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COMMONWEALTH OF VIRGINIA

Board of Juvenile Justice

MEETING MINUTES

November 7, 2018

Main Street Centre, 600 East Main Street, 12th Floor, South Conference Room
Richmond, Virginia 23219

Board Members Present: Michael Herring, David Hines, Scott Kizner, Robyn McDougle, Dana Schrad, and Jennifer Woolard

Board Members Absent: Tyren Frazier, Quwanisha Roman, and Robert "Tito" Vilchez

Department of Juvenile Justice (Department) Staff Present: Diane Abato (Attorney General's Office), Dhara Amin, Ken Bailey, Andrew "Andy" K. Block, Jr., Valerie Boykin, Carol Brown, Ken Davis, Greg Davy, Lisa Floyd, Joyce Holmon, Russell Jennings, Joanna Laws, Mark Murphy, Charisse Mullen (Attorney General's Office), Shaun Parker, Kristen Peterson, Deron Phipps, Maurice Sessoms, Romilda Smith, Lara Todd, James Towey, and Angela Valentine

Guests Present: Jaime Bamford (Commonwealth Center for Children and Adolescents), Asif Bhavnagri (Office of the Secretary of Public Safety and Homeland Security), Marilyn Brown (Chesterfield County Juvenile Detention Center), Kerry Chilton (disAbility Law Center of Virginia), Kelly Dedel (One in 37 Research, Inc.), Will Egen (Commission on Youth), Jason Houtz (Fairfax County Juvenile Detention Center), Monica Jackson (Department of Criminal Justice Services), Hal Johnson (Williams Mullin), Adele McClure (Office of the Lieutenant Governor), Cathy Roessler (Blue Ridge Juvenile Detention Center), Michael Umpierre (Georgetown University), Carla White (Rappahannock Juvenile Detention Center), Tom Woods (Annie E. Casey Foundation), and Amy Woolard (Legal Aid Justice Center)

CALL TO ORDER

Chairperson Jennifer Woolard called the meeting to order at 9:44 a.m.

INTRODUCTIONS

Chairperson Woolard welcomed all who were present and asked for introductions.

APPROVAL of September 5, 2018, MINUTES

The minutes of the September 5, 2018, Board meeting were provided for approval. On motion duly made by David Hines and seconded by Robyn McDougle, the Board approved the minutes as presented.

PUBLIC COMMENT PERIOD

There was no public comment.

DIRECTOR'S CERTIFICATION ACTIONS

Ken Bailey, Certification Manager, Department

Included in the Board packet were the individual audit reports and a summary of the Director's certification actions completed on October 1, 2018. Mr. Bailey did not review each action to save time for the restraint panel discussion.

Anchor House received 100% compliance on its audit. The audits for Aurora House, Henrico Juvenile Detention Home, and Northern Virginia Juvenile Detention Home and Post-dispositional Program found deficiencies. The Certification Team conducted follow-up monitoring visits, and all programs were determined to be 100% compliant with the regulations. All three programs were certified for three years.

FISCAL YEAR 2018 HUMAN RESEARCH REPORT

Dhara Amin, Research Analyst, Department

As required by regulations, the Department must present an annual report to the Board on the human research studies conducted with the residents in the Department. Ms. Amin provided a summary of the information contained in the report. In fiscal year 2018, the Human Research Review Committee received eight research proposals. Of those, the Director approved six proposals and two projects are pending approval. This is in addition to the 15 research studies approved in previous years that remain active.

One such study conducted by Sarah Jane Brubaker and Hayley Cleary of Virginia Commonwealth University evaluated the Community Treatment Model, which was valuable to the Department. The research was completed 18 months ago during the Beaumont Juvenile Correctional Center closure period. Despite all the changes the Department experienced during that time, over 90% of the residents reported feeling safe in the facility and during activities led by the facility. The residents also reported having positive perceptions of staff. The Committee is currently working on a follow-up study to examine the Community Treatment Model in the new fiscal year.

Director Block noted that Child Trends, a national research organization, recently received a grant from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to study the

Department's reentry reforms. The Department welcomes this involvement in order to learn what is and is not working in the reentry program.

Chairperson Woolard noted this was a huge accomplishment because those grants are not easy to obtain, and observed that it is a testament to the work of the Department that OJJDP is willing to invest money with Child Trends to conduct an evaluation.

ADDITIONAL AMENDMENTS TO REGULATION GOVERNING JUVENILE SECURE DETENTION CENTERS, CONTRACTS WITH SEPARATE ENTITIES
Kristen Peterson, Regulatory and Policy Coordinator, Department

Ms. Peterson presented additional proposed amendments to the Regulations Governing Juvenile Secure Detention Centers. At the September 5 Board meeting, the Board approved an amendment to this regulation to address contracts between secure juvenile detention centers and separate entities in which detention centers agree to house residents under the custody of the separate entity. The approved amendment will require contracts entered into by juvenile detention centers to contain certain provisions that will give the Department additional monitoring authority and correct the oversight gap currently in existence. The amendments include:

- A provision requiring such programs operated within juvenile detention centers to be subject to the Department's applicable regulations, and
- A provision allowing the Department the same access to the residents, their records, and reports as is authorized currently for all the residents in postdispositional and predispositional programs within the juvenile detention centers.

An issue left outstanding at the September 5 meeting was whether these contracts should be required to be written. Department staff asserted that if the contracts are not written, the Department may not be able to prove a facility has complied with the regulatory requirement. There is also a concern the parameters of the agreement would not be clearly established if the contract is not written. Therefore, the Department recommends including a requirement in the proposed language that the agreement be written.

An additional question that arose at the previous Board meeting dealt with whether the Department has access to these contracts and is notified when juvenile detention centers and separate entities enter into such agreements. The Department recommends adding a requirement that once these agreements are entered into, the Department must be notified immediately, and a copy of the written agreement must be provided to the Department immediately. The text for these additional proposed amendments is highlighted in yellow on page 73 of the Board packet.

Ms. Peterson reminded the Board that the amendments approved at the September 5 meeting were submitted through the fast-track regulatory process. Since that meeting, the fast-track

regulation has undergone review by the Office of the Attorney General, the Department of Planning and Budget, and the Secretary of Public Safety and Homeland Security and is currently undergoing Governor's Office review. A public comment period will follow the Governor's Office review.

If the Board approves the two additional recommended changes, these provisions will be incorporated into the overall comprehensive packet that the Board approved at the June 13 Board meeting. The comprehensive packet would advance to the Proposed Stage of the regulatory process. Once effective, this amendment would replace the fast-track regulation.

On motion duly made by Jennifer Woolard and seconded by Robyn McDougle, the Board approved the additional amendments to proposed 6VAC35-101-45, Contracts between detention centers and separate entities, as agreed upon at the November 8, 2018, Board meeting, and granted the Department permission to incorporate the amendment into the comprehensive package for advancement to the Proposed Stage of the standard regulatory process.

REGULATORY UPDATE
Kristen Peterson, Regulatory and Policy Coordinator, Department

The regulatory update can be reviewed in the Board packet on pages 74-75.

MECHANICAL AND PHYSICAL RESTRAINT PANEL DISCUSSION

At the September 5 Board meeting, Director Block presented an update and overview of the investigation the Governor's Office directed the Department to conduct at Shenandoah Valley Juvenile Center (SVJC). The Department discussed the need for the fast-track regulation to address an oversight gap, which was corrected. The Department also reviewed the regulations for juvenile correctional centers and juvenile detention centers on the use of mechanical and physical restraints, specifically the restraint chair, which garnered attention during the SVJC investigation. Director Block noted this was an information session on mechanical and physical restraints; the Board will not be asked to vote at this meeting on any changes to regulations concerning the restraint chair. The regulatory review will come at the January meeting.

Director Block introduced five panel speakers who provided different perspectives and areas of expertise.

- Jason Houtz, Superintendent, Fairfax Juvenile Detention Center, and Cathy Roessler, Director, Blue Ridge Juvenile Detention Center. Mr. Houtz has been a juvenile justice professional with Fairfax County for 24 years. Ms. Roessler has worked in the Blue Ridge system since 2010 and served children in other capacities in prior years.
- Dr. Jaime Bamford is the Medical Director for the Commonwealth Center for Children and Adolescents. Dr. Bamford is a board-certified psychiatrist and pediatric psychiatrist.

- Michael Umpierre is the Deputy Director for Juvenile Justice System Improvement and Communication at Georgetown University.
- Dr. Kelly Dedel is a psychologist and court-appointed monitor of federal government cases involving conditions of confinement practices in juvenile detention centers and correctional centers across the country.

The speakers provided PowerPoint presentations, which are attached to these minutes. The following is a summary of the speakers' presentations.

THE USE OF THE MOBILE RESTRAINT CHAIR IN VIRGINIA'S JUVENILE DETENTION CENTERS

Jason Houtz, Superintendent, Fairfax County Juvenile Detention Center
Cathy Roessler, Director, Blue Ridge Juvenile Detention Center

Mr. Houtz began the two-part presentation by noting that he and Ms. Roessler are speaking on behalf of their respective juvenile detention centers as well as the Virginia Juvenile Detention Association, which represents the 24 detention centers across the Commonwealth. Mr. Houtz and Ms. Roessler surveyed other detention facilities regarding their use of restraint chairs.

Background

Youth are placed in juvenile detention centers (JDCs) for the public's safety or for the safety of the juvenile by a judge, magistrate, or intake officer. JDCs do not have the option of turning away juveniles despite the severity of their needs or the JDC's ability to meet those needs. Many of the residents are not known to the JDCs, or if they are known, they have changed while in the community. Thus, the therapeutic rapport takes time to build.

Virginia's JDCs are faced with managing youth who are physically aggressive toward other residents and staff or are a danger to themselves. JDCs are responsible for maintaining a safe, secure environment, which requires a quick response to behaviors. Generally, the initial response is to intervene physically using an appropriate restraint technique. JDCs do not use mace, pepper spray, tasers, or weapons.

Mechanical restraints, such as handcuffs and leg irons, limit but do not absolutely restrict movement. Most youth in a physical restraint quickly calm down, and the physical restraint ends. On those occasions when youth do not regain composure, however, JDCs must look at other methods of maintaining control for the safety of staff and residents.

Juvenile Detention Population

Any of the JDCs' youth can present with a number of issues including behavioral or conduct disorders, suicidal ideation, past suicide attempts, self-abusive behavior, poor anger management, and limited coping skills. Many use physical aggression as a means to resolve conflict. Therefore, when they are faced with real or perceived conflict in detention, physical aggression often is their first response.

The Larger Problem

As many as two-thirds of the youth in detention centers meet the criteria for having a mental health disorder. Detention often has become a dumping ground for the courts when dealing with criminogenic behavior or criminal conduct because of the inability to manage mental health issues in the community. Until the courts can determine the best placements for these youth, they are placed in detention based on their criminal conduct. The JDCs are left to address mental health issues that may not have received attention while the youth was in the community. One detention center administrator told Congress, "we are receiving juveniles that five years ago would have been in an inpatient mental health facility. We have had a number of juveniles who should no more be in our institution than I should be able to fly."

Risk of Self Harm

One of every ten newly detained youth has a history of attempted suicide. Past suicide attempts are a powerful predictor of future attempts. Detained youth are at greater risk than youth in the general population.

Youth in detention may respond to their situations either by self-abuse or thoughts of self-harm. JDCs are faced with managing these situations. Every facility has some level of mental health attention or care, and treatment is provided through therapeutic programs. JDCs seek to manage these issues while the youth are detained, and then try to link them to services once they return to the community. JDCs are managing these situations by using rapport and therapeutic interventions, but when a youth is self-abusive, a JDC's first response is to stop that behavior and hope it does not escalate.

Keeping our Kids Safe

Detention's responses are not focused solely on physical responses. All programs are built on care. Many JDCs in the Commonwealth incorporate the ideas noted in this slide to try and create an environment that deters physically acting out or self-abusive behavior. JDCs have recreational programs, structured daily activities, incentive-based behavior programs, mental health treatment, and crisis intervention. JDCs try to create a positive and welcoming environment. They train staff in evidence-based programming, focus on nutrition and education, and try to create an environment that deters behavior that could lead to a physical intervention and use of a physical restraint.

Mr. Houtz then turned the presentation over to Ms. Roessler.

Physical Interventions

Physical interventions in detention centers are authorized for the following: self-defense; the defense of others; to prevent an escape; to protect someone from self-harm; to prevent the commission of a crime; and to prevent property damage. Only when other alternatives have failed may the JDC employ physical force, and only the minimal amount of physical force necessary may be used.

Mobile Restraint Chair

There are 24 detention centers in Virginia, and 13 of them have a mobile restraint chair. The restraint chair is regulated, used only in situations of imminent danger, and only as a last resort. It is never used for punishment, behavior modification, or as a disciplinary measure.

Ms. Roessler then discussed use of the restraint chair at the Blue Ridge Juvenile Detention Center, noting that each time the restraint chair is used at Blue Ridge, it initiates a call and immediate referral to the Region Ten Community Services Board for an emergency evaluation.

Blue Ridge has used the mobile restraint chair six times for four difference residents since opening in 2002. The situations were all precipitated by an act of self-harm, active suicide attempt, or suicidal ideations. Blue Ridge has never been cited for improper use, and no resident injuries were sustained during its limited use. The last time the facility used the mobile restraint chair was in 2013.

Of the 13 facilities that have a mobile restraint chair, some have had it for a long time, while others recently acquired it. The use of the restraint chair varies in these facilities from seldom to never. None of the JDCs reported frequent or routine use of the restraint chair, and it is always the last option available. Programs that reported a higher frequency of use attributed it to the occasional individual resident. No programs reported incidents of injury as a result of using the restraint chair.

Those that possess the chair but have reported no use have cited specific historic cases that led them to acquire the restraint chair without similar situations presenting afterward.

Research Studies and Findings

Listed on the slide are research studies and findings about the dynamics of the population. The research shows that with well-established protocols, the restraint chair can be used effectively and safely. The legal cases that focused on the use of the restraint chair stem from inappropriate use of the chair and deviation from established protocols, not harm by the device itself.

SureGuard Medical Chair and SureGuard Correctional Chair

These slides show an example of the medical chair and the correctional chair. There are a few companies that make the mobile restraint chair.

In the medical chair, there is a head rest with no hole cut out in the back. The correctional chair has a cut out in the back with no headrest. The cut out is for transitioning a resident with handcuffs into the mobile restraint chair; the hole allows movement for the resident.

Research Studies and Findings Continue

The slide shows researchers who compared three methods of seclusion and restraint and found that restraint chairs are no more likely to cause injury than four-point mechanical restraints. Blue Ridge does not use four-point mechanical restraints.

The restraint chair resulted in a lower chance of staff injury compared to four-point mechanical restraints.

The study aimed to contribute to the overall goal of identifying the unique needs of psychiatric patients and reducing the use of more intrusive methods of de-escalation.

In Blue Ridge's experience, the mobile restraint chair was utilized when it was considered the safer option. The residents are in a sitting position, their breathing is not restricted, and staff can look them in the eye and have conversation. Staff help de-escalate the situation face-to-face rather than having a resident face down on the floor with several staff trying to control their movement. Ms. Roessler finds it a safer option in extreme cases. Blue Ridge does not use the chair often, but when they have, it has been a useful tool.

Restraint episodes can be shortened when residents are sitting up or talking with staff whereas, if residents are on the ground, the situation can be extended or escalated.

Considerations for Enhanced Regulation

JDCs considered the following potential enhancements to the current regulations regarding the chair: (i) require constant monitoring of residents in restraint chairs by staff; (ii) require an immediate mental health referral and a serious incident report to the Department whenever the chair is used; and (iii) require aggregate records be maintained of incidents in which the chair is utilized. Currently, JDCs are not required to submit a serious incident report to the Department when the restraint chair is used, but Ms. Roessler would support this amendment. Furthermore, incident reports are completed and remain in the resident's legal file, but aggregate records of the use of the chair are not maintained.

USE OF EMERGENCY RESTRAINT CHAIR AT COMMONWEALTH CENTER FOR CHILDREN AND ADOLESCENTS

Dr. Jaime M. Bamford, Medical Director, Commonwealth Center for Children and Adolescents

What is the Commonwealth Center?

The Commonwealth Center for Children and Adolescents (CCCA) is located in Staunton and is the only state psychiatric hospital for children. Psychiatric hospitals for children used to be located across the Commonwealth; however, through the years they have gradually closed.

The Commonwealth Center has 48 beds with 4 units of 12 beds each: three adolescent units and one unit for children 12 years of age and younger. There is a mix of male and female patients.

The "bed of last resort" legislation in 2014 provides that if any person in this state needs psychiatric hospitalization, the state hospitals are the last resort. This has caused the state hospitals' census to increase 300% including adult and children patients. The Commonwealth Center is the only hospital for children in the state; there are multiple hospitals for adults.

Last year, the Commonwealth Center received 36% of all temporary detaining orders (TDO) issued for children and adolescents, which equates to 1,000 admissions, the highest in its history. The facility historically receives 25%.

Who comes to CCCA?

Most admissions to the Commonwealth Center result from severe aggressive behavior, either to self or to others. The context of conflict is in the community, at home, or in school.

The average age is 14; 65% are male, 35% are female, 47% are white/Caucasian, and 53% are minorities. This speaks highly to disparities in mental health care. Forty percent are African American, 10% are Hispanic or Asian, and 3% are Alaskan, Native American, or unknown.

Sadly 30% have autism, intellectual disability, and developmental disability. These individuals are mixed within the units. The Commonwealth Center does not have a specific forensic or autism unit. Ten percent are forensic referrals from detention and courts, 10% are under Department of Social Services custody, and 17% are from group homes and residential centers. The length of stay for youth has dropped considerably to seven days. Eight years ago, the average length of stay was approximately 30 days. The Commonwealth Center does not have a lot of time to establish a relationship with a child who only stays for one week.

What do we do at CCCA?

The Commonwealth Center's mission is to provide a safe, high quality psychiatric evaluation and crisis stabilization in order to return the child to the community as quickly as possible, strengthening their hope, resilience, and self-esteem.

The Commonwealth Center believes it should be collaboration- and relationship-based and trauma-focused. The facility perceives all children as traumatized individuals and tries not to re-traumatize them, recognizing some of the Center's behaviors and practices can be traumatic to the children.

The Commonwealth Center recently trained 25 staff in dialectical behavioral therapy. Even though the facility only has the child for seven days, they have begun work on aggression and self-harm behaviors on an inpatient basis.

Where do they go after CCCA?

Sixty-eight percent of CCCA patients return home to family or guardians; 30% return to a detention center, group home, foster care, or residential treatment center, which is high for a psychiatric hospital and is problematic. The Commonwealth Center is sending more children to out-of-state residential centers, meaning these children have exhausted all other options and are being transitioned to Texas, Arizona, Florida, and Pennsylvania.

Use of Emergency Restraint Chair (ERC) at CCCA

The Commonwealth Center has always used seclusion, physical restraints, and mechanical restraints, and previously the facility used bed restraints. The Commonwealth Center changed in 2014; it has only been four years since the facility started using the chair. The decision to move to the restraint chair was based on trauma associated with bed restraints and the desire to make beds a safe place for patients. Also, there were safety issues related to transporting individuals to restraints. Facility staff would pick up children and carry them to their rooms, and while in transport, patients and staff were sometimes injured.

There is a high risk of injuries in a physical restraint. Facilities see more patient and staff injuries related to long physical restraint, such as staff being bitten, spat on, or bruised.

Another benefit of the restraint chair is that it is difficult to move individuals to a restraint, but staff can bring the chair to them, which involves a less dramatic, drawn-out situation.

Steps taken to implement ERC

Once the Commonwealth Center decided to implement the restraint chair, they looked at other facilities and adult state hospitals that used the restraint chair. The Commonwealth Center also reviewed the data related to the emergency restraint chair and children; presented to their local human rights committee, which approved implementation; developed policies and procedures; trained staff before implementation, retrained them at six months, then at 12 months, and now train annually. The Commonwealth Center uses the Therapeutic Options of Virginia as its training method for restraints. They evaluated adherence and reviewed incidents with the chair to determine if staff followed procedure and gave feedback. This was not a punitive process but a learning process to keep all involved individuals safe.

Seclusion and Restraint Policy

The Commonwealth Center may use seclusion and restraints only if there is immediate danger of a child physically harming himself or others. The Commonwealth Center uses physical restraints, where hands are on the patient, and mechanical restraints, such as the restraint chair. The facility also has four-point mechanical restraints.

The Commonwealth Center requires physician orders for seclusion and restraint immediately before or after the incident. Dr. Bamford indicated if she is present with a patient and can see the incident, she can authorize the use of seclusion or restraint. She can also authorize it immediately after the incident because the facility does not have physicians on call 24 hours a day; they are only present during the day. Adult state hospitals have 24-hour coverage. The Commonwealth Center has very few child analysts and psychiatrists. A nurse or physician can also authorize seclusion and restraint.

A direct care staff can initiate a physical restraint or seclusion in an emergency situation but must consult with a physician or nurse immediately afterwards. Mechanical restraints, including four-points or the chair, must be authorized by a nurse or a physician. A direct care staff may not put a patient in the chair without medical oversight.

CCCA Policy on ERC

CCCA's current policies allow for an initial order (for time in the chair) of up to two hours and a maximum time of four hours. The adult hospitals have struggled with prolonged use of the chair with issues like deep vein thrombosis. Although children may be healthier, the facility sets a cap of four hours to reconsider its options at that point.

There is no variation in how the chair may be used. No extra straps and no use of towels or blankets is permissible. The chair must be used as directed and only staff trained in the use of the chair may use it.

Once the patient is in the chair, the patient is moved to a private area, either a seclusion room or a room away from other patients. Staff continuously monitor the situation. The Center for Medicaid Services requires the facility to report on children every five minutes. While in the chair, the patient is also under constant observation; there is always a staff person sitting with them.

The facility abides by the guidelines from the chair manufacturer. The patient must be at least 80 pounds and their feet must lie flat on the floor.

The facility offers fluids and meals with bathroom use at least every two hours or as needed; however, it is very rare for the facility to restrain a child in a chair for that long. Offering the patient something to drink is important because getting them to the chair involves adrenaline; the child gets hot and agitated.

Assessment while in ERC

A direct care staff remains with the restrained child during the entire restraint, talking with him or her and helping the child refocus. The nurses conduct checks every hour for psychological trauma and physical response and determine whether the seclusion or restraint should continue. Checks generally are conducted more frequently than once per hour, but this

is the minimum requirement under the facility's policy. If any changes are noted in the child's condition, staff notifies the physician immediately.

Release from ERC

The facility's general release criteria are that the patient is non-threatening to themselves or to others, is calm, and is re-directable. There are, however, situations where an individual appears calm and redirectable, and is aggressive once released from the chair. The facility will set different criteria for repeated patterns of behavior. For example, if a patient has assured a physician that he is calm and will not hurt anyone, and then immediately assaults staff upon release, the facility will set individual release criteria for that person; however, these situations are rare.

The Commonwealth Center does not seclude or restrain patients longer than is necessary to address the issue.

Advantages of ERC

The Commonwealth Center's goal is never to use physical restraints on any child at any point; however, some dangerous situations require restraints. Most children hate seclusion. Many of them have been traumatized and locked in rooms and will tell staff they do not want to be in their room by themselves where someone looks at them through a small window. They do not know when they are getting out, and there is no human interaction. This can be terrifying for children. Sometimes, the children may request the chair instead of seclusion if they are not calming or if they feel the need to hurt someone and cannot control themselves.

The facility does not use the chair all the time, but some children cannot control themselves. Hands-on restraint could result in more injuries.

Dr. Bamford provided an example of a female child who was too small for the chair, so staff physically restrained her for 15-20 minutes. It was a miserable experience for her, and she asked to be put in the chair. The female child was sexually traumatized and being held down was more traumatic than being in the chair. Unfortunately, her feet did not fully touch the floor, so the facility needed special approval from the patient, the human rights group, and her family to make sure the facility could put something under her feet while in the chair. The female child had been with the facility before and had multiple holds and restraints because she wanted to harm herself. The chair is not ideal, but for some children they have requested it, and it is safe.

When you have a patient who is psychotic or attacking others, it is hard to rationalize with them in that moment and to use the tools of establishing a relationship, engagement, and making them feel safe and calm. Having the ability to restrain in a manner that is safe is an advantage.

The chair avoids a prolonged physical hold, which has the greatest risk of injury or death. When the facility looked at transitioning to the chair, there was a study through a joint commission

that looked at deaths related to restraints; a third of those deaths were adults, a third were children, and a third were geriatric. All of the deceased children had been placed in a hold, either in a prone or supine position, with something compressing their airway or chest. These deaths resulted from physical restraints rather than mechanical restraints.

The facility focuses on engaging with individuals while they are in the chair. This includes face-to-face conversations about what happened and a walk through the chain of analysis so staff can understand how it started and how they could intervene at a different point. This level of engagement is difficult during seclusion because staff is trying to talk through a door with a small window and is not getting a good sense of who the patient is and what he is doing.

The chair provides secure containment for children who are banging their heads, punching walls, or feeling overwhelmed because they are totally out of physical control.

Disadvantages of ERC

Any restraint is traumatic to watch or to take part in and can diminish the patient/doctor relationship.

Sometimes it takes many well-trained staff to use the chair. For a patient weighing 250 pounds, more than four staff are necessary to get the resident into a chair. A leader is necessary to help direct which limb goes into the restraint at which point. When injuries occur related to placement in the chair, they usually result either from inexperienced staff or from staff's failure to adhere to the applicable policies. Sometimes these injuries result from poor training.

Dr. Bamford explained that sometimes patients view time in the chair as a punishment, and while staff know the patients are at the facility for treatment, they still might use the chair as a threat. This is a training issue. In a perfect world, the facility would be restraint free, but that would require highly trained staff.

Impact of ERC

The facility had a reduction of workers' compensation claims as a result of moving to the chair restraint. There were more staff back and limb injuries related to the bed restraints, requiring them to be put on long- and short-term disability.

The facility saw less time in a physical restraint.

The facility had one serious patient injury of a broken wrist. During the investigation, the facility could not determine if it was related to the restraint itself, the placement in the chair, or the aggression beforehand (the patient punched a wall).

Parting Thoughts and Until Then….

Last year, the Commonwealth Center used the restraint chair 400 or 500 times.

Reduction in seclusion and restraint comes from recognizing high-risk, violent patients, screening for aggression, and having a plan. It also requires ensuring development of individualized plans and that intervention strategies are in place. If a child does not handle the transition back from school to the unit well, how will staff handle that transition differently? Would it be better for the child to go to the playground first, or does the child not get along with the other children in the unit and need to be separated? This is what is meant by recognizing aggression.

Facilities also should have the staff available to do the work; and if staff are running around putting out fires, then more incidents of aggression, physical restraints, and seclusion will occur.

It is also important to remember that most injuries happen when new staff have not developed the face-to-face relationships necessary to talk a patient down or are not familiar with the facility's policies and procedures.

The environment must work and be calm. Facilities should have open air, open spaces, room to move, and structured situations. The patients should have productive activities; otherwise, they get bored. There should be engagement with people.

USE OF THE RESTRAINT CHAIR IN JUVENILE FACILITIES

Michael Umpierre, J.D., Deputy Director, Juvenile Justice System Improvement and Communications, Center for Juvenile Justice Reform, Georgetown University

Mr. Umpierre provided the board with his background information. He is from the Center for Juvenile Justice Reform (CJJR), a research organization housed in the McCourt School of Public Policy at Georgetown University. CJJR conducts juvenile justice research and provides training and technical assistance to juvenile justice staff and stakeholders around the country.

Mr. Umpierre's presentation focused on the state of national practice with respect to the use of the restraint chair as well as relevant national standards of the practice. He advised that any facility-based practice should begin with a commitment to safety. The time a young person spends in a detention center or a long-term treatment facility is an opportunity for growth, development, and rehabilitation. In order for young people to grow and develop, they need to feel physically, emotionally, and psychologically safe. This also applies to staff that serve young people in the facilities. Staff must feel safe in order to do their jobs well.

Mr. Umpierre advised the Board, when considering restraint chair practices, to keep in mind Maslow's Hierarchy of Needs, maintaining a focus on safety with the understanding that foundational needs must be met before moving into a higher level of goal achievement.

The other theme to consider when thinking of the restraint chair is CJJR's research in juvenile justice. This research shows that juvenile justice approaches, including what happens at the

facility, must be rooted in a developmental therapeutic approach. CJJR's practices, services, and approaches are designed to promote positive youth development, including youth skill development, as well as to facilitate connections to prosocial, positive adults who will support the youth throughout their lives.

Mr. Umpierre highlighted the conclusion of the meta-analysis of juvenile justice studies conducted by Mark Lipsey and his colleagues: outcomes are significantly improved if the focus is on programs that embrace the therapeutic developmental approach. This was also the central theme of the National Research Council's publication "Reforming the Juvenile Justice Developmental Approach."

Mr. Umpierre discussed the foundational dimensions of a high quality facility approach and environment. Any particular practice relates to the overall culture and environment trying to be achieved within the facility. The research and experience say operating these programs are central and critical dimensions of any facility practice, whether it be opportunities for education and programming; comprehensive medical and behavioral health services; and safe physical and social environment, including prioritizing family engagement, elevating voices of youth in the facilities, and encouraging positive staff-youth relationships.

Behavior motivation systems allow young people to receive incentives for positive behavior and to recognize them for their positive decisions. At the same time, responses to undesired behavior should allow for skill development and restorative justice features. It is not sufficient to have a response for the sake of response; youth need to be taught to behave differently. This cannot be accomplished without a highly trained and supported workforce.

Even in the best facilities critical incidents will occur. It is incumbent on facility staff to be prepared and have approaches to address situations. Facility practices recommended in the Youth and Custody Practice Model should be part of the discussion as the Board thinks about the use of the restraint chair.

Mr. Umpierre advised starting with de-escalation and focusing on ways to stem incidents from increasing in intensity using non-verbal and verbal strategies. Non-verbal strategies may include maintaining eye contact, gestures, and expressions. Para-verbal refers to the notion of altering speech, such as the rate of speech, the tone of voice, and the volume. All can make a difference in terms of de-escalation of youth and preventing incidents.

Facilities should also provide youth with space in order to calm down. Some jurisdictions use a voluntary time-out process where young people are removed from a physical area until they are able to calm down.

When physical force is absolutely necessary, it is incumbent on staff to exercise it in a way that is safe, proportional, well timed, and well executed.

CJJR promotes physical force techniques that are safe, minimize risk of injury to youth and staff, are careful about airway restriction, and do not subject young people to undue joint manipulation.

Proportionality is also a key component. The facility should use only the amount of force necessary to control the situation. As soon as the young person shows signs they are complying and calming down, the level of force should be reduced proportionally.

Well timed means staff is using physical force only when necessary.

Well executed means the facility has an approved set of physical force techniques, and staff execute them in the way intended. This is where a commitment to training, to supervision, and to ongoing quality assurance becomes absolutely essential. In a situation where a practice is rarely used, training is especially important to ensure staff are able to address the situation.

Most professional standards in the juvenile justice field govern facility-based practices and explicitly prohibit the use of fixed restraints, particularly the restraint chair, or limit its use significantly.

The Annie E. Casey Foundation has a set of juvenile detention facility assessment standards produced through the Juvenile Detention Alternative Initiative (JDAI). These standards prohibit the use of fixed restraints. Annie E. Casey Foundation has operated JDAI for over twenty years and is implemented in upwards of 300 counties across the country. The JDAI standards are widely considered to be the most comprehensive the field has to offer.

The American Correctional Association (ACA) Juvenile Detention Standards also address the use of these types of restraints including four- or five point-restraints. They are limited to "extreme instances" and require superintendents to sign off before used. The ACA standards also state they should only be used when other restraints have been ineffective, when the continuum of alternatives has been exhausted, or the safety of the youth is in jeopardy. The standards require facilities to notify the health authority to assess whether the youth's medical and mental health condition warrants a transfer to a mental health unit. If the youth is not transferred to a mental health unit, the ACA standards require continuous direct visual observation of the youth before getting approval from the health authority, subsequent visual observation every 15 minutes, that all restraint procedures are approved by the health authority, and that the facility document every use of the restraint.

Performance Based Standards (PBS) is an initiative developed in 1995 by the Council of Juvenile Correctional Administrators with the support of the OJJDP. It provides a way for juvenile facilities, both detention and correctional facilities, to compare data on key practices with similarly situated facilities around the country. PBS establishes a set of facility-based practice standards as well as indicators and works with the facility and agencies to collect data on those

key indicators, all in an effort to lead a facility improvement process. The PBS staff track the data and work with facilities to improve practices.

PBS does track data on the use of the restraint chair and beds. PBS believes the restraint chair is permissible only as a last resort with supervisor approval and the engagement of health and mental health staff with protocols governing its use.

The National Commission on Correctional Health Care (NCCHC) offers another set of standards. NCCHC permits the use of restraint devices including four-point restraint and the restraint chair. The NCCHC standards are difficult to follow because they have different standards for restraints ordered by custody staff and clinicians. The standards caution against the use of restraints noting "serious injuries and deaths are rare occurrences as a result of the process of applying restraints and many programs choose not to use fixed restraints."

Standards developed by the National Advisory Committee for Juvenile Justice and Delinquency Prevention in 1980 also prohibit their use.

In 2003, the OJJDP conducted a survey of over 7,000 young people in residential placements, representing 205 facilities nationwide, including detention, correction, community–based facilities and camps. Young people were asked whether they were ever subjected to placement in the restraint chair or bed. Only 4% of the surveyed respondents indicated they were put in the chair. This is consistent with the notion that this practice is rarely used.

A 1994 study on conditions of confinement that looked at nearly 1,000 facilities found 5% of juvenile facilities surveyed indicated using fixed restraints.

PBS looked at two months (April and October) of data in no particular year at a participating facility. In April 2006 across 89 correctional facilities, there were 34 incidents in which the restraint chair or bed was used. It was used one time across 45 detention facilities. In April 2018, it was used once across 117 correctional facilities and five times across detention facilities.

Many juvenile justice agencies either exclusively prohibit the use of the restraint chair or in practice just do not use it. Mr. Umpierre noted that Connecticut, Massachusetts, and Missouri never use the restraint chair, but have yet to update their policies. The District of Columbia and Florida have policies that explicitly prohibit the use of the practice.

When developing the Youth and Custody Practice Model and putting together CJJR guidance for sites that use fixed restraints, CJJR ultimately concluded that they would not recommend the use of fixed restraints. The reasons include potential harm to young people and staff. There have been legal cases involving young people who have suffered injuries. The youth and custody population has experienced trauma, and CJJR thinks about what impact a practice like that might have on a young person with a trauma history.

The national data and CJJR's experience nationally shows the vast majority of juvenile justice facilities, both detention and correctional centers, are not resorting to this practice. These are agencies and facilities handling the highest risk, highest need youth in their jurisdictions. They are figuring out alternatives to keep staff and youth safe and achieve positive outcomes.

There have been several legal cases on this practice, including cases brought by the Department of Justice, and CJJR is concerned about legal liability.

OBSERVATIONS ON THE USE OF THE RESTRAINT CHAIR
Kelly Dedel, One in 37 Research, Inc.

Dr. Dedel works as a court appointed monitor and subject matter expert in conditions of confinement cases. Those cases are brought primarily by the Justice Department, although increasingly by groups like the ACLU, Legal Aid Society, and people concerned about the level of safety in detention and correctional facilities.

Over the past 20 years, Dr. Dedel worked with approximately 20 jurisdictions and visited 100 different facilities across the country. Dr. Dedel helps to adopt and promote practices that she sees throughout the country.

Dr. Dedel is not brought in to work in high functioning systems. Rather, she assists systems that are struggling and have high rates of youth injuries, staff injuries, and self-harming behavior. Much of what she sees is a product of failures of full systems at different levels.

Dr. Dedel works with Mr. Umpierre and the Youth in Custody Practice Model, which is built on systems wanting to change and improve. Through her travels across the country, Dr. Dedel understands facilities have the same problems but solve them differently and with different resources. Fundamentally, all are concerned with the safety of the youth and staff, positive outcomes, staff morale, and retention.

Dr. Dedel focused her presentation on two jurisdictions that used the restraint chair and have been subject to litigation. The practice is infrequent; even in places that permit it, the restraint chair is not used often.

Each of these places had policies that resemble the ones discussed today that require engagement, focus on de-escalation, and restraint being the last resort. For various reasons and at various points in time, all of the oversight mechanisms for otherwise well-written policies failed. There were opportunities onsite to ensure the policy was followed, as well as opportunities immediately after the incident and oversight bodies such as the Board; however, none was sufficient to ensure the practices conformed to the policies, which was brought to the attention of the Department of Justice.

The use of the chair is not the starting point. There are things that happen in the moments before the chair is used. The use of the chair is a narrow sliver of what goes on in the facility and during a crisis.

Relationships between youth and staff are essential to preventing and reducing crises. The youth seeing the staff as a source of comfort rather than a source of stress is important to that relationship. This is consistently absent in many facilities. The staff are not seen as someone to help the youth. Promoting these relationships and helping staff figure out how to engage with youth are essential.

Facilities also must have well-trained staff who are present in the moment of crisis; otherwise, no technique will be implemented safely or well.

Because of the prevalence of youth with mental health issues in juvenile justice facilities, there has been a great focus on mental health issues. Many youth escalate quickly due to their trauma experiences. In addition, many of the staff share those same traumatic experiences by virtue of either their pasts or the stressful nature of their work in the facilities. Those two cycles together can spiral out of control in unproductive ways. It is essential to have mental health services working with youth and good staff support in place to understand their experience with trauma in order to create a safe facility.

Dr. Dedel explained that her experience with other jurisdictions is that the use of force and conditions of confinement are always central factors in what draws the attention of the Justice Department. The Justice Department is focused on harm youth experience at the hands of staff through excessive and unnecessary uses of force; at the hands of other youth; and at their own hands through self-harming behaviors and lack of treatment services. The Justice Department also is focused on how staff engaged or chose not to engage in a crisis.

One of the mottos in the Youth and Custody Practice Model involving the use of force is that when it is used, it should be safe, proportional, well-timed, and well-executed.

It is an acceptable and well-embraced philosophy that there should be a continuum and that the least restrictive option necessary for controlling the youth and creating safety should be used. The use of force continuum starts with non-physical measures by giving the youth time, choices, and distance to de-escalate and change staff interaction with the youth. If those steps fail and staff must apply physical restraints, they must follow another continuum and must consider how restrictive those physical holds should be, how many people are involved in implementation, whether the youth is sitting, standing, or lying down supine, and whether other restraint devices are used. These are not linear; they depend upon the youth's level of resistance and their level of control. Once the youth's level of control is restored or begins to be restored, the use of physical force should be scaled back.

It is important to recognize that the chair is one moment in this use of force continuum. There are other options available, but facilities need to determine the best-case scenario to prevent the crisis from escalating and to ensure no one is hurt.

If the chair is not an option, what else can be used? One of the other options to consider is a team restraint. If the chair is used, the device is doing the work and there may be fewer injuries. On the other hand, in a team restraint, the staff are doing the work. An uncontrolled large child with unlimited energy is strong and has adrenaline coursing through his body. A team physical restraint is an exhausting experience for both the youth and staff. In those situations, it is the staff, not the device, exerting the effort, the power, and the control over the youth.

The slide showing the restraint chair and the team restraint depicts a device-powered immobilization and a human-powered immobilization. There are some differences in staff contributions. With the device, once the child is in the chair, staff does not have a physically active role; the device is doing the work. With a team restraint, the staff is doing the work, and more staff are needed to facilitate the immobilization of arms, legs, and head. If the restraint is prolonged, staff will get tired and need replacements. Substitutes must be on hand.

When the Justice Department brings a lawsuit, it submits a findings letter saying the department observed certain incidents that contribute to a pattern or practice where the child's civil rights are being violated by virtue of these practices.

Dr. Dedel looks at the staff and how they respond to the child, the outcomes of the situations for the child and staff, and how the problems evolved. It is useful for quality oversight to videotape incidents via a stationary camera or a handheld camera. Observing this footage can show what staff could do differently with the youth and what the staff needed in order to implement this practice safely. The facilities Dr. Dedel visited had this built in as part of their protocol and policies. Dr. Dedel was able to watch these incidents and did not have to be present at the facility to see things happen.

The two jurisdictions that Dr. Dedel visited were a detention facility and a long-term commitment facility. These were all juvenile justice youth, not mental health or child-welfare placements. One facility used the chair as its deep end use of force continuum. On paper, the facility had a system of lesser restrictive measures, and if one was not sufficient, they moved to the next measure in order to control the youth. The other facility predominately used the chair in situations where the youth was self-harming. Interestingly, the problems clustered around the same themes. The facility had not exhausted the lesser restrictive options but instead dropped to the deep end and used the most extreme without attempting the other options on the continuum. The other piece is the long-duration. Some of the self-harming youth were in the chair for hours. Even though it appeared that the youth had regained control, staff required that they remain in the chair for long periods, well beyond when they appeared to be in control.

Dr. Dedel shared an example dealing with the lack of engagement by staff with restrained residents. The children were monitored with staff physically present, but there was no interaction or engagement. One video showed a child pleading with staff to talk to them. The staff were following their policies and conducting the required checks but were doing nothing in between those checks to calm the child. They had videos but were not using them constructively. The videos would have shown that staff needed more training and better interaction with the child so that staff could know how to address these situations.

The use of the restraint chair had an appearance of punishment due to staff's failure to follow the continuum, the extended duration of the restraint, and the lack of staff engagement with residents during restraint.

Dr. Dedel noted that she has seen similar problems with physical restraint. Terminating the restraint chair, OC spray, or seclusion will not resolve the situation without ensuring that these important values and practices are observed.

In the two facilities Dr. Dedel visited, these concerns were less prevalent when the facilities switched to a team physical restraint. Both jurisdictions resorted to physical restraint when all other alternatives failed. Unlike the chair, staff were engaged with the child and talked him through the physical de-escalation. None of this happened in a vacuum; the facilities talked about the misuse of the chair and how to improve. Things did improve after they started using the physical restraint. It was difficult for those facilities to move away from the use of the chair. Staff were resistant to the idea of losing a tool like the chair due to fear that they might get hurt, or hurt the child, and not be able to control the situation. The staff do not like being under such close scrutiny. Staff need to be trained adequately on the use of alternative methods; otherwise, they or the child will get hurt. While none of these tools are foolproof, through good training and timelines, whether using the chair or transitioning to something else, facilities must ensure they have enough staff with the proper skills to execute these techniques safely.

Dr. Dedel closed with a few things to keep in mind. First, with regard to the message, she encouraged facilities that plan to prohibit the use of any restraint to own the change and openly discuss with staff why the change is necessary, rather than using the DOJ, or other oversight authorities, as the "fall guy."

Second, she encouraged facilities to understand the circumstances in which the chair is used, such as for self-harm or for force situations. Those behaviors have different precursors, different ways to prevent them, and different responses to situations.

Third, she emphasized the importance of providing skill development to staff by giving them enough training, opportunity for drill practice, staff feedback, and other resources, such as videotapes. This is particularly important in situations where the tool is used infrequently.

Fourth, she encouraged facilities to use a reasonable timeline for employing any changes. Facilities may be required by regulation or DOJ mandate to make huge changes in very short periods. Both of the facilities Dr. Dedel visited had 90 days to eliminate the use of the chair and hundreds of staff to train. She advised developing a reasonable and achievable timeline that allows for gradual implementation and constructive use of the implementation period.

She also advised facilities that are eliminating the chair to listen to staff and invite their input regarding what problem the chair solves, why staff feel they need it, and what other alternatives have been effective. These conversations should occur throughout the implementation process as staff input is important, and changes cannot be accomplished without a properly trained workforce.

QUESTION AND ANSWER PERIOD

All the Board members thanked the speakers for their presentations and the varying points of view.

Board Member Hines said the panel probably has seen more mental health issues in the facilities than ever before, and the pattern is playing out throughout the nation in both juvenile and adult facilities. Board Member Hines asked Mr. Umpierre if much of the research shows the chair should never be used, what restraint device should be used.

Mr. Umpierre answered, that based on his research and experience at a DC juvenile facility, in those rare situations when it was needed, the facility used the team restraint approach. There are considerations such as appropriate staffing, a strong influence of mental health professionals in the facility, and a commitment to the therapeutic environment. It did not mean problems did not arise.

Board Member McDougle asked about the team restraint, when there is a four- or five-person team addressing the needs of one child, what that means for the staff ratio and staff resources, particularly since this is not prescribed ahead of time, and extra staff may not be on call when this happens. How should a facility balance the other children's needs while addressing the situation?

Dr. Dedel responded that in the places she worked, certain staff are identified as responders and are part of a crisis team. If there were no incidents, these staff were in the units interacting with the children and running programs. If they were called to leave, there were still sufficient staff on the units to satisfy the ratio requirements and ensure resident safety. Dr. Dedel also indicated some places keep children locked in their rooms while staff responds to an emergency, which is not advisable.

Mr. Houtz responded that Fairfax County Juvenile Detention Center does not use the chair because they have never truly considered it; however, they always managed in those situations.

Regarding staff resources, Mr. Houtz is fortunate to have a facility with a full staff that meets the staff ratios, mostly due to population trends and hiring practices. When events occur that require a staff response, Fairfax places other residents in their rooms to prevent remaining staff from the threat of attack. He acknowledged that these approaches do disrupt case programming until a plan is devised to bring the remaining population back. Regarding the team restraint, Mr. Houtz's facility does Handle with Care training. There are other restraint devices such as soft restraints, which are not reliable and could be slipped off by residents and used as a weapon if they are too loose. This may cause the resident to be re-restrained, which may cause the highest risk of injury to the resident or to staff.

Board Member Kizner said that years ago he worked in a residential school for children with emotional disabilities and does not recall receiving training but remembered being involved in restraints. Board Member Kizner saw many of the issues the presenters talked about when staff do not receive training. He asked whether the Commonwealth Center's seven-day average length of stay is a therapeutic decision or a funding decision.

Dr. Bamford responded that it is a therapeutic decision. At the Commonwealth Center, once the crisis or conflict has abated and the facility has stabilized the child, they are discharged. This is partially due to the facility's mission to serve every child that comes in on a TDO. If the facility does not move them out, they would have 50 or 60 children. This is a significant shift in the Commonwealth Center's mission, which used to be longer term stabilization. The outcome in data does not show that acute hospitalization reduces suicide rates, aggression, or anxiety.

Board Member McDougle asked if the longer term stabilization had an impact on those rates.

Dr. Bamford said she saw a decrease in seclusion and restraint, since the longer a facility has patients, the better the staff can understand their behavior, develop a plan specific for their needs, and intervene prior to a physical intervention. The best practice is to be able to learn by establishing a relationship, but right now, that is challenging.

Board Member Schrad said she has heard from law enforcement officers about the inability to find a bed at the Commonwealth Center when they are on a court- ordered transport and asked, when patients are released, whether they must be released to an aftercare program.

Dr. Bamford responded that the adult system of mandatory outpatient treatment is very weak compared to other states where there are some teeth to a mandatory outpatient court order. Dr. Bamford cannot think of a single child that was court-ordered for treatment. It is all voluntary.

Board Member Schrad recalled Dr. Bamford's comment that the chair was often better received than being under physical restraint and asked how much research there is on the impact of physical restraints on a child? The presenters talked about staffing, resources, and in an ideal world never having to restrain a child.

Dr. Bamford responded that in preparing for this presentation, she could not find anything relating to the child's perspective. When the facility implemented the chair, some negative feedback followed. Regarding the earlier example of the sexually assaulted patient, it took the facility employing four separate physical restraints before they understood that she did not like being physically restrained.

Board Member Schrad said that Dr. Dedel's comments were helpful because the failings had not just been about a piece of equipment, but whether there was proper supervision, interaction, training, and length of time to be successful.

Dr. Dedel said the policies looked fine on paper; it was the implementation that was troubling. If facilities had been following their policies faithfully, they would not have come under the oversight of the Department of Justice. The restraint chair is not an unconstitutional practice, nor is the use of pepper spray, but the misuse of it and the pattern of practice tends to surround those types of tools when facilities are not functioning well, which is why they get the attention of the courts.

Ms. Roessler said the Blue Ridge Juvenile Detention Center videotapes every time the chair is used. The facility requires one or more staff to sit with the youth and talk with them for the duration of the restraint. They are not locked in a room and left there. When the youth starts to show signs of calming down, de-escalating, or being able to follow instruction, they are gradually released from the chair. Blue Ridge follows some of the recommendations presented at this meeting, which may explain why the chair has been a useful tool that has kept some youth more safe.

Dr. Dedel said the places she has worked used videotapes as a tool for staff and addressed Board Member Schrad's question about how the child is experiencing the restraint. Dr. Dedel encouraged gathering information and asking the child about their experience, including what calmed them down and which intervention worked better.

Mr. Umpierre said it is equally important to recognize staff for their good work when they do things the right way and keep youth and staff safe.

Mr. Houtz noted with randomly based aggression there is no time to grab a video camera, but almost every program does have surveillance cameras. The Fairfax County Juvenile Detention Center makes it a practice to review tapes with almost every physical restraint to learn about precipitating events that led up to the incident and what staff did right and wrong. It is equally important to process episodes that went extremely well where staff responded correctly as events that did not go well. Mr. Houtz noted the common themes in the literature that address using the chair according to the manufacturer's directions/instructions and the complexity of training for something that is used rarely.

Dr. Bamford noted there is adrenaline flowing for the patient and the staff. Sometimes staff need to step away to take care of themselves before returning to work with the patients. The staff are heightened and on edge, so the facility is focusing more on the debriefing process.

Director Block asked Dr. Bamford how many staff it takes to transition a child to the chair safely.

Dr. Bamford responded that generally it takes an average of four or five staff members (one staff person for each limb and personnel to manage the straps). It has been done with three staff persons if the facility had a good plan. .

Director Block followed up by asking whether staff are trained generically on the use of the chair or whether there is specific training.

Dr. Bamford responded they do not do specific limb training; nurses are the leaders and they direct the restraint. A nurse is on every unit in addition to nurse managers. All staff is trained in general, and all sit in the chair, feel the straps, and strap them on themselves so they have a sense of what it is like to sit in the chair. For big patients, it may take six or seven staff members to safely move the child into the chair. They can be strong.

Director Block asked Dr. Dedel, while recognizing that all kinds of restraints are susceptible to misuse, whether the chair is uniquely susceptible to certain kinds of bad practices because the chair allows staff to disengage.

Dr. Dedel responded that this is true of all the deep end types of restraints and pepper spray. That is not to say that team restraints are not misused. Once the child is in the chair, the amount of staff involvement is decreased and five staff members are not needed to continuously hold the child. There might be ten staff needed to get the child in the chair, but once in the chair, there is one staff member to supervise and de-escalate the child, whereas in physical restraint throughout the time that child is escalated there are four or five staff exerting physical and emotional energy to maintain that child's position on the floor. While that is problematic in one way, it is also a silver lining in other ways because they cannot hold that position forever. Dr. Bamford indicated that she saw unnecessarily extensive periods of restraint with the chair, and this was not prevalent with the team restraint. People get tired, absent the child who is being triggered by the amount of physical contact by other people; therefore, team restraints generally were brought under control faster. Dr. Dedel thinks what it takes to get the child in the chair, is a point worth considering, and that is where staff sustain the most injuries.

Director Block asked whether it is a more complicated maneuver then having a prone restraint.

A panelist responded that one child has died from a supine restraint in a residential facility. There are unsafe practices around restraints and the staff need to be aware of these practices. No restraint is ideal or 100% safe.

Board Member Schrad asked if the child's medical condition and the child's medication are taken into consideration during restraint situations.

Dr. Bamford answered that as part of the Commonwealth Center's admission orders, they screen for contraindications to the chair such as an unstable medical condition or uncontrolled seizures. The process includes documenting why staff used the restraint if the patient had a contraindication, how the risk outweighed the contraindication, and what staff used to monitor the contraindications.

Dr. Dedel said that one of the jurisdictions she worked in performs the same review of medical contraindications and recently expanded to looking at traumatic experiences.

DIRECTOR'S COMMENTS
Andrew K. Block, Jr. Director, Department

Director Block discussed the transformation report, which was released the previous week. This report has been submitted annually since 2016 and documents specific enumerated items of the Department's transformation efforts. Director Block promised to send the report to the Board and encouraged them to read the executive summary, which has key data points. Some highlighted outcomes experienced in FY 18 included a decrease in the use of isolation, the number of incidents, and the number of staff injured. Last year the Department hit an all-time low in the number of youth placed in juvenile detention centers and the number of new cases coming into the system.

Director Block reminded the Board that they will be asked to vote on the use of the restraint chair in the detention centers and the juvenile correctional centers. The Board will vote on either maintaining the status quo, permitting the restraint chair under much more specific conditions, or eliminating the chair in state and local facilities. These proposals will be discussed in January.

BOARD COMMENTS
There were no Board comments.

NEXT MEETING
The next Board meeting is scheduled for January 8, 2019, at Main Street Centre, 600 East Main Street, Richmond.

ADJOURNMENT
Chairperson Woolard adjourned the meeting at 12:18 p.m.

THE USE OF THE MOBILE RESTRAINT CHAIR IN VIRGINIA'S JUVENILE DETENTION CENTERS

Presentation to the Board of Juvenile Justice

By the Virginia Juvenile Detention Association

Jason Houtz, Superintendent at Fairfax County Juvenile Detention

Cathy Roessler, MSW, Director at Blue Ridge Juvenile Detention

November 7, 2018

BACKGROUND

- Juveniles are placed in detention for the public's safety or for the safety of the juvenile by a judge, a magistrate, or an intake officer
- Juvenile Detention Centers (JDCs) receive juveniles who have been expelled/rejected/banned from their schools, homes and communities
- JDCs do not have the option of turning away any juvenile, despite severity of needs and the inability to meet those needs
- Such juveniles are some of our most vulnerable citizens, the majority suffering from one or more mental health diagnoses and a significant history of trauma
- Many residents are not known to the JDCs; therefore a therapeutic rapport has not yet been established
- Suicidal ideation is more prevalent amongst detained/incarcerated youth than in general population

BACKGROUND

- Virginia's JDCs are faced with managing youth who are physically aggressive toward other residents, staff, or themselves as an act of self-harm
- JDCs are responsible for maintaining a safe, secure environment which requires quick response to such behaviors, the initial response being to physically intervene using approved restraint techniques
- JDCs do not use mace, pepper spray, tasers, weapons, or pharmacological/chemical restraints
- Mechanical restraints such as handcuffs and leg irons limit movement but do not absolutely restrict movement and may be weaponized against self or others

COMMON DYNAMICS IN JUVENILE DETENTION POPULATION

- History of trauma
- Impulse disorders
- Alcohol/drug use and abuse
- Learning disorders
- Cognitive impairments
- Poverty
- Homelessness
- Domestic violence
- Behavioral or conduct disorders
- Suicidal ideation / past attempts
- Pervasive developmental disorders
- Mood disorders
- Anxiety disorders
- Sexual abuse / offending
- Truancy / runaway
- Social isolation / bullying
- Poor anger management / coping skills
- Physical aggression / violence

THE LARGER PROBLEM

- Upward of two-thirds of young people in detention centers could meet the criteria for having a mental disorder, a little more than a third need ongoing clinical care – a figure twice the rate of the general population.
- Detention has become a new "dumping ground" for young people with mental health issues.
- A 2004 Special Investigations Division Report of the U.S. House of Representatives found that two-thirds of juvenile detention facilities were holding youth who were waiting for community mental health treatment, and that on any given night, 7 percent of all the youth held in detention were waiting for community mental health services.

Holman, B. and Ziedenberg, J. (2006). The dangers of detention: The impact of incarcerating youth in detention and other secure facilities. *Justice Policy Institute.*

THE LARGER PROBLEM

As one detention administrator told Congress, "we are receiving juveniles that 5 years ago would have been in an inpatient mental health facility... [W]e have had a number of juveniles who should no more be in our institution than I should be able to fly."

Holman, B. and Ziedenberg, J. (2006). The dangers of detention: The impact of incarcerating youth in detention and other secure facilities. *Justice Policy Institute*.

RISK OF SELF HARM

One of every ten newly detained youth has a history of attempted suicide. Because past suicide attempts are a powerful predictor of future attempts (Hayes, 2004), detained youth are at greater risk than youth in the general population (Gould et al., 1998; Foley et al., 2006: Johnson et al., 2002; Kessler, Borges, and Walters, 1999; Lewinsohn, Rohde, and Seeley, 1996).

(OJJDP Juvenile Justice Bulletin, July 2014)

KEEPING OUR KIDS SAFE

- Creating a positive, welcoming , safe environment
- Thorough intake process (health screenings, MH screenings, etc.)
- Structured daily schedule
- Incentive-based behavior management programs
- Mental health / crisis intervention services
- Accredited school programs
- Recreation
- Special events
- Family engagement / visitation
- Volunteer programs
- Staff training
  - Evidence-Based Programming
  - Verbal De-Escalation
  - Adolescent Brain Development, Trauma-Informed Care, Self-Awareness
- Nutritional meals and snacks

PHYSICAL INTERVENTIONS

- Physical interventions are authorized for:

  - ✓ self-defense
  - ✓ the defense of others
  - ✓ to prevent an escape
  - ✓ to protect a resident from harming himself or herself
  - ✓ to prevent the commission of a crime
  - ✓ to prevent property damage

Physical intervention should be used only when other alternatives have failed or appear unsuitable. When it is deemed necessary to use physical intervention to control a resident, only the minimal amount of physical force necessary is to be used.

MOBILE RESTRAINT CHAIR (MRC)

- Number of Juvenile Detention Centers in Virginia - 24
- Number of Juvenile Detention Centers possessing the MRC - 13
- Allowable and regulated according to 6VAC35-101-1130 and 6VAC35-101-1140
- Used only in situations of imminent danger
- Used only as a last resort after other methods have been exhausted
- Never used for punishment, behavior modification or as a disciplinary measure
- Specifically –
  - At Blue Ridge Juvenile Detention (BRJD), each use automatically initiates a call to Region Ten Community Services Board for TDO evaluation
  - BRJD has utilized the MRC six times since 2002, for four residents, all precipitated by active self-harm
  - BRJD has never been cited for improper use
  - No resident injuries were sustained during its limited use

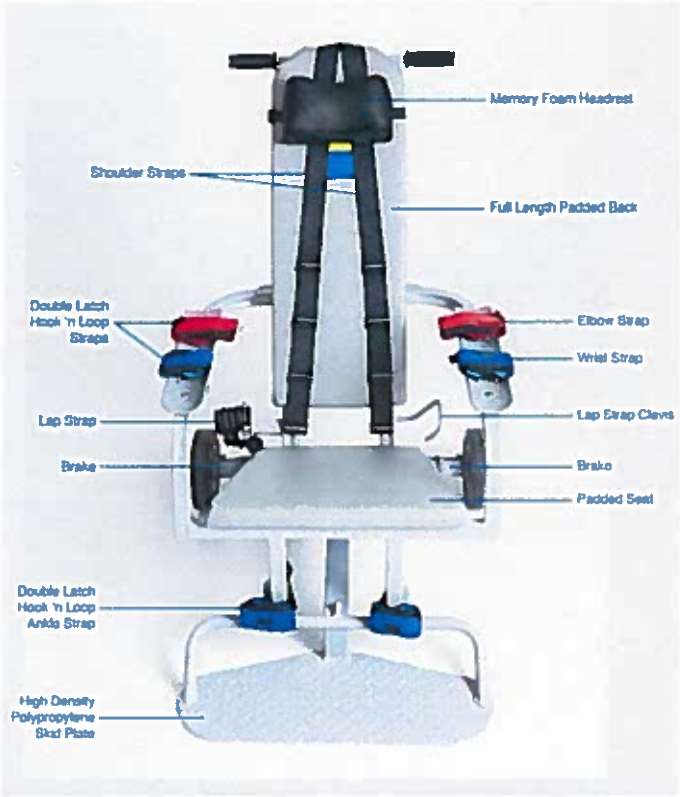
MOBILE RESTRAINT CHAIR

- Of the 13 facilities that have a Mobile Restraint Chair:
  - Some programs have had MRC for over 15 years, others have recently acquired it
  - Use varies from seldom to never with no program reporting frequent or routine use
  - All report that use of MRC is the last option available and only when all lesser methods have failed
  - Programs who report higher frequency attribute this to spikes in use due to an occasional individual resident with high severity of need
  - No programs report instances of injury to residents as a result of using MRC
  - Those that report no use have cited specific historic cases that caused them to acquire MRC, without similar situations presenting afterwards

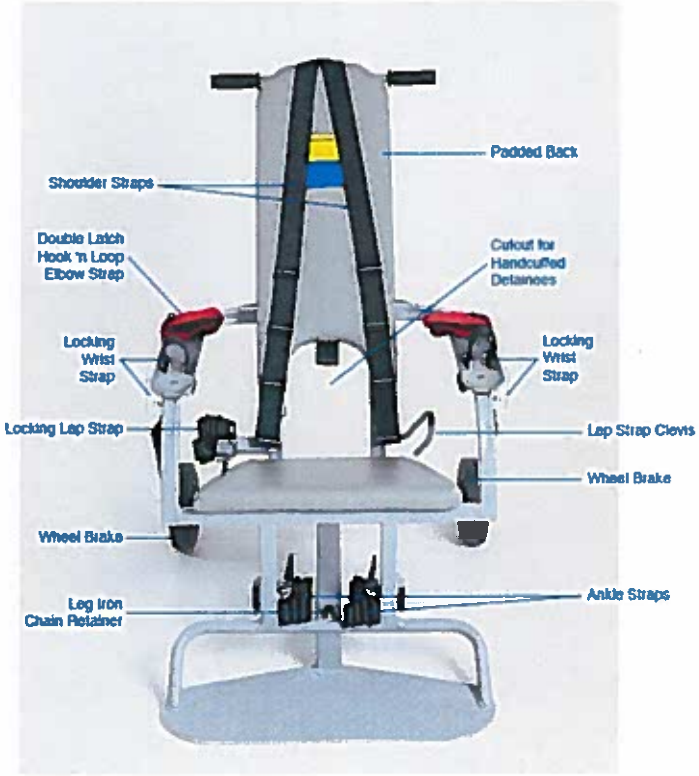
RESEARCH STUDIES AND FINDINGS

- Castillo, E.M., Coyne, C.J., Chan, T.C., Hall, C.A., & Vilke, G.M. (2015). Review of the medical and legal literature on restraint chairs. *Journal of Forensic and Legal Medicine*, 33, 91-97.
    - Law enforcement and corrections personnel often confront violent, dangerous individuals who must be physically restrained for the safety of staff as well as the individuals themselves.
    - Identified very few risks directly related to the restraint chair when used for this purpose.
    - Of legal cases that focused on the use of the restraint chair, many of the issues stemmed from inappropriate use of the chair and deviation from established protocols, not harm inflicted by the device itself.
    - With well-established protocols that clearly delineate when and how to use the chair, and how to monitor individuals placed in the chair, this device can be effectively and safely used.

SureGuard Medical Chair



SureGuard Correctional Chair



RESEARCH STUDIES AND FINDINGS

- Visaggio, N., Phillips, K.E., Kischefski, K., McElhinney, J., Idiculla, T.B., Blair, E.W., ...Young, S.C. (2018). Is it safe? The restraint chair compared to traditional methods of restraint: A three hospital study. *Archives of Psychiatric Nursing, 32*, 723-728.
  - Study compared three methods of seclusion and restraint, including the newly introduced restraint chair.
  - Findings indicate that the restraint chair is no more likely to cause patient injury than four-point mechanical restraint or seclusion.
  - Restraint chair resulted in a lower chance of staff injury when compared to episodes of four-point mechanical restraint.
  - Study aims to contribute to overall goal of identifying the unique needs of psychiatric patients and reduce the use of more intrusive methods of de-escalation.

RESEARCH STUDIES AND FINDINGS

- Visaggio, N., Phillips, K.E., Kischefski, K., McElhinney, J., Idiculla, T.B., Blair, E.W., ...Young, S.C. (2018). Is it safe? The restraint chair compared to traditional methods of restraint: A three hospital study. *Archives of Psychiatric Nursing, 32*, 723-728.

  The ability to have patients in an upright position provides for ease of control for nursing staff during emergency situations while reducing the risk to patients by not resulting in changes to oxygen saturation of the restrained patient (Castillo et al., 2015). The position of the patient could also contribute to a shorter restraint period.

RESEARCH STUDIES AND FINDINGS

- Visaggio, N., Phillips, K.E., Kischefski, K., McElhinney, J., Idiculla, T.B., Blair, E.W., ...Young, S.C. (2018). Is it safe? The restraint chair compared to traditional methods of restraint: A three hospital study. *Archives of Psychiatric Nursing, 32*, 723-728.

Gildberg et al. (2015) recognize that restraint episodes are shortened when supporting factors provided by the staff in the form of expectations, validating positive behavior, and developing a therapeutic relationship are present. The sitting position allowed by the restraint chair is thought to facilitate the effectiveness of supportive factors by providing the patient the ability to remain in a comfortable, eye-to-eye position with staff, as opposed to the submissive supine position of four-point mechanical restraint or the isolation of seclusion. The ongoing implementation of de-escalation and calming techniques are important to developing the therapeutic relationship and reducing the risk of further violent behavior (Bilici, Sercan, and Tufan, 2013).

CONSIDERATIONS FOR ENHANCED REGULATION

Constant monitoring of resident by trained staff member

Use warrants a referral for mental health services

Use warrants a Serious Incident Report to the Department

Aggregate record keeping of incidents in which MRC was utilized

6VAC35-101-1090. Physical restraint.

A. Physical restraint shall be used as a last resort only after less restrictive interventions have failed or to control residents whose behavior poses a risk to the safety of the resident, others, or the public.

1. Staff shall use the least force deemed reasonable to be necessary to eliminate the risk or to maintain security and order and shall never use physical restraint as punishment or with the intent to inflict injury.

2. Staff may physically restrain a resident only after less restrictive behavior interventions have failed or when failure to restrain would result in harm to the resident or others.

3. Physical restraint may be implemented, monitored, and discontinued only by staff who have been trained in the proper and safe use of restraint.

4. For the purpose of this section, physical restraint shall mean the application of behavior intervention techniques involving a physical intervention to prevent an individual from moving all or part of that individual's body.

B. Written procedures shall govern the use of physical restraint and shall include:

1. The staff position who will write the report and time frame;

2. The staff position who will review the report and time frame;

3. Methods to be followed should physical restraint, less intrusive interventions, or measures permitted by other applicable state regulations prove unsuccessful in calming and moderating the resident's behavior; and

4. An administrative review of the use of physical restraints to ensure conformity with the procedures.

C. Each application of physical restraint shall be fully documented in the resident's record including:

1. Date and time of the incident;

2. Staff involved;

3. Justification for the restraint;

4. Less restrictive behavior interventions that were unsuccessfully attempted prior to using physical restraint;

5. Duration;

6. Description of method or methods of physical restraint techniques used;

7. Signature of the person completing the report and date; and

8. Reviewer's signature and date.

6VAC35-101-1130. Mechanical restraints.

A. Written procedure shall govern the use of mechanical restraints. Such procedures shall be approved by the department and shall specify:

1. The conditions under which handcuffs, waist chains, leg irons, disposable plastic cuffs, leather restraints, and a mobile restraint chair may be used;

2. That the facility administrator or designee shall be notified immediately upon using restraints in an emergency situation;

3. That restraints shall never be applied as punishment or a sanction;

4. That residents shall not be restrained to a fixed object or restrained in an unnatural position;

5. That each use of mechanical restraints, except when used to transport a resident or during video court hearing proceedings, shall be recorded in the resident's case file or in a central log book; and

6. That a written record of routine and emergency distribution of restraint equipment be maintained.

B. Written procedure shall provide that (i) all staff who are authorized to use restraints shall receive training in such use, including how to check the resident's circulation and how to check for injuries and (ii) only trained staff shall use restraints.

6VAC35-101-1140. Monitoring restrained residents.

A. Written procedure shall provide that when a resident is placed in restraints, staff shall:

1. Provide for the resident's reasonable comfort and ensure the resident's access to water, meals, and toilet; and

2. Make a direct personal check on the resident at least every 15 minutes and more often if the resident's behavior warrants, such checks shall include monitoring the resident's circulation in accordance with the procedure provided for in 6VAC35-101-1130 B.

B. When a resident is placed in mechanical restraints for more than two hours cumulatively in a 24-hour period, with the exception of use in routine transportation of residents, staff shall immediately consult with a health care provider and a mental health professional. This consultation shall be documented.

C. If the resident, after being placed in mechanical restraints, exhibits self-injurious behavior, (i) staff shall immediately consult with and document that they have consulted with a mental health professional and (ii) the resident shall be monitored in accordance with established protocols, including constant supervision, if appropriate. Any such protocols shall be in compliance with the procedures required by 6VAC35-101-1150 (restraints for medical and mental health purposes).

Use of Emergency Restraint Chair at Commonwealth Center for Children and Adolescents

Jaime M. Bamford, MD

Medical Director

November 7th, 2018

What is the Commonwealth Center?

- Commonwealth Center for Children and Adolescents (CCCA)
- Located in Staunton Virginia
- Only state psychiatric hospital for children
- 4 units, 12 beds each unit (total of 48 beds)
- Due to bed of last resort legislation, only able to accept TDO's or civil commitment
  - CCCA typically received 36% of all TDO's issued for children and adolescents during FY18. 27% in FY17.

Who comes to CCCA?

- Most admissions are related to severe aggressive behavior
- Average age 14 yo
- 65% male, 35% female
- 47% White/Caucasian
- 53% Minorities
  - 40% African American
  - 10% Other (Hispanic, Asian)
  - 3% Alaskan, Native American or Unknown

Who comes to CCCA?

- 30% have Autism, ID or DD diagnoses
- 10% Forensic referrals
- 10% in DSS custody
- 17% admitted from group homes or residential treatment centers
- Average length of stay is 7-9 days

What do we do at CCCA?

- Mission of CCCA: ***To provide safe, high quality acute psychiatric evaluation, crisis stabilization, and intensive short-term treatment that restores the child to an appropriate community setting and that strengthens children's hope, resilience, and self-esteem.***
- Utilize collaborative, relationship based, trauma informed care approach to treatment
- Recently trained 25 staff in Dialectical Behavioral Therapy

Where do they go after CCCA?

- 68% return home to family or guardian with community based services
- 32% discharged to detention, group home, foster care or residential treatment center

Use of Emergency Restraint Chair at CCCA

- Prior to ERC, were using bed restraints in addition to seclusion and physical restraints
- Decision to consider ERC was based on
  - Trauma related to bed restraints in traumatized population (making beds a "safe place")
  - Safety issues related to transporting someone to their bed for restraint
  - Timeliness of restraint
- Started using ERC in November 2014

Steps taken to implement ERC

- Utilized knowledge from other facilities using ERC
- Review of data related to ERC use in children
- Presented to Local Human Rights Committee who approved implementation
- Developed policies and procedures
- Trained staff prior to implementation, retrained at 6 months and 12 months
  - Therapeutic Options of Virginia (TOVA)
- Evaluated adherence to procedure

Seclusion and Restraint Policy

- Seclusion and restraint may be used only in emergencies in which there is an *immediate danger of a child physically harming himself or others*.
- Seclusion or restraint use must be ordered by a physician and must be time-limited.
- If the seclusion or restraint is initiated in an emergency in which the physician order cannot be obtained prior to the event, then the RN will contact the physician immediately after the seclusion or restraint is initiated and the nurse has conducted an assessment of the child.
- In general, seclusion and restraint will be initiated only at the direction of an RN or physician

Seclusion and Restraint Policy

- When a physician or trained nurse is not immediately present or available, a properly trained direct care staff person may initiate physical restraint or seclusion. In such cases, the direct care staff must immediately notify the nurse of the use of seclusion/restraint.
- *Use of mechanical restraints must be first approved by a physician or on-duty nurse who witnesses the need for such interventions.*

CCCA Policy on ERC

- Initial order is up to 2 hour, maximum time is 4 hours.
- The chair shall be used as indicated in the training instructions.
- There shall be no variation in how the straps or points of restraint are used.
- No additional belts or restraint devices shall be used or added to the ERC.
- Only staff trained in the use of the ERC may place a patient in the ERC.
- The ERC and patient shall then be moved to a private area such as seclusion room.
- The default positioning of the ERC shall be at an angle that facilitates staff observation

CCCA Policy on ERC

- Patient must be at least 80 pounds and their feet must be flat on the floor.
- Continuous Observation is required for all patients
- Patient's progress and functioning is documented in the clinical record every five minutes.
- Bathroom use will be offered every 2 hours and as needed
- Patient will be offered fluids at least once per hour and provided meals at scheduled meal times if restraint use continues through a meal time.

Assessment while in ERC

- Within 1 hour after the initiation of seclusion or restraint, every 1 hour thereafter and at the conclusion of the intervention, a physician or nurse will conduct a face-to-face evaluation of the patient.
- The face-to-face evaluation and subsequent documentation in the clinical record will include:
  - An evaluation of the physical and psychological response to seclusion and/or restraint; and
  - A determination of whether restraint or seclusion should be continued.

Assessment while in ERC

- If the nurse conducts the re-evaluation, s/he must notify the physician immediately if any unusual physical or psychological problems are noted and take immediate action to resolve those problems.
- A physician must do a face-to-face re-evaluation of the child or adolescent within 24 hours of the initiation of each restraint or seclusion event, and this evaluation will be documented in the clinical record.

Release from ERC

- Universal criteria for release from S/R shall be used in most instances of emergency seclusion or restraint. The release criteria which shall be used are:
  - non-threatening to self or others
  - calm
  - Redirectable
- A patient will be secluded or restrained no longer than is deemed clinically necessary.

Release from ERC

- When a patient deescalates to a point where there is no longer a threat to self or others, seclusion or restraint will end.
- When staff who are monitoring the child determine that the release criteria described in the written order have been exhibited by the child:
  - Staff must immediately report this determination to a nurse or a physician;
  - The nurse or physician will evaluate the child to determine if the seclusion or restraint can safely end
- The physician or nurse will assess the child for physical and psychological trauma immediately upon release from restraint or seclusion and provide care as needed.

Advantages of ERC

- Avoids prolonged physical holds which have the greatest risk for injury and death
- Avoids prone or supine restraints
- Allows face to face conversation with individual
- Allows closer supervision of patient and staff engagement
- Can bring the chair to the patient rather than risk transporting to seclusion
- Less vulnerable or "one down position relative to others
- Avoids contamination of bed with negative connotations
- Avoids isolation of seclusion
- Provides secure containment for kids at risk of banging head, punching walls, feeling overwhelmed because totally out of physical control

Disadvantages of ERC

- Any restraint is traumatic and can diminish your therapeutic relationship with a client
- Sometimes need a lot of staff to place patient in ERC
- Need to have a leader for how the process of placement will take place
- Patients viewing the ERC as a punishment

Impact of ERC

- Decline in staff injuries
- Less time in physical restraint
- Some patients prefer the ERC to seclusion
- Since implementation, 1 serious patient injury (broken wrist)
  - Investigation unable to determine if related to ERC or aggression prior to ERC when staff deflected a punch.

Parting Thoughts

- Reduction in seclusion and restraints comes from...
  - Recognition of patients at high risk for violence (screening)
  - Development of individualized intervention strategies (safety plans)
  - High staff to patient ratios
  - Well trained staff
  - Ideal environment (less patients in spaces, structured activities, consistent expectations)
  - Thus in a perfect world.

Until then....

- The ERC has been effective at CCCA for improved patient and staff safety as well as an efficient way to manage severe aggression.
- Questions?

Words are our most inexhaustible source of magic, capable of both inflicting injury and remedying it.

– Albus Dumbledore

Practice Parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities

ABSTRACT

This practice parameter presents recommendations for the mental health assessment and treatment of youths in juvenile detention and correctional facilities. Mental and substance-related disorders are significant public health problems affecting youths in juvenile justice settings. Sufficient time is necessary to conduct a comprehensive diagnostic assessment, interview collateral historians, and review pertinent records to identify primary and comorbid conditions. Potential role conflicts (i.e., forensic evaluator versus clinical care provider) need to be clarified before beginning any evaluation or treatment program, and particular attention must be paid to the issue of patient confidentiality. Issues of special concern in correctional health care, such as self-mutilative behaviors, suicide attempts, malingering, mandated reporting, ethical issues, cultural competency, institutional policies affecting clinical care, and the role of the clinician, are reviewed. *J. Am. Acad. Child Adolesc. Psychiatry*, 2005;44(10):1085–1098. **Key Words:** practice parameter, practice guideline, child and adolescent psychiatry, juvenile delinquent, juvenile corrections, detention facilities, juvenile justice.

There has been a significant increase in the need for mental health services for youths in the juvenile justice system. Although as many as 75% of juvenile offenders (Teplin et al., 2002) have one or more diagnosable psychiatric disorders, most juvenile correctional facilities do not have the resources to provide services. Although many child and adolescent psychiatrists consult on a part-time or an infrequent basis to community mental health centers, group homes, residential facilities, juvenile detention and correctional facilities, and other juvenile justice settings that house youths with juvenile/family court involvement, there is scant literature regarding effective psychiatric evaluation, consultation, and policy development in these settings. Psychiatrists infrequently receive formal training or continuing medical education regarding these topics. Child and adolescent psychiatrists and other mental health professionals who work in juvenile justice face a myriad of challenges: potential role conflicts, confidentiality issues, interface of multiple systems (i.e., police, probation, family courts, social services), negative perceptions toward delinquent youths, and other practical issues in addressing the multiple needs of these youths.

This practice parameter was written on behalf of the American Academy of Child and Adolescent Psychiatry (AACAP) to provide clinical guidelines for child and adolescent psychiatrists working in juvenile justice settings, but it has broad applicability to other child mental health professionals. Thus, the term *clinician* will be used to define a child and adolescent psychiatrist or

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This parameter was developed by Joseph V. Penn, M.D., and Christopher Thomas, M.D., and the Work Group on Quality Issues: William Bernet, M.D., and Oscar G. Bukstein, M.D., Co-Chairs, and Valerie Arnold, M.D., Joseph Beitchman, M.D., R. Scott Benson, M.D., Joan Kinlan, M.D., Jon McClellan, M.D., Jon Shaw, M.D., and Saundra Stock, M.D. AACAP staff: Kristin Kroeger Ptakowski. A group of invited experts, including members of the AACAP Committee on Rights and Legal Matters and the AACAP Committee on Juvenile Justice Reform, also reviewed the parameter.

This parameter was reviewed at the member forum at the 2003 annual meeting of the American Academy of Child and Adolescent Psychiatry.

During July to October 2004, a consensus group reviewed and finalized the content of this practice parameter. The consensus group consisted of representatives of relevant AACAP components as well as independent experts: William Bernet, M.D., Chair; Joseph V. Penn, M.D., and Christopher Thomas, M.D., authors of the parameter; Saundra Stock, M.D., and Jon McClellan, M.D., representatives of the Work Group on Quality Issues; Louis Kraus, M.D., and David Fassler, M.D., representatives of the AACAP Council; William Arroyo, M.D., and Andres J. Pumariega, M.D., representatives of the AACAP Assembly of Regional Organizations; Diane H. Schetky, M.D., independent expert reviewer; and Kristin Kroeger Ptakowski, Director of Clinical Affairs, AACAP.

This practice parameter was approved by AACAP Council on November 8, 2004.

This practice parameter is available on the Internet (www.aacap.org). Reprint requests to the AACAP Communications Department, 3615 Wisconsin Ave., NW, Washington, D.C. 20016.

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any other licensed child mental health professional in these settings.

METHODOLOGY

The list of references for this parameter was developed by searching *PsycINFO*, *Medline*, and *Psychological Abstracts*; by reviewing the bibliographies of book chapters and review articles; and by asking colleagues for suggested source materials. The searches covered the period 1990 through 2004 and yielded about 60 articles. Each of these references was reviewed, and only the most relevant were included in this document.

DEFINITIONS

These are general definitions only, and the reader should be aware of local differences by jurisdiction.

Adjudication

Adjudication refers to a court proceeding in which a delinquency case is reviewed and settled. As used in this guideline, the judicial process for determining guilt in criminal or in juvenile/family courts.

Detention

Detention refers to the period following arrest in which a youth is held in secure custody before or after court proceedings. A detention center, sometimes referred to as a "youth jail," is a short-term secure facility in which. a youth may be held at any time during the processing and disposition of the youth's legal case for the purposes of evaluation or placement if a secure environment is deemed necessary.

Placement

Placement refers to the period following court proceedings in which a judge has issued orders including the location where the youth will reside. Examples of locations may include reception or diagnostic centers, community-based or other residential treatment programs, or juvenile correctional facilities.

Mental Health Professionals

These include psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their credentials are permitted by law to evaluate and care for the mental health needs of patients.

Status Offender

Status offender refers to a youth who has violated a law that would not be a crime if the youth were an adult (e.g., curfew violation, truancy, runaway, incorrigibility, underage drinking).

Youthful Offender

Youthful offender refers to any youth found by the juvenile/family court to have committed an offense. Many states have enacted "youthful offender" laws, in which youth charged with certain specific offenses, usually violent or serious crimes, may be automatically transferred to adult criminal court or provided sentences in juvenile court that may extend beyond the maximum age of juvenile court discretion.

YOUTHS IN JUVENILE JUSTICE SETTINGS

Youths with mental illness present a special challenge to the juvenile justice system. Although epidemiological studies on the prevalence of mental and substance-related disorders among youths in the juvenile justice system are limited, research suggests that these problems are significantly more common among youthful offenders than in other youths (Atkins et al., 1999; Cocozza, 1992; Garland et al., 2001). Although as many as 65% to 75% of youthful offenders have one or more diagnosable psychiatric disorders (Teplin et al., 2002; Wasserman et al., 2003), most juvenile detention facilities do not have the capacity to serve them. This situation is aggravated by multiple problems including overcrowding, dilapidated institutions, inadequate funding for services and programs, and inadequately trained custodial and mental health staff. These factors are associated with an increased risk of suicide, physical assaults, and accidental injuries (National Juvenile Detention Association, 2000).

Although there are no current national data regarding the incidence of suicide attempts among youths in custody, the information available suggests a high incidence of suicidal behavior in juvenile correctional facilities. There have been several national studies conducted regarding the extent and nature of suicide in adult jail and prison facilities (Hayes, 2004), but there has not been any comparable national research conducted to date regarding juvenile suicide in confinement. There is only one national survey of juvenile suicides in custody, but this contained several flaws in the calculation of suicide rates (Flaherty, 1980). Reanalyses of suicide rates in that study found that youth suicide in juvenile detention centers was estimated to be

more than four times greater than that in the general population (Memory, 1989). In 1988, the first year of the Children in Custody census, juvenile officials reported 17 suicides occurring in public detention centers, reception/diagnostic centers, and training schools throughout the country. Twenty such deaths were reported during 1994. Given the epidemiological data regarding adolescent suicide, coupled with the increased risk factors associated with detained youths, the number of "reported" suicides in custody appears low. Most juvenile justice clinicians and experts believe the problem to be severely underreported.

There is growing attention to the overrepresentation and disproportionate confinement of minority youths in the juvenile justice system (American Academy of Child and Adolescent Psychiatry, 2001; Krisberg et al., 1991; Pope and Feyerherm, 1993). The Census of Juveniles in Residential Placement (CJRP; Snyder and Sickmund, 1999) revealed that 67% of all confined youths belong to minority groups, although they make up only 34% of the national population. The proportion of minorities confined in private facilities was somewhat less, 55%. The rates of confinement per 100,000 youths were 204 for white, 203 for Asian American, 515 for Hispanic, 525 for Native American, and 1,018 for African American. This disparity in confinement was also found on a state-by-state comparison, although there was some variation.

While girls represented 23% of all cases handled by juvenile courts in 1997 (Puzzanchera et al., 2000), they made up only 14% of all youths in correctional facilities according to the CJRP. The CJRP documented other important sex differences for juveniles in detention and placement. The age distribution is younger for girls: 26% were below the age of 15 compared with only 16% for boys. The proportion of girls was greater in private than public facilities, 18% and 12%, respectively. Girls were also more likely than boys to be in placement for a status offense, representing 45% of all female cases. Although minority girls were overrepresented (51%), the proportion was smaller than that of minority boys (64%). Incarcerated girls also reported high rates of prior abuse, posttraumatic stress disorder, and anxiety disorders, with inadequate resources focused on their sex-specific needs, such as sexual assault counseling. Community-based dispositions for female delinquents continue to be extremely problematic because of the paucity of resources centered on their specific needs.

CHALLENGES TO EFFECTIVE MENTAL HEALTH EVALUATION AND TREATMENT OF INCARCERATED JUVENILES

Numerous issues raise challenges for clinicians working in juvenile justice settings (Thomas and Penn, 2002). Seeing youths in correctional attire, chained, or handcuffed may elicit a wide range of responses in clinicians. Secure juvenile correctional settings present a stark contrast to more traditional mental health treatment settings. Although there are limited systematic data regarding specific ages of youths in juvenile justice facilities, there appears to be an increasing national trend for younger youths, even prepubertal youths, to be incarcerated. In many states, juveniles as young as 9 and as old as 20 are held in the same correctional facility. This wide range of chronological and developmental maturity in juvenile justice youths has multiple clinical implications and is further complicated by differences in (1) offenses ranging from status offenses to more violent crimes (e.g., murder, attempted murder, assault with a deadly weapon); (2) stage of court proceeding and legal status (e.g., detained, preadjudication versus sentenced, postadjudication); (3) legal history (e.g., first-time offender versus repeat offender, multiple incarcerations); (4) gang affiliation; (5) family and psychosocial resources or other supports; (6) youth's and family's attitudes toward law enforcement, the court, state social services, or medical and mental health services; and (7) diversity issues, such as race, culture, ethnicity, religion, and sexual identity.

RECOMMENDATIONS

Each recommendation in this parameter is identified as falling into one of the following categories of endorsement, indicated by an abbreviation in brackets after the statement. These categories indicate the degree of importance or certainty of each recommendation.

[MS] *Minimal standards* are recommendations that are based on substantial empirical evidence (e.g., well-controlled, double-blind trials) or overwhelming clinical consensus. Minimal standards are expected to apply more than 95% of the time (i.e., in almost all cases). When the practitioner does not follow this standard of care in a particular case, the medical record should indicate the reason.

[CG] *Clinical guidelines* are recommendations that are based on empirical evidence (e.g., open trials, case

studies) and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time. These practices should always be considered by the clinician, but there are exceptions to their application.

[OP] *Options* are practices that are acceptable but not required. There may be insufficient empirical evidence to support recommending these practices as minimal standards or clinical guidelines. In some cases, they may be the perfect thing to do, but in other cases, they should be avoided. If possible, the practice parameter will explain the pros and cons of these options.

[NE] *Not endorsed* refers to practices that are known to be ineffective or contraindicated.

Recommendation 1. The Clinician should Have an Awareness and Understanding of the Operations of the Juvenile Correctional Facility and the Issues Affecting it, Including the Interface with Multiple Systems (e.g., Police, Probation, Family/Juvenile Courts, Social Services, Child Welfare Agencies) and the Existing Educational and Health Care Systems within the Facility [CG]

Effective consultation in juvenile justice settings requires knowledge of the organizational structure, policies, procedures, and other systems issues relevant to mental health issues and the routine schedule of youths in the institution (DePrato and Hammer, 2002). Orientation and continuing education activities designed for juvenile correctional facility staff should include training across child service agencies or areas including correctional, educational, health, mental health, and juvenile court. Mental health clinicians benefit from training and orientation by the security staff in the correctional setting, including such matters as social order, gang affiliations, and attitudes toward sexual offenders. Similarly, cross-training can improve the correctional staff's understanding of juvenile's suicide risk factors, psychopathology, and early development, including the sexual and psychological domains. Facility personnel can provide perspective on youths' use and manipulation of the mental health professional and system (American Psychiatric Association, 2000).

Clinicians should collaborate with correctional staff to promote and develop effective mental health programs, attempt to reduce stigma and other biases toward mental health evaluation and treatment, and encourage culturally competent and evidence-based practices. Clinicians also should contribute to and participate in the development of rehabilitative programs for incarcerated youths, including behavioral management; therapeutic, recreational and educational activities; and staff training, policies and procedures relating to these components to enhance the outcome and positive impact on involved youths.

Incarcerated youths are often excellent sources of information regarding institutional rules, security levels, behavioral expectations, and adaptive and covert behaviors demonstrated by some youths. For example, cigarettes, alcohol, illicit drugs, and seemingly innocuous institutional cleaning supplies (spray cans, air fresheners) may be abused by youths in many presumably "secure" or "drug-free" settings.

Clinicians should recognize that although all are working in the "best interests" of an incarcerated juvenile, there is a dynamic tension between the safety, security, and punishment approach by direct-care staff and the rehabilitative or therapeutic approach of clinicians. Each of the institutional service areas has its own legal mandates. Thus, it is paramount to learn the strengths, weaknesses, communication patterns, and relationships among mental health clinicians, direct-care and other professional staff, outside agencies that interface with or provide other services to the juvenile correctional facility, educational staff and systems, and ocal medical staff (e.g., nursing, pediatric, dental).

Clinicians should be attuned to any overly punitive as opposed to rehabilitative efforts by institutional staff. Mandated reporting requirements for the use of excessive force or abuse of incarcerated youths by other youths or staff may vary by state and jurisdiction, and thus clinicians should be knowledgeable about their ethical and local statutory reporting requirements and seek administrative or professional guidance when questions arise.

Recommendation 2. All Youths Entering a Juvenile Justice Detention or Correctional Facility should be Screened for Mental or Substance Use Disorders, Suicide Risk Factors and Behaviors, and Other Emotional or Behavioral Problems [MS]

Numerous studies have documented the higher prevalence of mental disorders and emotional and behavioral problems among youths in the juvenile justice system when compared with the general population. These findings are not entirely surprising because youths charged with offenses would be expected to have

symptoms of conduct disorder (Melton and Pagliocca, 1992). Other mental disorders are also present at rates much higher than those found in the general population, including attention-deficit/hyperactivity disorder, mood and anxiety disorders, and substance use disorders. The potential involvement with substance abuse and violence places many youths at particular risk of posttraumatic stress disorder.

In some cases, youths with serious mental disorders are being routinely detained solely for status offenses or because of a lack of alternate less-restrictive community-based placements; for example, detention centers are used as holding areas because no inpatient bed or residential placement is available (U.S. House of Representatives, 2004).

The prevalence of mental disorders in incarcerated adolescent girls may be much higher than that found in boys. Kataoka and colleagues (2001) found that 80% of incarcerated girls met the criteria for diagnosis of an emotional disorder or substance use/abuse. Another study among incarcerated adolescents diagnosed current PTSD in 49% of the girls, significantly higher than the 32% of boys that met the criteria for diagnosis (Cauffman et al., 1998).

The U.S. Supreme Court set forth minimum requirements for mental health services in correctional placements, including screening and evaluation, in Ruiz v. Estelle (1980). Although this ruling concerned adult facilities, it serves as the basis for broader standards for correctional care, including juvenile placements. Intake screening to identify those in need of mental health care is required for accreditation of correctional facilities by the American Correctional Association and the National Commission on Correctional Health Care (NCCHC). Differences in existing guidelines and standards create wide variations in mental health screening practices across settings (detention, court, corrections, diversion) and jurisdictions (even within the same state) and often do not reflect the highest standard of care (Weibush et al., 1995). In general, youths undergo mental health screening during the first 24 hours of incarceration. In addition, NCCHC standards require a postadmission assessment of all juveniles with positive screens within 14 days of admission (National Commission on Correctional Health Care, 2004).

On arrival at a juvenile justice facility, youths should undergo systematic mental health screening by trained correctional staff and qualified health care professionals. To respond effectively to the high prevalence of mental health and substance abuse problems among incarcerated youths, the intake process should include comprehensive screening for suicide risk, alcohol and other drug abuse, and adjustment to the juvenile justice setting. Policies and procedures regarding referral of youths to mental health or medical personnel should be in place. Intake screening for suicide risk should include questions regarding past suicidal ideation and/or attempts; current ideation, threat, or plan; prior mental health treatment and/or hospitalization; recent significant loss (relationship, death of family member or close friend); history of suicidal behavior by family member or close friend; suicidal ideation or behavior during prior confinement; and initiation or discontinuation of psychotropic medication(s).

The ideal mental health screening tool in juvenile justice should be brief, easily administered and interpreted by facility staff, and proven to identify common problems and safety concerns among newly incarcerated youths. The threshold for referral for a more comprehensive mental health assessment by a mental health professional should also be clearly established in any screening instrument. Many standardized screening and assessment instruments that are routinely used in community settings have not been validated in juvenile justice populations, are overly time intensive, require extensive training or numerous clinicians to administer, or rely on parents or teachers who may not be available. Any potential racial, ethnic, or socioeconomic biases in screening procedures or methods should be removed to ensure fair and timely attention and response (Rogers et al., 2001).

An evidence-based mental health screening should be undertaken as part of the general health screen (Wasserman et al., 2003). One instrument specifically developed to assess youths in the juvenile justice system is the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2), a brief 52-item self-report questionnaire (Grisso et al., 2001). Features of the MAYSI-2 include the following: (1) it can be completed within 10 minutes; (2) it uses youth self-report; (3) it is easy to read; (4) it requires no special clinical expertise to administer, score, and interpret; (5) it uses low-cost materials; (6) it may be used with a wide range of adolescents (by age, sex, and ethnicity); and (7) it has sound preliminary psychometric properties. The MAYSI-2 is intended primarily for use at the front door of juvenile

justice systems by nonclinical staff to identify youths who may be in need of immediate clinical intervention (Grisso et al., 2001). The MAYSI-2 shows promise as a reliable and valid screening tool to assist juvenile justice staff in identifying youths who may need immediate response and additional clinical assessment of potential mental or emotional problems.

Recommendation 3. All Youths Held in a Juvenile Justice Detention or Correctional Facility should Receive Continued Monitoring for Mental or Substance Use Disorders, Emotional or Behavioral Problems, and Especially for Suicide Risk [MS]

Even with adequate screening, mental or substance use disorders and other emotional or behavioral problems may not be recognized on intake and only become apparent through additional observation. Newly detained youths are often guarded and suspicious and often present as poor and unreliable historians. In addition, detention or placement in a correctional facility is stressful and may precipitate emotional or behavioral problems that were not present at the time of intake.

In view of the high prevalence of mental disorders and the high incidence of suicidal behavior in youths in juvenile correctional facilities, every juvenile justice facility should have a suicide prevention program for identifying and responding to each potentially suicidal youth. It is therefore necessary for youths held in detention or correctional placements to receive continued monitoring and repeated assessment for emotional or behavioral problems during confinement. Two essential components of a successful suicide prevention program are properly trained staff and ongoing communication between direct-care personnel and clinical staff. Continued observation and reassessment is particularly important in the prevention of suicide for detained youths.

The American Psychiatric Association (APA) Task Force to Revise the APA Guidelines on Psychiatric Services in Jails and Prisons (2000) has identified some high suicide risk periods for incarcerated adults and has recommended several key components for an adequate suicide prevention program. Although a youth may become suicidal at any point during incarceration, particularly high-risk periods include initial detention, transfer for court appearance, return to the correctional facility, sentencing, receipt of new legal problems, receipt of bad news, feelings of humiliation or rejection, confinement in isolation or segregation, and a prolonged stay in the facility (National Commission on Correctional Health Care, 2004). Youths with mental and substance-related disorders may pose an even higher suicide risk during any of these periods.

Incarcerated youths may engage in a variety of suicidal and self-mutilative behaviors including threats, wrist lacerations, strangulation or hanging, cell arson, and swallowing foreign objects. Youths who are malingering suicidal behaviors may cause inadvertent serious harm, injury, or complete suicide. Thus, any youth who engages in self-mutilative behavior, even if believed by staff to be manipulative or a gesture for secondary gain, warrants prompt evaluation by a healthcare professional to (1) assess whether additional medical treatment (e.g., debridement, suturing, wound care, bandaging) is needed, (2) clarify whether direct-care staff interventions and special levels of observation are required, (3) initiate evaluation by a qualified mental health professional, and (4) determine whether urgent psychiatric consultation is indicated. Youths who ingest medications or foreign objects or engage in more violent or potentially lethal behaviors (e.g., stabbing, hanging) will likely require emergency medical evaluation.

Recommendation 4. Any Youth with Recent/Current Suicidal Ideation, Attempts, or Symptoms of a Mental or Substance-Related Disorder During the Period of Incarceration should be Referred for Additional Evaluation by a Mental Health Clinician [MS]

Past medical and mental health records are often unavailable, or there may be delays in obtaining releases of information and copies of records. Access to parents, family members, and collateral historians and records is often problematic. After the intake process, should any staff hear a youth verbalize a desire or intent to commit suicide or hear about such a desire or intent from other staff or residents, observe a youth engaging in any self-harm, or otherwise believe a youth is at risk for suicide, a procedure should be in place that requires staff to take immediate steps to ensure that the resident is constantly observed until appropriate medical, mental health, and/or supervisory assistance is obtained (Hayes, 2004).

Although there are no published standards delineating a specific time frame by which youths who screen positive for suicide risk factors and/or other mental

or substance-related problems on intake should receive additional clinical evaluation, every effort should be made to conduct such an evaluation as soon as possible. Excessive delays, failure to adhere to community standards of care for timely and clinically appropriate referrals, or any negative outcomes would raise liability issues. Youths with acute medical or psychiatric issues, such as delirium, seizures, psychotic symptoms, or evidence of substance intoxication or withdrawal, and those in need of acute mental health services beyond those available at the facility warrant immediate evaluation by a qualified mental health professional (National Commission on Correctional Health Care, 2004) and/or immediate transfer to an appropriate medical treatment setting. Some juvenile justice facilities' relationships with appropriate medical and psychiatric treatment settings may be limited or inadequate. The clinician may help solidify these relationships so that transfers may occur in an efficient manner.

Recommendation 5. Clinicians Working in Juvenile Justice Settings must be Vigilant about Personal Safety and Security Issues and Aware of Actions that may Compromise their Safety and/or the Safety and Containment of the Incarcerated Youths [MS]

Before entering any facility, the clinician must become aware of (1) the type and functioning of the correctional facility (i.e., staff secured, facility secured, medium versus maximum security), (2) personal safety issues (in the event of a fire alarm, altercation, riot, hostage situation), (3) the location and physical surroundings in which the evaluation will be conducted, (4) the proximity and methods of accessing correctional staff in the event of any problems, and (5) what to do and where to go upon completion of the interview. The clinician and youth should be afforded a quiet evaluation site (ideally in a clinic setting) that ensures confidentiality and is conducive to conducting the diagnostic interview while maintaining safety and security.

Recommendation 6. All Qualified Mental Health Professionals should Clearly Define and Maintain their Clinician Role with Youthful Offenders and their Family Members [MS]

It is critical for clinicians working in juvenile justice settings to define and maintain their role as a clinician as opposed to as an agent of the court or of the state. This role delineation is especially important during preadjudication with detained youths. Laws, professional ethics, and administrative rules usually limit mental health clinicians in the degree to which they can provide treatment while a youth awaits trial. Additional restrictions placed on clinicians may exist with specific court-imposed no-contact orders that prohibit interrogation regarding an alleged offense without the presence of legal counsel. Treating psychiatrists must be aware of their state mental health codes.

Because results of any medical or mental health assessment become part of the juvenile's correctional health record, clinicians making written entries should be attentive to legibility and careful documentation. In particular, clinicians should refrain from recording specific details regarding the youth's criminal offense or, alternatively, if thought to be clinically necessary, should list only the alleged offense(s). Information that a clinician obtains from a youth may compromise the youth's defense if the clinician is called to testify (Grisso, 1998).

Because of concerns of potential role conflicts and confidentiality issues, it is extremely important to maintain strict role boundaries if any treatment is initiated with detained or pretrial youths. Some practical suggestions for therapists may include the avoidance of exploration into the details or circumstances of the alleged criminal act(s), the youth's state of mind, criminal intent, mitigating factors, or defense strategies. Another role that demands careful clarification for the youths and family is court-mandated or forced treatment, in which clinicians are required to provide periodic updates to the court or a designee (e.g., probation officer) regarding compliance and progress in treatment.

Clinicians should be extremely careful regarding verbal or written communication with attorneys and other court personnel, and they should avoid inappropriate communication with the media. Responses to media requests regarding specific youths should be declined and instead directed to appropriate juvenile justice administrative personnel. If asked to evaluate youths who are charged with particularly heinous or high-profile crimes, clinicians should be especially mindful of all communications to correctional and clinical staff, parents, and family members. Even confirmation of having seen a specific individual may represent a violation of confidentiality. After adjudication, the issues of any court-ordered treatments, including the therapist's role, agency, and mandated reporting to the court or

probation office, should be delineated for the youth and family.

Recommendation 7. Adequate Time and Resources are Needed to Perform a Mental Health Assessment of Incarcerated Youths using a Biopsychosocial Approach with Special Attention to Cultural, Family, Gender, and other Relevant Youth Issues [CG]

Clinicians working in juvenile correctional facilities will perform various types of evaluations. These include problem-focused brief mental health assessments at the time of admission such as assessment of a youth's suicide risk or determination of the appropriate level of services needed for a youth. These brief assessments may result in the implementation of additional supervision such as "suicide precautions," transfer to an alternate setting, referral for a more comprehensive mental health evaluation, or other treatment recommendations.

A more comprehensive postadmission mental health assessment may require several hours to complete (American Academy of Child and Adolescent Psychiatry, 2003) and may include a structured diagnostic interview and review of available health care records and collateral sources of information. The postadmission mental health assessment includes more detailed inquiry into the youth's history of psychiatric hospitalizations and outpatient treatment, family history (including psychiatric history), current and prior use of psychotropic medications, treatment responses, suicidal ideation and history of suicidal behavior, drug and alcohol use, history of sexual offenses, violent behavior, victimization or abuse, special education placements, history of cerebral trauma or seizures, and emotional response to incarceration (National Commission on Correctional Health Care, 2004). Clinicians should document a diagnostic formulation and an initial treatment plan (American Psychiatric Association, 2000).

All evaluations of youths in juvenile justice settings require an assessment for substance use disorders and withdrawal symptoms because of the high percentage of youths with this problem and the association of recidivism and substance use problems in this population (Randall et al., 1999). Clinicians should work together with medical staff to enable facilities to intervene early in assessing and treating chemical dependency including withdrawal symptoms (National Commission on Correctional Health Care, 2004).

Although a clinician may diagnose conduct disorder and possibly comorbid substance abuse such as alcohol and cannabis abuse, it is crucial to assess for additional comorbid conditions. The clinician should also identify psychosocial stressors such as the adjustment to an out-of-home placement, peer teasing, conflict with peers and staff, and limited visitation by family members.

A complete developmental, social, and medical history is a part of any comprehensive assessment involving adolescents (American Academy of Child and Adolescent Psychiatry, 1997). Clinicians should attempt to gather relevant collateral information whenever possible from family members; clinical, educational, and correctional staff; previous service providers; treatment records; and educational records. It should include an assessment of the youth's strengths and available resources in addition to any problems and deficits. This information will be instrumental in identifying the youth's past behavioral patterns, prior level of functioning, adaptation to incarceration, disruptive or problematic behaviors, interaction with peers and staff, and overall level of impairment, adjustment, and functioning in a correctional unit setting.

All newly incarcerated youths require educational evaluations and, on adjudication, will require an individualized treatment plan using the multidisciplinary role of educators and clinicians. It is helpful for clinicians and educational personnel to communicate because ongoing communication between clinicians and educators enhances both treatment and education. Some youths may already have a previous special education designation with an individualized education program, which should be implemented in the facility.

Also, some youths may benefit from additional evaluations, including psychological testing; specialized educational, speech, and language assessment; occupational or physical therapy evaluation; or additional specialized assessments such as evaluation for substance abuse, fire setting, and sexual offender or neurological consultation.

When performing any type of mental health evaluation of an incarcerated youth, it is critical for clinicians to use a biopsychosocial model with attention paid to unique adolescent developmental, peer, gender, cultural, religious, and family issues. Clinicians should also evaluate for histories of trauma, peer and family relationships and functioning, and family psychopathology, including domestic violence, physical and sexual abuse,

and family criminality, substance abuse, or mental illness. A detailed assessment of the youth's past exposure to violence and perpetration of violent or illegal behaviors is essential. Clinicians should also carefully elicit any history of high-risk behaviors, such as unprotected intercourse, promiscuity, multiple sex partners, gang activities, prostitution, running away, comorbid eating, somatoform, and gender-identity disorders.

Recommendation 8. Clinicians should be Alert to Symptoms, Behaviors, and other Clinical Presentations of Malingering, Secondary Gain, and Manipulative Behaviors by Incarcerated Juveniles [CG]

Facing the prospect of incarceration, it is not surprising that some youths may malinger, feigning suicidality or other psychiatric symptoms. Clinicians should be aware that some psychiatric symptoms such as hallucinations, delusions, physical complaints, self-mutilative behaviors such as actual or attempted ingestion of chemicals or foreign objects, superficial cutting, or other actual or threats of self-injury may be attempts to avoid incarceration or to be placed into a perceived less restrictive and more therapeutic environment (e.g., medical hospital, psychiatric hospital) or alternatively a nonsecure setting for possible elopement. Although structured interviews and additional psychological testing may be helpful, the mainstay of diagnosis remains a high index of suspicion combined with careful data collection and ongoing assessment for discrepancies in historical information and for clinical inconsistencies in the mental status examination. It is important to collect collateral information when suspicions of malingering arise; staff observations are particularly invaluable. This additional information will help to identify inconsistencies and discrepancies commonly found in adolescent malingerers (McAnn, 1998; Oldershaw and Bagby, 1997).

Recommendation 9. All Clinically Referred Youths should be Evaluated for Current and Future Risk of Violent Behavior [CG]

At the time of detention or adjudication, many juvenile justice facilities routinely conduct nonclinical (e.g., based largely on number, type, and severity of past legal offenses; assaultive behaviors toward staff or peers; other disciplinary infractions during prior incarcerations) or clinical "risk assessments" of newly incarcerated youths in an attempt to triage youths with violent crimes or a history of violence to more secured and contained settings and to maintain safety for confined youths, correctional staff, and clinical staff. For example, youths with histories of sexually offending behaviors or sexual victimization may require special observation, placement, or housing.

Although psychiatrists cannot predict dangerousness with definitive accuracy, they can often identify risk factors associated with an increased likelihood of violent behavior (American Psychiatric Association, 2001). Exploration into the youth's history of violence should include such variables as how chronic or recent as well as the frequency, severity, and context of violent behavior. The clinician should clarify the youth's history of exposure to domestic violence, past physical and sexual abuse and other traumatic events, perpetration of violence against others (e.g., cruelty to animals, bullying, fire setting, sexually assaultive behaviors), substance abuse, and other risk factors for future violence. In addition, a standardized approach should be used to elicit a history of weapon possession, access to and use of weapons preincarceration, and assaultive or threatening behaviors against peers or staff before or during incarceration (American Academy of Child and Adolescent Psychiatry, 1999; Pittel, 1998; Schetky, 2002).

Recommendation 10. Mental Health Professionals should be Aware of Unique Therapeutic and Boundary Issues that Arise in the Context of the Juvenile Correctional Setting [CG]

Aside from maintaining issues of personal safety and security, clinicians should be attuned to youths, family, institutional staff, and clinician interactions and relationship issues and should strive for clearly defined therapeutic clinical boundaries with incarcerated youths, families, and staff. Clinicians may feel overly sympathetic toward some youths or alternatively hostile, resentful, or angry toward youths with antisocial personality traits, juvenile sexual offenders, or youths allegedly involved in heinous or high-profile crimes. Understandably, many youths and their families view incarceration as unfair or punitive and see any other alternative legal disposition as preferable. For a variety of reasons, including the perceived loss of control or power during courtroom proceedings, families may seek other assistance or interventions from clinical staff, such as writing a favorable letter to the court. Alternatively, some families with a history of unfavorable interactions with juvenile justice or other agencies may shun or be suspicious of evaluation or treatment efforts by clinical staff. This may present in the form of not returning

telephone calls, not signing releases, refusing treatments offered, or not attending family therapy or treatment planning meetings. Identifying these and other dynamics and appreciating relevant cross-cultural, family, and religious issues can be crucial.

Clinicians working in juvenile justice settings should be attuned to institutional and staff perceptions and behaviors toward youths in their custody and any allegations or observation of abusive behaviors toward any youths. Mandated reporting requirements for use of excessive force or abuse of incarcerated youths by other youths or correctional staff may vary by state and jurisdiction, and clinicians should follow their local statutes or reporting requirements.

Recommendation 11. Clinicians should be Knowledgeable about the Facility's Policies and Procedures Regarding Seclusion, Physical Restraints, and Psychotropic Medication and in Support of Humane Care should Advocate for the Selective Use of Restrictive Procedures Only When Needed to Maintain Safety or When Less Restrictive Measures have Failed [CG]

As a general rule, without a court order, any use of psychotropic medications needs to be voluntary and not coerced or forced on a youth, except during psychiatric emergencies. Clinicians should be especially careful to avoid the use of psychotropic medications for staff benefit. Clinicians should have knowledge of current institutional seclusion and restraint policies and procedures. In general, current national standards require written institutional or department policy and defined procedures for the appropriate use of therapeutic restraints for patients under treatment for a mental illness (American Academy of Child and Adolescent Psychiatry, 2002). The NCCHC, the American Correctional Association, and other national organizations that develop health care standards for correctional facilities have created and promulgated national guidelines and standards for the use of punitive (restraints by properly trained direct-care staff for immediate control of behavioral dyscontrol) versus therapeutic restraints (restraints for youths under treatment for mental illness) in juvenile correctional facilities. They specify the types of restraint that may be used and when, where, how, and for how long restraints may be used. A physician or other qualified health care professional as allowed by the state health code authorizes the use of therapeutic restraints in each case on reaching the conclusion that no other less restrictive treatment is appropriate. Physicians should use caution and discretion in using restraints in youths with histories of sexual abuse and be vigilant about the risk of airway obstruction with prone restraints and/or excessive pressure on a youth's back. For restrained patients, the treatment plan addresses the goal of removing juveniles from restraint as soon as possible. The health care staff does not participate in the nonmedical or punitive restraint of incarcerated juveniles except for monitoring their health status (National Commission on Correctional Health Care, 2004).

Recommendation 12. Clinicians should use Psychotropic Medications in Incarcerated Juveniles in a Safe and Clinically Appropriate Manner and Only as Part of a Comprehensive Treatment Plan [CG]

Clinicians often will evaluate youthful offenders presenting with insomnia, depression, disruptive behaviors, or other symptoms and initiate referrals to psychiatrists for further diagnostic evaluation and possible psychotropic medication treatment. Many youths in the juvenile justice system are taking multiple medications when initially detained, whereas others have never received medications; a comprehensive mental health assessment, when clinically indicated, provides an opportunity to reassess their treatment needs. The current literature on the use of psychotropic medications in juvenile justice settings is limited, and the emerging medication studies on the treatment of youths with conduct disorder are confined to outpatient studies with small sample populations. If psychotropic medications are used, then they should augment a comprehensive and individually developed mental health treatment plan with the youth's compliance and active participation including the modalities of individual, group, and family therapy and other appropriate treatment interventions. Clinicians can also recommend the implementation of behavioral interventions and strategies such as regular exercise and improved sleep hygiene, encouragement of available family members and other social supports to rally around an incarcerated youth, facilitation of additional staff supervision and support, development of additional supportive relationships with both peers and direct-care staff, and use of other correctional, clergy, and community resources.

Psychotropic medications should be used with great caution and only after reviewing the potential

risks, benefits, side effects, and alternatives with the youth and the youth's parent or legal guardian if the youth is still a minor. Generally speaking, signed informed consent is needed for minors according to particular state mental health code. Multiple psychotropic medications—polypharmacy—should be used judiciously because of numerous potential risks and possible medication interactions and side effects. Newly detained youths taking one or more psychiatric medications require careful assessment and monitoring, and attempts should be made to serially reevaluate the youth or gradually reduce the need for multiple medications. Ideally, to ensure that the treatment trial can proceed in a safe and supervised fashion, a youth's legal disposition and placement should be clarified or resolved before any psychiatric medication is reduced or initiated.

As with any mental disorder, it is unwarranted to prescribe psychotropic medications in the absence of distinct target symptoms or when placement and mental health follow-up services are unclear. Issues that are particularly relevant with detained youths include weighing the risk–benefit of the proposed psychotropic medication: the medication's risk in overdose, side effects, anticipated youth and family compliance with medication and follow-up treatment, prescription coverage and health plan benefits, and the potential for diversion (e.g., psychostimulants). The youth's clinical treatment team should reassess the need for previously prescribed psychotropic medications on the basis of current symptoms, level of functioning, and treatment needs. Many juvenile justice youths have a history of mental health treatment noncompliance and may have abused or been noncompliant with stimulant medications.

Clinicians and direct-care staff must be aware of the potential abuse of psychiatric medications, as well as trading medication for money or sexual favors or its use as barter goods. Clinicians should educate nursing staff, other clinical staff, and direct-care staff when appropriate and should review the evaluation and management of medication noncompliance, including surreptitious behaviors such as "cheeking" medications.

Finally, clinicians should assess a youth's medication compliance and perform ongoing follow-up and monitoring for the emergence of problematic side effects. It is important for clinicians to explore the circumstances and rationale for a youth's pattern of medication refusal with the youth, clinical team, other relevant staff, and the youth's family when indicated.

Recommendation 13. Clinicians should be Involved in the Development, Implementation, and Reassessment of the Youth's Individualized Treatment Plan While in the Correctional Setting and with the Planning Process for Re-entry to the Community that Best Incorporates Multidisciplinary, Culturally Competent, Family-Based Treatment Approaches [CG]

As with any mental health intervention, planning should begin with the indicated treatments for the disorders and symptoms identified by a thorough evaluation. Treatment should include consideration and implementation of a full range of both psychosocial and psychopharmacological interventions and should incorporate as broad a range of disciplines and modalities as indicated. The recommendations and treatment plan should be clearly written in a way that is understandable and useful to court and others who will need the information to assist with implementation of treatment.

Numerous therapeutic strategies can be used across various juvenile correctional settings including individual, family, and group therapy modalities. Kazdin (2000) described the evidence in support of parent management training, cognitive problem-solving skills training, functional family therapy, and multisystemic therapy. Cognitive problem-solving skills training describes a broad range of treatments that seek to correct the deficits in interpersonal skills that antisocial youth exhibit, especially problem solving in conflicts with family members, authority figures, and peers and conflict resolution with peers regarding perceived or actual threats. Anger management and verbalization skills are also included in some treatment programs. Because of the high prevalence of substance use disorders in juvenile offenders, youths should receive substance abuse education and prevention training. Multisystemic therapy is an evidence-based intervention that uses a multimodal approach to address the typically multifaceted issues relating to delinquency (Henggeler et al., 1998; Schoenwald et al., 1996). Multisystemic therapy is one of only a few community-based treatments with proven efficacy in this population.

Apart from treatments directed at antisocial behaviors and substance use, there is limited research

on treatment of other mental health problems among delinquents. Model programs have been developed that advocate better integration of mental health care between juvenile justice settings and community-based levels of care. One example is Milwaukee Wraparound, which demonstrated cost-effective reductions in recidivism and improved mental health services for delinquents (Kamradt, 2000). An important feature of this systems approach to providing treatment is the continuity of care across settings.

Discharge planning in a juvenile correctional setting is defined as all procedures for an incarcerated youth in need of additional mental health or substance abuse treatment at the time of release from the correctional setting to the community to obtain continuing care. There are additional challenges to effective postrelease treatment planning and family involvement. Some examples include (1) the premature release of a youth to the community without appropriate services in place and (2) the placement of a youth in a distant or out-of-state location. There are several national efforts (e.g., Office of Juvenile Justice and Delinquency Prevention, Coalition for Juvenile Justice) to reduce the recidivism and provide opportunities for the successful reentry of youthful offenders returning to their communities from juvenile correctional facilities. Failure to follow up with mental health services after release from detention or placement is a significant problem with young offenders (Lewis et al., 1994). It is important for any mental health professional to be aware of the continuing research and advances in treatment as well as the availability of services in the community to assist in disposition planning.

Recommendation 14. It is Paramount that Clinicians Working in Juvenile Justice Settings are Aware of Relevant Financial, Fiscal, Reimbursement, Agency, and Role Issues that may Affect their Ability to Provide Optimal Care to Incarcerated Youths and Consultation to the Juvenile Correctional System [OP]

Both public and private correctional facilities handle detained and committed youths. Although there are currently about twice as many private facilities, they hold less than half the number of youths detained in public facilities (Snyder and Sickmund, 1999). Since the 1984 changes in federal regulations regarding Medicaid, responsibility for financing health services to youths in juvenile justice facilities has shifted from federal to state or local governments, creating health care disparities. There is a growing trend in juvenile corrections and juvenile justice facilities away from traditional state support to privatization, and in many settings, certain evaluative and treatment functions are further contracted to private "for-profit" corporations or groups.

Because of this variability by jurisdiction (i.e., county, state, region) and the growing phenomena of privatization and a managed care model, clinicians should have an understanding of (1) the existing or proposed infrastructure and payment/reimbursement model for mental health evaluation and treatment delivery; (2) various roles and responsibilities (caseload, expected daytime availability, after-hours and emergency coverage); (3) volume of referrals and amount of time per evaluation, collateral contact, and follow-up evaluations; (4) any expectations regarding training and supervision of other mental health or correctional staff; and (5) any financial or other administrative constraints that may limit or ration appropriate treatment and care and thus increase medicolegal and other liability issues. Clinicians should be aware that the same professional standards and most of their state regulations pertaining to clinical practice apply to the services that they provide in juvenile correctional settings.

Clinical work in any correctional setting can be frustrating, and burnout is an inherent risk. Clinicians are encouraged to participate in professional activities, pursue continuing medical education, and communicate with colleagues working in correctional facilities to share experiences and provide mutual support. Clinicians should be aware of other organizations in addition to the AACAP involved in advocacy regarding mental health issues in juvenile justice settings including the American Psychiatric Association, American Academy of Psychiatry and the Law, Society of Correctional Physicians, and the National Commission on Correctional Health Care.

CONCLUSION

Numerous challenges confront mental health professionals serving the needs of incarcerated juveniles. Effective screening, timely referral, and appropriate treatment require interagency collaboration, adherence to established standards of care, and continuing research on the mental health needs of youths in the juvenile justice system. This will require continued development and

validation of mental health screening and other assessment tools in juvenile correctional settings. In addition, more research is needed on the prevalence of mental illness and the efficacy of various treatments for juvenile offenders to provide improved mental health services and effective transition upon release. Clearly, better mental health care for youths in the juvenile justice system serves the intended goal of rehabilitation.

SCIENTIFIC DATA AND CLINICAL CONSENSUS

Practice parameters are strategies for patient management, developed to assist clinicians in psychiatric decision-making. AACAP practice parameters, based on evaluation of the scientific literature and relevant clinical consensus, describe generally accepted approaches to assess and treat specific disorders or to perform specific medical procedures. These parameters are not intended to define the standard of care, nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The clinician, after considering all the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources, must make the ultimate judgment regarding the care of a particular patient.

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Center Instruction Number 2411
(Seclusion and Restraint Policy)

Date: XX
Rescinds CI Number 2411 dated 08/11/16

Seclusion & Restraint Philosophy

CCCA is committed to reducing seclusion and restraint and to using therapeutic interventions to deescalate agitated or aggressive patients whenever possible.

References

- *Center for Medical and Medicare Services: Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals under Age 21 (42 CFR Parts 483.350 – 483.376)*
- *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and developmental Services (DBHDS), (12VAV35-46-10 ET SEQ) January 2009*
- *DBHDS Departmental Instruction 211(RTS)00, Use of Seclusion and Restraint in DBHDS Hospitals*
- *Joint Commission on the Accreditation of Health Care Organizations Comprehensive Accreditation Manual for Behavioral Health Care*

Policy

- Seclusion and restraint may only be used in an emergency to protect the child and others from injury.
- Except when safety needs dictate, non-physical and non-restrictive supportive interventions will be always be used before restrictive interventions are implemented.
- Each child will have a safety plan which specifically addresses alternative interventions designed to help eliminate the need for seclusion or restraint.
- Seclusion and restraint shall be used, when necessary, in accordance with Human Rights regulations and other applicable standards.

Definitions

- **Mechanical restraint:** the use of approved mechanical devices that involuntarily restricts the freedom of movement or voluntary functioning of a limb or a portion of a person's body as a means of controlling his physical activities when the child does not have the option to remove the device. This would include the Emergency Restraint Chair.
- **Physical restraint:** the use of approved non-mechanical physical interventions to restrict freedom of movement and to prevent a child from moving his body to engage in a behavior that places him or others at risk of physical harm. Every effort is made to avoid prolonged physical restraint.
- **Seclusion:** the involuntary placement of a child in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical or verbal means, so that the individual cannot leave it.

Child & Family Involvement

- At admission, designated staff will discuss with the child and family:
  - The facility's policy regarding the use of seclusion and restraint,
  - Previously effective interventions to prevent or respond to dangerous behavior on the part of the child,
  - Child and family preferences related to the use of seclusion or restraint
  - Preferences regarding notification of a restrictive interventions (RI)
    - Notified for every restrictive intervention
    - Notified for initiation of RI only

- Notified for continuation of RI beyond # hours
- Hour preferences for notification (e.g., not after 9:00 pm, not before 8:00 am)
- No notification requested
- Staff may leave a message
- Staff may text to call CCCA
- If parent/guardian does not select one of the options, the parent/guardian will be notified for every restrictive intervention.

- If a child is placed in seclusion or restraint, the nurse will contact the family per their preferences and document this notification in the child's record on the seclusion/restraint flowsheet.

Restrictions for use

- Standing orders or PRN (as needed) orders for seclusion or restraint are prohibited.
- Seclusion or restraint will not be used as punishment, reprisal, as a convenience for staff, as a substitute for treatment, or in a manner that causes physical discomfort or harm to the child.
- Under no circumstances may staff hold an individual's jaw/chin closed or place something that could obstruct breathing over child's nose or mouth.
- Use of prone physical restraint is prohibited
- Under no circumstances may staff lie on or apply pressure to a child's chest/trunk while the child is in a supine position.
- Seclusion or restraint shall be used on an emergency basis only, and shall not be used as part of a child's individual treatment plan
- A child will not be restrained physically or mechanically at the same time s/he is secluded.
- For the Emergency Restraint Chair (ERC) a patient must be at least 80 pounds and their feet must be flat on the floor.

Required Training

- Designated staff will be trained to use the DBHDS-approved behavior interaction and crisis management techniques, which include methods for positive proactive counseling and approved physical management techniques.
- Only staff members who have completed all training components and are currently certified as having successfully completed the Therapeutic Options of Virginia (TOVA) training may use seclusion or restraint.
- Training will include the following elements:
  - The importance of building positive helping relationships with children so that staff/child interactions are positive, supportive, and therapeutic at all times.
  - Techniques to identify staff and child behaviors, events, and environmental factors that may trigger the need for seclusion or restraints so that these may be avoided if possible;
  - The use of nonphysical intervention skills to prevent the use of seclusion or restraint; and
  - The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in children who are restrained or in seclusion.
  - Information about the viewpoints of children who have experienced restraint or seclusion and the potentially traumatizing effects of seclusion and restraint
  - Certification in CPR and training in first aid (including taking vital signs).
- Training will be documented for each staff member, including the date training was completed and the name of persons certifying the completion of training.
- Staff must demonstrate competency before participating in seclusion or restraint.
- Staff who perform continuous observation of children who are restrained or secluded

will be trained and demonstrate competence in:

- Recognizing signs and symptoms of physical distress that require notification of a physician or nurse;
- Responding to a child who complains of pain or discomfort during a physical intervention;
- Recognizing and addressing nutritional/hydration needs;
- Addressing personal hygiene and toileting needs;
- Recognizing when problems of circulation and range of motion in the extremities must be addressed and who to contact;
- Addressing comfort needs and recognizing unusual reactions or responses from the child;
- Helping the child meet criteria for discontinuation of restraint or seclusion by providing verbal intervention and support;
- Recognizing when the child has met criteria for discontinuation of restraint or seclusion; and,
- Recognizing when to contact a physician, nurse, or emergency services.

Procedures

Approved Mechanisms:

- Physical Restraint
- Only physical restraints that are in full compliance with Therapeutic Options of Virginia (TOVA) training and are administered by TOVA certified staff are permitted.
- Seclusion Rooms
- All seclusion rooms will conform to all requirements of DBHDS standards for children's facilities and other applicable standards.
- The interior of the room must allow staff full view of the child in all areas of the room.
- The room must be free of any potentially hazardous conditions or items. The room will be inspected and cleaned after each use by unit staff..
- Problems with or damage to the physical environment of seclusion rooms must be reported.
- Mechanical Restraints
- For ambulatory mechanical restraint only Posey® Twice-as-Tough, Soft Key Locking Wrist/Ankle restraints shall be used.
- For non-ambulatory mechanical restraint only the Emergency Restraint Chair (ERC) shall be used.
- For the Emergency Restraint Chair (ERC) a patient must be at least 80 pounds and their feet must be flat on the floor.

Contraindications:

- As part of the admissions assessment, physicians and nurses will determine:
- Any preexisting medical conditions or any physical disabilities and limitations that may place the child at greater risk of harm during seclusion and restraint;
- Any other factors that might influence a child's needs or behaviors during a seclusion or restraint.
- Such conditions must be documented in the child's clinical record.

Initiating Seclusion or Restraint:

Use of Less Restrictive Interventions

- Before initiating restraint or seclusion, staff must first attempt to manage the child's behavior using less restrictive interventions if possible. These should be documented on the seclusion/restraint flowsheet.
- In some instances, the threat of harm to the child or to others may require the use of

emergency seclusion or restraint without first attempting less restrictive interventions. In such cases, staff must clearly document in the clinical record on the seclusion/restraint flowsheet why less restrictive interventions were not used.

Procedure for Seclusion or Restraint

- Seclusion and restraint may be used only in emergencies in which there is an immediate danger of a child physically harming himself or others.
- Seclusion or restraint use must be ordered by a physician and must be time-limited. If the seclusion or restraint is initiated in an emergency in which the physician order cannot be obtained prior to the event, then the RN will contact the physician immediately after the seclusion or restraint is initiated and the nurse has conducted an assessment of the child.
- In general, seclusion and restraint will be initiated only at the direction of an RN or physician
- In emergency situations, when a physician or trained nurse is not immediately present or available, a properly trained direct care staff person may initiate physical restraint or seclusion. In such cases, the direct care staff must immediately notify the nurse of the use of seclusion/restraint.
- Use of mechanical restraints must be first approved by a physician or on-duty nurse who witnesses the need for such interventions.

Evaluation and Documentation

Initial Assessment

- Once restraint or seclusion occurs, a physician or a nurse must personally, as soon as is possible after the restraint or seclusion:
- Conduct a face-to-face assessment of the child;
- Check for the correct application of restraints or seclusion and any signs of injury;
- Initiate continuous observation;
- Check the child's record for contraindications to seclusion or restraint use or other factors that require attention and ensure that necessary actions to minimize risk of harm are taken;
- Review with PNAs the criteria for ending the intervention and make a determination of the need for continued use of restraint or seclusion;
- Inform the child of the criteria for release or for a reduction in restraint or seclusion; and
- The ordering physician must be available to staff for consultation as needed, at least by telephone, throughout the period of the seclusion or restraint.
- Upon completion of the initial assessment, a nurse will contact a physician and ensure documentation in the clinical record on the seclusion/restraint flow sheet:
    - Circumstances that led to the use of seclusion or restraint;
    - Names of staff who participated in applying the intervention;
    - Time, location, and antecedent behaviors of the child and staff;
    - Less restrictive interventions that staff attempted or reasons why they were not attempted;
    - That child was informed of the release criteria; and
    - Name of physician contacted and time contacted.
    - Notification of family and/or guardian, if applicable per family's preference

Physician's Orders

- The physician's order for seclusion or restraint will include the following:

- Type of intervention authorized
- Duration of initial order
- Time the procedure began
- Specific measures for meeting the special needs of the child, if applicable;
- Criteria for release; and
- Signature, date, and time.
- Verbal and telephone orders will only be accepted by a nurse, who will;
- Write the order on the physician's order form in the clinical record;
- Read it back to the physician for verification;
- Note the date and time of the order, and that it was a verbal or telephone order; and
- Signature.
- Duration of the initial order

Physical restraint:

- For all ages, initial order of up to 30 minutes maximum.
- Every effort is to be made to avoid prolonged physical restraint. If patient shows no signs of calming after 15 minutes, the MD or NP can be notified so that other interventions can be considered.

Seclusion:

- >12 years-old, initial order of up to 2 hours maximum.
- <12 years-old, initial order of up to 1 hour maximum.
- The patient shall not be kept in seclusion any longer than 4 hours

Emergency Restraint Chair (ERC):

- Initial order is up to 2 hour maximum.
- The chair shall be used as indicated in the training instructions.
- There shall be no variation in how the straps or points of restraint are used.
- No additional belts or restraint devices shall be used or added to the ERC.
- Only staff trained in the use of the ERC may place a patient in the ERC.
- The ERC and patient shall then be moved to a private area such as seclusion room.
- The default positioning of the ERC shall be at an angle that facilitates staff observation
- The patient shall not be kept in the ERC any longer than 4 hours
- If a patient is in the ERC up to 4 hours:
  - The physician shall be contacted to decide whether the patient can be released or still requires some form of restraint/seclusion.
  - After weighing risks and benefits, the physician shall decide if the patient shall be placed into a reduced level of ambulatory restraint and provide the appropriate order.

Ambulatory restraints:

- Initial order is up to 4 hour maximum.
- For patients who require ambulatory restraints after the initial order, there shall be a physician order for ambulatory restraints given every four hours.
  - 1 Point Ambulatory: one wrist secured to a connecting belt at waist level.
  - 2 Point Ambulatory:1 restraint to each wrist secured to a connecting belt at waist level.
  - 3 Point Ambulatory: 1 wrist secured to a connecting belt at waist level and 1 restraint to each ankle connected to the belt sufficiently long enough to

allow patient to take short steps
    - 4 Point Ambulatory: 1 restraint to each wrist secured to a connecting belt at waist level and 1 restraint to each ankle connected to the belt sufficiently long enough to allow patient to take short steps.

Face-to-Face Re-Evaluation

- Within 1 hour after the initiation of seclusion or restraint, every 1 hour thereafter and at the conclusion of the intervention, a physician or nurse will conduct a face-to-face evaluation of the child. The face-to-face evaluation and subsequent documentation in the clinical record will include:
    - An evaluation of the child's physical and psychological response to seclusion and/or restraint; and
    - A determination of whether restraint or seclusion should be continued.
- If the nurse conducts the re-evaluation, s/he must notify the physician immediately if any unusual physical or psychological problems are noted and take immediate action to resolve those problems.
- A physician must do a face-to-face re-evaluation of the child or adolescent within 24 hours of the initiation of each restraint or seclusion event, and this evaluation will be documented in the clinical record.

Continuous Observation of Children in Seclusion or Restraint

- Continuous Observation is required for all children in seclusion or restraint to ensure monitoring for and response to
    - Signs of any injury or trauma associated with applying seclusion or restraint;
    - Nutrition and hydration;
    - Circulation and range of motion in the extremities;
    - Vital signs;
    - Hygiene and elimination;
    - Physical and psychological status and comfort;
    - Readiness for discontinuation of restraint or seclusion.
- The child's progress and functioning while in restraint or seclusion will be documented in the clinical record at least every five minutes.
- The nurse may delegate such monitoring and documentation to trained direct care staff.
- Staff monitoring the child will be stationed directly outside the seclusion room door and will provide continuous observation throughout the duration of the event.
- When a child is placed in ambulatory mechanical restraints, staff will maintain continuous visual monitoring of the child for the duration of the event and be within arm's reach at all times to maintain the individual's safety.

Patient Care during Seclusion and Restraints

- Bathroom use will be offered every 2 hours and as needed during seclusion or restraint. If the child cannot be safely released to use the bathroom, alternative options will be offered that provide the maximum degree of privacy and dignity.
- The child will be offered fluids at least once per hour and will be provided meals at scheduled meal times as desired by the child if seclusion or restraint use continues through a meal time.
- For mechanical restraints, the child will be evaluated for range of motion at least every 2 hours and as needed.
- A child who is ambulatory restraints for greater than 24 hours will have the opportunity

to bathe at least once every 24 hours.

- A face-to-face Nurse Assessment of the child's physical and psychological status will be conducted immediately and results documented in the clinical record at any point if
    - There is a change in the child's level of consciousness or responsiveness (e.g., sleep, drowsiness);
    - There is a change in vital signs that may signal a change in physical status, or
    - A staff member monitoring the child raises a valid concern.

Restraint to Give Intramuscular Medication (IM)

- A restraint may be used to give an IM medication, but only to ensure the immediate medical and/or physical safety of the individual, a staff member, or others and must be discontinued at the earliest possible time. There are typically three instances in which it is permissible to apply a restraint to give a medication:
    - A restraint is used to give a medication to manage violent behavior that jeopardizes the immediate physical safety of the individual, a staff member, or others.
    - A restraint is used to give a medication to manage self-destructive behavior that jeopardizes the immediate physical safety of the individual.
    - A restraint is used to give a medication for health-related purposes, but only when failure to take action will jeopardize the immediate physical safety of the individual and appropriate consent or authorization for the treatment has been obtained.
- The individual receiving services, his authorized representative, or a family member may not authorize the use of a restraint to give a medication.

Physical Restraint for Medication Administration/Phlebotomy:

- If a physician has written an order for medication to be given or blood drawn for laboratory studies over a patient's objection and a manual hold is required to safely accomplish the procedure, this shall be managed in the same manner as all other S/R procedures.
- A manual hold shall only be used when it is the least restrictive intervention to carry out the medication administration or phlebotomy procedure

Patient Transport in Restraints to Outside Facilities:

- On rare occasion, a patient may need to be transported to another facility for evaluation or care while in restraints.
- Prior to the transport of the patient, the physician shall write an order for the appropriate level of restraints, the appropriate number and type of staff to transport as well as the type of vehicle used, if necessary.
- In order to maintain safety of both patient and staff, the patient shall travel in the back seat of the vehicle in restraints.

Continuation of Seclusion or Restraint

- Seclusion or restraint may be continued at the end of the time period designated in the original, time-limited order:
- Only upon a new written or verbal order of a physician; and
- Only after a face-to-face reevaluation of the child by a physician or a nurse.
- Orders for continuation of restraint or seclusion are limited to the maximum time

frames specified for new orders. Orders can be given for a shorter period than the maximum.

- The documentation in the clinical record must include:
    - The results of the physician's or nurse's evaluation;
    - Justification for use of seclusion or restraint; and
    - If contraindications exist, why the use of the procedure outweighed the risks of non-use.
    - Family and/or guardian notification based on their preferences

General Documentation – the Seclusion/Restraint Flow Sheet

- All seclusion and restraint events will be documented in the child's clinical record using the "Seclusion/Restraint Flow Sheet" (CCCA Form #1300CW) and will include documentation of:
    - Date and time intervention began and ended, specific location, and type of intervention;
    - Special observation requirements for the child;
    - The child's behaviors and condition during the event;
    - Staff interventions during the event;
    - Less restrictive interventions attempted or an explanation why they were not attempted;
    - Continuous observation or one-to-one observation as required
    - Continuous monitoring every 5 minutes
    - That bathroom privileges, fluids, and meals were offered at appropriate intervals for the child;
    - Narrative of the events leading to the use of seclusion or restraint;
    - Staff involved in the event;
    - Criteria for termination of seclusion or restraint;
    - Condition of the child after the event;
    - Notification of the family; and
    - Information about the child's responses and suggestions during the debriefing
    - The staff-to-staff debriefing discussion and conclusions
    - Any injuries to the child that resulted from the use of seclusion or restraint
- Within 1 hour after the initiation of seclusion or restraint, every 1 hour thereafter and at the conclusion of the intervention, a physician or nurse will also conduct a face-to-face evaluation of the child.
- A physician must do a face-to-face re-evaluation of the child or adolescent within 24 hours of the initiation of each restraint or seclusion event, and this evaluation will be documented in the clinical record.

Terminating the Seclusion or Restraint

- Universal criteria for release from S/R shall be used in most instances of emergency seclusion or restraint. The release criteria which shall be used are:
    - non-threatening to self or others,
    - calm, and
    - redirectable.
- A child will be secluded or restrained no longer than is deemed clinically necessary.
- When a child deescalates to a point where there is no longer a threat to self or others, seclusion or restraint will end.
- When staff who are monitoring the child determine that the release criteria described in

the written order have been exhibited by the child:

- Staff must immediately report this determination to a nurse or a physician;
- The nurse or physician will evaluate the child to determine if the seclusion or restraint can safely end;
- The physician or nurse will assess the child for physical and psychological trauma immediately upon release from restraint or seclusion and provide care as needed.

Special Considerations for Termination:

- There may be situations where soon after release a patient is very rapidly engaging in dangerous, threatening/aggressive or self-injurious behavior such that it is felt that the patient was not actually calm or redirectable at the time of release. In these situations, it may be necessary to individualize the release criteria that would indicate more clearly that the individual is safe to terminate the restrictive intervention.
- If individualized release criteria are indicated, the physician will specify the individualized release criteria in the order.
- The Medical or Facility Director shall be consulted regarding any change in the management of emergency behavioral seclusion/restraint release criteria.
- If the patient has had multiple episodes of rapidly re-engaging in behavior dangerous to self or others after release from a restrictive intervention, it may be necessary to consider step down to a less restrictive level of restraint with ongoing assessment. The attending physician shall document in a progress note that step down from the ERC to ambulatory restraint is indicated to maintain the safety of the patient and/or others.

Debriefing

Staff-Child Debriefing

- A staff-to-child debriefing occurs as soon as possible after the event and at a time appropriate for the child – in general by the end of the shift on which the event terminated, but in any case no longer than 24 hours after the episode of seclusion or restraint. The debriefing must be face-to-face and will include the child, and, if appropriate, the child's family.
- The debriefing discussion with staff and children (in a language the child understands) will include, as determined clinically appropriate:
  - A discussion of the circumstances that resulted in the use of restraint or seclusion;
  - Strategies all parties can employ to prevent the need for restraint or seclusion in the future including discussion of the child's personal safety plan; and
  - An assessment of any physical or psychological trauma resulting from the intervention.
- Information from the debriefing is used:
  - To determine if the child's physical and psychological needs and right to privacy were addressed during seclusion or restraint;
  - To identify what led to the incident and what could have been handled differently;
  - To modify the child's treatment or safety plan, when indicated; and
  - In performance improvement activities.
- The staff-to-child debriefing discussion will be documented in the child's clinical record including names of staff that were present and any changes to the child's treatment or safety plan that resulted from the debriefing.

Staff-to-Staff Debriefing

- A separate staff-to-staff debriefing occurs as soon as possible after the event and at a time appropriate for the staff involved, in general by the end of the shift on which the event terminated, but in any case no longer than 24 hours after the episode of seclusion or restraint. Participants should include the staff involved in the restraint or seclusion event as well as others as appropriate.
- The staff will discuss, at a minimum:
  - The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;
  - The child's perspective on the events
  - Alternative techniques that might have prevented the use of restraint or seclusion;
  - The interventions the staff are to attempt in the future to prevent any recurrence of the use of restraint or seclusion; and
  - The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion

Thresholds for Review

- When a patient has been in restraint or seclusion three times in a 7-day period, the treatment team reviews the treatment plan and revises it as needed.
- When a child has been in mechanical restraint or seclusion for more than 48 hours in a seven (7) day period, the Attending Psychiatrist will notify the CCCA Medical Director to determine if a special restrictive behavioral plan is necessary to maintain the safety of patients and staff on the unit.
- A quorum of the Clinical Management Committee shall review and discuss the proposed plan. If there is provisional approval by CMC, then the Patient Advocate shall be notified about the restrictive plan. The treatment team in collaboration with the Advocate may present the restrictive plan to the LHRC committee for review.

Data Analysis

- Seclusion and restraint data will be analyzed by facility leadership and by the facility's clinical staff as part of its performance improvement activities to:
  - Ascertain that restraint and seclusion are used appropriately; as defined by treatment guidelines, best-practice protocols, and regulations
  - Identify opportunities to reduce the rate of use and improve the safety of restraint and seclusion interventions; and
  - Identify any need to redesign care processes.

Special Consider-ations

Injuries during Interventions

- If a child sustains an injury during a restraint or seclusion event, immediate medical care will be provided by qualified medical personnel, and when medically necessary, an injured child will be transported to an appropriate emergency department for continued care and treatment, as with other injuries.
- Reporting of injuries sustained in a seclusion or restraint event will be reported as required to the parent/guardian and both departmental and external agencies.

Managing Children in Seclusion or Restraint During Emergencies or Drills

- Emergency events:
  - When emergency events occur that are life threatening or dangerous to the safety of a child who is secluded or restrained, unit staff will provide for the safety of the child by escorting the child to a secure area of the building or removing the child from the building as part of a facility-wide evacuation plan.
  - Decisions to maintain a restraint or seclusion must consider the overall safety needs of that child and others.
- Drills:
  - During emergency drills, staff will use clinical judgment and discretion to determine if the child in seclusion or restraint should participate in the drill.

- Whenever the child does not participate, unit staff will inform the Director of Safety and Risk Management of the reasons for non-participation in the drill.

Effective: **Immediately.**

Tammy Peacock, PhD.
Executive Facility Director

Date

Administrative Review Dates:

Use of the Restraint Chair in Juvenile Facilities

Michael Umpierre, J.D.

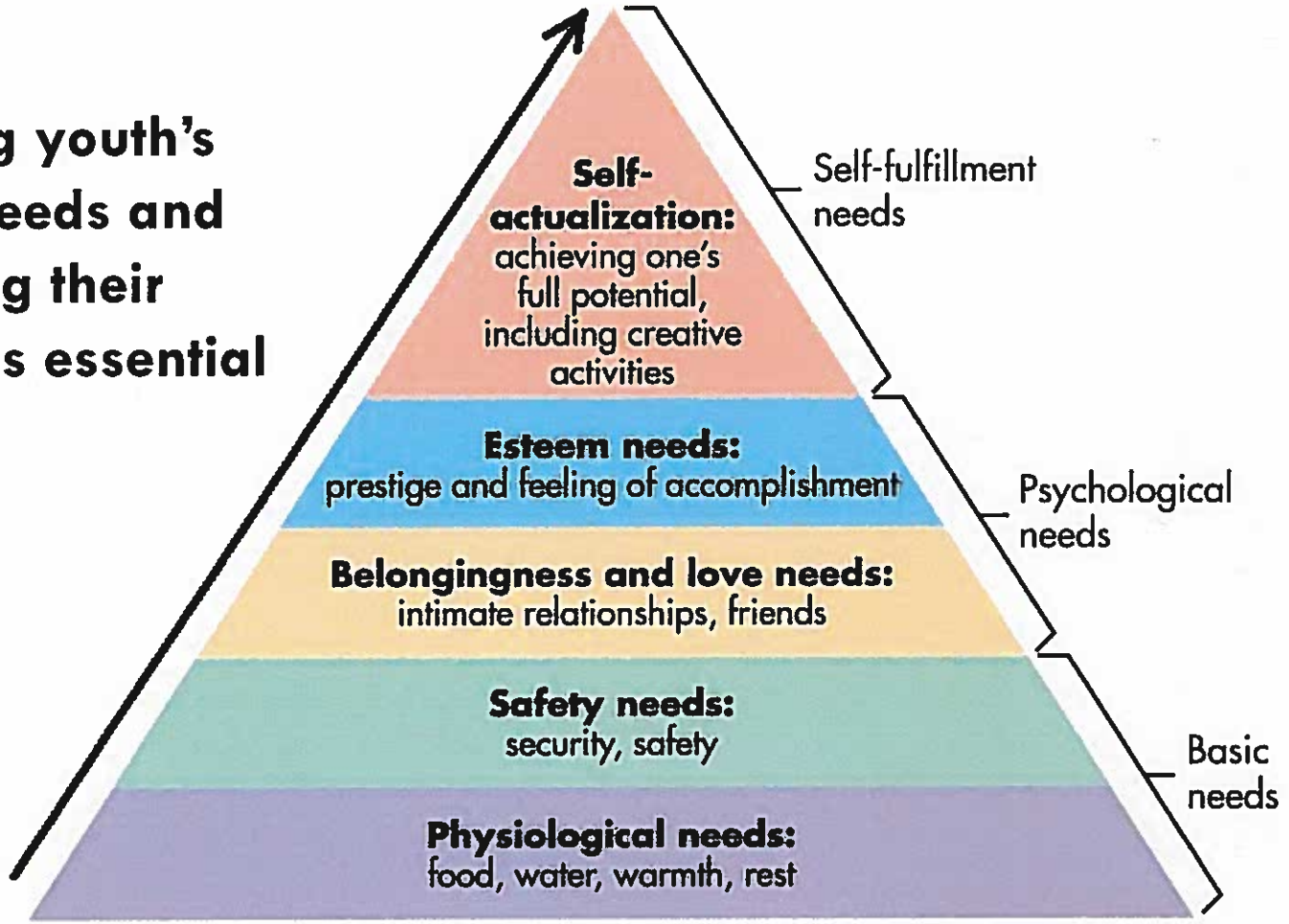
Deputy Director, Juvenile Justice System Improvement and Communications

Center for Juvenile Justice Reform

November 7, 2018

Principles of Effective Facility Practice

- **Meeting youth's basic needs and ensuring their safety is essential**



Principles of Effective Facility Practice

- **Juvenile justice programs and practices must be steeped in therapeutic philosophies**
  - See "Improving the Effectiveness of Juvenile Justice Programs: A New Perspective on Evidence-Based Practice," Lipsey, et al., 2010
  - See "Reforming Juvenile Justice: A Developmental Approach," National Research Council (2013)

Important Questions to Consider When Evaluating Facility Practice

- **Does the practice help to keep youth and staff safe?**
  - Physically safe
  - Psychologically and emotionally safe

- **Does the practice contribute to a developmental/therapeutic approach?**
  - Promote skill development
  - Promote positive relationships/connections to others

Foundational Dimensions of a High Quality Facility

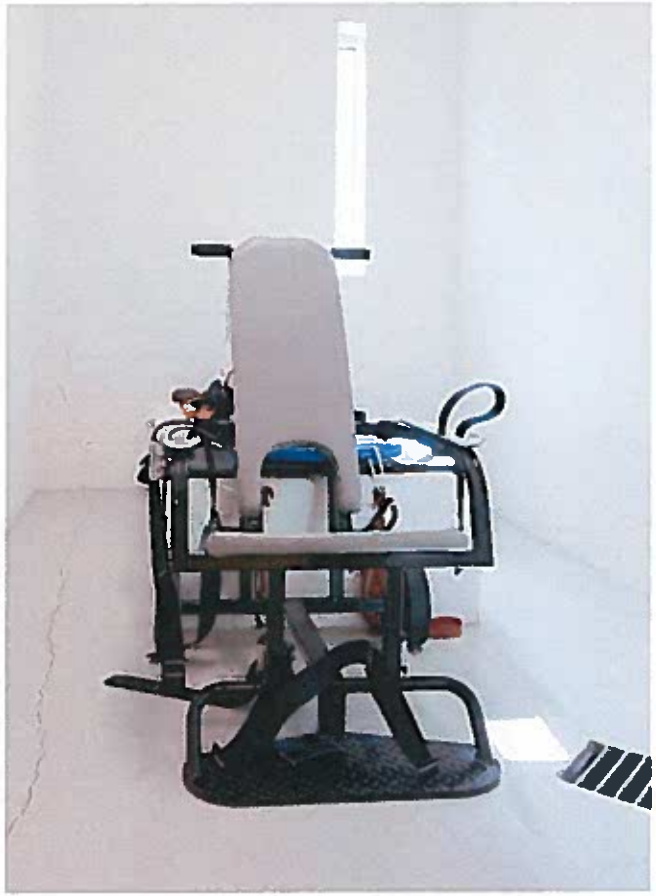
- **Rigorous academic and career/technical education**
- **Ample programming opportunities**
- **Comprehensive medical and behavioral health services**
- **A strength-based and safe physical and social environment** (e.g., youth voice, family engagement, positive staff-youth relationships)
- **Behavior motivation systems/approaches**
- **Highly trained and supported staff**

Crisis Management: A Key Component of Facility Safety

Recommended facility practices:

- **De-escalation**
  - Nonverbal, para-verbal, verbal strategies
- **Providing youth with "space"**
  - Time-outs
  - Room restriction only as a temporary response to behavior that threatens immediate harm to the youth or others
- **Use of appropriate physical force when necessary**
  - Safe, proportional, well-timed, and well-executed

Use of Restraint Chairs



Source: Richard Ross

Source: www.pro-straint.com

Professional Standards

Most professional standards either prohibit the use of fixed restraints or limit it significantly

Examples:

- **JDAI Juvenile Detention Facility Assessment Standards:** fixed restraints prohibited
- **American Correctional Association Juvenile Detention Standards:** 4- or 5-point restraints permitted in "extreme instances" with superintendent approval and when other restraints have been ineffective

Professional Standards (cont.)

- **Performance-based Standards:** restraint chair permitted only as a last resort with supervisory approval and medical/MH protocols to monitor use
- **National Commission on Correctional Health Care Standards:** use of restraint devices (e.g., 4-point restraints, restraint chair) permitted with health staff approval/notice and monitoring
- **Standards for the Administration of Juvenile Justice:** fixed restraints prohibited

Restraint Chair Use: National Data

OJJDP's Survey of Youth in Residential Placement

- Sample of 7,000+ youth in placement in 2003
- 205 facilities represented
  - Detention
  - Correction
  - Community-based (e.g., shelters, group homes)
  - Camps (e.g., boot/forestry camps)

Sedlak, A.J. (2016). Survey of Youth in Residential Placement: Conditions of Confinement. SYRP Report. Rockville, MD: Westat.

Restraint Chair Use: National Data

Table 17. Methods of control youth experienced in current facility, overall in 2003 and by program and security level.

Control Method	All Youth		Program Type					Security	
	Percent	95% C.I.	Detention	Correctional	Camp	Community-based	Residential Treatment	Locked	Not Locked
Strip searched	47	(42-51)	56	60	53	18	29	55	31
Put into handcuffs or wristlets	26	(22-29)	27	40	21	6	16	34	10
Held down	21	(19-23)	16	29	19	12	25	24	16
Put into security belt or chains	12	(10-14)	14	17	14	4	9	16	5
Sprayed with pepper spray	7	(6-9)	7	11	13	3	2	8	5
Put into a restraint chair	4	(3-5)	No Difference†					No Difference†	
None of the above	41	(37-44)	33	28	36	72	50	32	57

Notes: Estimated percents are rounded to the nearest whole percent. CI = confidence interval.

† Subgroups that do not differ resemble the overall population of youth in placement.

Sedlak, A.J. (2016). Survey of Youth in Residential Placement: Conditions of Confinement. SYRP Report. Rockville, MD: Westat.

Restraint Chair Use: National Data

Study: "Conditions of Confinement: Juvenile Detention and Corrections Facilities" (1994)

- Fewer than 5% of juvenile facilities in the survey reported using fixed restraints

U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, Conditions of Confinement: Juvenile Detention and Corrections Facilities (Research Report), prepared by Dale G. Parent, et al., Abt Associates, Inc. (1994)

Performance-based Standards Data

- **PbS collects data on key facility measures and helps to guide facility improvement processes**
- **Data on use of restraint chair/bed**
  - April 2006:
    - 34 uses across 89 corrections facilities
    - 1 use across 45 detention facilities
  - April 2018:
    - 1 use across 117 corrections facilities
    - 5 uses across 49 detention facilities

Agency Practice Nationally

- **Many juvenile justice agencies prohibit the use of restraint chairs via policy or simply do not engage in the practice**
- **Some examples:**
  - Connecticut Judicial Branch – Court Support Services Division
  - District of Columbia Department of Youth Rehabilitation Services
  - Florida Department of Juvenile Justice
  - Massachusetts Department of Youth Services
  - Missouri Department of Social Services, Division of Youth Services

Youth in Custody Practice Model (YICPM)

- **Developed by CJJR and the Council of Juvenile Correctional Administrators, the YICPM is a best practices guide to serving youth in custody**
- **The YICPM recommends not using fixed restraints for several reasons:**
  - Potential for harm to youth and staff (physical and psychological; impact on staff-youth relationships)
  - Not necessary—majority of facilities do not use it
  - Legal liability

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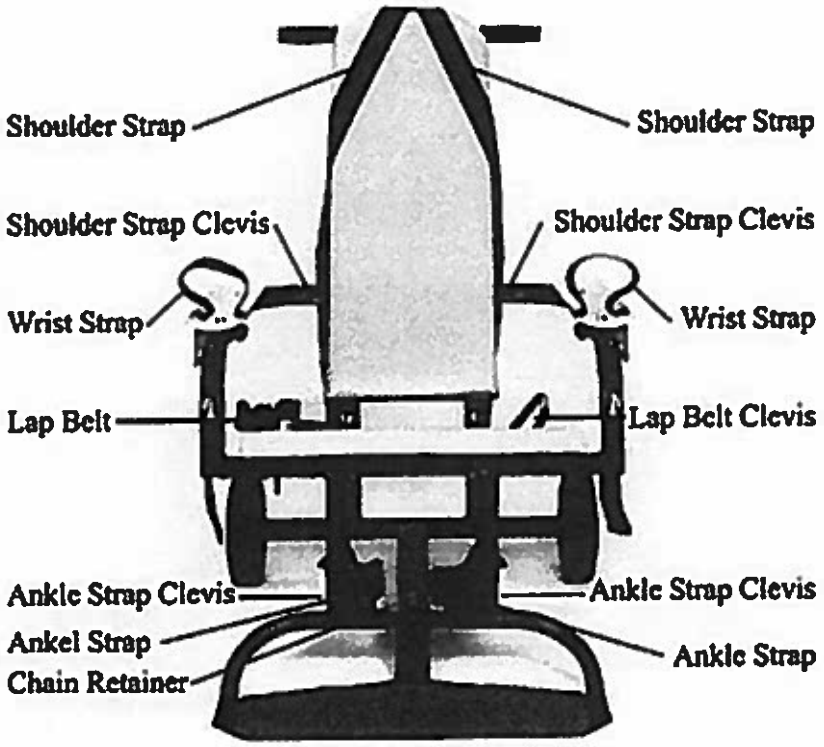

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OBSERVATIONS ON THE USE OF RESTRAINT CHAIRS

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REDUCING THE LIKELIHOOD OF A CRISIS

As a necessary precursor to considering the use of force continuum, facilities should also fortify their environments to ensure they are strength-focused and effective in shaping youth's behavior.

Constructive, healthy relationships between staff and youth	Daily schedules filled with structured programs led by an adult.	High-quality education, mental health and medical services.
Multi-disciplinary case planning and service-need matching.	Sufficient numbers of well-trained staff who actively supervise youth.	Quality behavior management programs that reward positive behavior and sanction negative behavior.

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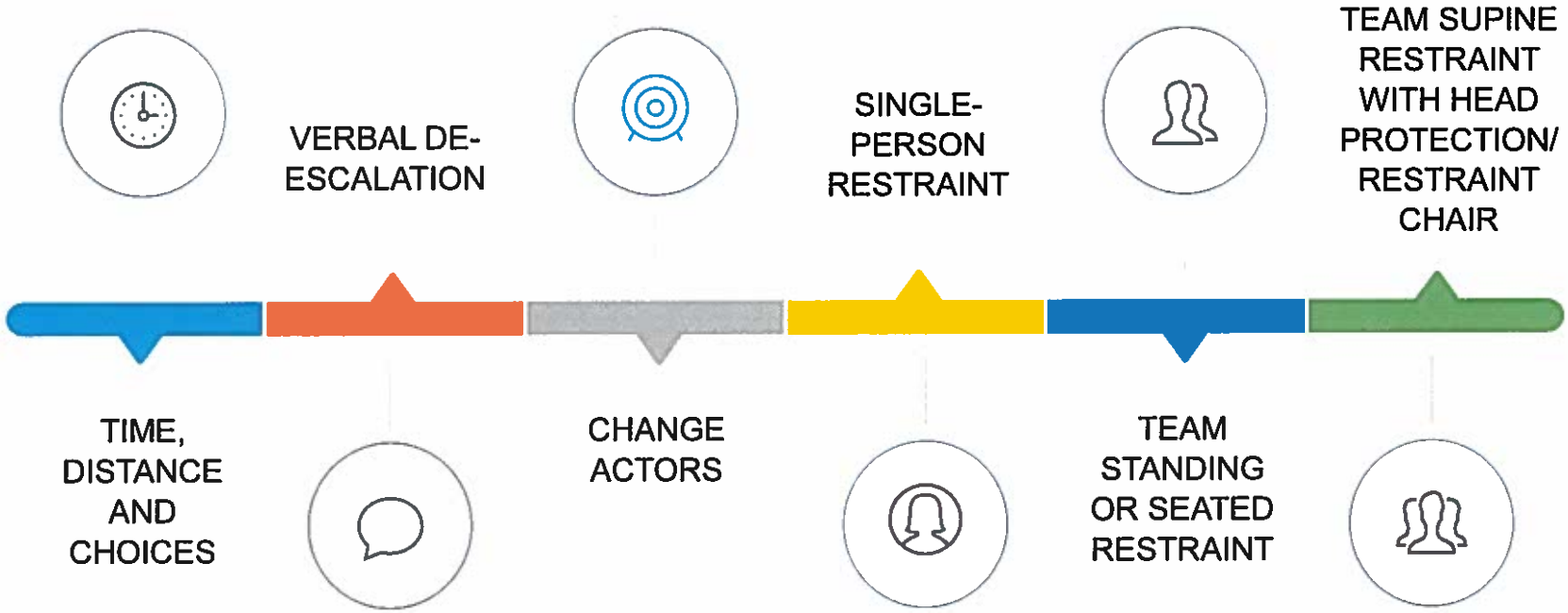
USE OF FORCE CONTINUUM

Failing prevention efforts, the physical intervention needs to be safe, proportional, well-timed and well-executed.



RESTRAINT CHAIR

Once youth is placed in the chair, the equipment immobilizes the youth.

Monitoring the youth requires fewer staff (e.g., one staff to supervise, medical/MH staff to monitor vitals).

WHAT'S INVOLVED?

TEAM RESTRAINT

Staff must continually exert pressure/effort to immobilize the youth.

A larger number of staff are required (e.g., at least four to execute the technique, plus medical/MH staff to monitor vitals, plus additional staff to replace the original staff as they tire).

WHAT'S INVOLVED?

SITUATIONS THAT CAUSED CONCERN

LESS RESTRICTIVE MEASURES HAD NOT BEEN EXHAUSTED

One jurisdiction used the chair as part of its UOF continuum, but youth walked to the chair totally under control; another jurisdiction used it to address the youth's risk of self-harm, but had not implemented any other precautions (reduce access to instruments of self harm, treatment-focused responses)

LONG DURATION

Youth remained in chair for long periods of time, several hours in some situations; no apparent effort to transition to less restrictive measures even as risk dissipated.

LACK OF STAFF ENGAGEMENT

Staff passively observed youth in chair, even when youth were pleading for engagement; staff's supervision duties did not include using verbal de-escalation or other crisis management skills to help youth to regain control.

APPEARANCE OF PUNISHMENT

At times, the use of the chair appeared to be punitive in nature.

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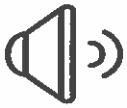
STRATEGIES FOR ELIMINATING THE USE OF THE RESTRAINT CHAIR



MESSAGE

Own the message; not "because the Monitor said so" but "we are committed to reducing harm and trauma among our youth."

TIMING

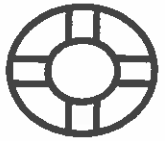
The time not to eliminate the practice is when the facility is in crisis.

CIRCUMSTANCES

Identify the circumstances that are leading to the use of the chair in your jurisdiction.

REASONABLE TIMELINE

Ensure sufficient time for staff training and competency development.



SKILL DEVELOPMENT

Identify the skills that staff will need in order to properly manage the crisis.

INPUT/DATA

Create opportunities for staff input; provide accurate information; hear their concerns.