FAQ received during the launch of 'Restrictive Practices in Mental Health Settings – Revised Rules' event

When do the new rules commence and what support will be provided to services?

Answer: The date of commencement of these Rules is 1 January 2023, following which, the Inspector of Mental Health Services will begin assessing compliance with the revised Rules. The current rules and code of practice will remain in place until that date. The Inspector of Mental Health Services will be assessing how services implement the revised regulations as part of the inspection and monitoring process. The Inspector will be updating the Judgement Support Framework for 2023 to reflect same and will be communicating with services about this in due course.

The revised rules and code of practice are being published more than three months in advance of the 'go-live' date in order to provide services with time to familiarise themselves with the changes.

Prior to the commencement date, the MHC will provide resources and e-learning training modules covering each category of restrictive practice. These resources will be available to all staff working in approved centres and will be available on the MHC and HSeLanD websites. The training will provide leaners with high level information and instruction on some of the key changes made to the revised rules and code of practice. It is recommended that service providers do not wait until the commencement date to make the required updates to their policies and procedures.

How many approved centres use restrictive practices?

Answer: The use of restrictive practices is declining, and a number of services do not use them for various reasons including lack of access to seclusion facilities, successful elimination policy initiatives and the type of service offered. Restrictive practices, including physical restraint and/or seclusion, were used in 47 services (70%) of inpatient mental health services in 2021, down from 73% in 2020. (Broken down by restrictive practice, seclusion was used in 40% of approved centres in 2021, while physical restraint was used in 70% of services).

What are the requirements for staff training in the new rules?

Answer: Each approved centre that uses seclusion/restraint must implement a policy and have procedures in place for the training of all staff involved in seclusion/restraint. This policy must include the areas to be addressed within the training programme, which includes training in:

- trauma-informed care
- cultural competence
- alternatives to the use of restrictive practices
- human rights including the legal principles of restrictive interventions
- the prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques)
- positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic.

A record of attendance at training must be maintained.

What is required in terms of the reduction policy?

Answer: Every approved centre that uses, or permits the use of, seclusion and/or restraint, must develop and implement a reduction policy which must be published on the Registered Proprietor's website. This policy must:

- clearly document how the approved centre aims to reduce, or where possible eliminate, the use of seclusion and/or restraint within the approved centre;
- address leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice;
- clearly document how the approved centre will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of seclusion and/or restraint within the approved centre.

The Registered Proprietor has overall accountability for the reduction policy. The Registered Proprietor must appoint a named senior manager who is responsible for the approved centre's reduction of seclusion and/or restraint.

As part of the review process, an expert presented to the MHC and the Expert Advisory Group on the WHO Quality Rights training initiative Strategies to end seclusion and restraint: WHO QualityRights Specialized training: course slides).The MHC considers that this resource, alongside other documents such as the MHC's Seclusion and Restraint Reduction Strategy, will prove useful to services when developing and implementing a reduction policy for their approved centre.

Will services be issued with new Registers and Clinical Practice Forms for Seclusion and Physical Restraint when the new guidelines are implemented?

Answer: The Register for Seclusion is included in Appendix 2 in the Rules governing the use of Seclusion. The Clinical Practice Form for Physical Restraint is contained in Appendix 2 of the Code of Practice on the use of Physical Restraint. It is the responsibility of the Registered Proprietor to accurately reproduce these documents and ensure that the mandatory information is recorded in paper or electronic format.

The Register/Clinical Practice Form may be printed from the Rules/Code. The MHC will not be issuing paper versions of the Registers or the revised Rules/Code to services.

Will trauma-informed approaches be included in the revised Rules/Code?

Answer: The revised Rules and Code of Practice stipulate that training for staff who participate in, or may participate in, the use of seclusion and/or restraint must include training in trauma-informed care.

The regulations include an acknowledgement that the use of seclusion and/or restraint may increase the risk of trauma and may trigger symptoms of previous experiences of trauma. For example, the Code of Practice on the use of Physical Restraint states that it should be assumed that any person who is restrained may have a past history of trauma and/or abuse. Therefore, the principles of trauma-informed care should underpin the use of restraint on a person.

As any use of a restrictive intervention may be traumatic for the person who experiences it, the regulations specify that appropriate emotional support must be provided to the person in the aftermath of an episode of seclusion or restraint. Staff must also offer support, if appropriate, to other persons who may have witnessed the restraint or seclusion of the person.

What are the main changes that apply to the use of restrictive practices on children?

Answer: Children are particularly vulnerable to trauma and harm as a result of restrictive interventions. Seclusion and physical restraint can have particularly adverse implications for the emotional development of a child.

In addition, the size and physical vulnerability of children and young people should be taken into account when considering physical restraint. Physical restraint should be used with extreme caution when it involves children and young people because in most cases their musculoskeletal systems are immature which elevates the risk of injury.

Upon admission to an approved centre that uses seclusion/physical restraint as a restrictive intervention on children, a documented risk assessment must be carried out by a registered medical practitioner or registered nurse. This must show that careful consideration has been given to the potential effects of secluding/restraining a child or adolescent, having regard to the physical status

and emotional development of the child, and their particular vulnerability to trauma and harm as a result of restrictive interventions. The outcome of the risk assessment shall determine if seclusion/physical restraint can be safely used or not.

The use of mechanical means of bodily restraint (as it pertains to Part 3 of the Rules) must **never** be used on children. Examples of mechanical restraint include the use of handcuffs.

Does the MHC record the number of staff who have been injured, resulting in the use of a restrictive intervention being used on the person?

Answer: At present, the MHC is not notified of every occasion where a staff member is injured. From 1 January 2023 onwards, every approved centre will be obliged to record whether 'actual harm caused to others' was a reason for the use of seclusion or restraint in the Seclusion/Restraint Register. This will result in better data around the reason for each use of a restrictive intervention and facilitate analysis on any correlations.

In addition, each episode of seclusion/restraint will be reviewed by members of the multidisciplinary team involved in the person's care and treatment. As part of this review, the team will identify the trigger/antecedent events which contributed to the seclusion/restraint episode, and this will inform the person's care and treatment going forward.

It should also be note that the Seclusion/Restraint Register now includes a question which asks whether the person who was secluded/restrained was injured during the course of the episode.

Is it possible that the reduction and elimination of restrictive practices could result in an increased number of injuries to staff?

Answer: As shown by the MHC's evidence review there is increasing evidence to show that the use of restrictive practices does not reduce overall levels of violence and aggression. It has been noted, for example, that in other jurisdictions that have eliminated seclusion, and reduced restraint (physical, mechanical and chemical), contrary to fears, there was no increase in assaults on staff, and in some cases, the number of assaults on staff decreased.

The revised rules emphasise the role of trauma-informed care, positive behaviour support, and the role of data to inform practice in achieving a reduction in violence, among others.

Did the review address how we currently define restrictive practices? For example, many patients are often not permitted to go outside, or they have restricted access to their belongings which may also be considered restrictive practices.

Answer: This review of restrictive practices was limited to the use of seclusion, mechanical restraint and physical restraint in line with the MHC's legal mandate:

- Seclusion: “the placing or leaving of a person in any room, at any time, day or night, such that the person is prevented from leaving the room by any means.”
- Mechanical means of bodily restraint: “the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a person’s body”.
- Physical restraint: “the use of physical force (by one or more persons) for the purpose of preventing the free movement of a person’s body when the person poses an immediate threat of serious harm to self or others”.

However, the MHC acknowledges that restrictive practices may take many other forms. The MHC will continue to focus on this area as part of ongoing inspection and monitoring activities which emphasise the need for a rights-based approach to be adopted by all approved centres. Furthermore, the training which the MHC is rolling out to centres will specifically address the need to adopt a broader view on the wider elimination of restrictive practices in services.

It should also be noted that, from the 1 January 2023 the use of bed rails, cot sides and lap belts, for example, will be subject to the Rules Governing the Use of Mechanical Means of Bodily Restraint for Enduring Risk of Harm to Self or Others.

Do these Rules apply to adults with intellectual disabilities living in units under the care of mental health services?

Answer: The rules and code of practice are applicable to all **inpatient** mental health services in the public, voluntary and independent sectors including services for persons with an intellectual disability and a mental illness, children and adolescents, adults, older persons, and forensic mental health services.

The MHC currently does not have a remit to regulate community residences where people with a dual diagnosis of intellectual disability and mental illness may live. However, the MHC does not consider that community residences are appropriate settings for the use of restrictive practices. Any community residence, which is using, or which may need to use, restrictive practices in the future should contact the MHC with a view to registering the service as an approved centre.

Are so-called “chemical restraints” or over-use of “as prescribed” (PRN) medications addressed in the revised rules?

Answer: While there is no current legal requirement for the MHC to draft rules in this area, the MHC considers the use of 'chemical restraint’ is a restrictive practice. The Mental Health Act 2001-2018 is undergoing substantial revision and the draft Heads of Bill to amend the Act currently includes the introduction of rules to govern the use of “chemical restraint” in inpatient mental health services. Once the 2001 Act has been updated, the MHC will address this area.

What is the position on the use of pelvic positioning belts on wheelchairs?

Answer: The use of pelvic positioning belts is subject to the rules governing the use of mechanical means of bodily restraint on an ongoing basis for enduring risk of harm to self or others. The MHC considers that such restraints may be appropriate in certain situations but must be used only to address an identified clinical need and/or risk.

While the use of pelvic positioning belts (and bed rails, cot sides, etc.) may be considered a restrictive practice, it is important to note that they may also be an important safety measure for some people. Staff must regularly review and assess their use. For further information on the use of mechanical restraint for enduring risk of harm to self or others, please refer to Part 4 of the Rules: Rules Governing the Use of Mechanical Means of Bodily Restraint

Could you elaborate on the specifics of Rule 8.2 in the *Rules Governing the Use of Seclusion:* 'The person who is secluded must have ready access to sanitary facilities and sanitary items (unless there is a clearly documented reason recorded in the Seclusion Care Plan).'?

Answer: Any toileting arrangements for persons in seclusion require a balance between ensuring the safety of the person and maintaining their dignity and physical well-being. Total privacy when accessing toilet and bathing facilities is not always achievable in seclusion. The MHC considers that best practice is for seclusion rooms to have direct access to an en-suite bathroom which contains a toilet, washing facilities and has sanitary items (for example incontinence pads or feminine hygiene products (tampons and pads)). This will also help to ensure that the person does not have to ask to use the toilet or have to request a sanitary item every time this is needed. Where ready access is not provided then there must be a clear and up-to-date risk assessment documenting the reason for same.

If the seclusion room is a single room and includes a toilet, the room should as far as is practicable be arranged or adapted to provide elements of privacy afforded by en-suite arrangements. Where a seclusion room has no toilet facility, persons should be escorted to use toilet facilities that are immediately outside the seclusion room, unless the outcome of a risk assessment finds otherwise.

For further information please contact standards@mhcirl.ie