

TITLE 89: SOCIAL SERVICES
CHAPTER III: DEPARTMENT OF CHILDREN AND FAMILY SERVICES
SUBCHAPTER b: PROGRAM AND TECHNICAL SUPPORT

PART 325
ADMINISTRATION OF PSYCHOTROPIC MEDICATIONS
TO CHILDREN FOR WHOM THE DEPARTMENT OF
CHILDREN AND FAMILY SERVICES IS LEGALLY RESPONSIBLE

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AUTHORITY: Implementing Section 5 of the Children and Family Services Act [20 ILCS 505/5], the Juvenile Court Act of 1987 [705 ILCS 405], the Mental Health and Developmental Disabilities Code [405 ILCS 5/1-100] and the Administration of Psychotropic Medications to Children Act [20 ILCS 535].

SOURCE: Adopted at 19 Ill. Reg. 8600, effective June 15, 1995; emergency amendment at 35 Ill. Reg. 16877, effective October 1, 2011, for a maximum of 150 days; amended at 36 Ill. Reg., effective February 24, 2012.

Section 325.10 Purpose

The following standards and procedures shall govern the administration of psychotropic medications to persons under the guardianship of the Department pursuant to court order or for whom the Department has custody and has, by court order or via an adoptive surrender, been authorized to consent to major medical procedures. It is the purpose of this rule to create a system which promptly identifies and evaluates the needs of children for psychotropic medication, provides timely access to such medication, and monitors children on such medication, while recognizing the risks that such medications pose, particularly if they are not prescribed and monitored with care. Psychotropic medication must not be used simply for the convenience of staff members or caregivers, to punish children, or as a substitute for adequate staffing and programming.

(Source: Amended at 36 Ill. Reg., effective February 24, 2012)

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Section 325.20 Definitions

"Administrative Case Review" means a review of permanency planning, open to the participation of the parents of the child, conducted by a person who is not responsible for the case management of, or the delivery of services to, either the child or the parents who are the subjects of the review. (See 42 USCA 675.) The administrative case review is also open to the participation of other professionals involved in assessing or treating the child, any legal representative of the parent or child, and the foster parents or relative caregivers as specified in 89 Ill. Adm. Code 316.50 (Conduct and Participation at Administrative Case Reviews).

"Administrative Case Review Chronic Report" means a report generated as a result of an administrative case review that identifies unmet services or casework needs identified in previous reviews. Categories of service or casework needs include counseling, medical, dental, school reports, visitation, assessments and worker contacts.

"Administrative Case Review Critical Alert Report" means a report generated as a result of an administrative case review that identifies actions or inactions in violations of rule, procedure or law, or acts of gross impropriety that endanger the safety, well being and permanency of children. Examples of critical issues include caregiver violation of licensing standards or law; worker violation of law; court ordered visitation changed without notification; and neglect of a child's critical medical needs.

"Administrative Case Reviewer" means a trained professional who is not responsible for the case management of, or delivery of services to, either the child or the parents who are the subjects of the review.

"Authorized Agent" means Department staff who have been appointed and authorized by the Guardianship Administrator to officially act in the place of the Guardianship Administrator to authorize and consent to matters concerning children for whom the Department has legal responsibility.

"Centralized Consent Unit" means the staff of authorized agents under the Department's Division of Guardian and Advocacy responsible for processing all psychotropic medication consents on a statewide basis during working hours.

"Child Care Facility" means any person, group of persons, agency, association or organization, whether established for gain or otherwise, who or which receives or arranges for care or placement of one or more children, unrelated to the operator of the facility, apart from the parents, with or without the transfer of the right of custody, in any facility as defined in the Child Care Act of 1969, established and maintained for the care of children. "Child care facility" includes a relative who is licensed as a foster family home under Section 4 of the Child Care Act of 1969. [225 ILCS 10/2.05]

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"Children for Whom the Department Is Legally Responsible" means children for whom the Department has temporary protective custody as authorized by the Abused and Neglected Child Reporting Act, children for whom the Department has been appointed legal custodian or guardian by order of a Juvenile Court, children whose parents have signed an adoptive surrender, or children for whom the Department has temporary custody via a voluntary placement agreement. For purposes of consenting to the administration of psychotropic medications, the Department must be the legal guardian or custodian with the authority to consent to major medical care.

"Department" or "DCFS" means the Illinois Department of Children and Family Services.

"Emergency Medication" means psychotropic medication given to a child when circumstances exist in which a child for whom the Department is legally responsible poses a threat of imminent serious harm to self or others.

"Emergency Reception Center" or "ERC" means the staff of authorized agents under the Department's Division of Child Protection responsible for processing all psychotropic medication consents on a statewide basis after working hours and on holidays and weekends.

"Foster Child" means a child in the custody or guardianship of the Department who is currently living in a child care facility licensed by the Department.

"Licensed Prescriber", for purposes of this Part, means a physician, a physician assistant licensed in accordance with the Physician Assistant Practice Act of 1997, or an advanced practice nurse in accordance with a written collaborative agreement required under the Nurse Practice Act.

"Medication Monitoring" means the use of clinical observation, physical examination, and laboratory testing to monitor a child's or youth's response to one or more prescribed psychotropic medications to determine if a psychotropic medication is safe, effective and being prescribed at the optimal dose using approved best practice monitoring methods.

"One-time, Non-emergency Medication" means the one-time administration of a psychotropic medication prescribed by a licensed prescriber to a child or youth for whom the Department is legally responsible for the acute management of symptoms of insomnia or other troublesome symptoms that may adversely affect a child's or youth's sense of well being following an evaluation conducted by a qualified health professional.

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"Oversight Treatment Team" means a committee appointed by the Department that is comprised of the Department's Chief Psychiatric Consultant, Medical Director and Chief Nurse and representatives from the Division of Guardian and Advocacy and the Division of Clinical Services. A least one representative must be a Board certified Child and Adolescent Psychiatrist. This Committee shall have the powers and duties prescribed in this Part.

"PRN Medication" or "Pro re nata medication" means standing medication orders to administer a psychotropic medication for the emergency management of aggression, psychotic agitation, insomnia and other troublesome symptoms without a physician assessment or specific approval according to parameters set by the licensed prescriber.

"Psychiatric Consultant" means a Board-certified Child and Adolescent Psychiatrist as defined in 405 ILCS 5/1-121 who has specialized in child and adolescent psychiatry and who provides consultation to the Department's Guardian and Advocacy Division and authorized agents.

"Psychiatric Hospital" means a mental health facility that can provide 24-hour psychiatric services. This includes:

psychiatric facilities operated by the Illinois Department of Human Services-Division of Mental Health;

private psychiatric hospitals licensed by the Illinois Department of Public Health; or

a specific unit in a general hospital in which diagnosis, treatment, and care for persons with mental illness is provided and that is licensed by the Illinois Department of Public Health.

"Psychotropic Medication" means any medication capable of affecting the mind, emotions and behavior. This includes medications whose *use for antipsychotic, antidepressant, antimanic, antianxiety, behavioral modification or behavioral management purposes is listed in AMA Drug Evaluations, latest edition, or Physician's Desk Reference, latest edition or that are administered for any of these purposes* [405 ILCS 5/1-121.1]. For the purpose of this definition, medications used to induce or sustain sleep or to treat symptoms of aggression, enuresis and psychotropic medication-induced adverse effects are also included.

"Residential Facility" means a group home, child care institution, maternity center, youth transitional living program, or secure child care facility licensed by the Department or an institution or group home licensed by the Illinois Department of Public Health that provides full time treatment and/or care for

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children. Facilities operated by the Illinois Department of Corrections and the Illinois Department of Juvenile Justice are not residential facilities, as defined in this Part.

"Substitute Care" means the care of children who require placement away from their families. Substitute care includes foster family care, care of a child for whom the Department is legally responsible provided in a relative family home, and care provided in a residential facility as defined in this Part.

(Source: Amended at 36 Ill. Reg., effective February 24, 2012)

Section 325.30 General Provisions

- a) The administration of psychotropic medication is prohibited to children for whom the Department is legally responsible as punishment for disruptive or inappropriate behavior, for the convenience of staff members or caregivers or as a substitute for adequate ongoing programming for the children's needs.
- b) Except in an emergency, and subject to subsections (a), (c), (d) and (g), psychotropic medication shall never be administered to children for whom the Department is legally responsible without the prior approval of an authorized agent as set forth in this Part.
- c) PRN medications for the purpose of behavioral management, inducing sleep, or treating other emotional, behavioral or psychiatric illnesses are prohibited.
- d) One-time, non-emergency medications may be used for the acute management of sleep disturbances or to treat other non-emergent emotional, behavioral or psychiatric symptoms that adversely affect a patient's well being. Licensed prescribers are required to notify the Department's Division of Guardian and Advocacy, in writing, of the administration of an emergency psychotropic medication or a one-time, non-emergency medication.
- e) Upon taking protective custody, the Department's investigation specialists shall identify potential medical and mental health issues through contact with the child's parents, relatives, schools or current and/or previous physicians and observation of the child's behaviors. The investigation specialist shall attempt to obtain information on all medications and/or medical equipment needed by the child. If the child is on psychotropic medication, when possible, the investigation specialist shall ensure appropriate consent is provided from the parent or legal guardian.
- f) The child's caseworker shall ask parents, relatives and foster parents if the child is on any medications and whether the child has any known or suspected medical or mental health issues. The caseworker shall obtain identified mental health

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documents and all medications and/or medical equipment needed by the child. If the child is on psychotropic medication, the caseworker shall ensure appropriate consent is provided from the parent or legal guardian to continue administration of that medication.

- g) Children for whom the Department is legally responsible who have been committed to facilities operated by the Illinois Department of Corrections or the Illinois Department of Juvenile Justice are governed solely by the rules of the Illinois Department of Corrections (20 Ill. Adm. Code 415, Health Care) which also pertains to committed adults and emancipated minors, the Unified Code of Corrections [730 ILCS 5], and corrections case law for purposes of the administration of psychotropic medications. In its role as guardian, the Department of Children and Family Services may contest decisions made by the Illinois Department of Corrections or Department of Juvenile Justice in accordance with 20 Ill. Adm. Code 415 regarding the involuntary administration of psychotropic medications to Department wards placed in those facilities.
- h) A Psychotropic Medication Consent Form shall be attached as an exhibit to each child's Client Service Plan for each psychotropic medication being administered to the child. The caseworker shall ask each youth age 18 or older to sign a consent for release of information for this purpose.
- i) The Department shall provide a Psychotropic Medication Request Form. Copies of the Request Form shall be completed by licensed prescribers prescribing psychotropic medications for wards of the Department. Additionally, the Department shall distribute the Request Form to all substitute care agencies and hospitals in which wards of the Department reside and to all authorized agents. At a minimum, the Request Form shall request the following information:
 - 1) The child's name, date of birth and weight;
 - 2) The medication to be administered;
 - 3) The dosage and frequency of administration;
 - 4) The duration, which in no event shall exceed 180 days;
 - 5) Diagnosis, target symptoms and behavior;
 - 6) Other medications the child is taking;
 - 7) The name and specialty of the licensed prescriber;
 - 8) Whether the child objects to the administration of the medication and the reason for the child's objection;

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- 9) Cultural/ethnic information about the child;
 - 10) Tests/procedures that monitor potential side effects that are of greatest concern;
 - 11) Over the counter or herbal supplements the child is taking;
 - 12) Medications that were discontinued and the reason for the discontinuation; and
 - 13) Whether completion of the form is notification of emergency administration of a psychotropic medication and, if so, a brief explanation of the nature and circumstances for administering that medication.
- j) The Department shall employ or contract with one or more psychiatric consultants. The psychiatric consultants shall provide clinical consultation for all requests to administer psychotropic medication to a Department ward as provided in [Section 325.40 \(Medication Approval Standards\)](#).
- k) The Guidelines for the Utilization of Psychotropic Medications for Children in Foster Care are listed in [Appendix A](#). The Department will also publish these Guidelines on its website and the websites of the Department's psychiatric consultants. The Guidelines shall include basic information for licensed prescribers regarding the administration of psychotropic medications to foster children. In addition, the Department shall publish the DCFS Psychotropic Medications List on its website and the website of the Department's psychiatric consultants. The Medications List shall include all psychotropic medications, including medications used to treat sleep problems, bedwetting and medication-induced adverse effects, that may be prescribed for children in the custody or guardianship of the Department; their FDA indications; contraindications; the acceptable range of dosages; and monitoring requirements, if any. ([See Appendix B of this Part.](#)) The Guidelines for the Utilization of Psychotropic Medications for Children in Foster Care and the DCFS Psychotropic Medications List shall be approved, reviewed at least annually, and updated as necessary by the Oversight Treatment Team. The names, qualifications and professional positions of the members of the Oversight Treatment Team shall be listed in the Guidelines and the DCFS Psychotropic Medications List.
- l) The Guidelines and the DCFS Psychotropic Medications List (and any revisions) shall be provided to all authorized agents and to substitute care agencies and hospitals that accept children in the custody or guardianship of the Department for placement or treatment.

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- m) The Centralized Consent Unit and Emergency Reception Center (ERC) staff shall be provided with regular periodic training in the use and contents of the Guidelines and the DCFS Psychotropic Medications List. The Guardianship Administrator shall appoint, subject to the review of the Oversight Treatment Team, an individual to provide training to the Centralized Consent Unit and ERC Staff on the use of the Guidelines and the DCFS Psychotropic Medications List.

The training shall include:

- 1) initial training before the authorized agent assumes the responsibilities of the Centralized Consent Unit or ERC position. This training shall include an explanation of the purpose of the Guidelines, the contents of the Guidelines, including an explanation of commonly prescribed psychotropic medications, the appropriate dosages for children and adolescents, side effects, conditions for which medications are commonly prescribed, and the procedure for approval or denial of the psychotropic medications;
 - 2) annual training; and
 - 3) training before any revisions to the Guidelines take effect.
- n) Administrative Case Reviews
- 1) During the Administrative Case Review process, the reviewer shall inquire into the following:
 - A) Whether the child has any mental health issues and, if so, whether those issues are being addressed;
 - B) Whether the child is on psychotropic medications;
 - C) Verification that appropriate consents and other documentation are present in the child's case record;
 - D) Verification that psychotropic medications are being monitored according to accepted standards of care;
 - E) Identification of the licensed prescriber; and
 - F) Whether a referral has been or should be made to a DCFS Regional Nurse.

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- 2) If the reviewer finds any deviation from the requirements of the six areas listed in [subsection \(n\)\(1\)](#), the reviewer shall issue an ACR Critical or Chronic Alert Report to the Guardianship Administrator and other appropriate Department management staff.
- o) Oversight Treatment Reviews
- 1) The Oversight Treatment Team shall conduct reviews of a child's psychotropic medications when:
 - A) A child or youth has been prescribed more than four psychotropic medications at one time;
 - B) Psychotropic medications are prescribed for a child under four years of age (excluding stimulants);
 - C) A child has been taking the same psychotropic medication for more than two years with no changes in dosage;
 - D) A child has been prescribed more than one psychotropic medication from the same class;
 - E) A child is prescribed frequent changes of psychotropic medications for the same condition or illness (occurring more frequently than every four weeks) without a clear rationale (e.g., side effects);
 - F) Dosages prescribed for a child exceed standard weight and age protocols;
 - G) Notices for emergency medications administered to a child exceed more than two a day for three consecutive days;
 - H) A worker's observations of the child or the child's behavior raise concerns that have been referred to the DCFS Regional Nurse; and
 - I) When requested by the DCFS Guardian.
 - 2) The Oversight Treatment Team may contact the licensed prescriber to discuss the rationale for the prescribed medications and will make decisions and give approval for actions needed regarding service delivery based on the outcome of the treatment team's review.

(Source: Amended at 36 Ill. Reg., effective February 24, 2012)

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Section 325.40 Medication Approval Standards

- a) Centralized Consent Unit and Emergency Reception Center staff may provide consent for the administration of a psychotropic medication only after the Department's Psychiatric Consultant has provided clinical consultation and deemed the requested medication as appropriate. If a request for administration of any psychotropic medication that does not meet the criteria listed in this subsection is deemed appropriate by the Department's Psychiatric Consultant and the Centralized Consent Unit or ERC staff consents, the staff shall note this fact on the consent form. If all requested information has been provided to the Centralized Consent Unit or ERC staff and consultation has occurred, the staff must provide consent or denial of psychotropic medication within 24 hours for inpatient requests and 48 hours for all other requests. If approval or denial of the request for medication is not provided within specified time frames, the requesting party may contact the Office of the Guardianship Administrator or designee for assistance in obtaining a response.
- b) Additionally, whenever the Centralized Consent Unit or ERC staff is advised that a child for whom the Department is legally responsible objects to the administration of psychotropic medication, Centralized Consent Unit or ERC staff may consult with both the licensed prescriber who is recommending the medication and the Department's psychiatric consultant prior to approving or denying the medication. Centralized Consent Unit or ERC staff shall assess the basis for the child's objection to the psychotropic medication. This assessment may include asking the child's caseworker to interview the child to determine the basis for his/her objection. The reason for the child's objection must be fully documented on the Psychotropic Medication Request Form. Although the Guardianship Administrator may give consent notwithstanding the child's objection, the licensed prescriber must follow all provisions of the Illinois Mental Health and Developmental Disabilities Code [405 ILCS 5].
- c) Every consent for the administration of psychotropic medication shall be limited in time. Under no circumstance may psychotropic medication be authorized for a period exceeding 180 days. At the expiration of the period set forth in the authorization, psychotropic medication may be reauthorized pursuant to the standards and procedures contained in this Part. The duration of consent may be less than 180 days if deemed clinically appropriate by the Department's psychiatric consultant.
- d) When the Department grants consent for the administration of a psychotropic medication to a foster child, it is granting consent to all prescribers who subsequently care for the child in other treatment settings until the consent expires.

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- e) Psychotropic Medication Monitoring. The licensed prescriber and facility shall monitor a child's response to medications according to the Guidelines for the Utilization of Psychotropic Medications for Children in Foster Care and the DCFS Psychotropic Medications List to determine if the psychotropic medications being administered are safe and effective based on criteria identified in the treatment plan and are being prescribed at the appropriate dosage. Means of monitoring safety, effectiveness and appropriateness of dosage include but are not limited to:
 - 1) Clinical observations of symptoms and/or side effects documented in the patient's chart;
 - 2) Vital signs (blood pressure, pulse and temperature);
 - 3) Weight and height;
 - 4) Symptom severity scales;
 - 5) Adverse effects scales;
 - 6) Blood tests to assess the medications' effects on the body, such as a complete blood count, metabolic panel, and thyroid function tests; and
 - 7) Blood levels of specific medications such as lithium and various anticonvulsant mood stabilizers.
- f) Continued use of medications that appear not to have the desired clinical effects or that are associated with problematic adverse effects must be re-evaluated by the licensed prescriber to determine the appropriateness of continuing the medication.
- g) At least every 90 days, the licensed prescriber shall assess and document the status of the child/youth for any adverse reactions and document the presence or absence of tardive dyskinesia in a child/youth on antipsychotic medications. The licensed prescriber shall assess the continued need for the medication at least annually. The caseworker shall document this assessment in the child's case record.
- h) Centralized Consent Unit and ERC staff may deny consent to the administration of psychotropic medications, whether the medications are among those listed in the Guidelines for the Utilization of Psychotropic Medications for Children in Foster Care and the DCFS Psychotropic Medications List or have been approved by the psychiatric consultant. However, Centralized Consent Unit and ERC staff may only deny consent after consulting both the licensed prescriber and the Department's psychiatric consultant. The Guidelines for the Utilization of Psychotropic Medications for Children in Foster Care and the DCFS Psychotropic

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Medications List shall contain a statement setting forth this authority. In the event of a denial of a medication request, the specific reasons for the denial shall be set forth on the Psychotropic Medication Consent Form.

- i) Whenever a licensed prescriber recommends the administration of one or more psychotropic medications to a child for whom the Department is legally responsible, the child shall be advised of the purposes and effects of the medication and of the potential side effects of the medication to the extent that such advice is consistent with the nature and frequency of the side effects and the child's ability to understand the information communicated. The child shall also be provided written information concerning the medication and its side effects, unless it has been determined that such information could not be understood by the child. This written information shall be provided in the child's primary language.

(Source: Amended at 36 Ill. Reg., effective February 24, 2012)

Section 325.50 Children in Residential Facilities and/or Psychiatric Hospital Settings

Residential facilities licensed by the Department shall have a written policy, approved by each facility's on-call physician and governing body, for the safe and accurate administration of medications to all children and youth in the facility.

- a) Residential facilities and psychiatric hospitals that provide care to children for whom the Department is legally responsible shall submit a Psychotropic Medication Request Form when requesting consent from Centralized Consent Unit or Emergency Reception Center staff for the administration of psychotropic medications. When consent is granted, the authorized agent shall ensure that a copy of the Psychotropic Medication Consent Form is provided to the child welfare worker and the residential facility or hospital that submitted the request. The residential facility and/or hospital shall place a copy of the Psychotropic Medication Consent Form in the child's case or medical record. For after hours consent requests, authorized agents at the ERC shall send a copy of the Psychotropic Medication Consent Form to the Department's psychiatric consultant.
- b) Prior consent from an authorized agent at the Centralized Consent Unit or ERC is not required when an emergency exists as defined in this Part, or for the administration of a one-time non-emergency medication. However, the Centralized Consent Unit shall be notified in writing of the administration of medication within one week of its initial administration. The Psychotropic Medication Request Form shall be used by the residential facility or psychiatric hospital to report the administration of emergency medication or for the administration of one-time non-emergency medication. When used for notification of the use of a psychotropic medication due to an emergency or a one-

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time non-emergency situation, the Request Form shall be completed by either a registered nurse or a physician who has examined the child and shall contain the information set forth in [Section 325.30\(h\)](#). Additionally, the Request Form shall require a brief explanation of the nature and circumstances for the administration of the emergency medication or for the administration of a one-time non-emergency medication. A copy of the Request Form shall be placed in the child's case record or medical file. Emergency or one-time non-emergency medications may only be administered on a one-time basis. Each administration of an emergency or one-time non-emergency medication requires submission of the Psychotropic Medication Request Form, notifying the Department of the use of the one-time emergency or non-emergency medication.

- c) PRN medications are prohibited under this Part.
- d) The administration of psychotropic medication shall be monitored as follows:
 - 1) The medical director of each residential facility or hospital, or designee who has been licensed in accordance with the provisions of the Nurse Practice Act [225 ILCS 65], shall conduct a monthly review of all psychotropic medications and record that review in writing. This record shall be reviewed during the on-site inspections required by this Part. During this monthly review, the medical director or designee shall conduct an inventory of all psychotropic medications and shall verify that:
 - A) psychotropic medications are labeled with the child's name, directions for administering the medication, the date and licensed prescriber's name, prescription number, and drug store or pharmacy;
 - B) all medications are stored in a locked cabinet or within a locked refrigerator, if required for proper storage;
 - C) all controlled substances are accounted for or, if any amount of a controlled substance is missing, an incident report has been filed with the Director of the facility or hospital;
 - D) psychotropic medications are dispensed in accordance with the requirements of the prescription;
 - E) written consents for administration of psychotropic medications have been received from the parent or guardian, as appropriate;
 - F) any medications for children who have left the facility or hospital or who have been on runaway status 14 days or longer have been properly disposed.

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- 2) The Department shall conduct unannounced on-site reviews at least annually to assure that the approval forms reflect the actual practice in the residential facility or hospital and that the facility/setting is in compliance with this Part. Such reviews shall include an investigation into whether the Psychotropic Medication Approval Forms, whether for notification of emergency administration, one-time non-emergency administration or routine use, accurately reflect those children/youth who have objected to the administration of medication.
- e) The Department shall offer training at least once a year for personnel employed by residential facilities and/or hospitals concerning the content of this Part and the procedures through which psychotropic medication may be authorized. This training shall also encompass medical consultation, consent, general psychiatric admission processes, and review of the Guidelines for the Utilization of Psychotropic Medications for Children in Foster Care and the DCFS Psychotropic Medications List as training resources and informational tools.

(Source: Amended at 36 Ill. Reg., effective February 24, 2012)

Section 325.55 Children in Temporary Living and Independent Living Programs

- a) Temporary Living and Independent Living programs shall have a written policy, approved by each program's on-call physician and governing body, for the safe and accurate administration of medications to all youth in the program.
- b) Youth entering Temporary Living and Independent Living programs should be able to self-administer their medications.
 - 1) If a youth entering a Temporary Living program is unable to self-administer his/her medications, the program staff shall determine whether it is appropriate to support and train the youth to do so, or to deny placement.
 - 2) If a youth entering an Independent Living program is unable to self-administer his/her medications, the program staff shall deny admission.
- c) Each youth age 18 and over entering a Temporary Living or Independent Living program shall be asked to sign a consent authorizing program staff to obtain information from the youth's medical and psychiatric providers. If a youth refuses or is reluctant to sign a consent, the caseworker shall be contacted. The caseworker shall explain to the youth that program staff need this information to help the youth learn to meet his/her medical and mental health needs and provide appropriate consultation review of prescribed psychotropic medication. If a youth over age 18 still refuses to sign a consent, it should be noted in the youth's service plan.

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- d) Centralized Consent Unit and ERC staff shall use the same standards, forms and rules for approving psychotropic medication for youth under 18 years of age in Temporary Living and Independent Living programs as are set forth in [Section 325.40](#).

(Source: Added at 36 Ill. Reg., effective February 24, 2012)

Section 325.60 Children in Foster Care

- a) The Department shall offer training and materials for foster parents and relative caregivers concerning the procedures for approving psychotropic medication, the need for and use of psychotropic medications and possible side effects. This training shall also address circumstances in which the child may self-medicate, where appropriate.
- b) No psychotropic medication shall be administered to any child for whom the Department is legally responsible who resides in foster care unless the licensed prescriber has obtained prior consent for the medication from the Centralized Consent Unit or Emergency Reception Center staff.
- c) The Health Passport, issued by the Department to all children for whom it is legally responsible, shall contain the following statement: "Consent of the DCFS Guardian is required prior to the administration of any psychotropic medication. Consent must be obtained from the Centralized Consent Unit or Emergency Reception Center."
- d) Centralized Consent Unit and ERC staff shall use the same standards, forms and rules for approving psychotropic medication for children in foster care as are set forth above in [Section 325.40](#).
- e) The foster parent shall inform the licensed prescriber that:
 - 1) the child is in foster care;
 - 2) the consent of the Centralized Consent Unit or ERC staff is required before psychotropic medication may be administered to the child; and
 - 3) psychotropic medications may only be administered pursuant to this Part.

(Source: Amended at 36 Ill. Reg., effective February 24, 2012)

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Section 325.70 Miscellaneous Provisions

- a) Youth who have been declared emancipated for the purposes of consent to medical treatment by any court shall have the qualified right to refuse psychotropic medication as provided for adults in Sections 2-107 and 2-107.1 of the Illinois Mental Health and Developmental Disabilities Code [405 ILCS 5/2-107 and 2-107.1] but subject to [Section 325.30\(g\)](#).
- b) Youth for whom the Department is legally responsible who have reached the age of 18 shall have the qualified right to refuse psychotropic medication as provided for adults in Sections 2-107 and 2-107.1 of the Illinois Mental Health and Developmental Disabilities Code [405 ILCS 5/2-107 and 2-107.1] but subject to [Section 325.30\(g\)](#).

(Source: Amended at 36 Ill. Reg., effective February 24, 2012)

Section 325.80 Violations of this Part

- a) Violations by Physicians
 - 1) For psychotropic medications that were started without consent, the Psychotropic Medication Consent Form from the Centralized Consent Unit shall indicate that it is a violation of this Part to prescribe a psychotropic medication to a foster child without the consent of the Guardian.
 - 2) A first warning letter from the Department's Division of Guardian and Advocacy shall be sent to physicians who have received five such notifications. The letter shall inform the physician that it is a violation of this Part to prescribe a psychotropic medication to a foster child without the consent of the Guardian and that any further violations of this Part may result in a complaint being filed with the Illinois Department of Financial and Professional Regulation.
 - 3) A second warning letter from the Division of Guardian and Advocacy shall be sent to any physician who has received an additional five such notifications. The letter shall inform the physician that it is a violation of this Part to prescribe a psychotropic medication to a foster child without the consent of the Guardian and that any further violations of this Part shall result in a complaint being filed with the Illinois Department of Financial and Professional Regulation.

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- 4) A Violation Notification letter from the Division of Guardian and Advocacy shall be sent to any physician who has received an additional such notification. The letter shall inform the physician that the Guardian is lodging a complaint with the Illinois Department of Financial and Professional Regulation. The Guardian shall notify the Illinois Department of Financial and Professional Regulation by certified mail that the physician has repeatedly violated the consent requirement of this Part.
- b) Violations by Group Homes and Residential Treatment Facilities
- 1) For psychotropic medications that were started without consent, the Psychotropic Medication Consent Form from the Centralized Consent Unit shall indicate that it is a violation of this Part to prescribe a psychotropic medication to a foster child without the consent of the Guardian.
 - 2) A first warning letter from the Division of Guardian and Advocacy shall be sent to group homes and residential treatment facilities (institutions) who have received 10 warning letters. The letter shall inform the institution that it is a violation of this Part to prescribe a psychotropic medication to a foster child without the consent of the Guardian and that any further violations of this Part may result in a licensing complaint being filed with the DCFS Division of Monitoring.
 - 3) A second warning letter from the Division of Guardian and Advocacy shall be sent to institutions who have received an additional 10 warning letters. The letter shall inform the institution that it is a violation of this Part to prescribe a psychotropic medication to a foster child without the consent of the Guardian and that any further violations of this Part shall result in a licensing complaint being filed with the Division of Monitoring.
 - 4) A Violation Notification letter from the Division of Guardian and Advocacy shall be sent to any institution that has received an additional notification. The letter shall inform the Director of the institution that the Guardian is lodging a licensing complaint with the Division of Monitoring. The Guardian shall notify the Division of Monitoring that the institution has repeatedly violated the consent requirement of this Part.
- c) Violations by Psychiatric Hospitals or Psychiatric Units
- 1) For psychotropic medications that were started without consent, the Psychotropic Medication Consent Form from the Centralized Consent Unit shall indicate that it is a violation of this Part to prescribe a psychotropic medication to a foster child without the consent of the Guardian.

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- 2) A first warning letter from the Division of Guardian and Advocacy shall be sent to psychiatric hospitals or psychiatric units (hospitals) who have received 10 warning letters. The letter shall inform the hospital that it is a violation of this Part to prescribe a psychotropic medication to a foster child without the consent of the Guardian and that any further violations of this Part may result in a licensing complaint being filed with the Illinois Department of Public Health.
 - 3) A second warning letter from the Division of Guardian and Advocacy shall be sent to hospitals who have received an additional 10 warning letters. The letter shall inform the hospital that it is a violation of this Part to prescribe a psychotropic medication to a foster child without the consent of the Guardian and that any further violations of this Part shall result in a licensing complaint being filed with the Illinois Department of Public Health.
 - 4) A Violation Notification letter from the Division of Guardian and Advocacy shall be sent to any hospital that has received an additional notification. The letter shall inform the Director of the hospital that the Guardian is lodging a complaint with the Illinois Department of Public Health as a licensing violation. The Guardian shall notify the Illinois Department of Public Health by certified mail that the hospital has repeatedly violated the consent requirement of this Part.
- d) Notice to Guardian ad Litem

The Guardian shall notify *the guardian ad litem appointed pursuant to Section 2-17 of the Juvenile Court Act of 1987 [705 ILCS 405/2.17] of a ward who has been administered a psychotropic medication in violation of this Part when the guardian ad litem has requested notification and provides the Department with documentation verifying that, pursuant to the Mental Health and Developmental Disabilities Confidentiality Act, the court has entered an order granting the guardian ad litem authority to receive and review this information or with a properly executed consent. [20 ILCS 535/10(e)]*

(Source: Added at 36 Ill. Reg., effective February 24, 2012)

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Section 325.APPENDIX A Guidelines for the Utilization of Psychotropic Medications for Children in Foster Care

Introduction

With few exceptions, children and youth in State custody have experienced abuse and/or neglect and often have chaotic caretaking histories with disrupted attachments and multiple placements. Additionally, they may be genetically predisposed to mental illness and may have been exposed in utero to substances of abuse. Not surprisingly, children in foster care are at higher risk for developing emotional and behavioral disturbances and mental illness, utilize mental health services at higher rates, and are more likely to receive psychotropic medications than youth from comparable backgrounds.

The utilization of psychotropic medications, defined as drugs used to affect psychological functioning, perception, behavior or mood, for the treatment of children and youth in foster care with severe emotional and behavioral disturbances, has increased dramatically over recent years. The increased utilization of psychotropic medications is paralleled by an equally dramatic increase in the rate of polypharmacy, the co-administration of two or more psychotropic medications. Data on the safety and efficacy of many of the psychotropic medications used in children and youth and research supporting the practice of polypharmacy in this population is limited.

As a result of the increased use of psychotropic medications in children and youth, several highly publicized cases of seemingly inappropriate prescribing, and the recent FDA warnings on the psychostimulants (such as Adderall, Ritalin and Concerta) and the SSRIs (e.g., Prozac, Zoloft, Celexa, Lexapro and Luvox), the treatment of children and youth in State custody with psychotropic medications has come under intense scrutiny from the press, child advocacy groups, and State and federal regulatory agencies.

The provision of psychiatric care for children and youth in the child welfare system faces several hurdles. Not uncommonly, children in foster care are treated in multiple settings, including psychiatric hospitals, residential treatment centers, juvenile detention facilities, outpatient clinics and therapeutic day schools. Communication between providers in each of the settings is often quite poor resulting in fragmented psychiatric care. Additionally, the dependable, ongoing therapeutic and caregiving relationships these children desperately need are hampered by the high turnover among child welfare caseworkers and child care providers. Furthermore, unlike mentally ill children from intact families, often no consistent interested party is available to coordinate treatment planning and clinical care, provide informed consent for treatment, or provide longitudinal oversight of a foster child's treatment.

By law, the Illinois Department of Children and Family Services (DCFS) is responsible for consenting to the medical, surgical and psychiatric care for children and youth in its custody. To meet these guardianship responsibilities, DCFS established the Centralized Psychotropic Medication Consent Program in the Office of the Guardian to provide consent for the prescription of psychotropic medications. To support the consent process, DCFS has contracted

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with the University of Illinois at Chicago to provide an independent review of all consent requests from clinicians to prescribe psychotropic medications for children in its care.

In June 2006, DCFS convened an Expert Panel to provide consultation to the Department to establish a set of treatment guidelines for these children and youth. It was the consensus of the participants in the Expert Panel that children in the child welfare system present with such complicated clinical pictures that the formation of rigid treatment algorithms that clinicians must rigidly adhere to is unrealistic. Instead, the Expert Panel recommended principles to guide prescriptive practices. The guidelines that follow serve to inform the practice of pediatric psychopharmacology in this population and to provide a framework to assure the provision of quality psychiatric services to DCFS wards. These guidelines are not meant to supersede clinical judgment.

Guidelines

1. **This Part requires that written consent from the DCFS Guardian must be obtained prior to prescribing a psychotropic medication to a child or youth under 18 years of age.** In addition the child should give informed assent prior to starting the medication. In order to be effective, informed assent should be based on an honest discussion of risks versus benefits and potential side effects of the proposed treatment, availability of alternative treatments, prognosis with and without the proposed medication treatment, and potential for drug interactions. The treating clinician should document this discussion in the patient's medical record.
2. **The prescription of psychotropic medications is just one component of a comprehensive treatment plan that includes psychosocial and behavioral interventions.** Psychotropic medications are not to be used in place of psychosocial or behavioral interventions that the child or youth requires. Furthermore, 89 Ill. Adm. Code 384 (Behavioral Treatment in Residential Child Care Facilities) specifically prohibits the use of psychotropic medications for chemical restraint. Chemical restraint is defined as the use of any psychoactive medication that is not a part of the patient's treatment plan during a behavioral crisis or psychiatric emergency that results in the sedation of the child for the express purpose of restricting an individual's freedom of movement.
3. **All children and youth must receive a diagnostic assessment prior to starting a psychotropic medication.** A diagnostic assessment should include, at minimum:
 - a. history of the present illness;
 - b. past psychiatric history, including medication history;
 - c. medical and surgical history;
 - d. allergies;

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- e. current medications;
- f. family history (when available and relevant);
- g. mental status examination;
- h. DSM-IV¹ diagnosis; and
- i. treatment plan.

In addition, a physical examination should be done. Baseline laboratory studies and/or an EKG should be obtained if medically indicated and in accordance with accepted standards of care and in congruence with the prescribing clinician's medical judgment.

4. **It is strongly recommended that the prescribing clinician communicate with other clinicians involved in the child's care, particularly other prescribers. The clinician must document that attempt in the medical record.** The purpose of this recommendation is to obtain collateral information to enhance continuity of care and to facilitate the monitoring of the outcome of the medication trial. This communication is particularly important in the treatment of wards hospitalized on a psychiatric unit. According to the Illinois Department of Healthcare and Family Services, 50% of all medications prescribed to patients discharged from State operated psychiatric facilities are discontinued and alternative medications initiated within 2 weeks after discharge. Communication among prescribers is also important when a ward moves from one treatment setting to another (i.e., a lateral move from one residential treatment facility to another) or from one level of care to another (e.g., discharge from a psychiatric hospital back to a foster home). Treatment summaries from the treating clinician should follow the patient detailing the treatment course with particular emphasis on results of psychotropic medication trials.
5. **Prescription of a psychotropic medication should be based on research showing it to be safe and effective for the disorder being treated. Medications that have been approved by the Federal Drug Administration (FDA) for the treatment of a specific disorder in children or youth meet this requirement by definition and should be used preferentially over non-FDA approved medications when they are available.** Exceptions can be made when a patient has had a history of a successful trial of an off-label medication, if a first degree relative has responded to the medication being requested, if the patient is allergic to the FDA approved medication, or if the patient is on other medications that react unfavorably with the preferred medication. Few medications used to treat psychiatric disorders in children and youth are approved by the FDA for use in this age group; however, off-label use of drugs by prescribers is not only legal, but may represent the standard of care. Prescribers have the responsibility to be well informed about the product, to base its off-label use on firm scientific rationale and sound medical evidence, and to maintain records of the product's use and effects. If data

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supporting the use of the medication in children and youth are not available, data can be extrapolated from the adult literature, though caution is advised.

6. **Medications prescribed should be appropriate to the patient's diagnosis and target symptoms and must be part of the treatment plan.** For patients in whom the diagnosis is not clear or there is no appropriate DSM-IV diagnosis, the decision to prescribe a psychotropic medication may be based on the presence of target symptoms that are likely to be responsive to psychotropic medications.

7. **Existing medication algorithms should be consulted when making the decision about which medication to use for a specific disorder.** Algorithms designed for use by the consultants to the DCFS Centralized Psychotropic Medications Consent Line are based on the Children's Medication Algorithm Project (ADHD and depression), the American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameter for the Assessment and Treatment of Children and Adolescents with Bipolar Disorder, and various AACAP Practice Parameters all available from the American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue, NW, Washington DC 20016-3007, (202)966-7300 or AACAP's website at <http://www.aacap.org> and the American Academy of Pediatrics Attention Deficit Hyperactivity Disorder diagnostic guidelines available from the American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village IL 60007-1098, (847)434-4000 or AAP's website at <http://www.aap.org>.

8. **The decision to utilize polypharmacy (more than one psychotropic medication) or copharmacy (more than one psychotropic medication in the same medication class) should be based on a solid clinical rationale and accepted medical practice.** Research supports the use of polypharmacy in the treatment of certain co-morbid conditions, for augmentation for partial responders, for treating the adverse effects of other psychotropic medications, and for treating multiple symptoms of a single disorder. The following guidelines should be followed when considering polypharmacy or copharmacy:
 - a. Unless otherwise indicated in published treatment algorithms for children and youth, monotherapeutic options should be exhausted before considering polypharmacy or copharmacy.
 - b. When polypharmacy is necessary, the fewest medications should be used as possible.
 - c. Clinicians should be ready to support their use of polypharmacy or copharmacy should DCFS request a review of the case.
 - d. The concurrent use of slow-release and immediate-release formulations of the same chemical (e.g., Concerta and methylphenidate) is not considered to be polypharmacy or copharmacy.

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- e. To the extent possible, medications should be started and titrated one at a time. Copharmacy with antipsychotic medications has little evidence to support its use in adults and no quality data to support that practice in children and youth. All requests for concurrent pharmacotherapy with two or more antipsychotic medications will be closely scrutinized.
9. **The prescription of psychotropic medications should be accompanied by education for the patient, his or her foster family or treatment team, and (when indicated) his or her family of origin.** The nature of the diagnosis, the prognosis, and the risks and benefits of treatment, as well as non-treatment, and alternative treatment options should be discussed in detail.
10. **Pharmacotherapy with psychotropic medications must be monitored closely. The frequency of visits depends on the phase of treatment.**
- a. Initiation phase – the initiation phase of treatment warrants frequent visits, weekly for some treatments, to monitor early treatment emergent side effects, the development of suicidal ideation in patients treated with antidepressant medications, and the effectiveness of treatment. Clinicians should not implement treatment with psychotropic medications that cannot be monitored closely.
 - b. Acute treatment phase – this phase is defined as the period of time between initiation of treatment and remission of symptoms and is characterized by frequent visits. The duration of the acute duration phase of treatment is variable.
 - c. Continuation phase – once the symptoms have remitted, treatment continues to prevent relapse. This phase of treatment lasts between four and six months and is characterized by regular visits.
 - d. Maintenance phase – treatment after the continuation phase is for the prevention of recurrence of the underlying disorder. Not all pharmacotherapy requires maintenance treatment. For example, successful treatment of a single episode of depression in a child does not require maintenance treatment. In contrast, treatment of ADHD with stimulants often requires a long maintenance phase. Visits during the maintenance phase can be less frequent. Depending on the stability of the patient, visits could be as infrequent as two to three times per year.
 - e. Discontinuation phase – the prescribing clinician should consider discontinuation of the psychotropic medications when the patient has recovered from the underlying episode and is no longer at risk for relapse. Medication discontinuation requires a separate treatment plan with increased frequency of visits to monitor for signs of relapse. Medications should be tapered slowly to prevent withdrawal effects.

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11. **Response to treatment should be monitored through the use of standardized symptom severity scales and instruments to measure treatment emergent side effects.** Follow-up may also include height, weight, abdominal girth, blood pressure, pulse, CBC with differential, thyroid function studies, lipid profile panels, liver function tests, EKGs and drug levels as indicated by the patient's medication regimen.
12. **In order to be effective, medication trials must be adequate in terms of dosage and duration.** A medication may be falsely characterized as ineffective if the trial is inadequate. Inadequate medication trials frequently occur due to changes in treatment setting. For example, admission to and discharge from an inpatient unit is often accompanied by a change in medication, often before an adequate trial has been completed. When available, blood levels of medications should be followed to assure an adequate dosage. At times the dose of a medication needed to maintain a therapeutic blood level may exceed the maximum recommended dosage for that medication. In those cases, the blood levels, not the dosage, should inform treatment.
13. **If a child does not respond to the medication trial despite adequate dosage and duration, the prescribing clinician should assess patient compliance, reassess the diagnosis, rule-out the presence of co-morbid conditions, including substance abuse and general medical disorders, and evaluate the influence of psychosocial stressors.**
14. **DCFS specifically prohibits the use of pro re nata (PRN) medications.** Prior consent for the one-time administration of a psychotropic medication is not necessary when an emergency exists. However, all administration of emergency medications must be reported to DCFS.

Case Review

The following situations will trigger a closer review of a patient's care and possible denial of psychotropic medication requests:

1. Four or more psychotropic medications prescribed concomitantly (three or more for children six years of age or younger).
2. Prescription of psychotropic medications, with the exception of stimulants, for children under the age of four.
3. The concomitant prescription of:
 - a. two or more antidepressants²;
 - b. two or more antipsychotic medications;
 - c. two or more stimulant medications³; or

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- d. three or more mood stabilizer medications.
- 4. Frequent changes of psychotropic medications without a clear rationale, such as adjusting medication dosages or in response to treatment emergent side effects.
- 5. The requested psychotropic medication is not consistent with the patient's diagnosis or the patient's target symptoms.
- 6. Polypharmacy is utilized before exhausting monotherapeutic options.
- 7. The psychotropic medication dose exceeds usually recommended doses for weight and age.
- 8. The prescription of psychostimulants to an actively psychotic child.
- 9. Children for whom emergency medications are used more than twice a day for three or more consecutive days.

End Notes:

- 1 "DSM-IV" means the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association, 1400 K Street NW, Washington DC 20005 (1994)) or most current edition.
- 2 The prescription of trazodone or mirtazepine as a sleep aid in addition to another antidepressant does not constitute concomitant prescribing.
- 3 The prescription of a long-acting stimulant and an immediate release stimulant of the same chemical entity (e.g., Concerta and methylphenidate) does not constitute concomitant prescribing.

(Source: Added at 36 Ill. Reg., effective February 24, 2012)

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Section 325.APPENDIX B DCFS Psychotropic Medications List

The DCFS Psychotropic Medications List identifies all psychotropic medications, including medications used to treat sleep problems, bedwetting and medication-induced adverse effects that may be prescribed for children in DCFS custody or guardianship; their FDA indications; contraindications; the acceptable range of dosages; and monitoring requirements, if any. The DCFS Psychotropic Medication List is compiled by the University of Illinois Chicago (UIC) Department of Psychiatry, 1747 W. Roosevelt Rd., Chicago IL 60608, (312)996-7723 (2011).

The DCFS Psychotropic Medications List is available on the DCFS website (www.state.il.us/dafs) and the UIC Department of Psychiatry website (http://www.psych.uic.edu/csp/DCFS_Psychotropic_Medication.pdf).

(Source: Added at 36 Ill. Reg., effective February 24, 2012)

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