Ask the Experts

Response to Ahrendt, Houlihan, and Buchanan

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The implementation of seclusion time-out (STO) described by Ahrendt, Houlihan, and Buchanan (2013) reveals several contemporary practice standards within the domain of clinical behavior analysis. First, the “time-in” environment of the inpatient facility included a token-based incentive program by which staff reinforced “positive behavior” and consumers exchanged tokens for primary reinforcers. Thus, the intent was to increase motivation to avoid STO in favor of remaining in the reinforcing environment (Marlow, Tingstrom, Olmi, & Edwards, 1997).

Presumably, the incentive program was based on preference assessments that guided selection of reinforcers. Second, STO, or “closed seclusions,” was reserved for the most challenging behaviors, namely “punching, kicking, spitting, throwing of objects, throwing feces, and destruction of property.” This stipulation conforms to the guiding principle of programming seclusion and other similarly restrictive procedures (e.g., physical restraint) exclusively for high-risk behaviors that pose a threat to self, others, and property (Ryan, Peterson, Tetreault, & Van der Hagen, 2007). And third, staff applied STO with proper authorization and documented the date, time, and duration of each incident, thereby measuring intervention effects directly.

I note several other considerations, starting with functional behavioral assessment (FBA) of the behaviors leading to STO. That is, without FBA, staff at this facility run the risk of imposing seclusion for behaviors that are escape-motivated and in consequence, reinforcing instead of decreasing those behaviors. Of course, STO

might be sufficiently aversive to override this contingency but that effect hardly meets the mandate for function-based intervention (Cipani & Shock, 2011). Therefore, I would want to know how FBA was conducted and informed the decision to use STO (at least selectively) at this facility.

Another concern relates to the duration of STO which, in addition to frequency, should be reported as a critical outcome measure. For example, low-frequency STO is a misleading metric if the average duration per application remains elevated or increases over time. Duration of STO is also a procedural matter in light of research, which shows that terminating time-out after a fixed duration is as equally effective as behavior-contingent release while reducing total exposure to seclusion (Mace, Page, Ivancic, & O’Brien, 1986).

Finally, implementing STO can be a complex process that requires staff to intervene precisely when targeted problem behaviors are observed, possibly escort a resistant consumer to the time-out location, moni-

tor duration, and adhere to STO termination criteria. Accordingly, any setting with STO should have supervisors conduct regularly scheduled intervention integrity assessments (DiGennaro Reed & Coddington, 2011) that can verify the level of procedural fidelity and correct staff implementation as warranted. It was unclear whether Ahrendt et al. (2013) provided intervention integrity assessment as a component of staff training and performance management (Luiselli, 2013).

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