Submission to the Mental Health Commission on the Development of the Code of Practice on the use of **Pharmacological Restraint**

April 2026

Mental Health Reform

Introduction

This submission is made to the Mental Health Commission as part of the consultation on the development of the Code of Practice on the Use of Pharmacological Restraint, arising from the provisions of the forthcoming Mental Health Bill 2024. We welcome the opportunity to contribute to this important process and to support the establishment of a robust, rights-based framework governing the use of pharmacological restraint within mental health services in Ireland.

Pharmacological restraint has been a central focus of advocacy by Mental Health Reform (MHR). Through sustained and strategic engagement with policymakers, alongside the voices of people with lived experience, clinicians, and human rights bodies, MHR explicitly advocated for the legislative regulation of this practice and successfully secured its inclusion in the new Mental Health Bill 2024. This legislative recognition represents a significant milestone in advancing a more transparent, accountable, and humane mental health system, reflecting a growing consensus that restrictive practices must be clearly defined, rigorously monitored, and progressively reduced with the ultimate aim of their elimination.

This submission advocates for a Code of Practice that is firmly grounded in a human rights–based, person-centred, and trauma-informed approach. The Code should emphasise that pharmacological restraint is an exceptional measure, to be used only as a last resort when there is an immediate and serious risk of harm, and always in the least restrictive and most proportionate manner. Furthermore, it should embed strong safeguards, transparency, accountability, and mechanisms for oversight, learning, and continuous reduction.

We also emphasise the importance of cultural change within mental health services. While regulation provides essential standards, meaningful reform depends on fostering therapeutic environments that prioritise collaboration, respect, and the use of non-coercive alternatives.

The voices and experiences of people who have been subject to restrictive practices must remain central to the development, implementation, and ongoing review of the Code. Ultimately, this submission seeks to support the Mental Health Commission in developing a Code of Practice that not only regulates the use of pharmacological restraint but also contributes to a broader vision of a modern, rights-respecting mental health system in Ireland.

1. What principles should guide the code of practice on the use of pharmacological restraint?

The code should be explicitly grounded in a human rights based, reduction-and-elimination approach and include consideration of the following key principles:

- Human rights and dignity: Pharmacological restraint must be framed as an exceptional derogation from the person's rights, never as routine care. The person's dignity, bodily integrity, privacy, and autonomy must be central in every decision and review.
- Safety: The safety of the person must be the primary consideration at every stage before, during, and after any use of pharmacological restraint. This includes physical safety, psychological safety, and the prevention of avoidable harm. Safety must not be interpreted narrowly as "risk management"; it must include the person's subjective experience of safety, their trauma history, and their right to be protected from coercion, intimidation, or degrading treatment.
- Last resort and least restrictive: It should only be used when there is an immediate and serious risk of harm, when all other deescalation and non-restrictive options have been tried or are clearly inappropriate, and when it is the least restrictive option available in that moment.
- Proportionality and necessity: The dose, route, and choice of medication must be strictly proportionate, not used for staff convenience, behavioural control, or punishment.
- Time limited and closely monitored: Pharmacological restraint should be for the shortest possible duration, with clear criteria for when its effect is considered to have ended and when a full review must occur.
- Person-centred and trauma-informed: The person's history, preferences, trauma, culture, and communication needs must be considered. The code should explicitly require trauma-informed practice and recognition that restrictive practices can be retraumatising.
- Accountability and governance: Strong governance, mandatory reporting, data collection, and regular audit should be required.
- Reduction and eventual elimination: The code should explicitly align with the broader goal of reducing and, where possible, eliminating restrictive practices over time.
- Informed Consent: The Code should require that informed consent is sought wherever the person has the capacity to give it, even in crisis situations. Where

capacity is impaired, staff must still make every effort to explain what is happening, why, and what alternatives exist. The person's advance directives, stated preferences, and crisis plans must be central to decision-making. Consent must not be seen as a one-off event but an ongoing process of communication, respect, and partnership.

- Transparency: Transparency is essential for accountability and trust. The Code should require clear documentation of the rationale for any use of pharmacological restraint, the alternatives attempted, the medication used, and the monitoring undertaken. Transparency must also include open communication with the person themselves (and where appropriate their families, nominated persons or supporters), including during the event and a meaningful debrief afterwards, as well as transparent reporting at service and system levels to support oversight, learning, and reduction.

2. How can the code of practice ensure that the human rights of the person are upheld prior to, during, and after the use of the restraint?

Before pharmacological restraint

- Rights based assessment and justification:
    - Clear threshold: The MHC Code of Practice must outline a clear threshold for pharmacological restraint.
    - Informed discussion where possible: If the person has capacity in that moment, there should be an attempt to explain the situation, seek cooperation, and obtain informed consent.
    - Advance statements and preferences: The code should require staff to check any advance directives, crisis plans, or stated preferences about medications and restrictive practices.
- Exhaustion of alternatives:
    - Deescalation first: Mandate the use and documentation of deescalation, environmental changes, sensory supports, peer support, and other non-restrictive interventions.
    - Multidisciplinary input: Where time allows, decisions should be made by more than one clinician.

During pharmacological restraint

- Respect for individual:

- Explain what is happening: Even if the person is highly distressed, staff should continue to explain what they are doing, why, and for how long they expect the effects to last.
- Language and tone: Require trauma informed (calm, nonthreatening, nonjudgemental communication) and explicitly prohibit the use of derogatory, stigmatising or threatening language.
- Privacy: Administer medication in as private a setting as safely possible, with attention to exposure, gender preferences, and cultural differences.

- Monitoring and safety:
  - Side effects: Vital signs and side effects must be monitored at defined intervals, with clear escalation criteria.
  - Staffing levels and competence: Only staff with appropriate training and competence in emergency psychopharmacology and physical health monitoring should be allowed to authorise and administer pharmacological restraint.

After pharmacological restraint

- Debrief with the person:
  - Rights based debrief and support: Where possible, if the person is willing to engage after the event, there should be a structured debrief that explores their experience, perceived harms, and what could be done differently next time.
  - Validation of Impact: Acknowledge the impact, validate distress, and, where warranted, apologise for the need to use restraint.
- Documentation, Review and learning:
  - Review: Clear documentation of the incident should occur, including medication choice, dose, and alternatives. A timely multidisciplinary review should also occur. The review should also consider whether the person's rights were restricted more than necessary, whether any follow-up is needed and what could be done better if the circumstances were to arise again (with a strong focus on the wishes of the individual).
  - Service level learning: Aggregate data should be used to identify patterns (e.g., particular wards, times, groups) and drive reduction strategies.
- Family/supporter involvement (with consent):

- Where appropriate and with the person's consent, families or nominated supporters should be informed and, where possible, involved in post-incident review/planning.

3. **What experience should staff be required to have, and what training should they undertake in order to apply pharmacological restraint?**

- Baseline professional competence:
  - Only registered medical practitioners with demonstrable experience in psychopharmacology should authorise pharmacological restraint.
- Additional training content:
  - Human rights and legal framework: understanding of relevant legislation, regulatory standards, and best practice guidance governing restrictive practices, with a strong emphasis on proportionality, necessity, and the least restrictive alternative.
  - Trauma-informed and person-centred care: understanding trauma, power dynamics, and the psychological impact of coercion, as well as building skills for collaborative safety planning, relationship-based practice and non-coercive engagement.
  - Crisis intervention, including deescalation and alternatives to restraint: understanding of verbal and nonverbal deescalation techniques, training in environmental and sensory strategies, and use of peer support. Emphasis on recognising early warning signs and intervening before crisis escalation.
  - Psychopharmacology and physical health: training on side-effect profiles of medications used in emergencies to ensure recognition and management of adverse events. Training on the risks of over-sedation, potential interactions with other medications and risks of polypharmacy.
  - Cultural competence and communication: training in awareness of how cultural background and language barriers influence expressions of distress, help seeking, and responses to sedation, as well as skills in adapting communication styles to these circumstances.
  - Training on working with those with additional disability (such as intellectual disability or neurodiversity) or other disabilities that may affect communication, behaviour, or sensory processing. It should be noted that those with intellectual disability are particularly vulnerable to chemical

restraint and polypharmacy and this should be recognised and mitigated against.

- Training on dual diagnosis and substance use: training to understand how addiction, withdrawal, and substance interactions influence crisis presentation and medication safety. Training on strategies for safe and appropriate intervention in the context of dual diagnosis.
    - Incident review and reflective practice: training on how to conduct debriefs with staffs and those who experienced the restrictive practice, how to document incidents, and how to participate in service level learning, quality improvement and reduction of restrictive practices.

- Ongoing requirements: regular refresher training to maintain competence and keep aware of evolving best practice. Access to supervision and mentoring that explicitly addresses use of restrictive practices, with an emphasis on rights-based care, trauma-informed practice and reflective learning.

4. In your view, in which circumstances, if any, should pharmacological restraint never be used in an emergency?

The code should clearly prohibit pharmacological restraint in certain situations, even in emergencies, and require alternative responses. Examples are outlined below:

- For staff convenience or service pressures: never to compensate for understaffing, poor environment, or lack of therapeutic engagement.
- As punishment or behavioural control: never as a response to perceived "noncompliance", verbal aggression alone, or behaviour that is merely disruptive rather than posing an immediate risk of serious harm.
- Where there is a clear medical contraindication: never where there is a known allergy, high risk of life-threatening interaction, or physical health status that makes the risk disproportionate (e.g., severe respiratory compromise, certain cardiac conditions), unless a senior clinician explicitly documents why the benefit outweighs the risk and what additional safeguards are in place.
- As a substitute for appropriate medical care: not instead of urgent medical assessment (e.g., delirium, hypoglycaemia, head injury, intoxication) where the primary issue is physical, not psychiatric.
- For children and for adults who are deemed to lack capacity, the threshold should be even higher and more closely monitored. It should be used never simply to in

place of meaningful engagement or to manage distress or behaviour that could be addressed by specialist, non-restrictive approaches.

- If a person has a valid AHD refusing specific medications, these should not be used.

5. What safeguards should the code of practice contain to ensure the safety of the person during and after the restraint?

Baseline safeguarding: Assessment for pre-existing medical conditions

- All individuals' medical histories must be thoroughly reviewed prior to administration:
    - Identify pre-existing conditions: cardiovascular, respiratory, neurological, metabolic, or hepatic disorders.
    - Review current medications: to avoid potentially dangerous drug interactions.
    - Assess risk factors: including older age, frailty, or respiratory compromise, which may increase the likelihood of adverse reactions.

- Safety must be prioritised through comprehensive assessment for patients with pre-existing medical conditions
    - Dose adjustments, selection of short-acting agents, and multidisciplinary input are recommended to minimise the risk of adverse effects such as hypotension, respiratory depression, or cardiac complications.
    - Continuous monitoring of vital signs during and after administration, along with detailed documentation of the rationale, drug, dose, and patient response, ensures both clinical safety and accountability.

The code should have safeguards at every level, including:

- Individual level safeguards:
    - Clear authorisation process including the named responsible clinician, time-limited order, explicit documentation of incident, alternatives tried, and expected duration.
    - Standardised observation protocol for physical health monitoring and for potential side-effects, with mandatory escalation triggers and access to emergency medical support.
    - Safe environment (to mitigate risk of falls, aspiration, pressure injury)

- Post-incident review of the person's regular medication to avoid cumulative sedation or polypharmacy risks.

- Team level safeguards:
  - Multidisciplinary review of each incident within a defined timeframe (e.g., 24-72 hours), including the person's own account where possible.
  - Structured debrief for to address clinical, ethical, and emotional aspects, with a focus on learning and reduction.

- Organisational level safeguards:
  - Standardised incident forms, including demographic data, diagnosis, context, and alternatives attempted, as well as regular reporting to senior management and the MHC.
  - Routine audits of frequency, patterns, and outcomes; feedback to teams; action plans where use is high or increasing.
  - Involvement of people with lived experience in reviewing policies, training content, and aggregate data.

6. Please indicate any policy documents/evidence/initiatives we should consider when developing the Code of Practice and/or key individuals/organisations the MHC could engage with during this consultation.

- **Key Documents:**

Below is a list of key documents and initiatives that have informed this submission and warrant further consideration by the Mental Health Commission as part of this consultation process.

Human Rights Instruments including the CRPD and ECHR case law:

- Council of Europe (1950) *European Convention on Human Rights*. Strasbourg: Council of Europe. Available at: https://www.echr.coe.int/documents/convention_eng.pdf (Accessed: 3 April 2026).
- Council of Europe (2025) Report to the Irish Government on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 21 to 31 May 2024. Available at: https://rm.coe.int/1680b6c60a (Accessed 26 March 2026)
- Council of Europe (2020) Report to the Irish Government on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman

or Degrading Treatment or Punishment (CPT) from 23 September to 4 October 2019. Available at: https://rm.coe.int/1680a078cf (Accessed 26 March 2026)

- United Nations (2006) *Convention on the Rights of Persons with Disabilities*. New York: United Nations. Available at: https://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf (Accessed: 3 April 2026).
- United Nations (1991) *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*. New York: United Nations. Available at: https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-protection-persons-mental-illness-and-improvement (Accessed: 3 April 2026).
- CRPD and ECHR case law

International Policy, Research and Clinical Guidance

- Cusack, P., Cusack, F.P., McAndrew, S., McKeown, M. and Duxbury, J., 2018. An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings. *International journal of mental health nursing*, *27*(3), pp.1162-1176. Available at: https://doi.org/10.1111/inm.12432 (Accessed: 3 April 2026).
- de Bruijn, W., Daams, J.G., van Hunnik, F.J., Arends, A.J., Boelens, A.M., Bosnak, E.M., Meerveld, J., Roelands, B., van Munster, B.C., Verwey, B. and Figee, M., 2020. Physical and pharmacological restraints in hospital care: protocol for a systematic review. *Frontiers in psychiatry*, *10*, p.921. Available at: https://doi.org/10.3389/fpsyt.2019.00921 (Accessed: 3 April 2026).
- Dickinson, T. and Clark, L.L., 2020. Rapid tranquillisation: an issue for all nurses in acute care settings. *British journal of nursing*, *29*(15), pp.880-883. Available at: https://doi.org/10.12968/bjon.2020.29.15.880 (Accessed: 3 April 2026)
- Hupé, C., Larue, C. and Contandriopoulos, D., 2024. Defining chemical restraint: a preliminary step towards measurement and quality assessment. Aggression and Violent Behavior, 77, p.101926. Available at: https://doi.org/10.1016/j.avb.2024.101926 (Accessed: 3 April 2026).
- Morrison, E., Henderson, C., & McKenna, B. (2014) 'Rapid tranquillisation in mental health settings: safety and clinical considerations', *Journal of Psychiatric and Mental Health Nursing*, 21(9), pp. 805–816. doi:10.1111/jpm.12129. (Accessed: 3 April 2026).
- Muir-Cochrane, E., Grimmer, K., Gerace, A., Bastiampillai, T. and Oster, C., 2020. Prevalence of the use of chemical restraint in the management of challenging behaviours associated with adult mental health conditions: A meta-synthesis. Journal of Psychiatric and Mental Health Nursing, 27(4), pp.425-445. Available at:

https://doi.org/10.1111/jpm.12585Digital Object Identifier (DOI) (Accessed: 3 April 2026).

- Nash, M., McDonagh, C., Culhane, A., Noone, I. and Higgins, A., 2018. Rapid tranquilization: an audit of Irish mental health nursing practice. *International Journal of Mental Health Nursing*, *27*(5), pp.1449-1458. Available at: https://doi.org/10.1111/inm.12445 (Accessed: 3 April 2026).
- National Institute for Health and Care Excellence (2015) *Violence and aggression: short-term management in mental health, health and community settings (NG10)*. London: NICE. Available at: https://www.nice.org.uk/guidance/ng10 (Accessed: 3 April 2026). [Under review and update as of 2024].
- Pedersen, M.L., Bricca, A., Baker, J., Schjerning, O., Munk-Olsen, T. and Gildberg, F.A., 2025. Ethnic disparities in rapid tranquillisation use and justifications in adult mental health inpatient settings: a systematic review and meta-analysis. *BMJ Mental Health*, *28*(1). Available at: https://mentalhealth.bmj.com/content/28/1/e301399 (Accessed: 3 April 2026).
- Royal College of Psychiatrists (2020) *The management of violence and aggression in mental health settings*. London: RCPsych. Available at: https://www.rcpsych.ac.uk (Accessed: 3 April 2026).
- World Health Organization (2021) *Guidance on community mental health services: Promoting person-centred and rights-based approaches*. Geneva: WHO. Available at: https://www.who.int/publications/i/item/9789240025707 (Accessed: 3 April 2026).
- World Health Organization (2021) *Guidance on community mental health services: Promoting person-centred and rights-based approaches*. Geneva: World Health Organization. Available at: https://www.who.int/publications/i/item/9789240025707 (Accessed: 3 April 2026).

- **Key individuals/organisations to engage:**
  - People with lived experience, DPOs and representative organisations: lived experience and survivor groups (particularly those with experience of restrictive practices).
  - Representative and advocacy organisations.
  - Family/carer/supporter groups/organisations
  - Service providers.
  - Professional bodies: nursing and midwifery bodies, psychology and social work organisations, college of psychiatrists and emergency medicine/acute medicine representatives.

- Regulators and oversight bodies: HIQA (where relevant interfaces exist), Ombudsman, and equality/human rights bodies.
- Academic and clinical experts: researchers in coercion reduction, trauma-informed care, human-rights, psychopharmacology, and implementation science.
- Peer support and community organisations: groups working on alternatives to coercion, crisis houses, and community based crisis supports.

7. Any additional thoughts or comments?

Need for a System Wide Review of Sedation Practices

It is also critical that a comprehensive, systemwide review is undertaken on how sedation, in all its forms, is currently used across mental health settings. At present, there is limited clarity and consistency in how services distinguish between *therapeutic sedation*, *rapid tranquillisation*, and *chemical/pharmacological restraint*. Without a clear national picture, it is extremely difficult to understand the true scale, and impact of chemical restraint in Ireland.

In its 2020 Inspection of Approved Centres, the European Committee for the Prevention of Torture noted the following:

"The CPT found that pro re nata (PRN) medicine was not being used in an appropriate manner at the establishments visited. It recommends that the Irish authorities carry out a review of this type of prescription at all psychiatric institutions in Ireland, particularly as regards potential overmedication, chemical restraint and involuntary treatment and that, thereafter, they draw up guidelines on the use of PRN medication."

"The CPT recommends that the Irish authorities review the use of PRN at all psychiatric institutions in the light of the above comments, particularly as regards potential overmedication or chemical restraint, and thereafter draw up guidelines on the use of PRN medication. These guidelines should specify that PRN medication should always be prescribed by a fully qualified psychiatrist, preferably the patient's treating psychiatrist, with the consent of the patient, the prescription must clearly state the maximum dose for single use, intervals for use over a period of 24 hours, the route of application and the need to observe the patients' reactions. Long-acting psychotropic drugs (depot and acutard formulations) should not be used as PRN medication. In addition, every use of PRN medication should be documented, it should be administered by a fully qualified registered nurse on duty and should be regularly reviewed."

While it should be acknowledged that the 2025 CPT report focused more on rapid tranquilisation than PRN medication, this is likely because the only approved centre inspected was the Central Mental Hospital. We believe a review of PRN medications such as recommended in the 2020 CPT Report is overdue and would be very timely and useful to inform this Code of Practice.

A structured review would allow the Mental Health Commission and the wider system to:

- identify where sedation is being used as a de facto restrictive practice

- understand variations between services, disciplines, and clinical cultures
- examine whether sedation is being used in situations where nonrestrictive alternatives could have been effective
- assess the extent to which sedation is being used to compensate for systemic issues such as understaffing, environmental pressures, or lack of therapeutic supports
- gather lived experience accounts of how sedation is perceived, experienced, and its longer term psychological effects
- develop clearer definitions, thresholds, and safeguards that distinguish legitimate clinical treatment from coercive practices

This kind of review would provide the evidence base needed to ensure that the new Code of Practice is grounded in reality, not assumptions, and that it meaningfully addresses pharmacological restraint as it is actually experienced by those with lived experience.

Clarifying the Definition of Pharmacological Restraint

The Mental Health Bill defines pharmacological restraint as the administration of medication where the only purpose is to control behaviour or restrict a person's movement, and explicitly excludes medication given to "treat or ameliorate a mental disorder". While this distinction is important in principle, as noted above, in practice it is often extremely difficult to draw a clear line between medication used therapeutically and medication used as a form of restraint.

In real world mental health settings:

- The same medications used to treat symptoms can also be used in ways that limit autonomy, reduce mobility, or suppress behaviour.
- PRN (as-needed) medications can be overused or misused, leading to cumulative sedation that effectively functions as chemical restraint even if the stated intention is symptom relief.
- A person may be "treated" with medication in a way that results in oversedation, loss of agency, or inability to communicate – outcomes that are indistinguishable from restraint in their lived experience.

For this reason, the Code of Practice must recognise that intent alone is not a sufficient safeguard. The effect of the medication on the person is equally important. If a person is sedated to the point that they cannot meaningfully engage, move freely, or exercise control over their own body, then, regardless of the stated clinical purpose, they are experiencing a form of restraint.

This has several implications for the Code:

- Oversedation should be explicitly recognised as a restrictive practice, even when the medication used is also part of a therapeutic regimen.
- Clear thresholds and monitoring requirements are needed to ensure that PRN medication is not used in a way that drifts into coercion or behavioural control.
- Documentation must include both the intended purpose and the actual observed effects of the medication on the person's functioning, autonomy, and ability to participate in their own care.
- The Code should require clinicians to consider whether the medication is being used to address underlying distress or simply to manage behaviour or compensate for environmental or staffing pressures.

By acknowledging the blurred boundaries between treatment and restraint, the Code can better protect people from subtle or unintended forms of coercion and ensure that pharmacological interventions are used safely, ethically, and in a genuinely rights-based manner.

Need to prohibit threats of pharmacological restraint

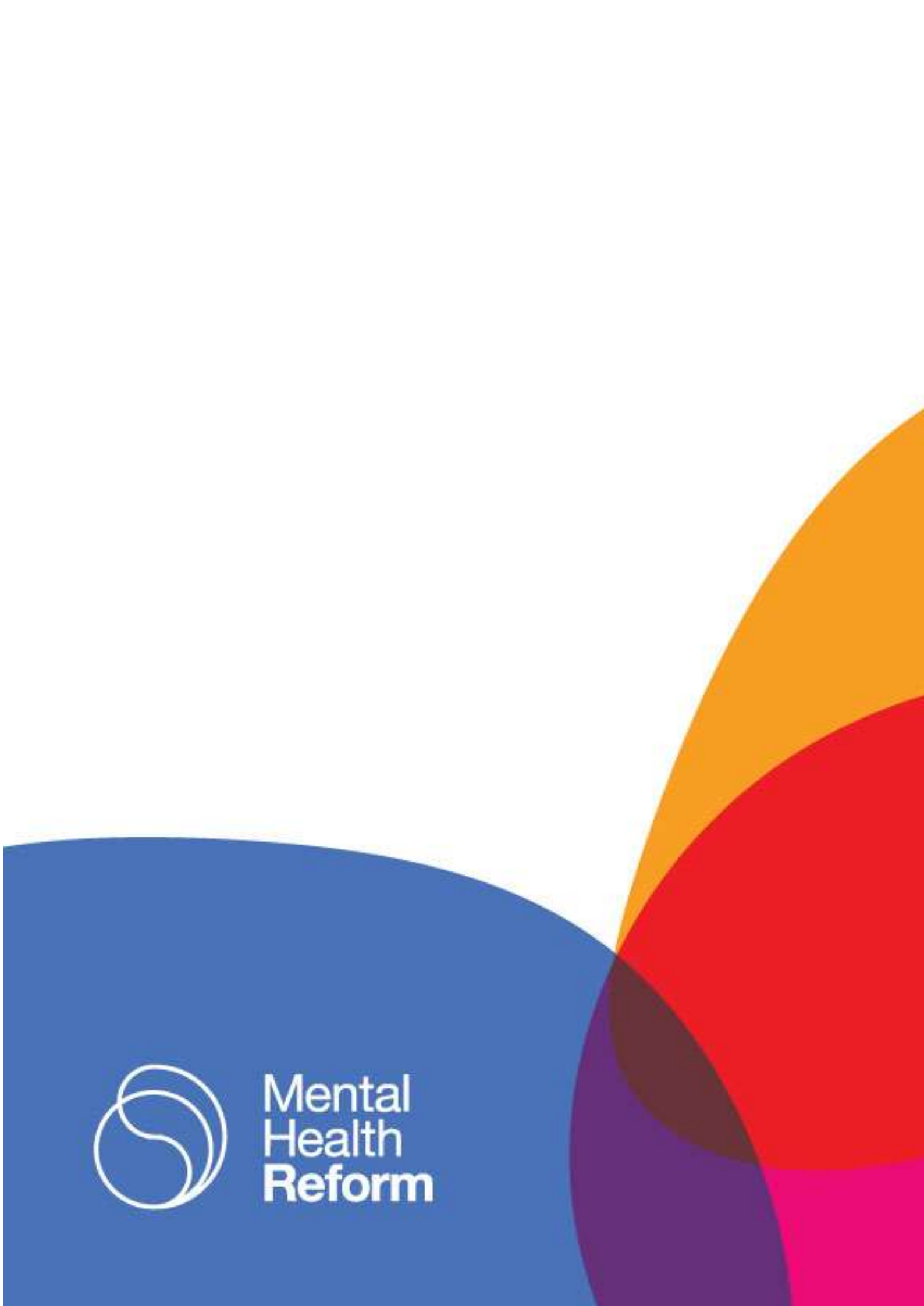
A code of practice can set minimum standards, but the real impact is dependent on culture, namely how teams think about power, risk, and partnership with service users and those with lived experience. The code should explicitly link pharmacological restraint to a wider programme of culture change, human rights implementation, and investment in alternatives.

Therefore, the Code of Practice should also explicitly prohibit the use of threats of chemical restraint (or any suggestion that sedation will be administered) to coerce compliance or control behaviour. This practice is itself a form of psychological coercion and can be profoundly traumatising, particularly for people with previous negative experiences of restraint or forced medication.

Threats of restraint:

- undermine trust and therapeutic relationships
- escalate fear, distress, and agitation
- create a coercive environment even when no medication is ultimately administered
- disproportionately impact people who have experienced trauma, institutionalisation, or previous coercive interventions
- blur the line between legitimate clinical decision-making and punitive or controlling behaviour

Embedding a clear prohibition in the Code against threats of pharmacological restraint would send an important signal that coercion of any form has no place in a rights-based mental health system. It would also support staff by setting unambiguous professional boundaries and reinforcing the expectation that de-escalation, communication, and collaborative approaches must always be prioritised.


Mental
Health
Reform