A NEW WAY OUT

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Seclusion, its purpose and use is seldom understood. Seclusion is effective because it is expedient, allo is not a satisfactory treatment method, seldom provides a "learning experience," and, when applied without understanding, only serves to intensify the treatment problem.

Explanations for using seclusion vary from "the staff is afraid of the resident" to "it stopped the resident from suicide or homicide."

As a temporary expedient measure in a therapeutic setting, seclusion should occur only when:

1. The resident is engaged in behavior which is actually physically harmful to himself,
2. The resident is engaged in behavior which is actually harmful to someone else (staff or another resident.)
3. The resident is engaged in behavior which is destructive of another's personal or state property.
4. The resident cannot presently be contained within the treatment facility, i.e., persists in running away. (Here, the therapy team must try to find the reason why and correct it.)

PRINCIPLES OF APPLICATION:

1. The process of seclusion should always be used as a temporary intervening measure to interrupt behavior in the general classes noted above. It should be imposed immediately after the behavior is interrupted.
2. The contingency for a resident being in seclusion should be based only on the resident's actual behavior. No resident should be secluded because of staff inability to deal with their own feelings whether the feelings be anger, fear, or inadequacy. (Some very rare and unusual exceptions to this occur with severely depressed patients on admitting units in Psychiatric Receiving Facilities.)
3. At the time of the application of a seclusion procedure, a contingency plan must be formulated which will provide the resident an opportunity to "behave" his way out of seclusion. Contingencies such as "being quiet," "settling down," sleeping or resting through the remainder of the night, etc., may be appropriate.
4. The contingency for increasing amounts of time "free" from seclusion should be based upon the resident's behavior both "in" and "out" of seclusion. This may range from:
   "You can come out and eat your breakfast *when* you settle down.[n]
   "Then, if you remain calm and don't hurt anyone, you. can remain out of seclusion*"
   to:
   "You can earn 5 extra minutes each hour when we take you out of seclusion to walk around."

(Example of Schedule:)

	In (Minutes)	Out with continuous observation (Minutes)
8 **a.m.**	50	10
9 a.m.	45	15
10 a.m.	40	20
11 a.m.	35	25
etc.	30	30
	25	**35**
	20	40
	15	45

This schedule would represent an exceptionally strict one *for* someone who is periodically very combative. It might include ''starting over" if aggression occurred during an "out" period.

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(Principles of application)

5. "Creature comforts" should not be denied as a part of the seclusion program. Pood, toilet, ventilation, and adequate furnishings should be provided for on a regular basis. (Rarely, it may be necessary to remove all furnishings from a room.)
6. The explicit and implicit "message" to the resident should be: "Your behavior is unacceptable right now to those of us who want to treat you", rather than "you are an unacceptable person" or "no good" or (even more destructive to a total treatment program)"uncontrollable." (Residents, like staff, may at times be "uncontrolled" but are never "uncontrollable.")
7. Seclusion and the process of initiating it should provide less gratification and reinforcement for the resident rather than more. (Is there any other way a resident might obtain privacy?). If the amount of seclusion (measured by frequency of occurrence and total duration) increases rather than decreases, the seclusion process in toto is acting as a positive reinforcer. This strengthens the behavior antecedent to the seclusion process which results in more rather than less, difficulty.
8. The result of initiating a seclusion procedure increases the amount of work for the staff rather than decreasing it. Using seclusion to avoid responsibility, punish, reduce staff anxiety or temporise for insufficient numbers of staff is contra-therapeutic.

To prevent behavior which leads to seclusion requires a little talent, some experience and considerable ambition. The relative effectiveness of a line level staff member could probably be measured by the quantity of seclusion initiated if each of us were to be confronted with the exact same situations.

Under the best of circumstances, solutions to problems posed by the use of seclusion should occur prior to the necessity of initiating seclusion procedure. Some of the prophylactic techniques of proven value are:

1. Clear definitions of the limits of tolerable behavior should be made to the resident and communicated to the staff so that there is consistency throughout the entire unit. This will eliminate the necessity for the resident to continually test limits with each and every staff person.
2. Lack of activity with organized structure and which is engaged in with the residents can only result in random efforts on their part for discharge energy and emotion. It would seem obvious that designing a program of activity for an individual or a group would be easier than attending to the emergencies which are a natural and product of inactivity.
3. Activity programs which are successful will be those in which the resident engages voluntarily and enthusiastically without coercion. Activities in which the patient-is unwilling to engage but which are justifiably a part of the total treatment program may be enhanced by following an approximation of the appropriate behavior with a reinforcer. Approaching the resident with the attitude "do it or else," more often than not, results in the "or else" the "or else" may occur at a later date thus presenting to the staff a seemingly unexplainable incident.
4. Provision of opportunities for the resident to gain recognition, acceptance and. in addition, social praise by providing other methods.
5. *Competitive behavioral chains"* should be strengthened by following them with the "reinforcer". thus, if "privacy" is a resident's goal, other means to obtain it are less disruptive than any of the above four conditions which result in seclusion.

The disruptions resulting from repeated and prolonged seclusion measures detract to such an extent from a therapy program that the whole program is soon oriented only to the emergencies and resident suppression. To say that this is inefficient is to understate reality.

The only talent, initiative, ambition and skill it takes to lock a door is that required to "turn a key." No member of a therapy team should be satisfied with that as a job inscription.