



Practice Alert

Informed Consent vs. Consent to Treat

Through the first three months of implementation of the Informed Consent policy, an issue has been identified that may be creating a misunderstanding and barriers. This Practice Alert is intended to clarify the difference between Informed Consent and Consent to Treat:

Consent to Treat is a form you will likely sign at the very beginning of any type of medical or behavioral health treatment episode. Each agency has its own “Consent to Treat” form and these will vary in the language used.

Most forms for *outpatient* treatment likely will be relatively vague and will denote your rights around treatment. Typically, this can be signed. However, some *inpatient* “Consent to Treat” forms will have statements that go beyond just consenting to admit or treat but will also allow for medications to be administered and non-pharmaceutical interventions (ex, therapies – individual, group, art, etc) to be implemented without additional consent provided. Children’s Division/FCCM is no longer able to sign these forms with these additional allowances. If you come across such a form for admission, you would need to have that section removed and/or line it out with your initials before signing and clearly note that prior to starting any therapy or any medication being administered, short of an emergency situation, **PRIOR** consent is required.

Informed Consent is specific to a medication or procedure **after** Consent to Treat is provided. CD/FCCM is not required to have a specific form that you sign for this purpose **at this time**. Informed Consent is a process of communication between the patient/parent of patient and the treating physician in order to learn about and think about a treatment before agreeing to it. You are required to obtain information from the provider regarding side effects, diagnosis, and all the other information listed in the Informed Consent policy. You will need to document that you obtained that information from the provider. IF the provider has a form for you to sign or gives you a document with that information you are required to include that in the file. You will need to share this information with any caregivers including parents, resource providers and residential providers.

Example: Think about this in terms of your own healthcare or that of your children. Your doctor wants to prescribe a certain medication for a condition. You would want to know as much as possible about that medication or procedure such as

purpose, frequency/dosage, side effects, lab work, monitoring etc. You don't, however, sign anything additional for that prescription with the doctor. If you were concerned about the side effects and didn't want to take the medication or have the procedure done, you would likely talk with your doctor about alternatives and come up with a plan together. The only difference is we do have to document the information we are required to obtain per the policy.

CD policy **requires** case management staff attend the first appointment to be assessed for psychiatric medication. If the assigned case manager cannot attend in person, provide a phone number to the adult accompanying the child so staff can participate in the appointment and be available to provide the informed consent. If the case manager cannot be available by phone, the supervisor should be the backup. For any follow up visit to the prescriber, the case manager and/or supervisor should consider whether the child is considered stable on the medication(s), based on information gathered from the resource provider or other sources of information. If no changes are expected, the resource provider or others can attend with the child. If there continues to be concerns, the case manager should expect that changes may be made and, particularly if that includes a new medication, they should plan on attending that appointment to be able to provide the informed consent.

This only works if case management staff are easily accessible to the prescriber's office. Contact information for Circuit offices is being provided to many prescribing agencies. Staff must be prompt in returning phone calls and providing the consent. We have also encouraged these agencies to reach out to local Circuit Managers to work out the logistics to make this an easier process for everyone involved.

The child's parents/guardians should be encouraged to attend the initial and follow up appointments as well so there is no delay in providing the informed consent in consideration of the parents' preferences. If the parent is unable to attend, you can ask if they have any restrictions or concerns they wish to share prior to the appointment so the case manager can discuss with the prescriber.

Case Management staff should professionally assert their rights as the legal custodian, looking out for the best interest of the child while balancing that with respect for the prescribers' training and expertise. This, again, should not be much different than how you would respond as an informed advocate for yourself or your children in regards to healthcare. We want to be good partners with the prescribers in the care of children in state custody. Engaging with providers to obtain enough information to provide informed consent should be conversational and respectful in nature and tone with a natural progression of questions; this conversation should not feel like an interrogation with a barrage of unrelated or unnecessary questions aimed at the provider. IF a prescriber becomes angry or uncooperative, please inform your supervisor and discuss guidance and possible next steps.

Program Development Specialist:
Lori Masek
Lori.Masek@dss.mo.gov 573-592-1007

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