PBS Implementation Bulletin: Understanding Operational Principles with respect to Seclusion, Time-out from Positive Reinforcement, and Self-Management

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The focus of PBS as an approach to improving quality of life for individuals is to teach skills and arrange physical and social environments to prevent challenging behavior. Circumstances may present for individuals in which our obligation to ensure health and safety protections is a necessary component of teaching and skill building, and this may require one or more temporary restrictions of certain rights. This guidance describes how to ensure that interventions which include temporary restrictions on rights for safety reasons, avoid the use of prohibited practices, and specifically, seclusion.

Seclusion and Time-out Defined

Seclusion is a prohibited practice pursuant to DDS regulation 115 CMR 5.14(15)(a)5. Seclusion is defined as "any act which involuntary places an individual alone in a locked room or other area from which there is no egress." [115 CMR 5.02].

Further, the CMS 1915(c) Home and Community-Based Waiver Application, Instructions, Technical Guide and Review Criteria [Version 3.6, January 2019] defines Seclusion as "the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving." This document also states that "for the purposes of this item, seclusion means involuntarily isolating an individual as a means of controlling the person's behavior."

Time-out from positive reinforcement is defined as "the contingent withdrawal of the opportunity to earn positive reinforcement or the loss of access to a form of positive reinforcement for a specified period of time. Time out from positive reinforcement is limited to a period not to exceed 15 minutes." 115 CMR 5.02

Distinctions between Seclusion and Time-out

When an emergency health or safety circumstance exists, time-out can occur through the use of a physical escort over active resistance to place an individual into a separate room or area from which positive reinforcement exists. (NB: this type of escort is also a restraint.) In these scenarios, the person's relocation is considered to be "involuntary," which is one of the criteria defining seclusion (i.e., "involuntarily placed" in

the room or area). If the individual also does not have the ability to exit the room or area, the intervention may be seclusion, depending on what other conditions are present (that is, if the individual is alone in the room or area).

Time-out can occur by staff cueing a person to move to a different room or area, away from access or opportunity for positive reinforcement, and no physical escort over active resistance is executed. For example, the use of "walk with me/talk with me." In these scenarios, the person is not "involuntarily placed" in the room or area and the intervention is unlikely to constitute seclusion.

Time out can also occur by staff cueing a person to spend a short period of time unable to access positive reinforcement, but remain in the area. For example, a person may be asked to briefly step away from an activity, or temporarily surrender a piece of equipment. In these scenarios, the person is neither "involuntarily placed" in a separate room or area nor is the person alone in an area and unable to exit. Thus, these interventions would not constitute seclusion.

In summary, the use of time-out from positive reinforcement could include a person being "involuntarily placed" in separate room or area, leaving a room or area with the help of staff cueing, or remaining in an area but briefly losing access or opportunity for positive reinforcement. In each of these scenarios, there is the expectation that time out exists in conjunction with the opportunity for learning. That is, the intervention is part of a teaching plan to build skills in self-regulation, coping, or problem solving.

NOTE: Although instances in which an individual is "involuntarily placed" into a time-out room or area over the individual's active resistance do not necessarily constitute seclusion in and of themselves, they are always considered to be a Restrictive Procedure and always considered to be a Restraint. Restrictive Procedures must receive Peer Review and Human Rights Committee review. Restraints must be documented, monitored, and examined in accordance with 115 CMR 5.11.

Distinctions between Self-Management and Time-out

Time out is distinguished from the occurrence of an individual electing to remove himself or herself from a room, area, or activity for the purpose of calming, de-escalation, or prevention of escalation. Time out does not include this type of determination by an individual that he or she will take a break from an activity in order to regain control. This would be considered self-management or exercising coping skills rather than time out. This is because in these examples, the withdrawal of opportunity for reinforcement was not imposed upon the person as a contingent.
If an individual elects to relocate to another room or area and is subsequently encouraged to remain in the space as part of a contingency, this would now be considered time-out and may not extend beyond 15 minutes.

If an individual elects to relocate to another room or area in which he or she is alone and is subsequently prevented from exiting that room or area, this would constitute seclusion. This is because in addition to the criteria of being alone and unable to exit, the person is also, de facto, "involuntarily placed" in the space.

Decision Tree for Determining whether Seclusion is Present

Seclusion means placing a person involuntarily to a room or area from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the person from leaving the room.

There are three elements in the definition of seclusion to consider when determining whether a proposed overall intervention constitutes seclusion:

1. The individual is **alone** in the room or area, regardless of whether there is video, voice, or other means of monitoring the individual from outside the room or area;
2. The individual is **involuntarily** placed in or subsequently prevented from exiting the room or area;
3. There is **no egress** from the room or area; this means the room or area is secured against exit by the individual, and includes actual door locks, magnets or any other device which prevents the individual from exiting the space, and staff holding the door shut or otherwise physically positioning themselves to prevent egress.

If these conditions are met, then the proposed intervention is considered Seclusion.

Additional Guidance

If it is determined that an intervention currently in practice likely constitutes seclusion, it will be important to adjust the intervention with respect to one or more of the three key elements considered above or change to a completely alternative intervention. The process for making these adjustments should include a re-examination of the individual's Positive Behavior Support Plan, including possible updates to the Functional Behavior Assessment (FBA) and adjustments to Universal Supports wherever possible. Where circumstances present unique and/or multi-faceted safety challenges, DDS clinical staff may be consulted to assist in developing alternatives which do not constitute prohibited practices.

If as a result of the information provided in this bulletin there are concerns as to whether a prohibited practice exists, the provider shall notify DDS. DDS clinical consultation and Statewide Peer Review are required to review these concerns.

NOTE: "Exclusionary Time-Out" is not a defined term under DDS regulations. The pertinent definitions to this bulletin are "seclusion" and "time out from positive reinforcement." 115 CMR 5.02.

Attachment A
Guidance for Examining and Adjusting Interventions so as to Avoid Seclusion

The purpose of this Guidance is to provide additional details and assistance for how to examine and adjust interventions pursuant to the PBS Implementation Bulletin containing references to Seclusion.

In August of 2023, the Department issued the *PBS Implementation Bulletin: Understanding Operational Principles with respect to Seclusion, Time-out from Positive Reinforcement, and Self-Management.* The Bulletin describes how to determine whether seclusion is present in an intervention. According to this Bulletin, if there are concerns as to whether a prohibited practice such as seclusion exists, the provider shall notify DDS; DDS clinical consultation and Statewide Peer Review are required to review these concerns.

If it is determined that an intervention currently in practice likely constitutes seclusion, it will be important to examine all the elements involved in order to move away from seclusion. Removing one of the elements (e.g., involuntarily placed; alone; without egress) that comprise seclusion is necessary but not sufficient. Continuing an intervention without regular challenge because of historic acuity or hypothesized future acuity assumes a person is fundamentally incapable of organic growth and change. Teaching a person more than how not to get worse or that behavior can be contained is our shared responsibility. The process for making these changes or adjustments should include a re-examination of the individual's Positive Behavior Support Plan, including possible updates to the Functional Behavior Assessment (FBA) and adjustments to Universal and Targeted Supports wherever possible. While this is not an exhaustive list, below are specific evaluative activities that may be used to examine existing interventions and generate actions steps to preclude the need for and/or eliminate the practice of seclusion:

- Assess the current Universal and Targeted tiers of support operating. Pursuing opportunity to add and/or modify interventions that strengthen the proactive prevention of and/or the planned deceleration of target behaviors that result in seclusion can include (but is not limited to):
    - Ensuring data integrity such that decision making is not limited.
    - Ensuring that both Universal and Targeted supports are implemented with fidelity.
    - Considering additional supports to mitigate antecedent conditions (visuals such as schedules, social articles/stories, etc.).
    - Addressing features of the environment which may contribute to the perceived need for seclusion such as safety issues, suboptimal staffing patterns, and the unique safety needs of others served.
    - Addressing poverty of choice and expanding meaningful options offered in schedule.
    - Addressing difficulty identifying, acquiring or mastering functionally equivalent replacement behavior(s) [FERB] or coping skills.
    - Addressing difficulty identifying and/or enriching reinforcement for FERB(s) and/or coping skills.

    - Monitoring and addressing possible treatment drift.
- **Assess** for and identify the specific interventions that likely constitute seclusion, including the concrete trajectory of the individual's escalation and the staff intervention(s) that result in the individual being unable to choose being alone with no ability to egress.
- **Revisit the FBA** to ensure that all current information can be part of hypothesis development for response class(es) maintaining the target behaviors that result in seclusion. This includes revisiting possible trauma-driven motivations which may or may not be within a person's conscious control. Implementing interventions, including those that result in seclusion, should produce a treatment effect that confirms the FBA's working hypothesis.
- **Assessing the learning risks** when planning to adjust interventions for target behaviors that result in seclusion must include consideration for teaching a person more than how not to get worse or that behavior can be contained. The growth trajectory of a person who has experienced seclusion can be challenged.
    - "I am capable of tolerating you in here briefly to help me re-start."
- " I am capable of staying where I am to calm down, even when I know the door can open."
    - "I am capable of letting people know I need space, and you may need to help me get there and stay there, at first."
- **Assessing safety risks when planning to adjust interventions** for target behaviors that result in seclusion can include:
    - Attempting trials of different interventions for target behaviors to replace interventions that result in seclusion.
    - Where safety risk is heightened, adjusting the in-place interventions for target behaviors that result in seclusion by attempting trials…
        - …whereby the individual in treatment is not alone [Example: staff entering the time-out room to cue task acceptance of a small portion of the previously taught or mastered de-escalation strategies/exit criteria; shaping tolerance by incrementally increasing the demand cue in content or length of time.]
        - …whereby the individual in treatment can egress [Example: a green card is placed in monitoring window for short period of time while staff let go of the door or disengage the closing mechanism; incrementally increasing time periods.]
        - …whereby the individual can- in part or in whole- voluntarily self-manage behavior to choose a location to cope [Example: functional communication; walk with me/talk with me; graduated guidance to scaffold more independence]

Providers and support staff will undoubtedly continue to encounter circumstances that may present for individuals in which our obligation to ensure health and safety protections is a necessary component of teaching and skill building, and this may require one or more temporary restrictions of certain rights. The methods of exploring alternative interventions and supports so as to eliminate seclusion that are contained in this Guidance are not exhaustive. As providers and Department staff continue to share knowledge and update best practice together, additional pathways and solutions will be added to this Guidance.