U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT
ENFORCEMENT AND REMOVAL OPERATIONS
ICE HEALTH SERVICE CORPS

USE OF EMERGENCY PSYCHOTROPIC MEDICATION, CLINICALLY ORDERED RESTRAINT AND SECLUSION

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By Order of the Assistant Director
Stewart D. Smith, DHSc, FACHE STEWART D SMITH Digitally signed by STEWART D SMITH Date: 2023.04.05 14:07:11 -04'00'

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1. **PURPOSE:** The purpose of this directive is to set forth policy and procedures for the use of emergency psychotropic medication, clinically ordered restraint, or seclusion when a noncitizen with a health condition poses an immediate and serious threat of harm to self or others. The directive emphasizes the prevention and reduction of the use of these methods.

2. **APPLICABILITY:** This directive applies to all U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) personnel, including but not limited to, Public Health Service (PHS) officers, civil service employees, and contract personnel. It applies to IHSC personnel supporting health care operations in ICE-owned and contracted detention facilities and to IHSC Headquarters (HQ) staff. It applies to contract personnel when supporting IHSC in detention facilities and at HQ. Federal contractors are responsible for the management and discipline of their employees supporting IHSC.

3. **AUTHORITIES AND REFERENCES:**

   3-1. Title 8, Code of Federal Regulations, Section 235.3 (8 CFR 235.3), Inadmissible Aliens and Expedited Removal.

   3-2. Section 232 of the Immigration and Nationality Act (8 USC 1222), Detention of Aliens for Physical and Mental Examination.

   3-3. Title 8, Code of Federal Regulations, section 232 (8 CFR 232), Detention of Aliens for Physical and Mental Examination.

   3-4. Section 322 of the Public Health Service Act (42 USC 249(a)), Medical Care and Treatment of Quarantined and Detained Persons.

3-5. Title 42, U.S. Code, Public Health Service Act, (42 USC 252), Medical Examination of Aliens.

3-6. ICE Policy 11065.1, Review of the Use of Segregation for ICE Detainees.

3-7. ICE Directive 11032.4, Identification and Monitoring of Pregnant, Postpartum, or Nursing Individuals.

4. POLICY: During emergency situations, the use of emergency medications, therapeutic restraints, seclusion, or other interventions vary in onset and duration of effectiveness. The clinical director (CD) or physician designee must authorize and document the use of emergency psychotropic medication, clinically ordered restraints, or seclusion for medical purposes in an emergency when a patient is in imminent danger of harming self or others, and that all less restrictive treatment options were attempted. As the emergency evolves, decisions about alternative interventions and/or hospital transfers will depend on patient response to treatment.

4-1. In the absence of a CD or physician designee, a medical or psychiatric advanced practice provider (APP) may authorize use of emergency psychotropic medication, clinically ordered restraints, or seclusion, after declaring a medical emergency.

4-2. Emergency Psychotropic Medication: Use of emergency psychotropic medication (hereafter referred to as medication) is the most restrictive intervention. The clinical director or physician designee must use the current psychiatric diagnosis as a guide when selecting the medication. The medical provider selects the appropriate medication based on the psychiatric diagnosis and never orders these medications "as needed." IHSC clinical directors should opt for short-acting pharmacologic options and use the lowest dose for the shortest amount of time. Clinical directors must renew medication orders every 24 hours in conjunction with appropriate observation and follow-up care. When the emergency psychotropic medications fail to produce therapeutic benefit within 72 hours, the clinical director or physician designee must immediately transfer the patient to a hospital emergency department for further assessment and treatment.

4-3. Clinically Ordered Restraints: Clinically ordered restraints (hereafter referred to as 'restraints') are less restrictive than medication and help the patient regain control after health staff have exhausted de-escalation efforts. All physical limitations of independent movement must not jeopardize the patient's health, nor should staff restrain the patient in an unnatural, sprawled, or prone position.

IHSC uses the same types of restraints deemed appropriate and used in community settings. Health staff must maintain the patient's dignity at all times. Health staff must not apply restraints to pregnant women in ICE custody, whether during transport, in a detention facility, or at an outside medical facility. Refer to IHSC Directive 04-01, *Female Health Services*.

4-4. Clinically Ordered Seclusion: Clinically ordered seclusion (herein referred to as seclusion) is less restrictive than previously mentioned interventions. Clinicians should use seclusion during an emergency, when unable to stabilize the patient, and when all other de-escalation efforts are unsuccessful. Separation of a patient from others for the purpose of reducing stimulation must not jeopardize the patient's health. Clinicians should order seclusion for the shortest duration of time, not to exceed four hours, and with appropriate one-to-one constant observation.

5. RESPONSIBILITIES:

5-1. Clinical Director (CD) or Physician Designee:

5-1.1 Oversees initiation and cessation for medications, restraints, or seclusion.

5-1.2 Coordinates immediate consultation, referral, and follow-up for medications, use of restraints, or seclusion. Coordinates these activities both on-and off-site.

5-1.3 Documents the use of any medications, restraints, or seclusion. Documentation must include clinical indications patient assessment criteria, duration of use, treatment goals and physical or mental contraindications to medications, restraints, or seclusion.

5-2. Medical or Psychiatric Advanced Practice Providers (APP):

5-2.1 Screens and evaluates prior to using medication, restraints, or seclusion in emergency situations. The APP considers the risk for exacerbation of any previously diagnosed medical or mental illness. The APP may order interventions during immediate or emergent situations; however, must consult CD or physician designee within one hour.

5-2.2 Consults with CD or physician designee for use of any medication, restraint, or seclusion; any physical and mental health concerns; type and duration of intervention; post- intervention referral; and disposition.

5-2.3 Provides follow up evaluation within 72 hours.

5-3. Nursing Staff:

5-3.1 Execute orders and administers medication(s).

5-3.2 Ensure medical observation within 15 minutes after administering medication, applying restraints, or placing in seclusion. Nursing staff must observe every 30 minutes until the patient transfers to an inpatient setting or no longer requires observation.

5-3.3 Ensure patient receives one-to-one constant observation throughout duration of the order.

5-4. Health Services Administrator (HSA):

5-4.1 Ensures notification of ERO representative, and communication with the clinical director or physician designee and facility field office director (FOD), via daily reports of clinical restraint and seclusion.

5-4.2 Oversees performance improvement for activities related to this directive.

5-4.3 Collects data on all incidents of restraints and seclusion (medication or physical) to both monitor performance and guide improvement initiatives.

5-5. Behavioral Health Provider (BHP):

5-5.1 Provides risk assessment, de-escalation, redirection, reorientation, crisis intervention and clinical debriefing to the patient.

5-5.2 Provides reevaluation of the treatment plan.

5-6. Health Staff:

5-6.1 Health staff must use the least restrictive modes of treatment and discontinue more restrictive modes of treatment when the patient regains better control of their behavior or when custody staff transport them to the hospital.

5-6.2 Health staff must never use emergency psychotropic medication, clinically ordered restraints or seclusion for behavior control or disciplinary sanctions.

6. PROCEDURES:

6-1. Notification of Emergency. Clinical or custody staff identify a patient with a health condition who poses an immediate and serious threat of harm to self or others, and, if left untreated, the patient may harm their self or others.

6-2. Alternatives to emergency psychotropic medication, restraints, or seclusion.

6-2.1 Clinicians consider less restrictive measures and provide justification for why emergency medication, restraint, or seclusion is necessary.

6-2.2 Clinicians identify and document and evaluate any pre-existing medical, mental conditions, or physical disabilities and limitations that may place the patient at greater risk during use of medication, restraints, or seclusion prior to intervention.

6-2.3 Clinicians must exhaust all least restrictive options prior to using medication, restraints, or seclusion. Once clinicians identify a least restrictive method, they must document the patient's response to the less restrictive measures in the medical record.

Less restrictive measures include, but are not limited to:

- Increased staff interaction and/or observation.
- Consideration of medication review.
- Redirection and reorientation.
- Reevaluation of the treatment plan.

6-3. Orders for emergency psychotropic medication.

6-3.1 Clinicians must obtain a written order from the CD or physician designee to include the type of medication to administer, dose, route, and direct observation instructions for assessing any adverse reactions or side effects.

6-3.2 Standing or 'as needed' orders are prohibited. Clinicians may use a repeat order only after a CD or physician designee performs a thorough assessment.

6-4. Medication consents:

6-4.1 Whenever possible, nurses or medical providers must obtain consent for the use of medication. Although the right to refuse treatment is inherent in informed consent, exceptions may arise in mental health emergencies. State laws vary on this matter; but, as a rule, nurses, or medical providers use emergency psychotropic medication only in the following conditions:

6-4.1.a The patient is a danger to themselves or others from mental health conditions.

6-4.1.b The less restrictive or intrusive measures medical providers employ are inadequate.

6-4.2 The health care provider clearly documents in the health record the patient's condition, the threat posed, the reason for proposing medication, and other treatments attempted.

6-4.3 The CD or physician designee writes the order for restraints, not to exceed four hours, and documents the patient's medical record:

6-4.3.a When, where, how, and for how long custody staff may apply restraints.

6-4.3.b How to maintain proper peripheral circulation.

6-4.3.c Required 15-minute health provider checks.

6-4.3.d Provisions for proper nutrition, hydration, and toileting.

6-4.4 The treatment plan includes removing patient from restraints or seclusion as soon as possible.

6-5. Execution of the restraint orders:

6-5.1 A medical provider or nurse assesses the patient, and documents in the medical record every 15 minutes for the order duration.

6-5.2 Custody staff maintain one-to-one constant observation of the patient while restrained.

6-6. Renewal of emergency restraint orders.

6-6.1 The CD or physician designee must personally observe the patient within four hours to assess whether to continue restraint or seclusion beyond the initial order.

6-6.2 The ordering physician re-evaluates and documents the order every four hours.

6-7. Application of clinically ordered restraints. Health care providers coordinate with custody staff when the situation warrants the use of clinical restraints, or the clinical director or physician designee orders their use.

6-8. Custody-initiated emergency restraints or seclusion.

6-8.1 When notification of a patient is in custody-initiated restraints or segregation:

6-8.2 A qualified health care professional reviews the patient's health record.

6-8.2.a A qualified health care professional notifies custody staff, of existing medical, dental, or mental health needs require accommodation.

6-8.2.b A qualified health care professional must document the review and notification in the health record.

6-8.2.c The health care provider bases the degree of isolation on observation of the segregated patient.

- Patients in *solitary confinement* have little or no contact with other individuals. Health care providers must monitor these patients daily; mental health staff must monitor at least once a week.
- Patients who are segregated have limited contact with staff and other patients. Medical or mental health staff must monitor these patients three days a week.

6-8.2.d Documentation of segregation rounds is made on individual logs or cell cards, or in the health record, and includes:

- The date and time of the contact,
- The signature or initials of the health staff member making the rounds,
- Significant health findings are documented in the health record.

6-8.3 Health care providers should promptly identify and inform custody officials of patients who demonstrate physical or psychological deterioration and exhibit other signs or symptoms of failing health or mental status.

6-9. Clinically ordered seclusion requirements.

6-9.1 Clinicians must obtain a written order from the CD or physician designee to place a patient in seclusion. Seclusion must not exceed four hours. The order must include date, time, location, duration, and specific observation instructions.

6-9.2 If a CD or physician designee is not on-site, a medical or psychiatric APP can initiate medication, restraints, or seclusion after a medical emergency. The APP must notify and obtain an order from the CD or physician designee within one hour of initiation of the emergency intervention.

The CD or physician designee grants approval when there is clear evidence that staff exhausted all other alternatives, as documented in the health record.

6-10. Execution of seclusion orders.

6-10.1 A nurse assesses a patient in seclusion every two hours and documents notes in the medical record for the duration of the order.

6-10.2 Custody staff maintain constant one-to-one observation of the patient while in seclusion.

6-11. Direct observation during emergency restraint application.

6-11.1 A health care provider evaluates the patient and collaborates with the CD, HSA, and ICE personnel to place the patient in the most appropriate housing location for observation. Custody should employ restraints in a manner that best preserves the patient's dignity.

6-11.2 A health care provider evaluates the patient and collaborates with the CD, HSA, and ICE personnel to place the patient in the most appropriate housing location for observation. Custody should employ restraints in a manner that best preserves the patient's dignity.

6-11.3 During the required direct observations of clinically secluded patients, health care providers observe the patient and document the following minimum information in the medical record:

6-11.3.a Signs of injury related to restraint application and wear.

6-11.3.b Nutrition and hydration.

6-11.3.c Circulation and range of motion in the extremities.

6-11.3.d Vital signs.

6-11.3.e Hygiene and elimination.

6-12. Direct observation during seclusion.

6-12.1 A health care provider evaluates the patient and collaborates with the CD, HSA, and ICE personnel to place the patient in the most appropriate housing location for observation.

6-12.2 During the required direct observations of clinically secluded patients, health care providers observe the patient and document the following minimum information in the medical record:

6-12.2.a Signs of injury.

6-12.2.b Nutrition and hydration.

6-12.2.c Vital signs.

6-12.2.d Hygiene and elimination.

6-13. Recurring offerings to the patient in restraints or seclusion.

6-13.1 Health care providers offer patients in seclusion fluids, food, and use of the toilet every two hours.

6-13.2 Custody serves meals on Styrofoam with plastic spoons. Iced or hot beverages are prohibited. Custody removes and accounts for all meal items after each meal.

6-14. Maximum Time Period. Use of clinically ordered restraints or seclusion for the shortest time necessary to protect the patient from harming themselves or others.

6-14.1 Clinicians use emergency restraints for a specified time, not to exceed 12 hours, and document the necessity for the restraints in the patient health record.

6-14.2 The CD or physician designee must personally observe the patient after the initial order and prior to renewal. The CD or physician designee may renew the use of restraints or seclusion, beyond the initial 12 hours, by issuing a new written order after direct observation.

6-14.3 Clinicians must observe the restrained patient's behaviors while restrained. The CD or physician designee may order brief removal from restraints or seclusion to assess the patient's readiness for less restrictive treatment.

6-14.3.a If the patient exhibits the same behavior and continues to require restraint or seclusion, a new order is not required if the existing order remains current.

6-14.3.b If the patient exhibits different behavior and no longer requires restraint or seclusion, the CD or physician designee should issue a new order.

6-14.3.c If the patient demonstrates new behavior that requires restraint or seclusion and the current order expired, the CD or physician designee should issue a new order.

6-14.3.d The CD or physician designee reevaluates the patient after 12 hours. If the patient requires two or more restraints within the four hours, the CD or physician designee may consider hospitalization.

6-15. BHP Consultation.

6-15.1 When the CD or physician designee places a patient in restraints or seclusion, the physician contacts the BHP as soon as practical to conduct an evaluation.

6-15.2 The BHP conducts a mental health assessment when the CD or physician designee uses clinically ordered restraints or seclusion for any period of eight hours or more.

6-15.3 Facilities without a BHP on-site must send the patient for an off-site assessment as soon as possible.

6-16. Patient/Patient Education. Health care staff explain to the patient the reason and procedures for the emergency medication, restraint, or seclusion to prevent misinterpretations and gain cooperation. Health care staff provide interpretation as necessary to overcome any limitations in the patient's understanding (i.e., foreign language, hearing limitations, and comprehension difficulties) in their native language with the use of an interpreter, if necessary. Clinicians must document the education provided to the patient in the electronic medical record.

6-17. Documentation requirements.

6-17.1 The health care provider documents:

6-17.1.a The behavior that led to the use of medication, restraints, or seclusion.

6-17.1.b Implementation or failure of non-physical less restrictive intervention and the patient's response.

6-17.1.c Behavior criteria to discontinue clinically ordered restraints or seclusion.

6-17.1.d Patient notification of the behavior criteria for discontinuation.

6-17.1.e Assistance provided to assist with meeting the behavior criteria for discontinuation and patient's response.

6-17.1.f Any injuries sustained and treated.

6-17.1.g Accommodations made recognizing the patient's age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse.

6-17.2 If clinician administered medications, documentation in the medical record should include:

6-17.2.a Mental status: orientation and alertness; motor activity; speech; extra pyramidal symptoms of antipsychotic medications (e.g., dystonia, parkinsonism, akathisia, tremor, or dyskinesia).

6-17.2.b Presence of any psychotic behavior specifically hallucinations, delusions, disorganized speech, or behavior, noting agitation, or assaultive behaviors.

6-17.2.c Any signs of dehydration, (e.g., muscle rigidity, diaphoresis, alteration in consciousness) or autonomic dysfunction (e.g., orthostatic hypotension, drooling, urinary incontinence, unusually rapid breathing).

6-17.2.d Vital signs, to include blood pressure, pulse, temperature, and respirations.

6-17.3 Clinicians document the following for patients in seclusion:

6-17.3.a Provision of proper nutrition, hydration, and toileting.

6-17.3.b Treatment plan for patient removal from seclusion as soon as possible.

6-17.3.c Standing orders for implementing restraints or seclusion are prohibited.

6-18. Clinically ordered emergency restraints or seclusion debriefing.

6-18.1 After each episode of restraint or seclusion concludes, the CD or physician designee leads a debriefing within the health care providers involved and encourages the patient's participation.

6-18.2 The debriefing should occur as soon as possible after the episode, but no longer than 24 hours after the event.

6-19. Annual Training.

6-19.1 All health care staff must complete training annually for emergency, use psychotropic medication, therapeutic seclusion, and restraints, as outlined in this directive.

6-19.2 The Psychiatric Services Program provides staff education for emergency use psychotropic medications, clinically ordered restraints and seclusion.

6-20. Special Considerations for children:

6-20.1 Use of emergency psychotropic medication

6-20.1.a The clinician must consider less restrictive measures and provide justification of why emergency medication is necessary.

6-20.1.b Clinicians identify and document and evaluate any pre-existing medical, mental conditions, or physical disabilities and limitations that may place the patient at greater risk during use of medication, restraints, or seclusion prior to intervention.

6-20.1.c All least restrictive options must be exhausted prior to determination of utilizing medication.

6-20.1.d Less restrictive measures include, but are not limited to:

- Increased staff interaction and/or observation.
- Consideration of medication review.

6-20.1.e Redirection and reorientation.

6-20.1.f Reevaluation of the treatment plan.

6-20.2 Orders for emergency psychotropic medication.

6-20.2.a Clinicians must obtain a written order from the CD or physician designee prior to medication administration. The order should include the type of medication, dose, route, and direct observation instructions for assessing adverse reactions or side effects.

6-20.2.b Standing or as needed orders are prohibited. The CD or physician designee orders additional psychotropic medications. After an in-person thorough assessment has been performed.

6-20.2.c Clinicians will never medicate minors without parental consent, unless there is imminent danger that the minor will injure himself or others, and the parent is unavailable to provide consent.

- The health care provider determines that all less restrictive or intrusive measures are inadequate.
- The health care provider clearly documents in the health record the patient's condition, the threat posed, and the reason for proposing medication, including other treatments attempted.

6-20.2.d Clinicians immediately refer a child to a local hospital for further evaluation and treatment when the child poses an immediate and serious threat of harm to their self or others.

6-20.2.e The child's parents should accompany the child through the hospital admission process.

6-21. Use of Restraints.

6-21.1 If the parent is immediately unavailable or unable to control their child's behavior and the child's behavior poses an immediate risk of physical harm to self or others, staff may use physical control measures and/or restraints to prevent such harm. However, they must use special consideration for the possible effects on the child.

Staff must consider the child's size, age, gender, and comprehension level when considering the use of physical control measures and/or restraints. If the parent/guardian are present, they must provide consent. The use of physical control measures and/or restraints on minors are only authorized as follows:

6-21.1.a Use of restraints on minors ages 12 and under is always prohibited. Physical control measures and/or restraints should only be used on minors ages 12 and under to prevent a minor from injuring him/herself or others.

6-21.1.b Use of restraints on minors ages 13–14 requires authorization from the Center Administrator; and

6-21.1.c Use of restraints on minors ages 15–17 requires shift supervisor authorization.

6-21.1.d In the event of unaccompanied minors, authorization is required from the FOD for restraints greater than one minute.

6-21.1.e In all cases, Center staff should first use a short personal restraint that lasts no longer than one minute if doing so does not put the minor or staff at risk of physical harm, before moving on to more involved techniques.

6-21.2 All medical restraints must minimize the risk of physical discomfort, harm, or pain to the minor.

6-21.3 Clinicians immediately refers a child who poses an immediate and serious threat of harm to self or others to local hospital for further evaluation and treatment.

6-21.4 Custody staff provides one-to-one continuous observation until transferred.

6-21.5 The child's parents should accompany the child through the hospital admission process.

7. HISTORICAL NOTES. This directive replaces IHSC Directive 03-44, *Use of Emergent Psychotropic Medication, Clinically Ordered Restrain, and Seclusion* dated January 3, 2022.

7-1. Summary of Changes: Technical update. Language "detainee" changed to "patient" throughout the document in the appropriate context.

8. DEFINITIONS. The following definitions apply for the purposes of this directive only and all other definitions can be found in the IHSC Policy Library.

8-1. Emergency psychotropic medications - Medications given without the patient's consent for short-term use in emergency situations where the health and welfare of the patient or others is threatened.

8-2. Clinically ordered restraints - Therapeutic interventions initiated by medical or mental health staff to use devices designed to safely limit a patient's mobility in a crisis due to physical or mental illness.

8-3. Clinically ordered seclusion - Therapeutic intervention initiated by medical or mental health staff to use rooms designed to safely limit a patient's mobility in a crisis due to physical or mental illness.

9. APPLICABLE STANDARDS:

9-1. Performance Based National Detention Standards: 2011, rev. 2016.

9-1.1 Part 2: Security; Section 2.15 Use of Force and Restraints.

9-1.2 Part 4: Care; 4.3 Medical Care; O. Mental Health Program; 6. Involuntary Administration of Psychotropic Medication.

9-1.3 Part 4: Care; 4.3 Medical Care; Y. Restraints.

9-1.4 Part 4: Care; 4.4 Medical Care (Women).

9-2. ICE Family Residential Standards (FRS):

9-1.5 Part 2: Security; 2.10 Use of Physical Control Measures and Restraints.

9-1.6 Part 4: Care; 4.3 Health Care; O. Mental Health Program; 6. Involuntary Administration of Psychotropic Medication.

9-1.7 Part 4: Care; 4.3 Health Care; Y. Restraints.

9-3. American Correctional Association (ACA):

9-3.1 4-ALDF-4D-21: Use of Restraints.

9-4. National Commission on Correctional Health Care (NCCHC):Standards for Health Services in Jails, 2018:

9-4.1 J-G-01: Restraint and Seclusion.

9-4.2 J-G-03: Emergency Psychotropic Medication.

10. PRIVACY AND RECORDKEEPING. ICE uses patient medical records and information maintained in accordance with the DHS/ICE-013 Alien Health Records System of Records to provide for the care and safety of patients. IHSC limits access to patient health records and information to those individuals who need to know the information for the performance of their official duties, and who have appropriate clearances or permissions. IHSC secures paper records in a locked cabinet or room when not under the direct control of an officer or employee with a need for the paper record to perform their duties.

10-1. IHSC staff complete annual training on the protection of patient health information and Sensitive Personally identifiable information.

10-2. IHSC staff reference the Department of Homeland Security Handbook for Safeguarding Sensitive PII (Handbook) at DHS Handbook for Safeguarding Sensitive PII for additional information concerning safeguarding sensitive PII.

10-3. All relevant documents produced or provided in accordance with this Directive must be maintained in accordance with an applicable National Archives and Records Administration (NARA) General Records Schedule (GRS) or a NARA-approved agency-specific records control schedule. If the records are not subject to a records schedule, they must be maintained indefinitely by the agency. In the event the records are subject to a litigation hold, they may not be disposed of under a records schedule until further notification. Prior to the disposition of any records referenced in this directive, ICE Records Officer approval must be obtained.

11. **NO PRIVATE RIGHT STATEMENT:** This directive is an internal statement of IHSC. It is not intended to, and does not create any rights, privileges, or benefits, substantive or procedural, enforceable against the United States, its departments, agencies, or other entities, its officers or employees, or any other person.

12. **POINT OF CONTACT:** Chief, Psychiatry Services.