110 CMR 11.00: MEDICAL AUTHORIZATIONS

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11.01: Introduction

 To determine who can consent to medical care for children in Department care or custody, the first determination is whether an emergency exists as defined in 110 CMR 11.03 and 11.14. If it is an emergency, no one's consent is required. If there is no emergency, the question is whether the treatment is routine as defined in 110 CMR 11.04 or extraordinary as identified in 110 CMR 11.11, 11.12, 11.14 and 11.15. If the particular treatment is not identified specifically in 110 CMR 11.00, it is necessary to weigh the factors outlined in 110 CMR 11.17 to determine whether the contemplated treatment is extraordinary. If it is not extraordinary, it is routine. There is no other possibility.

If the treatment is routine, the Department may consent. In the case of treatment for drug dependency, pregnancy (except abortion and sterilization), family planning, and treatment for a venereal disease or a disease dangerous to the public health, the consent of the minor is sufficient. If the treatment is extraordinary the Department may never consent, but must obtain parental consent for children in the care of the Department or prior judicial approval for wards and children in the custody of the Department. The terms "emergency", "routine", and "extraordinary" medical treatment are defined in 110 CMR 11.00 and only those definitions apply. Neither common parlance nor medical terminology may be used in their place.

11.02: Medical Authorization Definitions

In the Custody of the Department: means a child placed in the Department's custody through court order or through adoption surrender. *For purposes of 110 CMR 11.00 only*, this phrase shall also include the period occasioned by an emergency removal pursuant to M.G.L. c. 119, § 51B between removal and appearance in Court on the next available court date.

In the Care of the Department: means a child receiving services from the Department pursuant to a Voluntary Placement Agreement. *For purposes of 110 CMR 11.00 only*, this phrase shall also include the involvement of the Department after the issuance of a mittimus which commits a child to the custody of the Department, pursuant to a Child Requiring Assistance (“CRA”) proceeding. For child in the custody of the Department through a CRA, the Department shall be deemed to have delegated back to the parents the power to determine the child's extraordinary medical care.

11.03: Emergency Medical Care

 (1) "Medical emergency" means any immediately life threatening condition and shall include but is not limited to the below-listed conditions.

(a) severe, profuse bleeding

(b) choking, blocked airway

(c) unconsciousness

(d) cardiac arrest

(e) cardio-vascular accident

(f) any fracture

(g) extensive burns

(h) severe cuts

(i) other similar severe injury

(j) other sudden signs of serious physical illness

(k) any condition where delay in treatment will endanger the life, limb or mental well being of the patient. *See*, M.G.L. c. 112, § 12F.

(2) Possibility that a disease may deteriorate to an irreversible condition at an uncertain but relatively distant date is not an emergency. *See, In the Matter of Guardianship of Richard* *Roe, III*, 421 N.E.2d 40, 55; 383 Mass. 415 (1981). In determining whether a medical emergency exists the relevant time period to be examined begins when the claimed emergency arises, and ends when the individual who seeks to act in the emergency could, with reasonable diligence, obtain parental consent or judicial review, as applicable.

(3) Consent. When there is a medical emergency, no one's consent is required in order to allow a child to receive necessary medical care. *See*, M.G.L. c. 112,§ 12F.

11.04: Routine Medical Care

 (1) "Routine medical care" shall include but is not limited to the following:

(a) Allergy Shots.

(b) Blood Pressure Test.

(c) Comprehensive Physical Examination - documenting the finding of an unclothed physical examination including a complete system review pertinent to the age of the child, funduscopic examination of the eyes for children over five years of age, and observation of the teeth and gums for children three years of age or older. (d) Dental care.

(e) Developmental Assessment - the child's current levels of functioning in the below-listed areas, as appropriate to the child's age:

1. gross motor development, including strength, balance, and locomotion;

2. fine motor development, including eye-hand coordination;

3. language development, including expression, comprehensive and articulation;

4. self-help and self-care skills;

5. social interaction and emotional development; or

6. cognitive skills, including problem-solving and reasoning abilities.

(f) Diseases dangerous to the public health, treatment of. *See*, M.G.L. c. 112, §. 12F and 105 CMR 300.100*, et. seq.*.

(g) Drug dependency treatment. *See*, M.G.L. c. 112, §. 12E.

(h) Family planning services. (i) Fractures, Treatment of

(j) Hearing Test. (k) Immunization - against diptheria, pertussis, tetanus, measles poliomyelitis, mumps, rubella and such other communicable diseases as may be specified from time to time by the Department of Public Health. *See* M.G.L. c. 76, §. 15 and 105 CMR 220.000.

(l) Laboratory tests and special medical studies - when determined by the examining physician to be necessary.

(m) Lead Poisoning Test.

(n) Nutritional Status Assessment - the evaluation of the child's nutritional health in light of dietary practice and the entire health assessment (that is, history, physical examination, height and weight measurements, and the laboratory tests) and documentation of any nutritional disturbance or dysfunction.

(o) Pelvic Examination.

(p) Pregnancy Treatment - except abortion or sterilization.

(q) Preventive health services.

(r) Psychiatric assessment, evaluation, or treatment on out-patient basis or up to ninety (90) days on in-patient basis.

(s) Treatment - commonly prescribed for a specific physical illness, which *does not pose risks of permanent serious side effects or risk of death, See*, Custody of a Minor, 375 Mass. 733, 379 N.E.2d 1053, 1064 (1978) or is determined not to be extraordinary medical treatment by using the analysis outlined in 110 CMR 11.00.

(t) Tubercular skin test or chest x-ray.

(u) Venereal Disease Treatment. *See*, M.G.L. c. 112, § 12F.

(v) Vision Test.

(2) Consent. The Department may consent to routine medical care for a child in the care of the Department or a child in the custody of the Department or a child who is a ward of the Department. The Department may also delegate to the substitute care provider the right to consent to routine medical care.

(3) Parent's Religious Beliefs Regarding Routine Medical Treatment. If parents refuse to sign a standard Voluntary Placement Agreement because they refuse to delegate to the Department the power to consent to routine medical treatment for their child on the basis that such routine medical treatment conflicts with the parents' sincere religious beliefs, the Department shall elect one of the following actions:

(a) Amend the standard Voluntary Placement Agreement by adding the following paragraph:

"Whereas the undersigned parents hold sincere religious beliefs opposed to all medical treatment, the Department shall have the right to approve only medical, psychological and dental care, testing or studies for the child relative to: (i) drug dependency; (ii) diseases dangerous to the public health; (iii) venereal diseases; (iv) emergency medical treatment; and (v) routine physical examination and laboratory test."

(b) Determine whether the parents' refusal to delegate to the Department the power to consent to the medical treatment constitutes medical neglect, and if so, institute appropriate court action on that basis.

11.04A: Periodic Medical Exams for Children in Placement

1. **Generally**

 The Department strives to ensure that comprehensive, quality healthcare services are provided to all children, in accordance with the standards in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Schedule. EPSDT standards outline the requirements for healthcare providers to follow when delivering services to children of different ages. EPSDT aims to ensure that children receive quality, comprehensive health services on a periodic and continual basis.

The Department is committed to preventive healthcare and to addressing the healthcare needs of children in a timely way. In order to promote the health and well-being of all children in DCF care or custody, the Department assumes responsibility for assuring that the children receive medical examinations at the time of placement if needed, routine medical and dental examinations within age-specific time-frames, any required follow-up, and routine and emergency mental health care.

1. **Health Care - Training**

 Health care training for social work staff and substitute care providers shall be provided by the Department on an ongoing and periodic basis.

1. **Health Care – Frequency**

 The Department will adhere to the periodicity of health care checks established by the EPSDT Schedule.

1. **Medical Passport**

 The Department shall implement a program of utilization of a "medical passport" for all children in substitute care. The medical passport shall record pertinent and available medical/dental/mental health and developmental data about the child. Department social workers and medical providers shall each complete relevant portions of the passport. The passport shall be held by the substitute care provider and shall remain with the child for the duration of his/her placement. If a child moves to a new substitute care placement or returns home, the medical passport moves with the child.

1. **Emergency Treatment at Time of Placement**

 At the time of placement, children will be provided with emergency medical/dental/mental health care if needed. If such care is necessary, the social worker shall arrange for the provision of emergency care with an appropriate health care provider. If appropriate and if time permits, the social worker may delegate all or part of the responsibility for the procurement of emergency medical/dental/mental health treatment to the substitute care provider (*i.e*., foster/pre-adoptive parents, group care facility, *etc*.). If the child does not have a Mass Health card at the time of placement and requires emergency treatment, the social worker shall obtain a temporary Mass Health card to ensure the provision of needed treatment. Following the provision of emergency medical/dental/mental health treatment at time of placement, a record of such treatment shall be entered into the child's case record. When a "Medical Passport" is completed for this child, the social worker, in completing the relevant portions, shall make reference to the emergency treatment provided at placement.

1. **Routine Treatment After Placement**

 At time of placement, the Department shall arrange for the child to have a medical screening within 7 days of placement, and a comprehensive medical exam, which includes an EPSTD examination, within 30 days of placement. The Department will also determine if a child is in need of routine medical and/or dental examinations by determining the date of the child's most recent routine medical and dental examinations and will assume responsibility for ensuring that such examinations are arranged if such examinations have not occurred within the required periodicity schedule.

At time of placement the social worker shall complete an application for Medicaid and shall obtain a temporary Medicaid card if necessary. As soon as practicable after placement, the social worker shall provide the child with a "Medical Passport". If routine medical and dental examinations have occurred within the required periodicity schedule prior to placement, the social worker shall obtain records of these examinations for the medical passport.

 If, prior to placement, medical and dental examinations have not occurred within the required periodicity schedule, the social worker shall insure that a medical examination is scheduled within two weeks of substitute care placement and that a dental examination is scheduled as soon as possible. The social worker may delegate all or part of the process of health care procurement to the substitute care providers and/or biological parents, but only if the social worker has clearly delineated those responsibilities to be assumed to the substitute care providers and/or biological parents.

1. **Responsibilities of Substitute Care Providers**

 It is the policy of the Department that substitute care providers, at the request of the social worker, will assume responsibility for the provision of health care services. Substitute care providers will:

(1) Arrange for emergency treatment when necessary.

(2) Schedule appointments for routine health care and any needed follow-up and will insure that these appointments are kept.

(3) Hold the child's medical passport and request written documentation from medical providers for inclusion in the passport.

(4) Provide non-specialized care (e.g., administration of oral medication) as required.

(5) Arrange for or coordinate the provision of specialized care (*e.g*., physiotherapy) as required.

(6) Advise the responsible social worker of changes in the child's health status.

(7) Access available nutrition programs for eligible children in placement.

11.05: Family Planning Services

 (1) "Family Planning Services" means medical, educational and social services, excluding abortion and sterilization, which enable individuals voluntarily to limit family size or plan spacing of children. Family planning services include the below-listed services.

(a) Information and referral (including outreach & follow-up)

(b) Individual and group counseling

(c) A physical examination

1. for a female, includes thyroid, breast, heart, abdominal, speculum, pelvic, and rectal examinations, and measurements of height, weight and blood pressure;
2. for a male, includes thyroid, heart, genital, abdominal, and rectal examinations, and measurements of height, weight and blood pressure. .

(d) A pap smear for females. .

(e) Any laboratory test indicated by the child's history or examination. .

(f) A medically approved method of contraception. .

(g) Medical examinations, consultations, laboratory tests and contraceptive services rendered by a licensed physician

(h) Medical treatment for related conditions, such as venereal diseases or vaginal infections

(i) Prescriptions and medical items related to family planning services including drugs, supplies and devices

(j) Clinical follow-up

(2) Provision of Information.

(a) Department staff shall inform a child in the care or custody of the Department, or a child who is a ward of the Department, about family planning services available to sexually active minors if such child requests this information or if in the judgment of Department staff such child has need for this information.

(b) Department staff shall not coerce any child in any way to receive family planning services or to employ any particular method of family planning. A child's use of family planning services must be completely voluntary.

(3) Consent by Child. Any child who requests family planning services, whether such child is in the care or custody of the Department, or is a ward of the Department, may consent to his/her own medical and laboratory family planning services. The consent of the Department is not necessary in such cases. *See*, 106 CMR 421.427(A) which provides that "services must be made available to all recipients who request services, without regard to...age...".)

(4) Consent by Department or Parent. If the child consents to family planning services but the medical provider insists on parental or Department consent, the Department may consent. If the child is not able to consent, the Department may consent.

11.06: Pregnancy

(1) Consent By Child. A child who is pregnant or believes herself to be pregnant may give consent to her own medical and dental care (except abortion or sterilization). The consent of the Department is not necessary to authorize medical or dental care for any such child in the care or custody of the Department, or any such ward of the Department. *See*, M.G.L. c. 112, § 12F.

(2) Consent By Department or Parent. If a medical provider refuses to treat a child who is pregnant or believes herself to be pregnant without parental or Department consent, or if such child refuses to consent or is not able to consent to medical or dental care, the Department may consent (except to abortion or sterilization).

11.07: Abortion

 (1) Consent By Child in Care of Department.

(a) If a minor in the care of the Department is pregnant both the minor and both of her parents must consent to an abortion, or she must obtain prior judicial approval pursuant to M.G.L. c. 112, § 12S.

(b) If one of the pregnant minor's parents has died or is unavailable to give consent within a reasonable time, consent of the remaining parent shall be sufficient. *See*, M.G.L. c. 112, § 12S.

(c) If both parents have died or are otherwise unavailable to the physician within a reasonable time, and in a reasonable manner, consent of the minor's guardian or guardians shall be sufficient. *See*, M.G.L. c. 112, § 12S.

(d) If the pregnant minor's parents are divorced, consent of the parent having custody shall be sufficient. *See*, M.G.L. c. 112, § 12S.

(e) If one or both of the pregnant minor's parents or guardian refuse to consent to the performance of an abortion or if she elects not to seek the consent of one or both of her parents or guardians, the minor must seek authorization for an abortion from a judge of the Superior Court, pursuant to M.G.L. c. 112, §. 12S.

(2) Consent By Child in Custody of Department.

(a) If a minor, in the custody, of the department, is pregnant and wants to have an abortion, Department staff shall not consent to the abortion. Such a minor must obtain prior judicial approval pursuant to M.G.L. c. 112, § 12S.

(b) If the minor requests assistance from the Department in seeking court authorization for an abortion, or if in the judgment of the Department's social work staff such minor has need for this information, the Department social work and legal staff shall provide her with the necessary information on how to go to court to file a petition or motion under the provisions of M.G.L. c. 112, § 12S. However, Department attorneys shall not represent pregnant minors in their petition or motion pursuant to M.G.L. c. 112, § 12S.

(3) Consent By Department As Guardian. If a minor is pregnant and wants an abortion, and both her parents have died or are otherwise unavailable to the physician within a reasonable time and in a reasonable manner, and if the Department has been appointed guardian of the minor by a Probate Court, the Department shall follow the requirements and procedures of M.G.L. c. 112, s. 12S.

11.08: Drug Dependency

(1) Consent. A child 12 years of age or older who is found to be drug dependent by two or more physicians may give his/her consent to the furnishing of hospital and medical care related to the diagnosis or treatment of such drug dependency. The consent of the Department is not necessary to authorize hospital or medical care related to drug dependency for any child over 12 years of age in the Department's care or custody, or any child for whom the Department has been appointed guardian. *See*, M.G.L. c. 112, § 12E.

(2) Consent By Department or Parent. If a medical provider refuses to treat a child without parental or Department consent, or if a child refuses to consent or is not able to consent to medical or hospital care related to the diagnosis or treatment of drug dependency, the Department may consent; provided that the Department shall not consent to the administration of antipsychotic medication or shock therapy or any other extraordinary medical treatment for diagnosis or treatment of drug dependency.

11.09: Diseases Dangerous To The Public Health

 (1) As set forth 110 CMR 2.00, diseases dangerous to the public health are defined by the Department of Public Health at 105 CMR 300.100.

(2) Consent by Child. If any ward or child in the care or custody of the Department reasonably believes herself or himself to be suffering from or to have come in contact with any disease dangerous to the public health, such child may consent to his or her own medical care or dental care related to the diagnosis or treatment of such disease. The consent of the Department is not necessary to authorize medical or dental care related to the diagnosis or treatment of diseases dangerous to the public health for any ward or child in the Department's care or custody. *See*, M.G.L. c. 112, §. 12F.

(3) Consent by Department or Parent. If a medical provider refuses to treat the child without parental or Department consent, or if a child refuses to consent or is not able to consent to medical or dental care related to the diagnosis or treatment of a disease dangerous to the public health, the Department may consent.

1. (4) AIDS. All children under 18 years old, who are in DCF care or custody and who are identified as being at risk for HIV infection, will be referred for HIV testing. The Department’s role in arranging HIV testing depends upon whether the child is in Department care or custody. **Child is in DCF Care:** Parental consent is required if the child is in DCF care through a Voluntary Placement Agreement or a CRA petition. If the parent is unwilling, unable or unavailable to give consent for testing and the testing is necessary to ensure proper medical care for the child, the Social Worker and Supervisor shall consult with the HIV Monitor and legal staff to determine if custody should be pursued.
2. **Child is in DCF Custody:** Parental consent is not required when the child is in DCF custody. However, the Social Worker should seek to involve the parents in obtaining the testing and any needed follow-up medical care unless she/he, in consultation with her/his Supervisor, determines that parental involvement is not in the child’s best interests.
3. **Child Age 13 or Older Obtaining Testing and Treatment Without Consent:** Children age 13 or older may access HIV testing, diagnosis and treatment without consent of a parent or legal guardian. See, MGL c. 112, § 12F.

11.10: Venereal Disease

 (1) "Venereal Diseases" means the following:

(a) Chancoid

(b) Gonorrhea

(c) Granuloma Inquinale

(d) Lymphogranulom Venereum

(e) Syphilis

(2) Consent by Child. If any ward of the Department or child in the care or custody of the Department reasonably believes himself or herself to be suffering from or to have come in contact with any venereal disease, such child may consent to his or her own medical care or dental care related to the diagnosis or treatment of such venereal disease. The consent of the Department is not necessary to authorize medical or dental care related to the diagnosis or treatment of venereal disease for any ward or child in the care or custody of the Department. *See*, M.G.L. c. 112, § 12F.

(3) Consent by Department or Parent. If a medical provider refuses to treat the child without parental or Department consent, or if a child refuses to consent or is not able to consent to medical or dental care related to the diagnosis or treatment of venereal diseases, the Department may consent.

11.11: Sterilization

 (1) No Consent By Department. Department staff shall not consent to the sterilization of any ward or child in its care or in its custody. Prior judicial approval is necessary under all circumstances for the performance of a sterilization upon any child who is a ward of the Department, or who is in the care or custody of the Department. *See, Matter of Moe*,385 Mass. 555, 559, 432 N.E.2d 712 (1982); M.G.L. c. 112, § 12W.

11.12: Life-Sustaining Medical Treatment

(1) "Life-sustaining medical treatment"(LSMT), as distinguished from life-saving treatment, encompasses all interventions that may prolong the patient’s life, such as cardiopulmonary resuscitation, respiratory and circulatory support, and artificially administered nutrition, hydration and medications. (2) No Consent By Department. Department staff shall not consent to forgo or discontinue LSMT for any child who is a ward of the Department or for any child in its care or custody. *See*, M.G.L. c. 119, § 38A. (3) Consent By Parents or Court.

(a) With respect to a child who is in the care of the Department, the right to consent or to refuse to consent to forgo or discontinue LSMT shall remain with the child's parents unless otherwise limited by statute or court order. If the Department has reason to believe that the parents are guilty of medical neglect by their consent to forgo or discontinue LSMT, the Department shall seek custody through a court proceeding which alleges medical neglect.

(b) With respect to a child who is a ward of the Department or is in the Department's custody, when a medical provider seeks the Department's consent to an order to forgo or discontinue LSMT, the Department shall obtain:

(i) a written recommendation from the child’s treating physician;

(ii) a second opinion from a physician of the same specialty who is not affiliated with the treating physician’s hospital nor have a business or financial relationship with the treating physician; and

(iii) a recommendation from the ethics committee of the treating hospital.

The recommendations and opinions will be reviewed by the Commissioner, Deputy Commissioner for Field Operations, and the General Counsel. The Commissioner will determine if the agency will seek a judicial order to forgo or discontinue LSMT, even if the child's biological parents have consented to the entry of such order. When seeking a judicial order, the Department shall file a Motion for Appointment of a Guardian ad Litem to investigate whether such order should enter for a ward of the Department or child in the Department's custody.

11.13: Medication Administration Program

Community Connected Residential Treatment programs under contract with the Department are subject to the standards set forth in the Department of Public Health’s medication administration program under 105 CMR 700.003(F) and 700.004.

11.14: Antipsychotic Drugs

 (1) "Antipsychotic drugs" shall mean drugs which are used in treating psychoses. Antipsychotic drugs are defined in 110 CMR 2.00.

(2) No Consent By Department. The Department shall not consent to the administration of antipsychotic medication for any individual, but shall in all cases seek parental consent for children in Department care, or prior judicial approval for children in Department custody and for wards of the Department.

(3) Consent by Parents for Children in Department Care.

(a) When any individual, organization, facility or medical provider seeks to medicate with antipsychotic drugs a child, who is in the care of the Department, Department staff shall not consent to such medication nor shall the Department seek prior judicial approval for administration of such medication. The decision of whether to consent to such medication shall remain with the parents.

(b) If the Department has reason to believe that the parents are guilty of medical neglect by their consent to medicate with antipsychotic drugs or by their refusal to consent to medicate with antipsychotic drugs, the Department shall seek custody of the child through a court proceeding which alleges medical neglect.

(c) The 110 CMR 11.14(3) (a) and (b) apply whether or not the child consents to the administration of antipsychotic medication.

(4) Judicial Approval for Wards and Children in Department Custody.

(a) When any individual, organization, facility, or medical provider seeks the Department's consent to medicate with antipsychotic drugs a child, who is a ward of the Department or who is in Department custody, the Department shall seek prior judicial approval for administration of such drugs even if the child's biological parents have consented to the medication. *See, Rogers v. Commissioner of the Department of Mental Health*, 390 Mass. 489 (1983); M.G.L. c. 190B, § 5-308.

(b) Where antipsychotic medications have been previously prescribed for a child who is a ward of the Department or who is in the custody of the Department, and that child is currently being treated with antipsychotic drugs without judicial authorization, the Department shall initiate the process for judicial review and application of substituted judgment. Pending judicial review the Department shall not discontinue the prescribed treatment with antipsychotic drugs, because interruption or discontinuance of the treatment might cause severe medical complications and might violate the individual's legal right to treatment.

(c) Neither a ward of the Department, nor a child in the custody of the Department, who has attained age 16, and who has voluntarily admitted him/herself to a mental health facility, shall have the power to consent to the administration of anti-psychotic drugs. The Department shall seek prior judicial approval for medicating such a child with antipsychotic drugs, even if such child consents to its administration.

(5) Guardianship for Individuals Over Age 18.

(a) The Department shall not consent to the administration of antipsychotic drugs to an individual over 18 years of age who is in the care or custody of the Department.

(b) Any individual over the age of 18 who is in the care or custody of the Department, and who is competent to make medical decisions, may consent to the administration of his/her antipsychotic medication.

(c) If the Department believes that an individual over the age of 18 in the care or custody of the Department is not competent to make medical decisions, and failing action by the individual's parents, the Department of Mental Health, or other third person, the Department will file incompetency proceedings under M.G.L. c. 190B. If the individual is adjudicated competent, then only such individual may consent to the administration of antipsychotic drugs. If the individual is adjudicated incompetent then the judge will apply a substituted judgment standard to determine whether antipsychotic drugs ought to be administered, and will issue appropriate orders.

(6) Emergency Treatment with Antipsychotic Drugs.

(a) Antipsychotic drugs may be administered for treatment purposes without parental consent or prior judicial approval only in an emergency (even though no threat of violence exists) and only if there is no less intensive alternative to antipsychotic drugs.

(b) An emergency for purposes of administering antipsychotic drugs for treatment purposes is an unforeseen combination of circumstances or the resulting state that calls for immediate action. *See In the Matter of Guardianship of Richard Roe III*, 421 N.E.2d 40, 42. It includes a situation where doctors, in their professional judgment, determine that the medication is necessary to prevent the immediate, substantial, and irreversible deterioration of a serious mental illness. *See Rogers v. Commissioner of the Department of Mental Health*, 390 Mass. 489, 511. The possibility that a mental condition might deteriorate into a chronic, irreversible condition at an uncertain but relatively distant date is not an emergency. *See, In the Matter of Guardianship of Richard Roe III*, 421 N.E.2d 40, 55.

(c) In situations that fall within the purview of 110 CMR 11.00, no consent by the Department or parents is necessary (since the medical provider may make such determination) and therefore the Department shall not give consent nor seek parental consent.

(d) If a child is medicated with antipsychotic drugs in an emergency situation and the doctors determine that the antipsychotic drugs should continue, then the Department shall follow the procedures for obtaining consent as though no emergency existed. See, *Rogers v. Commissioner of the Department of Mental Health*, 390 Mass. 489, 512.

(7) Use of Antipsychotic Drugs for Restraint.

(a) Antipsychotic drugs shall not be administered as a restraint of any ward or child in the care or custody of the Department.

11.15: Electroconvulsive Treatment or ECT ("Shock Treatment")

 (1) Consent by Child If Age 16 or Older. No person other than the child may consent to ECT if the child is 16 years of age or older and:

(a) is not a patient at a mental health facility; or

(b) is on voluntary admission status or conditional voluntary admission status to a mental health facility.

(2) Consent by Parents for Children in Department Care.

(a) When any individual, organization, facility or medical provider seeks to administer ECT to a child under 16 years who is in the care of the Department, the Department shall not consent to such treatment nor shall the Department seek prior judicial approval for administration of such treatment. The decision of whether to consent to ECT shall remain with the parents.

(b) If the Department has reason to believe that the parents are guilty of medical neglect by their consent to ECT or by their refusal to consent to ECT, the Department shall seek custody of the child through a court proceeding which alleges medical neglect.

(c) The 110 CMR 11.15 (2)(a) and (b) apply to any child under 16 years of age whether or not the child consents to the administration of ECT.

(3) Judicial Approval for Children in Department Custody.

(a) When any individual, organization, facility or medical provider seeks the Department's consent to administer ECT to a child who is in Department custody, or to a ward of the Department, the Department shall seek prior judicial approval for administration of such treatment, even if the child's biological parents have consented to the ECT.

(b) Where ECT has been previously prescribed for a child in the custody of the Department, and that child is currently being treated with ECT without judicial authorization, the Department shall immediately initiate the process for judicial review and application of substituted judgment. Pending judicial review the Department shall not attempt to discontinue the prescribed treatment with ECT, because interruption or discontinuance of the treatment might cause severe medical complications and might violate the child's legal right to treatment.

11.16: Commitment to a Mental Health Facility

(1) Definition. Mental health facility means a public or private facility for the inpatient care or treatment or diagnosis or evaluation of mentally ill or mentally retarded persons, except for the Bridgewater State Hospital. *See* M.G.L. c. 123. § 1. Community connected residential treatment programs are not mental health facilities for purposes of 110 CMR 11.00.

(2) Consent By Child If Age Sixteen or Older. Any child who has attained the age of sixteen may apply or voluntary admission to a mental health facility. In the case of such an application by the child, no additional consent either from the Department or from parents is necessary. *See* M.G.L. c. 123, § 10(a).

(3) Consent By Parent. A parent may consent to the admission of his/her child to a mental health facility when:

(a) the child is in the care of the Department and is under 16 years of age; or

(b) the child is in the care of the Department and is between 16 and 18 years of age and does not consent to admission to a mental health facility.

(4) Consent By Department Area or Regional Director. The Department (by an Area or Regional Director only) may consent to the admission of a person:

(a) in the custody of the Department;

(b) in the care of the Department if that person's parent(s) is unavailable for consultation or if that person's parent(s) after consultation consent or authorize the Department to consent; but the Department may not consent to the admission of a person in the care of the Department if that person's parent(s) after consultation refuse to consent or refuse to authorize the Department to consent; or

(c) who is a ward of the Department only if the Department as guardian has the specific power to consent to the admission of the ward to a mental health facility for an initial period of time not to exceed a maximum of 90 days.

(5) Judicial Review After 90 Days. In any case where the Department has consented to the admission of a person to a mental health facility, the Department shall seek judicial review before it consents to an extension of the admission of such person to a mental health facility beyond a period of 90 days.

11.17: Other Extraordinary Medical Treatment

(1) Recognizing that it is impossible to itemize every extraordinary medical treatment, the Department shall utilize the following factors to determine whether medical treatment is extraordinary:

(a) Complexity, risk and novelty of the proposed treatment: the more complex the treatment, the greater the risk of death or serious complications, the more experimental the procedure, then the greater the need to determine that the treatment is extraordinary and to obtain parental consent or to seek judicial approval prior to authorizing treatment. *See, In the Matter of Guardianship of Richard Roe III*, 421 N.E.2d 40, 53 (1981). *In the Matter of Spring*, 405 N.E.2d 115 (1980). *In the Matter of Moe*, 43d 712 (1982).

(b) Possible side effects: The more serious and permanent the side effect, the greater the need to determine that the treatment is extraordinary, and to obtain parental consent or to seek judicial approval prior to authorizing treatment. *See, Superintendent of Belchertown State School v. Saikewicz,* 370 N.E.2d 417 (1977). *Rogers v. Commissioner of DMH*, 390 Mass. 489, 501-502 (1983). *In the Matter of Guardianship of Richard Roe III*, 421 N.E.2d 40 (1981). *Custody of a Minor*, 385 Mass. 697, 434 N.E. 601 (1982).

(c) Intrusiveness of proposed treatment: The more intrusive the treatment the greater the need to determine that the treatment is extraordinary, and to obtain parental consent or prior judicial approval. *See*, *In the Matter of Hier*, 18 Mass. App. Ct. 200, 464 N.E.2d 959, (1984). *Superintendent of Belchertown State School v. Saikewicz*, supra*. In the Matter of Moe*, supra. *In the Matter of Spring*, supra.

(d) Prognosis with and without treatment: The less clear the benefit from the proposed treatment the greater the need for parental consent or prior judicial approval. *See*, *Superintendent of Belchertown State School v. Saikewicz*, supra: *Custody of a Minor*. 385 Mass. 697, 434 N.E.2d 601 (1982); *In the Matter of Spring*, supra.

(e) Clarity of professional opinion: The more divided the medical opinion, the greater the need for parental consent or prior judicial approval. *See*, *In The Matter of Spring*, supra.

(f) Presence or absence of an emergency: In a medical emergency a physician can act without anyone's consent. See, M.G.L. c. 112, s. 12F.

(g) Prior judicial involvement: if a court has been involved in past medical decisions, this argues for judicial involvement in any future medical treatment decision, but this is not conclusive. *See*, *In The Matter of Guardianship of Richard Roe III*, supra at 56.

(h) Conflicting Interests: Where the interests of the decision maker conflict with the interests of the child, there is greater need for obtaining parental consent or prior judicial approval. *In the Matter of Guardianship of Richard Roe III*, 421 N.E.2d 40 (1981).

(2) No Consent By Department. The Department shall not give its consent to extraordinary medical treatment for any child in the care or custody of the Department. For all such children, the Department shall seek for judicial approval for any extraordinary medical treatment (unless parental consent is obtained for children in the care of the Department, as set forth at 110 CMR 11.17(3).

(3) Consent By Parent. With respect to a child in the care of the Department, the right to consent to extraordinary medical treatment shall remain with the parent(s), except to the extent such right has been specifically limited by the legislature or by the findings of a court or by written agreement between the parents and the Department.

(4) Guardianship. The Department shall not give its consent to extraordinary medical treatment for its ward, except where it is specifically empowered to do so by statute, regulation or case law. In all other cases the Department shall seek prior judicial approval for extraordinary medical treatment.

11.18: Legal Proceedings

(1) Whenever the Department may not consent to a medical procedure, but must seek prior judicial approval for such procedure, the Department shall seek the appointment of a guardian ad litem to investigate whether such procedure should be administered, and thereafter report back to the court.

(2) At any subsequent hearing when the court is considering the question of whether such treatment ought to be administered, the Department shall not request that the court authorize the Department to consent to such treatment; but rather the Department shall request that the court, using a substituted judgment standard, make the decision whether to authorize such treatment.

11.19: Autopsy

 For children in the care of the Department at the time of their death, the right to consent or refuse to consent to an autopsy belongs to the parent(s). The Department shall not consent to an autopsy for children who die while in the care of the Department, unless the Department, after diligent efforts, is unable to contact the parent(s) to seek their consent, in which case the Department may then consent.

For wards or children in the custody of the Department at the time of their death, the Department may request and may consent to an autopsy.

11.20: Burial

 Burial of wards or children in the care or custody of the Department at the time of their death shall be accomplished by consulting with the parents, in the first instance. If the parents refuse to make burial arrangements or cannot be contacted, the Department shall make and pay for appropriate burial arrangements, consistent with the provisions of M.G.L. c. 119, § 23(d).

11.21: Organ Donation

 For children in the care of the Department at the time of their death, the right to consent or refuse to consent to a request for organ donation after the child's death belongs to the parent(s). The Department shall not consent to organ donation by children who die in the care of the Department.

For wards or children in the custody of the Department at the time of their death, the Department shall determine on a case-by-case basis whether to consent to a request for organ donation.

11.22: Confidentiality of Medical Records and Information

 (1) Except for cases in litigation in which case 110 CMR 12.09 shall govern, with respect to the medical records of a child in the care or custody of the Department or a child who is a ward of the Department:

(a) The Department shall not distribute or release medical documents or information contained anywhere in a child's record or case file to any unauthorized person (as defined at 110 CMR 11.22(3)) without the written consent of one of the child's parents or without an order of a court of competent jurisdiction.

(b) The child's parent(s) or attorney or guardian or guardian ad litem shall have access to all medical documents or information contained anywhere in a child's record or case file; unless the person who contributed such information has requested in writing to the Department that the information not be disclosed (for which purpose the mere stamp "Confidential" shall not be sufficient), or unless otherwise provided by statute. The child's parent(s) may also request medical documents regarding their child directly from the hospital or medical provider pursuant to the provisions of the "Patient's Bill of Rights" at M.G.L. c. 111, § 70E.

(c) a District Attorney’s office may have access to a child’s medical records for a child in Department care or custody when access to those records will aid in the identification and prosecution of the person responsible for abusing or neglecting a child.

 (2) With respect to the medical records of a child surrendered for adoption to the Department or in the custody of the Department after adjudication under M.G.L. c. 210, § 3:

(a) The Department shall not distribute or release information in a child's medical record to any unauthorized person without court order.

(b) Unauthorized person for purposes of 110 CMR 11.22(2) shall include the biological parents of the child.

(3) Unauthorized person for purposes of 110 CMR 11.22(1) and (2) shall include everyone except: the child's physician or any other medical provider, the child's foster parents, the appropriate authorities at a residential facility in which the child is or is intended to be living, the appropriate authorities at any school the child is attending, the child's substitute care provider, the subject child if over 14 years of age, a district attorney’s office for the purpose of investigating and/or prosecuting child abuse or neglect of a child in Department care or custody, or any other person who the Department determines requires such information to render medical or other professional assistance to the subject child.

(4) When any ward or child in the care or custody of the Department requests that the Department not notify his or her parents of intended medical treatment, the Department shall determine on a case-by-case basis whether to consent to the child's request, but shall comply with the provisions of M.G.L. c. 112, § 12F.

11.23: Children as Research Subjects

 Parents shall retain the right to consent to participation by their child in any medical or psychological research. If the parents consent, the Department shall also consent. If the parents refuse to consent, the child shall not participate. Medical research includes physical examinations, laboratory tests of any kind, and psychological examinations and tests. For children in the custody of the Department pursuant to a surrender for adoption, termination of parental rights, or where parents cannot be located, the Department shall seek prior judicial approval.

11.24: Consent Standard

 In all cases where the Department has the right to consent to medical care for a ward or a child in its care or in its custody, the Department shall consider exclusively what will serve the child's best interests.

REGULATORY AUTHORITY

M.G.L. c. 18B, § 7(i); M.G.L. c. 119, § 37.