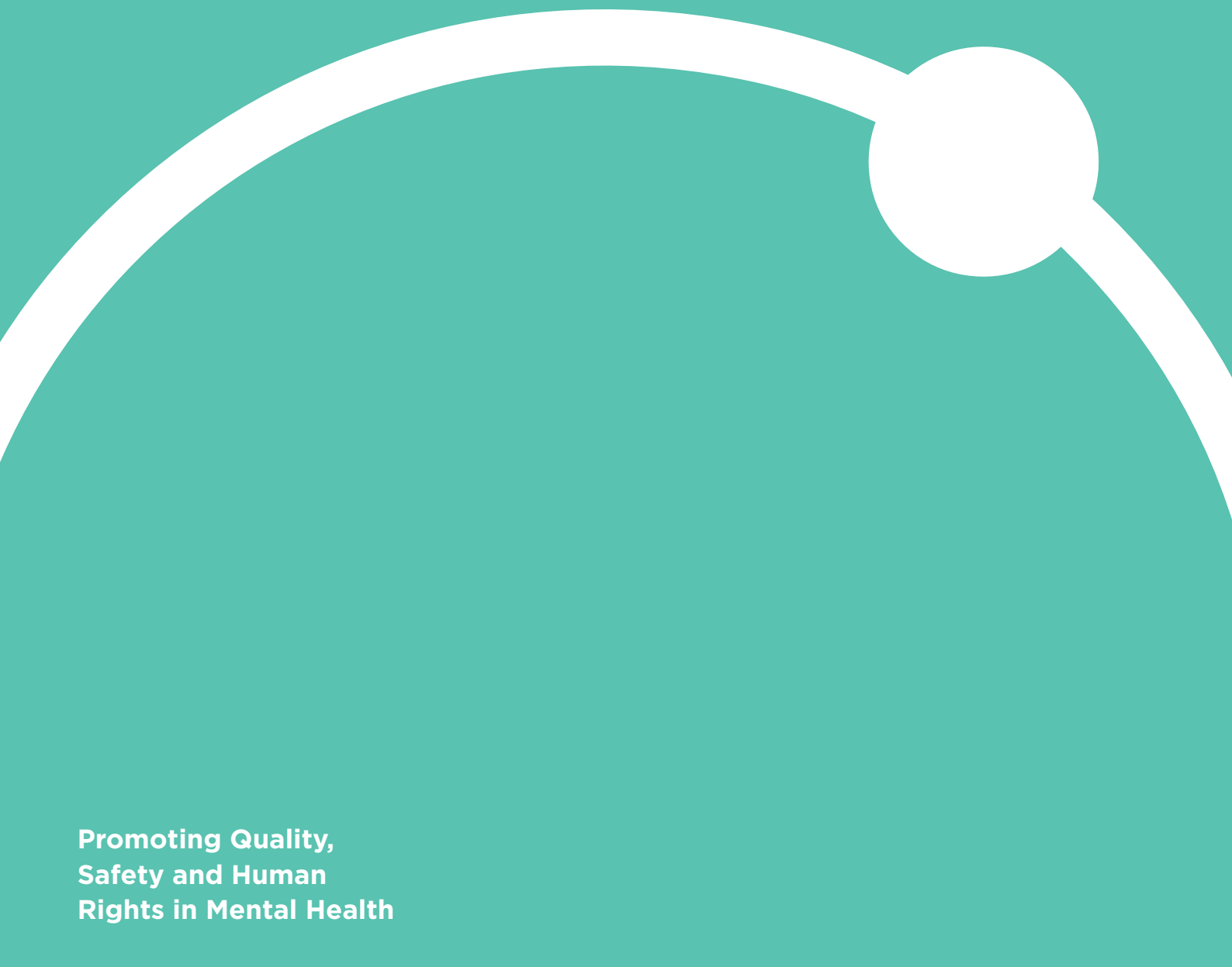
mhc
coimisiún meabhair - shláinte
mental health commission

Consultation Report

Revision of the Rules and Code of Practice relating to the use of seclusion, mechanical means of bodily restraint, and physical restraint in approved centres

September 2022



Promoting Quality, Safety and Human Rights in Mental Health

Acknowledgements

The Mental Health Commission (MHC) wishes to acknowledge the contributions of everyone who was involved in the consultation which informed the revision of the Rules and Code of Practice relating to the use of seclusion, mechanical means of bodily restraint, and physical restraint in approved centres. The Mental Health Commission is grateful to those who took the time to complete the public questionnaire or to attend a focus group or interview. The constructive feedback provided was much appreciated.

The MHC particularly wishes to thank the members of both Advisory Groups for generously giving their time and expertise to the review.

The MHC is cognisant of the impact that the revised Rules and Code of Practice will have on persons being cared for in approved centres and very much hopes that it will lead to positive changes in the way care is delivered and much improved outcomes for persons in approved centres.

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Glossary

Approved centre

A “centre” means a hospital or other inpatient facility for the care and treatment of persons suffering from mental illness or mental disorder. An “approved centre” is a centre that is registered pursuant to the Mental Health Act 2001-2018. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the Mental Health Act 2001-2018.

CAMHS

Child and adolescent mental health service.

Individual Care Plan

A documented set of goals developed, regularly reviewed and updated by the person’s multidisciplinary team, so far as practicable in consultation with each person receiving care and treatment. The individual care plan must specify the treatment and care required which must be in accordance with best practice, must identify necessary resources and must specify appropriate goals for the person. For children, individual care plans must include education requirements. The care plan is recorded in the one composite set of documentation.

Trauma-informed care

Trauma-informed care is an approach which acknowledges that many people who experience mental health difficulties may have experienced some form of trauma in their life. A trauma-informed approach seeks to resist traumatising or re-traumatising persons using mental health services and staff.

Chapter 1: Introduction

Background

The Mental Health Commission (MHC) is the regulator for mental health services in Ireland. The MHC is an independent statutory body that was established in 2002, and its main purpose is to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to protect the interests of persons admitted and detained under the Mental Health Act 2001-2018 (the '2001 Act'). The MHC's remit was extended in 2015 to include the establishment of the Decision Support Service, which promotes the rights and interests of people who may need support with decision-making.

One of the core elements of the MHC's statutory function is to independently monitor the quality and safety of mental health services in Ireland.

Section 69(2) of the 2001 Act obliges the MHC to make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient. In addition, Section 33(3)(e) of the 2001 Act permits the MHC to *"prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services".*

In accordance with these sections of the 2001 Act, the MHC published 'Rules governing the Use of Seclusion and Mechanical Means of Bodily Restraint', and a 'Code of Practice on the Use of Physical Restraint in Approved Centres' in November 2006. These Rules and the Code of Practice are applicable to all inpatient mental health services in the public, voluntary and independent sectors including services for children and adolescents, adults, older persons, persons with an intellectual disability and a mental illness, and forensic mental health services. These are key documents for people who use, deliver, and work in mental health services in Ireland.

The Rules and Code of Practice were last updated in 2009. The MHC is committed to the reduction in both the frequency and duration of seclusion and restraint episodes in approved centres and is mindful of the significant and progressive developments in mental health care that have occurred since 2009, and the need to build on the MHC's Seclusion and Restraint Reduction Strategy, published in 2014.

In early 2021, the MHC established a Project Team[1] to review and update the existing Rules and Code of Practice.

Along with consideration of national and international legislation, policy and best practice, and having regard to the in-depth Evidence Review[2] carried out by the Royal College of Surgeons in Ireland (RCSI) on its behalf, the MHC undertook an extensive stakeholder engagement process to inform the revision of the Rules and Code of Practice.

[1] Membership of the Project Team is outlined in Appendix A

[2] The Evidence Review is available at www.mhcirl.ie

Consultation Process

Over the 12-month period July 2021 to July 2022, the Project Team consulted with a wide range of stakeholders to inform the content of the revised documents and, subsequently, to obtain feedback on the draft Rules and Code of Practice.

The consultation process is summarised in Table 1, below.

Table 1: *Summary of the consultation process*

Expert Advisory Group	Five meetings July 2021 – July 2022	17 members (plus Service User Group representation)
Public Consultation Questionnaire	July – September 2021	100 responses (88 individual and 12 organisation responses)
Service User Group	Three meetings September 2021 – July 2022	Eight members who had experience of seclusion and/or restraint in an approved centre
Focus groups (7) and interviews	September 2021 - February 2022	39 participants (individuals and organisation representatives). Visit to a child and adolescent approved centre.
Focus Groups and interviews – feedback on draft documents	July 2022	20 participants representing 14 organisations plus interviews with two individuals

This report details the information obtained from this engagement process, and how it informed the revision of the Rules and Code of Practice.

Note regarding amendments to the 2001 Act and "Chemical Restraint"

This review occurred at a time when the 2001 Act was undergoing substantial revision. The draft Heads of Bill to amend the 2001 Act contained a number of provisions relevant to this review, including the introduction of rules to govern the use of "chemical restraint" in approved centres. "Chemical restraint" was defined in the draft Heads of Bill as *"the use of medication to control or modify a person's behaviour when no medically identified condition is being treated, or where the treatment is not necessary for the condition, or the intended effect of the drug is to sedate the person for convenience or disciplinary purposes"*. It was intended to publish a code of practice on the use of chemical restraint alongside the revised Rules and Code of Practice relating to the use of seclusion, mechanical restraint and physical restraint, in anticipation of the publication of the revised 2001 Act.

The feedback obtained by the MHC from the public consultation questionnaire, focus groups, and Expert Advisory Group, made it clear that the term and current definition of 'chemical restraint', as set out in the draft Heads of Bill, was 'problematic' and 'not fit for purpose'.

The MHC has communicated these concerns regarding the term and definition to the Department of Health; however, at the time of writing (September 2022), the Heads of Bill are still making their way through the legislative review and reform process, and it remains uncertain what the term (and definition) 'chemical restraint' will likely be changed to in the amended 2001 Act. The MHC therefore made the decision not to proceed to draft a code of practice on this matter at this time. As such, this report does not go into detail on submissions received in relation to 'chemical restraint'. However, it is acknowledged that with the eventual publication of the revised 2001 Act, the MHC will be obliged to review the existing Rules and Code of Practice and develop new rules as appropriate.

Chapter 2: Information gathering

2.1 Expert Advisory Group

At the outset of the review of the Rules and Code of Practice, the Project Team established an Expert Advisory Group (EAG) to inform the revision process. The EAG comprised a diverse range of stakeholders, including mental health nurses and psychiatrists with direct experience in the use of restrictive practices in approved centres[3], advocacy group representatives, and staff from other professional backgrounds and other government agencies. A representative from the Service User Group, which ran in parallel to the EAG and also advised on the review, attended the EAG meetings. The Terms of Reference stipulated that, while all of the feedback from the EAG would be collated and carefully considered, the MHC is the decision maker in relation to the content and final version of the Rules and Code of Practice. A list of members of the EAG is contained in Appendix B.

Five meetings of the EAG were held. The first two meetings took place in July and November 2021 and members provided feedback on what they considered were the main changes needed to the regulation of each category of restrictive practice. Prior to the first meeting, a scoping consultation questionnaire was sent to members to complete, with the results shared at the July meeting. A third meeting was convened in March 2022 to specifically discuss the MHC-commissioned Evidence Review that had been received from the Royal College of Surgeons in Ireland (RCSI). These three meetings informed the development of the first draft of the Rules and Code of Practice. A further two meetings were held in June and July 2022; these will be discussed in Chapter 3. Acknowledging that membership of the EAG was diverse, and opinions varied, the following non-exhaustive list outlines some of the points that were raised in the discussions over the course of the three meetings:

Feedback and suggestions from the EAG pertaining to the current Rules and Code of Practice: General Points
■ Include principles which highlight human rights, legal principles, service user dignity, privacy and empowerment, trauma-informed principles.
■ Emphasise the importance of good staff training, as this has been proved to be effective at reducing restrictive practices. It was suggested that staff training should be broadened to include violence and aggression prevention, the therapeutic management of violence and aggression, trauma-informed care, human rights, de-escalation techniques. Members of the Group advised that training should also be based on the individual needs of the staff member.
■ Separate the rules relating to seclusion and mechanical means of bodily restraint (currently are dealt with in the same document).
■ State that restrictive practices are not therapeutic interventions.
■ Emphasis to be given to the distress and psychological consequences of seclusion and restraint.
■ Consider the regulation of other restrictive practices as the use of environmental restraints in centres without adequate governance and oversight can seriously impact on the basic rights of residents (e.g. locked doors, the use of bed rails to restrict movement).

[3] The MHC wrote to the College of Psychiatrists to seek a nomination for three psychiatrists (one psychiatrist with forensic experience, one with general adult experience and one with child/adolescent experience, to sit on the EAG). Mental health nurses were recruited via the Area Directors of Nursing Group for Mental Health and Mental Health Nurse Managers Ireland.

Feedback and suggestions from the EAG pertaining to the current Rules and Code of Practice: General Points
■ Make it clear that the use of restrictive practices should be used as an emergency procedure, only to be resorted to when there is an immediate risk of physical harm and as a last line response when all other options have been tried.
■ Stipulate that service providers should be obliged to provide evidence of the alternative measures or interventions that were used prior to using restraint or seclusion.
■ Include a greater focus in the Rules and Code on positive behaviour support plans and interventions with a focus on negating the need for seclusion or restraint.
■ Outline the content of the post incident review (e.g. learning that can be achieved from the incident, including missed opportunities that could have prevented the seclusion or restraint, what were the trigger events).
■ Consider unintended consequences of regulation and increasing penalties for non-compliance (e.g. use of some practices may go 'underground' or regulating or banning one type of restrictive practice may lead to the increased uptake of another unregulated restrictive practice).
■ Reflect the cultural shift away from the current paternalistic, 'best interests' paradigm to a 'will and preferences paradigm'.
■ Bear in mind that the patient may view restraint as violence towards them.
■ The Rules and Code need to be workable for staff: 'practical and applicable on the ground'.
■ Emphasise the importance of strong governance and oversight.
■ Service users (and the families of younger service users) to have input into behavioural care plans ("they know their own triggers").
■ Emphasise person-centred care.
■ Consider the unique needs of people with sensory and linguistic difficulties.
■ Record and publish episodes of violence.
■ The objectives of the review should reflect the government's commitment towards a 'zero seclusion, zero restraint' policy as outlined in 'Sharing the Vision'.
■ Include that a transparent environment with open communication and dialogue needs to be culturally embedded in services.
■ State that there is a need to provide aftercare to the service user following the seclusion or restraint episode.
■ Make it compulsory for services to continually review how they reduce the use of restrictive practices. It was put forward that there should be guidance on how services carry out these reviews.
■ Emphasise the importance of culture in embedding the reduction of restrictive practices in services. It was pointed out that there is a need for more systematic reporting and staff need to work as a team to embed reduction efforts into the culture. It was noted that there also needs to be more consistent examination of the service user's 'whole journey' which led up to the restrictive event and to understand why it happened.

Feedback from the EAG specific to the Rules governing the use of Seclusion
■ Provide for direct observation throughout the person's seclusion episode, and not just for the first hour.
■ Give further emphasis to human rights issues (for example, seclusion is detention within detention, further reducing a person's liberty).

Feedback from the EAG specific to the Rules governing the use of Mechanical Means of Bodily Restraint.
■ Stipulate in the rules, the maximum duration of restraint.
■ Patients requiring mechanical restraint should have a nurse assigned to them for the duration of the restraint.

Feedback from the EAG to improve the Code of Practice on the use of Physical Restraint
■ Clearly define the maximum amount of time somebody can be physically restrained.
■ Emphasis on prohibiting obstruction of eyes and ears so the restraint does not impact the service user's ability to communicate.
■ Monitoring of the patient throughout the episode of restraint.

2.2 Service User Group

Alongside the EAG, a Service User Group, which consisted of people who had direct experience of, or who had witnessed, seclusion and/or restraint while an inpatient in an approved centre was established. Nominations to the Group were sought through relevant organisations.

The Project Team considered that it was essential for the review to have the advice and input of experts by experience, and that the revised Rules and Code of Practice reflect the needs, experiences and views of service users. A representative of the Service User Group attended the EAG meetings to represent the service users' voice and convey their experiences and views.

The Service User Group was established as it was considered necessary for service users to have a safe space to share their personal experiences and thoughts in a forum that did not consist of clinicians who had experience in the use of seclusion and/or restraint. All Service User Group meetings were chaired by Dr Susan Finnerty, the MHC's Inspector of Mental Health Services, and attended by other members of the Project Team.

The Service User Group met three times between September 2021 and July 2022. The Group initially comprised eight members, however after the first meeting, three members withdrew from the Group. The first two meetings provided insight into the perspectives of service users and obtained valuable feedback for the development of the revised Rules and Code of Practice. The main themes which emerged from both meetings are outlined below.

Communication with patients

Communicating patient's rights

Service users, on the whole, expressed a wish for more information and transparency about their rights, as *"…the information was not forthcoming"* while they were receiving care as inpatients. It was communicated that information should be given freely, for example, print out copies of information sheets (in non-technical language) and leave them with the patient to read soon after they arrive at the service.

Communication prior to the use of seclusion/restraint

Those who experienced seclusion or restraint advised that there often appeared to be no forewarning that the use of seclusion or restraint could occur. It was stated that information on the types of restrictive practices used in the service should be provided to people when they arrive at a service, and that a choice should be given as to what option they would prefer in the event that the use of a restrictive practice becomes necessary. For example, some said that they would not want physical restraint used due to previous assault and others said that they would not want to be placed in a seclusion room due to being claustrophobic. It was suggested that these needs could be included in an Advanced Directive or in the person's individual care plan in order to better inform decisions about their care. It was discussed that when patients are provided with all of the information, they should be allowed to make an informed choice. Additionally, service users advised that if they had been appropriately informed that seclusion or restraint was being considered, they could take this on board, and the threat of seclusion or restraint may have a de-escalating effect.

Communication with the person at the time that seclusion or restraint is used

Service users commented that they needed to be informed of the reasons for the use of seclusion or restraint and given basic information such as how long the seclusion or restraint would last. In relation to seclusion, one service user reported *"I was just put into a padded cell and was not informed of the reasons for this*".

Debrief with the person secluded or restrained

It was noted that a debrief following an episode of seclusion or restraint "*does not always occur"* and it was the view of the service users that this should be "*obligatory".* Service users described the importance of the need to have a discussion after the restraint or seclusion so that they can understand the reasons why it occurred and can reflect on what happened. It was highlighted that witnesses to the restrictive intervention are also often traumatised by the experience and a debrief should be offered to witnesses to acknowledge their *"vulnerability from seeing people incarcerated in an aggressive manner*". One service user commented: *"[when I witnessed restraint], people are not making the most sensible decisions and sometimes did need restraint… suddenly there are security staff, the bell is pressed, people are running…things are chaotic, and everything goes crazy. It is scary…you go into fight or flight mode".*

Regarding the timing of the debrief, one service user advised that *"…it should take place when they are ready to talk about it and when they are in a better place…not when they are at their most vulnerable…it's not nice to sit in a room immediately after being in the seclusion room to do a debrief. It's hard to keep track of what is happening…it's intimidating to communicate what you felt…what you need. It is demeaning and stressful…I think it should be up to the person when the debrief happens and have someone neutral there."*

Alternatives to restrictive interventions

Service users described a lack of alternatives to 'de-stress' prior to the use of seclusion or restraint. It was suggested that having a quiet space or de-escalation room or sensory room on the ward where a person could voluntarily go to de-stress away from others, would provide alternatives before things escalate to the point that seclusion or restraint is required: *"There have*

to be alternatives provided to decompress before things escalate and have to go into seclusion. Things escalate too fast and too quickly…I'd like to explain this is what I would need, this is what I would like. Could I go to a quiet area…I think that de-escalation needs to be tried first."

One service user described her preference to de-escalate: *"My way of calming down is to create…I mould with clay…I knew it would get the anger out and [I could] de-escalate that way…I was refused because I was told it would make a mess. Then I got upset and was put into seclusion."*

It was pointed out that the current Clinical Practice Form requires services to specify: *"the range of therapeutic options considered"* and it was suggested that this be amended to *"the range of therapeutic options tried"* so that it would be clear whether, and which, alternative interventions were attempted prior to using the restrictive practice.

Staff training

It was reported that there was often no consistency in the use of restraint and seclusion and service users expressed concern about the lack of consistency in how restrictive practices were used*: "…different staff might react to my behaviour by trying to calm me down. Another goes straight to restraint. There is no consistency…every staff member has a different approach".* Additional training in de-escalation techniques was recommended, particularly in active listening and trauma-informed care. Service users were in agreement that there needs to be a shift towards trauma-informed care in mental health services.

Culture

Several service users described being "*vulnerable to staff personalities and staff mood"*. One service user described how patients were '*terrified from a heavy-handed nurse manager'* and were *a "victim of her mood".* Service users wanted 'staff members who come into work in bad form' or 'who get up on the wrong side of the bed' to be held accountable for a lack of respect shown to patients *("patients are treated as lesser").* Another service user relayed how she felt 'pressure to comply' otherwise she would be restrained or secluded.

A fear of speaking out or lodging a complaint against an 'abusive' staff member or service was also discussed. The reasons service users reported that they were afraid were two-fold. Firstly, service users described a fear that complaining would result in "repercussions". Secondly, there is a fear that the complaint will not be taken seriously; as one patient explained, "*I am mental health patient so, unlike a patient who complains in a general hospital, there is a blurred line of telling the truth and not being believed*").

Another service user commented that 'poor hospital culture' was 'the opposite of what you need when you are in hospital'. There was a wish that all staff should be 'empathetic' and 'kind' to patients.

Environment

Several service users described the inpatient service that they had experience of as *"sterile and clinical'* or "*prison-like"* and advised that this was *"reinforced when staff do not communicate with a patient".* It was observed by one service user that "*hospital is not a place for recovery or respite".*

Location of the seclusion room

One service user stated that when they had been an inpatient the seclusion room was directly beside the communal sitting area. Other patients could hear the person in seclusion "*banging on the door and screaming… when they came out, they knew everyone had heard them…the room needs to be somewhere private".* In order to provide the patient with privacy and dignity, it was recommended that the seclusion room be located away from communal areas.

Advocates

There was consensus amongst service users that the presence of advocates and peer support workers is required at every service. Service users felt that having a 'constant empathetic presence; possibly from someone with lived experience', could have a de-escalating effect. It was reported that when a patient first arrives at the service, they 'do not understand hospital life', are often 'terrified' and having their belongings taken adds to the distress. It was therefore considered essential to have someone 'on the ground' to 'protect patients' rights while in hospital'. One service user described how having a family member advocate for him by explaining his concerns to the medical team, made him feel 'empowered' and that he was 'able to stand-up' for himself. It was noted that not all service users have a family member or friend who will advocate for them – in which case an independent advocate or peer support worker would be 'vital'.

The impact of restrictive practices on patients

Service users reported feeling that they felt 'controlled', 'abused', 'frightened', 'anxious', 'angry', 'helpless', 'disempowered', 'humiliated', 'vulnerable', and 'disrespected', when seclusion or restraint was used. There was general agreement that the trauma experienced as a result of seclusion or restraint had a subsequent negative impact on their recovery: *"It [seclusion] was traumatising for me. People should be offered counselling afterwards…you are still in shock at what happened to you".* Another service-user described: "*If in life you find yourself in a distressing situation, you need to talk to someone…instead you are locked up…seems like a punishment rather than a treatment and that is a long way from being person-centred."*

The use of seclusion or restraint was reported as leading to a "*lack of trust"* and a *"…change in dynamics…you now feel threatened by the staff that are supposed to be taking care of you…you think these people have absolute power over you".* One service user described: *"There is a huge power imbalance when you are being restrained and going forward…dealing with the staff who restrained you."* It was considered that *"staff really need to know the impact that [seclusion and restraint] has on people."*

One service user spoke of their experience of lengthy seclusion (three weeks): "*It felt lonely and isolated in the seclusion room …I missed social interaction…staff should communicate with the person in seclusion…through a closed door…so they know that they aren't forgotten about".* Another commented: *"When you are in seclusion there is nothing to read or see…You're just alone with your thoughts…this isn't the best thing [for me] …it's important to be able to speak to someone you can trust when in [seclusion]…maybe have some sort of communication device so you can talk to a family member or advocate…that would ground you and calm you."*

Another service user detailed how she was "*…put in a gown in a padded cell so there is no way to harm yourself. Heavy, woolly thing - horrible. You don't feel like a person in that environment…it is dehumanising, rights are taken*". She reiterated the need for staff to communicate with patients in seclusion: *"I was given no information. I didn't know how long for or when I will get out."* It was also pointed out that people in seclusion need to be informed about the use of CCTV in the room, and that *"family, or someone else close to you, needs to be told when you go into seclusion."*

In addition, there was discussion relating to the distressing impact that witnessing the use of seclusion and restraint on others has on service users.

This feedback provided valuable insight into the issues that are the most pertinent to service users and every suggestion was considered during the drafting stage, which will be discussed in Chapter 3.

2.3 Public Consultation Questionnaire

2.3.1 Background

A public consultation questionnaire was developed at an early stage in the process to obtain as wide a range of feedback as possible to inform the drafting of the revised Rules and Code of Practice. The survey ran for approximately six weeks during the period late July to early September 2021. Due to the survey running over the summer period, late responses were accepted (the final response was received in late November).

The survey was widely advertised including on the MHC website and was promoted on its social media channels (LinkedIn and Twitter). Advertisements were placed in the *Irish Independent* newspaper and on the 'journal.ie' website. The questionnaire was hosted on the 'EasyFeedback' online survey tool. In addition, an editable PDF and hard copies of the survey were available on request. On the first day that the survey went 'live', the MHC contacted over 50 key stakeholders to inform them of the launch of the survey and the various ways they could respond. A reminder email was also sent one week prior to the closing date.

The main section of the survey comprised 24 questions which examined respondents' views in relation to the regulation of restrictive interventions in general, as well as specific questions relating to the Rules and Code of Practice governing the use of Seclusion, Mechanical Means of Bodily Restraint and Physical Restraint.

Additional follow-up questions were displayed to respondents who answered that they were staff who had experience in the use of restraint and/or seclusion in an inpatient mental health service. One supplementary question was visible to individuals who answered 'yes' to having been an inpatient in a mental health service and had experience of restraint and/or seclusion.

Survey respondents

In total, 100 full or partial responses were received. This comprised 88 individual, and 12 responses that were submitted by organisations. A list of organisations that completed the survey is detailed in Appendix C.

As shown in Table 2 below, the majority (51%) of the responses received from individuals were staff working in mental health services, followed by persons who are using, or have used, mental health services in Ireland (25%).

Table 2: *Demographics of individuals who responded to the questionnaire*

	%	n
A staff member or other person working in mental health services in Ireland	51	45
A person who has used or is currently using mental health services in Ireland.	25	22
A friend, family member or carer of a person who has used mental health services in Ireland.	17	15
Other	7	6
Total	**100**	**88**

2.3.2 Questions answered by all categories of respondent

The survey included a number of questions that were applicable to all restrictive practices. These included questions relating to principles that should underpin the use of restrictive practices, protection of human rights, the safety and minimisation of the use of restrictive practices, and safeguarding patients.

What principles should inform the revised Rules and Code of Practice?

Respondents suggested that the revised Rules and Code of Practice should adhere to principles including 'human rights', 'person-centred', 'least restrictive', 'trauma-informed', 'dignity', 'respect', 'safety', and 'equality'. However, it was pointed out by some staff members that a trauma-informed, and least-restrictive, approach should be balanced with the safety of staff "*whose constitutional and human rights must also be maintained".* An advocacy group representative advised that a commitment to 'zero restraint, zero seclusion' as per *Sharing the Vision* should be included in the guiding principles.

In your opinion, do the current Rules and Code of Practice ensure that human rights are adequately protected? Do you have suggestions on where and how the Rules and Code of Practice could be further strengthened in this regard?

A minority of respondents considered that the current Rules and Code of Practice do adequately protect human rights in that they provide for their use only in rare and exceptional circumstances. However, a majority considered that the current Rules and Code of Practice do not go far enough in protecting the human rights of service users, noting that they are based on the 'outdated' Mental Health Act 2001 which is 'out of sync with international human rights.'

Respondents reported that there is a lack of independent advocacy for patients and that the revised Rules and Code of Practice should provide more protection for children who are subject to restrictive practices. There was a general consensus amongst all categories of respondents that trauma-informed care should feature in the revised documents.

In your opinion, do the Rules and Code of Practice adequately address the issues surrounding restrictive practices to ensure their minimisation and safe application? If not, what further guidance do you recommend?

On the whole, respondents considered that the current Rules and Code of Practice ensure accountability of services that use restrictive practices. However, there were several suggestions on how the reduction of restrictive practices could be improved. For example, it was put forward that there should be guidelines around mandatory training for staff, and what content should be covered (e.g. the therapeutic management of aggression and violence). It was suggested that individual care plans could include actions aimed at reducing restrictive practice recurrence as well as de-escalation techniques that have proven to be successful for the person. It was submitted that there be guidelines on creating trauma-informed, therapeutic environments for patients.

Feedback on Rules governing the use of Seclusion

Respondents considered that a clear definition of seclusion is required to avoid ambiguity. In addition, it was deemed by some, that the duration of a seclusion order needs to be reduced, and clearer guidelines on making and extending seclusion orders is warranted. It was also proposed that services must be able to demonstrate to the MHC that they are attempting to reduce the use of seclusion. It was felt that seclusion training should be mandatory for staff, and for it to occur on an annual basis. Respondents requested additional guidelines on standards and requirements for seclusion facilities (e.g. access to natural lighting). Some respondents considered that there should be a case review of individuals who have been subject to multiple seclusion orders. Furthermore, it was submitted that an easy-to-read version of the revised Rules be developed to improve accessibility.

Feedback on the Rules governing the use of Mechanical Means of Bodily Restraint

According to a number of respondents, the revised Rules should specify what exactly constitutes mechanical restraint and list the relevant devices (e.g. belts, handcuffs). It was put forward that the Rules governing the use of Mechanical Means of Bodily Restraint ought to be a stand-alone document, and not included under seclusion as is currently the case. Some respondents considered that certain terms in the Rules are 'ambiguous' and require clarification, for example, 'ongoing basis' and 'certain clinical situations' in Section 21.1. It was suggested that staff should be required to complete annual training in the use of mechanical restraint and alternatives to its use (e.g. de-escalation techniques). It was advised that Section 20, which relates to child patients, should be based on international guidance and evidence-based practice. One staff member asserted that the revised Rules "should not infringe on the right of staff to work in a safe environment" and should "reflect Health and Safety legislation where the safety of service users, staff and visitors is regarded as being essential and equal".

Feedback on the Code of Practice on the use of Physical Restraint

Several respondents considered that some of the language used in the current Code of Practice is 'ambiguous' and 'requires clarification', for example *"special consideration should be given when restraining a resident…who is known to have experienced physical or sexual abuse"*.

Other feedback received proposed that in order to "*bolster the rights of residents*", the Code of Practice should be upgraded to a set of Rules in line with seclusion and mechanical restraint. Additionally, it was considered by some that the maximum duration of 30 minutes for physical restraint prior to a renewal order being required is 'excessive and should be reviewed'.

A number of respondents discussed the use of physical restraint in relation to the provision of treatment: "*It should be viewed as necessary, used as a last resort when all alternatives have proved ineffective, and its use should not be seen as a failure of the preceding treatment and care"*.

It was put forward that Part 1 of the Code of Practice should be in line with Section 69 (2) of the 2001 Act and include a definition for the use of physical restraint as a treatment for residents (e.g. for life threatening malnutrition, blood tests, and NG feeding).

2.3.3 Feedback from individuals who indicated that they had experienced or witnessed seclusion/restraint in an approved centre

Of the 22 respondents that advised they had experience of using mental health services, most (19/22) had been an inpatient at a mental health service. Of these, 11 had direct experience of restrictive practices, and the remainder (8/19) advised that they had witnessed seclusion and/or restraint.

As outlined above, a follow-up question, which asked for the person's views on the use of restrictive practices, was visible to individuals who answered 'yes' to having been an inpatient in a mental health service and had experience of restraint and/or seclusion.

The key message from persons who had experience of restrictive practices was that their use had a very negative impact on the person who has a mental illness and should not be permitted. The consensus was that the use of restrictive practices is 'traumatic' for the person. It was considered that the ward environment, as well as factors such as lack of staffing, influence the frequency of restrictive practices being used in a service. Some respondents felt that the use of restrictive practices should be viewed as unethical and outdated, and that services should consider alternative approaches such as employing de-escalation techniques.

2.3.4 Feedback from Staff

In respect of the 45 respondents who advised that they were staff working in mental health services, the majority (39/45) stated that they had direct experience in the use of seclusion and/or restraint. These were primarily mental health nurses (29/39) and psychiatrists (9/39). Staff were asked an additional set of questions in the survey, with specific questions on each restrictive intervention. The tables below detail some of the feedback received from staff in relation to each Rule and Code of Practice.

Staff feedback specific to the Rules governing the use of Seclusion
■ Increase training requirements (only 47% of respondents who had experience in the use of seclusion reported that they were sufficiently trained in its use).
■ Create a stand-alone training course on seclusion, along with refresher CPD sessions. The creation of mandatory and standardised training modules would also ensure that agency staff would then receive the same training as permanent staff.
■ Training to cover themes such as trauma-informed and person-centred care, and de-escalation.
■ Mandatory training to be held more frequently than at present (every two years).
■ The Rules should require that alternatives such as de-escalation had been tried first, especially in repeated cases of seclusion.
■ Stipulate what is to be covered in the debrief with the person who has been secluded.
■ The Rules to reflect best practice in the design of seclusion facilities.
■ Specify that seclusion facilities should be therapeutic in design, e.g., larger area to allow for resident de-escalation and self-regulation space: *"the environment in the seclusion room should be less like a cell and more like a safe comfortable room".*
■ The seclusion room should provide outdoor and indoor space that is solely designed as quiet/safe/calm spaces, and these *"should be designed and informed by trauma informed principles to help soothe activated parasympathetic nervous systems".*
■ Respondents reported that the revised Rules on the use of Seclusion should provide guidelines on the role of particular staff members in ending a seclusion episode, e.g., senior nurses.
■ Clarification around the orders for seclusion needed in the revised Rules.
■ The need to monitor the physical health of persons who are secluded (e.g. include a medication plan due to the relationship between drug use/withdrawal and seclusion orders).
■ The current Rules on the use of seclusion on children are underdeveloped.

Recommendations made by staff in relation to the Rules governing the use of Mechanical Means of Bodily Restraint
■ In general, feedback on the current Rules was that they are 'underdeveloped' and require an 'overhaul'.
■ The maximum duration for mechanical restraint should be congruent with seclusion.
■ Provide additional detail in the Rules – it was advised that services have had to develop their own documentation and guidelines to support staff, as this is 'lacking' in the current Rules.
■ The Rules on mechanical restraint should be a stand-alone document (currently in the same document as the Rules governing the use of seclusion).
■ Expand on the 'principles' section of the Rules, as well as the 'recording restraint episodes' and 'clinical governance' sections.

Staff suggestions specific to the Code of Practice on the use of Physical Restraint
■ Include guidelines to help staff reduce violent behaviour.
■ Reference the traumatic impact that physical restraint can have on patients.
■ Revised Code of Practice to stipulate the use of physical restraint when providing treatment to a patient.
■ Increase the frequency of staff training (e.g. TMVA) to annually and monitor and record staff training.
■ Training should cover trauma-informed care and include the link between drug use and aggressive behaviour.
■ Training to also include alternatives to physical restraint, including de-escalation techniques.
■ Staff advised that a HSeLanD online training course would be beneficial.
■ The revised Code should include guidance on debriefing for staff to ensure that the voice of the patient is heard. It was suggested that the Code should also utilise guidance from the BILD restraint reduction network.
■ It was recommended that the section on 'child patients' in the Code be expanded as it is 'poorly developed'.
■ Staff should be required to outline in detail all de-escalation actions that were taken before implementing physical restraint.
■ The Clinical Practice Form should be online.
■ Clinical governance provisions in the revised Code to include arrangements for the reduction of physical restraint.

2.4 Focus Groups and Interviews

2.4.1 Focus Groups

As part of the public consultation questionnaire, respondents who were interested in attending a focus group meeting to further inform the review of the Rules and the Code of Practice were asked to contact the MHC via the contact details provided on the form. In total, 16 focus group participants were sourced via the consultation questionnaire. All but two of these participants were members of staff working in an approved centre or their representative body (mental health nurses and psychiatrists, or an organisation representing nurses or psychiatrists).

It was identified that a broader range of participants was required for the focus groups – particularly service users, family members, MDT staff, advocacy groups and ethnic minority groups. In this regard, letters were composed to over 40 targeted organisations or individuals, and invitations to take part in a focus group were sent by e-mail. This resulted in the participation of additional advocacy groups, MDT staff and family members. One service user (from an ethnic minority group) also attended a focus group. While it was hoped that the opinions of more service users would be heard through these meetings, the MHC was also mindful of the opportunity to hear the in-depth views of service users who sat on the Service User Group and had regard to the feedback of the 19 service users with experience of restrictive practices who responded to the consultation questionnaire.

Composition of the focus groups

Focus groups took place in late September and October 2021 and lasted between 60 and 70 minutes. Table 3 below details the 35 individuals or organisations who participated in the seven focus groups. The majority of attendees (21) were staff members employed in an inpatient mental health service.

Table 3: *Focus Group Composition*

Staff*	Organisations Represented***	Service User & Family Members
Mental Health Nurses (10) ■ CAMHS x 4 ■ Adult x 5 ■ Forensic x 1 **Psychiatrists (4)** ■ CAMHS x 1 ■ Adult x 2 ■ Forensic x 1 **Multidisciplinary Team Members (6)** ■ **Social Worker** x 1 (Forensic inpatient service) ■ **Clinical Psychologists** x 2** (Adult inpatient service) ■ **Occupational Therapist** x 1** (Adult inpatient service) ■ **Speech and Language Therapist** x 1 (CAMHS inpatient service) ■ **Pharmacist** x 1 (Adult inpatient service & President, College of Mental Health Pharmacy) **Other (1)** ■ Programme Manager for Clinical Governance, St Patrick's Hospital	■ **Psychiatric Nurses Association** Ms Aisling Culhane, Research and Development Advisor ■ **Mental Health Ireland** Mr Martin Rogan, CEO Dr Fiona Keogh, Director of Policy & Research ■ **Irish Hospital Consultants Association** Mr Martin Varley, Secretary General Dr Alice McGarvey, Assistant Secretary General ■ **Grow Ireland** Ms Michele Kerrigan, CEO ■ **National Advocacy Service for People with Disabilities/Patient Advocacy Service** Ms Lisa Walsh, Advocacy Team Leader ■ **Psychological Society of Ireland**** Nominated a Senior Clinical Psychologist (adult inpatient service) to participate in the focus group ■ **Decision Support Service** Ms Aine Flynn, Director ■ **HSE Mental Health Engagement and Recovery Office** Mr Michael Ryan, Head of Mental Health Engagement and Recovery ■ **National Traveller Mental Health Service/ Exchange House Ireland** Mr John O' Brien, Manager National Traveller Mental Health Service ■ **Association of Occupational Therapists Ireland**** Nominated a Senior Occupational Therapist (adult inpatient service) to participate in the focus group.	**Family Members (3)** ■ Family member of adult inpatient x 1 ■ Family members of forensic inpatients x 2 **Service User (1)** ■ Recent arrival to Ireland when they were an adult inpatient (experienced language barrier).

* Staff who participated in the focus groups worked across four CHOs and two independent services: 12/21 worked in adult services, six in CAMHS and three in forensic inpatient services.
** Staff member who also represented an organisation.
*** Of the 10 organisations that participated in the focus groups, five had also submitted a response to the public consultation questionnaire.

Focus Group Questions

Participants were advised that the feedback obtained from the focus group discussions would be used to inform the revision of the Rules and Code of Practice on the use of restrictive practices in inpatient mental health services. Focus group attendees were informed that any personal information they provided would be held securely and would not be published, subject to legal requirements under Freedom of Information legislation. Participants were also advised that, as part of the final consultation report, the MHC will include the names and representatives of organisations that attended the focus group meetings but would not publish the names of individuals who responded on their own behalf. Attendees were asked to advise the MHC if they worked for an organisation and did not want their name to be published.

The following questions were asked in each focus group:

Table 4: *Focus Group questions*

1.	Do the Rules and Code of Practice adequately help to safeguard service users and ensure that human rights are protected? *If not, do you have suggestions on where and how the Rules and Code of Practice could be further strengthened in this regard?*
2.	In what ways could the current Rules and Code of Practice be revised so that people have a say in their own care and their wishes are taken into account?
3.	What could be done to reduce the use of seclusion and restraint in approved centres?
4.	What is/isn't working at the moment in the current Rules and Code of Practice? *What should be included/changed in the Rules and Code of Practice relating to seclusion and restraint.*

Discussion

The following themes emerged as part of the focus group discussions:

Human Rights and Safeguarding Service Users

The focus groups commenced with the facilitator asking whether the current Rules and Code of Practice adequately safeguard service users and ensure that human rights are protected. In general, participants considered that the Rules and Code of Practice adequately protect service users in that they provide a transparent and structured way of using restrictive practices: "*subjectivity is removed so there is consistency in the treatment of patients*".

However, it was highlighted that seclusion and restraint, by their nature, are "*likely to have a traumatic impact on the patient*" and this should be acknowledged. Mental health nurses, in particular, noted that trauma-informed care is not adequately included in the Rules and Code of Practice. They also reported that further trauma-informed care training is required.

All of the focus groups discussed that there is a need to look at safeguarding as a whole and consider the human rights of all service users, staff and visitors – for example, the distress caused to other service users who witness aggression or who are subject to violence by another service

user. Some staff members observed that when service users feel unsafe in the environment, they may request to leave even though they are too ill to go home.

The rights of service users in a setting where "*often it is the nurse's word versus the patient's word*" were discussed by several participants. For example, it was stated by an advocacy group representative that service users had reported to them that seclusion and restraint are used *"as a tool of control and convenience in certain situations"*, and it was noted that a wider conversation on the issue of how to change this behaviour needs to occur.

It was suggested by another participant that the collection and publication of data on the ethnicity of persons who are secluded and restrained would highlight if restrictive practices are used more frequently amongst some ethnicities (e.g. Travellers or service users whose first language is not English). Providing service providers with cultural competency training and ensuring that translators are available (particularly in the admission period to assist with medication and diagnosis) was deemed "*essential*" for staff to be able to communicate with service users from different backgrounds and it was reported that there is a "*critical need for cultural and linguistic competence in services*".

The rights of voluntary and involuntary patients were also highlighted, and this has been clarified by the draft Heads of Bill which states that restrictive practices are not to be used on voluntary patients[4].

It was noted that while the Rules and Code of Practice make it clear that the use of seclusion and restraint should be used as a last resort, they do not go into detail regarding the threshold for putting someone into seclusion or using restraint. It was recommended to make the criteria clear in the Rules.

It was also considered that the Rules need more information on clothing, dignity, bedding, the specifications of the seclusion room and the physical design of units "*which are often not therapeutic*" (e.g. access to outdoor space from the seclusion room).

Individual will and preference versus 'best interests' – a move towards a more participatory system

Trauma-informed care was frequently discussed, and it was suggested that the trauma history of the service user is taken on admission. It was noted, for example, that "*being held down during physical restraint can be triggering and re-traumatising for patients who have been a victim of physical or sexual assault*". The staff could then take this history into account and use an alternative restrictive intervention, if necessary, appropriate and available.

It was proposed that at a non-crisis time, it would be useful for a staff member or advocate to engage with individuals shortly after admission, to explain the potential for restrictive practices to be used and describe the circumstances where seclusion and restraint might be used so people know what to expect. The service user can then consider this and express their wishes and preferences for their care (e.g. seclusion to be used over physical restraint).

However, several staff members pointed out that involving the service user is already in the Rules and Code of Practice in that the service user is informed of the reasons for the use of the restrictive practice and afterwards during the debrief. One psychiatrist advised that he would have difficulty discussing restrictive practices with every service user on admission as this could be interpreted as an implicit threat to the patient.

[4] Correct at September 2022

It was noted that the Assisted Decision-Making Capacity Act 2015 is due to commence in the near future and moves from the concept of 'best interests' to the individual's will and preferences. It was further noted that the Act applies to adults only.

Many participants advised that the use of Advanced Healthcare Directives which can contain information on treatment preferences should be commonplace. It was considered that service users would be "*empowered*" if they are involved in developing their individual care plan, but it was discussed that there does need to be an acknowledgement that staff should be honest with service users and "*there is no guarantee that a very unwell patient might not be subject to a restrictive intervention*".

It was noted by several participants that the current Rules and Code of Practice contain "*problematic language*". For example, there are references to the term 'next of kin' which can be misinterpreted, and it was recommended that a move towards a more participatory model should be reflected in the Rules.

Debrief with the person secluded/restrained and Multidisciplinary Team Review

The importance of meaningful discussion after the restraint or seclusion episode with a view to informing future care was also discussed. It was considered that it is "*crucial*" to obtain the service user's perspective of the event. For example, to gain an understanding of what their trigger was and "*to plan for next time*". As well as involving the service user, it was recommended to provide for a representative such as a family member or advocate to attend the meeting or have a neutral person present who was not directly involved in the seclusion or restraint (for example a member of the multidisciplinary team like an occupational therapist or a psychologist).

It was advised that the debrief "*should not be a tick box exercise*" but should provide the framework for a "*genuine therapeutic conversation*". It was pointed out by some staff members that holding the debrief too soon after the event can escalate the situation again and "*it is not the right time for it to take place*". It was queried by some whether the debrief, and also the MDT review, are held merely to be in compliance with the Rules and Code of Practice. Regarding the MDT review, it was pointed out that staff who were involved in the seclusion or restraint may not be in a position to attend the review due to not being on duty within 48 hours of the episode. A review of the timeframes and more guidance and structure to the debrief and MDT review was requested for both to be worthwhile events.

Seclusion and Restraint Reduction

While some participants were of the opinion that seclusion and restraint "*do not have any place in a modern mental health service*", the majority considered that restrictive practices cannot be eliminated due to the potential for violence against staff and other service users. Most agreed that seclusion and restraint should be used "*as a last resort to prevent imminent violence*" and should be used for the shortest period of time possible.

In order to reduce the use of restrictive practices, it was stated that viable alternatives need to be made available to staff (for example having mandatory, standardised training on alternatives such as de-escalation techniques). It was suggested that a one-off training day every two years is not sufficient – refresher training is required – and reduction needs to be embedded in the service. It was noted that a change in culture and a commitment by every member of staff is needed to achieve this. There was an emphasis on person-centred care in the group discussions.

Changing the physical environment was also considered necessary to lead to a reduction in the use of restrictive practices - for example, the inclusion of sensory rooms in units to reduce aggression and distress. It was also suggested that these rooms could be used as an "*in-between space*" between the seclusion room and the ward to allow the person to regain self-control. It was stated that the design of some units is not therapeutic (for example, bright lights and doors banging can make people stressed).

It was highlighted that consideration needs to be given to the unintended consequences of reduction or elimination. For example, if the Rules and Code of Practice become too stringent, or a service is mandated to further reduce, or eliminate the use of restrictive practices, then that service may increase thresholds for admission and not admit service users if they are considered at risk of being secluded or restrained. Several clinicians expressed concern that in moving to a situation where restraint and seclusion are not permitted, care and treatment "*could be denied to very unwell patients who may end up homeless or in prison as an alternative to receiving care*".

It was recommended that, as a starting point, services could analyse their data on restraint and seclusion, identify trends and conduct audits of records to better understand what is happening at a granular level (for example, are restrictive practices used more frequently during night shifts, and at what point in a person's admission is it used). Participants also advised looking to how other services keep their use of restrictive practices to a minimum (for example staff highly trained in de-escalation techniques) and suggested that sharing of best practice would be beneficial.

It was acknowledged by most participants that adequate resourcing is required to ensure that the use of seclusion and restraint is reduced. It was noted that when services are under resourced, staff are "*more likely to use a restrictive practice*" to manage an escalating situation. It was highlighted that service users need time to be dedicated to them in a person-centred care environment. One participant commented that whilst it might take a relatively longer time for a service user to de-escalate using active listening, "*this will not succeed if staff are short on time*".

Changes required

It was considered that the current regulations focus on a "*one size fits all approach*" and this does not reflect the way that units work (e.g. there are differences in terms of adult/child/forensic and length of stay). Several participants recommended that children, in particular, need a separate code/rules and approach. It was also considered that seclusion and mechanical restraint need to be separate and distinct in the Rules, and it was observed that mechanical restraint is currently an add-on to seclusion and is "*underdeveloped*". It was noted that the draft Heads of Bill have addressed this point and it is the intention that each restrictive practice will have a separate set of Rules in the amended 2001 Act[5].

Participants also made recommendations relating to the terminology used in the Rules and Code of Practice. These included having gender-neutral terms in the Rules and Code rather than the current 'him/her, 'himself/herself'. Several staff members stated that the term 'residents' in the Rules and Code of Practice is "*inappropriate*" and "*stigmatising*", commenting that "*it suggests that people live in the service but the average stay in the service may only be two weeks*". It was noted that there is inconsistency in the Rules and Code of Practice with the Rules and Code of Practice switching between the terms 'patient', 'resident' and 'service user'.

A number of participants who work in CAMHS remarked that the Rules and Code of Practice are underdeveloped for nasogastric (NG) feeding which "*is considered to be a both a restrictive practice and a therapeutic intervention.*" The CAMHS staff advised that physical restraint may be required to administer NG feeding to a service user. It was suggested that the Rules and Code of Practice are insufficiently detailed with regard to the administration of treatment and that the Rules and Code of Practice should explicitly specify what treatments restrictive practices can be used for.

Several participants considered that there is lack of a recovery culture in acute units ("*the aim is to prevent suicide rather than promote recovery*"). In terms of co-production, it was suggested that the service user and their representative need to be empowered and involved much more in their care and in policy making at a higher level.

[5] Correct at September 2022

2.4.2 Additional consultation prior to drafting the Rules and Code of Practice

Following the focus group meetings, a stocktake was undertaken to ascertain which groups and organisations the MHC had heard from via the focus groups and public consultation survey. It was established that one group which was not represented in the focus groups or public consultation was child/adolescent service users and their family members or advocacy groups. A second group which was under-represented in the consultations was disability organisations.

Invitations were sent to a number of organisations representing children, young people and disability groups. Three organisations responded to the request to interview:

- The Ombudsman for Children,
- The National Disability Authority (NDA)
- Youth Advocate Programmes (YAP)

Focused interviews with these three organisations were conducted in December 2021 and January 2022.

The NDA provided insight into the issues faced by persons with disabilities. For example, it was advised that persons with an intellectual disability and a mental health condition may display challenging behaviour as a result of triggers in the environment. It was stated that careful consideration must be given to how services respond to behaviour that challenges.

It was recommended that staff are appropriately trained in trauma-informed care, how to care for service users with complex needs and those who may have communication challenges. It was suggested that person-centred care is embedded in the revised Rules and Code of Practice.

The Ombudsman for Children and representatives from YAP provided feedback on how they considered that the Rules and Code of Practice should be amended to reflect the particular experiences of children and young people.

The Ombudsman for Children stated that the current Rules and Code of Practice could be further strengthened by embedding a children's rights approach into the documents. He advised that a recent report into the experiences of children in inpatient mental health services in Ireland recommended that children and young people are provided with greater autonomy, including *'less restrictions on freedom of movement within the units, more autonomy to self-regulate, and fewer restrictions within the physical environment in inpatient units.'*

The Ombudsman also drew the Project Team's attention to the UN Committee on the Rights of the Child which recognises that '*every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which considers the needs of persons of his or her age.'* It also stipulates that restraint ought to be used against children *'exclusively to prevent harm to the child or others and only as a last resort'.* Furthermore, it advises that disaggregated data on the use of restraint and other restrictive interventions on children should be *'systematically and regularly collected and published in order to monitor the appropriateness of discipline and behaviour management for children in all settings…including mental health settings.'*

YAP highlighted the need for children and young people to be involved in their individual care plans. The interview attendees advised that children reported to them (YAP advocates) that they were 'traumatised' after the seclusion or restraint episode, and it 'damaged their relationship with staff'. It was noted that, at times, the language used by staff, had an escalating and 'damaging effect' on children and young people. For example, advocates relayed that when paternalistic language was used during restraint (such as 'grow up' or 'you're being silly'), that added to the upset and stress of an already stressful situation. It was recommended that a support person (e.g. a parent or advocate) should attend the debrief with the child or young person, to counteract

the power imbalance. It was also considered important for the child or young person's individual care plan to reflect the content of the debrief, for example to record the triggers that lead to the seclusion or restraint episode.

In order to fully understand the challenges as they apply to child and adolescent services where restrictive practices are used, the Project Team visited a child and adolescent approved centre in February 2022. This visit provided the Project Team with an opportunity to speak with staff and observe the physical layout of the approved centre (e.g. the seclusion room). Staff in the approved centre discussed their approach to restrictive practices, the unique challenges faced by CAMHS and provided a presentation on their use within the centre.

Furthermore, in December 2021, an interview was conducted with Dr Kevin McKenna, an expert in the area of reducing restrictive practices. Dr McKenna co-authored the MHC's 2014 Seclusion and Restraint Reduction Strategy and was, at the time of the interview, involved in the 2021/2 HSE pilot to reduce the use of restrictive practices in approved centres.

By March 2022, the Project Team considered that it had obtained as much information as was practicable in terms of stakeholder engagement, and it was noticeable that the same themes were repeated across the various consultation methods.

Chapter 3: Process for drafting the revised Rules and Code of Practice

3.1 Development of the draft Rules and Code of Practice

The Project Team commenced work on drafting the revised documents in March 2022. Each individual comment from the public consultation questionnaire, Advisory Group meetings, focus groups and interviews was recorded in an excel spreadsheet which had been grouped into multiple themes (e.g. suggestions specifically relating to the design of the seclusion room, all comments that related to the debrief with the person who was secluded or restrained, feedback relating to the monitoring of the person during physical restraint). To each theme, relevant points from the Evidence Review were added, including how each jurisdiction addressed each aspect of the Rules and Code of Practice (e.g. the maximum duration of an order for each restrictive practice in each of the jurisdictions reviewed). Thirdly, any relevant national or international best practice (e.g. NICE guidelines), legislation or policy was included (e.g. each recommendation made by the CPT[6] in relation to restrictive practices following its last three visits to Ireland).

The Project Team met frequently in March 2022 to assess each individual comment and determine whether it was in the scope of the review. Where constructive feedback was out of scope, it was recorded for use in future projects, or to inform future policy.

It should be noted that, as the relevant legislation has not yet been amended, there were aspects of the current rules that the MHC was unable to change in response to some of the feedback provided. For example, it was the proposed to include a statement that would declare that restrictive practices are not therapeutic and should never be regarded as such. However, this would not be in keeping with the present wording in Section 69 of the 2001 Act.

Once all non-relevant information and duplicate suggestions had been removed from the spreadsheet, the Project Team then met twice or thrice weekly between early April and early June 2022 to consider every piece of feedback and evidence and produce a first draft of each Rule and Code of Practice.

3.2 Consultation on the draft Rules and Code of Practice

The first drafts of the documents were circulated to both Advisory Groups to consider in advance of meetings held in June (EAG) and July (Service User Group). A 'key changes' document which outlined the main changes made to the existing Rules and Code of Practice were also sent to the Group members, as a significant number of changes had been made to the versions last updated in 2009.

The Advisory Groups provided feedback on the first draft documents, and members, in the main, advised that they welcomed the documents and the level of detail included in them. It was commented that the content reflected the discussions that had taken place during the previous Group meetings. Some minor, but important, suggestions were made to improve the draft documents, for example re-ordering the principles, and ensuring consistency in the use of terms. Relatively few reservations were made; these included concerns in relation to any unintended

[6] The Council of Europe's Committee for the Prevention of Torture

consequences of the changes, and the perceived 'extra bureaucracy' and 'increased amount of paperwork' by some staff.

While the feedback obtained from the Advisory Groups on the first drafts was positive and did not require significant changes to the documents, the Project Team considered that it would be beneficial to consult more widely on the draft documents. Invitations to participate in a focus group to discuss the draft Rules and Code of Practice were sent to organisations that had previously advised that they wished to partake in further consultation on the review of the Rules and Code of Practice. A copy of the draft Rules and Code of Practice, as well as the 'Key Changes' document accompanied the invite. In total, feedback on the drafts was obtained from 20 individuals representing 14 organisations over the course of four focus groups which were held in July 2022.

The organisations that commented on the first draft of the revised Rules and Code of Practice are outlined in Table 5 below.

Table 5: *Organisations that participated in a focus group to discuss the draft Rules and Code of Practice*

Psychiatric Nurses Association	Mental Health Ireland	Irish Hospital Consultants Association
Grow Ireland	National Traveller Mental Health Service / Exchange House Ireland	College of Mental Health Pharmacy
Irish Association of Social Workers	Psychological Society of Ireland	Association of Occupational Therapists Ireland
The Ombudsman for Children	Youth Advocacy Programme	National Disability Authority
National Advocacy Service for people with Disabilities	Patient Advocacy Service	

Individual interviews with Dr Kevin McKenna and Professor Denis Ryan, the independent reviewer of the MHC-commissioned Evidence Review, also took place at this time.

The feedback received on the draft documents was largely positive. The majority of participants welcomed the documents and considered that they were 'far more robust' than the current Rules and Code of Practice. The ban on the use of mechanical restraint (as it pertains to Part 3 of the Rules governing the use of Mechanical Means of Bodily Restraint) on children was welcomed by many focus group participants; particularly by the Irish Association of Social Workers and the Ombudsman for Children. A number of suggestions were made to improve the Rules and Code of Practice. These included:

- Using the debrief to 'co-author a plan for the future'.
- Including positive behaviour support in the Rules and Code of Practice.

- Extending the timeframe for the MDT review to take place within five working days of the seclusion or restraint episode, rather than the current two working days. It was suggested that this timeframe would be more practical, in terms of the availability of staff who were involved in the event. It would also mean that the outcome of the person-centred debrief may be available to consider if the timeframe was extended.
- There was discussion on when an appropriate point would be to ask people about their preferences in relation to which restrictive practice they really would not like to be used – it was suggested that this take place after the first instance of a restrictive intervention being used.

A minority of participants, who mostly represented one organisation, expressed reservations which included:

- The increased time and resources that would be required to adhere to the revised Rules and Code of Practice.
- The extra administrative burden of having to make more renewal orders due to the reduction in time that an order for seclusion and physical restraint can be made.
- The stipulation that the person who has been secluded or restrained is entitled to have a support person with them during the debrief raised concern that staff 'would be subject to cross-examination'.

Finally, an internal review of the first draft was conducted by members of the MHC's Inspectorate team and legal team.

3.3 Finalisation of the revised Rules and Code of Practice

The MHC considered all of the feedback received on the first draft of the revised Rules and Code of Practice from the Advisory Groups, focus groups and interviews. Each comment was recorded in a spreadsheet and discussed by the Project Team. The MHC made some minor changes to the documents and circulated the second draft to the EAG in advance of the final meeting which was held at the end of July 2022.

In general, feedback on the second and final draft was positive, with Group members commenting that many of the suggestions put forward during previous consultation on the first draft had been incorporated into the second drafts. It was commented by one member that the documents *"struck a good balance between implementing restrictive practices and paying attention to human rights*". The EAG gave their support for the second draft to proceed to the MHC's senior leadership team for approval and sign-off. It was noted, however, that the implications of the changes need to be considered by services, particularly in relation to staffing resources.

A small number of the EAG members also asked that the MHC give further consideration to the ban on the use of mechanical restraint (as it pertains to Part 3 of the revised Rules) on children. It was argued that its use should be permitted in a 'rare and exceptional' event, and the ban could lead to some children ending up in the criminal justice system or having to travel to the UK for treatment. Other members of the group were not supportive of this change and highlighted that in the disability sector, even when dealing with very violent behaviour, mechanical restraint is never used on adults or children. Another member noted that the use of mechanical restraint was not in keeping with the UN Convention on the Rights of Persons with Disabilities.

The MHC had regard to the fact that only one CAMHS unit has ever reported using mechanical restraint on a child, since the rules came into effect in 2006 (additionally, the use of mechanical restraint on adults has never occurred in an approved centre, aside from the Central Mental Hospital where it is used for transportation purposes). The MHC further noted the content of the RCSI Evidence Review which highlighted the international concern regarding the physical

and psychological impact of mechanical restraint on children. It observed that the jurisdictions reviewed do not provide for the use of mechanical restraint on a child. In addition, the European Committee for the Prevention of Torture (CPT), following its 2019 visit to Ireland, asserted that mechanical restraint should never be used on a child.

In late August 2022, the Senior Leadership Team gave its approval to all of the documents noting the contributions of the wide range of stakeholders that were involved in the consultation. The revised Rules and Code of Practice were considered by Board of the MHC on 15 September 2022.

Chapter 4: Conclusion

The revised Rules governing the use of Seclusion, Rules governing the use of Mechanical Means of Bodily Restraint, and Code of Practice on the use of Physical Restraint are intended to be published by the MHC on 28 September 2022 to allow for a period of time for services to familiarise themselves with the changes prior to the commencement date of 1 January 2023. The Inspector of Mental Health Services will then begin assessing compliance with the revised Rules and Code of Practice.

The MHC would like to sincerely thank all those who contributed to the development of the revised Rules and Code of Practice through membership of the EAG and Service User Group, or participation in focus groups, interviews and the public consultation. In addition to obtaining the feedback of staff working in approved centres and people who had experienced seclusion and restraint, 27 organisations also participated in the review[7]. This extensive stakeholder engagement, together with consideration of national and international best practice, policy and legislation, contributed to ensuring that the revised Rules and Code of Practice are in line with contemporary best practice.

The MHC considers that these Rules and Code of Practice will encourage continual efforts to avoid, reduce and, where possible, eliminate restrictive practices. The MHC will review the revised Rules and Code of Practice as required in terms of any relevant case law and/or amending legislation, but no later than five years from the date of commencement of the revised Rules and Code of Practice.

[7] See Appendix D which details the list of organisations that took part in the consultation process

Appendices

Appendix A: Membership of the MHC Project Team

Appendix B: Membership of the Expert Advisory Group

Appendix C: Organisations that submitted a response to the public consultation survey

Appendix D: Organisations that engaged with the consultation on the revision of the Rules and Code of Practice governing the use of seclusion, mechanical restraint and physical restraint in approved centres

Appendix A: MHC Project Team

Name, Title	Membership
Mr Gary Kiernan, Director of Regulation	March 2021-September 2022
Dr Susan Finnerty, Inspector of Mental Health Services	March 2021-September 2022
Ms Alison Connolly, Acting Head of Regulatory Practice and Standards	June 2021-March 2022
Ms Elena Hamilton, Head of Regulatory Practice and Standards	March 2021-June 2021
Ms Aisling Downey, Research Executive	March 2021-September 2022
Ms Laurie O' Donnell, Research Executive	November 2021-April 2022

Appendix B: Membership of the Expert Advisory Group

Name, Title	Organisation
Ms Fiona Coyle, CEO*	Mental Health Reform
Mr Jim Walsh, Training and Development Officer	Irish Advocacy Network (Peer Advocacy in Mental Health)
Ms Una Twomey, Service Improvement Lead, HSE Mental Health**	HSE
Mr Michael Keating	HIQA
Ms Deirdre O' Flaherty, Mental Health Unit	Department of Health
Dr Maria Lawlor - Child Psychiatrist	College of Psychiatrists nomination
Dr Mary O'Hanlon - Adult Psychiatrist	College of Psychiatrists nomination
Professor Harry Kennedy – Psychiatrist (Forensic)	College of Psychiatrists nomination
Professor Agnes Higgins	Professor in Mental Health, Trinity College Dublin
Dr Charles O' Mahony	Head of the School of Law, NUI Galway
Mr Brian O' Malley, Mental Health Nurse (Child/ Adolescent)	Merlin Park, Galway
Mr Padraig O Beirne, Mental Health Nurse (Adult/General)	Cavan Monaghan MHS
Mr David Timmons, Mental Health Nurse (Forensic)	Central Mental Hospital
Mr Tom Maher, Director of Services	St Patrick's Hospital
Mr Paddy Lavin, Mental Health Nurse (Adult)	Roscommon Hospital
Dr Susan Finnerty, Inspector of Mental Health Services	Mental Health Commission
Ms Orla Keane, General Counsel	Mental Health Commission
Service User Representation	From the Service User Group

* Replaced by Róisín Clarke, Interim CEO, Mental Health Reform June 2022.

** Replaced by Tony McCusker, General Manager, HSE Mental Health July 2022.

Appendix C: Organisations that submitted a response to the public consultation survey

Psychological Society of Ireland	Irish Hospital Consultants Association	Association of Occupational Therapists of Ireland
Mental Health Reform	St. Patrick's Hospital	Psychiatric Nurses Association
Irish Association of Social Workers	State Claims Agency	National Advocacy Service
Irish Human Rights and Equality Commission	NDMHS Ashlin Centre	Psychology Department, St. Vincent's Hospital

Appendix D: Organisations that engaged with the consultation on the revision of the Rules and Code of Practice governing the use of seclusion, mechanical restraint and physical restraint in approved centres

Irish Hospital Consultants Association	Psychiatric Nurses Association	Grow Ireland
State Claims Agency	Irish Association of Social Workers	Association of Occupational Therapists Ireland
Ombudsman for Children	Psychological Society of Ireland	Patient Advocacy Service
Youth Advocate Programmes Ireland	Mental Health Nurse Managers Ireland	College of Mental Health Pharmacy
Mental Health Reform	Irish Advocacy Network	Mental Health Ireland
Decision Support Service	National Traveller Mental Health/Exchange House	Cairde
National Advocacy Service for people with Disabilities	Irish Human Rights and Equality Commission	National Disability Authority
College of Psychiatrists	HSE Mental Health Engagement and Recovery Office	HIQA
Department of Health	HSE – National Mental Health	Central Mental Hospital Carers Group

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