Key points

✓ If the person uses behaviours of concern, a functional behavioural assessment must be completed, regardless of whether seclusion is used.
✓ A person in seclusion should be monitored frequently, and workers should maintain ongoing engagement.
✓ Workers must be appropriately trained to observe the person to ensure that they are safe.
✓ If the person has difficulty communicating, then a communication assessment will help find strategies the person could use to communicate their issues.
✓ If you are unsure whether a practice is seclusion or not, seek advice.

Introduction to seclusion

Seclusion is a restrictive practice involving the sole confinement of a person with disability in a room or physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted.

Although seclusion is used widely in both disability and mental health settings, most of the literature on the use of seclusion is from the mental health sector, and relatively little is specific to people with disability. A small Canadian study of restrictive practices in a disability support context found that 44% of people in the study were secluded as a response to a behaviour of concern. Some people with behaviours of concern are subject to frequent seclusion, for example, a Victorian study over a 12 month period found that 147 people had been secluded 2,352 times, or an average of more than once per month.

Seclusion can be an effective intervention to prevent or manage actual or imminent violence, to immediately reduce environmental stimuli that may cause agitation or frustration, and to reinforce coping skills. Risks of secluding a person with disability include self-harm, emotional trauma, escalation of the behaviour of concern, injury or death in the event of an emergency, undermining the rights and dignity of the person, and deprivation.

A restrictive practice is an intervention which has the effect of restricting the rights, freedom of movement, or access of a person with a disability who is displaying a behaviour of concern. Restrictive practices should be used only in limited circumstances as a last resort and not as a first response to behaviours of concern, or as a substitute for adequate supervision. We are working towards the reduction and elimination of the use of restrictive practices.

Restrictive practices include:

- Seclusion
- Physical Restraint
- Mechanical Restraint
- Chemical Restraint
- Environmental Restraint.

The NSW Government oversees authorisation of restrictive practices by registered NDIS providers. The NDIS Quality and Safeguards Commission provides leadership in behaviour support and in the reduction and elimination of restrictive practices.
Does the definition of seclusion include all exclusionary time-out strategies?

Seclusion incorporates the former category of restricted practice known in NSW as ‘exclusionary time-out,’ which was the removal of a person from a situation. It may include time-out alone in a room, time-out behind a barrier or partition, or time-out ‘outside’ a space where other people are located (e.g. in a hallway or backyard).

The key defining feature of seclusion is that the freedom of movement of the person in seclusion is restricted because they cannot voluntarily exit, or believe that they cannot voluntarily exit, a physical space. Examples of practices and when they do, or do not, require authorisation as seclusion are discussed below.

A person being locked alone in a bedroom “to calm down” in response to a display of physical aggression toward another person is seclusion. Authorisation is required.

A person being sent to a room alone “to calm down” and told that the door is locked in response to a display of aggression to another person is seclusion because the person believes that they are not free to leave the room. Authorisation is required.

A person being sent to their room alone and told that they cannot come out until they have “calmed down” in response to a display of aggression to another person is seclusion because the person believes that they are not free to leave the room until they are no longer upset. Authorisation is required.

A person being encouraged to engage with an object in their bedroom “to calm down” in response to a display of aggression toward another person is not seclusion if the person knows that they are free to leave the room at any time. Authorisation is not required.

What issues do I need to consider for participants when using seclusion?

Seclusion is prohibited for any person under the age of 18, e.g. sending a child to their room and preventing them from leaving the room. A Restrictive Practices Authorisation Panel cannot authorise a prohibited practice. The use of a prohibited practice is a reportable incident to the NDIS Quality and Safeguards Commission.

Seclusion is also prohibited where it results in denial of key needs, such as access to bedding, water, climate controls or toilet facilities. A Restrictive Practices Authorisation Panel cannot authorise a prohibited practice and will require evidence that any environment used for seclusion presents minimal risk of harm, allows easy observation, has adequate light and ventilation, is a comfortable temperature, and has access to toilet facilities.

Seclusion is usually used as a crisis response and should be only for short periods of time, not normally exceeding 15 minutes.

Seclusion should not be used without consent. For consent to be valid it must be voluntary, informed, specific and current. Where possible, consent should be obtained from the person. Consent may also be given by other people, such as a guardian with a restrictive practices function, including a person appointed by the Guardianship Division of the NSW Civil and Administrative Tribunal.
What kind of monitoring and supervision are required for a person during seclusion?

Seclusion is usually used only as a crisis response and for short periods, not normally exceeding 15 minutes. Seclusion should be restricted to the shortest period required to manage the behaviour of concern and should not exceed any limit on duration indicated in the behaviour support plan for the person with disability. iv

Although the duration is short, there are risks that the client may injure themselves or become more distressed when isolated if they are not adequately observed and supported.

If seclusion has been authorised, it must only occur within an environment that is safe and non-threatening to the person with disability, while maintaining the dignity of the person. Close supervision and monitoring are required to ensure the safety and wellbeing of the person for the duration of seclusion. iv

A person in seclusion should be monitored frequently, and workers should maintain ongoing engagement with the person for the duration of the seclusion. Intervals between visual monitoring and reviewing the status of a person in seclusion may need to be more frequent depending on their circumstances. v

The physical environment used for seclusion should be assessed in advance for safety risks. If necessary, the physical environment should be modified to prevent risk of injury. Any items offered to the person to ensure that they have appropriate sensory input should also undergo risk assessment. v

What less restrictive alternatives to seclusion should I consider?

A range of positive behaviour support strategies may assist a person to manage behaviours of concern without seclusion. This may include less restrictive environmental changes that can influence the person’s behaviour and helping them to learn new behaviours vi without infringing on their rights.

Using calming routines before situations that are known to be potential triggers, or using sensory focused activities, can help some people to regulate their emotions and decrease the potential for behaviours of concern. Whole-body actions like pushing and pulling, oral actions like blowing and chewing, using hands like squeezing or fidgeting, and deep pressure touch, like weighted items or heavy blankets can also be effective for helping a person to calm down. vii

Room-based interventions without seclusion, such as sensory rooms, relaxation rooms, and safe or comfort rooms may be effective for some people. viii Preferred sensory stimulation may also help some people to manage behaviours of concern.ix

Behaviour support interventions that are consistent with functional assessment findings are more effective in managing behaviours of concern. vi For example, some people who are distressed when routines change can benefit from help to prepare for changes so that they are less distressed. All behaviour support plans need to be based on a functional behaviour assessment so that strategies can address the purposes of the behaviour.
What duty of care issues should I consider when using seclusion?

Anyone for whom seclusion is recommended or used should have a functional behavioural assessment to identify the purpose of the behaviour and the appropriate environmental, personal, and social supports needed to decrease the occurrence of that behaviour.

While there is research that supports using time out to control behaviour, some people who have difficulty self-regulating their emotions may feel more insecure or distressed when separated from other people who can help them to regulate their emotions.

Seclusion should be minimised, used with sensitivity, and never associated with punishment. Many people with disability have experienced social exclusion and rejection and the experience of seclusion may cause distress. If the person finds the use of seclusion to be an aversive experience, then use of this practice is prohibited.

People who have complex communication needs should be assessed by a speech pathologist and supported to communicate, their needs, both during seclusion, and as a way of reducing the use of seclusion.

Sometimes behaviours of concern have physical causes, such as an illness like gastro-oesophageal reflux or untreated fractures, which may result in the person feeling sad, angry or aggressive. Prior to behaviour support, a medical practitioner needs to conduct a thorough health assessment.

Further reading


