoptive parent, or legal guardian.
Perioperative	Around the time of surgery, usually lasting from the time the patient goes into the hospital or doctor's office for surgery until the time the patient goes home.