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Seclusion

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Applicability: All Licensed Residential Programs

BACKGROUND

The Department of Early Education and Care (EEC) regulations, 606 CMR 3.00, require residential programs to provide individualized supports that are the least restrictive necessary to ensure the safety of residents and others while promoting dignity, well-being, privacy, comfort, and community integration.

Accordingly, seclusion, as defined in 606 CMR 3.02(1), is prohibited in EEC-licensed residential programs, except as narrowly authorized under 606 CMR 3.07(8). In such limited circumstances, seclusion may be implemented only as a last resort and, on an individualized basis when a resident's behavior poses an imminent threat of serious physical harm to self or others, and only when all applicable regulatory safeguards are met.

Consistent with best practices, EEC emphasizes crisis prevention, de-escalation, and the use of the least restrictive alternatives, and prohibits the use of seclusion as discipline, punishment, or as a standard response to any resident's actions.

This approach reflects EEC's desire to promote safe, dignified, supportive environments for residents of EEC licensed residential programs while recognizing that unpredictable crisis situations may arise within the residential facilities it licenses.

AUTHORITY

- 102 CMR 1.00
- 606 CMR 3.01
- 606 CMR 3.02
- 606 CMR 3.03(7)(d)(13)
- 606 CMR 3.04(3)(h)
- 606 CMR 3.04(5)
- 606 CMR 3.05
- 606 CMR 3.07(7)
- 606 CMR 3.07(8)

DEFINITIONS

For purposes of this policy, **Seclusion** shall have the meaning established in 606 CMR 3.02(1).

Seclusion means the involuntary confinement of a resident alone in a room or area, with or without adult supervision, from which the resident is not permitted to leave.

Seclusion does **not** include:

- Environments where all residents generally require permission to leave;
- Monitored separation in an unlocked setting from which the resident is free to leave and is implemented for calming purposes;
- A resident's voluntary separation from a group;
- Actions specifically authorized for the Department of Youth Services under 606 CMR 3.07(8)(d); or
- Any situation where a staff member is in the same room with the resident.

POLICY STATEMENT

General Prohibition

Seclusion is prohibited in EEC licensed residential programs, except as expressly authorized under 606 CMR 3.07(8). When implemented, it may be used only as a last resort and on an individualized basis when a resident’s behavior poses an imminent threat of serious physical harm to the resident or others, and only when all required regulatory prerequisites, safeguards, and documentation requirements are fully satisfied.

- Consistent with 606 CMR 3.07(8)(a)(12), seclusion shall not be used:
    - As a form of discipline;
    - As a punishment;
    - As retaliation;
    - As coercion;
    - For staff convenience;
    - As a substitute for adequate staffing; or
    - As a standard response to resident behavior that does not constitute an imminent threat of serious physical harm to self or others.

Nothing in this policy shall be interpreted to authorize the use of seclusion outside the circumstances permitted by 606 CMR 3.07(8).

Requirements for Any Use of Seclusion

Consistent with 606 CMR 3.07(8)(a)(1-12), a program may only implement seclusion with a resident when all the required conditions are met, including:

- **Documented History:** The resident has a documented history of repeatedly engaging in serious self-injurious behavior or causing injuries to other residents or staff, with the exception of a one-time emergent safety response to an unexpected or imminent crisis and undertaken to prevent serious injury to the resident, other residents, or staff.
- **Less restrictive interventions have failed or are inappropriate:** The resident is not responsive to less restrictive behavior interventions, these interventions are deemed inappropriate or ineffective under the circumstances, or such interventions have failed to ensure the safety of the resident and others.
- **Medical Review:** A licensed physician or health care practitioner has documented that there are no medical contraindications to seclusion.
- **Clinical Justification:** A licensed mental health professional has documented a psychological or behavioral rationale for the use of seclusion. The assessment must confirm that no contraindications are present. In evaluating contraindications, the clinician shall consider the resident's past or current history of trauma and/or abuse, although such history shall not, in and of itself, preclude the use of seclusion.
- **Consent and Approval:** The program has obtained consent, as defined in 606 CMR 3.02(1), to use seclusion from the parent or guardian, the placement agency, or the referral source, and from the resident, if appropriate. The use of

seclusion must also be approved in writing by the program's chief administrative officer or designee.

Emergency Use Exception

EEC recognizes that unforeseen emergencies may arise in which immediate action is necessary to prevent serious physical harm.

Accordingly, a single emergency use of seclusion may occur without prior completion of the authorization and planning requirements otherwise required by 606 CMR 3.07(8) and only when necessary to prevent an imminent threat of serious physical harm to the resident, other residents, staff, or others.

This exception applies only to the authorization requirements described above and shall not relieve a program of its obligations under:

- 606 CMR 3.07(8) regarding monitoring and safeguards;
- 606 CMR 3.04(3)(h) regarding incident reporting;
- 606 CMR 3.04(5) regarding required notifications; or
- any applicable documentation and oversight requirements.

If a program determines that seclusion may be required again for the same resident, all requirements of 606 CMR 3.07(8)(a) shall be satisfied prior to any subsequent use.

Safeguards During Use of Seclusion

During any permitted seclusion procedure, the program shall meet all the required conditions under 606 CMR 3.07(8)(a-c), including:

- **Continuous monitoring:** A staff member must continuously and actively monitor and observe the resident and remain immediately available to them at all times;
- **Administrative oversight:** The chief administrative officer or designee on the premises shall be consulted for approval prior to the use of seclusion and kept informed through completion of the event.
- **Constant visibility:** The resident must be observable in all parts of the room and kept in full sight of the staff member at all times;
- **Ongoing de-escalation:** A staff member shall continue to implement de-escalation and calming strategies when clinically appropriate, unless doing so is unsafe or counterproductive; and

- **Immediate termination:** The seclusion must end as soon as the resident's behavior no longer poses an imminent threat of serious physical harm, or if the resident is observed to be in severe distress.

Consistent with 606 CMR 3.07(8)(a), seclusion shall end immediately if the resident exhibits severe distress or other circumstances requiring termination of the intervention.

Physical Space Requirements

Any room or space used for seclusion must minimally meet all requirements in 606 CMR 3.07(8)(b)-(c), including, that any such space must be:

- Clean, safe, and sanitary;
- Appropriate in size;
- Equipped with appropriate lighting, ventilation, heating, and cooling;
- Free of inherently dangerous fixtures or objects;
- In compliance with fire and building codes;
- Inspected by program administration at least weekly during periods of use, with written documentation maintained for each inspection;
- Configured to provide full line of sight and sound monitoring at all times.

Internal Policy Requirements

Per 606 CMR 3.03(7)(d)(13) and 3.04(3)(b), the Licensee shall develop, maintain, and implement written policies and procedures regarding seclusion that are consistent with this policy and the requirements of 606 CMR 3.00.

The Licensee shall maintain up-to-date policies and oversight processes to ensure that any staff who may implement seclusion are adequately trained and are able to do so safely and in accordance with policy. Documentation and Reporting

Consistent with 606 CMR 3.04(3)(h), 606 CMR 3.04(5), and 606 CMR 3.07(8), an incident report shall be completed for every instance in which seclusion is implemented, regardless of the duration, outcome, or whether an injury occurred.

All incident reports involving seclusion shall be completed immediately and no later than twenty-four (24) hours following the event and shall include, at minimum:

- The date, time, location, and duration of the seclusion;

- The precipitating events and behaviors that resulted in the intervention;
- Less restrictive interventions attempted prior to implementation;
- The staff involved in the intervention and monitoring;
- Supervisory notifications and approvals;
- Continuous monitoring actions taken during the event;
- The resident's presentation during and following the intervention;
- Any injuries, medical concerns, or indications of distress; and
- Actions taken following termination of the seclusion intervention, including debriefing and follow-up planning.

In accordance with 606 CMR 3.04(5)(l)(2), the licensee shall submit a quarterly report, in a Department-approved format, setting forth data related to the use of seclusion implemented under 606 CMR 3.07(8)(a)-(c).

Prevention, Reduction, and Elimination of the Use of Seclusion

- Per 606 CMR 3.01(4), programs shall prioritize individualized, trauma-informed, least restrictive interventions and behavior support strategies designed to prevent escalation and avoid the need for seclusion whenever possible.
- In accordance with 606 CMR 3.07(7)(a), the licensee shall include goals related to the prevention, reduction, and/or elimination of the use of seclusion in its written statement.
- Programs shall implement all behavior support and crisis response practices, including any emergency use of seclusion, in a trauma-informed and responsive manner designed to minimize retraumatization, preserve dignity, and support emotional and physical safety, consistent with 606 CMR 3.01(3)-(4), 606 CMR 3.02 (Definitions: Trauma-Informed and Responsive Care; De-escalation), and 606 CMR 3.04(7)(c)(10).
- In accordance with 3.05(1)(e), programs shall seek and document in the treatment plan and/or discharge summary recommendations regarding effective and ineffective behavior de-escalation and crisis management strategies, antecedent management strategies, and identified or known triggers to crisis behavior.
- In accordance with 606 CMR 3.07(8)(a)(6), the licensee shall ensure that all staff are adequately trained regarding the use of less restrictive, trauma-informed and responsive alternative behavior support interventions.

- Per 606 CMR 3.05(4), programs must identify the resident's needs, the services to be provided and the staff responsible within the resident's treatment plan.
- Programs shall integrate individualized behavior support planning, crisis prevention strategies, de-escalation interventions, and restrictive intervention safeguards into treatment planning processes designed to promote resident safety, emotional well-being, and the use of least restrictive supports, consistent with 606 CMR 3.01(4), 606 CMR 3.02 (Definitions: De-escalation; Trauma-Informed and Responsive Care), 606 CMR 3.03(7)(d)(13), 606 CMR 3.04(7)(c)(9)-(10), and 606 CMR 3.05(1)(e) and 3.05(4)(a)-(b).
- Programs shall incorporate known resident-specific triggers, antecedent management strategies, and effective de-escalation interventions into individualized treatment and behavior support planning, consistent with 606 CMR 3.01(4), 606 CMR 3.02 (Definition: De-escalation), 606 CMR 3.05(1)(e), 606 CMR 3.05(2)(c), and 606 CMR 3.05(4)(a)-(b).

Post Event Follow Up

Following any use of seclusion, programs shall implement timely post-event follow-up care designed to assess resident well-being, support stabilization and recovery, minimize retraumatization, evaluate the effectiveness of prevention and de-escalation efforts, and identify opportunities to reduce future restrictive interventions, consistent with 606 CMR 3.01(3)-(4) and 606 CMR 3.02 (Definitions: De-escalation; Trauma-Informed and Responsive Care; Restraint Debriefing.)

Programs shall ensure that:

- The resident receives an appropriate post-event physical, emotional, and behavioral assessment consistent with 606 CMR 3.01(3)-(4), which require programs to support resident safety, dignity, well-being, and individualized supports;
- The resident is provided an opportunity, whenever possible, to participate in a developmentally appropriate, trauma-informed debriefing process to review the event, identify triggers, discuss effective supports, and support emotional stabilization, consistent with 606 CMR 3.02 (Definition: Trauma-Informed and Responsive Care), 606 CMR 3.05(1)(e), and 606 CMR 3.05(4)(d);
- Staff and supervisory personnel conduct a timely post-event debriefing and clinical review of precipitating factors, antecedents, de-escalation efforts, staff response, and opportunities for preventative intervention, consistent with 606

CMR 3.04(7)-(8), 606 CMR 3.05(1)(e), and 606 CMR 3.02 (Definition: De-escalation);
- All required incident reporting and documentation obligations are completed consistent with 606 CMR 3.04(3)(h) and all other applicable incident reporting requirements under 606 CMR 3.00 and 606 CMR 3.07(8); and
- Treatment plans, behavior support strategies, and crisis response interventions are reviewed and modified as necessary to reduce the likelihood of future restrictive interventions, consistent with 606 CMR 3.01(4), 606 CMR 3.05(4)(a)-(b), and 606 CMR 3.02 (Definition: De-escalation).

Programs shall utilize post-event review and debriefing processes to support ongoing quality improvement, staff competency development, resident safety, and the use of least restrictive interventions, consistent with 606 CMR 3.01(4), 606 CMR 3.04(7)-(8), and 606 CMR 3.05(1)(e).

Training & Workforce Development

Per 606 CMR 3.04(7)(a)-(e), no program staff shall participate in, implement, monitor, supervise, or authorize the use of seclusion unless they have successfully completed all required training related to:

- Behavior support;
- Crisis prevention;
- Trauma-informed and responsive care;
- De-escalation strategies,
- Safe implementation procedures,
- Resident monitoring,
- Documentation and reporting; and
- Emergency response protocols.

Programs shall provide ongoing refresher training and competency review regarding seclusion prevention, de-escalation, trauma-informed intervention, and safe emergency response procedures at least annually, and more frequently as necessary based on incident trends, resident needs, or identified staff performance concerns, consistent with 606 CMR 3.04(7)(a)-(e), including 606 CMR 3.04(7)(c)(9)-(10) and 606 CMR 3.04(7)(e)(2), and 606 CMR 3.04(8).

SUGGESTED GUIDANCE

EEC may issue additional guidance that supports compliance with this policy.

COMPLIANCE

EEC may review program compliance with this policy through licensing visits, incident reviews, investigations, and other oversight activities. Failure to comply may result in licensing action consistent with 606 CMR 3.00 and 102 CMR 1.00.

ADDITIONAL INFORMATION

Additional guidance, training materials, and related resources may be provided by EEC to support program compliance with this policy.

OBSOLETE

- Separation from the Group policy issued on September 8, 2016