



Provider Guide--Changes to the NC Juvenile Code re: Consent

This document addresses questions about North Carolina's new law governing the consent process for infants, children, adolescents, and young adults in the custody of a Consolidated Human Services Agency/Department of Social Services (DSS). Importantly, the laws discussed below have not yet been tested in the court system. As such, the Fostering Health NC Advisory Team offers the following material for educational purposes only. ***This document is not intended to serve as legal advice; healthcare providers should seek legal counsel if they are uncertain about their authority to perform treatment or to release information.***

Why did the legislature change the laws governing the consent process for children/youth in foster care?

Prior to the new statute taking effect, there was nothing in the Juvenile Code that authorized a DSS Director/designee to consent to medical treatment of any kind for a child when initially placed in nonsecure custody (before the child was adjudicated and placed at disposition in DSS custody). The statute that addressed DSS authority to consent applied after adjudication only. The new statute fills the gap between initial nonsecure custody and adjudication.

The new statute also seeks to reduce ambiguity. For example, while the old statute gave authority to the DSS Director/designee to consent to "routine" and "emergency" care (again, post adjudication), the statute did not define routine care. As a result, confusion persisted as to which types of treatment comprised routine care. The new statute provides some guidance in defining "non-routine and non-emergency care" by specifying six types of treatment that it does not consider routine or emergency. However, these treatment types are not an exhaustive list.

Importantly, the new statute attempts to strike a better balance between a parent's right to due process and the state's interest in expediting care for youth coming into DSS custody. Some have expressed the concern that practices to date have favored the state's interest too heavily (i.e., court orders rendering full authority to the DSS Director/designee to consent to any medical treatment prior to a court hearing that adjudicates abuse or neglect). To address this, the new law applies a standard across the child's entire time in DSS custody and reserves some health care decisions for the parent/previous caregiver while allowing for a judge to override that decision-making capacity via court order if he/she determines it is in the child's best interest.

What part of the Juvenile Code changed?

While House Bill 669/Session Law 2015-136 changed a number of provisions in the NC Juvenile Code, the most important change for healthcare providers to understand is the new statute, N.C.G.S. 7B-505.1. This statute establishes who can consent to treatment of children/youth in foster care under various circumstances.

When did the new law (and consent process) take effect?

October 1, 2015.

To whom does the law apply?

The law applies to children/youth who are in DSS custody.



Who can give consent for a child whose parents' rights have been terminated?

This is established by the court through a court order.

As a provider, how will I know if there is a change in a child's custody status?

Your local DSS office should keep you informed about changes in custody status. It is important to establish a notification protocol with DSS to ensure you have the latest information. Fostering Health NC developed a notification template that may be used for this purpose: http://www.ncped.org/resource/collection/61759CF6-82FB-455A-ADC3-C616A2B92244/Custody_Status_Notification_Template_10-27-15.docx

Whose responsibility is it to obtain consent?

The DSS Director/designee should consult the court order in effect to make sure he/she understands the court's directions with respect to consent; the DSS Director/designee should share this direction with the applicable provider(s) and facilitate the consent process.

DSS must obtain authorization from a parent/guardian/custodian (via DSS-1812) or a court order to consent to non-routine, non-emergency care. Without either of these two documents, healthcare providers should look to the parent, guardian, or custodian for consent for non-routine, non-emergency care.

For which types of care may DSS Directors/designees provide consent?

1. Routine medical and dental care or treatment.
2. Emergency medical, surgical, psychiatric, psychological, or mental health care or treatment.
3. Testing and evaluation in exigent [pressing, emergency] circumstances.

Which types of care are considered non-routine and non-emergency?

Routine and emergency care are not expressly defined by the statute. However, the statute does provide examples of types of care that require a court order or a parent's authorization for consent. The treatment examples include:

1. Prescriptions for psychotropic medications.
2. Participation in clinical trials.
3. Immunizations when it is known that the parent has a bona fide religious objection to the standard schedule of immunizations.
4. Child Medical Evaluations not governed by subsection (b) of this section [Section 5 of House Bill 669/Session Law 2015-136], comprehensive clinical assessments, or other mental health evaluations.
5. Surgical, medical, or dental procedures or tests that require informed consent.
6. Psychiatric, psychological, or mental health care or treatment that requires informed consent.

Please see a table with examples illustrating the consent process on pages 6 and 7.



Non-routine and non-emergency category #4 requires DSS Directors/designees to obtain consent for Child Medical Examinations (CME) from biological parents/previous caregivers—won't that be a problem if said parent/caregiver is suspected of perpetrating the abuse?

Yes, this may be problematic. However, the law allows the court upon a child's *initial* placement into DSS custody to authorize the DSS Director/designee to consent to a CME based on written findings that demonstrate the Director's compelling interest in having the child evaluated prior to a hearing (see N.C.G.S. 7B-505.1(b)). This authorization will be documented in the court order for nonsecure custody (see AOC-J-150: <http://www.nccourts.org/Forms/Documents/483.pdf>).

Should the need for a CME arise later in a child's case, DSS will need to secure consent from a parent (see Form DSS-5143: <http://info.dhhs.state.nc.us/olm/forms/dss/dss-5143-ia.pdf>) before proceeding with a CME. If the parent refuses to consent, DSS will need to seek a court order authorizing the Director/designee to consent to the CME per N.C.G.S. 7B-505.1(c)(4).

What types of care fall into non-routine, non-emergency category #6, "Psychiatric, psychological, or mental health care or treatment that requires informed consent?"

Since it is generally accepted practice for psychiatrists and therapists to obtain informed consent before beginning any form of treatment, most mental health and behavioral health treatments will fall into this category (note that psychotropic medications comprises its own category of non-routine and non-emergency treatment). This means that DSS must obtain authorization to consent to these types of treatment from the biological parent/previous caregiver or obtain authorization to consent via court order. **See the section below on the seven day hearing.**

Importantly, routine screenings such as those recommended by the American Academy of Pediatrics Bright Futures Guidelines would not fall into this category: https://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf

What if the biological parent/previous caregiver is unable or unwilling to provide consent for non-routine and non-emergency care (e.g., psychotropic medication) and, as a provider, I feel it is in the child's best interest to receive that care?

You can engage the DSS Director/designee in petitioning the court for an order authorizing the Director/designee to consent to the proposed treatment (e.g., psychiatric, psychological, or mental health care requiring informed consent). The court will hear the evidence and make a decision based on the best interest of the child. You may need to be available to testify at a hearing in order to assist DSS in proving the proposed treatment is in the child's best interest.

As a provider, do I have to obtain consent (from DSS) for every routine action I take with a child/youth in foster care?

No. When DSS establishes a provider to serve as the medical home for a child/youth in foster care, that action carries with it the expectation that routine/age-appropriate standards of care will be applied.



What is the “seven-day hearing” and why is it important to the issue of consent?

The “seven-day hearing” or “hearing to determine need for continued nonsecure custody” (per N.C.G.S. 7B-506) is required to be held within seven calendar days of a child’s entry into DSS custody to make certain that the child’s placement in custody is warranted and necessary. Because a child may enter DSS custody under a variety of circumstances, including situations where a hearing could not be held in advance, the seven-day hearing is usually the first opportunity for parents, guardians, custodians, or caretakers to be heard in court. This is important because in order to preserve due process of law, parents must have an opportunity to be heard if their fundamental rights--in this case, the right to make decisions concerning the care, custody, and control of their child(ren)--are to be curtailed by the state.

It is strongly recommended that DSS Directors/designees engage the parents, custodians, or guardians before the seven-day hearing to explain the importance of assessing and treating behavioral health/social-emotional concerns as soon as possible and to obtain authorization to consent to such care. If the parent, guardian, or custodian is unwilling or unable to provide consent, DSS directors/designees should use the seven-day hearing to ask the presiding judge to authorize them to consent to these needed (non-routine and non-emergency) services via court order.

What implications does the new law have with respect to minor’s consent?

Minors do not lose their right to consent to certain types of care while they are in DSS custody. N.C.G.S. 90-21.5 allows minors (who demonstrate decision-making capacity) to consent to the prevention, diagnosis, and treatment of:

1. Venereal disease and other diseases reportable under GS 130A-135;
2. Pregnancy;
3. Abuse of controlled substances or alcohol; and
4. Emotional disturbance.

Do parents, guardians, and custodians have a right to know about care their child receives while in DSS custody?

Yes. Regardless of the type of care provided or the means of securing consent, DSS is required to share information with parents, guardians, or custodians about all care provided unless:

- 1.) the court orders otherwise;
- 2.) the minor consented to his/her own care AND requested his/her records not be shared AND no threat to the minor’s life or health would supersede the request for confidentiality (see N.C.G.S. 90-21.4(b)); or
- 3.) the information pertains to results of a Child Medical Evaluation—such results must be disclosed according to N.C.G.S. 7B-700.

Importantly, healthcare providers (except as prohibited by federal law or by court order) are required to share confidential information with DSS and a parent, guardian, or custodian (see N.C.G.S. 7B-505.1(f)). This includes information about treatment and care plans (again, subject to constraints imposed by state or federal law or court order).



Does the new consent law change DSS' ability to access medical records during an open Child Protective Services (CPS) investigation?

No.

What is the process by which DSS can ask for and obtain medical records during a CPS investigation?

DSS may send a demand letter to health care providers (and other entities) requesting records during a CPS investigation. DSS has the authority to obtain medical records and other confidential information without parental consent in accordance with N.C.G.S. 7B-302(e). The child's custody status does not matter; as long as the case is an open investigation, DSS can gain access (again, through a demand letter) to a child's medical records. Providers may release medical records to DSS--without parental consent--in answer to a demand letter.

Where can I find the consent law to read it myself?

<http://www.ncga.state.nc.us/gascripts/BillLookUp/BillLookUp.pl?Session=2015&BillID=h+669&submitButton=Go>

Where can I find other publications/resources on this topic?

UNC School of Government published two excellent blog posts on consent:

Consenting to Medical Treatment for a Child Placed in the Custody of County Department Part I: Routine and Emergency Care and Evaluations in Exigent Circumstances (11/4/15):

<http://civil.sog.unc.edu/consenting-to-medical-treatment-for-a-child-placed-in-the-custody-of-county-department-part-i-routine-and-emergency-care-and-evaluations-in-exigent-circumstances/>

Consenting to Medical Treatment for a Child Placed in the Custody of County Department, Part II: Non-routine and Non-emergency Medical Care (11/6/15):

<http://civil.sog.unc.edu/consenting-to-medical-treatment-for-a-child-placed-in-the-custody-of-county-department-part-ii-non-routine-and-non-emergency-medical-care/>

UNC Family & Children's Resource Program Webinar:

Concurrent Planning and Making Medical Decisions (2/11/16): <http://fcrp.unc.edu/webinars.asp>

Who can answer further questions about this change in law?

Child Welfare Policy Team
NC Division of Social Services
(919) 527-6340

Authority to consent for care for a child ordered into DSS custody unless otherwise ordered by the court (examples provided below do not represent an exhaustive list):

| <u>Type of Care</u> | <u>Example</u> | <u>Who Consents</u> | <u>Unless</u> | <u>Then</u> |
|--------------------------------------|---|---|---|---|
| Emergency | Emergency surgery | DSS Director or designee | | |
| | Psychotic episode requiring immediate hospitalization | DSS Director or designee | | |
| Routine | Immunizations* | DSS Director or designee | DSS or health care provider knows of a parent's bona fide religious objection | Court order or parent, guardian, custodian (DSS-1812) authorizes DSS to consent |
| | Sick visit with provider (<i>e.g., child has fever</i>) | DSS Director or designee | | |
| | Routine social-emotional and developmental screening** | DSS Director or designee | | |
| | Well check visits | DSS Director or designee | | |
| | Dental varnishing/cleaning | DSS Director or designee | | |
| Non-routine and non-emergency | Psychotropic medications | Parent, guardian, or custodian | Minor with capacity to consent; or court order authorizes DSS; or parent/guardian authorizes DSS (DSS-1812) | Minor may consent; DSS may consent if court order or parent authorization |
| | Clinical trials | Parent, guardian, or custodian | Court order; or parent/guardian authorizes DSS | DSS may consent if court order or authorization |
| | Child Medical Evaluation (medico-legal evaluation) | Parent, guardian, or custodian (DSS-5143) | Court order; or parent/guardian authorizes DSS | DSS may consent if court order or authorization |
| | Comprehensive Clinical Assessment | Parent, guardian, or custodian | Minor w/capacity to consent; or court order; or parent/guardian authorizes DSS | Minor may consent; DSS may consent if court order or authorization |

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| Non-routine and non-emergency (continued) | Surgical/med./dental requiring informed consent (e.g., cosmetic dental surgery, chemotherapy) | Parent, guardian, or custodian | Court order; or parent/guardian authorizes DSS | DSS may consent if court order or authorization |
| | Psychiatric/mental health requiring informed consent (e.g., Trauma-Focused CBT or other, similar, evidence-based practice) | Parent, guardian, or custodian | Minor w/capacity to consent; or court order; or parent/guardian authorizes DSS | Minor may consent; DSS may consent if court order or authorization |
| | Substance abuse treatment | Parent, guardian, or custodian | Minor w/capacity to consent; or court order; or parent/guardian authorizes DSS | Minor may consent; DSS may consent if court order or authorization |
| | Treatment for sexually transmitted infection | Parent, guardian, or custodian | Minor w/capacity to consent; or court order; or parent/guardian authorizes DSS | Minor may consent; DSS may consent if court order or authorization |
| | Treatment for the prevention of pregnancy | Parent, guardian, or custodian | Minor w/capacity to consent; or court order; or parent/guardian authorizes DSS | Minor may consent; DSS may consent if court order or authorization |

*Under N.C.G.S. 90-21.5, minors may consent to immunizations that would prevent reportable communicable diseases. For a comprehensive list of NC reportable diseases, click here: http://epi.publichealth.nc.gov/cd/lhds/manuals/cd/reportable_diseases.html

**See American Academy of Pediatrics Bright Futures Guidelines: https://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity_Schedule_FINAL.pdf