	DEPARTMENT OF CORRECTIONS AND REHABILITATION CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES	EFFECTIVE DATE: January 01, 2024	POLICY NO.: COR.10.G.01
		SUPERSEDES (Policy No. & Date): COR.10.1I.01 of February 02, 2011	
	SUBJECT: RESTRAINT AND SECLUSION (CLINICALLY ORDERED)		Page 1 of 12

1.0 PURPOSE

The purpose of this policy is to provide direction and procedures for the safe use of medically directed physical restraints and seclusion initiated for assessment and behavior management of an incarcerated individual with a mental disorder who is disruptive to a therapeutic environment, while maintaining the incarcerated individual's dignity and protecting the safety of the incarcerated individual and staff.

The Department of Corrections and Rehabilitation (DCR) is committed to preventing, reducing, and striving to eliminate all medically directed physical restraints and seclusions, including wrist-waist restraints, without increasing incarcerated individual or staff injury by:

- Always respecting the dignity and ensuring the safety of the incarcerated individual.
- Raising awareness of staff about how restraint or seclusion may be experienced by the incarcerated individual.
- Working to prevent seclusion or restraint use by employing lesser restrictive measures at first sign of incarcerated individuals moving away from safe baseline behaviors.
- Awareness that non-physical interventions are preferred for many reasons, including the unintended effects that may result from seclusion and restraint (e.g. emotional trauma, risk of harming the therapeutic relationship, or physically harming incarcerated individuals or staff).
- Limiting the use of seclusion or restraint to emergencies, as a last resort, in which there is a danger to self or others that cannot be otherwise safely avoided.
- Discontinuing the use of seclusion or restraint as soon as possible. Release criteria must be understood by the incarcerated individual and clearly attainable in a reasonable amount of time.
- Ensuring the use of seclusion or restraint is not based on the individual's history of seclusion or restraint or history of dangerous behavior.

2.0 SCOPE

This policy and procedure shall apply to all correctional facilities and their assigned personnel.

3.0 REFERENCES, DEFINITIONS & FORMS

.1 References

a. Hawaii Revised Statutes, Section 26-14.6, Department of Corrections and Rehabilitation; and Section 353-A, Director of Corrections and Rehabilitation, Powers and Duties.

b. Hawaii Revised Statutes: Section 334-60.1 to 62, and Section 334-74.

c. Psychiatric Services in Jails and Prisons (Second Edition), American Psychiatric Association, (2000).

d. Standards for Health Care Services in Prisons Use of Restraint and Seclusion in Correctional Facilities, and Emergency Psychotropic Medications, National Commission on Correctional Health Care (2008).

e. Use of Restraint and Seclusion in Correctional Mental Health Care, American Psychiatric Association, (Dec. 2006).

.2 Definitions

a. Comprehensive Treatment Plan (CTP): A prescriptive document that identifies strengths and needs relative to an individual's behavioral disorder that is created in collaboration with the incarcerated individual, which outlines and prioritizes measurable goals and objectives for treatment in order to stabilize and improve the disorder.

b. Injurious (repetitive) behavior: Behavior that is unsafe and presents a substantial, continuing and unpredictable danger that cannot be appropriately addressed by means other than safety measures of last resort.

c. Lesser Restrictive Measures: Non-physical and physical methods that de-escalate an incarcerated individual, including "Quiet Time", which is an incarcerated individual's voluntary use of an unlocked room or other area to calm down and whereby stress reducing techniques can be practiced (not

considered seclusion). Although staff may suggest an incarcerated individual attempt quiet time, the incarcerated individual shall not be coerced or threatened with more serious outcomes if the incarcerated individual does not volunteer for quiet time.

d. Physical Management: Any physical contact with an incarcerated individual by properly trained correctional staff that is intended to redirect or contain harmful behavior such as a two or more persons interlocking hold; floor containment until struggling subsides and applied restraints.

e. Restraint: Any method (physical/mechanical or device) that restricts freedom of movement or normal access to one's body. Restraint includes, but is not limited to, wrist-waist restraints, 2 or 4-point restraints, full body restraints, and walking restraints.

f. Soft Restraints: Restraints made with a soft material such as fleece-lined leather, rubber, canvas or other material that restricts movement to eliminate harm to self and/or others.

g. Mechanical Restraints: Restraints usually made of metal or high-density plastic used to restrain suspects, detainees or prisoners during transport. Mechanical restraints shall not be substituted for therapeutic restraints.

h. Wrist–Waist Restraint: The restraint of the hands to the waist to prevent the individual from causing harm to self or others while maintaining movement.

i. Two Point Restraint: The restraint of two extremities.

j. Four Point Restraint: The restraint of four extremities.

k. Full Body Restraint: The restraint of four extremities and the immobilization of the mid-section.

l. Helmet: A lockable helmet that is placed on the head of an incarcerated individual to prevent the individual from hitting his or her head on a hard surface and causing injury to the head.

m. Spit-hood: A mesh hood that is placed over the incarcerated individual's head to prevent spit directed at staff. Incarcerated individuals shall never be left unattended when the hood has been applied.

n. Seclusion: The *involuntary* confinement of a person alone in a room where the person is prevented from leaving. Constant observation. Record the time and observations at least once every 15 minutes.

o. Licensed Mental Health Professional (LMHP): A psychiatrist, a licensed or license eligible psychologist, an advanced practice nurse with a psychiatric clinical nurse specialist (APRN/CNS), a registered nurse with a Adult Psychiatric Mental Health Nursing certification from the American Nursing Credentialing Center (ANCC) or an appropriately qualified physician whom has been provided training in the following policies and procedures: e.g. Suicide Prevention (Suicide and Safety Watch), Seclusion and Restraint.

p. MHSA: Mental Health Section Administrator

q. MHBA: Mental Health Branch Administrator

r. Serious Mental Illness (SMI): A diagnosable mental disorder characterized by alterations in thinking, mood, or impaired behavior associated with distress an/or impaired functioning; primarily inclusive of schizophrenia, severe depression and bipolar disorder, and severe panic disorder, obsessive compulsive disorder, and post-traumatic stress disorder.

.3 Forms

a. Form 0425: Suicide/Safety Watch/Seclusion Monitoring Log (attached)

b. DCR 0443 (Side 1), Incarcerated individual Post-Event Interview and the Watch Commander or designee will complete; (Side 2), Staff Post-Event Report (attached)

c. DCR 0457, Transfer Authorization and Information Order Form (attached)

d. DCR 0484, Restraint Monitoring Flow Sheet (attached)

4.0 POLICY

.1 The medical and mental health treatment teams assigned to the mental health modules identify incarcerated individuals who should not be secluded or restrained due to pre-existing mental health, trauma, medical conditions or physical disabilities that would place the incarcerated individual at greater risk during restraint or seclusion, or who have a history of sexual or physical abuse that would place the incarcerated individual at greater psychological risk during restraint or

seclusion. The treatment team will attempt to identify these individuals for possible alternative interventions to seclusion or and/or restraint, where feasible. Identification will be indicated in the Health Maintenance Summary or identifying materials retained on the modules so that staff will take these conditions into consideration when faced with a possible seclusion or restraint event.

.2 The use of restraint and seclusion as treatment interventions are prohibited other than for incarcerated individuals who exhibit behavior that is self-injurious or injurious to others, have not responded to traditional interventions, and are unable to restrain themselves or to exhibit self-control.

.3 Restraints and seclusion shall be limited to emergencies for incarcerated individuals who exhibit injurious behavior.

.4 Restraints and seclusion for seriously mentally ill incarcerated individuals shall not be conducted in general lock down modules or general special holding units. Seriously Mentally Ill (SMI) incarcerated individuals requiring seclusion or restraint shall be transferred to an appropriate module or setting.

.5 An LMHP's order is required for the application of restraints or seclusion. The order must be obtained within one (1) hour.

.6 A Physician or Psychologist's order is required for the release from restraints or seclusion.

.7 Restraint or Seclusion **cannot be ordered on an "as needed" or "PRN" basis**.

.8 Health care nurses participating in seclusion and restraint activities shall be trained, credentialed and privileged by the mental health staff.

.9 Medical monitoring is required when an incarcerated individual is restrained or secluded. The Warden or Watch Commander of a facility without round-the-clock nurse coverage shall make arrangements with the Clinical Section Administrator for nurse coverage or shall make arrangements for the transfer of the incarcerated individual to an appropriate correctional facility.

.10 The health care section of the sending facility shall notify the health care section of the receiving facility of the transfer and the reasons for the transfer. The incarcerated individual must be maintained in a safe location with continuous observation until more appropriate treatment can be initiated. The MHBA shall be notified of all inter-correctional facility transfers for mental health treatment purposes.

.11 All physical contact with an incarcerated individual takes into consideration the incarcerated individual's gender, history of sexual or physical abuse, trauma, the incarcerated individual's physical health and mental disabilities and limitations, and preferences.

.12 All correctional employees are obligated to report to their supervisor any improper or inappropriate use of restraints that may jeopardize the health of the incarcerated individual.

.13 All Correctional officers, social workers, case managers, nurses and health care providers shall receive eight (8) hours of training annually to know the purpose of, and the differences between suicide watch, administrative and disciplinary segregation, seclusion and restraint. Staff working on or assigned to the mental health modules will receive an additional four (4) hours of training.

.14 The Warden or Watch Commander may authorize supervisory aids, such as video monitors, other staff to assist the Correctional Officer assigned to a mental health module; however, these are only used to supplement required direct observation. Cells, equipment and staff shall be designed or assigned to ensure that no blind spot exist in the seclusion rooms. Staff assigned to monitor incarcerated individuals shall not have other duties, while assigned to the monitoring post. Staff assigned to video monitoring of seclusion cells will be rotated at least one time during an eight (8) hour period.

.15 Correctional officers, social workers, case managers, nurses and health care providers involved in the administration of seclusion and restraint shall be trained in, have demonstrated proficiency, passed their competency and be current in either "Conflict, Prevention, Management and Resolution" (CPMR) or Crisis Prevention Institute (CPI) training.

5.0 PROCEDURES

.1 The facility mental health or nursing staff shall be notified whenever an incarcerated individual begins exhibiting behaviors that deviate from his or her norm, and that may pose a danger to self or others. The incarcerated individual shall be visually assessed and alternatives to restraint and seclusion implemented. The observations shall be documented in the Medical Record. If required, the appropriate LMHP will be contacted for further evaluation and/or treatment orders.

If there is no LMHP on site during an emergency when the incarcerated individual is actively hurting self or attempting to hurt others, restraints may be applied under the direction of the nurse and subsequently the order shall be obtained from the

physician-on-call, as soon as possible after the application. The physician shall be notified if the restrained incarcerated individual has a known medical condition to allow for appropriate medical orders. A specified period for restraints or seclusion shall be determined, not to exceed four (4) hours for the initial authorization and up to twelve (12) hours for subsequent authorization periods.

.2 Less restrictive interventions shall be attempted, reviewed and determined by the LMHP to be inadequate before restraints may be applied to an incarcerated individual or before the incarcerated individual may be placed in involuntary seclusion. At a clinically appropriate time, but as soon a possible after an emergency, the LMHP or Registered Nurse will provide specific guidelines to the incarcerated individual of the positive behavior changes necessary to suspend and avoid restraints or seclusion. Goals should be simple and achievable. **Restraints shall be removed as soon as possible after implementation even if the incarcerated individual does not agree to the treatment terms so long as the incarcerated individual is no longer a threat to self or others.**

.3 Adult Correctional Officers (ACO's) shall apply the restraints when they become necessary, with the assistance of mental health staff, as available and appropriate. All requirements of the Use of Force Policy and Procedures (ERC 14.01) shall be strictly followed.

.4 When an incarcerated individual is restrained in a supine position, staff ensures that the incarcerated individual's head is free to rotate to the side. If an incarcerated individual is restrained in the prone position, staff ensures that the airway is unobstructed at all times, and assures lung expansion is not restricted.

.5 An incarcerated individual placed in seclusion will be placed in a suicide resistant cell and monitored by a trained Adult Corrections Officer or other mental health care trained staff, as ordered by the LMHP, every fifteen (15) minutes. If a suicide resistant cell is unavailable, the incarcerated individual will be provided continuous observation. The ACO or health/mental health care staff will personally review release criteria established by the LMHP with the incarcerated individual placed in clinically ordered seclusion. Once the incarcerated individual has met the release criteria, the ACO or health care staff assigned monitoring responsibilities will notify the Supervising Correctional Officer who will contact the LMHP or Registered Nurse. The LMHP or Registered Nurse will conduct a face-to-face assessment of the incarcerated individual and release/obtain the order to release the incarcerated individual from seclusion, if clinically appropriate. Results of this monitoring are documented in the Form 0425: Suicide/Safety Watch/Seclusion Monitoring Log. The document will be submitted to the Watch Commander at the end of the

Correctional Officer's watch. The shift supervisor will initial the document and submit it to the MHSA, or designee.

.6 An incarcerated individual placed in restraints will be maintained in an open seclusion room and monitored and documented every fifteen (15) minutes for respirations (e.g. chest is rising and falling). In the event that nursing staff in unavailable, respirations shall be monitored and documented by assigned health care staff or ACO staff. A nurse shall monitor the physical condition of the incarcerated individual within the first hour of being restrained, every two (2) hours thereafter and shall document the monitoring on DCR 0484: Restraint Monitoring Flow Sheet. The nurse shall check bony prominences and circulation to extremities distal to the restraint every two (2) hours. A check for full range of motion shall be performed on each extremity every two (2) hours or more often as needed. The temporary release of each restraint for all extremities in turn shall be done with the assistance of the ACO, unless clinically contraindicated.

.7 For incarcerated individuals placed in restraints, fluids shall be offered every two (2) hours or more often, as needed. Bathroom accommodations shall be offered at least every two (2) hours. The ACO shall apply mechanical restraints during movements until the therapeutic restraints are re-applied.

.8 The entire restraint and/or seclusion episode shall be documented in the incarcerated individual's medical record. The following information also shall be included:

- The date and time of the entry.
- The reason for the seclusion or restraints.
- The reasonable efforts made to inform the incarcerated individual of the reasons for the restraint or seclusion; the reasonable efforts made to have the incarcerated individual comply with less restrictive alternatives and the temporary nature of the restraint.
- The restraint/seclusion order including the type and anticipated duration of the restraint/seclusion.
- Restraint/Seclusion admission and discharge notes.
- Special monitoring needs, if indicated; and

- The signature and title of the LMHP.

.9 Physician's, Psychologist's or other LMHP's responsibilities:

- The LMHP personally examine the incarcerated individual within four (4) hours of the beginning of a seclusion or restraint episode, and personally examine the incarcerated individual every twelve (12) hours thereafter, completing DOC 0432: Mental Health LMHP Individual Seclusion Monitoring Log and the applicable section of DOC 0484: Restraint Monitoring Flow Sheet. If an LMHP is not available, a *mental health privileged.* Registered Nurse will examine the incarcerated individual and complete the required document forms. If the LMHP is not a Psychiatrist, the LMHP will consult the Psychiatrist within the four (4) hour period and subsequent twelve (12) hour period and document consultations on DCR 0457.

- The LMHP will provide the order (DCR 0457: Transfer Authorization and Information Order Form). If there is not LMHP available, the Registered Nurse will obtain and carry out the order from the LMHP.

- If an incarcerated individual has been restrained or secluded for twelve (12) hours without improvement, the LMHP shall make a determination, in collaboration with other the mental health and clinical staff monitoring the incarcerated individual, whether to remove/discontinue or continue the restraints or seclusion. If a second twelve (12) hour period is determined necessary, the monitoring clinical and mental health staff shall enter a progress note in the incarcerated individual's medical record until the restraints are removed or the seclusion discontinued. (**Note: for restraints only – every two (2) hour documentation is required for restraint review in the progress notes – DCR 0484: Restraint Monitoring Flow Log).** A second twelve (12) hour period shall commence with an order from the LMHP to continue the restraints or seclusion. The restraint or seclusion order shall not exceed 4 hours and is renewable twice (2 times). All renewals shall be made and communicated in writing to the facility staff.

- A Physician or Psychologist shall conduct a face-to-face assessment at least once every twenty-four (24) hours while the incarcerated individual remains in seclusion or restraint. If a Physician conducts the initial four (4) or subsequent twelve (12) hour assessment, a redundant assessment is not required within the same twenty-four (24) hour period.

- A Psychiatrist must assess the incarcerated individual at least once every seventy-two (72) hour period while the incarcerated individual remains in seclusion or restraint. (If a Physician or Psychiatrist conducts the four (4), twelve (12) or twenty-four (24) hour assessments, a redundant assessment is not required within the same seventy-two (72) hour period).

- Any non-Psychiatrist LMHP must obtain a consultation from a Psychiatrist, when feasible, for any instance where an incarcerated individual is in seclusion or restraint for over forty-eight (48) hours. Consultation or the attempt to consult a Psychiatrist will be documented on the DCR 0457.

- The LMHP shall notify the Mental Health Section Administrator (MHSA) or designee of any seclusion or restraint beyond twelve (12) hours or two or more separate episodes of restraint and/or seclusion of any duration within twelve (12) hours. Notify the MHSA or designee every twenty-four (24) hours that the seclusion or restraint continues.

- An LMHP shall direct staff in the release criteria necessary for the incarcerated individual.

- Am LMHP shall provide any reorders before the expiration of the current order.

- An LMHP shall complete any other appropriate documentation.

- An LMHP shall document the requirement for continuous monitoring of the incarcerated individual.

.10 Assigned staff responsibilities:

- Adult Corrections Officers (ACO's) to monitor incarcerated individual continuously.

- ACO's complete DCR 0425: Suicide/Safety Watch/Seclusion Monitoring Log.

- LMHP's complete DOC 0457 (Physicians Order Form), DOC 0432 (Mental Health LMHP Individual Seclusion Monitoring Log) and the applicable section of DOC 0484 (Restraint Monitoring Flow Sheet).

- ACO's shall monitor the incarcerated individual consistent with status.
- An LMHP shall provide assessment and oversight to all incarcerated individuals who are on suicide, safety watch, secluded or restrained.
- ACO's shall notify professional staff of any changes in the incarcerated individual's condition, and for order renewal, if required.

.11 The MHBA, CSBA, MSBA or CHCA approves all inter-correctional facilities transfer requests.

.12 Post-Seclusion or Restraint:

- Upon release from any seclusion or restraint, the LMHP or RN completes DCR 0443 (Side 1): Incarcerated individual Post-Event Interview and the Watch Commander or designee will complete DCR 0443 (Side 2): Staff Post-Event Report with the incarcerated individual and staff involved in the episode, when possible, within twenty-four (24) hours of the event when possible, but no later than seventy-two (72) hours. The original interview is sent to the treatment team, who attaches it to the CTP. DCR 0443 is used in performance improvement activities.
- Following each episode of seclusion or restraint, mental health staff shall review and modify the incarcerated individual's CTP Plan, as necessary, in order to identity interventions or strategies that may assist in reducing future use of seclusion or restraint. The review shall take place within seventy-two (72) hours following the discontinuation of the last event. Outcomes of the review are documented in the CTP.
- If additional supportive debriefing is recommended for the staff or ACO's following seclusion or restraint events, DCR will attempt to provide the Critical Incident Stress Debriefing (CISD), as time and resources allow.

6.0 OVERSIGHT OF SECLUSION AND/OR RESTRAINT:

.1 DCR requires performance improvement oversight of all episodes of use of suicide watch, seclusion or restraint. The performance improvement process is a critical component in reducing the occurrence of seclusion/restraint. The organization collects data on the use of suicide watch, restraint or seclusion in order to monitor and improve its performance relative to the processes that involve risks to incarcerated individuals or staff. The data collection and quality indicators must include, at a minimum, general frequency, prolonged individual events and multiple uses of seclusion and or restraint by an individual within a six (6) month period.

Reports are made to the MHSA or designee and aggregated for review for Quality Management.

.2 The MHSA conducts a monthly review of the Post-Event forms to identify problematic trends and reports the findings quarterly to MHBA, or designee.

.3 The MHSA is notified daily of suicide watch, seclusion or restraint events (Monday-Friday) via the morning report. Restraint and seclusion logs are reviewed daily, as well as gathered for quality reporting

.4 Staff training concerning suicide watch, seclusion and restraint includes learning about the incarcerated individuals' experiences of such episodes.

APPROVAL RECOMMENDED:

JAN 0 1 2024

Deputy Director for Corrections Date

APPROVED:

JAN 0 1 2024

DIRECTOR Date