BILD Factsheet on Time Out and Seclusion

There is growing concern that the use of time out and seclusion are terms which are being used in an interchangeable way to describe a variety of practices. This information page will seek to clarify the differences between both practices and enable professionals to review their own practice.

Seclusion is defined as;

'the supervised confinement of a patient in a room. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others'

(Department of Health, 2008)

Seclusion is viewed as a behaviour management tool providing short term management for the target behaviour; it is implemented to eliminate immediate high risk presented by the behaviour of the person exposed to seclusion. In itself, seclusion has no therapeutic value to the person exposed to it and it is in fact possible that seclusion may have adverse affects on the person exposed to it. These may include post traumatic stress disorder for some people. In the absence of any evidence to the contrary we should also consider that any person who we work with may have experienced abuse,(Beail, 2009). Principles of trauma informed care would suggest that the use of seclusion as a practice would be contraindicated for many people that have an intellectual disability and or autism, as well as children and young people who have severe social and emotional difficulties.

.

Professionals who support the use of seclusion sometimes claim it to be safer than physical intervention; it is possible this may be negated by the use of physical restraint to get the person to the room in which they are to be secluded. In fact the evidence to support such an argument is poor. In order to implement seclusion one must also get the person to the room in which it will occur. The fact is that the person will need to be taken to the room in which seclusion will be implemented; this introduces the element of physical (or personal) intervention/ restraint which will increase the risk of the procedure

A second argument used to support the use of seclusion is that people can learn to 'self calm' there is no evidence that this is the case. Personal experience of seclusion suggests that people find it distressing, confusing and dehumanizing.

Time Out as a term properly describes a behaviour intervention; the joint guidance published by the Department for Health and Department for Education and Skills (2002) describes time out as "restricting the service user's access to all positive reinforcements as part of the behavioural programme". It (time out) differs from seclusion in that it should be delivered as 'part of the behavioural programme' time out is and evidenced based behaviour change strategy. It is

arguably a punitive strategy and should not be implemented where more appropriate less aversive strategies could be implemented.

Time out may be implemented as part of a behaviour support plan and might include;

- Preventing a person being involved in the activities which reinforce their target behaviour until the behaviour stops and the person engages appropriately.
- Asking/ instructing the person to leave the activity and return when they feel ready to be involved and stop the behaviour that is of concern
- Accompanying the person to another setting and preventing them from taking part in the activity they were undertaking/ participating in for a set period of time

It is usual that time out is implemented as part of a structured behaviour support plan, time out from seclusion; the function of time out is to achieve change in a person's behaviour over a period of time as part of an individual support plan, used alongside other behaviour interventions. The implementation of time out is not contingent on placing a person in a specific room.

Time Out Rooms there is some anxiety about the reference to time out rooms as a term (McDonnell, 2009; Paley et al 2009). This terminology suggest that specific rooms are being developed in which 'time out' can be delivered. This may suggest some confusion in practice between seclusion as a behaviour management and time out as a behavioural change strategy. The implementation of time out does not depend on having a room in which it will take place. Other terms may also be employed to describe the same practice such as;

- Chill out room
- Time out room
- Quiet space
- Rest room
- Relaxation space
- Safe room

There is some legitimate concern that such rooms/ spaces or areas may actually be used for a practice which is much closer to seclusion in practice that it is time out. This is cause for considerable concern, in that the deprivation of people's liberty is effectively 'flying under the radar' the practice is not monitored, it may be delivered or undertaken by teams who do not have appropriate training or believe, incorrectly, they are acting within the law.

Questions to ask............

- ✓ Does the person access the room or space voluntarily
- ✓ Is the person accompanied by a support worker/ teacher or other person in the room
- ✓ Can the person leave the room independently, do they know how to get out of the room or area

- ✓ Is the ‘time out’ part of an assessed and agreed behaviour support plan, that includes short term and long term goals
- ✓ Can the time out strategy be implemented outside of the area where the person lives, works or is educated

If the answer is yes to most of the above it is likely that you are using a time out strategy

- ✓ Do support staff/teachers or other take the person to the room or space
- ✓ Is the person left in the room or space alone
- ✓ The person is unable to leave the room independently or cannot understand out how to leave the room when they choose to
- ✓ People watch/monitor the person from outside the room
- ✓ The practice is dependent on a room or space which is available at the place the person lives, works or is educated

If the answer is yes to the above the practice is more likely to be seclusion, and may be illegal except in specific circumstances described in legislation such as The Mental Health Act (1983) or in preventing a criminal offence

Summary

In short there is no evidence that seclusion as a practice has any therapeutic value to the person exposed to it. Further to this the practice of planned seclusion in services other than those that have lawful excuse is illegal. Sections 13.13 & 13.14 of the Guidance for the Use of Restrictive Physical Interventions (2002) gives further some clarification on lawful excuse.

Seclusion must only ever be considered as a last resort; in terms of efficacy the evidence base is extremely poor. It is not appropriate that it be part of any positive behaviour support plan as it is purely a management strategy, practitioners must look at the practice they are undertaking as calling it something else will not change what is happening if practice infringes a person’s human rights or deprivation of liberty legislation.

.

Beail N. Trauma Informed Care. BILD Positive Behaviour Support Conference. York, 7th May 2009.

Department of Health & Department for Education & Skills (2002). *Guidance for Restrictive Physical Interventions.* London: HMSO.

McDonnell A. *Reducing Restrictive Practices. Tip of the Iceberg- Developing Person Centred Specialist Services*. South Birmingham NHS Trust. 13th February 2009.

Paley, S. *Defining Restrictive Practices. Mental Capacity Act and Use of Restrictive Practices*. British Institute of learning Disabilities. Kidderminster 3rd March 2009.