Submission to the Mental Health Commission on the Development of the Reduction Strategy for **Restrictive Practices**

April 2026

Mental Health Reform

What key areas should the revised reduction strategy focus on?

The themes identified in the 2014 Strategy remain very relevant. Key areas the revised reduction strategy should focus on include:

- *Embedding human rights as a core foundation*: The 2014 strategy referenced values such as partnership with service users, respect for rights, and trauma sensitive practice. The revised strategy should deepen and operationalise these commitments, ensuring they are central to all decision-making and service design. It should reflect the legislative shift toward stronger human rights based protections and a modernised regulatory framework, emphasising the individuals' will and preferences, the right to least restrictive care, enhanced oversight, and the safeguarding of service users' dignity, autonomy, and bodily integrity.
- *Building on progress already made*: While we welcome the reductions in regulated restrictive practices in recent years, it is essential that progress in reducing seclusion, physical restraint, mechanical restraint, and involuntary medication does not result in the increased use of other restrictive or coercive interventions. The revised strategy should therefore examine not only where gains have been made, but also what practices may have replaced regulated interventions and whether any unregulated or informal restrictive practices have emerged. This analysis is crucial to ensuring that reductions are meaningful, sustainable, and genuinely reflective of improved, rights-based care rather than a shift toward less visible forms of restriction.
- *Integrating contemporary best practice and evidence*: The updated strategy should incorporate the growing evidence base supporting trauma informed, person centred, and recovery-oriented approaches. These approaches have been shown internationally to reduce the use of restrictive practices and improve service user experience. Aligning with international standards and emerging models of care will help ensure that Irish services are progressive, safe, and rights based.
- *Targeting the reduction and elimination of restrictive practices*: The strategy should reaffirm the MHC's commitment to reducing and ultimately eliminating restrictive practices, recognising their profound and often traumatic impact. It should clearly acknowledge that these practices do not have therapeutic benefit and should only ever be used as a last resort, with a clear pathway toward their elimination.
- *Strengthening service user and lived experience involvement*: Lived experience is essential to designing safe, respectful, and effective alternatives to restrictive practices. The revised strategy should seek to embed coproduction at all levels,

from policy development and governance to frontline practice and incident review. This includes meaningful involvement of service users, families, and peer workers.

- *Supporting culture change across the system*: Reducing restrictive practices requires more than procedural compliance; it demands a shift in attitudes, values, and organisational culture. The strategy should promote a culture of continuous improvement, reflective practice, and shared learning. Leadership development, staff wellbeing, and psychologically safe team environments should be recognised as critical enablers of sustained change.
- *Recognising and regulating currently unregulated restrictive practices*: As outlined in more detail in the additional comments section, the strategy should address the use of unregulated restrictive practices, ensuring they are properly defined, monitored, and subject to oversight. This includes practices that may be informal, environmental, or embedded in routine care but nonetheless restrict autonomy.
- *Workforce development and resourcing*: Sustained reductions in restrictive practices require adequate staffing levels, stable teams, and ongoing training in deescalation, communication, trauma informed care, and rights-based approaches. Investment in staff wellbeing and retention is crucial.
- *Enhancing the therapeutic environment*: Physical environments can either escalate or reduce distress. The strategy should promote environments that support sensory regulation, privacy, meaningful activity, and calm spaces, all of which are key components of reducing the need for restrictive interventions.
- *Ensuring consistent implementation across services*: Variation in practice across services remains a challenge. The strategy should include mechanisms for national consistency, shared learning, and clear expectations for service providers, supported by robust oversight.
- *Strengthening community-based alternatives*: A well-resourced community system reduces crisis presentations and pressure on inpatient units. The strategy should recognise the role of crisis alternatives, peer led supports, and early intervention services in preventing situations where restrictive practices might otherwise be used.
- *Recognition of those most likely to experience restrictive practices*: Certain groups – such as people with communication difficulties, people with disabilities (particularly neurodivergent individuals and those with intellectual disabilities), people from marginalised communities, and individuals who are unfamiliar with the service environment – are disproportionately vulnerable to experiencing restrictive practices. It is important that the updated strategy explicitly identifies these groups, examines why they are at heightened risk, and outlines targeted measures to reduce the likelihood of restrictive interventions being used on them.

Building in specific protections and tailored approaches will help ensure that restraint reduction efforts are equitable and effective across all populations.

What alternatives do you consider could be used instead of restrictive interventions?

Reducing and eliminating restrictive practices requires a strong focus on a rights-based approach and on prevention, early intervention, and supportive environments. A wide range of effective alternatives can be used instead of restrictive interventions, many of which are already well-established in international best practice. Examples include the following:

- Trauma-informed de-escalation approaches: Services should prioritise trauma informed communication and de-escalation techniques that reduce distress and prevent escalation. This includes calm, non-threatening engagement, validating the person's experience, offering time and space, and avoiding confrontational interactions. These approaches help maintain trust and reduce the likelihood of crisis responses.
- Individualised care planning and advance directives: Co-produced care plans and advance directives can identify triggers, preferred supports, early warning signs, and personalised strategies for managing distress. When staff understand what helps a person feel safe and in control, restrictive interventions become far less likely.
- Sensory-based and environmental supports: Access to sensory rooms, quiet spaces, weighted items, soothing lighting, and other sensory modulation tools can help individuals regulate their emotions. This is particularly important for those who are also neurodivergent. Improvements to the physical environment, including reducing noise, overcrowding, and overstimulation, can also play a key role in preventing escalation.
- Peer Support and lived-experience involvement: The involvement of peer workers can reduce fear, increase feelings of safety, and offer alternatives that feel less coercive and more collaborative.
- Collaborative and relationship and person-centred approaches: Strong therapeutic relationships are one of the most effective preventative tools. Consistent staffing, relational security, and proactive engagement outside of crisis moments help build trust and reduce the need for restrictive responses. Working with the person to identify what they need in the moment, offering alternatives, and involving trusted supporters where appropriate can help resolve situations without coercion. Collaborative approaches reduce power imbalances and promote safety.

- Emotional regulation and coping supports: Grounding techniques, breathing exercises, mindfulness, and other self-regulation strategies can be offered as alternatives to restrictive interventions. Providing choices and restoring a sense of control is central to reducing distress.
- Enhanced staffing presence: Increased staff presence during high stress periods and proactive engagement can prevent escalation. Staff availability and calm, confident presence often reduce the need for restrictive measures.
- Access to therapeutic and meaningful activities: Access to therapeutic and meaningful activities, creative outlets, social engagement, and outdoor space can reduce boredom, frustration, and isolation.
- Community based alternatives: Strengthening crisis cafés, peer led crisis services and other community supports can reduce the need for inpatient admission and the restrictive practices associated with acute settings.
- Reflective practice and post-incident learning: Regular, learning focused reviews of incidents, ideally involving service users, help identify root causes and prevent recurrence. This supports a culture of continuous improvement rather than blame.
- Leadership, culture and organisational supports: Sustaining alternatives requires leadership commitment, psychologically safe teams, and a culture that prioritises dignity, autonomy, and least restrictive care. Staff wellbeing and reflective practice are essential enablers.

What, in your opinion, are the biggest challenges or barriers to the reduction of restrictive practices in services?

- Staffing Shortages and Skill Gaps: In our consultations respondents repeatedly noted that insufficient staffing levels often lead to crisis driven responses rather than preventative, person centred approaches. High turnover and reliance on agency staff reduce continuity of care, weaken therapeutic relationships, and undermine confidence in deescalation techniques. Without a stable, well trained workforce, services may struggle to implement alternatives to restrictive practices consistently.
- Inadequate Therapeutic Environments: Overcrowded or poorly designed inpatient units can heighten distress and agitation. Limited access to sensory rooms, quiet spaces, or other supportive environments makes it more difficult to use non-restrictive responses. Environmental factors can significantly influence whether situations escalate.
- Lack of Consistent Training and Culture Change: Staff may not all receive regular, high-quality training in trauma-informed care, deescalation, communication, and human rights-based approaches. In some services, restrictive practices (particularly currently unregulated practices) may be normalised, particularly

where organisational culture has not shifted toward prevention and least restrictive care. Sustained cultural change requires ongoing training, reflective practice, and leadership commitment.

- Insufficient Community Supports: Underresourced community services lead to more frequent crisis presentations, increasing the likelihood of restrictive interventions in inpatient settings. The absence of stepdown options or crisis alternatives places additional pressure on acute units and limits the availability of non-restrictive responses.
- Limited Involvement of People with Lived Experience: Policies, care plans, and service improvements are often developed without sufficient meaningful codesign. Without lived experience leadership, services may overlook the emotional, psychological, and long-term impacts of restrictive practices. This limits the development of effective, rights based alternatives.
- Poor Data Collection and Transparency: Inconsistent recording and reporting (particularly of currently unregulated restrictive practices) makes it difficult to understand patterns, identify high use areas, or evaluate progress. Without reliable data, services cannot effectively monitor trends, learn from incidents, or ensure accountability.
- Risk Averse Organisational Cultures: Fear of adverse incidents, complaints, or perceived safety risks may lead staff to default to restrictive measures rather than explore alternatives. Services may prioritise short-term control over autonomy, even when evidence shows that non-restrictive approaches are more effective and safer in the long term.
- “Best Interests” Narratives and Cultural Norms: A belief that is pervasive in some settings that restrictive practices are in the “best interests” of the individual can reinforce their use, even when they are unnecessary or harmful. This narrative can obscure the rights based imperative to pursue least restrictive options and can hinder the adoption of more progressive, person-centred approaches.

How can services practically sustain / embed the reduction and, where possible, the elimination of restrictive practices?

Sustaining reductions in restrictive practices depends on long-term cultural, organisational, and structural change. Some key things to consider include:

- Building a strong, human rights based- culture:
    - Embed principles of autonomy, dignity, and least restrictive care into everyday practice.

  - Recognise that all restrictive practices, including those currently unregulated, should be recognised as restrictive and reduced as much as possible.
  - Ensure leadership consistently reinforces that restrictive practices are a last resort, not a default response.
  - Highlight and celebrate examples of successful non-restrictive interventions to shift norms and expectations.

- Investing in Staffing, Supervision, and Team Stability:

  - Adequate staffing levels reduce crisis driven decision-making.
  - Regular reflective practice and supervision help staff process challenging situations and avoid reliance on restrictive responses.
  - Stable teams build trust with service users, making deescalation more effective and reducing the need for coercive measures.
- Providing Ongoing, High Quality and Rights-Based Training
  - Deliver routine training in trauma-informed care, deescalation, communication, and sensory based approaches.
  - If possible, include lived experience educators to deepen understanding of the impact of restrictive practices.
  - Ensure training is refreshed regularly to maintain skills and confidence.
- Improving the Physical and Therapeutic Environment
  - Create calming, sensory friendly spaces that support emotional regulation.
  - Ensure access to meaningful activities, outdoor space, and peer support.
  - Reduce overcrowding and environmental triggers that contribute to agitation.
- Strengthening Community Based Alternatives to Reduce Pressure on Inpatient Services:
  - Expand crisis alternatives such as crisis cafés and peer-led supports.
  - Reduce unnecessary admissions, which in turn reduces the use of restrictive practices in inpatient settings.
- Embedding Codesign and Lived Experience Leadership
  - Lived experience must be central to designing safe and effective alternatives.
  - Coproduce policies, care plans, and deescalation strategies with people who use services.
  - Involve lived experience partners in staff training, service reviews, and governance structures.
  - Ensure service users have a meaningful role in monitoring and evaluating restrictive practice use.

- Improving Data Collection, Transparency, and Accountability
  - High quality data is essential for monitoring progress and driving improvement.
  - Require recording of all restrictive practices, including less visible or informal practices, consistently and accurately.
  - Use data to identify patterns, hotspots, and opportunities for prevention.
  - Promote transparency to support learning and accountability.
- Embedding Continuous Quality Improvement:
  - Sustained change requires ongoing learning rather than oneoff initiatives.
  - Regularly review incidents to understand root causes, not to assign blame.
  - Use learning from reviews to inform service improvements and prevent recurrence.
- Strengthening Multidisciplinary Collaboration:
  - A whole team approach is essential for reducing restrictive practices.
  - Ensure all disciplines, including nursing, psychology, social work, occupational therapy, peer workers, contribute to prevention strategies.
  - Promote shared decision-making and consistent communication across teams.
- Supporting Staff Wellbeing:
  - Staff who feel supported are better able to respond calmly and compassionately.
  - Burnout, stress, and compassion fatigue increase the likelihood of restrictive responses.
  - Provide access to wellbeing supports, debriefing, and psychologically safe team cultures.

Please indicate any policy documents/evidence/initiatives we should consider for the revised strategy:

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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].

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Any additional thoughts or comments

Need to Recognise and Address Unregulated Restrictive Practices

Reducing restrictive practices is not only about eliminating seclusion and restraint; it requires transforming the everyday experience of care. We therefore strongly welcome the MHC's proposed plan to examine currently unregulated restrictive practices in its revised strategy. While we applaud the reductions in regulated restrictive practices in recent years, as noted by the MHC, it is essential that progress in reducing seclusion, physical restraint, mechanical restraint, and involuntary medication does not lead to an increase in other restrictive interventions or adverse events.

Unregulated restrictive actions or environmental conditions are often embedded in culture, justified as safety measures, and implemented without documentation. Their hidden nature means their effects on rights, trust, and therapeutic relationships often go unexamined.

Unregulated restrictions frequently conflict with principles of autonomy, proportionality, and leastrestrictive practice. They can limit freedom of movement, access to personal belongings, social contact, and daily living choices. They may also undermine therapeutic relationships by creating dynamics rooted in control rather than collaboration, while remaining largely invisible within quality and safety oversight.

Examples of currently unregulated restrictive practices include:

- Environmental Restrictions: These include things such as locked internal or external doors, limited or supervised access to outdoor spaces, controlled access to kitchens or lounges, restrictions on personal items, and furniture arrangements that limit movement. While sometimes justified as safety measures, they often lack individualised assessment or regular review.
- Constant Observation: Although observation can be clinically necessary, it is also restrictive, particularly when used routinely rather than based on individual need, implemented without clear criteria, or experienced as surveillance like.
- Blanket Rules and Routine Restrictions: Rules applied to all service users regardless of individual need (such as fixed meal times, set bedtimes, restricted phone use, limited visiting hours, or prohibitions on leaving the ward) often arise from staffing patterns or tradition rather than clinical necessity and can be experienced as deeply restrictive and institutional.
- Restrictions on Personal Liberty and Movement: Examples include locked bedrooms during the day, supervised or escorted access to outdoor spaces, curfews, or limits on movement even when risk is low.
- Restrictions on Communication: These include limits on phone use, internet access, or contact with family, friends, or visitors.
- Financial Restrictions: Limiting access to money, bank cards, or personal financial decision-making.
- Restrictions on Daily Living Activities: This includes limits on cooking or preparing snacks, inflexible showering or hygiene schedules, restricted access to laundry facilities, limited access to communal spaces, or staff determined participation in activities.
- Procedural or Administrative Restrictions: Delays in granting leave due to staffing or administrative issues, or unclear processes for appealing restrictions can be deeply disempowering for individuals.
- Psychological or Cultural Forms of Restriction, such as:
    - Threats of increased observation or loss of privileges
    - Withholding activities or access as a behavioural consequence
    - Staff using tone, positioning, infantilising language or authority to compel compliance.
    - Discouraging self advocacy or questioning of decisions
    - Retaliation against complaints
    - Normalising restrictions as being for the person’s “own good” without explanation
- Medication Related Restrictions: Beyond forced medication, pressuring service users to accept medication in order to access privileges or freedoms or so as not to have it forced on them, is also a restrictive practice.

Addressing unregulated restrictive practices in this strategy would improve transparency, accountability, and proportionality. The revised strategy could support this by introducing:

- Clear definitions and categorisation of unregulated restrictive practices
- Requirements for documentation, review, and justification
- Individualised assessments rather than blanket rules
- Alternatives rooted in coproduction, deescalation, and rights-based practice
- Staff training on autonomy, rights, and trauma-informed approaches
- Environmental design that supports freedom, choice, and sensory regulation
- Mechanisms for service users to question or challenge restrictions

Structure of Strategy:

The MHC's Seclusion and Restraint Reduction Strategy 2014 has provided an important framework for reducing restrictive practices and its eight core themes remain very relevant. However, the document itself is long, dense, and written in a way that may be difficult for staff, service users, and families to navigate. As the strategy is now being updated, it will be important to ensure that the revised version is far more accessible – concise, clearly structured, and written in plain, user friendly language – so that the principles and key points of the strategy can be more easily understood and consistently applied across services.

It is also essential that the updated strategy includes a clear and realistic implementation timeline, with short, medium and long-term targets that services can plan around and measure progress against. In addition, there should be explicit clarity on when the strategy will next be reviewed and updated, ideally every five years, so that it remains current, relevant and responsive. This is particularly important given the significant gap in time between the publication of the 2014 strategy and its current revision.

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