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Declining use of restrictive practices in approved centres in Ireland in 2023 and 2024

Steps taken by the Mental Health Commission and by service providers to improve quality care through the adoption of a human rights-based approach.

The Office of the Inspector of Mental Health Services at the Mental Health Commission

Thematic Report 2025

INTRODUCTION

The use of restrictive practices (physical restraint and seclusion) (see Glossary) in approved centres in Ireland is declining[1]. In this paper, we present data on the acceleration of this trend following the implementation of revised, human rights-based rules governing the use seclusion and mechanical restraint, and a Code of Practice on the use of physical restraint. These Rules and Code of Practice, developed by the Mental Health Commission (MHC), came into effect on 1 January 2023.[2,3,4] We describe steps taken by the regulator and by approved centres to sustain this welcome trend.

BACKGROUND

The Mental Health Commission (MHC) is the independent statutory regulator of mental health services in Ireland with a duty to promote high standards and good practices in the delivery of inpatient mental health services (approved centres) in Ireland. Registered proprietors of approved centres are obliged to respond to MHC regulations and to any revisions to the Rules and Code of Practice regarding restrictive practices, by taking positive steps to ensure centres are in compliance with them. The Rules and Code of Practice are part of the inspection and monitoring framework and are inspected against at least annually.

This paper describes data on the continuing decline in the use of restrictive practices in approved centres in Ireland and the acceleration of this trend since the revision by the MHC of its Rules and Code of Practice, and the requirement for near-real time reporting of episodes of seclusion and physical restraint to the regulator. The authors describe measures taken by the regulator and the registered proprietors of approved centres to sustain this progress in inpatient mental health services in Ireland.

DATA ON RESTRICTIVE PRACTICE USE IN APPROVED CENTRES IN IRELAND

Seclusion Data in 2023 and 2024

Twenty-seven approved centres reported on their use of seclusion in 2023 and 2024.

The number of people secluded fell from 473 people in 2023, to 434 people secluded in 2024. Comparing these numbers to pre-2023 (the first year where the revised Rules were applicable), 2022 saw 620 people secluded. This equates to a 30% reduction in the number of people secluded in the period 2022 to 2024 (for reference there was a 43% decrease in the period 2018 to 2024).

The total number of seclusion episodes also declined. In 2022, (the final year where the original Rules were still applicable), there were 1,364 episodes of seclusion in approved centres in Ireland. In 2023, there were 895 seclusion episodes, and this fell to 744 seclusion episodes in 2024. This represents a 45% decrease in the number of seclusion episodes since the revised Rules came into effect. The seclusion rate per 100,000 population also declined from a rate of 26.5 per 100,000 population in 2022 to 17.4 in 2023 and to 14.4 in 2024.

The seclusion rate per 1,000 occupied bed days declined by 5% between 2018 and 2022 and by a significant 49% between 2022 and 2024. For the first time, the seclusion rate per 1,000 occupied bed days was less than 1. The MHC is encouraged that services are on a path towards the elimination of seclusion (Table 1).

The profile of persons secluded did not change significantly over the two years 2023 and 2024. Figures for 2024 reveal that males were more likely to be secluded (69.4%) than females (30.6%). The mean (+/- SD) age of those secluded was 36 (+/- 1) for both males and females. Since 1 January 2023, additional information regarding the people who are subject to restrictive practices is required to be included in the notification to the MHC. This information includes the ethnicity of the person, and their legal status.

In 2023 the ethnicity was described as 'White Irish' in 76% of seclusion episodes. This is in line with the profile of the overall inpatient population (the Health Research Board reported that 75% of all inpatients had an ethnicity of 'White Irish').[5]

The majority of those secluded in 2023 and 2024 were involuntarily detained under the Mental Health Acts 2001-2018 (64.4% and 77.7% respectively). Under the Mental Health Acts 2001-2018 it is permissible in Irish law to apply restrictive practices

Table 1: *Use of seclusion in approved centres 2018-2024*

	2018	2019	2020	2021	2022	2023	2024
Seclusion episodes	**1799**	**1719**	**1840**	**1176**	**1364**	**895**	**744**
Reduction since 2018		4%	+2%	35%	24%	50%	59%
Reduction since 2022						34%	45%
Seclusion rate per 100,000 population	**37.8**	**36.1**	**38.65**	**24.7**	**26.5**	**17.4**	**14.4**
Reduction since 2018		4%	+2%	35%	30%	54%	62%
Reduction since 2022						34%	45%
Seclusion rate per 1,000 occupied bed days	**2**	**2**	**2.5**	**1.6**	**1.9**	**1.2**	**0.97**
Reduction since 2018		0%	+25%	20%	5%	40%	52%
Reduction since 2022						37%	49%
Number of people secluded	**760**	**653**	**699**	**645**	**620**	**473**	**434**
Reduction since 2018		14%	8%	15%	18%	38%	43%
Reduction since 2022						24%	30%
Number of approved centres that used seclusion	**27**	**28**	**27**	**27**	**26**	**27**	**27**

to persons who have not been detained under the legislation i.e. voluntary patients.

Table 2: *Legal status of person at initiation of seclusion episode*

Legal status of person at initiation of seclusion episode	2023	2024
Involuntary	64.36%	77.69%
Voluntary	32.52%	21.24%
Section 25	1.23%	0.40%
Ward of Court	1.9%	0.67%

Physical restraint data in 2023 and 2024

Fifty-two approved centres in Ireland used physical restraint in 2023 and 51 did so in 2024.

In 2022 (the final year where the original Code of Practice was still applicable), there were 2,945 episodes of physical restraint involving 1,078 persons. The following year in 2023, there were 2,572 restraint episodes (involving 879 residents). This fell to 2,092 episodes in 2024 (involving 844 residents). Restraint episodes thus fell by 29% between 2022 and 2024. The number of people physically restrained in approved centres in Ireland has fallen by 22% since 2022 and by 30% since 2018. The restraint rate per 100,000 population declined from 57.2 in 2022 to 49.9 in 2023, and to 40.6 in 2024. This demonstrates a fall of 29% in the rate per 100,000 population between 2022 and 2024, and a decrease of 66% since 2018.

The restraint rate per 1,000 occupied bed days has fallen by 57%, from a rate of 6.3 events per 1,000 occupied bed days in 2018 to 2.7 in 2024 (i.e. for every 1,000 days a bed was occupied in 2024, physical restraint was used 2.7 times).

Another feature of the new electronic notification process (see also Appendix 1) was the requirement for services to notify the MHC of the type of physical restraint used on a person. Five types of physical restraint were reported (upright, supine, side, prone and other). Upright restraint fell from 1090 episodes in 2023 to 882 episodes in 2024. Supine restraints fell from 428 episodes in 2023 to 269 episodes in 2024. Side restraints rose from 495 episodes in 2023 to 538 in 2024 and restraints described as 'other' also rose from 149 in 2023 to 209 in 2024.

Prone restraint fell from 411 episodes in 2023 to 194 episodes in 2024. This represents a reduction of 53% between 2023 and 2024. This decrease can be explained in part due to the MHC now having the information to allow it to follow up with services with high rates of prone restraint in real time. Where concerning trends are identified, services may be contacted by the regulator to request assurances about their arrangements for compliance with the Rules and Code of Practice, and this often results in behaviour change. Other regulatory interventions such as unannounced inspections, regulatory notices and requests for meetings are also common. The Code of Practice stipulates: "Use of physical restraint involving the person in the "prone", face down position is only permitted in the most exceptional of circumstances by staff who have received appropriate and specific training in its safe use".

Table 3: *Use of physical restraint in approved centres 2018-2024*

	2018	2019	2020	2021	2022	2023	2024
Restraint episodes	**5665**	**5029**	**3990**	**3460**	**2945**	**2572**	**2092**
Reduction since 2018		11%	30%	39%	48%	55%	63%
Reduction since 2022						13%	29%
Restraint rate per 100,000 population	**119**	**105.6**	**83.8**	**72.7**	**57.2**	**49.9**	**40.6**
Reduction since 2018		11%	30%	39%	52%	58%	66%
Reduction since 2022						13%	29%
Physical restraint rate per 1,000 occupied bed days	**6.3**	**6**	**5.3**	**4.8**	**4**	**3.3**	**2.7**
Reduction since 2018		8%	16%	24%	37%	48%	57%
Reduction since 2022						18%	33%
Number of persons physically restrained	**1207**	**1144**	**1211**	**1145**	**1078**	**879**	**844**
Reduction since 2018		5%	+0.3%	5%	11%	27%	30%
Reduction since 2022						18%	22%
Number of ACs that used PR	**55**	**58**	**48**	**47**	**47**	**52**	**51**

The profile of persons physically restrained did not change significantly in the years 2023 to 2024. Males were slightly more likely to be restrained than females in 2024 (M: F, 53.4%: 46.4%). The mean (+/- SD) age of persons restrained was 40 (+/-) 1 years and the ethnicity of 79.6% of people restrained in 2024 was described as 'White Irish'.

Most individuals restrained in 2024 had been involuntarily detained under the Mental Health Acts 2001-2018 (68.3%). Others restrained included people admitted voluntarily (23.8%), people described as wards of court (2.2%), and children held under Section 25 of the Mental Health Acts 2001-2018 (5.7%). It is encouraging to see the continued decline in the proportion of people with a voluntary legal status who were restrained between 2023 and 2024 (33% and 23.8% respectively)

Table 4: *Legal status of person at initiation of physical restraint episode*

Legal status of person at initiation of the physical restraint episode	2023	2024
Involuntary	56%	68.31%
Voluntary	33%	23.76%
Section 25	7%	5.74%
Ward of Court	4%	2.2%

Since 1 January 2023, an order for physical restraint may be made by a registered medical practitioner or registered nurse for a maximum of 10 minutes, with two renewal orders permitted (equating to a maximum duration of 30 minutes for an episode of physical restraint). Up to and including 2022, an order could be made for a maximum of 30 minutes with one renewal permitted, allowing for a maximum duration of 60 minutes.

Physical restraint duration fell in the years 2023 and 2024. In 2023 and 2024, most episodes (97.4% and 97.9%) of physical restraint were of a duration of ten minutes or less, with over three quarters (75.54% and 80.8% respectively) lasting for five minutes or less. **A notable 89% decrease in the number of physical restraints lasting over 15 minutes was seen between 2022 (271 physical restraints) and 2024 (when 31 physical restraint episodes had a duration of over 15 minutes)**.

The total duration of physical restraints across all approved centres in 2023 of 189 hours and 30 minutes fell to 141 hours and 10 minutes in 2024. In both years, the median duration of physical restraint was three minutes.

Table 5: *Episodes of restrictive practices (seclusion and physical restraint) 2018-2024*

Total Episodes of Restrictive Practices	2018	2019	2020	2021	2022	2023	2024
Episodes	7464	6748	5830	4636	4309	3467	2836
Reduction on previous year		10%	14%	20%	7%	20%	18%
Since 2018		10%	22%	38%	42%	54%	62%
Since 2022						20%	34%

Figure 1: *Episodes of restrictive practices (seclusion and physical restraint) 2018-2024*

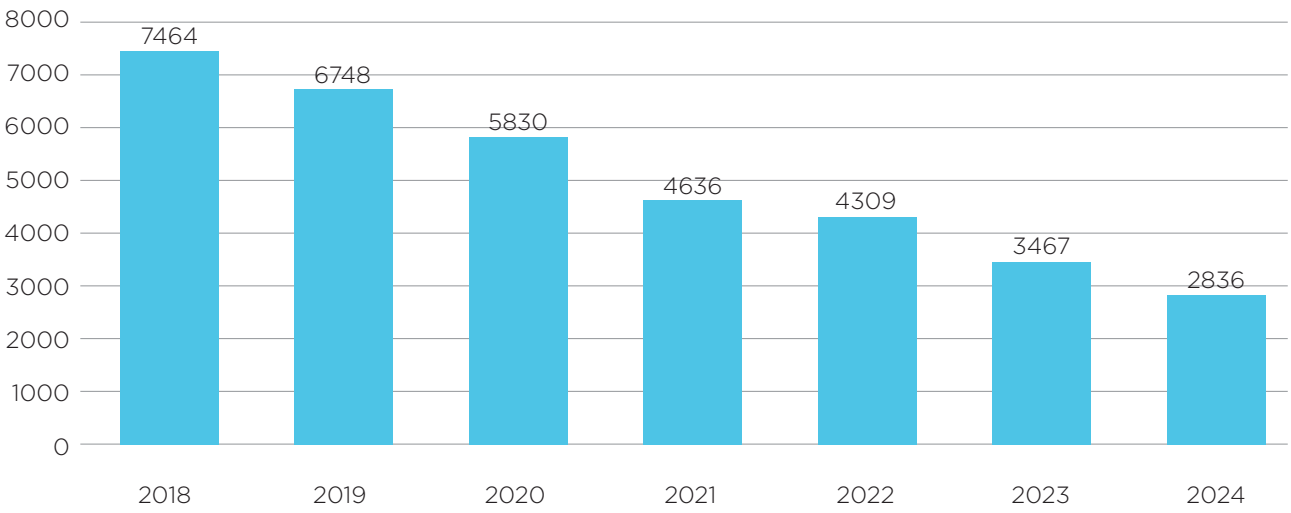


Table 6: *The use of seclusion and physical restraint per 100,000 population*

	2018	2019	2020	2021	2022	2023	2024
Physical restraint rate per 100,000 population	119	105.6	83.8	72.7	57.2	49.9	40.6
Seclusion rate per 100,000 population	37.8	36.1	38.65	24.7	26.5	17.4	14.4
RP rate per 100,000 population	156.8	141.7	122.45	97.4	83.7	67.3	55
Reduction on previous year		10%	14%	20%	14%	20%	18%
Since 2018		10%	22%	38%	47%	57%	65%
Since 2022						20%	34%

Table 7: *Restrictive Practice (Seclusion and Physical Restraint) Rate per 1000 occupied bed days*

	2018	2019	2020	2021	2022	2023	2024
Physical restraint rate per 1,000 occupied bed days	6.3	6	5.3	4.8	4	3.3	2.7
Seclusion rate per 1,000 occupied bed days	2	2	2.5	1.6	1.9	1.2	0.97
Total RP rate per 1,000 occupied bed days	8.3	8.1	7.8	6.5	5.9	4.5	3.7
Reduction since 2018		2%	6%	22%	30%	46%	55%
Reduction since 2022						24%	37%

Mechanical Restraint: Data in 2023 and 2024

The revised Rules effective from 1 January 2023 define mechanical restraint as "the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a person's body".

The Rules differentiate between two types of mechanical restraint. The first type of mechanical restraint ("Part 3 of the Rules") is used in instances where there is an immediate threat of serious harm to self or others and usually involves the use of soft cuffs. The second type of mechanical restraint ("Part 4" of the Rules) is used in instances where there is an enduring risk of harm to self or others. The use of mechanical means of bodily restraint on an ongoing basis for enduring risk of harm to self or others may be appropriate in certain clinical situations but must be used only to address an identified clinical need and/or risk. Examples include the use of cot sides, bed rails, and lap belts.

Note: While the use of bed rails and cot sides 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 the use of bed rails and cot sides. Bed rails and cot sides must not be used where a person is severely confused and mobile enough to climb over them.

Part 3: Use of mechanical restraint for immediate risk of serious harm to self or others

Two approved centres reported on the use of Part 3 mechanical restraint in 2023 but only one approved centre reported on mechanical restraint in 2024.

Six residents were mechanically restrained in 2023 over nine episodes. Five residents were restrained in 2024 over 10 episodes with a median duration of 123 minutes and a range of 25 to 240 minutes. The revised Rules governing the use of Part 3 mechanical restraint introduced a maximum duration of four hours for an order of mechanical restraint for immediate risk of harm to self or others. The circumstances in which all episodes of Part 3 mechanical restraint in 2023 and 2024 were used were described as "for transfer purposes to and from court/hospital" where there was an immediate threat of serious harm to self or others.

Note: The MHC banned the use of mechanical restraint Part 3 on children in the revised Rules effective 1 January 2023.

Part 4: Use of mechanical restraint for enduring risk of harm to self or others

Prior to 1 January 2023, the Rules governing the use of mechanical restraint for enduring risk of harm to self or others stated that the use of cot sides or bed rails shall not be regarded as a use of mechanical means of bodily restraint. However, the revised Rules stipulate that the use of devices such as cot sides, bed rails, and lap belts are restrictive and are considered to be a form of mechanical restraint for enduring risk of harm. Cot sides and bed rails have therefore been subject to the Rules on mechanical restraint since 1 January 2023 and services must report on their use of Part 4 mechanical restraint to the MHC every six months.

Use of restrictive practices on children

The revised Rules and Code of Practice note that 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. These considerations must be taken into account by services in any decision to seclude or restrain a child.

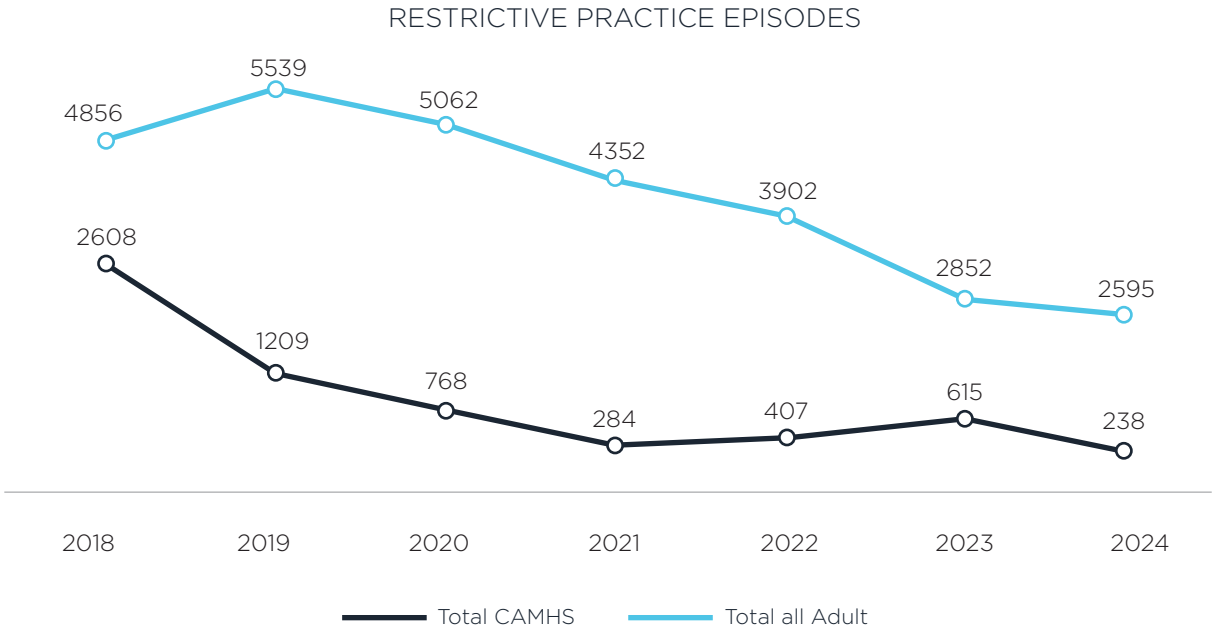
Since 1 January 2023, upon admission to an approved centre that uses seclusion or physical restraint as a restrictive intervention on children, a documented risk assessment must be carried out by a registered medical practitioner or registered nurse for each child. This must show that careful consideration has been given to the potential effects of secluding or 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 determines if seclusion or physical restraint can be safely used or not.

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.

The MHC is encouraged to see a 57% decrease in the number of episodes of physical restraint in child and adolescent (CAMHS) approved centres between 2023 and 2024, and an 80% decrease in the number of seclusion episodes between the same years. This notable reduction is an escalation of a downward trend witnessed since 2018 which has seen **a 91% reduction in the use of seclusion and physical restraint in CAMHS services (from 2,608 episodes in 2018 to 238 in 2024**).

As discussed above, since 1 January 2023, mechanical means of bodily restraint (as it relates to Part 3 of the Rules) must never be used on children. Examples of mechanical restraint include the use of handcuffs. The use of mechanical restraint for enduring risk of harm on children (Part 4 of the Rules e.g. bed rails, lap belts) is still permitted in certain clinical situations to address an identified clinical need and/or risk.

Figure 2: *Number of restrictive practice (seclusion and physical restraint) episodes 2018 to 2024 (Adult v CAMHS).*



Reasons for the use of restrictive practices

Every approved centre is now obliged to record whether 'actual harm caused to self or others', or 'immediate threat of serious harm to self or others' were reasons for the use of seclusion, physical restraint or Part 3 mechanical restraint as part of the notification of the episode to the MHC via the Comprehensive Information System (CIS). The reason for the use of the restrictive practice is also required to be recorded in a Seclusion Register; Register for mechanical restraint for immediate threat of serious harm to self or others; or in a Physical Restraint Clinical Practice Form. The Registers and the Clinical Practice Form include a question asking whether the person who was secluded or restrained was injured during the episode.

The reasons recorded in 2023 and 2024 for the use of restrictive practices (seclusion, Part 3 mechanical restraint and physical restraint) were 'Immediate threat of serious harm to self or others' (77%) and 'Actual Harm to self or others' (22%) (combined average across both years).

DEVELOPMENT OF THE REVISED RULES AND CODE OF PRACTICE AND STEPS TAKEN BY THE MHC TO PROMOTE HUMAN RIGHTS-BASED STANDARDS OF CARE

The MHC established an internal project team to review the Rules and Code of Practice governing the use of restrictive practices in approved centres in Ireland in 2022, using a human rights-based approach. This review was prompted by international developments in the understanding of human rights, advances in person-centred care, and evidence[6] demonstrating harmful physical and psychological consequences of these restrictive practices.

The team also considered an in-depth evidence review commissioned by the MHC and undertaken by the Royal College of Surgeons Ireland (RCSI) following a tender process.[6] This review concluded that there is compelling international evidence to show that seclusion and restraint have no therapeutic value and they are not treatments. Indeed, the evidence review reported that the effect of these types of restrictive practices can be deleterious both physically and psychologically. Their use has been shown to increase the risk of trauma and may trigger symptoms of previous experiences of trauma and should only be used in rare and exceptional circumstances as an emergency measure.

The MHC team established an Expert Advisory Group (EAG) of key stakeholders which included persons with lived experience. The EAG considered the available evidence and provided advice to the MHC on revisions to the Rules and Code of Practice. The MHC also considered the results of an extensive consultation process involving a public consultation survey, focus groups, and interviews with key stakeholders.[7] During the consultation process the MHC team met with people who had experienced seclusion and/or restraint in Irish approved centres. Some of this group reported that their experience of these practices caused them trauma, leading to a subsequent negative impact on their recovery, resulting in damage to the therapeutic relationship due to a 'lack of trust' and 'power imbalance'.

The MHC project team defined a human rights-based approach as one in which the principles of equality, respect and freedom from discrimination are central. Such an approach prioritises the dignity, autonomy and well-being of service users.

The revised Rules and Code of Practice stipulate that approved centres must recognise the inherent rights of a person to personal dignity and freedom in accordance with national and international human rights instruments and legislation. People who are restrained/secluded must be treated with dignity and respect at all times before, during, and after the episode of restraint/seclusion.[2,3,4] The principles of trauma-informed care underpin the revised Rules and Code of Practice.

IMPLEMENTATION OF THE REVISED RULES AND CODE

The MHC developed training resources and e-learning modules covering each category of restrictive practice and made these available to all staff working in approved centres via the HSELanD website. This training provides information and instructions on the key changes to the revised Rules and Code of Practice.

The MHC also compiled Frequently Asked Questions (FAQ) documents which were circulated to all approved centres, as were the detailed changes made to each Rule and Code of Practice.

The MHC updated its Comprehensive Information System (CIS) to assist approved centres with their reporting. The updated CIS enables the MHC's regulatory team to monitor the use of restrictive practices in a timely manner and respond accordingly. Since 1 January 2023, approved centres use the CIS to report each episode of seclusion or restraint to the MHC within three working days of the commencement of each episode. Since this data is collected in near real-time the quality of data and the accuracy of reporting has improved. More data is supplied with each notification on CIS, than would have been supplied annually in aggregate form per approved centre prior to 2023. The CIS allows for the improved reporting on people who might otherwise appear in more than one data set.

In summary, in 2023 the MHC revised its Rules and Code of Practice around restrictive interventions and launched these revised Rules and Code of Practice following extensive stakeholder consultation, scholarly review of national and international best practice, the implementation of an improved CIS and the development of training modules which demonstrated the changes to the Rules and Code of Practice.

RESPONSE OF APPROVED CENTRES TO THE REVISED MHC RULES AND CODE OF PRACTICE

Approved centres in Ireland adapted to these revisions by making changes in policy and practice to reduce or, where possible, eliminate restrictive practices.

Reduction policy

Approved centres have developed and implemented a reduction policy which addresses leadership, the use of data to inform practice, the use of specific reduction tools, the development of the workforce, and how the approved centre will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of restrictive practices in the service. Positive behavioural supports include the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic. The approved centre's reduction policy also addresses the use of post incident reviews to inform practice. Services are guided by the MHC's Seclusion and Restraint Reduction Strategy (due to be revised in 2026).

Annual Report

The new Rules and Code of Practice are matters which are inspected by the Inspector of Mental Health Service in Ireland, in accordance with the Mental Health Acts 2001 –2018.

Since 2023, approved centres publish non-identifiable aggregate data annually on their use of seclusion, mechanical restraint and physical restraint on the registered proprietor's website within six months of the end of the calendar year.

Along with data on the number of restrictive practices episodes, and the number of people subjected to seclusion, mechanical restraint, and physical restraint, the annual report contains a statement about the effectiveness of the approved centre's actions to reduce and, where possible, eliminate each restrictive practice. Approved centres also report on their compliance with each Rule and Code of Practice, as per the MHC's inspection findings.

Post incident reviews

Three distinct categories of post-incident review have been adopted to inform on-going clinical practice.

Firstly, a debrief with the person who was secluded or restrained takes place following every episode of seclusion or restraint (excluding Part 4 mechanical restraint). This debrief is person-centred and gives the person the opportunity to discuss the seclusion or restraint with members of the multidisciplinary team involved in their care and treatment as part of a structured debrief process.

This in-person review occurs within two working days of the episode (unless it is the preference of the person who was secluded/restrained to have the debrief outside of this timeframe). The debrief includes a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future. The person's individual care plan is updated to reflect the outcome of the debrief, and in particular, the person's preferences in relation to restrictive interventions going forward.

Secondly, within five working days, the episode of seclusion or restraint is reviewed by members of the multidisciplinary team involved in the person's care and treatment. As part of this review, the team identifies any trigger/antecedent events contributing to the seclusion or restraint episode; reviews any missed opportunities for earlier intervention in line with the principles of positive behaviour support; assesses factors in the physical environment that may have contributed to the use of seclusion/restraint; and identifies alternative de-escalation strategies to be used in future. The outcome of the person-centred debrief, if available,

is also considered at the multidisciplinary team review. The review is documented and records the actions decided upon and follow-up plans to eliminate or reduce restrictive interventions for the person.

Thirdly, each approved centre is required to establish a multidisciplinary review and oversight committee to analyse in detail every episode of seclusion or restraint. This committee meets at least quarterly to determine compliance with the Rules or Code of Practice for each episode of seclusion or restraint and provides assurance to the Registered Proprietor Nominee that each use of seclusion or restraint is in accordance with the MHC's Rules or Code of Practice. The committee identifies and documents any areas for improvement and details the timeframe for the completion of actions. A report is produced following each meeting of the review and oversight committee and is made available to staff who participate, or may participate, in seclusion or restraint, to promote on-going learning and awareness. The MHC may also request sight out this report as part of its inspection or regulatory processes.

Training

Since the revised Rules and Code of Practice have come into effect, approved centres have worked to ensure that all staff who participate, or may participate, in the use of seclusion or restraint receive the appropriate training, which includes training in human rights and in related policies and procedures. Key areas addressed within the training programme include mandatory (since 2023) training in trauma-informed care, in cultural competence, and in alternatives to the use of restrictive practices. This training is intended to expand the understanding of human rights to include the legal principles of restrictive interventions, the prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques), and positive behaviour supports as required.

Staff training reveals how the use of seclusion and/or restraint may in some incidences trigger symptoms of previous experiences of trauma. Staff are trained to assume that any person who is subject to a restrictive practice may have a history of trauma and/or abuse. Appropriate emotional support is provided by staff to people who are secluded or restrained in the aftermath of an episode of seclusion or restraint. Staff also now offer support, if appropriate, to other persons who may have witnessed the restraint or seclusion of a person.

A record of attendance at training is maintained in the approved centre.

DISCUSSION

The downward trend in the use of restrictive practices, already noted in approved centres in Ireland (see Figure 1), accelerated in 2023 and 2024. Progress in human rights based clinical practices continued following the introduction of the revised Rules and Code of Practice and after the implementation of a timely notification system. Far from slowing down, the momentum of change towards a less restrictive form of care in approved centres has increased.

The MHC welcomes these positive results. The frequency of episodes of restrictive interventions and the number of people subjected to restriction has declined in Ireland every year since 2018. There are several reasons to conclude that the level of restrictive practice use has fallen since 2018 (1) including the fact that the first prosecution under the Mental Health Acts 2001-2018 occurred in early 2019 on foot of an inspection in 2018. The registered proprietor was convicted of failing to ensure adherence to the rules governing the use of seclusion and mechanical means of bodily restraint.

In total, there were 2,836 episodes of restrictive practices in 2024. This demonstrates a 34% reduction since 2022 (the last year that approved centres were inspected on the old Rules and Code of Practice) and a 62% reduction since 2018 (see **Table 5**). The restrictive practice (seclusion and physical restraint) rate per 100,000 population declined by 65% between 2018 and 2024 (see **Table 6**). The restrictive practice (seclusion and physical restraint) rate per 1,000 occupied bed days declined by 55% between 2018 (8.3 events per 1,000 occupied bed days) and 2024 (3.7) (see **Table 7**). The publication of rates per 1,000 occupied bed days will allow the MHC to make international comparisons on the prevalence of restrictive practices and it intends to conduct this analysis in the near future.'

There is increasing evidence that restrictive practices are counterproductive.[6] They do not reduce overall levels of violence and aggression in approved centres[9].

The MHC published previously on the declining use of restrictive practices in approved centres in Ireland over the period from 2018 to 2022.[1] These earlier data were collected before the revised Rules and Code of Practice came into force and before the requirement to notify the MHC of the use of restrictive practices in the CIS system within three working days. The current data collected in near-real-time circumstances confirms and extends these earlier findings and this is encouraging. For example:

- The rate of fall in seclusion episodes in 2023 and 2024 is almost twice that seen in the preceding four years. Between 2018 and 2022, the number of seclusion episodes decreased by 24% (1,799 v 1,364). Between 2022 and 2024, the number of seclusion episodes decreased by 45% (1,364 v 744) (see **Table 1**).
- The rate of reduction in the number of people physically restrained is twice that seen in the preceding four years. Between 2018 and 2022, the number of people who were physically restrained decreased by 11% (1,207 v 1,078). Between 2022 and 2024, the number of people physically restrained fell by 22% (1,078 v 844) (see **Table 3**).

The revised Rules and Code of Practice are applicable to all approved mental health centres in the public, voluntary and independent sectors including centres admitting persons with an intellectual disability and a mental illness, children and adolescents, adults, older persons, and people using forensic mental health services.

These revisions set stricter criteria and require greater oversight by registered proprietors regarding the use of restrictive practices within their approved centres. Experience with the CIS points to the value of contemporaneous data to inform practice development and human rights-based care. It has also enabled the MHC to conduct risk rating, trend analysis and request for assurances / focused inspections if necessary.

Reduced use of restrictive practices requires the successful introduction of policy initiatives in approved centres and reform of services offered to acutely distressed patients. The results presented here could not have been achieved without the enthusiastic participation of the leadership and staff in approved centres in Ireland. These staff are to be commended for their work. The MHC also acknowledges the work of the HSE at regional and national levels to reduce restrictive practices through training, education and other HSE initiatives. The burden of a transition of this scale is great. The investment in time needed to sustain these reforms is considerable, but the value of their achievement is substantial. Progress towards a human rights-based standard of care is worth striving for.

For the MHC setting standards and monitoring compliance is only the start. The delivery of high-quality care consistent with these standards is to the credit of all those at the care face. It is the MHC's hope that this human rights approach will be applied more broadly to include all areas of care where human rights may be compromised in mental healthcare and to other restrictive practices which are not yet governed by Rules and Codes of Practice.

CONCLUSIONS

The use of restraint and seclusion in approved centres in Ireland continues to fall. The rate of this decline has increased since the introduction of the revised Rules and Code of Practice and following the implementation of timely means of reporting to the MHC. The MHC welcomes this trend as a tangible indicator of progress in human rights-based mental healthcare.

The MHC's function 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 take steps to protect the interests of persons detained under the Mental Health Acts 2001-2018. This paper is an acknowledgement of the positive contribution of clinical staff and service leaders to this progress in approved centres. The essential factor required for the achievement of our shared goals is the full cooperation of the service providers and staff in the approved centres.

Credit for progress regarding restrictive practices must therefore be shared. Reductions year-on-year in the use of restrictive practices in approved centres are matters to celebrate. Many people deserve credit for this achievement, not only those within the MHC who are setting standards, but also those in the approved centres who are rising to them. All deserve commendation and positive regard.

The MHC acknowledges that restrictive practices take many forms, other than those which are covered by the Rules and Code of Practice addressed in this paper. The MHC considers the use of 'pharmacological restraint', (the use of medication, which is prescribed and administered for the specific and exclusive purpose of controlling or subduing acute or episodic aggressive, disturbed, or violent behaviour) to be a restrictive practice. The much-anticipated new Mental Health Act will, it is hoped, include rules to govern the use of 'pharmacological restraint' in inpatient mental health services. The MHC looks forward to consulting on ways to address this area in the not-too-distant future.

The MHC remains focused on standards of care as part of its ongoing inspection and monitoring activities. We will continue to emphasise the benefits of a human rights-based approach to care and continue to highlight the need to work together towards the reduction and, where possible, elimination of restrictive practices in mental health services.

The data presented here represent an achievement many thought impossible. Success has many parents, but failure, as they say, is an orphan. Leadership, education and training have all played a role in promoting human rights-based standards of care. Many people contributed to this positive story and so this report is intended to recognise and celebrate their good work.

The MHC wishes to congratulate all who have contributed so meaningfully. We highlight these data out of respect for all those delivering our mental health services and regard for those using them. Respect for the service and the service user is at our core.

APPENDIX 1: KEY CHANGES TO THE RULES AND CODE OF PRACTICE EFFECTIVE 1 JANUARY 2023

New initiatives (applicable to all types of regulated restrictive practices):

- Notification of each episode of seclusion/physical restraint/Part 3 mechanical restraint within three working days of the commencement of the episode.
  - For the first time, the notification records the ethnicity of the person; reason for the use of the restrictive practice; role of the person who initiated the restrictive practice; the legal status of the person secluded/restrained, and, in the case of physical restraint, the notification records the type of restraint used (prone/supine/side/upright/other).
- The introduction of the requirement for a reduction policy for each approved centre.
- The establishment of a Multidisciplinary Review and Oversight Committee to meet at least quarterly to analyse each episode of seclusion and restraint.
- Mandatory staff training in trauma-informed care; cultural competence; human rights including the legal principles of restrictive practices; training in the prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques); positive behaviour support.
- Children (applicable to seclusion and physical restraint): a documented risk assessment should be carried out by a registered nurse or a registered medical practitioner. This should show that careful consideration has been given to the potential effects of restraining/secluding 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 practices. The outcome of the risk assessment should determine if seclusion/physical restraint can be safely used or not.

The Rules and Code of Practice are more prescriptive on the following:

- Specify the details of what ought to be covered in the debrief with the person and in the MDT review.
- Specify what each approved centre's annual report must contain information on.

Seclusion

- The duration of a seclusion order has changed from a maximum of 8 hours to 4 hours.
- Introduction of a seclusion care plan for each person secluded (see glossary).
- Seclusion can now only be initiated by a registered medical practitioner and/or the most senior registered nurse on duty in the unit/ward (previously a registered medical practitioner or any nurse).
- Where seclusion is initiated by a registered nurse, a registered medical practitioner must be notified of the seclusion episode as soon as is practicable, and no later than 30 minutes following the commencement of the episode.

Physical restraint

- Can only be initiated and ordered by registered medical practitioners and registered nurses (previously any MDT member).
- Order changed from a maximum of 30 minutes (could be renewed once up to a maximum of 60 minutes continuous restraint) to 10 minutes (two renewal orders permitted up to a maximum continuous duration of 30 minutes).
- Additional safety measures included such as the requirement to conduct and record observations, including vital clinical indicators such as the monitoring of pulse, respiration and complexion (with special attention for pallor/discolouration); and a requirement to monitor the person's physical and psychological health for as long as clinically necessary after using physical restraint.

Mechanical restraint for immediate risk of serious harm to self or others (Part 3)

- Can now only be initiated and ordered by a consultant psychiatrist (previously any registered medical practitioner or registered nurse).
- Each order is for a maximum of four hours. A medical examination by a registered medical practitioner is required before a renewal order can be made (previously an order had no maximum limit).
- Where mechanical restraint is used on a person for a period beyond 24 hours, it must be subject to an independent review by a consultant psychiatrist who is not directly involved in the person's care and treatment (prior to 1 January 2023, this independent review was undertaken after mechanical restraint had been in use for a period of one month).
- Additional safety measures included such as the requirement for a registered nurse to monitor and record the following every fifteen minutes for the duration of the period of mechanical restraint: respiratory status/rate; pressure areas/tissue viability check; colour/movement/sensation of restricted limb (list is not exhaustive).
- Since 1 January 2023, children must never be subjected to Part 3 mechanical restraint.

Part 4: Use of mechanical restraint for enduring risk of harm to self or others

- The use of mechanical restraint on an ongoing basis for enduring risk of harm to self or others may be appropriate in certain clinical situations but must be used only to address an identified clinical need and/or risk. Examples include the use of cot sides, bed rails, and lap belts. While the use of bed rails and cot sides 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 the use of bed rails and cot sides. Bed rails and cot sides must not be used where a person is severely confused and mobile enough to climb over them (prior to 1 January 2023, bed rails and cot sides were not considered a mechanical restraint).

GLOSSARY

The definitions of the restrictive practices of seclusion, mechanical restraint and physical restraint, as defined by the MHC in its revised Rules governing the use of seclusion and mechanical restraint, and Code of Practice on the use of physical restraint, are as follows:

Seclusion

Seclusion is defined in the revised Rules Governing the Use of Seclusion as "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".[4] Each episode of seclusion must be notified on CIS within three working days of its commencement, including the start date and time and the end date and time. Seclusion may only be used when there is an immediate threat of serious harm to self or to others.

Key changes made to the Rules on seclusion, effective 1 January 2023 (refer to Appendix 1 for a complete list), include changing the duration of an order (a seclusion order can be made for up to four hours - prior to 2023 an order was up to eight hours), and the introduction of a requirement for a Seclusion Care Plan for the person to be developed by a registered nurse.

A Seclusion Care Plan must include as a minimum:

- Personal details.
- Known clinical needs (including mental and physical considerations).
- How de-escalation strategies will continue to be used.
- The person's preferences in relation to seclusion, where known (e.g. access to music or reading material while in the seclusion room), and take into account outcomes of any previous debrief with the person, if applicable.
- Recognising signs where the person's behaviour is no longer deemed an unmanageable risk towards themselves or others, e.g. evidence of tension reduction, improved communication etc.
- How potential risks may be managed.
- Reference to specific support plans for the person and details of how the person's mental health needs will continue to be met while in seclusion.
- Meeting of food/fluid needs.
- Meeting of needs in relation to personal hygiene/dressing.
- Meeting of elimination needs (with specific reference to how privacy and dignity will be managed).
- Medication reviews (in consultation with a registered medical practitioner);
- Monitoring of physical observations; and
- A strategy for ending seclusion; indicating the criteria required for this to be reached.

Physical Restraint

Physical restraint is defined in the revised Code of Practice on the Use of Physical Restraint as "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".[3] Each restraint episode must be reported to the MHC on CIS including the start date and time and end date and time, within three working days of the commencement of the episode. Five types of physical restraint are reported (upright, supine, side, prone and other).

The revised Code of Practice states that "An order for physical restraint shall last for a maximum of 10 minutes" and that "An episode of physical restraint may be extended by a renewal order made by a registered medical practitioner or the most senior registered nurse on duty in the unit/ward following a medical examination or nursing review, for a further period not exceeding 10 minutes – to a maximum of two renewals of continuous restraint. The continuous period of physical restraint should never be longer than 30 minutes. Previously an order was for up to 30 minutes with a maximum period of continuous physical restraint being 60 minutes.

A full list of the substantive changes made to the Code of Practice can be found in Appendix 1.

Mechanical Restraint

Mechanical means of bodily restraint is defined in the revised Rules[2] as "the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a patient's body" in circumstances of 'immediate threat of serious harm to self or others (Part 3).

Each episode of mechanical restraint Part 3 must be reported to the MHC using the CIS including the start date and time and the end date and time, within three working days of the commencement of the episode. The use of mechanical restraint for enduring risk of harm to self and others (Part 4 of the Rules) must be reported to the MHC, including type of restraint used (lap belt, buxton chair, bed rail, other) six monthly.

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