nonviolent crisis intervention
a CPI specialised offering

Seclusion: Applying *Nonviolent Crisis Intervention*® Concepts

CPI's *Nonviolent Crisis Intervention*® training program promotes a safe, nonharmful behavior management and intervention system, designed to help professionals who deal with potentially disruptive and assaultive behaviors maintain the *Care, Welfare, Safety, and Security*SM of staff and those in their care. The focus of the program is on preventing incidents of disruption and aggression by increasing staff understanding of situations, feelings, and factors that may lead to escalating behaviors, which, in turn, may lead to crisis situations. Helping staff develop effective skill sets and strategies to safely intervene and respond may de-escalate a potentially volatile or aggressive person in their care.

Efforts to reduce the use of physical interventions, including physical restraint and seclusion, are laudable, and CPI is proud to be a part of these efforts, by offering organizations effective training to provide staff with the knowledge, skills, and confidence to help defuse disruptive incidents before physical interventions become necessary.

Efforts to reduce the use of physical interventions are most successful when an organizational philosophy is followed that assures that these restrictive interventions will be used only as a last resort to manage specific incidents when a care receiver's behavior poses an imminent danger to self or others, and when less intrusive methods to de-escalate the behavior will not adequately maintain the safety of all involved. The intent of staff must be to maximize the safety of the individual and of staff to employ the least restrictive intervention, not for convenience, for punishment, or to incur pain. When these values are embedded within the organization and translate into day-to-day care, the risks of injury to the individual and to staff are minimized.

To help mitigate the risks associated with these interventions, the *Nonviolent Crisis Intervention*® training program includes a unit focusing on *Nonviolent Physical Crisis Intervention*SM, which offers practical solutions for staff who must intervene with an individual whose behavior has become physically aggressive. The principles and dynamics of *Nonviolent Physical Crisis Intervention*SM are taught and rehearsed through the use of Classroom Models, which provide a starting point for staff to learn ways to reduce the risks of physical, social, and emotional harm associated with any physical intervention. Understanding the Control Dynamics of physical intervention techniques aids staff in effectively reducing the strength, energy, and momentum of an individual who is physically acting out.

Local organizational or regulatory governing policy will often dictate if or when employees are authorized to utilize physical interventions to respond to such violent behavior. To ensure compliance with these safety guidelines provided by law, CPI stresses that Certified Instructors should review all applicable regulations, policies, laws, and accreditation standards, whether they be organizational, state, provincial, federal, or international in nature. These statutes, policies, and governing regulations are often

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amended and/or updated. Certified Instructors should also ensure that through an ongoing training process, all staff are thoroughly informed of and aware of what requirements exist and apply.

This discussion is intended to depict the stated position of CPI and the CPI Instructor Association, regarding "seclusion" as an intervention. Regarding the use of seclusion as commonly defined within practice and the literature, *Nonviolent Crisis Intervention*® training does not make recommendations for the dimensions of a seclusion area, does not specify special physical techniques to restrict someone within a seclusion space, and does not formally include a content Unit dedicated to seclusion within the formal training program curriculum. We do regularly encourage Instructors to include seclusion as a related topic to restraint within their trainings, if permitted within their organization's policy and/or regulatory guidance, as well as alignment with the further guidance provided in this paper.

CPI recognizes that the only safe restraint is the one we do not have to utilize, that any physical intervention is inherently potentially dangerous, and that although we do teach physical interventions, we advocate for restraint-free facilities.

Within the same context, CPI recognizes the inherent physical and emotional dangers, as well as the historical misuse of seclusion within care facilities, and therefore also advocates for the reduction in use of seclusion, toward seclusion-free facilities. However, CPI does recognize the realities that facilities we serve face, and that they sometimes do utilize more restrictive interventions within their array of range of force, beyond the scope of *Nonviolent Physical Crisis Intervention*SM. These more restrictive interventions include, but are not limited to, interventions such as seclusion, environmental restraints, medical restraints, and other security devices. We also recognize that these more restrictive interventions may be needed on an interim basis, for persons who present a propensity for significant self-harm, or other potentially lethal and deadly behavior toward self or others. CPI remains available to converse with and assist Certified Instructors to problem-solve related issues and apply *Nonviolent Crisis Intervention*® training content to these settings.

Values, attitudes, and themes within the philosophical orientation of *Nonviolent Crisis Intervention*® training can be applied to settings that do use seclusion. Facilities that use seclusion are further advised to:

- Commit to advancing the *Care, Welfare, Safety, and Security*SM of all stakeholders.
- Clearly define what is meant as *last resort* and *imminent danger to self or others*.
- Delineate clearly in policy and guidance facility-specific parameters for use.
- Maximize supportive, respectful, and positive communication strategies throughout the duration of a seclusion intervention.
- Not utilize seclusion as a punishment or to inflict pain.
- Allow acting-out individuals to reintegrate into the facility and activities once they have regained control of their behavior and actions.

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A review of legislative and regulatory guidance documents regarding the use of restraints indicates that often these are implemented in conjunction with further guidance associated with the use of seclusion. Certified Instructors have increasingly sought guidance from CPI regarding the use of seclusion. Thus again has surfaced the need for CPI to more formally offer guidance and assume a position of leadership for these Instructors and their organizations. A listing of examples of legislative and regulatory initiatives across the United States, Canada, and the United Kingdom is included at the end of this document. As this is only a partial listing at a given time, and recognizing that regulatory activity is a fluid, dynamic, and constantly evolving process, readers are advised to access current local, state, provincial, authority, or other regulatory policies and guidance that specifically apply to their organizations.

The practice of seclusion, more typically seen in medical, mental health, or security settings, can be best understood when viewed as a continuum, or an array of options, from a least restrictive to most restrictive perspective. On one end of the continuum is the practice of allowing a person in crisis the time or space to calm down and consider more appropriate behavior. For example, staff might offer an acting-out person a few minutes to consider a staff request for a desired behavior and the consequence of choosing to comply with the request. Often, individuals will comply with requests if they understand what is inappropriate about their behavior, are given clear limits or choices to exhibit a more appropriate behavior, and are allowed time to gather their thoughts to demonstrate more appropriate responses. The philosophy of the *Nonviolent Crisis Intervention®* program is congruent with practices that maintain respect for the individual and are not punitive. Individuals should be allowed to re-engage as soon as they have de-escalated, incurred appropriate consequences, if necessary, that are consistent with the limits that were set, and have demonstrated the appropriate behavior for the situation.

Closer to the more restrictive end of the continuum are seclusion practices that remove the individual to a separate area, location, room, or enclosed space. Seclusion is commonly defined within the literature and regulatory guidance as the confinement of an individual, at times involuntarily, to a space or room which prevents the individual from leaving, and, in some cases, even physically contains the individual to the secluded space. Timeout, more commonly used in educational settings, is often defined within the literature and regulatory guidance as associated with the removal of access to positive reinforcement with an individual. Regulatory guidance may also further define isolated timeout, or exclusionary timeout, as a space, room, or location that allows for removal of the individual from reinforcement to a designated space for a specified time. However, the individual's movement to, within, and from this space is not typically physically restricted.

If over-utilized or inappropriately employed, more invasive and restrictive practices such as seclusion have the potential to conflict with the philosophical underpinning of the *Nonviolent Crisis Intervention®* program, which is advancing the *Care, Welfare, Safety,*

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and Security℠ of all stakeholders. Such practices may include, but are not limited to, the following:

- If not utilized within an appropriate context of an array of less restrictive options.
- If the individual has already begun to calm down and regain some control.
- If the physical intervention needed to move the person or restrict the person to a confined area escalates the situation into a more violent and dangerous physical episode, beyond the level of the original incident.

One must continuously assess, within the crisis moment, whether the dangers of the physical intervention exceed or outweigh the dangers associated with the intensity of the behavior being presented. Such restrictive seclusion intervention practices may also be psychologically damaging to the person in care. A summary listing of pros and cons of seclusion as reported in the literature are also cited later in this paper.

An array of interventions within the range of force continuum depicted below and the subsequent discussion illustrate a hypothetical example of how seclusion could be considered less restrictive than a physical intervention. This is not suggested as a static listing. The order or progression from least to most restrictive may vary greatly from one client to another or from one facility to another. This progression should be evaluated within such a context and is to be considered individual specific and situational specific.

- ☐ Nonverbal intervention, such as space or body movement
- ☐ Verbal intervention, such as limit setting
- ☐ Timeout, removal of access to positive reinforcement
- ☐ CPI *Personal Safety Techniques*℠
- ☐ Manual restraints, such as *Nonviolent Physical Crisis Intervention*℠
- ☐ Timeout, move person to a designated place
- ☐ Seclusion intervention to a confined area
- ☐ Chemical intervention, such as PRN or rapid tranquilization
- ☐ Environmental/territorial restriction to a secure unit or fenced-in area
- ☐ Mechanical restraints, such as a bed rail, soft restraints, or a mechanical device
- ☐ Handcuffs or other security devices

For the sake of this illustration and this discussion, if staff were working with a patient who has a documented pattern of significant, recurring, predictable violent physical episodes, the use of medication or seclusion as an alternative to a physical intervention may have the potential to avert a physical altercation. If a physical altercation is avoided, one may be able to consider such an intervention less restrictive within the range of force continuum, as a potentially more dangerous physical intervention was, in fact, averted. However, staff are again cautioned not to use such a hypothetical example based on a predication of behavior, or as a reason or excuse to justify seclusion.

The graphic model depicted below is intended to represent restraint and seclusion as two alternate possibilities to respond to a physically acting-out person in Level 3 of the CPI *Crisis Development Model*℠. The individual is presenting a behavior that constitutes

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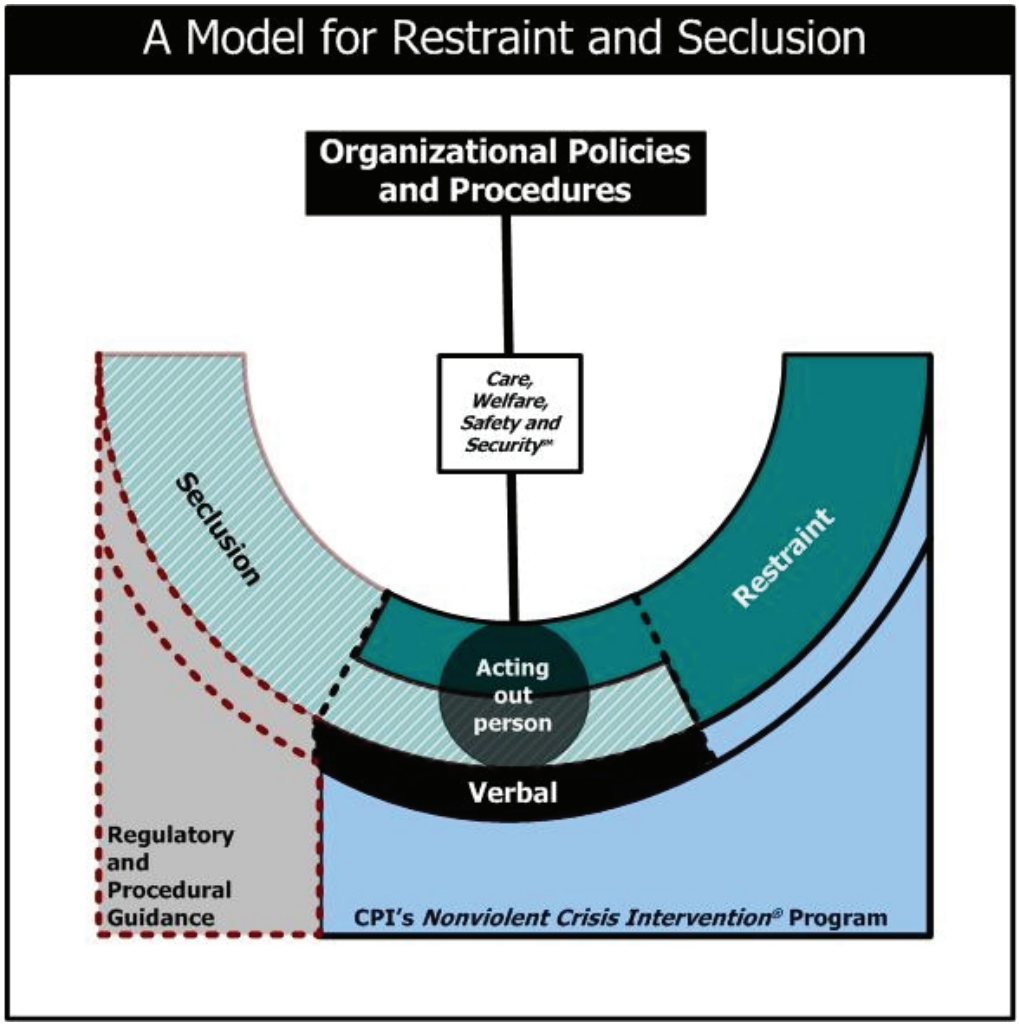
a last resort—an imminent danger to self or others. Which direction the pendulum swings toward depends on organizational policies and procedures, keeping in mind the *Care, Welfare, Safety, and Security*SM of all stakeholders. CPI advocates always keeping a situation in the verbal intervention array of interventions and not escalate to a physical episode. This model may also be used to address a dynamic and evolving situation that starts in restraint, but requires a transition to seclusion, or the reverse. Such an event would require a high level of ongoing verbal/nonverbal communication with the acting-out person and staff. *Nonviolent Crisis Intervention*® training is designed to provide techniques in both verbal and physical restraint interventions.



A review of the selected literature sources cited below regarding seclusion surfaces the following pros, or purported advantages, and cons, or possible detrimental results, of seclusion. These are offered for readers for evaluating and assessing the appropriateness of seclusion as an alternative within their organizations.

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***Pros, as articulated in the literature, suggest that*:**

- Seclusion is ethically permissible if used under the specified circumstances.
- Seclusion can protect safety for self and others during episodes of extremely violent behavior.
- Seclusion is seen as beneficial more often from a staff's point of view.
- Seclusion is viewed by some as having some therapeutic value.
- Seclusion may be used effectively as a last resort when a person poses an extreme danger to self or others.
- Some persons report feeling safe in seclusion.
- After time, some persons are able to understand the reason for their seclusion.
- Debriefing may help re-establish Therapeutic Rapport and may help the person cope with the experience better.
- Informing the person of seclusion practices in advance may help reduce seclusion use, or at least help the person understand the reasons for its use.
- Seclusion may be effective for security measures.
- Holmes (2004) suggested that 50% of patients thought seclusion protected them and 40% believed that it also protected other patients.
- Perceptions may improve if facilities use seclusion in a culture of care and sustain contact with the person while he is in seclusion.
- Spaces should be designed to incorporate elements that support patient safety.
- Seclusion rooms are a last-resort intervention, and should be used for the shortest amount of time possible.
- Wynn (2002) reports that seclusion may be safest and most effective with older persons (60+ years of age).
- In some instances, pharmacological restraint and seclusion may be viewed as less restrictive than physical restraint and seclusion.

Cons, as articulated in literature, suggest that:

- Seclusion endangers the dignity of a person and can result in loss of self-control and autonomy.
- Individuals who have experienced seclusion often report a negative view of seclusion.
- Seclusion is not found to be therapeutic.
- Additional harm may be caused by using seclusion.
- The physical effects of seclusion are not always clear and must be researched further.
- The person may misinterpret the use of seclusion.
- Power struggles emerge between staff and the person in seclusion.
- The person may feel that staff have a sense of control and satisfaction, and that the person is "getting what they deserve" when put in seclusion.
- There is a conflict between autonomy and protecting the person’s safety.
- The person feels powerless, as if staff have all the power.

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- The person fears the recurrence of seclusion, inequitable care during seclusion, and the lack of opportunity to talk about the experience.
- Seclusion prompts feelings of fear, anxiety, and confusion.
- Seclusion may increase aggression, anxiety, and out-of-control behavior, especially in self-injurious and suicidal persons.
- Seclusion is associated with an increase in negative emotions and perceptions.
- Seclusion is potentially damaging to the staff–client relationship.
- The person may view seclusion as a punishment—that staff are using seclusion as punishment.
- There is a lack of government attention to seclusion use and regulation.
- The status and physical condition of rooms used for seclusion are often inadequate.
- Seclusion and restraint may be seen as more of a punishment, while pharmacological restraint may be seen as more therapeutic.

Nonviolent Crisis Intervention® Certified Instructors are further directed to follow all local or regional policies and regulatory guidance if a determination is made to employ seclusion on a person-specific, as well situational-specific, basis. Additional training and local administrative governance regarding implementation of these policies and procedures is strongly recommended. The *Care, Welfare, Safety, and Security*SM of the care receiver and caregiver must not be compromised if seclusion alternatives are used. The following guidance and recommendations regarding use of seclusion appear regularly in guidance documents. Seclusion practices and areas should:

- ☐ Adhere to all regulatory or guidance policies regarding seclusion that your agency is governed by.
- ☐ Be used only for extreme emergency situations and for an interim period.
- ☐ Be of sufficient size and provide for adequate ventilation, lighting, viewing by staff, and safety for the person being contained.
- ☐ Remain unlocked if a door is provided.
- ☐ Be prescribed in a behavior or treatment plan.
- ☐ Be authorized by the appropriate medical personal, administrator, parent, or guardian.
- ☐ Provide access for basic needs such as water, nutrition, communication, and bodily functions.
- ☐ Sustain continuous supervision by staff within the immediate proximity, for the duration of the seclusion.
- ☐ Be used only for a period of time that allows the person to regain control and re-engage in regular activities, as soon as de-escalation is reasonably occurring.
- ☐ Have access to and use of electronic surveillance of the seclusion space.
- ☐ Be used only if a less restrictive intervention is not available or appropriate for the behavior being immediately presented.
- ☐ Be used when a sufficient number of staff is available, and after staff have had extensive orientation and training regarding seclusion.
- ☐ Should not be used for punishment, pain compliance, or staff convenience.

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CPI further recommends that after the use of seclusion has been employed, staff engage in an individual care-receiver-specific assessment of the antecedents, precursors, causes, and Precipitating Factors that initiated the behavior. Additionally, the development of a plan to teach replacement or substitution behaviors, as well as more positive appropriate behavior alternatives, is strongly recommended. Staff responses and skill sets must also be critiqued and reassessed to determine whether additional training is needed, or whether further instruction is merited in alternate interventions of a less restrictive nature.

The following sampling of legislation and regulations was used as source material in the development of this document.

- Alabama Admin. Code R. 580-2-13-19: Adult Restraint and Seclusion
- Arizona Report from the Task Force on Best Practices in Special Education and Behavior Management Created by Arizona Senate Bill 1197
- Arkansas Department of Education Special Education and Related Services 20.00 Time-Out Seclusion Room
- California S 130: Use of Seclusion and Behavioral Restraints in Psychiatric Facilities
- Colorado State Board of Education 1 Colorado Code of Regulations 301-45 Rules for the Administration of the Protection of Persons from Restraint Act
- Connecticut Public Act No. 07-147 An Act Concerning Restraints and Seclusion in Public Schools
- Connecticut H 6226: An Act Concerning the Connecticut Juvenile Training School
- Council for Children with Behavioral Disorders (CCBD) Position Statement with regard to Restraint and Seclusion
- District of Columbia Chapter 25, Subtitle E of Title 5 of the District of Columbia Municipal Regulations 5-A2502 Restraint and Seclusion
- District of Columbia Chap. 5, Title 22A52 DCR 8691: Use of Restraint and Seclusion
- Florida Statute 1003.573 - Use of seclusion and restraint on students with disabilities
- Florida 28875: Mental Health Involuntary Outpatient Placement
- Florida HB 7199: Forensic Treatment and Training
- Georgia Guidance for State Board of Education Rule 160-5-1-.35 Seclusion and Restraint for All Students
- Illinois State Board of Education Section 1.285 Requirements for the Use of Isolated Time Out and Physical Restraint
- Indiana Department of Education Policy Guidance for the Use of Seclusion and Restraints in Schools

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- Iowa Administrative Code 281, Chapter 103: “Corporal Punishment Ban; Restraint; Physical Confinement and Detention”
- Kansas State Department of Education Seclusion and Restraint Guidelines
- Kentucky 902 KAR 20:320: Psychiatric Residential Facility Operation
- Kentucky Department of Education Restraint/Seclusion/Effective Use of Time Out
- Louisiana R.S. 28:171 (adults) and Children’s Code Article 1409(D) (minors)
- Maine 05-071 Chapter 33: Regulations Governing Timeout Rooms, Therapeutic Restraints and Aversives in Public Schools and Approved Private Schools
- Maine 8105 2005: Children’s Residential Child Care Facilities
- Maryland State Board of Education 13A. 08.04 Student Behavior Interventions
- Maryland State Board of Education Technical Assistance Bulletin September 2009 Division of Special Education/Early Intervention Services, Use of Exclusion, Restraint and Seclusion
- Maryland 14.31.01-.07: Restraint and Seclusion in Certain Facilities
- Michigan State Department of Education - Supporting Student Behavior: The Emergency Use of Seclusion and Restraint (Michigan)
- Michigan HB 5476: Licensing and Regulation of Child Care Organizations
- Minnesota 125A.0942 Standards for Restrictive Procedures
- Nebraska Department of Education, Developing School Policies & Procedures for Physical Restraint and Seclusion in Nebraska Schools: A Technical Assistance Document
- New Mexico Restraint & Seclusion Work Group
- New York 8 NYCRR §200.22(c) Use of Time Out Rooms
- North Carolina Gen. Stat.§115C-391.1 Permissible Use of Seclusion and Restraint
- Ontario Canada, R.R.O. 1990, Regulation 70: Child and Family Services Act
- Oregon Department of Education Technical Assistance: Use of Physical Restraint and Seclusion
- Oregon OAR 581-021-0062 Use of Physical Restraint and Seclusion

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- Oregon 26349 2005: Restraint and Seclusion in Oregon Youth Authority
- Oregon 26455 2005: Continuous Care Coordination
- Pennsylvania ADC Ch. 13.1-9: Use of Restraints in Treating Patients/Residents
- Rhode Island Regulation: Restraint and Seclusion in Public Education Programs
- Tennessee Special Education Isolation and Restraint Modernization and Positive Behavioral Supports Act
- Texas Education Code (TEC—State Statute) Sec. 37.0021. Use of Confinement, Restraint, Seclusion, and Timeout
- Texas 37 TAC 3.97.A.97.23: Physical Restraint in the Texas Youth Commission
- Texas S 325: Residential Behavior Management
- Texas 40 TAC 9: Mental Retardation Services—Medicaid State Operating Agency Responsibilities
- Texas 40 TAC 19: Nursing Facility Requirements for Licensure and Medicaid
- Texas 40 TAC 92: Licensing Standards for Assisted Living Facilities
- United Kingdom, Mental Health Bill, 2006
- Utah 27724 2005: Behavior Interventions (DHS)
- Virginia 2252 2002: Physical Restraint in Private Day Schools
- Virginia Guidelines for the Development of Policies and Procedures for Managing Student Behaviors in Emergency Situations in Virginia Public Schools Focusing on Physical Restraint and Seclusion
- Washington 24374 2005: Residential Treatment Facilities for Impaired Children
- Washington WAC 392-172A-03120 through 03135 Aversive Interventions
- Wisconsin Department of Public Instruction: Directives for the Use of Seclusion and Physical Restraint in Special Education Programs (Wisconsin)
- Wisconsin 20403 2004: Restraint and Seclusion in Group Foster Care

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Selected literature sources:

American Psychiatric Nurses Association. (2007). APNA position papers: 2007 position statement on the use of seclusion and restraint (electronic copy). Arlington, VA: Author. Retrieved from http://www.apna.org/resources/postionpapers/ SRPositionStatementFinal.pdf

Child Welfare League of America. (2004a). *CWLA best practice guidelines: Behavior support and intervention training.* Washington, D.C.: Author.

Curran, C., Adnett, C., & Zigmond, T. (2005, 14 Jan.). Seclusion: Factors to consider when designing and using a seclusion suite in a mental health hospital. Hospital Development.

Finke, L. M. (2001). The use of seclusion is not evidence-based practice. *Journal of Child and Adolescent Psychiatric Nursing*, 14(4).

Greene, R., Albon, J., & Martin, A. (2006). Use of collaborative problem solving to reduce seclusion and restraint in child and adolescent inpatient units. *Psychiatric Services, 57*, 610–612.

Hoekstra, T., Lendemeijer, H.H.G.M., & Jansen M.G.M.J. (2004). Seclusion: The inside story. *Journal of Psychiatric and Mental Health Nursing*, 11.

Horsfall, J., & Cleary, M. (2003). Patient concerns about seclusion: Developing a leaflet. *Issues in Mental Health Nursing*, 24.

Holmes, D., Kennedy, S., & Perron, A. (2004). The mentally ill and social exclusion: A critical examination of the use of seclusion from the patient's perspective. *Issues in Mental Health Nursing, 25*(6), 559–578.

Muir-Cochrane, E. C., & Holmes, C. A. (2001). Legal and ethical aspects of seclusion: An Australian perspective. *Journal of Psychiatric and Mental Health Nursing*, 8.

Meehan, T., Bergen, H., & Fjeldsoe, K. (2003). Staff and patient perceptions of seclusion: Has anything changed? *Journal of Advanced Nursing*, 47(1).

Stokowski, L. (2007). Nursing perspectives: Alternatives to restraint and seclusion in mental health settings: Questions and answers from psychiatric nurse experts (electronic copy). *Medscape Nurses*. Retrieved from http://www.medscape.com/ viewarticle/555686__print

Tilley, S., & Chambers, M. (2005). Review of seclusion policies in high secure hospitals and medium secure units in England, Scotland, and Wales. *Journal of Psychiatric and Mental Health Nursing*,12.

Wynn, R. (2002). Medicate, restrain or seclude? Strategies for dealing with threatening behaviour in a Norwegian university psychiatric hospital. *Scandinavian Journal of Caring Sciences*, 16.

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