

	State of Indiana Indiana Department of Correction Division of Youth Services	Effective Date	Page 1 of	Number
HEALTH CARE SERVICES DIRECTIVE-YOUTH SERVICES Manual of Policies and Procedures		4/1/2022	10	4.02Y

Title THERAPEUTIC SECLUSION AND RESTRAINT IN MENTAL HEALTH CARE

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5	01-02-101	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) provides guidelines for the therapeutic use of highly restrictive interventions in the treatment of youth with mental illness. This HCSD is not applicable to restraints used for security reasons, for the movement of youth from place to place, prevention of escape, etc.

II. DEFINITIONS:

- A. **MULTIDISCIPLINARY TEAM (MDT):** A treatment team comprised of individuals from different disciplines that contribute a broad range of perspectives and treatment modalities in the management of youths' needs.
- B. **QUALIFIED MENTAL HEALTHCARE PROFESSIONAL (QMHP):** A person with professional training, experience, and demonstrated competence in the treatment of mental illness. QMHPs include physicians, psychiatrists, psychologists, social workers, mental health counselors, mental health nurse practitioners, mental health-trained nurses, or other qualified persons as designated by the Executive Director of Behavioral Health Services.
- C. **RESTRAINT:** Any manual method, physical or mechanical device, material or equipment that restrict body movement by immobilizing or reducing the ability of the youth to move their arms, legs, body or head freely. Orthopedic devices, surgical dressings, protective helmets, or other devices used to provide support or to protect the youth during activities of daily living are not considered restraint.

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- D. **SECLUSION:** A therapeutic intervention by which staff use rooms designed to safely limit a youth's mobility or exposure to stimuli that overwhelms the youth's ability to regulate their emotions.

III. GENERAL GUIDELINES:

The safe management of youth with mental illness may, on occasion, require restrictive and/or intrusive interventions. Restraint and seclusion are safety interventions of last resort, to be used only when an individual poses an imminent danger to self or someone else.

When establishing the mental health treatment plan, mental health staff shall consider the youth's risk of violence, previous restraint and seclusion history, history of emotional triggers, and environmental stressor which may lead to self-destructive behavior. Staff shall also establish de-escalation strategies or safety plans with youth to help reduce the need for restraint or seclusion in the future. This shall be included as part of the treatment plan.

Therapeutic restraint or seclusion shall be used in mental health treatment only when the intervention is necessary to ensure the physical safety of the youth or the safety of others. These interventions must not be used simply because a youth is loud, rude, non-violently disruptive or non-compliant.

Health Services staff are absolutely forbidden to use restraints or seclusion for purposes of retaliation, punishment, or for any disciplinary purpose.

Restraint or seclusion may be used only after less restrictive interventions have been implemented and failed to protect the youth and others from harm or less restrictive measures have been considered and determined to be ineffective. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the youth or others from harm.

In order of increasing restrictiveness, the interventions available for addressing dangerous and destructive behavior by youth with mental illness or altered mental status are:

- A. Verbal intervention and increased surveillance by staff;
- B. Close Observation or Safety Precautions;
- C. Supervised separation from the rest of the population on the unit in a separate space or in an unlocked and separate room;
- D. Therapeutic seclusion;

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- E. Short-term physical or mechanical restraint;
- F. Emergent voluntary or involuntary psychotropic medication administration; and,
- G. Emergent voluntary or involuntary psychotropic medication administration in combination with any of the measures in A through F.

A registered nurse (RN) must be physically present, on site, whenever therapeutic restraints are used.

When restraint or seclusion is necessary, it must be:

Implemented in written modification to the youth's plan of care in the electronic medical record (EMR);

Implemented in accordance with safe and appropriate restraint and seclusion techniques; and,

Discontinued when clinical parameters or specific behavior goals are met that support the removal of restraints, or the youth being removed from seclusion, regardless of the amount of time identified in the order for restraint or seclusion.

IV. SECLUSION:

Seclusion shall be used when a youth's behavior is endangering the physical safety of others and other less restrictive means of managing the youth's behavior have failed or are thought not to be clinically appropriate. Seclusion is contraindicated if the youth has significant medical problems requiring immediate care, is engaging in self-injurious behavior, or is at risk of attempting suicide.

When therapeutic seclusion is necessary, the youth must be placed in a safe and secure room with the door locked. The room must be free of potentially hazardous items and conditions (e.g., electrical outlets, etc.). Youth Developmental Specialists shall be responsible for ensuring that the cell is searched and the youth is strip-searched prior to initiation of therapeutic seclusion.

Youth placed in seclusion shall have orders determined by a Mental Health Professional (MHP) in consultation with psychologist and/or psychiatrist.

V. RESTRAINTS:

A youth is to be therapeutically restrained in situations in which serious violence or injurious acts to self have occurred or the acts are determined to be imminent and

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seclusion has not been effective or has been determined to be inadequate or clinically inappropriate.

Therapeutic restraint is contraindicated if the youth has significant medical problems requiring immediate care.

Therapeutic restraints must be used as humanely as possible and for the shortest period of time possible.

The use of therapeutic restraint may be implemented only on the order of a physician. Orders for the use of restraint must never be written as a standing order or on an as needed basis (e.g., PRN). When an on-call physician, who is not the youth's attending psychiatrist, initiates the order for restraint, the attending psychiatrist shall be consulted as soon as possible.

In emergency situations, when restraint is necessary for the management of a violent or self-destructive behavior which jeopardizes the immediate physical safety of the youth; an RN, psychiatric nurse practitioner, psychologist, or other licensed independent practitioner may initiate restraint or seclusion and obtain a verbal or telephone order from the attending or on-call physician as soon as possible. This order must be obtained within one (1) hour after the youth is placed in restraints.

The Warden, as the legal guardian, Executive Director of the Division of Youth Services, and Executive Director of Behavioral Health Services must be notified that the youth has been placed in restraints immediately.

Whenever restraints are used, the nurse responsible for obtaining the order must document the following in the EMR:

- A. Events leading up to the use of therapeutic restraints;
- B. A description of the youth's behavior;
- C. The other methods of management attempted or the reason why other methods of management were not considered effective;
- D. The type of therapeutic restraints used;
- E. The initial, one hour face-to-face evaluation and any subsequent evaluation(s) which were completed;
- F. All contacts with the attending psychiatrists or physician; and,
- G. The length of time the restraints were employed.

The prescribing physician or on call physician must identify the clinical parameters or specific behavior changes that support the removal of restraints.

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The order for restraint may not exceed two (2) hours without being renewed by the attending psychiatrist or on call physician.

Restraints must be discontinued at the earliest possible time when specific behavioral criteria have been met. For this reason, periodic assessment of the youth's mental status and adherence to behavioral objectives must be done on the following schedule:

- Within one (1) hour after the youth is placed in restraint and every two (2) hours thereafter, the youth must be seen face-to-face by an RN trained to perform mental status assessment to determine:
 - The youth's current mental status
 - The youth's reaction to restraint
 - The youth's medical condition;
 - The youth's behavioral condition; and,
 - The need to continue or terminate the restraints.

Assessment intervals must be increased for youth with medical risk factors such as morbid obesity, respiratory and cardiac disease which place them at increased risk for injury, difficulty breathing, or other medical problem when restrained.

- At two (2) hours, the RN must obtain a new order to continue the intervention. The order may be renewed every two (2) hours up to a maximum of twenty-four (24) hours. At twenty-four (24) hours, before a new order for restraint may be implemented, a QMHP or RN must perform a comprehensive mental health assessment, completing the mental status exam in the behavioral health progress note or behavioral health suicide observation templates of electronic medical record. The assessment must be shared with the attending psychiatrist. Restraint may be continued if the youth remains acutely suicidal or poses a threat of serious physical harm to self or others and less restrictive interventions will not provide adequate safeguards.
- At the end 72 hours, if restraints are still necessary for the safety of the youth or others, the treating psychiatrist must conduct a face-to-face evaluation of the youth. The treating psychiatrist must consult with the Health Services vendor's Regional Director of Psychiatry for direction regarding ongoing management.
- Restraints shall be terminated upon authorization of a physician, psychiatrist, or RN in consultation with a physician or psychiatrist.

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The use of restraints, including all monitoring and support activities, must be documented in the electronic medical record and on applicable State forms.

Once restraint has been discontinued, the treatment plan shall be updated and debriefing with the youth must be completed by a mental health staff member on the next business day and on State Form 56887, "Individual Debrief." This debriefing and the completed form shall be documented in the EMR. There should be a focus on symptom recognition, triggers that led to the crisis, and problem solving or conflict resolution skills that could have been utilized. There should also be a focus on strategies to manage emotions effectively through de-escalation and what interventions should be implemented to avoid placement in restraints in the future. A copy of State Form 56887 should be shared with the Warden, Chief Medical Officer, Executive Director of the Division of Youth Services, Executive Director of Behavioral Health, Director of Mental Health, the Health Services vendor's Regional Director of Psychiatry, Regional Director of Behavioral Health Services, Regional Director of Mental Health, and the site's Quality Assurance Manager within five (5) business days of the date restraint was discontinued.

A second debriefing with the multidisciplinary team including the psychiatrist, Warden, mental health staff, program staff, and Custody staff must be completed within one (1) week of the use of restraint on State Form 56888, "Multi-Disciplinary Team Debrief." This formal debriefing must review environmental stressors, staff responses, and whether the de-escalation or safety plan(s) was (were) appropriately implemented to identify and implement any modifications to the environment, unit procedures, processes, or staff training to reduce the chance of restraint being necessary in the future. A summary of this team debriefing and the completed form shall be documented in the patient's EMR. A copy of State Form 56888 should be shared with the Warden, Chief Medical Officer, Executive Director of the Division of Youth Services, Executive Director of Behavioral Health Services, Director of Mental Health, the Health Services vendor's Regional Director of Psychiatry, Regional Director of Behavioral Health Services, Regional Director of Mental Health, and the site's Quality Assurance Manager within five (5) business days of the multidisciplinary team meeting.

A notice shall be posted by the Health Services Administrator (HSA) in the Health Services area and in the Control Center indicating the location of therapeutic restraints in the facility.

The types of restraints which may be used, but not limited to:

- A. Mittens;
- B. Helmets; and,
- C. Limb restraints.

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Padded leather or other soft medical restraints shall be used unless there is a reason to believe that soft restraints will not achieve restraint, **and** such reason(s) is (are) documented by the ordering physician. Security restraints, such as leg irons, waist chains, handcuffs, etc., shall generally not be used as therapeutic restraints unless ordered by the attending psychiatrist or on-call physician for protection from harm under extreme circumstances. This applies both to ambulatory and fixed restraints.

A youth shall never be face-down, hog-tied or spread-eagled when in restraints.

Therapeutic restraints shall be applied by Custody personnel who have been trained, with documentation of training, in appropriate methods for applying therapeutic restraints. The application of therapeutic restraints must be conducted under the supervision of Health Services staff. In health settings when delay may be dangerous, Health Services staff are permitted to make the initial application of restraint, even using gauze ties as necessary, provided that they have been trained in restraint application. Such application must be very short term and requires continuous supervision.

The youth's clothing shall be removed only if this is ordered for clinical or security reasons. If clothing removal is ordered, the reasons for this order must be documented in the health record. Minimally, the youth shall be allowed to wear appropriate underwear.

At no time will any youth be restrained nude.

A youth in restraints shall be observed continuously, face to face, by mental health trained Custody staff. Camera monitoring is not allowed. At 15 minute intervals, the staff must observe for any signs of injury or medical distress until the restraints are removed.

Vital signs including blood pressure, radial pulse, and respirations must be obtained every hour while the youth is restrained.

Range of motion activities shall be conducted jointly by Custody and Health Services staff, for each limb, one (1) limb at a time, every hour. When possible, skin integrity should be assessed when range of motion is conducted.

Nursing staff shall assess circulation to all four (4) extremities every two (2) hours including an assessment of capillary refill, the youth's ability to move fingers and toes, and the presence or absence of edema. The last circulation check should be conducted two (2) hours after restraints have been removed.

The youth must be offered liquids and the opportunity to attend to physical needs (e.g.,

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use of toilet facilities, personal hygiene, etc.) every hour. This may be accomplished by providing the youth with a bedpan or urinal or partially removing the restraints to fulfill the necessary functions.

Medication shall be administered only as needed and as ordered by the psychiatrist or other physician on a voluntary basis. When necessary, involuntary psychotropic medications shall be provided in accordance with Health Care Services Directive 4.04Y, "Emergent Involuntary Psychotropic Medication."

Therapeutic interventions other than medication should be continued by the mental health staff to the extent possible.

A no-utensil/no-packaging diet may be offered if the patient is in restraints for longer than four (4) hours.

Restraints must be discontinued when clinical parameters or specific behavioral goals identified by the prescribing psychiatrist or on call physician are met. Trained Custody staff shall remove the restraints under the supervision of Health Services staff. Following the removal of the restraints, the youth may be placed under close or constant observation until it is determined by an MHP that this level of supervision is no longer necessary.

After being released from the therapeutic restraints, should the youth renew the behaviors that led to the application of therapeutic restraints, the youth may be placed in therapeutic restraints again, with a new order. At this point, the twenty-four (24) hour limitation begins again, and the situation is treated as a new incident.

Therapeutic restraints must be removed immediately, in their entirety or in part, in an emergency so that timely emergency services may be provided.

Custody and Health Services staff must adhere to the reporting requirements including the completion of any use of force forms found in Policy 03-02-109, "The Use of Physical Force in Youth Services Facilities." All staff members that are expected to manage youth in seclusion or restraints must be trained at new employee training and annual in-service training. Successful completion of training and demonstration of competency must be documented in staff training records.

VI. STAFF TRAINING:

All staff that are expected to manage youth in restraints or seclusion must be trained at new employee orientation and annually. Successful completion of training and demonstration of competency must be documented in staff training records.

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Custody staff must be sufficiently trained in:

- A. All provisions of the HCSD;
- B. The proper use of seclusion and restraint;
- C. The proper implementation of seclusion;
- D. The application of restraints;
- E. Required monitoring activities;
- F. Maintaining nutrition and hydration during restraint;
- G. Range of motion activities; and,
- H. Release from restraint procedures.

Health Services staff must be trained in:

- A. Techniques to identify actions, circumstances, events, and environmental factors that may trigger behaviors which result in the use of seclusion or restraint;
- B. The use of nonphysical intervention skills which may reduce the need for seclusion or restraint;
- C. Selecting the least restrictive intervention based on an individualized assessment of the youth's medical or behavioral status or condition;
- D. The safe application and use of all types of restraints used, including training in recognizing and responding to signs of physical and psychological distress (e.g., positional asphyxia);
- E. Monitoring, assessment, and the provision of care for a youth in restraint or seclusion including the expectation and parameters of the face-to-face evaluations; and,
- F. Identification of specific behavioral changes that indicates that restraint or seclusion is no longer necessary.

Health Services staff who are expected to apply therapeutic restraints in emergency circumstances shall be trained in their appropriate use and application.

VII. OUTCOME MONITORING:

The HSA is responsible for maintaining data on use or restraint and seclusion including the number of youths restrained or secluded and episodes and duration of each use of

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restraint or seclusion. The HSA shall notify the Chief Medical Officer, Executive Director of Behavioral Health Services, Executive Director of Physical Health, the Health Services vendor's Regional Director of Psychiatry, Regional Director of Behavioral Health Services, and the site's Quality Assurance Manager within 24 hours of initiation of the use of therapeutic restraint with a youth. Use of restraint or seclusion shall be documented on the facility's monthly Health Services Report and shall be reviewed for quality assurance.

VIII. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to youth.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date