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ALTERING THE USE OF SECLUSION WITH EMOTIONALLY DISTURBED CHILDREN IN A RESIDENTIAL TREATMENT CENTER

The Ohio State University

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ALTERING THE USE OF SECLUSION
WITH EMOTIONALLY DISTURBED CHILDREN IN A
RESIDENTIAL TREATMENT CENTER

DISSERTATION

Presented in Partial Fulfillment of the
Degree Doctor of Philosophy in the Graduate School
of The Ohio State University

BY

David E. Miller, B.A., M.S.

The Ohio State University
1982

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Family Relations
And Human
Development
ACKNOWLEDGEMENTS

The efforts which went into the production of this dissertation involved many people who gave generously of their time, energy, experience and knowledge. The members of my committee, Dr. Barbara Newman, Dr. Patrick McKenry and Dr. Henry Leland deserve much appreciation for their numerous readings, helpful comments, and continual support and guidance. Staff members of the treatment teams at Hannah Neil Center for Children were willing participants and helped to facilitate easy implementation of the treatment interventions. The interagency staff committee for the Ohio Association of Child Caring Agencies and the Hannah Neil staff development committee assisted greatly in helping to assess the content and face validity of the attitude questionnaire as well as reviewed the content of inservice presentations. Diana Gregory deserves much recognition for her many contributions. Members of the Miller family -- my wife -- who gave much encouragement, son Scott, and daughter Lori Anne, who offered much support as they often shared daddy's time and attention with his studies.
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CHAPTER I

INTRODUCTION

Background and Setting

The National Center on Child Abuse and Neglect report that over 400,000 children in the United States live in residential institutions such as treatment centers, temporary and long-term shelters, detention centers, centers for the mentally retarded and developmentally disabled, and group homes (U.S. Department of Health, Education and Welfare, 1977). Harrell and Orem (1980) describe these children as largely voiceless and at the mercy of adults who operate such institutions, becoming victims of maltreatment in the very institutions which are operated to care for them and serve their needs.

In recent years, much attention has focused on institutional child abuse and neglect probably resulting from an increased concern for studying familial child abuse and neglect. The U.S. Department of Health and Human Services has reported that an ever increasing number of voices are being raised to prevent abuse and neglect of institutionalized children, and has advocated that systems be developed and implemented to ensure that prompt corrective action be taken when maltreatment occurs (Harrell and Orem, 1980). Maltreatment
is further explained as types of abuse and neglect which are not only institutional, that is occurring within the context of an institution; but, also "institutionalized" as well. "Institutionalized" child abuse and neglect is that which is directly a derivative from the nature of institutions; and, in most cases, at least tacitly supported by them (Harrell and Orem, 1980). Institutional child abuse is generally viewed as the actions or practices referring to staff behavior which results in impaired psychological growth or development of the child (i.e., verbal abuse, excessive demands, interactions resulting in negative self concept and/or disturbed behaviors) (OACCA, 1980).

It is within this context that the use of seclusion -- although a very well accepted practice with inpatient and residential programs -- can become an abusive phenomenon if used incorrectly or under aversive conditions. The use of seclusion, otherwise referred to as "timeout," "isolation," "quiet room," "control," and a form of "restraint" is described with a vast array of meanings throughout the literature. These meanings range from asking a child to go to his room or sit along the sidelines during a recreational activity to physically placing a child by force in isolation, usually in a locked room.

With such a variety of interpretations of its meaning and use, it follows that the process by which the practice of seclusion becomes institutionalized within the treatment setting is easily understood. Although the procedure for the use of seclusion may be established
initially by a program administrator to take place only under certain conditions, through time its use is generalized to a large number of conditions and applications by staff. Seclusion then takes on different meanings and application becomes further differentiated among staff. This inconsistency leads to a lack of cohesiveness among staff with regard to such a practice as an acceptable treatment intervention. Instead of seclusion being used only under very controlled parameters as initially established, it is indiscriminately chosen by staff as an intervention and utilized very inconsistently in practice. Staff training or in-service regarding practices such as seclusion is many times minimized due to time constraints with other training issues taking a higher priority.

Hobbs and Forehand (1977) maintain that despite the abundance of data suggesting the effectiveness of timeout, relatively few investigations have reported detailed information on the exact procedures used to describe timeout. Kazdin (1981) refers to timeout from reinforcement as a period of time in which the child does not have access to available reinforcers in the situation. Gast and Nelson (1977) define timeout operationally as contingent withdrawal of those reinforcing stimuli thought to be maintaining the behavior of interest and functionally as resulting in a decrease in frequency of behavior upon which reinforcer removal has been made contingent. Timeout strategies have included removal of materials, reduction or elimination of room illumination, removal of adult social attention, and removal of the student from a potentially reinforcing situation. Due to confusion between the two interventions,
unknowledgeable persons have occasionally labeled punitive procedures, such as extended periods of seclusion, timeout (Fox and Shapiro, 1978).

Budd and Baer (1976;212) clarify differences between timeout and seclusion, solitary confinement, or segregation practices with the following criteria: (1) timeout is consistently administered contingent on occurrences of an undesirable behavior, (2) timeout is a brief procedure, often lasting between one and five minutes and rarely longer than 15 minutes, and (3) the use of timeout is coupled with objective observations of whether or not it is fruitful in remediating the problematic behaviors, (4) seclusion procedures are usually employed on an unsystematic basis, and when used contingently, probably only for extreme examples of behaviors, and (5) seclusion procedures are typically lengthy ones, lasting for several hours or even days without any monitoring of their effectiveness.

Gast and Nelson (1977) reported that timeout procedures have been successfully applied across a variety of behavior problems, situations, and populations including noncompliance, out-of-control behaviors, nonattending and incorrect responding in classrooms, inappropriate mealtime behaviors, and certain classes of behavior exhibited by severely handicapped children. According to Parsons and Davey (1978), timeout from a positive reinforcer can act as a powerful punishing event and quickly reduces the frequency of antecedent behaviors. However, Mansdorf (1977) reports that in spite of its effectiveness, the use of subject isolation as a timeout technique has several detrimental effects including stimulation of
strong emotional behavior such as crying and banging. Some studies have shown that use of isolation may have paradoxical effects, usually serving as a positive reinforcer instead of a punishing stimulus for some individuals (Mansdorf, 1977). Although a very widely accepted behavioral strategy for controlling or suppressing problematic behaviors, Caraffa, Truckey and Golden (1974) point out that clinical observation of children placed in timeout appears to indicate that anxiety is one likely result of a frustration inherent in the timeout situation which may manifest itself in running away behavior, active resistance (failure to do school work, refusal to speak) as well as the various abusive and destructive behaviors which take place while in timeout (kicking, screaming, etc.). Although indisputably effective, timeout -- if used improperly -- is a potentially highly aversive procedure (Gast and Nelson, 1977).

Further implications deal with litigation or legal parameters for the use of seclusion. The Wyatt v. Stickney case referred to the client's right to treatment as including the right to be free from isolation. Ethically, consent from appropriate persons should be obtained to insure that the child's rights are not violated (Hobbs and Forehand, 1977). Several researchers have noted that public reaction to the use of timeout with children often has been quite negative.

In a survey conducted by the Ohio Association of Child Caring Agencies in 1980, as an effort to initiate proposed standards for the prevention of institutional child abuse within the State of Ohio, twenty-two of the forty-nine reporting child care agencies
indicated their program included the use of a "seclusion," "isolation," or "quiet room." Of the twenty-two agencies reporting their program utilized seclusion; a variety of reasons were given as acceptable reasons for using it. The results of the survey can be summarized in the following categories (O.A.C.C.A. - O.D.P.W., 1980).

1. 71% of respondents reported seclusion to be used when child was out of control (physically) and in order to prevent harm to self or others

2. 24% of respondents reported seclusion used only when a child needed time to regain self control, but not as a punishment

3. 5% of respondents reported seclusion to be used when a child returned from AWOL

What constitutes "out of control" or "regaining self control" and who makes such a decision or interpretation? If a child returns from AWOL, but has cooperatively returned remorsefully, does he still need to be placed in a seclusion room utilized by others for "out of control" behaviors or children "needing to regain control" or "dangerous to self or others?" A further question asked on the same survey involved whether or not every instance of the use of seclusion would be documented in a special report. To this question, 87.5% of respondents reported that all seclusions would be documented on a special written report while 13.5% indicated such reporting would not be an expectation within their program (O.D.P.W. - O.A.C.C.A., 1980).

A similar study was reported by Endres and Goke (1973) which involved questionnaire responses from 50 residential treatment centers within a three state area including Iowa, Minnesota and Wisconsin. In this study, 40% of the 42 respondents indicated
inclusion of a seclusion or "control" room within their residential program. References to this room by staff as well as students varied including such things as "quiet room," "control room," "timeout room," "seclusion," "Unit V," "Ego Room," "Green Room," "Crisis Intervention," "Cooler," "Lock-Up," and "Looney Room." Reasons for placement in the room varied considerably with the majority of respondents stating most common reasons to be "out of control" or "dangerous to self or others." Although the majority of respondents reported usual time durations for using the room to be under two hours, some respondents indicated a student could be placed in a "control room" for as long as one week, with several reporting durations of 4-8 hours, 8-16 hours and 16-24 hours. "Some observations may be made concerning replies to the questionnaire. Several replies had underlined words, indicating strong belief. In some cases the inference was that this technique was punitive, is abused by staff and also inferred that relationships between staff and residents should replace use of timeout rooms (Endres and Goke, 1973)."

In order that we might study the use of seclusion within a residential facility, one must do so within the natural setting and with a minimal number of artificial experimental conditions. The best theoretical model to allow this is the ecological perspective, for this perspective promotes experimentation within the natural context and attempts to incorporate the importance of the interaction of related contexts. According to Whittaker (1971:2), the ecological perspective encourages us to view residential treatment as a complex interplay of many different elements
both within and outside the formal treatment program and also places as much emphasis on environmental assessment as on individual assessment.

From the ecological perspective, perhaps Bronfenbrenner (1979) summarized the theory best when he talked about the four properties of an ecological environment that foster the processes of human development. These properties are as follows:

(1) the child can observe and engage in ongoing patterns of progressively more complex activity jointly with or under adult guidance of persons who possess knowledge and skill not yet acquired by the child and within whom the child has developed a positive emotional relationship.

(2) the child is given opportunity, resources and encouragement to engage in the activities he or she has learned, but without the active involvement or direct guidance of another person possessing knowledge and skill beyond the levels acquired by the child.

(3) the developmental potential of the child care setting depends on the extent to which third parties present in setting support or undermine activities of those actually engaged in interaction with the child.

(4) the developmental potential of childrearing setting is increased as a function of the number of supportive links between that setting and other contexts involving child and persons responsible for his care.

The emotionally disturbed child has been diagnosed as such since the sequence and progression of his developmental stages has somehow become dysfunctional, causing the child to experience maladjustment. For this child, activities for remediation or a redevelopment of those dysfunctional parts seem important. Children placed within a residential treatment facility for treatment
services can observe and participate in progressively more complex activities with the supportive guidance of trained staff. As the child progresses, the direct guidance of staff can be reduced while the child is encouraged to continue participating within these very important tasks. This step seems vitally important if the child is to ever gain self-confidence for self-sufficiency as well as allowing an unsuccessful child an opportunity to experience failure while still in a supportive, protective environment. The residential facility's potential to enhance this developmental process of treatment depends to a great extent upon all third parties including administration, support service staff, community representatives, volunteers and the child's family.

If treatment staff are attempting to provide experiences for helping a child learn pro-social relationships, yet fail to teach this through modeling, the developmental potential for that setting is greatly damaged. Ideally, everyone involved with the facility would have agreement for a common purpose and philosophy of treatment and the types of experiences needed for remediation. Lastly, the developmental potential of the residential facility is greatly enhanced if it can demonstrate supportive links with the other important contexts in the child's life. These other important contexts obviously include the home, school, neighborhood or community and church. Swap (1974) in writing about disburbing classroom behaviors, reports that the ecological perspective describes emotional disturbances in children with more emphasis on the interaction between the child and his environment rather
than the disturbance residing in the child. If this assumption is accepted, then seclusion could further deteriorate rather than resolve the interaction between child and the adult in the child's environment. Although Bronfenbrenner (1979) talks about the family as "the juice of life," the other parts of the child's system must not be neglected as an important potential source of support to the developing child. Many of these latter settings or persons representing these groups will provide support and continuing services for the child after leaving residential care.

It is most difficult to ascertain just how the use of seclusion would fit within those four properties since this perspective refers to the child's participation in progressively more complex activities or tasks with supportive adult guidance, and seclusion by definition is removing adult attention. Since the use of seclusion is being questioned by governmental agencies, courts, parents, mental health professionals, community representatives, and others external to the facility, it is not possible to demonstrate the supportive links between the residential facility and these other settings.

It is accepted, that seclusion used with emotionally disturbed children within the residential facility can have an appropriate place and be successful in managing a child who otherwise might injure himself or others. It is the treatment agency's responsibility to protect all children residing within the facility; and, seclusion of the overtly aggressive child may prevent him from bringing harm to himself or peers. However, the intervention
only becomes appropriate when utilized under strict parameters and as a "last resort" measure after having first attempted other interventions.

It appears that staff continue utilizing seclusion as a result of insufficient or inadequate alternative interventions for managing the out-of-control child. After seclusion becomes an institutionalized practice within a treatment program, staff tend to resist changing such a practice. How can staff continue to be effective in management of this uncontrollable child, yet avoid utilizing an institutionalized approach which reduces their ability to remediate those tasks the child needs within the treatment context? An exploration of alternative approaches that facilitate a positive relationship between child and staff member but also prove successful in managing an out-of-control child is needed. It would appear that approaches that permit the staff member to be seen in a "helping," "caring" relationship would enhance the creation of a positive atmosphere within the treatment context. Such an atmosphere should illicit support from the child's family as well as enhance the "modeling" potential and influence the staff member has with the child.

Two additional questions which appear necessary in our analysis become how the child being secluded perceives such an experience as well as the effects it may have on his peer group. Bandura (1977: 120) reports that children who see assaultive conduct consistently punished display virtually no imitative behavior. However, from observation within the residential living unit, one would be
impressed with what could be termed group contagion which sometimes results from utilizing seclusion with one child who is exhibiting aggressive behavior. After one child is placed in seclusion, it is not uncommon for a second, third, or even fourth child to also seemingly require the same intervention due to aggressive or out of control behavior. The atmosphere of the treatment context seems to become chaotic and disorganized. It is doubtful if the adult is perceived in a positive way by the children within the environment. Perhaps the intervention of seclusion is perceived by the child and his peers as mere punishment. Krumboltz and Krumboltz (1972:185) report that punishment has some serious dangers which include:

1. attempted punishment may actually serve as reinforcement, thereby increasing rather than reducing his undesired behavior,
2. children tend to resist punishment by fighting back, by actively escaping, or by withdrawing into passive apathy, and
3. a child tends to avoid the punisher whenever he can. Obviously, these drawbacks can seriously hamper a staff member's relationship with that child, and subsequent ability to influence change in behavior.

Statement of Problem and Objectives

If one assumes that misuse of seclusion results from a lack of effective alternatives for managing an out-of-control child, an increase in available alternatives should ultimately reduce or perhaps eliminate the misuse of seclusion. As stated earlier, misuse results when seclusion is utilized excessively or at times when other approaches have not been attempted. Obviously,
if the goal is to reduce the use of seclusion by staff as an intervention for controlling the "out-of-control" child, several methods could be utilized administratively to bring about this goal. Ultimately, the seclusion room could be completely eliminated by padlocking the room or converting it to accommodate some other purpose. If complete elimination appears too radical, a more subtle approach could be implemented by designing more restrictive procedural guidelines for using the room, thus making it more difficult to use. This latter approach was attempted at Hannah Neil Center during January-March of 1981, when the four existing rooms were converted to storage closets and two new rooms were constructed to use as seclusion rooms. Not only was the number of available rooms reduced from four to two, the position of the rooms was also re-located to a more central location outside of the treatment unit as opposed to the former rooms located on the treatment units (See Appendix C for floor plan). This change in the physical location of the room within the facility made the supervision and mandated monitoring of the room more difficult to follow. As a result, use of the room became more difficult and treatment staff started initiating other approaches for controlling the "out-of-control" child formerly secluded. Some of the "other" or "instead of" behaviors on the part of staff such as therapeutic restraining effectively helped to de-escalate the child without seclusion. However, other less creative staff employed methods which proved ineffective and tended to only further escalate the child or continued to use the room but without appropriately monitoring the secluded child.
Although staff were informed as to the rationale for closing the existing rooms and the need for construction of new rooms in order to comply with accreditation standards, many staff verbalized they resented the change and felt as if the administration had taken away one of their "needed tools or strategies" for accomplishing their assigned tasks. Others complained that although they could understand the rationale for constructing new rooms, they felt the administration had not provided supporting structures or alternatives for being able to utilize the new rooms.

For these reasons, it is felt that by increasing the resources available to staff for handling the "out-of-control" child, there should be less need to use the seclusion strategy, thereby causing a more natural reduction in use of the room by staff. This approach also permits the administration to have a direct impact upon helping staff in selection and subsequent implementation of more effective strategies for working with the "out-of-control child." The Ohio Association of Child Caring Agencies in the introductory comments to the most recent publication of standards for the prevention of institutional child abuse, purport that misuse of seclusion and timeout are considered types of the most rampant forms of institutional abuse. In light of this as well as recent litigation altering or severely controlling the use of these interventions, it seems only logical for residential facilities to look at alternatives.
Research Questions

In the present study, the research questions are stated as follows:

1. Can the use of seclusion by direct care staff at the Hannah Neil Center for Children be reduced as a result of staff training related to use of seclusion?

2. Will direct care staff attitudes about the use of seclusion change as a result of staff training related to the use of seclusion?

3. Are different types of staff training more effective than others in reducing the use of seclusion by direct care staff?

Hypotheses

Two null hypotheses to be tested in this study were established as follows:

1. There will be no statistically significant change in the use of seclusion from before to after treatment intervention for treatment groups 1, 2, 3, and 4.

2. There will be no statistically significant change between the mean responses from before to after treatment interventions on the attitude questionnaire related to seclusion by treatment groups 1, 2, 3, and 4.

Definition of Terms

The following operational definitions were employed in this study:

1. Seclusion is defined as the isolation of a child in a closed room, locked or unlocked, for the purpose of controlling behavior (O.A.C.C.A., 1981)
(2) **timeout** refers to temporary removal of the child from the group or from environmental stimulation for the purpose of controlling behavior. Timeout may be spent in the same room with the group but restricted from group activity, or in another room entirely away from the group and has often been called "timeout from reinforcement" (O.A.C.C.A., 1981)

(3) **direct care staff** is defined as staff working in a child care role having professional responsibility for complete care of child including child care, recreational and clinical functions and works in the milieu or life space of the child as opposed to therapist seeing the child for an hour of therapy

(4) **educateur** refers to direct care staff in accordance with job description (See Appendix C)

(5) **treatment team** is defined as a group of direct care staff working together as a team with a specified group of children

(6) **life space** is defined as the set of phenomena in the environment and in the organism itself which influence present behavior or the possibility of behavior with emphasis being placed on the interaction between the organism and its environment in an organized, unified field (Wolman, 1973:220)

(7) **milieu** refers to the social and physical environment of the residential program, the natural setting or context where a child resides the majority of his treatment day

(8) **life-space interview** is defined as a set of interviewing strategies developed by Redl and Wineman (1957) and elaborated by Long, Morse and Newman (1971) designed specifically for use in the life space of a child by child care workers. . .may help the child manage a particular upset ("emotional first-aid") or it may deal with a chronic pattern of behavior ("clinical exploration of life events") (Whittaker, 1978:49)
(9) mediation refers to a way of teaching children self control through helping them learn to think through problem situations.
CHAPTER II

Literature Review

When reviewing the literature available on the topic of seclusion or timeout, one is impressed to learn that very few references are made to seclusion but that a majority of references are made to timeout instead. Perhaps this results from the popularity that behavioral approaches have received and the better connotation "timeout" conveys as compared to "seclusion." The literature review which follows was undertaken with the specific purpose of identifying in empirical studies the various forms and uses of timeout or seclusion within a variety of situations. Of interest for the present study, was the effectiveness of its use as an intervention for controlling or managing that child who had become completely out-of-control; and, the specific conditions of the seclusion approach. In addition, knowledge about alternative strategies and their effectiveness as compared to timeout or seclusion as well as information related to both legal and ethical considerations and published standards or guidelines appeared necessary.

The literature reviewed here falls into four major categories which include: (1) litigation, ethical and legal implications, (2) standards and procedural guidelines for implementation, (3) variations of the timeout or seclusion situation, and (4) alternative strategies for timeout and seclusion.
The use of seclusion and timeout has been very much confused with terminology used synonymously even though they remain to be two very different things. Foxx and Shapiro (1978) report that knowledgeable persons have occasionally labelled punitive procedures, such as extended periods of seclusion, timeout. Kazdin (1980) in studying the acceptability of alternative treatments for deviant child behavior, reported that reinforcement of incompatible behavior was evaluated as the most acceptable treatment, followed in order, by timeout from reinforcement, drug therapy and electric shock. Similarly, Kazdin, French, Sherrek (1981) reported that timeout was the least acceptable of the treatments among positive reinforcement of incompatible behavior, positive practice, medication and timeout from reinforcement. Evaluations of acceptability were done by children, parents and treatment staff, and interestingly enough, although children rated treatments as less acceptable than parents, the relative standing of the different treatments were identical for the three groups, thus implying that children and their parents can readily distinguish the acceptability of various treatment strategies. Timeout involved 10 minutes of isolation; and although varied extremely differently in acceptability, no differences in potency or strength of the intervention were noted by the three groups of evaluators. Kazdin (1980) did find isolation to be more acceptable when
included in a contingency contract and when used to back up another form of timeout than when utilized by itself, thus demonstrating that procedures could be added to a particular treatment to increase its acceptability.

Perhaps this is why there exists ethical questions related to use or misuse of seclusion. Kazdin (1980) refers to acceptability of treatment as the judgments about the treatment procedures by nonprofessionals, lay persons, clients, and other potential consumers of treatment. If these judgments by others raise questions about the procedure, their support will be questionable. Ethically, consent from appropriate persons should be obtained to insure that the child's rights are not violated. The treatment plan for the child should specify a timeout duration and provide mechanisms for data collection and for monitoring the child while in timeout (Hobbs and Forehand, 1977).

Although indisputably effective, timeout — if used improperly — is a potentially highly aversive procedure. Gast and Nelson (1977) reported that seclusion timeout frequently referred to as "room timeout," is potentially the most aversive yet the most frequently used timeout procedure. Typically, this procedure consists of physically removing the student from the activity area and placing him in a barren or isolated room. "Several psychiatrists argue that physical restraint is a more humane and therapeutic method for protecting the out-of-control child than seclusion, chemical restraints or impersonal methods of restraint such as a harness or strait jacket (Drisko, 1981)."
Very little litigation has specifically addressed the use of timeout or seclusion as a procedure for dealing with emotionally disturbed children within a residential facility. Those proceedings which have discussed it have been applicable to residential facilities housing the developmentally retarded or mentally ill. Gast and Nelson (1977) report about two court cases; (1) Morales v. Turman, 1973, and (2) Wyatt v. Stickney, 1972. In the Morales v. Turman case, the court permitted dormitory confinement which was defined as the placement of a student alone in a locked room within his own dormitory under the following conditions: (1) to prevent imminent substantial physical harm to the student or others, (2) to prevent imminent substantial destruction of property, or (3) to prevent behavior which creates substantial destruction. Dormitory confinement was not to exceed 20 minutes of duration; and the word "substantial" although used quite extensively in proceedings was not defined.

In the Wyatt v. Stickney case, the court stated that the right to treatment included the right to be free from isolation. An exception to this included emergency situations to prevent a resident from harming himself or others, and then only when less restrictive means of behavioral control were not feasible or had proven ineffective. No exceptions were authorized with respect to mentally retarded persons. In addition to these stipulations, the court outlined the following guidelines for use with "mentally ill" persons (Gast and Nelson, 1977):

1. the patient should not be placed in an isolation room for longer than one hour before calling a "qualified mental health professional"
who evaluates for further duration and provides a written rationale

(2) the written order for continuing timeout stands for a maximum of 24 hours

(3) while the patient is in a prolonged timeout period, he must be observed a minimum of once every hour

(4) records of the patient's behavior while in isolation should be charted

In addition, the case reported that "legitimate timeout" procedures could be used under "close and direct professional supervision as a technique in behavior shaping programs," but the court did not specify what it meant by a legitimate timeout procedure.

Budd and Baer (1976:212) in writing about implications of recent judicial decisions regarding behavior modification techniques, reported the most common aversive technique as timeout which may consist of simply looking away from the subject, moving subject to a chair off by itself, or moving the subject to an isolated room. In addition to referencing the above two court cases, these authors also referred to a case concerning the rights of juveniles -- Inmates of Boys Training School v. Affleck -- where the court ordered several standards during solitary confinement but also went on record of strongly urging solitary confinement not be used. In addition, the Carey consent decree prohibited the use of seclusion, defined therein as the placement of a resident alone in a locked room; and, the Horacek consent stated that aversive behavior modification and isolation, except for valid medical reasons which are necessary to prevent the spread of communicable diseases, were prohibited.
Although litigation has mostly been initiated for settings other than treatment centers for emotionally disturbed children, these proceedings can be interpreted as a precedent by the courts if such questions should be raised about practices with emotionally disturbed children. The residential facility which chooses to ignore these precedents as they develop, leave themselves vulnerable to legal suit if practices within that setting are permitted to exist in a way which might violate the child's rights. It appears that institutional practices such as seclusion are being challenged more by various groups including governmental agencies, parents, community representatives and others external to the treatment agency. This process is usually a forerunner of subsequent change within the institution, even though institutions change slowly. Gast and Nelson (1977) report that recent litigation, presumably stemming from concern over the potential misuse of timeout, has resulted in strict controls, severe limitations, or the abolishment of timeout in some institutions.

Standards and Procedural Guidelines
For Implementation

The Ohio Association of Child Caring Agencies (O.A.C.C.A.), a voluntary organization of both private and public child caring agencies within the State of Ohio has recently become quite active in the study of institutional child abuse. Through a grant project awarded from the Ohio Department of Public Welfare, OACCA has
worked for almost two years writing standards for residential facilities whereby implementation would provide safeguards against institutional child abuse. Although the most recently published proposed standards cover a variety of areas within residential care, there are several specific references to seclusion and time-out within a residential child care context. Insisting that seclusion must not be utilized as a punishment, standards reference the use of seclusion as an absolute last resort measure which can be used when children are physically assaultive and out of control endangering themselves or others (O.A.C.C.A., 1981, 12-14). These standards also deal with the need for written policies which clearly designate authorized use of seclusion. Such policies should recommend short intervals of seclusion with longer than 30 minutes duration requiring supervisory approval, the filing of a critical incident report, routine staff monitoring of the secluded child, staff training in appropriate use and conditions of seclusion, as well as regulations about the seclusion room itself including size, lighting, ventilation, and capability of staff monitoring. For timeout, the OACCA standards require written policies, documentation in a daily log of each time timeout is used with a child, as well as sets up conditions for staff supervision (See Appendix A for specific standards).

In addition to OACCA, both the National Association of Homes for Children (NAHC) and the Interstate Consortium on Residential Child Care have been active in publishing standards which promote regulation in the use of seclusion. While NAHC standards are
written very similar to OACCA standards with respect to timeout and seclusion, the Interstate Consortium on Residential Care takes a slightly different perspective. Although recognizing the considerable controversy concerning the use of what they term "locked isolation," the Consortium recognizes that locked isolation may prevent the use of more restrictive forms of restraint for managing a child whose behavior is unmanageable. These standards further emphasize that "locked isolation," must have an effective means of minimizing the danger of the child injuring himself and continual monitoring of the child (See Appendix A for specific standards).

While the available literature related to seclusion or timeout seem to confuse terminology or equate the two interventions rather than differentiate them, the published standards and procedural guidelines define the two interventions clearly and set specific parameters for use within residential settings. The increased focus on providing standards for residential agencies seem to convey an interest in raising the level of expectation for residential child care facilities; and, should be viewed as a sign of the times. To maintain credibility with funding and governmental agencies, the professional community, and families of clientele, agencies must respond to increased expectations for their level of services by responding appropriately to such standards.
Variations of Timeout or Seclusion

Timeout and seclusion as treatment interventions have been utilized in a multiple of ways within various settings. Available literature not only confuse the two interventions by sometimes treating them equally, but many studies also fail to clearly specify under what conditions the timeout or seclusion intervention is utilized. While some studies place emphasis upon removing the child from reinforcement but allowing him to remain in the social context, others require isolation to a separate room designed for seclusion. Some researchers have been more interested in duration of the timeout or seclusion and have minimized the setting where it takes place. Still, others have examined various applications of the seclusion intervention or a combination of seclusion with some other intervention. Although studies overlap, the discussion which follows review studies in the following categories: (1) seclusion by isolation of child, (2) duration of seclusion, and (3) miscellaneous applications of seclusion or timeout.

Seclusion by Isolation of Child

Timeout, consisting of placing the child in a timeout room until quiet for five minutes, was demonstrated by Sachs (1973) as successful for working with emotionally disturbed children exhibiting self stimulative behavior, uncooperative behavior and other inappropriate behaviors. Ramp, Ulrich, Dulaney (1971) found delayed timeout from reinforcement signaled by illumination of a light on the subject's desk to be effective in reducing disruptive classroom
behavior of a 9 year old boy. Illuminating the light represented loss of free time which was usually spent in a timeout booth consisting of a small room measuring 4 by 3 by 5 feet high containing only a table and chair. When conditions for the light and timeout were removed, disruptive behavior returned to its previous levels.

Lahey, McNees and McNees (1973) demonstrated treatment of an obscene verbal tic for a 10 year old boy through the use of timeout. Timeout here consisted of placing the child in a timeout room for a minimum of five minutes and until he remained quiet for a minimum of one minute following the target behavior. Allison and Allison (1971) reported timeout from social reinforcement was effective in reducing aggressive behaviors of a 26 month old girl toward a younger sibling. Timeout in this study consisted of the child being socially isolated in her bedroom for five minutes.

Burchard and Barrera (1972) concluded that both timeout and response cost were similarly successful in suppressing inappropriate behavior. These authors recommended utilizing a response cost measure since it did not remove the subject from the opportunity to engage in desirable behavior, but provided a more realistic learning situation by not removing subject from ongoing situation. "From that standpoint, any time spent in timeout is wasted time (Burchard and Barrera, 1972)." Murray and Hobbs (1977) demonstrated self imposed timeout procedures were successful in modifying excessive alcohol consumption of a husband and wife by isolating oneself from spouse in a separate room.

In comparing timeout with punishment and extinction, Harder (1977) reported timeout to be ineffective, probably resulting from the
absence of any cognitive or verbal structure to the intervention. Although more efficient, timeout did not produce any more suppression of aggressive behaviors than punishment or extinction.

Drabman and Spitalnik (1973) investigated "contingent social isolation" as a punishment procedure for disruptive behavior exhibited by emotionally disturbed children in a classroom setting. This procedure involved placing a child in a small, empty, dimly lit, sound resistant room for 10 minutes following aggression or out-of-seat behavior. This intervention significantly reduced the frequency of both behaviors of which remained significantly below baseline levels following termination. Similarly, Pendergrass (1972) reported timeout from positive reinforcement successful in suppressing disruptive behaviors of two severely retarded withdrawn children. Changes in a variety of positive behaviors including looking, touching, speaking, responding and other non-punished misbehaviors were observed when timeout was administered contingent on only one misbehavior. Timeout here consisted of an isolation booth of plywood attached to two cabinet doors, resembling a triangular, open-topped enclosure preventing the child from viewing others in the room.

Duration of Seclusion

Hobbs, Forehand and Murray (1978), investigating duration of timeout and noncompliant behavior of 28 four to six year old children, concluded that even short durations (10 seconds, one minute) of timeout decreased deviant child behaviors. Longer durations (four minutes) appeared to produce greater response suppression and more
effectively maintained suppression following removal of timeout con-
tingencies. In a study comparing effects of timeout, punishment, and
extinction on aggressive behavior in children, Harder (1977) demon-
strated that short durations of timeout (30 seconds) suppressed ag-
gressive behaviors of 61 first, second and third graders. No signif-
icant differences were found between punishment consisting of a low or
high intensity tone following the behavior and extinction involving
the subjects' continuing behavior without any reinforcement or punish-
ment.

Pendergrass (1971) found long timeout periods administered on an
intermittent schedule were ineffective in controlling undesirable
behavior, while short timeouts administered consistently produced
substantial suppression of aggressive behavior in a brain damaged
child. Although suppressing undesirable behavior, strong conditioned
emotional responses such as freezing, trembling and wetting also
resulted. Timeout here made use of a small 4' x 6' plywood chamber
situated in the corner of the classroom with a locked door. Brief
periods of isolation to control disruptive behaviors emitted by a
mentally retarded preschool child revealed that some schedules of
intermittant punishment was as effective as continuous punishment
(Clark, Roubury, Baer and Baer, 1973). As a larger percentage of
responses were punished, a greater decrease in the frequency of that
response occurred. Kendall, Nay, and Jeffers (1975) compared two
durations of timeout with adolescent male delinquents. Five minute
durations suppressed verbal aggression and out-of-seat behavior,
and moderately reduced physical aggression when presented prior to
the 30 minute duration. When the 5 minute phase followed the 30 minute phase timeout, these behaviors occurred at greater frequency than baseline rate.

Bostow and Baily (1969) found brief timeout periods of two minutes duration effective in suppressing longstanding disruptive and aggressive behaviors of two retarded patients in a state hospital. For the one who was confined to a wheelchair for mobility, timeout resulted by simply placing her on the floor for sitting — thus making her immobile. For the other, timeout consisted of placement within a timeout booth, measuring 4' x 2' x 5' 5" and constructed of half inch plywood in the corner of the day room. White, Nielson and Johnson (1972) reported the effects of three different timeout durations in a group of twenty institutionalized retarded children. The child was placed in an isolation room following exhibition of any deviant behavior of aggression, tantrums and self destruction. In a counter balanced design, 1, 15 and 30 minute durations of timeout revealed that 15 and 30 minute timeout durations produced a 35% decrease in deviant behavior with little difference between effectiveness of the two durations. One minute was more effective when preceding the 15 or 30 minute durations.

Pease and Tyler (1979) found self-imposed timeout duration was as effective as teacher imposed timeout duration in reducing disruptive behavior of LBD students in a rural elementary classroom. One minute of timeout, when presented first, was as effective in reducing disruptive behavior as 15 minutes or 30 minutes.
Miscellaneous Applications of Seclusion and Timeout

Firestone (1976), in utilizing timeout to alter aggressive behaviors of a nursery school child, reported a reduction in both physical aggression and verbal aggression even though timeout only followed physical aggressive behaviors. Timeout consisted of putting the child in a chair until quiet for two minutes each time he performed a physically aggressive behavior. Constructive interactions with peers also increased. In a similar application of timeout by confining the child to an area of room or on a chair, Roberts, Hatzenbuchler and Bean (1981), reported timeout assisted preschool children acquire compliance to verbal requests.

Wilson, Robertson, Herlong and Haynes (1979) illustrated vicarious effects of timeout, defined as contingent social isolation. Timeout consisted of isolating the child from others by placing him in an open booth which blocked visual contact with other students following aggressive behavior. Aggressive behaviors of the target child and untargeted classmates within the academic classroom was reduced. Hobbs and Forehand (1975) reviewed effects of differential release from timeout for 12 children aged 4-6½ with timeout consisting of having their mother pick up playroom toys and leave playroom. Results strongly favor use of contingent release of timeout requiring an absence of disruption for three consecutive five second intervals.

Through a combination of ignoral for minor misbehaviors and timeout for aggressive or disobedient behaviors, Zeilberger, Sampen, and Sloane (1968) demonstrated these behaviors could be modified
within the home setting with parents acting as therapists for their 4 year old boy. Timeout here consisted of isolating the child in a bedroom in the home for two minutes. Parsons and Davey (1978) found a combination of reinforcement for correct imitations and timeout following failure to imitate was more effective in imitation training of a 4 year old retarded boy than reinforcement procedures utilized alone. However, Straka (1975) found that the imposition of timeout led to aggression among retarded adults as compared to reinforcement schedules. Alevzos and Alevzos (1975) reported that a brief factual verbalization or reason for the contingency neither facilitated nor inhibited the discrimination or application of time-out from positive reinforcement.

Grayson, Kiraly and McKinnon (1979) discussed the behavioral approach and cooling-off approach to using timeout with disruptive students in an academic setting. The behavioral approach included removal of child to a timeout area devoid of all distractions and any contact with others upon the emission of an inappropriate behavior. This approach was found most effective for decreasing specific inappropriate behaviors but was not designed to discover underlying causes of these behaviors. The cooling-off approach not only decreased specific inappropriate behaviors but also provided an opportunity to understand underlying emotions or feelings of the child which may have caused inappropriate behaviors. Here, the student needed a less stimulating environment. This approach, also referred to as "crisis intervention," involved the student in the decision making with teacher or adult care giver. The teacher or adult care giver was available to the student at all times during
the cooling-off period; and, it was viewed as a time when contact should be made because the pupil is more open to assistance.

Caraffa, Truckey, and Golden (1976) compared traditional time-out called "naked timeout" with an approach termed "modified timeout" consisting of providing a light and a dummy in the timeout room. Based on clinical observation of children placed in timeout, the authors reported that anxiety was one likely result of frustration inherent in the timeout situation. "Behavioral manifestations of anxiety in the timeout situation might include running away behavior, active resistive behavior (i.e., fighting, verbal abuse), passive resistance (i.e., failure to do school work, refusal to speak), as well as, the various abusive and destructive behaviors which take place while in timeout (i.e., kicking, screaming, etc.) (Caraffa, et. al., 1976:41). The authors compared return-to-task behavior (RTT) and flight-from-task behavior (FFT) which were both viewed as an indirect measure of anxiety. Return-to-task behavior was described as the subjects return to the classroom upon request while flight-from-task behavior referred to subject leaving the classroom during a prescribed task or refusing to return following timeout. Timeout, consisting of isolation within the timeout room, was arranged anytime the subject became physically aggressive including hitting, kicking, pulling hair, biting and scratching other students or staff members. Results revealed a decrease in physical aggression of the 6 year old hyperactive male student subject, for both traditional timeout and modified timeout with the modified approach leading to the greater decrease. Further analysis of return-to-task behavior revealed a significantly greater number of successful returns to task
behavior under the modified timeout conditions as compared to the naked timeout condition. More flight-from-task behavior was observed during traditional timeout as compared to the modified approach.

Summary

Evidence from the literature appears to promote short durations of timeout over longer durations, low rate schedules over high rate schedules, the need for a rewarding natural environment from which timeout can oppose, and contingent release from the timeout situation. Findings argue for use of short timeout intervals since one can easily increase the length of timeout if the shorter duration proves ineffective. Although out of room timeout (isolation) seems more efficient than in room timeout, both procedures have been found successful in decreasing oppositional behavior and increasing child compliance. Modified timeout rooms can have positive results and appear to be less anxiety ridden for the child being secluded as well as increase return-to-task behavior which should be a goal anytime the timeout intervention is utilized. Those applications placing emphasis upon discovering underlying causes of misbehavior as well as altering it to a more desirable form, maintain the greatest potential for providing a "warm, caring, supportive treatment atmosphere." Various combinations of strategies including timeout have been successful and usually include reinforcement procedures for correct or appropriate responses. In reviewing the parameters in the use of timeout with children, Hobbs and Forehand (1977) reported that data from most studies suggest that timeout is generally effective in reducing maladaptive child behaviors.
regardless of specific parameters employed with the exception of high ratio schedules, and timeout imposed in an impoverished natural environment.

Alternative Strategies for Timeout and Seclusion

The literature available regarding the use of timeout have some rather innovative approaches described. Foxx and Shapiro (1978) designed a non-exclusionary timeout procedure for five mentally retarded boys due to various questions raised about timeout rooms within schools and treatment agencies. Here, each subject wore a different colored ribbon as a tie and received both social as well as non-social rewards when wearing the ribbon. Following disruptive behavior, the child's ribbon was removed and teacher attention and participation in activities ceased for three minutes or until the misbehavior stopped. Results revealed children misbehaved 42% and 32% of the time during baseline and reinforcement conditions but only 6% of the time during timeout conditions.

Looking for an alternative to timeout due to legal and practical questions related to its use, Mansdorf (1977) studied "reinforcer isolation." Rather than placing the subject in a timeout room, reinforcing elements were removed from the subject. Results revealed total elimination of non-compliance within five weeks for a moderately retarded institutionalized female. Rather than removing this subject from the dayroom or quiet room where television, music, and other residents were available as reinforcers, the television and music
were turned off and the other residents requested to leave for another activity. Upon compliance by subject, the reinforcers were reinstated. Paced instructions recited to the child at a set pace regardless of the child's behavior, was attempted as an alternative to timeout by Plummer, Baer and LeBlanc (1977). This intervention was successful for decreasing inappropriate behavior when timeout was unsuccessful for the eight children aged four to six and experiencing behavior problems preventing enrollment in a regular classroom setting. Rather than decreasing inappropriate behavior, these authors felt timeout instead functioned as a reinforcer in a negative reinforcement paradigm.

Wahler and Fox (1980) demonstrated that a reduction in aggressive behavior could result from increasing solitary toy play as compared to timeout for children aged 5 to 8 years. Improvement of parents attitudes toward the child was also reported following reduction in the child's aggressive behavior. Still another alternative to timeout was considered by Doleys, Wells, Hobbs, Roberts and Cartelli (1976) in comparing the use of social punishment, positive practice, and timeout for dealing with noncompliance of developmentally handicapped children. Here, social punishment consisted of a loud verbal reprimand followed by a silent "glare" on the child's non-compliant behavior. The positive practice intervention consisted of the adult leading the child to the commanded task and manually guiding him through appropriate play activities by assuming a position behind the subject, taking the subject's hand and directing task related activity for 40 seconds with whatever pressure or force necessary to get subject to perform the task. Timeout involved placing child in the corner of room for 40 seconds with the adult standing quietly beside him.
Results revealed lower levels of noncompliance with social punishment than with timeout or positive practice. Although some "emotional" signs (i.e., soiling, wetting and brief periods of crying) were observed during the social punishment intervention in the study, reportedly these subsided in time with suppression effects of the intervention remaining stable. Although recommending further study of social punishment prior to wide spread application, timeout appeared to enhance aggression in the subject while positive practice appeared to produce little change. Advantages of the social punishment intervention were reported to include: (1) it requires no special facility, space or apparatus, (2) it can be easily taught to others, (3) can be administered in a variety of situations and (4) intensity can be easily moderated.

Azrin and Powers (1975) demonstrated positive practice procedures effective in eliminating disruptive behaviors within a classroom setting for six disruptive male students aged 7 to 11. These procedures consisted of requiring the child to engage in a positive action of asking permission to speak out or to leave his seat following a disruption by that child. The advantage of this procedure over other alternative methods is its re-educative value resulting from requiring the child to engage in a positive action of asking permission to speak out or leave seat following a disruption by that student. Forehand, Roberts, Doleys, Hobbs and Resick (1976) found negative attention, isolation, ignoring and a combination of these procedures effective in reducing noncompliant behavior of 32 children ranging in age 4-6½. The negative attention, consisting of a verbal reprimand followed by a brief period in which the authority
person stood rigidly and glared intently at the child, precluded both the ethical and legal issues involving isolation.

Luce, Delquadri, and Hail (1980) utilizing a multiple baseline design, investigated the effects of a treatment called "contingent exercise" which involved having a child exhibit a simple exercise task requiring him to stand up and sit on the floor five to ten times contingent on an inappropriate behavior. Proposed as an alternative to timeout or painful consequences, results revealed contingent exercise eliminated hitting, kicking, pushing, and aggressive verbal comments of the two mentally retarded child subjects.

In a rather innovative approach entitled "The Good Behavior Clock," Kibany, Weiss and Sloggett (1971) provided an alternative to timeout by fitting a false face on an electric timer. Found to be effective in reducing the highly disruptive behaviors of a first grade boy, the approach simply involved allowing the timer to run when he was quiet and in his seat, thereby earning a treat for the entire class, and discontinued when disruptive. Results revealed a generalization of conditioning to tardiness from recess behavior as well.

Porterfield, Herbert-Jackson, and Risley (1976) also looking for a procedure that would appear humane, educational, and would be acceptable to parents and day care workers but assist in reducing disruptive behaviors of young children developed an alternative to timeout isolation. The procedure entitled "sit and watch" consisted of having a child sit for a brief time on the periphery of an activity area and observe the appropriate behavior of other children.
prior to inviting him to rejoin the group activities. Observation with a combination of instructions and a brief time of "sit and watch" was found to be effective in maintaining low levels of disruptive behaviors and considered quite acceptable by parents as well as caregivers.

Risley (1968) demonstrated success in eliminating dangerous climbing behavior of a 6 year old severely disturbed autistic child with electric shock after having first attempted use of timeout, extinction and reinforcement of incompatible behaviors without success. Side effects of the punishing approach included decreased eye contact, increased imitative clapping behaviors, and climbing on chair and table as a substitution for climbing on wall or window ledge.

In a comparison of command training and timeout on child non-compliance, Roberts (1978) concluded that command training resulted in more powerful effects than timeout training for 36 children between the ages of 3 and 7, although child compliance increased as a result of both interventions. Command training consisted of specific unitary alpha commands followed by maternal silence until the child complied or until five seconds elapse, whichever occurred first. The timeout procedure consisted of two-minutes during which time the child was denied access to parental attention, toys and the opportunity to move about the playroom.

Carson (1972) demonstrated that a combination of extinction and counter conditioning as well as a combination of extinction, counter conditioning and timeout procedures to be effective in
lowering rates of undesirable behaviors in preschool aged children. Counter conditioning here referred to reinforcement of a response incompatible with the undesired one. Wahler (1969) examined changes in parental reinforcement value as a function of parental use of timeout and differential attention with two early elementary school aged children whose parents sought out-patient counseling due to their oppositional behavior. Timeout, consisting of isolating the child in his bedroom immediately following an oppositional behavior was alternated with social approval after cooperative behavior. Resulting from this approach was a reduction in the child's oppositional behavior as well as an increase in parental reinforcement value including talking more to child, smiling more frequently, and having more physical contact with them.

Although not always containing empirical findings, the literature contains several approaches to treatment which are designed to deal with the out-of-control child in a manner other than physical restraint or seclusion. Many of these studies emphasize a cognitive approach and include self-guidance programs, mediation training, and the life space interview. In one study entitled "Think Aloud," Camp, Blom, Herbert, and Doorninch (1977) demonstrated success of a cognitive approach with twelve aggressive second grade boys for reducing aggressive outbursts. This study placed emphasis on modeling of cognitive strategies and concentrating on developing answers to the following questions: (1) What is my problem? (2) What is my plan? (3) Am I using my plan?, and (4) How did I do?
Meichenbaum and Goodman (1971) demonstrated that a cognitive self-guidance program which trains impulsive children to talk to themselves is effective in modifying their behavior on a variety of psychometric tests which assess cognitive impulsivity. Bem (1967) demonstrated that self generated cues could be established experimentally for developing verbal self-control in three year old children. Similar to the "Think Aloud" approach is mediation training, which is a way of teaching children self control (Blackwood, 1971:13). An underlying assumption of mediation training is that a child thinks in at least three ways: (1) with words, (2) with mental images, and (3) with motor movements. A child can learn mediation training through verbal thinking skills, role playing and imagery. For most children, the verbal thinking approach seems most economical. Through mediation training, a child is taught self control by helping him think through problems by asking the following four questions: (1) What did you do wrong? (2) What happens when you (name of misbehavior) that you don't like? (3) What should you have been doing? and (4) What happens that you like when you (name of appropriate behavior)?

In a recent workshop at the Ohio Association of Child Caring Agencies' semi-annual conference (1981), staff from Sagamore Hills Psychiatric Hospital presented their approach for working with a child during problematic behavior outbursts. Their approach was entitled "re-mediation -- a mutual problem solving technique" and referred to "a mini-psychotherapy session." Steps outlined for remediation included the following:

1. **Intervention** -- stopping the behavior by some means (e.g., physical containment, timeout, etc.)
2. **Problem Identification** — isolating the problem from situation, helping child define problem and take ownership of responsibility in the situation

3. **Development of alternative plan** — consideration of alternative ways of handling situation (e.g., ask child what could you have done differently to avoid the problem? How could you have handled it differently?)

4. **Commitment** — have child make a commitment for choosing the alternative behavior (e.g., "Are you willing to try this?"

5. **Rehearsal** — setting up a hypothetical situation and having child role play or rehearse alternate behavior

6. **Reinforcement** — staff member looks for a way in which child can be reinforced for working through the problem (e.g., let child know that you are supporting him, care for him and are behind him)

7. **Re-involvement in program** — child re-enters activities (e.g., "O.K., we now have a plan, can we re-join the group and handle future problems like this differently, by using our plan? Let's try!"

In addition to mediation training, another very popularly received approach originated by Fritz Redl is the "life space interview." Wineman (1959) refers to the life-space interview as an approach which can simply pull a youngster through a tight spot without any specific intention or clinical motive toward cure. Primarily aimed at offering emotional first aid on the spot, the approach supports the ego in overcoming a temporary, sometimes critical, loss of function (Wineman, 1959). Obviously, on the long run, these mini sessions with a child can deal with long term goals as well as short term goals. To one who advocates this approach, a problem becomes a potential growth situation and the child can be
supported by the staff member as he de-escalates his behavior. In addition to viewing elements of diagnosis for the problem behavior, the life-space interview offers techniques for the process of working through the problem with the child within the child's very own space immediately following the emission of problematic behavior rather than two or three days later in a sterile therapist's office when the child has probably forgotten about the incident as well as the feelings associated with it. Entering the child's life space and helping him clarify feelings and consider alternate, more pro-social responses to the problem seems to be an ideal way to build rapport with the child and hence further cultivate a helping, supportive relationship between staff member and child. After working through the process, the life space interview technique recommends closure and subsequently re-entry of the child into the "Life Space Orbit" or mainstream of activities.

This approach is utilized quite successfully at Beech Brook, a residential facility for children ranging in age 5-12. Although utilizing seclusion several years ago, it was abolished for what staff feel is a more intense level of intervention for the out-of-control child. Heavily dominated by psychoanalytic theory, there is an emphasis placed upon staff members working through on a cognitive level with the child any problems that arise which might escalate to an out-of-control situation. A rather unique approach which they refer to as "rovers" provides additional staff who float and are available for crisis intervention or assuming responsibilities of on-duty direct care staff so that person can work through problems with the out-of-control child.
Various alternative strategies to seclusion have been reviewed which have included a multiple of populations and settings. Alternatives to seclusion have included substitution of exclusionary timeout for various non-exclusionary measures such as wearing a ribbon or article of clothing which is removed while in timeout signalling a non-reinforcement situation. Another variation includes removing the reinforcing agent or article from the child rather than placing child in isolation. Increasing the child's solitary toy play, as well as paced instructions have been found to be effective alternatives for altering behaviors previously requiring seclusion. Other alternative approaches that have met with popularity include social punishment, positive practice, mediation, lifespace interviewing, counter conditioning, and contingent exercise -- all of which have been promoted as effective alternative approaches to managing or controlling the "out-of-control" child.

With such an array of alternatives to seclusion, why do staff continue utilizing an intervention that precludes their ability to maintain a helpful, caring relationship with the child yet still manage his out-of-control behaviors? Perhaps human nature causes one to continue utilizing a familiar approach -- one that has become an institutionalized practice. Without regard for how the child perceives such an intervention or considering the research findings for alternative approaches, the staff member continues to utilize an approach that fails to accomplish its intended purpose. Although many of the alternatives to seclusion have been designed specifically
for certain populations and settings, it's time to begin exploring these alternatives to ascertain applicability to a residential center for emotionally disturbed children. Instead of looking at a reduction in a certain behavior, our treatment methodology must also be concerned with the internalization of behavioral change on the part of the child. Although attempting change within an institution can be anxiety ridden for staff, if things are ever to move forward, someone must be willing to risk new approaches. It is for these reasons that this study was chosen so that the institutionalized practice of seclusion could be evaluated in terms of its effectiveness as compared to some alternative approaches felt to be more conducive in managing the out-of-control child while still maintaining a positive relationship with the child.
CHAPTER III

Methodology and Procedures

In the previous two chapters, a rationale was made which demonstrated a need for further study of the use of seclusion by residential direct care staff within an institutional structure. The present study was undertaken to determine the effectiveness of certain interventions made with staff on changing their use of seclusion with clients with whom they are assigned to work. The chapter which follows outlines the methods and procedures which were utilized in carrying out the study.

Research Design

The design of the research study is determined in part by the purpose or end sought; and, the conditions possible for control within the setting of the experiment. The present study made use of staff groupings or teams consisting of naturally assembled collectives where a re-assignment for randomization purposes would not have been feasible. Since it was possible to randomly assign the treatment intervention to each group, a non-equivalent comparison group design was chosen as the research design. Because the four treatment team groups could not be assumed to have pre-experimental sampling equivalence, the pre-testing permitted in
this design helped to add control for testing the effects of the treatment intervention. This design is technically classified as a quasi-experimental design by Kerlinger, Campbell, and others which are those designs lacking full requirements of "true experimentation," but where the experimenter has partial control over the conditions. Kerlinger (1973) refers to this design as a Compromise Experimental Group-Control Group Design and maintains this design is valuable for experimentation when conditions of control prevent choice of true experimental designs.

Subject Selection

The Hannah Neil Center for Children (HNC), a residential treatment center for emotionally disturbed children ranging in ages 5-13, already had a staff organization which placed groups of staff in relatively permanent structures or groups called treatment teams. The Center's residential program is organized into four treatment teams with each serving approximately 10-11 children. Although several support services and related staff assist the treatment team, the team has the bulk of responsibility for planning and implementing the treatment plan for each of the children assigned to their unit. At the time of starting this study, residential population at HNC numbered thirty-nine residents ranging in age from 5 years-8 months to 12 years-11 months. Of the total number of residential clients, 29 (or 74%) were males with the remaining 10 (or 26%) females; and 21% representing minorities. Initial diagnoses for these clients were very similar for all groups with
generally worked with a regular team member for continuity of programming. From an analysis of the seclusion reports from 1979-1981, it appeared that the use of seclusion by substitutes working in place of another staff member still tended to be very similar to the team's use of seclusion since a substitute always worked with an experienced staff member who advised him on such practices.

Each grouping otherwise known as a treatment team was composed of the following:

- Group #1 (Red Team): 5 full time staff, 2 interns, 1 part-time staff
- Group #2 (Blue Team): 5 full time staff, 3 interns
- Group #3 (Gold Team): 5 full time staff, 2 interns, 1 full time staff member working half time in Gold Unit
- Group #4 (Green Team): 5 full time staff, 3 interns

The team's full time staff members were three Educateurs, one Teacher and one Teacher-Assistant (See Appendix C for job descriptions). Interns were students working approximately 20 hours weekly at HNC and completing coursework within the Educateur Training Program co-sponsored by Ohio State University and HNC. The interns worked predominantly weekends as their coursework precluded their availability for weekday shifts. The one part-time employee in Red Unit worked the same shift as interns and was hired as a replacement for one who dropped out of the training program. The Gold Unit had a similar situation develop,
but due to a hiring freeze at that time, one of the full time
staff members in a support service role was reassigned half-time
to fill the vacancy.

Of the total employees on treatment teams, five had completed
master of science or arts degrees, twenty-four bachelor of
science or arts degrees, and the remaining three had training at
a two year level degree. Their academic training represented a
variety of fields including education, special education, social
work, recreation, nursing, mental health technology, theology
and child care training. The average age of this staff was 27 with
the range of ages between 22-34. Of the treatment team staff, 25
were females while seven were males; minority staff numbered five
of the 32 total staff members. The average tenure of staff on
teams was 2.3 years; and, even the two least tenured staff had
been volunteers and substitute staff for a number of months prior
to becoming employees. A more specific team by team description
of demographic information is summarized in TABLE 4 in the
Appendix and TABLE 5 below.
### TABLE 5

Summary Demographic Information About Treatment Team Composition

<table>
<thead>
<tr>
<th>Team</th>
<th>RED TEAM</th>
<th>GOLD TEAM</th>
<th>GREEN TEAM</th>
<th>BLUE TEAM</th>
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</thead>
<tbody>
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<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
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<td>7</td>
<td>6</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
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<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Age</td>
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<td>25-32</td>
<td>22-30</td>
<td>23-34</td>
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<tr>
<td>Average</td>
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<td>28</td>
<td>25</td>
<td>27</td>
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<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
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<td>5</td>
<td>8</td>
</tr>
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<td>.3-.4.5</td>
<td>.5-.7.5</td>
<td>.5-.4.5</td>
</tr>
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<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Race</td>
<td>Non-Minority</td>
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<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Minority</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

**Treatments**

The four treatment teams were each randomly assigned one of the following treatment interventions by drawing square lettered dice from a bowl:

1. staff training related to use of seclusion and timeout consisting of clarification of terms, standards and procedures
(2) #1 (above) and simulation activities aimed at increasing staff sensitivity to use of seclusion as a treatment intervention

(3) #1 and #2 (above) and staff training related to alternatives to use of seclusion including life-space interview and mediation training

(4) Comparison group - staff training in activity planning

The inservice presentations described in intervention #1 were primarily a lecture-discussion format accompanied by several handouts to aid in staff understanding content of material. It was felt this method would provide an efficient way to present the same information to all three experimental groups and insure equivalent content of information since this invention was primarily aimed at a cognitive level of understanding of seclusion and timeout (See Appendix B for copies of handouts). Simulation activities for intervention #2 included viewing a short film followed by a discussion between staff and experimenter. Although the film, entitled "Joshua In The Box," was designed to enhance discussion about interpersonal skills, the character of Joshua is locked in his box in a similar way a child is locked in seclusion. It was hoped that staff could partially experience some of the frustration a child must feel through Joshua's characterization. In addition, this team of staff members also had the opportunity to experience seclusion for themselves for 8-10 minutes while being monitored by another staff member as well as view drawings and written accounts of seclusion by several children currently in residence at HNC.
Staff training related to alternatives for seclusion shared with Group #3 (See Appendix B for copies of handouts) included training in "mediation" techniques as well as "life-space interviewing" among other alternative approaches. From an analysis of incident reports for a number of months prior to implementation of the present study, it appeared clear that many times staff members chose seclusion as the choice of interventions to deal with noncompliance which generally escalated to "out-of-control" behavior by the time the child was placed in seclusion. It was felt that if an intervention could be utilized by staff in those times to de-escalate the child prior to needing seclusion, staff would not choose to use seclusion. Mediation training as well as the life-space interview technique lend themselves very well to this process. For the 4th group or intervention which served as the comparison group in the present study, equal time was spent in similar activities of lecture-discussion inservice training and related activities under the general topic of "activity planning" (See Appendix B for copies of handouts). Since the simulation activities for groups #2 and #3 included some active participation from team members in addition to a lecture-discussion format, part of this group's training sessions included similar activities as well. Extreme caution was followed by the examiner to insure the four treatment interventions were only alike on those parts designed for more than one group with all other parts kept very separate. To facilitate this process, the discussion outlines for each group were adhered to rigidly.
Total time spent with each treatment team amounted to four hours and was arranged in two 2 hour sessions separated by one week. Inservice sessions took place on Wednesday mornings at either 8:30-10:30 AM or 10:45-12:45 PM with each treatment group having one session at each time determined by randomization method of drawing square lettered dice from a bowl. A schedule and time frame for implementation of the treatment intervention follows:

**Group #1:**

a. completion of pre-test survey and post-test survey...20 min.

b. lecture-discussion on use of seclusion and timeout...1 hr.

c. inservice training activities on topic of "activity planning"...2 hrs. 40 min.

Total 4 hrs.

**Group #2:**

a. completion of pre-test survey and post-test survey...20 min.

b. lecture-discussion on use of seclusion and timeout...1 hr.

c. movie entitled "Joshua In The Box"...15 min.

d. follow-up discussion...15 min.

e. seclusion experiential activity...20 min.

f. discussion of drawings/written accounts of seclusion from child's perspective 20 min.

g. inservice training activities on topic of "activity planning"...1½ hrs.

Total 4 hrs.
Group #3:

a. completion of pre-test survey and post-test survey.................................20 min.
b. lecture-discussion on use of seclusion and timeout..............................1 hr.
c. movie entitled "Joshua In The Box".........................15 min.
d. follow-up discussion..................................................15 min.
e. seclusion experiential activity..............20 min.
f. discussion of drawings/written accounts of seclusion from child's perspective..............20 min.
g. lecture-discussion of alternatives to seclusion including life-space interview technique and mediation training..................................................1½ hrs.

Total 4 hrs.

Group #4:

a. completion of pre-test survey and post-test survey.................................20 min.
b. inservice training activities on topic of "activity planning" consisting of both discussion of conceptual ideas as well as participation in developing an activity plan........................................3 hr. 40 min.

Total 4 hrs.

As described above, the interventions for the treatment groups were "layered" with an increasing number of activities from Group #1 to Group #3. While Group #1 was exposed primarily to a presentation at a cognitive level of learning, Group #2 received exposure to this level as well as simulation activities designed to help sensitize them to the phenomenon of seclusion. Group #3 had both the cognitive level of learning experience as well as the simulation experiences described for Group #2; and also was given additional cognitive level experiences of reviewing alternatives for seclusion. Since this group received the most
number of resources in training, it was predicted that Group #3 should show the greatest reduction in the use of seclusion and change in attitude regarding its practice. Likewise, Group #2 was expected to show a greater reduction in use of seclusion and greater change in attitude regarding its practice than Group #1. Obviously, as a comparison group, significant changes in these two areas for Group #4 were not expected.

Outcome Measures

Outcome measures for this study included an attitude questionnaire designed to ascertain any change in attitude by staff from pre-testing to post-testing as well as frequency counts of the actual use of seclusion by staff. In accordance with standards and ethical requirements for utilizing seclusion, a monitoring system was already established to document each time the seclusion room was used at HNC. Data with regard to the use of seclusion at HNC had been collected for the past several years due to this required documentation. Although quite sketchy and containing omissions in early years, the most recently collected reports appeared fairly complete; probably resultant from requirements made by the Joint Commission on Accreditation for Hospitals (JCAH) in their site visit of 1978 and again in 1980. In 1978, formalized procedures for the use of timeout as it was then called consisted of a log sheet for documenting when the room was used including the child's name, length of timeout, and monitoring times (See Appendix C). This format of documentation was for the
most part maintained until March of 1980 when in preparation for
the most recent JCAH accreditation site visit, it was determined
that such an intervention would be termed "seclusion" and would
require the filing of a critical incident report (See Appendix C)
thus making the terminology and requirements for documentation
consistent with JCAH standards.

Of importance with the change in documentation for seclusion
is the more detailed information related in the incident report.
Not only is information such as name, monitoring times and length
of time contained in the report, but also a description of the
events leading up to the use of seclusion. The previous logging
system gave only a small one or two word description of behavior
necessitating seclusion as compared to the present system which
allows for one or more paragraphs in narrative form. Procedural
guidelines required writing of this report and filing it with
the administrator for daily review and a monthly review by
a peer review committee composed of direct service staff. Since
previous documentation consisted of a form located on a clip
board on the outside of the seclusion room door which many times
was damaged or destroyed by the child being placed against his
will into the seclusion room, this documentation is certainly
not as complete as the current data.

Data in frequency counts had been collected since March of
1980 and was utilized in part as baseline data for comparison of
rates following the administration of the treatment interventions.
Frequency counts were taken monthly; and, short term changes consisting of 30 days and 60 days were considered in the final analysis of this study.

The staff attitude questionnaire (See Appendix C) containing twelve items was designed to ascertain staff sentiments about the practice of seclusion and its application at HNC. While six of the questions related to existing practices at HNC, the remaining six referred to a staff member's desire or willingness to change current practices. For efficiency in analysis, questions related to existing practices were made even numbered questions and the willingness for change items were made odd numbered questions. The response by staff was a part of the training sessions and involved circling letters representing Strongly Agree (SA), Agree (A), Not Sure but Probably Agree (PA), Not Sure but Probably Disagree (PD), Disagree (D) and Strongly Disagree (SD). This six point scale without a neutral midpoint was chosen since it encourages respondents to force direction of choice. Following the questions, a space was provided to allow staff to respond to the following open ended question:

Please add any further comments you wish to express regarding your feeling about the use of seclusion in general or what you feel the child learns while in seclusion.

To check the reliability of incident reports documenting seclusion, several spot checks were made by this examiner and other designated staff throughout data gathering to determine agreement for number of seclusions reported. Content and face
validity of the attitude questionnaire was assessed by several professionals representing agencies similar to HNC who had assisted in writing standards for OACCA related to the use of seclusion. This group as well as the HNC Staff Development Committee and the Starr Commonwealth Schools Research Review Committee were consulted to evaluate the appropriateness and feasibility of the planned inservice training activities and content of material.

Conditions of Testing

Staff inservice training activities seemed to be a well established precedent and considered fairly routine at Hannah Neil Center and so scheduling the training sessions of this study did not seem to create any novel reaction from staff. This experimenter shared with staff during the first session that they were participating in a research study; and that their participation was greatly appreciated.

The staff attitude questionnaire was completed by staff at the beginning of the first training session as a request for their opinion about the use of seclusion and timeout. At that time, staff were informed that the administration had planned a series of staff training activities which included the topics of seclusion and activity planning and their opinions about seclusion were valued for further planning. Upon completion of the second training session, a post-test consisting of the same
questionnaire was completed by staff. At this time, staff were informed that after having completed the training sessions we were now interested in ascertaining any change in their thinking regarding the use of seclusion and, therefore, responding a second time to the questionnaire was necessary. Both questionnaires were answered anonymously by staff and collected by an independent staff person assisting the examiner. Questionnaires were held by this person until all training sessions had been completed. To facilitate analysis, each questionnaire for the pre-test contained a number for which the staff member was asked to remember for the second session. Upon given instructions for completing the second questionnaire, staff were requested to write their number on the top corner of the questionnaire so both of their questionnaires could be compared for changes in ratings.

To encourage accuracy of reporting frequency of seclusions and durations of time periods, a supply of incident report forms were made available in the observation office of seclusion room and a clock installed on the wall. With these conveniences, it was hoped that staff would initiate the report while observing the child in seclusion and exact timing could be reported even if the staff person did not wear a watch.

**Data Analysis**

The data analyzed consisted of any change in responses by staff on the staff attitude questionnaire from pre-test to
post-test as well as change in frequency with which each team utilized seclusion from pre-experimental treatment conditions to post-experimental treatment conditions. On the staff attitude scale, respondents were asked to respond on a six point scale to each of twelve questions. The rating system involved one, meaning strong agreement and six, meaning strong disagreement with the remaining digits indicating degrees of agreement relative to the two extremes. For more efficient analyses, the questionnaire was organized into two major categories with even numbered questions referring to existing practices at HNC and odd numbered questions reflecting staff willingness for changing practices. The principle objective to be accomplished in the analyses was to test the two following null hypotheses:

(1) There will be no statistically significant change in the use of seclusion from before to after treatment intervention for treatment groups 1, 2, 3, and 4.

(2) There will be no statistically significant change between the mean responses from before to after treatment interventions on the attitude questionnaire related to seclusion by treatment groups 1, 2, 3, and 4.

The level of significance established for failing to accept or reject the null hypothesis was set at the conventional p \( \leq .05 \).

To evaluate these two null hypotheses, two different statistical procedures were employed. Due to the small sample size, nominal scale of measurement, and use of frequencies, rather than measurements, Chi square was employed for the first hypothesis.
Chi square tests whether the frequencies observed in the sample deviate significantly from some theoretical or expected population frequencies (Spence, Underwood, Duncan and Cotton, 1968). For the second hypothesis, analysis of variance seemed in order as the questionnaire provided mean scores and a difference in the mean scores from pre-testing to post-testing would reveal effects of the treatment interventions.

In addition to the statistical analyses conducted, the examiner arranged for an independent staff person to observe the unit activities within the milieu in an effort to ascertain the progression of events which typically led up to a child being placed in seclusion. Also, seclusion reports for the last 3-4 years and the narrative description contained in the most recent reports were reviewed for trends or significant findings in an effort to pinpoint problematic areas of concern for this research project.
CHAPTER IV

Results

The chapter which follows reports descriptive findings relevant to the experimental problem as well as results of the hypotheses testing and will be presented in two sections below. The first section refers to various observations drawn from a descriptive analysis of seclusion data for HNC as an entire agency as well as for each individual unit over the past four years. Here, trends in use of seclusion and how it related to other functions within the residential program are compared. The second section refers to the data analysis and tests of significance as related to the established hypotheses for this project.

Descriptive Analysis

In studying the use of seclusion by direct care staff, one must first investigate pre-experimental conditions to ascertain trends existing prior to introducing the experimental conditions. Whittaker (1972:2) views residential treatment as a complex interplay of many different elements. The use of seclusion is one of these elements; and as such, can be further considered as a complex interplay of several different sub-elements. In this study, the sub-elements included implementation of several administrative efforts for altering the use of seclusion by staff. A comparison of these efforts and
how they related to frequencies of use for seclusion was made. Other sub-elements considered include the rate of admissions and discharges for clientelle, reasons given by staff as justification for utilizing seclusion, conclusions drawn from direct observation within units, and a description of the childrens' perception of seclusion based on their drawings and written accounts about the seclusion room. General trends of staff and child utilization of seclusion on a team by team basis were also observed. Here trends were considered involving the number of staff on a team using seclusion, the average use and range of utilization by that staff, the number of different children being secluded, and the average use and range of seclusions for these children. Times as well as durations of seclusions within each group are also considered. From a content analysis of critical incident reports, trends or any change of content from pre-experimental to post-experimental times were observed. Finally, a comparison of the frequency for use of restraint with the frequency for use of seclusion was made in an effort to ascertain any observed relationship as restraint was sometimes utilized to manage an out of control child in lieu of seclusion.

Implementation of Administrative Changes & General Trends

As reported in Chapter 1, there have been two major administrative changes in the use of seclusion at HNC over the past two years. The first of these changes involved a change in documenting the use of seclusion initiated in March of 1980. A critical incident report written as a narrative description was adopted to replace a simple log sheet stipulating the name of child and a one or two word description
of the reason for seclusion. The second of these changes came about one year later in March of 1981 which involved physically relocating the seclusion rooms and reducing the number available from four rooms to two. Several minor changes may have contributed to an overall change in use of seclusion by direct care staff. These include a continual effort made by administrative staff to encourage an exploration for alternatives to seclusion over the past four years, the initiation of periodic review of critical incident reports by a peer review committee with membership composed primarily of direct care staff, a reduction in staff turnover since 1979, and a major recomposition of teams resultant from staff transfers which took place between May and August of 1981.

General trends for the entire residential center can be seen from TABLE 6 in Appendix D, and Figure 1 below:

![Figure 1](image-url)

**FIGURE 1**
Total Number of Seclusions for HNC During 1978-1981
Point A on the graph represents the change in documentation utilized by staff to report seclusion and point B represents the change in physical location of the seclusion rooms (See Appendix D for Schematic Floor Plan). Point C represents the approximate time of staff transfers causing a recomposition of team structures. An extensive reduction in the use of seclusion and accompanied interventions A and B can be seen in FIGURE 1. This reduction may even be greater than the data reflect because early data from 1978 and 1979 is felt to be incomplete with frequency of use probably greater than reflected in FIGURE 1. The reduction in use of seclusion seen both at points A and B is short lived with an increase resulting within about 4 months. Although the staff transfers took place over a 4 month period of time, an existing trend of reduction was reversed during this time as reflected at point C on the graph. This change appeared to be a difficult transition for some staff as the majority of staff were transferred to a different age group of clientelle with whom they had not previously worked.

For further analysis on a unit by unit basis, please refer to TABLES 7, 8, 9 and 10 in Appendix D and FIGURES 2, 3, 4 and 5 below.
FIGURE 2
Total Number of Seclusions for Red Unit (1978-1981)

FIGURE 3
Total Number of Seclusions for Blue Unit (1978-1981)
FIGURE 4
Total Number of Seclusions for Gold Unit (1978-1981)

FIGURE 5
Total Number of Seclusions for Green Unit (1978-1981)
Similar to the overall center trends, a reduction in use of seclusion for all four units is reflected at point A with a gradual increase after a few months. While Blue Unit and Gold Unit show a reduction at Point B, Green Unit remains stable at less than 5 seclusions per month with Red Unit showing an increase from 3 seclusions in March to 22 in April, then a reduction back to 1 for May. In a further analysis of reports from those months, it appears that the increase in seclusions for April, 1981 in Red Unit was predominantly caused by three or four residents with one child being secluded 12 of the 23 times reported. Red Unit maintained the lowered rate of seclusion all through the four months involving staff transfers (Point C); however, Gold Unit shows variation with one month at 45 seclusions, the next month reduced to 11, and then increasing again within the following two months to 28. Both Green Unit and Blue Unit reflected an increase in use of seclusion during this time period with a slight increase in Green Unit and a more drastic increase from a low of 2 for July to 53 by September in Blue Unit.

Rates of Admissions and Discharges

Although considered distributed to all four groups, the number of children admitted to or discharged from a particular unit might show some association with the rate of seclusion within that unit. Newly admitted children occasionally make an attempt to test the limits of staff, and some children being discharged frequently behave in a manner which seems to convey the attitude "nothing matters anymore since I'm leaving soon." Both these situations as well as children being
discharged who refuse to accept a foster home or adoptive placement appear to have a higher potential for acting out those behaviors which may lead to staff utilizing seclusion as a control measure. However when a child has remained in residential treatment beyond the optimum length of time because of family problems precluding his return home or a lack of aftercare plan, there appears to be a higher potential for seclusion with this child.

FIGURE 6 below, illustrates changes in population due to admissions and discharges for all four groups. A more complete breakdown is summarized in TABLE 11 in Appendix D.
In comparing FIGURE 6 with FIGURE 1, overall trends within the use of seclusion following periods of increased admissions and discharges can be observed. In February of 1980, the admission/discharge rate increased to a high of 14 and seclusions also increased from 89 in February to 123 in March, then dropped in April when the admission/discharge rate stabilized. A similar trend also occurred in 1981 during the month of August when the admission/discharge rate again increased to 11 which was subsequently followed by an increase of almost double the frequency of seclusions in September as compared to August and slightly less than four times July's frequency of seclusion.

These overall trends were distributed fairly evenly among the four treatment groups as seen in the following FIGURES 7, 8, 9 and 10. To test whether the intake/discharge rate was correlated to the number of seclusions for a given unit, a rank order correlation coefficient test was calculated for the twelve month period of 1981. Calculated p values for the four treatment groups were -.19, -.30, -.56, and -.13 for Red, Blue, Gold, and Green Units respectively. Although Gold Unit's value nears significance at .05 level, no significant correlation between the intake/discharge rate and the number of seclusions for a given unit was found.
FIGURE 7
Total Number of Intakes/Discharges for Red Unit During January 1980-March 1982

FIGURE 9
Total Number of Intakes/Discharges for Gold Unit During January 1980-March 1982
FIGURE 9
Total Number of Intakes/Discharges for Gold Unit
During January 1980-March 1982

FIGURE 10
Total Number of Intakes/Discharges for Green Unit
During January 1980-March 1982

Reasons Given by Staff for Justification of Seclusion

During 1978 and 1979, the seclusion record or log made available a small space for the staff member to indicate the "reason for seclusion" as compared to the Critical Incident Report Form utilized for this purpose following those years. The following list summarizes
several reasons given by staff as justification for choosing seclusion
as reported on the seclusion log for 1978-1979:

hitting peers
refusal to go to bed
not making bed, not sitting time
bothering others at naptime
knocking toys off shelf
leaving unit without permission
stealing candy out of office
defeating toys
locked himself in bathroom
fight/out of control
disruptive
non-compliant - wouldn't dress
breakfast problems
playful and very loud
aggression
wild, uncontrollable behavior
group misbehavior
gross non-compliance
rough housing
antagonizing
stabbing knife at peer
refusal to go to school
poor dinner behavior
climbing over furniture constantly
stole peers' candy and lied about it
overturning furniture
"farting" - obnoxious behavior
negative interaction
off task/not getting along with others/non-compliance
threw dust pan
flakey at bedtime/flakey
refusal to sit time
AWOL
locking kid in trunk
urinated on floor
not taking bath
pestering
disrespectful, yelling at staff
ripping button off shirt
hyperactive
pouting
violent behavior
poor table manners
threw milk
spitting water
hitting kids for no reason
As can be seen from the above list, the seclusion intervention was used many times for behaviors not reflective of a need for seclusion. Of the 49 reasons for choosing seclusion above, only those which reflect out of control behavior - "endangering self or others" can be a legitimate reason for placing a child in seclusion in accordance with current procedural guidelines and standards described earlier. Such things as "flaky," "poor table manners," "pestering," "not taking bath," "farting - obnoxious behavior," "not making bed" as well as many others certainly raise questions as to the legitimacy for choosing seclusion as an appropriate treatment intervention. However, with the format of documentation being so simplistic, it is difficult to understand the full context of the reported behavior.

With the new reporting system implemented in March of 1980, a more comprehensive report documenting when seclusion was used resulted. A narrative description allowed for more understanding of the behavioral context and many times included other interventions first attempted but unsuccessful in managing the child's uncontrollable behavior. Many of these reports describe incidents beginning with child exhibiting non-compliance but escalating to total out of control and aggression exhibited to staff member or peer. Although the new reports were comprehensive, they still contained many behaviors which, if interpreted even within the context of the situation, raise questions as to the appropriateness of the use of seclusion. Such items include "noncompliance," "tantrums," "runaway," "agitation of peers," "disruptive bedtime after several warnings," and "failure to follow directions." Starting with January of 1981, a further analysis of incident reports was made in
order to ascertain trends within specific units. Generally, many inci-
dents started with noncompliance and escalated to a full tantrum
characterized by assaultive behavior to peers or staff, destruction of
property and physical aggression. From a review of the narrative re-
ports from January to December of 1981, reports seem to fall into three
major categories with a few exceptions:

1. noncompliant behavior, property destruction
   or out-of-control behaviors

2. aggression exhibited to others including self,
   peers or staff, and

3. out-of-control behaviors

From an analysis and classification of reports by this experimenter,
over 50% of the total number of incidents fell within the noncompliance
category. To further assess the reliability of these ratings, two in-
dependent staff persons not participating in this study were chosen and
asked to categorize incident reports for two different months selected
randomly from the 1981 reports. Their independent ratings along with
this experimenter's ratings are shown in TABLE 12 below. The two in-
dependent ratings of reports into categories appeared to closely re-
semble the experimenter's with all three raters choosing the noncom-
pliance category 52%-66% of the time for May of 1981 and 55%-61% for
November of 1981.
TABLE 12
Independent Evaluations of Incident Reports
For May and November of 1981

<table>
<thead>
<tr>
<th>MAY 1981</th>
<th>RATER 1</th>
<th>RATER 2</th>
<th>EXPERIMENTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noncompliance - property destruction or DOC</td>
<td>32 (52%)</td>
<td>39 (64%)</td>
<td>40 (66%)</td>
</tr>
<tr>
<td>Aggression to peer/staff/self</td>
<td>19 (32%)</td>
<td>19 (32%)</td>
<td>13 (21%)</td>
</tr>
<tr>
<td>Out of Control</td>
<td>10 (16%)</td>
<td>3 (4%)</td>
<td>8 (13%)</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>61 (100%)</td>
<td>61 (100%)</td>
<td>61 (100%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NOVEMBER 1981</th>
<th>RATER 1</th>
<th>RATER 2</th>
<th>EXPERIMENTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noncompliance - property destruction or DOC</td>
<td>37 (55%)</td>
<td>41 (61%)</td>
<td>40 (60%)</td>
</tr>
<tr>
<td>Aggression to peer/staff/self</td>
<td>18 (27%)</td>
<td>21 (31%)</td>
<td>17 (25%)</td>
</tr>
<tr>
<td>Out of Control</td>
<td>12 (18%)</td>
<td>5 (8%)</td>
<td>10 (16%)</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>67 (100%)</td>
<td>67 (100%)</td>
<td>67 (100%)</td>
</tr>
</tbody>
</table>

Direct Observation Within Units

In order to understand the sequence of events that lead up to seclusion, several periods of observation within the unit milieu were scheduled for an independent observer to observe the progression of events which might lead up to a child being placed in seclusion. The observer was requested to record her observations in a running record format. Excerpts which follow represent the typical use of seclusion.

3/20/82 Gold: Stewart was aggressive twice with peers and had to be restrained by two staff on the unit. He had been told to stay in his room. The other kids were in the Commons. When the second shift staff came, Stewart refused to stay in his room. It became necessary to restrain him again. He was threatening to run.
After 20 minutes of constant restraint and struggle, Stewart was placed in seclusion. He seemed to calm down after 15 minutes in seclusion but after coming out of seclusion he went AWOL.

12/12/81 Blue: Early Saturday morning the entire group of boys were chaotic. They were throwing popcorn, cursing and causing general confusion. Johnny and Jason were the ringleaders. Repeated attempts to get them to comply and discontinue their disruptive behavior failed; and, what seemed as a last resort, they were taken to seclusion.

11/8/81 Green: It was a Sunday evening and bedtimes had been chaotic including disruptive behavior by Jeremy, Billy and Anthony. Greg came out of his room acting extremely silly — shaking his penis at staff, making very inappropriate sexual statements and gestures and screaming. Staff attempted to restrain Greg off the unit while also keeping Anthony under control. It seemed impossible. Anthony escalated and staff took him to seclusion.

Children's Perception of Seclusion

As a part of the simulation activities involved in the treatment intervention for the Red and Gold Units, drawings of the seclusion room and written accounts of the meaning of seclusion were shared with staff. All 39 children residing at HNC at the time of initiating the study were requested to draw a picture of the seclusion room. The older children completed this task in groups of 5-6 while the younger children completed the task in groups of 2-4 or individually -- dependent upon when the child was available for task and his ability to perform task within a small group. The older children were also requested to write two, three or more sentences to the question "What is seclusion or timeout?" Instructions made reference to both seclusion or timeout rather
than just seclusion since both terms were used by staff and children synonymously to refer to the seclusion rooms.

Of the 43 total pictures, only 14 contained people with the remaining 29 void of any human figure within the drawing. Only in one of the 14 pictures with human figures is a staff member pictured. Here the staff member is on the outside of the room talking through the observation window to the child. Of the 14 pictures containing people, the figures portrayed do not seem to be gaining control. In explaining the pictures to this examiner, several children described their person portrayed as "saying help," "sad and mad," "mad," "making nasty things," "kid crying on floor," and "kid crying."

Further observation of the drawings reveal an emphasis upon locks and security with 15 of the 43 drawings clearly depicting the dead bolt locks on each door as illustrated in PLATE I and PLATE II below. Several pictures contain aggressive themes as emphasized by comments such as "kid saying 'ha ha' to another kid," "kids making nasty things," "kids mad," "broken window...marking on doors," as illustrated in PLATE III. Punitiveness and a lack of warmth is conveyed by several descriptions of drawings such as "little windows like cells...bars," "chains to attach person to wall," (Plate II) "doghouse, pig pen, slammer." The concept of punitiveness seems further promoted by the person dressed in prison garb (PLATE IV) in one child's drawing as well as the three walls of only block and mortar in another (PLATE V). One child even stated "...reminds me of dead people here...I get scared...I think of dead people...sometimes I imagine a head cut off" in describing his picture. Of further interest in the analyses of the pictures was the
emphasis on the room's structural details of block and mortar, windows, vents, sprinkler heads, light switches, hinges, clip board on door, lights, protective screens and observation windows. Twenty-nine pictures portray or emphasize physical structure of the room. While one picture portrayed a minute sized person in an over-sized seclusion room (PLATE VI), another one allotted the size of the seclusion room to be equivalent to the living unit although in actuality, the room is probably one-twentieth in size as compared to a living unit.

PLATE I

(Male: 10 yrs.-11 mos.)
PLATE II
(Male: 10 yrs.-9 mos.)

PLATE III
(Male: 12 yrs.-10 mos.)
PLATE IV

(Female: 7 yrs.-7 mos.)
PLATE V
(Male: 11 yrs.-11 mos.)

PLATE VI
(Female: 12 yrs.-11 mos.)
A total of twenty written descriptions of seclusion were written by the older children with two of these written by a teacher since the child was incapable of writing his own comments. Although many of the comments talk about calming down and the usefulness of the room, this is inconsistent with the pictures which do not seem to reveal this perception. By cross referencing comments to seclusion reports, one finds that many children making comments about the usefulness of the seclusion room are those who are never or very infrequently secluded by staff.

Some of the same themes from the pictures are also revealed in the written comments with a heavy emphasis upon the punitiveness of the room with comments such as "it was like jail," "we got lock up in heat, and it gets scarey," "they lock you up," and "seclusion is a room where staff lock you up like an animal..." The emphasis of structural details rather than behavior seems to be revealed in comments such as "timeout is a small room that kids...has two windows...," "timeout is a plain wall room with 3 doors, 5 windows...," "seclusion is a small lonely isolated room..." (See Appendix C for complete listing of descriptions).

**Utilization of Seclusion by Units**

To review general trends about a team's utilization of seclusion as a group, a further analysis of critical incident reports was made to ascertain the number of staff members on a team which utilize seclusion, the range of use by these staff members, the number of different children residing in that unit being secluded, and the range of seclusions for these children. TABLES 13, 14, 15, 16 and 17 below summarize seclusion utilization on a unit by unit basis for these issues. These tables report data for two randomly selected months in
1981 as well as the 30 days representative of pre-experimental condition, first 30 days post-experimental condition, and second 30 days post-experimental condition.

By reviewing TABLES 13 and 14, a comparison of numbers of children within each unit involved in seclusion to the total number of seclusions for that unit can be made. The number of different children secluded on each unit ranged from a low of one in both Red Unit and Green Unit for May, 1981 to a high of seven in Gold Unit for May of 1981 as well as the pre-experimental 30 days. Whereas the number of children being secluded in Green Unit remained stable throughout the times associated with this study, Red Unit's rate varied from 3 to 6, Blue Unit's from 3 to 5 and Gold Unit's from 3 to 7.

TABLE 13

Number of Different Children Secluded by Unit

<table>
<thead>
<tr>
<th></th>
<th>RED UNIT</th>
<th>BLUE UNIT</th>
<th>GOLD UNIT</th>
<th>GREEN UNIT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 1981</td>
<td>1</td>
<td>5</td>
<td>7</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>November 1981</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>A</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>B</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>C</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>18</td>
</tr>
</tbody>
</table>

A  Pre-experimental 30 days
B  First Post-experimental 30 days
C  Second Post-experimental 30 days
TABLE 14

Total Number of Seclusions by Unit

<table>
<thead>
<tr>
<th></th>
<th>RED UNIT</th>
<th>BLUE UNIT</th>
<th>GOLD UNIT</th>
<th>GREEN UNIT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 1981</td>
<td>1</td>
<td>11</td>
<td>48</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>November 1981</td>
<td>12</td>
<td>17</td>
<td>26</td>
<td>2</td>
<td>67</td>
</tr>
<tr>
<td>A</td>
<td>20</td>
<td>6</td>
<td>33</td>
<td>12</td>
<td>71</td>
</tr>
<tr>
<td>B</td>
<td>23</td>
<td>11</td>
<td>20</td>
<td>19</td>
<td>73</td>
</tr>
<tr>
<td>C</td>
<td>7</td>
<td>8</td>
<td>11</td>
<td>15</td>
<td>41</td>
</tr>
</tbody>
</table>

A Pre-experimental 30 days
B First Post-experimental 30 days
C Second Post-experimental 30 days

As the total number of seclusions for a unit increased, the numbers of different children involved with seclusion also increased. During the experimental periods as compared to the pre-experimental period, the number of different children secluded either remained stable or increased with the exception of Gold Unit where a decrease is noted from 7 to 6 to 3, and Red Unit where the rate changes from 3 to 6 to 4 during times A, B and C respectively.

TABLE 15 reflects the average number of seclusions for children being secluded within each of the units as well as the range of seclusions per child for that unit. The range of seclusions for any one child varied from a low of one in Red Unit for May of 1981 to a high of 17 in Gold Unit for May of 1981. Range of seclusions per child for Green and Blue Units fell between 1 and 7 while Red and Gold Units fell between 1 - 17. The average number of seclusions per child also reflected similar trends with lower averages of 3.4 and under for Green and Blue Units as compared to averages up to 6.5 for Gold Unit and 6.7 for Red Unit.
TABLE 15

Average Number and Range of Seclusions
Per Child by Unit

<table>
<thead>
<tr>
<th></th>
<th>RED UNIT</th>
<th>BLUE UNIT</th>
<th>GOLD UNIT</th>
<th>GREEN UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 1981</td>
<td>1 (1)</td>
<td>2.2 (1-4)</td>
<td>6.5 (1-17)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>November 1981</td>
<td>4 (2-5)</td>
<td>3.4 (1-7)</td>
<td>5.2 (1-15)</td>
<td>2 (1-4)</td>
</tr>
<tr>
<td>A</td>
<td>3.8 (1-5)</td>
<td>2.2 (1-4)</td>
<td>3.3 (1-7)</td>
<td>2.8 (1-6)</td>
</tr>
<tr>
<td>B</td>
<td>1.8 (1-3)</td>
<td>1.8 (1-3)</td>
<td>2.7 (1-6)</td>
<td>2.5 (1-6)</td>
</tr>
<tr>
<td>C</td>
<td>6.7 (1-8)</td>
<td>2 (1-3)</td>
<td>4.7 (1-12)</td>
<td>2 (1-4)</td>
</tr>
</tbody>
</table>

( ) Range
A Pre-experimental 30 days
B First Post-experimental 30 days
C Second Post-experimental 30 days

In a further analysis of incident reports, it was learned that four male residents were primarily responsible for the rate of seclusion in Gold Unit during Period A. This trend with the same four residents continued for Period B, but only three of these four residents continued for Period C. Blue Unit reports did not reveal such trends since the resident responsible for the high of 3 during Period A differed from the child responsible for the high of 4 during Period B. One child was secluded 6 of the 19 times for Green Unit during Period B; and 6 of the 15 seclusions for Period C. Red Unit's seclusions involved predominantly two male residents during Period A, a different child for Period B, and one of two children from Period A resuming the high for Period C.

Also of interest for this study was the number of staff working within a team who were involved in using seclusion. As discussed earlier, the primary team was composed of 8 persons although substitutes were used from time to time for vacations or sickness. Generally, substitutes were only used with another regular team member and from an
earlier analysis of reports it appears that the use of substitutes did not change significantly the manner in which a team utilized seclusion. TABLE 16 reports staff involvement with using seclusion as varying from a low of one staff member in Red Unit for May of 1981 to a high of 12 staff members in Gold Unit for pre-experimental time A. This latter figure included one substitute, four staff members in a supportive role to the team including administration, family service, and nursing in addition to 7 primary team members.

TABLE 16
Total Number of Staff Utilizing Seclusion by Unit

<table>
<thead>
<tr>
<th>May 1981</th>
<th>Blue Unit</th>
<th>Gold Unit</th>
<th>Green Unit</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6</td>
<td>11</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>November 1981</td>
<td>6</td>
<td>9</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>A</td>
<td>10</td>
<td>3</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>B</td>
<td>7</td>
<td>7</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>C</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>20</td>
</tr>
</tbody>
</table>

A Pre-experimental 30 days
B First Post-experimental 30 days
C Second Post-experimental 30 days

The number of staff utilizing seclusion varied considerably within units as reflected in Gold Unit's increase from 9 to 12 for Periods A to B, and then decrease to 6 for Period C. The data in TABLE 16 can be misleading since it includes substitute staff, students, and supportive service staff in addition to regular team members. A trend that did seem to remain constant is that persons substituting on a unit appear to utilize seclusion very similar to the primary team members. This trend was confirmed by identifying two substitutes and observing
them on the unit as well as reviewing seclusion reports which revealed
different trends of utilization from one unit to another by that same
person. Ranges of utilization by each staff member varied on each
team with Red Unit reflecting a range of 1-9, Blue Unit, 1-4, Gold Unit,
1-10, and Green Unit, 1-5. TABLE 17 summarizes average and range of
utilization of seclusion by staff for each unit. During Period A to B,
Red Unit and Green Units increased and Gold and Blue Units decreased
average utilization. From Period B to C, Blue and Gold increased while
Green Unit remained stable and Red Unit decreased.

Similar trends were noted for range of utilization with Red Unit
increasing from 1-5 to 1-9 and Gold Unit decreasing from 1-8 to 1-5
during Periods A and B. For this same time period, Blue and Green
Units' range only varied by one. During Periods B to C, Gold and Red
Units decreased in range from 1-5 to 1-2 and from 1-9 to 1-2 respective­
l y. In a further analysis of incident reports for Gold Unit, the same
staff person was identified with the higher part of range for both
Periods A and B, but did not utilize seclusion at all during Period C.
For Red Unit, three different persons were responsible for the higher
part of range in comparing Periods A, B and C.

TABLE 17

Average Utilization and Range of Seclusion Utilization
Per Staff Member by Unit

<table>
<thead>
<tr>
<th></th>
<th>RED UNIT</th>
<th>BLUE UNIT</th>
<th>GOLD UNIT</th>
<th>GREEN UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 1981</td>
<td>1 (1)</td>
<td>1.8 (1-2)</td>
<td>4.4 (1-10)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>November 1981</td>
<td>2 (1-3)</td>
<td>1.9 (1-4)</td>
<td>4.3 (1-8)</td>
<td>2.4 (1-5)</td>
</tr>
<tr>
<td>A</td>
<td>2 (1-5)</td>
<td>2 (1-3)</td>
<td>3.7 (1-8)</td>
<td>2 (1-3)</td>
</tr>
<tr>
<td>B</td>
<td>3.3 (1-9)</td>
<td>1.6 (1-2)</td>
<td>1.7 (1-5)</td>
<td>2.1 (1-4)</td>
</tr>
<tr>
<td>C</td>
<td>1.8 (1-2)</td>
<td>2.7 (1-5)</td>
<td>1.9 (1-2)</td>
<td>2.1 (1-2)</td>
</tr>
</tbody>
</table>

{ } range
A Pre-experimental 30 days
B First Post-experimental 30 days
C Second Post-experimental 30 days
Time and Duration of Seclusion

Duration of seclusion for a given child was not identified as a variable of interest for this study since maximum limits of seclusion durations are controlled by policy and regulations. However, in making a comparison of durations between units as well as within units during this study, several trends are noted. All groups except Red Unit decreased average duration of seclusion during times A to B. Red and Blue Units decreased average duration during times B to C while Green and Gold Units' average increased during the same time period.

TABLE 18 summarizes changes in average durations for all four groups. Although frequency of use increased in three units during Period A to B, a reduction in the average duration of seclusion was noted for two of the three.

TABLE 18

Average Durations of Seclusions for Each Unit From Pre-Experimental to Post-Experimental Times

<table>
<thead>
<tr>
<th></th>
<th>RED UNIT</th>
<th>BLUE UNIT</th>
<th>GOLD UNIT</th>
<th>GREEN UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>17.5</td>
<td>20.0</td>
<td>18.3</td>
<td>10.3</td>
</tr>
<tr>
<td>B</td>
<td>20.7</td>
<td>13.6</td>
<td>14.0</td>
<td>8.7</td>
</tr>
<tr>
<td>C</td>
<td>17.5</td>
<td>13.1</td>
<td>18.2</td>
<td>11.7</td>
</tr>
</tbody>
</table>

A Pre-experimental 30 days
B First Post-experimental 30 days
C Second Post-experimental 30 days

Another important analysis for an overview in utilization of seclusion has to do with times seclusion is used. TABLES 19, 20 and 21 report times seclusion was implemented within each team. Weekend days
are broken out separately as many children go on home visits during Saturdays and Sundays. The children remaining are those who have little if any family involvement and perhaps have a higher potential for acting out those behaviors subsequently followed with seclusion. The rate of seclusion on week-end days is proportionately higher than week-day rates. In most cases, a pattern existed with progressively higher reported seclusions for a.m., afternoon, and p.m. times, for both week-days and week-end days. Seclusion rooms were generally not utilized as a part of the school program, therefore limiting the potential for a.m. seclusion to 7 a.m. - 9 a.m. and afternoon seclusions to 3 p.m. - 6 p.m. on school days.

TABLE 19

Times of Seclusion Utilization by Each Unit During Pre-Experimental 30 Days

<table>
<thead>
<tr>
<th>TIME</th>
<th>RED UNIT</th>
<th>BLUE UNIT</th>
<th>GOLD UNIT</th>
<th>GREEN UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>1</td>
<td>0</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>AFTERNOON</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>PM</td>
<td>7</td>
<td>3</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>AM</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>AFTERNOON</td>
<td>3</td>
<td>0</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>PM</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>TOTALS</td>
<td>20</td>
<td>6</td>
<td>33</td>
<td>12</td>
</tr>
</tbody>
</table>
### TABLE 20

Times of Seclusion Utilization by Each Unit
During First Post-Experimental 30 Days

<table>
<thead>
<tr>
<th></th>
<th>RED UNIT</th>
<th>BLUE UNIT</th>
<th>GOLD UNIT</th>
<th>GREEN UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.M.</strong></td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td><strong>AFTERNOON</strong></td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td><strong>P.M.</strong></td>
<td>12</td>
<td>4</td>
<td>9</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>A.M.</th>
<th>1</th>
<th>1</th>
<th>0</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AFTERNOON</strong></td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>P.M.</strong></td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>23</td>
<td>11</td>
<td>20</td>
<td>19</td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 21

Times of Seclusion Utilization by Each Unit
During Second Post-Experimental 60 Days

<table>
<thead>
<tr>
<th></th>
<th>RED UNIT</th>
<th>BLUE UNIT</th>
<th>GOLD UNIT</th>
<th>GREEN UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.M.</strong></td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>AFTERNOON</strong></td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>P.M.</strong></td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>A.M.</th>
<th>0</th>
<th>3</th>
<th>1</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AFTERNOON</strong></td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>P.M.</strong></td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>7</td>
<td>8</td>
<td>11</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>
Content Analysis of Incident Reports

To ascertain any changes in the content of incident reports from pre-experimental to post-experimental times, several incident reports from times A, B and C were analyzed for comparison purposes. Reports following the treatment intervention appeared longer and contained more details about events leading up to seclusion as compared to reports prior to this time. Some reports even enumerated interventions which had been attempted by staff prior to utilizing seclusion. This trend was most recognized in Gold and Red Units, although not exclusive to Blue and Green Units. One of Gold Unit's reports included preceeding events, alternatives to seclusion attempted first, and documentation of the incident and events surrounding the child's response as well as processing these events with the child following seclusion. Another example from Red Unit illustrates this same idea from the following two excerpts:

**Time A:** ...did not sit time...went on for quite a time...became violent

**Time B:** ...tantrumming, very aggressive, attempting to bite, scratch, kick staff...was restrained for 20 minutes...seclusion necessary

Although content of reports lengthened from times A to C and the narrative became more descriptive, there still existed many references to "non-compliance," or "major compliance problems" as justification for secluding child.
Use of Physical Restraint by Staff

To ascertain if a reduction in seclusion could be associated with an increase in some other control intervention such as restraint, critical incident reports were examined to observe any trends in this direction. TABLE 22 summarizes the frequency of restraint for each treatment unit from pre-experimental to post-experimental times.

TABLE 22

Frequencies of Restraint by Each Treatment Group from Pre-Treatment to Post-Treatment (30 days) and Post-Treatment (60 days)

<table>
<thead>
<tr>
<th></th>
<th>PRE-EXP. FREQUENCY</th>
<th>30 Days POST-EXP. FREQUENCY</th>
<th>60 Days POST-EXP. FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLUE</td>
<td>16</td>
<td>(2/17-3/18/82)</td>
<td>(3/19-4/17/82)</td>
</tr>
<tr>
<td>GOLD</td>
<td>8</td>
<td>(2/17-3/18/82)</td>
<td>(3/19-4/17/82)</td>
</tr>
<tr>
<td>GREEN</td>
<td>13</td>
<td>(2/3-3/4/82)</td>
<td>(3/5-4/3/82)</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>(2/3-3/4/82)</td>
<td>(3/5-4/3/82)</td>
</tr>
</tbody>
</table>

Red Unit's greatest reduction in the use of seclusion from times B to C was followed with a reduction in number of restraints from 16 to 3. Although Gold Unit's rate of seclusion also significantly changed from times B to C their use of restraint remained stable.

Hypotheses Testing

In order to determine if the actual utilization of seclusion from before to after treatment intervention could be changed due to the various treatments offered as inservice training sessions, a Chi Square
Analysis was calculated by utilizing a SPSS computer program, for time periods of both 30 days post-experiment and 60 days post-experiment. Of interest here were differences in utilization of seclusion associated with the different levels of training received by each group. While Green Unit was the comparison group, Red Unit received the cognitive level of training, Blue Unit a cognitive level and simulation activities, and Gold Unit both cognitive and simulation activities, as well as an exploration of alternative strategies. TABLES 23, 24 and 25 summarize frequencies and Chi Square statistics.

**TABLE 23**

Frequencies of Seclusion by Each Treatment Group From Pre-Treatment to Post-Treatment (30 Days) and Post-Treatment (60 Days)

<table>
<thead>
<tr>
<th>GROUP</th>
<th>Pre-exp. frequency</th>
<th>30 days post-test frequency</th>
<th>60 days post-exp. frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>RED</td>
<td>(1/16-2/16/82)</td>
<td>(2/17-3/18/82)</td>
<td>(3/19-4/17/82)</td>
</tr>
<tr>
<td>BLUE</td>
<td>6</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>GOLD</td>
<td>33</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td>GREEN</td>
<td>(1/4-2/7/82)</td>
<td>(2/3-3/4/82)</td>
<td>(3/5-4/3/82)</td>
</tr>
</tbody>
</table>

**TABLE 24**

Summary Chi-Square Statistic by Each Treatment Group From Pre-Treatment to Post-Treatment (30 Days)

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>x²</th>
<th>df</th>
<th>p &lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. RED</td>
<td>.209</td>
<td>1</td>
<td>.65</td>
</tr>
<tr>
<td>2. BLUE</td>
<td>1.471</td>
<td>1</td>
<td>.23</td>
</tr>
<tr>
<td>3. GOLD</td>
<td>3.189</td>
<td>1</td>
<td>.07</td>
</tr>
<tr>
<td>4. GREEN</td>
<td>1.581</td>
<td>1</td>
<td>.21</td>
</tr>
</tbody>
</table>
Hypothesis 1 was stated as follows:

There will be no statistically significant change in the use of seclusion from before to after treatment intervention for treatment groups 1, 2, 3 and 4.

As can be seen from TABLE 24 and based on the criterion established, the null hypothesis of no difference between before to after treatment (30 days) was retained. A p < .07 for Gold Unit nears the .05 level of significance; and Gold Unit also had the greatest reduction in observed frequencies from 33 to 20. It is this group that was predicted to have the most change since it received the greatest number of elements in the inservice training sessions.

Based on the data reported in TABLE 25 and on criterion established, the null hypothesis of no difference between before to after treatment (60 days) was retained for Blue and Green Units, but rejected for Red and Gold Units. These latter two groups also reflected the greater reduction in frequencies with Gold Unit of 33 to 11 and Red Unit 20 to 7 during the 60 day post-experimental time.

**TABLE 25**

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>$x^2$</th>
<th>df</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. RED</td>
<td>8.680</td>
<td>2</td>
<td>.01</td>
</tr>
<tr>
<td>2. BLUE</td>
<td>1.520</td>
<td>2</td>
<td>.47</td>
</tr>
<tr>
<td>3. GOLD</td>
<td>11.469</td>
<td>2</td>
<td>.003</td>
</tr>
<tr>
<td>4. GREEN</td>
<td>1.609</td>
<td>2</td>
<td>.45</td>
</tr>
</tbody>
</table>
In order to determine if the various treatments offered in inservice training sessions led to a significant change in attitude on the part of staff from pre-test to post-test, analysis of variance was carried out for each group's responses to the attitude questionnaire by utilizing the BMDRZU BIOMED program which handles analysis of variance and co-variance with a repeated measures design. The questionnaire contained two categories to facilitate analysis with even numbered items relating to existing practices at HNC and odd numbered items relating to a willingness to change current practices. All four treatment groups started with 8 staff members who completed the pre-test questionnaire; however, Blue Unit had one staff member hospitalized during the inservice meetings resulting in one less member for that group. A total of 31 cases were involved in the analysis with cell sizes of 8 for each group except Blue Unit with a cell size of 7. Content and face validity of the attitude questionnaire instrument were evaluated by the several professionals reviewing the instrument. Internal reliability was measured using Cronbach's alpha which is widely accepted for use with Likert-type scales such as the one utilized in this attitude questionnaire (Ebel, 1965). For the even numbered items which related to existing practices category, an alpha of 0.338 was found; and for the odd numbered items which related to a willingness to change category, an alpha of 0.434 was found. Positive correlations ranging from a low of 0.14 to a high of 0.51 were reported for all questionnaire items with the exception of items 8, 10 and 12 which were negative ranging from -0.039 to -0.21. The wording of these three items seemed to demand an
opposite direction of response as compared to the other nine items. Therefore, they were re-coded prior to conducting the statistical analysis for experimental control. Re-coding consisted of reversing the set point scale so that SA=6 rather than 1, A=5 rather than 2, ...SD=1 rather than 6.

The small sample size and few items on the attitude scale were two factors which limited the magnitude of the reliability coefficient. The Spearman-Brown formula has frequently been utilized to predict the increase in reliability resulting from lengthening the test by the addition of items like those in the original test (Ebel, 1965). This formula is as follows:

\[ r_{1} = \frac{2r_{s}}{r_{s} + 1} \]

When employing this formula for predicting the increase in reliability resulting from doubling the six items, the existing practices category attains an alpha of .51 and willingness to change category attains an alpha of .61.

Mean score responses and standard deviations along with analysis of variance were obtained for each group for both existing practice and willingness to change categories. A lower score means more agreement while a higher score means less agreement on the existing practices items. For the willingness to change items, lower scores reflect more willingness while higher scores reflect less willingness to change existing practices. The following TABLES 26 and 27 summarize the findings of the analysis:
TABLE 26

Mean Score and Standard Deviations
For All Four Treatment Groups

<table>
<thead>
<tr>
<th>Willingness To Change</th>
<th>Group</th>
<th>Pre-Test Mean</th>
<th>S.D.</th>
<th>Post-Test Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RED</td>
<td>15.6</td>
<td>3.2</td>
<td>15.5</td>
<td>4.2</td>
</tr>
<tr>
<td></td>
<td>BLUE</td>
<td>18.7</td>
<td>3.5</td>
<td>19.9</td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td>GOLD</td>
<td>16.1</td>
<td>1.7</td>
<td>15.0</td>
<td>3.0</td>
</tr>
<tr>
<td></td>
<td>GREEN</td>
<td>15.4</td>
<td>4.9</td>
<td>17.0</td>
<td>4.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Existing Practices</th>
<th>Group</th>
<th>Pre-Test Mean</th>
<th>S.D.</th>
<th>Post-Test Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RED</td>
<td>22.5</td>
<td>3.7</td>
<td>21.6</td>
<td>3.4</td>
</tr>
<tr>
<td></td>
<td>BLUE</td>
<td>22.6</td>
<td>3.2</td>
<td>22.1</td>
<td>4.2</td>
</tr>
<tr>
<td></td>
<td>GOLD</td>
<td>21.3</td>
<td>3.6</td>
<td>18.4</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td>GREEN</td>
<td>22.3</td>
<td>4.8</td>
<td>21.1</td>
<td>5.0</td>
</tr>
</tbody>
</table>

TABLE 27

ANOVA Summary Table

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willingness To Change</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A(treatment)</td>
<td>3</td>
<td>137.4</td>
<td>45.8</td>
<td>2.01</td>
<td>.136</td>
</tr>
<tr>
<td>s/a</td>
<td>27</td>
<td>614.7</td>
<td>22.8</td>
<td>.89</td>
<td>.334</td>
</tr>
<tr>
<td>B(time)</td>
<td>1</td>
<td>2.6</td>
<td>2.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AB(treatment x time)</td>
<td>3</td>
<td>19.6</td>
<td>6.5</td>
<td>2.23</td>
<td>.107</td>
</tr>
<tr>
<td>SB/A</td>
<td>27</td>
<td>79.1</td>
<td>2.9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing Practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A(treatment)</td>
<td>3</td>
<td>64.7</td>
<td>21.6</td>
<td>.80</td>
<td>.503</td>
</tr>
<tr>
<td>s/a</td>
<td>27</td>
<td>724.1</td>
<td>26.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B(time)</td>
<td>1</td>
<td>25.9</td>
<td>25.9</td>
<td>6.5</td>
<td>.012</td>
</tr>
<tr>
<td>AB(treatment x time)</td>
<td>3</td>
<td>11.9</td>
<td>4.0</td>
<td>1.00</td>
<td>.409</td>
</tr>
<tr>
<td>SB/A</td>
<td>27</td>
<td>107.5</td>
<td>4.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hypothesis 2 was stated as follows:

There will be no statistically significant change between the mean response from before to after treatment interventions on the attitude questionnaire related to seclusion for treatment groups 1, 2, 3 and 4.

As can be seen from TABLE 27, based on criterion established, the null hypothesis of no differences between before to after treatment was retained for willingness to change items but can be rejected for existing
practices items for B (time). Due to negative correlations for three of the six items on the existing practices portion of the scale, the significance of \( p \leq .01 \) should be only tentatively accepted. For this reason, no further post hoc comparisons were made.
CHAPTER V

Discussion

In the previous chapters, the use of seclusion with emotionally disturbed children within a residential treatment center has been discussed in light of the available literature as well as actual practice in an applied setting — Hannah Neil Center for Children. Since much attention has been recently focused on institutional child abuse including inappropriate use of seclusion, it appeared that further study of this subject was highly relevant. Ambiguous definitions of seclusion and confusion with timeout has made available literature, litigation, as well as professional and ethical standards for its use very complex. These problems were addressed throughout Chapters 1 and 2. The chapter which follows will be devoted to a summary of findings, a discussion of implications for further research, limitations of the current study, possible sources of error, and overall conclusions and recommendations.

Summary of Findings

Four units within a residential treatment center participated in in-service training related to the use of seclusion for managing out-of-control children. Of the four groups, Gold Unit appeared to have the best reaction and was most receptive to ideas expressed about seclusion
during the inservice training. Many contributions in comments and questions were made by staff, and this group appeared quite open to looking at alternatives to seclusion. The simulation activities seemed enjoyable as they discussed openly the movie entitled "Joshua In The Box" and how the stages Joshua went through resembled closely the stages a secluded child experiences. Several of the team members commented how long a 10 minute duration of seclusion seemed to them. When sharing the children's drawings and written comments about seclusion, this group appeared to have the most insight and was able to make good observations of a child's perception from the drawings. The group utilized seclusion more frequently than other groups prior to the treatment intervention, but their reaction appeared least defensive as compared to the other two treatment groups. Red and Blue Units responded more defensively with several Blue Unit team members becoming quite defensive following the simulation activities. One team member asked "Are you saying we're doing away with seclusion rooms?...It's plain you're against them with everything you've said..." By the second session for this group, they had become more defensive with one staff member becoming discourteous to speaker as he talked rather loudly to his neighbor throughout session, another resisting eye contact and keeping her head downward throughout the majority of the session, and others verbalizing quite openly their negative responses to the idea of eliminating the seclusion rooms even though this idea had not been expressed by the experimenter. Red Unit staff did not become openly defensive, but their lack of enthusiasm and openness as compared to the Gold Unit staff appeared somewhat defensive. The general tone of atmosphere during both sessions for the Red Unit seemed dull with staff perhaps participating as if it were required.
Responses to the open ended question varied among treatment groups and seemed to confirm observations made during the presentations. Gold Unit staff appeared least defensive as related in the following statements in answer to the open ended questionnaire item related to further comments about seclusion:

While I am in favor of abolishing the use of seclusion, I feel a need to have extensive inservice training for teams in alternative crisis intervention techniques and also techniques for preventing a crisis and/or escalating inappropriate behavior. I also feel that as long as seclusion rooms are made available, staff will continue utilizing them, in spite of strict regulations - having seclusion rooms tends to inhibit the use of other creative interventions but I feel this will continue unless rooms are no longer provided.

I don't think a child learns anything in seclusion - I'm not in favor of seclusion but can two staff sit on one child and leave 10 others unattended? This is probably the #1 reason for seclusion with out-of-control kids. It is probably used too quickly. If seclusion was done away with, as I'm sure it will be eventually, we will all manage, but the initial reaction would be something.

Only one or two comments of a general nature were made in the Green Unit (comparison group) and the Blue Unit for both pre-test as well as post-test questionnaires. Red Unit responses tended to resemble more defensiveness as evidenced by the following two examples:

...as for the questions regarding the use of seclusion at HNC - I think it is a useful tool as a last ditch effort for those children who really enjoy restraint attention and out-of-control situations.

The major difficulty in using seclusion seems to be "monitoring". In many instances it is difficult or impossible to remain in the seclusion room for the entire time. I do not believe our unit is abusing seclusion in any way. We rarely use seclusion and when used, it is a last resort. I would be strongly against abolishing the use of seclusion. This would leave possible harm to child or staff open if a child became physically violent which occurs occasionally. Sometimes you have to remove the child from stimuli, prior to counseling.
Generally, all four groups commented to some degree about the lack of alternatives to seclusion other than physical restraint which precludes a staff members' attention to the other children in the program. Although some comments were made by several respondents defending the need for seclusion to calm an out-of-control child and indicated it was only used as a last resort measure and not misused, Chapter 4 reported that over 50% of all seclusions during a randomly chosen two month period of time resulted from or was initiated because of non-compliant behavior. A perusal of critical incident reports for the times associated with this project reveals that this trend still existed although perhaps not as high as 50%. According to litigation and the professional standards reviewed in Chapter 2, non-compliance is not a legitimate reason for secluding a child in an isolation room. It appears that if staff would choose interventions designed to deal with noncompliance more effectively, perhaps there would be less escalation of behavior and less need for the use of seclusion. Not only would the choice of intervention be critical, but also the timing of its introduction to the child to maximize effectiveness in altering or controlling the behavior which ultimately would lead to the need for seclusion.

Discussion of Hypothesis Testing

Through offering more resources to staff by in-service training sessions, it was felt that a significant impact on changing the use of seclusion by direct care staff would result. While the cognitive level of training was intended to share literature findings and standards related to the use of seclusion with staff, it was felt that this level
as well as simulation activities designed to help staff be sensitive to the child's feelings about seclusion would begin to bring about change in its use. Significant change in the utilization of seclusion was expected when providing the additional training in alternatives since staff could then make a choice from available interventions to control the out-of-control child.

The null hypothesis related to change in use of seclusion by staff was retained for all four treatment units for the first 30 days post-experimental period; however, rejected for Red and Gold Units for the 60 day post-experimental period. Two extraneous conditions occurred within these two groups which could have partially contributed to the significant change in use of seclusion by the group. During the 60 day post-experimental time in Gold Unit, a major problem involving four of the ten residents resulted with three boys having assault changes filed against them for having beaten up the fourth. When appearing in Juvenile Court on these charges a week later, the three boys were placed in the juvenile detention center for one week; and, one removed from the residential program permanently. Three of the 4 boys involved in this situation were among the group frequently secluded by staff for times A and B; therefore, removing them during C for 7 of the 30 days appears to have effected the use of seclusion. It appeared that other children in the Gold Unit tended to reduce misbehavior when these peers were removed from the program and placed in detention. However, one of the other children frequently secluded during times A and B was not involved with the detention; and, this rate of seclusion decreased considerably during time C thus reflecting staff effort at reducing their use of seclusion during this time.
A similar occurrence took place in Red Unit with one boy who had been frequently secluded during time A, removed from the program. Although this child had not been secluded often during time B, his influence over peers tended to be quite negative, and staff felt that other children often ended up in the seclusion room due to his antagonism of them. After he was administratively removed from the program, the use of seclusion dropped rapidly and the unit atmosphere seemed to experience a calm for the next few days. In light of this observation, some consideration for temporarily moving a child from a unit or group of staff during those times when he becomes such a disruptive force could be a viable alternative to the use of seclusion. Although not viewed as a positive approach, the fear of removal to detention probably results in short term changes in behavior of acting-out children. In addition to this change, a staff member from the Red Unit was promoted to another position at about this same time. This person had been responsible for more seclusions than other team members for period A; and, his replacement appeared to utilize seclusion less frequently thus providing a different model for co-workers.

The null hypothesis related to change in staff attitude about seclusion was retained for the willingness to change category of items and tentatively rejected for the existing practices category of items due to questionable reliability on that portion of the attitude scale. In examining the means for the willingness to change category, Blue and Green Units show an increase, Red Unit remains about the same, and Gold Unit shows a decrease in the predicted direction following the treatment intervention. Gold Unit therefore showed a greater willingness
for change while Red Unit remained about the same, and Green and Blue Unit less willingness for change following the training sessions. The existing practice category revealed a downward trend in means of all four groups; however, again Gold Unit shows the greatest change from pre-test to post-test thus showing less satisfaction with existing practices as a result of the training sessions. With such a small sample size (n=31) and minimal cell sizes, the approaching significance for interaction of treatment and time with the willingness to change category of $p < .107$ should not be ignored.

It was this group which had been exposed to the maximum number of training levels including a cognitive level of learning through lecture-discussion of seclusion, simulation activities, and training in alternatives. Blue Unit, having had the next greatest number of levels including the cognitive and simulation activities actually showed less change in their mean responses than did the Red Unit who only received the one level of training in cognitive learning through the lecture-discussion format. The comparison group - Green Unit - received inservice training equal in time with the other groups but of a completely different subject matter and reflected approximately as much change in their mean as did both Red and Blue Units. This comparison would lead one to believe that the combination of methods including training in alternatives received by Gold Unit may have contributed towards the reduction of their mean since the other groups within the study did not receive this level of training. The absence of defensiveness appeared to be an important variable for maximizing the learning taking place in the training sessions and subsequent application within the treatment unit. It appeared that defensiveness
minimized the learning for Blue Unit and perhaps hindered effectiveness of the simulation activities designed to help sensitize staff to the child's perception of seclusion. Therefore the attitude of staff about an intervention such as seclusion seems paramount to the team's potential for change in the use of that intervention as a result of staff training levels described in this study.

Discussion of Descriptive Analysis

Changes in the rate of seclusion utilization at HNC have varied considerably over the past four years since 1978; and, the downward trend is viewed as positive. It appears that several efforts implemented to help reduce its use and utilize alternatives to manage an out-of-control child have been effective in helping to bring about this reduction. However, a multiple of influences within the treatment center appear to influence staff's use of seclusion. The change in documentation which requires a staff member to complete a critical incident report for secluding a child, the decrease of availability of seclusion rooms brought about by physically re-locating the room to a less convenient location as well as the other administrative efforts emphasizing reduction of its use and exploration of alternatives have assisted in reducing utilization of seclusion by staff. The change in documentation resulted in a greater reduction than physically re-locating the seclusion rooms which made them much less available for use. This trend probably resulted from seclusion being interpreted as a "critical incident" and requiring a more detailed report than previously practiced. Perhaps by forcing staff to cognitively consider the incident by requiring a more detailed report, increased motivation to explore other alternatives prior to deciding
upon seclusion. Initiation of administrative and peer review emphasized the importance placed on this intervention; and staff seeking approval from co-workers as well as administration may have reduced the tendency to choose this intervention. These reductions were seemingly short lived as reported trends reveal an increase in rate after one, two or three months following these changes. As expected from human nature, one seems to revert back to behavior most common when faced with obstacles or difficult challenges. Institutionalized practices such as the use of seclusion resists long term changes even though short term changes are possible. However, after the novelty of the new expectation level diminishes with time, expectation levels seem to revert back to previous levels. Conditions of difficult transition for staff as with the staff transfers to an unfamiliar group of clients and peers, also appeared to increase use of the institutionalized practice.

Rates of admission to a unit or discharge from a unit was felt to contribute to the overall rate of seclusion for a given unit; however, when tested by rank order correlation, no significance was found. Gold Unit approached significance at .05 level with a negative correlation coefficient of -.56. The approaching significance may reveal a trend for association between a decrease in admission/discharge rate and an increase in the frequency of seclusion in Gold Unit. Three of the children frequently secluded in this group were children characterized by family problems hindering their progress and precluding return home within the near future. Perhaps the lack of active family involvement on the part of these clients partially contributed to their frequently being secluded due to out-of-control behavior.
Reasons given by staff for secluding a child were often not justifiable in 1978-79 and some of these same reasons have continued over recent years but less frequently. Recent reports contain a more detailed account of seclusion - particularly ones written by some of the staff in Gold and Red Units. All four units have critical incident reports describing seclusion which appeared from the narrative description to have started from non-compliance and escalating to out-of-control, destructive, or aggressive behavior. Direct observation within the units by an independent observer seems to support this observation on several occasions.

Willingness on the part of staff to consider the child's perception of seclusion seems critical to the present study. Clinical observation of a child placed in timeout appears to indicate that anxiety is one likely result of the frustration inherent in the timeout situation which may manifest itself in running away behavior, active resistive behaviors (fighting, verbal abuse), passive resistance (failure to do school work, refusal to speak) as well as the various abusive and destructive behaviors which take place while in timeout (kicking, screaming, etc.) (Caraffa, Truckey, and Golden, 1974). Although usually indisputably effective, timeout -- if used improperly -- is a potentially highly aversive procedure (Gast and Nelson, 1977). The aversive nature of seclusion cannot be ignored if in fact a treatment staff remains concerned about the quality of staff to child relationship and atmosphere of the treatment setting.

From an analysis of utilization of seclusion by units, the multiple factors influencing the use of seclusion can be further demonstrated. As the total number of seclusions for a unit increased, the numbers of
different children involved with seclusion also increased for all units. If staff utilize seclusion for some children, it seemingly becomes easier to utilize it for others or use it more routinely for behaviors not requiring this intervention. Perhaps this is the reason that non-compliance remains a frequent justification for use of seclusion. In those units where the seclusion rate was determined primarily by certain residents such as Gold Unit, perhaps a temporary removal to another unit could be an alternative to seclusion and provide support for staff members who have possibly exhausted their resources for managing such children. As noted earlier, the rate for Red and Gold Units decreased during period C. This reduction was felt to be a result of the treatment intervention in Gold Unit partially, but also a result of the three boys being placed in detention. As noted by staff at that time, such a situation seems to reduce misbehavior on the part of other residents within the treatment unit. The number of staff utilizing seclusion, range of utilization, and time of utilization within a team varied considerably, however this data can be misleading as substitutes or staff from supportive service roles often were involved in utilizing seclusion on a given unit. Few observations can be made here without further systematic study with more control over such factors. The team appeared to have a set style for seclusion as co-workers on a team many times had a consensus for its use. This concept supported by the defensiveness of Red and Blue Units and openness of Gold Unit in the training sessions. Gold Unit seemed ready for change as seen in the attitude questionnaire while Blue and Red Units appeared less willing to consider changes.
Although the majority of studies have found brief periods of seclusion successful in suppressing inappropriate behaviors, staff seem to have a tendency for secluding a child longer than 1, 5 or 10 minute durations recommended from empirical findings. All groups with the exception of Red Unit decreased the average duration of seclusion during times A to B perhaps as a result of the inservice training sessions which placed some emphasis upon empirical findings related to seclusion duration. Red and Blue Units decreased also during times B to C while Green and Gold Units increased average duration of 3 minutes and 4 minutes respectively. Since longer durations have been characteristic, the shorter durations attempted during times A to B were not successful therefore encouraging staff to utilize longer durations.

Since restraint has been utilized in lieu of seclusion for controlling a physically aggressive child, it was felt that this measure might increase if the rate of seclusion was reduced. Red Unit's greatest reduction in the use of seclusion from times B to C was followed with a reduction in number of restraints from 16 to 3 as well. Although Gold Units rate of seclusion also significantly changed from times B to C, their use of restraints remained stable. Although further systematic study is needed for generalizing, it would appear that restraint was not substituted for seclusion which might lead one to believe an earlier intervention may have been chosen which successfully prevented the child from escalating behavior to an out-of-control situation.
Implications for Further Research

Further research related to the use of seclusion as a treatment intervention with emotionally disturbed children within a residential treatment center or other inpatient setting needs much attention. In the present study, attitudes of staff related to use of seclusion was not changed which confirms the idea that institutional practices such as seclusion resist change. Closing the room without providing alternatives would not have been successful; and, it appeared that a more systematic plan for change was necessary. In light of Gold Unit showing the most change in desirable direction of mean scores, we can assume that the training received by this group may have been more effective than levels received by the other groups. Perhaps, future treatment interventions such as the training sessions in this study should be designed to alter attitudes rather than staff behavior. Staff attitudes in the present study contributed greatly toward the benefits in learning and subsequent application of that learning. A change in attitude should produce a measurable change in behavior; therefore, the focus of training should be in that direction rather than in methodology or strategy.

The idea of a child's perception of seclusion as revealed by his drawings and written description of seclusion needs continued research. The use of seclusion when it becomes an "institutionalized" practice within the residential setting, can become abusive. It can impair psychological growth and development of the child and result in disturbed behaviors, negative self concept, and a distorted view of the "helping professional." As institutionalized practices tend to be unquestionably accepted, staff may lose sight of the aversive quality
thereby necessitating frequent refresher training sessions to maintain staff sensitivity.

Further study of the group contagion element that seclusion appears to have within a unit setting needs done. Why does it become necessary to seclude a second or third child after the first child has been secluded on a treatment unit? The concept of temporarily removing a child to another unit or setting as an alternative to using seclusion deserves further study.

A major premise of the ecological model of emotional disturbance is that disturbance is located in the interaction between the child and the people and elements in the child's environment (Pastor and Swap, 1978). Based on this premise, would a more objective, uninvolved staff person be better able to implement seclusion for an out-of-control child? Additional research is needed to determine appropriate parameters which distinguish timeout from seclusion as there appears to be much confusion throughout the literature. We also need to determine those parameters of timeout that are most effective and functional (Bostow and Baily, 1969). Some studies have made use of self-imposed timeout which has proven effective in modifying a range of target behaviors. Self-imposed seclusion within a residential context might prove beneficial as an alternative for some children as opposed to being placed in seclusion by a staff member.

Calhoun and Lima (1977) suggest that the punishment history of a subject and the rate of target behaviors may be important parameters for further study. If seclusion is perceived as punishment, then one can expect the serious dangers associated with it as summarized by
Krumboltz and Krumboltz (1972:85) with the child tending to resist punishment and fighting back, escaping, or withdrawing into passive apathy. The child will tend to avoid the punisher whenever he can; thereby, precluding the staff members' accessibility to him as a client. This process seems quite contradictory to the general process of treatment. Dahms (1978) refers to authority being enhanced by relationship which is a consensus and agreement among the youth that those in authority are caring, honest, fair, right, reasonable, dependable and openly support and respect each other. Anything less than this foundation for a staff member's authority becomes authority without a foundation; and, these staff will be forced to resort to the dead-end street of intimidation, threats and fear, as the means of forcing and imposing their will on a client (Dahms, 1978). Developing relationships generally is regarded as a favored method of helping children build inner controls as well as remediate problem behaviors (Endres and Goke, 1973).

Although several alternatives to seclusion have been promoted as empirically sound, some alternative interventions pose the same ethical questions as seclusion. As expressed by the additional comments of staff on the attitude questionnaire, staff need resources which provide them with the capability to work with the out-of-control child in a therapeutic manner.

In light of the attitude questionnaire for this study lacking standardization, further work in standardizing a reliable assessment tool is needed to enable further research in this area. Methods of assessing when a child is in fact out-of-control is needed. Many
seclusions are resultant from an initial incident of noncompliance. Endres and Goke (1973) infer a basic question for those staff members secluding a child — "Is the child out of control of himself or is he out of control of the staff person?"

Although Kazdin, French and Sherich (1981) have published findings related to acceptability of various treatments based on evaluations from children, parents and staff, additional research in this area would be most valuable. "Evaluations of acceptability of treatment may identify ways of presenting and delivering available treatments to make them much more palatable to persons who, for whatever reasons, are likely to adhere to treatment prescriptions" (Kazden, French and Sherich, 1981). Since this study was designed as relatively short term, a longitudinal study designed to measure similar trends over a longer time should be beneficial as well as ascertain if resulting changes in use of seclusion by staff can remain over time. In addition, generalization studies across settings are needed (Roberts, Hatzenbueler, and Bean, 1981).

Limitation of Current Study and Possible Sources of Error

The present study involved studying staff behavior to ascertain intervention effects within the natural setting of the residential milieu. It was therefore necessary to utilize the pre-existing groups of staff members or teams as subjects, although a random selection of subjects for each team would have insured more experimental equality of teams prior to experimentation. The experimental design of this study was primarily
concerned with comparing each group with itself over time. Although
every effort to add experimental control was made by this experimen-
ter, since the four groups were within the same facility and social
relationships crossed over teams, one can assume that some discussion
of in-service content and reactions to the training sessions may have
occurred thus producing some contamination of data. It is recognized
that attitude questionnaires sometimes elicit responses that can be
biased based on the current feeling of respondent. Although all four
group sessions were conducted in two hour blocks on subsequent
Wednesdays separated by one week, Gold and Green Units were exposed
to their treatment intervention the first two weeks while Red and
Blue the second two weeks. Perhaps one could speculate a higher
potential for contamination resulting from shared opinions with the
two second groups as they had more time to elicit reactions of the
in-service from the first two groups, which would appear commonly
practiced among professionals working together.

In an effort to control for extraneous variables effecting
the treatment interventions, attempts were made to follow
Kerlingers (1973) Max-Min-Con Principle with maximizing the exper-
imental treatments' variance, minimizing the error variance, and
controlling for extraneous variance. Discussion outlines for the
training sessions were followed rigidly in order to minimize
opportunity for varying content of those parts of the in-service
session that more than one group received. Handouts for each
participant were a part of the training session which may have
been shared among groups by participants. These in-service
sessions were conducted on a team by team basis rather than in larger
groups which may have added some novelty effects to the experiment
since most in-service sessions involve larger groups of staff. This
experimenter was extremely cautious in discussions about seclusion
outside of the training sessions and made sure that all four teams
received generally the same content in way of announcements or
supervisory comments related to the use of seclusion, but little con­
trol if any was possible for discussion among groups by participants.

Effort was also made to observe those variables which might
cause a change in utilization of seclusion and it was felt that
these conditions were distributed among all four groups and did not
add invalidity to our results. An exception to this trend did occur
during the 60 day post-experimental period in Gold Unit when three
residents who had been frequently secluded were placed in the
juvenile detention center by Juvenile Court for seven days and one
of the three removed from the program at that time. With three
of the eleven residents in detention for one week during the 60
day post-experimental period, fewer seclusions resulted during
this period because of this condition rather than as a result of
the treatment intervention. A similar situation involved a Red
Unit resident also removed from program during the same time
period, which may have caused their rate of use to decline since
the milieu atmosphere and residents' behavior seemed to change
following his discharge. A change in staff for Red Unit was made
during the course of the 60 day post-experimental period with a
member added to the team who was experienced at HNC but had not
participated in the in-service training sessions.

Part of the data for this study involved responses to an attitude questionnaire which presumably reflected the opinions of the respondents about seclusion at a particular point in time. There are a number of problems associated with questionnaires in general. The subject matter of our study appears to be an emotional one for direct care staff working within residential treatment centers and such was evidenced by several of the comments made in the questionnaire. Some problems in reliability of the questionnaire existed; and, a better standardized tool would have increased validity of results. Although a six point scale without a neutral midpoint was chosen because it encourages respondents to force direction of choice, three of the questions were directed opposite the other nine and this could have caused some misinterpretation on the part of the respondent especially due to the latent emotional quality of the subject matter. If staff really felt that the seclusion rooms were inevitably being closed within the future as some expressed, perhaps their bias for preserving this intervention may have prejudiced their response somewhat rather than conveying their true opinion. Although the questionnaires were anonymous, perhaps some respondents desired to please the experimenter since he was in a supervisory role. Other problems with questionnaires involve such things as response set and response bias; however, Kerlinger (1973) infers that response set is only a mild threat to a valid instrument and should not be overrated. Campbell and Stanley (1963) refer to pre-test sensitization and post-test sensitization as two
Important threats to ecological validity; however, since all four groups were exposed to both with the same instrument utilized by all groups, any error in measurement or threat to invalidity should be theoretically distributed among the four groups equally.

Limits must be placed in generalizing the findings in this study to other facilities treating emotionally disturbed children. It is doubtful that many facilities have the level of training represented by staff at HNC. An interrelationship of variables such as family involvement, treatment philosophy, operating budgets, co-educational units, staffing models and many other related issues would need to resemble the structure inherent at the HNC for generalization of findings to be valid.

Conclusions and Recommendations

In conclusion, several recommendations can be drawn based upon the findings herein and a synthesis of the available literature on this subject. The overall purpose has been to study the use of seclusion by direct care staff within a residential context, and ascertain if by providing increased resources through in-service training, the use of seclusion within that setting could be altered. Various levels of training consisting of a cognitive lecture -- discussion, simulation activities, and an exploration of alternatives were considered. It was assumed at the onset of the project that seclusion could become abusive to children and a generalized or institutionalized practice resisting change. Through
providing more resources to staff within the system, it was hoped that a more functional system could be created. As a result of this change, it was hoped that a reduction in seclusion would result. The present findings hint at a tentative change in attitude and does indicate significant change in practice for two of the four groups. However, these findings must be accepted tentatively due to the many extraneous variables at work within a residential center.

It would therefore appear that such efforts were in vain; and, that perhaps another approach should have been chosen to accomplish such a goal. However, it is our feeling that such efforts were valuable. For by attempting to influence change by offering alternatives, support and direction rather than mandating it, preparation for a gradual change in practice can become a reality even if that change is slow and over a longer period of time than had been planned. Obviously, locking the seclusion rooms in the current project would have completely brought their use to a halt -- but possibly also thrown staff into a terrible disorganization and chaos for having removed a resource without replacing it with some other form. The slightest hint that such an intervention should be removed caused much defensiveness on the part of some staff. Perhaps this defensiveness was not as a result of resisting change -- but rather a result of fear of losing a very important resource to staff without having an alternative. However, the fact remains, just increasing resources through in-service training is not enough. Additional effort must also be made if an alteration of staff behavior is to occur. Perhaps by first increasing resources in training, intense day to day supervision of its
current use, modeling of alternatives, as well as severely restricting its use or completely removing the room as a possible intervention may then bring about desirable change. A comment from the attitude questionnaire summarizes it well in the following excerpt:

I also feel that as long as seclusion rooms are made available, staff will continue utilizing them, in spite of strict regulations -- having seclusion rooms tends to inhibit the use of other creative interventions but I feel this will continue unless rooms are no longer provided!

Perhaps having the rooms set up an expectation to use them. It should be interesting to observe the outcome in staff behavior as well as childrens' behavior if the seclusion room was eliminated.

With these thoughts in mind, the following recommendations are made regarding the use of seclusion within a residential facility such as HNC:

1. All standards related to seclusion within an inpatient facility should be followed with procedural guidelines for the agency incorporating the standards as well as applicable regulations for litigation.

2. Seclusion and timeout should not be confusing to staff; and procedural guidelines should add clarity to definition as well as practice. It is of critical importance to have a plan and a procedure for the use of timeout rooms (seclusion rooms) and then insist that they be adhered to (Endres and Goke, 1973).

3. At least three times as much training and supervision time should be devoted to alternatives to seclusion as to the seclusion intervention. Training as well as philosophical orientation should place emphasis on relationship and interventions other than seclusion.

4. Supervision of seclusion must be of a high priority and ongoing on a day-to-day basis to avoid misuse of the intervention and the "institutionalization" of the practice within the facility.
Due to the questionable nature of seclusion as an intervention, the following suggestions are made for implementation:

(a) Implementation of seclusion should be on a team decision. Because timeout (seclusion) is a relatively high-risk intervention, we feel it is best implemented as a team strategy, i.e., prescribed by a team of professionals (Gast and Nelson, 1977).

(b) The acknowledged limitations on the efficacy of punishment lend considerable support to the concept of an aversive treatment committee, human-rights committee, or other legally constituted group to pass judgement on the implementation of intrusive or experimental focus of punishment (Harris and Ersner-Hershfield, 1978).

(c) As an ethical consideration, documentation of such intervention should be made within the treatment plan and reviewed by both the professional team as well as the consumer. Child and parent participation in the treatment evaluation process may have direct benefits to therapy by assessing whether family support for and participation in treatment is likely to be productive (Kazdin, French and Sherick, 1981).
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APPENDIX A

Standards
54.1 A SECLUSION ROOM SHALL ONLY BE USED AS A LAST RESORT WHEN CHILDREN ARE PHYSICALLY ASSAULTIVE AND OUT OF CONTROL, ENDANGERING THEMSELVES OR OTHERS.

54.2 SECLUSION SHALL NOT BE USED AS A PUNISHMENT.

54.3 A FACILITY SHALL HAVE WRITTEN POLICIES WHICH CLEARLY DESIGNATE THE STAFF MEMBERS WHO MAY AUTHORIZE THE USE OF SECLUSION AND THE CONDITIONS UNDER WHICH IT MUST BE USED.

54.4 SECLUSION SHALL BE USED IN SHORT INTERVALS, E.G., 10 OR 15 MINUTES. ANY SECLUSION REQUIRING LONGER THAN 30 MINUTES MUST HAVE ADMINISTRATIVE/SUPERVISORY APPROVAL.

54.5 THE USE AND REASON FOR SECLUSION SHALL BE NOTED IN WRITING ON A CRITICAL INCIDENT REPORT. FAILURE OF ALTERNATIVE, LESS RESTRICTIVE METHODS SHALL ALSO BE DOCUMENTED.

54.6 WHEN SECLUSION ROOMS ARE USED, THERE SHALL BE NO MORE THAN ONE LOCKED DOOR BETWEEN THE CHILD AND A STAFF MEMBER, WHO IS WITHIN HEARING DISTANCE AND WHO CONSTANTLY MONITORS THE CHILD.

54.7 NO MORE THAN ONE CHILD MAY BE PLACED IN EACH SECLUSION ROOM.

54.8 THE SECLUSION ROOM SHALL HAVE LIGHT, PROPER AIR VENTILATION, SUPERVISED ACCESS TO TOILET FACILITIES, AND A VIEWING WINDOW. THE ROOM SIZE SHALL MEASURE AT LEAST 60 SQUARE FEET AND BE AT LEAST 7½ FEET IN HEIGHT.

54.9 FAILURE OF ALTERNATIVE, LESS RESTRICTIVE METHODS SHALL BE DOCUMENTED ON EACH CRITICAL INCIDENT REPORT INVOLVING USE OF SECLUSION.

54.10 FACILITIES PERMITTING USE OF SECLUSION ROOMS SHALL PROVIDE STAFF TRAINING AT LEAST ANNUALLY IN GENERAL CHILD CARE. THE NEED TO USE SECLUSION AS A PART OF TREATMENT MUST BE REVIEWED AND THE USE OF APPROPRIATE BUT LESS RESTRICTIVE ALTERNATIVES SHALL BE ENCOURAGED.

54.11 FACILITIES USING "TIME-OUT" AS A METHOD OF HELPING CHILDREN TO CONTROL BEHAVIOR, SHALL HAVE WRITTEN POLICIES TO SET LIMITS AND GUIDE STAFF IN ITS USE.


A. SECLUSION SHALL NOT BE USED AS PUNISHMENT. SECLUSION MAY BE USED AS A MEANS OF INTERVENTION WHEN THE RESIDENT IS OUT OF CONTROL OR IS IN DANGER OF HARMING SELF OR OTHERS. SECLUSION SHALL BE USED ONLY FOR THE TIME NEEDED TO CHANGE THE BEHAVIOR COMPELLING ITS USE.

B. IN AN OPEN SETTING A RESIDENT SHALL NOT BE LOCKED IN ANY ROOM OR SPACE OTHER THAN A SECLUSION ROOM WHICH HAS THE PRIOR APPROVAL OF THE LICENSING AUTHORITY.
WHERE PROVISION IS MADE FOR SECLUSION, WHETHER IN AN OPEN OR SECURE SETTING, THE FOLLOWING CONDITIONS SHALL APPLY:

1. All staff shall be furnished with a copy of the policies regarding the use of seclusion. This policy must specify who may approve the placement of a resident in seclusion. Staff involved in the use of the seclusion shall participate in staff training related to the policies and proper implementation.

2. No more than one child shall be placed in each seclusion room.

3. A child in seclusion shall be observed visually by staff and the observations recorded in a seclusion log. The log shall include: name of child, time of placement in seclusion, name of staff responsible for the placement, description of specific behavior requiring seclusion and time of removal.

4. When isolation rooms are used, there should be no more than one locked door between the child and a staff member, who is within hearing distance.

Standards: The Interstate Consortium (The Interstate Consortium, 1980: 135-7)

R14.9 A SECURE RESIDENTIAL FACILITY WHICH USES LOCKED ISOLATION SHALL ENSURE THAT A CHILD PLACED IN LOCKED ISOLATION IS NOT IN POSSESSION OF BELTS, MATCHES, WEAPONS OR ANY OTHER OBJECT OR MATERIAL WHICH MIGHT BE USED TO INFLECT SELF-INJURY.

R14.10 A SECURE RESIDENTIAL FACILITY WHICH USES LOCKED ISOLATION SHALL PROVIDE A STAFF PERSON WITH NO OTHER IMMEDIATE RESPONSIBILITY THAN TO MONITOR A CHILD WHO IS PLACED IN LOCKED ISOLATION.

R14.10.1 This staff person shall be in visual and auditory contact with the child at all times.

R14.10.2 This staff person shall ensure that all personal needs of the child are satisfactorily met, the child shall have prompt access to washroom facilities.

R14.10.3 This staff person shall ensure that the child receive all meals and snacks provided to other children in care.

R14.10.4 Whenever possible, a staff person shall be physically present in the isolation room to assist the child in controlling his/her behavior.

R14.11 WHEN A CHILD IS PLACED IN LOCKED ISOLATION FOR MORE THAN 30 MINUTES IN ANY 12-HOUR PERIOD, THE CHIEF ADMINISTRATOR OF A SECURE RESIDENTIAL FACILITY OR A PERSON DESIGNATED BY THE ADMINISTRATOR SHALL GIVE APPROVAL FOR EACH ADDITIONAL PLACEMENT IN LOCKED ISOLATION. THIS APPROVAL MUST BE RENEWED EVERY TWO HOURS.
R14.12 WHEN A CHILD HAS BEEN PLACED IN LOCKED ISOLATION FOR 8 HOURS IN ANY 12-HOUR PERIOD AND FURTHER PLACEMENT OR CONTINUATION OF PLACEMENT IN LOCKED ISOLATION IS CONSIDERED NECESSARY, A SECURE RESIDENTIAL FACILITY SHALL TAKE THE FOLLOWING ACTIONS:

R14.12.1 The facility shall immediately call an emergency meeting to discuss the appropriateness of the child's continued placement at the facility and develop an emergency plan for the child. This meeting shall take place within 10 hours of the initial placement of the child in locked isolation. The chief administrator, a physician who has examined the child and all appropriate staff persons shall attend this meeting. A report of this meeting signed by all persons attending shall be on file.

R14.12.2 The facility shall make every effort to notify the responsible agency and the parent(s) or guardian of the child of this situation. If possible, a representative of the placing agency and/or the parent(s) or guardian shall be present at the emergency meeting. Documentary evidence of the attempts made to notify the responsible agency and the parent(s) or guardian shall be placed in the child's case record.

R14.12.3 The facility shall ensure that the child is examined by a physician. This examination shall take place within 2 hours of the initial placement in locked isolation.

R14.12.4 For the purposes of these requirements, when a child is in locked isolation at the time of routine nighttime lock-up, the child shall be considered in locked isolation for the duration of nighttime lock-up.

R14.13 A SECURE RESIDENTIAL FACILITY SHALL ENSURE THAT ANY ROOM USED FOR LOCKED ISOLATION IS DESIGNED AND CONSTRUCTED TO ENSURE THE HEALTH, SAFETY AND WELL-BEING OF CHILDREN PLACED IN LOCKED ISOLATION.

R14.13.1 The floor space of an isolation room shall not be less than 74 square feet; ceiling height shall not be less than 8 feet.

R14.13.2 There shall be carpeting or padded covering on the entire floor and on the walls to the six foot level. Floor and wall coverings, as well as any contents of the room, must have a one-hour rating and must not produce toxic fumes if burned.

R14.13.3 The walls must be kept completely free of objects.

R14.13.4 A lighting fixture, equipped with a minimum of a 75-watt bulb, shall be mounted in the ceiling and be screened to prevent tampering by an occupant of the isolation room.

R14.13.5 The door of an isolation room shall be equipped with a window mounted in a manner which allows inspection of the entire room. Glass in such windows shall be impact-resistant and shatter-proof.

R14.13.6 An isolation room must be adequately ventilated either by natural or mechanical means.
APPENDIX  B

Staff Training Outlines
TOPIC: Seclusion vs. Time-Out

I. Introduction:
   A. There exists much confusion regarding "Seclusion"
      (1) Literature has almost no references to seclusion — but all references are made to time-out.
      (2) Time-out and Seclusion terminology is confusing with both terms used interchangeably and synonymously.
      (3) Seclusion -- otherwise referred to as "time-out", "isolation", "quiet room" and a "form of restraint".
      (4) Meanings for time-out range from asking a child "to go to his room" or asking a child to sit along the sidelines during an activity to physically placing a child by force against his will in isolation usually in a locked room.

II. Definitions:
   A. Kazdin (1981) refers to time-out from reinforcement as a period of time in which the child does not have access to available reinforcers in the situation.
   B. Cast and Nelson (1977) defined time-out operationally as contingent withdrawal of those reinforcing stimuli thought to be maintaining the behavior of interest and functionally as resulting in a decrease in frequency of that behavior upon which reinforcer removal has been made contingent.
   C. Time-out strategies have included:
      (1) Removal of materials
      (2) Reduction or elimination of room stimulation
      (3) Removal of adult social attention
      (4) Removal of student from a potentially reinforcing situation.
   D. Foxx and Shapiro (1978) state "Unknowledgeable persons have occasionally labeled punitive procedures such as extended periods of seclusion, time-out."
   E. Definitions from O.A.C.C.A. Standards
      Seclusion: The isolation of a child in a closed room, locked or unlocked, for the purpose of controlling behavior.
      Time-out: Temporary removal of the child from the group or free environmental stimulation for the purpose of controlling behavior. Time-out may be spent in the same room with the group but restricted from group activity, or in another room entirely, away from the group and has often been referred to as "time-out from reinforcement."
III. Litigation, Ethical, and Legal Implications:

A. Kardin (1980) refers to acceptability of treatment as the judgments about the treatment procedures by nonprofessionals, by persons, clients, and other potential consumers of treatment.

B. Cast and Nelson (1977) report that seclusion time-out, frequently referred to as "room time-out" is potentially the most aversive yet the most frequently used time-out procedure...

... Recent litigation, presumably stemming from concern over the potential misuse of timeout, has resulted in strict controls, severe limitations, or abolition of time-out in some institutions.

C. Court Cases regarding time-out

Cast and Nelson (1977) report on two court cases related to use of seclusion/time-out.

(1) Morales vs. Thurman (1973)
   a. Court permitted dormitory confinement which was defined as placement of student alone in locked room within his own dormitory when: (1) to prevent imminent substantial physical harm to self or others, (2) to prevent imminent substantial destruction of property, or (3) to prevent behavior which creates substantial disruption.
   b. Dormitory confinement limited to 30 minutes
   c. "Substantial" not defined

(2) Wyatt vs. Stickney (1972)
   a. Court stated the right to treatment included right to be free from isolation.
   b. An exception to above included emergency situations to prevent resident from harming himself or others -- but then only when less restrictive means of behavioral control were not feasible or proven unsuccessful.
   c. No exceptions authorized for mentally retarded persons.
   d. Following guidelines for implementation during the emergency situations described in (b) above:
      1. Patient should not be placed in isolation room for longer than 1 hour before calling a "qualified mental health professional" who would evaluate situation resulting in patient's need for isolation.
2. If further continuation of time-out duration is necessary, written rationale for decision required.

3. The written order for continued time-out stands for maximum of 24 hours.

4. While patient is in prolonged time-out period, he must be observed a minimum of once every hour.

5. Records of patient's behavior while in time-out should be charted.

c. Court permitted "legitimate time-out" procedures under "close and direct professional supervision" as a technique in behavior shaping programs, but failed to specify what constituted legitimate time-out procedure.

Budd and Baer (1976) referred to a case concerning the rights of juveniles along with consent decrees.

(3) Inmates of Boy's Training School vs. Affleet

a. Several standards ordered during solitary confinement but went on record of "strongly urging solitary confinement not to be used".

(4) Carey consent decree (New York State Asa's for Retarded Children vs. Carey, 1975) prohibited the use of seclusion defined therein as the placement of a resident alone in a locked room.

(5) Horacek consent decree (Horacek vs. Exon, 1975) stated that aversive behavior modification and isolation, except for validly prescribed medical reasons which are necessary to prevent the spread of communicable diseases, are prohibited.

IV. Selected Standards for Implementation of Seclusion:


54.1 Use of the seclusion room is an absolute last resort when children are physically assaultive and out of control endangering themselves or others.

54.2 Seclusion shall not be used as a punishment.

54.3 A facility shall have written policies which clearly designate the staff members who may authorize the use of seclusion and the conditions under which it must be used.

54.4 Seclusion shall be used in short intervals, e.g. 10 or 15 minutes. Any seclusion requiring longer than 30 minutes must have administrative/supervisory approval.
Topic: Seclusion vs. Time-Out

54.3 The use and reason for seclusion shall be noted in writing on a critical incident report.

54.6 Seclusion shall be used only for the time needed to change the behavior compelling its use.

54.7 When seclusion rooms are used, there shall be no more than one locked door between the child and a staff member, who is within hearing distance and who monitors the child at intervals of 5 to 15 minutes.

54.8 No more than one child may be placed in each seclusion room.

54.9 The seclusion room shall have light, proper air ventilation, supervised access to toilet facilities, and a viewing window. The room size shall measure at least 60 square feet and be at least 7½ feet in height.

54.10 Failure of alternative, less restrictive methods shall be documented on each critical incident report involving use of seclusion.

54.11 Facilities permitting use of seclusion rooms shall provide staff training at least annually to review the need to use seclusion as a part of treatment, and to promote the use of appropriate, but less restrictive alternatives.

B. National Association of Homes for Children

(1) Seclusion shall not be used as punishment. Seclusion may be used as a means of intervention when the resident is out of control or is in danger of harming self or others. Seclusion shall be used only for the time needed to change the behavior compelling its use.

(2) In an open setting a resident shall not be locked in any room or space other than a seclusion room which has the prior approval of the licensing authority.

(3) Where provision is made for seclusion, whether in an open or secure setting, the following conditions shall apply:

a. All staff shall be furnished a copy of the policies regarding the use of seclusion. This policy must specify who may approve the placement of a resident in seclusion. Staff involved in the use of the seclusion shall participate in staff training related to the policy and proper implementation.

b. No more than one child shall be placed in each seclusion room.
Topic: Seclusion vs. Time-Out

c. A child in seclusion shall be observed visually by staff and the observations recorded in a seclusion log. The log shall include: name of child, time of placement in exclusion, name of staff responsible for the placement, description of specific behavior requiring seclusion and time of removal.

d. When isolation rooms are used, there should be no more than one locked door between the child and a staff member, who is within hearing distance.


VI. Selected Studies/Findings on Seclusion/Time-Out:

A. Murray and Hobbs (1977) demonstrated self-imposed time-out procedures to be successful in modifying excessive alcohol consumption in adults.

B. Wilson, Robertson, Herlong, and Haynes (1979) illustrated time-out (isolating child from others by placing him in an open booth which blocked visual contact with other students) reduction in aggressive behaviors of targeted child as well as classmates.

C. Straka (1975) demonstrated that time-out leads to aggression among retarded adults as compared to reinforcement schedules.

D. Harder (1977) found short durations of time-out (30 seconds) were as effective as longer durations (60 seconds) in suppressing aggressive behaviors of 61 first, second, and third graders. Results revealed that time-out didn't produce anymore persistent suppression of aggressive behaviors than punishment or extinction.

E. Firestone (1976) reported that time-out (sitting in chair for 2 minutes each time physical aggressive behavior exhibited) successfully reduced both physical and verbal aggressive behaviors of nursery school child.

F. Sachs (1973) demonstrated time-out (preventing reinforcement) successful in working with emotionally disturbed children exhibiting self-stimulative behavior, uncooperative behaviors, and inappropriate behaviors.

G. Lahey, McNeese and McNeese (1973) demonstrated effective treatment of obscene verbal tics for a 10 year old boy through time-out (placement within time-out room for minimum of 5 minutes and until quiet for 1 minute after each target behavior).

H. Prase and Tyler (1979) reported self imposed time-out duration was as effective as teacher imposed time-out duration in reducing disruptive behavior with 25 LED elementary students. One minute of time-out when presented first was as effective in reducing disruptive behavior as 15 minutes or 30 minutes.

I. Hobbs, Forehand, Murray (1978) investigated relationship of duration of time-out and non-compliant behavior of 28 children between 4-6 years of age. Conclusions revealed very short durations (10 sec. 1 min.) of time-out decreased deviant child behaviors but longer durations (4 min.) produced greater suppression and maintained suppression longer.
Topic: Seclusion vs. Time-Out

J. Hobbs and Forehand (1977): Review of Parameters with time-out

1. Time-out generally effective in reducing maladaptive child behavior except for
   a. High ratio schedules
   b. Time-out imposed in an impoverished natural environment

2. Moderate durations of time-out (e.g., 4 min.) and contingent release from time-out are more effective than short durations (e.g., 1 min.) and non-contingent release.

3. 1 minute time-outs were demonstrated to be as effective as 15 minute and 30 minute time-outs when they preceded the longer duration time-outs. (Short time-outs were found ineffective when presented after longer durations.)

4. Out of room time-out (e.g., isolation) appeared more efficient than in-room (e.g., ignoring) although results indicate both forms equally effective in reducing oppositional behavior and increasing child compliance.

5. Presence or absence of explanation prior to time-out appeared inconsequential to effectiveness of procedure.

K. Bostow and Harper (1969): Illustrated brief time-out (wheel-chaired patient placed on floor sitting and becoming immobile and other patient placed in time-out booth in isolation) of 2 minute durations were effective in suppressing long standing disruptive and aggressive behaviors of 2 mentally retarded patients at state hospital.

L. Caroffa, Truskey, and Golden (1974): Clinical observation of children placed in time-out appears to indicate that anxiety is one likely result of the frustration inherent in the time-out situation which may manifest itself in running away behavior, active resistive behavior (fighting, verbal abuse), passive resistance (failure to do schoolwork, refusal to speak) as well as the various abusive and destructive behaviors which take place while in time-out (kicking and screaming, etc.).

M. Mansdorf (1977) reports: The use of subject isolation as a time-out technique has several detrimental effects including stimulation of strong emotional behavior such as crying and hanging... some studies have shown that use of isolation may have paradoxical effects, actually serving as a positive reinforcer instead of a punishing stimulus for some individuals.
TOPIC: Alternatives to Seclusion

I. Introduction:

Consideration of both interventions that are utilized in lieu of seclusion as well as interventions designed to prevent a child from escalating to the point of making seclusion necessary.

A. Fox and Shapiro (1976) introduced a non-exclusionary time-out procedure where child subjects wore a different colored ribbon and time-out resulted in removing a child's ribbon which subsequently signaled adult staff to remove all staff attention/reinforcement for 3 minutes or until misbehavior stopped.

Results revealed child subjects misbehaved 42% and 32% during baseline but only 6% during time-out conditions intervention.

B. Mansdorf (1977) reported success with "reinforcer isolation" which essentially removed the reinforcing elements from the subject (e.g. television, music, dayroom activities).

Mansdorf reported total elimination of non-compliance within 3 weeks for a moderately retarded institutionalized female.

C. Asher and Fox (1980) demonstrated that increasing solitary toy play for aggressive and oppositional 5 to 8 year olds reduced aggressive/oppositional behaviors.

D. Kubany, Weiss, and Sloggett (1971) designed an alternative to time-out entitled "The Good Behavior Clock". Highly disruptive behaviors of a 1st grade boy was reduced by fitting a false face on a 15 minute electric timer and permitting him to earn a treat for entire class when clock was running. When misbehaving, the clock was turned off and only resumed when behavior subsided.

E. Porterfield, Herbert-Jackson and Risley (1976) in looking for a procedure to reduce disruptive behaviors of young children developed an alternative to isolation which they called "sit and watch". This procedure consisted of having child sit for a brief time on periphery of an activity area and observe appropriate behavior of other children prior to returning to activities. The authors concluded that this procedure combining it with instruction by staff member while observing proved considerably effective.

F. Camp, Blom, Herbert and Dourlinck (1977) demonstrated how a program entitled "Think Aloud" was effective in reducing aggressive outbursts of 12 aggressive second grade boys. Similar to mediation training, the cognitive strategies are based on the following questions:

1. What is my problem?
2. What is my plan?
3. Am I using my plan?
4. How did I do?

G. Blackwood (1971), Mediation Training (see handout)

H. Redl (1950), Life Space Interview (see handout)
STAFF IN-SERVICE TRAINING OUTLINE

TOPIC: Mediation Training

I. Mediation Training defined: a way of teaching children self-control.
   A. Children who have self control resist a temptation to misbehave probably by thinking or talking to himself.
      (1) Telling himself not to misbehave.
      (2) Telling himself the unpleasant consequences of misbehavior.
      (3) Telling himself what he should be doing.
      (4) Telling himself the nice consequences of appropriate behavior.
   B. Impulsive children on the other hand seldom think/talk prior to exhibiting a behavior — controlled by external stimuli.

II. Thinking controls behavior:
   A. There are at least 3 ways to think
      (1) Words
      (2) Mental images
      (3) Motor movements
   B. Teaching a child verbal thinking skills (words) seem easiest, although role playing and imaginary are also possible to use in mediation training.
   C. Mediation training is effective with children who are verbal and can use language; it does not require that the child be highly articulate (has been found effective with both slow learners and pre-school children).

III. Mediation Training Applied:
   A. A child can cue his own behavior — but must learn to cue himself.
   B. Self-control by self-cueing or verbal mediation is a skill — to learn the skill takes much practice and drilling.
   C. Self-cues are covert words (thoughts) which act as commands or as warnings against misbehaviors and promises of the rewards of appropriate behaviors.

IV. Thinking Skills to Enhance Self-Control:
   A. To teach self-control effectively, staff should teach the child to think by using the following 4 questions and answers to those questions:
      (1) What did you do wrong?
      (2) What happens when you (name the misbehavior) that you do not like?
      (3) What should you have been doing?
      (4) What happens that you like when you (name the appropriate behavior)?
B. For self-control, the child must learn to describe behaviors and their consequences in concrete terms and specifics—not generalities. (e.g. not "good", "bad", "mean", "lazy", — but instead "hitting", "studying", "failure to do assigned work" or whatever specific behavior is.)

V. Sagamore Hills Psychiatric Hospital: "Remediation — Mutual Solving Technique"

A. Problem solving is both a skill and a process.

B. Steps for re-mediating problem

(1) Intervention to stop behavior. (e.g. physical containment, timeout, etc.)

(2) Problem Identification — attempt at isolating problem from situation (e.g. helping child realize his part or responsibility in situation).

(3) Development of an alternative plan (e.g. ask child: What could you have done differently to avoid the problem? How could you have handled it differently?)

(4) Commitment — Have child make a commitment for choosing the alternative behavior. (e.g. ask child, "Are you willing to try this?")

(5) Rehearsal (similar to commitment) — set up a hypothetical situation and have child practice by rehearsing alternative behavior (e.g. role play situation).

(6) Reinforcement — Look for a way in which staff member can reinforce child for working through the problem. (e.g. Let the child know you are supporting, care for, and are behind him.)

(7) Re-involved in program (e.g. say to child, "O.K., we now have a plan. Can we rejoin the group and handle future problems differently by using our plan? Let's give it a try!")
THE LIFE SPACE INTERVIEW

S. Roberts
A. Jurin

Preliminary factors as significant determinants of Life Interviews

A. When a child engages in a type of behavior that indicates a need for adult intervention, there are many factors that need to be assessed in order to determine the character of the LSI that may follow.

B. The behavioral incident is not seen as an isolated act but one performed by a particular child within a certain setting at a certain time and at a certain point in the child's life experiences.

For example:

1. The incident itself:
   a. Where did the incident occur?
   b. In what setting?
   c. How clear was the incident?
   d. Was it dangerous?

2. The child:
   a. How clearly was the incident representative of his difficulties?
   b. When did the behavior start -- yesterday, today, or at what point, after what incident, etc.?
   c. What events may be influencing the present behavior indirectly? (i.e. a nightmare last night and/or enuresis, being scapegoated by others, guilt or anger toward an unresolved incident in the recent past, a series of frustrating situations all day, etc.)
   d. What was the quality of affect that accompanied the behavior?
   e. What is the relationship of the preceding behavior to the child's past (pre-camp) history?

3. The timing:
   a. To what degree is the child able to tolerate working through the situation at this time?
   b. Is it 10:00 a.m. or 10:00 p.m.?
   c. How many times has he been in session today and for what issues?
d. Does this indicate a need for more or less work on the issue?
e. With what activity are you competing -- one that holds a high or low level of gratification for him?
f. Is he avoiding an activity that is anxiety--provoking or unpleasant?

C. Who Conducts the LSI and Where:
1. How familiar is the adult with the particular child -- with his camp background, etc.?
2. How skilled is one adult in dealing with this child, this type of behavior or situation?
3. What are the feelings of the adult toward the child?
4. What type of behavior?
5. What are the feelings of the child toward the adult?
6. How comfortable does the adult feel in working with the affect present?
7. Does this situation require a session room for more control, reduction of external stimuli distractions, privacy for kid who is acting out in manner that may cause him later embarrassment or evoke harassment from other kids?
8. Is he able to tolerate an open setting, classroom athletic field, etc.?

D. Other Considerations for LSI Process: Exploration of a behavior may reveal that this has been a neat-clean-cut example of a deep seated problem area, but if the incident has occurred five minutes before the opening of the Carnival, exploitation of the event would not only be highly inappropriate but also probably fruitless. Three sessions in one day around similar issues followed by a blow-up at bedtime may indicate need for exploration of the issue to a depth not previously pursued or indicated.

II. Diagnosis of the Problem: Exploration of the situation stimulus leads to a diagnosis of the problem. Generally the problem may be related to one of the following areas which may be pure in form or overlay or overlap each other.

A. Peer relationships: The child may not be able to relate to one or more members of his cabin (may be a problem of scapegoating, a power struggle, struggle for leadership, etc.).

B. Adult relationships:
1. May be testing limit setting ability of adult.
2. May be expressing feelings of omnipotence and need to control adults and environment through a power struggle.
3. May be testing adults' ability to care for them. -- "You can't really love me because I'm bad."
4. May seek closeness and affection through veil of negative attention - getting or provoking behavior.

C. Other problem:
1. Nostalgia/sickness (no family contact through letters, visits, etc.)
2. Concerns related to events that occurred prior to coming to camp.
3. Events that may occur after camp, i.e., returning to unpleasant and/or unsettled home situation (foster home or institutional placement).
D. More deep-seated, characterological problem: (Example: masochism, sadism, severe ego defects, sexual exhibitionism, etc.)

E. Present management (control?) problem: (Example: May be behaving in a manner indicating need for case work, live-away, send home.)

III. Diagnosis of the Defense

The presenting behavior may be viewed as a defense used by the child to deal with the given situation. The initial defense the child uses is generally characteristic of the modus operandi which he has found to be most successful in his past experiences with adults. It may also reveal to us how adults have in turn responded to him in the past. A child may present one or all of the following behaviors in any order throughout an LSH. He may act:

A. Silly or "crazy":

Example: Laughing, silly, giggling, jumping around acting out animal sounds and other pseudo-bizarre stuff. Child may have found that such behavior has exasperated adults, resulted in an I-give-up attitude or feeling that child is "too crazy"; therefore, abandoning efforts at working toward verbal exploration of problem.

B. Frightened or withdrawn:

Example:

1. May curl up in a fetal position, feign sleep, deafness, muteness.
2. May cry or scream with genuine fright or panic.
3. May threaten adults with aggressive attacks but the latter are highly tinged with real fear of adults, particularly of physical reprisal from adults (May even suggest: "Go ahead, beat me... Get it over with..."; May provoke or invite open combat)

C. To maintain or gain power:

Example: May be aggressive toward adults but flavored more with need to control, boss adults rather than fear of them. Omnipotent defiance of adult control — "you keep your hands off me or I'll kill you." "Shut up, I'll do what I goddam please." etc. May indicate child has been successful in controlling adults thru defiance, threats, etc.

D. Manipulative:

Example:

1. Covers a wide range of techniques such as being seductively appealing.
2. May be weak, contrite and use touching penitence and quick promises of better behavior to avoid any discussion or exploration of the problem.
3. Usually has been highly successful at generating soft, lenient forget-and-forget feelings in adults, thus continually bypassing confrontation of his own behavior.
E. Embarrassed, ashamed: May often relate to deeper characterological problems such as sexual problems, enuresis, encopresis, etc. May indicate that child has been humiliated, teased, shamed, rejected by adults for such behavior. The defensive maneuvers may also overlay or overlap. For example, a defensive maneuver of manipulation may be followed by an expression of power which in turn may be a defense against extreme fright. Withdrawn frightened behavior may obscure deep-seated feelings of shame or embarrassment.

IV. Readiness to the Defenses

A. Silly behavior: Indicates a need for a serious approach from adults. The behavior may yield to direct interpretation such as "you're acting silly (or crazy) because you want us to leave you alone and not talk about this".

B. Frightened or withdrawn behavior: Indicates need for softness in approach. Child needs reassurance, support from adults. Verbalization by adult for child of his unexpressed fears of adult reprisal may be indicated.

C. Need to gain or maintain power: Indicates need for a firm, tough line. Child needs to know that adult is in control, not his omnipotence.

D. Manipulative behavior: Adult indicates awareness of manipulative maneuvers and interprets them as defenses to prevent discussion of the real problem.

E. Embarrassment, shame: Indicates need for more careful handling. May require much reassurance and support that adult is not going to scold, punish, reject child if problem is verbalized.

V. Techniques Used in Working-Through Process of LSIs:

A. Direct appeal: Appealing to kid's sense of fairness, logic.

B. Reality testing: Assisting kids to do this.

Example:

1. What did you think Johnny would do when you called him a name, hit him, etc.?
2. Does this make sense?
3. Why did counselor try to stop you?
4. Why did she say you couldn't do this or that, etc. Invitation.

C. Use of dialogue: Talking as though kid not present.

1. May be to another adult present.
2. May be useful to help kid verbalize who is resisting this for one reason or another.
3. May also communicate feelings, ideas, etc. to him which he can't accept directly.
D. **Limit setting:**

1. May demand that child stop certain activity in session room to point where you may demand he sit in chair even to being held.
2. May be necessary and valuable with kid who is expressing powerful omnipotence.
3. May include responding to threats with extremely firm, "No, you are not" and conveying that adults run the camp, not kids.

E. **Re-enactment of the "crime"**:

1. May occur in session room or on the spot.
2. Can include witnesses, confiscated goods, weapons, other evidence, adult can "play dumb". Regaining repeated clarification which may eventually reveal the truth. (Pitfall for adult is an inadvertently providing kids with excuses and ideas he didn't have to begin with.) Adults can also re-enact, mimicking back in manner that points out fallacy, i.e., "You just went up to and 'Pow'."

VI. **Goals of LSP**

A. The goal of any LSP is to bring about a change in the behavior of the child, be that change temporary so that he may continue to function adequately in his immediate situation or deeper so that he may gradually acquire new ways of dealing with similar situations in the future.

B. There are many goals that one may hope to accomplish in addition to resolution or solution of the presenting situation.

1. Assisting the child to develop an awareness of his own inner feelings and being able to identify (express and utilize) them. Guilt feelings or feelings of shame, sorrow or grief or tenderness may be particularly difficult for a child to experience or express.
2. Assisting kid to appropriately express his feelings more directly with diminishing need for defensive maneuvers or acting out behavior.
3. Assisting child to develop new patterns of relating to others. Assisting him to analyze how he relates to others may reveal his need to learn new methods of interacting.
4. Assisting child to develop better self-identity -- who he is, his abilities, resources -- building up his self-esteem, ability to resist group contagion; identifying and developing his own control system.
5. Assisting child to perceive adults differently -- as helping him and who have and can have positive feelings toward him despite his behavior.

VII. **Closure of the LSP:** Actual closure of the LSP may involve action on the part of the child, and/or adult, or combination of both.

A. **On the part of the child:**

1. There may be a need for reconciliation with other kids, counselors,
etc. Repair, replacement or restoration of stolen goods, broken property, etc. May need adult help in the actual process.

2. Assenting to a mutual agreement as to how child will attempt to handle subsequent similar situations.

B. On the part of the adult:
   a. Arrange for signals kid can give when needs assistance in similar situations.
   b. May arrange a phone call home.
   c. May call agency to clarify an issue.
   d. Special or live-away.
   e. Assess kid's emotional readiness to re-enter the life space.

VIII. Re-entry of Kids into Life Space Orbit

Some techniques that the adult can use to assist the child in this process may include:

A. Moving out into the life space with the child. Adult may be casual, close in a parallel but not pushy manner, particularly if kid has need to withdraw, sulk a bit. May introduce neutral external topics to help child regain his composure, nonchalance.

B. Let child sit alone -- together.

C. May express highly positive and/or affectionate feelings in manner sincerely acceptable to child particularly if he's just working thru highly charged areas after much negative behavior.

D. May also participate in actual reconciliation process involving others.

E. May feel child back into pleasant or gratifying situation or structure something special that will provide him with same.
TOPIC: Activity Planning


A. "Activity Planning" is an integral part of the Educateur approach to treatment.

1. Creation of milieu in which the youngster can be given appropriate stimulus nutriment to actualize all his/her potentials -- physical, affective, cognitive, social, spiritual -- despite deficits of ego or internal conflict.

2. Educateur involves programming
   a. Cognitive
   b. Affective
   c. Recreative
   d. Expressive

3. All elements of environment are components of re-education process.

4. There is no segregation between "re-education" and other activities. Everything must be planned and programmed so the environment constantly favors the re-education process.
   a. Planning takes format of lesson plan or "fich" (see examples attached)
   b. Education philosophy: "utilizing every moment of everyday--every situation as a learning situation--a problem = potential for learning"

B. Roles and Responsibilities of Psycho-Educators

1. Pedagogical - Socio-Cultural Activities (see handout attached)


A. The Re-Education Process


"Work Mastery" (Erikson) is the backbone of identity formation.

Ego strengths according to Erikson's Schema that are differentiated and nurtured during re-education process are:
1. Hope: basic trust is acquired through time perspective, and repeated life experiences of trust give rise to rudiments of hope.

2. Will: autonomy is reinforced by self-assurance in living experiences, and the exercise of autonomy calls forth the rudiments of will.

3. Purpose: initiative can be developed only by role experimentation and by assuming responsibilities tailored to the adolescent's capabilities; thus initiatives call for purpose.

4. Competence: satisfaction in work achievement or industry will be intensified only by "anticipated success," and this repeated satisfaction in work achievement will lead to competence.

5. Fidelity: identity in adolescence will be realized only if a psychosocial self-definition is experience, that is, if experiences allow the adolescent a vision of self within social structures in a group experience. The strengthening of this identity is shown by the gradual acquisition of fidelity, meaning fidelity in terms of one's self.

B. Four phases of the re-education process:

1. Acclimatization (2-12 months ± 3 months):
   External nutrient is highly structured and requires such an organized daily schedule that it includes every moment of daily life, whether devoted to work or to play.
   Orientation to milieu takes place at this state -- must be global, coherent, and simplified in time and in space.
   --Formation of body ego to be acquired by provision of numerous physical performance activities.

2. Control (8-13 months, ± 9 months)
   Appropriate external nutrient remains highly organized, especially for activities; but limited and obvious choices are permitted within the framework of activities.
   --Youngster learns to control surface behavior.
   --Integration into group life as a social reality acquired through implicit and explicit traditions that help conformity to group life.

3. Production (14-25 months; ± 20 months)
   Nutriment becomes more internal because child begins discovering his own particular aptitudes.
   --Personal attributes to be explored and exploited.
   -- learns to plan work in realistic time schedule -- learns to be productive with time and energies.
4. **Personality (20-36 months; 24 months)**

Nutrients come almost entirely from internal sources; child displays a personal style, appropriate to his own aptitudes and creative possibilities.

---Discovery and awareness of the individual's own style and identity.

**C. Specific Guideposts for Each Phase:**

1. **First phase**—sole requirement is to achieve efficient performance at the sensorimotor level. (Time, space, rational articulation of means to achieve the objective).

2. **Second phase**—symbolic representational level.

3. **Third phase**—represents the concrete operational level and involves reversibility and association, emphasis on "casual relationships."

4. **Fourth phas**—stresses stimulation of individual creativity.

---


**A. First Phase: Acclimatization**

1. **Objectives in Activities:**

   a. **Step 1** — Constant supervision by staff; child will be able to start at given signal; he will be able to proceed as supposed to; he will be able to complete amount of work he is scheduled to do; product finished during one session

   e.g. pottery activity -- simple ash tray

   b. **Step 2** — Constant supervision continues by staff; child will be able to proceed and complete work with less adult supervision.

   c. **Step 3** — Time, space, tools, activities still structured but child begins to have more control. Child will begin working by himself at given signal and proceed by himself.

2. **Programming of Activities:**

   a. Activity organized in such a way that a completely finished product is possible during period of activity.

   b. Signal to start activity will be clearly given in a stable recognizable way.

   c. General procedure of activity period will be clearly defined; will not change from period to period or from staff to staff ("consistency" in structure).
3. Nature of Educator's Interventions:
   a. **Step 1** -- Staff will support child in a way that he will become able to stay on specific task for whole period of activity.
   b. **Step 2** -- Staff gives child direct support to help him start on time -- then lessens it to become more "indirect".
   c. **Step 3** -- Staff support directed so that child starts working at given signal and follows the general and specific procedures by himself.
   d. **First Level of Autonomy:**
      Child knows what tools to use and when as well as techniques of activity.

B. Second Phase: Control

1. Objectives in Activities:
   a. **Step 1** -- (in acclimatization, child learned how to use tools for specific activity)
      Learn ability to choose, among a few alternatives, one means or another to reach a specific goal.
   b. **Step 2** -- After completing product, child is able to retrace steps and sees end result was reached by logic, not chance.
   c. **Step 3** -- After understanding logic of action; he should gain ability to realise his role in selecting the right tool(s) and sequence of utilization.

2. Programming of Activities:
   a. Finished product is still clearly defined by program.
   b. More than one work period, but not more than 1 week should be necessary to complete finished product.
      e.g. more complex products than ash tray -- candle holders
   c. More than one technical alternatives should be possible to complete product,
   d. When product completed, a means should be available to help child retrace the tools and techniques he used and time sequences

3. Nature of Educator's Interventions:
   a. **Step 1** -- Staff selects for the child a goal in terms of product. Clearly specifies to child what and product will he, time and space required for completion.
b. **Step 2** -- Staff supports child so he consciously selects his tools and techniques.

c. **Step 3** -- Staff supports child so he can retrace the tools and techniques he used and time sequence required for completion.

d. **Second Level of Autonomy:**
   
   Child selects the means (tools, techniques, procedures) to reach a specified goal within logic of action.

C. **Third Phase: Production**

1. **Objectives in Activities:**
   
   a. **Step 1** -- Child will learn to plan his work in a realistic time schedule over which he has complete control to reach goals defined by activity.

   b. **Step 2** -- Without any specific help from the staff, he will keep on planning his total time schedule to reach goals.

   c. **Step 3** -- Child will now be able to plan his work schedule in such a way that planning will take into account the needs of the group.

2. **Programming of Activities:**
   
   a. Finished product is still defined by general program.

   b. Finished product will be less and less programmed as final in itself, but rather as a sequence of finite steps in the whole program.

   c. Means and time should be made available (such as blank work schedule) so that the child can plan his work schedule at the beginning of a week and check how it came out at the end of it.

3. **Nature of Educateur’s Interventions:**
   
   a. **Step 1** -- Staff will help child plan work schedule so that no part is omitted and so his provisions take into account amount of time available... assisting child with learning how to organize time, etc.

   b. **Step 2** -- Staff becomes less and less involved in daily routine of checking the work schedule with child. He will refrain from intervening on each occasion but keep material on hand for weekly sessions with child.

   c. **Step 3** -- The weekly careful checking up of the time schedule will be less and less necessary... emphasis will rather be in a happy relationship between his own way of life and group needs and his involvement in group.
d. **Third Level of Autonomy:**

To plan and control time and space utilization to reach a specified goal within logic of action.

D. **Fourth Phase: Personality**

1. **Objectives in Activities:**
   a. **Step 1** — Child will select his own immediate goal in direct relationship with the general vocational objectives he wants to reach at discharge.
   b. **Step 2** — Child's vocational objectives will be defined in relationship with life style he wishes to have.
   c. **Step 3** — Child's vocational objectives and life style defined in relationship with the personal values he wishes to pursue at the time of discharge from program.

2. **Programming of Activities:**
   a. Finished product will be defined by vocational interests of child.
   b. General activity program will allow individual adjustments regarding time schedules, curriculum, etc.

3. **Nature of Educator's Interventions:**
   a. **Step 1** — Staff support will become less and less at technological level, help child plan his action according to logic.
   b. **Step 2** — Staff to be on lookout for child's verbalization in relationship with his vocational choice, so as to equate his choice with a chosen life style.
   c. **Step 3** — When available opportunity arises, staff helps child relate his vocational choice and life style to his personal values.
   d. **Fourth Level of Autonomy:**

To plan everyday activities in relationship with a life style based on a value system.
TOPIC: Activity Planning


   A. Play, individually or in groups, organized or unplanned, is a universal phenomenon in human life.

   B. Play, for children, provides outlets for physical energy, emotional expression, fantasy; and opportunities for education, skills, incorporation of values, and socialization.

   C. Disturbed children may not feel the exuberance, joy, and fun generally experienced by children during play.

      1. The withdrawn child may find greater security in individualized play which seems to provide refuge from group living requirements.

      2. The hyperactive child, motivated by anxiety to dominate or win, deprives himself of experiencing a sense of pleasure and relaxation.

      3. The aggressive child's play may serve as an outlet for hostile feelings.

   D. Since disturbed children generally do not know how to plan or utilize free time constructively, adult planning and involvement in their play and recreation is essential.

   E. Play can be viewed as authorized regression to more immature behavior.

      1. Verbalizations and actions which are typically not acceptable in everyday living are acceptable when expressed in play.

   F. Planned recreation provides an opportunity in which a child can relate, can reorganize his ego strengths, and then return to more serious business of the day's activities.

      1. A recreational program should provide different types of activities or forms of play adapted to meet therapeutic needs of different kinds of children.

         a. A hostile, aggressive child in a group game such as baseball or basketball will tend to make it an intense rivalry situation — the group will disapprove or staff will employ sanctions against such efforts — youngster learns cooperation.

         b. An inhibited youngster can be helped to use play to drain off a great deal of repressed hostility which may immobilize him.
G. Direct care worker involved in play with children has the opportunity to teach skills, game rules, sportsmanship, and through active participation, to strengthen his relationship with child.

H. Negativism, lethargy, and apathy may be manifestations of a child’s emotional difficulties rather than attempts made to frustrate workers.

I. According to Whittaker (1969: pp 103-112), the worker’s enthusiasm and enjoyment in a creative activity, game, or sport “provides a model for the children of how a person relates to an activity”.

J. Planning activities for leisure time must include considering the following variables:

1. Competency of staff
2. Availability of necessary materials and tools
3. Sufficiency of staff coverage
4. The children’s interest and motivation
5. Particular mood of the group
6. Timing and nature of activity — (e.g. physically active games should be avoided prior to bedtime -- perhaps quiet games, group singing, or story telling more preferable

(See attached Activity Planning Sheet & Activity Evaluation Checklist)

K. A comprehensive activity program contributes to individual and group development and includes:

1. Arts & crafts
2. Group games and sports
3. Creative work projects
4. Dramatics and music
5. Nature walks
6. Camping

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>GOALS</th>
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</thead>
<tbody>
<tr>
<td>Arts &amp; Crafts</td>
<td>--development of skills in working with materials</td>
</tr>
<tr>
<td></td>
<td>--creating outlets for excess energy</td>
</tr>
<tr>
<td></td>
<td>--deriving satisfaction from completing a creative task</td>
</tr>
<tr>
<td>Group Games &amp; Sports</td>
<td>--promote social interaction</td>
</tr>
<tr>
<td></td>
<td>--provide an experience in cooperation</td>
</tr>
<tr>
<td></td>
<td>--learning to follow rules of games</td>
</tr>
<tr>
<td></td>
<td>--provide outlet for physical energy</td>
</tr>
<tr>
<td>ACTIVITY</td>
<td>GOALS</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Musical Activities &amp; Dramatics</td>
<td>— provide group participation and enjoyment</td>
</tr>
<tr>
<td></td>
<td>— outlets for individual talents</td>
</tr>
<tr>
<td></td>
<td>— learning teamwork</td>
</tr>
<tr>
<td>Constructive Work Projects</td>
<td>— learning in joint planning and teamwork, skill development, cooperative work, aesthetic development, and a sense of achievement</td>
</tr>
<tr>
<td>Outdoor Activities, Nature Hikes, &amp; Camping</td>
<td>— expansion of child's perceptions about nature</td>
</tr>
<tr>
<td></td>
<td>— learning appreciation for nature's laws</td>
</tr>
</tbody>
</table>

I. A direct care worker's observations and participation with children in recreation and/or activities will contribute significantly to planning and implementation of appropriate therapeutic programming.

(See attached Leisure-Time Activity Profile and Assessment for Activity Planning)

II. Television — viewing is an important leisure-time activity in our society. Unfortunately it can be misused.

1. It becomes an obstacle to relationships when it is used as a substitute for personal interaction.
2. When children are indiscriminately exposed to inappropriate, frightening programs and films of violence, T.V. is harmful.
3. Its use in residential living to fill empty leisure hours is evidently poor planning of cottage activities.
4. Staff participation in viewing television can be constructive by representing a time of sharing time together and providing opportunities to clarify content of program with children.

III. Examples of Projects/Crafts

(available sample projects shared with short explanation of materials needed, skill level required, and goals for activity)

IV. Examples of Activities for Recreation; leisure time, arts & crafts, drama

(see attached handout from O.A.E.C.A. Conference Workshop)

IV. Suggestions for Activity Planning and Index of Activities

(see attached HNC Activity File)
ACTIVITY EVALUATION CHECKLIST

Staff Member or Intern: ________________________ Evaluator: ________________________

Unit: ________________________ Date: ________________________ Number of Children: ____________

Nature of Activity: (Attach copy of Activity Plan if possible) ________________________

1. Activity Plan has been written ________________________ Yes_____ No _____*

2. Activity has clearly defined goals ________________________ Yes____ No____

3. Adequate prior preparation has been done
   (e.g., practiced in advance; materials prepared) ________________________ Yes____ No____

4. Implementation sequence was effective ________________________ Yes____ No____

5. Activity has been presented in motivating way ________________________ Yes____ No____

6. Group management techniques were adequate ________________________ Yes____ No____

7. The activity was evaluated with the children ________________________ Yes____ No____

8. How might activity be changed to improve future implementation?

* Evaluator should add comments for any "No" response

ph 8/3/81
ACTIVITY PLANNING SHEET

I. Description of Activity

Recreational Activity: obstacle course in course suitable for all ages, although this activity is geared for a co-ed group of children between ages of 6 and 8. (Approx. 4 hour required to complete)

II. Specific Goals for this Activity

- Following directions of staff: starting and stopping on signal.
- Learning and following a sequential order: learning names of each apparatus: taking turns, working positively with peers and staff (cross motor skills)

III. Materials Required

- Balance Beam (high & low)
- Chute
- Swivel rope
- 1 hula hoop
- Poles (ones used in water park)

IV. Implementation Sequence

1. Sit children down in circle and state activity and expectations
2. Have children review expectations and ask if there are any questions.
3. Explain that one child will be going through the course at a time.
4. Show them how to go through the course.
5. Have first child begin. Repeat until everyone has had turn.
6. Spur, repeat again, giving each child another turn.
7. Could time the children in steps within.
8. Prated throughout activity of expectations.
9. End activity by sitting all children down and discussing the activity: (ask if they would like to do it again, areas next difficult, etc.)

V. Evaluation of:

A. Plans: -- Sequence and ease effective. Problems with coordination: Children had trouble getting across the poles. Did not have discussion of activity use the result.

B. Children--responded very well to activity. Scale not very effective and all were met with the exception of positive review. (Began arguing at times, video levels loud, etc. adjusted level)
C. Staff worked well in presenting activity to kids and we were prepared. Materials were set up prior to activity and controls used throughout activity were effective in management.

VI. Implications for Future Plans

Will repeat activity in future, next time stressing how to end activity. Try to design added technique for gathering group together at end.

IDEAS FOR SIMPLE ACTIVITIES

Word games
Making letters and words
  with your bodies
Making vegetables
Singing a song
Simon Says
Duck, Duck, Goose
Wander Ball
Tumbling exercise
Running a Unit Meeting
Follow the Leader
Brushing your teeth
Paper airplanes
Telephone
Charades
Hide and Seek
Red Light
Giant Steps
Tag (Freeze, T.V., letter)
Leap Frog
Scavenger Hunt
Musical chairs
Hopscotch
Who's Leading?
Farmer in the Dell
ASSESSMENT FOR ACTIVITY PLANNING


Observations on the Individual Child

1. Does he prefer individual play or group activities?
2. Is his play reality-oriented or primarily make-believe or fantasy? If predominantly make-believe, does he switch back to reality quickly? Does he do so reluctantly or with difficulty?
3. What kind of group activities does he prefer? Active or passive games? Competitive or noncompetitive activities? Athletic or aesthetic, such as dance or music? Does he prefer watching T.V. to playing games?
4. Does he have any special interests or hobbies?
5. Does he have any special skills or talents? Is he eager to learn new skills, or is he fearful or evasive?
6. Is he a leader or a follower in games?
7. Is he well coordinated? Poorly coordinated or clumsy? Inhibited? Spontaneous?
8. Is he destructive with toys or equipment?
9. Does he conform to the rules of a game? Try to dominate a group activity? Cheat or try to, in order to win? Try to avoid getting into group play? Blame others if the team loses? Is he aggressive, even hurting playmates? Disruptive in a game?
10. Does he have fun, enjoy himself at play?
11. Is he fearful of getting hurt?
12. Is he reckless, accident-prone?
13. Is he accepted and liked by his playmates?
14. What is his attitude toward recreation staff—friendly, hostile, ambivalent, or indifferent?

Observations on the Group

1. Is it easy or difficult for the group as a whole to get involved in group activities?
2. Are there subgroups (two or three children) who enjoy playing together?
3. Is the group responsive to planned activities?
4. What kind of activities or group games do they prefer?
5. Is it easy or difficult to get them involved in planning group activities?
6. Are they responsive to workers' suggestions?
7. Can they function as a team, a cohesive group?
8. Does the group have a natural leader?
9. Are there isolates who do not get involved in group activities?
10. Is anyone treated as a scapegoat by the others?

The Worker's Self-Evaluation

1. Do you enjoy organizing play activities?
2. Do you feel insecure about organizing group activities?
3. Do you like to play with a child individually, with small groups, or with the total group?
LEISURE-TIME ACTIVITY PROFILE


Name of Child: ______________________

Age: ______________________

Group Care Unit: ______________________

1. PROFILE (To be completed by child care staff by time of initial evaluation conference)

1. ACTIVITIES AND INTERESTS (check all those that he/she participates)

   Outdoor sports   Music   
   Gym activities   Socials  
   Art   T.V.   
   Crafts   Other: (specify actual or expressed interest)
   Hobbies   
   Quiet games   

2. STRENGTHS (check those applicable)

   Well coordinated   
   Good playing skills   
   Positive attitude toward activities   
   Positive attitude toward staff in activities   
   Positive attitude toward peers in group activities   
   Good leadership qualities   
   Other: (Specify)   

3. COORDINATION PROBLEMS (check appropriate item)

   None   In finger dexterity   
   In running   In catching ball   
   In jumping   In throwing ball   
   In hand dexterity   In batting ball   


4. MOTIVATION TO LEARN SKILLS (check one)
   Eager to learn __
   Gets anxious about it ____
   Is not cooperative ____
   Refuses instruction ____

5. ATTITUDE TOWARD LEISURE-TIME ACTIVITIES (check one)
   Positive __
   Fearful ____
   Hostile ____
   Indifferent ____

6. DEGREE OF PARTICIPATION IN GROUP ACTIVITIES (check those applicable)
   Initiates peer group activities ____
   Participates actively ____
   Needs encouragement to join group activity ____
   Refuses to participate ____

7. BEHAVIOR IN GROUP ACTIVITIES (check one or more)
   Is always involved in it ____
   Seems to enjoy himself/herself ____
   Is cooperative ____
   Is highly competitive ____
   Gets frustrated easily ____
   Is mostly quiet and passive ____
   Is angry most of the time ____
   Gets into fights ____
   Is disruptive ____
   Seems anxious most of the time ____

8. LEADERSHIP QUALITIES (check one)
   Is leader, using his role constructively ____
   Is leader, using his role destructively ____
   Is a follower ____
   Is an isolate ____
9. **ACCEPTANCE BY PEERS IN ACTIVITIES** (check one)
   - Is liked ______
   - Is tolerated but not liked ______
   - Is disliked ______
   - Refuse to play with him ______

10. **ATTITUDE TOWARD STAFF** (check one)
    - Seeks out staff ______
    - Avoids contact with staff ______
    - Rejects staff attention ______
    - Is indifferent to staff ______

11. **GOALS** (formulated at initial conference and evaluated periodically)
    Determined at scheduled interdisciplinary case conference.
    List them in terms of priority:
    1. ______________________________________
    2. ______________________________________
    3. ______________________________________

111. **MEANS and STRATEGIES** to achieve above goals and designation of person(s) who is most suited to work with child to achieve goals.
    1. ______________________________________
    2. ______________________________________
    3. ______________________________________
APPENDIX C

Staff Attitude Survey
Timeout Record Forms
Job Descriptions
HNC Floor Plan
Written Comments From Children
STAFF SURVEY

As you are aware from recent discussions at staff meetings and recently published standards by the Ohio Association of Child Caring Agencies, much attention has focused upon the use of seclusion and time-out within residential treatment facilities. The following survey is an attempt to solicit your opinion about the use of seclusion as a direct care staff at Hannah Neil Center.

Please answer the following questions by circling the response that most closely resembles your opinion about each statement.

<table>
<thead>
<tr>
<th></th>
<th>SA - Strongly Agree</th>
<th>A - Agree</th>
<th>PA - Not Sure but Probably Agree</th>
<th>PD - Not Sure but Probably Disagree</th>
<th>D - Disagree</th>
<th>SD - Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>As a staff member, I need more in-service training related to the use of seclusion and/or time-out.</td>
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<tr>
<td>2.</td>
<td>Seclusion is used too frequently by staff and sometimes prior to first attempting other measures for managing an &quot;out of control&quot; child.</td>
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<td></td>
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<tr>
<td>3.</td>
<td>I feel there are acceptable alternative strategies that can be used in lieu of seclusion for managing the &quot;out of control&quot; child.</td>
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<tr>
<td>4.</td>
<td>In actual practice, procedural guidelines relating to use of seclusion are not always followed by staff.</td>
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<td>5.</td>
<td>The use of seclusion by direct care staff should require strict controls to safeguard against its misuse.</td>
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<tr>
<td>6.</td>
<td>Seclusion is sometimes utilized as a punishment in an effort to teach the child to behave more acceptably.</td>
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<tr>
<td>7.</td>
<td>The use of seclusion should be retained as a &quot;last resort&quot; measure for a child who will not respond to other measures.</td>
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<td>8.</td>
<td>The existing HNC procedural guidelines addressing the use of seclusion are adequate.</td>
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<td>9.</td>
<td>I would be in favor of completely abolishing the use of seclusion.</td>
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</table>
STAFF SURVEY

10. The procedural guidelines for utilizing seclusion seem entirely too restrictive for staff.  
SA A PA PD D SD

11. The choice to use seclusion for an "out of control" child should require a joint decision by two staff members prior to implementation as a safeguard for objectivity on the part of staff and to prevent using it when other alternative interventions could be utilized.  
SA A PA PD D SD

12. The use of seclusion at HMC is effective in calming down or de-escalating an "out of control" child.  
SA A PA PD D SD

Please add any further comments you wish to express regarding your feelings about the use of seclusion in general or what you feel the child learns while in seclusion, in the space below.

COMMENTS:

Note: For analysis purposes, the following numerical values will be assigned to ratings: SA=1, A=2, PA=3, PD=4, D=5, and SD=6.
**TIME-OUT RECORD FORM**

<table>
<thead>
<tr>
<th>CHILD'S NAME</th>
<th>DATE</th>
<th>TIME-IN</th>
<th>MONITOR BY INITIALIZING EACH 5 MIN.</th>
<th>TIME-OUT</th>
<th>STAFF NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>5  10  15</td>
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</table>

(This form is to be turned into Assistant Director's office when filled, or at end of month.)
CRITICAL INCIDENT REPORT

UNIT:

CHILD: __________________________ DATE: ___________ TIME: _______________________

Injury - Medical Problems - child
Injury - Medical Problems - staff
Runaway
Seclusion

Property damage
Physical aggression
Other (please specify)

Seclusion Monitoring Record:

Time In: __________________ Monitoring Times: _____ 5 min. _____ 10 min. _____ 15 min.
Time Out: __________________ _______ 20 min. _____ 25 min. _____ 30 min.

Description of Occurrence:


Action Taken:

Administrative Review:

_________________________ Staff Member _____________ Date

_________________________ Director __________________ Nurse
STARK COMMONWEALTH SCHOOLS
COLUMBUS CAMPUS

INCIDENT REPORT

UNIT: ____________________________ INCIDENT DATE: ____________ TIME: ____________

PLACE OF INCIDENT: ____________ REPORT DATE: ____________ TIME: ____________

<table>
<thead>
<tr>
<th>CHILDREN INVOLVED</th>
<th>EMPLOYEES INVOLVED</th>
<th>OTHERS INVOLVED</th>
</tr>
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<tbody>
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</tbody>
</table>

( ) Injury/Medical Problem ( ) Restraint
( ) Runaway ( ) Seclusion
( ) Property Damage ( ) Other: (please specify)
( ) Physical Aggression

SECLUSION MONITORING RECORD

STAFF MEMBER—PLEASE initial each monitoring time.

TIME IN: ____________ MONITORING OBSERVATION: ______ 5 min. ______ 10 min. ______ 15 min.
TIME OUT: ____________ 20 min. ______ 25 min. ______ 30 min.

*EXCEPT: SECLUSION MUST BE AUTHORIZED BY ADMINISTRATION OR ON CALL PERSON.

DESCRIPTION OF INCIDENT: (If additional space is needed, please use back side.)

__________________________  ____________________________
Child (optional)            Staff Member

Parent notified? ______ Yes ______ No Caseworker notified? ______ Yes ______ No

ADMINISTRATIVE REVIEW: ____________  Asst. Director ______ Nurse ______ Director
Position Title: Educateur I

Purpose of Position: To function as a milieu treatment specialist, providing a variety of therapeutic interventions for a unit of children with emotional and behavioral problems, providing treatment programming for the total living environment of the child in the residential setting.

Principal Responsibilities:

1. Is responsible along with other team members for design and implementation of all aspects of behavioral milieu treatment program for a unit of up to eleven children, providing treatment through daily care and planned therapeutic activities.

2. Is responsible for coordinating the treatment program developed by the team for five children in the unit and therefore must have full knowledge of the assigned child's social history, reason for placement, evaluation data, and treatment plans; as a member of the team is also knowledgeable about the remaining children in the unit.

3. Provides developmentally-appropriate individual group and/or counseling for assigned children, using a variety of treatment modalities as indicated in the child's treatment plan.

4. Provides, together with other team members, high interest goal-directed activities to accomplish therapeutic goals for individuals and groups.

5. Provides along with other team members on-going daily documentation of events in the unit; problems and progress of individual children, and such other reporting as shall be requested by administrative staff.

6. Along with other team members provides on-going documentation of treatment procedures and results; gathers required material for periodic case conferences on assigned children, develops individual service plans following the case conference, and submits to these to referring agencies and other relevant sources.

7. In cooperation with Family Service Coordinator and the team, arranges off-campus visits for children to parents, relatives, foster homes, and other off-campus sites.

8. Communicates regularly with Family Service Coordinators to insure cooperative efforts with referring agencies and parents related to the child's needs.

9. Makes referral to Family Service Coordinator, nurse, volunteer coordinator, or other appropriate staff to access special services identified by the team as needed for assigned children.

10. Attends all required staff and team meetings and is an active participant as a cooperative team member, exhibiting professional conduct at all times; serves in rotation with other team members as team captain or recorder.

11. Assists along with other team members, in orienting and training new staff members assigned to unit, and when possible participates in pre-screening of applicants for employment on team.

12. Assumes other related responsibilities as requested by Administrative Staff.
Position Title: Educateur II

Purpose of Position: To function as a milieu treatment specialist, providing a variety of therapeutic interventions for a unit of children with emotional and behavioral problems, providing treatment programming for the total living environment of the child in the residential setting.

Principal Responsibilities:

1. Is responsible along with other team members for design and implementation of all aspects of behavioral milieu treatment program for a unit of up to eleven children, providing treatment through daily care and planned therapeutic activities.

2. Is responsible for being fully informed about each child in the unit in relation to social history, reason for placement, evaluation data, and treatment plans.

3. Provides, together with other team members, high-interest goal-directed activities to accomplish therapeutic goals for individuals and groups.

4. Provides along with other team members on-going daily documentation of events in the unit, problems and progress of individual children, and such other reporting as shall be requested by administrative staff.

5. Along with other team members provides documentation of treatment procedures and results.

6. In cooperation with Family Service Coordinator and the team, arranges off-campus visits for children to parents, relatives, foster homes, and other off-campus sites.

7. Communicates regularly with Family Service Coordinators to insure cooperative efforts with referring agencies and parents related to the child’s needs.

8. Attends all required staff and team meetings and is an active participant as a cooperative team member, exhibiting professional conduct at all times; serves in rotation with other team members as team captain or recorder.

9. Assists along with other team members, in orienting and training new staff members assigned to unit, and when possible participates in pre-screening of applicants for employment on team.

10. Assumes other related responsibilities as requested by Administrative Staff.
Position Title: Classroom Teacher - Residential Program

Position Purpose: To develop and provide a learning experience for each student that is responsive to his unique educational needs and is congruent with the broader treatment goals developed by the treatment team.

Principal Responsibilities:

1. To demonstrate a high level of competence, motivation, and commitment as a full treatment team member, carrying out responsibilities in a manner that will foster the cognitive, social, and emotional growth of children within the treatment milieu.
2. To understand thoroughly the treatment techniques and philosophy of the residential program and implement these when interacting with children.
3. To assume leadership on the treatment team in developing and implementing individualized plans to attain appropriate educational goals for each child.
4. To provide a classroom environment which facilitates dealing with and resolving emotional problems of each child.
5. To develop and maintain a classroom environment that is conducive to learning.
6. To maintain complete records on the academic progress and achievement of each student.
7. To supervise the work of the teacher assistant assigned to the classroom.
8. To build positive, caring relationships with children based on respect, trust, and good communication, serving as a positive role model for children.
9. To work cooperatively with staff and administrators to improve the quality of the total treatment program.
10. To work effectively with the treatment team to facilitate team and individual development, to foster meaningful and harmonious relationships among team members, and to ensure that each team member and the team itself is accountable for the success of the child. To be able to accept and give professional evaluation regarding team members.
11. To fulfill responsibilities on a treatment team in a manner that fosters the involvement and participation of fellow treatment team members.
12. To work to promote an atmosphere of openness, honesty, and understanding among all staff and administrative personnel.
13. To demonstrate a commitment to professional growth by actively participating in in-service and other professional workshops and/or institutes and pursuing graduate training when appropriate.
14. To develop and participate in special experiences outside of the classroom or school such as field trips, outdoor recreation, cultural and social events, and projects which can enhance children's self esteem.
STARR COMMONWEALTH SCHOOLS
COLUMBUS CAMPUS

POSITION GUIDE

Position Title: Crisis Aide

Position Purpose: To assist wherever needed in crisis or unusual situations.

Principal Responsibilities:

1. Will substitute for unit staff in emergency situations when approved by supervisor or on-call person.
2. Will temporarily fill vacated unit staff positions when assigned by administration.
3. Will transport children to necessary appointments at outside agencies in late afternoon and evening.
4. Will assist in crisis situations or in any situations in which third person coverage seems advisable or necessary.
5. Will monitor, observe and evaluate children while they are here for preplacement conferences.
6. Will perform other related duties as requested by supervisory and or administrative personnel.
7. Will only attend team meetings and staffings when covering a particular unit for an extended period; at all other times will be available for coverage during team meetings.
8. Will attend educational and in-service programs.
9. Will attend "all-Staff Meetings," unless assigned elsewhere for unit coverage.
10. Will assist with bedtime routine in Green Unit whenever conditions and/or time allows.
PLATE VII

Schematic Floor Plan of HNC

HANNAH NEL RESIDENTIAL TREATMENT CENTER

- OFFICE
- CONFERENCE
- LR LIVING ROOM
- R RECEPTIONIST
- S STORAGE
- T THERAPY

NEW CONSTRUCTION

\[ \text{former floor} \]

ONE-BED ROOM

\[ \text{bath} \]

TWO-BED ROOM

\[ \text{mud room} \]
WRITTEN COMMENTS FROM CHILD CLIENTS

Red Unit

Plate R2 1. "1) Time out is stupid
   2) I wish CIDE didn't have to go to time out"

Plate R3 2. "I think time out is for someone out of control. I
   think who ever made time out got alot of money"

Plate R5 3. "What Time out is

Well it's a place to close down and so you could go
back on the unit and talk with staff."

Plate R6 4. "Time out is a bad place and we go here to cool off. And
   the staff you and see how you are doing in time out
   and then you go back to the unit and stay in your room
   and when come out of your room you call talk to staff
   and play games with staff and kids

   The End"

Plate R7 5. "Seclusion is a small, lonely, isolated room for kids
   who have overreacted to calm down and think about their
   problems."

Plate R8 Plate R9 6. "Time out is a small room that kids go to when they are
   out of control and it has tow windows and it is tiring it
   is no fun to be in that one little room."

Plate R10 7. "Time Out is a plain wall room with 3 doors, 5 windows.

   Staff takes you there restrained or not. If you refuse
   what staff tells you to do you go to time out.

   Time Out is a boring place to go to."

Plate R11 Plate R12 8. "It is a place were kids can cool down. The walls
   would be painted pink. I saw on that incredible they
   had a guy come in and lift barbells they showed him a
   blue piece of cardboard he lifted the barbell then they
   showed him a piece of pink cardboard but he could not
   lift it so that is why it would by pink because they
   could cool down faster."

Plate R13 9. "Seclusion is a room were staff lock you up like an
   animal when you are out of control. The reason they
   lock you up is because they can't handle you.

   I do not think it is right that they lock us up like
   animals. They think it calms you down but it doesn't.
   People do not get locked up in there homes so they
   shouldn't here because they told me to act like I was
   at home."
WHITTEN COMMENTS FROM CHILD CLIENTS

Cold Unit

Plate G1  1. "I have not been in time out. It was like a jail but was for people that. Got in a fits or destroyed so stuff.

   the End"

Plate C2  2. "I hate t.o. because we get lock up in heat, and it gets scary to and some times it get cold in ther to and It is a place to calm down"

Plate C3  3. "I Don't like. t.o. because they lock you up, and they put you in. t.o. to calm Down F"

   "I thick. t.o. atake I Don't like staff when they put me in"

Plate G4  4. "I thing I want to be in time out because I behavior thing I sad"

   assisted by teacher—"I should be in time out because I can keep calm in timeout. I do not want to hit staff."

Plate G5  5. "time out is a place to come done. I don't like it. It isn't fun to be in there."

Plate C6  6. "Time out is to me like a Room when That some people so going awol we get Hiper that's where they But you."

Plate C7  7. assisted by teacher—"T.O. is sweaty and hot. It looks alright and I don't like being in it. (twey) don't like t.o.

   I am glad I got out of t.o. because I'm happy."

Plate G8  8. "I think, that time out, or seclusion is a place where kids go when they are out of control. Quite often kids have to be restrained before going to time out, but that isn't how it always is. Time out help kids calm them-selves down, or time thier selves out."

Plate G9  9. "I fill that it is a place where staff put the child to get it out of the way of other and to get away from the child. It can help the child. It can also help everyone."

Plate G10 10. "What T.O.means is when somebody is doing bad then the staff will take you to T.O. When you go awol they will take you to T.O. And I have not been to T.O. alot because I will like to go home."

Blue Unit

Plate C1  1. "To me I think timeout is a place where you can calm yourself down when your very angry

   also its' for you when you need to talk out problems of what you done wrong so that you don't blow up in your unit."
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**SUMMARY DEMOGRAPHIC INFORMATION ABOUT CLIENT COMPOSITION FOR EACH TREATMENT UNIT**

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### DEMOGRAPHIC INFORMATION ABOUT TREATMENT TEAM COMPOSITION

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* half-time employee or intern

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## TABLE 7

### Total Number of Exclusions For Red Unit (1978-1981)

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NR = no report
### TABLE 8

**Total Number of Seclusions For Blue Unit (1978-1981)**

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**NR** = no report

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**Total Number of Seclusions For Gold Unit (1978-1981)**

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**NR** = no report

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**Total Number of Seclusions For Green Unit (1978-1981)**

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**NR** = no report
TABLE 11

Admissions and Discharges by Unit For HNC
During January 1980 - March 1982

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