Issue: The case of Gabriel Myers

On April 16, 2009, seven year old Gabriel Myers was found hanging in the residence of his foster parents. Gabriel had been adjudicated dependent on June 29, 2008, following the arrest of his mother. During the subsequent ten months, he had been placed first in the home of a family member and, later, two other foster homes. While in care, he received numerous mental health and behavioral assessments and underwent regular treatment from both a psychiatrist and two psychotherapists, one of whom documented that "it is clear that this child is overwhelmed with change and possible re-experiencing trauma." Gabriel demonstrated a number of incidents of destructive behavior and conduct problems and was treated through the administration of several psychotherapeutic medications.

In February and March, 2009, Gabriel experienced a number of significant events in life, including changes in foster homes, psychotherapists, after-school programs, and visitation arrangements with his mother, all of which may have contributed to his mental status at the time of his death.

Findings:

- It is clear that, throughout his placement in foster care, Gabriel Myers was no one's child; no single individual became a champion to ensure that his needs were met in a timely fashion.

- Responsibility for the treatment and care of Gabriel Myers was not clearly fixed or effectively carried out. No one person stepped forward to act as his parent.

- There was no sense of urgency driving the agencies and individuals responsible for the welfare of Gabriel Myers.

- The case itself was replete with missed opportunities to more effectively serve the needs of this child; numerous "red flags" signaling problems in Gabriel Myers' life were evident but were not adequately or in a timely fashion addressed.

- There was a lack of on-going and regular communication between the agencies and individuals responsible for the welfare of Gabriel Myers, and reports on his behavior were not fully and regularly shared among those charged with ensuring his welfare. Recommendations for Gabriel's case were not adequately staffed among members of his treatment team.

- Responsible parties failed to follow established law and operating procedures governing the administration of psychotherapeutic drugs and the obtaining of either informed parental consent or

judicial authorization, including the notification of all involved parties.

- There was inadequate supervision of the assigned Childnet case manager.

- There was inadequate oversight of the involved agencies by Department of Children and Families personnel.

- There was inadequate, incomplete, repetitive, and at times inaccurate documentation in the case files relating to Gabriel Myers.

- There was no documented effort to gather all available information on Gabriel's complete background.

- Appropriate agencies failed to act when the foster parent clearly indicated by e-mail a number of behavioral issues and that the placement of Gabriel Myers was in jeopardy. No action was taken to deal with the clearly expressed stress of the foster parent.

- From the information provided to the Work Group, it appears that school staff was not aware or sufficiently involved in resolving problems/concerns with Gabriel Myers.

- Broward County personnel failed to follow up with Ohio authorities concerning the medical and welfare history of Gabriel Myers, and his claims of sexual abuse were not investigated in a timely manner.

- Recommendations contained in the Comprehensive Behavioral Health Assessment and in reports by other therapists, including the Family Services Planning Team, were not completely followed.

- Gabriel Myers was not provided specific and upfront therapy to deal with identified trauma, possible post-traumatic stress disorder, and depression; intensive therapy was only directed at the prevention of sexual behaviors.

- Unnecessary delay from the time of referral (October 28) to the time of treatment (December 11) occurred.

- No recommended training to deal with Gabriel Myers' unique background and behavior was provided to foster parents.

- Parents and treatment team members apparently accepted discipline and punishment as the solution to Gabriel Myers' behaviors. There is little evidence of behavioral analyses and positive efforts to support Gabriel and encourage his success.

- No signed consent form was maintained in the medical records.

- Too many changes occurred in the life and environment of Gabriel Myers in too short a period of time with only marginal communication between and without a coordinated assessment or response by those charged with his care.

- There was no placement stability, and Gabriel Myers' final home was with working parents who were not always available for his unique needs.

- Gabriel Myers was left with an unauthorized caretaker on at least one occasion.

- The case demonstrated the need for a behavioral analyst to support the foster parents and more effectively deal with Gabriel Myers; none was utilized, however.

- As a result of the death of Gabriel Myers, the Broward County Child Welfare Community has identified a number of measures which, if vigorously implemented, monitored, and institutionalized, should ensure more effective and comprehensive treatment of children in the future.

Issue: The Use of Psychotherapeutic Drugs to Treat Children in Foster Care

Data presented to this Work Group indicated that, nationally, some 5% of all children are treated through the use of psychotherapeutic medications. In Florida's foster care system, ___% of its children receive at least one such medication. While this Work Group recognizes that that the nature of this particular group of children may require an expanded use of medication, safeguards within the system must ensure that children are not needlessly medicated to make their care, not their lives, easier. In treating our children on foster care, we must recognize that they are victims, who have been abused, neglected, or abandoned, and whose lives require the attention and appropriate intervention of the State.

It should be noted that existing statutes and, consequently, DCF rules, policies, and procedures utilize the term "psychotropic medication." The more appropriate term, and the one used throughout the Report of the Findings of this Work Group, is "psychotherapeutic medication."

Findings:

- It is essential that all elements of Florida's child welfare system understand that each foster child should be cared for and treated as we would our own children.

- The primary issue is not whether psychotherapeutic drugs are over prescribed or whether they are under prescribed; instead, it is whether they are necessary and properly prescribed for a child in care.

- As we reviewed the inadequacies and errors in information provided on foster care children receiving psychotherapeutic drugs, it became clear that a framework for safeguards exists and is proscribed by statute, administrative rule, and operating procedures. The core failures in the system, however, centered on failures in execution, in supervision, and in monitoring.

- We have not clearly articulated the standard of psychiatric care expected for children in state foster care.

- There must be a balance of administrative requirements placed on those involved in the system with meeting the needs of the child.

- Pre-authorization requirements for psychotherapeutic medications must allow for a timely response (within 24 hours) and specify emergency exceptions.

- The designation of a health care surrogate for each foster child could ensure an on-going review and responsiveness to the medical needs of each child.

- There is no requirement for the reporting of adverse consequences of a psychotherapeutic drug.

- Policies on the use of psychotherapeutic medication for non-psychotherapeutic purposes are not clear.
- The administration of psychotherapeutic medications cannot be viewed as an action separate and apart from the child's treatment plan.
- Psychotherapeutic medications are often being used to help parents, teachers, and other child workers quiet and manage, rather than treat, children.

- Children receiving medications with “Black Box” warnings are not adequately monitored, nor are those involved in the process adequately informed.
- The Department lacks a plan for the regulation of the psychotherapeutic medication. A good model has been the forensic bed crisis in terms of a daily report and weekly review by senior leadership.
- Use of psychotherapeutic medications varies significantly among DCF regions.
- There is currently no standardized, comprehensive, on-going statewide program to train case workers on issues related to psychotherapeutic medications, including requirements relating to informed consent.
- Department training on psychotherapeutic medications in 2004-05 was not comprehensive and has not been regularly repeated.
- Understanding of psychotherapeutic medications and approval process is not there.
- When medication is indicated, a combination of therapy and medication produces better outcomes. Consideration should be given to requiring children who are prescribed medication for symptoms associated with mental health or substance abuse diagnoses to receive services and supports in addition to medication management.
- Prescribers must engage children of all ages in the prescription process.
- The prescriber should document the child's perspective and position in the treatment visit notes.
- The concurrent Quality Assurance reports show that existing records are not being provided to Prescriber.
- The child's Guardian ad Litem should be responsible for ascertaining and informing the court of the child's position
- Any child who objects to the administration of medication, at any point in time, should be appointed counsel to directly represent his or her position.
- A better practice is to appoint an attorney for each child whose mental health needs rise to the level of psychotherapeutic medication as that child has complex needs deserving of sustained attention of individual counsel.

- The best practice is for all children in dependency to be appointed an attorney (with sufficient training and experience to provide meaningful and effective assistance of counsel).

- There is no process to ensure that there is a coordination of care between therapeutic service providers and psychotherapeutic medication prescribers.

- It is not clear whether existing Medicaid funding will support more active involvement by prescriber in therapeutic treatment of children (in contrast to payment for medication management visits).

Issue: Comprehensive Behavioral Health Assessments
Introductory paragraph to be added here

Findings:

- The goal of the Department of Children and Families is that all children 17 or younger entering out of home care who are Medicaid eligible are provided a Comprehensive Behavioral Health Assessment. Testimony before this Work Group, however, indicated that not every child in foster care is eligible for or receives the Comprehensive Behavioral Health Assessment in a timely manner.

- Children currently entering state care who do not always receive comprehensive behavioral health assessments include children who are not Medicaid eligible (primarily immigrant children); children who do not enter via or remain in "shelter status" long enough for a CBHA to be ordered; and children who are placed in unlicensed settings (relative or non-relative placements).

- While used early in a foster child's involvement with DCF, the Comprehensive Behavioral Health Assessment is not used on a regular basis to indicate progress of the child within the system unless there are clear emotional disturbances or the use of the instrument is requested.

- While subsequent CBHAs may be performed in certain circumstances, this Work Group received no evidence that CBHAs are routinely ordered for all children whose behaviors are deteriorating and whose emotional needs are escalating.

- Prescribing physicians often lack medical history (including CBHA), yet still prescribe medications.
- There appears to be a gap between those services identified in the CBHA and being included in the child's case plan

- There appears to be a gap between services included in the case plan and those actually being provided to the child.

Issue: Information contained in the Florida Safe Families Network (FSFN)

At the outset of the review by the Gabriel Myers Work group, records contained in the Florida Safe Families Network (FSFN) reflected that, of Florida's ____ children in out-of-home care, approximately 1800 were being treated through the use of psychotherapeutic medications. A subsequent, more detailed analysis conducted on ___, 2009, indicated that ____ were actually receiving psychotherapeutic medications.

Since that time, the Department of Children and Families, working with its community partners, has been conducting a detailed review of all cases involving the administration of psychotherapeutic medications to foster children. The Gabriel Myers Work Group has received on-going briefings on the progress of these quality assurance reviews, which are clearly identifying deficiencies in data contained in FSFN and specifying corrective action needed. Each of these reports has been included on the website reflecting the activities of this Work Group.

Findings:

- FSFN data are frequently incomplete and inaccurate. The information contained in FSFN is only as good as the information entered from the field; errors in input, regardless of the reasons for such errors, will continue to yield faulty information.

- A number of representatives from both DCF and the Community Based Care Lead Agencies indicated that, as currently structured, FSFN is a data capture system that provides little support for effective case management.

- The pilot project being conducted by OurKids, the Community Based Care Lead Agency for Miami-Dade/Monroe Counties, using MindShare as a platform for better analysis and case management use of FSFN data is an outstanding option which should be reviewed by the Department and all Community Based Care Lead Agencies.

- Case managers are required to enter medical information into FSFN, yet often do not understand the information and cannot verify its accuracy.

- FSFN has too many "free text" and "other" sections to serve as an adequate monitoring device.

- The list of psychotherapeutic medications, while extensive, does not include all drugs used for such purposes.

- It must be recognized that FSFN is only a data system; by itself, it does not replace adequate supervision and monitoring.

Issue: Informed Consent and Judicial Review

Section 39.407, Florida Statutes, describes in detail the process for obtaining express and informed consent for the administration of psychotherapeutic medications to children in the custody of the department. Subsection (3)(a) of that statute requires that any physician prescribing such medications to a child in the custody of the department must attempt to obtain "express and informed consent" as defined in s. 394.455(9), F.S. and described in s. 394.459(3)(a), F.S. For children whose parents' rights have not been terminated, the prescribing physician must attempt to obtain written express and informed consent from the child's parent or legal guardian.

Express and informed consent is defined in s. 394.455(9), F.S., and is described in s. 394.459(3)(a), F.S. Before giving express and informed consent, the following information must be provided and explained in plain language to the child's parent or legal guardian and to the child, if age appropriate:

- the reason for admission or treatment;
- the proposed treatment;
- the purpose of the treatment to be provided;
- the common risks, benefits, and side effects thereof;
- the specific dosage range for the medication, when applicable;
- alternative treatment modalities;
- the approximate length of care;
- the potential effects of stopping treatment;
- how treatment will be monitored; and
- that any consent given for treatment may be revoked orally or in writing before or during the treatment period by the parent.

To assist the physician with securing the express and informed consent of the parent or legal guardian, the Department of Children and Families or its local partners must take steps necessary to facilitate the inclusion of the parent or legal guardian in the child's consultation with the physician.

If the parent is unavailable or unwilling to give express and informed consent, if the parent is unknown, or if the parent's parental rights have been terminated, a court order authorizing the administration of psychotherapeutic medication must be sought when such administration is recommended by the child's physician. That court authorization must be entered prior to the administration of the medication.

The motion requesting authorization for the administration of the medication must be filed by attorneys representing DCF and must be accompanied by a written report, signed by the prescribing physician, supporting the motion. The required elements of the medical report are outlined in the statute and closely track the requirements for express and informed consent, above. The prescribing physician is not required to testify in any hearing on the motion unless the court orders attendance or a party subpoenas the physician. Any objection to the motion must

be filed within 2 working days of receipt of the motion by a party. If an objection is received, the court must schedule a hearing on the motion "as soon as possible."

Findings:

- The on-going analysis of data contained within the Florida Safe Families Network (FSFN) clearly showed that a significant portion of cases involving the administration of psychotherapeutic medications to foster children did not meet the legal requirements relating to express and informed consent.

- The on-going analysis of data contained within the Florida Safe Families Network (FSFN) clearly showed that a significant portion of cases involving the administration of psychotherapeutic medications to foster children did not meet the legal requirements relating to judicial review.

- Psychotherapeutic medication is routinely administered to children in Florida without express and informed consent.
- The prescribing physician's report/affidavit varies between circuits; there is no common, statewide form.
- Prescriptions do not include a "when will medications stop" consideration in the informed consent process.
- Informed consent for use of psychotherapeutic medications in a systemic problem. It appears that, too often, parents and/or the court are unaware of critical issues involving medications, procedures are not followed, and documentation requirements are ignored.
- There is often insufficient exchange of information for parents or judges to make an informed decision involving psychotherapeutic medications.
- Pre-consent process is unclear, particularly if child is already taking a medication.
- Pre-consent age requirement is not understood (under 5 or under 6?)
- The prescriber has a legal and ethical duty to obtain informed consent before psychotherapeutic medication is administered.

- Informed consent cannot be obtained absent a <u>direct</u> conversation between the prescriber, or a trained designee, and the person with authority to provide the consent, whether the parent or the judge. An exchange of paper can never substitute for the oral interchange and visual cues required for the prescriber (or designee) to ascertain that the "consenter" understands the decision being made.

- Child welfare workers do not currently have sufficient training to obtain informed consent.

- There are numerous barriers to arranging a personal meeting between the "prescriber" and "consenter" - whether that be the parent or the court (e.g., it may be difficult for parents working full-time at low wage jobs to leave work for a physician's appointment, and frequently physicians do not have time to appear before the judge).

- Coordination with AHCA pharmacy management computer can ensure that no prescription will be filled unless the procedural requirements regarding informed consent have been met.

- Courts lack what was referred to as the "intimacy of daily association" with the affected foster children. Consequently, in determining the appropriateness of psychotherapeutic medication, they must rely on information provided by a variety of other individuals, including the case manager, foster parent, Guardian ad Litem, and physician.

- Age appropriate children should be fully involved in and allowed to participate in court hearings involving their welfare and treatment.

- Court orders approving the use of psychotherapeutic medications do not always contain other specific medical follow-up steps necessary to ensure the child's well-being.

Issue: Information Sharing

Introductory paragraph to be added here

Findings:

- Data systems (e.g., FSFN, AHCA Medicare, and MedConsult Line) are not regularly reviewed to indicate anomalies in the number of children receiving psychotherapeutic medications or to ensure accuracy of data.

- The results of the Comprehensive Behavioral Health Assessment are not always transmitted to and shared between others involved in the child's treatment, including the treating psychiatrist.

- There is a need for a web-based information system which, with proper security safeguards, allows access by all designated members of a foster child's treatment team.

- Florida lacks data on children aging out of foster care and, especially as a result of their common loss of Medicaid benefits, their continued use of psychotherapeutic medication.

- Child fatality reviews have consistently identified the need for multidisciplinary staffings on complex cases.

- Prescribers do not always have access to all of the information about the child's medical, therapeutic and behavioral history that is available in the child welfare system.

- Current system requires the generation and flow of numerous pieces of paper, necessitating duplication of information entries and creating a burden for all involved, and may result in inaccurate or incomplete information going to the persons who need it.

- Technology can be better employed to: eliminate the duplication of entries; track the status of a prescribed medication in the prescription/consent/administration process; allow all parties (and counsel) to view and confirm the accuracy of information; generate a "stop" or flag when system requirements, such as informed consent, do not occur; and facilitate and document information exchanges between therapists and prescribers.

- Prescribers lack incentive to participate in multi-disciplinary treatment teams.

- All persons with daily contact with child (caregiver, school, day care) should have access to pertinent information concerning issues such as symptoms, side effects, expected changes in behavior, when to contact prescriber or an emergency room, and necessary on-going monitoring.

- Standardized information sheets should be prepared for dissemination on most commonly used drugs, and a template provided for new or additional drugs being prescribed.

- Complete and accurate medical records are indispensable to safe and effective usage of psychotherapeutic medications.

- Continuity of medical care, to the extent possible, will promote the well-being of children.

- No existing Quality Assurance review determines whether the child's health records are complete and up to date.

- Information systems and information-sharing practices should be capable of triggering a specific response from designated agencies when a pattern of "red flags" emerges.

Issue: Behavioral Health Care

Coverage of those children within the State's foster care system is provided by a number of mental health plans. The Child Welfare Pre-Paid Mental Health Plan (CWPPMHP) covers children in licensed out of home care in most, but not all of the state. Community Mental Health covers children in licensed out of home care in AHCA Area 1 and 6 (except Hillsborough). A managed care plan covers children in Broward. Children who are not in licensed out of home care (at home under supervision, in relative or non-relative care) are not eligible for the CWPPMHP. Children who move between licensed and unlicensed placements will almost always change therapists. Even within the CWPPMHP, children who move between contracted residential providers often change therapists as the providers employ the therapists.

Findings

- The child welfare system does not maximize outcomes for children when it fails to provide them with consistent therapy provided by persons with whom they have a positive therapeutic relationship.
- The fragmentation of the existing mental health delivery ensures discontinuity of care when a child's residence changes.
- Coverage is fragmented among mental health plans.
- Current mental health coverage does not adequately provide behavioral support to caregivers.
- Medicaid will not pay for non-cognitive behavioral therapy for children with cognitive impairments who are not on a waiver from the Agency for Persons with Disabilities.
- Children are enrolled and disenrolled in health care plans without the knowledge and participation of caregivers which can cause discontinuity of care.
- Evidence based practices show improved outcomes for caregivers who receive parent training and direct support when caring for children with problem behaviors, yet those services are not routinely offered and are difficult to obtain when requested.
- Funding for behavioral supports have decreased.
- Caregivers are able to select health care providers for the children; a change of caregiver may result in change in health care provider.

- It is important to leave selection of provider to the caregiver; they will most often choose providers that are convenient and they trust, thus enhancing the likelihood that they will obtain care.

- If children have a "medical home" then their complete record can easily be transferred to a new provider.

- Caregivers can be required to select providers who meet requirements of providing "medical home" (perhaps the CMS Network Credentialing Criteria?)

Issue: Individual and Agency Accountability

Findings:

- The roles and responsibilities of all those involved in the treatment of a foster child are not clearly defined or promulgated.

- Within the Department of Children and Families, issues related to the mental health of children fall within the responsibilities of both the Office of Family Safety and the Office Children's Mental Health, with no clear definition of the responsibilities or coordination required of each.

- The Department of Children and Families lacks a Chief Medical Officer, charged with ensuring coordination of all medical and psychiatric efforts of and decisions by the agency.

- Regardless of any other areas of personal skills or expertise, it is critical that the case manager be viewed as the subject matter expert on one item: each child assigned to his/her care.

- There is a need for enhanced oversight of children in foster care by the judiciary assigned to dependency cases.

- Assigned responsibility, and the subsequent accountability, for ensuring compliance with agreements between agencies and for action plans resulting from cases such as Rilya Wilson or the Red Item Report, are lacking.

- We recognize that "people do what they're graded on." As a result, the performance measures in place for the Department of Children and Families and their community-based partners should reflect the core issues related to the use of psychotherapeutic medication to treat Florida's foster children, including compliance with statutory safeguards.

- The Department of Children and Families should ensure that its efforts at quality assurance are structured and performed in such a manner and with

such regularity to identify and correct in a timely fashion the issues that are the focus of this Report.

- Contractual accountability and performance requirements for community-based care agencies appear to be loosely enforced by the Department of Children and Families

Issue: Implementation of the Red Item Report on Psychotherapeutic Drug Use in Foster Care

In its 2003 Report to Governor Jeb Bush, the Statewide Advocacy Council recommended that the State:

- Develop and implement a quality assurance program for monitoring the use of these drugs in children. Such a system would ensure that appropriate attempts at behavior management were implemented and that the prescribing of drugs is a last resort.
- Develop a Plan of Care to include counseling for anger, self-esteem, positive reinforcement, dealing with fear and attitude, and character building traits. Not all foster children will need this counseling but it should be available for those that do.
- Ensure that appropriate standardized written informed consent is obtained prior to starting any child on psychotherapeutic medication. This consent should include information about any risks and expected benefits, including possible side effects and alternative treatments.
- Ensure that everyone who administers psychotherapeutic medications to children in a foster care setting is trained to recognize the side effects of medications.
- Ensure that pediatric psychiatrists perform medical examinations prior to implementation of these drugs. These doctors understand and recognized potential side effects of these drugs when used in children.
- Ensure that foster care records for each child contain organized information and that medical records are easily found.
- Ensure when more than one physician is ordering medications that Medical Passports are current and made available to each physician.

The Statewide Advocacy Council concluded that "It is imperative that the foster care children in the State of Florida receive the necessary medical treatment they need, however, unnecessary dispensing of psychotherapeutic medication remains a threat to them. Until there is more information regarding the safety and efficiency of these drugs, Florida's foster care children should be monitored closely. The information in this report should be immediately incorporated into an agenda in order to preserve and protect the health, safety, welfare and rights of children in foster care."

Findings:

- These recommendations offer a common sense approach to protecting those foster children who face the administration of psychotherapeutic medication as a treatment alternative.

- While the Department of Children and Families began implementation of some of these recommendations, their practice has not been institutionalized into the policies, procedures, or performance of the agency or its community-based partners.

Issue: Ensuring Best Practices

In a presentation before the Gabriel Myers Work Group, Dr, Christopher Bellonci offered a number of principles necessary to ensure best practices in screening, assessment, and treatment of mental health issues in child welfare:

Principle 1: In establishing informed consent, information must be given to the child, youth, family (bio-parent, foster parent, or caregiver), and the caseworker/state-assigned decision maker about the treatment options (both medication and non-medication options), the risks/side effects and benefits of the medication, the targeted symptoms, and the course of treatment.

Principle 2: The child welfare agency must document (for example, in the medical passport) the medications the child or youth is taking, the child's or youth's response to the medications, risks/side effects and benefits of the medications, and the time-frames for the elicited response. This documentation will follow the child or youth throughout his or her stay in care.

Principle 3: The prescriber should have ongoing communication with the child and caregiver to monitor treatment response and side-effects on a continuing basis, and discuss with the child adherence to medications and any medication changes in the context of an engaged collaborative therapeutic relationship.

Principle 4: Recognized clinical rating scales or other measures should be used to quantify the response of the child's target symptoms to treatment and the progress made toward treatment goals. In the initial phase of treatment (during the initial three months on a particular medication or regiment), visits should take place on at least a monthly basis, or more frequently if the child's condition is unstable or worsening.

Principle 5: Caseworkers will know or have training on:

-child and adolescent development
- neuro-developmental effects of prenatal substance exposure
-common mental health disorders in the child welfare population
-effective treatment options for these mental health disorders

Principle 6: Youth and families should be provided ongoing information on the diagnosed mental health disorder, effective treatment options, and managing life with the condition, including:

-what to expect in the future
-how severe the condition is
-can the youth not take medication in the future
-what can be dine instead of medication
-how to access help in the future

Principle 7: The agency should ensure transition planning in advance of youth leaving care that includes identification of providers and source of payment for treatment.

Principle 8: The child welfare agency should encourage, support, and monitor the mental health needs and access to psychotherapeutic medications and other mental health services for birth families.

Principle 9: The agency should periodically conduct reviews of patterns of psychotherapeutic medication use within its caseload, on an aggregate- and provider-specific basis, and take necessary action in response to findings of such reviews.

Findings:

- These principles should be accepted and clearly articulated as necessary and appropriate for the treatment of children within Florida's child welfare system.

Issue: Prescriber Practices **(This will probably fit better in the "Future Actions Required" section of the main body of the report…just don't want to forget it).** Sufficient concerns have arisen to warrant further investigation, by appropriate professionals or agencies, into the prescribing practices of doctors with large volume of psychotherapeutic medication prescriptions.

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