Elgin Mental Health Center

PLAN OF COMPLIANCE

This Plan of Compliance, while including several elements which have been initiated independently by the Illinois Department of Mental Health and Developmental Disabilities (IDMHDD), is in response to an investigation instituted by the Attorney General of the United States, by and through the Assistant Attorney General, Civil Rights Division, Wm. Bradford Reynolds.

I. PSYCHOTROPIC MEDICATION USE

IDMHDD has initiated several actions to enhance the quality and scope of psychotropic drug treatment of recipients in IDMHDD facilities, including Elgin MHC. These actions have taken the forms of IDMHDD Rules, computerized recipient profiles, a computerized Drug-Drug Interaction System, a computerized Drug-Pre-existing Physical Abnormalities System, and IDMHDD Clinical Directives.

The IDMHDD Rules are specifically designed to address the rational administration of approved psychotropic medications within IDMHDD facilities. Rule 112.80 (Attachment 1) establishes an IDMHDD Drug Review Committee whose function is to review the efficacy and safety of psychotropic medications and to recommend to the Associate Director for Clinical Services psychotropic medications which may be authorized for use within IDMHDD facilities. This Rule establishes requirements to be met to receive authorization for use of any psychotropic medication not already listed as authorized for use. Rule 112.90 (Attachment 1) addresses the initiation of ongoing clinical monitoring of responses to pharmacotherapy with psychopharmacologic agents. This Rule requires a physician's periodic review of all recipients on psychoactive agents at least every thirty days, and requires that the physician document in the recipient's clinical record the rationale for prescribing the psychotropic medication; the medication's intended effect; and in the event of a verbal order, the reason the medication order was given verbally rather than after personal examination. The prevention of Tardive Dyskinesia is also addressed in this Rule and will be described in greater detail below.

The Clinical Directive (Attachment 1), revised as of August 17, 1986, expands and enhances Rules 112.80 and 112.90. Procedures for consideration of alternatives to pharmacotherapy, physician examination of the recipient, definition and guidelines for use of polypharmacy, and guidelines for adjusting dosage and dosing schedules are enumerated in this Directive. The Clinical Directive establishes the Daily Average Acute Treatment Dose, the Daily Maximal Dose Limit, and the general means of determining the maintenance dose for adult (under age 65) recipients. The precautions and guidelines for use of contingent (PRN) medication and antiparkinsonian medication and for the long-term use of sedative - hypnotic medication is established in the Directive as well. The Directive also establishes the process to be followed to exceed the IDMHDD Daily Maximal Dose Limits and the documentation to be forwarded to the Chairperson of the IDMHDD Drug Review Committee for approval.

The Table of Drug Dosages (Attachment 2) will be issued to physicians at Elgin MHC. It establishes clinical guidelines for dosage ranges by age of the recipient. Medication doses for each recipient must be individualized, based upon clinical condition, metabolism, and response. However, with large groups of recipients, statistical norms are expected. The Table of Drug Dosages is based on these statistical norms and the listed doses will be used as indicators to initiate a review of drug use. The use of these indicators will be facilitated by IDMHDD's computerized pharmacy Unit Dose System interaction function. This system will allow for the generation of automated reports to the Facility Director, the Facility Medical Director, and the IDMHDD Chief of Medical Services on any recipient receiving dosages in excess of those dosages listed in the Table of Drug Dosages issued for use at Elgin MHC. These reports will be summarized by subunit, individual recipient, and attending physician. For any subgroups of recipients for which the reports identify more than 20% of the recipients whose dosages exceed the upper limit of the Daily Average Acute Treatment Dose for that subgroup, a specific Drug Utilization Review will be initiated by the Facility Medical Director. The following actions will be undertaken based upon the results of the Drug Utilization Review:

1. If the Drug Utilization Review supports the clinical necessity of the higher dosages, no further action is required at the facility level.

2. When the Drug Utilization Review concludes that the necessity of the higher dosage is questionable:

   a. The attending physician will be notified of the Drug Utilization Review outcome;

   b. the Facility Medical Director may instruct the attending physician to responsibly reduce the dosage; and

   c. education for the individual attending physician and/or Elgin MHC physicians as a group shall be conducted to address the dosage issues.

3. Whenever Drug Utilization Review is indicated, the results of the review and documentation of corrective action, if needed, will be forwarded to the IDMHDD Chief of Medical Services.

The requirements in Section I should be implemented no later than 6 months after entry of the consent decree.

II. TARDIVE DYSKINESIA

Because of the special risk of late, emergent, and persistent neurological side-effects of antipsychotic drugs, i.e., Tardive

Dyskinesia, the IDMHDD has adopted and promulgated to all IDMHDD facilities, including Elgin MHC, the following policies on the prevention, identification, and reduction of Tardive Dyskinesia (see Attachment 1) The following policy shall be implemented at Elgin MHC:

1. Use of antipsychotic drugs shall be restricted to the treatment of psychotic disorders, including schizophrenic disorders, paranoid disorders, schizophreniform disorders, brief reactive psychosis, atypical psychosis, manic episode, major depressive episode with psychotic features, infantile autism and toxic or organic psychosis, Tourette's disorders, and severe behavioral disturbance in a recipient having a developmental disability. Use in any other conditions shall be specially justified in the recipient's medical record.

2. Psychotropic drugs shall be prescribed for specific doses and time, not to exceed 30 days.

3. Each recipient receiving psychotropic medication shall be individually examined by a physician as often as necessary consistent with the judgement of a qualified professional but no less often than once every month. For a recipient receiving antipsychotic medication, this examination shall include an evaluation for signs of Tardive Dyskinesia. The physician's evaluation of the recipient shall include review of his/her medical record and conferences with appropriate staff and shall consider the results of medication administered including both beneficial effects and side effects. The attending physician shall document the status of the recipient's condition in the recipient's medical record as often as the recipient's clinical condition warrants, but no less often than once per month. Documentation of the rationale for the dose of medication shall be included in the progress notes and/or the treatment or habilitation plans no less often than once per month. Significant side effects, that is those side effects of medication determined by a licensed physician, when exercising his/her professional clinical judgement to be severe, dangerous, and/or annoying for the recipient, (or their absence) shall be noted in the recipient's medical record. A recipient who has resided in and IDMHDD facility for more than six months who receives antipsychotic medication shall be individually examined by a psychiatrist for signs of Tardive Dyskinesia no less often than once every six months. Results of these examinations , including any drug-induced side effects, shall be documented in the recipient's medical record.

4. Use of antipsychotic drugs for more than six months shall be prescribed only when a continuing response can be shown, or when exacerbation occurs or has occurred upon cessation of medication. Long-term medication shall be prescribed for recipients if a significant potential for relapse is present and if clinically indicated.

5. The lowest effective dose shall be used for long-term treatment. Maintenance doses to prevent relapse shall be adjusted to the individual recipient's need. The maintenance dose to prevent relapse is usually 1/2 to 1/6 of the average daily acute treatment dose.

6. Whenever a recipient has received antipsychotic medication continuously for three months, the recipient or, if the recipient is under guardianship, the guardian, or, if the recipient is a minor, the recipient's parent or guardian, shall participate in the decision regarding continuation of the recipient's medication based on the need to balance the risk of Tardive Dyskinesia with the risk of continuing in, exacerbating, or developing a psychotic state, Tourette's symptoms or severe behavioral disturbance in a recipient having a developmental disability. If the recipient is an adult not under guardianship, and a clinical assessment of the recipient's intellectual and emotional capabilities puts in doubt the recipient's ability to meaningfully participate in this decision process, timely efforts shall be undertaken to obtain guardianship. The participation of the recipient, guardian, or parent and the decision regarding continuation of medication shall be recorded in the recipient's medical record. The recipient's response to medication shall be monitored and shall be re-evaluated with the participation of the recipient, guardian or parent at no less than six month intervals, and this re-evaluation and participation shall be recorded in the recipient's medical record.

7. Reduction in dose shall be periodically considered for recipients receiving medication for six months or longer. Antipsychotic drug treatment shall be evaluated at least once yearly by reducing the dose by about 10% every three to seven days until the drug has been stopped completely or the clinical condition worsens. This procedure indicates whether antipsychotic medication is still beneficial and also helps to detect signs of Tardive Dyskinesia upon withdrawal of the masking effect of the neuroleptic.

In addition, the IDMHDD has initiated a project to identify and evaluate all recipients in IDMHDD facilities, including Elgin MHC, who may have abnormal involuntary movement disorders. To assist in this endeavor, a contract was entered into in State FY-1986 to determine the prevalence of Tardive Dyskinesia in IDMHDD facilities, including Elgin MHC, through appropriate differential diagnostic methods, and to provide technical information to assist in the development of treatment and/or management alternatives for recipients. Workshops were held to train Department professionals in rating recipients for abnormal involuntary movements, including Tardive Dyskinesia. Separate workshops were arranged for trainers in each facility whose job is to train additional trainers as well as supervise inter-rater reliability. The survey of all Elgin MHC recipients by the trainers and raters is well underway and is expected to be completed by November 1, 1986.

During State FY-1987, the contractual arrangement will continue and will include quality assurance checks at each IDMHDD facility. Workshops will also be held to provide the trainers with an update on research literature, legal ramifications of Tardive Dyskinesia, and reliability check training, among other things.

A second contract has been developed for State FY-1987 to provide the Elgin MHC with a consultant psychiatrist who will spend 1/2 day per week at Elgin MHC for the purpose of psychiatrically evaluating individuals whose abnormal involuntary movements are diagnosed as Tardive Dyskinesia, to determine the need for special management or treatment measures. The consultant will also spend another 1/2 day per week in the IDMHDD Central Office to assist in the organization and interpretation of Tardive Dyskinesia ratings at Elgin MHC, to assist in the computerization of lists of recipients who manifest movement disorders, and to assist in the development and implementation of further policy on the prevention, identification, and management of Tardive Dyskinesia.

The requirements in Section II should be implemented no later than 6 months after entry of the consent decree.

III. TREATMENT PLANNING AND IMPLEMENTATION

To ensure the interdisciplinary development of recipients' treatment plans, the following procedures have been initiated:

1. Interdisciplinary Treatment Staffings (ITS) will require the participation of all major disciplines represented on the treatment unit - physician, nurse, social worker, psychologist, activity therapist, unit director, and recipient individual caseworker. Additional unit staff will be present as appropriate.

2. An ITS for each recipient shall be convened no less often than every 30 days, in coordination with the requirement that treatment plans be reviewed and modified every 30 days.

3. The actual development of the treatment plan for the recipient shall occur during the ITS.

4. The ITS shall be conducted by a chairperson and there shall be an appointed recorder, who shall take accurate notes on the process, which shall be entered in the recipient's record.

5. The format of the ITS and the Treatment Plan Form shall be as follows:

   A. Comprehensive Treatment Plan (10 day)

      a. List interdisciplinary staff present.

b. Identifying Data (Age, sex, reason for hospitalization, legal status, commitment status and admitting diagnosis).

c. Assessment Data and Diagnostic Formulation (Summarize Psychiatric and social history, Psychological assessment, Nursing assessment, Physician assessment, Activity Therapy assessment; formulate final diagnosis).

d. Current level of functioning.

e. Problem Identification (Identify functional problems, specify problems to be entered as treatment targets, specify deferred problems and justify deferral).

f. Identify strengths and assets.

g. Record recipient input.

h. Treatment Planning (For each problem identified in step 5, assign a number. Develop proposed intervention and specify for each problem. Specify goal, criteria and target resolution, time table and staff responsible).

i. Formulate Discharge Plan. (Criteria for termination of treatment, needed aftercare services, court involvement if required.)

B. Review and Update (Every 30 days after Comprehensive Treatment Plan, or after a special incident).

a. List interdisciplinary staff present.

b. Identifying Data.

c. Assessment Data and Diagnostic Formulation.

d. Current level of functioning.

e. Response to Treatment (Summarize general response to treatment. Describe response to specific treatments for each identified numbered problem from previous treatment plan).

f. Treatment Planning (Specify problems to be deleted from plan, reason for deletion, specify problems to be carried over, new problems to be added. Develop new interventions, goals, criteria, time targets, staff responsible).

g. Discharge Plan (Modify if necessary).

6. All ITS treatment plans will be reviewed by Program Psychiatrists. The psychiatrist will also review progress notes, in order to evaluate the relationship between progress and treatment planning, and will provide written feedback to the unit ITS for their subsequent 30 day review ITS and treatment plan development.

7. The ITS and treatment planning process will be monitored through the Elgin MHC Patient Care Monitoring and quality assurance process. Each program and unit will develop by December 1, 1986, its recipient care monitoring plan. These program and unit plans will detail program and unit based supervisory systems, and unit case reviews. The unit case reviews will be conducted by professional staff not assigned to the unit. Each unit will be required to schedule one such external case review per month (facility wide, approximately 260 such reviews will be conducted yearly). Discipline and unit case reviewers will evaluate the adequacy of a wide range of treatment related issues from the adequacy of assessments, treatment plans, interdisciplinary staffings, progress notes, and general service delivery issues, to specific requirements of good treatment practice, such as the monitoring of vital signs while a recipient is in restraints.

8. The IDMHDD Central Office will monitor the ITS and Treatment Plan process by sending a psychiatrist to Elgin MHC once a month for the first 6 months of this agreement, and no less often than once per quarter thereafter.

The requirements in Section III should be implemented no later than 30 days after entry of the consent decree.

IV. PSYCHIATRIC COVERAGE

In order to improve the quantity and quality of psychiatric services to Elgin MHC recipients, the following program has been initiated:

1. Presently Elgin MHC has 32.1 full-time equivalent (FTE) physicians, 9.7 FTE of whom are psychiatrists, for a recipient population of approximately 812. Ultimately, the IDMHDD projection for Elgin MHC will increase the number of physician FTE's to 36.5, with a considerable increase in the ratio of psychiatrists to non-psychiatrically trained physicians. In order to ensure in the interim that Elgin MHC will not drop below a minimally acceptable level of psychiatric coverage, additional psychiatrists will be added to the Elgin MHC staff through employment and contractual relationships to ensure that the following minimum psychiatrist-to-recipient ratios are achieved for each Elgin MHC program within twelve (12) months of this agreement:

a.	Acute Treatment Program	1 FTE:40
b.	Extended Care Program	1 FTE:85
c.	Medical Program	1 FTE:85
d.	Mental Illness/Mental Retardation Program	1 consultant
e.	Forensic Program	1 FTE:60

In addition, Elgin MHC will hire a psychiatrist for the position of Medical Director.

To assist in the recruitment of additional psychiatrists, the State of Illinois will raise salaries for psychiatrists. IDMHDD has requested and the Illinois Department of Central Management Services has agreed to complete a full study of psychiatrist salary levels.

2. Non-psychiatrically trained physicians currently employed at Elgin MHC will be clinically supervised by psychiatrists in the areas of diagnosis and pharmacologic treatment of psychiatric disorders.

3. Non-psychiatrically trained physicians currently employed at Elgin MHC will receive education in the area of diagnosis and medical treatment of psychiatric disorders.

   a. A consultant psychiatrist, effective July 1, 1986, began providing eight (8) hours per week of lectures and seminars to non-psychiatrically trained Elgin MHC physicians. Every week all such physicians (in two separate groups, each of one-half of the physicians) receive two (2) hours of lectures on psychiatric diagnosis and psychopharmacology, and every two weeks all such physicians (in four separate groups, each of one-quarter of the physicians) participate in a seminar involving case presentations. Tests before and after the 28 week lecture series will identify further educational needs on a group and individual physician basis.

   b. Beginning September 2, 1986, all non-psychiatrically trained Elgin MHC physicians, four at a time, will take six week full-time rotations at the Illinois State Psychiatric Institute, the IDMHDD research and psychiatric residency training hospital, where each Elgin MHC physician will be individually proctored, based on a syllabus on differential diagnosis and psychopharmacology, and will receive supervised clinical training on the Institute's inpatient units. Tests before and after the 6 week rotations will identify further educational needs on a group and individual physician basis. All non-psychiatrically trained Elgin MHC physicians will have completed their supervised inpatient rotation by August 31, 1987.

V. PSYCHOLOGY

To appropriately integrate the expertise of clinical psychologists into recipient care at Elgin MHC on a programmatic and on an individual recipient basis, a number of steps have been initiated. Each direct care psychologist is supervised by a unit senior psychologist. The four program senior psychologists are supervised by the facility Chief Psychologist.

The formalized supervision structure and process of the psychology department is directed by the facility Chief Psychologist, now a member of the Facility Administrative Board. The Chief Psychologist assures that functional supervision of all psychologists occurs on a regular basis. Direct treatment psychologists are supervised in formal sessions no less than twice monthly. The delivery of psychology supervision and the quality of psychological services delivered is monitored through the Psychology Patient Care Monitoring Plan which requires documentation of individual supervision sessions (reviewed by the program senior psychologists and the Chief Psychologist) and Psychology Case Reviews conducted by the Chief Psychologist and program senior psychologists on each unit (approximately twenty-five such case reviews will be completed each year). The results of this monitoring will feed into the hospital's overall patient care.

All psychologists are members of the facility Interdisciplinary Professional Staff Organization (PSO) and abide by PSO bylaws, and the psychology manual is incorporated into the PSO bylaws. Psychology meetings are convened quarterly and all psychologists are expected to attend; the supervision committee meets monthly; and, the standards committee meets on an ad hoc basis. This latter committee is developing psychology service standards and at this time has developed hospital-wide standards for psychological assessment. The psychology training committee meets at least quarterly to plan training events for psychologists. The psychology Patient Care Monitoring Committee meets monthly in addition to conducting case reviews. The Psychology Credentials and Privileging Subcommittee of the PSO meets on an ad hoc basis to review the credentials and privileging requests of newly hired psychologists and to review periodically the privileges of currently employed psychologists. The chair of this committee and the Chief Psychologist are both members of the Professional Staff Organization Executive Committee.

Psychologists function as members of the interdisciplinary team. As members of the interdisciplinary team, psychologists are involved in treatment planning for each resident during the interdisciplinary staffing, and provide assessment and treatment services. Psychologists play a major role in the development of the treatment plan, and their clinical function includes traditional assessment and therapeutic services. In addition, psychologists are involved with the objective identification of treatment problems and the assessment of treatment progress.

VI. DISSEMINATION OF PLAN

This Plan of Compliance, as incorporated by the Settlement Agreement, shall be distributed to the Governor, Attorney General, Director of the Illinois Department of Mental Health and Developmental Disabilities, Facility Director of Elgin MHC, and to each physician and pharmacist serving recipients at the Elgin MHC.

VII. EFFECTIVE DATE

Unless otherwise stated, the provisions of the Plan of Compliance at Elgin MHC, as incorporated by the Settlement Agreement, will become effective thirty (30) days from the date of entry by the Court.

VOLUME: 02 State-Operated Programs

SECTION: 06 Clinical Practices

SUBSECTION: 01 Medications and Drugs

POLICY: 02 Psychotropic Drugs and Narcotics

AUTHORITY: Department's Powers and Duties (IRS, ch. 91½, par. 100-5.1); Department Rule 112.80, "Use of Narcotics and Psychotropic Drugs in Department Facilities"; Department Rule 112.90, "Administration of Psychotropic Drugs" (59 Ill. Adm. Code 112)

I. Policy Statement:

Department medical staff shall prescribe psychotropic drugs and narcotics in accordance with Department Rules 112.80, 112.90 and this Directive.

II. Definitions:

"Psychotropic drugs" refer to drugs whose use for antipsychotic, antidepressant. antimanic and/or antianxiety purposes is listed in AMA Drug Evaluations, latest edition (American Medical Association) or Physician's Desk Reference (PDR), latest edition (Medical Economics Company).

"Narcotics" refer to those drugs listed as narcotics in the same references.

III. Procedures:

A. Alternatives to Drug Treatment: Prior to the initiation of psychotropic medication, the physician shall consider, and discuss with the recipient or, if the recipient is under guardianship, the guardian or, if the recipient is a minor, the recipient's parent or guardian, as much as possible, alternative treatments, including their effectiveness, availability and risks. Documentation of this communication shall be made in the recipient's medical record.

B. Physician Examinations:

Each recipient receiving psychotropic medication shall be individually examined by a physician as often as necessary but no less often than once every month. For a recipient receiving antipsychotic medication this examination shall include an evaluation for signs of Tardive Dyskinesia. A recipient who has resided in a DMHDD facility for more than six months who receives antipsychotic medication shall be individually examined by a psychiatrist for signs of Tardive Dyskinesia no less often that once every six months. Results of these examinations, including any drug-induced side effects, shall be documented in the recipient's medical record.

C. Polypharmacy: Since it is only rarely clinically indicated to concurrently prescribe two or more psychotropic drugs of the same class (i.e., antipsychotic, or antidepressant, or antimanic, or antianxiety drugs), the prescribing physician shall obtain prior consultation with a psychiatrist and the specific reason(s) for the use of polypharmacy shall be documented in the recipient's medical record.

NOTE: Use of polypharmacy is never appropriate as a means to avoid exceeding the Daily Maximal Dose Limits set for individual psychotropic drugs.

D. Adjusting Dosages: The prescribing physician shall adjust the dose of a psychotropic drug to each individual recipient's need. Since different recipients may require different doses because of variability in metabolism and individual susceptibility to drugs, flexible dose strategies shall be employed to find the optimal dose for a given recipient. For most antipsychotic, antidepressant, and antimanic psychotropic medications, the therapeutic effect of a given dose is usually not observed for at least seven days.

Medication changes in either dosage or type of drug and their behavioral effect(s) shall be communicated clearly to direct care staff. Anticipated changes in recipient behavior as a result of medication changes shall be discussed and staff shall be informed of alternative means of treatment/habilitation/management available to the recipient.

E. Dosing Schedules:

1. Once-a-day or twice-a-day (B.I.D.) dosing is recommended for most psychotropic drugs. Once-a-day or B.I.D. regimes have been shown to enhance recipient compliance with medication taking.

2. For antipsychotic drugs, once-a-day dosing in the evening would:

   a) maximally utilize sedative effects during the night, and may thus eliminate the need for prescription of sedative-hypnotics,

   b) allow the recipient to sleep through EPS activity thus reducing or eliminating the need for anticholinergic medication, and

   c) may reduce daytime sedation.

F. Cost of Medication:

1. Many Department recipients are eligible for Medical Assistance from the Illinois Department of Public Aid (IDPA) upon discharge. However, IDPA will pay only for medications listed in the IDPA Reimbursement Formulary. The recipient must pay for all medications not listed in the IDPA Formulary. Therefore, medications initiated in the facility shall be prescribed after consideration is given to the availability of coverage under Medical Assistance upon discharge. Whenever clinically appropriate, Medical Assistance-eligible recipients shall be prescribed only medications listed in the IDPA Reimbursement Formulary upon discharge.

2. Recipients not eligible for Medical Assistance from IDPA may find significant differences in cost between generic and brand name medications. Since the cost of medication may influence compliance in taking prescribed medication after discharge, generic medications shall be prescribed upon discharge whenever clinically appropriate.

3. The fewer doses prescribed per day, utilizing larger dose tablets or capsules, the less the total cost of medication, thereby further enhancing the compliance for recipients who pay for medication themselves. Therefore, B.I.D. or once-a-day dosing shall be prescribed for discharged recipients whenever clinically appropriate.

G. Dosages and Treatment for all Drugs:

1. Adequate doses shall be used to treat acute illnesses effectively.

2. Long-term medication shall be prescribed for recipients if a significant potential for relapse is present and if clinically indicated (see Rule 112.90(c)).

3. Reduction in dose shall be periodically considered for recipients receiving medication for six months or longer.

H. Dosages and Treatment for Antipsychotic Drugs:

1. Higher than the average acute treatment dose shall be considered for recipients who are not adequately responding to lower doses.

2. The lowest effective dose shall be used for long-term treatment. Maintenance doses to prevent relapse shall be adjusted to the individual recipient's need. The maintenance dose to prevent relapse is usually 1/2 to 1/6 of the average daily acute treatment dose.

I. Average Acute Daily Treatment Dose and Daily Maximal Dose Limits for Psychotropic Drugs:

Psychotropic Drug	Daily Average Acute Treatment Dose (Milligrams)	Daily Maximal Dose Limit (Milligrams)
Acetophenazine	75-150	600
Alprazolam	.75-4	10
Amitriptyline	150-200	350
Amoxapine	150-300	600
Chlordiazepoxide	15-100	300
Chlorpromazine	100-800	2000
Chlorprothixene	75-300	600
Clorazepate	15-60	60
Desipramine	100-200	300
Diazepam	4-40	40
Doxepin	100-300	300
Fluphenazine*	10	100
Flurazepam	15-30	60
Halazepam	80-160	160
Haloperidol**	12	120

Hydroxyzine Pamcate	200-400	400
Imipramine	100-200	350
Isocarboxazid	20-30	30
Lithium	***	***
Lorazepam	2-6	10
Loxapine	30-60	250
Maprotiline	100-150	250
Meprobamate	800-1600	2400
Mesoridazine	200-400	500
Molindone	50-100	225
Nortriptyline	75-100	150
Oxazepam	30-120	120
Perphenazine	30-60	100
Phenelzine	60-90	90
Pimozide	1-10	20
Prazepam	20-40	60
Prochlorperazine	30-100	200
Protriptyline	15-60	80
Temazepam	15-30	60
Thioridazine	400-800	800
Thiothixene	20-40	150
Tranylcypromine	20	30
Trazodone	75-500	600
Triazolam	.25-.5	1.5
Trifluoperazine	20	100
Triflupromazine	100-200	250
Trimipramine	100-200	300

* Flupherazine Enanthate or Decanoate - The average acute treatment dose is 6.25 to 50 mg every two weeks, and maximal dose limit is 200 mg every two weeks.

** Haloperidol Decanoate - The average acute treatment dose is 50 to 100 mg per month; maximal dose limit is 100 to 300 mg per month

*** Lithium Carbonate shall be monitored by clinical effects and blood levels. Antimanic lithium blood levels should fall approximately in the range of 0.6-1.4 milliequivalents per liter (meq/l), and less than 1.6 meq/l. Since blood levels cannot be adjusted precisely, occasionally the suggested blood level may be exceeded. In this case, the oral dose should be adjusted downward to achieve blood levels within the recommended limits.

J. Narcotics:

1. Physicians shall follow, without exception, treatment indications, precautions and dosages as stated in either AMA

Drug Evaluations or Physician's Desk Reference when prescribing narcotic drugs for use in Department facilities (pursuant to Department Rule 112.80).

2. Physicians shall prescribe narcotics for a specific number of doses and for a time not to exceed 48 hours.

K. Use of List of Psychotropic Drugs:

1. Maximal dose limit

a) Maximal dose limits specified in the list (see Section III (I) above) shall not be exceeded except as authorized pursuant to Section IV (A) of this Directive.

b) The maximal dose limit for anti-anxiety drugs is applicable to their use as anti-anxiety agents. When anti-anxiety drugs are used to treat acute alcohol and/or drug withdrawal, the dose shall be in accordance with the maximal dose recommended in the most recent edition of either AMA Drug Evaluations or Physician's Desk Reference (PDR), whichever is greater, except as authorized pursuant to Section IV (A) of this Directive.

2. Drugs not appearing in Section III (I) and which are newly approved for marketing and labeled for psychotropic indications by the U.S. Food and Drug Administration within the previous 12 months shall only be prescribed in accordance with Department Rule 112.80 (c) (3). Such drugs shall not be prescribed in doses above the maximal dose recommended in the most recent edition of either AMA Drug Evaluations or Physician's Desk Reference, whichever is greater, except as authorized pursuant to Section IV (A).

3. Drugs not appearing in Section III (I) and which are approved for marketing by the U.S. Food and Drug Administration, but which are not labeled by the U.S. Food and Drug Administration for psychotropic indications, but whose use for psychotropic indications is listed in AMA Drug Evaluations shall only be prescribed in accordance with Department Rule 112.80 (c) (4). Such drugs shall not be prescribed in doses above the maximal dose recommended in the most recent edition of AMA Drug Evaluations, except as authorized pursuant to Section IV (A).

4. Drugs not appearing in Section III (I) and which are approved for marketing by the U.S. Food and Drug Administration, but which are neither labeled for psychotropic indications by the U.S. Food and Drug Administration nor listed as having

psychotropic indications in AMA Drug Evaluations, but for which there is medical literature supporting their use for psychotropic indications shall only be prescribed in accordance with Department Rule 112.80 (c) (5). Such drugs shall not be prescribed in doses above the maximal dose documented in the medical literature as having been safely prescribed for psychotropic indications.

5. It shall be the facility director's responsibility to ensure that there are adequate numbers of copies of the above-named publications to meet the needs of the facility staff.

6. Use for psychotropic purposes of any drug or drug dose not authorized pursuant to Sections III (I) (J) (K) and IV (A) is prohibited, unless its use has been approved for research, in writing, by the Chairperson of the Drug Review Committee.

L. Contingent Medication (short-term): The casual (and at times regular) use of "PRN" orders for psychotropic medication within DMHDD facilities shall not be permitted. If a recipient can be treated on a low dose with occasional use of contingent medication for acute exacerbation, this strategy is preferable to continuous higher dose therapy. When a physician wishes to address a recipient's acute exacerbation of symptoms he/she shall consider ordering contingent (additional short-term) dosages of the psychotropic medication. The exact dose limits and specific contingent indication shall be documented in the medication orders of the individual recipient (DMHDD-44, Physician's Orders).

   a. Contingent medication orders for injections of psychotropic drugs used in emergency situations shall be for the same drug in the injectable form as the recipient otherwise receives in the liquid or tablet form, unless no alternative injectable dosage form of the drug exists.

   b. If frequent contingent injectable medication is utilized in a week's time, the need for a higher maintenance dose of the medication shall be considered. This increase should be added to the regular dose of medication to arrive at the new maintenance dosage.

   c. When ordering contingent (additional short-term) medication the physician shall state (use form DMHDD-44) the specific medication to be used, the dosage limits per administration, the frequency and route of administration, the maximum 24-hour limit, and the specific behavioral symptoms which the contingent medication is intended to influence.

All contingent medication orders shall be reviewed by the attending physician at least every seven (7) days.

M. Antiparkinsonian Medication: Antiparkinsonian medication for extrapyramidal symptoms shall be given on a long-term basis only when clinically justified. A recipient who needs antiparkinsonian medication early in his/her treatment or habilitation may not need this medication months later. Therefore, when medication in a treatment or habilitation plan is reviewed, the prescribing physician shall consider whether or not the recipient still needs antiparkinsonian medication. After four months of antiparkinsonian medication, it shall be gradually reduced (and eliminated) unless extrapyrmidal symptoms persist or recur.

N. Long-term Use of Sedative-Hypnotic Drugs: The long-term use of sedative-hypnotic drugs shall be avoided. Whenever such drugs are prescribed for more than 30 days, the prescribing physician shall document the specific reason for such a prescription in the recipient's medical record.

IV. Reporting/Compliance Requirements:

A. Applications for Exemption:

1. Reports and applications pursuant to Department Rule 112.80 (c) (3) (4) and (5) and Section III (K) of this Directive shall be submitted to the Chairperson of the Drug Review Committee on the attached form, which can be reproduced locally.

2. Doses exceeding the maximal dose authorized in Section III (K) may be utilized by an attending physician for up to three calendar days if necessary for effective treatment. The physician shall document the reason for such use in the recipient's medical record and shall notify the facility's medical director of the use no later than the next working day after initiation of the higher dose. If higher than the maximal dose is to be utilized for more than three calendar days, authorization shall be obtained from the facility's medical director who is responsible for applying to the Chairperson of the Drug Review Committee for authorization. If the facility's medical director has submitted a written application for authorization to the Chairperson of the Drug Review Committee, the facility's medical director may authorize continuation of the higher than maximal dose for up to seven calendar days beyond the initial three (total of 10 calendar days). The written response of the Chairperson of the Drug Review Committee or his/her designate shall be filed in the recipient's medical record together with a copy of the medical director's application for authorization.

B. Periodic Evaluation of Antipsychotic Drug Treatment: Antipsychotic drug treatment shall be evaluated at least once yearly by reducing the dose by about 10% every three to seven days until the drug has been stopped completely or the clinical condition worsens. This procedure indicates whether antipsychotic medication is still beneficial and also helps to detect signs of Tardive Dyskinesia upon withdrawal of the masking effect of the neuroleptic.

7/86

Illinois Department of Mental Health and Developmental Disabilities

APPLICATION FOR EXEMPTION
TO PPD 02.06.01.02, SECTION III (K)

PSYCHOTROPIC DRUGS AND NARCOTICS

Facility: _____ Unit or Ward: _____

Recipient Name: _____ Admission Date: _____

Age: _____ Sex: ____ Male ____ Female

Attending Physician: _____

Physician Consultant, if any: _____

Recipient's Diagnosis, DSM-III:

Axis I.

II.

III.

IV. (optional)

V. (optional)

Status of recipient's physical condition (Please attach a completed copy of the Medical-Drug Alert Form (DMHDD-715)):

Treatment/Habilitation and rationale:

Drugs concurrently prescribed:

Drug	Daily Dose	Rationale	Response	Adverse Effects

Drug and/or dose requested for exemption:

1. Drug: _____

2. If currently prescribed:

   Current daily dose: _____

   Maximum dose documented for recipient, including response and adverse effects: _____

   _____

   _____

3. Other drugs tried previously:

Drug	Date Started	Date Stopped	Maximum Daily Dose	Response	Adverse Effects

4. Non-drug treatments tried previously:

Treatment	Response	Adverse Effects

5. Requested daily dose:

6. Type of exemption requested (please check appropriate category(s)):

   Exemption to list of approved psychotropic drugs, Department Rule 112.80 (c):

   _____1 _____2 _____3 _____4 _____5

   Exemption to maximal dose limit in Policy and Procedures Directive 02.06.01.02, Section III (K).

   _____a _____b _____c

7. Narrative justification for exemption:

8. Please attach copies of medical references if exemption is to Department Rule 112.80.

Signatures:

Attending Physician: _____, M.D. Date:_____

Facility Medical Director: _____, M.D. Date: _____

Section 112.80 Use of narcotics and psychotropic drugs in Department facilities

a) In accordance with Section 5.1 of "AN ACT codifying the powers and duties of the Department of Mental Health and Developmental Disabilities" (Ill. Rev. Stat. 1985, ch. 91½, par. 100-5.1), below is a list of narcotics and psychotropic drugs authorized for use in Department facilities. For the purposes of this Section, "psychotropic drugs" refers to drugs whose use for antipsychotic, antidepressant, antimanic and/or antianxiety purposes as listed in the AMA Drug Evaluations (American Medical Association, 1983, latest edition) or the Physician's Desk Reference (PDR) (Medical Economics Company, 1986, published annually). "Narcotics" refers to those drugs listed as narcotics in the same references.

b) The Department shall establish a Drug Review Committee of eight members of which four shall be the Department's Associate Director for Clinical Services (Chairperson), the Department's Director of Research, the Department's Chief of Medical Services, and the Department's Chief of Pharmacy Services. The Associate Director for Clinical Services shall appoint four additional Department employees representing a broad scope of the pharmacological services and skills required in the Department. The Drug Review Committee shall review the use of and information on the efficacy and safety of psychotropic drugs and narcotics listed in subsections (c)(1) and (c)(2) and other marketed psychotropic drugs at least annually. The Drug Review Committee shall recommend to the Associate Director for Clinical Services revisions to the list of approved drugs in subsections (c)(1) and (c)(2), and the Associate Director for Clinical Services shall propose amendments to this Section based on his/her professional medical judgment. Notwithstanding the authorized use of any drug pursuant to subsections (c)(1), (c)(2), (c)(3), (c)(4), or (c)(5), the Associate Director for Clinical Services may, based on his/her professional medical judgment, order the immediate discontinuation of the use of a drug in Department facilities whenever it is withdrawn from marketing in the United States, and/or the U.S. Food and Drug Administration rescinds its approval for marketing in the United States, and/or the Drug Review Committee recommends discontinuation based on information, from Department experience with the drug or from the medical literature, that the drug lacks efficacy or is unsafe.

c) List of narcotics and psychotropic drugs for use in Department facilities.

1) Narcotics

Alphaprodine Hydrochloride
Butorphanol Tartrate

Codeine Phosphate
Codeine Sulfate
Hydrochlorides of Opium Alkaloids
Hydrocodone Bitartrate
Hydromorphone Hydrochloride
Levorphanol Tartrate
Meperidine Hydrochloride
Methadone Hydrochloride
Morphine Sulfate
Nalbuphine Hydrochloride
Oxycodone Hydrochloride
Oxycodone Terephthalate
Oxymorphone Hydrochloride
Pentazocine Hydrochloride
Pentazocine Lactate
Propoxyphene Hydrochloride
Propoxyphene Napsylate

2) Psychotropic drugs

Acetophenazine
Alprazolam
Amitriptyline
Amoxapine
Butaperazine
Carphenazine
Chlordiazepoxide
Chlorpromazine
Chlorprothixene
Clorazepate
Desipramine
Diazepam
Doxepin
Fluphenazine
Flurazepam
Halazepam
Haloperidol
Hydroxyzine Pamoate
Imipramine
Isocarboxazid
Lithium
Lorazepam
Loxapine
Maprotiline
Meprobamate
Mesoridazine
Molindone
Nortriptyline
Oxazepam
Perphenazine

Phenelzine
Pimozide
Piperacetazine
Prazepam
Prochlorperazine
Protriptyline
Temazepam
Thioridazine
Thiothixene
Tranylcypromine
Trazodone
Triazolam
Trifluoperazine
Triflupromazine
Trimipramine

3) Drugs not appearing in subsection (c)(2) and which are newly approved for marketing and labeled for psychotropic indications by the U.S. Food and Drug Administration within the previous 12 months shall be prescribed only on the written authorization of the facility's medical director. The use of any such medication shall be reported to the Chairperson of the Drug Review Committee within 15 days of initiation of the drug use. At its next meeting, the Committee shall review the drug and shall approve or disapprove the use of the drug in Department facilities on the basis of scientific information available and shall give written interim notice to facility directors pending the next review and amendment of this Section.

4) Drugs not appearing in subsection (c)(2) and which are approved for marketing by the U.S. Food and Drug Administration, but which are not labeled by the U.S. Food and Drug Administration for psychotropic indications, but whose use for psychotropic indications is listed in the AMA Drug Evaluations shall be prescribed only on the written authorization of the facility's medical director. The Committee shall review the drug and shall approve or disapprove the use of the drug in Department facilities on the basis of scientific information available and shall give written interim notice to facility directors pending the next review and amendment of this Section.

5) Drugs not appearing in subsection (c)(2), and which are approved for marketing by the U.S. Food and Drug Administration, but which are neither labeled for psychotropic indications by the U.S. Food and Drug Administration nor listed as having psychotropic indications in the AMA Drug Evaluations, but for which there is medical

literature supporting their use for psychotropic indications may be prescribed by the attending physician for up to three calendar days. The physician shall document the reason for such use in the recipient's medical record and shall notify the facility's medical director of the use no later than the next working day after administration of the drug. If the drug is to be utilized for more than three calendar days, authorization shall be obtained from the facility's medical director who is responsible for applying to the Chairperson of the Drug Review Committee for authorization. If the facility's medical director has submitted a written application to the Chairperson of the Drug Review Committee, the facility medical director may authorize continuation of the use of the drug for up to seven calendar days beyond the initial three-day period (total of 10 calendar days). The written response of the Chairperson of the Drug Review Committee or his/her designate shall be filed in the recipient's medical record together with a copy of the medical director's application.

6) Use of any drug not authorized pursuant to subsections (c)(1), (c)(2), (c)(3), (c)(4) or (c)(5) for psychotropic purposes is prohibited, unless its use has been approved for research in writing by the Chairperson of the Drug Review Committee.

(Source: Amended at 10 Ill. Reg. 11894, effective July 11, 1986.)

Section 112.90 Administration of psychotropic drugs

This Section addresses the initiation of drug treatment with psychotropic drugs (as defined in Section 112.80) in the newly admitted recipient and the on-going monitoring of drug treatment thereafter. Each Department facility shall establish procedures consistent with this Section, in accordance with professional practice requirements, Departmental directives, and the facility's organization, resources, and clinical population. Professional practice means those practices which a licensed physician (Ill. Rev. Stat. 1983, ch. 111, pars. 4401 et seq.) would use when exercising his/her professional clinical judgment in prescribing medication and which a licensed registered nurse (Ill. Rev. Stat. 1983, ch. 111, pars. 3401 et seq.) would use when exercising his/her professional clinical judgment in administering medication.

a) Initiation of drug treatment

1) All recipients shall receive a medical history, physical examination and either a psychiatric or, in the case of developmentally disabled recipients, a psychological examination within 24 hours of their admission to a Department facility and those laboratory tests determined by a licensed physician, when exercising his/her professional clinical judgment in administering medication, shall be ordered.

2) No medication shall be prescribed for a recipient unless:

A) A medical, physical, and either a psychiatric or, in the case of developmentally disabled recipient, a psychological examination of the recipient has been conducted and documented in the recipient's medical record. The prescribing physician shall conduct the examinations personally, or shall review the record of the examinations. The prescribing physician shall record and sign the prescription, and shall also record in the recipient's medical record the recipient's mental status (as defined in The American Psychiatric Association's Psychiatric Glossary, 5th Edition, Washington, D.C., 1980), the intended effects of the prescribed medication, and other pertinent information, such as the relationship of the drug therapy to other forms of treatment or habilitation and potential interaction with any other medication being delivered to the recipient, or

B) The prescribing physician has determined by personal observation that the recipient is in need of immediate medication in order to prevent physical harm to himself/herself or others, and shall so document this in the recipient's medical record, or

C) The prescribing physician cannot immediately examine the recipient in person, but has determined, based on a description of the recipient's behavior, other medications, and known medical problems, that immediate administration of psychotropic medication is in the recipient's best interest in order to prevent physical harm to himself/herself or others. The prescribing physician shall document this determination in the recipient's medical record within 48 hours of prescribing medication.

3) The prescribing physician may verbally (including by telephone) authorize the administration of medication. The prescribing physician shall dictate the oral medication order to a registered nurse pursuant to the Illinois Nursing Act (Ill. Rev. Stats. 1983, ch. 111, pars. 3401 et seq.) and shall sign the order within 24 hours. In each case, within 48 hours of any oral authorization, the prescribing physician shall also enter a progress note in the recipient's record that states:

A) The reasons for prescribing the psychotropic medication, including the information given by the person requesting the prescription;

B) The medication's intended effect, and

C) The reason the medication order was given verbally, rather than after personal examination of the recipient.

4) Whenever medication is administered pursuant to a verbal order, the registered or licensed practical nurse who administers the drug shall immediately enter in the recipient's medical record a detailed description of the recipient's behavior prior to the administration of the drug and of the circumstances which in his/her opinion required the administration.

5) Psychotropic drugs shall be prescribed for specific doses and time, not to exceed 30 days.

b) Ongoing monitoring of drug treatment

1) The attending physician shall review as often as the recipient's clinical condition warrants, but no less often than once per month, through personal examination of the recipient, and/or the recipient's medical record, and/or staff conferences, the results of medication administered including both beneficial effects and side effects.

2) The attending physician shall document the status of the recipient's condition in the recipient's medical record as often as the recipient's clinical condition warrants, but no less often than once per month. Documentation of the rationale for the dose of medication shall be included in the progress notes and/or the treatment or habilitation plans no less often than once per month. Significant side effects, that is, those side effects of medications determined by a licensed physician, when exercising his/her professional clinical judgment, to be severe, dangerous, and/or annoying for the recipient, (or their absence) shall be noted in the recipient's medical record.

3) Facility staff shall document in the recipient's medical record additional medical, psychiatric, psychological, and social history and psychiatric, psychological and physical findings and laboratory results as this information becomes available.

c) Reduction of the risk of tardive dyskinesia

1) Use of antipsychotic drugs shall be restricted to the treatment of psychotic disorders, including schizophrenic disorders, parancid disorders, schizophreniform disorders, brief reactive psychosis, atypical psychosis, manic episode, major depressive episode with psychotic features, infantile autism and toxic or organic psychosis, Tourette's disorders, and severe behavioral disturbance in a recipient having a developmental disability. Use in any other conditions shall be specially justified in the recipient's medical record.

2) Use of antipsychotic drugs for more than six months shall be prescribed only when a continuing response can be shown, or when exacerbation occurs or has occurred upon cessation of medication.

3) Whenever a recipient has received antipsychotic medication continuously for three months, the recipient or, if the recipient is under guardianship, the guardian, or, if the recipient is a minor, the recipient's parent or guardian, shall participate in the decision regarding continuation of the recipient's medication based on the need to balance the risk of tardive dyskinesia with the risk of continuing in, exacerbating, or developing a psychotic state, Tourette's symptoms or severe behavioral disturbance in a recipient having a developmental disability. If the recipient is an adult not under guardianship, and a clinical assessment of the recipient's intellectual and emotional capabilities puts in doubt the recipient's ability to meaningfully participate in this decision process, timely efforts shall be undertaken to obtain guardianship. The participation of the recipient,

guardian, or parent and the decision regarding continuation of medication shall be recorded in the recipient's medical record. The recipient's response to medication shall be monitored and shall be re-evaluated with the participation of the recipient, guardian or parent at no less than six month intervals, and this re-evaluation and participation shall be recorded in the recipient's medical record.

(Source: Amended at 9 Ill. Reg. 12785, effective August 1, 1985.)

Attachment #2

TABLE OF DRUG DOSAGES

ELGIN MHC

PSYCHOTROPIC DRUG	UPPER LIMIT OF DAILY AVERAGE ACUTE TREATMENT DOSE (MILLIGRAMS)			DAILY MAXIMAL DOSE LIMIT (MILLIGRAMS)
	Adult 18-65	Over 65 (without OBS[1])	Over 65 (with OBS[1])	
Acetophenazine	150	75	40	600
Alprazolam	4	2	1	10
Amitriptyline	200	100	50	350
Amoxapine	300	150	75	600
Chlordiazepoxide	100	50	25	300
Chlorpromazine	800	400	200	2000
Chlorprothixene	300	150	75	600
Clorazepate	60	30	15	60
Desipramine	200	100	50	300
Diazepam	40	20	10	40
Doxepin	300	150	75	300
Fluphenazine*	10	5	2.5	100
Flurazepam	30	15	15	60
Halazepam	160	80	40	160
Haloperidol**	12	6	3	120
Hydroxyzine Pamoate	400	200	100	400
Imipramine	200	100	50	350
Isocarboxazid	30	15	7.5	30
Lithium	3600	1800	900	***
Lorazepam	6	3	1.5	10
Loxapine	60	30	15	250
Maprotiline	150	75	50	250
Meprobamate	1600	800	400	2400
Mesoridazine	400	200	100	500
Molindone	100	50	25	225
Nortriptyline	100	50	25	150
Oxazepam	120	60	30	120
Perphenazine	60	30	16	100
Phenelzine	90	45	24	90
Pimozide	10	5	2.5	20
Prazepam	40	20	10	60
Prochlorperazine	100	50	25	200
Protriptyline	60	30	15	80
Temazepam	30	15	15	60
Thioridazine	800	400	200	800

TABLE OF DRUG DOSAGES

ELGIN MHC

PSYCHOTROPIC DRUG	UPPER LIMIT OF DAILY AVERAGE ACUTE TREATMENT DOSE (MILLIGRAMS)			DAILY MAXIMAL DOSE LIMIT (MILLIGRAMS)
	Adult 18-65	Over 65 (without OBS[1])	Over 65 (with OBS[1])	
Thiothixene	40	20	10	150
Tranylcypromine	20	10	5	30
Trazodone	500	250	125	600
Triazolam	0.5	0.25	0.125	1.5
Trifluoperazine	20	10	5	100
Triflupromazine	200	100	50	250
Trimipramine	200	100	50	300

* Fluphenazine Enanthate or Decanoate - The upper limit of the Average Acute Treatment Dose for adults 18-65 years of age is 50 mg every two weeks, and the Maximal Dose Limit is 200 mg every two weeks.

** Haloperidol Decanoate - The upper limit of the Average Acute Treatment Dose for adults 18-65 years of age is 100 mg per month, and the Maximal Dose Limit is 300 mg per month.

*** Lithium Carbonate shall be monitored by clinical effects and blood levels. Antimanic lithium blood levels should fall approximately in the range of 0.6-1.4 milliequivalents per liter (meq/l), and less than 1.6 meq/l. Since blood levels cannot be adjusted precisely, occasionally the suggested blood level may be exceeded. In this case, the oral dose should be adjusted downward to achieve blood levels within the recommended limits.

[1]OBS = Organic Brain Syndrome