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## 5122-2-17 Seclusion and restraint use in regional psychiatric hospitals.

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(A) The provision of a physically and psychologically safe environment is a basic foundation and requirement for effective mental health treatment. Treatment environments free of coercive interventions and violence promote positive, trusting relationships and facilitate treatment and recovery.

Physical restraint and seclusion are emergency interventions intended to prevent injury. They are not a form of therapy and may actually be traumatizing to a patient. We thus strive continually to reduce and minimize the use of seclusion and restraint. We recognize that these emergency interventions are to be used only by trained and competent staff and as a last resort in order to eliminate dangerous and potentially harmful behaviors and to preserve safety and dignity. All patients should be assessed for any past exposure to these emergency interventions along with possible alternative interventions based on patient preference and experience.

The fundamental goal of inpatient care is to facilitate recovery from serious mental illness, especially from acute exacerbation of illness that may affect judgment, perception and emotion. Quality inpatient care includes a physically and psychologically safe environment for both patients and staff. The policy and preference of the department is for more positive, supportive and less intrusive measures, including counseling, positive relationships, and creating a therapeutic environment that facilitates treatment and recovery.

To reduce incidents that may lead to injuries, staff should employ a multi-modal approach and interdisciplinary, trauma-informed, proactive intervention treatment perspective. ODMH policy MD-19 "Proactive Positive Interventions" describes appropriate early staff intervention to maximize safety; recommended actions when symptoms of aggression erupt; and necessary debriefing, communication and medication reevaluation after an episode of aggression. In the final section, the policy outlines a staged process for the clinician role in the treatment paradigm for safe and quality care, including psychotropic medication specifics.

Best practices include careful early assessment and documentation of a person's history with a particular emphasis on past trauma or abuse. Seclusion and restraint are extremely intrusive measures to control potentially harmful behavior and to preserve safety. At times, restraint is experienced by patients as a recapitulation of past experience(s) of abuse. Special attention must be given to anticipate, and prevent if possible, or minimize restraint in such cases. The experience of seclusion and restraint is stressful for both staff and patients, requiring debriefing and support for these individuals. The purpose of this rule shall be to define and establish uniform procedures governing the safe, humane, and appropriate use of

seclusion and restraint consistent with this philosophy, standards of quality treatment and respect for the rights of patients.

(B) The provisions of this rule shall be applicable to all regional psychiatric hospital inpatient settings operated by the department of mental health.

(C) The following definitions apply to this rule in addition to or in place of those appearing in rule [5122-1-01](#) of the Administrative Code:

(1) "Chief clinical officer (CCO)" means the medical director of a regional psychiatric hospital as defined in division (K) of section [5122.01](#) of the Revised Code.

(2) "Clear treatment reasons" means that permitting the patient to participate will present a substantial risk of physical harm to the patient or others or will substantially preclude effective treatment of the patient. If a restriction is imposed for clear treatment reasons, the patient's written treatment plan shall specify the treatment designed to eliminate the restriction at the earliest possible time.

(3) "Direct care personnel" means personnel with special training, competency and experience in assessing and treating persons with mental illness and whose primary responsibility is for such functions.

(4) "Emergency" means an impending or crisis situation which demands immediate action for preservation of life or prevention of serious bodily harm to the person or others as determined by a licensed physician or registered nurse.

(5) "Hospital services security personnel" means special police as defined in section [5119.14](#) of the Revised Code and security officers of the regional psychiatric hospital.

(6) "Mechanical supports" means items used for the purpose of achieving proper body alignment, position and balance. Mechanical supports shall not be considered restraints under this rule when used in this manner. Examples include orthopedic-prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm.

(7) "Physical restraint" means any method, or device that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. For purposes of this rule, physical restraint refers to:

(a) "Manual restraint" means physically holding an individual to restrict an individual's ability to move his or her legs, arms, head, or body, freely.

(b) "Physical restraint with devices" means any method of restricting a person's freedom of movement, physical activity, or normal use of his or her body, using an appliance or device manufactured for this purpose.

(c) "Prone restraint" means all items or measures used to limit or control the movement or normal functioning of any portion, or all of an individual's body while the individual is in a face-down position for an extended period

of time. Prone restraint includes manual or physical restraint with devices.

(d) "Transitional hold" means a restraint involving a brief physical positioning of an individual face-down for the purpose of quickly and effectively gaining physical control of that individual in order to prevent harm to self and others, or prior to transport to enable the individual to be transported safely.

(8) "PRN order" means a practitioner's written order for a medication, treatment, or procedure which is only carried out when an individual patient manifests a specific clinical condition.

(9) "Quiet time" means a voluntary procedure through which a patient removes him/herself to an unlocked area from a situation which is too stimulating, in an effort to regain self-control.

(10) "Seclusion" means confinement of a patient alone in a room, locked or unlocked, in which that patient is physically prevented from leaving for any period of time.

(11) "Treatment plan" means a written statement of specific, reasonable and measurable goals and objectives for an individual established by the treatment team, in conjunction with the patient, with specific criteria to evaluate progress towards achieving those objectives.

(12) "Treatment team" means a team comprised of the patient, patient's family as defined and authorized by the patient, psychiatrist, or physician so privileged by the facility, registered nurse, social worker, and other appropriate personnel (such as activity therapist, CPST worker, interpreter, reader, dietitian, occupational therapist, pharmacist, psychologist, and others as appropriate) based on patient needs and requests, and standard-setting agency requirements.

(D) It is the policy of the department that seclusion and restraint shall be applied in a safe and humane manner as measures of last resort. The goal of seclusion and restraint use is to assist the patient in regaining self control and maintaining dignity while reducing the risk of injury to patients and staff. The use of seclusion and restraint shall be consistent with nationally recognized standards for quality treatment and applicable laws.

(1) Regional psychiatric hospital (RPH) policies for seclusion or restraint must require that these measures shall:

(a) Only be imposed to ensure the immediate physical safety of the patient, a staff member, or others, and must be discontinued at the earliest possible time;

(b) Not employ a drug or medication when it is used as a restriction to manage the patient's behavior, or restrict the patient's freedom of movement, and is not a standard treatment or dosage for the patient's condition;

(c) Be employed as a last resort when lesser restrictive measures aimed at assisting a patient to control his or her behavior have failed;

(d) Not be used as coercion, discipline, or punishment; for the convenience of staff; or longer than clinically necessary;

(e) Be employed using the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff or others.

(f) Not cause injury to the patient;

(g) Not be used in place of more appropriate treatment interventions;

(h) Be used in a manner that best protects and maintains the dignity and individuality of each patient, and considers:

(i) Gender;

(ii) Age;

(iii) Developmental issues;

(iv) Ethnicity;

(v) History of physical or sexual abuse, or other trauma;

(vi) Medical conditions;

(vii) Physical disabilities; and

(viii) If individual is deaf, hard-of-hearing, or whose primary spoken language is other than English.

(i) Be ordered only by physicians;

(j) Be used to allow the greatest possible comfort of the patient; and

(k) Be vigorously supervised and monitored using individual medical record reviews and aggregate data reviews as part of an ongoing and systematic quality improvement program.

(2) Position in restraint. RPH policies and procedures shall ensure that:

(a) The use of prone restraint is prohibited.

(b) A patient shall be placed in a position that allows airway access and does not compromise respiration, regardless of the method of restraint utilized.

(c) The use of a transitional hold shall be subject to all of the following requirements:

(i) Applied only by staff who have current training on the safe use of this procedure, including how to recognize and respond to signs of distress in the patient.

(ii) Applied only in a manner that does not compromise breathing, including, but not limited to the following:

(a) The weight of the staff shall be placed to the side, rather than on top of the patient. No transitional hold technique shall allow staff to straddle, or bear pressure or weight on, the patient's back while applying the restraint, i.e. no downward pressure may be applied.

(b) No soft device, such as a pillow, blanket or other item, shall be placed under the patient's head or upper body; and

(c) No transitional hold technique shall allow placing the patient's or staff's arms under the patient's head, face, or upper body.

(iii) All staff involved in the procedure must constantly observe the patient's respiration, coloring, and other signs of distress, listen for any complaints of breathing problems, and immediately respond to any observed concerns with the intent to ensure that the patient is safe and suffers no harm.

(iv) Transitional hold may be applied only for the reasonable amount of time necessary to safely bring the patient or situation under control and to ensure the safety of the individuals involved; and

(v) After conclusion of the transitional hold, the patient shall be assessed at least every fifteen minutes, for two hours, to assure that the patient is not in need of medical attention. The results of each assessment shall be documented.

(3) RPH restraint and seclusion policies shall incorporate the following:

(a) Restraint shall be applied with concern for good body alignment and comfort of the patient, and recognition of any medical conditions;

(b) Seclusion may be employed only in rooms which contain proper temperature control, ventilation and lighting, a visual panel of safety glass for staff to make observations, a safe and sanitary environment void of wall/ceiling fixtures and sharp edges, electrical outlets; and include a bed, mattress, bed sheets and pillow unless the patient's condition warrants their removal. Removal requires a physician's written order and documentation of rationale for removal, however, a nurse may initiate their removal and then obtain the physician's order within sixty minutes after the removal.

(4) Steel cuffs or other restraining devices may be used by security staff for custody, detention, and public safety reasons and are not considered behavioral restraints. The use of steel cuffs to restrain a patient on a unit is prohibited.

(E) Standards

(1) RPHs may distinguish between manual or physical restraint with devices in policy consistent with regulating and accrediting authorities and this rule.

(2) Approved restraints are indicated below and are to be used in accordance with the limitations stated in this rule.

(a) Physical restraints with devices:

(i) Padded leather cuffs, vinyl flexicuffs, waist/wrist cuffs (pads), and two- and four-point belts and cuffs;

(ii) Mittens securely fastened around the wrist with a tie;

(iii) Any item which inhibits bending of the elbow, wrist, or fingers that was devised by clinical staff to prevent patients who engage in chronic self-mutilation from inflicting injury to themselves and cannot be readily

removed by the patient. These items must be approved prior to use by the CCO and the team designated to review behavioral therapy at the RPH;

(iv) Helmets only if the helmets are of an approved type and affixed in such a manner that removal or choking cannot be easily accomplished by patients;

(v) Mechanical supports used for restraint rather than support purposes (e.g., soft ties, geri chairs, and tie jackets) shall be considered physical restraint devices under this rule.

(vi) Items used for medical, surgical or dental procedures shall not be considered restraints under this rule.

(b) Manual restraint. A patient may be physically held by staff in either an emergency situation to prevent injury to the patient or others until appropriate physical restraint devices may be applied, or to control for transporting/transferring. Manual restraint is typically applied for only a brief period of time (less than five minutes).

(3) Quiet time shall not be considered restraint or seclusion.

(a) Quiet time may be initiated by either a staff person or the patient;

(b) The use of quiet time may be part of the plan of care and documented in the patient's medical records;

(c) The quiet area/room utilized for quiet time may be the patient's room or a special room or area designated for quiet time;

(d) Special care must be maintained when a suicidal or self-injurious patient is being authorized to use the quiet area/room; and (e) Only one patient is allowed in the quiet area/room at a time.

(4) Personnel designated below shall be the only individuals permitted to implement/employ specific seclusion and restraint techniques cited if they have been trained and are competent to do so:

(a) Direct care and nursing personnel shall be permitted to implement seclusion and restraint only if these employees have successfully completed training programs on minimizing the use of restraint or seclusion and to maximize safety when using seclusion and/or restraint;

(b) RPH security personnel shall implement seclusion and restraint and assist in the use of these interventions when a patient's behavior is beyond the control of nursing or other direct care personnel only if they have successfully completed training programs on minimizing the use of restraint or seclusion and maximizing safety when using seclusion and/or restraint; and

(c) Any employee who has successfully completed training programs on minimizing the use of restraint or seclusion and maximizing safety when using seclusion and/or restraint shall be permitted to assist in the application of restraints.

(F) Procedures

(1) RPH policies shall

- (a) Allow a patient, as part of treatment planning, the opportunity to identify techniques that would help the patient control his or her behavior; and
- (b) Consider a patient's advance directive addressing special safety and treatment if seclusion or restraint is warranted.

(2) Orders

(a) Any application of seclusion or restraint of a patient shall require a physician's order. Physician orders are obtained beforehand, as much as possible, but in emergent situations, a registered nurse can direct the use of seclusion or restraint (either a physical restraint with devices or a manual restraint) and obtain a physician's order as soon as possible afterward in accordance with paragraph (F)(2)(e) of this rule. The physician must order seclusion and restraint separately. Each order shall be documented and placed in the patient's medical record.

(b) With the exception of orders for the use of mittens and helmets for patient who exhibit self-injurious behavior, each order for seclusion or restraint shall be in force for no longer than one hour for an initial order, or up to two hours for a renewal. A physician shall personally examine the patient and substantiate the need for continuing the use of physical restraint with devices, or seclusion prior to renewing any order.

(c) The CCO or designee must review any episode of seclusion or restraint which exceeds eight hours before another order may be written.

(d) Orders for restraint devices to prohibit self injury including mittens and helmets shall not exceed four hours, and require a face-to-face evaluation by a physician for renewal in accordance with paragraph (F)(6) of this paragraph.

(e) In situations where, after a series of less restrictive interventions have failed and a seclusion or restraint is needed immediately to control the emergency situation, a patient may be restrained or secluded at the direction of a registered nurse without a written physician's order, if the following requirements are met:

(i) A physician shall be contacted by a registered nurse as soon as possible to obtain a telephone order, but no longer than thirty minutes after the initiation of restraint or seclusion;

(ii) The registered nurse shall explain to the patient the reason for seclusion or restraint and the behaviors of the patient which would indicate sufficient self-control to discontinue the measure;

(iii) The registered nurse shall document the physician's telephone order in the patient's medical record; and

(iv) The physician shall personally examine the patient and document in the chart within one hour after giving/receiving a telephone order to:

(a) Substantiate the need for such a measure, including the clinical indications. Documentation should show that the physician considered both

the benefits and risks of these measures;

(b) Perform the medical assessment noted in paragraph (F)(3) of this rule; and

(c) Countersign, date and time the telephone order.

(v) When a nurse initiates seclusion or restraint without a physician's order, and the physician, upon examination, does not substantiate the need for such a measure, the seclusion or restraint shall be terminated immediately.

(a) The results of the examination and rationale for not ordering seclusion or restraint shall be documented by the physician.

(b) The CCO or designee shall review all of the documentation related to the seclusion or restraint.

(f) Standing or PRN orders for seclusion or restraint shall not be used.

### (3) Examinations/assessments

The physician shall personally examine the patient who has been secluded or restrained in conjunction with writing orders for these interventions. The patient shall be given an explanation of the reason for the restraint or seclusion, and the behaviors of the patient which would indicate sufficient behavioral control to discontinue the intervention. The examination shall include the following unless clinically contraindicated and documented in the patient's record:

(a) An assessment of any physical problems or an unstable medical status that might contraindicate the use of seclusion or restraint. If there are none, the evaluator shall document in the patient's medical record that there are no known contraindications to this seclusion or restraint procedure;

(b) Vital signs including temperature, pulse, respiration, and blood pressure, or documentation if not done, and why;

(c) A review of current medications if the evaluation is conducted by a physician;

(d) Documentation to substantiate the clinical indication for seclusion or restraint use, and that the evaluator considered both the benefits and risks of these measures; and

(e) If the one hour face-to-face evaluation is conducted by a physician other than the attending physician, the attending physician or other licensed independent practitioner responsible for the care of the patient must be consulted as soon as possible.

(4) Rationale for the release from seclusion or restraint shall be documented by the registered nurse or licensed practical nurse in the patient's medical record.

(5) The treating physician shall be contacted as soon as possible if the restraint or seclusion was ordered by another physician.

(6) Patient care and documentation standards.

(a) All prior interventions used before seclusion or restraint shall be documented in the patient's medical record.

(b) To ensure proper safety, body comfort, and circulation of a patient placed in restraints, checks of the patient's condition shall be made by direct care personnel.

(i) Patients placed in restraints or seclusion shall be continuously monitored. Observations of the condition of the patient shall be made and documented in the patient's medical record at least every fifteen minutes or more often if the patient's condition so warrants.

(ii) Appropriate assessments of a patient in restraint or seclusion shall be conducted every fifteen minutes by trained and competent staff, and documented in the patient's medical record. The fifteen minute assessments shall include, as applicable: signs of any injury; nutrition/hydration; circulation and range of motion in the extremities; vital signs; hygiene and elimination; physical and psychological status and comfort; and readiness for discontinuation of restraint or seclusion.

(iii) When a patient is removed from physical restraint with devices, nursing staff shall continue to monitor the progress of the patient and make at least one entry, including vital signs, within two hours in the patient's medical record concerning the patient's status. More frequent monitoring may be necessary if warranted by the patient's condition.

(c) All patients placed in restraint or seclusion shall be visited by a registered nurse or licensed practical nurse no less than every hour to assess the patient. These visits shall be documented in the patient's medical record. This contact may be modified by a physician's order if the patient's need for reduced stimulus outweighs the need for continued medical assessment.

(d) A patient placed in restraint or seclusion shall be provided the opportunity for motion and exercise for at least ten minutes during each two hour period in which these devices are employed. This shall be documented in the patient's medical record.

(e) The patient's medical record shall include documentation of fluids being offered and monitoring for fluid intake and output. Monitoring may be modified by a physician's order if the patient's condition warrants reduced monitoring. The physician's order shall include rationale for the reduction in monitoring of fluid intake and output.

(f) The rationale for each episode of seclusion or restraint shall be clearly documented in the patient's medical record by the physician who examined the patient.

(g) The physician shall specify criteria for discontinuation of seclusion and/or restraint.

(h) With the patient's consent, the patient's family is notified of the initiation of restraint or seclusion.

(7) Conduct debriefings after an incident. (See ODMH policy MD-19

"Proactive Positive Intervention Treatment and Safety").

(a) The goals of debriefing are to: (1) minimize the negative effects of the incident on all involved individuals; and (2) identify alternative strategies to prevent or minimize future occurrences.

(b) Each patient shall be given the opportunity to debrief each episode of seclusion or restraint, unless specifically contraindicated in the treatment plan for clear treatment reasons. As part of the debriefing, the patient shall be given the opportunity to identify techniques that would assist the patient to control his or her behavior. In addition, patient debriefing provides an opportunity to minimize trauma and reestablish the therapeutic staff-patient relationship. Families may also participate in the debriefings at the patient's request.

(c) Each RPH shall develop procedures to debrief staff after an episode of restraint. Conduct a staff debriefing when a physical intervention occurs to:

(i) Assess for any injury;

(ii) Plan next steps for the patient's care and protection for the remainder of the shift;

(iii) Determine how management of the situation could have been handled differently;

(iv) Provide information to patient's treatment team to assist in treatment plan revisions;

(v) The following are examples of questions that may be included in a staff debriefing:

(a) Were there alternative actions that could have been taken to prevent the incident?

(b) Could some intervention earlier in the prodrome have prevented the outcome?

(c) In the case of restraint, could seclusion have been an alternative?

(d) Would it be possible to achieve a better outcome if an assist team were called?

(e) Are we medicating optimally? Is the patient adherent? How do we respond to possible non-adherence?

(f) What environmental changes might minimize the risk of further dangerous behaviors (e.g., room changes, roommate changes, ambient noise, light, or congestion on the unit, access to exits, response to visitors, etc.)?

(8) Monitoring and quality improvement requirements

(a) Each unit shall be responsible for preparing a daily log indicating name of patient, patient number, living unit, time of day in, time of day out, for each episode of seclusion or restraint.

(b) The regional psychiatric hospital CCO or his/her designee and the

director of nursing/nurse executive and/or his or her designee shall review, daily, all uses of seclusion or restraint.

(c) The quality improvement review of restraint and seclusion shall include, at a minimum, the following:

(i) A review of the aggregate monthly totals of the use of restraint or seclusion by type, ward, time of day, and other data required in paragraph (F) of this rule;

(ii) The review of any major incidents that resulted in the use of seclusion or restraint;

(iii) Within one business day, the treatment team shall conduct a review of any patient who required any seclusion or restraint. During this review the current treatment plan shall be assessed and revised as needed to contain specific elements that are aimed at reducing the use of seclusion or restraint. All prior interventions shall be reviewed. If successive treatment plan revisions are not successful in reducing the use of seclusion or physical restraint with devices in a clinically reasonable amount of time, consultation from outside the treatment team must be obtained. The department or regional psychiatric hospital behavior therapy committee, the CCO, other treatment teams, private consultants etc. may be sources utilized to conduct a consultation; and

(iv) The findings from the activities under paragraph (F) of this rule shall be reviewed monthly. This review shall identify any trends, increases, and problems. The need for additional training, consultations, or corrective action will be noted in the minutes of that review and forwarded to the CCO for possible action.

(v) The data collected in paragraph (F) of this rule and other related quality improvement review information shall be available to central office.

(d) Each patient, unless specifically contraindicated in the treatment plan for clear treatment reasons, shall be given the opportunity to debrief each episode of seclusion or restraint. As part of the debriefing, the patient shall be given the opportunity to identify techniques that would assist the patient to control his or her behavior. This shall be documented in the patient's medical record.

(e) Each regional psychiatric hospital shall develop procedures to debrief staff after an episode of restraint.

(G) Orientation and training

(1) Each chief executive officer shall be responsible for ensuring that orientation and training programs regarding the use of seclusion and restraint are provided. These programs shall be provided and conducted by appropriate personnel.

(2) Training shall emphasize the use of non-physical crisis intervention, behavioral and other treatment strategies to prevent exacerbation of aggression, and other techniques that will reduce the use of restraints. Special attention shall be placed on the humane use of any restraint

technique.

(a) All personnel shall have appropriate training during employee orientation.

(b) All new and existing direct care personnel and regional psychiatric hospital security personnel shall receive training in behavioral and other techniques to reduce the use of seclusion or restraint, and the proper use of physical restraint, manual restraint, and seclusion. This training will be conducted at least annually or more often if indicated by quality improvement reviews.

(c) Upon successful completion of each orientation or training program, a record of this training shall be documented and maintained in each employee's personnel folder.

#### (H) Implementation

The chief executive officer of each RPH shall be responsible for implementation of this rule.

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## **5122-14-10 Patient safety and physical plant requirements.**

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(A) The purpose of this rule is to:

(1) Require written policies and procedures for building and fire inspections, sanitation standards, patient safety;

(2) State requirements concerning the patient living environment including designated smoking areas, patient sleeping rooms, and common patient areas;

(3) Ensure inpatient services have appropriate space, equipment and facilities;

(4) Ensure inpatient services are appropriately and sufficiently staffed; and

(5) State required procedures for seclusion and restraint.

(B) The provisions of this rule are applicable to each inpatient psychiatric service provider licensed by the department.

(C) Definitions applying to this rule are those appearing in rule [5122-14-01](#) of the Administrative Code.

(D) Each inpatient psychiatric service provider shall comply with all applicable TJC, HFAP and/or DNV, and/or federal, state, and local laws and regulations regarding patient care, safety, sanitation, and fire protection.

(1) A building inspection shall be made upon application for an initial license, repeated whenever renovations or changes in the building are made that would affect either the maximum number of licensed patient beds or substantially change the services provided by the inpatient psychiatric service provider, or whenever the department deems necessary.

(2) If an inpatient psychiatric service provider occupies part of a building, the entire building shall be inspected except where there is a fire wall or other fire resistant separation between the part of the building to be licensed and the rest of the building. If this fire separation does not exist the total building shall be used to determine safety for inspection purposes only.

(3) A building inspection shall be performed by a local certified building inspector or, where none is available, by the chief of the division of factory and building inspection of the Ohio department of industrial relations.

(4) The inpatient psychiatric service provider shall be inspected annually by a certified fire authority or, where none is available, by the division of state fire marshal of the Ohio department of commerce. Copies of annual

inspections shall be maintained by the inpatient psychiatric service provider for a period of at least three years or until the next on-site licensure survey.

(5) The inpatient psychiatric service provider's food service shall be inspected annually by the authorized local municipal county health department. Copies of annual inspections shall be maintained by the inpatient psychiatric service provider for a period of at least three years or until the next on-site licensure survey.

(6) If the inpatient psychiatric service provider's water supply and sewage disposal is not part of a municipal system, it shall comply with applicable state or local regulations, rules, codes, or ordinances.

(E) Each inpatient psychiatric service provider shall provide an environment that is clean, safe, aesthetic, and therapeutic. Appropriate space, equipment, and facilities shall be available to provide services.

(1) If smoking is permitted, separate enclosed area(s) shall be used for smoking;

(2) Each patient's sleeping room shall have a:

(a) Window, with an operable covering for privacy, that has a view to the outdoors;

(b) Minimum of one hundred net square feet of usable floor space per bed for single occupancy, and a minimum of eighty net square feet of usable floor space per bed for multi-occupancy;

(c) Minimum of a bed, chair, storage for personal belongings, and other therapeutic furnishings as appropriate; and

(d) Degree of privacy from other patients if there is more than one bed in the room.

(3) Child/adolescent patients shall not share the same sleeping room with adult patients.

(4) For all patients, a safe and secure storage area(s) for personal belongings accessible to the patient shall be provided. Personal belongings that may pose safety issues for patients may be placed in a safe and secure storage area accessible to patients through a request of staff.

(5) Each inpatient psychiatric service provider shall provide common patient areas that adequately meet patient needs and program requirements.

(a) There shall be a minimum of eighty total square feet of usable social space per licensed bed to include:

(i) Patient lounge area(s) totaling at least thirty square feet per licensed bed, including separate smoking and non-smoking areas if smoking is permitted in the lounge area;

(ii) Patient activity area(s) totaling at least thirty square feet per licensed bed which may include indoor recreation areas;

(iii) Dining room facilities to meet patient needs;

(iv) Patient kitchen area to include a sink, a refrigerator, and cooking facilities as appropriate to patient need; and

(v) Patient laundry area.

(6) Patient lounge, activity, and dining area(s) may be shared space(s) as appropriate to patient need. Child/adolescent patients shall be provided the use of a patient lounge area(s) appropriate for their use separate from adult use of patient lounge areas.

(7) There shall be private areas to include:

(a) Private area(s) for visitation from family members, significant others, or other persons;

(b) Private area(s) for telephone use;

(c) Group therapy area(s) as appropriate to patient need; and

(d) Private areas to include places and times for personal privacy.

(8) Each inpatient psychiatric service provider shall provide an environment that is accessible to persons with disabilities and make reasonable accommodations in accordance with all applicable federal, state and local laws and regulations.

(9) Each inpatient psychiatric service provider shall develop policies and procedures regarding services designed to assist deaf/hard of hearing persons as well as persons for whom English is not the primary language.

(a) Services shall be provided at such a level so that the patient and patient's family or significant others are not denied the benefits of participation in the inpatient psychiatric service provider's treatment program. Services shall comply with all applicable state, federal and HIPAA guidelines regarding the maintenance of patient confidentiality. As applicable, such services shall consist of but may not be limited to availability of:

(i) Qualified interpreters with demonstrated ability and/or certification;

(ii) Telecommunication devices for the deaf/hard of hearing; and

(iii) Television closed caption capability.

(b) Such services shall be available to patients and their family members or significant others who are receiving services. Specifically for emergency services, the inpatient psychiatric service provider shall have policies and procedures that address the need for immediate accessibility to qualified interpreters, telecommunication devices for the deaf/hard of hearing, and/or other assistance with communication.

(c) Direct care staff and treatment team members shall be trained in issues relating to barriers to traditional verbal/English communication.

(d) Services to assist patients and families of patients or significant others

shall be available at no charge to the patient, family or significant others.

(10) Each inpatient psychiatric service provider shall implement a falls prevention program that is monitored through its quality improvement process.

(F) Each inpatient psychiatric service provider shall have a sufficient number of professional, administrative, and support staff to meet both census needs and patient needs.

(1) Staffing for all services shall reflect the volume of patients, patient acuity, and the level of intensity of the services provided to ensure that desired outcomes of care are achieved and negative outcomes are avoided.

(2) Staffing of any organized patient activity (e.g., rehabilitation therapy services or nursing services provided to groups of patients), shall be sufficient to ensure safety and may be dependent on the type, duration and location of the activity and the immediate accessibility of other staff.

(3) For nursing services:

(a) A 1:4 minimum nursing staff-to-patient ratio shall be maintained as an overall average in any four week period with the exception of night hours when patients are sleeping.

(b) For reasons of safety at least two staff shall be present at all times.

(c) A registered nurse must be on site twenty-four hours each day, seven days a week.

(d) A registered nurse must be available for direct patient care when needed.

(G) Each inpatient psychiatric service provider shall meet all applicable medicare conditions of participation, TJC, HFAP and/or DNV standards for seclusion and restraint in addition to the following:

(1) The following shall not be used under any circumstances:

(a) Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises;

(b) Any technique that obstructs the airway or impairs breathing;

(c) Any technique that obstructs vision;

(d) Any technique that restricts the individual's ability to communicate;

(e) Weapons and law enforcement restraint devices, as defined by CMS in appendix A of its interpretive guidelines to 42 C.F.R. 482.13(f) and found in manual publication No. 100-7, "Medicare State Operations", used by any hospital staff or hospital-employed security or law enforcement personnel, as a means of subduing a patient to place that patient in patient restraint/seclusion; and

(f) Chemical restraint. A drug or medication administered involuntarily to an individual in an emergency may be considered a chemical restraint if both conditions cited in paragraph (C)(6) of rule [5122-14-01](#) of the Administrative Code are met.

(2) Position in physical or mechanical restraint.

(a) An individual shall be placed in a position that allows airway access and does not compromise respiration.

(i) The use of prone restraint is prohibited.

(ii) A transitional hold shall be limited to the minimum amount of time necessary to safely bring the person under control, at which time staff shall either terminate the transitional hold, and begin the post-restraint process required by this rule, or, if the individual cannot safely be released from the transitional hold, re-position the individual into an alternate restraint position.

The use of transitional hold shall not be utilized with mechanical restraint.

(b) The use of transitional hold shall be subject to the following requirements:

(i) Applied only by staff who have current training on the safe use of transitional hold, including how to recognize and respond to signs of distress in the individual.

(ii) The weight of the staff shall be placed to the side, rather than on top of the individual. No transitional hold shall allow staff to straddle or bear weight on the individual's torso while applying the restraint, i.e. no downward pressure may be applied that may compromise the individual's ability to breathe.

(iii) No transitional hold shall allow the individual's hands or arms to be under or behind his/her head or body. The arms must be at the individual's side.

(iv) No soft device, such as a pillow, blanket or other item, shall be used to cushion the client's head, since such a device may restrict the individual's ability to breathe.

(v) All staff involved in the procedure must constantly observe the individual's respiration, coloring, and other signs of distress, listen for the individual's complaints of breathing problems, and immediately respond to assure safety.

(vi) After conclusion of the transitional hold, the hospital shall monitor and document the condition of the individual at least every fifteen minutes, for two hours. The inability to complete the fifteen minute monitoring and rational shall be documented.

(3) The agency shall identify, educate and approve staff members to use seclusion or restraint. Competency of staff in the use and documentation of seclusion or restraint methods shall be routinely evaluated. The results of

evaluations shall be maintained by the agency for a minimum of three years for each staff member identified.

Staff shall have appropriate training prior to utilizing seclusion or restraint, and, at a minimum, annually thereafter. The exception to annual training is a first aid and/or CPR training/certification program of a nationally recognized certifying body, e.g. the American Red Cross or American Heart Association, when that certifying body establishes a longer time frame for certification and renewal.

(a) Staff shall be trained in and demonstrate competency in the safe application of all seclusion or restraint interventions he or she is authorized to perform, including specific training in utilization of transitional holds, if applicable;

(b) Staff shall be trained in and demonstrate competency in choosing the least restrictive intervention based on an individualized assessment of the patient's behavioral and/or medical status or condition;

(c) Staff shall be trained in and demonstrate competency in recognizing and responding to signs of physical distress in clients who are being secluded or restrained;

(d) Staff shall be trained and certified in first aid and CPR;

(e) Staff shall be trained in and demonstrate competency in recognizing and responding to signs of physical distress in clients who are being secluded or restrained;

(f) Staff authorized to take vital signs and blood pressure shall be trained in and demonstrate competency in taking them and understanding their relevance to physical safety and distress;

(g) Staff shall be trained in and demonstrate competency in assessing circulation, range of motion, nutrition, hydration, hygiene, and toileting needs; and

(h) Staff shall be trained in and demonstrate competency in helping a client regain control to meet behavioral criteria to discontinue seclusion or restraint.

(4) The presence of advance directives or client preferences addressing the use of seclusion or restraint shall be determined and considered, and documented in the medical record. If the agency will be unable to utilize seclusion or restraint in a manner in accordance with the patient's directives or preferences, the agency shall notify the patient, including the rationale, and document such in the ICR

(5) In each patient's medical record, upon admission and upon any relevant changes in the patient's condition, any perceived medical or psychiatric contraindications for the possible use of seclusion or restraint shall be documented. The specific contra-indication shall be described and shall take into account the following which may place the patient at greater risk for such use:

- (a) Gender;
- (b) Age;
- (c) Developmental issues;
- (d) Culture, race, ethnicity, and primary language;
- (e) History of physical and/or sexual abuse, or psychological trauma;
- (f) Medical and other conditions that might compromise physical well-being, e.g., asthma, epilepsy, obesity, lung and heart conditions, an existing broken bone, pregnancy, and drug/alcohol use; and
- (g) Physical disabilities.

(6) Orders shall be written only by an individual with specific clinical privileges/authorization granted by the agency to order seclusion and restraint, and who is a:

- (a) Psychiatrist or other physician; or
- (b) Physician's assistant, certified nurse practitioner or clinical nurse specialist authorized in accordance with his or her scope of practice and as permitted by applicable law or regulation.

(c) Countersignatures to telephone orders for seclusion and/or restraint shall be signed within twenty four hours by an individual with specific clinical privileges/authorization granted by the hospital to order seclusion and restraint, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist

(7) Following the conclusion of each incident of seclusion or restraint, the patient and staff shall participate in a debriefing(s).

(a) The debriefing shall occur within twenty-four hours of the incident unless the client refuses, is unavailable, or there is a documented clinical contraindication.

(b) The following shall be invited to participate unless such participation is clinically contraindicated and the rationale is documented in the clinical record:

- (i) For a child/adolescent client, the family, or custodian or guardian, or
- (ii) For an adult client, the client's family or significant other when the client has given consent, or an adult client's guardian, if applicable.

(8) As part of the inpatient psychiatric service provider's performance improvement process, a periodic review and analysis of the use of seclusion and restraint shall be performed.

(9) The inpatient psychiatric service provider shall maintain an ongoing log of its seclusion and restraint utilization for departmental review A log shall be maintained for department review of each incident of mechanical restraint, seclusion, and physical restraint, and for time-out exceeding sixty minutes per episode. The log shall include, at minimum, the following

information.

- (a) The person's name or other identifier;
- (b) The date, time and type of method utilized, i.e., seclusion, physical or mechanical restraint, or time-out. The log of physical and mechanical restraint shall also describe the type of intervention as follows:
  - (i) For mechanical restraint, the type of mechanical restraint device used;
  - (ii) For physical restraint, the type of hold or holds as follows:
    - (a) Transitional hold, and/or
    - (b) Physical restraint; and
- (c) The duration of the method or methods.

If both transitional hold and physical restraint are utilized during a single episode of restraint, the duration in each shall be included on the log. For example, a physical restraint that begins with a one minute transitional hold, followed by a three minute physical restraint shall be logged as one restraint, indicating the length of time in each restraint type.

(10) Plan to reduce seclusion and/or restraint.

(a) An agency which utilizes seclusion or restraint shall develop a plan designed to reduce its use. The plan shall include attention to the following strategies:

- (i) Identification of the role of leadership;
  - (ii) Use of data to inform practice;
  - (iii) Workforce development;
  - (iv) Identification and implementation of prevention strategies;
  - (v) Identification of the role of clients (including children), families, and external advocates; and
  - (vi) Utilization of the post seclusion or restraint debriefing process.
- (b) A written status report shall be prepared annually, and reviewed by leadership.

(H) Pursuant to rule [5122-14-14](#) of the Administrative Code, the hospital shall notify ODMH of each:

- (1) Instance of physical injury to a patient that is restraint-related, e.g., injuries incurred when being placed in seclusion and/or restraint or while in seclusion or restraint, with the exception of injury that is self-inflicted, i.e. a patient banging his/her own head;
- (2) Death that occurs while a person is restrained or in seclusion;
- (3) Death occurring within twenty four hours after the person has been removed from restraint or seclusion, and

(4) Death where it is reasonable to assume that a person's death may be related to or is a result of such seclusion or restraint.

(I) Staff actions commonly known as therapeutic, supportive or directional touch, utilized to direct an individual to another area without the use of force and which do not restrict an individual's freedom of movement, are not considered restraint and are not subject to the provisions of paragraph (G) of this rule

Replaces: 5122-14-10

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**Route: [Ohio Administrative Code](#) » [5122 Department of Mental Health - Administration and Director](#) » [Chapter 5122-26 Policies and Procedures for the Operation of Mental Health Services Agencies](#)**

## **5122-26-16 Seclusion, restraint and time-out.**

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(A) The provision of a physically and psychologically safe environment is a basic foundation and requirement for effective mental health treatment. Adopting trauma informed treatment practices, creating calm surroundings and establishing positive, trusting relationships are essential to facilitating a person's treatment and recovery.

The goal of reducing and minimizing the use of seclusion and restraint is one that must be shared and articulated by the organization's leadership. The elevation of oversight by leadership of each use of seclusion or restraint in order to investigate causality, ascertain relevancy of current policies and procedures, and identify any associated workforce development issues, is core to the successful achievement of this goal.

These methods are very intrusive techniques to be used by trained, qualified staff as a last resort in order to control dangerous and potentially harmful behaviors and to preserve safety. Best practices include careful early assessment of a person's history, experiences, preferences, and the effectiveness or ineffectiveness of past exposure to these methods.

Use of seclusion or restraint must be subject to performance improvement processes in order to identify ways in which the use of these methods can be decreased/avoided and more positive, relevant and less potentially dangerous techniques used in their place.

When individuals experience repeated or sustained use of these methods, leadership should evaluate all causative factors and consider alternative treatment interventions and/or possible transfer to/placement in a more structured treatment setting with the capacity to meet individual needs with reduced exposure to these intrusive interventions.

(B) The purpose of this rule is to state the general requirements applicable to the use of seclusion and restraint, and to the adoption of processes to reduce their utilization.

(C) The following definitions shall apply to rules 5122-26-16 to [5122-26-16.2](#) of the Administrative Code and supersede those contained in rule [5122-24-01](#) of the Administrative Code:

(1) "Advance directives" means a legal document an adult can use to direct in advance the decisions about his or her mental and/or physical health treatment, if in the future he/she lacks the capacity to make his/her own health care decisions. Two types of advance directives related to mental health treatment are: a "Declaration for Mental Health Treatment" subject to the requirements of Chapter 2135. of the Revised Code, and a "Durable Power of Attorney for Health Care" subject to the requirements of sections [1337.11](#) to [1337.17](#) of the Revised Code.

(2) "Behavior management" means the utilization of interventions that are applied in a systematic and contingent manner in the context of individual or group programs to change or manage behavior or facilitate improved self-control. The goal of behavior management is not to curtail or circumvent an individual's rights or human dignity, but rather to support the individual's recovery and increase his/her ability to exercise those rights.

(3) "Comfort rooms", (formerly known as quiet or time-out rooms), are adapted sensory rooms that provide sanctuary from stress and/or can be places for persons to experience feelings within acceptable boundaries.

(4) "Individual crisis plan" means a written plan that allows the person to identify coping techniques and share with staff what is helpful in assisting to regain control of his/her behavior in the early stages of a crisis situation. It may also be referred to as a "behavior support plan."

(5) "Mechanical restraint" means any method of restricting a person's freedom of movement, physical activity, or normal use of his or her body, using an appliance or device manufactured for this purpose.

(6) "Physical restraint", also known as "manual restraint", means any method of physically restricting a person's freedom of movement, physical activity, or normal use of his or her body without the use of mechanical restraint devices.

(7) "PRN (pro re nata)" means as the situation demands.

(8) "Prone Restraint" means all items or measures used to limit or control the movement or normal functioning of any portion, or all, of an individual's body while the individual is in a face-down position for an extended period of time. Prone restraint may include either physical (also known as manual) or mechanical restraint.

(9) "Qualified person" means an employee and/or volunteer who carries out the agency's tasks under the agency's administration and/or supervision, and who is qualified to utilize or participate in the utilization of seclusion or restraint by virtue of the following: education, training, experience, competence, registration, certification, or applicable licensure, law, or regulation.

(10) "Seclusion" means the involuntary confinement of a person alone in a room where the person is physically prevented from leaving.

(11) "Sensory rooms" means appealing physical spaces painted with soft colors with the availability of furnishings and objects that promote relaxation and/or stimulation.

(12) "Time-out" means an intervention in which a person is required to remove him/herself from positive reinforcement to a specified place for a specified period of time. Time-out is not seclusion.

(13) "Transitional hold" means a brief physical (also known as manual) restraint of an individual face-down for the purpose of quickly and effectively gaining physical control of that individual, or prior to transport to

enable the individual to be transported safely.

(14) "Vital signs" means the rates or values indicating an individual's blood pressure, pulse, temperature, and respiration.

(D) General requirements

(1) Seclusion or restraint shall not be used unless it is in response to a crisis situation, i.e., where there exists an imminent risk of physical harm to the individual or others, and no other safe and effective intervention is identified.

(a) They shall not be used as behavior management interventions, to compensate for the lack of sufficient staff, as a substitute for treatment, or as an act of punishment or retaliation.

(b) Absent a co-existing crisis situation that includes the imminent risk of physical harm to the individual or others, the destruction of property by an individual, in and of itself is not adequate grounds for the utilization of these methods.

(2) The following shall not be used under any circumstances:

(a) Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises.

(b) Any technique that restricts the individual's ability to communicate, including consideration given to the communication needs of individuals who are deaf or hard of hearing;

(c) Any technique that obstructs vision;

(d) Any technique that obstructs the airways or impairs breathing;

(e) Use of mechanical restraint on individuals under age eighteen;

(f) A drug or medication that is used as a restraint to control behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's medical or psychiatric condition or that reduces the individual's ability to effectively or appropriately interact with the world around him/her; and

(g) The use of handcuffs or weapons such as pepper spray, mace, nightsticks, or electronic restraint devices such as stun guns and tasers.

The presence of weaponry in an agency poses potential hazards, both physical and psychological, to clients, staff and visitors. Utilization by the agency of non-agency employed armed law enforcement personnel (e.g., local police) to respond to and control psychiatric crisis situations, shall be minimized to the extent possible.

(3) Position in physical or mechanical restraint.

(a) An individual shall be placed in a position that allows airway access and

does not compromise respiration.

(i) The use of prone restraint is prohibited.

(ii) A transitional hold shall be limited to the minimum amount of time necessary to safely bring the person under control, at which time staff shall either terminate the transitional hold, and begin the post-restraint process required by this rule, or, if the individual cannot safely be released from the transitional hold, re-position the individual into an alternate restraint position.

(b) The use of transitional hold shall be subject to the following requirements:

(i) Applied only by staff who have current training on the safe use of transitional hold techniques, including how to recognize and respond to signs of distress in the individual.

(ii) The weight of the staff shall be placed to the side, rather than on top of the individual. No transitional hold shall allow staff to straddle or bear weight on the individual's torso while applying the restraint, i.e. no downward pressure may be applied that may compromise the individual's ability to breathe.

(iii) No transitional hold shall allow the individual's hands or arms to be under or behind his/her head or body. The arms must be at the individual's side.

(iv) No soft device, such as a pillow, blanket or other item, shall be used to cushion the client's head, since such a device may restrict the individual's ability to breathe.

(v) All staff involved in the procedure must constantly observe the individual's respiration, coloring, and other signs of distress, listen for the individual's complaints of breathing problems, and immediately respond to assure safety.

(4) The choice of the least restrictive, safe and effective use of seclusion or restraint for an individual is determined by the person's assessed needs, including a consideration of any relevant history of trauma and/or abuse, risk factors as identified in paragraph (G)(3) of this rule, the effective or ineffective methods previously used with the person and, when possible, upon the person's preference.

(a) Upon admission/intake and when clinically warranted, the person and his/her parent, custodian or guardian, as appropriate, shall be informed of the agency's philosophy on the use of seclusion or restraint as well as of the presence of any agency policies and procedures addressing their use by the agency. Such policies and procedures shall be made available to the person and/or to his/her parent, custodian or guardian upon request.

Adult clients shall be offered the opportunity to give consent for the notification of their use to a family member or significant other.

(5) Within twenty-four hours of the initiation of seclusion or restraint, the

agency shall notify the following individuals:

- (a) For children/adolescents, the client's parent, custodian or guardian;
- (b) For adults, the client's guardian, when applicable, or family or significant other when the client has given his/her consent for such notification.

(6) Following the conclusion of each incident of seclusion or restraint, the client and staff shall participate in a debriefing(s).

(a) The debriefing shall occur within twenty-four hours of the incident unless the client refuses, is unavailable, or there is a documented clinical contraindication.

(b) The following shall be invited to participate unless such participation is clinically contraindicated and the rationale is documented in the clinical record:

- (i) For a child/adolescent client, the family, or custodian or guardian, or
- (ii) For an adult client, the client's family or significant other when the client has given consent in accordance with paragraph (D)(4)(a) of this rule, or an adult client's guardian, if applicable.

(7) A thorough review and analysis of each incident of the use of seclusion or restraint shall be undertaken in order to use the knowledge gained from such analysis to inform policy, procedures, and practices to avoid repeated use in the future and to improve treatment outcomes. Secondly, such analysis should help to mitigate, to the extent possible, the adverse and potentially traumatizing effects of a seclusion or restraint event for involved staff, clients, and for all witnesses to the event.

(8) The inclusion of clients (including children), families, and external advocates in various roles and at all agency levels to assist in reducing the use of seclusion or restraint shall be considered.

(E) Policies and procedures

(1) The agency shall establish policies and procedures that reflect how the utilization of seclusion or restraint is reviewed, evaluated, and approved for use. The agency shall document if and how the inclusion of clients and families in the development of such policies occurred.

(2) Policies and procedures governing the use of seclusion or restraint shall include attention to preservation of the person's health, safety, rights, dignity, and well-being during use. Additionally:

(a) Respect for the person shall be maintained when such methods are utilized;

(b) Use of the environment, including the possible addition of comfort and sensory rooms, shall be designed to assist in the person's development of emotional self-management skills; and

(c) The number of appropriately trained staff available to apply or initiate seclusion or restraint shall be adequate to ensure safety. The use of non-

agency employed law enforcement personnel, e.g., local police, to substitute for the lack of sufficient numbers of appropriately trained staff in such situations is prohibited.

(F) Staff training.

(1) The agency shall ensure that all direct care staff and any other staff involved in the use of seclusion or restraint receive initial and annual training designed to minimize their use.

(a) Staff shall be trained and demonstrate competency in the correct and appropriate use of non-physical techniques for intervention, such as mediation and conflict resolution, and de-escalation of disruptive or aggressive acts, persons and/or situations; and

(b) Staff shall be trained in understanding how their behavior can affect the behavior of clients.

(2) The agency shall identify, educate and approve staff members to use seclusion or restraint. Competency of staff in the use and documentation of seclusion or restraint methods shall be routinely evaluated. The results of evaluations shall be maintained by the agency for a minimum of three years for each staff member identified.

(a) Staff shall have appropriate training prior to utilizing seclusion or restraint, and, at a minimum, annually thereafter. The exception to annual training is a first aid and/or CPR training/certification program of a nationally recognized certifying body, e.g. the American Red Cross or American Heart Association, when that certifying body establishes a longer time frame for certification and renewal.

(i) Staff shall be trained in and demonstrate competency in the identification and assessment of those possible risk factors identified in paragraph (G) of this rule and to understand how these may impact the way a client responds to seclusion or restraint, and place an individual at greater risk to experience physical or psychological trauma during an episode of seclusion or restraint;

(ii) Staff shall be trained in and demonstrate competency in choosing the least restrictive intervention based on an individualized assessment of the client's behavioral and/or medical status or condition;

(iii) Staff shall be trained in and demonstrate competency in the safe application of all seclusion or restraint interventions he or she is authorized to perform, including specific training in utilization of transitional hold, if applicable;

(iv) Staff shall be trained and certified in first aid and CPR;

(v) Staff shall be trained in and demonstrate competency in recognizing and responding to signs of physical distress in clients who are being secluded or restrained;

(vi) Staff authorized to take vital signs and blood pressure shall be trained in and demonstrate competency in taking them and understanding their

relevance to physical safety and distress;

(vii) Staff shall be trained in and demonstrate competency in assessing circulation, range of motion, nutrition, hydration, hygiene, and toileting needs; and

(viii) Staff shall be trained in and demonstrate competency in helping a client regain control to meet behavioral criteria to discontinue seclusion or restraint.

(b) Leadership shall maintain a current list of staff authorized to utilize seclusion or restraint interventions which is readily available to all agency staff who may be asked to participate in these interventions; and

(c) The curriculum used to train staff shall be documented and shall be made available to ODMH upon request.

(G) Documentation.

(1) The presence of advance directives or client preferences addressing the use of seclusion or restraint shall be determined and considered, and documented in the ICR. If the agency will be unable to utilize seclusion or restraint in a manner in accordance with the person's directives or preferences, the agency shall notify the individual, including the rationale, and document such in the ICR.

(2) In conjunction with the person's active participation, an individual crisis plan shall be developed at the time of admission and incorporated in the person's ISP for each child/adolescent resident of an ODMH licensed residential facility, for each client known to have experienced seclusion or restraint, and when otherwise clinically indicated.

The plan shall be based on the initial mental health assessment, and shall include and be implemented, as feasible, in the following order:

(a) Identification of the methods or tools to be used by the client to de-escalate and manage his or her own aggressive behavior;

(b) Identification of techniques and strategies for staff in assisting the person to maintain control of his or her own behavior; and

(c) Identification, in order of least restrictive to most restrictive, of the methods/tools to be used by staff to de-escalate and manage the client's aggressive behavior.

(3) Initial and ongoing identification of individual-specific contraindications to the use of seclusion or restraint shall be documented. Consideration of the use of such methods shall take into account the following which may place the person at greater risk of physical or psychological injury as a result of the use of seclusion or restraint:

(a) Gender;

(b) Age;

(c) Developmental issues;

(d) Culture, race, ethnicity, and primary language;

(e) History of physical and/or sexual abuse, or psychological trauma;

(f) Medical and other conditions that might compromise physical well-being, e.g., asthma, epilepsy, obesity, lung and heart conditions, an existing broken bone, pregnancy, and drug/alcohol use; and

(g) Physical disabilities.

(4) Debriefings following the conclusion of each incident of seclusion or restraint shall be documented, and shall include, at a minimum:

(a) The incident and antecedent behaviors which lead to the use of seclusion or restraint;

(b) What actions might have prevented the use of seclusion or restraint; and what techniques and tools might help the individual manage his or her own behavior in the future;

(c) The person's reaction to the method, including whether there is any need for counseling or other services related to the incident; and

(d) Whether any modifications to the person's ISP or individual crisis plan are needed.

(5) Each incident of seclusion or restraint shall be clinically and/or administratively reviewed. Such review shall be documented.

(H) Logs and notifications.

(1) A log shall be maintained for department review of each incident of mechanical restraint, seclusion, and physical restraint, and for time-outs exceeding sixty minutes per episode. The log shall include, at minimum, the following information:

(a) The person's name or other identifier;

(b) The date, time and type of method or methods utilized, i.e., seclusion, mechanical restraint, physical restraint and/or transitional hold, or time-out. The log of physical and mechanical restraint shall also describe the type of intervention as follows:

(i) For mechanical restraint, the type of mechanical restraint device used;

(ii) For physical restraint, as follows:

(a) Transitional hold, and/or

(b) Physical restraint; and

(c) The duration of the method or methods.

If both transitional hold and physical restraint are utilized during a single episode of restraint, the duration in each shall be included on the log. For example, a physical restraint that begins with a one minute transitional hold, followed by a three minute physical restraint shall be logged as one restraint, indicating the length of time in each restraint type.

(2) Pursuant to rules [5122-26-13](#) and [5122-30-16](#) of the Administrative Code, the agency shall notify ODMH of each:

(a) Instance of physical injury to a client/resident that is restraint-related, e.g., injuries incurred when being placed in seclusion or restraint or while in seclusion or restraint, with the exception of injury that is self-inflicted, i.e. a client/resident banging his/her own head;

(b) Death that occurs while a person is restrained or in seclusion;

(c) Death occurring within twenty four hours after the person has been removed from restraints or seclusion, and

(d) Death where it is reasonable to assume that a person's death may be related to or is a result of such seclusion or restraint.

(l) Performance improvement.

(1) The agency shall collect data on all instances of the use of seclusion or restraint and integrate the data into performance improvement activities.

(2) Data shall be aggregated and reviewed at least semi-annually by agencies and at least quarterly by ODMH licensed residential facilities. The minimum data to be collected for each episode shall include:

(a) Staff involved, including staff member(s) who initiated the seclusion or restraint;

(b) Duration of the method;

(c) Date, time and shift each method was initiated;

(d) Day of week;

(e) Type of method, including type of physical hold or mechanical restraints utilized;

(f) Client age, race, gender and ethnicity;

(g) Client and/or staff injuries;

(h) Number of episodes per client; and

(i) Use of psychotropic medications during an intervention of seclusion or restraint.

(3) Data shall be reviewed:

(a) For analysis of trends and patterns of use; and

(b) To identify opportunities to reduce the use of seclusion or restraint.

(4) The agency shall routinely compare how its practices compare with current information and research on effective practice.

(5) The results of data reviews and performance improvement activities shall be shared with staff at least semi-annually with the goal of reducing the use of seclusion or restraint.

(J) Plan to reduce seclusion or restraint.

(1) An agency which utilizes seclusion or restraint shall develop a plan designed to reduce its use. The plan shall include attention to the following strategies:

(a) Identification of the role of leadership;

(b) Use of data to inform practice;

(c) Workforce development;

(d) Identification and implementation of prevention strategies;

(e) Identification of the role of clients (including children), families, and external advocates; and

(f) Utilization of the post seclusion or restraint debriefing process.

(2) A written status report shall be prepared annually, and reviewed by leadership.

(K) Staff actions commonly known as therapeutic, supportive or directional touch, utilized to direct an individual to another area without the use of force and which do not restrict an individual's freedom of movement, are not considered restraint and are not subject to the provisions of this rule.

Replaces: 5122-26-16, Part of 5122-26- 16.1, Part of 5122-26- 16.2, Part of 5122-26- 16.3

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**Route: [Ohio Administrative Code](#) » [5122 Department of Mental Health - Administration and Director](#) » [Chapter 5122-26 Policies and Procedures for the Operation of Mental Health Services Agencies](#)**

## **5122-26-16.1 Mechanical restraint and seclusion.**

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(A) The purpose of this rule is to state the specific requirements applicable to mechanical restraint and seclusion.

(B) The requirements for the use of mechanical restraint or seclusion do not apply:

(1) To restraint use that is only associated with medical, dental, diagnostic, or surgical procedures and is based on standard practice for the procedure. Such standard practice may or may not be described in procedure or practice descriptions (e.g., the requirements do not apply to medical immobilization in the form of surgical positioning, iv arm boards, radiotherapy procedures, electroconvulsive therapy, etc.);

(2) When a device is used to meet the assessed needs of an individual who requires adaptive support (e.g., postural support, orthopedic appliances) or protective devices (e.g., helmets, tabletop chairs, bed rails, car seats). Such use is always based on the assessed needs of the individual. Periodic reassessment should assure that the restraint continues to meet an identified individual need;

(3) To forensic and corrections restrictions used for security purposes, i.e., for custody, detention, and public safety reasons, and when not involved in the provision of health care.

(C) Mechanical restraint or seclusion shall not be used unless it is in response to a crisis situation, i.e., where there exists an imminent risk of physical harm to the individual or others, and no other safe and effective intervention is possible. It shall be employed for the least amount of time necessary in order that the individual may resume his/her treatment as quickly as possible.

(D) Implementation of mechanical restraint or seclusion.

(1) Authorized staff may implement mechanical restraint or seclusion at the direction and in the presence of an individual with specific clinical privileges/authorization granted by the agency to authorize mechanical restraint or seclusion, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, clinical nurse specialist, or registered nurse.

(2) Upon any implementation of mechanical restraint or seclusion, an individual with specific clinical privileges/authorization granted by the agency shall:

(a) Perform an assessment and document it in the clinical record. This assessment shall include, at minimum:

- (i) The reason for the utilization of mechanical restraint or seclusion;
- (ii) All prior attempts to use less restrictive interventions;
- (iii) Notation that any previously identified contraindication(s) to the use of mechanical restraint or seclusion were considered and the rationale for continued implementation of mechanical restraint or seclusion despite the existence of such contraindications(s); and
- (iv) A review of all current medications.

(b) Assess and document vital signs; and

(c) Explain to the individual the reason for mechanical restraint or seclusion, and the required behaviors of the individual which would indicate sufficient behavioral control so that mechanical restraint or seclusion can be discontinued.

(3) For adults in mechanical restraint, an assessment shall include health and related safety concerns including body positioning, comfort and circulation.

(E) Ordering mechanical restraint or seclusion.

(1) Orders shall be written only by an individual with specific clinical privileges/authorization granted by the agency to order mechanical restraint or seclusion, and who is a:

(a) Psychiatrist or other physician; or

(b) Physician's assistant, certified nurse practitioner or clinical nurse specialist authorized to order restraint or seclusion in accordance with his or her scope of practice and as permitted by applicable law or regulation.

(2) Orders may be written for a maximum of:

(a) Two hours for mechanical restraint or seclusion of adults eighteen years of age or older;

(b) One hour for seclusion of children and adolescents age nine through seventeen; or

(c) Thirty minutes for seclusion of children under age nine.

(3) Prn orders are prohibited, whether individual or as a part of a protocol.

(4) When indicated, a verbal order from an individual with specific clinical privileges/authorization granted by the agency to order mechanical restraint or seclusion, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist shall be obtained by a registered nurse upon implementation of mechanical restraint or seclusion, or within one hour. Such order shall be signed within twenty four hours by an individual with specific clinical privileges/authorization granted by the agency to order mechanical restraint or seclusion, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist.

(5) After the original order for mechanical restraint or seclusion expires, the individual shall receive a face-to-face reassessment, as described in subsection five of this paragraph. The reassessment shall be performed by an individual with specific clinical privileges/authorization granted by the agency to order mechanical restraint or seclusion, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist, who shall write a new order if mechanical restraint or seclusion is to be continued. However, agency policy and the original order may permit a registered nurse to perform such reassessment and make a decision to continue the original order for an additional:

(a) Two hours for mechanical restraint or seclusion of adults eighteen years of age or older up to a maximum of twenty-four hours;

(b) One hour for seclusion of children and adolescents age nine through seventeen up to a maximum of twenty-four hours; or

(c) Thirty minutes for seclusion of children under age nine up to a maximum of twelve hours.

(6) Continuation of orders cannot under any circumstances exceed the maximums stated in this paragraph without a face-to-face reassessment and a new written order. The reassessment shall be performed and new order written by an individual with specific clinical privileges/authorization granted by the agency to order mechanical restraint or seclusion, and who is a psychiatrist or other physician, physician's assistant, certified nurse practitioner, or clinical nurse specialist.

Such assessment shall be documented in the clinical record. It shall address the need for continued mechanical restraint or seclusion. It shall include a mental status examination, physical assessment, gross neurological assessment, and an assessment of the individual's verbal statements, level of behavioral control, and responses to stimuli and treatment interventions, unless contra-indicated for clear treatment reasons which shall be documented in the clinical record.

(7) Mechanical restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

(F) Continuous monitoring of persons in mechanical restraint or seclusion.

(1) While in mechanical restraint or seclusion, persons shall be continuously monitored, i.e., constant visual observation by staff in a manner most conducive to the situation and/or person's condition.

(2) Documentation of the condition of the person shall be made in the clinical record at routine intervals not to exceed fifteen minutes or more often if the person's condition so warrants. Such documentation shall address attention to vital signs, circulation, range of motion, nutrition, hydration, hygiene, toileting, the need for continued mechanical restraint or seclusion, and other needs as necessary, and the appropriate actions taken.

(3) Upon conclusion of the mechanical restraint or seclusion, the results of a check of injuries shall be conducted and documented.

The appropriate actions taken for any injuries noted shall also be documented.

(G) Seclusion room requirements.

(1) The type of room in which seclusion is employed shall ensure:

(a) Appropriate temperature control, ventilation and lighting;

(b) Safe wall and ceiling fixtures, with no sharp edges;

(c) The presence of an observation window and, if necessary, wall mirror(s) so that all areas of the room are observable by staff from outside of the room; and

(d) That any furniture present is removable or is securely fixed for safety reasons.

(H) Clinically appropriate reason(s) for the inability to implement any portion of this rule shall be documented in the clinical record, and shall be addressed in any staff de-briefing of the episode and in the agency's performance improvement process.

Replaces: 5122-26- 16.1

Effective: 01/01/2012

R.C. [119.032](#) review dates: 01/01/2017

Promulgated Under: [119.03](#)

Statutory Authority: [5119.22](#) , [5119.61](#) , [5119.611](#)

Rule Amplifies: [5119.22](#) , [5119.61](#) , [5119.611](#)

Prior Effective Dates: 1/1/91, 4/16/01



**Route: [Ohio Administrative Code](#) » [5122 Department of Mental Health - Administration and Director](#) » [Chapter 5122-26 Policies and Procedures for the Operation of Mental Health Services Agencies](#)**

## 5122-26-16.2 Physical restraint.

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(A) The purpose of this rule is to state the specific requirements applicable to physical restraint.

(B) Physical restraint shall not be used unless it is in response to a crisis situation, i.e., where there exists an imminent risk of physical harm to the individual or others, and no other safe and effective intervention is possible. It shall be employed for the least amount of time necessary in order that the individual may resume his/her treatment as quickly as possible..

(C) Implementation of physical restraint.

(1) Physical restraint must be authorized by a trained, qualified staff member in accordance with the requirements of the agency's behavioral health accrediting body; or

(2) For an agency who has not achieved appropriate behavioral health accreditation, the agency must identify and approve staff who are qualified to authorize physical restraint.

Staff approved by the agency must have received all training in accordance with paragraph (F) of rule [5122-26-16](#) of the Administrative Code.

(D) Documentation of each episode of the use of physical restraint shall be made in the clinical record and shall include:

(1) The reason for implementation of the physical restraint;

(2) All prior attempts to use less restrictive interventions;

(3) Notation that any previously identified contraindication(s) to the use of physical restraint were considered and the rationale for continued implementation of physical restraint despite the existence of such contraindication(s);

(4) A review of all current medications;

(5) Explanation to the person for the reason for implementation of physical restraint and the required behaviors of the person which would indicate sufficient behavioral control so that the physical restraint could be discontinued;

(6) The condition of the person at routine intervals not to exceed fifteen minutes or more often if the person's condition so warrants. Such documentation shall address attention to vital signs, circulation, range of motion, nutrition, hydration, hygiene, toileting, need for continued restraint, and other needs as necessary, and the appropriate actions taken; and

(7) Upon conclusion of the physical restraint, the results of a check of

injuries shall be conducted.

The appropriate actions taken for any injuries noted shall also be documented.

(E) Clinically appropriate reason(s) for the inability to implement any portion of this rule shall be documented in the clinical record, and shall be addressed in any staff de-briefing of the episode and in the agency's performance improvement process.

Replaces: 5122-26- 16.2

Effective: 01/01/2012

R.C. [119.032](#) review dates: 01/01/2017

Promulgated Under: [119.03](#)

Statutory Authority: [5119.22](#) , [5119.61](#) , [5119.611](#)

Rule Amplifies: [5119.22](#) , [5119.61](#) , [5119.611](#)

Prior Effective Dates: 1/1/91, 4/16/01



Route: [Ohio Administrative Code](#) » [3793:2 Program Standards](#) » [Chapter 3793:2-1 Alcohol and Drug Addiction Programs](#)

## 3793:2-1-05 Clinical management.

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(A) The purpose of this rule is to state the minimum clinical management requirements that a program must meet in order to be certified by the Ohio department of alcohol and drug addiction services as an alcohol and drug addiction outpatient treatment program, residential treatment program, ambulatory or sub-acute detoxification program or licensed as an opioid agonist program.

(B) The provisions of this rule are applicable to all of the following Ohio alcohol and drug treatment programs, public and private, regardless of whether they receive any public funds or funds that originate and/or pass through the Ohio department of alcohol and drug addiction services in accordance with division (A) of section [3793.06](#) of the Revised Code.

- (1) Alcohol and drug addiction outpatient treatment programs.
- (2) Alcohol and drug addiction residential treatment programs.
- (3) Opioid agonist programs.
- (4) Alcohol and drug addiction ambulatory detoxification programs.

(C) The provisions of this rule are not applicable to the following programs:

- (1) Alcohol and drug prevention programs.
- (2) Alcohol and drug addiction sub-acute detoxification and acute hospital detoxification programs.
- (3) Criminal justice therapeutic community programs.
- (4) Treatment alternatives to street crime programs.
- (5) Driver intervention programs.

(D) Each program shall be abstinence-based.

(E) Clinical organization:

The admission, continued stay and discharge/referral to each level of care based on the Ohio department of alcohol and drug addiction services' protocols for levels of care (youth and adult) for publicly-funded clients shall be predicated upon the following factors:

- (1) A substance related disorder diagnosis based on the current "Diagnostic and Statistical Manual of Mental Disorders" for adult clients admitted to levels I-IV and levels I-III for youth.
- (2) The degree of severity for the following dimensions:

- (a) Intoxication or withdrawal potential.
- (b) Biomedical conditions and complications.
- (c) Emotional/behavioral/cognitive conditions and complications.
- (d) Treatment acceptance/resistance.
- (e) Relapse potential.
- (f) Recovery environment.
- (g) Family or care giver functioning (for youth).

(F) The admission, continued stay and discharge/referral to each level of care for non-publicly-funded clients shall be based on the Ohio department of alcohol and drug addiction services' protocol or other objective placement criteria.

(G) Each alcohol and drug treatment program shall have written policies and/or procedures that include, but are not limited to:

(1) Admission criteria including criteria for financial eligibility and for determining appropriateness of services.

(2) Admission procedures.

(3) Procedures to follow when an individual has been determined to be inappropriate for admission to the program.

(4) Procedures for transferring clients to a different treatment program within the same agency.

(5) Identification and description of the alcohol and drug addiction services provided under each level of care.

(6) Procedures for making a referral to other organizations, including a determination of the appropriateness of the referral, referral when the appropriate level of care is not provided by the program and provisions for obtaining a properly completed release form.

(7) Procedures for transporting clients to other organizations, when necessary that include, but are not limited to:

(a) A hospital.

(b) A mental health facility for individuals who present a danger to self and/or others.

(8) Procedures for terminating client services, including terminating against the advice of the program.

(9) Procedures for the release of client information.

(10) Procedures for obtaining an assessment for each client admitted or re-admitted to the program, including acceptance of an assessment performed by another program certified by the department or an assessment containing comparable elements of assessment per rule [3793:2-1-08](#) of the

Administrative Code that has been performed within one year of the admission or re-admission date of a client. A copy of the assessment shall be filed in the client's record and updated, signed and dated by a staff member of the admitting program authorized to conduct an assessment pursuant to agency 3793 of the Administrative Code.

(11) Procedures for developing an individualized treatment plan that addresses problems identified in the client's assessment.

(12) Procedures for reporting suspected child abuse and/or neglect, consistent with sections 2151.42.1 and [2151.421](#) of the Revised Code, rule [5101:2-34-06](#) of the Administrative Code and rule [3793:2-1-03](#) of the Administrative Code.

(13) All programs certified by the Ohio department of alcohol and drug addiction services shall have a policy on client behavioral interventions that includes, but is not limited to, the following:

(a) A statement that the use of all cruel and unusual punishments and practices including, but not limited to physical or verbal abuse is prohibited:

(b) Statement indicating what types of interventions shall be employed.

(c) Statement that isolation in a locked, unmonitored room shall not occur.

(d) Statement that behavioral intervention shall only be administered by the program director, clinical director or program employees with direct care responsibilities who have been trained in the program's approved behavioral interventions policy and procedures.

(14) Policy/procedure for referring or providing client education on exposure to, and the transmission of, tuberculosis, hepatitis type B and C, and HIV disease for each client admitted to the program. Documentation shall appear in the client record.

(H) Dietary services:

(1) Each program shall operate its dietary services in accordance with laws, regulations and/or ordinances of the Ohio board of dietetics, Ohio department of health and/or local health department.

(a) Each program shall have policies and procedures for planning menus, preparing and serving food, procurement and storage of food, sanitation and waste disposal.

(b) Halfway house treatment programs and residential treatment programs shall make provisions for three nutritionally balanced meals daily for each client.

(2) Each program that prepares and/or serves meals as part of its daily scheduled activities, shall follow written dietary policies and/or procedures that include, but are not limited to, the following:

(a) Planning menus that meet the nutritional needs of clients in accordance with the current recommended daily allowance established by the national academy of science.

(b) Provisions for preparing and serving meals for persons with special dietary needs.

(c) Procurement, storage, preparation and serving of food.

(d) Maintaining the food service areas and storage areas in a sanitary condition.

(e) Waste disposal.

(3) Each program that prepares and/or serves food shall have documentation to reflect that a dietician, who is licensed by the Ohio board of dietetics, has reviewed, signed, dated and approved:

(a) The program's dietary policies and procedures.

(b) The program's menus.

(c) Special diets.

(l) Pharmaceutical services:

(1) Each program that dispenses, administers and/or prescribes medications, shall have a license for the terminal distribution of dangerous drugs from the Ohio board of pharmacy.

(a) "Administer" means the direct application of a drug to a person, whether by injection, ingestion or any other means.

(b) "Dispense" means the final association of a drug with a particular client pursuant to the prescription, drug order or other lawful order of a prescriber and the professional judgment of and the responsibility for: interpreting, preparing, compounding, labeling and packaging a specific drug.

(2) Each program that dispenses, prescribes and/or administers medications shall have written policies and/or procedures for pharmaceutical services, that include, at a minimum, the following in accordance with 21 C.F.R. 1305m, 21 C.F.R. 1307 and Chapter 4729. of the Revised Code:

(a) Individuals who can dispense, prescribe and/or administer over-the-counter and prescription medications for the program.

(b) Ordering, receiving and storing prescription and over-the-counter medications.

(c) Administering medications.

(d) Dispensing and labeling medications.

(e) Procedures for disposal of all medications.

(f) Procedures for reporting theft or loss of prescription or over-the counter medications..

(3) Each program that permits clients to medicate themselves shall have written policies and/or procedures that include, but are not limited to, the following:

- (a) Procedures for storing medications in a locked cabinet.
- (b) Procedures for self-medication.
- (c) Procedures for accounting for medications that are kept for the client while she/he is at the program site.
- (d) Policy prohibiting clients from having unsecured prescription medications in their possession at the alcohol/drug program site or while involved in program activities off site unless required for medical necessity.
- (e) Procedures for obtaining and for accounting for medications (prescription and over-the-counter) from clients at the time of admission to or upon entering the program site and return of same, as appropriate, at the time of the discharge/departure.

(4) Clients shall not be denied admission to a program due solely to their use of prescribed psychotropic medication(s).

(J) Each program certified by the Ohio department of alcohol and drug addiction services shall have a clinical director (this title may be referred to as clinical coordinator, etc.) who has demonstrated experience and/or education in substance abuse treatment and holds one or more of the following credentials from a professional regulatory board in Ohio:

(1) Physician who is licensed to practice medicine in Ohio by the Ohio state medical board.

(2) Psychologist who is licensed by the Ohio state board of psychology.

(3) Professional clinical counselor who is licensed by the state of Ohio counselor, a social worker and marriage and family therapist board and whose declaration statement includes substance abuse assessment and counseling and supervision.

(4) Licensed independent social worker who is licensed by the state of Ohio counselor, social worker and marriage and family therapist board and whose declaration statement includes substance abuse assessment and counseling.

(5) Registered nurse with the Ohio board of nursing who has demonstrated experience and/or education in substance use disorder treatment.

(6) Certified chemical dependency counselor III-E, or licensed independent chemical dependency counselor, who is licensed by the chemical dependency professionals board.

(7) Licensed independent marriage and family therapist who is licensed by the state of Ohio counselor, social worker & marriage and family therapist board and whose declaration statement includes substance abuse assessment and counseling and supervision.

(K) Individuals qualified to be alcohol and drug treatment services supervisors pursuant to rule [3793:2-1-08](#) of the Administrative Code shall:

(1) Conduct regularly scheduled individual and/or group supervision sessions.

(2) Develop written goals and methods for supervision that are agreed upon with the supervisee.

(3) Document what occurred during supervision sessions and progress with supervision goals.

Effective: 02/14/2011

R.C. [119.032](#) review dates: 11/10/2010 and 07/15/2015

Promulgated Under: [119.03](#)

Statutory Authority: [3793.02\(D\)](#) , [3793.06](#) , [3793.11](#)

Rule Amplifies: [3793.06](#) . [3793.11](#)

Prior Effective Dates: 7/1/91, 7/1/01, 6/13/04, 11/17/05

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By [Rita Price](#)

*The Columbus Dispatch* • Sunday May 25, 2014 10:36 AM

Comments: 0

MOUNT VERNON, Ohio — It used to happen dozens of times each year. A deeply troubled child would rage uncontrollably, and staff members would ride out the storm with holds and restraints.

The high-water mark came in 2008, when the Knox County Children's Resource Center recorded 217 restraints.

This year, there have been just two. The former seclusion room at the residential treatment center is now a storage closet.

"We're celebrating," said Dave Paxton of the Village Network, a behavioral-health and foster-care agency with 13 sites in Ohio, including the one in Mount Vernon.

Paxton said that much of the turnaround is rooted in neurobiology. Over the past few years, agency staff members have been trained to identify and zero in on ways in which the children's traumatic experiences — abuse, neglect, prenatal drug exposure and other horrors — might have altered their developing brains.

"It's asking what a kid has been through, not what he has done wrong," said Paxton, the agency's chief strategy and innovation officer. "This is going to change the way we do business."

Village Network is among a growing number of agencies nationwide using a trauma-based therapeutic approach developed by Dr. Bruce Perry and the ChildTrauma Academy in Houston.

At its core are Web-based tools that analyze information to "map" a troubled child's brain, drawing attention to areas where functional and chronological age do not match. That allows for targeted interventions instead of cookie-cutter

responses to common diagnoses such as oppositional defiant disorder or depression, Paxton said.

"It gives us their developmental age," said Jerry Hartman, program manager at the Children's Resource Center. "Maybe they're 17, but they're still having temper tantrums like a 2-year-old. What does a 2-year-old need? To be soothed."

He and Paxton think trauma-based care has the potential to revamp child-welfare systems, save billions in spending on future social ills and aid states' efforts to curb overuse of psychotropic-medication on foster children. In 2012, Ohio Medicaid officials said that nearly 1 in 4 foster children had been prescribed mind-altering drugs.

"We have one boy who was on 16 different medications when we got him," said Jerry Hartman, program manager at the Children's Resource Center. The heavily drugged child was "shuffling along being compliant," but not necessarily healing.

The advocacy organization Disability Rights Ohio also called last week for an end to restraints and more trauma-informed care in the wake of a death at a northeastern Ohio group home. The Cuyahoga County coroner said the 15-year-old died by asphyxiation during a physical restraint.

The brain-mapping approach championed by Perry is example of "trauma-informed care," which isn't a brand-new idea. But its associated therapies are rapidly gaining ground. "It's very popular, and I think this is not just a passing fad," said Dr. Mark Hurst, medical director of the Ohio Department of Mental Health and Addiction Services. "The research is very impressive."

The department launched a Trauma-Informed Care Initiative this year to help agencies, practitioners and facilities become competent in trauma-informed practices for Ohioans of all ages.

No particular approach, such as Perry's, is endorsed. Hurst said the aim is to "generically" support care that takes into account the potential scars of past trauma and experience.

The need for that kind of sleuthing might sound obvious. But in the world of mental-health treatment, experts acknowledge, diagnoses often cast the longest shadow. Perry says that about 90 percent of troubled children receive one of just five diagnoses.

"Characteristically, our approach has been very phenomenally based: you do or do not meet the criteria for a disorder," Hurst said. "That's fine. We get some very good results from that. But the individual is more than a constellation of the symptoms they bring. A trauma-informed care approach considers what those experiences were."

At the Knox County Children's Resource Center, the brain mapping that is part of its trauma-informed care starts with an extensive assessment.

From intrauterine experiences and parental histories to family dysfunction and medical markers such as heart rate, temperature and sleep patterns, the information is used to create a kind of neuro-portrait.

Much of the time, the mapping reveals developmental problems in the more-primitive areas of the brain, Hartman said. Early chaos and violence affect developing neural systems and can make it biologically impossible for children

to regulate their emotions and behavior. "Fight or flight" responses play out in an endless loop.

Yoga breathing exercises, popsicle-stick sculptures and long walks figure into the care plans of the six teenage girls in an afternoon class at the Children's Resource Center.

"This is another tool in your stress-relieving toolkit," art therapist Liz Hartz said as she told the girls to count 10 breaths silently, using their fingers to keep track. The girls inhale and exhale deeply, giggle occasionally and name a few sources of stress.

"School."

"Tests."

"Home."

One girl's arms are lined with scars. Another smiles and says she'd like to smash one of the sculptures. All are at the Knox County center because they need more help than a regular foster home can give.

"We're just doing art together, but we're having a therapeutic conversation," Hartz said. "It's a catalyst."

Such activities are regular parts of trauma-informed care because movement, repetition and sound can help children's brains regulate and repair, said the ChildTrauma Academy's Perry, in Columbus last month to speak to community groups.

Traditional cognitive-based therapies that rely on "talking things out" aren't effective when a child's brainstem isn't regulated and can cause more stress, Hartman said. Punishment and isolation often backfire.

One boy who was badly abused "just wanted to follow us around," Hartman said. "So we let him."

The center now has a calming area with big rocking chairs, soft lighting and 15-pound blankets whose beanbag-style heft soothes agitated kids.

Paxton said the center has seen reductions in high-risk behaviors such as self-mutilation, preoccupation with suicide and running away. Although restraints haven't been officially banned, the need to use them has declined because of the new strategy, he said.

"There are times when you gotta duck, be moving," Hartman said, smiling. "Trauma is not just a memory. It shapes the way they view the world."

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# Ohio Department of Mental Health and Addiction Services

## Seclusion and Restraint Six Month Data Report Results

### Inpatient Psychiatric Service Providers

#### January through June 2012

Ohio Department of Mental Health & Addiction Services (OhioMHAS) OAC 5122-14-14 requires that inpatient hospital providers report certain incident data every six months. Mental health providers that are required to report incidents include Type 1 Residential Facilities, Inpatient Psychiatric Service Providers, and Community Mental Health Agencies.

### Inpatient Psychiatric Service Providers

Hospital providers are comprised of psychiatric inpatient units within general hospitals and freestanding psychiatric hospitals in Ohio. OhioMHAS licenses acute inpatient beds on these units for adults, adolescents, and children; some adult licensed units have programming specific to the geriatric population. All acute inpatient units and/or hospitals provide programming and treatment for individuals who are experiencing an acute psychiatric crisis and require hospitalization.

Hospitals were required to report their service utilization (bed days), number and minutes of Seclusion<sup>1</sup>, Physical Restraints<sup>2</sup>, Mechanical Restraints<sup>3</sup>, number of patient injuries or illnesses, and number of injuries to staff from Seclusion and Restraint.

During this six-month reporting period OhioMHAS licensed 78 inpatient hospitals (three units reported as one; 76 hospitals reported data):

- 68 hospitals provide services to adults age 18 and over.
- 16 hospitals provide services to children and adolescents under the age of 18.
- 8 hospitals provided services to both children/adolescents and adults.

Comparisons. In order to compare across organizations frequencies were calculated on the number of Seclusions and Restraints per 1000 patient days, and the average duration per Seclusion and Restraint.

$$\text{Seclusion/Restraints per 1000 Patient Day} = \frac{\text{Total \# of Seclusions/Restraints}}{\text{Total \# of Patient Days}} \times 1000$$

$$\text{Avg. Duration per Seclusion/Restraint} = \frac{\text{Total mins of Seclusion/Restraint}}{\text{Total \# of Seclusions/Restraints}}$$

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<sup>1</sup> Seclusion means a staff intervention that involves the involuntary confinement of a patient alone in a room where the patient is physically prevented from leaving.

<sup>2</sup> Physical Restraint, also known as Manual Restraint, means a staff intervention that involves any method of physically/manually restricting a patient's freedom of movement, physical activity, or normal use of his or her body without the use of Mechanical Restraint devices.

<sup>3</sup> Mechanical Restraint means a staff intervention that involves any method of restricting a patient's freedom of movement, physical activity, or normal use of his or her body, using an appliance or device manufactured for this purpose.

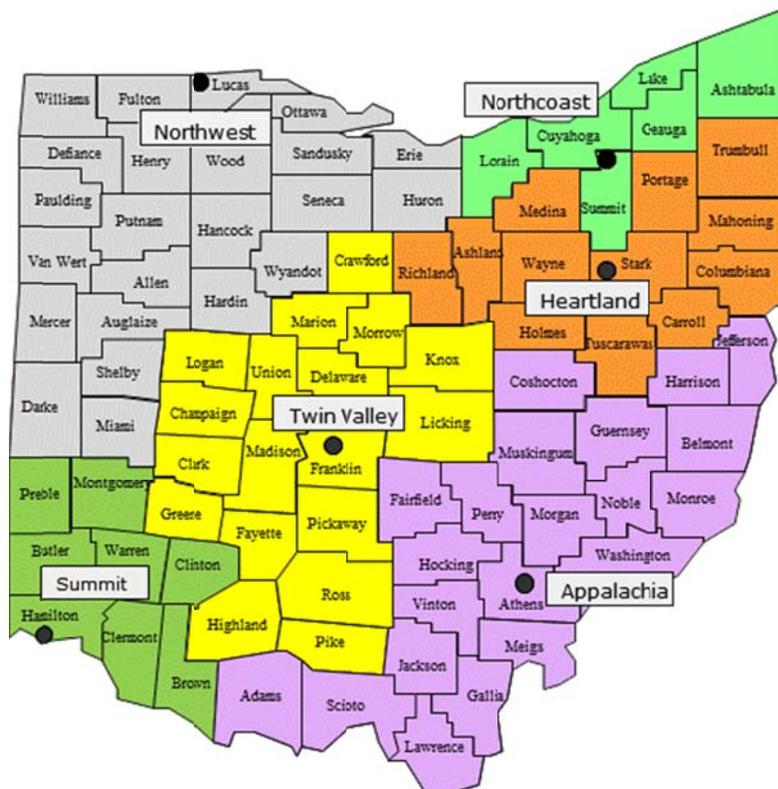
For example, if an organization reported 600 patient days, 15 incidents of Seclusion, and 500 total minutes of Seclusion, the Seclusions per 1000 patient days would be 25 ( $15/600 = 25$ ) and the average duration would be 33.3 minutes ( $500/15 = 33.3$ ).

Geographic Areas Served.

The figure below shows the counties that refer people to the six OhioMHAS Regional Psychiatric Hospitals. Inpatient Psychiatric Service Providers were also classified by these geographical areas. Table 1 below reports the number of hospitals in each geographical area. The Northeast region has the highest number of hospitals for both adults, and children and youth. The second and third regions with the highest percentage of hospitals were the Northwest and Southwest regions. The Southeast region had the fewest number of hospitals serving both groups. Results will be reported by region for hospitals serving adults; the subsample size was too small to report results by region for the child and youth-serving hospitals.

**Table 1. Inpatient Psychiatric Service Providers by Geographical Region.**

Region/Hospital	Adult Private Inpatient		Child/Youth Private Inpatient	
Northeast/Northcoast	18	26.5%	5	31.3%
Heartland	8	11.7%	2	12.5%
Southeast/Summit	7	10.3%	1	6.3%
Southwest/Appalachia	13	19.1%	3	18.8%
Central/Twin Valley	8	11.8%	2	12.5%
Northwest	14	20.6%	3	18.8%



## Inpatient Psychiatric Hospitals Serving Adults

### *Patient Days*

Patient days<sup>4</sup> summarize hospital service utilization. Table 2 below reports the monthly average, and six-month total, patient days for the OhioMHAS hospitals and the inpatient psychiatric service providers serving adults. On average, private inpatient hospitals reported 620 patient days and public hospitals reported 5,266 patient days per month.

**Table 2. Total number of patient days per month**

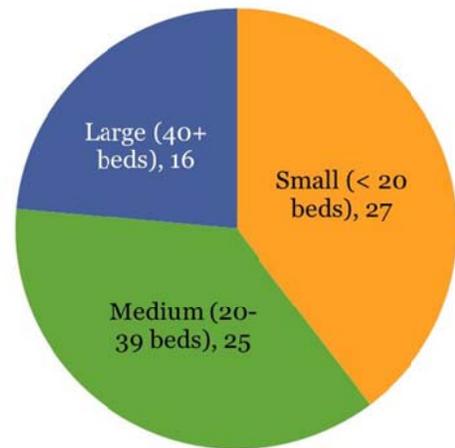
		6 month Total	Jan	Feb	Mar	Apr	May	Jun
Inpatient Psychiatric Service Providers (Adult-serving; N = 68)	<b>Mean</b>	<b>3,718</b>	<b>635</b>	<b>590</b>	<b>633</b>	<b>606</b>	<b>626</b>	<b>628</b>
	SD	3,102	535	490	530	510	515	539
	Min	24	7	4	0	7	4	2
	Max	12,093	2,061	1,872	2,044	2,032	2,077	2,053
OhioMHAS Hospitals (N = 6)	<b>Mean</b>	<b>31,595</b>	<b>5,403</b>	<b>5,004</b>	<b>5,344</b>	<b>5,189</b>	<b>5,399</b>	<b>5,255</b>
	SD	14,118	2,426	2,261	2,440	2,336	2,374	2,294
	Min	14,271	2,552	2,282	2,298	2,211	2,475	2,453
	Max	47,586	8,163	7,491	8,017	7,749	8,243	7,923

### *Capacity*

Private psychiatric units/hospitals are licensed annually and full licensure renewal requires an on-site survey every three years. The minimum number of licensed beds by a hospital was 6, and the maximum number of licensed beds by a hospital was 96. The average number of licensed beds was 31.0 (sd = 21.7). Based on the number of licensed beds, hospitals were grouped in to 3 categories:

- 27 hospitals with less than 20 beds (39.7%)
- 25 hospitals with 20-39 beds (36.8%)
- 16 hospitals with 40 or more beds (23.5%).

Seclusion and Restraint results will be reported below by hospital capacity groups.



<sup>4</sup> Patient days are the sum of all census days less the sum of all leave days.

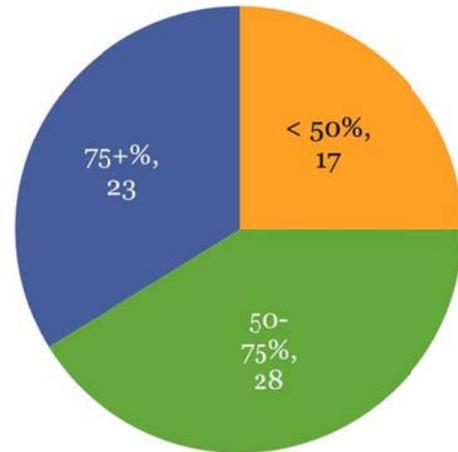
## Occupancy

Occupancy was calculated for each hospital. The formula used to calculate occupancy was:

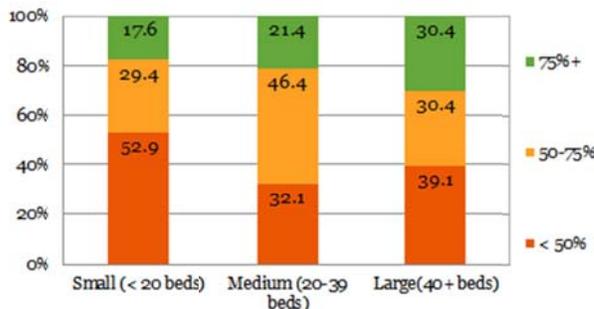
$$\text{Occupancy} = \frac{\text{Total \# of Patient Days}}{\# \text{ of licensed beds} * 182 \text{ (days in the 6-month period)}}$$

The minimum occupancy was 0.7%, and the maximum occupancy was 102.1%. The average occupancy was 63.4% (sd = 20.5%). Based on the occupancy percentages, hospitals were grouped in to 3 categories:

- 17 hospitals with occupancy less than 50% (25.0% of hospitals)
- 28 hospitals with occupancy between 50 and 75% (41.2% of hospitals)
- 23 hospitals with occupancy over 57% (33.8% of hospitals)



### Occupancy by Capacity



The Figure at left compares Occupancy by Capacity. Small capacity hospitals (less than 20 beds) had the largest number of hospitals in the lowest occupancy category, under 50% (52.9%). Medium capacity hospitals (20-39 beds) had the largest number of hospitals at the 50-75% occupancy (46.4%). Large capacity hospitals (with 40 or more beds) had the largest number of hospitals at 75%+ capacity (30.4%).

## Average Daily Census

The Average Daily Census (ADC) was calculated for each hospital. The formula used to calculate ADC was:

$$\text{ADC} = \frac{\text{Total \# of Patient Days}}{182 \text{ (days in the 6-month period)}}$$

The minimum ADC was 0.1, and the maximum ADC was 66.5. The average ADC was 20.4 (sd = 17.1). OhioMHAS hospitals ADC during the six-month period was 173.6. Based on the ADC figures, private hospitals were grouped in to 3 categories:

- 22 hospitals with ADC 0-10 patients per day (32.4%)
- 23 hospitals with ADC 11-19 patients per day (33.8%)
- 23 hospitals with ADC 20+ patients per day (33.8%)

Seclusion and Restraint results will be reported below by hospital ADC groups.

## Utilization of Seclusion or Restraint

The data reporting form does not ask about hospital policy allowing or prohibiting the use of Seclusion or Restraint. Most hospitals (N = 57, 83.8%) reported using some type of Seclusion or Restraint January through June 2012; 11 hospitals (16.2%) reported they did not utilize any type of Seclusion or Restraint. In an effort to better understand the data, OhioMHAS has calculated the data three ways:

- Hospitals reported using Seclusion/Restraint (N = 42 for Seclusion, N = 24 for Physical Restraint, and N = 45 for Mechanical Restraint)
- Hospitals that do use some type of Seclusion/Restraint as they reported any type of Seclusion/Restraint (N = 57), and
- All hospitals (N = 68)
- As the denominator increases, the average frequency scores decrease.

Additionally, the private hospitals wanted to see how their Seclusions and Restraints compared with the public hospitals. The Seclusions and Restraints for the six public Regional Psychiatric Hospitals have been aggregated and included.

## Seclusions

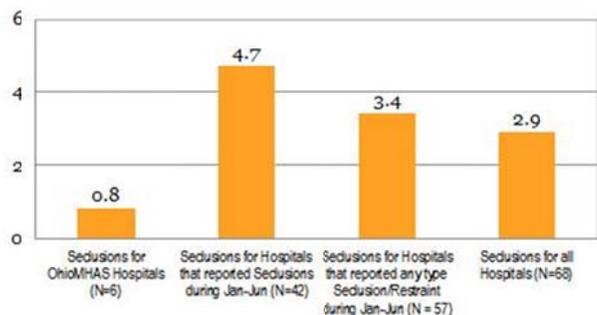
Table 3 reports the frequency of Seclusions, Table 4 reports the average duration of Seclusions, and Table 5 reports the frequency and duration of Seclusions by Geographical Area, by Capacity, and by Average Daily Census.

### Frequency

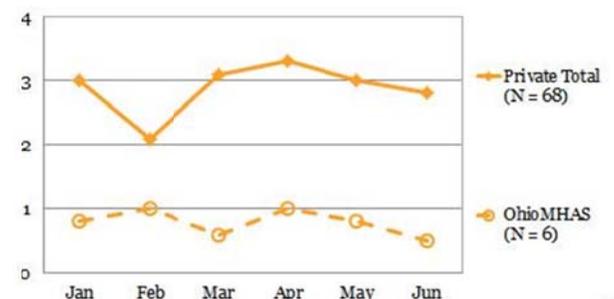
Almost two-thirds of hospitals (N = 42; 61.8%) reported using Seclusions this six-month period; over one-third of hospitals (N= 26; 38.2%) did not use Seclusion this six-month period. Of the 42 hospitals that did report Seclusions, the minimum number reported by a hospital was 1, the maximum number reported was 144, and the average total number reported was 21.4.

- When standardizing across hospitals by patient days, the minimum was 0.2, the maximum was 25.5, and the average number of Seclusions per 1000 patient days was 4.7.
- The average number of Seclusions per 1000 patient days decreases to 3.4 for hospitals that reported any type of Seclusion or Restraint (N = 57) this six-months.
- The average number of Seclusions per 1000 patient days decreases to 2.9 for all hospitals (N = 68).

Frequency of Seclusions (per 1000 Patient days) 6-month Avg.

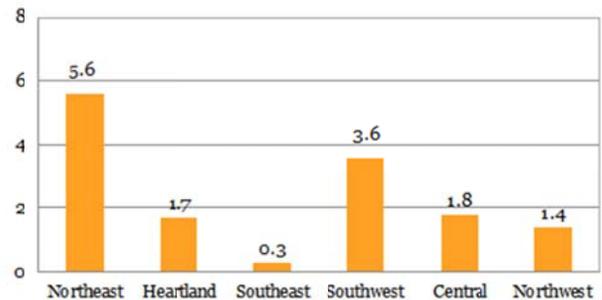


Frequencies of Seclusions (per 1000 Patient Days)

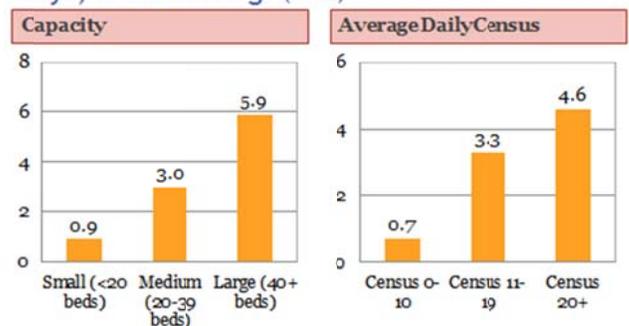


- The average number of Seclusions per 1000 patient days was 3.0 in January, decreased in February, increased in March and April, and then decreased slightly through June.
- The six OhioMHAS hospitals reported an average of 0.8 Seclusions per 1000 patient days; the average fluctuated across months, ranging from a low of 0.5 in June to highs of 1.0 in February and April.
- By Geographical Area:
  - Hospitals in the Northeast region reported the highest average frequency of Seclusion per 1000 patient days (M = 5.6).
  - Hospitals in the Southwest region reported the second highest average frequency (M = 3.6).
  - Hospitals in the Central (M = 1.8), Heartland (M = 1.7), and Northwest (M = 1.4) regions reported between one and two Seclusions per 1000 patient days.
  - Hospitals in the Southeast region reported the lowest average frequency (M = 0.3).

Frequency of Seclusion (per 1000 Patient days) 6-month Avg. by Geographic Area (N=68)



Frequency of Seclusion (per 1000 Patient days) 6-month Avg. (N=68)



- The average frequency of Seclusions per 1000 patient days increased with capacity, from a low of 0.9 for hospitals with less than 20 beds, to a high of 5.9 for hospitals with more than 40 beds.
- The average frequency of Seclusions per 1000 patient days also increased by Average Daily Census group, from a low of 0.7 for hospitals with 0-10 Census days, to a high of 4.6 for hospitals with 20 or more Census days.

Table 3. Frequency of Seclusions per 1000 Patient Days (Means across hospitals)

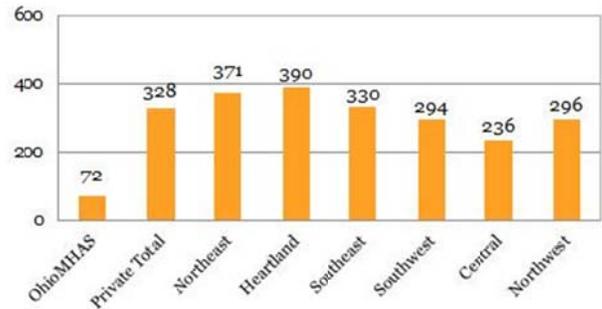
			6 months	Jan	Feb	Mar	Apr	May	Jun
Private Hospitals	Hospitals that reported Seclusions during Jan-Jun (N = 42)	<b>Mean</b>	<b>4.7</b>	<b>4.9</b>	<b>3.4</b>	<b>5.0</b>	<b>5.4</b>	<b>4.9</b>	<b>4.6</b>
		SD	5.8	6.7	4.8	9.1	10.4	8.6	6.1
	Hospitals that reported any type Seclusion/ Restraint during Jan-Jun (N = 57)	<b>Mean</b>	<b>3.4</b>	<b>3.6</b>	<b>2.5</b>	<b>3.7</b>	<b>4.0</b>	<b>3.6</b>	<b>3.4</b>
		SD	5.4	6.1	4.3	8.1	9.2	7.7	5.6
	All Hospitals (N = 68)	<b>Mean</b>	<b>2.9</b>	<b>3.0</b>	<b>2.1</b>	<b>3.1</b>	<b>3.3</b>	<b>3.0</b>	<b>2.8</b>
		SD	5.1	5.8	4.1	7.6	8.5	7.2	5.3
	OhioMHAS Hospitals (N = 6)	<b>Mean</b>	<b>0.8</b>	<b>0.9</b>	<b>1.0</b>	<b>0.6</b>	<b>1.0</b>	<b>0.8</b>	<b>0.5</b>
		SD	0.7	0.8	0.8	0.7	1.2	1.1	0.3

Duration

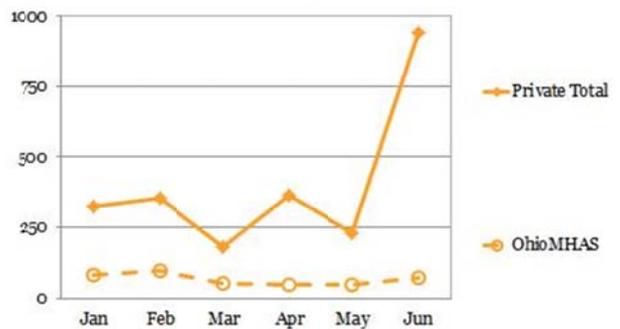
Hospitals reported on the minutes of Seclusion per month. The minimum number of minutes of Seclusion reported by a hospital across the six-month period was 13, the maximum number of minutes was 115,308, and the average number of minutes was 7,787.2.

- Average duration was computed to standardize across hospitals, using only the hospitals that reported incidents (see calculation above). The minimum average duration was 1.6 minutes, the maximum was 2,956.6 minutes, and the average duration of Seclusions was 328.3 minutes.
- The average duration of Seclusions is fairly stable January through May (183 to 366 minutes) but is much higher in June (940 minutes).
- The six OhioMHAS hospitals reported an average duration of 72.3 minutes of Seclusion; average duration remained fairly stable across the six-month period.
- By Geographical Area:
  - Hospitals in the Northeast (M = 371 minutes) and Heartland (M = 390 minutes) regions reported the highest average duration of Seclusions.
  - Hospitals in the Southeast, Southwest, and Northwest regions reported average durations in the high two-hundred and low three-hundred minutes.
  - Hospitals in the Central region reported the lowest average duration (M = 236 minutes).
- The average duration of Seclusions varies by capacity; small and large capacity hospitals reported average durations below 200 minutes while the medium capacity hospitals reported a higher average duration (M = 463 minutes).
- The average duration of Seclusions decreased by Average Daily Census group, from a high of over 500 minutes in the 0-10 Census day group, to 400 minutes for hospitals with 11-19 Census days, and 222 minutes for hospitals with 20 or more Census days.

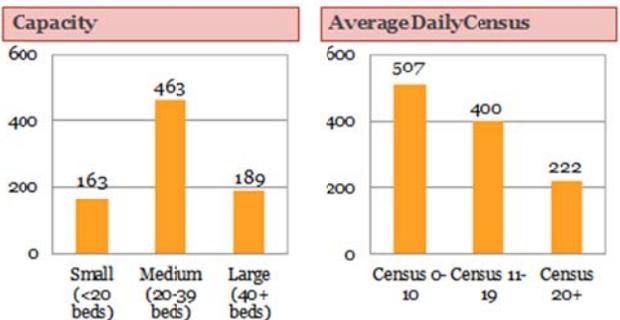
Duration of Seclusion (Minutes) 6-month Avg. by Geographical Area



Duration of Seclusions (Minutes)



Duration of Seclusion (Minutes) 6-month Avg.



**Table 4. Average Minutes of Duration of Seclusion (Means across hospitals)**

		6 months	Jan	Feb	Mar	Apr	May	Jun
Private Hospitals Seclusions for all Hospitals	<b>Mean</b>	<b>328.3</b>	<b>324.5</b>	<b>356.2</b>	<b>183.0</b>	<b>366.2</b>	<b>232.6</b>	<b>940.5</b>
	SD	541.6	439.5	631.9	144.8	441.8	396.5	3,122.0
	N	42	30	24	29	20	27	29
OhioMHAS Hospitals	<b>Mean</b>	<b>72.3</b>	<b>83.7</b>	<b>99.2</b>	<b>52.7</b>	<b>48.6</b>	<b>48.2</b>	<b>71.1</b>
	SD	36.2	27.8	79.9	52.5	30.1	30.3	43.2
	N	6	5	6	4	5	4	6

\*The formula for computing duration only includes reported Seclusions for that period; therefore the N changes based on the number reported each month.

**Table 5. Average (Mean) Seclusion Frequency and Duration (combined January through June 2012).**

		Frequency per 1000 patient days (N = 68)		Average Duration (mins) (N varies)	
		N	Mean	N	Mean
By Geographic al Area	Northeast	18	<b>5.6</b>	14	<b>370.7</b>
	Heartland	8	<b>1.7</b>	5	<b>390.4</b>
	Southeast	7	<b>0.3</b>	1	<b>330.0</b>
	Southwest	13	<b>3.6</b>	11	<b>294.5</b>
	Central	8	<b>1.8</b>	3	<b>236.4</b>
	Northwest	14	<b>1.4</b>	8	<b>296.0</b>
Capacity	Small (<20 beds)	27	<b>0.9</b>	7	<b>163.2</b>
	Medium (20-39 beds)	25	<b>3.0</b>	15	<b>463.1</b>
	Large (40+ beds)	16	<b>5.9</b>	13	<b>189.0</b>
Average Daily Census	0-10 per day	22	<b>0.7</b>	5	<b>507.3</b>
	11-19 per day	23	<b>3.3</b>	17	<b>399.6</b>
	20+ per day	23	<b>4.6</b>	20	<b>223.0</b>

### ***Physical Restraints***

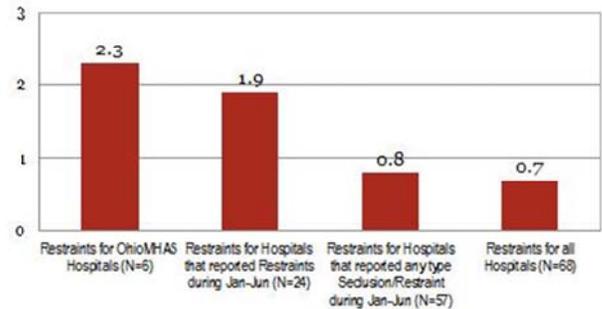
Table 6 reports the frequency of Physical Restraints, Table 7 reports the average duration of Physical Restraints, and Table 8 reports the frequency and duration of Physical Restraints by Geographical Area, by Capacity, and by Average Daily Census.

#### ***Frequency***

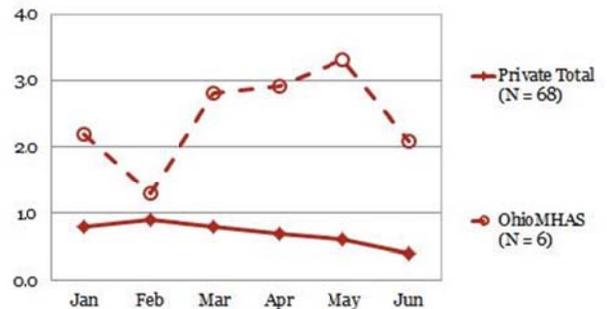
Over one-third of hospitals (N = 24; 35.3%) reported using Physical Restraints this six-month period; almost two-thirds of hospitals (N= 44; 64.7%) did not use Physical Restraints this six-month period. Of the 24 hospitals that did report Physical Restraints, the minimum number reported by a hospital was 1, the maximum number reported was 53, and the average total number reported was 9.0.

- When standardizing across hospitals by patient days, the minimum was 0.2, the maximum was 6.1, and the average number of Physical Restraints per 1000 patient days was 1.9.
- The average number of Physical Restraints per 1000 patient days decreases to 0.8 for hospitals that reported any type of Seclusion or Restraint (N = 57) this six-months.
- The average number of Physical Restraints per 1000 patient days decreases to 0.7 for all hospitals (N = 68).
- The average number of Physical Restraints per 1000 patient days was less than 1.0 across all six months, January through June.
- The six OhioMHAS hospitals reported an average of 2.3 Physical Restraints per 1000 patient days; the average was fairly stable across months, ranging from a low of 1.3 in February to a high of 3.3 in May.
- By Geographical Area: hospitals in the Central (M = 1.3) and Southwest (M = 1.1) regions reported the highest average frequency of Physical Restraints per 1000 patient days; hospitals in the Heartland, Southeast, and Northwest regions reported the lowest average frequencies (Means ranged from 0.2 to 0.3).
- The average frequency of Physical Restraints per 1000 patient days was low across all groups but increased slightly with capacity, from 0.5 for hospitals with less than 20 beds, to 1.1 for hospitals with more than 40 beds.
- The average frequency of Physical Restraints per 1000 patient days was low across all groups, for the Average Daily Census group with 0-10 Census days (M = 0.2); frequencies for hospitals in the Census group with 11-19 days (M = 0.9), and 20 plus days (M = 0.8) were fairly similar.

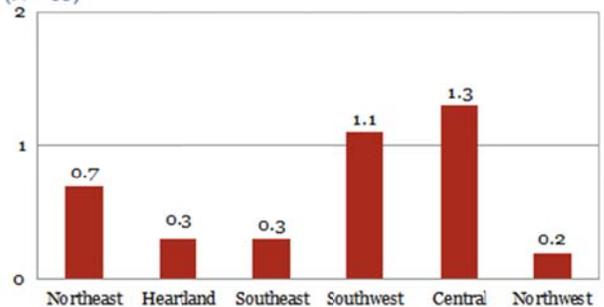
Frequency of Physical Restraint (per 1000 Patient days) 6-month Avg.



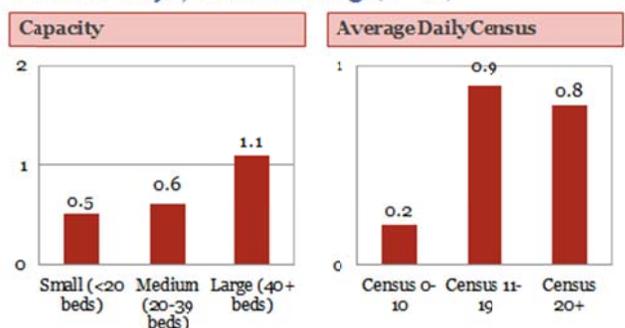
Frequencies of Physical Restraints (per 1000 Patient Days)



Frequency of Physical Restraints (per 1000 Patient days) 6-month Avg. by Geographical Area (N = 68)



Frequency of Physical Restraints (per 1000 Patient days) 6-month Avg. (N = 68)



**Table 6.** Frequency of Physical Restraints per 1000 Patient Days (Means across hospitals)

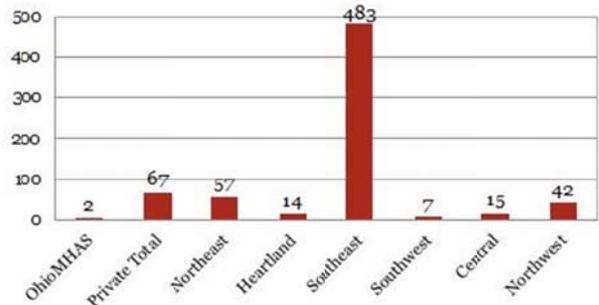
			6 months	Jan	Feb	Mar	Apr	May	Jun	
Private Hospitals	Hospitals that reported Seclusions during Jan-Jun (N = 24)	<b>Mean</b>	<b>1.9</b>	<b>2.2</b>	<b>2.5</b>	<b>2.2</b>	<b>2.0</b>	<b>1.6</b>	<b>1.0</b>	
		SD	1.8	3.3	3.8	2.8	4.3	2.3	1.8	
	Hospitals that reported any type Seclusion/ Restraint during Jan-Jun (N = 57)	<b>Mean</b>	<b>0.8</b>	<b>0.9</b>	<b>1.0</b>	<b>0.9</b>	<b>0.8</b>	<b>0.7</b>	<b>0.4</b>	
		SD	1.5	2.4	2.7	2.1	2.9	1.6	1.2	
	All Hospitals (N = 68)	<b>Mean</b>	<b>0.7</b>	<b>0.8</b>	<b>0.9</b>	<b>0.8</b>	<b>0.7</b>	<b>0.6</b>	<b>0.4</b>	
		SD	1.4	2.2	2.5	1.9	2.7	1.5	1.1	
OhioMHAS Hospitals (N = 6)			<b>Mean</b>	<b>2.3</b>	<b>1.8</b>	<b>1.3</b>	<b>2.4</b>	<b>2.9</b>	<b>3.3</b>	<b>2.1</b>
			SD	1.5	1.4	1.2	1.8	2.5	2.1	1.2

Duration

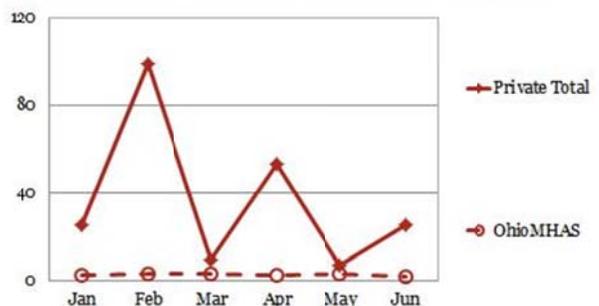
Hospitals reported on the minutes of Physical Restraint per month. The minimum number of minutes of Physical Restraint reported by a hospital across the six-month period was 2, the maximum number of minutes was 4,635, and the average number of minutes was 339.0.

- Average duration was computed to standardize across hospitals, using only the hospitals that reported incidents (see calculation above). The minimum average duration was 0.6 minutes, the maximum was 960.0 minutes, and the average duration of Physical Restraints was 67.0 minutes.
- The average duration of Physical Restraints varied across months; low months were January (M = 25.5), March (M = 9.5), May (M = 6.7), and June (M = 24.6), with February and April averages above 50 minutes.
- The six OhioMHAS hospitals reported an average duration of 2.4 minutes of Physical Restraints; average duration remained fairly stable across the six-month period.
- By Geographical Area:
  - For Northeast, Heartland, Southwest, Central, and Northwest regions, hospitals reported fairly similar average duration of Physical Restraints (ranging from 7 minutes to 57 minutes).
  - Hospitals in the Southeast region had a higher average duration (M = 483 minutes).

Duration of Physical Restraints (Minutes) 6-month Avg. by Geographical Area

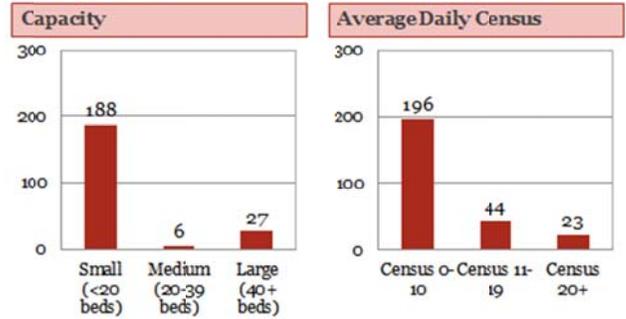


Durations of Physical Restraints (Minutes)



- Small capacity hospitals reported a higher average duration (M = 188 minutes) of Physical Restraints than medium capacity or high capacity hospitals (Means were below 30 minutes).
- Similarly, hospitals with smaller Average Daily Census (Census 0-10) had a higher average duration (M = 196 minutes) of Physical Restraints than hospitals with Census 11-19 and Census 20 or above (Means were below 50 minutes).

### Duration of Physical Restraints (Minutes) 6-month Avg.



**Table 7.** Average Minutes of Duration of Physical Restraints (Means across hospitals)

		6 months	Jan	Feb	Mar	Apr	May	Jun
All Private Hospitals	<b>Mean</b>	<b>67.0</b>	<b>25.5</b>	<b>99.1</b>	<b>9.4</b>	<b>53.0</b>	<b>6.7</b>	<b>15.6</b>
	SD	202.9	67.2	256.3	12.1	151.6	8.0	31.2
	N	24	12	14	13	10	11	9
OhioMHAS Hospitals	<b>Mean</b>	<b>2.4</b>	<b>2.2</b>	<b>2.8</b>	<b>2.9</b>	<b>2.5</b>	<b>2.8</b>	<b>1.9</b>
	SD	0.8	0.5	1.2	1.6	1.5	2.6	0.6
	N	6	5	6	5	6	6	6

\*The formula for computing duration only includes reported Physical Restraints for that period; therefore the N changes based on the number reported each month.

**Table 8.** Average (Mean) Physical Restraints Frequency and Duration (combined January through June 2012).

		Frequency per 1000 patient days (N = 68)		Average Duration (mins) (N varies)	
		N	Mean	N	Mean
By Geographical Area	Northeast	18	<b>0.7</b>	6	<b>57.5</b>
	Heartland	8	<b>0.4</b>	3	<b>14.4</b>
	Southeast	7	<b>0.3</b>	2	<b>483.3</b>
	Southwest	13	<b>1.1</b>	6	<b>7.0</b>
	Central	8	<b>1.3</b>	3	<b>15.0</b>
	Northwest	14	<b>0.2</b>	4	<b>41.8</b>
Capacity	Small (<20 beds)	27	<b>0.5</b>	7	<b>188.7</b>
	Medium (20-39 beds)	25	<b>0.6</b>	8	<b>5.7</b>
	Large (40+ beds)	16	<b>1.1</b>	9	<b>26.9</b>
Average Daily Census	0-10 per day	22	<b>0.2</b>	5	<b>196.0</b>
	11-19 per day	23	<b>0.9</b>	9	<b>44.1</b>
	20+ per day	23	<b>0.9</b>	10	<b>23.2</b>

## Mechanical Restraints

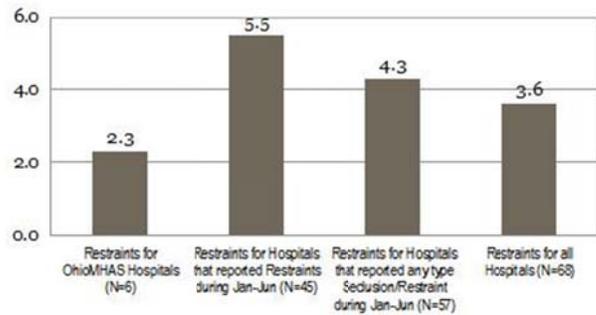
Table 9 reports the frequency of Mechanical Restraints, Table 10 reports the average duration of Mechanical Restraints, and Table 11 reports the frequency and duration of Mechanical Restraints by Geographical Area, by Capacity, and by Average Daily Census.

### Frequency

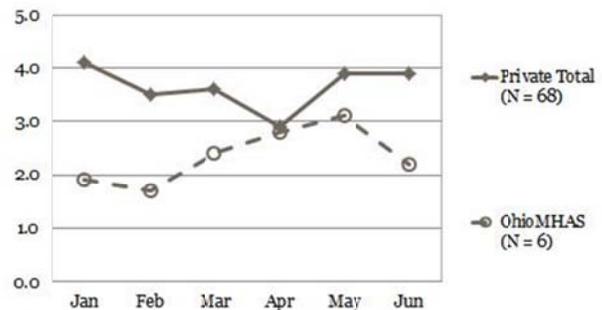
Almost two-thirds of hospitals (N = 45; 66.2%) reported using Mechanical Restraints this six-month period; about one-third of hospitals (N= 23; 33.8%) did not use Mechanical Restraints this six-month period. Of the 45 hospitals that did report Mechanical Restraints, the minimum number reported by a hospital was 1, the maximum number reported was 640, and the average total number reported was 28.6.

- When standardizing across hospitals by patient days, the minimum was 0.2, the maximum was 97.0, and the average number of Mechanical Restraints per 1000 patient days was 5.5.
- The average number of Mechanical Restraints per 1000 patient days decreases to 4.3 for hospitals that reported any type of Seclusion or Restraint (N = 57) this six-months.
- The average number of Mechanical Restraints per 1000 patient days decreases to 3.6 for all hospitals (N = 68).
- The average number of Mechanical Restraints per 1000 patient days was fairly stable across all six months, ranging from a low of 2.9 in April to a high of 4.1 in January.
- The six OhioMHAS hospitals reported an average of 2.3 Mechanical Restraints per 1000 patient days; the average was fairly stable across months, ranging from a low of 1.7 in February to a high of 2.7 in April.

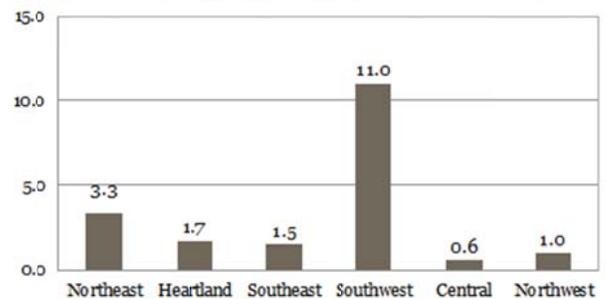
Frequency of Mechanical Restraint (per 1000 Patient days) 6-month Avg.



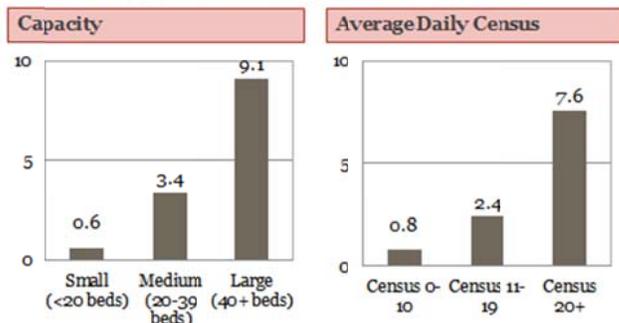
Frequencies of Mechanical Restraints (per 1000 Patient Days)



Frequency of Mechanical Restraints (per 1000 Patient days) 6-month Avg. by Geographical Area (N=68)



Frequency of Mechanical Restraints (per 1000 Patient days) 6-month Avg. (N=68)



- By Geographical Area: hospitals in the Southwest region reported the highest average frequency of Mechanical Restraint per 1000 patient days (M = 11.0); hospitals in the Heartland, Southeast, Central, and Northwest regions reported fairly similar average frequencies of Mechanical Restraint (Means ranged from 0.6 to 1.7).
- The average frequency of Mechanical Restraints per 1000 patient days increased with capacity, from a low of 0.6 for hospitals with less than 20 beds, to a high of 9.1 for hospitals with more than 40 beds.
- The average frequency of Mechanical Restraints per 1000 patient days was low for the Average Daily Census group with 0-10 Census days (M = 0.8), increased for hospitals in the Census group with 11-19 days (M = 2.4) and for hospitals in the 20 plus days (M = 7.6).

**Table 9.** Frequency of Mechanical Restraints per 1000 Patient Days (Means across hospitals)

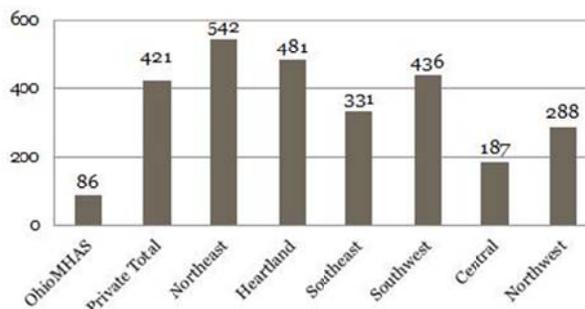
			6 months	Jan	Feb	Mar	Apr	May	Jun
Private Hospitals	Hospitals that reported Mechanical Restraints during Jan-Jun (N = 45)	<b>Mean</b>	<b>5.5</b>	<b>6.2</b>	<b>5.4</b>	<b>5.3</b>	<b>4.4</b>	<b>5.8</b>	<b>5.9</b>
		SD	14.5	14.2	15.8	14.6	13.8	16.2	16.8
	Hospitals that reported any type Seclusion/ Restraint during Jan-Jun (N = 57)	<b>Mean</b>	<b>4.3</b>	<b>4.9</b>	<b>4.2</b>	<b>4.2</b>	<b>3.5</b>	<b>4.6</b>	<b>4.7</b>
		SD	13.1	12.8	14.2	13.2	12.3	14.5	15.1
	All Hospitals (N = 68)	<b>Mean</b>	<b>3.6</b>	<b>4.1</b>	<b>3.5</b>	<b>3.6</b>	<b>2.9</b>	<b>3.9</b>	<b>3.9</b>
		SD	12.1	11.9	13.1	12.2	11.4	13.4	13.9
	OhioMHAS Hospitals (N = 6)	<b>Mean</b>	<b>2.3</b>	<b>1.9</b>	<b>1.8</b>	<b>2.4</b>	<b>2.8</b>	<b>3.1</b>	<b>2.2</b>
		SD	1.0	1.0	0.8	1.7	1.8	1.7	1.2

Duration

Hospitals reported on the minutes of Mechanical Restraint per month. The minimum number of minutes of Mechanical Restraint reported by a hospital across the six-month period was 32, the maximum number of minutes was 1,506,242, and the average number of minutes was 39,143.

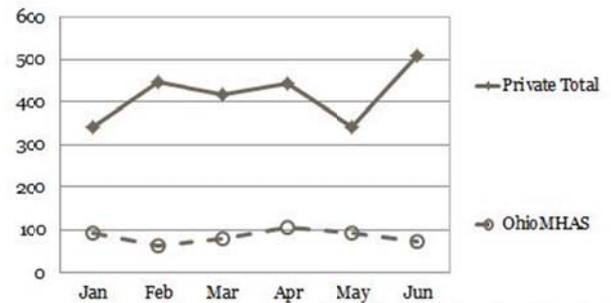
- Average duration was computed to standardize across hospitals, using only the hospitals that reported incidents (see calculation above). The minimum average duration was 32 minutes, the maximum was 3,060 minutes, and the average duration of Mechanical Restraints was 421 minutes.
- The average duration of Mechanical Restraints varied across months; low months were January (M = 342) and June (M = 343). March through May average durations ranged from 417 minutes to 448 minutes.

**Duration of Mechanical Restraints (Minutes)**  
6-month Avg. by Geographical Area



- The six OhioMHAS hospitals reported an average duration of 86 minutes of Mechanical Restraints; average duration remained fairly stable across the six-month period ranging from 65 minutes to 105 minutes.
- By Geographical Area:
  - Hospitals in the Central region reported the lowest duration of Mechanical Restraints (M = 187 minutes). Hospitals in the Northwest and Southeast regions reported durations between 250 and 350 minutes.
  - Hospitals in the Heartland and Southwest regions reported durations between 400 and 500 minutes. Hospitals in the Northeast region reported the highest duration of Mechanical Restraints (M = 542 minutes).
- Small capacity hospitals reported lower average duration (M = 317 minutes) of Mechanical Restraints; medium and or high capacity hospitals reported average durations between 450 and 500 minutes.
- Hospitals with smaller Average Daily Census (Census 0-10) and hospitals with Census 11-19 had a similar average duration (M = 374 and 378 minutes) of Physical Restraints; hospitals with a Census 20 or above had a higher duration (M = 486 minutes).

Durations of Mechanical Restraints (Minutes)



Duration of Mechanical Restraints (Minutes) 6-month Avg.

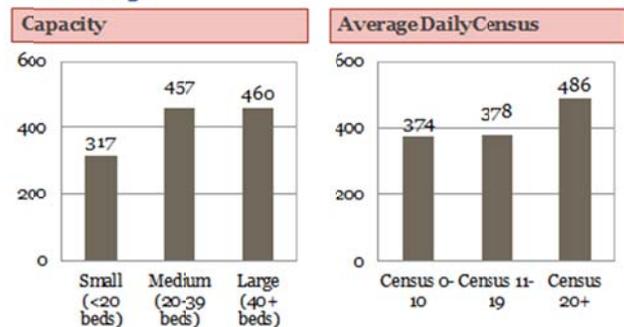


Table 10. Average Minutes of Duration of Mechanical Restraints (Means across hospitals)

		6 months	Jan	Feb	Mar	Apr	May	Jun
All Private Hospitals	<b>Mean</b>	<b>420.9</b>	<b>342.0</b>	<b>447.7</b>	<b>416.8</b>	<b>442.4</b>	<b>342.9</b>	<b>509.6</b>
	SD	606.3	527.1	695.3	505.9	535.7	471.0	957.1
	N	45	28	27	29	21	25	22
OhioMHAS Hospitals	<b>Mean</b>	<b>85.9</b>	<b>93.6</b>	<b>64.6</b>	<b>81.0</b>	<b>105.4</b>	<b>37.1</b>	<b>72.6</b>
	SD	18.3	73.5	13.1	10.2	38.8	23.4	28.5
	N	6	6	6	6	6	6	6

\*The formula for computing duration only includes reported Mechanical Restraints for that period; therefore the N changes based on the number reported each month.

**Table 11.** Average (Mean) Physical Restraints Frequency and Duration (combined January through June 2012).

		Frequency per 1000 patient days (N = 68)		Average Duration (mins) (N varies)	
		N	Mean	N	Mean
By Geographic al Area	Northeast	18	<b>3.3</b>	15	<b>542.2</b>
	Heartland	8	<b>1.7</b>	6	<b>481.2</b>
	Southeast	7	<b>1.5</b>	4	<b>331.2</b>
	Southwest	13	<b>11.0</b>	9	<b>436.6</b>
	Central	8	<b>0.6</b>	5	<b>187.4</b>
	Northwest	14	<b>1.0</b>	6	<b>288.5</b>
Capacity	Small (<20 beds)	27	<b>0.6</b>	12	<b>317.2</b>
	Medium (20-39 beds)	25	<b>3.4</b>	21	<b>457.7</b>
	Large (40+ beds)	16	<b>9.1</b>	12	<b>460.5</b>
Average Daily Census	0-10 per day	22	<b>0.8</b>	9	<b>374.6</b>
	11-19 per day	23	<b>2.4</b>	18	<b>378.5</b>
	20+ per day	23	<b>7.6</b>	18	<b>486.5</b>

## Inpatient Psychiatric Hospitals Serving Children and Adolescents

### ***Patient Days***

Patient days summarize hospital service utilization. Table 12 below reports the monthly average, and six-month total, patient days for the OhioMHAS hospitals and the inpatient psychiatric service providers serving adults. On average, private inpatient hospitals serving children and adolescents reported 439.8 patient days.

**Table 12. Total number of patient days per month**

		6 month Total	Jan	Feb	Mar	Apr	May	Jun
	<b>Mean</b>	<b>2,639.0</b>	<b>447.1</b>	<b>463.6</b>	<b>507.9</b>	<b>439.1</b>	<b>466.9</b>	<b>314.4</b>
Inpatient Psychiatric Service Providers (Child/Youth-serving)	SD	2,812.1	499.2	475.5	520.8	483.1	497.4	351.3
	Min	39	3	12	19	5	102	87
	Max	11,159	1,999	1,842	1,968	1,915	1,985	1,450
	N	16	16	16	16	16	15	15

### ***Capacity***

Private psychiatric units ‘hospitals’ licenses are renewed annually and full licensure renewal requires an on-site survey every three years. The minimum number of children/youth licensed beds by a hospital was 8, and the maximum number of licensed beds by a hospital was 85. The average number of licensed beds was 24.3 (sd = 20.3). Because of the small number of hospitals serving children and youth, capacity groups were not created.

### ***Occupancy***

Occupancy was calculated for each hospital. The formula used to calculate occupancy was:

$$\text{Occupancy} = \frac{\text{Total \# of Patient Days}}{\text{\# of licensed beds} * 182 \text{ (days in the 6-month period)}}$$

The minimum occupancy for hospitals serving children and youth was 2.7%, and the maximum occupancy was 78.7%. The average occupancy was 54.1% (sd = 19.4%). Because of the small number of hospitals serving children and youth, occupancy groups were not created.

### ***Average Daily Census***

The Average Daily Census (ADC) was calculated for each hospital. The formula used to calculate ADC was:

$$\text{ADC} = \frac{\text{Total \# of Patient Days}}{182 \text{ (days in the 6-month period)}}$$

The minimum ADC for hospitals serving children and youth was 0.2, and the maximum ADC was 61.3. The average ADC was 14.5 (sd = 15.4). Because of the small number of hospitals serving children and youth, census groups were not created.

## ***Utilization of Seclusion or Restraint***

The data reporting form does not ask about hospital policy allowing or prohibiting the use of Seclusion or Restraint. All of the child and youth-serving hospitals reported using some type of Seclusion or Restraint January through June 2012. In an effort to better understand the data, OhioMHAS has calculated the data two ways:

- Hospitals reported using Seclusion/Restraint (N = 12 for Seclusion, N = 10 for Physical Restraint, and N = 11 for Mechanical Restraint)
- All hospitals (N = 16)
- Because the denominator is higher for all hospitals, the average frequency scores are lower for all hospitals than just for the hospitals that reported Seclusions and Restraints.

Additionally, while the private hospitals wanted to see how their Seclusions and Restraints compared with the public hospitals and Seclusions and Restraints for the six public Regional Psychiatric Hospitals were included above, OhioMHAS does not have any public hospitals serving children and youth.

Table 13 reports the frequency of Seclusions and Restraints, and Table 14 reports the average duration of Seclusions and Restraints.

## ***Seclusions***

### *Frequency*

Three-quarters of hospitals serving children and youth (N = 12; 75.0%) reported using Seclusions this six-month period; one-quarter of hospitals (N= 4; 25.0%) did not use Seclusion this six-month period. Of the 12 hospitals that did report Seclusions, the minimum number reported by a hospital was 2, the maximum number reported was 237, and the average total number reported was 48.5.

- When standardizing across hospitals by patient days, the minimum was 1.6, the maximum was 44.0, and the average number of Seclusions per 1000 patient days was 13.5.
- The average number of Seclusions per 1000 patient days decreases to 10.1 for all hospitals serving children and youth (N = 16).
- The average number of Seclusions per 1000 patient days varied slightly over the six months, with a slight downward trend. The months with the highest number of Seclusions per 1000 patient days were March (M = 12.8) and January (M = 12.6); the months with the lowest number of Seclusions were April (M = 7.4) and June (M = 7.4).

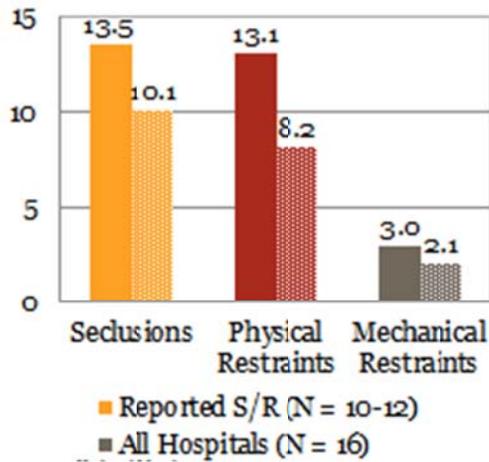
### *Duration*

Hospitals reported on the minutes of Seclusion per month. The minimum number of minutes of Seclusion reported by a hospital across the six-month period was 82, the maximum number of minutes was 8,491, and the average number of minutes was 1,689.6.

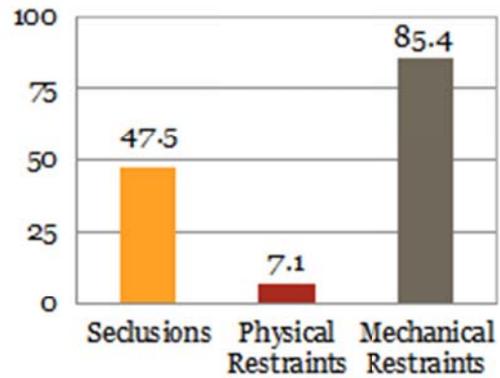
- Average duration was computed to standardize across hospitals, using only the hospitals that reported incidents (see calculation above). The minimum average duration was 16.4 minutes, the maximum was 128.8 minutes, and the average duration of Seclusions was 47.5 minutes.
- The average duration of Seclusions is between 30 and 40 minutes but peaks higher in March (M = 68.8 minutes) and June (M = 53.7 minutes).

## Seclusion and Restraint

Average Number (per 1000 Patient Days)

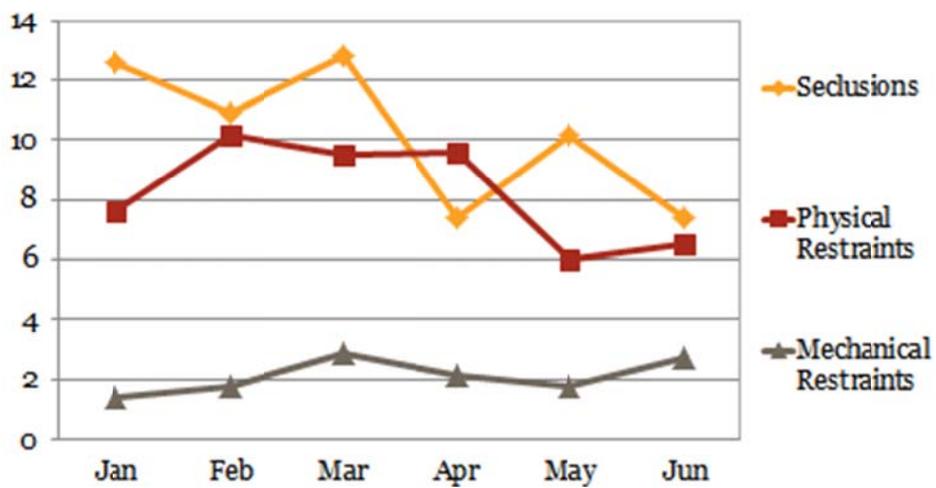


Average Duration (Minutes)



12

## Frequencies of Seclusions and Restraints (per 1000 Patient Days) for All Hospitals (N = 16)



**Table 13. Frequency of Seclusions and Restraints per 1000 Patient Days (Means across hospitals)**

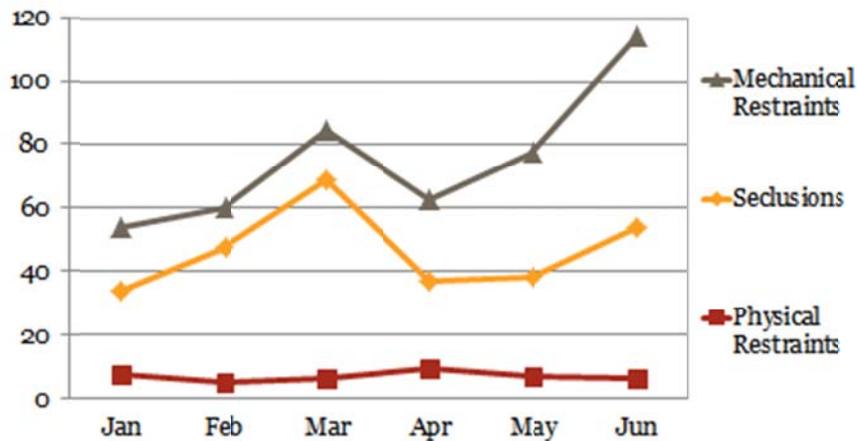
			6 months	Jan	Feb	Mar	Apr	May	Jun
Seclusions	Hospitals that reported Seclusions (N = 12)	<b>Mean</b>	<b>13.5</b>	<b>16.8</b>	<b>14.5</b>	<b>17.1</b>	<b>9.9</b>	<b>12.7</b>	<b>9.2</b>
		SD	12.3	18.9	23.9	16.4	9.8	10.8	12.5
	All Hospitals (N = 16)	<b>Mean</b>	<b>10.1</b>	<b>12.6</b>	<b>10.9</b>	<b>12.8</b>	<b>7.4</b>	<b>10.2</b>	<b>7.4</b>
		SD	12.2	17.9	21.5	16.0	9.4	11.0	11.7
Physical Restraints	Hospitals that reported Physical Restraints (N = 10)	<b>Mean</b>	<b>13.1</b>	<b>12.2</b>	<b>16.3</b>	<b>15.3</b>	<b>15.4</b>	<b>9.0</b>	<b>9.7</b>
		SD	9.9	11.0	12.6	11.0	13.2	11.0	15.8
	All Hospitals (N = 16)	<b>Mean</b>	<b>8.2</b>	<b>7.6</b>	<b>10.2</b>	<b>9.5</b>	<b>9.6</b>	<b>6.0</b>	<b>6.5</b>
		SD	10.1	10.5	12.7	11.4	12.8	9.8	13.5
Mechanical Restraints	Hospitals that reported Mechanical Restraints (N = 11)	<b>Mean</b>	<b>3.0</b>	<b>2.0</b>	<b>2.6</b>	<b>4.3</b>	<b>3.1</b>	<b>2.5</b>	<b>3.7</b>
		SD	2.1	2.9	2.5	4.2	3.6	3.0	4.6
	All Hospitals (N = 16)	<b>Mean</b>	<b>2.1</b>	<b>1.4</b>	<b>1.8</b>	<b>2.9</b>	<b>2.1</b>	<b>1.8</b>	<b>2.7</b>
		SD	2.3	2.6	2.4	4.0	3.3	2.8	4.2

**Table 14. Average Minutes of Duration of Seclusion and Restraint (Means across hospitals)**

		6 months	Jan	Feb	Mar	Apr	May	Jun
Seclusions	<b>Mean</b>	<b>47.5</b>	<b>33.7</b>	<b>47.6</b>	<b>68.8</b>	<b>37.0</b>	<b>38.1</b>	<b>53.7</b>
	SD	29.3	16.9	34.2	65.2	27.2	20.2	34.5
	N	12	10	10	10	10	11	7
Physical Restraints	<b>Mean</b>	<b>7.0</b>	<b>7.5</b>	<b>5.0</b>	<b>6.5</b>	<b>9.3</b>	<b>7.1</b>	<b>6.3</b>
	SD	4.4	5.9	2.4	3.6	4.9	5.7	3.2
	N	10	8	8	8	8	6	6
Mechanical Restraints	<b>Mean</b>	<b>85.4</b>	<b>53.7</b>	<b>60.4</b>	<b>84.4</b>	<b>62.5</b>	<b>77.5</b>	<b>114.2</b>
	SD	57.7	20.7	21.0	67.4	48.8	51.9	128.6
	N	11	5	8	9	7	6	5

\*The formula for computing duration only includes reported Seclusions for that period; therefore the N changes based on the number reported each month.

## Duration of Seclusions and Restraints (Minutes) (N varies based on number of S/R reported each month)



### ***Physical Restraints***

#### Frequency

Three-quarters of hospitals serving children and youth (N = 10; 62.5%) reported using Physical Restraints this six-month period; one-quarter of hospitals (N= 6; 37.5%) did not use Seclusion this six-month period. Of the 10 hospitals that did report Physical Restraints, the minimum number reported by a hospital was 2, the maximum number reported was 357, and the average total number reported was 70.1.

- When standardizing across hospitals by patient days, the minimum was 1.4, the maximum was 32.0, and the average number of Physical Restraints per 1000 patient days was 13.1.
- The average number of Physical Restraints per 1000 patient days decreases to 8.2 for all hospitals serving children and youth (N = 16).
- The average number of Physical Restraints per 1000 patient days varied slightly over the six months. February (M = 10.2), March (M = 9.5), and April (M = 9.6) had higher numbers of Physical Restraints per 1000 patient days; May (M = 6.0) and June (M = 6.5) were the lowest.

#### Duration

Hospitals reported on the minutes of Physical Restraints per month. The minimum number of minutes of Physical Restraints reported by a hospital across the six-month period was 6, the maximum number of minutes was 2,125, and the average number of minutes was 310.8.

- Average duration was computed to standardize across hospitals, using only the hospitals that reported incidents (see calculation above). The minimum average duration was 2.0 minutes, the maximum was 15.8 minutes, and the average duration of Physical Restraints was 7.0 minutes.
- The average duration of Physical Restraints remained fairly stable (ranging from a low of 5.0 minutes in February to a high of 9.3 minutes in April).

## ***Mechanical Restraints***

### Frequency

More than two-thirds of hospitals serving children and youth (N = 11; 68.8%) reported using Mechanical Restraints this six-month period; less than one-third of hospitals (N= 5; 31.3%) did not use Mechanical Restraints this six-month period. Of the 11 hospitals that did report Mechanical Restraints, the minimum number reported by a hospital was 2, the maximum number reported was 34, and the average total number reported was 8.1.

- When standardizing across hospitals by patient days, the minimum was 1.0, the maximum was 8.2, and the average number of Mechanical Restraints per 1000 patient days was 3.0.
- The average number of Mechanical Restraints per 1000 patient days decreases to 2.1 for all hospitals serving children and youth (N = 16).
- The average number of Mechanical Restraints per 1000 patient days varied slightly over the six months, showing a slight increasing trend. The lowest Mechanical Restraint average was in January (M = 1.4) and the highest averages were in March (M = 2.9) and June (M = 2.7).

### Duration

Hospitals reported on the minutes of Mechanical Restraint per month. The minimum number of minutes of Mechanical Restraint reported by a hospital across the six-month period was 101, the maximum number of minutes was 2,029, and the average number of minutes was 381.4.

- Average duration was computed to standardize across hospitals, using only the hospitals that reported incidents (see calculation above). The minimum average duration was 33.7 minutes, the maximum was 236.7 minutes, and the average duration of Mechanical Restraints was 85.4 minutes.
- The average duration of Mechanical Restraints increases over the six-month period, ranging from a low in January of 53.7 minutes to a high in June of 114.2 minutes.

## **Patient Injury or Illness**

Hospitals reported on the number of patient-related injuries and illness (injury and illnesses are reported for all hospitals combined; N = 76):

- About one-third of hospitals (N = 25, 32.9%) reported injuries<sup>5</sup> to patients requiring emergency/unplanned medical treatment or hospitalization. For hospitals that reported injuries, the minimum number of injuries reported was 1, the maximum was 32, and the average for the 25 hospitals was 4.2.
- Almost two-thirds of hospitals (N = 53, 63.7%) reported illnesses/medical emergencies<sup>6</sup> requiring immediate and/or unplanned admission to a hospital medical unit. For hospitals that reported illnesses, the minimum number of illnesses reported was 1, the maximum was 43, and the average was 7.96.

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<sup>5</sup> An illness is a sudden, serious or abnormal medical condition of the body that requires immediate or unplanned admission to a hospital medical unit for treatment.

<sup>6</sup> An injury is an event requiring medical treatment that is not caused by a physical illness or medical emergency, and does not include scrapes, cuts or bruises.

## Injuries to Staff from Seclusions and Restraints

Hospitals also reported on the number of injuries to staff members related to Seclusion and Restraint (reported for all hospitals combined; N = 76):

- Almost one-quarter (N = 17, 22.4%) of hospitals reported injuries to staff requiring first aid. For hospitals that reported injuries, the minimum number of injuries reported was 1, the maximum was 39 and the average was 5.4.
- Less than one-fifth (N = 13, 17.1%) of hospitals reported injuries to staff requiring emergency/unplanned medical intervention. For hospitals that reported injuries, the minimum number of injuries reported was 1, the maximum was 7, and the average was 1.9.
- No hospitals reported injuries to staff that required hospitalization.

## Summary

- **For private hospitals serving adults:**
  - Hospitals reported using a higher number of Mechanical Restraints (M = 3.6 per 1000 Patient Days), followed by Seclusions (M = 2.9 per 1000 Patient Days), and a lower number of Physical Restraints (M = 0.7 per 1000 Patient Days).
  - The numbers of Seclusions, Physical Restraints, and Mechanical Restraints all increased by average daily census groups while the average duration of both Seclusions and Physical Restraints decreased by average daily census groups; the duration of Mechanical Restraints was similar by average daily census groups.
  - Average duration per incident was longer for Mechanical Restraints (M = 421 minutes), followed by Seclusions (M = 328 minutes), with a lower average duration for Physical Restraints (M = 67 minutes).
- **For hospitals serving children and youth:**
  - Hospitals reported using a higher number of Seclusions (M = 10.1 per 1000 Patient Days), followed by Physical Restraints (M = 8.2 per 1000 Patient Days), and a lower number of Mechanical Restraints (M = 2.1 per 1000 Patient Days).
  - Average duration per incident was longer for Mechanical Restraints (M = 85 minutes), followed by Seclusions (M = 48 minutes), with a lower average duration for Physical Restraints (M = 7 minutes).
- **Comparing hospitals serving adults to hospitals serving children and youth:**
  - Hospitals serving children and youth report more Seclusions (M = 10.1 per 1000 Patient Days) compared with hospitals serving adults (M = 2.9 per 1000 Patient Days). Hospitals serving adults report a longer average duration of Seclusion (M = 328 minutes) compared to hospitals serving children and youth (M = 47.5 minutes).
  - Hospitals serving adults report more Mechanical Restraints (M = 3.6 per 1000 Patient Days) than hospitals serving children and youth (M = 2.1 per 1000 Patient Days). Hospitals serving adults report a longer average duration of Mechanical Restraints (M = 421 minutes) than hospitals serving children and youth (M = 85.4 minutes).
  - Hospitals serving children and youth report more Physical Restraints (M = 8.2 per 1000 Patient Days) than hospitals serving adults (M = 0.7 per 1000 Patient Days). Hospitals serving adults report a longer average duration (M = 67 minutes) than hospitals serving children and youth (M = 7.1 minutes).

**Ohio Department of Mental Health and Addiction Services**  
**Seclusion and Restraint Six Month Data Report Results**  
**Community Mental Health Agency**  
**January through June 2012**

The Ohio Department of Mental Health & Addiction Services (OhioMHAS) has statutory and regulatory authority over providers of mental health services to Ohio consumers. Community Mental Health Agencies require certification by ODMH when they provide mental health services that are funded by a community mental health board; they may also voluntarily request certification. The Office of Licensure & Certification performs on-site surveys, inspections and reviews to determine compliance with the applicable administrative rules and agencies are certified every three years.

OhioMHAS requires that community mental health agencies report certain incident data every six months (Ohio Administrative Code 5122-26-13). Agencies were required to report their number and minutes of Seclusion<sup>1</sup>, Physical Restraints<sup>2</sup>, Mechanical Restraints<sup>3</sup>, number of patient injuries or illnesses, and number of injuries to staff from Seclusion and Restraint, by type of service (Crisis services, Partial Hospitalization, and Other Mental Health Services).

During this six-month reporting period ODMH had 391 certified agencies:

- 331 (84.7%) agencies prohibit all types of Seclusion and Restraint
- 60 (15.3%) agencies allow some type of Seclusion and Restraint

Comparisons. In order to compare across organizations frequencies were calculated on the number of Seclusions and Restraints per 1000 service hours, and the average duration per Seclusion and Restraint.

$$\text{Seclusion/Restraints per 1000 Service Hours} = \frac{\text{Total \# of Seclusions/Restraints}}{\text{Total \# of Service Hours}} \times 1000$$

$$\text{Avg. Duration per Seclusion/Restraint} = \frac{\text{Total mins of Seclusion/Restraint}}{\text{Total \# of Seclusions/Restraints}}$$

For example, if an organization reported 600 service hours, 15 incidents of Seclusion, and 500 total minutes of Seclusion, the Seclusions per 1000 service hours would be 25 (15/600 = 25) and the average duration would be 33.3 minutes (500/15 = 33.3).

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<sup>1</sup> Seclusion means a staff intervention that involves the involuntary confinement of a client alone in a room where the client is physically prevented from leaving.

<sup>2</sup> Physical Restraint, also known as Manual Restraint, means a staff intervention that involves any method of physically/manually restricting a client's freedom of movement, physical activity, or normal use of his or her body without the use of Mechanical Restraint devices.

<sup>3</sup> Mechanical Restraint means a staff intervention that involves any method of restricting a client's freedom of movement, physical activity, or normal use of his or her body, using an appliance or device manufactured for this purpose.

## ***Agencies providing Crisis Services***

Of the 60 agencies that allow Seclusion and Restraint 45 (75.0%) agencies were not certified to provide crisis services, and 6 (10.0%) agencies prohibit Seclusion or Restraint in their crisis services. This leaves nine agencies (15.0%) that allow Seclusion and Restraint in crisis intervention:

- 5 provide adult crisis services
- 6 agencies provide youth crisis services.

### ***Crisis Intervention Service Utilization***

Agencies that allow Seclusion and Restraint reported on the total number of Crisis Intervention clients served and the hours of Crisis Intervention provided (N=9). Table 1 displays these reports for the six-month period by adult and youth crisis services.

**Table 1.** Descriptive Statistics of the number of Crisis Intervention people served and hours

		6 month Total	Jan	Feb	Mar	Apr	May	Jun
Number of adults receiving Crisis Intervention (N=5 agencies)	<b>Mean</b>	<b>2329.4</b>	<b>399.4</b>	<b>369.2</b>	<b>398.0</b>	<b>386.6</b>	<b>405.4</b>	<b>370.8</b>
	SD	1758.7	304.4	284.1	314.8	283.5	307.7	268.0
	Min	780	127	128	126	130	137	132
	Max	5275	898	855	931	856	927	808
Total hours of adult Crisis Intervention	<b>Mean</b>	<b>11700.3</b>	<b>1777.8</b>	<b>1726.7</b>	<b>2023.9</b>	<b>1947.5</b>	<b>2128.3</b>	<b>2096.1</b>
	SD	14417.3	2009.5	2001.6	2492.6	2379.0	2760.8	2808.6
	Min	333.9	55	54	55	54	56	60
	Max	35942	5022	4989	6195	5941	6852	6943
Number of youth receiving Crisis Intervention (N=6 agencies)	<b>Mean</b>	<b>255.2</b>	<b>54.2</b>	<b>47.3</b>	<b>49.0</b>	<b>39.7</b>	<b>40.3</b>	<b>24.7</b>
	SD	253.5	48.5	51.6	56.3	44.0	48.5	28.6
	Min	27	3	0	0	0	0	0
	Max	672	115	124	141	110	116	73
Total hours of youth Crisis Intervention	<b>Mean</b>	<b>1247.0</b>	<b>799.5</b>	<b>94.7</b>	<b>103.9</b>	<b>90.3</b>	<b>101.3</b>	<b>57.3</b>
	SD	1632.4	1750.1	110.1	126.1	106.4	129.4	70.8
	Min	40.2	6	0	0	0	0	0
	Max	4368	4368	255	310	231	272	151

Of the nine that allow Seclusion or Restraint in crisis services, five agencies did not use Seclusion or Restraint in crisis between January and June; four agencies did use Seclusion or Restraint in crisis during this period. Because of the small number of agencies that reported use monthly statistics are not included, statistics are reported for the six-month total (see Table 2 for frequency and Table 3 for duration).

### ***Seclusions***

The total number of Seclusions reported for adults in Crisis Services was 6. One agency serving adults reported Seclusions; when standardizing by utilization the average number of Seclusions per 1000 crisis utilization hours was 2.5. The average duration of Seclusions for adults in crisis was 92.5 minutes.

The total number of Seclusions reported for youth in Crisis Services was 9. One agency serving youth reported Seclusions; when standardizing by utilization the average number of Seclusions per 1000 crisis utilization hours was 20.1, higher for youth than adults. The average duration of Seclusions for youth in crisis was 40.3 minutes, lower for youth than adults.

Physical Restraints

The total number of Physical Restraints reported for adults in Crisis Services was 74. Two agencies serving adults reported utilizing Physical Restraints in crisis services; when standardizing by utilization the average number of Physical Restraints per 1000 crisis utilization hours was 12.1. The average duration of Physical Restraints for adults in crisis was 2.2 minutes.

The total number of Physical Restraints reported for youth in Crisis Services was 3. Two agencies serving youth reported Physical Restraints in crisis services; when standardizing by utilization the average number of Seclusions per 1000 crisis utilization hours was 2.6, lower for youth than adults. The average duration of Seclusions for youth in crisis was 18.3 minutes, higher for youth than adults.

Mechanical Restraints

The total number of Mechanical Restraints reported for adults in Crisis Services was 142. Four agencies serving adults reported Mechanical Restraints in crisis services; when standardizing by utilization the average number of Mechanical Restraints per 1000 crisis utilization hours was 15.1. The average duration of Mechanical Restraints for adults in crisis was 108.5 minutes. The average duration of Mechanical Restraints reported in crisis was higher than the duration of Seclusions and Physical Restraints. Mechanical Restraints are not allowed to be used on youth clients.

**Table 2. Frequency of Seclusions and Restraints (Means across all six months across agencies)**

	N of agencies	per 1000 Crisis Utilization Hrs				Total N of Seclusions/ Restraints
		Mean	SD	Min	Max	
Agencies that reported Seclusions (Adults)	<b>1</b>	<b>2.5</b>	n/a			<b>6</b>
Agencies that reported Seclusions (Youth)	<b>1</b>	<b>20.1</b>	n/a			<b>9</b>
Agencies that reported Physical Restraints (Adults)	<b>2</b>	<b>12.1</b>	1.8	10.8	13.4	<b>74</b>
Agencies that reported Physical Restraints (Youth)	<b>2</b>	<b>2.6</b>	0.5	2.2	3.0	<b>3</b>
Agencies that reported Mechanical Restraints (Adults)	<b>4</b>	<b>15.1</b>	12.8	5.4	33.8	<b>142</b>

**Table 3. Average Minutes of Duration of Seclusion and Restraint in Crisis Utilization (Means across agencies)**

	N	Mean	SD	Min	Max
Agencies that reported Seclusions (Adults)	<b>1</b>	<b>92.5</b>	n/a		
Agencies that reported Seclusions (Youth)	<b>1</b>	<b>40.3</b>	n/a		
Agencies that reported Physical Restraints (Adults)	<b>2</b>	<b>2.2</b>	1.2	1.3	3.0
Agencies that reported Physical Restraints (Youth)	<b>2</b>	<b>18.3</b>	9.5	11.5	25.0
Agencies that reported Mechanical Restraints (Adults)	<b>4</b>	<b>108.5</b>	99.2	1.5	240.0

## ***Agencies providing Partial Hospitalization***

Of the 60 agencies that allow Seclusion and Restraint 29 (48.3%) agencies were not certified to provide partial hospitalization, and 1 (1.7%) agency prohibits Seclusion or Restraint in their partial hospitalization. This leaves 30 agencies allow Seclusion and Restraint in partial hospitalization:

- 10 agencies provide adult partial hospitalization
- 20 agencies provide youth partial hospitalization.

### ***Partial Hospitalization Service Utilization***

Agencies that allow Seclusion and Restraint reported on the total number of Partial Hospitalization clients served and the hours of Partial Hospitalization provided. Table 4 displays these reports for the six-month period.

**Table 4.** Descriptive Statistics of the number of Partial Hospitalization people served and hours

		6 month Total	Jan	Feb	Mar	Apr	May	Jun
Number of adults receiving Partial Hospitalization (N=10 agencies)	<b>Mean</b>	<b>258.5</b>	<b>45.9</b>	<b>42.9</b>	<b>44.1</b>	<b>43.3</b>	<b>43.7</b>	<b>38.6</b>
	SD	292.4	49.2	50.7	48.4	52.7	53.7	39.4
	Min	17	9	0	0	0	0	0
	Max	989	169	171	163	178	180	128
Total hours of adult Partial Hospitalization	<b>Mean</b>	<b>7,837.9</b>	<b>1,352.2</b>	<b>1,260.5</b>	<b>1,347.2</b>	<b>1,300.0</b>	<b>1,319.6</b>	<b>1,258.4</b>
	SD	12,856.9	1924.9	2127.4	2369.3	2241.8	2258.5	1990.0
	Min	127	21	0	0	0	0	0
	Max	41,552	6339	6733	7531	7247	7330	6372
Number of youth receiving Partial Hospitalization (N=20 agencies)	<b>Mean</b>	<b>541.2</b>	<b>88.9</b>	<b>88.6</b>	<b>91.7</b>	<b>81.1</b>	<b>91.0</b>	<b>100.0</b>
	SD	673.7	114.3	114.3	114.6	112.2	115.5	113.6
	Min	82	15	8	8	9	7	9
	Max	3110	525	526	525	520	526	488
Total hours of youth Partial Hospitalization	<b>Mean</b>	<b>18,673.2</b>	<b>2,964.4</b>	<b>3,348.0</b>	<b>3,283.4</b>	<b>2,820.1</b>	<b>3,459.0</b>	<b>2,798.3</b>
	SD	24,208.0	3,908.9	4,409.6	4,477.8	3,390.5	4,642.2	3,549.5
	Min	345	54	48	66	63	66	48
	Max	97,406	15,834	17,485	18,538	12,339	18,707	14,501

Of the 30 agencies which are certified to provide Partial Hospitalization and allow Seclusion/Restraint, nine allowed Seclusion or Restraint, but did not utilize it during partial hospitalization in the six-month period. And 21 agencies did report some type of Seclusion/Restraint use during partial hospitalization. Table 5a reports the number and Table 6a report the duration of Seclusions and Restraints for the six-months.

### ***Seclusions***

No agencies serving adults reported Seclusions in partial hospitalization.

The total number of Seclusions reported for youth in Partial Hospitalization was 7. One agency serving youth reported Seclusions in partial hospitalization; when standardizing by utilization the average number of Seclusions per 1000 partial hospital utilization hours was 29.6. The average duration of Seclusions for youth in partial hospitalization was 39.3 minutes.

Physical Restraints

No agencies serving adults reported utilizing Physical Restraints in partial hospitalization.

The total number of Physical Restraints reported for youth in Partial Hospitalization was 2,202. Twenty agencies serving youth reported Physical Restraints in partial hospitalization; when standardizing by utilization the average number of Physical Restraints per 1000 partial hospitalization hours was 169.5.

- Table 5b breaks out the Physical Restraints for youth in partial hospitalization by month; the highest number of Physical Restraints reported was in May (M=294.5) and the lowest number of Physical Restraints reported was in June (M=91.3).

The average duration of Physical Restraints for youth in partial hospitalization was 9.0 minutes.

- Table 6b breaks out the duration of Physical Restraints for youth in partial hospitalization by month; the highest average duration of Physical Restraints was reported in January (M=8.6) and the lowest average duration of Physical Restraints was reported in March (M=7.3).

Mechanical Restraints

No agencies serving adults reported Mechanical Restraints in partial hospitalization. Mechanical Restraints are not allowed to be used on youth clients.

**Table 5a. Frequency of Seclusions and Restraints (Means across all six months across agencies)**

	N of agencies	per 1000 Partial Hospitalization Hrs				Total N of Seclusions/ Restraints
		Mean	SD	Min	Max	
Agencies that reported Seclusions (Adults)	0					0
Agencies that reported Seclusions (Youth)	1	29.6	n/a			7
Agencies that reported Physical Restraints (Adults)	0					0
Agencies that reported Physical Restraints (Youth)	20	169.5	190.8	3.4	583.3	2,202
Agencies that reported Mechanical Restraints (Adults)	0					0

**Table 5b. Frequency of Physical Restraints per 1000 Partial Hospitalization Hours by month (Means across agencies)**

	Jan	Feb	Mar	Apr	May	Jun
Agencies that reported Physical Restraints (Youth N = 20)	<b>Mean</b> 172.4	<b>164.3</b>	<b>209.1</b>	<b>193.5</b>	<b>294.5</b>	<b>91.3</b>
	<b>SD</b> 223.5	181.2	311.3	284.3	551.5	156.8

**Table 6a. Average Minutes of Duration of Seclusion and Restraint in Partial Hospitalization (Means across agencies)**

	N	Mean	SD	Min	Max
Agencies that reported Seclusions (Adults)	0				
Agencies that reported Seclusions (Youth)	1	39.3	n/a		
Agencies that reported Physical Restraints (Adults)	0				
Agencies that reported Physical Restraints (Youth)	20	9.0	6.8	1.2	35.0
Agencies that reported Mechanical Restraints (Adults)	0				

**Table 6b. Average Minutes of Duration of Physical Restraints in Partial Hospitalization by month (Means across agencies)**

		Jan	Feb	Mar	Apr	May	Jun
Agencies that reported	<b>Mean</b>	<b>8.6</b>	<b>7.4</b>	<b>7.3</b>	<b>7.7</b>	<b>7.7</b>	<b>7.8</b>
Physical Restraints (Youth)	SD	7.9	3.1	4.6	3.9	4.1	3.9
	N	17	17	17	16	17	13

\*The formula for computing duration only includes reported Seclusions for that period; therefore the N changes based on the number reported each month.

### ***Agencies providing Other Certified Mental Health Services***

Of the 60 agencies that allow Seclusion and Restraint overall, 11 (18.3%) agencies prohibit Seclusion or Restraint in their other mental health services, and 34 (56.7%) did not use Seclusion or Restraint in their other certified mental health services. One quarter (N=15) of the agencies used Seclusion or Restraint in other certified mental health services. Table 7 reports on the number of Seclusions and Restraints for the six-months; Table 8 reports on the duration of Seclusions and Restraints.

#### *Other Certified Mental Health Services Utilization*

Agencies were not asked to report on the number of other certified mental health hours provided. Therefore, the number of Seclusions and Restraints reported per 1000 client hours is not able to be calculated, and thus the frequencies reported in Table 7 are not standardized.

#### *Seclusions*

No agencies serving adults or youth reported utilizing Seclusions in other certified mental health services.

#### *Physical Restraints*

The total number of Physical Restraints reported for adults in Other Certified Mental Health Services was 1,049. Four agencies serving adults reported Physical Restraints in other certified mental health services; the average number of Physical Restraints was 74.8. The average duration of Physical Restraints for adults in other certified mental health services was 7.6 minutes.

The total number of Physical Restraints reported for youth in Other Certified Mental Health Services was 299. Thirteen agencies serving youth reported Physical Restraints in other certified mental health services; the average number of Physical Restraints was 80.7. The average duration of Physical Restraints for youth in other certified mental health services was 6.70 minutes.

#### *Mechanical Restraints*

No agencies serving adults reported Mechanical Restraints in other certified mental health services. Mechanical Restraints are not allowed to be used on youth clients.

**Table 7. Frequency of Seclusions and Restraints in Other Mental Health Services (Means across all six months across agencies)**

	N of agencies	Mean	SD	Min	Max	Total N of Seclusions/ Restraints
Agencies that reported Seclusions (Adults)	0					0
Agencies that reported Seclusions (Youth)	0					0
Agencies that reported Physical Restraints (Adults)	4	74.8	144.8	1	292	299
Agencies that reported Physical Restraints (Youth)	13	80.7	103.3	1	275	3,254
Agencies that reported Mechanical Restraints (Adults)	0					0

**Table 8. Average Minutes of Duration of Seclusion and Restraint in Other Mental Health Services (Means across agencies)**

	N	Mean	SD	Min	Max
Agencies that reported Seclusions (Adults)	0				
Agencies that reported Seclusions (Youth)	0				
Agencies that reported Physical Restraints (Adults)	4	7.6	7.1	1.0	17.7
Agencies that reported Physical Restraints (Youth)	13	6.7	3.6	0.0	15.0
Agencies that reported Mechanical Restraints (Adults)	0				

### ***Injuries to Staff from Seclusions and Restraints***

Agencies also reported on the number of injuries to staff members related to any Seclusions and Restraints. Of the 60 agencies that allow Seclusion and Restraint, 15 reported some type of staff injury.

- The 15 agencies reporting an injury requiring First Aid reported a total of 83 injuries, with an average number of 5.5 injuries per agency.
- The 6 agencies reporting an injury requiring emergency or unplanned medical intervention reported a total of 17 injuries, with an average number of 2.8 injuries per agency.
- There was only 1 injury reported requiring hospitalization.

**Table 9. Seclusion and Restraint-Related Injury to Staff (Means across agencies)**

	N	Mean	SD	Min	Max	Total Injuries
Injuries Requiring First Aid	15	5.5	7.9	1	24	83
Injuries Requiring Emergency/Unplanned medical intervention	6	2.8	2.8	1	8	17
Injuries Requiring Hospitalization	1	1	n/a			1

**Ohio Department of Mental Health and Addiction Services**  
**Seclusion and Restraint Six Month Data Report Results**  
**Residential Facility (Type 1)**  
**January through June 2012**

Ohio Department of Mental Health & Addiction Services (OhioMHAS) OAC 5122-30-16 requires that mental health providers report certain incident data every six months. Providers that are required to report incidents include Type 1 Residential Facilities, Inpatient Psychiatric Service Providers, and Community Mental Health Agencies.

**Type 1 Residential Facilities**

Type 1 facilities provide room and board, personal care, and certified mental health services to one or more adults, or children or adolescents with mental illness. Type 1 facilities were required to report their service utilization (bed days), number and minutes of Seclusion<sup>1</sup>, Physical Restraints<sup>2</sup>, Mechanical Restraints<sup>3</sup>, and number of related injuries to staff.

**Adult Residential Facilities**

OhioMHAS currently licenses 81 adult residential treatment centers:

- 74 (91.4%) facilities prohibit the use of Seclusion and Restraint in all certified services, and did not use Seclusion and Restraint during the report period.
- 7 (8.6%) facilities do permit the use of Seclusion and Restraint.
  - These 7 facilities reported their number of Resident Days:
    - The minimum number of days was 80
    - The maximum number of days was 2,137
    - The average (mean) number of days was 1,372
  - None of these facilities reported any Seclusion incidents within this six-month period
  - None of these facilities reported any Mechanical Restraint incidents within this six-month period
  - None of these facilities reported any Physical Restraint incidents within this six-month period
- Because there were no reported Seclusion or Restraint incidents for adult facilities during this six-month period, no injuries to staff were reported.

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<sup>1</sup> Seclusion means a staff intervention that involves the involuntary confinement of a resident alone in a room where the resident is physically prevented from leaving.

<sup>2</sup> Physical Restraint, also known as Manual Restraint, means a staff intervention that involves any method of physically/manually restricting a resident's freedom of movement, physical activity, or normal use of his or her body without the use of Mechanical Restraint devices.

<sup>3</sup> Mechanical Restraint means a staff intervention that involves any method of restricting a resident's freedom of movement, physical activity, or normal use of his or her body, using an appliance or device manufactured for this purpose.

## Youth Residential Facilities

The remainder of this report provides information on youth residential facilities. OhioMHAS licenses 22 youth residential treatment centers:

- 2 (9.1%) facilities prohibit the use of Seclusion and Restraint in all certified services, and did not use Seclusion or Restraint during the report period.
- 20 (90.9%) facilities do permit the use of Seclusion and Restraint:
  - 3 (15.0%) facilities reported using Seclusion; 17 (85.0%) did not use Seclusion
  - All 20 facilities reported using Physical Restraints
  - No youth facilities reported Mechanical Restraints. Mechanical Restraints are only permitted to be used with individuals age 18 and over.

### ***Facility Size Categories***

Facilities were categorized by size; facilities were considered small if they had 25 or fewer licensed beds, medium if they had 26-69 licensed beds, and large if they had 70 or more licensed beds.

### ***Resident Days***

The average number of Resident days are presented in Table 1. As expected, larger facilities reported higher numbers of resident days.

**Table 1.** Descriptive Statistics of the number of Youth Resident Days

	Minimum	Maximum	Mean	SD
Total (N = 20)	653	14,830	6,490.1	4687.1
Large Facilities (N = 7) (70+ Licensed beds)	7,883	14,830	11,914.4	2,261.5
Medium Facilities (N = 8) (26-69 Licensed beds)	2,157	8,584	4,679.6	2,261.5
Small Facilities (N = 5) (25 or fewer Licensed beds)	653	3,298	1,792.6	1,066.9

In order to compare across organizations frequencies were calculated on the number of Seclusions and Restraints per 1000 resident days, and the average duration per Seclusion and Restraint.

$$\text{Seclusion/Restraints per 1000 Resident Day} = \frac{\text{Total \# of Seclusions/Restraints}}{\text{Total \# of Resident Days}} \times 1000$$

$$\text{Avg. Duration per Seclusion/Restraint} = \frac{\text{Total mins of Seclusion/Restraint}}{\text{Total \# of Seclusions/Restraints}}$$

For example, if an organization reported 600 resident days, 15 incidents of Seclusion, and 500 total minutes of Seclusion, the Seclusions per 1000 resident days would be 25 (15/600 = 25), and the average duration would be 33.3 minutes (500/15 = 33.3).

Figure 1 and Table 2 display the *frequency* of Seclusions and Physical Restraints per 1000 resident days by month. Figure 2 and Table 3 display the *average minutes of duration* of Seclusions and Restraints by month. Because of the small number of facilities that reported Seclusions, only Physical Restraints results are displayed by facility size (large, medium and small).

### ***Seclusions***

The total number of Seclusions reported across the 6-month period was 92. For the 20 agencies that allow Seclusion, the number of Seclusions per 1000 resident days for the six months ranged from a low of 0.0 to a high of 17.6 with an average number 1.4 Seclusions per 1000 resident days. See Figure 1 and Table 2 for the average number of Seclusions per month.

- For the three facilities that reported Seclusions, the number of Seclusions per 1000 resident days for the six months ranged from a low of 0.9 to a high of 17.6 with an average number 9.06 Seclusions per 1000 resident days.

The duration of Seclusions for the six months ranged from a low of 2.0 minutes to a high of 40.3 minutes with an average duration of 23.5 minutes per Seclusion.

Compared with Physical Restraints, Seclusions are used less frequently but have longer duration.

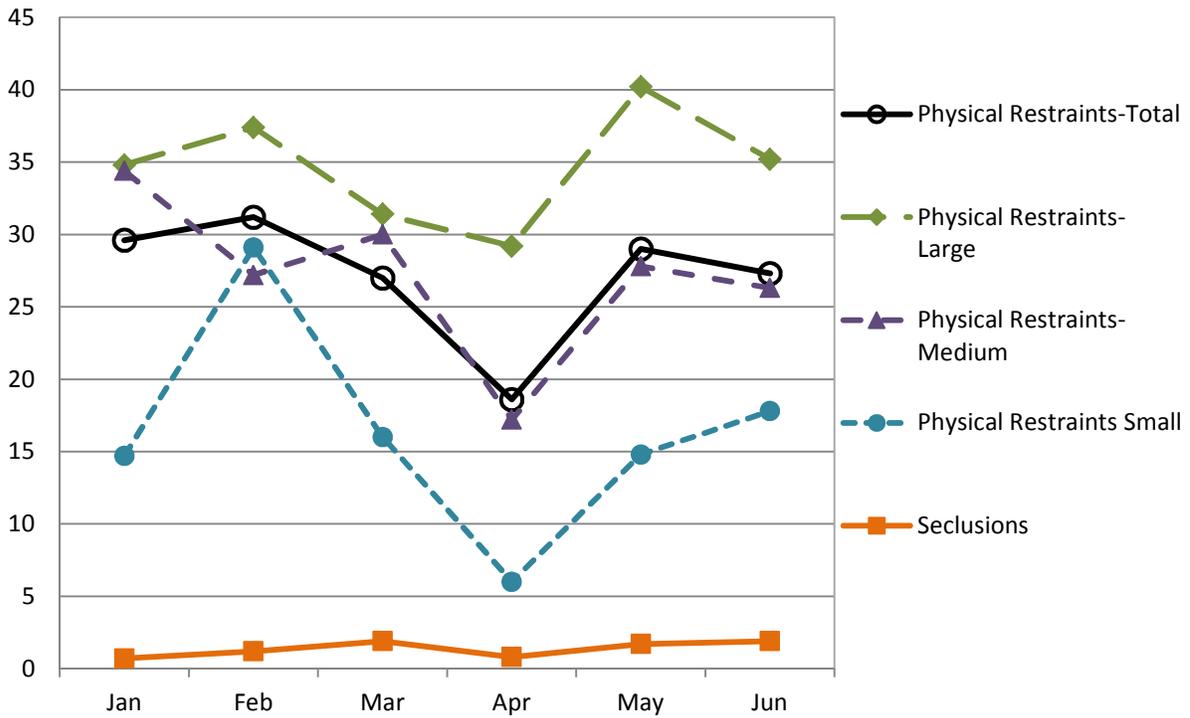
### ***Physical Restraints***

The total number of Physical Restraints reported across the 6-month period was 4,014. For the 20 facilities that reported Physical Restraints, the number of Physical Restraints per 1000 resident days for the six months ranged from a low of 1.1 to a high of 68.9, with an average of 27.1. There is a lower number of Physical Restraints reported in April than all other months; more data is needed across time to determine whether how fluctuations vary over time.

The average duration of Physical Restraints for the six months ranged from a low of 1.8 minutes to a high of 25.0 minutes, with an average duration of 9.3 minutes per Restraint.

Compared with Seclusions, Physical Restraints are used more frequently but have shorter durations. While it appears that larger facilities may report more Physical Restraints than medium or smaller sized facilities, trends with small sample sizes per group should be interpreted extremely cautiously. The average duration of Physical Restraints does not appear to vary much by facility size.

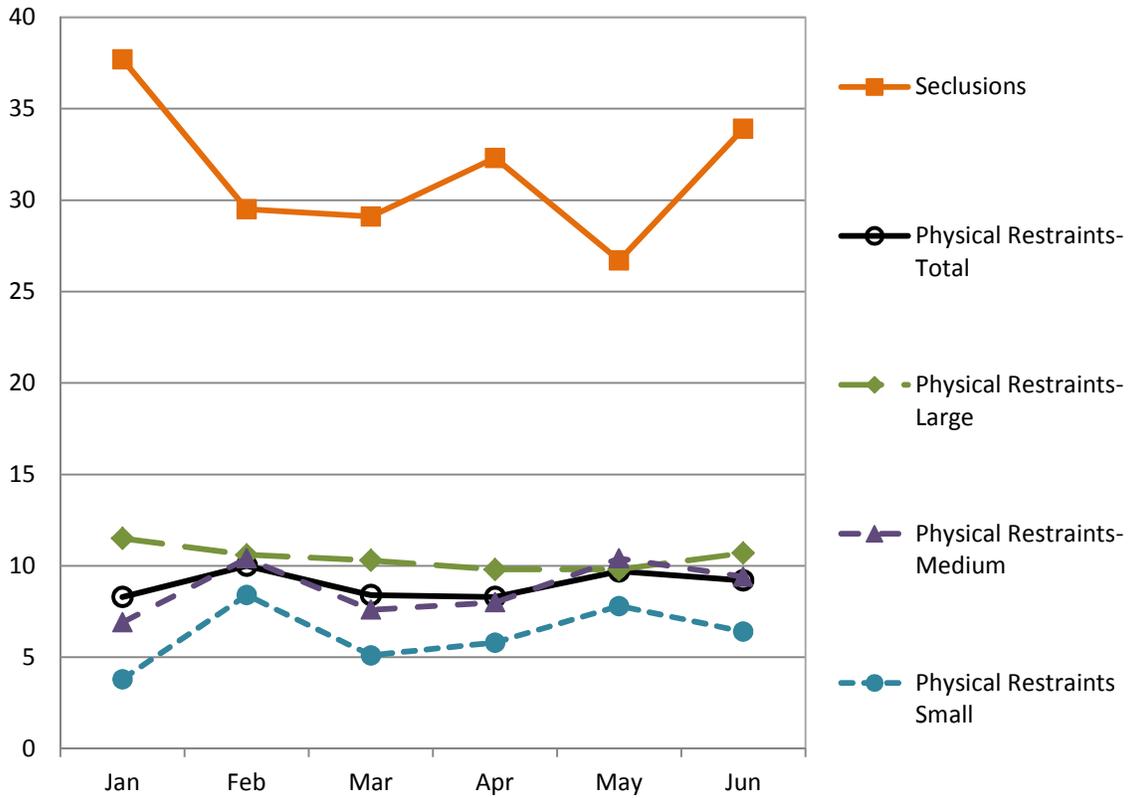
**Figure 1.** Frequency of Youth Facility Seclusions and Restraints per 1000 Resident Days (Means across facilities)



**Table 2.** Frequency of Youth Facility Seclusions and Restraints per 1000 Resident Days

		6 months	Jan	Feb	Mar	Apr	May	Jun
Physical Restraints - Total (N = 20)	<b>Mean</b>	<b>27.12</b>	<b>29.59</b>	<b>31.18</b>	<b>26.97</b>	<b>18.63</b>	<b>28.89</b>	<b>27.28</b>
	SD	17.05	28.17	23.55	19.83	13.43	21.20	20.21
Physical Restraints – Large Facilities (N = 7) (70+ Licensed beds)	<b>Mean</b>	<b>34.73</b>	<b>34.79</b>	<b>37.36</b>	<b>31.36</b>	<b>29.22</b>	<b>40.17</b>	<b>35.19</b>
	SD	15.80	21.25	27.24	14.73	10.69	15.47	17.49
Physical Restraints – Medium Facilities (N = 8) (26-69 Licensed beds)	<b>Mean</b>	<b>27.41</b>	<b>34.35</b>	<b>27.16</b>	<b>30.01</b>	<b>17.23</b>	<b>27.81</b>	<b>26.29</b>
	SD	17.05	34.19	17.13	20.94	10.95	23.41	22.93
Physical Restraints – Small Facilities (N = 5) (25 or fewer Licensed beds)	<b>Mean</b>	<b>16.01</b>	<b>14.70</b>	<b>29.10</b>	<b>15.96</b>	<b>6.05</b>	<b>14.55</b>	<b>17.77</b>
	SD	15.41	25.97	30.09	23.91	8.75	18.55	18.33
Seclusions (N = 20)	<b>Mean</b>	<b>1.36</b>	<b>0.69</b>	<b>1.18</b>	<b>1.88</b>	<b>0.83</b>	<b>1.72</b>	<b>1.88</b>
	SD	4.37	2.12	3.94	7.23	3.69	5.22	6.64

**Figure 2.** Average Minutes of Duration of Youth Facility Seclusion and Restraints (Means across facilities)



**Table 3.** Average Minutes of Youth Facility Duration of Seclusion and Restraints

		6 months	Jan	Feb	Mar	Apr	May	Jun
Physical Restraints – Total (N = 20)	<b>Mean</b>	<b>9.28</b>	<b>8.25</b>	<b>9.95</b>	<b>8.42</b>	<b>8.31</b>	<b>9.74</b>	<b>9.22</b>
	SD	5.64	5.20	6.92	4.21	4.08	4.44	5.86
Physical Restraints – Large Facilities (70+ Licensed beds) (N = 7)	<b>Mean</b>	<b>10.31</b>	<b>11.68</b>	<b>10.58</b>	<b>10.28</b>	<b>9.76</b>	<b>9.83</b>	<b>10.68</b>
	SD	4.99	5.91	4.61	4.76	5.04	4.39	6.49
Physical Restraints – Medium Facilities (26-69 Licensed beds) (N = 8)	<b>Mean</b>	<b>8.33</b>	<b>6.90</b>	<b>10.38</b>	<b>7.62</b>	<b>7.99</b>	<b>10.38</b>	<b>9.36</b>
	SD	4.09	3.41	7.61	3.73	3.33	5.19	6.15
Physical Restraints – Small Facilities (25 or fewer Licensed beds) (N = 5)	<b>Mean</b>	<b>9.38</b>	<b>3.85</b>	<b>8.39</b>	<b>5.14</b>	<b>5.81</b>	<b>7.83</b>	<b>6.38</b>
	SD	8.98	2.51	9.49	0.02	3.02	2.89	4.23
Seclusions (N = 20)	<b>Mean</b>	<b>23.52</b>	<b>37.70</b>	<b>29.50</b>	<b>29.12</b>	<b>32.25</b>	<b>26.72</b>	<b>33.93</b>
	SD	19.60	28.71	1.65	1.24	0.00	24.03	8.59

**Table 3.** Average (Mean) Youth Facility Seclusion and Restraint Frequency and Duration (combined January through June 2012).

	Seclusions		Physical Restraints	
	Frequency per 1000 resident days	Average Duration (mins)	Frequency per 1000 resident days	Average Duration (mins)
<b>Large Facilities</b> (70+ Licensed beds)	0.09	2.00	68.89	11.75
			29.43	10.66
			36.52	14.87
			28.50	8.02
			27.38	4.27
			31.76	4.87
			20.66	17.72
<b>Medium Facilities</b> (26-69 Licensed beds)			24.31	10.39
			13.81	6.99
			21.09	7.95
	17.55	28.23	39.17	6.73
			42.68	12.16
			16.23	14.94
			56.48	5.67
<b>Small Facilities</b> (25 or fewer Licensed beds)			5.51	1.78
			12.25	8.13
			28.16	6.85
			35.78	3.92
	9.54	40.33	1.06	25.00
			2.84	3.00

Note. Blank cells indicate no reports of Seclusion or Restraint.

### ***Injuries to Staff from Seclusions and Restraints***

Facilities also reported on the number of injuries to staff members related to Seclusion and Restraint:

- Injuries requiring First aid:
  - 6 facilities reported no first aid
  - 8 facilities reported between 1 and 5 injuries requiring first aid
  - 3 facilities reported between 6 and 15 injuries requiring first aid
  - 3 facilities reported more than 15 but less than 40 injuries requiring first aid
- Injuries requiring Emergency/unplanned medical intervention:
  - 10 facilities reported no emergency visits
  - 8 facilities reported less than 5 injuries requiring emergency medical intervention
  - 1 facility reported 8 injuries requiring emergency intervention
  - 1 facility reported 21 injuries requiring emergency intervention
- No facilities reported injuries to staff that required hospitalization.