

TITLE 89: SOCIAL SERVICES
CHAPTER III: DEPARTMENT OF CHILDREN AND FAMILY SERVICES
SUBCHAPTER d: LICENSING ADMINISTRATION

PART 384

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

Section

384.5	Behavior Management Techniques (Repealed)
384.10	Purpose
384.20	Definitions
384.30	Agency Behavior Treatment Plans in Child Care Facilities
384.40	Limitations of Discipline (Repealed)
384.45	Behavior Intervention Requirements for the Use of Discipline
384.50	Behavior Management Requirements for the Use of Manual Restraints
384.60	Behavior Management Requirements for the Use of Mechanical and Medical Restraints
384.70	Behavior Management Requirements for the Use of Seclusion
384.80	Self-Governance Programs
384.90	Reports
384.100	Secure Residential Care (Repealed)
384.110	Severability of this Part
Appendix A	Matrix of Behavior Treatment Techniques

AUTHORITY: Implementing and authorized by the Child Care Act of 1969 [225 ILCS 10].

SOURCE: Adopted and codified at 6 Ill. Reg. 13713, effective November 15, 1982; emergency amendments at 18 Ill. Reg. 8474, effective May 20, 1994, for a maximum of 150 days; emergency expired October 17, 1994; amended at 19 Ill. Reg. 8165, effective June 9, 1995; amended at 26 Ill. Reg. effective March 15, 2002.

Section 384.10 Purpose

- a) The purpose of this Part is to explain acceptable behavior treatment techniques and to assure that these techniques are used only under controlled conditions by appropriately trained personnel. This Part will also identify limitations and restrictions on specific behavior treatment techniques related to crisis prevention, behavior intervention, and behavior management.

- b) This Part applies only to the following types of facilities licensed by the Department of Children and Family Services: secure child care facilities, child care institutions, group homes, and youth emergency shelters (as restricted by 89 Ill. Adm. Code 410, Licensing Standards for Youth Emergency Shelters). No other facility licensed by the Department is authorized to use manual restraint or seclusion.

(Source: Amended at 26 Ill. Reg., effective March 15, 2002)

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

Section 384.20 Definitions

"Agency Behavior Treatment Plan" means a child care facility document that outlines to the Department all behavior treatment procedures that may be employed at the facility. The plan shall include:

- Behavioral Treatment Purpose Statement: This statement shall stipulate the agency's rationale for using behavioral treatment techniques and the appropriateness and rationale for use with the populations served, as well as its intended forms (i.e., crisis prevention, behavior interventions, and/or behavior management).
- Definitions Section: This section shall identify the facility-specific definitions for all forms of behavior treatment and related procedures/protocols used by the facility.
- Behavior Treatment Restrictions: This section shall detail the behavior treatment procedures that are prohibited by the facility.
- Behavior Treatment Components: This section shall identify one of the five models of crisis intervention and behavior management currently allowable under this section and provide an outline of each specific method of crisis prevention, behavior intervention, and behavior management to be employed at the agency. A designee of the Director must independently review and recommend any model of crisis intervention and behavior management not outlined in this section for approval by the Director before it can be employed at any facility. This section shall also include an agency's specific response to situations in which a behavior management intervention intentionally or unintentionally results in either the child and/or the staff being prone on any surface. For each identified treatment procedure, the outline shall include: the ultimate purpose, clinical criteria/determination process, general operational details, general overview of the quality assurance and improvement mechanisms, emergency procedures, employment and training criteria, and family/guardian and child's attorney notification procedures.
- Appendices: Appendices may be included, as necessary, to describe the behavior treatment techniques used by the facility.

"Approved crisis intervention and prevention procedures and models" are those procedures and models approved by the Department of Children and Family Services and the governing body of the child care facility. (The approved models under this Part are listed in [Appendix A](#).) The procedures are taught as part of mandatory training expressly for use in responding to emergency situations when a child presents dangerous behavior that could not have been anticipated, or the procedures specified in the child's current individual treatment plan would not successfully control the imminently dangerous behavior.

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

"Behavior intervention techniques" refers to the systematic application of the methods designed to influence the behavior of one or more individuals through behavioral techniques (e.g., token economies and point systems) that have been approved in compliance with the requirements set forth in [Section 384.30](#).

"Behavior management techniques" are techniques that prevent or limit an individual's ability to initiate or continue presenting some specific dangerous behaviors. Behavior management techniques include manual restraint, seclusion, and other restrictive procedures approved in compliance with the requirements of [Section 384.30](#). Examples of this type of procedure include, but are not limited to, the re-direction of a child and/or manual restraint.

"Behavior Treatment Committee" means a professional review or behavior treatment review committee formed by one or more child care facilities and composed of persons with technical expertise in the use of crisis prevention, and behavior management techniques. At least one member of the committee must be a person who is not an owner, employee, principal shareholder owning at least 5% of the stock of the corporation or member of the governing body of any of the participating child care facilities. This committee fulfills a quality assurance function and reviews for technical acceptability the use of a facility's applicable behavior treatment procedures that have been outlined in the facility's Behavior Treatment Plan. This would include a retrospective examination of at least 13% of all interventions, or 25% of all interventions in the case of programs with fewer than 25 total residents, and all grievances submitted concerning the use of restrictive intervention to determine whether there is a clinical basis for the use of the procedure, whether a procedure of this level is warranted, and what is the standard of best clinical practice. The committee shall meet at least once per quarter, and written documentation (i.e., minutes) of all meetings shall be maintained. A quality assurance/quality improvement committee may function as the Behavior Treatment Committee when the committee membership meets the requirements of this definition.

"Chemical restraint", a prohibited practice by this Part, means the use of any psychoactive medication that is not a part of a medical diagnostic or treatment procedure for the express purpose of restricting an individual's freedom of movement that is used during a behavioral crisis or behavioral emergency and results in the sedation of the child.

"Child for whom the Department is legally responsible" means a child for whom the Department has temporary protective custody, custody or guardianship via court order, or a child whose parents have signed an adoptive surrender or voluntary placement agreement with the Department.

"Child care facility" or "facility", as used in this Part, means a child care institution, group home, youth emergency shelter (as restricted by 89 Ill. Adm. Code 410, Licensing Standards for Youth Emergency Shelters), secure child care facilities or any other facility approved by the Department to use manual restraint or seclusion.

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

"Child care supervisor" means a person who supervises those persons whose primary responsibility is daily care of children, known as child care staff, and who are qualified in accordance with 89 Ill. Adm. Code 404.13.

"Child welfare supervisor" means a person with a Masters of Social Work degree from an accredited school of social work or an equivalent Masters degree in a human services field and two years of full time supervised experience in a social work setting. At least one child welfare supervisor in a facility shall have at least two years of experience as a supervisor.

"Dangerous behavior" means behavior that is likely to result or has resulted in harm to self or others, if not immediately contained.

"Department" means the Illinois Department of Children and Family Services. (Section 2.02 of the Child Care Act of 1969 [225 ILCS 10/2.02])

"Developmental disability" means a disability that is attributable to mental retardation, cerebral palsy, epilepsy or autism; or any other condition that results in impairment similar to that caused by mental retardation and that requires services similar to those required by mentally retarded persons. Such disability must originate before the age of 18 years, be expected to continue indefinitely, and constitute a substantial handicap.

"Director" means the Director of the Department of Children and Family Services.

"Discipline" means providing specific consequences for infractions of the rules of a child care facility as a means of helping children both to develop self-control and to learn they are responsible for their actions. For purposes of this Part, discipline is a behavior intervention technique.

"Extended restriction" means periods of touching or holding by direct person-to-person contact for a period of less than five minutes. Physical restriction shall not constitute manual restraint if it is accomplished with minimum force and is used to prevent a child from completing an act that is likely to result in harm to self or others or to escort a child to a quieter environment. Extended restriction must be documented in the child's record, i.e., in progress notes.

"Human Rights Committee" means a group of three or more persons that includes an attorney, or access to an attorney, who understands mental health law. At least one member of the Human Rights Committee shall not be an owner, employee, principal shareholder owning at least 5% of the stock of the corporation, or member of the governing body of any of the participating child care facilities. Human Rights Committees may be formed by one or more child care facilities. Human Rights Committees are charged with assuring that children's rights are protected. The Committee is responsible for reviewing procedures and practices for intrusive or restrictive behavior interventions that are expressed in the child care facility's Behavior Management Plan. The committee assures that the facility's procedures assure, among other things,

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

that processes and practices address informed consent, due process and grievances, least restrictive practices, and appropriateness of fit to the population served and that they broadly reflect community standards for conduct. The Committee also recommends acceptance of the facility's practices to the Chief Executive Officer for referral to the governing body for approval. The Human Rights Committee must meet at least annually.

"Individual treatment plan" means the current intervention and treatment program for a specific child that has been prepared by an interdisciplinary team that may include, but is not limited to, the child, DCFS caseworker, private agency/institution caseworker, therapist or psychiatrist, foster parents and parents, as clinically and legally appropriate.

"Manual restraint" means a behavior management technique involving the use of physical contact or force, characterized by measures such as arm or body holds, subject to the provisions of [Section 384.50](#).

"Mechanical restraint", as used in this Part, means any device (including but not limited to straight jacket, arm/leg restraints, and four-point restraints), other than personal physical force, used to directly restrict the limbs, head or body of a person. The term does not include medical restraint. Mechanical restraint may not be used in facilities licensed by the Department of Children and Family Services, except as allowable under 89 Ill. Adm. Code 411 (Licensing Standards for Secure Child Care Facilities).

"Medical restraint" means a process used for the partial or total immobilization of a person for the purpose of performing or maintaining a medical/surgical procedure under the supervision of a licensed physician or registered nurse or as a physician-ordered treatment for self-injurious behavior.

"Mental health professional (MHP)" means a person who provides services under the supervision of a qualified mental health professional (QMHP) and who possesses a bachelor's degree in human services, a practical nurse license pursuant to the Illinois Nursing and Advanced Practice Nursing Act [225 ILCS 65], or who has a minimum of five years supervised experience in mental health or human services. The mental health professional responsible for making clinical decisions regarding the use of manual restraint, seclusion, or other restrictive behavior management techniques shall have completed at least 15 clock hours of training in the application of the specific behavior management techniques used by the facility.

"Physician" means a person licensed in the State of Illinois to practice medicine in all of its branches.

"Qualified mental health professional (QMHP)" means one of the following as defined in 59 Ill. Adm. Code 132.25 (Medicaid Community Mental Health Services Program): licensed physician, psychiatrist, psychologist, social worker possessing a master's or doctoral degree in social work, registered nurse with at least one year of clinical experience in a mental health setting or who possesses

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

a master's degree in psychiatric nursing, an occupational therapist with at least one year of clinical experience in a mental health setting, an individual with a master's degree and at least one year of clinical experience in mental health services and who is licensed to practice marriage and family therapy, or an individual possessing a master's or doctoral degree in counseling and guidance, rehabilitation counseling, social work, vocational counseling, psychology, pastoral counseling, or family therapy or related field, who has successfully completed a practicum and/or internship which includes a minimum of 1,000 hours, or who has one year of clinical experience under the supervision of a QMHP, or who is a licensed social worker holding a master's degree with two years of experience in mental health services or who is a permanently licensed professional counselor under Professional Counselor and Clinical professional Counselor Licensing Act [225 ILCS 107] holding a master's degree with one year of experience in mental health services.

"SASS" means Screening, Assessment and Support Services, and the services are provided by agencies under contract with the Department of Children and Family Services or the Illinois Department of Human Services.

"Seclusion" means the contingent withdrawal of reinforcing stimuli by removing the child from an area to a specifically designated room from which egress is restricted.

This procedure is considered a behavior management technique and as such must be used only as a therapeutic response to dangerous behavior. There are two forms of seclusion:

- Staff-assisted seclusion means the room is secured by a locking mechanism that engages only when a key, button, or handle is being held by a staff member. When that staff member takes his or her hand off the device, the door unlocks and the child is able to easily and readily open the door from the inside. The door to such a room may not/does not remain locked when unattended.
- Key-locked seclusion means the seclusion room has a locking device that remains engaged without staff presence. Key-locked seclusion is prohibited under this Part

"Self-governance program" means an organized program that allows peers to participate in the discipline or behavior management of peers under the supervision and control of staff. Effective April 1, 2006, peers shall be prohibited from participating in the manual restraint of another child. Self-governance programs shall be restricted to programs identified and recognized by the Illinois Association of Peer Treatment Agencies and the Department of Children and Family Services as using a positive peer group treatment model.

"Time-out" means a specific behavior intervention technique of short duration used to assist a child in regaining self-control that may be authorized by any facility staff person for a maximum of ten minutes beyond the time when the child regains self-control, if included in the agency's Behavior Treatment Plan submitted to the governing body and the Department and approved in

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

accordance with the requirements of this Part. Staff are required to document in writing each incident of time-out that exceeds 10 minutes. Any series of three or more Exclusionary Timeouts during a facility's standard work shift must be reviewed by the Child Care Supervisor within 24 hours. There are two types of time-out permitted by this Part.

- Non-exclusionary or Instructional Time-out: A procedure involving the contingent withdrawal of reinforcing stimuli, while the child remains in the area (e.g., child is seated away from the group, but in the same area).
- Exclusionary Time-out: A procedure involving the contingent withdrawal of reinforcing stimuli by removing the child from the area (e.g., to the hallway or bedroom that does not involve a locked or restricted exit). A seclusion room may be used as a time-out room only if egress from the room remains unrestricted through closure or by staff and a child is appropriately supervised.

(Source: Amended at 26 Ill. Reg., effective March 15, 2002)

Section 384.30 Agency Behavior Treatment Plans in Child Care Facilities

Each child care facility that accepts children for whom the Department of Children and Family Services is legally responsible shall develop an Agency Behavior Treatment Plan that describes the facility's programming. In addition, each child for whom the Department is legally responsible shall have an individual treatment plan that identifies those specific components of the overall Behavior Treatment Plan that will be applied to that child and the specific behaviors the individual treatment plan is intended to address. All plans submitted to the Department shall be written to assure that the facility will use behavior treatment techniques in a safe, humane manner that fosters a child's self-discipline.

- a) Licensed child care facilities or their supervising agency shall develop an Agency Behavior Treatment Plan describing the behavior treatment techniques, as defined in [Section 384.20](#), to be used by the facility. This plan shall include a detailed description of:
 - 1) each of the facility's approved crisis prevention/intervention procedures as defined in [Section 384.20](#);
 - 2) each of the facility's approved specific behavior intervention techniques as defined in [Section 384.20](#); and
 - 3) each of the facility's approved behavior management techniques, as defined in [Section 384.20](#), to control actions that present a danger to self or others.
- b) The Agency Behavior Treatment Plan shall be approved by the governing body of the facility and the Department (the guardian or authorized agents of the guardian). The specific requirements for the plan are set forth in subsections (c) through (e). Licensed child care facilities shall submit their written Agency

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

Behavior Treatment Plans to the Department (through their licensing representative) for approval by October 1, 2002. Agency Behavior Treatment Plans shall not be implemented until approval by the Department has been obtained. At the Director's designation and appointment, individuals familiar with acceptable practices of crisis intervention and behavior management shall review with appropriate Department licensing staff the Agency Behavior Treatment Plan. The Department shall respond in writing within 14 days after receipt of the written plan with regard to approval, denial or request for amendment of the new plan.

- c) The Agency Behavior Treatment Plan shall contain the following general components:
 - 1) a written statement of the ultimate purpose in employing any treatment procedure;
 - 2) a detailed description of the full range of treatment procedures or combination of procedures employed, including the operational details of the treatments themselves;
 - 3) a detailed description of the agency's ongoing system for collecting and reviewing monthly aggregate data that reflect the use of restrictive treatment elements, including the number of applications of seclusion and/or manual restraint, the number of individuals whose behavior resulted in seclusion and/or manual restraint, the names of staff members who participated in each instance of seclusion or restraint, the range and average length of seclusion and/or manual restraint, and unusual incidents and injuries;
 - 4) a procedure for handling and reporting behavior emergencies; and
 - 5) procedures for carrying out these provisions consistent with the needs of disabled individuals.

- d) The Agency Behavior Treatment Plan shall contain the following information regarding personnel:
 - 1) a description of the credentials of the personnel involved in designing, approving, implementing, monitoring and overseeing the implementation of the behavior treatment procedures;
 - 2) a system for required training and assuring the competency (both written and practical) of individuals involved in all facets of behavior treatment, including a plan for ensuring that all nursing staff associated with the agency receive annual training on the potential consequences, complications, and/or physical side effects associated with being physically restrained while taking any medications;

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

- 3) documentation that all personnel who come into contact with children subscribe to a Code of Ethics adopted by the governing body. The agency's or institution's Code of Ethics must be endorsed by or reflect the Codes of Ethics of a professional and reputable organization (i.e., National Association of Social Workers, Association of Public Human Service Agencies, the Department or the DCFS Office of the Inspector General) but it must specifically address an employee's obligations with respect to interventions and contact with children as a child welfare professional;
 - 4) a policy for the discipline and/or discharge of personnel who violate the facility's policies and procedures on the use of behavior treatments;
 - 5) a procedure providing for training and the annual certification of all persons using behavior intervention treatment techniques, including training in the areas of the physiology of respiration, the circulatory system, and the body's response to excitement and stress; and
 - 6) a procedure for ensuring that documentation of all training and retraining in the use of behavior treatment shall be maintained in the personnel files of staff. If the facility operates an organized self-governance program, documentation of all training and retraining of each child authorized to participate in behavior management and discipline shall be maintained in the child's case file.
- e) Agency Behavior Treatment Plans shall contain a quality assurance mechanism that includes:
- 1) a procedure for review of the child's medical record that shall contain explicit documentation by the consulting physician for the facility that there are no medical contraindications to the use of specific behavior treatment techniques. This assessment and documentation must be renewed following any significant change in the child's medical condition.
 - 2) a procedure for review of any determination made by the treatment team at the child's initial case staffing as to whether any of the established behavior treatment procedures would be contraindicated due to psychological or developmental reasons and documentation by the team in the child's permanent record. This review and documentation shall be renewed following any significant change in the child's developmental or psychological condition and at least once per quarter as part of a treatment review.
 - 3) a process for monitoring and reviewing a statistically significant sample of individual treatment plans and restraints, including review by a Human Rights Committee, as defined in [Section 384.20](#);

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

- 4) a process to ensure that members of the Behavior Treatment Committee and the Human Rights Committee have been instructed in the provisions of Part 431 (Confidentiality of Personal Information of Persons Served by the Department of Children and Family Services) and that the members have signed an agreement to abide by the requirements of Part 431;
 - 5) a policy regarding the use of restrictive behavior treatment techniques that identifies instances in which such procedures may be contraindicated;
 - 6) a system where instances of behavior that are dangerous to self or others shall be brought to the attention of appropriately trained personnel for review;
 - 7) a policy that requires that unanticipated occurrences, as in emergency circumstances or repeated instances of the use of potentially restrictive treatments, be brought to the attention of the administrator;
 - 8) a policy for informing the child, referring agencies, parents, and guardians prior to admission concerning the behavior treatment techniques employed by the facility and the procedures for their administration;
 - 9) a procedure for obtaining the informed consent of clients/parents/guardians at intake of the behavior treatment techniques that will be used as indicated by the client's treatment plan, except in cases of an unanticipated behavioral emergency; and
 - 10) a policy providing that the child's parents (unless parental rights have been terminated), guardian, and attorney shall be advised of their right to be notified of each instance of manual restraint or seclusion.
- f) The facility shall establish policies and procedures designed to ensure that individual treatment plans are developed, implemented and reviewed in accordance with current standards of acceptable behavior practice. At a minimum, these policies and procedures shall provide as follows:
- 1) relevant individual client strengths, adaptive and maladaptive behaviors will be defined and quantified for non-emergency circumstances before any program that includes potentially restrictive elements, such as manual restraint and seclusion, is implemented. The quantification of relevant target behaviors or a functional analysis shall be an ongoing and integral part of the pre-treatment, treatment, and post-treatment process;
 - 2) every individual's treatment plan shall include positive reinforcement strategies for adaptive, socially acceptable behavior;

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

- 3) satisfactory evidence that maladaptive behaviors under consideration for treatment are not the result of medical/physical problems that would contraindicate behavior treatment;
 - 4) for any child posing documented medical or clinical risk factors that may be negatively impacted by the use of specific behavior treatment techniques, a licensed physician or registered/licensed nurse must conduct a physical exam of the child during each application of the procedures, with documentation of the examination to be noted in the medical record;
 - 5) not less than quarterly review of potentially restrictive elements included in individual treatment plans with consideration given to decreasing and eventually discontinuing those program elements; and
 - 6) provisions shall be included in individual treatment plans for the maintenance and generalization of adaptive behaviors.
- g) Agency Behavior Treatment Plans shall be reviewed and approved at least every three years by the governing body of the agency and the Department.
 - h) The governing body of the agency and the Department must approve any amendments to the plan before they are implemented.
 - i) Agencies may appeal adverse licensing decisions concerning the approval of their Agency Behavior Treatment Plan pursuant to 89 Ill. Adm. Code 383 (Licensing Enforcement).

(Source: Old Section 384.30 renumbered to Section 384.45; new Section 384.30 renumbered from Section 384.50 and amended at 26 Ill. Reg. effective March 15, 2002)

Section 384.40 Limitations of Discipline (Repealed)

(Source: Repealed at 26 Ill. Reg., effective March 15, 2002)

Section 384.45 Behavior Intervention Requirements for the Use of Discipline

- a) Discipline may only be used to help a child develop self-control and learn to assume responsibility for his or her own actions.
- b) In order to help a child know the rules of a child care facility, each facility shall have simple, understandable rules for both children and staff. The rules shall set the limits of behavior required for the protection of the group. The rules shall be explained orally in the child's primary language or preferred mode of communication and a written copy in the child's primary language or preferred mode of communication shall be given to each child at the time the child is admitted to the facility.

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

- c) Each staff member shall receive training in the rules of the child care facility and shall be given a written copy of the rules prior to starting active service.
- d) With respect to all discipline as described below in subsections (e)(1) through (e)(5):
 - 1) prior to the application of the discipline, the child shall be informed of the rule infraction;
 - 2) prior to application of the discipline, the reasons for, the nature of, and duration of the discipline shall be explained to the child;
 - 3) the case record shall contain documentation of the discipline applied, specifying the conduct of the child leading to the discipline and the nature and duration of the discipline; and
 - 4) the administrator of the facility or designee shall review discipline applied to individual children within 48 hours after administration of the discipline. The reviewer shall not be the individual who imposed the disciplinary measure. The administrator of the facility or designee shall approve or disapprove of the discipline imposed and shall indicate review and approval/disapproval by signing and dating the report of discipline. If the administrator or designee disapproves of the discipline imposed, the administrator or designee shall state the reasons for disapproval and shall correct the use of improper disciplinary techniques.
- e) Acceptable discipline for the purpose of this Section includes:
 - 1) assigning special or additional tasks for periods not to exceed one month;
 - 2) temporary removal of privileges (e.g., electronic entertaining equipment, special activity outside the facility) for periods not to exceed one month;
 - 3) withholding a child's personal spending money under the following circumstances:
 - A) for reasonable restitution for damages done by the child; or
 - B) for breaking the rules after the child had been given an oral warning that his/her spending money will be reduced for the infraction. Spending money may not be withheld for more than one month as discipline for a rules infraction.

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

- i) When a child's spending money has been withheld because he or she has broken a rule, the caregiver shall give the child opportunities to earn the money back and shall explain to the child how the money can be earned back. The facility shall keep complete records of all spending money that was withheld and any payments to the child.
 - ii) If a child fails to earn back the spending money before his or her discharge from the facility, the withheld spending money must be given to the child's parent or guardian;
- 4) restriction to the child's sleeping quarters or room under reasonable supervision (as defined by the individual treatment plan) for periods not to exceed three hours per day; or
- 5) restriction to the premises or specified areas of the premises for periods not to exceed three days.
- f) No child shall be subjected to discipline that is out of proportion to the particular inappropriate behavior, nor shall a child be subjected to discipline that is initiated more than 24 hours after facility staff learn of the inappropriate behavior.
- g) No child shall be subjected to discipline by the child's peers except as part of an organized self-governance program approved through [Section 384.80](#).
- h) No child shall be subjected to discipline because of the misbehavior of another member of the group unless discipline of the group is part of an approved self-governance program under [Section 384.80](#).
- i) No child shall be subjected to verbal abuse, threats, or derogatory remarks about him/her or his/her family under any circumstances.
- j) No child shall be subjected to corporal punishment under any circumstances.
- k) No child shall be deprived of food (e.g., a meal, a part of a meal, a snack) as discipline.
- l) No child shall be deprived of visits or weekly telephone contacts with family, attorneys or their legal assistants, assigned caseworkers or other persons who have established a parenting bond unless otherwise indicated for clinical or safety reasons (as documented in the record by way of guardian signature).
- m) No child shall be deprived of clothing as discipline unless otherwise indicated for clinical or safety reasons.
- n) No child shall be deprived of sleep as discipline.

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

- o) No child shall be deprived of items necessary for personal hygiene (e.g., toothpaste, toothbrush, soap, comb, etc.) as discipline.
- p) No child shall be deprived of an opportunity for a daily shower or bath, access to toilet and water fountain as discipline.
- q) No child shall be subjected to unclean and unsanitary living conditions as discipline.
- r) No child shall be deprived of health care, including counseling, as discipline.
- s) No child shall be deprived of exercise, assigned exercise, forced to take an uncomfortable position, or assigned strenuous or harsh work, including work that is beyond the physical, mental, or emotional capacity of the child.
- t) No child shall be deprived of a right to receive and send uncensored mail as discipline. However, if a child care facility suspects that a child is sending or receiving contraband materials (e.g., drugs, weapons) via the mail, the child may be required to open the mail in the presence of staff so the contents may be examined for contraband. Where a clinical determination is made that a child could be emotionally harmed by the receipt of inappropriate mail or e-mail from a certain person or persons, and the reasons for the determination are clearly documented, the agency has the authority to intercept particular mailings.
- u) No child shall be deprived of an opportunity to attend religious services and/or religious counseling of his/her choice as discipline.
- v) No child shall be disciplined for toilet accidents.
- w) No child shall be subjected to behavior management procedures (e.g., restraint, seclusion, etc.) as discipline.
- x) No child shall be deprived of educational services as discipline.
- y) In addition to all other prescribed discipline as set forth in this Part, no child shall be subjected to cruel or unusual punishment under any circumstances.

(Source: Section 384.45 renumbered from Section 384.30 and amended at 26 Ill. Reg., effective March 15, 2002)

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

Section 384.50 Behavior Management Requirements for the Use of Manual Restraints

Each application of manual restraint may be used only as a therapeutic measure when a child presents a threat of physical harm to self or others. Such threat shall include any dangerous behavior reasonably expected to lead to physical harm to self or others. Manual restraint shall not be used until after other less restrictive procedures or measures have been explored and found to be inappropriate. Manual restraint shall not be used for a child whose medical condition, mental illness, or developmental or psychological status contraindicates the use of this technique, as documented in the child's individual treatment plan.

- a) Manual restraint may be used to prevent runaway only when the child presents a threat of physical harm to self or others, or as specified in the individual treatment plan.
- b) Manual restraint shall not be used as discipline for rule infractions or as a convenience for staff.
- c) A child may not be restrained for more than 15 minutes beyond the point at which the child ceases presenting the specific behavior for which the restraint was ordered or any other behavior for which restraint is an appropriate intervention, unless specific clinical justification to the contrary is documented in the child's treatment plan.
- d) For every restraint episode that exceeds 30 consecutive minutes, a registered nurse or a licensed physician must be notified and consulted by telephone or in person concerning the restraint. The licensed physician or registered nurse must confirm, in writing, the content of the consultation and document that the restraint does not pose an undue risk to the child's health given the child's physical or medical condition. At the same time, the treatment team must explore alternative treatment strategies, such as an emergency SASS assessment or transporting the child to a hospital or mental health facility.
- e) No child may be restrained for more than two hours within a 24 hour period. However, within the two hours of restraint, there may be no period of continuous restraint that exceeds one hour.
- f) If a child has been in and out of manual restraint for a total of two hours, the treatment team must explore alternative treatment strategies, such as an emergency SASS assessment or transporting the child to a hospital or mental health facility.
- g) Manual restraint shall be administered in such a manner as to avoid provoking further and escalating incidents of the behavior in the child.
- h) Manual restraint shall not consist of, or be accompanied by, the use of mechanical restraints, the use of excessive or unnecessary force, or any other action that produces pain, covers the head or any part of the face, or in any

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

way restricts normal circulation and respiration of the child. Manual restraints that include neck holds or a staff member lying across the torso of a client are prohibited.

- i) When manual restraint is imposed upon any child whose primary mode of communication is sign language, the child shall be permitted to have his or her hands free from restraint for brief periods during the restraint, except when such freedom may result in physical harm to the child or others.
- j) Manual restraint shall be employed only by persons who are certified as having successfully completed a competency based training program presenting the specific procedures to be used. This certification must be renewed through a competency based assessment at least every 12 months. Current certification of competency shall be documented in the individual's permanent personnel record. If an organized self-governance program, as defined in [Section 384.20](#), approved by the governing body and the Department allows for peer participation, only peers having completed such training may assist with the technique. This training shall include demonstrated competency in the humane and efficient implementation of the restraint program as demonstrated in applications of the procedures on participants in the training.
- k) Application of manual restraint requires direct authorization, supervision and management by the mental health professional, as defined in [Section 384.20](#), designated as responsible for making clinical decisions at the time restraint is applied. If this person is not present when restraint is first applied, he or she must be summoned immediately and maintain supervision and management of the restraint until the restraint episode is concluded or he or she is relieved by a similarly qualified and clinically responsible person. Supervision of a restraint episode does not require in person supervision throughout the duration of the restraint provided that the mental health professional has viewed the restraint in person, has confirmed that the restraint is being applied according to the agency's selected model and is confident that the restraint will continue to be so applied. The mental health professional must review the restraint episode immediately upon conclusion of the restraint to ensure that the restraint continued and concluded in a manner that is consistent with the model and the child's interest. Each use of manual restraint shall be reported as soon as practicable and a written record forwarded within 24 hours to the administrator of the facility or designee, the assigned caseworker in the facility, and the social work supervisor. If the use of manual restraint results in an injury requiring emergency medical treatment by medical personnel or exceeds 60 consecutive minutes, the senior agency administrator shall be contacted immediately.
- l) The written record of manual restraint shall include: the date of the occurrence, the precipitating incidents; the age, height, weight, sex and race of the restrained child; the persons (including other residents) who participated in restraining the child; any witnesses to the precipitating incident and subsequent restraint; the exact methods of restraint used; the beginning and ending time of the restraint; a detailed description of any injury arising from the incident or restraint; and a summary of any medical care provided. The supervisor in

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

charge at the time of the incident and restraint shall review the report submitted by staff, inquire into any irregularities, and sign and date the written report indicating the date it was reviewed and approved or disapproved.

- m) The administrator of the facility or designee shall review all written records of manual restraint the next business day. The administrator or designee shall approve or disapprove of the use of restraint under the circumstances described and shall indicate review and approval/disapproval by signing and dating the report of behavior treatment. If the administrator or designee disapproves of this instance of manual restraint, the administrator or designee shall state the reasons for disapproval and shall correct the improper use of manual restraint. The decision concerning the need for further action, if any, should be documented whenever any of the following occurs:
- 1) restraint is used repeatedly and excessively by any staff person;
 - 2) restraint is used repeatedly and excessively on any child;
 - 3) the duration of the restraint exceeds 30 minutes;
 - 4) any provision in this Part is violated; or
 - 5) the restraint results in an injury requiring emergency medical treatment by medical personnel.
- n) Upon request, the administrator of the facility or designee shall notify the child's parents (unless parental rights have been terminated), guardian and attorney, in writing, within two business days, when a child is subjected to manual restraint, and shall provide such notice for any manual restraint that results in injury to the child within 12 hours. Communication to the child's parent or guardian shall be conducted in the parent's or guardian's primary language or preferred mode of communication.

(Source: Old Section 384.50 renumbered to Section 384.30; new Section 384.50 renumbered from Section 384.60 and amended at 26 Ill. Reg., effective March 15, 2002)

Section 384.60 Behavior Management Requirements for the Use of Mechanical and Medical Restraints

No child in a facility licensed by the Department of Children and Family Services shall be subjected to mechanical restraints, as described in [Section 384.20](#).

(Source: Old Section 384.60 renumbered to Section 384.50; new Section 384.60 renumbered from Section 384.70 and amended at 26 Ill. Reg., effective March 15, 2002)

Section 384.70 Behavior Management Requirements for the Use of Seclusion

Seclusion is limited to children age six and older who have been placed in a child care facility and who pose a threat of physical harm to themselves or others. Such threat may include any dangerous behavior reasonably expected to lead to physical harm to self or others. Seclusion shall not be used until after other, less restrictive procedures or measures have been explored

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

and found to be inappropriate. Seclusion shall not be used for a child whose medical condition, mental illness or developmental or psychological status contraindicates the use of the technique, as documented in the individual treatment plan.

- a) Seclusion may be administered provided:
 - 1) the use of seclusion is under the direct management and supervision of a mental health professional specifically trained in behavior management who has demonstrated both written and applied competency in the use of this procedure. Supervision of a seclusion episode does not require in person supervision provided that the “mental health professional” has viewed the seclusion in person and is confident that the seclusion is being applied according to the agency’s selected model. (The “mental health professional” must review the seclusion episode immediately upon conclusion of the seclusion to ensure that the seclusion continued and concluded in a manner that is consistent with the model and the child’s interest.);
 - 2) seclusion shall be in a room at least 40 square feet with the shortest wall at least 6 foot with an 8 foot ceiling which is heated, lighted, and ventilated as the other rooms of the facility. Seclusion rooms are to be unfurnished and may have padding that is designed specifically for use in psychiatric or similar settings and approved by the local health and fire authorities. Light fixtures are to be screened or recessed, and interior door knobs are to be removed. Seclusion rooms shall be approved by the Department’s licensing unit prior to usage. The Department is authorized to waive certain space requirements that represent a minimal variance from the requirements of this subsection (a)(2). Seclusion rooms must be inspected and approved under the regulations adopted by the Office of the State Fire Marshal;
 - 3) a staff member trained in the use of the seclusion shall monitor the child by direct, in-person, visual observation on a continuous basis. A staff member assigned to monitor a child in a seclusion room shall have this monitoring as his or her sole job duty throughout the period of seclusion in order to ensure the child’s safety while in the room, and will maintain a written record of the observations. Such observation may be through an uncovered one way mirror or regular window that provides for observation of the entire room at all times, if the staff person has unimpeded access to the seclusion room and normal daily sounds are audible. (There shall be sufficient staff to insure appropriate supervision of all other children while the staff member is monitoring the child in seclusion.);
 - 4) a written log is to be kept of each seclusion episode. The staff member monitoring the seclusion shall make an entry in the log at least once every 15 minutes, clearly describing the behavior of the child at that time and a clinical impression of whether the behavior requires continuation of the seclusion;

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

- 5) a child may not be kept in seclusion more than 15 minutes beyond the point at which the child ceases presenting the specific behavior for which the seclusion was ordered or any other behavior for which seclusion is an appropriate intervention;
 - 6) no child may be kept in seclusion longer than a total of four hours in any 24 hour period. If continuous seclusion is necessary for more than two hours, a mental health professional shall approve continuing the seclusion on an hourly basis with a total episode of seclusion not to exceed four hours. The treatment team must explore alternative treatment strategies, such as an emergency SASS or transporting the child to a hospital or mental health facility.
 - 7) belts, shoes, matches, weapons, or any other object that can be used to inflict self-injury are to be taken from the child or removed from the room prior to placement of the child in the seclusion room if there are indications in the child's record or the child's current behavior that such precautions are warranted;
 - 8) children placed in seclusion shall not be deprived of clothing (other than belts or items that may be used to inflict self-injury), food, toileting, medication, or other basic living functions.
- b) Seclusion may be used to prevent runaway only when the child presents a threat of physical harm to self or others.
 - c) Seclusion shall not be used as discipline for rule infractions or for the convenience of staff.
 - d) Each use of seclusion shall be reported as soon as practicable and a written record forwarded within 24 hours to the administrator of the facility or designee, the assigned caseworker in the facility, and the social work supervisor. The administrator of the facility or designee shall approve or disapprove the use of seclusion under the circumstances described and shall indicate review and approval/disapproval by signing and dating the report. If the administrator or designee disapproves the use of seclusion in this instance, the administrator or designee shall state the reasons for disapproval and shall correct the improper use of seclusion. If the use of seclusion results in an injury requiring emergency medical treatment by a physician, the senior facility administrator shall be notified immediately.
 - e) A written report shall be created and maintained for each episode of seclusion. This report shall state the events and behavior leading to the initiation of seclusion; any additional behavior presented by the child during the seclusion period that required continuation of seclusion; the date of the occurrence; the age, height, weight, sex and race of the secluded child; the precipitating incidents; the persons (including other peers) who participated in secluding the child; any witnesses to the precipitating incident and subsequent seclusion; the

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

exact methods of seclusion used; the beginning and ending time of the seclusion; and a detailed description of any injury occurring as a result of the incident and seclusion. The supervisor on duty at the time of the incident and seclusion shall review the report submitted by the child care staff, inquire into any irregularities, and sign and date the written report indicating the date it was reviewed.

- f) Upon request, the child's parents (unless parental rights have been terminated), guardian and attorney shall be notified in writing within two business days when a child remains in seclusion for two hours and within 12 hours when seclusion results in injury. Communication to the child's parent or guardian shall be conducted in the parent's or guardian's primary language or preferred mode of communication.
- g) All seclusion episodes lasting longer than 15 minutes beyond the time that indicated behaviors have ceased, or lasting longer than two hours in total, are considered highly restrictive and should be a rare occurrence. Copies of the facility's documentation of the event must be forwarded to the Department of Children and Family Services, Attention: Chief of Licensing, Central Office of Licensing, 406 E. Monroe Street, Station #60, Springfield, Illinois 62701, for an independent clinical review.

(Source: Old Section 384.70 renumbered to Section 384.60; new Section 384.70 renumbered from Section 384.80 and amended at 26 Ill. Reg., effective March 15, 2002)

Section 384.80 Self-Governance Programs

- a) Child care facilities may institute organized self-governance programs supervised by staff, that allow peers to participate in the discipline or behavior management of peers upon compliance with this Section; however, effective April 1, 2006, the manual restraint of a child in any form by another child is prohibited by this Part. In an organized self-governance program, staff retain full responsibility for ensuring that all discipline or behavior management is appropriate for the circumstances and does not violate the requirements of this Part. An organized self-governance program shall not be utilized as a substitute for adequate staffing.
- b) A child care facility may only implement an organized self-governance program following approval of a written plan by the child care facility's governing body and the Department. The Department will not approve a plan for an organized self-governance program unless it includes at least the following:
 - 1) parents, guardians and children are advised of the self-governance program prior to admission to the facility;
 - 2) the admissions policy clearly specifies the ages, behavior, functional level, and history of children to be accepted for the self-governance

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

program. Children who do not meet the admissions policy shall not be admitted to the program;

- 3) facility staff have education, experience, and training directly related to the administration and delivery of services in a self-governance program;
 - 4) the facility has developed and implemented a regular, ongoing monitoring, evaluation, and recordkeeping system for the self-governance program that can demonstrate whether the program, as implemented, is consistent with the plan approved by the Department; and
 - 5) the discharge policy clearly specifies the criteria for successful completion of the program and also specifies what attitudes and behaviors will be reason for involuntary discharge from the self-governance program. The policy must identify who in the facility has authority to approve the successful completion or the involuntary discharge of a child from the program.
- c) The Department's review of the plan for an organized self-governance program and any amendments shall be performed by a review team composed of qualified persons appointed by the Director which shall be representative of the Department and the Illinois Association of Peer Treatment Agencies. This review team shall review the plan for an organized self-governance program and any plan amendments and recommend a decision for the Director's final approval. The Department's final decision shall be made within 14 days after receipt of the complete plan for organized self-governance.
- d) The written plan shall be reviewed and approved at least once every two years by the child care facility's governing body and the Department.

(Source: Old Section 384.80 renumbered to Section 384.70; new Section 384.80 renumbered from Section 384.90 and amended at 26 Ill. Reg., effective March 15, 2002)

Section 384.90 Reports

Child care facilities shall report to the Department licensing authority unusual incidents regarding discipline and behavior management of children placed in the facility.

- a) The facility shall report as an unusual incident:
 - 1) any injury received by a child as a result of discipline or behavior management;
 - 2) any 30-day period in which five or more instances of restraint and/or confinement of a specific child occurred;
 - 3) any violation of this Part.

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

- b) Reports shall be made in writing and postmarked within two business days after the unusual incident.

(Source: Old Section 384.90 renumbered to Section 384.80; new Section 384.90 renumbered from Section 384.110 at 26 Ill. Reg., effective March 15, 2002)

Section 384.100 Secure Residential Care (Repealed)

(Source: Repealed at 26 Ill. Reg., effective March 15, 2002)

Section 384.110 Severability of this Part

If any court of competent jurisdiction finds any Section, clause, phrase, or provision of this Part is unconstitutional or invalid for any reason whatsoever, this finding shall not affect the validity of the remaining portions of this Part.

(Source: Old Section 384.110 renumbered to Section 384.90; new Section 384.110 renumbered from Section 384.120 at 26 Ill. Reg., effective March 15, 2002)

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES

March 15, 2002 – P.T. 2002.11

APPENDIX A

MATRIX OF BEHAVIOR TREATMENT TECHNIQUES

Accepted Crisis Intervention and Behavior Management Models	
Organization/Models	Address
Crisis Intervention Training Associates (CITA)	Tom Ronquillo 1214 East Grove Street Bloomington, Illinois 61701 Phone 309.828.0010
Crisis Prevention Institute (CPI)	Crisis Prevention Institute, Inc. 3315-K North 124 th Street Brookfield, Wisconsin 53005 Phone 262.783.5787
The Mandt System	The Mandt System P.O. Box 831790 Richardson, Texas 75083-1790 Phone 972.495.0755
Professional Assault Response Training (PART)	Professional Assault Response Training 619 East Main Street Carlinville, Illinois 62626 Phone 217.854.3231
Therapeutic Crisis Intervention (TCI)	Cornell University Family Life Development Center Martha Van Rensselaer Hall Ithaca, New York 14853 Phone 607.255.7794

(Source: Added at 26 Ill. Reg., effective March 15, 2002)

BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES
March 15, 2002 – P.T. 2002.11

This page intentionally left blank.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

POLICY GUIDE 2020.14

SECURE TRANSPORTATION SERVICES

DATE: October 2, 2020

TO: All DCFS and POS Staff, Supervisors and Managers and DCFS Licensed Congregate Care Providers

FROM: Marc D. Smith, Acting Director

EFFECTIVE: Immediately

I. PURPOSE

Youth in DCFS care are regularly transported to various locations, including appointments, schools, and family visits. Typically, transportation is by car, and a caseworker or caregiver drives the youth from one location to another. An Ambulance should be called to transport youth in DCFS care in the event of a medical or psychiatric emergency.

The purpose of this Policy Guide is to identify those very limited circumstances when it is determined to be unsafe for a youth, who presents as a risk of harm to themselves or others, to be transported by a caseworker, caregiver or public transportation to an authorized placement, including temporary placements such as shelters, and Secure Transportation Services instead are appropriate.

This Policy Guide outlines procedures for requesting and obtaining approval for Secure Transportation Services with or without the use of Soft Restraints, when applicable. This Policy Guide pertains to the limited circumstances in which DCFS will approve Secure Transportation Services.

Under no circumstances shall any agent or employee of DCFS, any agent or employee of any provider, or any transportation company designated to transport youth in DCFS care use Mechanical Restraints of any kind, including without limitation metal handcuffs, shackles or zip ties, when transporting any youth in DCFS care. This prohibition applies to all forms of such transportation, including Secure Transportation Services. Only after approval has been obtained through this policy may Soft Restraints be applied during a Secure Transport. No other forms of restraint are acceptable.



II. PRIMARY USERS

All DCFS and POS Staff, Supervisors and Managers and DCFS-licensed Congregate Care Providers and contracted providers of transportation services.

III. DEFINITIONS

“Ambulance” means a vehicle authorized by the Emergency Medical Services (EMS) Director pursuant to the Emergency Medical Services (EMS) Systems Act [210 ILCS 50]. For the purpose of this policy guide, transportation in an ambulance includes the usage of soft restraints for the protection and safety of the youth.

“DCFS Consulting Psychiatrist” means a psychiatrist with whom DCFS has a contract for consulting services.

“Mechanical Restraints” means any device, material or equipment (including but not limited to straight jacket, arm/leg restraints, four-point restraints, and zip ties), other than personal physical force, used to immobilize or directly restrict the limbs, head or body of a youth. Mechanical Restraints does not include:

child restraint systems as defined in the Child Passenger Protection Act or devices for medical immobilization, adaptive support, or medical protection, such as orthopedically prescribed devices, straps or protective helmets. For the purpose of this policy, Soft Restraints are excluded from this definition.

“Safety Car” means a vehicle that has all vehicle door locks controlled by the driver and inoperable by passengers in the front or back seats of the vehicle, and that is staffed with two Transporters. A Safety Car may include a partition separating the front and back rows.

“Secure Transportation” is defined as transport by a transportation company via Safety Car, Ambulance or other similarly secured vehicle that involves having all vehicle doors locked by the driver and inoperable by passengers in the front or back seats of the vehicle. Secure Transportation requires at least two Transporters and includes both in-state and out-of-state travel.

“Soft Restraints” means a soft material or fabric that is padded and designed to safely fit around the limbs of an individual to limit mobility in order to prevent self-harm or harm to others.

“Transport Provider” means the operator of an Ambulance or Safety Car service contracted by DCFS to provide Secure Transportation for youth in care.

“Treating Psychiatrist” means a psychiatrist who has a current relationship with and has met in person with the youth within the last six months.

“Transporter” means an employee of the transportation company responsible for safely transporting youth in care.

IV. WHEN SECURE TRANSPORTATION SERVICES MAY BE REQUESTED

DCFS has determined there are only three circumstances in which Secure Transportation Service is appropriate for youth in DCFS care. Documentation and DCFS approval are required for each, as described in this Policy Guide. The three circumstances are:

- 1) if a court enters an order requiring the use of Secure Transportation Service for transporting a youth;
- 2) if, based on a youth's mental health needs, the Treating Psychiatrist prescribes the use of Secure Transportation Services and attests that this is the least restrictive means in the best interests of the youth; or
- 3) if, in exceptional circumstances, the DCFS Director approves the use of Secure Transportation Services after a Critical Decision has been made and documented in SACWIS and an attestation has been provided by a DCFS Consulting Psychiatrist that the requested transportation method is the least restrictive means in the best interests of the youth.

The use of Soft Restraints for the protection of the youth during transport is prohibited unless authorized as described in this Policy Guide. **Under no circumstances shall any Transport Provider designated to transport a youth in DCFS care use Mechanical Restraints of any kind when transporting the youth.**

V. CRITICAL DECISION ABOUT SECURE TRANSPORTATION SERVICES

- a) The caseworker and supervisor can pursue Secure Transportation in the very limited circumstances when no less restrictive means is in the best interests of the youth, and it is unsafe for a youth, who presents as a risk of harm to themselves or others, to be transported by a caseworker, caregiver or public transportation to an authorized placement, including temporary placements such as shelters. In these instances, the case shall be staffed with the area administrator and regional administrator in consultation with Clinical and Child Services staff. If a POS case, the case shall be staffed with the Deputy Director of Permanency, or designee, in consultation with Clinical and Child Services staff. The outcome shall constitute a Critical Decision and shall be recorded in SACWIS.
- b) If the Critical Decision is in favor of the need for Secure Transportation, one of the following must be secured or in the file:
 - 1) a Treating Psychiatrist's written order for Secure Transportation;
 - 2) a written court order requiring the use of Secure Transportation, with or without Soft Restraints; or
 - 3) written approval from the DCFS Director when exceptional circumstances exist. (See Section VI below.)

VI. PROCEDURES FOR FACILITATING SECURE TRANSPORTATION SERVICES AFTER CRITICAL DECISION

a) How to Request Secure Transportation Services

1) With Court Order or Youth's Treating Psychiatrist's Order

The DCFS/POS Permanency Worker and Permanency Supervisor shall:

- A) Complete and sign the CFS 417-F, Request for Secure Transportation Services.**
- B) Attach all supporting documentation, including the Critical Decision, copy of the court order and/or the Treating Psychiatrist's order to the CFS 417-F.**
- C) Email the signed CFS 417-F with all required signatures, orders and supporting documentation to the Clinical Placement Administration mailbox (DCFS.ClinicalRef@illinois.gov).**

2) Requesting DCFS Director Authorization in Exceptional Circumstances

When a youth may need Secure Transportation Services but there is no court order or order of a Treating Psychiatrist available in the time available before the transportation is to occur, the DCFS/POS Permanency Worker and Permanency Supervisor shall:

- A) Complete and sign the CFS 417-F, Request for Secure Transportation Services.**
- B) Attach all supporting documentation and Critical Decisions to the CFS 417-F.**
- C) Email the signed CFS 417-F with all required signatures, orders and supporting documentation to the Chief Deputy Director of Operations, or designee, for approval and presentation to the Director.**
- D) The Director approved CFS 417-F with all required signatures, orders and supporting documentation shall be emailed to the Clinical Placement Administration mailbox (DCFS.ClinicalRef@illinois.gov).**

b) **Secure Transportation Coordination Process**

Secure Transportation Coordination. The DCFS Associate Deputy Director of Clinical Placement Administration, or designee, shall immediately review the **CFS 417-F** and supporting documentation and assign a clinical placement coordinator to facilitate a staffing with the relevant stakeholders to coordinate the transportation plan. The following relevant stakeholders **must** be invited:

- DCFS/POS Permanency Worker and Permanency Supervisor*
- DCFS General Counsel (or designee)
- DCFS Guardianship Administrator (or designee)
- the youth (as age appropriate)
- the youth's guardian ad litem
- authorized personnel from the discharging and receiving facilities*
- authorized representative from the Transport Provider*

* Indicates mandatory participants

For emergency discharges or moves involving fewer than two days' advanced notice, the staffing must be held within 24 hours of receiving the completed **CFS 417-F** and supporting documentation.

The purpose of the staffing is to:

- discuss the circumstances around the need to transport this youth;
- ensure all required documents have been completed, signed and attached;
- ensure the youth's medication list is up-to-date and any medical and/or special needs (e.g., mental health, hearing impairment, language) are identified for the receiving facility;
- identify the youth's legal status (e.g., probation, parole, pending charges);
- identify any necessary precautions that must be taken to ensure the youth is transported safely;
- determine the least restrictive means in the best interests of the youth for transport including the potential use of approved Soft Restraints;
- identify who will be present when the Transport Provider arrives to transport the youth;
- identify the person with whom the youth has a relationship who will accompany the youth during the transport and note the nature of the relationship, if possible;
- document any unresolved disagreements among participants in the staffing regarding the transportation plan; and
- complete the **CFS 417-F-1, Secure Transportation Services Staffing Sheet**. The Staffing Sheet must include the names and titles of each person who will be present when the Transport Provider arrives to transport the youth, and when the Transport Provider and youth arrive at the arranged destination, and whether those persons participated in this staffing.

After the staffing, the Associate Deputy Director of Clinical Placement Administration, or designee, must complete the remainder of the **CFS 417-F**. The Staffing Sheet must be attached to the **CFS 417-F**.

c) **Final Approvals**

Secure Transportation without Soft Restraints:

- 1) The Deputy Director of Clinical Practice, or designee, shall sign the completed **CFS 417-F**, and email the **CFS 417-F**, Staffing Sheet and all supporting documentation for final review and approval to the Chief Deputy Director of Clinical and Child Services.
- 2) The Chief Deputy Director of Clinical and Child Services shall provide the final approval permitting Secure Transportation without Soft Restraints.

Secure Transportation with Soft Restraints:

- 1) The Deputy Director of Clinical Practice, or designee, shall sign the completed **CFS 417-F**, and email the **CFS 417-F**, Staffing Sheet and all supporting documentation for final review and approval to the Chief Deputy Director of Clinical and Child Services.
- 2) The Chief Deputy Director of Clinical and Child Services, or designee, shall email the completed **CFS 417-F** to the DCFS Guardianship Administrator, Chief Deputy Director of Operations, General Counsel and Chief Deputy Director for review and approval.
- 3) The DCFS Chief Deputy Director shall provide the final approval permitting Secure Transportation with Soft Restraints.

d) **Changes Require an Addendum and Approval of DCFS Chief Deputy Director**

Proposed changes to the approved Secure Transportation request must be submitted as a written addendum to the **CFS 417-F** and approved by the DCFS Chief Deputy Director of Operations and DCFS Chief Deputy of Clinical and Child Services, before being submitted for final approval to the DCFS Chief Deputy Director.

When an addendum is approved, the Associate Deputy of Clinical Placement Administration, or designee, shall contact the Transport Provider by phone before the Secure Transportation occurs to verbally relay the information in the addendum and provide the company with a copy of the addendum. The Transport Provider shall sign and return the addendum as acknowledgment and affirmation to adhere to the addendum.

VII. ADDITIONAL REQUIREMENTS PRIOR TO SECURE TRANSPORTATION OF YOUTH

- 1) **Notice to the Youth is Required When Soft Restraints Are Authorized.** The Permanency Worker must verbally notify the youth that the court or the youth's Treating Psychiatrist and/or DCFS Director has approved Secure Transportation Services with the use of Soft Restraints on the date shown on the **CFS 417-F**. The Permanency Worker must document the notice in a case note in SACWIS.
- 2) **Notice to the Secure Transportation Provider.** The Associate Deputy Director of Clinical Placement Administration, or designee, shall provide the approved **CFS 417-F** to the Transport Provider. The Transport Provider shall sign and return the approved **CFS 417-F** as acknowledgment and affirmation to adhere to the transportation plan.
- 3) If the youth is being discharged from a DCFS-licensed congregate care facility, the Associate Deputy Director of Clinical Placement Administration, or designee, shall also email the approved **CFS 417-F** to the discharging facility.

VIII. NEW AND/OR REVISED FORMS

- **CFS 417-F, Request for Secure Transportation Services (Rev. 10/2020)**
- **CFS 417-F-1, Secure Transportation Services Staffing Sheet (New 10/2020)**

IX. QUESTIONS

Questions regarding this Policy Guide may be directed to the DCFS Office of Child and Family Policy at 217-524-1983 or via Outlook at DCFS.Policy. Non-Outlook users may e-mail questions to DCFS.Policy@illinois.gov.

X. FILING INSTRUCTIONS

File this Policy Guide behind Rules 384, Behavior Treatment in Residential Child Care Facilities.

This page intentionally left blank.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

POLICY GUIDE 2020.12

**RULE 384 BEHAVIOR TREATMENT IN RESIDENTIAL CHILD CARE FACILITIES
APPENDIX A - MATRIX OF BEHAVIOR TREATMENT TECHNIQUES**

DATE: September 8, 2020

TO: DCFS Licensing and Monitoring Staff and Supervisors, and Residential and Group Home Administrators and Staff

FROM: Marc D. Smith, Acting Director

EFFECTIVE: Immediately

I. PURPOSE

The purpose of this Policy Guide is to inform staff of an amendment in Rule 384 Behavior Treatment in Residential Child Care Facilities Appendix A – Matrix of Behavior Treatment Techniques. This revision will provides Residential Providers permitted to use an approved and accepted behavior treatment technique referred to as UKERU.

II. PRIMARY USERS

The primary users of this Policy Guide are DCFS Licensing Staff, Monitoring Staff, Supervisors, and Residential Administrators and Staff.

III. BACKGROUND AND SUMMARY

Residential Administrators and Staff are now able to utilize an approved and accepted behavior treatment technique referred to as UKERU. “UKERU” is Japanese for “receive”. UKERU is a safe and comforting restraint-free approach to crisis management. The UKERU model is rooted in staff being more trauma-informed and more trauma-aware, builds on relationships first instead of rules first; and encourages staff/youth relationships and comfort over control. Extensive, in depth training is required before a residential provider adopts UKERU as a formal behavior treatment technique. As part of the training, staff are taught how to use UKERU pads to block physical aggression by youth instead of using restraint or seclusion to manage physical aggression.

The Department will propose amendments to appropriate rules to comport with this Policy Guide. Licensing and Monitoring staff shall make note of this amendment.



VI. QUESTIONS

Questions regarding this Policy Transmittal may be directed to the Office of Child and Family Policy at 217-524-1983, or via Outlook at DCFS.Policy. Non-Outlook users may e-mail questions to DCFS.Policy@illinois.gov. During the Department's response to COVID-19 the listed phone number to the Office of Child and Family Policy is being checked remotely, but we do ask that if you need immediate assistance Monday – Friday (8:30 – 5:00) please utilize the email address provided.

VII. FILING INSTRUCTIONS

File this Policy Guide immediately following Rule 384 - Behavior Treatment in Residential Child Care Facilities Appendix A – Matrix of Behavior Treatment Techniques, as an Accepted Crisis Intervention and Behavior Management Model.