RCSI FACULTY OF NURSING & MIDWIFERY

Evidence review to inform the review of the code of practice on the use of physical restraint and the rules governing seclusion and mechanical means of bodily restraint in inpatient Mental Health Services

September 2022

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For
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With acknowledgement and thanks to Professor Denis Ryan (President, Irish College of Humanities and Applied Sciences, Ireland) who provided an expert independent review of this work in the form of critical feedback and input into the final document and an independent validation of process and findings.

Section 1- Background & Context

1. Introduction

Coercion has marked the history of psychiatric care (Abderhalden et al 2006) and can be traced to the beginnings of psychiatry. Likewise, the use of seclusion, physical and mechanical restraint have been a human rights concern for many years (Office of the United Nations High Commissioner, 1991). Over 30 years ago, the United Nations (1991) established the desired underlying principle to rely on the least restrictive or intrusive treatment appropriate to the persons health needs. Further refined by the United Nations convention on the rights of persons with disabilities in 2006 (United Nations, 2006), these principles have informed the legal provisions and regulation of seclusion and restraint internationally. In particular, seclusion, physical and chemical restraint are considered to be at odds with contemporary evidence-informed approaches to Mental Health Care which should be based on a recovery orientated ethos and principles of ensuring human rights (WHO, 2019). However, there has been an escalating concern about restrictive practices in the broader sense in psychiatry for the past 22 years (Muir-Cochrane, Oster and Grimmer, 2020). These include but are not limited to physical restraint, mechanical restraint, chemical restraint, seclusion, time out, open area seclusion or environmental restraint, close observations, locked doors, night-time clothing.

The evidence is clear that restrictive practices can cause deleterious physical and psychological consequences (Chieze, Hurst et al. 2019) for those subjected to them. There have been numerous reports and incidents supporting the need to reduce or eliminate these practices internationally. In response, many governments and health services globally have acknowledged the issues associated with restrictive practices and have instigated national policies and guidance to reduce or eliminate them in Mental Health Services. The most recent impetus for the reduction of restrictive practices occurred in the UK in 2018, when the UK Government passed the Mental Health Units (Use of Force) Act (2018). This Act, known as Seni's Law, legislated for mandatory reporting and reduction in restrictive practices and was brought into effect following a serious incident review into the death of Olaseni Lewis. Mr Lewis died as a result of excessive and disproportionate restraint by police in the presence of staff in a seclusion room at the Bethlem and Maudsley Hospital in 2010.

It is clear that practices which were once considered standard in the management of challenging behaviours and in best interests of the patient, have entered a new paradigm of risk and safety management as opposed to therapeutic intervention. This presents a challenge to regulators, service providers, professionals and service users alike. There are instances where restrictive practices are considered necessary for the safe management of high-risk patients and where apparent reductions in the level of restriction over time can indicate progress in the rehabilitative sense (Kennedy et al, 2020). There are also instances where it is considered necessary to maintain safety in the day-to-day environment of inpatient mental health care which involve different forms of restrictive practices (Wilson et al, 2017).

The international and evidentiary developments combined with these normative practices, have created an ethical quagmire for staff working in these environments. Evidence over the past two decades or so, has highlighted the complexities associated with the precursors of behaviours and

events which may lead to restrictive practices. In inpatient care restrictive practices are known to be preceded by internal (patient), external (environmental) and interpersonal (relationships) factors (Duxbury, 2002; Duxbury and Whittington, 2005). Evidence-based approaches such as Safewards (Bowers, 2014) are reorienting day to day practice to avoid conflict and containment and maximise therapeutic engagement between staff and patients. At an organisational level seclusion and restraint reduction imperatives and evidence-based approaches are now established as essential in the governance of mental health services, including in the Irish context (MHC, 2014). What is important here is the recognition that the issues associated with restrictive practices are complex, involve all levels of the healthcare organisation and as such all levels of the healthcare organisation must address the issue. In its role as regulator of Irish Mental Health Services, the Mental Health Commission (MHC) of Ireland is empowered to develop regulatory and/or practice guidelines on these critical issues.

To date within the Irish context the MHC has provided regulatory and practice guidance on the use of seclusion and mechanical means of bodily restraint (MHC 2009) and physical restraint (2009). Following extensive consultation with experts and stakeholders, a strategy for the reduction of seclusion and restraint in Irish Mental Health Services was published in 2014 (MHC, 2014). This strategy had a strong evidence base and provided services with a suite of actions designed to support reduction in the use of seclusion and restraint. However, despite this, seclusion and restraint remains a feature of Irish Mental Health Care and there has been little difference in reporting trends over time. In fact, the MHC reports on activity on the use of seclusion and restraint in approved centres show that physical restraint has increased in the intervening period.

To this end and in the context of the review of the Mental Health Act (MHA) (2001), the MHC is reviewing the evidence and international practices associated with restrictive practices in order to progress a contemporary evidence- based approach to the issue in Ireland, that is commensurate with evidentiary, international and national legislative imperatives.

1.1. Overview of the MHC

The Mental Health Commission is a regulatory body established under the Mental Health Act (2001). The work of the MHC includes regulating in-patient Mental Health Services; protecting the interests of people who are involuntarily admitted and setting quality standards for best practice across Mental Health Services (MHC, 2021). Additionally, the MHC has established the Decision Support Service to support the enactment of the Assisted Decision-Making (Capacity) Act, (2015). In its role as regulator, the MHC registers and inspects approved centres and Mental Health Services in order to monitor the implementation of legislative requirements and best-practice standards.

As a regulating body, the MHC has 3 core functions (HIQA and MHC, 2019).
They are:

1. Registration and enforcement — registering approved centres and enforcing associated statutory requirements, such as attaching registration conditions.

2. Inspection — inspecting approved centres and community Mental Health Services and reporting on regulatory compliance as well as the quality of care.
3. Quality improvement — developing and reviewing rules under the Mental Health Act (2001). Developing standards, codes of practice and good practice guidelines. This includes monitoring the quality-of-service provision in approved centres and community services through inspection and reporting.

1.2. Focus of this review

It is within its role as regulator that the MHC has commissioned this report to inform a review of the rules governing seclusion and mechanical means of bodily restraint and the code of practice for physical restraint in inpatient mental health services. The review will also inform the future regulation of chemical restraint in line with the review of the MHA. The Commission is also aware of the broader context of restrictive practices and as such these are included to a lesser extent in this review. Therefore, this review will focus on:

- Current evidence around reduction in restrictive practices.
- Current evidence around restrictive practices including seclusion, physical restraint, mechanical restraint, chemical restraint (other terms referring to chemical restraint include pharmacological restraint, forced medication, rapid tranquillisation).
- Current models of service delivery in comparable jurisdictions to include model of service, key legislation, policies, standards and guidelines, and governance issues.
- This review will summarise key points arising from best practice and evidence for the consideration of the MHC. However, specific recommendations for change will not be made as the remit for decisions around the utilisation of the collated evidence appropriately rests with the MHC.

1.3. Structure of this report

This report will outline the Irish context within which Mental Health Services are delivered and the legislation and standards which impact on restrictive practices. The international context including service models, relevant legislation, standards and governance processes around mental health and restrictive practices from five comparable jurisdictions will be presented in Section 3. Section 4 will present the methodology for the literature review and evidence will be presented under the following headings:

- Reduction in Restrictive Practices
- Child and adolescent mental health
- Adult
- Forensic
- Mental healthcare of older people
- Other

On the basis of the best practice review and literature review, Section 6 will critique the Rules Governing Mechanical Means of Bodily Restraint and the Code of Practice for Physical Restraint. Evidence and international perspectives on Chemical Restraint will be discussed and key issues for other restrictive practices will be highlighted. Finally, Section 7 will summarise and conclude the report.

2. Section 2: Overview of Mental Health Services in Ireland

2.1. Model of Service

The Minister for Health and the Department of Health set the strategic direction for Healthcare in Ireland and the Health Service Executive (HSE) manages the delivery of all public health services in Ireland. Responsibility and funding is devolved to 9 geographical HSE administrative areas known as Community Healthcare Organisations (CHO). The CHO's are responsible for the co-ordination and delivery of local services, including Mental Health Services. Mental Health Services comprise inpatient services, mental health residential units, day services, community mental health teams and specialist services. They are managed by area management teams comprising the Executive Clinical Director, Area Director of Nursing, Chief Officer and Heads of Disciplines. Inpatient forensic services are delivered through the National Forensic Mental Health Service There are also independent providers of Mental Health Services which are self-governing but whose approved centres are also regulated by the MHC (e.g., St Patrick's and St. John of God's Mental Health Services and Nua Healthcare etc.). The health service structure is presented graphically in Fig. 1:

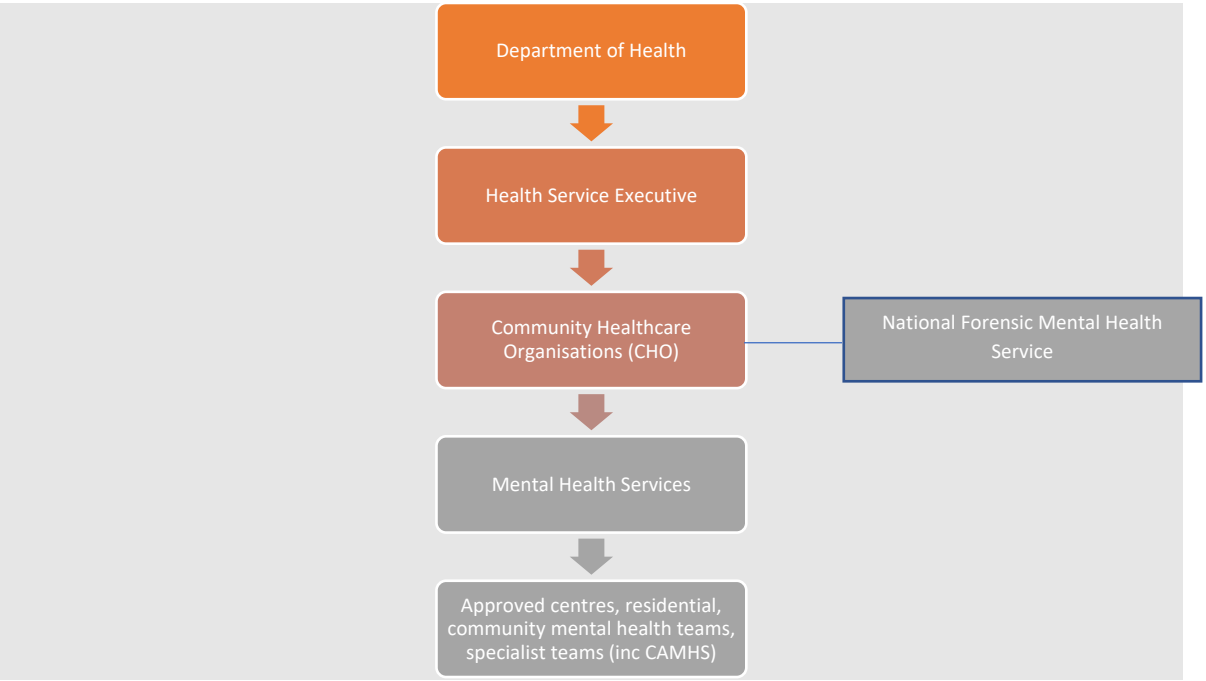


Figure 1-Structure of Irish Mental Health Services

2.1.1 Sláintecare

The Irish Health Service is currently undergoing a programme of reform. This programme arises from the Sláintecare report published in 2017 which provides for new governance structures, funding mechanisms, organisational re-alignment and enhancement in the overall Irish health system. Sláintecare aims to deliver universal healthcare and there are five key components to the programme:

- Population health
- Entitlements
- Integrated health care

- Funding
- Implementation

The current Sláintecare implementation strategy and action plan outlines key projects and deliverables from 2021-2023. Two Sláintecare Reform Programmes have been prioritised for focused implementation over the next three years. They are:

Reform Programme 1: Improving Safe, Timely Access to Care and Promoting Health & Wellbeing
Reform Programme 2: Addressing Health Inequalities — towards Universal Healthcare.

Notably, the strategy aims to continue with the implementation of Sharing the Vision; A mental health policy for everyone (Government of Ireland, 2020) which will be outlined in this section of the review.

2.2. Legislation

2.2.1. MHA (2001)

The Mental Health Acts 2001-2018 (the 2001 Act), which were fully implemented in 2006, replaced the 60-year-old Mental Health Act (1945). The 2001 Act provided a modern framework within which people with mental health illness were to be cared for and treated. Bodily restraint and seclusion are provided for under Part 6, section 69 of the Act – the provisions of which will be outlined in section 6 of this review.

Section 32 of the 2001 Act established the MHC as the regulator of Mental Health Services. The MHC has a dual role; to establish quality standards for Mental Health Services and to monitor, inspect, and regulate Mental Health Services. The 2001 Act also established mental health tribunals to ensure automatic independent admissions review of all involuntary to approved centres. Approved Centres are subject to registration and regulation by the MHC, and these are required to be monitored, inspected and regulated by the MHC under the Act. To remain registered, Approved Centres must meet the minimum requirements as laid out by the Mental Health Act, associated Regulations, Rules and Codes of Practice.

2.2.1.1. Approved Centre Regulations

Approved centre regulations are enacted by statutory instrument 551/2006. The regulations are inspected by the MHC and in order to remain a Registered provider of approved centres, services must comply with each element of the statutory instrument. The instrument does refer to the need to have control measures in place to manage assault, however there is no specific reference to restrictive practices in the Instrument.

2.2.2. Rules

Rules governing seclusion and mechanical means of bodily restraint are outlined and critically reviewed in Section 6.

2.2.2.1. Rules governing ECT for involuntary patients (2006/2015)

The MHC prepared Rules that came into force on 1st November 2006. An independent review of the Rules was undertaken between September and December 2008 which involved extensive stakeholder consultation. The Rules were revised to take account of the recommendations arising from the review and the amended Rules came into effect on 1st January 2010. Following the implementation of the 2015 Act, a key change relating to consent emerged in relation to the use of Electroconvulsive Therapy (ECT) for involuntary patients. From that time, ECT can only be administered to a patient without consent where it has been determined that the patient is unable to give consent to the treatment. The rules define ECT and make clear the requirements for information and consent and the administration of ECT.

2.2.3. Health Act (2007)

This Act established the Health Information and Quality Authority (HIQA). This body was established to oversee the registration and inspection of all residential services for older people, people with disabilities and children. HIQA also issue quality standards which must be attained to achieve or maintain registration.

2.2.4. Mental Health Act (2008)

This act made provisions for unexpired and expired renewal of orders under the MHA 2001.

2.2.5. Mental Health (Amendment) Act (2015)

This Act amended the law on mental health in relation to the use of involuntary procedures for the treatment of certain persons.

2.2.6. Assisted Decision-Making (Capacity) Act (2015)

A new law was passed which maximises a person's right to make their own decisions, with legally recognised supports, whenever possible. This Act applies to everyone and is relevant to all health and social care services. The Act is about supporting decision-making and maximising a person's capacity to make decisions.

2.2.7. Mental Health (Amendment) Act (2018) (Renewal Orders)

This Act amended and extended the Mental Health Act (2001):

- To make further and better provision relating to the treatment of persons under the Mental Health Act 2001
- To improve the provision of Mental Health Services
- To promote the rights of persons subject to the Mental Health Act (2001)
- To provide for related matters.

2.2.8. Reform of the MHA (2001)

The reform of the MHA 2001 is currently in the process of development and as such full details are not available at this time. However, the Heads of Bill were approved in July 2021 for review of the Act in full. The following details are provided on the Department of Health Website (October 2021) with regards to the Heads of Bill:

- Contains over 120 proposed changes to the Act
- Introduces guiding principles for adults and children into the Act
- Enhances the voice of people using mental health services
- Strengthens provisions for consent to treatment
- The inclusion of the use of chemical restraint to be goverened by Rules
- The use of physical restraint to be governed by Rules (currently a Code of Practice)
- Seclusion and restraint cannot be used on involuntary persons

The changes proposed are based on the report of the expert committee on the review of the MHA (2001) (2014). The most recent update is that the public consultation is complete. A summary of the report by the expert committee is now provided; however, it should be noted that this is a consultative report and the particulars for review of the Act have yet to be published at time of writing.

2.2.8.1. Report of the expert group on the review of the Mental Health Act (2001) (2014)

This report is now over a decade old, however it is included here as it has been critical in informing the Heads of Bill for the new Mental Health Act. The report sets out the proposed fundamental philosophical basis for the review of the Act from the outset. This philosophical position is grounded in a rights-based approach, which espouses protection of fundamental civil rights and sets forth a principled rejection of unnecessary restriction, control or coercion. Essentially it sets out to ensure that the rights of mentally ill people are protected and that where people require treatment, they have access to the appropriate treatment and environment. This rights-based approach is comparable with other jurisdictions reviewed in this report and is commensurate with requirements under the European Convention on Human Rights Act (2003) (ECHR) and espouses a commitment to fulfil the relevant requirements in this regard. In the context of mental health service provision this will require a reorientation from more traditional views of mental health and illness and from traditional means of how care and treatment is delivered. Furthermore, the report seeks to reconcile developments in mental health services provision, from an institutional to community base and to consider changes in approaches, such as the recovery approach. To some extent the national policy has overtaken the law

in this regard with the national Vision for Change documents and the review of the Act will aim to make these developments and legislative provision more cohesive.

Importantly, the expert group identified a set of guiding principles to underpin the review of the Act. This is an important development in the context of creating a value base for the legislation and practice going forward. It is also commensurate with the principles identified in other jurisdictions. For example, in Scotland the Milan Principles (see Section 3) underpin all national legislation and guidance in the development and delivery of mental health services and in particular, restrictive practices. A move from the traditional paternalistic approach towards a person-centred approach is advocated in the report in order to deliver on the changes necessary in a meaningful way. The following guiding principles were recommended by the Group (p.16):

- The enjoyment of the highest attainable standard of mental health, with the person's own understanding of his or her mental health being given due respect.
- Autonomy and self-determination
- Dignity (there should be a presumption that the patient is the person best placed to determine what promotes/compromises his or her own dignity)
- Bodily integrity
- Least restrictive care.

Recommendations were made for a review of the term mental disorder and the definition of treatment which is commensurate with contemporary developments. From a restrictive practices perspective, the final recommendation in this section is important in removing such practices from the treatment paradigm. To this end the report cautions that 'The provision of safety and/or a safe environment alone does not constitute treatment' (p. 18).

Recommendations for detention provisions (including exclusions) within the Act are strengthened and made explicit. Capacity features strongly in the report and considerations which are included to avoid 'institutional influence' (pg. 27) are important in the context of non-restrictive or coercive practices which can strongly influence patient-staff interactions, relationships and patient experiences. The recommendations also recognise the fluid nature of consent and capacity in the context of mental illness and voluntary admission.

Procedures for involuntary admission and the roles of the Approved Officer and Registered Medical Practitioners were recommended by the Group to strengthen approaches to admission. Furthermore, recommendations to clarify medical examinations and treatments prior to and during admission are made. Substantial recommendations are made around mental health review tribunals, review of title, role and clarification around functions. Renewal orders, absence without leave and grounds for appeal also have recommendations made. Of note, the recommendation around grounds for appeal places the burden of proof on the service rather than the individual.

2.3. Standards, Guidance, Policy, Codes and Rules

2.3.1. Sharing the Vision: A mental health policy for everyone (2021)

This policy was published in 2020 and follows on from 'A Vision for Change' (Government of Ireland, 2006) which was the national policy for mental health initiated in 2006. Briefly, the document A Vision for Change set out an inclusive and Service User orientated framework for mental health service delivery in Ireland. Its overarching intent was to ensure that Service Users and their carers were to be a central and integral part of every aspect of service development and delivery. The policy aimed to reorientate Mental Health Services towards a multi-disciplinary community-based model of care delivery. Recovery was introduced as the underpinning philosophy for care processes and care plans for Service Users were to address factors which might support or impede recovery. The Vision for Change made provisions for services to be managed in local catchment areas and for how these services were to be monitored. Provisions were also made for the establishment of minimum data sets. The closure of all mental hospitals was prioritised and how funding was to be allocated was outlined.

Sharing the Vision: A mental health policy for everyone (Government of Ireland, 2020), brings forward key elements of the Vision for Change and identifies new recommendations to progress the reform agenda. This document clarifies that the core values to underpin mental health service delivery in Ireland include respect, compassion, equity and hope. The principles upon which these values are to be enacted include recovery orientation, trauma-informed practices, a human rights orientation, a valuing and learning ethos. These values and principles form the baseline for the organising framework which is divided into 4 domains including:

1. Promotion, prevention and early intervention
2. Service access, co-ordination and continuity of care
3. Social inclusion
4. Accountability and continuous improvement.

Actions and processes are based on these domains with specific outcomes identified. There is a commitment to enabling these outcomes through Mental Health Information Systems, Legislative enablers/reform, Investing in the workforce and Commissioning Models and Frameworks. Critical success factors identified are leadership, implementation structures, planning, communication and data, and research evaluation.

Mental health and wellbeing over the life cycle is a major feature in the report and recommendations are made accordingly. Domain 2 is recovery focussed and identifies the need for services to be Service User oriented with recovery plans to include Service Users, family members, carers and significant others. Services are organised in a 4-tier stepped down care approach including Community mental health supports (Tier 1), Primary care (Tier 2), Specialist Mental Health Services- CMHTs (Tier 3) and Specialist inpatient or residential services (Tier 4). Access to the continuum of care and service alongside the integrated nature of care provision is outlined.

With reference to restrictive practices "Sharing the Vision stipulates that mental health services should, in the short term (0-18 months), develop an action plan for 'zero restraint, zero seclusion' (p110). Recommendation 92 is key and recommends a 'zero seclusion, zero restraint policy'. Of note is that 'Involuntary medication, that is when a person receives intramuscular or intravenous medication against their will', is included alongside physical and mechanical restraint as one of the three types of restraint used in approved centres and the reduction/elimination policy also applies to this form of restraint. Furthermore, within Tier 4, two additional Psychiatric Intensive Care Units are to be commissioned. The development of individualised packages of care for those Service Users with particular needs because of their behaviour which may be challenging to services is a new departure. Although targeted towards clients in or potentially requiring forensic services, this may provide a more focussed, preventative approach to minimise the needs for restrictive practices across the services.

2.3.2. MHC Strategy (2019-2022) - Protecting people's rights

This strategy firmly establishes protecting people's rights as the underpinning value and mission of the MHC. There are 5 strategic objectives that the MHC has outlined for achievement between 2019-2022. Each standard has identified criteria for achievement. They are:

1. Promote and uphold human rights to meet the MHCs responsibilities and remit under national and international legislation.
2. Implement the Commission's legislative mandate and pursue appropriate changes to the Mental Health Act 2001, the Assisted Decision Making (Capacity) Act 2015 and other relevant legislation.
3. Promote awareness of and confidence in the role of the MHC.
4. Develop an organisation that is responsive to the external environment and societal changes.
5. Develop an agile organisation with an open and inclusive culture.

2.3.3. National Standards for Adult Safeguarding (Developed with HIQA) (2019)

All adults have the right to be safe and to live a life free from harm. Safeguarding means putting measures in place to promote and protect people's human rights and their health and wellbeing, and empowering people to protect themselves. It is fundamental to high quality health and social care (MHC and HIQA, 2019 p.8).

Central to safeguarding is the need for people and services to work together and to adopt an underpinning value of dignity and respect. Ensuring that people are empowered to make decisions about their own lives is the goal. Presumption of capacity to make own decisions is a fundamental principle and recognising that capacity can change over time is important. Preventing risk of harm as a result of abuse or neglect is the responsibility of everyone working in health and social care. Six safeguarding principles are outlined in the document (p. 9). They are:

- Empowerment
- Rights-based approach

- Proportionality
- Prevention
- Partnership
- Accountability

To enact these principles in services HIQA and the MHC have identified 14 standards laid out in 8 themes for implementation across health and social care. These themes are:

1. Person centred care and support
2. Effective care and support
3. Safe care and support
4. Health, well-being and development
5. Leadership, governance and management
6. Responsive workforce
7. Use of resources
8. Use of information

2.3.4. National Framework for Recovery in Mental Health (2018-2020)

The Framework was published by the HSE to advance recovery-based services in Ireland. The framework was co-produced with, and by, Service Users, family members and mental health professionals.

The Framework defines recovery as being "intrinsically about people experiencing and living with mental health issues in their lives and the personal goals they want to achieve in life, regardless of the presence or severity of those mental health issues". Four core principles that underpin a recovery-oriented service are identified and guidance is provided. The core principles are:

1. The centrality of the Service User lived experience.
2. The co-production of recovery promoting services by all stakeholders.
3. An organisational commitment to the development of recovery oriented Mental Health Services.
4. Supporting recovery-oriented learning and recovery-oriented practice across all stakeholder groups.

2.3.5. Seclusion and Restraint Reduction Strategy (MHC, 2014)

The MHC of Ireland (MHC, 2014 p. 3) published the above strategy for approved centres which aimed to:

- Raise awareness of seclusion and restraint.
- Provide an opportunity for services to review current practices and encourage exploration of alternative approaches.
- Foster a trauma informed culture respective of human rights, collaboration and recovery.

- Create a therapeutic mental health service environment.
- Provide organisations with a list of evidence-based actions that have been demonstrated to assist in efforts to reduce the use of seclusion and restraint.

To this end, the MHC consulted with international experts and engaged in an extensive stakeholder consultation process to produce a strong evidence-based strategy for implementation in Mental Health Services in Ireland. The strategy comprised of 8 key themes as follows:

1. Leadership
2. Engagement
3. Education
4. Debriefing
5. Data
6. Environment
7. Regulation
8. Staffing

These eight themes are reflective of international approaches and best evidence and are interrelated. Furthermore, the strategy values strong relationships between staff and Service Users and is based on the recovery philosophy (See Fig 2). Actions to achieve these overarching themes were identified and Mental Health Services were essentially provided with an evidence-based roadmap for seclusion and restraint reduction.

Figure 2 - ***MHC Seclusion and restraint reduction strategy (MHC, 2014 p.20)***

2.3.6. MHC Quality Framework for Mental Health Services in Ireland (2005)

The quality framework was developed by the MHC in their role as the independent statutory body with responsibility for regulation of Mental Health Services. The MHC is responsible for promoting, encouraging, and fostering the establishment and maintenance of high standards and good practices in the delivery of Mental Health Services (MHC, 2005 p. 7). The framework includes guidance to support the implementation of the Statutory Instrument (S.I. No. 551/2006 - Mental Health Act 2001 (Approved Centres) Regulations 2006) as well as the achievement of high standards and good practices to underpin practices in Mental Health Services. The framework is currently under review by the MHC and is due for publication in 2022.

2.3.7. Codes of Practice

The following Codes have been developed by the MHC under the MHA 2001 to regulate activities in approved centres:

- Admission, Transfer and Discharge to and from an Approved Centre (2009)
- Use of Physical Restraint in Approved Centres (2009) (See Section 6)
- Code of Practice Relating to Admission of Children under the Mental Health Act (2001)(2009)

These codes have been developed to ensure that practices and processes occurring within Mental Health Services are based on regulatory foundations. The Rules Governing Seclusion and Mechanical Means of Bodily Restraint and the Code of Practice on the Use of Physical Restraint in Approved Centres (2009) will be discussed in the context of the international and evidence review in Section 6.

2.3.8. Human Rights: Report of the Commission for the Prevention of Torture (CPT, 2020)

The CPT carried out its seventh visit to Ireland in 2019. As part of this process 3 psychiatric facilities, (all approved centres), were visited. The report highlighted in section C (104), the use of PRN medication and suggested its use could, in certain instances, amount to involuntary treatment. Consequently, the CPT recommended that 'the Irish authorities review the use of PRN at all psychiatric institutions particularly as regards potential overmedication or chemical restraint, and thereafter draw up guidelines on the use of PRN medication' (p. 56). Of note in relation to chemical restraint, the previous visit by the CPT in 2010, recommended that the use of "chemical restraint" be governed by clear rules and subjected to the same oversight as regards other means of restraint.

Interestingly the CPT include seclusion, mechanical restraint and physical restraint under the heading of 'restraint'. Whilst there is acknowledgement of a high level of regulation around these three restrictive practices in Ireland, the CPT recommended that where seclusion is initiated by a registered nurse, the Medical Doctor be informed immediately and attend asap- existing rules state within 4 hours. A further recommendation around seclusion included a requirement for 'continuous direct personal supervision from the very outset of the measure (so that the patient can fully see the staff

member and the latter can continuously observe and communicate with the patient at all times)' (p. 60). Further recommendations on this restrictive practice include seclusion to take place for 'the shortest possible time, have ready access to sanitary facilities without having to ask to use them and it should be ensured that the room itself is kept at a moderate temperature, with the provision of sufficient blankets' (p. 60).

In relation to the use of security staff to manage agitated patients, restrain or seclude patients, the CPT made clear recommendations for this practice to cease and for staff in psychiatric establishments to receive appropriate training in managing agitated patients and have refreshers on a regular basis. Recommendation 114 (p. 60) refers to the use of seclusion for children and recommends that the only acceptable form of intervention is the use of manual restraint until such time as the child has calmed down. Finally in recommendation 116, the CPT addresses the issue of the use of pyjamas as a means of monitoring patients and preventing them from leaving. The CPT has recommended that this practice be reviewed so that patients can wear their own clothes as much as possible. This practice should be seen as a restrictive intervention given the outlined purpose and potential for marginalising a person's dignity.

3. Section 3: International Review

3.1 Introduction

This international review provides an overview of Mental Health Services and associated legislation in 6 comparable jurisdictions. The high-level governing structures, principles, legislation, policy, standards, and the model of service will be outlined for each country, with specific reference to restrictive practices. Core considerations for Ireland will be outlined at the end of the section. The content is summative and does not include all provisions which can be accessed in the documents referenced. The jurisdictions for review are:

- England
- Scotland
- Wales
- Northern Ireland
- South Australia
- New Zealand

These jurisdictions were identified by the MHC Oversight Group as relevant and comparable. It was the intention to review all Australian jurisdictions, however time constraints prevented this and South Australia was recommended as having the most recent standards on the reduction of restrictive practices. The information provided arises from interviews with Senior Mental Health Service personnel from each jurisdiction, a desktop review of regulatory sites and statutory bodies, and an accuracy check by Senior Mental Health Service Personnel or Regulatory Managers for each jurisdiction. For each international jurisdiction the following five areas were explored:

1. Model of service
2. Relevant legislation and regulation
3. Standards, guidance, and policies
4. Restrictive practices including seclusion, physical restraint, mechanical restraint, chemical restraint
5. Governance processes

3.1. England

3.1.1. Model of Service

Overall responsibility for health services, including mental health services lies with NHS England and Improvement, which is funded by the Department of Health and Social Care. Healthcare in England has undergone significant reconfiguration in the last number of years. Several former governance structures in NHS England are being amalgamated to become NHS England and NHS Improvement under new legislation, with responsibility for unified and national leadership of the NHS. The amalgamated structures include NHS development authority; Patient safety; National reporting and learning system; Advancing change team; and Intensive support teams. In February of 2021 the UK Government published the White Paper- Integration and innovation: Working together to improve health and social care for all. This paper represented a shift towards a new model of collaboration, partnership and integration and brought forward proposals made by NHS England and NHS Improvement in 'Integrating care: next steps to building strong and effective integrated care systems across England' (NHS, 2020) which in turn was developed to operationalise The NHS Long Term Plan 2019-2029 (NHS, 2019). At the core of all documents is the determination that the NHS will move to a new service model which is based on the principle of integrated care.

In line with these documents Care Commissioning Services will be reconfigured from Clinical Commissioning Groups (CCGs), which were NHS bodies, to Integrated Care Services (ICS) reporting to NHS England and Improvement. This will occur as soon as the current Health Bill receives Royal Assent and is enacted. ICSs will be statutory bodies with two constituent parts, the ICS NHS body and the ICS health and social care partnership. The primary aim of ICSs will be to deliver triple integration of primary and specialist care, physical and mental health services, and health with social care. The ICS will be responsible for NHS strategic planning and allocation decisions and will be accountable to NHS England for budgetary and spending matters. Whilst the ICS will be required to work with providers (NHS, independent and charitable) to commission services, they will not have any powers to direct NHS Trusts. The ICS health and care partnerships will be responsible for developing the plans to address health and social care needs and the ICS NHS bodies and local authorities will engage with these bodies in the planning and delivery of services.

Trusts have responsibility for care provision. However, a significant proportion of mental health inpatient services are provided by charities or independent sector providers such as Cygnet and Huntercombe. These providers are inspected by the CQC accordingly. Of relevance to this report, the contracting process for independent providers funded by the NHS, includes a requirement to report data around restrictive interventions to the national mental health services dataset and all training must be certified as complying with the Restraint Reduction Network training standards.

The NHS Mental Health Implementation Plan 2019/20 – 2023/24 sets out the long-term plan for mental health services. The priority is to improve adult and older adult mental health care within that timeframe. The plan has nine key areas of focus:

- Specialist community and perinatal mental health
- Children and young peoples (CYP) mental health
- Adult common mental illnesses
- Adult severe mental illnesses, Community Care
- Mental health crisis care and liaison
- Therapeutic acute mental health and inpatient care

- Suicide reduction and bereavement support
- Problem gambling mental health support
- Rough sleeping mental health support

These will be enabled by Provider Collaboratives, digitally enhanced mental health care and improving the quality of mental health data. The mental health agenda for the ICSs is to move towards integrated systems for mental health services, community services, and local authorities.

Devolution of funding and accountability for service delivery is outlined in Fig 3:

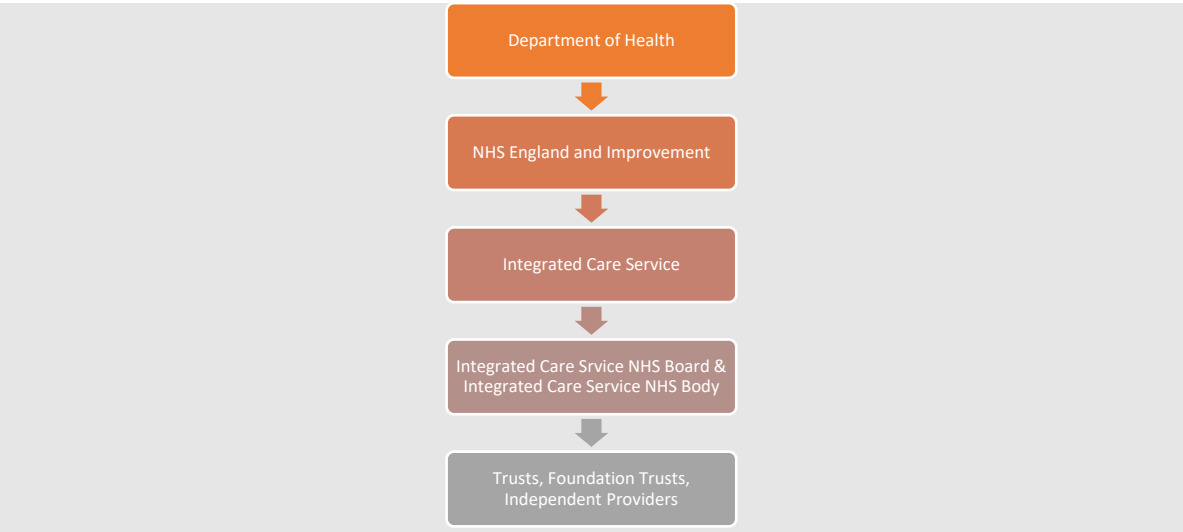


Figure 3 - Model of Service Delivery UK

All healthcare services are expected to meet 13 foundation standards. Foundation standards are inspected by the Care Quality Commission (CQC). Additionally, Mental Health Services must deliver care in accordance with the Mental Health Act 1983 (Amended in 2007) which is also inspected and regulated by the CQC.

3.1.2. Relevant legislation and regulation

3.1.2.1. The Mental Health Act (MHA) (1983)

The MHA 1983 is the primary legislation setting out the legal framework for compulsory powers in England. This Act was formerly regulated by the Mental Health Act Commission and is now regulated by the CQC.

3.1.2.2. The Mental Health Act (1983) Amended (2007) and changes to the Mental Capacity Act (2005)

The Mental Health Act 1983 Amended (1995) which introduced supervised discharge and after-care supervision in the community was replaced by the MHA 1983 Amended (2007). The main changes under this amendment are summarised as follows (Lawton-Smith, 2008):

- Definition of mental disorder changed to 'Any disorder or disability of the mind'.
- Exclusions:
    - Dependence of alcohol or drugs
    - Sexual deviancy
    - Learning disability unless 'that disability is associated with abnormally aggressive or seriously irresponsible conduct'.
- Requirement for availability of 'appropriate medical treatment' is defined and its purpose must be to alleviate or prevent deterioration, but it no longer needs to be 'likely to'. Services must be available to any patient placed under the Act.
- Approved social worker (ASW) requirement changed to 'approved mental health practitioner (AMHP). Occupational therapists, nurses, psychologists can train to be AMHPs- medical practitioners are excluded.
- Extension of treatment order and discharge changed from Responsible Medical Officer (RMO) to Responsible Clinician (RC) and the role is redefined as any professional who has undertaken the training.
- Supervised community treatment (SCT) introduced to extend powers of compulsion in the community through Community Treatment Orders (CTOs). This replaces the power of aftercare under supervision (Amended 1983 Act, 1995). Specific provisions around admission, treatment and duration of the order made. The RC is responsible for deciding as to whether Leave of absence (LOA) from hospital for more than 7 consecutive days or SCT are more appropriate.
- Right to advocacy: Patients subjected to detention (except those detained in an emergency and those taken into custody by police) must have advocacy services (independent mental health advocates – IMHAs) made available to them and it is a requirement for those under SCT and guardianship arrangements.
- Children's safeguards: Children under the age of 18 must be treated in appropriate settings- the responsibility to arrange this lies with the hospital managers.
- Changes to the Mental Capacity Act 1983 Amended (2005) – The 'Bournewood Gap'- new provisions on the restriction of the deprivation of liberty for someone who lacks capacity, known as the deprivation of liberty safeguards (DOLS). Before anyone can be deprived of their liberty specific provisions must be met.
- Statutory requirement to have guiding principles (DoH, 2015):

    1. Least restrictive option and maximising independence
    2. Empowerment and involvement
    3. Respect and dignity
    4. Purpose and effectiveness
    5. Efficiency and equity

- Nearest relative amended to include civil partner
- ECT- cannot be given without consent if the patient has decision-making capacity
- Victims' rights: Victims of sexual or violent offenses committed by individuals subsequently held in hospital as opposed to prison can make representations as to whether a patient should be conditionally discharged and what conditions should be placed on them under a CTO.

3.1.2.3. The Health and Social Care Act (2008)

The primary purpose of this Act was to create a new regulator, the Care Quality Commission (CQC) with responsibility for providing registration and inspection of health and social care services with the aim of ensuring quality and safety for Service Users. This includes regulating mental health services and the implementation of the Mental Health Act 1983, and the Mental Health Act 2007.

3.1.2.4. Health and Social Care Act (2012)

This Act enacted the program for reform of the structure of the public health system, the main provision being to move responsibility for commissioning and delivery to local NHS clinical commissioning groups (CCGs). To this end primary care trusts and strategic health authorities were disbanded. This move aimed to improve quality and care outcomes for patients and to restructure the commissioning of services to be more patient focused.

3.1.2.5. The Care Act (2014)

The Care Act 2014 set out a clear legal framework for promoting wellbeing through primary, secondary, and tertiary interventions. Importantly the Act also laid out how adults at risk of neglect or abuse should be protected. Local authorities were given new safeguarding duties and were required to put several structures in place to operationalise the safeguarding principle. Person centred care and support planning were required and were to be delivered through integrated services and partnership working.

3.1.2.6. The Mental Health Act Code of Practice (2015)

This Code of Practice is not the law but provides statutory guidance on the implementation of the Act and there is an expectation that all professionals comply with the guidance therein. The code is inspected by the CQC in their role as regulator of Mental Health Services. The Code lays out the guiding principles (as identified above) which are to inform all decisions taken under the Act. The Code provides detailed direction on the following:

- Protecting patients' rights and autonomy
- Assessment, transport, and admission to hospital
- Additional considerations for specific patients
- Care, support, and treatment in hospital
- Leaving hospital
- Professional support

3.1.2.6.1. Restrictive interventions including seclusion, physical restraint, mechanical restraint, chemical restraint

Chapter 26 of the MHA Code of Practice (2015) outlines the requirements for safe and therapeutic responses to disturbed behaviour. The Code is used as a framework for inspecting Mental Health Services by the CQC in their role as regulator. The Code refers to restrictive interventions as: Enhanced Observation, physical restraint, mechanical restraint, rapid tranquillisation, seclusion, and long-term segregation. The Code specifies that these should only be used in a way that respects human rights. In addition, it provides guidance on individualised assessments and care plans or treatment plans which include identified interventions at primary, secondary and tertiary levels. Guidance is also provided on the needs of children and young people and the importance of appropriate staff training.

The code underlines the importance of a positive and therapeutic culture aimed at preventing behavioural disturbances, early recognition, and de-escalation. Services are required to have policies in place, with clearly defined provisions in the Code included therein. The Code provides definitions of different restrictive measures when they can be used and specific action to be taken when used. These include physical restraint, mechanical restraint, rapid tranquillisation, seclusion, and deprivation of access to normal daytime clothes. The Code identifies action to be taken following behavioural disturbances including post incident review, de-briefing, and care planning.

Furthermore, Services are required to have a regularly reviewed and updated restrictive intervention Reduction programme which also aims to reduce injuries caused by restrictive interventions, improved patient satisfaction and reduced complaints. The Code refers to restrictive intervention reduction programmes as being overarching, multi-component action plans which aim to reduce the use of restrictive interventions. These should demonstrate (p. 280):

- Organisational commitment at a senior level
- How the use of data relating to restrictive interventions will inform service developments
- Continuing development of staff
- How models of development known to be effective in reducing restrictive interventions are embedded in care pathways
- How Service Users are engaged in service planning and evaluation
- How lessons are learned following the use of restrictive interventions.

3.1.2.7. Mental Health Units (Use of Force) Act (2018)

This law, known as Seni's Law, was brought forward following a serious incident review into the death of Olaseni Lewis. Mr Lewis died as a result of excessive and disproportionate restraint by police in the presence of staff in a seclusion room at Bethlem and Maudsley Hospital in 2010. This law requires mental healthcare services to reduce the use of force against mental health patients, to report the use of force and to train staff adequately in de-escalation and restraint. The Act extends the requirement for collection of data in relation to restrictive practices. Of note, mandatory reporting on physical restraint includes reason for restraint, position, timing, any injury sustained to staff or patient, provision of a post incident review. These provisions in the Act are designed to increase transparency and accountability around the use of force in mental health settings.

Finally, this Act also made provisions for police to wear body cameras when entering mental health units.

3.1.2.8. Mental Capacity Amendment Act (2019)

This Act focussed on deprivation of liberty provisions from the original Act and identified Liberty Protection Safeguards. These are aimed at strengthening safeguards for approving the deprivation of liberty. This includes three assessments to authorise deprivation of liberty:

1. The person who is subject to the arrangements lacks the capacity to consent to the arrangements
2. The person is of unsound mind
3. The arrangements are necessary and proportionate

Further provisions were made around independent review and the introduction of an approved mental capacity professional (AMCP) to review cases where the person objects to the proposed arrangements. Safeguards for the person receiving care and the appointment of an independent mental capacity advocate (IMCA) to represent and support the person during the process and implementation of authorisation were also put in place.

3.1.3. Standards, guidance, and policies

3.1.3.1. Positive and Proactive Care: Reducing the need for restrictive interventions (2014)

This Policy document, which applies to England only, was developed and issued in response to several reports focusing on the use and abuse of restrictive interventions in health and care services. It identified key actions to reduce restrictive interventions nationally, grouped together as follows:

- Improving care
- Leadership
- Transparency
- Monitoring and oversight (CQC)

Six key principles underpin the guidance:

1. Compliance with the relevant rights in the European Convention on Human Rights always.
2. Understanding people's behaviour allows their unique needs, aspirations, experiences, and strengths to be recognised and their quality of life to be enhanced
3. Involvement and participation of people with health and social care needs, their families, carers, and advocates are essential, wherever practicable and subject to the persons wishes and confidentiality obligations
4. People must be treated with compassion, dignity, and kindness

5. Health and social care services must support people to balance safety from harm and freedom of choice.
6. Positive relationships between people who deliver services and the people they support must be protected and preserved.

Whilst this is not inspected by the CQC it is an important guidance document for reducing restrictive practices.

3.1.3.2. NICE Guidance

The National Institute for Clinical Excellence (UK) updated a virtual pathway in 2020 which collated all best practice guidance for prevention and management of aggression (NICE, 2020) (http://pathways.nice.org.uk/pathways/violence-and-aggression). The recommendations within the pathway are to be read in conjunction with NICE guidance on the Service User experience, in particular the following principles are identified:

- Work in partnership with Service Users and their carers
- Adopt approaches to care that respect Service User's independence, choice, and human rights
- Increase social inclusion by decreasing exclusionary practices, such as the use of seclusion and the Mental Health Act (1983).
- Ensure that the safety and dignity of Service Users and the safety of staff are priorities when anticipating or managing violence and aggression
- Use of restrictive interventions must be undertaken in a manner that complies with the Human Rights Act (1998) and the European Convention on Human Rights.
- Unless a Service User is detained under the MHA (1983) or subject to a deprivation of liberty authorisation order under the Mental Capacity Act (2005), health and social care provider organisations must ensure that the use of restrictive interventions does not impose restrictions that amount to deprivation of liberty.
- Service Users must be involved in decision- making and specific direction is provided around care planning, risk management plans and involvement of carers. Further direction on the use of advance directives around the use of restrictive interventions are provided and the provision of information around rapid tranquillisation is specifically referred to.
- Guidance to prevent violations of Service User's rights is also summarised in addition to guidance for working with the police.

Two specific pathways are identified which follow these principles, Managing violence and aggression in adults (NICE, 2015), and Managing violence in and aggression in young people and children (NICE, 2015). It should be noted that the NICE guidelines are not regulatory in nature, but they are given due consideration by the CQC in the course of their inspections.

3.1.3.3. NICE guidance on managing violence and aggression in adults (2015)

The pathway for managing violence and aggression in adults (NICE, 2015) identifies three core elements under which more specific guidance is provided.

1. Anticipating, reducing the risk of, and preventing violence and aggression
2. Restrictive interventions.
3. The patient and Service User experience

Guidance is provided for pharmacological interventions and de-escalation.

3.1.3.3.1. Anticipating, reducing the risk of, and preventing violence and aggression in adults

A clear framework and associated policies are provided for anticipating and reducing violence and aggression in the NICE Guideline on Violence and aggression: Short term management in mental health, health, and community settings (NICE, 2015). Guidance around anticipating aggression and violence in inpatient psychiatric wards includes:

- Staff working as a therapeutic team, adopt a positive encouraging approach and maintain emotional regulation and self-management
- Ensure the Service User is offered appropriate psychological therapies, physical activities, and leisure pursuits.
- Recognise possible teasing, bullying, unwanted physical or sexual contact or miscommunication between Service Users
- Anticipate the impact of regulatory processes and or decisions on each Service User.
- Improve or optimise the physical environment (use unlocked doors where possible, décor, simplified ward layout, easy access to outside spaces and privacy).
- Carry out objective risk assessment with the Service User and carer (if Service User agrees) and consider the degree to which the risk can be verified. The BVC (Almvik, Woods and Rasmussen, 2000) or the DASA-IV (Ogloff & Daffern, 2006) are recommended tools.
- Develop plans or approaches designed to minimise likelihood of aggression occurring including specific strategies and interventions to be identified (minimum areas for assessment outlined in 1.2.10 p. 26) and agreed with the Service User.

3.1.3.3.2. Pharmacological interventions

A section on the use of PRN medication provides guidance on its use as a strategy to de-escalate or prevent situations that may lead to violence. This includes guidance around prescription practices, rationale, and maximum dosage in rapid tranquillisation. A further section on individualised pharmacological strategy to reduce the risk of violence and aggression outlines guidance on the action to be taken by the multi-disciplinary team, in particular the consultant psychiatrist and specialist pharmacist. This includes a pharmacological strategy reviewed and formally documented at least weekly and to include:

- Clarification of target symptoms
- Likely timescale for response to medication
- The total daily dose of medication, prescribed and administered including PRN medication
- The number of and reason for any missed doses
- Therapeutic response

- The emergence of unwanted effects

3.1.3.3.3. De-escalation

A section on de-escalation identifies the need for training based on an overarching principle to establish a close working relationship with Service Users at the earliest opportunity and to sensitively monitor changes that may lead to aggression or violence. This training should enable staff to:

- Recognise early signs of aggression
- Understand likely causes both generally and for each Service User
- Use techniques for distraction and calming
- Recognise the importance of personal space
- Respond to Service Users' anger in an appropriate, measured, and reasonable way and avoid provocation.
- Apply the Human Rights Act (1998), the Mental Capacity Act (2005) and the Mental Health Act (1983).

3.1.3.3.4. Restrictive Interventions

Restrictive interventions are defined as 'interventions that may infringe a person's human rights and freedom of movement, including observation, seclusion, manual restraint, mechanical restraint and rapid tranquillisation' (NICE NG10 p. 19). Restrictive interventions should not be used to 'punish, inflict pain, suffering or humiliation or establish dominance' (NICE NG10 p. 14). 5 principles around the use of restrictive interventions are identified (p.33) and techniques and methods used to restrict a Service User must be:

- Proportionate to the risk and potential seriousness of harm
- The least restrictive option to meet the need
- Be used for no longer than is necessary
- Take account of the Service Users' preferences, if known and it is possible to do so
- Take account of the Service Users physical health, degree of frailty and developmental age
- To this end guidance is provided on the use and safe practice of manual restraint and circumstances under which mechanical restraint should be used.

Guidance pertaining to rapid tranquillisation outlines a requirement for intramuscular lorazepam in the event of an emergency where the person has not taken anti-psychotic medication before. Also, the use of lorazepam as opposed to intramuscular haloperidol combined with intramuscular promethazine where there is evidence of cardiovascular disease. Furthermore, the section outlining the pharmacological strategy states that where rapid tranquillisation is being used, it should be review by a Senior Medical Practitioner at least once a day. Observations including temperature, pulse, respiration, level of hydration and level of consciousness should be monitored at least every hour after rapid tranquillisation. Patients should be monitored every 15 minutes where BNF maxims dose has been exceeded, appear to be asleep or sedated, has taken illicit substances, a pre-existing physical problem or has experienced harm because of the intervention.

Training content is identified to reduce restrictive interventions, skills to reduce, avert and/or diffuse imminent violence and skills/techniques to undertake restrictive interventions when they are

required. Associated with this the Guidance identifies the need to define staff patient ratios and the number of staff required to undertake restrictive interventions and restrictive interventions should take place when these number are available. Furthermore, the need for resuscitation equipment to be available when emergency restrictive interventions might be used, and staff trained in immediate life support and a Doctor trained to use resuscitation equipment are outlined.

Guidance around the development of a policy on searching and observation and procedures for doing so are outlined.

A reducing restrictive intervention programme should be in place and guidance on how to develop content is provided. The programme should be published, and data gathered and analysed. Additionally, there is a recommendation that a Service User experience monitoring group is established, led by Service Users, and including staff, to report and analyse data on violence and aggression and the use of restrictive interventions.

3.1.3.3.5. Post incident de-brief and review

Immediate post incident de-brief as well as formal external post incident review is undertaken no less than 72 hours after the incident. Provisions for the review include that it is led by a Service User, includes staff from outside the ward where the incident took place (who have training in undertaking investigations that aim to help staff to learn and improve rather than assign blame) and a specific framework is provided to support this process.

3.1.3.4. NICE guidance on managing violence and aggression in children and young people (2015)

The guidance in this section builds on that for adults and expands to include children and young people specific provisions. Training should be designed specifically for staff working with children and young people (specifics outlined) and should include the use of psychosocial methods to avoid restrictive interventions. The guidance states that the child or young person's level of physical, intellectual, emotional, and psychological maturity must be considered.

3.1.3.5. Reducing the need for restraint and restrictive intervention (Gov UK, 2019)

This national guidance document is *specific to children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings*. It is based on the principle of the best interests of the child and/or those around them in view of the risks presented. Of note the definitions of restrictive interventions and restraint include (in addition to seclusion, restraint, mechanical restraint, chemical restraint, seclusion):

- Restricting a child or young person's independent action, including removing aids or coercion, including threats to curtail the child or young person's independent actions.
- Withdrawal/Imposed withdrawal: Removing a child or young person involuntarily from a situation which causes anxiety or distress to themselves and/or others and taking them to a safer place where they have a better chance of composing themselves.

- Segregation: Where a child or young person in a health setting is not allowed to mix freely with others on a long-term basis.

A positive approach to behaviour and upholding children's rights forms the basis for minimising and eliminating unnecessary and inappropriate use of restraint through:

- Policies, strategies, and practices which promote a positive culture and improve the quality of children and young people's lives
- Arrangements which identify, assess, and manage risk well
- High quality training of staff
- Involvement of children and young people, parents and carers, and advocates as appropriate
- Arrangements for carefully assessing the needs of children and young people and the underlying causes of their behaviour, including behaviour support plans
- Tailored support for individual children and young people which takes account their wishes, vulnerabilities, learning disability, medical condition or impairments, and their interaction with the environment in which they are cared for and responds to their growth and development over time
- Clear arrangements for governance and accountability in respect of behaviour and responses to behaviour that challenges
- Settings and services should have a hierarchy of responses to support those whose behaviour challenges – suggestions for how this can be achieved are made and include the involvement of children and young people and their carers.
- Evidence based approaches are outlined, the use of positive behaviour supports and behaviour support plans.
- Training and development of staff underlines all risk assessments and interventions to ensure that staff have the necessary knowledge and skills to support children and young people and to achieve a consistent approach. Specific training required for risk assessment processes and the RRN standards are endorsed.
- Safeguarding measures for staff are outlined
- Debriefing and post incident reviews are identified as required and specific guidance is provided.

Further governance requirements around the recording, reporting, and monitoring of incidents and for reviewing how restraint is used in child and adolescent populations are outlined below. These are inspected by the CQC in their role as regulator of Mental Health Services.

- In health services, record keeping should be consistent with the requirements of the Mental Health Services Dataset and the National Reporting Learning System.
- Services must publish an annually updated, accessible report on their behaviour support planning and restrictive intervention reduction programmes.
- This must outline the training strategy, techniques used, with what frequency and Reducing the Need for Restraint and Restrictive Intervention reasons why, whether any significant injuries resulted, and details of ongoing strategies for bringing about reductions in the use of restrictive intervention.
- Settings and services are required to ensure policies and procedures are aligned with various legal and policy documents as well as this document.

3.1.3.6. Restraint Reduction Network (RRN) Training Standards (2021)

The Restraint Reduction Network was formed in 2010. It was an important development in the context of restrictive practices in England as it brought together providers, regulators, government departments and campaigners to work together on restraint reduction.

The first edition of the RRN training standards were published in 2019 (Ridley and Leitch, 2021). This book provides a national and international benchmark identifying evidence-based standards to be followed. The aim is to ensure that training is directly related and proportional to the needs of populations and individual people. Furthermore, the standards aim to ensure that training is provided by competent and experienced training professionals who can evidence knowledge and skills. They are applicable to education, health, and social care. In the context of this review, the standards have been validated for application in Mental Health Services in the NHS in England and have been incorporated into the CQC inspection processes since 2020. Critical contributions to these standards have been made by a significant number of specialist academics (including one Irish based expert) and numerous national stakeholders. They are evidence based and are applicable across all age groups.

The standards adopt a rights-based framework for training through the application of 4 overarching standard domains, within which 36 standards outline the best/evidence-based practice:

1. Standards supporting pre-delivery processes
2. Standards supporting curriculum content
3. Standards supporting post-delivery processes
4. Trainer standards

3.1.3.7. Towards Safer Services: Minimum Standards, Organisational Restraint Reduction Plans (RRN, 2021 in final draft)

Although titled 'minimum standards' it should be noted that these standards standards are not endorsed by the NHSE or CQC and don't have a 'national' status. The document is a good practice document which recommends the steps necessary to attempt to reduce restraint. It is designed to be a useful resource for services and campaigners alike in the context of the legal duty upon providers to reduce restraint as laid out in the Mental Health Units Use of Force Act (2018), informally referred to as 'Seni's law'. The document outlines standards that can support all reduction plans across Mental Health and Learning Disability settings. The standards are evidence based and in line with Chapter 26 of the Code of Practice (Safe and Therapeutic Responses to Disturbed Behaviour) and Human Rights Legislation. Leadership, assurance, accountability and monitoring arrangements are highlighted as necessary to ensure transparency and inform an organisational learning culture aimed at further improving care provision by (p. 7):

- Making prevention uppermost in the minds of all parties. This will promote cultures that recognise personal factors and types of environments which may cause behaviour, which then leads to the use of restrictive interventions in practice, and progress effective interventions to reduce risk.
- Implementing primary prevention strategies that mitigate certain cultural problems within services in relation to the nature of staff relationships with people receiving

the service, the role of practitioners and their wider skills. The effect of systemic factors physical environments and staffing levels must also be considered.
- Fostering organisational strategies that are evidence based and include procedures for regular self-appraisal, for example, against characteristics of successful restraint reduction initiatives.

Several enablers are identified for the implementation of the standards including (p.7/8):

- Named individuals at Senior level are to be responsible and accountable for the development, implementation, and robust evaluation of a proactive, evidence-based strategy.
- A refocus on therapeutic environments to reduce restrictive practices through co-production and rights based, recovery focused environments.
- On-going training and education with a focus on prevention and organisational learning
- Thoughtful planned strategic change
- The importance of individual formulation-based assessment of need to inform care planning is key, to respect people's autonomy.
- Clarity around what is organisationally permissible and not
- Policies to embed the strategic plan and that are compatible with the Human Rights Act. It is noted that the Equalities and Human Rights Commission has produced a framework which should be used to develop policies (EHRC, 2019).

Primary, secondary, and tertiary evidence-based approaches are outlined as well as review, support and debrief strategies.
There are three overarching sections each containing very specific standard recommendations:

Section 1: Board Level Organisational Compliance Standard: 15 standards each with actions required
Section 2: Effective Care Planning and Multidisciplinary Team Compliance Standard: 5 standards each with actions required
Standard 3: Training Content and Trainer Compliance Standard: 5 standards each with actions required.

3.1.4. Governance processes

The Care Quality Commission (CQC) is responsible for the registration, inspection and monitoring of health and care providers, including mental health providers under the Health and Social Care Act (2008).

Fundamental standards for care provision are inspected by the CQC on a regular basis, these are summarised below.

1. Person-centred care
2. Dignity and respect
3. Consent
4. Safety
5. Safeguarding from abuse
6. Food and drink
7. Premises and equipment

8. Complaints
9. Good governance
10. Staffing
11. Fit and proper staff
12. Duty of candour
13. Display of ratings

With reference to Mental Health Services, The Code of Practice (2015) is the starting point for the CQC. The CQC has regulatory powers to facilitate change and improvement where there is a failure to apply the Act and its Code. Although not directly mentioned in the Code- the CQC seeks to ensure that best practices as identified in NICE guidelines are adhered to as part of the inspection process.

3.1.5. Considerations for Ireland

Consideration	**Source**
Consider adding enhanced observations and deprivation of access to normal daytime clothing to restrictive practices	Code of Practice 2015: Chapter 26
Consider making a values-based approach explicit in all legal, guidance or standards documents relating to the prevention and management of aggression (including least restrictive practices): • Least restrictive option and maximising independence • Empowerment and involvement • Respect and dignity • Purpose and effectiveness • Efficiency and equity	MHA 2007 enacted in Code of Practice 2015
Consider providing foundation national standards on the prevention and management of aggression with further specialist guidance for Children, Adults and Older Adults.	NICE Guidance
Consider viewing antecedents of aggression from different perspectives, patient centric (illness, history, personal concerns inside and outside of hospital, communication), environment (other patients' behaviours, miscommunications, environmental restrictions, and spaces) and provide guidance accordingly.	NICE Guidance
In considerations around chemical restraint, consider differentiating the use of PRN medication to de-escalate or prevent situations which may lead to violence and aggression as separate from other considerations requiring PRN medication.	NICE Guidance
Consider the identification of a suite of core training requirements for staff on the prevention, management of aggression and use of restrictive practices based on best evidence and international best practice. Consider the adoption or adaptation of the RRN training standards in this regard.	NICE Guidance, Restraint Reduction Network (RRN) Standards (2021)

Consider alternative post incident de-briefing and review approaches that remove the responsibility from the ward where the event occurred, place the Service User at the centre and provide objective staff review	NICE Guidance (NG10)
Consider adopting a Service User led monitoring unit or similar for analysis of data on aggression and the use of restrictive practices in restrictive intervention reduction programmes.	NICE Guidance (NG10)
Consider developing national guidance on observations and adding search and observations to nationally monitored restrictive practices.	Code of Practice 2015: Chapter 26

3.2. Northern Ireland

3.2.1. Model of Service

Healthcare in Northern Ireland (NI) is devolved to the Northern Ireland Assembly and as such operates from an independent legislative framework. Health and social care are fully integrated and are overseen by the Health and Social Care Board (HCSB) which has strategic responsibility for commissioning services, resource management, performance management and service improvement. The model of service is outlined in Figure 4. The HSCB devolves responsibility for local planning and delivery to 5 local commissioning groups who in turn commission health services through 5 Health and Social Care Trusts (HCTs). The local commissioning groups and the HCTs are geographically aligned. Mental health services are delivered through the HCTs including inpatient, community, CAMHs and forensic services. The NI ambulance service is the sixth HCT, providing a service across all HCT areas.

Healthcare in NI is supported by three additional discreet healthcare services. The Public Health Agency (PHA) has overall responsibility for improving health and wellbeing and health protection. The PHA is also jointly responsible (with the HSCB) for the development of a fully integrated commissioning plan for health and social care in Northern Ireland. Second, The Patient and Client Council (PCC) covers all of NI and provides an independent voice for patients, clients, carers, and communities on health and social care issues. Finally, The Business Services Organisation (BSO) provides the business supports to Health and Social Care in NI including HR, finance, legal services, procurement and ICT.

Health and social care in NI is regulated by The Regulation and Quality Improvement Authority (RQIA). RQIA is an independent body with responsibility for continuous improvement and regulatory functions including inspections. These inspections extend to mental health services.

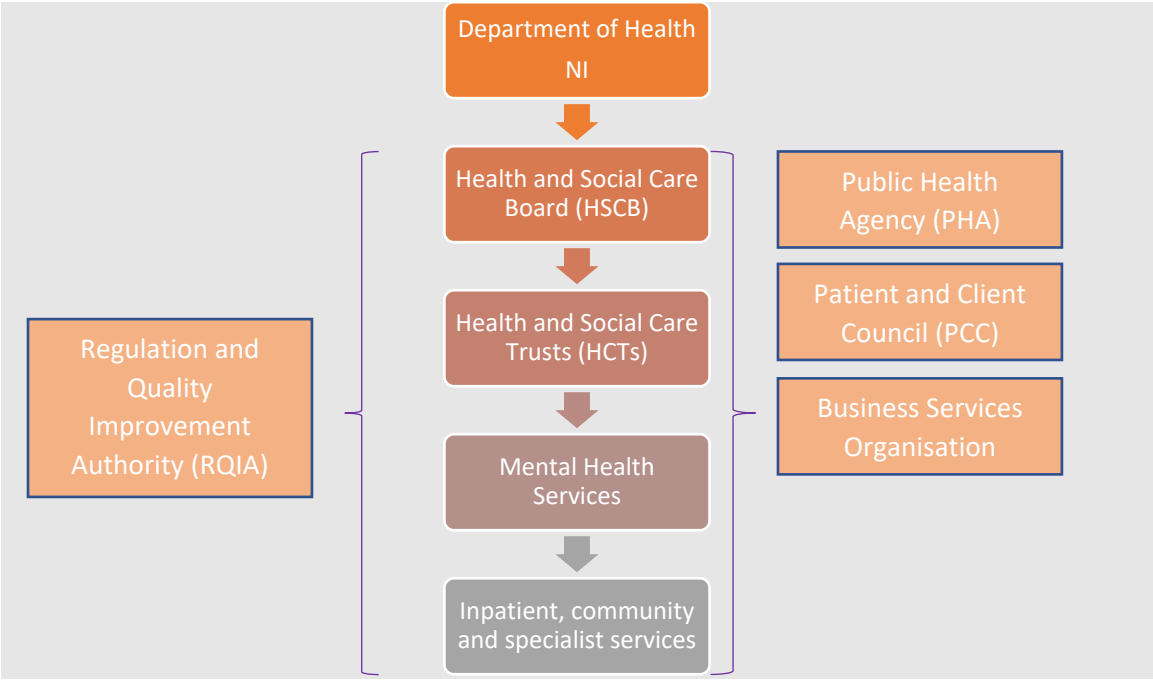


Figure 4 – Model of Service in Northern Ireland

3.2.2. Legislation

The Mental Health (Northern Ireland) Order (1986) (referred to as 'the 1986 Order') and the Mental Capacity (NI) Act (2016) are the primary Acts relating to mental healthcare in Northern Ireland.

The Mental Capacity (NI) Act (2016) ("MC(NI)A") provides a legal framework for people who lack capacity to make decisions for themselves and for those who have capacity to prepare for a time when they may lack capacity. It *combines* mental capacity and mental health law for people aged 16 years old and over in Northern Ireland. This Act is currently being introduced in stages and when all stages are in place it will replace the 1986 Order. Until such time as this process is complete there is a dual system in place. Therefore, at this time the legislative background is complex and both Acts provide the legal frameworks for mental health care in NI.

3.2.3. Relevant Standards, Guidance, Policy

3.2.3.1. Three Steps to Positive Practice: A rights-based approach when considering and reviewing the use of restrictive interventions (2017)

This document was developed by a multi-disciplinary group in the absence of any guidance or standard documents in relation to restrictive practices and is in use throughout NI. It is adopted as the underpinning process for the culture change necessary to reframe restrictive practices and to support the achievement of a new regulated approach to these measures. The document adopts a rights-based approach to decision making and positive practice as a means of achieving this. It is

incorporated into the Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the Use of Seclusion (2021).

The three steps to positive practice is a continuous and cyclical process (See Fig. 5) which requires the professional in practice to:

1. Consider and plan: Consider the nature of the intervention in the context of the definition of restrictive practice. Consider less restrictive means of managing the situation with due regard for the intention of the practice.
2. Implement the safeguards: Professionals to use a rights-based approach in line with professional accountability and legal frameworks to ensure that the restrictive practice is only used in the persons best interests
3. Review and reflect: Ensuring regular and timely review of restrictive practice as part of the therapeutic plan. The plan should meet the persons needs and include reduction and/or removal of restrictive practices as soon as is possible. Reflection here is essential for professional support systems and to consider the impact of the use of restrictive practices.

The framework provides guidance and a series of questions to support practitioners to identify restrictive practices at all levels and to consider alternative, less restrictive means. It is a practical usable and implementable framework.

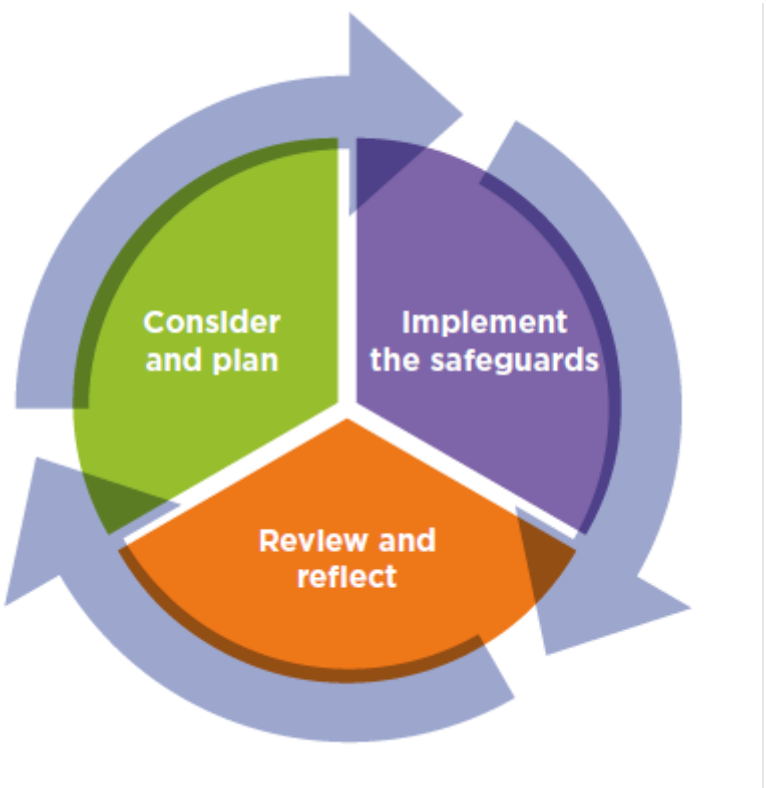


Figure 5 - Three steps to Positive Practice Framework (RCN, 2019 p. 4)

3.2.3.2. Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the Use of Seclusion (2021)

The mental health action plan was developed in 2020 to support the implementation of the Mental Health Strategy 2021-2031 (DoH NI, 2021). The Mental Health Strategy sets an agenda for the reform of mental health services in NI adopting a rights approach and a family recovery focused philosophy. However, the strategy does not address the issue of restrictive practices. To this end a separate regional policy on the use of Restrictive Practices in Health and Social Care Settings And regional operational procedure for the use of Seclusion was developed and completed the consultation process in October 2021. The consultation is currently under the consideration of the Department of Health and is overseen by the Mental Health Action Plan.

Whilst it is not clear what the final document will retain from the consultation, there are a number of issues worth noting. The policy sets out the expectations for minimising use of restrictive interventions, restraint and seclusion. Clear definitions are proposed for standardisation across the region. Requirements for decision making, reporting and governance arrangements for the use of any restrictive practice are clearly outlined and the draft policy proposes this through seven standards as follows:

1. All organisations must use the standard definitions to identify all interventions which are potentially restrictive.

2. All local policies and practices must embed use of the *Three Steps to Positive Practice Framework (RCN, 2017)* when considering and reviewing the use of restrictive interventions.

3. Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans.

4. Organisational strategies and related policies for minimising the use of restrictive interventions must follow a minimum content format.

5. Effective and person-centred communication must be central to care and treatment planning.

6. Roles and responsibilities are defined in terms of monitoring, reporting and governance.

7. Any use of seclusion as a last resort intervention must follow the regional operating procedures.

Four key principles underpin the Draft Document which adopts a rights approach to restrictive practices:

1. Restrictive Practice is an umbrella term that refers to the entire range of interventions that are considered restrictive and which infringe a person's rights.

2. Evidence of therapeutic benefits for use of restraint and seclusion is limited.

3. Organisations must have robust monitoring arrangements in place which provide assurances that restrictive practices are used only as a last resort.

4. Minimisation strategies, culture change and practice improvement will only be successful with robust monitoring, oversight and assurance, led by identified individuals in each organisation.

Critically, the *Three Steps to Positive Practice (RCN, 2017)* is adopted as the vehicle for culture change for both use of restrictive practices and minimisation strategies at both organisational and practice levels.

3.3.4 Considerations for Ireland

Consideration	**Source**
Consider incorporating the Three Steps to Positive Practice (RCN, 2017), or commensurate approach, into standards and decision-making processes	Three Steps to Positive Practice (RCN, 2017)
Consider some of the approaches identified in the Draft Standard as follows: • Explicit statement around the evidence base or therapeutic benefit of restrictive practices • Overall generic guidance on restrictive practices in advance of specific requirements to standardise approaches • Consider the key standards identified for organisations and practice • Consider anchoring all restrictive practice approaches in a Human Rights approach • Clarify the nature of restrictive practices beyond that which is reportable to the MHC and how these are to be managed • Guidance to staff around working within a legislative framework • Clear identification of proactive evidence-based approaches that can be applied in advance of decision to use a restrictive practice • Clear framework and requirements around review of restrictive practice incident reviews • Clarify roles across the organisation relating to restrictive practices • Use of seclusion: Clear incidences when it is not to be used • Robust guidance around seclusion facilities • Involvement of Senior Management in the process of restraint through notification and review to support • Include guidance around the use of rapid tranquillisation whilst in seclusion • Include provisions for management of emergencies such as fire or medical incidents	Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the Use of Seclusion (2021)

3.3. Scotland

3.3.1. Model of Service

The National framework identifies 11 overarching goals for Scotland with a clear underpinning purpose and associated values. This framework is the oversight national policy framework and national KPIs are identified and monitored. Data is public and available on the Health Service Website.

The responsibility for the funding and delivery of healthcare in Scotland rests with NHS Scotland. Funding and responsibility for care delivery is devolved to 14 NHS Boards and 7 Special NHS Boards. The NHS Boards are accountable to Scottish Ministers supported by Scottish Government Health and Social Care Directorates.

3.3.1.1. Mental Health and Social Care Directorate

The Mental Health and Social Care Directorate leads on mental health policy and on the delivery of the mental health aspects of the Programme for Government and the Mental Health Strategy 2017-2027 (Gov Scot, 2017).

The Directorate is responsible for:

- prioritising mental health and ensuring the delivery of high-quality services
- considering the effects mental health has on other areas of a person's life, including their physical health and social circumstances
- ensuring appropriate access to services by working closely with key stakeholders such as NHS Boards, Integrated Joint Boards and the third sector
- monitoring the delivery of key parts of the Mental Health Strategy
- promoting public health from a mental health perspective including through the Suicide Prevention Action Plan
- restricted patients
- reviewing mental health legislation and forensic Mental Health Services
- all aspects of mental health policy for children and young people
- leading on perinatal and infant mental health
- implementing the autism, learning disability and dementia strategies
- ensuring that the social care sector can provide compassionate, high-quality care on a fair and sustainable basis
- developing and implementing dementia policy and delivery of the 2017 to 2020 National Dementia Strategy

3.3.1.2. NHS Boards

The NHS Boards are regionalised and are responsible for the protection and the improvement of their population's health and for the delivery and management of frontline healthcare services. Health

Services (including Mental Health Services) in their designated area and are responsible for meeting the health needs of that region.

3.3.1.3. Special NHS Boards

The Special NHS Boards support the regional NHS Boards by providing a range of important specialist and national services. These Boards support the delivery of healthcare across all services:

- Public Health Scotland
- Healthcare Improvement Scotland
- NHS Education for Scotland
- NHS National waiting times centre
- NHS24
- Scottish Ambulance Service
- The State Hospitals Board for Scotland: Provides assessment, treatment, and care in conditions of special security for individuals with a mental disorder whom because of their dangerous, violent, or criminal propensities cannot be cared for within any other setting.
- NHS National Services Scotland

3.3.1.4. Mental Health Service Delivery

Mental Health Services are governed by the regional NHS Boards. These include inpatient services and community Mental Health Services. CAMHs services are provided by specialist teams. Inpatient forensic services are delivered by the Secure Services Special Board which includes high, medium, and low secure services.

Scottish Health Services are devolved as outlined in Fig 6.

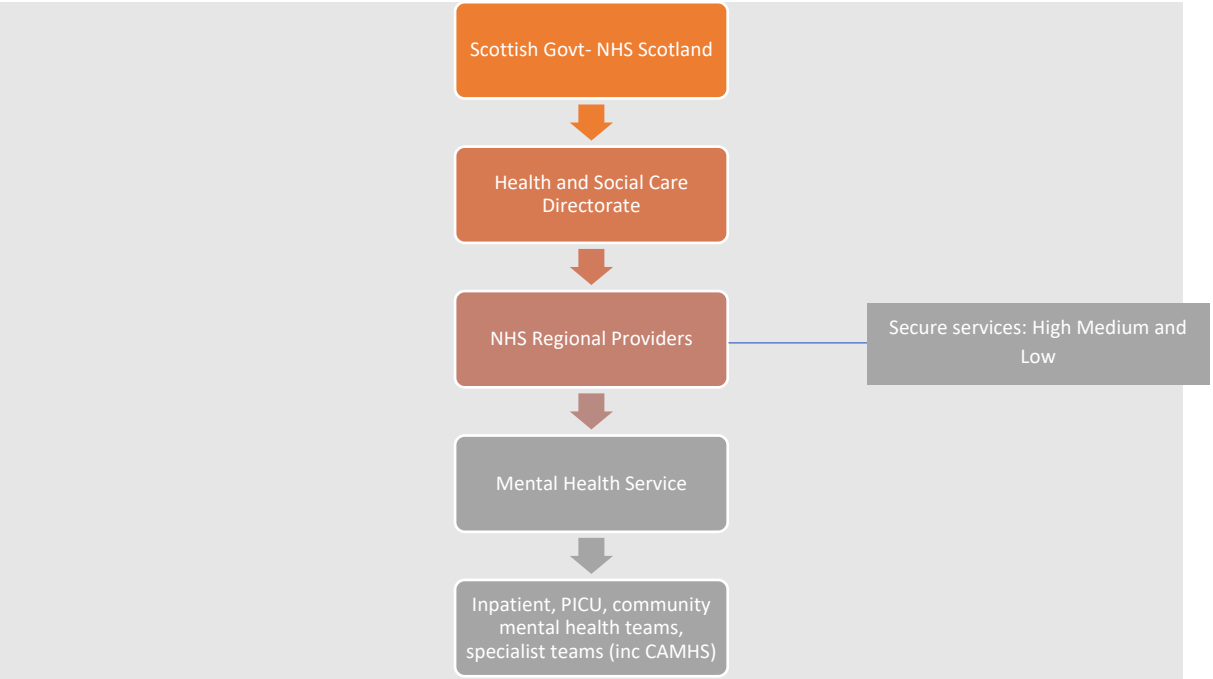


Figure 6 – Scottish Health Services Devolution Model for Mental Health Services

3.3.2 Relevant legislation and regulation

The MHA (1984) was reviewed by the Millan Report (2001) and was subsequently amended (Mental Health (Care and Treatment) (Scotland) Act (2003). The Millan report gave rise to the Millan Principles which changed the principles of care in Scotland and continue to have a huge impact in Scottish Mental Health. The Millan principles are important as they have been the foundation of all national guidance and legislation around restrictive practices since their publication:

- *Non-discrimination:* People with mental disorder should whenever possible, retain the same rights and entitlements as those with other health needs.
- *Equity:* All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, race, colour, language, religion or national or ethnic or social origin.
- *Respect for diversity:* Patients should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly considers their age, gender, sexual orientation, ethnic group, and social, cultural, and religious background.
- *Reciprocity:* Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide appropriate services, including ongoing care following discharge from compulsion.
- *Informal care:* Wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion.
- *Participation:* Patients should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken

of their past and present wishes, so far as they can be ascertained. Patients should be provided with all the information necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.

- *Respect for carers:* Those who provide care to patients on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs considered.
- *Least restrictive alternative*: Patients should be provided with any necessary care, treatment, and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.
- *Benefit:* Any intervention under the Act should be likely to produce for the patient a benefit which cannot reasonably be achieved other than by the intervention.
- *Child welfare:* The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

3.3.2.1 Mental Health (Care and Treatment) (Scotland) Act (2003)

This is a rights-based piece of legislation came into effect in April 2005 and gives individuals the statutory right to express their views about their care and treatment. It provides the right to access independent advocacy, the right to submit an advanced statement which states an individual's wishes (which should be respected unless there are compelling reasons not to do so) and the right to choose a named person who can make decisions on an individual's behalf. It also redefined the role and functions of the Mental Welfare Commission (MWC) for Scotland and established the Mental Health Tribunal as the principal forum for approving and reviewing compulsory measures for the detention, care, and treatment of mentally disordered persons, taking most decisions out of the criminal justice system and away from Sheriffs.

3.3.2.2 Adult Support and Protection (Scotland) Act (2007)

There was subsequently a review of the 2003 act called the McManus Review. This review had a specific remit to look at how the act operated in relation to people with Intellectual Disability / Autism Spectrum Disorder. The Act also sought to ensure that the Milan principles were enshrined in law which include the least restrictive principle. This Act made provisions for advanced statements for mental health Service Users. Advanced statements can relate to any treatment issue, made in advance by the Service User under certain witnessed conditions.

3.3.2.3 Public Bodies (Joint working) (Scotland) Act (2014)

This Act sets the framework for integrating adult health and social care, to ensure a consistent provision of quality, sustainable care services for the people in Scotland who need joined-up support and care, particularly people with multiple, complex, long-term conditions.

3.3.2.4 Mental Health Act Scotland (2015)

This Act made several provisions for Mental Health Care summarised as follows (adapted from NHS Scotland, 2021)

- Excessive Security
  The 2015 Act allows regulations to extend the right of appeal against being detained in an excessive level of security to qualifying patients in qualifying hospitals. These hospitals are named in the Act.
- Named persons
  The most significant change related to named persons in the 2015 Act is to remove provisions for the appointment of named persons by default so that adult patients only have a named person if they choose to have one (this does not apply to patients under 16). It also introduces a limited right, where the patient has no named person, for listed persons (the carer, nearest relative, guardian or welfare attorney) to apply or appeal to the Mental Health Tribunal, if the patient does not have capacity to do so on their own behalf. There is an associated limited right to information for guardians and welfare attorneys in certain circumstances
- Advance statements
  The 2015 Act introduces a requirement for NHS Boards to keep a copy of any advance statement received with the patient's records and to provide certain information about the existence and location of the statement to the Mental Welfare Commission, to be held on a register of information. It also requires NHS Boards to publicise the support that it provides to make and withdraw an advance statement.
- Independent advocacy
  The 2015 Act builds on the right in the 2003 Act to independent advocacy services and requires services to report to the MHC on this issue.
- Suspension of detention
  The 2015 Act makes some changes to the operation of suspension of detention provisions, particular in relation to calculating the total maximum allowed suspension of detention.
- Cross border transfers and absconding patients
  The 2015 Act extends certain provisions relating to cross-border transfers and absconding to EU patients outside the UK and sets out that the cross-border transfer regulations must include a right of appeal against the transfer for the named person or listed person where there is no named person.
- Support to patients (communication at medical exams/ services for mothers)
  The 2015 Act extends the provisions in the 2003 Act which require provision of support with communication to certain other medical examinations.
- Commission information
  The 2015 Act allows regulations to prescribe what statistical information must be provided by the Mental Welfare Commission to Ministers.
- Reviews of deaths of patients in hospital for treatment
  The 2015 Act requires Ministers to carry out a review of the arrangements for investigating the deaths of patients in hospital for treatment for a mental disorder. The review must be carried out within three years of this date.
- Technical changes to operation of orders and certificates

There are also a range of other provisions which make more minor changes to the operation of various orders and certificates, including to timescales and notification requirements.

3.3.3 Standards, guidance, and policies

3.3.3.1 Good Practice Guide: Human Rights in Mental Health Services (2017)

This is a very comprehensive guide which outlines patients-rights in all aspects of their care experience. Chapter 4 outlines the requirements for a recovery plan, minimum restrictions, safety, and security. The right to make an advanced statement and have it adhered to is explicit for detained patients.

The right to minimum seclusion includes clear direction that all detained patients have the right to not be secluded against their will unless it is the only way of managing risk to their self or others; that seclusion for as little time as necessary and there is discussion and support (debrief) afterwards.

Further rights around minimum physical restraint are outlined and it is explicit that detained patients must not be restrained unless it is the only way of managing risk to self or others, the restraint must be for as little time as necessary and with minimum force and there must be discussion and support (debrief) afterwards.

The right minimum levels of intrusive observations are also identified in this Chapter and a refocussing from containment associated with the intervention to engaging patients in a more therapeutic way is advocated. To support this the document refers to Engaging People: Observation of People with Acute Mental Health Problems CRAG (Clinical Resource and Audit Group, 2002).

3.3.3.2 Use of Seclusion: Good Practice Guide (2019)

This guide was produced and is inspected by the MWC in its role as regulator of Mental Health Services. The MWC require that seclusion is only used in the context of an approved policy on the management and prevention of violence, produced by the relevant NHS board for each hospital. Use must be based on a comprehensive risk assessment which must consider all available information and should be made, as far as possible in the circumstances, by the clinical and social care team. This must include consideration of the full range of options available which must be recorded. The Guide (p.9) states that 'there must be a clear benefit to the individual for whom seclusion is being considered. Whilst seclusion is usually seen as a protective measures for others, clearly, it would not be in the interests of the person concerned If he or she were allowed to harm someone else'. Furthermore, seclusion must take place only within the principle of the least restriction and benefit (p.15). This guide defines seclusion as follows:

"Seclusion in health settings refers to the supervised confinement of a patient or resident, away from other patients and residents, in an area from which the patient or resident is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. It does not matter whether the place of isolation is an enclosed room (rather than for example, a part of a larger space) or whether the door to such a

space is closed or open, locked or unlocked" (CWC, 2019 p.4) The document further delineates seclusion into Level 1 and Level 2.

Level 1: Seclusion refers to the following (CWC, 2019 p.11):

- Where staff lock a person alone in a designated seclusion room or seclusion suite
- Where staff lock a person alone in a room or a suite of rooms
- Where staff place a person alone in a room and prevent them from leaving either by holding the door shut, standing in the doorway, or instructing them not to leave

Level 2: Seclusion refers to the following:

- Where staff remain with a person in a room or suite of rooms and prevent them from leaving or instructing the person not to leave
- Where staff place restrictions on the physical environment the person can move to with the intention of keeping them separated from others

Monitoring procedures are dependent on the level of seclusion. Level 1 seclusion requires continuous observation by staff either directly or by CCTV and written reports should be maintained every 15 minutes on the persons physical and psychological state. Managers are required to maintain a record of all seclusions. Additionally, a Senior member of staff must formally review the requirement for seclusion at least every 4 hours. The Guide proposes that the Registered Medical Officer convenes a multi- professional review of the seclusion if it continues for longer than a period identified in the local policy but not more than 12 hours.

Managers are required to have oversight of seclusion and it should be closely scrutinised through clinical governance structures. The guide is clear that there must be oversight of the use of seclusion by clinical and management staff *distinct* from the treating team (p.17). Services are required to have a policy which includes the need for peer reviews every 72hrs for level 1 and external review as stated in the policy. Furthermore, the Guide recommends, due to the serious nature of seclusion, that reports are made regularly to the managers of the NHS services and in aggregated and anonymous form to NHS Boards.

3.3.3.3 Rights, risks, and limits to freedom: Good Practice Guide (2021)

This Guide is intended to provide health and social care staff with guidance around the legal, ethical and practical considerations in instances where staff are considering restrictive interventions to limit someone's freedom of movement. The guidance outlines the underpinning principles to be considered in relation to restrictive practices.

Definitions of restraint and mechanical restraint are clearly stated. The last resort principle is made clear. Circumstances under which either restraint is permissible are stated and reporting requirements are outlined. Locked doors are identified as a restrictive practice and supportive guidance is provided around how this can be managed and avoided where possible. The use of location technology and video surveillance is also covered as well as the circumstances under which these measures can be taken.

Medication as restraint is covered in the document and defined as 'the use of sedative or tranquillising drugs for purely symptomatic treatment of restlessness or stressed or distressed behaviour' (p. 30). There is a recognition that this is not a straightforward issue and that the boundaries between medication as restraint and side effects of therapeutic medication is not always clear. A process to assess the difference between these two issues is outlined in addition to a requirement for alternatives to medication as restraint to be explored. This issue will be further explored in Section 6 'Chemical Restraint'. Indirect limits to freedom and restraint by default or because of interpersonal control by staff are also addressed.

3.3.3.4 Good Practice Guide: Advanced statement guidance, my views, my treatment (2017)

An individual has a right to make advanced statements about their care or future care. This guide provides both staff and Service Users with guidance around how advanced statements can be developed and enacted.

3.3.3.5 The Scottish Mental Health Safety Programme

The Scottish Patient Safety Programme (SPSP) is a national quality improvement programme that aims to improve the safety and reliability of care and to reduce harm. Since the launch of SPSP mental health in 2012, the programme has worked to ensure people are and feel safe in adult mental health inpatient settings.

All projects and programmes introduced by the SPSP are underpinned by the robust application of quality improvement methodology. SPSP mental health has brought about significant change in outcomes for people across Scotland. Successful interventions in the reduction of restrictive practices have been co-ordinated and/or supported by the SMSP on a bottom-up basis including the introduction of Trauma Informed Care, the Six Cs and Safewards.

3.3.3.6 Reducing Restrictive Practices Network

This Network is co-ordinated by the Scottish Centre for Learning Disability and presently has membership from health, social care (including residential childcare) police and the prison service. It is not a decision-making forum but is developed to share best practice and ultimately to influence the direction of policy across government.

3.3.4 Seclusion, physical restraint, mechanical restraint, chemical restraint

Seclusion, physical restraint, mechanical restraint and to a lesser extent chemical restraint are all defined within the overarching documents governing legislation and best practice in Scotland. Guidance is provided by the Mental Health and Welfare Commission. All guidance is underpinned by patients-rights and the least restrictive principle. Of note there is an agenda towards reducing and eliminating the use of 1:1 observation and to re orientate towards a more therapeutic focus.

3.3.5 Governance processes

3.3.5.1 Healthcare Improvement Scotland

Healthcare Improvement Scotland has a remit across all health services to support service development to meet National Strategies and targets. The Department produces evidence-based guidelines and works with services to support improvements. With regards to mental health, Healthcare Improvement Scotland has been working for some years with Mental Health Services communities, people who use the services, and leadership teams to develop and deliver improvements to Mental Health Care services.

Health Improvement Scotland leads the Scottish Patient Safety Programme in Mental Health (SPSPMH) which is improving outcomes by focusing on reducing harm. This includes reducing the rates of restraint, violence, self-harm, and seclusion, while improving medicine safety at key transition points. This work has taken place in adult acute mental health wards and is underpinned by quality improvement methodology.

Of note since 2019 the SPSMH has been working with services to move away from the traditional practice of enhanced observations through the Improving Observation Practice Programme. The document 'From Observations to Interventions: A proactive, responsive, personalised care and treatment framework for acutely unwell people in mental healthcare' (Healthcare Improvement Scotland, 2019) is based on trauma informed principles with the aim of providing care services that will minimise the risk of further trauma. The core principles of trauma-informed care are choice, collaboration, trust, empowerment, and safety. Furthermore, the principle of the least restrictive intervention is paramount in the document, which also refers to seclusion and restraint as containment measures. The Broset Violence Checklist (BVC) is recommended as a means of assessing the likelihood of violence and taking positive steps to avoid.

The SPSMH also provides guidance and a suite of quality improvement tools to support practice developments in services.

3.3.5.2 The Mental Welfare Commission

The Mental Welfare Commission (MWC) was established in 1960 under the Mental Health Act. The MWC is the regulator of Mental Health Services in Scotland and is empowered under current mental health and incapacity law. The MWC has statutory duties to monitor the Mental Health (Care & Treatment) (Scotland) Act (2003) and the welfare parts of the Adults with Incapacity (Scotland) Act (2000). To this end the MWC operates as the monitor of all legislative and best practice requirements in Scottish Mental Health Services. The Commission does this through onsite inspections, one third of which are unannounced, and themed inspections.

It is mandatory that services providing care and treatment inform the MWC if:

- A person is detained under the Mental Health Act
- A person is detained without the consent of a mental health officer
- A person is placed under a compulsory treatment order

- A person is given care and treatment that is not in line with his or her advance statement, or if:
- a compulsory treatment order has been changed in an important way
- a welfare guardian has been appointed to make decisions on another person's behalf

The Commission carries out its statutory duties by focussing on five main areas of work as follows:

1. Visiting people
2. Monitoring the Acts
3. Investigations
4. Information and advice
5. Influencing and challenging.

The Commission produces an annual report based on these activities.

3.3.6 Considerations for Ireland

Consideration	**Source**
Consider the use of Quality Improvement Principles and Measures for reduction of restrictive practices as a matter of national policy.	Scottish Patient Safety Programme
Consider the adoption of a core set of principles as the basis for all guidance, interventions, restrictive practices, and restrictive practices reduction including but not limited to Trauma Informed Care and the least restrictive principle.	Milan Principles
Consider building in the requirement for leadership or management oversight of restrictive practices in particular seclusion and restraint into the rules and code of practice. This will remove discretion to implement one of the evidence-based measures for reducing seclusion and restraint.	Good Practice Guide: The use of Seclusion (2019)
Consider making advanced statements a right for all people accessing the services and provide guidance on how this should happen.	MHA Scotland (2015) Good Practice Guide: Human Rights in Mental Health Services (2017)
Consider providing guidance to reduce close observations as a restrictive practice and re-orientate the interventions to a more therapeutic focussed care process.	Good Practice Guide: Human Rights in Mental Health Services (2017) 'From Observations to Interventions' (SPSPMH 2019)

3.4 South Australia

3.4.1 Model of Service

Responsibility for healthcare in South Australia rests with the Department of Health and Wellbeing (DHW) in the State Government, who provide leadership in health reform, public health services, health and medical research, policy development and planning. The DHW is also responsible for distributing funding to Local health Networks (LHNs).

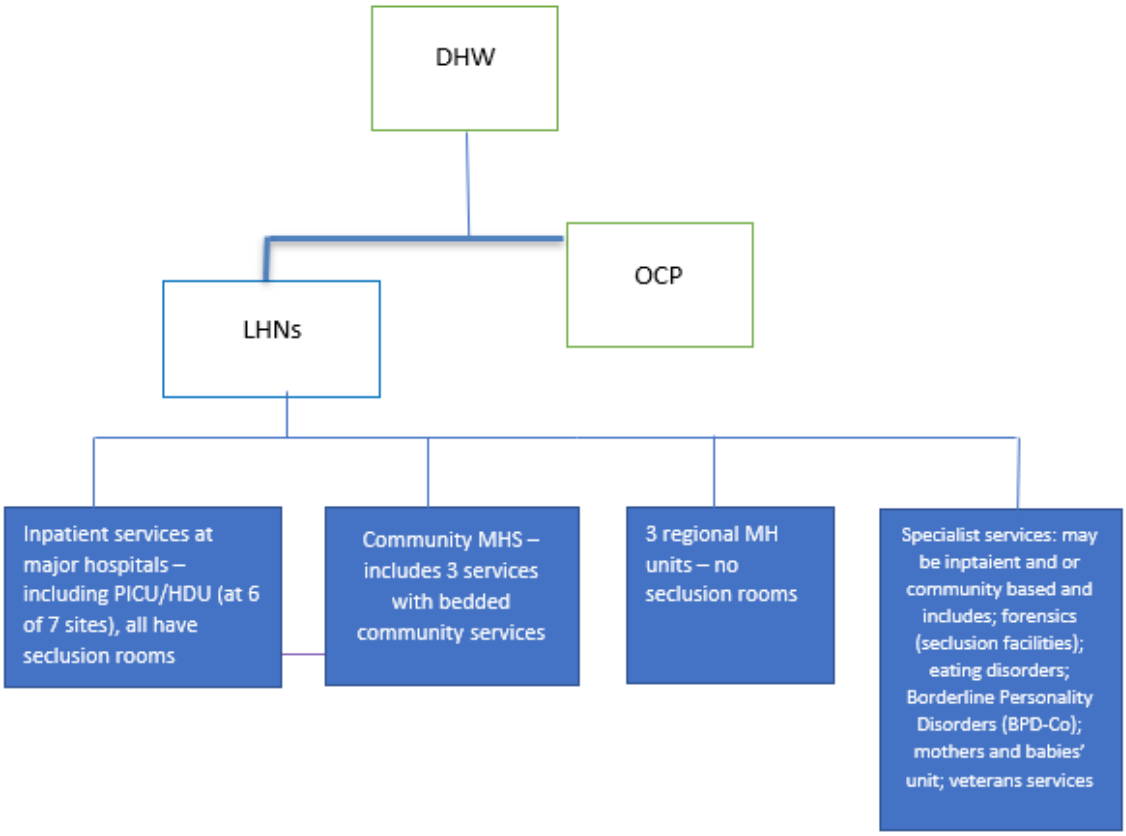
The DHW is overseen by the Minister for Health with an appointed Chief Executive. Statutory positions for Health include Chief Psychiatrist, Principle Community Visitor and the Health and Communities Services Complaints Commissioner – all of whom have monitoring and or inspection (sometimes both) responsibilities for ensuring quality health care. The DHW sets the policy framework and strategic direction for healthcare for South Australia.

Responsibility for service delivery is devolved from the DHW to 10 LHNs. Service delivery and state-wide planning occurs through service agreements with the LHNs. The LHNs are responsible for managing the delivery of public hospital services and other community-based services in an identified geographical area. These may include community health and residential functions for aged and vulnerable groups.

Each LHN has a Governing Board with an appointed Chief Executive Officer, with ultimate responsibility for delivering, managing, and monitoring health services in that area. The Board is accountable to the DHW for meeting performance measures as agreed in service agreements. The day-to-day management of and operations of the services within the LHNs is devolved to the LHN CEOs and Boards. Health 'departments', such as Mental Health, have Clinical Directors and Nursing Co-Directors who are responsible for services in their Local Health Network, including inpatient and community services. The LHNs set the mental health agenda for their area utilising Strategic Plans developed by the Office of the Chief Psychiatrist (OCP) and DHW.

All major hospitals have a Mental Health Unit attached. This unit includes a Psychiatric Intensive Care Unit (PICU) or High Dependency Unit (HDU) (except for 1) and all have access to a seclusion room. These units are approved for the admission of people under the MHA by the Office of the Chief Psychiatrist. The integrated care units in the Country Areas have limited approved centre approval. 2 separate specialist units exist for women and children in the state-wide Women's and Children's Health Network, the one LHN that is not geographically defined.

Model of service delivery is charted in Fig. 7.



DHW: Department of Health and Wellbeing
OCP: Office of the Chef Psychiatrist
LHN: Local Health Network

Figure 7 -Model of Service South Australia

3.4.2 Relevant legislation and regulation

3.4.2.1 Health Care Act (2008)

This Act reviewed the administration of hospitals and other health services into LHNs responsible for the development, delivery and monitoring of all health services in their identified region. The Act also provided for the establishment of a Health Performance Council and Health Advisory Councils to support the provision of high-quality outcomes and to provide licencing services for ambulance services and private hospitals.

3.4.2.2 MHA (2009) (the Act)

This Act makes provision for treatment, care, and rehabilitation of persons with severe mental illness with the goal of bringing about their full recovery. The Act makes provisions for orders for community

treatment, or inpatient treatment of people with severe mental illness as required. The Act provides for the freedom and legal rights of persons with mental illness and for other purposes. The Office of the Chief Psychiatrist was delegated powers under the Act to improve efficiencies in consumer management and mental health service provision.

Specifically, the Act:

- Provided a legislative basis for mental health reform in SA
- Introduced significant changes in practice to bring services in line with national and international best practice
- Increased accountability through the Office of the Chief Psychiatrist
- Strengthened consumer and carer involvement to improve outcomes for consumers and families
- Provided for high quality, safe and multi-disciplinary care, and treatment
- Balanced interventions and safeguards

The Act introduced the concept of recovery, provided a definition of 'relative' that accommodated the kinship rules of Aboriginal and Torres Strait Islander people and made provisions to work with natural healers (Ngangkari).

The guiding principles for the Act are identified as follows (Gov SA, 2009)

- Safeguard the rights of people with serious mental illness
- Recognise and respect people as individuals in terms of their culture and background
- Tailor their care and treatment (especially children and young people).

Care, treatment, and rehabilitation are to be provided in the least restrictive manner and the Act gives limited powers to make orders for involuntary treatment.

The Act is accompanied by a clinician's guide and code of practice. This guide is used as a basis for inspections by the office of the Chief Psychiatrist, as a training resource within organisations and for interagency education and training. It can also be used on an individual basis where clinicians wish or need to have a more in-depth knowledge of the Act.

During inspections of services by the OCP, checks are conducted to ensure services are utilising restrictive practices only in accordance with the requirements of the Chief Psychiatrist Standard and guiding principles of the Act.

3.4.3 Standards, guidance, and policies

National seclusion and restraint reduction project known as the Beacon Project was implemented between 2006-2009. This required every state in Australia and New Zealand to work to develop plans to reduce restrictive practices. Investment was made nationally to support the initiative. The seclusion and restraint reduction programme known as the 6Cs (Huckshorn, 2014) was widely adopted at that time. These are a set of evidence-based core interventions known to reduce restrictive practices when implemented as follows:

- Leadership in organisational culture change.
- Using data to inform practice.

- Workforce development.
- Inclusion of families and peers.
- Specific reduction interventions (using risk assessment, trauma assessment, crisis planning, sensory modulation and customer services).
- Rigorous debriefing

3.4.3.1 Chief Psychiatrist restraint and seclusion standard: A standard to reduce and eliminate where possible the use of restraint and seclusion under the Mental Health Act 2009. (Gov SA, 2021)

The above standard was issued by the Office of the Chief Psychiatrist in February 2021, for enactment in services and inspection by the Office of the Chief Psychiatrist by July 2021. The standards take the approach that seclusion and restraint reduction and elimination require sustained quality improvement programmes.

The standard identifies the underlying philosophy of care as being 'collaboration between consumers, carers and staff to allow for facilitation and empowerment' and identified 13 principles to be adopted in Mental Health Services. These are identified on page 3 of the document as follows:

- recognise the inherent rights of a person to personal dignity and freedom in accordance with international rights instruments.
- Mental Health Services will recognise and enable patient autonomy and choice in treatment and care.
- Mental Health Services will adopt a least restrictive environment for treatment and care.
- Mental Health Services will recognise and value the importance of allowing patients to guide their own recovery.
- the use of restrictive practices is not therapeutic and should not ever be regarded as a therapeutic practice.
- If seclusion or restraint is used for children and young people, staff involved must be aware of the significant vulnerability and psychological trauma from these practices for this age group.
- the use of restrictive practice increases the risk of trauma and may trigger symptoms of previous experiences of trauma.
- restrictive practices should only be used after reasonable attempts to use alternate means of calming and de-escalation to enable a person to regain self- control are unsuccessful.
- the use of restraint and seclusion is regarded as an exception and extreme practice for any person.
- all forms of restrictive practice should only be used temporarily in a behavioural emergency.
- restrictive practices when used, are implemented for the least amount of time possible and recorded, monitored, and reviewed.
- any use of restrictive practices must have tight safeguards in place that focus on minimising risk to consumers, staff, and others; and on empowerment, collaboration, preserving and promoting dignity, decency, humanity, and respect; and considers the needs of people from Aboriginal or Torres Strait Islander and Culturally and Linguistically Diverse backgrounds and.

- an effective restrictive practice policy will provide the framework to improve staff safety by preventing episodes of violence, and by employing effective procedures and training for staff who administer restrictive practices as a last resort.

The standard requires that comfort rooms and sensory modulation equipment is made available and accessible to consumers. Furthermore, every care and treatment plan should include restraint prevention strategies and consider consumer co-morbidities, past trauma, and preferences about restrictive practices should this be needed as a last resort. The care and treatment plan should be reviewed after every episode of restrictive practice. The standards require key policies and training to be in place and that there are clear reporting mechanisms to the Office of the Chief Psychiatrist. Services must offer debriefing, and peer workers or other representatives with lived experience are to be involved in restraint and seclusion reduction initiatives. The indications, authorisation processes, procedures, and review for the use of physical, mechanical, and chemical restraint are clearly identified. Of note the Standard provides that in addition to all other requirements, where a person has been mechanically restrained, physically restrained, or secluded on two or more occasions in the current admission or episode (p.7) the treatment plan must be reviewed by at least 2 disciplines at a senior level of the service.

The standard is accompanied by an online toolkit and several resources to support staff in seclusion and restraint reduction efforts.

3.4.3. Restrictive practices including seclusion, physical restraint, mechanical restraint, chemical restraint

Restrictive practices regulated by the standard outlined in the previous section, apply to mechanical restraint, physical restraint, chemical restraint, and seclusion. The standard acknowledges that there is a broad range of other restrictive practices that may occur in inpatient and residential settings, and it directs to the relevant guiding principles and requirements of the MHA 2009 in this regard.

3.4.4 Governance processes

3.4.4.1 Local Health Networks (LHNs)

The Board of the respective LHN is responsible for all healthcare in that area. This includes mental health and the monitoring of restrictive practices. Each LHN reviews each incident of restrictive practice and is responsible for ensuring correct procedures were followed and that action plans are developed accordingly.

3.4.4.2 Office of the Chief Psychiatrist

The Chief Psychiatrist has a statutory role and is appointed by the Minister for Health while employed by the DHW and is responsible for setting standards and inspecting Mental Health Services. Inspections can be undertaken by staff in the Office of the Chief Psychiatrist where delegated by the Chief Psychiatrist. The inspectorate can inspect any service at any time and can make recommendations for improvement. In every inspection, use of restrictive practice is reviewed to

ensure compliance with requirements. There is a process whereby the Inspectorate is informed of every episode of seclusion or mechanical or physical restraint. Where a restrictive practice duration lasts longer than an identified period of 4 hours, the relevant Inspector is alerted and contact is made with the service to establish the current situation, offer support, and ensure that all efforts are being made to reduce or avoid the restrictive practice.

3.4.4.3 Strategic Mental Health Quality Improvement Committee (SMHQIC)

The state-wide Strategic Metal Health Quality Improvement Committee with membership from the Chief Psychiatrists Office and each LHN, oversees all quality issues. As part of the TOR this Committee receives data from each LHN around seclusion, restraint, and mechanical restraint. The Committee reviews all data received monthly and is comprised of representatives from all LHNs and Lived Experience groups. The Committee membership includes equal numbers of consumers and carer and service representatives. This Committee reviews all applications for mechanical devices that LHNs have requested to use.

In addition to the SMHQIC all data pertaining to seclusion, restraint and mechanical restraint collated monthly is forwarded, collated, and reported to the Australian Institute of Health and Welfare (AIWH). This is a national mandatory process which occurs yearly.

3.4.5 Considerations for Ireland

Consideration	Source
Consider the monitoring of restrictive intervention data on a regional level through a quality committee with a specific remit for review, monitoring and intervention.	Strategic Mental Health Quality Improvement Committee (SMHQIC)
Consider Service User and carer membership of this committee as in SA	Strategic Mental Health Quality Improvement Committee (SMHQIC)
Consider the collation of data in formats similar to comparable jurisdictions to enable benchmarking and sharing of best practice.	Strategic Mental Health Quality Improvement Committee (SMHQIC)
Consider setting safety standards around the use of mechanical restraint and a requirement to have all mechanical restraints approved by the MHC prior to use.	A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009 (Gov SA, 2021) Strategic Mental Health Quality Improvement Committee (SMHQIC)
Consider adopting the standard 'where a person has been mechanically restrained, physically restrained or secluded on two or more occasions in the current admission or episode (A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009, Gov SA, 2021 p.7) the treatment plan must be reviewed by at least 2 disciplines at a senior level of the service'.	A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009 (Gov SA, 2021)
Consider the alert system (where the Inspectorate or other appropriate department) for implementation as a means of additional independent support, governance, oversight, and a reduction intervention under the leadership strategy.	Office of the Chief Psychiatrist
Consider a quality improvement approach to seclusion and restraint reduction.	A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009 (Gov SA, 2021)
Consider making advanced planning, and care and treatment plans as identified in the SA standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009 (Gov SA, 2021).	A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009 (Gov SA, 2021)

Consider the leadership reporting approach used in SA for monitoring and reduction of restrictive practices summarised in Figure 8.	

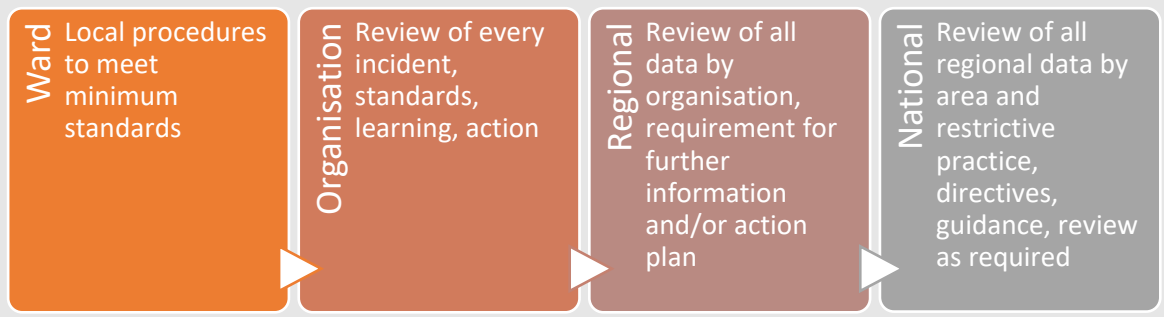


Figure 8 -Synthesis of South Australia Processes

3.5 New Zealand

3.5.1 Model of Service

The health services in New Zealand are funded by and accountable to the Ministry of Health. This includes Mental Health Services. Funding is devolved to 20 local District Health Boards (DHBs), 5 in the South Island and 15 in the North Island. The 15 DHBs of the North Island are regionalised into three overall regions. Access to mental health services is primarily via GP to Community Mental Health Teams (CMHTs) or Emergency Crisis Mental Health Teams. Each District Health Board has access to inpatient beds and a small number of psychiatric intensive care (PICU) beds. Seclusion rooms are only provided in the PICUs. Specialist psychiatric services are provided on a regional basis including Forensics, Mothers and Babies and Children and Youth Services. The model of service is depicted in Figure 9.

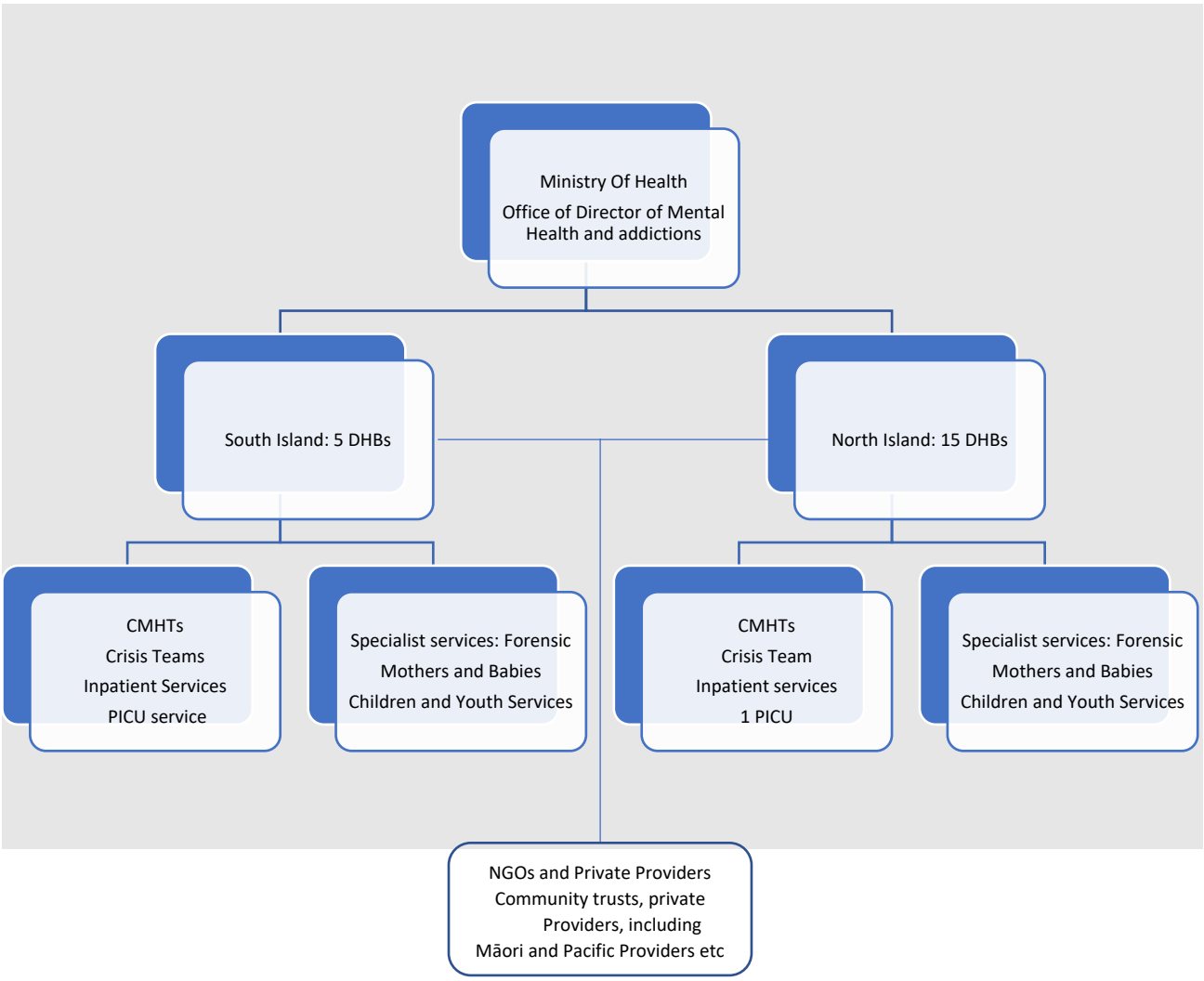


Figure 9 - Model of Service: New Zealand.

Ministerial level standards and guidance are established in relation to healthcare, including restrictive practices. In line with this there is a requirement that local policies are developed by the District Health Boards which must be approved by the Area Director of Mental Health Services.

New Zealand is currently in the process of reforming the Mental Health (Compulsory Assessment and Treatment Act 1992), so that it reflects a human rights-based approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment. The current status of the review is that the Government of New Zealand has accepted the need to repeal and review the existing Act, the Bill is currently under review by the Health Committee and an extensive public consultation is underway.

3.5.2. Key Legislation:

3.5.2.1 Mental Health (Compulsory Assessment & Treatment) Act (1992)

This Act is the current legal framework for those who require compulsory psychiatric assessment and treatment for people experiencing a mental illness. The Office of the Director of Mental Health and Addiction Services (referred to as the Office in the NZ documentation) within the Department of Health is regulator for the Mental Health Act and is responsible for its administration. At this time seclusion is the only mandatory reportable restrictive intervention under the Act, however there are mechanisms for recording physical restraint within the Health Service.

A number of Guidelines are produced by the Ministry for Health including general guidelines and guidelines relation to roles and functions under the Act. The general guidelines are as follows:

- Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992
- Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992
- Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992

3.5.3 Policy, Standards, Guidance

3.5.3.1 Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (2010)

The legal basis of seclusion for patients under the Mental Health Act is set out in section 71 of the Act. However, guidelines have been implemented to limit the use of seclusion and restraint on mental health patients over time. A number of overarching principles are identified in relation to the use of seclusion from the outset of the guidelines:

- Seclusion should be used for as short a time as possible.
- The decision to seclude should be an uncommon event, subject to strict review.
- The decision to use seclusion should be based on the duty of care required for the individual patient, or for other patients.
- Seclusion should only be used when no other safe and effective intervention is possible.
- Seclusion should not occur as part of a routine admission or therapeutic procedure, or be administered as discipline, or as a replacement for adequate levels of staff or resources.

Under The Mental Health (Compulsory Assessment and Treatment) Act (1992) seclusion can only be used with the authority of the responsible clinician, except in an emergency situation. If the responsible clinician cannot be involved in the immediate decision, the responsible clinician must be informed of the seclusion as soon as appropriate, at least at the start of the next working day, and should review the decision. The specificity of the review should be appropriate

to the level of risk and likelihood of harm occurring to the patient. In an emergency situation, a nurse or other professional with immediate responsibility for the patient may place the patient in seclusion but must inform the responsible clinician immediately.

3.5.3.2 Zero seclusion: Safety and Dignity for all (2019)

This project was initiated by the Health Quality & Safety Commission (HQSC) in 2019 with the ultimate aim of eliminating seclusion in New Zealand. This project was established as a result of the evidence that seclusion is traumatic and harmful for consumers, visitors and health workers alike and in the context that the elimination of seclusion in mental health was a government policy for over a decade.

The HQSC has been working closely with DHBs using a quality improvement (QIP) approach, building on the work DHBs had commenced using Huckshorns 6 Core Strategies (2014) for seclusion reduction and a number of specific interventions learned through the QIP processes over time. Quality improvement approaches and tools have been disseminated online and through training to ensure the QIP approach is embedded in seclusion reduction strategies. The project has shown demonstrable and consistent reduction in seclusion, with zero seclusion achieved in a number of services. The HQSC has a nominated zero seclusion team which oversees the project, uses collated data to inform developments and monitoring, in addition to providing supports to the services on a number of levels.

Of note, the Southern DHB is currently actively researching and working on advanced directives to inform the reform of the MHA with a number of publications on the issue which are identified in Appendix 9.

3.5.3.3 New Zealand Standard NZS8134: 2021: Health and Disability Services Standard Governance issues (2021)

This standard is overseen by the Ministry of Health. It outlines the minimum requirements for fair and equitable health and disability services and aims to improve the experiences and outcomes of people and whānau (family, extended family or family group of people who are important to the person receiving treatment) . The standard adopts a person and whānau centred approach to ensure that people are empowered to make decisions about their own care and support to achieve their goals. 5 principles underpin the document summarised as follows:

1. Achieving Māori health equality- Te Tiriti (Treaty between government and indiginous people of New Zealand) principles underpin the standards
2. Accessible health and disability services for all
3. Partners with choice and control- ‘nothing with us without us’ and ensuring that people accessing services have their rights upheld to make choices about their care
4. Best practice through collaboration and understanding the lived experience and ensuring shared decision making
5. Standards that increase positive life outcomes

The standards are structured into six overarching outcome related sections including rights; workforce and structure; pathways to wellbeing; person-centred and safe environment; infection prevention and antimicrobial stewardship; and restraint and seclusion.

3.5.3.3.1 Section 6 of the Standard: Restraint and Seclusion

This standard requires that services 'aim for a restraint and seclusion free environment, in which people's dignity and mana [prestige, authority, control, power, influece, status, spiritual power, charisma or a supernatural force in a person, place or object] are maintained' (p. 74). These provisions will be discussed in section 5 in the context of the critical review in section 6. The criteria are summarised here.

Restraint:

Six criteria are outlined in relation to the process of restraint. These are focussed on the overarching organisational commitments and processes required to ensure robust assessment processes, training requirements, reporting requirements around seclusion and restraint, requirements for policies and procedures aimed at eliminating these practices. A further seven criteria are identified in relation to safe restraint. This includes specific criteria around approval processes, monitoring, documentation of, debriefing and evaluation. Finally, a series of criteria are outlined in relation to review of all restraint practices.

Seclusion:

This standard outlines nine criteria, the first of which requires services to work towards a seclusion free care environment. Clear criteria are outlined for data provision, policies and procedures and for seclusion to take place only in a designated seclusion room. Debriefing requirements are outlined and Standard 6.2.5 stipulates that a person-centred debrief should follow each episode of emergency restraint. Requirements for evaluation should include the persons care and support plan, advance directives and preferences. Service providers are required to review all episodes of restraint and specific requirements for the review process are outlined.

3.5.4 Governance

3.5.4.1 Office of Director of Mental Health and Addictions

The Office of the Director of Mental Health and Addiction Services within the Department of Health is regulator for the Mental Health Act. Inspection responsibilities are devolved to District Inspectors. The Director of Mental Health reports to the Director General of Health and the Minister of Health. The Office produces a yearly report which includes its activities for the previous year and mandatory reporting around seclusion, reportable deaths and electroconvulsive therapy.

3.6.5 Considerations for Ireland

Consideration	**Source**
Consider an approach to restrictive practice standards that makes clear what the service user can expect and how their values will be considered in care processes	New Zealand Standard NZS8134: 2021: Health and Disability Services Standard Governance issues (2021)
Consider the use of QIP processes as standard for seclusion and restraint reduction	Expert consultation

Consider mandatory data reporting processes into a national dataset which can inform seclusion and restraint review and reduction	Expert consultation
Consider how seclusion and restraint reduction will be managed from a Governance Perspective- in New Zealand it is through the Health Quality & Safety Commission (HQSC) which operates independent of the service providers.	Expert consultation

3.6 Wales

3.6.1 Model of Service

NHS Wales has overall responsibility for Healthcare in Wales. In 2009 the Welsh Assembly published the document 'One Wales, A Progressive Agenda for Wales' (Welsh Assembly, 2007) which proposed major changes to the way Wales was governed. This included a programme of reform for NHS Wales which aimed to improve health outcomes and ensure that the NHS delivers care effectively with its partners. The programme aimed to 'put democratic engagement at the heart of the NHS' and guarantee public ownership, public funding and public control…' of the public service (Morris, 2007 p. 1). They are aligned with 7 NHS Boards, with responsibility for planning, securing and delivering services in 7 identified Board areas in Wales. Three NHS Trusts support healthcare delivery across Wales. These are the Welsh Ambulance Services Trust, The Velindre NHS Trust (specialises in Cancer care) and Public Health Wales.

In terms of overall structure and responsibility, The Department of Health is responsible for funding NHS Wales which is overseen by the National Delivery Group who in turn have responsibility for overseeing the development and delivery of NHS services in the 7 Health Boards across Wales. Mental Health Services are delivered through these Health Boards. However, a substantial amount of Mental Health Services are delivered independent of the NHS. These are regulated by the Healthcare Inspectorate Wales (HIW). However, although HIW monitors and inspects NHS Mental Health Services, it does not have regulatory responsibility in that area.

The overall service model is represented in Fig. 10.

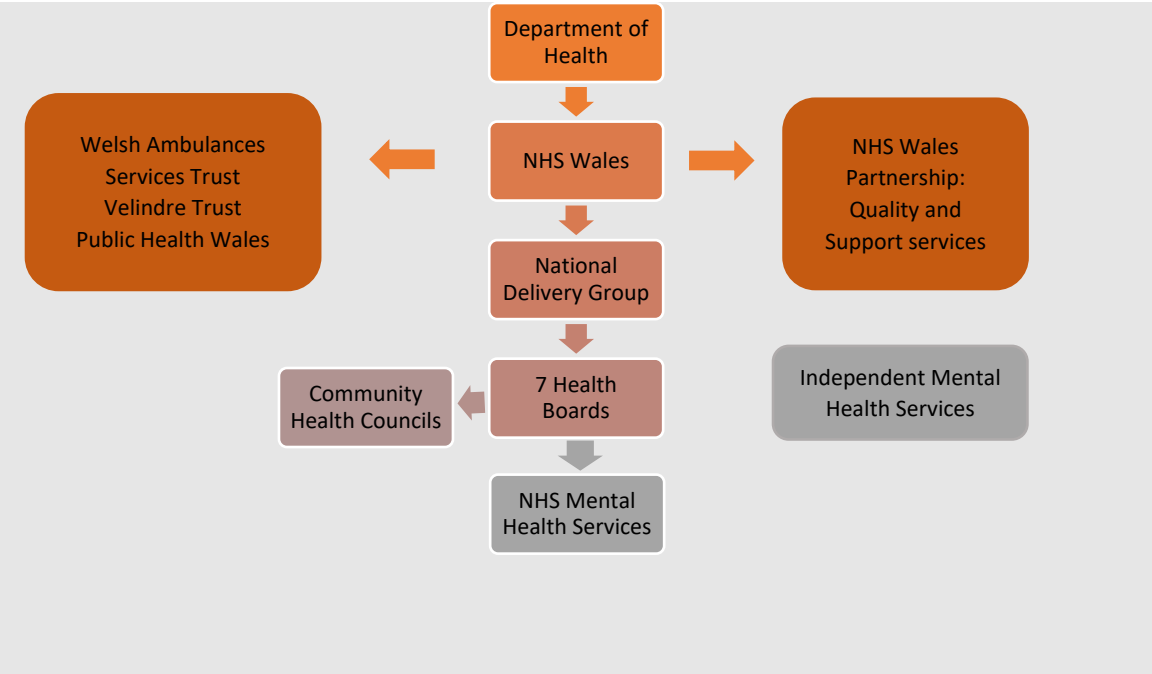


Figure 10 - Model of Service: Wales

3.6.2 Relevant legislation and regulation

The MHA (1983) is the primary legislation setting out the legal framework for compulsory powers in Wales, as in England. The Mental Capacity Amendment Act (2019) has also been enacted in Wales and there is currently a focus on Liberty Protection Safeguards in Wales. A consultation on the revision of the 1983 Act is now complete.

3.6.2.1 The Mental Health Act (1983) Code of Practice for Wales Review (2016)

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The Code is substantially different from the English Code of Practice, even though both refer to the same Mental Health Act (1983). This Code of Practice is not the law but provides statutory guidance on the implementation of the Act particularly around the role and function of Registered Medical Practitioners, Approved Clinicians, Approved Mental Health Professionals and Independent Mental Health Advocates under Section 118 of the Act (admission, guardianship and community patients). Additionally, the Code provides statutory guidance to Registered Medical Practitioners around medical treatment of patients with a mental disorder and to Local Authorities and their staff around their duties under the 1970 Social Services Act. All other matters of guidance within the code are referred to as 'Beneficial but not statutory guidance' (Welsh Government, 2016 p. 4), this includes matters relating to restrictive practices. However, there is an expectation that all professionals comply with the guidance therein. The Code lays out the guiding principles which are to inform all decisions taken under the Act:

- Dignity and respect
- Least restrictive option and maximizing independence
- Fairness, equality and equity
- Empowerment and involvement
- Keeping people safe
- Effectiveness and efficiency

3.6.2.1.1 Restrictive practices including seclusion, physical restraint, mechanical restraint, chemical restraint

Chapter 26 of the MHA Code of Practice (2016) outlines the requirements for safe and therapeutic responses to disturbed behaviour, these are in line with NICE guidance previously outlined. The Code is used as a framework for inspecting Independent Mental Health Services by the Healthcare Inspectorate Wales (HIW) which is the independent inspectorate and regulator of healthcare in Wales. However, in relation to mental health services, the HIW carry out inspections in all Mental Health Services, but they only use regulatory powers in the independent sector. Issues of non-compliance in NHS areas are dealt with through NHS procedures and NHS Wales Partnership.

This Chapter of the Code provides a general foundation which focuses on prevention and least restrictive measures. Restrictive interventions, with associated guidance, include observation, restraint, use of medication, seclusion and locked doors. Mechanical restraint is included in the restraint section and is recommended for secure services only and, in exceptional circumstances mechanical restraint can be used whilst a patient is awaiting transfer to secure services. However, this must be approved by the Hospital Managers, and the decision must be made in collaboration with the HIW. The code outlines circumstances under which the identified restrictive practices can be used, preventative measures and reporting procedures.

3.6.3 Standards Guidance and Policies

3.6.3.1 Reducing restrictive practices framework (Welsh Government, 2021)

This framework is applicable to mental health services, however it also applies to childcare, education, social care settings and sectors. This recently published framework sets out to promote measures that will lead to the reduction of restrictive practices and to ensure that where restrictive practices are used, it is as a last resort, to prevent harm to the individual or others. This document refers to restrictive practices as physical restraint, chemical restraint, environmental restraint, mechanical restraint, seclusion or enforced isolation, long term segregation and coercion.

The framework has a clear human rights baseline. Furthermore, it outlines that the use of restrictive practices must be informed by person centred planning, within the context of the service setting and in a way which safeguards the individual, those whom they interact with, and those who provide services to them (Welsh Government, 2021 p. 5).

In order to achieve the aims of the framework, the document identifies that organisations should have a 'threefold' focus:

- Preventing the necessity for restrictive practice through the development of reduction strategies and through the promotion of a human rights approach.
- Working with individuals through person centred planning to meet individual needs in a way that actively reduces the likelihood of situations arising where restrictive practices are used as a last resort.
- Having measures in place so that when situations arise where restrictive practice are used as a last resort, to prevent harm to the individual or others, there is prior planning and training in place to secure the safety of all concerned' (p. 5).

Guidance on the principles policies and procedures required for each restrictive practice measure are provided. In addition, requirements for de-briefing, safeguarding and measures to reduce restrictive practices are outlined.

3.6.4 Governance

3.6.4.1 Health Inspectorate Wales

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. According to the Code of Practice (2016 p. 5) the HIW's primary focus is on:

- Contributing to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, Service User, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed, and
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

In relation to Mental Health Services, the HIW has responsibility to inspect all mental health services in order to monitor the Act. However, their regulatory responsibility only extends to independent mental health services. Where there are issues of compliance in NHS Mental Health Services relating to the implementation of the Act or practices referred to in the Code of Practice, these are processed through the NHS quality and risk structures.

The HIW also has a Review Service for Mental Health, the purpose of which is to review the use of the Act and check that it is being used properly on behalf of Welsh Ministers. The Review Service is independent of all staff and managers of hospitals and mental health teams. The review service also manages the Second Opinion Appointed Doctor (SOAD) service. Furthermore, HIW is a member of the UK's National Preventative Mechanism (NPM). The United Kingdom (UK) ratified the United Nations Optional Protocol to the Convention against Torture in 2003. In that context the HIW carries out regular reviews of places where people are deprived of their liberty to ensure that they are not being abused and produces reports accordingly.

3.6.4.2 NHS Wales Risk Management Systems

All untoward incidents are reported through the national risk management system known as the Datix System. This includes all incidents of restrictive practice. This data is used to inform and monitor restrictive practices for the Welsh Government and Partner Agencies. Each Health Board must have adequate policies and systems to support effective risk assessment and management within its area.

3.6 .4.3 The National Collaborative Commissioning Unit

The NHS Wales National Collaborative Commissioning Unit is the collaborative commissioning service of NHS Wales. The purpose of the National Collaborative Commissioning Unit is to lead on quality assurance and improvement matters for NHS Wales. This includes working to improve patient outcomes and experience through the services it delivers. This Unit also has a role to play in inspecting mental health services, developing quality improvement services and working with CIW. The Commission reports on services commissioned to forensic units, low and medium and provides annual reports on the standards in the Adult Hospital Framework for Wales (2019) which sets out minimum standards for health and well-being in Wales. These standards refer to health promotion issues as opposed to restrictive practice issues.

3.6.5 Considerations for Ireland

Consideration	**Source**
Consider the 'threefold approach' as an organisational approach to restrictive practices in Ireland	Reducing restrictive practices framework (Welsh Government, 2021)

Section 4: Evidence synthesis methodology

4.1 Protocol

The protocol was agreed with the MHC Oversight Group at the outset of the process. A PICO framework within the PRISMA reporting model was used for the search. The P.I.C.O. framework (Richardson, Nishikawa et al. 1995) provides a structured approach to identify the key question or objective, identify complex search strategies and yield more precise search results. This together with PRISMA reporting process (Moher et al 2009) provided a robust approach to the review. Furthermore, to ensure a robust review, the services of a librarian was secured to undertake a complete database search. The screening process was undertaken by the primary author.

4.2 Objective:

The objective of the literature review agreed with the Oversight Group was as follows:

To review empirical evidence that inform action around seclusion, restraint, mechanical restraint, and chemical restraint in inpatient Mental Health Services from 1 Jan 2016 to 30 June 2021.

4.3 Search terms:

Search terms were agreed with the MHC Oversight Group and the services of a librarian were engaged to ensure rigor and completeness of the search. The following search terms were agreed:

Concept 1	Concept 2	Concept 3	Concept 4	Concept 5
Restraint AND Physical OR Manual	Seclusion OR Isolation OR open area seclusion OR PICU OR locked room OR segregation	Mechanical Restraint OR Device	Chemical Restraint OR *forced medication OR sedation OR covert medication OR pharmacological OR therapeutic restraint	Environmental restraint OR locked wards OR doors
OR **Regulated practices**				
OR **Restriction OR Limit* OR Prevent* of movement**				
OR **Containment measure**				
OR **Coercive measure**				
OR **Restrictive practices**				
OR **Confinement of bodily movement**				
OR **Preventing free movement**				
AND **In patient psychiat* OR in patient mental health**				
NOT **Schools**				
NOT **Police OR Prison OR penal system**				

An additional search was conducted at the request of the Expert Advisory Group as follows:

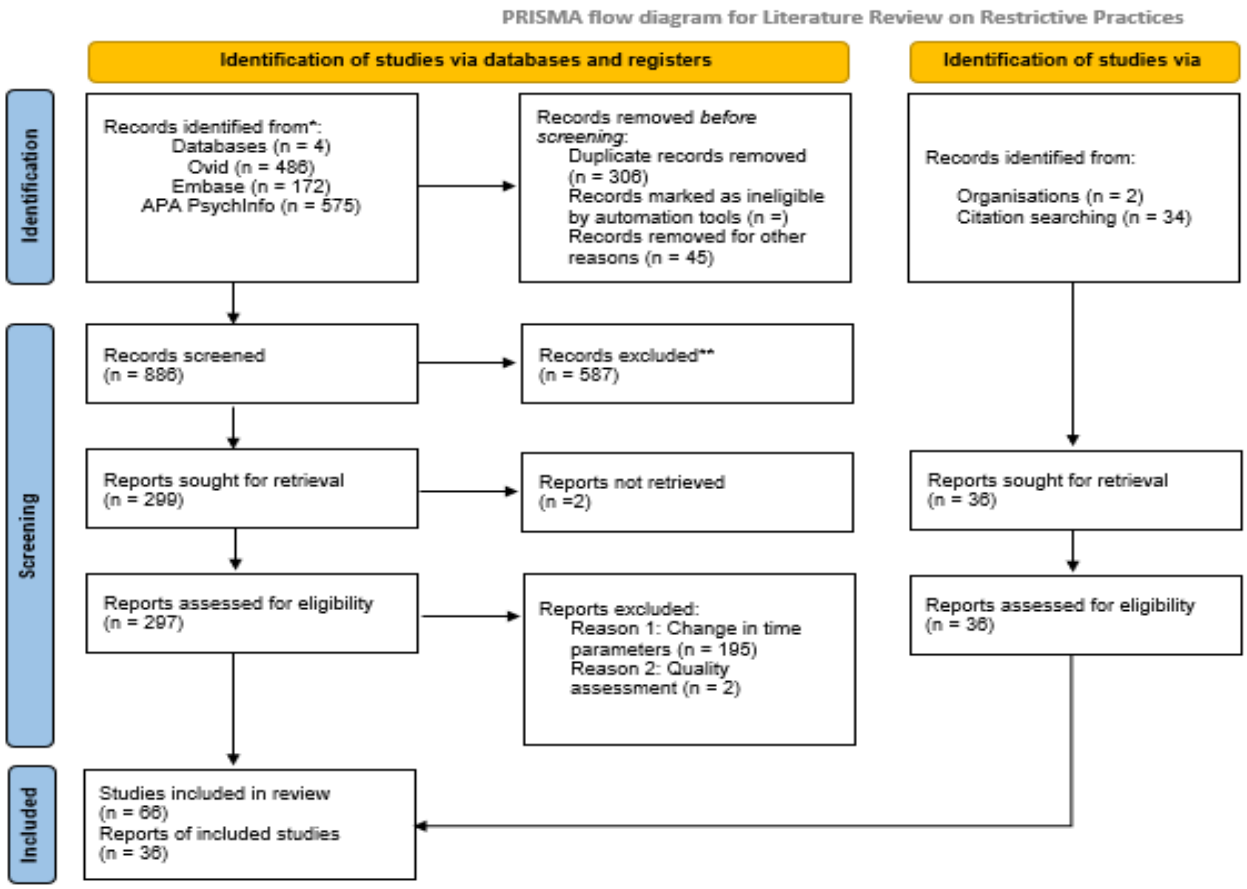
Concept 1	**Concept 2**	**Concept 3**	**Concept 4**	**Concept 5**
Restraint AND Physical OR Manual	Seclusion OR Isolation OR open area seclusion OR PICU OR locked room OR segregation	Mechanical Restraint OR Device	Chemical Restraint OR *forced medication OR sedation OR covert medication OR pharmacological OR therapeutic restraint OR rapid*	Environmental restraint OR locked wards OR doors
AND **In patient psychiat* OR in patient mental health**				

4.4 Search limits

The review focused on inpatient Mental Health Services only across all sub specialities of mental health. The timeline was altered after the first search and the final parameters were from 1 Jan 2017 to June 30, 2021, except for seclusion and restraint reduction literature which was from 1 Jan 2011 to June 30, 2021. Peer reviewed papers in the English language worldwide were included.

4.5 Information sources

A search was conducted using the agreed terms and limits of Medline, Embase, APA PsychInfo. Several references were obtained from review of papers obtained. The PRISMA diagram (Fig. 11) provides the overview of the search process, the process of exclusion and inclusion and the final papers included for review.



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: http://www.prisma-statement.org/

Figure 11 PRISMA

4.6 Study selection

Abstracts of all papers identified in the search process were reviewed for duplicates and relevance according to the inclusion criteria. Once this process was complete a second screening process was undertaken to review for relevance and to categorise the papers into sections agreed with the MHC Oversight Group. These sections were: Seclusion and restraint reduction, adult inpatient, Forensic Inpatient, Child and Adolescent inpatient, Mental Health Care of older persons inpatient, Physical, 'Other' and Chemical Restraint. A third screening process for relevance was undertaken once the papers were categorised.

Final numbers of studies included and reviewed by category are summarised on Table 1.

Category	Number of Studies
Seclusion and Restraint Reduction: Literature Reviews	9
Seclusion and Restraint Reduction Studies	11
Adult Inpatient	59
Forensic Inpatient	7
CAMHS Inpatient	8
Mental Health Care Older People Inpatient	1
Other	3
Chemical Restraint	4
Total Reviewed	**102**

Table 1 Studies Reviewed by Category

4.7 Data collation and analysis

Papers in each category were subjected to a quality review by the lead reviewer using relevant tools from the Joanna Biggs Institute. The type of study, location, context, question, and key findings were recorded for every paper reviewed. These were then synthesised into themes by category area. Where there was ambiguity, questions around quality or other concerns papers were further reviewed by a member of the expert committee. A decision was then made following discussion between the lead reviewer and the expert committee member around inclusion.

Section 5: Findings from and Synthesis of the Literature Based Evidence

5.1 Structure of the literature review

Due to the size of the yield from the search of databases, papers were subdivided into subcategories as follows:

- Seclusion and restraint reduction
- Forensic Services
- CAMH Services
- Adult Services
- Mental Health Care of older people (MHCOP)
- Physical and other
- Chemical restraint to be reviewed in Section 6).

These same categories will be used to structure this review. Each section will outline the outcomes and key findings of the review specific to that area.

5.2 Seclusion and Restraint Reduction

The time scale for review of seclusion and restraint reduction was 10 years (2011-2021). A total of 20 papers were reviewed under this category. 9 Literature reviews (See Appendix 1) and 11 studies (See Appendix 2). This section will be presented according to these categories and the findings will be synthesised accordingly.

5.2.1 Seclusion and Restraint Reduction: Literature reviews

The Joanna Briggs critical appraisal checklist for systematic reviews and research synthesis (JBI, 2020) was used to assess the quality of each review included. Summaries of the included studies are in Appendix 1.

5.2.1.1 Outcomes

The reviews included studies that had used a range of methodologies - qualitative, quantitative, mixed methods and in one instance, Quality Improvement Projects. Outcomes centred around the reduction of the identified coercive or restrictive measure/s and almost all studies described in the reviews showed a reduction in the measures under investigation.

Most literature reviews, studies, and quality projects on the issue of seclusion and restraint reduction are focussed on outcome measures for either a single or a combination of interventions or restrictive practice events (e.g., seclusion, restraint, mechanical restraint, violence). This makes it difficult to benchmark against baseline evidence for any one outcome measure. Explanations for effective

combinations of interventions are not known but reflect the priority focus in the area of study at the time due to legislation or local imperatives.

All authors expressed reservations about the strength of the evidence. This is suggested to be due to prevailing descriptive analysis of data and implementation studies with varying follow up methods (Stewart, Van Der Merwe et al. 2010). Additionally, heterogeneity of outcome measure categories, research methods applied, and organisational/cultural contexts render it impossible to provide a definitive set of evidence-based findings to support seclusion and restraint reduction. However, it is clear that reduction can be and has been achieved.

The nine reviews almost universally concluded that reduction can be achieved within a structured programme. Successful programmes are mainly multi-faceted, appear to be dependent upon the clinical context, study design and where they addressed targeted restrictive practice measures. This creates problems for generalisability. Despite this, a recent literature review by Goulet, et al. (2017) states that the Six Core Strategies model (Huckshorn, 2014) provides the most compelling evidence for reduction programmes. This approach is internationally recognised and has formed the basis of the current seclusion and restraint reduction strategy in Ireland (MHC, 2014). Goulet et al (2017) also identified the Safewards Model (Bowers, 2014) as providing a promising evidence-based approach to reduction. However, there is limited evidence to definitively support the Safewards model as a reduction strategy at this time.

Based on the literature reviewed, whilst it may not be possible to identify a single strategy, it is possible to identify a suite of interventions or strategy types (Johnson, 2010) from the reviews that are common to successful reduction programmes. These can be synthesised into three interrelated domains; leadership, organisation, and unit level characteristics/practices, see Figure 12.

Figure 12- Synthesis of successful seclusion and restraint reduction interventions into domains of leadership, organisation, and unit from literature reviews 2010-2021.

5.2.1.2 Leadership

Leadership has been consistently identified in the nine literature review papers as critical to the success of reduction programmes. It is patently evident that a strong leadership focus provides clear direction nationally, organisationally and on inpatient units. This leadership is transversal and is clearly identifiable in successful programmes. National leadership can be seen in the adoption of seclusion and restraint reduction policies, and organisational level leadership in the establishment of systems, interventions or enablers of reduction, as is evidenced in Goulet et al (2017). Unit level leadership can occur through increased involvement of champions (Goulet et al, 2017), clinical directors (Allen, Fetzer et al. 2018) and role models (Baker et al. 2021). Data obtained and analysed pertaining to occurrences and times can be used by leaders to challenge, reinforce and inform practice, engage with review procedures (Stewart et al. 2010; Bak et al. 2012; Goulet et al. 2017; Vakiparta et al. 2019), provide feedback to staff (Baker et al. 2021) and for benchmarking purposes (Scanlan, 2010). Additionally, the

continued monitoring of data through post-incident review with the patient, the team and at organisational level (Goulet et al, 2017) is critical to maintaining focus and monitoring the effectiveness of reduction programmes.

5.2.1.3 Organisational and unit level interventions

The importance of implementing the same intervention at different levels of the organisation is also evident across the literature. Having a clear organisational mission with integrated and coherent values supported by a consistent philosophy which is translated across national and organisational levels to unit level is noted as a prerequisite to maximising impact (Goulet et al. 2017). Programmatic, policy and directive level consistency (Bak et al. 2012; Baker et al, 2021) such as the adoption of a least restrictive approach (Scanlan, 2010; Stewart et al. 2010) is evident in successful programmes. Crisis intervention approaches through a dedicated team are highlighted as effective as well as early intervention strategies (Scanlan, 2010; Allen et al. 2018; Baker et al, 2021). However, the majority of successful interventions have a unit or staff level preventative focus including the use of advanced directives (Hirsch and Steinhert, 2019), a safety plan (Goulet et al. 2017; Allen et al, 2018), structured validated risk assessment (Bak et al. 2012; Goulet et al. 2017; Hirsch and Steinhert, 2019; Vakiparta et al. 2019; Baker et al, 2021) and evidence based individualised care plans (Goulet et al. 2017; Vakiparta et al. 2019; Baker et al 2021) or indeed an incident management focus which emphasises de-escalation or crisis management (Scanlan, 2010; Stewart et al. 2010; Allen et al. 2018).

Further therapeutic unit level interventions such as CBT (Bak et al. 2012) and other modalities of psychotherapy (Hirsch and Steinhert, 2019) are cited as being particularly successful in reduction programmes. Dedicated interventions, coupled with changes to communication style and processes, more involvement of family and carers in care giving, debriefing (Bak et al. 2012; Allen, Fetzer et al. 2018; Hirsch and Steinhert, 2019) increased positive involvement and empowerment of service users (Scanlan, 2010) are all identified as processes which support successful reduction programmes. Adopting sensory approaches (Scanlan, 2010; Baker et al, 2021) is also highlighted. Collectively, these interventions have one common thread – they all involve the use of structured, evidence informed and planned approaches rather than being based on ad hoc interventions which can be reactive rather than responsive to client need.

Finally, training for staff is common across successful programmes although the focus differs depending on the review and intervention focus. Having more highly educated staff and more experienced staff are both features associated with successful programmes (Bak et al 2012). Formal training (Scanlan, 2010; Stewart et al. 2010); supporting skills development and promoting attitudinal change (Scanlan, 2010) are consistently identified. More specifically, high quality content using different educational methods and more staff participation (Bak et al. 2012) is considered an important element of successful reduction programmes. Content identified as important in this context includes training in de-escalation techniques, approaches to crisis management (Scanlan, 2010; Goulet et al. 2017; Allen et al. 2018; Hirsch and Steinhert, 2019; Vakiparta et al. 2019), perspectives to enhance understanding of challenging patient behaviour, use of preventative measures, understanding evidence-based approaches, staff characteristics/ skill mix related factors, therapeutic interventions (Vakiparta et al. 2019) and changing philosophies (Goulet et al. 2017).

5.2.2 Seclusion and restraint reduction studies 2011-2021

This section will identify and synthesise the critical outcomes of studies associated with seclusion and restraint reduction between 2011 and June 2021. The papers retrieved were diverse in terms of method, outcome measures and context. Therefore, this review focused on describing the interventions, the key findings and synthesising them into themes. The Joanna Briggs Institute critical appraisal checklist for the relevant methods was used to assess the quality of each study (JBI, 2020). In addition, the revised standards for quality improvement reporting excellence (SQUIRE 2.0) tool (Ogrinc, Davies et al. 2016) was used to assess the quality of Quality Improvement Projects (QIPs).

A total of 11 papers were reviewed for this section and are summarised in Appendix 2.

5.2.2.1 Themes identified

Three of the studies reviewed were single intervention studies. The remainder involved 'bundled interventions'. Interventions differ from study to study and the extent of success varies. All studies report a reduction in the identified outcome variable, but 'bundled' or 'multifaceted interventions' continue to report more success as reported previously. The full extent of interventions by study are identified in Appendix 2. Four overarching themes emerged from the studies reviewed and are categorised as follows: Leadership and Training, Policy and Procedure Change, Evidence Based Assessment Tools and Sensory Modulation, Care Processes and Patient Involvement - see Fig 13.

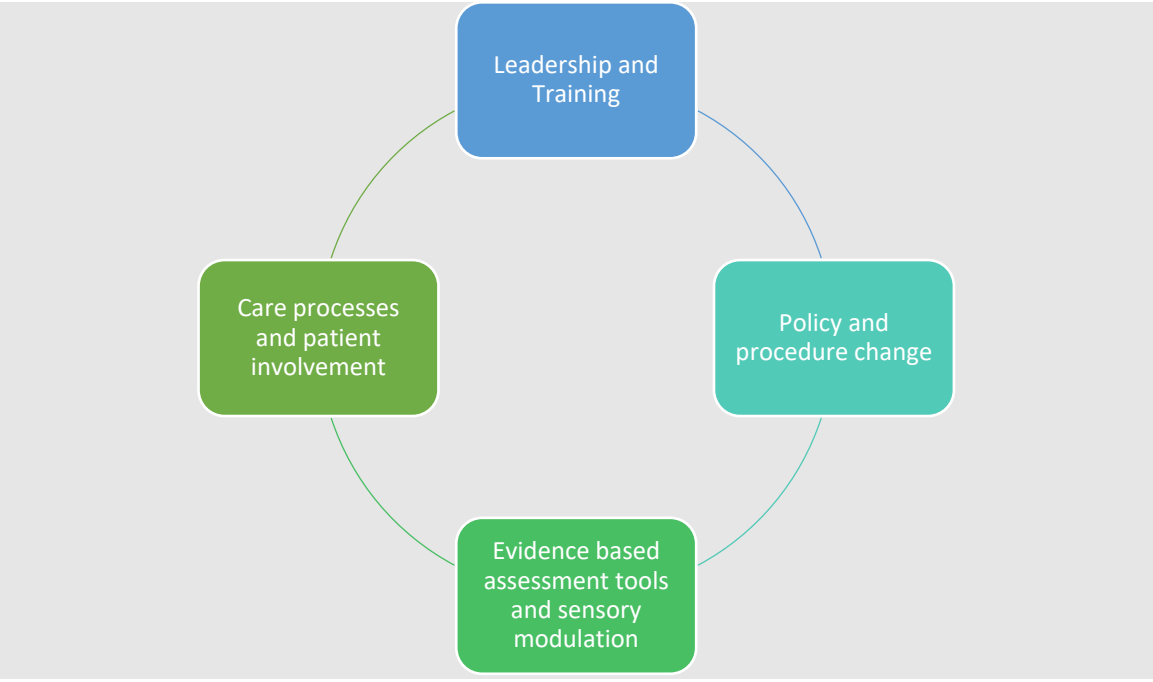


Figure 13 - Themes from seclusion and restraint reduction studies 2017-2021

5.2.2.1.1 Theme 1: Leadership and Training

Leadership featured strongly in almost all studies using multi-faceted interventions. This finding is hardly surprising as the importance of the potential contribution of (or in cases lack of) leadership – either clinical, professional or organisational has been evident for some time. Within the reference period for this review, a leadership component of the Blair et al (2017) study related to the implementation of routine screening of all seclusion and restraint episodes by the Nursing and Medical Directors and referral for formal administrative review as deemed necessary. A strong leadership focus, both deductive and inductive leadership featured across the implementation trajectory of the 12-intervention programmes reported by Mann-Poll et al. (2018).

Prior to that, visible leadership through the implementation of recovery rounds featured in the leadership- oriented programme reported by Hernandez et al. (2017). The members of the team undertaking the rounds consisted of representatives from senior management, professional practice, peer support and ethical practice. The goal of the team was to highlight the importance of restraint minimisation and recovery and to work with teams to minimise restraint. In addition to the rounds, leadership was demonstrated at unit level, whereby two members of the team responded to all codes relating to aggression and reviewed all episodes of seclusion or mechanical restraint daily. Whilst there was no significant change in seclusion events following initiation (increase of .3 per month), there was a steep decrease (1264.5 hours) in the duration of seclusion. There was also a small decrease in mechanical restraint events and duration.

Commitment to training and the support of best and/or evidence-based practices is the embodiment of leadership and demonstrates visible commitment to reduction in restrictive practices. Training features in all studies and tends to relate to the specific intervention. An example includes the case-controlled study undertaken by Anderson et al (2017) targeting forced medication and mechanical (belt) restraint using sensory modulation. This study included training for staff on the utility of sensory assessment tools and theory on sensory integration. Trauma informed care, crisis intervention and de-escalation (Blair et al, 2017) feature in many training programmes. Team training in the prevention of aggression, risk assessment and dealing with conflict, featured as one of twelve interventions in the highly successful longitudinal programme reported by Mann-Poll et al (2018).

5.2.2.1.2 Theme 2: Policy and Procedural change

There is consistent evidence in the literature reviewed that changes in policy imperatives which impact directly on practice have resulted in reductions in restrictive practice events and/or duration of events. These range from requirements to increase prescribing and reporting procedures to increasing the direct observation of the measure. For example, a single intervention programme targeting a change in protocol around the administration of PRN (Pro Re Nata- as required) medication, applied through a quality improvement project (QIP), resulted in a reduction in the reliance on oral and intramuscular medication (IM) administered on a PRN basis of between 30% and 50% respectively (Hayes and Russ, 2016). The modification of the protocol changed the practice which changed the administration of 'as required' medication from PRN at nurses' discretion to a requirement for emergency orders by a physician. Set against the drive for multi- disciplinary working, the dynamics associated with a protocol change of this nature would need to be carefully identified and managed. Furthermore, the

successful replicability of this intervention may depend upon the context and professional cultures prevailing.

A single intervention QIP reported by Allen (2018) aimed at reducing the duration of mechanical restraint also identified the impact of policy or procedural change. This QIP involved the implementation of a protocol for each person in mechanical restraints requiring such persons to be under the direct observation of a Registered Nurse. This QIP paper reported the findings from a third Plan, Do, Study, Act (PDSA) cycle. This phase achieved a 44% reduction in duration of mechanical restraint across 4 adult units and 1 CAMHS unit; a 70% reduction in the CAMHS 14-18 years unit; a 100% reduction in the >14 years unit after 3 months. The overall reduction across all intervention wards in cycle 1-3 was 33%.

5.2.2.1.3 Theme 3: Evidence based assessment tools and Sensory Modulation

The use of validated evidence-based tools remains a feature in the studies reviewed. The use of the BrØset Violence Checklist (BVC) (Almvik, Woods and Rasmussen, 2000) is noted in a number of successful programmes, sometimes combined with a local intervention checklist (Anderson et al. 2017; Blair et al.2017).

Before the studies reviewed within the reference period, there is longstanding evidence of the potential impact of environmental factors in these fields of study. Within the reference period, in that regard, evidence continues to emerge regarding the sensory modulation approaches. One study, which included the combined use of individual assessment and sensory plans using various sensory modalities and a sensory room were implemented as part of a multiple sensory oriented intervention approach by Anderson et al. (2017). The result was an overall reduction in belt restraints and the use of forced medication by 42%. Likewise, sensory modulation also featured as part of successful multi-faceted approaches in a paper by Blair et al. (2017) who referred to environmental enhancements such as comfort rooms, areas with calming lights, use of sensory items and music.

More recently, a QIP reported by Yakov et al. (2018) aimed at reducing restraints through the introduction of context specific interventions resulted in a 72% decrease in the use of restraint, which was sustained 11 months post intervention. It was reported that the use of failure mode and effect analysis to identify the specifics of the problem and contextual issues were critical to the success of this QIP. This enabled the use of targeted intervention specific to the presenting issues to be introduced incrementally over a 6-month period.

A further QIP reported by Seckman et al (2017) evaluated the use of a sensory room and its impact on restraint and seclusion in a 20 bedded child and adolescent unit in the USA. The methodology included the use of Plan-Do-Study-Act (PDSA) cycles, staff training and clarification, modification of procedures for use of the sensory room. Data compared restraint and seclusion utilisation for the periods 6 months pre and 6 months following the introduction of the sensory room intervention. The results showed an overall 26.5% reduction in restraint, 32.8% reduction in seclusion. Data analysis showed a steady downward trend except for two months which when analysed could be attributed to 3 outlier clusters. All aggression types reduced, except destruction of property which increased by 23.6%. This is not explained in the study.

5.2.2.1.4 Theme 4: Care processes and patient involvement

Changes in underpinning philosophy feature within the successful programmes reported. This includes adopting a recovery philosophy and person-centred approach (Hochstrasser et al. 2018). This impacts on care processes and interventions.

Philosophy and care processes are evident in the Safewards model which has gained increasing popularity and utility internationally. A trial of the ten Safewards interventions core to the Safewards Model (Bowers, 2014) reported by Fletcher et al (2017) resulted in a downward trend in seclusion episodes across the 13 intervention wards. An overall 36% reduction was achieved at the end of the trial, although there were variations noted across the wards. The process included train the trainers and 4 fidelity visits over the 12-month trial.

Further validation of the model for reduction in coercive measures is evident in the investigation undertaken by Stensgard et al. (2018), whereby there was a reduction of 2% in overall coercive measures (including forced detention, forced treatment, ECT, forced nutrition, forced treatment of somatic disease, straps used on arms and legs, coercive retention, personal shielding of the patient). Of note were the findings that there was no significant reduction in mechanical restraint, however there was a reduction of 11% per quarter in the use of forced medication. The implementation strategy used an identified champion (project manager), involved meetings with local unit management, the designation of key people responsible for implementation on each unit, holding regional networking events for staff and a common cut-off date for implementation of all 10 interventions.

The use of information, patient involvement and agreement, and family involvement, informed care processes and plans featured in 5 of the 12 interventions in Mann-Polls (2018) successful seclusion and restraint reduction programme (SRP). Additionally, the recognition that all MDT members had important inputs into care plans is made explicit in the final listed intervention.

5.2.3 Discussion

5.2.3.1 Process

While the impact of the specific approaches and interventions on the outcome variable is clearly important, it is also important to note the process of implementation. This is especially important in relation to Quality Improvement Projects and is one of the core values of the approach. The 7 QIPs reviewed provide a template for targeted context-related approaches to reduction. This use of QIP's as a methodology represented approximately 30% of the peer review papers retrieved for this literature review. There is reason to believe that gathering baseline data and the use of quality tools such as root cause analysis and failure mode and effect analysis, provides invaluable baseline measurement and identification of context specific variables for intervention. Furthermore, the nature of the QIP requires clear identification of not only the interventions but also the change management process and structures which were given due consideration over the course of implementation period. The number of QIPs may be an indication that this methodology may be more appropriate than traditional research approaches in the implementation of seclusion and restraint reduction strategies going forward.

Papers reporting long term effects had the benefit of being able to retrospectively identify the critical phases of project implementation. Mann Poll et al. (2018) reported a longitudinal cohort study (over 10 years) of the implementation of a multi-intervention seclusion and restraint reduction programme (SRP). They identified three phases: Preparing and implementation - 4years; Project phase - 3 years where the SRP was fully implemented; and consolidation period - 3 years. The analysis of data was undertaken over phase 2 and 3. This approach acknowledges a preliminary period to fully establish a programme and a clear data analysis period when all interventions are implemented. In addition, the authors were able to identify that the most important changes occurred in phase 2, with a total effect between phase two and three of 73% reduction in seclusion events and 80% reduction in duration.

5.2.3.2 Replacing one coercive measure with another

A concern for many researchers and services is to identify if reduction in a target coercive measure/s results in a substitution of one for another. This has required researchers and practitioners to take account of the broader data around restrictive practices to ensure a total perspective (Muir-Cochrane et al, 2020; Ashcraft and Anthony, 2008). Whilst a definitive relationship between cause and effect may not be possible, the data obtained in some interrelated measures can raise questions as to whether one measure was replaced by another. An example of this is where Blair et al (2017) succeeded in reducing seclusion events by 52% and duration by 34% in their multiple intervention study. However, restraint events reduced by a considerably lesser amount (6%) and the duration period of the restraints increased by 35%. This highlights the need to analyse data beyond the recording of numbers by restrictive practice.

5.2.3.3 Gender Issues

All studies in this review except for one, used the traditional gender binary of male and female. However, Elbin (2019) gathered data on male, female, and transgender young people in her study in Child and Adolescent Services. It is recommended that gender association is discussed in the context of restrictive practices at the appropriate time in the care pathway so that any needs can be identified and planned for.

5.2.4 Synthesis of literature review findings and study findings

The literature review findings and study findings reinforce and support each other. There are no major differences in the themes. However, the review of the studies highlighted the prevalence of QIPs as a means of achieving reduction and a need to interrogate data on events and duration to ensure that one measure is not being replaced by another. The literature review synthesis which captures the three interdependent level approach has therefore been amended to reflect this in Fig 14.

Figure 14 - Synthesis of successful seclusion and restraint reduction interventions 2010-2021

5.2.5 Issues for consideration in the Irish context

Based on the findings in this section of the review; the following collated points are recommended *for consideration* in the reduction of seclusion and restraint (in no particular order). Please note that these are not value judgements but are based on the literature reviewed:

- Continue to use the six core strategies as a baseline for seclusion and restraint reduction.
- Consider the adoption of a requirement for a Registered Nurse to be always present where seclusion, restraint, and mechanical means of bodily restraint are implemented (unless in situations of a recorded long-term risk based on a structured and audited risk assessment).
- Consider a three tier (national, organisational and unit level) approach to seclusion and restraint reduction with clear co-ordinated and integrated leadership responsibility, endorsement, visibility, and active review.
- Consider the use of quality improvement methodologies for seclusion and restraint reduction initiatives so that local contextual issues can be identified using quality improvement tools. Process measures and plans can be tailored to meet local contexts. Furthermore, consideration should be given to the use of change management issues enshrined in QIP methodology. This will enable consideration, planning and management of change processes within the local context.
- Consider a phased approach to achieve reductions, including an initiation phase, an implementation phase, and a consolidation phase.
- Consider a requirement for the standard use of validated evidence-based risk assessment tools known to contribute to seclusion and restraint reduction such as the Broset Violence Checklist (BVC).
- Consider a requirement for specific reduction programme intervention training as well as evidence-based training on trauma informed care, crisis intervention, de-escalation and training that focuses on attitudinal change and skills development.
- Consider requiring care processes which are based on positive and active patient and family involvement and empowerment principles, which are focussed on obtaining information to inform on triggers and preventing aggression.
- Consider a requirement for safety plans for all patients presenting with aggression or a history of aggression.
- Consider a requirement for advance directives and de-briefing to be part of care processes.
- Consider a requirement that all MDT members are actively involved in and accountable for seclusion and restraint reduction efforts.
- Consider a requirement for a clear philosophy (such as patient centredness and/or recovery) which embraces the known values associated with reduction or elimination of coercive measures to underpin all practices.
- Consider the requirement for a suite of evidence-based interventions and activities in areas where seclusion and restraint are used including sensory modulation interventions, CBT, psychotherapy, access to sports and anger management as standard.
- Consider a requirement to routinely collect, audit and review data at a unit, organisational and national level to ensure true reductions are being achieved in terms of event and duration and to monitor for situations of replacement of one measure with another.

- Consider a requirement to ensure adequate ongoing ratios of experienced and educated staff are in place.
- It is recommended that gender association is discussed in the context of restrictive practices at the appropriate time in the care pathway so that any needs can be identified and planned for, particularly in Child and Adolescent Mental Health Services.

5.3 Adult inpatient care

This section will identify and synthesise the critical outcomes of studies associated with restrictive practices and Adult Inpatient Care between 2017 and June 2021. The papers retrieved were diverse in terms of method, outcome measures and context. Therefore, this review focused on describing the interventions, the key findings and synthesising them into themes. The Joanna Briggs Institute critical appraisal checklist for the relevant methods was used to assess the quality of each study (JBI, 2020). In addition, the revised standards for quality improvement reporting excellence (SQUIRE 2.0) tool (Ogrinc, Davies et al. 2016) was used to assess the quality of Quality Improvement Projects (QIPs).

A total of 59 papers were reviewed for this section and are summarised in Appendix 3.

5.3.1 Themes identified

Three overarching themes were identified from the literature relating to restrictive practices in the adult population. They are:

1. Factors preceding: Patient factors including demographics, diagnosis, symptoms, extrinsic factors.
2. Restrictive Practices: Terms and types
3. Consequences of restrictive practices on patients (physical and psychological) and staff, aftercare.

These themes will provide a framework for this section and are depicted in Fig 15.

Figure 15 – Themes identified from the literature relating to restrictive practices in the adult population

5.3.1.1 Theme 1: Factors Preceding

This theme refers to the intrinsic or static patient factors associated with a risk of restrictive practices and the extrinsic or dynamic factors impacting on the patient, which create a risk of restrictive practices.

5.3.1.1.1 Intrinsic/Static Factors:

Demographics

Male gender has been associated with coercion and restrictive practices in 10 of the studies reviewed. Female gender was also cited as being associated with coercive practices (O'Callaghan, Plunkett et al, 2021) - particularly the use of forced medication and seclusion (Cullen, Bowers et al 2018) but not mechanical restraint (Välimäki, Yang et al. 2020). Furthermore, perceived procedural injustice on admission was statistically significantly associated with female gender (p = .015) (O'Callaghan, Plunkett et al, 2021).

Findings relating to age were conflicting - with 7 studies finding that younger people were more at risk of having a restrictive practice applied and a further 3 found that older people (greater than 40yrs) were more likely to experience coercion or a restrictive measure. In the Chavulak and Petrakis (2017) study the age range of those exposed to seclusion was between 17 and 74 years (mean - 36years) with 66% in the age bracket 18-39 years. Patients under 18 years who represented 10% of the patient population in the Payne-Gill, Whitfield et al study (2021) were involved in 20% more incidents than patients in other age cohorts.

Examining the relationship between restrictive practices and ethnicity, an observational study undertaken in the UK by Payne-Gill, Whitfield et al. (2021) found that Black Caribbean Service Users were more likely to be physically restrained than Caucasian Service Users and were at 55% greater odds of being subjected to prone restraint. Black African Service Users were also overrepresented in prone restraint and alongside a cohort of services titled Black 'other'. Those of mixed ethnic background had almost twice the odds of being secluded than Caucasian Service Users. However, there was no association between ethnicity and rapid tranquillisation. Ethnicity was identified as one of the most frequently cited risks for the use of coercive measures in a systematic review by Beames and Onwumere (2021) and specifically for seclusion in a study by van de Sande, Noorthoorn et al. (2017) in the Netherlands. Opposing findings were evident in two studies examining variation in seclusion rates in New Zealand where Lai, Jury et al. (2019) reported findings indicating that age, ethnicity (Māori/non- Māori) District Health Boards or clinical diagnoses did not significantly explain the variance in seclusion rates. The authors suggest that culture and practices across individual units and areas may be responsible for this variation. Conversely, ethnicity was clearly related to seclusion rates where Māori psychiatric inpatients were 39% more likely to experience a seclusion episode than non- Māori non-pacific (nMnP) adults in the study by McLeod, King et al (2017). Furthermore, Jury, Lai et al. (2019) concluded that people who experienced seclusion were more likely to be male, under compulsory treatment, and Māori or Pasifika peoples.

Diagnosis

It is clear that patients with a diagnosis of schizophrenia and mood disorder are consistently at greater risk of the application of coercive measures internationally. Dual diagnosis is associated with the phenomenon to a lesser degree. Dementia is associated with a prevalence in one study, however there is insufficient evidence in this group to determine the level of risk for any restrictive practice.

The systematic review undertaken by Beames and Onwumere (2021) identified patient clinical factors, in particular the diagnoses of mood disorder and schizophrenia to be associated with the overall risk of coercive practices (physical restraint, seclusion, and chemical restraint). Hu, Muir-Cochrane et al, (2019) found that patients with a diagnosis of schizophrenia, schizotypal and delusional disorders were the most prominent diagnoses of those restrained. The meta-analysis undertaken by Muir-Cochrane, Grimmer et al (2020) reported schizophrenia was also the most commonly reported diagnosis (41,3%) associated with chemical restraint, followed by 'other' diagnosis (28.9%) and mood disturbances (10.9%). In relation to seclusion, the main diagnoses of secluded patients in the study undertaken by Hazewinkel, de Winter et al (2019) in the Netherlands were schizophrenia (32%; n = 967); Mood disorders (25%; n = 767) and 22% other psychiatric disorders (n = 672). Similarly in Germany, Mielau, Altunbay et al. (2019) found that the main diagnoses associated with forced medications, mechanical restraint and seclusion combined were schizophrenia (62%; n = 49); schizoaffective (16.5%; n = 13) and bipolar disorder (20.3%; n = 16). For PICU, Cullen, Bowers et al. (2018) found that patients with a diagnosis of bipolar disorder were more likely to be transferred there.

In Denmark, the study undertaken by Thomsen, Starkopf et al. (2017) found that patients with organic mental disorder had 5-fold elevated odds of any coercive measure and 12-fold elevated odds of forced treatment. Mental retardation (referred to as Intellectual Disability in Ireland) or schizophrenia had the highest risk of being subjected to a coercive measure (compulsory admission, involuntary detention, restraint and forced treatment). Similarly, the study undertaken by Pawlowski and Baranowsk, (2017) in Poland found the patients most frequently exposed to coercion (physical restraint; forced medication; mechanical restraint and seclusion) had a diagnosis of schizophrenia, schizotypal or delusional disorders.

Dementia and depressive disorder were associated with a longer duration of Seclusion and Restraint in the Japanese study undertaken by Narita, Inagawa et al. (2019). Additionally, having a history of epilepsy increased the odds of seclusion and restraint. This variation in diagnosis prevalence may be due to the fact that the sample included all adults whereas the other studies reported in this review were predominantly adult 65 years and under.

In Denmark, Martensson, Johansen et al. (2019) in their retrospective analysis of a national register, reported that 23% of all admissions (n – 85736) had a dual diagnosis involving substance use as well as psychiatric disorders. These patients were more likely to be mechanically restrained compared to patients with singular psychiatric diagnoses or only other substance use diagnosis. However, with adjustment for characteristics of patients, patients with substance related diagnoses only were the most likely to be mechanically restrained.

5.3.1.1.2 Extrinsic/Dynamic factors

Legal Status

A total of 8 papers looked at the relationship between Involuntary status and restrictive practices, all except one (van de Sande & Noorthoorn et al. 2017) found that involuntary patients were at risk of coercive measures (all types).

Symptoms and behaviours

A mixed methods retrospective case control study undertaken by Stepanow, Stepanow et al (2019) investigated precursors of seclusion in narrative case notes in a group of patients who had experienced seclusion in comparison to a control group who had not. These precursors can be considered patient factors which are associated with both symptoms and behaviours. Staff subjectivity in terms describing patients' behaviour, terms associated with risk assessment, sleep behaviour, demanding behaviour, requests, high contact frequency with staff and non-compliance were all precursors to and predictors of seclusion.

Patient factors as described by staff in the case notes had significantly more negative undertones, potentially related to problematic behaviour. Examples included: agitated (which was the most frequently represented term), irritable, loud/screaming, obtrusive, restless, threatening, dysphoric, insulting/cursing, aggressive, bizarre/foolish, provocative. Descriptions of patients as threatening and unpredictable were used more often before an aggressive incident or escalation in the case group.

Patients in the case group showed significantly more sleep irregularities - in particular insomnia, in the days before seclusion. High frequency of contact initiated by patients with staff was documented in the case group- requests to leave, request cigarettes or food at inappropriate times and refusing medication more often. Predictors, following logistic regression found the terms 'unpredictable', 'sleep irregularities' and 'manageable' to be potential predictors of seclusion. The cross sectional study reported by van de Sande, Noorthoorn et al (2019) also found that violent behaviour, current substance abuse, suspiciousness, and negativism were dynamic factors associated with seclusion. Positive, negative, and manic symptoms as well as conceptual disorganization were assessed as being elevated in the week prior to seclusion.

The Health of the Nation Outcome Scale (HoNOS) was employed by Jury, Lai et al (2019) to assess symptomology and to provide a quantitative basis to examine associations between symptoms and

seclusion. All HoNOS items except item 5 were significantly associated with seclusion. Item 1 (which assesses overactive, aggressive, disruptive, or agitated behaviour) was the strongest factor and 14.02% of people with clinically significant scores on this item were secluded compared to 2.5% of people without. 11% of people with clinically significant scores on item 6 (which assesses problems with hallucinations and delusions) were secluded compared with 4.08% of people without clinically significant scores. Likewise, 10.38% of people with clinically significant scores on item 3 (which assesses problems with drinking or drug use) compared to 5.44% without were secluded. In the case of Item 2 (which assesses problems with non-accidental self-injury) 3.9% of people with clinically significant scores were secluded compared to 9.59% of people without. 4.11% of people with clinically significant scores in item 7 (which assesses problems with depressed mood) compared to 10.97% without.

Analysis of electronic health data undertaken by Danielsen, Fenger et al (2019) identified the ten most important patient-oriented predictors of mechanical restraint. These were (ordered by predictive ability) involuntary admission, BVC score, somatic comorbidity, sparse/non coherent verbal response and non-informative verbal response, abnormal behaviour, threatening behaviour, good social status, suicidal ideation, and persecutory ideation.

The main reasons for the use of all types of restrictive practice in the integrative review undertaken by Laukkanen, Vehvilainen-Julkunen et al (2019) were violence, self-harm, and behavioural control of the patients. Behaviours associated with the use of seclusion and restraint in the study by Narita, Inagawa et al (2019) included psychomotor agitation, suicidal ideation, self-harm, harmful behaviour to others, risk of falls, self-extraction of catheters.

Organisational Factors

The systematic review undertaken by Beames and Onwumere (2021) identified one of the risk factors associated with restrictive practices to be organisational, including the ward environment (décor, milieu, comfort) and the hospital itself. Furthermore, the authors also reported that staff factors can contribute to the use of restrictive practices.

A further systematic review of interventions to improve the use of constant observations undertaken by Reen, Bailey et al. (2020) identified a number of organisational and staff variables that can contribute to the patient experience of close observation. These in turn can reduce self-harm, aggression and subsequent restrictive practices including control close observations, defined as observations designed to keep the person safe. Replacing control-based observation, with care-based observations (designed to increase therapeutic input) reduced restrictive practices, self-harm, absconding and aggressive incidents. Development of a protocol to engage patients at low risk of self-harm and aggression as opposed to immediate close observations, also reduced aggression and restrictive practices. Other factors contributing to a reduction in the level of restriction associated with close observations were changes to team, staff education and training, record keeping and assessment.

5.3.1.2 Theme 2: Restrictive Practices

This theme refers to the types of restrictive events in use internationally and their prevalence as reported. Terminology is important and the differing terms for restrictive practices render it difficult for international comparatives and generalizability.

Terms

Whilst this review refers to restrictive practices, the umbrella terminology in the papers reviewed varied. Language can influence acceptability and unacceptability and use of such practices depending on the perspective or values of the reader. A summary of terms and associated practices (where present) in the reviewed papers are collated in Table 1.

Paper	Overarching Term	Events
Payne-Gill, Whitfield et al (2021)	Restrictive practices	Physical restraint (defined as with and without prone), seclusion, rapid tranquillisation
O'Callaghan, Plunkett et al (2021)	Formal coercive practices	Seclusion, restraint
Hammervold, Norvoll et al (2021)	Coercive measures	Restraints (not defined)
Beames and Onwumere (2021)	Coercive practices	Physical restraint (Defined as physically holding a person), seclusion, chemical restraint, environmental restraint, mechanical restraint, psychological restraint, seclusion
Varpula, Välimäki et al (2020)	Coercive measures	Seclusion and mechanical restraint practices
Reen, Bailey et al (2020)	Restrictive practice	Constant Observations: Two types: Control and Care
Nielsen, Milting et al (2020)	Coercive procedures	Forced medication
Muir-Cochrane, Grimmer et al (2020)	Coercive practice	Chemical restraint
Mangaoil, Cleverley et al (2020)	Coercive practices	Seclusion and mechanical restraint
Laukkanen, Kuosmanen et al (2020)	Containment	PRN medication, physical restraint, intermittent observation, seclusion, timeout, intramuscular medication, transfer of patient to a locked ward (PICU), mechanical restraint, constant observations, net bed, and open area seclusion
Laukkanen, Kuosmanen et al (2020)	Restrictive measures	Seclusion, mechanical and physical restraint, and involuntary medication
Doedens, Vermeulen et al (2020)	Coercive measures	Seclusion, restraint
Digby, Bushell et al (2020)	Restrictive practices	Seclusion, restraint
W. Haugom, Ruud et al (2019)	Intervention	Seclusion
Verbeke, Vanheule et al (2019)	Coercion	Seclusion/segregation
Sampogna, Luciano et al (2019)	Coercive measures	Restraint, seclusion, forced medication
Välimäki, Yang et al (2019)	Coercive measures	Seclusion, limb restraints, forced injection and physical restraint
Stepanow, Stepanow et al (2019)	Coercion	Seclusion
Mårtensson, Johansen et al (2019)	Coercive measures	Mechanical restraint
Laukkanen, Vehvilainen-Julkunen et al (2019)	Containment	PRN medication, physical restraint, intermittent observation, seclusion, timeout, intramuscular medication, transfer of patient to a locked ward (PICU), mechanical restraint, constant observations, net bed, and open area seclusion
Lai, Jury et al (2019)	Restrictive practice	Seclusion
Kersting, Hirsch et al (2019)	Coercive measures	*Restraint:* physical (manual holding), mechanical (1, 4, 5 and 11 point), mechanical (chair restraint), mechanical (bed rails) and vest restraint *Seclusion:* separating the patient in a locked room

		Forced medication: Meaning oral or parenteral (IV or IM) application of medication by force or by definite psychological pressure, e.g., announcing forced parenteral medication if medication is not immediately taken orally
Jury, Lai et al (2019)	Restrictive practice	Seclusion
Jacob, Holmes et al (2019)	Control interventions	Mechanical restraints
Hu, Muir-Cochrane et al (2019)	Coercive measures	Chemical restraint
Hazewinkel, de Winter et al (2019)	Restraining measures	Seclusion
Guzmán-Parra, Aguilera-Serrano et al (2019)	Coercive measures	Involuntary medication mechanical restraint and both combined
Gleerup, Østergaard et al (2019)	Coercive measures	Seclusion and mechanical restraint
Danielsen, Fenger et al (2019)	Coercive measures	Mechanical restraint
Chieze, Hurst et al (2019)	Coercive measures	Seclusion and restraint
Askew, Fisher et al (2019)	Restrictive practices	Seclusion
Mielau, Altunbay et al (2018)	Coercive Measures	Forced medications, mechanical restraint. seclusion
Krieger, Moritz et al (2018)	Invasive measures Non-invasive measures	Seclusion, mechanical restraint, forced medication, involuntary hospitalisation, seclusion, video surveillance
Khatib, Ibrahim et al (2018)	Restrictions	Physical restraint
Gowda, Lepping et al (2018)	Coercion	Physical restraint, forced pharmacological treatments (chemical restraints and involuntary medications), isolation, seclusion, and ECT
Goulet and Larue (2018)	Control measure	Seclusion, restraint
Dahan, Levi et al (2018)	Coercive measures	Restraint and mechanical restraint
Cusack, Cusack et al (2018)	Restrictive practices	Physical restraint
Cullen, Bowers et al (2018)	Coercive measures	PICU and seclusion
Barnett, Kusunzi et al (2018)	Coercive measure	Seclusion
Aguilera-Serrano, Guzman-Parra et al (2018)	Coercive measures	Mechanical restraint, seclusion, forced medication
Thomsen, Starkopf et al (2018)	Coercion	Compulsory admission, involuntary detention, restraint and forced treatment.
Pettit, Bowers et al (2017)	Coercive methods Containment	PRN medication, physical restraint, intermittent observation, seclusion, timeout, intramuscular medication, transfer of patient to a locked ward (PICU), mechanical restraint, constant observations, net bed, and open area seclusion
Pawlowski and Baranowski (2017)	Coercive measures	Physical coercion: physical restraint; forced medication; mechanical restraint and seclusion
McKenna, McEvedy et al (2017)	Restrictive practices	Seclusion, physical restraint, mechanical restraint.
Fletcher, Spittal et al (2017)	Restrictive practice	Seclusion
Chavulak and Petrakis (2017)	Restrictive practices	Seclusion

Table 2 Summary of terms in the reviewed papers

Restrictive Practices:

The papers in the review focus on different restrictive practices, either singularly or in combination. To gain an understanding of the number of restrictive practices they are collated in Table 2.

Physical restraint (defined as with and without prone)
Physical restraint (defined as manually holding a person)
Seclusion
Rapid tranquillisation
Chemical restraint
Environmental restraint
Forced medication
Mechanical restraint: mechanical (1, 4, 5 and 11 point), mechanical (chair restraint), mechanical (bed rails) and vest restraint, Limb restraints
Constant Observations: Two types: Control and Care
PRN medication
Involuntary medication
Intermitted observation
Constant observation
Net bed
Segregation
Forced medication: Meaning oral or parenteral (IV or IM) application of medication by force or by definite psychological pressure, e.g., announcing forced parenteral medication if medication is not immediately taken orally

Table 3 Restrictive Practices evident in the literature

5.3.1.3 Theme 3: Consequences

5.3.1.3.1 Patients: Psychological effects

The systematic review undertaken by Chieze et al (2019) was unequivocal in their findings that there is evidence that seclusion and restraint have deleterious psychological consequences for those patients subjected to them. The authors found evidence that negative effects have consistently been found across studies. It is noted that one study suggested a beneficial quality of life, however this is clearly in the minority. Cheize et al (2019) estimate that 25-47% of patients experience post-traumatic stress disorder. This was confirmed by Guzmán-Parra, Aguilera-Serrano et al. (2019) who used the Davidson Trauma Scale (DTS, Davidson et al, 1997) to assess patients stress levels after the application of restrictive measure. They found that participants who experienced combined measures and mechanical restraint had higher DTS scores than those who had received involuntary medication. Furthermore, patients subjected to the following practices, involuntary medication (n=5), mechanical restraints (n=4) and combined measures (n=5 were noted to have a score higher than the cut off for the DTS, indicating event-related post-traumatic stress disorder. This is unsurprising given that patients in the study undertaken by Khatib, Ibrahim et al. (2018) described the experience of being tied in a room alone as awful, terrifying, felt like they were going to die, and as a nightmare. Feelings of helplessness and descriptions of being at the mercy of the nurses for release, demonstrated traumatic experiences. The majority of patients experienced negative emotions such as hopelessness or desperation during the measures.

The 8 themes from the integrative review by Cusack, Cusack et al (2018) summarise the negative impact of physical restraint upon those subjected to it: Trauma/re-traumatisation due to the incident itself or retraumatised due to past trauma, distress, fear, feeling ignored, control, power, and dehumanising. Fear, anxiety, post-traumatic stress disorder, powerlessness, abandonment,

distrustfulness or loneliness, punishment, maltreatment, anger, rage, resentment, depression, impotence, sadness, humiliation, degradation, shame, loss of freedom and coercion. Similar findings were also identified by Aguilera-Serrano, Guzman-Parra et al (2018) in 24 of the 26 papers in their systematic review.

A qualitative systematic review undertaken by Mellow, Tickle et al (2017) found that seclusion has the potential to cause iatrogenic harm, particularly where interactions with nursing staff are not experienced as compassionate. The emotional impact of seclusion in 10 of 11 papers was identified as negative. This included intense effect, emotional impact, emotional experiences, loneliness, autonomy, fear, anger, frustration, powerlessness, and sadness.

The environmental experience of seclusion and the process of being placed in seclusion (disrobing and the locking of the door) was described as frightening, humiliating, and dehumanising and resulted in sensory deprivation and problems relating to lack of access to meet basic needs. The seclusion experience can also result in or exacerbate symptoms such as agitation, hallucinations, delusions, and the effects of sensory deprivation (Mellow, Tickle et al 2017).

In relation to restraint, contact with a staff member as soon as possible upon the application of restraint was important to patients. Mielau, Altunbay et al (2018) also found that the manner in which coercion is subjectively experienced has a direct influence on patients' perceptions of psychiatry and may mitigate against the distress experienced by the patient. The experience of feeling degraded and humiliated was offset against the presence of a caring staff member (Khatib, Ibrahim et al. 2018). Interactions with staff were seen as important but could be identified as either positive or negative (Mellow, Tickle et al 2017). Positive interactions included clear communication, support, understanding, whereas negative communication was characterised by poor quality interactions and a lack of communication or concern.

5.3.1.3.2 Patients: Physical effects

A systematic review of 67 studies undertaken by Kersting, Hirsch et al (2019) reviewed physical harm and death in the context of coercive measures in psychiatric patients. Death was the most frequently studied harm - documented in 42 studies. Cause of deaths were cardiopulmonary arrest in 17 studies whereby positional asphyxia or heart failure was not mentioned by default. Asphyxia caused by strangulation was found in 10 studies and pulmonary embolism in 8 studies. Other physical outcomes associated with coercive measures included suicide, bleeding to death, hemoperitoneum (sometimes referred to as intra-abdominal or intraperitoneal haemorrhage or bleeding) resulting from restraints, sudden unexpected death as well as asphyxia caused by a chokehold. A total of 5 studies documented increased mortality without being able to deduce direct causality. Second most frequently analysed harm was Venous Thromboembolism (VTE) in 14 studies, Deep Venous Thrombosis (DVT) in 8 studies, Pulmonology Embolism (PE) in 12 studies with the consequence of death in 8 studies.

5.3.1.3.3 Impact: Staff

The integrative review undertaken by Laukkanen, Vehvilainen-Julkunen et al (2019) found that nurses' attitudes towards restrictive practices have continuously become more negative over the last decades. The completion of the attitudes towards containment questionnaire (Bowers et al 2004) by staff indicates ethical conflicts and cognitive dissonance. An example of this is where staff may disapprove of a measure of containment (such as restraint) but can identify no other option to manage

the presenting behaviour. Overall, the review found that nurses have negative feelings such as frustration and regret regarding the use of containment methods.

These findings also resonate with the findings from the qualitative study by Wilson, Rouse et al. (2017). Their concluding rhetorical question, asking 'is restraint a necessary evil?' reflected staff appraisals of restraint. Staff reported predominantly negative emotional or relational outcomes in the sub theme of 'its never nice'. Where it was perceived as necessary, staff reported that restraint was used only as a last resort to deal with safety concerns in the sub theme 'but it's got to be done'. Staff acknowledged the dehumanising effect and the distress and fear experienced by patients which was induced by restraint. Staff themselves experienced fear and distress as the enforcers of the restraint. The process produced a conflict in staff whereby they felt forced to engage in a process which was contrary to the caring nature of their role and recognised the negative effect it could have on patient-staff relationships.

5.3.1.3.4 Aftercare: Debriefing

Three studies evaluated the experience of Post Incident Reviews (PIR) following restrictive practices. One study evaluated the patient experience (Hammervold, Norvoll et al 2021), one the staff experience (Hammervold, Norvoll et al 2020) and one the experience of both staff and patients (Goulet, Larue et al 2018). Patients' experiences of PIRs varied. From one perspective, patients felt the experience of the PIR strengthened them, engagement in a PIR supported them to process the incident and to develop new coping mechanisms (Hammervold, Norvoll et al 2021).

From the professionals' perspectives, PIRs had the potential to improve the quality of care through the incorporation of other perspectives and possible solutions, increase ethical and professional awareness and emotional and relational processing (Hammervold, Norvoll et al 2020). PIRs were seen as an opportunity to process tensions and staff struggled to 'get hold' of patient's voices. Staff also saw PIRs as an opportunity to prevent future use of restraint by reflecting, reviewing antecedents, and identifying alternative measures (Hammervold, Norvoll et al 2020).

A total of 12 staff and 3 patients participated in the study by Goulet, Larue et al (2018) involving the development of a PIR process. They describe 3 phases to the intervention:

1. 5 months: Development of the intervention: Immersion in the setting, individual interviews, and development of the post seclusion and restraint review (PSRR)
2. 3 months: Implementation: Informative presentations, adjustment of the intervention.
3. 6 months: Evaluation: Individual interviews, seclusion and restraint (SR) prevalence over 195 admissions.

The length of the PIR intervention was between 10-30 mins and the PIR was integrated into practice with the patients. However, PIR was less integrated into practice with the wider healthcare team-reasons outlined were that PIR was only considered relevant if the SR was perceived as difficult and PIR called into question the quality of relationships between staff members. At 6 months, 9 out of 12 SR incidents had a post seclusion and restraint review. In this context nurses felt able to explore the patients' feelings and this contributed to restoration of the therapeutic relationship following the SR incident. The use of seclusion and time spent in seclusion were significantly reduced 6 months after introduction of the PIR. However, it was not statistically significant for restraint.

5.3.2 Discussion

Quality of Research

The overall quality of the research undertaken as findings in this area, have been highlighted recently. Beames and Onwumere (2021), reported poor methodological quality, heterogenous findings and that practices are not applied uniformly across services. They cited these as the primary reasons it was not possible to identify any single variable as a robust risk factor for coercive practices. In relation to qualitative research, an interesting consideration was noted by Askew, Fisher et al (2019), who suggest that published qualitative research may have flaws with the quality of analysis, mainly due to limited researcher reflexivity. These issues are not uncommon in the critique of research and are mitigated here by inclusion of papers following assessment using recognised quality tools and careful consideration of context and outcome.

Terms

The terms restrictive practices, coercive interventions, coercive practices, and containment measures are used interchangeably in the literature. Whilst the same practices may be categorised under different headings, it is important that there is clarity around these terms so that accurate inferences can be drawn in practice, the full extent of restrictive practices are understood and reporting systems and research have aligned definitions.

Use of large national data sets or Electronic Medical Records

The findings of the studies referred to here are already reported. However, they are highlighted here as there is an increasing prevalence of studies using large datasets from electronic datasets and national datasets to investigate the phenomenon of aggression and measures to manage it. To this end 7 studies used large national datasets for analysis. A further 4 used Electronic Medical Records (EMR) and 1 trialed machine learning. This level of data analysis is new and commensurate with the ongoing technological advancements in the management of healthcare. It allows for large datasets to be established over long periods of time which adds considerable strength to the findings. For example Välimäki, Yang et al (2019) examined trends in the use of coercive measures in Finnish psychiatric hospitals through analysis of an established national register over the past two decades. This study sample was of 226,498 patients, admitted for 525,169 treatment episodes over 20 years. The availability of this level of data and current developments in text mining etc can provide valuable data on restrictive practices, those at risk of restrictive practices and the factors leading to restrictive practices.

5.3.3 Considerations for Ireland

Based on the findings in this section of the review, the following are collated recommendations *for consideration* in the reduction of seclusion and restraint (in no particular order). Please note that these are not value judgements but are based on the literature reviewed:

- Consider the use of a national reporting system (register) or EMRs to identify the specific factors (demographics, diagnosis, factors precipitating aggression) associated with different coercive measures including physical restraint, seclusion, close observations, forced medication, chemical restraint in Ireland.

- Consider the use of predictive data to target interventions to avoid restrictive practices.
- Consider the requirement for a nationally mandated evidence-based assessment tool for symptoms and severity (for example the HoNOS is widely used in the UK, Australia and New Zealand) to collate data - which can be used to assess illness related factors as predictors of aggression and restrictive practices in the Irish context.
- Consider the development of a taxonomy to enhance clarity and avoid use of imprecise terminology - given the prevalence of wide ranging and sometimes imprecise terms relating to a range of restrictive practices both nationally and internationally.
- Consider developing training content to ensure that staff are fully aware of the negative consequences of restrictive practice and can provide interventions that minimize distress and impact.
- Consider support structures to enable support and critical reflection on practice for nurses or other members of a Multidisciplinary Team who are engaged in restrictive practices.

5.4 Forensic inpatient care

This section will identify and synthesise the critical outcomes of studies associated with restrictive practices in Forensic Inpatient Care between 2017 and June 2021. The papers retrieved were diverse in terms of method, outcome measures and context. Therefore, this review focused on describing the interventions, the key findings and synthesising them into themes. The Joanna Briggs Institute critical appraisal checklist for the relevant methods was used to assess the quality of each study (JBI, 2020). In addition, the revised standards for quality improvement reporting excellence (SQUIRE 2.0) tool (Ogrinc, Davies et al. 2016) was used to assess the quality of Quality Improvement Projects (QIPs).

A total of 7 papers were reviewed for this section and are summarised in Appendix 4.

5.4.1 Themes identified

Three themes can be identified from the studies reviewed. These can be categorised into the process of restrictive practice in Fig 15.

Figure 16 - Synthesis of themes from Forensic Studies reviewed

5.4.1.1 Theme 1: Factors preceding

Patients:

A review by Kuivalainen et al (2017) in a forensic hospital in Finland (284 patients) over a 4-year period analysed 134 episodes of seclusion and 7 episodes of restraint. Because of the low numbers of restraint events, the two measures were merged. Over half of the patients in the secluded/restrained group were those whose treatment would have been difficult or dangerous in a general psychiatric ward. Furthermore, almost 30% of the group were patients who had committed a crime and were found not guilty by reason of insanity and almost 30% were referred for forensic examination.

Findings relating to gender varied. Most patients in the restrained/secluded group were male (n = 105; 72.9%) and were mainly from the group of patients who had committed a crime but were admitted by reason of insanity in Kuivalainen et al (2017). Conversely Griffiths et al (2018) found no gender difference in the 96 patients (N = 347) that had experienced seclusion in their study.

The top three diagnostic categories of patients subjected to seclusion in Griffiths et al (2018) were 1; Organic Personality Disorder group 2; Emotionally unstable Personality Disorder group and 3; Paranoid schizophrenia group.

Events Preceding:

It was reported that harmful events tended to precede episodes of seclusion/restraint (Kuivalainen et al. 2017). These included reports of harm to others (n = 65; 46.5%), harm to self (n = 35; 24.3%), harm to objects (n = 10; 6.9%) and no harm with clear target (n = 22; 15.3%). More specific dynamics around the patients' perceptions and their experiences leading to, within and coming out of mechanical restraints are captured in four themes in a qualitative study undertaken by Tingleff et al (2019). The first theme corresponds with the antecedents to a mechanical restraint event where participants described anger and frustration behaviourally reflected in violence, threats, or aggression towards staff. Interactions with staff, giving rise to conflict were outlined as both precursors to and amplifiers of the patient's behaviour. Patients' perceptions that staff were refusing to understand, enter a dialogue or were ignoring them resulted in feelings of inferiority to staff. These findings are consistent with previous research focusing on staff interactions with patients undertaken by Alexander (2006) Bowers (2009), Papadopoulos et al (2012), Bowers et al (2011), all of which informed the staff-patient interaction components of the Safewards Model (Bowers, 2014).

Attempts to avoid:

From 101 episodes where de-escalation was implemented, Kuivalainen et al (2017) were able to rank the de-escalation interventions used. The first (n = 74) highlighted was 1:1 discussion which included listening to the patient and trying to calm them down. The second consisted of administration of PRN (n = 37) or 'earlier than scheduled' medication (n = 2). The third, most used de-escalation technique was escorting the patient to their room (n = 15). De-escalation techniques used to a lesser extent included escorting the patient away from a certain space (n = 1), intensive observation (n = 3), activation and enabling a smoke (n = 4) and finally one patient was transferred to a locked ward. However, in 17 cases, Kuivalainen et al (2017) found that the staff interventions used were directed to restrict or direct the patient - these included physical restraint, limitations on privileges, seclusion before mechanical restraint, use of clothes to restrict movement and urine screening for drugs. These staff interventions or measures were more coercive in nature and led to more coercive/restrictive practice measures during the interaction/engagement with staff. This raises questions about the nature of staff patient interactions, what constitutes de-escalation and how coercive measures can be more subtle and pervasive than restrictive practice alone.

Contemporary psychiatry has moved towards a human rights approach as the underpinning basis for assessment and interventions in mental health. Whilst restrictive practices still characterise the management of challenging behaviours, there is a requirement to use the least restrictive means to manage them and to avoid their use where possible. However, evidencing that this has occurred in an evidence-based manner has been a challenge for services and clinicians. The development of the DRILL model (Kennedy et al 2020) may offer a system to support and evidence the decision-making processes, as well as offer a proactive means of assessing antecedents of aggression and providing proactive planning options. The DRILL is less of a tool and more of an overall systematic approach for identifying risks through a validated tool and using a decision-making pathway. Ladders represent a continuum of behaviour or interventions (DRILLs) and previous day assessment data using an

assessment tool (DASA) is used to complete Behaviour ladders (5 ordinal scales: Violence, self-harm, risk to others, absconding and non-compliance) and corresponding intervention ladders (8 ordinal scales: de-escalation, observations, personal searches, extra medication, situational coercion, manual restraint, seclusion and mechanical restraint). The utility of such an approach provides a clear context bound intervention pathway in practice, supports the use of the least restrictive means of managing challenging behaviours and the evidence to support decisions made accordingly. Whilst there is no evidence yet to demonstrate that this approach will reduce challenging behaviours, it is certainly possible that this approach will facilitate the means to avoid restrictive interventions once identified. Whilst this system has been developed and evidenced in the forensic context, there may be scope for this approach to be replicated or amended for the generalist setting.

5.4.1.2 Theme 2: Restrictive practices

Of the eight studies reviewed, half focussed on seclusion and restraint (mechanical and physical) (Jalil et al. 2020; Gunther et al. 2020; Flammer et al 2020; Kuivalainen et al. 2017), 2 focussed exclusively on mechanical restraint (Tingleff et al. 2019; Nielsen et al. 2018) and 2 on seclusion only (Askew et al. 2020; Griffiths et al. 2020). Room confinement was also addressed in the study by Flammer et al (2020). Jalil et al (2020) also examined manifestations of aggression and Gunther et al (2020) examined the use of involuntary medication with seclusion and restraint. In a comparison between general psychiatry inpatient units and forensic psychiatry inpatient units, Flammer et al (2020) found that the use of seclusion was eight times higher in general psychiatry. Use of seclusion in general hospitals was 8 times higher than in forensic psychiatry. Conversely, the use of mechanical restraint in general psychiatry was slightly lower. The use of involuntary medication in forensic hospitals was three times higher but still low >3%. Half of these were emergency measures and half were due to court orders. The remaining studies did not focus exclusively on the measures and numbers of events.

5.4.1.3 Theme 3: Consequence

At the point of mechanical restraint, Tingleff et al (2019) identify that patients may experience one of two responses - to overtly protest (fight) or to silently protest. Patients reported that they felt surrounded, overpowered, and humiliated when subjected to holding by staff. A lack of emotional engagement by staff exacerbated these feelings. Silent protests were characterised as a 'false calmness' as a way of coping with or repressing feelings of anger, frustration or sadness. Furthermore, patients reported feeling unable to respond in fear or being charged with a violent offense or because they knew they could not achieve their desired outcome. Following initiation and in the process of the restraint, the same overt or silent protests characterised the experience. However, the feelings behind these protests differed in that the patient directed their anger towards the nurses present and this was exacerbated by being forcibly medicated or forced to eliminate bodily wastes in the presence of staff. Patients reported feeling that prolonging the mechanical restraint was a misuse of staff power. Eventually this anger is reported to give way to either true calmness or false (arguably instrumental) calmness designed to secure release and patients reported that release was dependent upon whether it suited staff or not.

Loss of power, misuse of power and feelings of being abused by staff were also experienced by the patients participating in the qualitative study undertaken by Askew et al (2020) in the UK. Similar to

the participants in the Tingleff et al (2019) study, participants reported displaying docile behaviour to end the experience or displayed more overt behaviours to restore their power. The observation of patients in the bathroom by staff during the secluded period was also referred to as abusive.

Readiness for ending mechanical restraint was the focus of the study undertaken by Nielsen et al (2018) in Denmark. In that regard, the alliance between the patient and the staff members prior to the mechanical restraint was identified by clinicians as critical in determining the different stages of mechanical restraint, particularly the ending. Of note, the study gathered data from clinicians only. Clinicians reported that patients felt safe in mechanical restraints if they had a previous alliance with them and that their knowledge of the patient and their habitual state enabled them to determine readiness for release. The patients' mental state and to what extent this overrode their co-operation, coupled with their insight into their understanding of their current situation, were additional factors in determining eligibility for release. For clinicians, stability, predictability, and ability to maintain agreements made in the event of release were critical in the clinicians' assessment. A total quality alliance, whereby the overall team assessment for release was dependent upon the alliances made between the patient and the different clinicians was the ideal assessment standard for release.

5.4.2 Discussion

5.4.2.1 Definitions and continuum of coercion:

Definitions of coercive measures varied in the studies reviewed. Seclusion, physical restraint, mechanical restraint, room confinement and involuntary medication were the measures investigated. In a number of studies restraint was not clearly defined and it only became apparent over the course of the paper what type of restraint was being referred to. This may be because mechanical restraints are the main forms of restraint in use in Scandinavian countries, whereas physical (hands on) restraint is the main form in the UK. Common definitions or a more universal taxonomy across jurisdictions may be useful in enabling a more critical review of best evidence for application locally. Additionally, the use of the term coercion is applied to measures which physically restrict movement and to measures which confine freedom to leave. A global definition delineating what Bowers (2006) refers to as restrictive practice (including seclusion, physical restraint, manual restraint, involuntary medication) and coercive measures which could include involuntary admission, time-out, close observations and coercive interactions which connect compliance with freedom of choice, access to personal effects, services, or movement. This could take the form of a continuum which would not only raise awareness around the nature of interactions but would also allow for measurement of coercion in a more robust manner.

5.4.2.2 The patient experience of restrictive practice

The dynamics between staff and patients in inpatient forensic services are complex. Power dynamics exist at different levels in the relationship and patients have reported feeling disempowered and frustrated when they were not heard or perceive that they were being ignored by staff (Nielsen et al 2019). These feelings are exacerbated when restrictive practice is enacted, and patients are forced

into a dichotomy of reactions to end the process (Tingleff et al 2018). Anger and frustration, feelings of humiliation and abuse are consistent across the experience of seclusion (Askew et al 2020) and mechanical restraint (Nielsen et al 2018). Given the potential trauma associated with such experiences, the principle of defining and using actions of last resort is critical. When enacted, restrictive practice measures (where patients are rendered powerless and vulnerable in the deprivation of liberty or movement) must be undertaken only where other options are not possible and must be accompanied with positive, empathic, and clear communication. To this end, those implementing, and monitoring restrictive practice walk a fine line which requires experience and skill to maintain safety whilst meeting their ethical, clinical and legal duty to maintain the safety of patients entrusted to their care.

5.4.3 For consideration in the Irish context

Based on the findings in this section of the review the following are collated recommendations *for consideration* in the reduction of seclusion and restraint (in no particular order). Please note that these are not value judgements but are based on the literature reviewed:

- Consider providing clarity and more specific reporting requirements around coercion and restrictive practice, particularly around demonstrating proportionality and the least restrictive approach. The DRILL tool or system developed in forensic services in the Irish context is valid and in use (Kennedy, Mullaney et al. 2020) and may be useful or adaptable in wider generalist psychiatric services.
- Consider how staff can engage with patients in a way that avoids conflict. The Safewards Model (Bowers, 2014) contains evidence-based interventions in this regard.
- Consider strengthening the understanding, use and monitoring of the 'least restrictive' principle and identify control measures that can ensure this principle is upheld.
- Consider strengthening practices and de-briefing around intrusive practices particularly where staff are required to be present when patients are tending to bodily functions. It is recommended that this measure is also subjected to the 'least restrictive' principle.

5.5 Child and Adolescent Inpatient Care

This section will identify and synthesise the critical outcomes of studies associated with restrictive practices in Child and Adolescent Inpatient Care between 2017 and June 2021. The papers retrieved were diverse in terms of method, outcome measures and context. Therefore, this review focused on describing the interventions, the key findings and synthesising them into themes. The Joanna Briggs Institute critical appraisal checklist for the relevant methods was used to assess the quality of each study (JBI, 2020). In addition, the revised standards for quality improvement reporting excellence (SQUIRE 2.0) tool (Ogrinc, Davies et al. 2016) was used to assess the quality of Quality Improvement Projects (QIPs).

A total of 8 papers were reviewed for this section and are summarised in Appendix 5.

5.5.1 Themes identified

Two overall themes associated with the pre cursors and consequences of restrictive practice were identified. These included factors preceding restrictive practice (patients, events, interventions to avoid) and the consequences (restrictive practices, physical and psychological consequences). See Fig 16.

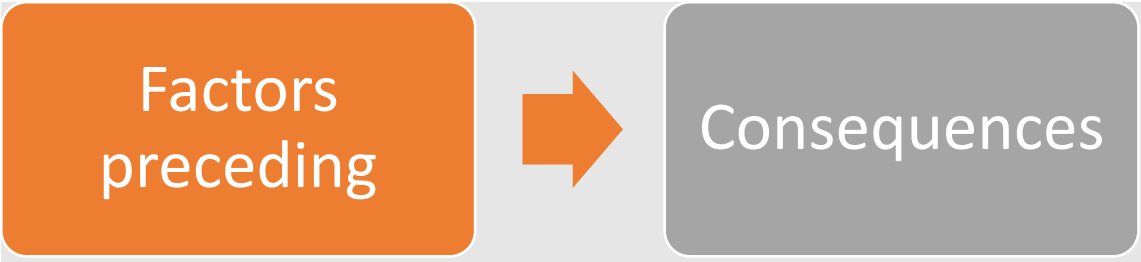


Figure 17 - Themes from CAMHS Studies

5.5.1.1 Theme 1: Factors preceding

This overarching theme includes the sub-themes patients, events, and interventions to avoid restrictive practice.

Patients

Children and young people admitted involuntarily or as an emergency are more likely to experience restraint as a singular measure alone (Nielsen et al 2021) or in combination with seclusion (Geng et al, 2021). Those with prior admissions (Nielsen et al 2021; Geng et al 2021; Vidal et al 2020) are also likely to experience restrictive measures. Highlighting first admissions, Geng et al (2021) found that over half (54.4%) of those subjected to seclusion and restraint were first admission. Furthermore, Nielsen et al (2021) found that patients from this population with a history of trauma, self-harm and aggression were more likely to experience physical restraint. Children and adolescents from minority

backgrounds, including those referred to in the paper as 'black race' (Vidal et al 2020) and immigrant background (Furre et al 2017) were also identified as being at higher risk of restraint.

In relation to age and gender, younger males have been found to be more likely to be restrained (Nielsen et al 2021; Vidal et al 2020). Younger children (gender not specified) were more likely to be administered PRN psychotropic medication as reported by Carlson et al (2020). Conversely, Geng et al (2021) found that there was little difference in the age of those who did (15.56 years ± 1.57) and who did not (15.17 years ± 1.86) experience seclusion and restraint. Females experienced multiple restraints in the systematic review undertaken by Nielsen et al (2021). The national Danish study examining restrictive practices (mechanical restraint, physical holding, pharmacological restraint, and seclusion) found that 55% of all incidents were experienced by girls (total of 2277 incidents).

Diagnoses of children and adolescents who were subjected to restrictive measures vary in the literature. The diagnoses of psychosis and mania are the only diagnoses common to all studies of children and adolescents who have experienced restrictive practices. The remainder are diverse to the extent that they are not repeated across the studies reviewed.

Children and adolescents with a diagnosis of developmental disorder, psychotic disorder, externalising and internalising disorder (with multiple co-morbid disorders increasing likelihood) were more likely to experience restraint in the systematic review undertaken by Nielsen et al (2021). Genge et al (2021) in their national study in China ranked the diagnosis of those subjected to seclusion and restraint as follows: psychotic symptoms (n = 31; 54.4%), mania related symptoms (n = 17; 29.8%) and depressive symptoms (n = 15; 26.3%). Additional diagnoses identified as predictors of seclusion in the Vidal et al paper (2020) included bipolar and related disorder, trauma, and stress disorders. Furre et al (2017) also recorded the prominent diagnoses in their national Norwegian study of 267 adolescents who experienced restraint as: externalising disorders (28%), affective disorders (22%), neurotic and stress related disorders (20%), psychotic disorders (12%) and no recorded diagnosis (18%).

A small group of patients experienced most of the seclusion and restraints, 6 patients received more than half of the restraints and 4 patients experienced more than half of the seclusions in the study undertaken by Geng et al (2021). This suggests that data should be carefully reviewed and used to target interventions for patients who experience more than the unit average number of restrictive events.

Antecedents

One recent paper concluded that both patient- specific (intrinsic) and environmental (extrinsic) factors lead to restraint of children and adolescents in Mental Health Services (Nielsen et al 2021). Intrinsic factors include aggressive behaviours (n = 17; 29.8%) and self-injurious/suicidal behaviours (n = 10; 17.5%) on admission were associated with seclusion and restraint by Genge et al (2021). An additional 78.9% (n = 45) and 19.3% (n = 11) of seclusions and restraints arising from aggression and self-injurious behaviours respectively occurred during admission. Patient history, including physical abuse and trauma are also identified as predictors of seclusion (Vidal et al 2020). Behaviour on admission can be categorised as intrinsic, however, admission itself is extrinsic and Nielsen (2021) delineated emergency and involuntary admission types to be associated with aggression. This is a good example of how the intrinsic and extrinsic impact upon each other as precursors to aggression.

Across the 16 studies reviewed by Nielsen et al (2021) risky behaviours such as agitation, aggression, threats, staff directed assault, self-harm, opposition, disinhibition and absconding were found to be patient centric precursors of restraint. Harm to others was the most common precursor to restrictive practices (53.2% of 2277 events) in the National Norwegian study undertaken by Furre et al (2017). This was followed by damaging property (16.5%), running away (13.9%), and acting out (11.2%). It was noted that patients who were restrained for harming self or others were restrained for significantly longer than other behaviours.

Several extrinsic factors are also identifiable from the literature. These include staff related factors where misperceptions around dangerousness and a lack of cultural awareness may have contributed to aggression and subsequently restraint (Nielsen, 2021). Further staff related variables predictive of seclusion (Yurbasi et al 2021) included lower nurse-patient ratios, more male nurses on shift, and the presence of temporary or agency nurses on shift. Conversely, greater numbers of female nurses on shift decreased the risk of seclusion.

An unexplained extrinsic factor related to the timing of incidents was identified by Nielsen et al (2021) whereby incidents were more prevalent at the start of the week, in the afternoons and evenings and in the early stages of admission. They further identify the potential for clusters, whereby one physical restraint can lead to another. Staff threshold for aggression was also noted to increase as time progressed with a focus on the most aggressive behaviours. These factors require careful unit by unit monitoring and can support the identification of unit specific factors which can be targeted for intervention.

Interventions to avoid restrictive practices:

The literature review undertaken by Nielsen et al (2021) found that 4 studies reported PRN medication was administered as an attempt to avoid restraint, no other interventions were identified. The use of PRN medication was substantially reduced in children admitted for aggression who were provided with a behaviour modification programme (BMP). In the absence of the BMP, Consultant oversight (.5 employment contract), young age and neuroleptic treatment were identified as factors influencing higher use of PRN medication.

5.5.1.2 Theme 2: Consequences

Restrictive practices

The main restrictive practices used in child and adolescent studies across the literature reviewed were restraint (manual holding), mechanical restraint and seclusion. One study (Carlson et al 2020) examined the use of psychotropic medication upon the withdrawal of behavioural management plans; however, it is unclear if the extent of the use constituted a restrictive intervention. Only one study reviewed, undertaken by Furre et al (2017) identified pharmacological restraint as a restrictive intervention and gathered data accordingly. This study was undertaken in Norway where the Norwegian Mental Care Act defines pharmacological restraint as single doses of medication with the intention of calming or sedating a patient in an acute situation. The study found that of the 2277 episodes of restrictive practices, 1.6% were pharmacological restraint. In this study the average duration was 3.5 hours for mechanical restraint, 30 minutes for seclusion and 10 minutes for physical holding.

Physical and Psychological consequences

Two studies reported in the systematic review by Nielsen et al (2021) discussed a relationship between longer duration of physical restraint and increased risk of physical harm and it highlighted that restraint should occur for the shortest duration possible to reduce any harmful effects. It is acknowledged that there is a dearth of research exploring the experience of children and adolescents who have been secluded or restrained (Nielsen et al 2021).

5.5.2 Discussion

Patient perspective

It has been noted by Nielsen et al (2021) in their systematic review, that no data relating to children's first-hand experience was recovered from the literature. This is concerning and needs to be provided for going forward.

5.5.3 Considerations for Ireland

Based on the findings in this section of the review the following are collated and recommended *for consideration* in the reduction of seclusion and restraint (in no particular order). Please note that these are not value judgements but are based on the literature reviewed:

- Consider risk assessment for aggression in this population to include previous admissions, history of trauma, self-harm, and aggression. Presentation on first admission and involuntary admission should also be considered.
- Consider using data on restrictive practices to identify young people subjected to seclusion and restraint more often than others and provide targeted interventions to these patients.
- Consider using data on restrictive practices to identify unit and staff specific factors such as timing of occurrences, numbers of staff on duty etc. This data can be used for targeted interventions.
- Consider ensuring that the child or young person's perspective around the experience of restrictive practices is noted as part of the care process. From this, needs can be properly identified, and steps taken to minimise trauma and further events.
- Given the limited literature on the patient experience in this population, consider liaising with HRB to prioritise some funding for this important area.
- Consider a requirement to ensure adequate ratios of educated and experienced staff for this population.
- Consider the Norwegian Mental Care Act definition of pharmacological restraint when considering chemical restraint definitions and data.

5.6 Mental Health Care of the Older Person

Only one study was retrieved for this population using the search terms and parameters outlined in Section 4. Chieze et al (2021) undertook a retrospective analysis over one year of all coercive events in the geriatric psychiatric division of a hospital in Geneva. The study is summarised in Appendix 6. Of the 494 patients admitted, 16.4% (n = 81) experienced at least one coercive measure. Coercive measures identified in the study were seclusion, restraint, and forced medication. Coercive measures requiring restraint prescription included use of bedrails, chair-tiding, bed tiding and immobilisation. Seclusion was the most used coercive measure at 77.4%, followed by restraint (16.7%). The remaining coercive measures accounted for 5.9% of all events. Demographic risk factors for coercion were identified as being male, married patients, patients who had spent more time in hospital and involuntary patients. Patients with a diagnosis of organic disorder and bipolar disorders were significantly associated with a higher risk of coercion, whereas patients with a diagnosis of substance use, psychotic, anxious and behavioural and personality disorders were at lower risk of coercive interventions.

5.6.1 Considerations for Ireland

- Given the dearth of evidence associated with this population within the timeframe of this review, consider broadening search terms and removing psychiatry/mental health, to identify areas for consideration.

5.7 Other Matters

This section will identify and synthesise the critical outcomes of studies associated with restrictive practices relating to issues that do not fit into patient categories between 2017 and June 2021. This review focused on describing the interventions, the key findings and synthesising them into themes. The Joanna Briggs Institute critical appraisal checklist for the relevant methods was used to assess the quality of each study (JBI, 2020).

A total of 3 papers were reviewed for this section and are summarised in Appendix 7.

Physical Issues

Two studies researched specific physical issues whilst patients are held in mechanical restraint. Funayama and Takata (2020) found that patients subjected to mechanical restraint in their retrospective cohort study in Japan (n = 110) had a substantially higher risk for Deep Vein Thrombosis (DVT) and aspiration pneumonia than those who were not restrained. They also found that bedridden status and poor psychiatric functioning (not defined) also affected the incidence of DVT and pneumonia.

Of note, mechanical restraint as considered by Funayama and Takata (2020) is defined as applied to the upper limbs - not a chest or shoulder vest. This differs in other studies included in this review.

Validation of an assessment tool

Two papers report on various stages in the development and validation of the Mechanical Restraint - Confounders Risk Alliance (MR-CRAS) tool (Nielsen et al 2017, 2019). This tool was developed to provide an overall assessment of the readiness of a patient in mechanical restraints to be released. Several dynamics contribute to this process and are assessed by the tool. The ultimate goal is to minimise unnecessary time in mechanical restraints. The tool showed excellent face to face content validity and was perceived as a comprehensible, useable risk assessment tool (Nielsen et al., 2017). It was subsequently field tested and reported by Nielsen et al (2019) to be a clinically valid tool.

5.7. Considerations for Ireland

Based on the findings in this section of the review the following is recommended *for consideration* in the reduction of seclusion and restraint. Please note that this is not a value judgement but is based on the literature reviewed:

- Consider the level of immobilization and duration associated with mechanical restraint and physical risks accordingly.

6. Critical review of restrictive practice issues for Ireland

This section of the review provides a critical review of restrictive practice issues for Ireland. At present the regulatory frameworks in Ireland around restrictive practice include the Rules Governing Seclusion and Mechanical Means of Bodily Restraint (2009) and the Code of Practice on the Use of Physical Restraint in Approved Centres (2009). To this end these two central documents are robustly reviewed in this section in context of the International comparators and the literature where relevant. The frame of reference with regards to restrictive practices has expanded considerably in the last decade internationally. To this end this section will provide baseline considerations for Ireland around restrictive practices not currently regulated in the Irish context to facilitate considerations for these practices going forward. Specific consideration will be provided around Chemical Restraint at the request of the Oversight Committee for this Report.

A pragmatic approach has been taken for this section of the report. Critical documents and practices around the governance and/or regulation of restrictive practice from the comparator jurisdictions were identified with the experts consulted and associated desktop review of the regulations in each Jurisdiction. These documents were used to critically review the existing Irish restrictive practice Rules and Code and to critically inform the issues relating to those practices not yet provided for in a regulatory context in Ireland. The review is not exhaustive and is necessarily limited to the comparator jurisdictions, however it does capture the critical and most up to date information, practices and guidance available at this time which can productively inform the Irish context.

The critical documents identified with the experts in the comparator jurisdictions which informed this section of the review are identified in Table 4. In addition to these documents, where relevant, other internationally influential guidance were referred to such as NICE Guidance and UN or WHO imperatives.

Jurisdiction	**Document**
Ireland	Irish Rules Governing Seclusion and Mechanical Means of Bodily Restraint (MHC, 2009)
Ireland	Code of Practice on the Use of Physical Restraint in Approved Centres (MHC, 2009)
England	Code of Practice, Mental Health Act 1983 (DoH, 2015)
Scotland	Use of Seclusion: Good Practice Guide (MWC, 2019) Rights Risks and Limits to Freedom, Mental Welfare Commission for Scotland (2021)
Wales	Mental Health Act 1983 Code of Practice Review for Wales (Welsh Government, 2016) Reducing Restrictive Practices Framework: A framework to promote measures and practice that will lead to the reduction of restrictive practices in childcare, education, health and social care settings for people of all ages. (2021)

Northern Ireland	Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021)
South Australia	'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021)
New Zealand	Guidelines on the use of Seclusion (2010) New Zealand Standard NZS 8134:2021: Health and Disability Services Standard

Table 4 Relevant documents by jurisdiction

6.1 Rules Governing Seclusion and Mechanical Means of Bodily Restraint (MHC, 2009)

Section 69 of the MHA stipulates that:

'A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules' (p. 13).

This stipulation clearly indicates that the use of such coercive measures is only permissible under restricted circumstances and applied solely for one of two purposes – namely facilitating treatment or as a preventative safety measure where injury to self or others is determined as a risk. These measures are not seen as therapeutic interventions and are clearly measures of last resort in order to facilitate therapeutic interventions or prevent harm. However, the Rules do refer to them as 'interventions' (p.15). The Rules are intended to ensure the rights of patients are upheld and that a culture of respect is fostered within approved centres (p. 3). The MHC inspects the application of these rules in its role as regulator and anyone who contravenes the rules shall be guilty of an offence and liable (on summary conviction) to a fine not exceeding £1,500. The rules also outline that services must be able to demonstrate that they are attempting to minimise the use of seclusion and mechanical means of bodily restraint.

Nine general principles are outlined and include the provision that seclusion and mechanical means of bodily restraint are to be used in rare and exceptional circumstances and only when all other interventions have been considered. It is explicit that their use is not to be prolonged beyond a period than is strictly necessary. As indicated, the terms seclusion and mechanical restraint are referred to as 'interventions' (p. 15) to be used professionally, within an ethical and legal framework and based on a thorough risk assessment. The use of the terms 'intervention' and 'treatment' warrant review on two levels. Firstly, Section 69 of the Act clearly envisioned the use of these measures as facilitating therapeutic intervention or as a means of harm minimisation to self or others only. Second, a review of these issues is certainly warranted in the context of the definitions in comparable jurisdictions, and

compelling evidence for some years now that seclusion cannot be considered a treatment (Salias and Fenton, 2000) and that both it and mechanical restraint pose significant physical and psychological risks to patients (Askew et al 2020; Kersting, Hirsch et al 2019; Chieze et al, 2019; Nielsen et al 2018, Mellow, Tickle et al 2017).

The rules provide comprehensive and clear direction for the use of seclusion and mechanical restraint in approved centres in Ireland and they are regulated by the MHC. Ireland appears to be the only jurisdiction to combine both of these restrictive practices into one set of rules or code. Consideration should be given to separating these rules into two distinct documents or chapters to ensure clarity and focus for each restrictive practice. There is evidence of good practice in all of the points in the General Principles of the Rules. However, the rules could benefit from some points being reviewed and/or moved to another section. For example, the first part of 1.2 (Services must be able to demonstrate that they are attempting to reduce the use of seclusion and mechanical means of bodily restraint, where applicable) could be moved to the section on Clinical Governance and expanded to include mandatory reporting on restraint reduction plans. The second part of 1.2 which refers to considering all other interventions to manage a patient's unsafe behaviour before deciding to use seclusion or mechanical means of bodily restraint, would be a useful prelude to the orders for the relevant restrictive practice. Furthermore, Part 9, which deals with recording seclusion, could be referred to throughout the document with other documentary requirements around care planning etc. The other alternative is to incorporate it into section 10 - Clinical Governance.

In the context of the existing guidelines/rules/standards in other jurisdictions and the evidence presented, a comparative discussion with considerations is presented herein under each heading of the Rules. Seclusion and mechanical means of bodily restraint will be separated at the definition section. The national regulatory or standards documents used as the critical comparators for this review are set out on Table 4. The headings of the Irish Rules Governing Seclusion and Mechanical Means of Bodily Restraint (MHC, 2009) will be used to structure the section.

6.1.1 Preliminary:

Section 69 (1) refers to seclusion and mechanical restraint being used for the purposes of treatment. This section of the Act is open to different interpretation and is currently under review as part of the reviewof the MHA. Section 69(1) specifically states that "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules".

There is a significant danger that the term 'for the purposes of treatment' may be interpreted to signify that the application of either of these measures may be applied 'as treatment' instead of as a means of facilitating some appropriate forms of therapeutic interventions. In this review, it is clearly evident in reading the Rules in their entirety that the overall intent was to ensure an environment that was governed by the principles of least restriction and supporting patient rights. Supporting that stance, it is now also evident that since the original rules were developed, there is sufficient and compelling

international evidence to show that seclusion and mechanical means of bodily restraint have no therapeutic value. Indeed, the evidence shows that the effect can be deleterious both physically and psychologically, as this review has demonstrated (Askew et al 2020; Kersting, Hirsch et al, 2019); Chieze et al, 2019; Nielsen et al 2018, Mellow, Tickle et al 2017). The issue here for consideration in the review of the Rules is whether it is perceived that seclusion and mechanical means of bodily restraint sits on a treatment or risk management paradigm. The Northern Ireland (2021) draft standard goes so far as to state clearly that there is no therapeutic value to seclusion. Furthermore, if situated within a human rights context, as evidenced in the Scottish standards, this may reorientate perceptions of these measures and promote a less restrictive approach. Therefore, it is suggested here that in the Irish context consideration is given to stating clearly, the evidentiary and human rights issues associated with seclusion and mechanical means of bodily restraint from the outset.

6.1.2 Part 1

Scotland have fore-fronted a human rights-based approach and all statements around seclusion and mechanical restraint are based on human rights principles. For example, the Good Practice Guide to Human Rights in Mental Health Services (2017 p.56) states that a person 'has the right not be secluded unless it is the only way of managing risk to self or others'. The principle of least restriction is also included in the Scottish Good Practice guide on the use of seclusion (2019). South Australia have also adopted a Human Rights perspective as the first of their 13 principles in 'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021 p.3).

Recovery or trauma informed care is not referred to in the Rules. To forefront human rights, reference to recovery and trauma informed care in this section would bring the Rules governing seclusion and mechanical means of bodily restraint into line with the underpinning principles of current Irish policy and strategy. This includes 'Sharing the Vision: A mental health policy for everyone (2021 p. 17)' and the MHC strategy (2019-2022) Protecting people's rights. Both of these documents also include the principle 'valuing learning' which is unique to the Irish setting in terms of policy documents. This recognises the importance of learning in the context of restrictive practices and it provides the baseline for activities such as de-briefing, critical reflection, case review etc. To deliver on these issues (ensuring respect for Human Rights, application of Least Restrictive Practices) consideration should be given to removing reference (explicit or implicit) to these practices as 'treatment' and mandate that forms of both bodily restraint and seclusion be only applied where they are deemed the only way of managing risk to self or others. Furthermore, incorporating reference to both Recovery ethos and Trauma Informed Care as well as promoting the concept of Learning Organisations in the Irish Rules would considerably strengthen the approach, safeguard patient rights and ensure that Ireland is adopting an approach commensurate with international 'Best Practice' approaches.

6.1.3 Part 2 Definitions:

Seclusion:

Definitions of seclusion vary across the jurisdictions and focus is on different issues associated with the practice. The Irish and Northern Ireland definitions provide specific definitions focussing on environmental conditions - whereby seclusion is seen to apply where a person is alone in a room

where they are prevented from leaving (MHC 2009 p. 17; DoH NI, 2021). New Zealand definitions also refer to a person placed alone in a room or area, at any time and for any duration, from which they cannot freely exit (DoH NZ, 2010 p. 1; DoH NZ p, 28). However, interestingly, the 2021 (p.28) definition prefaces this by referring to seclusion as a type of restraint.

The Welsh definition of seclusion in the Code of Practice for Wales (Welsh Government 2019 p. 124) refers to the supervised confinement of a patient in a room, which may be locked. However, the English definition focuses on the removal of the person from other patients (Code of Practice, DoH, 2015 p. 300). The reasons for this are specified as containment of severe behavioural disturbance which is likely to cause harm to others. The Scottish definition expands to cover the nature of isolation and says that it can occur in any space where the person is away from others and prevented from leaving. This is a significant departure from the traditional definitions associated with bedrooms and seclusion rooms. The MWC of Scotland outlines an overall definition (MWC, 2019 p.4) which is further delineated into seclusion practices level 1 and level 2 (MWC, 2019 p.11). Level 1 is the traditional definition of seclusion where the person is left alone in a locked room whereas level 2 is where staff accompany the person in the room or restrict their movements- see Table 4. The World Health Organisation (WHO, 2019) definition of seclusion includes telling a person they are not allowed to leave and implying negative consequences if they do. Again, this is a significant departure from the traditional view of seclusion in that it includes the threat of confinement or negative consequences, regardless of whether the door is locked or not. Conversely, The South Australia document (Gov SA 2021), Welsh MHA 1983 Code of Practice Review for Wales, (2016 p. 188/9), the English MHA 1983 Code of Practice (p.300), New Zealand Guidelines on the use of Seclusion (2010) and New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021) all identify that seclusion can only happen in a designated seclusion room. Definitions of seclusion in the different jurisdictions are presented in Table 4.

The Irish definition of seclusion in the Rules governing seclusion and mechanical means of bodily restraint is straightforward and not open to interpretation. As such it is a functional and reasonable definition of seclusion. However, the critical issue for the review of the aforementioned rules is whether to include the circumstances under which a person is in a room or space, but the door of the room or space is unlocked. Specifically, clarification is needed around issues identified in international definitions which extend to include if the person is prevented from leaving or they are coerced into remaining in the room or space. Furthermore, the issue of where seclusion can take place needs to be considered and the level of supervision required. In South Australia, New Zealand and Wales seclusion must take place in a dedicated seclusion room, in England it is isolation from others (no space defined). In Scotland seclusion occurs in a room, or a larger space and under two discreet sets of circumstances. Finally, the WHO's position that seclusion is enacted where the person is not allowed to move from an area either physically or by implied threat warrants consideration for inclusion in the rules. This traverses the issues of both containment and coercion and the means by which this might occur should be explained alongside how this might be avoided.

Jurisdiction and Source	Definition of seclusion
Ireland Rules governing seclusion and mechanical means of bodily restraint (MHC 2009 p. 17).	'the placing or leaving of a person in any room alone, at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving"
England (Code of Practice, Mental Health Act 1983, DoH, 2015 p. 300).	"Seclusion refers to the supervised confinement and isolation of a patient away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of containment of severe behavioural disturbance which is likely to cause harm to others"
Scotland Use of Seclusion: Good Practice Guide (MWC, 2019 p. 4, 11)	"Seclusion in health settings refers to the supervised confinement of a patient or resident, away from other patients and residents, in an area from which the patient or resident is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. It does not matter whether the place of isolation is an enclosed room (rather than for example, a part of a larger space) or whether the door to such a space is closed or open, locked or unlocked" Level 1 Seclusion refers to the following • Where staff lock a person alone in a designated seclusion room or seclusion suite • Where staff lock a person alone in a room or a suite of rooms • Where staff place a person alone in a room and prevent them from leaving either by holding the door shut, standing in the doorway, or instructing them not to leave Level 2 Seclusion refers to the following: • Where staff remain with a person in a room or suite of rooms and prevent them from leaving or instructing the person not to leave Where staff place restrictions on the physical environment the person can move to with the intention of keeping them separated from others
Wales Mental Health Act 1983 Code of Practice Review for Wales (Welsh Government, 2016 p. 188)	Seclusion is the supervised confinement of a patient in a room which may be locked
Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021 p.8)	The confinement of a person in a room or area from which free exit is prevented.
South Australia 'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021 p.17).	Defined as the confinement of a person, alone in a room or area from which free exit is prevented. It includes the presence of staff proximal to the room to prevent exit as well as the locking of a door.
New Zealand Guidelines on the use of Seclusion (2010 p.1)	'where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit'.

New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021 p.28)	A type of restraint where a person is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit
WHO (Strategies to end seclusion and restraint, WHO 2019 p.5)	Seclusion is broadly defined as isolating an individual away from others by physically restricting the individual's ability to leave a defined space (confinement). It may be done by locking someone in a specific space (e.g., room, shed, cell) or containing them in an area by locking access doors, telling them they are not allowed to move from that area or threatening or implying negative consequences if they do.

Table 5 Definitions of Seclusion by Jurisdiction

6.1.4 Part 3: Use of Seclusion

Orders and arrangements for seclusion

Orders for seclusion are explicit in Part 3 of the Rules governing seclusion and mechanical means of bodily restraint in Ireland (MHC, 2009). A Registered Nurse or Registered Medical Practitioner can order or initiate seclusion following a documented risk assessment. All jurisdictions (apart from Wales where it is not stated) provide for a Registered Medical Practitioner to initiate seclusion. This can be either the Registered Medical Practitioner responsible for the patient's care or the Medical Practitioner on call with delegated responsibility to do so.

The Rules do not clarify what division of the national nursing register the Nurse should be Registered. The initiation of seclusion by a Nurse is different in each jurisdiction reviewed. In Scotland and New Zealand, it is the Nurse in Charge of the Ward in an emergency situation. In both of these jurisdictions, registration status, grade, overall ward manager, or the day-to-day nurse in charge is not clarified. In South Australia, a Nurse Practitioner (a defined Advanced Nursing Role) may initiate seclusion. However, there is also provision for emergency situations whereby the most senior clinical person on duty can make an order for immediate seclusion in an emergency. This can be undertaken with an expectation that a medical practitioner or nurse practitioner will review the person as soon as possible to either write an order or discontinue seclusion (Gov of South Australia, 2021 p. 11).

In South Australia the emergency order for seclusion must attest that there are no other less restrictive ways to manage a person's agitation. A similar provision exists in New Zealand in addition to a series of conditions to be met in the determination of the need for seclusion which are highlighted in table 6. Such a series of provisions may prove useful in the Irish context as an additional layer of governance to ensure as far as is practicable, that the least restrictive means are being considered, used and documented.

In England, seclusion can be authorised by a Psychiatrist, an Approved Clinician (AC) or the Nurse in Charge. If none of these are the Responsible Clinician (RC) the RC must be informed immediately (MHA Code of Practice, 2016 Paragraph 26.112). The principle of all members of the MDT being eligible to

be an AC and consequently to have the ability to authorise seclusion, can promote equity and flexibility in the MDT context and warrants consideration for Ireland.

In the Irish context, if seclusion has been initiated by a Registered Nurse, a medical review of the patient in seclusion must take place as soon as practicable but no later than 4 hours. This has been highlighted by the CPT (2020) to be inadequate, and the report recommends that where seclusion is initiated by a registered nurse, a Medical Doctor be informed immediately and attend as soon as possible. In the existing rules, the Medical Practitioner can discontinue seclusion at this point or following discussion with nursing staff, can order for continuation of seclusion. The maximum duration of the order is 8 hours. Where seclusion is initiated by a Medical Practitioner the provisions are the same with the exception of the medical review. In all instances, the orders must be signed by the consultant psychiatrist responsible for the care and treatment of the patient as soon as practicable or in any case within 24hours. This differs in Scotland where the RMO or Duty Medical Practitioner must be notified immediately and must attend as soon as practicable. Comparisons of orders for seclusion are made in Table 5.

The key issue for consideration in the review of the Rules governing seclusion in relation to orders for seclusion relate to who can be empowered to do so under the new regulations and the timelines within which a review must be undertaken. Where nurses are empowered in this regard, clarity about registration status, division of the register, and grade should be given due consideration. Furthermore, the timeline for medical review should be decreased in line with CPT recommendations. Consideration should also be given to specifying seclusion as an emergency measure only, given the seriousness of the measure and the deprivation of a person's liberty associated with it.

Jurisdiction and Source	Orders for Seclusion
Ireland (Rules governing seclusion and mechanical means of bodily restraint, MHC 2009 p.19)	*Registered Nurse or Registered Medical Practitioner* can order or initiate seclusion following a documented risk assessment. If seclusion is initiated by a Registered Nurse a medical review must take place of the patient in seclusion as soon as practicable but *no later than 4 hours.* The Medical Practitioner can discontinue seclusion at this point or following discussion with nursing staff, can order for continuation of seclusion, the *maximum duration of the order is 8 hours*. Where seclusion is initiated by a Medical Practitioner the provisions are the same with the exception of the medical review. In all instances the orders must be signed by the consultant psychiatrist responsible for the care and treatment of the patient as soon *as practicable or in any case within 24 hours.*
England (Code of Practice MHA 1983, 2016 Chapter 36 paragraph 112)	Seclusion can be authorised by a Psychiatrist, an Approved Clinician or the Nurse in Charge. If none of these are the Responsible Clinician (RC) the RC must be informed immediately
Scotland Use of Seclusion: Good Practice Guide (MWC, 2019)	*Member of medical staff or Nurse in charge of the ward.* Decision should be made on the basis of available information and consideration of alternative interventions. The decision must be in response to a clearly identified risk of significant harm. The risk should be clearly documented. In addition, for Level 1: Where the decision is taken by someone other than the RMO then the *RMO or Duty Doctor* must be notified at once and should attend as soon as practicable, unless the seclusion has been for less than five minutes. Where the Duty Doctor is a junior member of medical staff they should discuss with the Senior on Call and document the decision. A Senior Member of Nursing Staff must be notified and attend as soon as practicable to consider whether additional resources are required to enable an alternative and less restrictive intervention.
Wales (Mental Health Act 1983 Code of Practice Review for Wales, Welsh Government**, 2016)**	Not stated
Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021 p.49)	The nurse in charge of the team providing the person's care at the time of seclusion. OR A doctor with responsibility for the care of the person or the duty doctor on call. The person making the decision to seclude should ensure that: i. There is an appropriate legal framework in place. ii. They have seen the person immediately before seclusion commences. iii. They have consulted with the team providing the person's care at the time of seclusion. iv. They are familiar with relevant aspects of the person's healthcare records (e.g., risk assessment) as far as possible. v. They are aware of the person's advance wishes in relation to what should happen in an emergency, as far as possible. vi. The intervention is necessary, appropriate and can happen safely, and that reasonable alternatives have been considered. vii. The necessary observation and review can take place to monitor the person's physical and mental wellbeing. viii. Where required, individual organisation search policies are adhered to, if there are concerns about any items that a person may have.
South Australia 'A standard to reduce where possible the use of restraint and seclusion as	On the order of a *Medical Practitioner or Nurse practitioner* where available or if not available, the *most senior clinician on duty*. Where a Medical Practitioner or Nurse practitioner is not available in person, phone contact should be made with them. (p.10)

applied under the MHA 2009', (Gov SA, 2021 p.10,11).	If not authorised by a psychiatrist, there must be a medical review *within one hour* or without delay if the individual is not known or there is a significant change from their usual presentation. In emergency situations where it is necessary to contain risk, the most senior clinical person on duty can make an order for immediate seclusion with an expectation that a medical practitioner or nurse practitioner will review the person as soon as possible to either write an order or discontinue seclusion. The order for seclusion will attest that there are no other less restrictive ways to manage a person's agitation (p.11).
New Zealand Guidelines on the use of Seclusion (2010 p.7) New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021)	In an emergency, a nurse or other health professional having immediate responsibility for a patient may place the patient in seclusion but shall forthwith bring the case to the attention of the responsible clinician. Not clear

Table 6 Orders for Seclusion by Jurisdiction

6.1.5 Part 4: Patient Dignity and Safety

In Ireland seclusion of a patient for whom such confinement would be contraindicated, must only be implemented when all other options have been unsuccessful (MHC, 2015 p. 20).

This section in the Irish Rules also provides direction on clothing, that is, it should respect the right to dignity, bodily integrity and privacy. However, there is a provision for patients to be secluded unclothed providing the reason is documented on the care and treatment plan. This is at odds with other jurisdictions. Within the seclusion section of The Welsh Code of Practice (2016 p. 189), it is clear that the patient should always be clothed and never be deprived of appropriate daytime clothing with the intention of restricting their freedom of movement. There is no discretion in this. The Scottish good practice guide (p.16) requires a risk assessment for clothing prior to seclusion to ensure that any potentially dangerous items are removed. The guide emphasises that whilst safety is vital, due regard must be given to the patients dignity. Patients must be afforded the opportunity to wash and dress in private in Section 8 of the English Code of Practice (2015 p.63) and a further section in Chapter 26 (p. 310) addresses deprivation of normal daytime clothing within the context of restrictive interventions. This section is clear that patients should never be deprived of appropriate clothing with the intention of restricting their movement (p. 310). However, where a risk assessment outcome is very high for self- harm or suicide using shredded clothing, tear proof clothing can be provided to the patient. This clothing should be fit for purpose, preserve dignity and cultural and/or religious requirements and should not be demeaning or stigmatising.

In Northern Ireland, the Draft Standard (2021) outlines dignity and safety issues in the context of the requirement for a seclusion care plan. This includes meeting the secluded person's needs with regards to personal hygiene/dressing and meeting of elimination needs, with specific reference to how privacy and dignity will be managed. Furthermore, the draft extends to state that Items of clothing must only be removed where there is potential for the person to use the items of clothing as ligatures and cause serious risk of harm to self. In that instance the use of tear proof clothing should be used. In New Zealand, dignity is outcome specific, therefore the overall outcome of the process of seclusion is for the persons dignity to be maintained. This is different from other jurisdictions where dignity is discussed in relation to process and places a different emphasis on the issue. Within the New Zealand context, dignity is the desired outcome and all interventions must aim towards that, whereas dignity referred to as part of the process, as in other jurisdictions, is compartmentalised and not part of the overall aim for the patient.

In the Irish context due consideration should be given to removing the discretion for patients to be unclothed in seclusion, as it is not referred to in any other jurisdiction reviewed and could be considered degrading in the context of a Human Rights approach. Furthermore, the term refractory clothing in the Irish Rules is not commensurate with contemporary practices or discourse in psychiatry and if desired for inclusion in the Rules, it perhaps should be referred to with more dignified terminology. In this instance consideration of the English and Northern Ireland provision for non-tear clothing for self-harm and suicide risk only may be appropriate.

The requirement for supervision whilst using the toilet or whilst looking after personal hygiene also warrants consideration. Considering the findings from Section 3 of this document, where patients in

seclusion felt watched, traumatised and humiliated, particularly around bathroom use (Askew et al 2020), more comprehensive guidance and risk assessment needs to be considered around this issue.

6.1.6 Part 5: Monitoring seclusion

In the Irish context direct supervision must be maintained by a Registered Nurse for the first hour of an episode of seclusion. After this period, the rules state that a written record must be maintained by a Registered Nurse every 15 minutes. The level of observation is not stated. The CPT (2020) highlighted this issue in their report and recommended 'continuous direct personal supervision from the very outset of the measure (so that the patient can fully see the staff member and the latter can continuously observe and communicate with the patient at all times)' (p. 60). Therefore, clarification is needed in this regard, to ensure that the patient is never left unattended to the extent that if they require or call for assistance, this might go unheard or unnoticed. This is provided for in the English, Scottish, Northern Ireland and Welsh documents where the person in seclusion must be within sight or sound of the observing professional at all times. Furthermore, the role of the allocated professional observing the secluded patient is made clear in these jurisdictions as well as New Zealand and ensures that the person's physical, psychological and behavioural status is monitored with a view to ensuring both safety and discontinuation of the measure when appropriate. The Northern Ireland draft Standard provides very comprehensive direction around the physical and psychological monitoring of the person in seclusion. Appropriate levels of observation can ensure that (following restraint and medication administration) physical and psychological issues are monitored when a person has been secluded and this warrants consideration in the Irish context. This addition to the existing Irish Rules would ensure a standardised approach to ongoing assessment and ensure key risk assessment and monitoring issues following restraint and administration of medication are identified and can be acted upon immediately.

The Scottish Best Practice Guide requires that a senior member of nursing staff must be notified and attend as soon as practicable to consider whether additional resources are required to enable an alternative and less restrictive intervention. This is unique to Scotland and this level of oversight warrants consideration in the Irish context as it ensures nurse leadership involvement and avoidance of seclusion as a means of ameliorating other issues. Furthermore, this approach is commensurate with reduction programmes and ensures a least restrictive focus and accountability in practice for those engaged in the seclusion process.

Following the first two hours of seclusion (and every two hours thereafter), The Irish Rules mandate that two members of staff, one of whom must be a Registered Nurse, must enter the seclusion room following a risk assessment and only if the patient or staff member would not be at risk of injury, and directly observe the patient and consider the discontinuation of the episode. This varies slightly across the jurisdictions reviewed. The Welsh guidance in the Code of Practice, indicates that the need for seclusion should be considered every two hours by two Nurses, or other suitably skilled practitioners. The qualifications or professions of the suitably skilled practitioners are not defined. The South Australia document also provides for a two hourly review by two Nurses but, similar to Ireland and Wales, the grade or registration status are unstated. The English Code of Practice provides for two Registered Nurses, one of whom must not have been involved in the original decision to seclude. This approach should be considered in the review of the Irish Rules as it provides clear definition of the

Nurse/s and supports a non-biased approach to the review. Furthermore, this approach allows for a professional dialogue and assessment of the patient by two Registered professionals. This could be altered to be one Registered Nurse and one Medical Practitioner to the same end.

The nature of the risk assessment and the nursing review is not evident in the Irish Rules, nor is the nature of the medical review which is required every four hours in Ireland. However, the requirements of the medical review are clear in the English context (see Table 6), but the specifics of the nursing review are not identified. These could be made explicit in the Irish context to ensure that an objective and streamlined approach to the review are in place for nurses and doctors alike.

Discretion and clinical judgement are permitted in the Irish rules when a patient is sleeping as to whether the patient should be woken for a nursing or medical review. This is commensurate with other jurisdictions. However, it can be suggested that the requirement for seclusion and the maintenance of seclusion when a person is sleeping are fundamentally at odds, as a patient cannot pose significant risk to self or others whilst asleep. This could be reconsidered or at least a less restrictive plan be established for instances where a patient is asleep.

As part of the review and monitoring process, consideration should be given to physical restraint occurring, or medication administered prior to or during the episode of seclusion. These might warrant additional physical monitoring of the patient and could be stated clearly in the Rules - as in the Scottish Best Practice Guide. Finally in this section, the Irish Rules state that the care and treatment plan should meet the needs of the patient whilst in seclusion, with the goal of bringing seclusion to an end. The Scottish guide also identifies some requirements with regard to care plans (p. 14) particularly around eating, drinking and toileting. The English Code of Practice (p. 307) provides guidance which extend beyond that identified by the Scottish guide including: a statement of clinical needs including any physical or mental health problems, risks and treatment objectives, how needs are to be met, details of bedding and clothing to be provided and details of any carer or family contact to be maintained. Within the Irish context more clarity around this would support practitioners to be more proactive in relation to care planning and introduce minimum standards around these important issues.

6.1.6 Part 6: Renewal of seclusion orders

The Irish Rules state that an order for seclusion can be extended by a further 8 hours to a maximum of 2 renewals (24 hours) of continuous seclusion. The extension order must be made by the Registered Medical Practitioner under the supervision of the consultant psychiatrist responsible for the care of the patient. After a period of 24 hours continuous seclusion, the patient must be examined by the consultant responsible for their care or the duty consultant and recorded accordingly in the patients file. The nature of this examination is not identified. The requirements for Medical review are made explicit in the English Code of Practice p. 305 (see Table 6). A similar explicit review process would benefit the Irish Rules and ensure an objective standardised approach to this issue.

In the Irish context there is a requirement to notify the MHC when a devision is made to continue to seclude a person for a period exceeding 72 hours. Where the consultant psychiatrist decides to renew the orders at 24 hrs, they must notify the MHC on a specified form which must include the range of therapeutic options considered and the reasons why seclusion is ordered. Where a patient has had 7 or more orders for seclusion over seven consecutive days the Inspector of Mental Health Services

must be notified on a specified form and the notification must include the range of therapeutic options and the reasons why seclusion has been reordered over that period of time. The nature of the renewal could benefit from clarification here with regards to whether renewal orders or initiation orders or both constitute 'orders over a period of seven consecutive days' (p. 22).

Review periods of 2 hours and 4 hours are standard across the jurisdictions, however the renewal orders outside of these times vary as can be seen in Table 6. The English Code of Practice has a very comprehensive approach which identifies clear time markers for assessment, renewal and reporting activity. A time related approach to requirements might provide staff with clearer markers around assessment, monitoring and reporting in relation to seclusion and should be considered. Of note, the South Australia Standard (2021 p.11) mandates that seclusion orders can only be for 30 minutes. At this time the orders must be endorsed and reviewed by the most senior clinical practitioner working on the unit, and thereafter every 30 minutes where assessed to be necessary. Additional reviews and endorsement of the seclusion order must occur by a medical practitioner or nurse practitioner at each 2-hour mark, with an additional review by a consultant psychiatrist after 4 hours which must be face to face when on site. A reduced time limit on seclusion orders in the Irish context commensurate with the South Australia approach warrants consideration. It would ensure more frequent oversight, encourage the least restrictive measure, promote frequent consideration of alternative means and accountability for continuing orders.

There is minimal provision for independent review in the Irish rules. This is built into the other jurisdictions to varying degrees. The English Code of Practice (2015) requires an independent MDT review after 8 consecutive hours or 12 hours intermittent within a 48-hour period. Membership of the independent review team should be determined by provider policies. The minimum membership should include an approved clinician who is not a Nurse or a Doctor, another professional, both of whom were not involved in the incident which led to seclusion, and an Independent Mental Health Advocate. In New Zealand the multi-disciplinary review is required when the cumulative time spent in seclusion exceeds 24hrs. In Scotland the independent review is required for Level 1 seclusion at 72hrs and can be undertaken by clinicians from other parts of the service (p. 17). A similar provision is evident in the Welsh Code of Practice (p. 125) whereby regular multidisciplinary review must take place with a requirement to consult with nurses and other mental health professionals not directly involved in the patient's care. However, there is an absence of specification of either prescriptive or indicative timelines which could lead to inequity in treatment processes and inconsistencies in practices. Finally, the South Australia Standard provides that in addition to all other requirements, where a person has been mechanically restrained, physically restrained, or secluded on two or more occasions in the current admission or episode (p. 7), the treatment plan must be reviewed by at least 2 disciplines at a senior level of the service. Independent or autonomous review commensurate with these approaches warrants consideration in the Irish context and would add an additional level of accountability and an intervention commensurate with a seclusion reduction stance.

Jurisdiction and Source	Monitoring and Renewing Seclusion
Ireland (Rules governing seclusion and mechanical means of bodily restraint, MHC 2009 p.21/22)	• *First hour:* Direct supervision a *Registered Nurse* • *Every 15 min:* Record by *Registered Nurse* around the level of distress and behaviour. Consider release if patients behaviour no longer unsafe. • *2hrs*: Risk assessment and review in seclusion by Registered Nurse and one other. Only if considered safe for patient and staff. • *4 hours: Medical review* • *If patient is sleeping*- medical review can be suspended but nursing must continue *every 2 hours* whilst the patient is sleeping. • Care and treatment plan: Must address the needs of the patient in seclusion with the goal of bringing it to an end.
England (Code of Practice MHA 1983, 2016)	• *Within one hour:* If not authorised by a psychiatrist. OR if authorised by a consultant immediately before seclusion, this constitutes the first review. • *Constant sight and sound* of the seclusion area: A suitably skilled professional: Aim is to safeguard and monitor the patient's condition and behaviour and to identify the earliest time at which seclusion can end. • *Every 15 minutes:* The suitably skilled person must document every 15 minutes- the patient's appearance, what they are doing or saying, their mood, their level of awareness and any evidence of physical ill health especially with regard to breathing, pallor or cyanosis. • *Every 2 hours:* Nursing reviews by two Registered Nurses, at least one of which must not have been involved directly in the decision to seclude. • *Every four hours UNTIL first MDT:* Medical review by responsible clinician or duty Doctor to deputise (must be in a local policy), who must also have access to an on-call consultant. Doctor must be identified as competent undertake the review. • *ASAP:* Full MDT review (membership determined by provider policy) THEN medical review twice daily, one of which must be by the responsible clinician AND one MDT review once every 24 hours of continuous seclusion. • *After 8 consecutive hours or 12 hours intermittent within a 48-hour period:* Independent MDT team review. Membership should be determined by provider policies, but minimum should include an approved clinician who is not a Nurse or a Doctor, and other professional who were not involved in the incident which led to seclusion and an Independent Mental Health Advocate. • *Where the person is asleep* in seclusion the professional observing should be alert and assess the level of consciousness and respirations as appropriate. • *Medical reviews:* Should be carried out in person and include: A review of the patient's physical and psychological health An assessment of adverse effects of medication A review of observations required A reassessment of medication required An assessment of the risk posed by the patient to others An assessment of any risk to the patient from deliberate or accidental self-harm An assessment of the need for continuing seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner • *Nursing reviews*: No assessment specifics identified except to immediately contact the patient's responsible clinician or duty Doctor in the event the nursing review identifies concerns for the patient's condition. • *If patient is sleeping*: Informed by policy to avoid waking the patient • *Where seclusion continues after any review*: Seclusion care plan must be amended as appropriate.
Scotland Use of Seclusion: Good Practice Guide (MWC, 2019 p. 13, 14, 17)	*Staff allocated:* Must be within sight and sound of the person at all times during seclusion either directly or through CCTV. The allocated staff member must be able to communicate with other staff without having to leave the area, must ensure the person is safe and pay particular attention to their consciousness level, particularly if the person has been given sedative medication and/or has been physically restrained prior to seclusion. *ASAP:* Senior Member of Nursing Staff must attend as soon as practicable to consider whether additional resources are required to enable an alternative and less restrictive intervention.

	30 mins: Plans for meeting the individuals needs for eating, drinking and toileting should be clearly recorded. Consideration as to how the person will be reintegrated into the unrestricted environment and inform the named person/carer where practical with the person's consent. *Monitoring* during seclusion is determined by local policy which must include: • Care planning during seclusion • Record keeping • The arrangements for continuous assessment and review during a period of seclusion • The provision and maintenance of a safe environment for seclusion • How senior management monitors the use of seclusion *Managers:* Seclusion must be closely scrutinised through clinical governance or other similar monitoring processes. Should ensure oversight of the use of seclusion by clinical and management staff distinct from the direct care team *72 hours level 1 seclusion*: External review required. Local policies should specify how often these should be repeated.
Wales (Mental Health Act 1983 Code of Practice Review for Wales, Welsh Government, 2016 p. 189)	*Every 15 minutes:* Monitoring by a skilled professional, who is within sight and sound of the secluded person, responsible for monitoring the persons condition, ensuring their safety and to identify when seclusion can be terminated. *Every 2 hours*: Review by nurses or suitably skilled practitioners *Every 4 hours*: Review by a Doctor or suitably skilled practitioner *More than 8 hours consecutively or 12 hours in a period of 48 hours:* A multidisciplinary review should be completed, and Nurses and other mental health professionals not involved in the care of the patient should be consulted.
Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021)	Observations must be completed within sight or sound of the seclusion room/area, either in person or via CCTV. *Immediately* after the commencement of the seclusion period, the person must be placed on 1:1 observation. A registered nurse must be delegated to observe the person within the seclusion room. Consideration must be given to the registered nurse chosen to support the person in seclusion, and any potential impact on the person. This must be considered on an individual basis. An observation record must be documented at a minimum of every *15 minutes*; this can be reviewed based on clinical presentation and risk assessment. The registered nurse completing the observations must monitor the following: i. Physical appearance and documenting any evidence of physical ill health such as shortness of breath, unusual facial pallor or potential cyanosis. ii. Mental state presentation. iii. What the person is doing or saying whilst in seclusion. iv. Level of communication; and v. Level of alertness/awareness (particularly following administration of medication). If medication has been administered prior to the person entering seclusion, with intent to subdue acute behavioural disturbance, individual organisational policies (developed in line with regional guidelines) should be followed and the person should be observed in accordance with same. It may be difficult at this time to complete full clinical monitoring and NEWS chart. As a minimum the registered nurse observing, should record: i. Person's respiration rate. ii. Person's response to verbal or tactile stimulation. iii. Person's level of movement. iv. Person's level of awareness; and v. Any attempts to complete physical monitoring, whether successful or not, must be recorded. Observing staff must have access to personal alarm or call system should they need to seek urgent assistance in an emergency situation Handover between staff observing must be documented. Observing staff should be able to respond to a situation where patient safety becomes compromised i.e., self-injurious behaviour. *Internal multi-disciplinary team review* *ASAP:* An internal multi-disciplinary team review must include the person's doctor, nurse in charge, and other professionals who may usually be involved with the person. *Every 24hrs:* An internal review must also take place once in every 24-hour period of continuous seclusion. *Independent multi-disciplinary team review* If a patient is secluded for more than 8 hours repeatedly or 12 hours over a period of 48 hours, there must be an independent review undertaken by professionals who were not involved in the incident that

	led to the period of seclusion or were part of the decision to commence seclusion period. The review team must be made up of a doctor, nurse and other professionals, and an independent advocate. Even if the seclusion period has since ended, once a trigger point has been reached, the review must be held. If the seclusion period is ongoing then the independent review can make additional recommendations as appropriate to the seclusion care plan
South Australia 'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021 p. 11, 12).	Must be within constant sight and sound of staff member Documented every 15 minutes Orders end at 30 minutes. When an order has expired the person must be reviewed every 30 minutes by the most senior clinical practitioner working on the unit, who endorses the continuation of the order. Additional reviews and endorsement of the seclusion order are to occur by a medical practitioner or nurse practitioner at each 2-hour mark. An additional review by a consultant psychiatrist is required after 4 hours which will be face to face when on site, and otherwise a clinical discussion involving the consultant psychiatrist, will meet this criterion. Nursing reviews every two hours by two Nurses Medical review every 4 hours until first multidisciplinary review First (internal multidisciplinary team review as soon as practicable Independent interdisciplinary review after 8 hrs continuous or 12 hours intermittent seclusion within 48-hour period Following first (internal) multi-disciplinary team continuing medical reviews at least twice daily (one by the responsible clinician)
New Zealand Guidelines on the use of Seclusion (2010 p.3/4) New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021)	*Continuous observations*- every 10 minutes minimum: The minimum observations within the 10-minute interval include but are not limited to general condition, colour (for example cyanosis, pallor), breathing, position, activity and behaviour. This will require physical observation and interaction with the patient and cannot be achieved through electronic surveillance. *Two hourly assessments:* An attempt should be made by a suitably qualified clinician (registered nurse or registered medical practitioner) at least once every two hours to enter the room to assess the physical wellbeing of the patient. If an attempt to enter the room is unsuccessful, the reason why should be recorded on the observations form. An assessment of the patient's mental state by a suitably qualified clinician shall be made at this time. Further assessment of physical state should be carried out as clinically indicated. Safety precautions should be taken when entering the room. The number of service providers required to enter the room should be appropriate to manage the potential risk involved. This should be determined prior to entry or detailed in local protocols. Each entry to the seclusion room is an opportunity to assess the readiness of the patient to reintegrate back into the ward. *Eight hours*: Responsibility for care delivery and observations during seclusion is that of the registered nurse. In particular they are responsible for ensuring the following: (a) Observations and care as described above are undertaken (10-minute and two-hourly observations). (b) Clinical consultation with the responsible clinician occurs and is documented (c) Communicating all care requirements both verbally and via the patient's plan to the following shift, for example: (i) food/fluid intake (ii) personal care/hygiene/toileting arrangements (iii) medication requirements (iv) exercise/physiotherapy (v) visitors (chaplain, advocates, family). Wherever practicable, care should be carried out predominantly by staff of the same gender and culture as the patient. It is mandatory that a suitably qualified clinician shall psychiatrically assess the person in seclusion at least once every eight hours. A record of this assessment is documented. Before the completion of an eight-hour period, when a decision is taken to extend seclusion, confirmation should be provided by the initiating and supporting clinicians or another suitably qualified nurse and doctor if the original clinicians are not available. The responsible clinician should be notified, at an appropriate time.

Table 7 Monitoring and Review Arrangements by Jurisdiction

6.1.7 Part 7: Ending seclusion

In the Irish context, reference to discontinuation of seclusion in the Rules is first mentioned in the 15-minute check phase of seclusion, with the requirement for release if the patient is no longer displaying unsafe behaviour. Furthermore, it is clear in section 7 of The Rules, that seclusion can be ended at any time following discussions between the Registered Medical Practitioner and The Registered Nurse In Charge. In the English context, seclusion can be ended following an MDT review (internal or independent), a medical review or an assessment by the professional in charge of the ward in consultation with the Responsible Clinician or Duty Doctor, the outcome of which determines that it is no longer warranted. A similar process is identified in the Northern Ireland Draft Standard whereby 2 suitably qualified clinicians can end seclusion in agreement with the Responsible Clinician if the goals for seclusion have been achieved.

The South Australia and the Draft Northern Ireland standards are clear that seclusion must end immediately when the risk behaviour of the person has abated. Authorisation is not prescribed. However, in Northern Ireland the responsibility for completion of ending documentation rests with the Registered Nurse and in South Australia the mandatory section of the standard requires the termination of this practice to be defined within clinical governance structures (p.4).

The South Australia standard states that seclusion is over once the door is opened and the patient is free to leave. Clarification that seclusion has only ended when the patient has free and unrestricted movement on the ward is explicit. Within the Irish rules, seclusion has ended when the patient is informed. This is the only requirement for such a communication in any of the jurisdictions and should be retained to ensure that there are no misunderstandings, perceived threats or misuse of the measure by omission of such a communication. Furthermore, as referred to in previous sections, regular reference to a move towards a less restrictive measure, ending seclusion or attempts to end should be considered throughout the process of seclusion.

Jurisdiction and Source	**Ending Seclusion**
Ireland (Rules governing seclusion and mechanical means of bodily restraint, MHC 2009 p. 23)	• Registered Medical Practitioner following discussion with the relevant nursing staff • Registered Nurse in charge in consultation with the Registered Medical Practitioner
England (Code of Practice MHA 1983, 2016 p. 306)	• When an MDT review, a Medical review or the Independent MDT review determine it is not warranted. • When the Professional in Charge of the Ward determines it is no longer warranted, can be ended following discussion with the RC or the Duty Doctor. This can take place in person or by telephone.
Scotland Use of Seclusion: Good Practice Guide (MWC, 2019)	No reference to ending
Wales	No reference to ending

(Mental Health Act 1983 Code of Practice Review for Wales, Welsh Government, 2016)	
Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021 p.56)	When assessed as no longer required.
South Australia 'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021 p. 4, p.11).	Accountability for termination of seclusion as a restrictive practice, must be defined within clinical governance structures. Individuals are to be removed from the seclusion room immediately once the danger to self or others is no longer imminent. The seclusion formally ends when the door is unlocked and opened, if it is the case that the person would not be prevented from leaving the seclusion room if they were to wake up and attempt to leave. Door to be unlocked and open if possible: If a person can be secluded with the door unlocked and open with a staff member at the door this is to be preferred if it is safe to do so. It is recognised that progressing to a locked door immediately may be required when there is a risk of extreme violence, or a person is not known well and may be at risk of unpredictable behaviour – in particular persons who are stimulant intoxicated and secluded in emergency departments. A person is still considered to be secluded in an unlocked room if they would be physically prevented from leaving the room or would have their door locked if they attempted to leave.
New Zealand Guidelines on the use of Seclusion (2010 p.4) New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021)	If the goals for seclusion have been achieved, a decision to end seclusion should be taken by two suitably qualified clinicians, in agreement with the responsible clinician.

Table 8 Ending Seclusion by Jurisdiction

6.1.8 Part 8: Seclusion Facilities

All jurisdictions make minimum provisions for seclusion facilities to varying degrees. The Irish Rules, in Part 8, are clear about the need for adequate toilet/washing facilities, furnishings and cleaning. The CPT in their report on their visit to Ireland (2020) highlighted the need to 'have ready access to sanitary facilities without having to ask to use them and it should be ensured that the room itself is kept at a moderate temperature, with the provision of sufficient blankets' (p. 60). The seclusion facility is not permitted to be used as a bedroom in the Irish context. Table 8 outlines all facility requirements by Jurisdiction for comparative purposes. There are some additional requirements common to other jurisdictions that warrant consideration. These include a clock, temperature and lighting control from outside of the room and viewing guidance to ensure that the person is visible, but their dignity is protected. Additionally, there is reference to the facility needing to be robust enough to withstand considerable violence. In the Irish context the provisions of the other jurisdictions may offer more robust guidance for existing and new seclusion rooms in Ireland. In particular, the Northern Ireland Draft Standard identifies what is to happen when the room is not in use, a maintenance schedule and action to be taken by the Nurse in Charge after each seclusion episode in relation to cleaning and

infection prevention and control. Of note, that draft standard is the only jurisdiction to require a plan for emergencies when a patient is in seclusion such as a power cut or a medical emergency, this is an issue that should be planned for in the Irish context.

Jurisdiction and Source	Seclusion facilities
Ireland (Rules governing seclusion and mechanical means of bodily restraint, MHC 2009 p. 23)	• Seclusion facilities must provide access to adequate toilet/washing facilities. • Seclusion facilities must be furnished, maintained and cleaned in such a way that ensures the patient's inherent right to dignity and ensures his/her privacy is respected. • All furniture and fittings in the seclusion facility must be of such a design and quality as not to endanger patient safety. • Seclusion facilities shall not be used as bedrooms.
England (Code of Practice MHA 1983, 2016 p. 300)	The following factors should be taken into account in the design of rooms or areas where seclusion is to be carried out: • The room should allow for communication with the patient when the patient is in the room and the door is locked, e.g., via an intercom • Rooms should include limited furnishings which should include a bed, pillow, mattress, and blanket or covering • There should be no apparent safety hazards • Rooms should have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside) • Rooms should have externally controlled lighting, including a main light and subdued lighting for night-time. • Rooms should have robust door(s) which open outwards • Rooms should have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature • Rooms should not have blind spots and alternate viewing panels should be available where required • A clock should always be visible to the patient from within the room • Rooms should have access to toilet and washing facilities.
Scotland Use of Seclusion: Good Practice Guide (MWC, 2019 p.16)	In Scotland the seclusion venue may be dependent upon the risk assessment. However, the Guide does provide good practice for developing or benchmarking within the context of maintaining the secluded persons safety and dignity. The below requirements are edited to remove any non-facility related points; the remainder are directly referenced. • The room should be set apart from others but not isolated • It should be large enough to accommodate the patient and the maximum number of staff who may be involved in restraint procedures • The structure of walls, windows, doors, hinges and locks must be robust enough to withstand high levels of physical violence aimed at damaging the environment • There must be no ligature points or access to electrical fixture and fittings that pose a risk of shock • There must be no opportunity to barricade the door to prevent entry • Furniture must be comfortable but safe and robust and not be of use as a weapon • Observation into the room should be clear and effective. It should not be possible for onlookers to view into the room from the outside. However, there should be a clear view to the outside for the person. • If CCTV is in use respect for the patients privacy should be taken into account. • Lighting should be externally adjustable to accommodate observation but should also include a light that is controllable by the person in the room. • It is essential that there is effective control of temperature and ventilation with temperature sensors to ensure effective monitoring. There is a high risk where restraint involving a number of staff has taken place that the person becomes overheated. This is very dangerous, particularly in the context of someone having high doses of medication • The room must be non-threatening and should be decorated in a calming manner. • It must be kept clean and fresh. • Bedding must be as safe as possible.

	• Any room identified in the care and support of plan for use in seclusion or environmental restraint must be regularly risk assessed by staff. Attention should be given to procedures for safe evacuation in the event of a fire.
Wales (Mental Health Act 1983 Code of Practice Review for Wales, Welsh Government, 2016 p.188/9)	Services that use seclusion should have a designated seclusion room that: • Provides privacy from other patients, but enable staff to observe and communicate with the patient at all times • Be safe and secure, and not contain anything which could cause harm to the patient or others • Be quiet, but not soundproofed, and with some means of calling for attention. • Is well insulated and ventilated, with temperature controls outside the room • Has access to toilet and washing facilities. • Has furniture, windows and doors that can withstand damage.
Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021 p.47/48)	Seclusion room specifics: i. The construction of the room must be designed to withstand high levels of violence with the potential to damage the physical environment e.g., walls, window, doors and locks. ii. There should be no: 1. ligature points 2. access to electrical fixtures iii. There must be an anti-barricade door system. iv. The room must allow for staff to be able to clearly observe the person within the designated room. v. The designated room should be in an area free from others but not isolated. vi. The person in seclusion must be able to have a clear view of the outside environment but those on the outside must not be able to have any view of the person within seclusion. vii. The room must be large enough to support the person and team of staff (who may be) required to use physical interventions during transition to seclusion. viii. Adequate lighting must be provided, in particular a window in order to provide natural light. Lighting should be able to be controlled both by the person within seclusion and those external. The room must be equipped with adequate temperature and ventilation system with heat sensor for effective monitoring. x. The room must be decorated in a calming manner that appears non-threatening to the person. xi. The room must be kept clean and fresh. xii. The room must have direct access to washing and toilet facilities. xiii. The room must be safe and secure. xiv. There must be a visible clock. xv. There should be limited furnishings. Any furnishings must be as safe as possible and must not include anything that could potentially cause harm. Furnishing must be comfortable and in good condition.
South Australia 'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021 p.12).	Any room designated as a seclusion room can only be used for this clinical purpose and should not be used as an interview room or waiting room.
New Zealand Guidelines on the use of Seclusion (2010 p.5) New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021)	As a minimum, the room must have: (a) adequate light, heat and ventilation (b) means to easily observe the patient that also allows the patient to see the head and shoulders of the observer (c) means for a secluded patient to call for attention (d) fittings recessed to avoid potential for harm (e) furnishings (other than bedding) that are fixed to avoid the potential for harm. In addition, it is desirable that: (a) doors open outwards flush with the walls and the environment should be pleasant and minimally stimulating (b) the secluded individual should be allowed as much of their normal clothing as possible within the dictates of safety, and should not be deprived of all their personal possessions (c) any items provided be considered on a case-by-case basis to establish the potential for harm and to relate to the indications for seclusion (d) assistance be given to provide a means of orientation (time, date, news and other information)

	(e) there is access to toileting, washing and showering facilities in, or adjacent to, the area (f) there is access to two-way communication (g) there is access to an equally safe external area to assist with reintegration (h) there is access to temperature regulation if required.

Table 9 Seclusion Facility Requirements by Jurisdiction

6.1.9 Part 10: Clinical Governance

The section on Clinical Governance begins with a statement which makes clear operational or organisational circumstances under which seclusion must not take place. This may be better placed in an earlier section titled exclusions before the actual rules for seclusion are outlined.

Policy

Part 10 outlines the policy requirements within the Irish context. The requirements for policy are consistent across all jurisdictions. However, the extent of the delegated authority extended to local policy vary. In Ireland this section primarily restates the salient rules to be incorporated into the local policies. Specifically, issues around who may carry out seclusion, provision of information to the patient, review of seclusion and a section around methods to reduce seclusion in the service. The minimum requirements for dissemination of the policy are also outlined in addition to the requirement for an annual report.

The Scottish Good practice guide on the use of seclusion (2019) makes clear that seclusion must take place in the context of an approved policy on the management and prevention of violence. This Is unique to Scotland and warrants consideration in the Irish context, as such a policy would consider preventative measures and provide the preliminary preventative framework to seclusion. For seclusion itself, the Scottish Guide provides a comprehensive suite of requirements and accompanying guidance for practitioners and hospital managers that must be addressed in a policy on the use of seclusion. Apart from authority to seclude and record keeping, the majority of the policy requirements differ to Ireland and warrant consideration in the Irish context. Areas for inclusion in the Scottish Guide are outlined in Table 9.

The Welsh Code of Practice (2016 p. 189) also requires a clear written policy on seclusion (26.47 p. 189) which sets out when it is appropriate to use seclusion and how it is to be implemented and kept under review. This is reinforced in the Welsh reducing restrictive practices framework (2021 p. 14). Furthermore, the Code states that guidelines are required (26.42 p. 189) but no specifics are outlined. However, the requirement for any guidelines to reflect guidance from the Welsh Government and/or other national guidance including NICE guidelines is made clear. The English Code adopts an alternative approach whereby, at the outset of Chapter 26 of that Code, the policies, referred to as 'provider policies', are clearly outlined as common for all restrictive practices. These are outlined in Table 9. This approach warrants consideration in the Irish context as it ensures a standardised policy approach across all restrictive practices.

The final principle of the Practice and Service Delivery section in the South Australian Standard (p.2) refers to the need for an effective restrictive practice policy. This policy is required to provide the framework to improve staff safety by preventing episodes of violence, and by employing effective procedures and training for staff who administer restrictive practices as a last resort. This preventative

approach, as a preliminary framework to the use of seclusion, is similar to Scotland's requirement for a prevention and management of violence policy and warrants consideration in the Irish context.

Jurisdiction and Source	Service Policy Requirements for Seclusion
Ireland (Rules governing seclusion and mechanical means of bodily restraint, MHC 2009 p. 24)	• Use of seclusion. • Who may carry out seclusion • Provision of information to the patient • How the approved centre is attempting to reduce seclusion, where applicable • Training: See Governance section

England
(Code of Practice MHA 1983, 2016 26.7 p.282)
	• Provider policies should include guidance on:
	• Assessments of risks and support needs
	• The use of positive behaviour support plans (or equivalent)
	• How risks associated with restrictive interventions can be minimised in particular:
	  ○ Assessment of their potential to cause harm to the physical, emotional and psychological wellbeing of patients
	  ○ How providers will take account of a patients individual vulnerabilities to harm (such as unique needs associated with physical/emotional immaturity, older age, disability, poor physical health, pregnancy, past history of traumatic abuse etc)
	• How restrictive interventions which are used by the provider, should be authorised, initiated, applied, reviewed and discontinued, as well as how the patient should be supported through the duration of the application of the restrictive intervention
	• Local recording and reporting mechanisms around the use of restrictive interventions
	• Post-incident analysis/debrief
	• Workforce development, including training requirements relating to the application of restrictive interventions, which are underpinned by their therapeutic intent.

Scotland Use of Seclusion: Good Practice Guide (MWC, 2019 p. 13)	• Situations where seclusion can be considered and guidance on risk assessment • Who can make the decision to use seclusion • Communication with the individual • Maintaining the safety of the secluded person • Care planning during seclusion • Record keeping • The arrangements for continuous assessment and review during a period of seclusion • The provision and maintenance of a safe environment for seclusion • How senior management in any care setting monitors the use of seclusion • The provision and maintenance of a safe environment for seclusion • How senior management in any care setting monitors the use of seclusion • The impact of seclusion • Staff and Service User debriefing • Staff training
Wales (Mental Health Act 1983 Code of Practice Review for Wales, Welsh Government, 2016 p. 189) Reducing Restrictive Practices Framework A framework to promote measures and practice that will lead to the reduction of restrictive practices in childcare, education, health and social care settings for people of all ages. (2021 p. 13)	Clear written policy on seclusion (26.47 p. 189) which sets out: • When it is appropriate to use seclusion • How it is to be implemented and kept under review. Guidelines are required (26.42 p. 189), must reflect guidance from the Welsh Government or and other national guidance including NICE guidelines. Organisations that use seclusion must have a policy with very clear guidance for workers in its use, There should be a clear definition of seclusion that all workers understand and its us must be carefully monitored (p. 14) The focus of policy and practice should be on the reduction of restrictive practices as part of patient centred care planning (p. 13) Organisations should have a policy that outlines conditions or the use of restrictive practices. This policy should be agreed by senior leadership for the organisation and should reflect up to date statutory guidance placed on them through legislation and guidance (p. 13) This policy should: • Reference human rights and legal frameworks relevant to the sector and setting

	• Ensure that definitions of restrictive practices are easily available and embedded through workforce development mechanisms, organisational messages and policy • Have clear protocols and governance guidelines for the use of restrictive practices as last resort, and for monitoring of people during and after use, including the requirement for medical checks • Be easy to understand and apply, and should be communicated to all practitioners, paid carers, people being supported and the families, unpaid carers and external agencies that the organisation works alongside • Make clear that it is never acceptable to use coercion and other forms of social and psychological restraint • Contain guidance about risk assessments which must be undertaken before using any restrictive practice. • Provide clear guidance for the recording of information following the use of any restrictive practice in relation to what is to be recorded when, by whom, and the purpose of the recording • Make clear that the use of any restrictive practice should be recorded even if its use is prescribed in a personal plan • Outline the process for seeking consent for the use of restrictive practices as a last resort to prevent harm to an individual or others Organisations should have a person-centred policy for providing both immediate and longer-term support after any use of restrictive practices, and this should inform the review of the individual plan for the person following any incident (p.16). Safeguarding policy (p. 17) Whistleblowing policy (p. 17) Children, adults and families should also be asked to contribute to policy review and development (p. 22) Organisations should (p. 10): • Have a clear policy in place for all practitioners that helps them to understand their duties under human rights and legal frameworks • Set out in such a policy the organisational commitment to reducing the use of any restrictive practices Ensure that all practitioners are aware of such a policy and understand its intended impact on their practice
Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021 p33/34.)	All organisations must follow a minimum policy content format in relevant policy documents that includes details of the organisational strategy for minimising the use of restrictive interventions. Local and organisational policy frameworks should be co-produced and must include as a minimum: i. the organisational values that underpin the approach to minimising restrictive interventions. ii. the detail of the organisational vision and strategy for minimising restrictive interventions. iii. details of job roles within the organisation with specific restrictive practice minimisation responsibility and accountability. iv. standard definitions. v. clear professional/clinical guidance. vi. reference to working within current legislative frameworks and professional registration requirements. vii. an emphasis on positive, proactive, preventative and evidence-based interventions and strategies viii. how the *Three Steps to Positive Practice Framework* as the organisational methodology for considering and reviewing the use of restrictive interventions is embedded and operationalised. ix. details of accredited training required, including training required for specific interventions. x. communication requirements and strategies. xi. details of interfaces with other regional and local policies, agreed protocols and any associated requirements. xii. reference to clear recording, reporting, monitoring and governance arrangements (including how data will be used in the minimisation strategy). xiii. support mechanisms for those who are subject to restrictive interventions; and xiv. Support mechanisms for staff who have to restrict, restrain and/or seclude those in their care.
South Australia 'A standard to reduce where possible the use of restraint and	Effective restrictive practice policy:

seclusion as applied under the MHA 2009', (Gov SA, 2021 p. 2).	This policy is required to provide guidance to improve staff safety by preventing episodes of violence, and by employing effective procedures and training for staff who administer restrictive practices as a last resort.
New Zealand Guidelines on the use of Seclusion (2010) New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021 p. 75)	The New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021) sets out the minimum standards required for seclusion and restraint. Specifically in relation to policy: Service Providers shall implement policies and procedures underpinned by best practice that shall include: a. The process of holistic assessment of the persons care or support plan. The policy or procedure shall inform the delivery of services to avoid restraint b. The process of approval and review of de-escalation methods, the types of restraint used and the duration of restraint used by the service provider **c.** Restraint elimination and use of alternative interventions shall be incorporated into relevant policies including procurement processes, clinical trials and use of equipment.

Table 10 Policy Requirements for Seclusion by Jurisdiction

6.1.10 Other Governance Issues:

There are minimal accountability and oversight requirements in the governance section of the Irish Rules. This is a clear gap that requires consideration in the context of this report. Monitoring is evident to an extent in earlier sections of the Rules, however other jurisdictions adopt a more stringent approach and include independent reviews and Senior Management oversight. The New Zealand and Northern Ireland documents are very strong in this area, setting clear standards and requirements to be met by the organisation as a whole in relation to seclusion. In addition, the New Zealand standard makes clear that moving towards zero seclusion is a matter of national policy which must be reflected throughout the local policies. It is abundantly clear in the review undertaken that all legislation, best practice guides and regulations/rules advocate an ethos of least restrictive practice. One of the key elements of achieving such an organisational ethos is through appropriate governance structures, which promote a recovery, person centred orientation and which actively promotes learning. While it should never be the case that administrative procedures should become overly burdensome, it is certainly the case that proper accountability, appropriate monitoring and review processes are essential where civil liberties are in danger of being diminished – for whatever reason. Therefore, good clinical and organisational governance structures need to apply.

These governance issues, previously outlined, warrant consideration in the Irish context, within the framework of Clinical Governance and seclusion and restraint reduction. For example, the South Australian standard refers explicitly to need for clear accountability for the initiation, usage and termination of restrictive practices to be defined, along with the oversight by clinical and service leaders responsible for clinical governance (Gov SA, 2021).

Training is referred to in all of the regulatory documents and the provisions tend to be similar and notably include prevention and trauma informed principles. In the Irish rules there is a requirement for a policy in this regard which must be specific to seclusion and include:

a) Who will receive training based on the identified needs of patients and staff
b) The areas to be addressed within the training programme, including training in alternatives to seclusion
c) The frequency of training

d) Identifying appropriately qualified person(s) to give the training
e) The mandatory nature of training for those involved in seclusion.

These five requirements are appropriate, however the evidence and standards around training in this area have changed significantly since the rules were established. To this end due consideration should be given to the most recent evidence-based training standards document Restraint Reduction Network (RRN) Standards (Ridley and Leitch, 2021) as outlined in section 3 of this document.

6.1.11 Post-seclusion debrief

The Irish Rules (7.4 p.22) state that the patient must be afforded the opportunity to discuss the episode with members of the multi-disciplinary team involved in his or her care and treatment. In the intervening years since the development of the rules, there have been considerable developments in the area of debriefing worldwide. This has primarily resulted from the considerable evidence of adverse psychological effects associated with the process of seclusion. All of the jurisdictions reviewed emphasised the importance of this support structure and in all instances, debriefing or post incident review is mandated either immediately or as soon as practicable with the multi-disciplinary team. The opportunity to learn and avoid future episodes is highlighted in most jurisdictions and this warrants consideration in the Irish context.

6.1.12 Child Patients and Seclusion

Section 13 of the Irish Rules Governing Seclusion and Mechanical Means of Bodily Restraint identify the rules around the seclusion of children in Approved Centres. These rules centre around informing the child's parent or guardian and having child protection policies and procedures in place. This appears to extend to other jurisdictions with varying degrees of detail on issues relating to children and seclusion. In the Welsh reducing restrictive practices framework (2021) there is an acknowledgement that children are particularly vulnerable to trauma and harm as a result of restrictive practices (p. 10). Consequently, the document does not recommend that children are secluded in any setting (p.14).

The South Australia Standard outlines principles for the use of seclusion for Child Patients. These include acting in the child's best interests, having a child safe environment and associated policies, and ensuring the least restrictive care is provided. The English Code of Practice acknowledges that seclusion can have particularly adverse implications for the emotional development of a child or young person. This should be taken into consideration in any decision to seclude a child or young person and requires careful assessment of the potential effects of seclusion by a trained child and adolescent clinician (p. 293).

The key issue for consideration for the review of the Irish Rules in relation to seclusion and children relate to permissibility of seclusion as a restrictive practice for children. If so decided, a robust assessment process by a child and adolescent mental health specialist should be identified. Adopting a children's rights-based approach as suggested in the Welsh Framework to reduce restrictive practices warrants consideration (p. 9). Interventions outlined in the South Australia Standard relating to managing distress (p. 14/15) should be considered as standard as a means of avoiding seclusion.

The adaptation or modification of any adult rules governing seclusion should be considered very carefully and by an expert group to ensure relevance and safety for children. The Australian Standard recommends the development of an observation protocol for restraint (page 15), this should be considered also for the use of seclusion in the Irish Context.

6.1.13 Part 4: Use of Mechanical Means of Bodily Restraint for Immediate Threat of Serious Harm to Self or Others

As previously noted, Ireland is the only jurisdiction that links these two restrictive practices together in terms of regulatory or standard documents. Although similar governance issues may be evident, it is recommended here that the two measures are separated to ensure that the correct measure of consideration is provided to services, staff and Service Users.

Definition:

The rules governing seclusion and mechanical means of bodily restraint define mechanical means of bodily restraint as "the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a patient's body" (2.3.1 p. 17). The rules exclude the use of cot sides or bed rails that prevent patients from falling or slipping from bed. The definitions of mechanical restraint vary considerably across the jurisdictions. The Irish definition provides for devices or garments preventing or limiting free movement. The English definition extends to identify the use of mechanical restraints as being for behavioural control. The Scottish definition includes a list of permissible restraints, the focus is on patients at risk of falls, repeated self-harm and restlessness at night. The Australian document also outlines the types of mechanical restraints that can be used, the process for applying mechanical restraint, the monitoring process, and the reporting process. See Table 10 for definitions by jurisdiction.

As with the definition of seclusion, the Irish definition of mechanical means of bodily restraint is clear and functional. The English and Scottish definitions identify the circumstances under which mechanical restraint can be used as being prevention of falls, restlessness and behavioural disturbance respectively. The Irish and WHO definitions make no such provision, the action itself is what is defined. The Welsh document differs in that it incorporates other restrictive practices into an all-encompassing definition of restraint, including mechanical restraint. This presents an issue for consideration by the MHC around whether to adopt a definition of restraint that incorporates all other restrictive practices as evident in the Welsh document. An advantage to such an approach is that it incorporates all forms of restrictive practice and provides a generic or inclusive basis from which all restrictive practices can be viewed. However, there is a danger in that approach that guidelines are also generic and opportunities to provide clear and prescriptive guidance around mechanical restraint and seclusion use could be missed. Given the seriousness of the practices under review, a more prescriptive approach around the use of either practice would avoid misunderstandings and misrepresentation of the measures in question.

Jurisdiction and Source	Definitions of mechanical restraint
Ireland (Rules governing seclusion and mechanical means of bodily restraint, MHC 2006 p. 14)	'the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a patient's body'
England (Code of Practice MHA 1983, 2016 26.7 p.296)	Mechanical restraint is a form of restrictive intervention that refers to the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control
Scotland Use of Seclusion: Good Practice Guide (Good Practice Guide: Rights Risks and limits to freedom, MWCS 2021 p.11)	The commonest form of direct mechanical restraint in use is the restraining chair and/or belts for people who are mobile or think they are mobile but are liable to fall or otherwise injure themselves when they walk or attempt to walk. Other forms of mechanical restraint sometimes considered include limb restrictions, for those who repeatedly harm themselves, and cot sides, or secure sleeping bags for those who are restless at night
Wales (Mental Health Act 1983 Code of Practice Review for Wales, Welsh Government, 2016) Reducing Restrictive Practices Framework A framework to promote measures and practice that will lead to the reduction of restrictive practices in childcare, education, health and social care settings for people of all ages. (2021 p.2)	Restraint: 'An act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently' (Welsh Government, 2016a) It includes: • physical restraint • chemical restraint • environmental restraint • mechanical restraint • seclusion or enforced isolation • long term segregation • coercion
Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021 p. 8)	The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.
South Australia 'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021 p. 17).	The application of devices (including belts, harnesses, manacles, sheets and straps) on a person's body to restrict their movement. This is to prevent the person from harming themselves or endangering others or to ensure the provision of essential medical treatment. It does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's capacity to get off the furniture except where the devices are used solely for the purpose of restraining a person's freedom of movement. The use of a medical or surgical appliance for the proper treatment of physical disorder or injury is not considered mechanical restraint.
New Zealand	No reference to mechanical restraint in documents reviewed

Guidelines on the use of Seclusion (2010) New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021)	
WHO (Strategies to end seclusion and restraint, WHO 2019 p.6)	Physical (or mechanical) restraint: • Physical (or mechanical) restraint commonly refers to interventions undertaken with the use of devices to immobilize the person or restrict a person's ability to freely move part of their body. • Restrictive devices generally include belts, ropes, chains, shackles and tightened cloth. Physical restraints also comprise disabling clothing such as straightjackets, disabling gloves, disabling furniture such as cage-beds, net-beds, or immobilization chairs. • Tying someone to a tree or to another object is also a form physical restraint

Table 11 Definitions of Mechanical Restraint by Jurisdiction

6.1.14 Orders for Mechanical Means of Bodily Restraint for Immediate Threat of Serious Harm to Self or Others

Part 4, section 14 outlines the rules governing orders for mechanical means of bodily restraint in Ireland. It is clear that the measure must only be initiated by registered medical practitioners and/or registered nurses. The consultant psychiatrist responsible for the care and treatment of the patient or the duty consultant psychiatrist must be notified by the registered medical practitioner or registered nurse who initiated the restraint as soon as is practicable. In both instances mechanical restraint can only occur following an assessment which must include a risk assessment. A standardised risk assessment or areas for consideration therein is not identified but warrant consideration in the interest of standardisation of approach. The rules are clear that where mechanical restraint is initiated by a Registered Nurse, there must be a medical review as soon as is practicable or in any event within 4 hours of the initiation of the restraint. At this point, the Medical Practitioner must discontinue the restraint or order its continued use following discussion with nursing staff and the duration of the restraint must be documented. However, the rules do not indicate a maximum duration for this order.

The English Code of Practice outlines in Chapter 26 that mechanical restraint can be approved only after multidisciplinary (MDT) consultation. Within that context, the Code states that the MDT membership must be identified by provider policies and there is no clear identification of the final approval requirement. However, there is some ambiguity between this and the requirement, later in the same section, for the responsible clinician or duty doctor to be notified if the professional initiating the mechanical restraint, within the permissions of the local policy, is a nurse or other professional.

Whilst there is no specification of types of permissible mechanical restraints, paragraph 26.86 in the English code, outlines that in circumstances where mechanical restraints prevent a person from reaching a door handle to leave, the person is also secluded. Therefore, the person is essentially subjected to two forms of restrictive interventions and two associated sets of governance or regulatory procedures. In considering such an approach, it would be the case that any mechanical restraint (or any other restraint) whereby a person is confined to a room or space would also be in seclusion. This is a serious overlap in terms of a rights-based approach and guidance for practice and warrants consideration to ensure that the correct requirements are fulfilled and that there is no conflicting guidance for Ireland.

In the Northern Ireland Draft Standard, mechanical restraint is identified as permissible in exceptional circumstances only, and then in secure settings and in other settings for management of extreme violence directed towards others, or to limit self-injurious behaviour of extremely high frequency or intensity. Whilst there is no professional authorised to order mechanical restraint in the draft, the process requires that a robust assessment is carried out to ensure that the least restrictive measure possible is used and that it will maintain the safety, well-being and dignity of the person. The code requires that mechanical restraint should occur in the context of a behaviour support plan. This plan should include actions and interventions that will bring about the circumstances where continued use of mechanical restraint will no longer be required.

An alternative approach is adopted in The Welsh Code of Practice which requires that mechanical restraint is only applied following agreement with the Hospital Manager and in collaboration with the Healthcare Inspectorate Wales (HIW). This process operates as a safeguard to ensure that when used,

mechanical restraint is absolutely necessary and is the least restrictive measure. In South Australia, mechanical restraint is permissible in emergency situations for up to 30 minutes, with a maximum of 6 orders in 3 hours, and is considered a rare and exceptional event. Orders can only be made by a Medical Practitioner or Nurse Practitioner where available or if not available, the most senior clinician on duty. Where a Medical Practitioner or Nurse Practitioner is not available in person, phone contact should be made with them. This sets an expectation that mechanical restraint outside of these time parameters is exceptional and can serve to alter perceptions and considerations for use accordingly.

This issue of what actual mechanical restraints are permissible within the context of the definitions is not consistent across the jurisdictions. The literature refers to differing types of restraints used in practice, however there is no reference to these types of restraints in the codes. In the Irish rules, there is no indication of permissible forms of mechanical restraint or process for approval of same. The only protocol identified for this review for the approval of mechanical restraint devices is in the South Australia standard. All devices must be approved by The Chief Psychiatrist who has this authority. The Chief Psychiatrist enacts this authority by involving a small team of safety and quality staff, a consumer and carer who together review applications for approval. This process includes reviewing the use of the device and the manufacturer's instructions for use. If necessary, the team seeks feedback from clinicians, consumers and carers if the device has already been used locally and feedback if available. In addition to approval, comment and feedback is provided to the service about their submission in the context of other interventions which have been tried to manage the persons behaviour. This process creates a strong independent and regulatory oversight of mechanical restraint and is worth consideration in the Irish context.

All of the jurisdictions reviewed adopted differing approaches to orders for mechanical restraint. It is possible to combine the best practice from each for Ireland to include a clear authorisation for mechanical restraint in an emergency situation and by a multidisciplinary team where planning is possible. In order to ensure that the measure is used in an emergency situation only or where no other least restrictive option is safe, the Welsh approach of an independent application to the Hospital Manager and involvement of HIW in the process warrants consideration. Furthermore, approval of specific types of mechanical restraint devices is only considered in the South Australia standard and including such specifications should be given serious consideration in the Irish context. Alternatively, where the Hospital Governance Structure includes a Clinical Director (or equivalent), Nursing Director (or equivalent) as well as an Administrative Manager, consideration should be given to the inclusion of such a panel of Senior Personnel in the decision making or the endorsement of the decision making.

Jurisdiction and Source	Orders for mechanical means of bodily restraint
Ireland (Rules governing seclusion and mechanical means of bodily restraint, MHC 2006 p.27)	Registered Nurse or Registered Medical Practitioner following an assessment, which must include a risk assessment
England (Code of Practice MHA 1983, 2016 Chapter 26 p. 296)	The use of mechanical restraint should be approved following multi-disciplinary consultation. Where the agreed provisions for the use of mechanical restraint in positive behaviour support plans (or equivalent) allow a nurse or other professional to authorise the actual use of mechanical restraint, then that professional should notify, without delay, the responsible clinician or duty doctor (or equivalent).
Scotland Rights Risks and Limits to Freedom, Mental Welfare Commission for Scotland (2021 p.19)	Any restraint used must be a considered part of the individual's care plan and included in an Adults with Incapacity Act section 47 treatment plan where appropriate. Its use should follow multi-disciplinary discussion, and be fully described in the care or treatment plan, together with the decisions taken and the arrangements for regular review within specified periods of time.
Wales (Mental Health Act 1983 Code of Practice Review for Wales, Welsh Government, 2016 p.188)	Agreement with Hospital Managers and in collaboration with the Healthcare Inspectorate Wales (HIW) Mechanical restraint should only be used as a last resort and for the purpose of managing extreme violence directed at other people or limiting self-injurious behaviour of extremely high frequency or intensity.
Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021 p.49)	Following robust assessment (unclear by who) and in the context of a behavioural support plan.
South Australia 'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021 p.10,11).	Authorisation for the application of mechanical restraint to a person in a hospital setting will only be on the order of a medical practitioner or nurse practitioner where available or if not available, the most senior clinician on duty. Where a medical practitioner or nurse practitioner is not available in person, phone contact should be made with them. Maximum order in emergency situations only for 30 minutes for a maximum of 6 orders in 3 hours.
New Zealand New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021 p.77)	The decision to approve restraint for a person (this includes mechanical restraint) shall be made by the most appropriate healthcare professional: As a last resort, after all other interventions and de-escalation strategies have been tried or implemented, after adequate time has been given for a cultural assessment, following assessment, planning and preparation which includes all available resources to be in place, when the environment is appropriate and safe.

Table 12 Orders for Mechanical Restraint by Jurisdiction

6.1.15 Monitoring and reviewing mechanical means of bodily restraint

Monitoring and review of mechanical restraint is provided for in sections 14.3 – 14.5 in the Rules Governing seclusion and mechanical means of bodily restraint. Ireland, England and South Australia are the only jurisdictions reviewed to have set clear timelines around the monitoring of a person in mechanical restraints. The timelines differ considerably. The most comprehensive review is outlined in South Australia where each authorisation for mechanical restraint is for a period of 30 minutes, up to a maximum of 6 authorisations to a total of 3 hours. This in itself implies a requirement for regular

review as authorisation cannot occur without assessment. Both the South Australia standard and the English Code of Practice make explicit the requirement for the person in mechanical restraint to be under continuous 1:1 observation and supported by a health professional (profession or qualification not specified). Furthermore, there is a requirement for health services to have an observation protocol to check the mental and physical state of a person who is restrained. With due consideration of this and the risks associated with mechanical restraint (Kersting, Hirsh et al 2019; Tingleff et al 2019), it is suggested here that the observing professional should be suitably qualified to be able to assess for risks both proactively and continuously in these areas and to intervene as required. The remaining English requirements include review by a nurse every fifteen minutes for the duration of the period of mechanical restraint and review by a Registered Medical Practitioner one hour after initiation and every 4 hours thereafter. In relation to long term use of mechanical restraint in the English context, a review must occur in the context of a positive behavioural support plan which can allow for less frequent nursing and medical reviews as deemed necessary.

In Ireland review is required by a registered Medical Practitioner within 4 hours in the instance where mechanical restraint is initiated by a Registered Nurse. However, there is no requirement for review in the event that orders are made by a Registered Medical Practitioner. A multidisciplinary team review is required as soon as possible following initiation of mechanical restraint or in any case within two working days. In all instances the consultant responsible for the patient must sign the required form but there is no mandatory requirement for review within the rules. Furthermore, there is no maximum order period identified, except that where a person has been mechanically restrained for one month, they must be reviewed by a medical practitioner independent of their care. Section 15.4 (within the dignity and safety section) states that the patient must be continually assessed when in mechanical restraints. The nature of the review is not prescribed and warrants further consideration to ensure that there is a minimum standard associated with the assessment and monitoring process, who undertakes it and what critical areas must be considered.

The Welsh Code is clear about the potential use of mechanical restraint being permissible only in rare and exceptional circumstances and the need for the decision to be made in collaboration with the HIW. Associated with this, the Code provides that the use of mechanical restraint should be risk assessed, be the least restrictive and used for the least period of time possible. Furthermore, there is an explicit requirement to reduce the use of the restraint and for its review on a regular basis, the details of which must also be agreed with the HIW. In this approach, the standard implies that normative use of mechanical restraint is not permissible, but in the event that it is deemed necessary, national structures must be involved in the decision-making process. This is an approach that warrants serious consideration as it is elevates decision making to a level involving (but not dictated solely by) the national regulator and may promote a more structured movement towards zero mechanical restraint except in clearly identified parameters and assessment processes.

Evidence from the papers by Kersting, Hirsch et al (2019) and Tingleff et al (2019), previously discussed, underline the concern around the physical and psychological impact of mechanical restraint. Overall, international policies, procedures and guidance are weak in this area, focusing on overarching statements of intent around assessment as opposed to providing clear and focussed direction with supporting rationale. South Australia is the exception here, requiring a regular physical and psychological assessment of the person in mechanical restraints. However, the specifics of these assessments and when they should occur are not specified. Given the risks associated with the use of

mechanical restraints, it is not unreasonable to suggest that clear measures for ongoing monitoring and assessment are put in place which support the minimisation of physical and psychological risk and the discontinuation of the restraint at the earliest opportunity. Monitoring and review processes in each relevant jurisdiction are outlined in Table 12.

Jurisdiction and Source	Monitoring and review
Ireland (Rules governing seclusion and mechanical means of bodily restraint, MHC 2006 p.27/28)	*4Hours:* If mechanical restraint is initiated by a registered nurse, there must be a review by a medical practitioner within 4 hours. At this point mechanical restraint can be discontinued following discussion between medical and nursing staff. If further orders are made, the duration must be indicated. *Max 2 days:* MDT review *1 month*: Independent review Section 15.4 The patient must be continually assessed throughout the use of mechanical means of bodily restraint to ensure his or her safety.
England (Code of Practice MHA 1983, 2016 Chapter 26 p 296)	*Continuous Observation:* An individual who is mechanically restrained should remain under continuous observation throughout. It may be necessary for the individual to remain at arm's length. *Every 15 minutes:* Review by a nurse every fifteen minutes for the duration of the period of mechanical restraint. *One hour after initiation:* Medical review by a registered medical practitioner *Every 4 hours:* Ongoing medical reviews at least every four hours by a registered medical practitioner. For long term use of mechanical restraint: Must occur in the context of a positive behavioural support plan which can allow for less frequent nursing and medical reviews
Scotland Rights Risks and Limits to Freedom, Mental Welfare Commission for Scotland (2021 p.16)	Managers of care homes, hospitals and community services should audit patterns of restraint use and relevant incidents or accidents. Such audit should inform local policy and practice and must be recorded.
Wales (Mental Health Act 1983 Code of Practice Review for Wales, Welsh Government, 2016 p.188) Reducing Restrictive Practices Framework A framework to promote measures and practice that will lead to the reduction of restrictive practices in childcare, education, health and social care settings for people of all ages. (2021 p. 13)	The use of mechanical restraint should be risk assessed and be the least restrictive for the least period of time. A plan to reduce the use of the restraint should be in place and the use of the restraint reviewed on a regular basis, the review process should be agreed with HIW at the time of agreeing the intervention. Permissible in exceptional circumstances only in Wales and must be approved by Hospital Managers and in partnership with the Healthcare Inspectorate Wales. Any restraint used must be a considered part of the individual's care plan. Its use should follow multi-disciplinary discussion and be fully described in the care or treatment plan, together with the decisions taken and the arrangements for regular review within specified periods of time.
Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational	Action 7: Each individual organisation is responsible for ensuring the requirements of this policy are implemented, providing evidence of monitoring, oversight and action to address deviation from the policy.

Procedure for the Use of Seclusion (2021 p.6)	
South Australia 'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021 p.8/9).	Each authorisation for mechanical restraint is for a period of 30 minutes, up to a maximum of 6 authorisations to a total of 3 hours. When an order has expired the person must be reviewed by a medical practitioner or nurse practitioner where available, or if not available, the most senior clinical staff member on site. Verbal and telephone orders will only be accepted in extenuating circumstance Persons subjected to mechanical restraint will be subject to continuous 1:1 observation and support by a health professional. Health services shall have an observation protocol to check the mental state and physical state of a person who is restrained.
New Zealand New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021 p.77)	The frequency and extent of monitoring of people during restraint shall be determined by a registered health professional and implemented according to this determination Monitoring restraint shall include peoples cultural, physical, psychological and psychosocial needs and shall address wairuatanga.

Table 13 Monitoring and Review of Mechanical Restraint by Jurisdiction

6.1.16 Section 15: Patient Dignity and Safety

Paragraphs 15.1 -15.5 outline the Irish Rules around patient dignity and safety whilst in mechanical restraints. No other document reviewed has a section devoted to this issue. Instead, issues of dignity are built into overarching principles or the maintenance of dignity as an outcome in the jurisdictions reviewed. The issue of dignity is fundamental to human rights and as such, it is clearly stated in Article 1 of the Universal Declaration of Human Rights (UN, 1948) which states that 'All human beings are born free and equal in dignity and rights'. The use of mechanical restraint and the maintenance of dignity are contradictory in terms and to try to reconcile the two into a situation where mechanical restraint can be dignified is difficult. This may be why most documents reviewed are vague in outlining how dignity can be maintained or promoted during episodes of restraint. Positions on the issue tend to be primarily viewed from an overarching principles-based approach to restrictive practices in general, as is evident in the Welsh reducing restrictive practices framework (2021 p. 10). There is little doubt that the use of coercive practices including mechanical restraint, diminishes human dignity. This position may be mitigated by the justification and proportionality of the measure employed, as outlined in Bures V Czech Republic (2012 cited in MWCS 2021 p. 39). To this end, staff must be able to demonstrate necessity based on appropriate risk assessment and justify the practice of mechanical restraint and in so doing demonstrate their consideration of the person's dignity. A principles-based approach is also evident in the Scottish Rights Risks and Limits to Freedom Good Practice Guide (MWCS 2021 p. 15) in relation to positive risk taking and in association with respect for freedom of action and movement, autonomy and privacy. This approach forms the baseline for decisions and actions taken in relation to mechanical restraint. An alternative view is that mechanical restraint may be used to maintain the persons dignity as indicated the Northern Ireland Draft Standard (p.14). However, the circumstances under which this may be manifest are not outlined. The same position is associated with the movement towards restraint and seclusion free environments in New Zealand.

Fundamentally, the issue of dignity and restrictive practices, including mechanical restraint are ethically and legally challenging. Adopting an overarching principles-based approach as opposed to a series of actions which may or may not directly impact on dignity may be more meaningful in reviewing the rules.

Advanced directives are highlighted as requiring consideration within the context of mechanical restraint in Section 15. Consideration should be given to moving this particular issue to the Governance section. However, in the context of this discussion, the issue of advanced directives grows increasingly important in the broader arena of contemporary healthcare. Within mental healthcare, advanced directives are referred to in the various jurisdictions reviewed, however the development of the issue is dependent upon the individual regulatory frameworks. It is noted that a considerable amount of work is underway in New Zealand to inform the use of advance directives within the context of regulatory change there. In the jurisdictions reviewed, the most comprehensive approach to the issue of advanced directives was evident in Scotland, where it has been incorporated into legislation since the enactment of the Mental Health Care and Treatment Act (2003). This rights-based piece of legislation gave individuals the statutory right to express their views about their care and treatment. With relevance to this section, it provided the right to submit an advanced statement which states an individual's wishes (which should be respected unless there are compelling reasons not to do so) and the right to choose a named person who can make decisions on an individual's behalf. This was expanded upon in the 2015 Act which required NHS Boards to keep a copy of any advance statement received with the patient's records and to provide certain information about the existence and location of the statement to the Mental Welfare Commission, to be held on a register of information. It also requires NHS Boards to publicise the support that it provides to make and withdraw an advance statement. The commitment to advanced statements was further outlined in the Scottish Good Practice Guide: Advanced statement guidance, my views, my treatment (2017) which provided both staff and Service Users with guidance around how advanced statements could be developed and enacted. Within the Irish context clear guidance around the making, processing and retention of such directives would clearly enhance commitments to person centred, recovery orientate care and are well placed to occur within the operationalisation of the Assisted Decision-Making Capacity Act (2015).

Other issues noted in this section of the Irish rules include the need for special consideration to be given when mechanically restraining a patient who is known by the staff involved in mechanically restraining the patient, to have experienced physical or sexual abuse. Furthermore, 15.3 outlines where practicable, the patient must have a same sex member of staff present during the initiation of restraint. This is unique to the Irish rules and where such issues are considered across jurisdictions it is in the care planning or overarching guidance around restrictive practices as in the English Code of Practice section 26.43.

Section 15.4 refers to the need for the patient to be continually assessed throughout the use of mechanical means of bodily restraint to ensure his or her safety. This has been discussed previously and consideration should be given to moving this rule to the section on Monitoring and Review of the Rules. Finally, section 15.5 states that the use of devices to deliberately inflict pain is prohibited. The Northern Ireland Draft Standard further states that mechanical restraint should not be used as a form of discipline or punishment (p. 14). This matter is addressed in other jurisdictions within overarching statements around the use of restrictive practices such as in the English Code of Practice section 26.36 (p. 288) 'Restrictive interventions should not be used to punish or for the sole intention of inflicting

pain, suffering or humiliation'. The South Australia standard makes explicit that it regulates mechanical restraint and other restrictive practices in order to uphold the guiding principle and requirement of the Mental Health Act (2009), that 'restrictive practice should be used only as a last resort for safety reasons and not as a punishment or for the convenience of others' (p.2). Consideration should be given to making an all-encompassing statement around this issue in relation to the ethical aspects of the wider issue of restrictive practices at the outset of a guidance, codes or rules, re-affirming that they should only be applied for the prevention of harm to self or others or to facilitate a safe environment when no other option is available. They should indicate clearly that such practices should never be used as a punishment; for the convenience of others; as a means of preventing damage to property, furniture etc.; their use be dictated by resource restrictions; or with the intent to cause suffering or pain.

6.1.17 Ending the use of mechanical means of bodily restraint

Section 16.1 of the Irish rules requires that an assessment must take place before mechanical restraint is ended. The specifics of this assessment or who the assessment should be undertaken by are not outlined. There is also minimal reference to the process of ending mechanical restraint in the documents reviewed from the different jurisdictions in this report. However, in the draft NI standard ending mechanical restraint is incorporated into the planning process from the outset in section 5.31 (p. 14), where it is made clear that the circumstances under which mechanical restraint will no longer be required must be outlined. Section 26.7 of the English Code of practice (p.282) requires that each service provider have a policy in place which outlines how restrictive interventions which are used by the provider, should be authorised, initiated, applied, reviewed and discontinued. Given the minimal national level guidance in this area, it is recommended that a combination of these two jurisdictional measures, together with the existing Irish rules for ending mechanical restraint be adapted and clarified into specific action to be taken in the Irish context.

Section 16.2 requires that the patient be afforded the opportunity to discuss the episode of mechanical restraint with their multidisciplinary team when the episode has ended. As indicated in the seclusion section above, there have been considerable developments in the area of debriefing internationally. This has primarily resulted from the considerable evidence of adverse psychological effects associated with restrictive practice processes and from the impetus to reduce restrictive practices. All of the jurisdictions reviewed emphasised the importance of this support structure following restrictive practice and, in all instances, debriefing or post incident review is mandated either immediately or as soon as practicable with the multi-disciplinary team. The opportunity to learn and avoid future episodes is highlighted in most jurisdictions and this warrants consideration in the Irish context. Clearly, within the context of incident review, where the use of coercive measures on a patient is under review, it is important that any patient involvement is supported by appropriate advocacy involvement and the review should consider appropriate means of incorporating the supported voice of Service Users.

6.1.18 Clinical Governance

The section on Clinical Governance begins with a statement which makes clear operational or organisational circumstances under which mechanical restraint must not take place. This may be

better placed in an earlier section titled exclusions before the actual rules for mechanical restraint are outlined.

6.1.19 Policy

Section 18.2 of the Irish Rules outlines the policy requirements within the Irish context. In Ireland this section is similar to that outlined for seclusion and primarily restates the salient rules to be incorporated into the local policies. Specifically, issues around who may initiate, order, monitor or discontinue mechanical restraint, provision of information to the patient and a section around methods to reduce the use of mechanical restraint in the service. The minimum requirements for dissemination of the policy are also outlined in addition to the requirement for an annual report.

The policy requirements specific to mechanical restraint are generally poorly identified across jurisdictions reviewed. This may be because of the exceptional nature of mechanical restraint. Overall, policy requirements governing restrictive practices in England, Scotland, Wales and Northern Ireland are applicable to mechanical restraint as a restrictive intervention. The requirements are particularly robust in the Welsh and Northern Ireland and warrant consideration in the Irish context. The specifics are identified in as can be seen on Table 13.

Jurisdiction and Source	**Service Policy Requirements for the Use of Mechanical Restraint**
Ireland (Rules governing seclusion and mechanical means of bodily restraint, MHC 2006 p.30)	• Each approved centre must have a written policy in relation to the use of mechanical means of bodily restraint. • The policy must identify who may carry out mechanical means of bodily restraint, include a section regarding the provision of information to the patient and include a section which details how the approved centre is attempting to reduce the use of mechanical means of bodily restraint, where applicable. • The written policy on mechanical means of bodily restraint must specify how the approved centre reviews cases of mechanical means of bodily restraint. An approved centre must review its policy on mechanical means of bodily restraint as required and, in any event, at least on an annual basis.

England
(Code of Practice MHA 1983, 2016 Chapter 26 p 282)
	Mechanical restraint specific: 26.82 Local policies should determine which of their registered medical practitioners should undertake medical reviews.
	
	• Provider policies should include guidance on:
	• Assessments of risks and support needs
	• The use of positive behaviour support plans (or equivalent)
	• How risks associated with restrictive interventions can be minimised in particular:
	  ○ As assessment of their potential to cause harm to the physical, emotional and psychological wellbeing of patients
	  ○ How providers will take account of a patients individual vulnerabilities to harm (such as unique needs associated with physical/emotional immaturity, older age, disability, poor physical health, pregnancy, past history of traumatic abuse etc)
	• How restrictive interventions which are used by the provider, should be authorised, initiated, applied, reviewed and discontinued, as well as how the patient should be supported through the duration of the application of the restrictive intervention
	• Local recording and reporting mechanisms around the use of restrictive interventions
	• Post-incident analysis/debrief
	• Workforce development, including training requirements relating to the application of restrictive interventions, which are underpinned by their therapeutic intent.

Scotland Rights Risks and Limits to Freedom, Mental Welfare	• Policies relating to personal autonomy and restraint should be considered by commissioners of services as part of the process of contracting for a service (p.16)

Commission for Scotland (2021 p.16)	• There should be an explicit policy which determines the balance between a person's autonomy and staffs duty to care. The principle aim of any policy, involving the need for the use of restraint, should be to respect and protect human rights (p. 15)
Wales (Mental Health Act 1983 Code of Practice Review for Wales, Welsh Government, 2016 p.188) Reducing Restrictive Practices Framework A framework to promote measures and practice that will lead to the reduction of restrictive practices in childcare, education, health and social care settings for people of all ages. (2021 p. 13)	None evident The focus of policy and practice should be on the reduction of restrictive practices as part of patient centred care planning (p. 13) Organisations should have a policy that outlines conditions or the use of restrictive practices. This policy should be agreed by senior leadership for the organisation and should reflect up to date statutory guidance placed on them through legislation and guidance (p. 13) This policy should: • Reference human rights and legal frameworks relevant to the sector and setting • Ensure that definitions of restrictive practices are easily available and embedded through workforce development mechanisms, organisational messages and policy • Have clear protocols and governance guidelines for the use of restrictive practices as last resort, and for monitoring of people during and after use, including the requirement for medical checks • Be easy to understand and apply, and should be communicated to all practitioners, paid carers, people being supported and the families, unpaid carers and external agencies that the organisation works alongside • Make clear that it is never acceptable to use coercion and other forms of social and psychological restraint • Contain guidance about risk assessments which must be undertaken before using any restrictive practice. • Provide clear guidance for the recording of information following the use of any restrictive practice in relation to what is to be recoded when, by whom, and the purpose of the recording • Make clear that the use of any restrictive practice should be recorded even if its use is prescribed in a personal plan • Outline the process for seeking consent for the use of restrictive practices as a last resort to prevent harm to an individual or others Organisations should have a person-centred policy for providing both immediate and longer-term support after any use of restrictive practices, and this should inform the review of the individual plan for the person following any incident (p.16). Safeguarding policy (p. 17) Whistleblowing policy (p. 17) Children, adults and families should also be asked to contribute to policy review and development (p. 22) Organisations should (p. 10): • Have a clear policy in place for all practitioners that helps them to understand their duties under human rights and legal frameworks • Set out in such a policy the organisational commitment to reducing the use of any restrictive practices • Ensure that all practitioners are aware of such a policy and understand its intended impact on their practice
Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021 p.33)	Local and organisational policy frameworks should be co-produced and must include as a minimum: i. the organisational values that underpin the approach to minimising restrictive interventions. ii. the detail of the organisational vision and strategy for minimising restrictive interventions. iii. details of job roles within the organisation with specific restrictive practice minimisation responsibility and accountability. iv. standard definitions. v. clear professional/clinical guidance. vi. reference to working within current legislative frameworks and professional registration requirements. vii. an emphasis on positive, proactive, preventative and evidence-based interventions and strategies viii. how the *Three Steps to Positive Practice Framework* as the organisational methodology for considering and reviewing the use of restrictive interventions is embedded and operationalised. ix. details of accredited training required, including training required for specific interventions. x. communication requirements and strategies.

	xi. details of interfaces with other regional and local policies, agreed protocols and any associated requirements. xii. reference to clear recording, reporting, monitoring and governance arrangements (including how data will be used in the minimisation strategy). xiii. support mechanisms for those who are subject to restrictive interventions; and xiv. Support mechanisms for staff who have to restrict, restrain and/or seclude those in their care.
South Australia 'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021 p.6).	No policy requirements other than the provisions stated in the State Policy
New Zealand New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021)	None identified

Table 14 Service Policy Requirements for Mechanical Restraint by Jurisdiction

6.1.20 Other governance requirements

Sections 18.4 and 18.5 refer to review and monitoring of mechanical means of bodily restraint and have been previously included in the section above. It is suggested here that these arrangements be moved to a new sub section following orders for seclusion, titled monitoring and review of mechanical means of bodily restraint. This should offer clarity around timelines and responsibilities.

The requirements around review of all cases of mechanical restraint is commensurate with international best practice around reduction of restrictive practices. Expanding on the process to be followed, accountability for review and the utility of information should provide a more robust and streamlined process for services and warrants consideration in the review of the Rules.

Training is referred to in all of the regulatory documents where mechanical restraint is provided for and extends to a requirement for staff applying the restraints to be adequately trained. The Irish rules are more comprehensive in this regard. There is a requirement for a policy for training staff which must be specific to mechanical restraint and include:

a) Who will receive training based on the identified needs of patients and staff.
b) The areas to be addressed within the training programme, including training in alternatives to seclusion.
c) The frequency of training.
d) Identifying appropriately qualified person(s) to give the training; and
e) The mandatory nature of training for those involved in seclusion.

These five requirements are appropriate. However, the evidence and standards around training in this area have changed significantly since the rules were first established. To this end, due consideration should be given to the most recent evidence-based training standards document Restraint Reduction Network (RRN) Standards (Ridley and Leitch, 2021) as outlined in section 3 of this document.

6.1.21 Child patients and mechanical means of bodily restraint

Section 20 of the Irish Rules Governing Seclusion and Mechanical Means of Bodily Restraint identify the rules around the use of mechanical restraint for children in Approved Centres. However, similar to the rules governing child patients and seclusion, the rules extend only to informing the child's parent or guardian and having child protection policies and procedures in place. No specific reference to the use of mechanical restraint in child patient populations could be found in any of the regulatory or standard documents reviewed. The absence of a statement of appropriateness or permissibility suggests that either the mechanical restraint of children is assumed to be inappropriate or that the matter is so complex that positions have yet to be established on the matter. Whatever the reason, in the current context of the Irish rules, the use of mechanical restraint is permissible for child patients. The absence of an international comparator from which to consider best practice renders it impossible to draw best practice specific for Ireland. To this end consideration should be given to establishing an expert group to further explore this issue.

6.2 Code of Practice on the Use of Physical Restraint in Approved Centres (2009)

The Code of Practice on the Use of Physical Restraint in Approved Centres was issued by the MHC in 2006 and reviewed in 2009 pursuant to Section 33(3)(e) of the MHA (2001). The Code aims to guide practice and to ensure that the rights of residents are respected in Approved Centres. The Code consists of two parts, the first is introductory and the second outlines practices expected around the use of physical restraint. This section will be structured according to the headings in the document to allow for comparison with other jurisdictions.

6.2.1 Part 1: Introduction

The introduction outlines nine general principles to underpin the use of restraint at all times. These principles are commensurate with international documents reviewed and clearly set out the most important and fundamental issues to be given consideration in the use of physical restraint. These are summarised in Fig. 17.

Figure 18 - Principles Underpinning the Irish Code of Practice for the Use of Physical Restraint

These principles are commensurate with contemporary approaches to restraint. However, rights principles, which are present to varying degrees in every jurisdictional document reviewed on restrictive practices, are absent in the Irish Code. Furthermore, other jurisdictions have adopted a generic principles and guidance approach to restrictive interventions, with the particulars of the specified practice addressed separately.

The English Code of Practice outlines five general principles to underpin the planning and delivery of care in mental health services within the context of the MHA (1983). These do not explicitly relate to the use of physical restraint or restrictive practices. However, principles can be identified from the

restrictive practices and human rights sections. These principles are similar to the Irish principles with proportionality, least amount of time and least restrictive options being highlighted together. Minimum interference with the person's autonomy, privacy and dignity in the use of physical restraint and limiting a person's freedom for no longer than is absolutely necessary are made clear. A separate section on respecting human rights also outlines the circumstances under which restrictive practices are permissible within the UK Human Rights Act (1998) and in line with the European Convention on Human Rights Articles (1950). This may offer an option for inclusion of Human Rights in the revised Code. A similar approach is adopted by the Welsh Code of Practice, whereby six general principles underpin all care practices. Additionally, restrictive practice specific principles are identifiable in the relevant section (26.30 p. 187) and are similar to those identified in the Irish Code of Practice.

The Scottish Good Practice Guide identifies ten general principles applicable to all restraint situations. These principles are outlined in such a way as to provide guidance to staff as well as outlining the principles. Of note, specific principles not directly reflected in the Irish Code include Human rights, Involvement of the patient in discussions around restraint, self-determination and freedom of choice, positive risk taking, unacceptable reasons for physical restraint, policy, training and monitoring. The first four warrant consideration as underpinning principles in the Irish context. However, the remaining principles are addressed in other areas of the Code and can be considered systems issues rather than underpinning principles.

Two key issues require consideration in the context of the review of the Code of Practice. The first relates to the incorporation of Human Rights as an underpinning principle into the Irish Code. The second issue for consideration is closely linked to the first and relates to providing an overarching set of principles for all restrictive practices or by individual practice. An overarching set of principles and common required actions for restrictive practices, to include human rights considerations, with a specific section identified for the individual practice would enable all restrictive practices to be addressed together and ensure a foundational principles-based approach common to all practices. Table 14 identifies international generic and specific principles to inform decision making on this issue.

Jurisdiction and Source	**Generic principles around restrictive practices**	**Specific Principles underpinning the standards/codes on the use of restraint**
England (Code of Practice MHA 1983, 2016 Chapter 26 p 290)	• Least restrictive option and maximising independence • Empowerment and involvement • Respect and dignity • Purpose and effectiveness • Efficiency and equity 26.37 Where a person restricts a patient's movement, or uses (or threatens to use) force then that should: • be used for no longer than necessary to prevent harm to the person or to others • be a proportionate response to that harm, and • be the least restrictive option. 26.41 Restrictive interventions should be used in a way that minimises any risk to the patient's health and safety and that causes the minimum interference to their autonomy, privacy and	

	dignity, while being sufficient to protect the patient and other people. The patient's freedom should be contained or limited for no longer than is necessary. 26.45 Any use of restrictive interventions must be compliant with the Human Rights Act 1998 (HRA), which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights (ECHR). 26.47 No restrictive intervention should be used unless it is medically necessary to do so in all the circumstances of the case. Action that is not medically necessary may well breach a patient's rights under article 3, which prohibits inhuman or degrading treatment. 26.48 Article 8 of the ECHR protects the right to respect for private and family life. A restrictive intervention that does not meet the minimum level of severity for article 3 may nevertheless breach a patient's article 8 rights if it has a sufficiently adverse effect on the patient's private life, including their moral and physical integrity. 26.49 Restrictions that alone, or in combination, deprive a patient of their liberty without lawful authority will breach article 5 of the ECHR (the right to liberty).	
Scotland Rights Risks and Limits to Freedom, Mental Welfare Commission for Scotland (2021 p.15)		• "Restraint must never be used as a threat in order to control behaviour." • Human rights: People who are in hospital, in care homes, or receiving care in the community retain their full human rights, unless these have been restricted by a legal process and then only to the extent allowed by the law. • Involvement: Individuals should, where possible, always be involved in any discussion of restraint, even where they lack capacity. • Self-determination and freedom of choice and movement should be paramount, unless there are compelling reasons why this should not be so. • Positive risk-taking: Some degree of positive risk-taking is an essential part of good care. • Alternatives to physical restraint should always be considered first. These may include medical, psychological or other treatments, and/or modifications of observation policy, care regimes, the person's activities, or even buildings. • Unacceptable reasons for considering restraint: Restraint should never be used to cover any deficiency of service, lack of professional skill, or defects in the environment. Restraint must never be used as a threat in an attempt to control behaviour seen as undesirable by staff. • Minimum necessary: If restraint is considered necessary it should be the minimum required to deal with the agreed risk, applied for the minimum possible time. • Policy: Policies relating to personal autonomy and restraint should be considered by commissioners of services as part of the process of contracting for a service.

		• Training: Restraint techniques require to be taught effectively with regular refresher courses. • Monitoring the use of restraint: Managers of care homes, hospitals and community services should audit patterns of restraint use and relevant incidents or accidents. Such audit should inform local policy and practice and must be recorded.
Wales (Mental Health Act 1983 Code of Practice Review for Wales, Welsh Government, 2016 p.8) Reducing Restrictive Practices Framework A framework to promote measures and practice that will lead to the reduction of restrictive practices in childcare, education, health and social care settings for people of all ages. (2021 p. 6)	• Dignity and respect • Least restrictive option and maximising independence • Fairness, equality and equity • Empowerment and involvement • Keeping people safe • Effectiveness and efficiency Human rights are the basic rights and freedoms that belong to every person in the world. They are based on core principles such as dignity, fairness, equality, respect and autonomy. Human rights are relevant to day-to-day life. They protect the freedom of people to control their own life, to take part effectively in decisions made by public authorities which impact upon their rights, and to receive fair and equal services from public authorities.	(p. 187) Any restraint used should: • be reasonable, justifiable and proportionate to the risk posed by the patient • apply the minimum, justifiable level of restriction or force necessary to prevent harm to the patient or others • be used for only as long as is absolutely necessary • be carried out in a way that demonstrates respect for the patient's gender and cultural sensitivities.
Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021 p.33)	The standards are underpinned by the principle of early intervention measures to minimise and eliminate their occurrence and promote the principle of lease restriction possible (p. 2) Key principles (p.5): 3.1. Restrictive Practice is an umbrella term that refers to the entire range of interventions that are considered restrictive and which infringe a person's rights. 3.2. Evidence of therapeutic benefits for use of restraint and seclusion is limited. 3.3. Organisations must have robust monitoring arrangements in place that provide assurances that restrictive practices are used only as a last resort. 3.4. Minimisation strategies, culture change and practice improvement will only be successful with robust monitoring, oversight and assurance, led by identified individuals in each organisation. Rights Based Approach 3.5. The value of each and every person receiving services is recognised through service delivery founded on a rights-based approach which empowers and involves the individual in decision making. 3.6. The lived experience is a critical contribution for all aspects of minimisation strategies. 3.7. Rights based approaches, evidenced based interventions, robust monitoring and governance, and a drive to "always do better" for people receiving services and staff delivering	

	care, treatment and support will be the foundations of any and all policy and practice. 3.8. The routine use of Three Steps to Positive Practice will drive any culture change necessary to realise the organisation's minimisation strategy at both practice and strategic levels. 3.9. Transparency is key in building relationships, authentic communication, developing person-centred, rights based and evidence-based care.	
South Australia 'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021 p.5).	• Mental Health Services will recognise the inherent rights of a person to personal dignity and freedom in accordance with international rights instruments • Mental health services will recognise and enable patient autonomy and choice in treatment and care • Mental health services will adopt a least restrictive environment for treatment and care • Mental health services will recognise and value the importance of allowing patients to guide their own recovery • The use of restrictive practices is not therapeutic and should not ever be regarded as a therapeutic practice • If seclusion or restraint is used for children and young people, staff involved must be aware of the significant vulnerability and psychological trauma from these practices for this age group • The use of restrictive practice increases the risk of trauma and may trigger symptoms of previous experiences of trauma • Restrictive practices should only be used after reasonable attempts to use alternate means of calming and de-escalation to enable a person to regain self- control are unsuccessful • The use of restraint and seclusion is regarded as an exception and extreme practice for any person • All forms of restrictive practice should only be used temporarily in a behavioural emergency • Restrictive practices when used, are implemented for the least amount of time possible and recorded, monitored and reviewed • Any use of restrictive practices must have tight safeguards in place that focus on minimising risk to consumers, staff, and others; and on empowerment, collaboration, preserving and promoting dignity, decency, humanity and respect; and considers the needs of people from Aboriginal or Torres Strait Islander and Culturally and Linguistically Diverse backgrounds • An effective restrictive practice policy will provide the framework to improve staff safety by preventing episodes of violence,	

	and by employing effective procedures and training for staff who administer restrictive practices as a last resort.	
New Zealand New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021)	Four key principles supported the development of the standard: • Achieving Māori equality • Accessible health and disability services • Partners with choice and control • Best practice through collaboration • Standards that increase positive life outcomes	

Table 15 Principles around Restrictive Practices by Jurisdiction

6.2.2 Sections 2 and 3: Scope and purpose of the Code

These sections outline the parameters of the Code and the individuals for whom the guidance is intended. It may be pertinent to include the Human Rights issues in these sections and the legal as well as ethical issues associated with them in the Irish context. Specifically, what is lawful and what is not in the context of restrictive practices and Irish legislative frameworks. Likewise, issues of permissible practice and ethical requirements, while frequently overlapping, may diverge also.

6.2.3 Section 4: Definition of Physical Restraint

The Code of Practice defines physical restraint as "the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident's body when he or she poses an immediate threat of serious harm to self or others" (p.14). This definition suggests the use of force to be the defining element of restraint as well as the threat immediacy of serious harm to self or others, which is at odds with definitions from other jurisdictions. Others do not directly refer to the severity of perceived harm. Likewise, the definition in the English Code outlines direct physical contact with the intent to prevent, restrict or subdue movement as being restraint. However, the Scottish Good Practice Guide extends its definition to include actual or threatened laying of hands on a person as being direct restraint. The issue of implied threat is a significant departure to the traditional view of restraint. The critical common definitional issue seems to be the intention to stop the person from some movement or harm related activity. These variants in the definitional nature of restraint render it difficult to establish a baseline comparative definition or to decide which definition is more appropriate and reflective of both practice and legal concerns. This is further complicated by the emergence of all-encompassing definitions of restraint in recent years. These definitions incorporate what would traditionally be viewed as discreet restrictive practices, with separate definitions and actions, into one overall definition of restraint. This is evident in the Welsh Framework for reducing restrictive practices (2021) and the Welsh Code of Practice (2016). Within these documents, measures traditionally associated with separate means of managing challenging behaviour are encompassed into an overall definition of restraint. These include limiting a patient's disruptive behaviour by giving clear but respectful instructions, holding techniques, confining patients to a limited space or closed room and locking doors to wards, physical restraint, chemical restraint, environmental restraint, mechanical restraint, seclusion or enforced isolation, long term segregation and coercion.

Northern Ireland and New Zealand offer two definitions of restraint. The first in both instances is vague enough to incorporate all other restrictive practices without naming them for example, the NI definition which refers to any direct physical contact where the intervener prevents, restricts or subdues movement of the body, or part of the body, of another person. Within the NI context, an additional definition for Clinical Holding emerged, which has not been identified in any of the jurisdiction standard or regulatory documents reviewed. However, it is referred to in the Restraint Reduction Network (RRN) Training Standards (Ridley and Leitch, 2020 p. 65) as a second definition for restraint. The idea has merit in the context of the provision of care in mental health services, particularly in elderly care where there are circumstances where 'softer' forms of restraint may be used to support a person to receive care or treatment. However, without very specific guidance, such a departure could result in a misuse of restraint in some contexts.

These variations in approach and definition create a dilemma for those considering definitions of not just restraint, but individual and collective restrictive practices. A balance will need to be found to satisfy the different approaches and required clarity in definitions intended to guide staff in the practices outlined. Table 15 outlines the definitions by jurisdiction for comparative purposes.

Jurisdiction and Source	**Definitions of Physical Restraint**
Ireland (Code of Practice on the Use of Physical Restraint in Approved Centres, MHC 2009 p.14)	For the purpose of this Code, physical restraint is defined as "the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident's body when he or she poses an immediate threat of serious harm to self or others".
England (Code of Practice MHA 1983, 2016 Chapter 26 p 295)	Physical restraint refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person.
Scotland Rights Risks and Limits to Freedom, Mental Welfare Commission for Scotland (2021 p.20)	Physical restraint is the actual or threatened laying of hands on a person to stop him or her from either embarking on some movement or activity, or following it through. The grounds for intervention are that the person's action is likely to lead to hurt or harm to the person or others, or prevent necessary help being given.
Wales (Mental Health Act 1983 Code of Practice Review for Wales, Welsh Government, 2016 p.186)	26.23 Interventions used to restrain patients may take several forms, the most common being verbal or physical restraint. Clinically acceptable methods of restraint include: • limiting a patient's disruptive behaviour by giving clear but respectful instructions • holding techniques • confining patients to a limited space or closed room • locking doors to wards. 26.24 In general terms, reasonable grounds for employing any form of restraint as a preventive intervention would include its use to control an immediately life-threatening or dangerous situation or limit a patient's freedom in order to prevent potential harm to the patient or others.
Reducing Restrictive Practices Framework A framework to promote measures and practice that will lead to the reduction of restrictive practices in childcare, education, health and social care settings for people of all ages. (2021 p. 2)	Restraint: 'An act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently' (Welsh Government, 2016a) It includes: • physical restraint • chemical restraint • environmental restraint • mechanical restraint • seclusion or enforced isolation • long term segregation • coercion

Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021 p.8)	Physical Restraint: Any direct physical contact where the intervener prevents, restricts or subdues movement of the body, or part of the body, of another person. Clinical Holding: Use of physical holds to assist or support a person who lacks capacity to consent to receive clinical or personal care or treatment
South Australia 'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021 p.17).	Physical Restraint: The application by health care staff of hands-on immobilisation or the physical restriction of a person to prevent the person from harming him/herself or endangering others or to ensure the provision of essential medical treatment. Restraint: The restriction of an individual's freedom of movement by physical or mechanical means. This applies to person's receiving specialist mental health care.
New Zealand New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021 p.9)	The use of any intervention by a service provider that limits a persons normal freedom of movement. Where restraint is consented to by a third party it is always restraint. Restraint episode: A single restraint event or where restraint is used as a planned regular intervention and is identified in the persons service delivery plan. The term may also refer to a grouping of restraint events.

Table 16 Definitions of Physical Restraint by Jurisdiction

6.2.4 Part 2: Use of Physical Restraint

6.2.4.1 Section 5: Orders for Physical Restraint

There are nine directions in the Irish code under the heading of orders for physical restraint. However, a number of the identified points do not relate to orders and may be better placed in another section as suggested in Table 16. Section 5 clearly identifies that physical restraint can only be initiated and ordered by Registered Medical Practitioners, Registered Nurses or other members of the multi-disciplinary care team in accordance with the approved centre's policy on physical restraint. Similarly, the South Australia Standard (2021) outlines that restraint can be authorised by a Medical Practitioner or Nurse Practitioner where available. In the instance where neither is available the most senior clinician on duty can authorise the restraint. The remaining jurisdictions allow service discretion to identify the most appropriate professional to be empowered to authorise restraint in either a policy, protocol or guideline. Given the seriousness of the Human Rights Issues associated with physical restraint, where service discretion is considered for the authorisation of the measure, this should be accompanied by clear guidance around accountability and competence to undertake the role. The issue therefore for the MHC in the review of the Irish Code relates to the extending of the authority to initiate restraint from Registered Nurses and Registered Medical Practitioners to other professionals as in the New Zealand Standard, the alternative being to leave the provision for orders as they exist. The issue of clarification around the Registered Nurse has been previously discussed in relation to seclusion and applies here also. Orders for physical restraint by jurisdiction are outlined in Table 17.

Suggested heading	Point suggested to be moved
Process of Physical Restraint	5.2 A designated member of staff should be responsible for leading the physical restraint of a resident and for monitoring the head and airway of the resident.
Review of Physical Restraint	5.4 As soon as is practicable, and no later than 3 hours after the start of an episode of physical restraint, a medical examination of the resident by a registered medical practitioner should take place.
Record keeping (existing heading 8)	5.7 a) The episode of physical restraint should be recorded in the resident's clinical file. b) The relevant section of the "Clinical Practice Form for Physical Restraint" should also be completed by the person who initiated and ordered the use of physical restraint as soon as is practicable and no later than 3 hours after the episode of physical restraint. c) The clinical practice form for physical restraint should also be signed by the consultant psychiatrist responsible for the care and treatment of the resident or the duty consultant psychiatrist as soon as is practicable and in any event within 24 hours.
Provision of Information	5.8 The resident should be informed of the reasons for, likely duration of and the circumstances which will lead to the discontinuation of physical restraint unless the provision of such information might be prejudicial to the resident's mental health, wellbeing or emotional condition. In the event that this communication does not occur, a record explaining why it has not occurred should be entered in the resident's clinical file. 5.9 a) As soon as is practicable, and with the resident's consent or where the resident lacks capacity and cannot consent, the resident's next of kin or representative should be informed of the resident's restraint and a record of this communication should be placed in the resident's clinical file. In the event that this communication does not occur, a record explaining why it has not occurred should be entered in the resident's clinical file. b) Where a resident has capacity and does not consent to informing his or her next of kin or representative of his or her restraint, no such communication should occur outside the course of that necessary to fulfil legal and professional requirements. This should be recorded in the resident's clinical file

Table 17 Suggested Headings for Physical Restraint Code

Jurisdiction and Source	Orders for Physical Restraint
Ireland (Code of Practice on the Use of Physical Restraint in Approved Centres, MHC 2009 p.15/16)	Physical restraint should only be initiated and ordered by registered medical practitioners, registered nurses or other members of the multi-disciplinary care team in accordance with the approved centre's policy on physical restraint. 5.3 The consultant psychiatrist responsible for the care and treatment of the resident or the duty consultant psychiatrist should be notified by the person who initiated the use of physical restraint as soon as is practicable and this should be recorded in the resident's clinical file. 5.5 An order for physical restraint shall last for a maximum of 30 minutes. 5.6 An episode of physical restraint may be extended by a renewal order made by a registered medical practitioner following an examination, for a further period not exceeding 30 minutes.
England (Code of Practice MHA 1983, 2016 Chapter 26 p 282)	Service Discretion: Organisational Policy: How restrictive interventions which are used by the provider, should be authorised, initiated, applied, reviewed and discontinued, as well as how the patient should be supported throughout the duration of the application of the restrictive intervention
Scotland Rights Risks and Limits to Freedom, Mental Welfare Commission for Scotland (2021 p.20)	Service Discretion: Organisational Guidelines 4.1.2 Guidelines Direct physical restraint must only be applied under clear guidelines with careful monitoring and review
Wales (Mental Health Act 1983 Code of Practice Review for Wales, Welsh Government, 2016 p.186) Reducing Restrictive	Not evident

Practices Framework A framework to promote measures and practice that will lead to the reduction of restrictive practices in childcare, education, health and social care settings for people of all ages. (2021 p. 19)	Service discretion: local protocols and guidelines Each service should have clear protocols and governance guidelines for the use of restrictive practices, and for monitoring of people during and after use, including the requirements for medical checks
Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021 p.11)	No named professional. The use of restraint should only be used following assessment and decision making measuring the likelihood and severity of the outcome.
South Australia 'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021 p.5).	Authorisation for Physical Restraint: The initiation of physical restraint is only to be on the order of a medical practitioner or nurse practitioner where available, or if not available the most senior clinician on duty. Where a medical practitioner or nurse practitioner is not available in person, phone contact should be made with them.
New Zealand New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021 p.77)	The decision to approve restraint for a person receiving services shall be made: • As a last resort, after all other interventions or de-escalation strategies have been tried or implemented • After adequate time has been given for cultural assessment • Following assessment, planning and preparation, which includes available resources able to be put in place • By the most appropriate health professional • When the environment is appropriate and safe

Table 18 Orders for Physical Restraint by Jurisdiction

6.2.4.2 Section 6: Patient Dignity and Safety

Sections 6.1 to 6.7 of the Irish Code of Practice cover issues relating to patient dignity and safety in the use of physical restraint. The first point covers the issue of advanced directives and indicates that staff who are involved in the use of restraint should be aware of any advanced directives/statements and the particulars of the persons care plan. The previous discussion around this issue relating to seclusion and mechanical means of bodily restraint discussed previously applies also here and should be considered accordingly.

The following two sections refer to considerations around patients with a history of physical and sexual abuse. Given the potential for trauma or indeed re-traumatisation arising from the process of restraint, it may be pertinent to include a history of trauma associated with previous physical restraint or sexual abuse here. Sections 6.4 to 6.7 relate to safety issues associated with the process of physical restraint and how the associated physical risks can be minimised. The measures outlined here are limited but commensurate with the evidence around risks associated with physical restraint. The English Code of Practice offers a more robust assessment process in relation to maintaining safety during restraint which warrants consideration in the Irish context. Sections 26.70 and 26.71 (p.295) in

particular outline specific concerns around the maintenance of the persons airway, ensuring adequate breathing and circulation. It is clear that prone restraint is not permissible in planned or intentional circumstances. Considerations around age, physical and emotional maturity, health status, cognitive functioning and any disability or sensory impairment, which may confer additional risks to the individual's health, safety and wellbeing are highlighted in this section. Additionally, the monitoring of the patient whilst restraint is ongoing is more robust than in the Irish Code, requiring specific delegation to one member of staff to monitor the person's airway and physical condition. Specific observations to be undertaken are identified including, vital clinical indicators such as pulse, respiration and complexion (with special attention for pallor/discolouration). Section 5.25 (p.13) of the Northern Ireland Draft Standard proffers a similar set of requirements to manage risks associated with physical restraint. This document differs from the English Code of Practice in relation to prone restraint and in section 5.22 (p. 12), identifies that prone restraint must not be used in HSC settings unless in exceptional circumstances and when used, restraint can also not be prolonged (exceeding 10 minutes) unless in exceptional circumstances and must follow best practice standards. The standard states that if restraint is required for longer than 10 minutes alternative non-physical interventions such as rapid tranquillisation or seclusion should be considered. This is the only reference found in the regulatory and standards documents reviewed, to substituting one restrictive practice for another. The rationale is not provided.

The Welsh Code of Practice (2016) leaves the issues associated with safety to the discretion of the service in the recommendation that each service has a policy which ensures that prone restraint is only used in exceptional circumstances and where is it essential to maintain the safety of the patient and others. Clear guidelines for staff to maintain the physical wellbeing of a patient, including position and the monitoring of vital signs and the patient's experience of restraint is considered and all efforts made to maintain their privacy and dignity. Whilst these offer overarching statements from which to provide direction to staff, when considering a high-risk activity such as physical restraint, in the context of a national Mental Health System, it would seem more appropriate and equitable to all Service Users, their families as well as staff to develop and apply a standardised, uniform and more detailed approach. This approach should clearly outline the particulars of risks associated with restraint and the specific measures to be taken to mitigate against them as evidenced in the South Australia, England and Northern Ireland Jurisdictions. Furthermore, consideration should be given to taking a more stringent position around the use of prone restraint both from a safety and policy perspective.

The South Australia standard (2021 p. 6, 7) identifies a clear procedure for physical restraint which includes a comprehensive set of requirements aimed at protecting the person's rights and maintaining safety. Prone restraint whilst not prohibited in adults is to be avoided. Considering best practice and addressing safety concerns, the South Australia procedure is the most comprehensive reviewed and may offer a robust approach for consideration in the Irish context. The key issue for the MHC in relation to this issue in the review of the Code pertains to strengthening the existing safety measures in the context of contemporary practices in other jurisdictions as outlined above. Given the dearth of evidence on this issue within the existing search parameters and timelines of this review, it may be appropriate to consult an expert on physical risks associated with physical restraint and provide definitive and contemporary safety guidance accordingly. Standard 1.3 of the Restraint Reduction Network (RRN) Training Standards (Ridley and Leitch, 2021 p. 43) may also provide some guidance here and will also provide robust guidance for section 10, training in the use of physical restraint.

6.2.4.3 Section 8: Ending restraint

Section 7.1 of the Code of Practice outlines the means by which physical restraint can be ended. The person responsible for leading the restraint of the resident and monitoring the head and airway as identified in section 5.2, is the person empowered under the code to end the restraint. However, the decision-making process is not identified and should be based on an assessment of the physical, psychological and behavioural presentation of the patient. Given the risks associated with physical restraint, consideration should be given to identifying the circumstances under which it should be terminated when there is an increased physical, psychological and/or behavioural risk. The Scottish Good Practice Guide recognises potential for increased risk in some circumstances and is clear that "It is completely unacceptable that the use of restraint increases the overall risk to an individual" (2021 p. 22).

As with mechanical restraint, there is minimal reference to ending physical restraint in the international documents. However, the generic standards in Section 26.7 of the English Code of practice (p.282) requires that each service provider have a policy in place which outlines how restrictive interventions which are used by the provider, should be authorised, initiated, applied, reviewed and discontinued. No further guidance is provided in this regard. Merging this with the principle of least amount of time necessary to manage the behaviour and the issues outlined above may provide a more comprehensive approach to the process of ending seclusion within the Irish context.

Section 7.2 relates to debriefing following physical restraint and states that the resident concerned should be afforded the opportunity to discuss the episode with members of the multi-disciplinary team involved in his or her care and treatment as soon as is practicable. This is a consistent measure across the jurisdictions which can prevent or minimise trauma and facilitate learning from the event. Of note the South Australia and New Zealand Standards refer to both patient and staff debriefing processes. Of note the New Zealand document in section 6.2.5 provides the caviat that the debrief should occir only when the person feels ready for this to occur. This warrants consideration in the Irish context to promote a critical review of the use of restraint, identify potential means of avoiding and learning going forward from a staff and organisational perspective.

6.2.4.4 Section 9: Clinical Governance

The section on Clinical Governance begins with a statement which makes clear that restraint must not take place to ameliorate staffing difficulties. This may be better placed in an earlier section titled 'exclusions' before the criteria for physical restraint are outlined.

6.2.4.4.1 Policy

Section 9.2 of the Code of Practice outlines the policy requirements within the Irish context. This section is commensurate with those outlined for both seclusion and mechanical means of bodily restraint. The code identifies a requirement for each approved centre to have a written policy which incorporates the provision of information to the resident and importantly, who may initiate and who may carry out physical restraint. The management of the dissemination and review of the policy is also

outlined. Each jurisdiction has policy requirements around the use of physical restraint, either through generic restrictive practice direction or specific to restraint or both. The requirements by jurisdiction are laid out in Table 18.

Jurisdiction and Source	Service Policy Requirements for the Use of Physical Restraint
Ireland (Rules governing seclusion and mechanical means of bodily restraint, MHC 2006 p. 17)	• Each approved centre should have a written policy in relation to the use of physical restraint. The policy should address the provision of information to the resident and identify who may initiate and who may carry out physical restraint. • The approved centre should maintain a written record indicating that all staff involved in physical restraint have read and understand the policy. • The record should be available to the Inspector of Mental Health Services and/or the Mental Health Commission upon request. • An approved centre should review its policy on physical restraint as required and, in any event, at least on an annual basis.
England (Code of Practice MHA 1983, 2016 Chapter 26 p. 282, 294)	26.74 (p. 294) Provider policies concerning the use of physical restraint should be kept under ongoing review in order to ensure consistency with national policy and best practice.26.7 (p. 282) Generic restrictive practices policy requirements: • Provider policies should include guidance on: • Assessments of risks and support needs • The use of positive behaviour support plans (or equivalent) • How risks associated with restrictive interventions can be minimised in particular: o As assessment of their potential to cause harm to the physical, emotional and psychological wellbeing of patients o How providers will take account of a patients individual vulnerabilities to harm (such as unique needs associated with physical/emotional immaturity, older age, disability, poor physical health, pregnancy, past history of traumatic abuse etc) • How restrictive interventions which are used by the provider, should be authorised, initiated, applied, reviewed and discontinued, as well as how the patient should be supported through the duration of the application of the restrictive intervention • Local recording and reporting mechanisms around the use of restrictive interventions • Post-incident analysis/debrief • Workforce development, including training requirements relating to the application of restrictive interventions, which are underpinned by their therapeutic intent.
Scotland Rights Risks and Limits to Freedom, Mental Welfare Commission for Scotland (2021 p. 15, 16, 20)	• 3.1.4 (p.15) There should be an explicit policy which determines the balance between a person's autonomy and staffs duty to care. The principle aim of any policy, involving the need for the use of restraint, should be to respect and protect human rights • 4.1.2 (p. 20) Guidelines: Direct physical restraint must only be applied under clear guidelines with careful monitoring and review. • 3.1.8 (p.16) Policies on restraint should always be discussed with individuals where possible, and certainly with the immediate family when available. • 3.1.10 (p.16) Policies relating to personal autonomy and restraint should be considered by commissioners of services as part of the process of contracting for a service (p.16)
Wales (Mental Health Act 1983 Code of Practice Review for Wales, Welsh Government, 2016 p. 189) Reducing Restrictive Practices Framework A framework to promote measures and practice that will lead to the reduction of	26.29 (p. 189) A locally agreed policy on restraint should, amongst other matters, ensure: • prone restraint is only used in exceptional circumstances and where is it essential to maintain the safety of the patient and others. • clear guidelines for staff to maintain the physical wellbeing of a patient, including position and the monitoring of vital signs • the patient's experience of restraint is taken into account and all efforts made to maintain their privacy and dignity. The focus of policy and practice should be on the reduction of restrictive practices as part of patient centred care planning (p. 13) Organisations should have a policy that outlines conditions or the use of restrictive practices. This policy should be agreed by senior leadership for the organisation and should reflect up to date statutory guidance placed on them through legislation and guidance (p. 13) This policy should:

restrictive practices in childcare, education, health and social care settings for people of all ages. (2021 p. 10, 13, 16, 17)	• Reference human rights and legal frameworks relevant to the sector and setting • Ensure that definitions of restrictive practices are easily available and embedded through workforce development mechanisms, organisational messages and policy • Have clear protocols and governance guidelines for the use of restrictive practices as last resort, and for monitoring of people during and after use, including the requirement for medical checks • Be easy to understand and apply, and should be communicated to all practitioners, paid carers, people being supported and the families, unpaid carers and external agencies that the organisation works alongside • Make clear that it is never acceptable to use coercion and other forms of social and psychological restraint • Contain guidance about risk assessments which must be undertaken before using any restrictive practice. • Provide clear guidance for the recording of information following the use of any restrictive practice in relation to what is to be recoded when, by whom, and the purpose of the recording • Make clear that the use of any restrictive practice should be recorded even if its use is prescribed in a personal plan • Outline the process for seeking consent for the use of restrictive practices as a last resort to prevent harm to an individual or others Organisations should have a person-centred policy for providing both immediate and longer-term support after any use of restrictive practices, and this should inform the review of the individual plan for the person following any incident (p.16). Safeguarding policy (p. 17) Whistleblowing policy (p. 17) Children, adults and families should also be asked to contribute to policy review and development (p. 22) Organisations should (p. 10): • Have a clear policy in place for all practitioners that helps them to understand their duties under human rights and legal frameworks • Set out in such a policy the organisational commitment to reducing the use of any restrictive practices • Ensure that all practitioners are aware of such a policy and understand its intended impact on their practice
Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021 p.33)	Local and organisational policy frameworks should be co-produced and must include as a minimum: i. the organisational values that underpin the approach to minimising restrictive interventions. ii. the detail of the organisational vision and strategy for minimising restrictive interventions. iii. details of job roles within the organisation with specific restrictive practice minimisation responsibility and accountability. iv. standard definitions. v. clear professional/clinical guidance. vi. reference to working within current legislative frameworks and professional registration requirements. vii. an emphasis on positive, proactive, preventative and evidence-based interventions and strategies viii. how the *Three Steps to Positive Practice Framework* as the organisational methodology for considering and reviewing the use of restrictive interventions is embedded and operationalised. ix. details of accredited training required, including training required for specific interventions. x. communication requirements and strategies. xi. details of interfaces with other regional and local policies, agreed protocols and any associated requirements. xii. reference to clear recording, reporting, monitoring and governance arrangements (including how data will be used in the minimisation strategy). xiii. support mechanisms for those who are subject to restrictive interventions; and xiv. Support mechanisms for staff who have to restrict, restrain and/or seclude those in their care.
South Australia 'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021 p.6).	No policy requirements other than the provisions stated in the State Policy

New Zealand New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021)	None evident

Table 19 Policy Requirements for Physical Restraint by Jurisdiction

6.2.4.4.2 Other governance requirements

Section 9.3 refers to review of physical restraint and indicates that each episode of physical restraint should be reviewed by members of the multidisciplinary team involved in the resident's care and treatment and documented in the resident's clinical file as soon as is practicable and, in any event, no later than 2 normal working days (i.e., days other than Saturday/Sunday and bank holidays) after the episode of restraint. This may be better placed in a section titled 'monitoring and review of physical restraint' under the overall heading of clinical governance. This is the only review process identified in the Irish Code of Practice. This process is minimal compared to other jurisdictions and restrictive practice measures previously discussed here where independent review is incorporated into the process after a minimum duration or a total number of episodes. The absence of an independent or autonomous approach to review may prevent robust and impartial review of the restraint. As such an independent review process incorporated into governance arrangements warrants consideration in the Irish context. Review measures which be incorporated into the governance arrangements for physical restraint.

Of note there is no reference to seclusion and restraint reduction in the context of clinical governance and restraint. The processes around responsibility for overall oversight and review of physical restraint, commensurate with reduction interventions, should be included in the Clinical Governance section. The requirement for minimum reporting arrangements to local or national datasets should also be included here to ensure that the organisation has data from which to develop plans for reduction of restrictive practices, including physical restraint.

6.2.4.5 Section 10: Staff training

This section outlines the requirements for training for staff in Approved Centres in relation to physical restraint. This policy should include, but is not limited to, the following:

a) Who will receive training based on the identified needs of residents and staff
b) The areas to be addressed within the training programme, including training in the prevention and management of violence (including "breakaway" techniques) and training in alternatives to physical restraint
c) The frequency of training
d) Identifying appropriately qualified person(s) to give the training
e) The mandatory nature of training for those involved in physical restraint

These five requirements are appropriate, however the evidence and standards around training in this area have changed significantly since the rules were established. To this end due consideration should be given to the most recent evidence-based training standards document Restraint Reduction Network (RRN) Standards (Ridley and Leitch, 2021) as outlined in Section 3 of this document, particularly around the issue of risks associated with physical restraint.

6.2.4.6 Section 11: Child patients and physical restraint

This section is primarily concerned with informing parents and guardians that a child has been restrained and the need for child protection policies. This is extended in other jurisdictions considerably including in the English Code of Practice which outlines a number of additional considerations in sections 26.52 – 26.61. The need for modifications to restraint processes to take account of the developmental status of children is outlined, specifically size and physical vulnerability. Furthermore, it is made clear that physical restraint should be used with caution when it involves children and young people because in most cases their musculoskeletal systems are immature which elevates the risk of injury. To this end the Code of Practice outlines that staff should always ensure that restrictive interventions are used only after having due regard to the individual's age and having taken full account of their physical, emotional and psychological maturity (26.54 p. 293). Within this context the need for staff to employ a variety of skills when dealing with children and young people both before and during the restraint process is highlighted. Whilst these modifications are not made clear, this highlights the fact that direct application of adult related processes are not appropriate.

The Welsh Code of Practice (2016) also provides for the use of measures appropriate to a child's age and extends to a requirement for training for all staff involved in the restraint of children. Section 26.64 provides specifics around the nature of this training to include the use of these interventions in these age groups, adaptation of the manual restraint techniques for adults, adjusting them according to the child's height, weight and physical strength and finally the use of resuscitation equipment recommended for children.

The South Australia Standard (2021 p. 18) also recognises that children and adolescents have different needs from adults in relation to restraint. Prone restraint is prohibited in children and the need to consider the developmental stage of the child at the decision-making point of the restraint is highlighted. The principle of all practices being the least restrictive and in the best interests of the child must be upheld. Child friendly policies and spaces are required within this standard.

Consideration should be given to expanding the provisions of the Irish Code of Practice to incorporate the salient points outlined herein from other jurisdictions in order to provide a more robust and risk focussed approach for staff engaged in the process of physical restraint of children.

6.3 Chemical restraint

Chemical restraint is not provided for in either regulation or guidance in the Irish context. As such this part of the review aims to support deliberations around this issue. The literature review had commenced when additional terms around this issue were forwarded from the MHC Expert Advisory Group on Restrictive Practice (see section 4). Therefore, a separate search was undertaken which yielded 11 papers. Of these papers, 6 examined rapid tranquillisation from a psycho-pharmacological perspective. These were excluded from this review as there was no reference to coercion, forced medication or involuntary administration of medication in any of these six papers. Of the 5 remaining papers, 2 were systematic reviews, 2 were meta-analyses and 1 was a survey research. 1 evidence-based consensus paper informed some definitional issues. The Joanna Briggs Institute critical appraisal checklist for the relevant methods was used to assess the quality of each study (JBI, 2020). The studies are summarised in Appendix 8.

Additionally, a number of documents from the comparable jurisdictions provided definitions and guidance on the issue.

Two key considerations emerged from the literature in relation to chemical restraint, the first relates to terms and definitions used to identify or categorise the issue as a restrictive practice, the second relates to best practice procedures and monitoring.

6.3.1 Terms and definitions

A number of terms appear to be used interchangeably in the literature; however, all have different connotations and implications when discussing this issue. The terms identifiable from this review are as follows:

Chemical restraint	Forced medication	Rapid tranquillisation
Pharmacological restraint	Medication as restraint	Involuntary medication
Non consenting administration of medicaiton	Coercive medication	Rapid titration (term used less often)

Table 20 Terms used to describe Chemical Restraint

It is important to note that it is unlikely that there will be a term will be acceptable to regulators, prescribers, healthcare professionals, administrators, Service Users and other stakeholders alike. Within the context of restrictive practices, the issue, as with other restrictive practices, is complex and

has amassed considerable concern in the context of contemporary psychiatry and human rights. The fact that so many terms are used interchangeably suggests a struggle to clearly label this issue consistently. However, in the context of this report, what is desired is an overarching approach to what is initially (for the purpose of clarity) referred to as chemical restraint (CR). The first issue is to attempt to clarify the definitional elements prevalent in the literature.

International variability in practices and in definitions of chemical restraint renders it difficult to establish a consistent definition (Robins et al 2021; Muir-Cochrane et al 2020). A recent meta-analysis undertaken by Muir Cochrane et al (2020) found 18 definitions of chemical restraint. All differed, however Muir Cochrane et al (2020 p. 429) found that there were consistencies across the 18 definitions which were noted to be a description of the use of medication, whether it was administered forcibly with or without consumers consent, and to control agitated or violent behaviours associated with mental health disorders that endangered the person or others. 16 of the 18 papers agreed that chemical restraint was a risk management strategy as opposed to therapeutic intervention. Similarly, in their review of all definitions of physical and chemical restraint in 86 papers, Patel et al (2018) found 51 discreet explicit definitions of physical restraint and 4 discreet explicit definitions of chemical restraint. This gives an indication of the extent of diversity of approaches in terms of definitions, which undoubtedly has an impact on diverse practices. The heterogeneity of definitions is compounded by the fact that there are no commonly accepted definitions across the spectrum of healthcare for behaviours such as acute disturbance, agitation, aggression and violence, which chemical restraint is normally intended to address (Patel et al 2018). With extensive debates on the issue and no international consensus, there is a risk that collective wisdom at a professional and organisational level forms the basis of this practice as opposed to a strong evidence base which is an expected norm in contemporary healthcare.

An extensive review by Muir Cochrane et al (2020) used the terms chemical restraint and rapid tranquillisation (RT) interchangeably. The authors identified forced medication and rapid tranquillisation to be the terms most used commensurate with CR in their review. The definition applied for their systematic review was: ‘Chemical restraint (CR), also known as rapid tranquillisation, is the forced (non-consenting) administration of medications to manage uncontrolled aggression, agitation or violence in people who are likely to harm to themselves or others’ (Muir-Cochrane et al 2020 p. 928). Clear distinction between consent and non-consent is an important feature of this definition, with non-consent being the differentiating factor between a person being chemically restrained or not. This further complicates the matter as to administer medication without consent involves physical restraint and administration of medication parenterally (Patel et al 2018). Consent issues are closely linked to process issues with RT. Recently identified terms such as enforced/forced medication and coerced intramuscular medication are highlighted by Nash et al (2018) to be more process oriented and focused on the fact that RT may be administered against a persons will. Their study reinforced this finding with a significant number of definitions proposed by participants being more outcome oriented with a focus on the desired result being calmness (Nash et al, 2018). Moreover, In the context of consent and pharmacological restraint, Stagg (2020 p.2) proposes ‘that the use of pharmaceuticals for therapeutic purposes is not considered restraint’.

Whilst RT is predominantly administered parentally, it is also administered orally (Nash et al 2018). NICE guidelines (2022) propose that rapid tranquillization is the use of medication by the parenteral route if oral medication is not possible or appropriate and urgent sedation is required. This implies

that the route of administration is considered a critical factor in determining if the administration of the medication is RT or not, specifically that RT is administered parenterally, and that oral medication is not considered RT.

The motivation or the desired effect for the administration of medications proposed to be effective in rapid tranquillization is critical in determining if the administration of the drug is for therapeutic purposes or to subdue or restrict a persons movement, which is the essence of restraint. It can be argued that where a person gives informed consent to the administration of a medication associated with RT for therapeutic purposes and subsequently takes this medication orally without duress, then this cannot be regarded as a restrictive practice, chemical restraint, forced medication, RT or any other commensurate term. Therefore, the issues in determining chemical restraint appear to be related to desired effect, consent, administration process and desired outcome.

This approach is closely aligned with the outcome of the review by Muir-Cochrane et al (2020 p. 935) whereby the most common ways CR was described in the studies reviewed related to what CR did, to whom, when and why CR was administered. The approach also resonates with the findings of the systematic review undertaken by Robbins et al (2021) which identified 7 thematic elements within definitions of physical and chemical restraint. With reference to chemical restraint, only four definitions were found, which were represented in two themes as follows:

- Restraint method- the medication class (no specific medications identified)
- Stated intent- The intent to control behaviour

These approaches are synthesised into 4 factors (See Table 20) to support the critical deliberation of existing international definitions from the comparator jurisdictions in order to inform the Irish context in this regard. These factors are important as they are measurable in practice and so any definition addressing these issues will be suitable for standardised implementation and data collection which is essential in monitoring restrictive practices. However, none of the international definitions cover the issues outlined in the four factors and indeed are so diverse that it is not possible to synthesise the existing definitions into one for consideration. Therefore, it is suggested here that the key considerations, from the literature, for the Mental Health Commission in determining a definition for Ireland is to incorporate the desired effect (manage risk, safety etc), consent (non), administration process (parenteral) and desired outcome (subdue, restrain, calmness etc).

Reference	Term	Definition	Stated intent Control/Therapeutic	Consent	Method Medication class	Administration Process Parenteral/Oral	Desired Outcome Subdue/Therapeutic
England: Code of Practice, Mental Health Act 1983 (26.91) (DoH, 2015 p. 298)	Rapid Tranquillisation	Rapid tranquillisation refers to the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression. This may provide an important opportunity for a thorough psychiatric examination to take place. Prescribers should aim to ensure that the degree of sedation arising from rapid tranquillisation does not compromise the patients capacity to understand and respond to what is said to them.	Not referred to	Not referred to	Not referred to	Not referred to	Calm or lightly sedate
England: NICE Guidelines (2020 p.15)	Rapid Tranquillisation	The Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed	Not referred to	Not referred to	Not referred to	Both	Urgent sedation
Scotland: Use of Seclusion: Good Practice Guide (3.8.1) (MWC, 2019 p.30) Rights Risks and Limits to Freedom, Mental Welfare Commission for Scotland (2021)	Medication as restraint	This is the use of sedative or tranquillising drugs for purely symptomatic treatment of restlessness or other disturbed behaviour. Drug treatments for medical or psychiatric conditions which underlie the disturbance are not included. For example, an antidepressant may be prescribed to treat a person who is suffering from depressive illness, one of the symptoms of which is agitation. It must be recognised, however, that the boundary between these two methods of drug use is not always clear. For example, it is sometimes postulated as a justification for tranquilliser use that restlessness is due to an underlying, but unidentified, distress.	Not referred to	Not referred to	Not referred to	Not referred to	Symptomatic treatment of restlessness or other disturbed behaviour

Wales: Mental Health Act 1983 Code of Practice Review for Wales (26.34, 26.37) (Welsh Government, 2016 p. 188)	Rapid tranquillisation	Other than in exceptional circumstances, behaviours that challenge should only be controlled by rapid tranquilisation after careful consideration, risk assessment and as part of an agreed care and treatment plan. Restraint may be used to administer medication, or other forms of treatment, to an unwilling patient, where there is legal authority to treat the patient without consent. It should never be used unless there is such legal authority.	Control	Non consent addressed	Not referred to	Not referred to	Not referred to
Wales Reducing Restrictive Practices Framework: A framework to promote measures and practice that will lead to the reduction of restrictive practices in childcare, education, health and social care settings for people of all ages. (2021 p.23)	Chemical restraint	This sometimes refers to the use of medication to manage an individual's behaviour. This can include either medication administered via intra-muscular injection or given orally. It includes medication routinely prescribed or used 'as required'.	Manage behaviour	Medication routinely used or 'as required'	Not referred to	Intra-muscular or oral	Not referred to
Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021 p.8)	Chemical restraint	The use of medication, which is prescribed and administered for the purposes of controlling or subduing acute behavioural disturbance, or for the management of on-going behavioural disturbance.	Control/Subdue	Not referred to	Not referred to	Not referred to	Not referred to
South Australia 'A standard to reduce where possible the use of restraint and seclusion as applied	Chemical restraint	Chemical restraint refers to the use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behaviour of a patient which restricts the person's	Control of acute or episodic aggressive behaviour	Drugs or chemicals	Not referred to	Not referred to	Sedate/Semi stuporous

under the MHA 2009', (Gov SA, 2021 p.19)		freedom of movement by rendering the person sedated or semi stuporous.					

Table 21 Review of Definitions of Chemical Restraint by Jurisdiction

6.3.2 Best Practice Procedures

6.3.2.1 Evidence

The literature reviewed offers little in relation to what is considered to be best practice in the area of monitoring and safety with regards to Chemical Restraint. In the absence of a robust evidence base, Nash et al (2018) suggest that clinicians rely on local protocols or guidelines to guide practice. Nonetheless contemporary governance in healthcare requires that all policies and procedures are evidence based (HSE, 2016). Without an evidence base, policies are based on normative practices and acquired experience which may or may not provide for best practice or risk issues in the area. However, Nash et al (2018) provide a synthesis of post RT monitoring from the literature which can inform this issue. As part of the development of the consensus statement on chemical restraint, Patel et al (2018) also reviewed physical health monitoring requirements for RT from the literature and conditions which may increase risk. The approach taken was the identification of the risks of adverse side effects from the literature and plan for monitoring accordingly. These are now merged with the synthesis undertaken by Nash et al (2018) to enumerate the requirements for monitoring post RT - outlined in Table 21.

Conditions/Issues that exacerbate risk	**Caution/Risk**	**Observation**	**Frequency Options**	**Other**
Pregnancy If higher than BNF recommended dose administered Illicit drugs or alcohol use Pre-existing physical health concerns	Extra pyramidal side effects Sedation Respiratory depression QTc prolongation and risk of arrythmia Postural hypotension Increased seizure potential Neuroleptic malignancy syndrome	Physical: Blood Pressure Pulse Pulse oximetry Respiration Ease of breathing Temperature Skin Colour Cyanosis Consciousness level Level of sedation Body and head posture Side effects Hydration level Blood test (which not stated) If patient is too agitated or there is risk associated with hands on observations the following is recommend: Respiratory rate Level of consciousness Pallor Observable signs of pyrexia Evidence of dystonia Evidence of dyskinesia Signs of dehydration	Every 10 minutes for 4 hours post RT Every 5-10 minutes for 1 hour, then every 30-60 minutes until patient is ambulatory or for up to 4 hours At least hourly until there are no concerns or every 15 minutes in certain circumstances (not identified)	Nurse presence (timescale not identified) 1:1 continuous observation If person is in seclusion additional measures may need to be taken to monitor safety Vigilant monitoring and documentation when physical restraint is used Use of NEWS tool
		Post incident psychological effects	Not stated	

Table 22 Post RT observations and risks adapted from Nash et al (2018) and Patel et al (2018)

A standardised approach to frequency of monitoring based on critical, high, medium and low risk is further identified by Patel et al (2018) see Fig. 8. This alternative approach may offer a valuable and more streamlined framework for practice. Regardless of the evidence base or approach, it is clear that there are key issues that must be monitored and taken into account when RT is used.

Table 7. Direct contact monitoring levels

Level	Criteria	Physical monitoring schedule	Suggested minimum psychiatric observations
Low	All patients following pre-RT medications	NEWS or equivalent every hour for minimum 1 hour	Standard psychiatric observations every hour
Medium	All patients post IM RT, who do not require high/critical level monitoring	NEWS or equivalent every 15 minutes for minimum 1 hour	Intermittent psychiatric observations every 15 minutes
High	All patients post IM RT, who are over-sedated, asleep, or significantly physically unwell	NEWS or equivalent every 15 minutes for minimum 1 hour and include pulse oximetry until patient is ambulatory	Continuous (within line of sight)
Critical	All patients post IV RT as well as patients who are unconscious (not rousable) or severely physically unwell	Continuous monitoring and resuscitation facilities are essential	Continuous (within arm's length)

IM: intramuscular; IV: intravenous; NEWS (National Early Warning Score): temperature, pulse, systolic blood pressure, respiratory rate, oxygen saturation, level of consciousness; RT: rapid tranquillisation.

Figure 19 From Patel et al (2018 p. 628)

6.3.2.2 International comparators

Further evidence to support deliberations on the issue of chemical restraint can be found from international comparators. For the purpose of this review the key issues will be presented by jurisdiction and collated into critical areas for consideration for Ireland. Each of the international comparators for this review have guidance on the issue of chemical restraint, which may also be referred to by terms outlined in Fig 19. For convenience, NICE evidence- based guidance on RT (NICE 2022), is included here.

Guidance specific to RT in The English MHA 1983 Code of Practice (2015) primarily outlines guidance around the prescribing of RT, however there is a non-specific reference to post RT observations. The former NICE guidance (NG10, 2015) is referred to in most of the international documents on RT. However, this guideline has now been reviewed and so the updated 2022 version is referred to herein. NICE (2022 p.8) outlines a specific medication protocol to be followed by clinicians when considering and prescribing RT. Factors to be considered pre administration of RT and specific monitoring actions are outlined. In addition, there is additional guidance for the event that RT is administered in seclusion. This matter should be given consideration within the Irish context to ensure that additional risks posed by that circumstance are planned for and managed.

In addition to already identified considerations, the Scotland document raises the issue of consent within legislative process. Furthermore, this guideline raises the issue of covert medication in the context of RT and the control of drugs is also referred to. A requirement for a formal post incident review of all CR or RT is made clear in the Draft NI document and the South Australian document and

it is noted that long term chemical restraint is prohibited in South Australia. In the context of restrictive practices, these issues warrant consideration to bring the regulation or governance of chemical restraint into line with other restrictive practices such as restraint and seclusion. The three steps to positive practice framework is advocated for use in determining what constitutes CR and what does not.

It was possible to structure all guidance reviewed into Pre RT, Administration of RT and Post RT as evidenced in Table 22. This may support deliberations in these stages of the RT process. Given the risks associated with this high-profile activity, it is surprising how diverse the guidance remains in terms of focus and content. However, the NICE guidelines are referred to in most instances and therefore warrant consideration as a baseline to work from in considering the critical issues requiring national guidance and/or regulation.

Jurisdiction and Source	**Term Used**	**Management of CR, RT or commensurate term by Jurisdiction**
England (Code of Practice MHA 1983, 2016 Chapter 26 p. 296)	Rapid Tranquillisation	• To be used as a very short-term strategy to reduce immediate risk- distinct from treating any underlying mental illness. **Pre RT:** • Characteristics or behaviours which warrant RT are clearly identified. • IM and Oral routes of administration, with oral being the preferred option • To be prescribed in accordance with NICE guidelines, legal and professional regulations **Administration of RT:** • Staff prescribing rapid tranquilisation are responsible for noting required post RT observations and monitoring and must make that clear to staff caring for the patient • Prescriber must list the factors to be considered in determining the route of the medication if a choice is indicated • Where administration is intramuscular (IM) the site options must avoid prone restraint • Physical restraint to administer RT must not be used unless there is such legal authority, whether under the Act (see provisions for treatment in chapter 24), the MCA or otherwise. • RT must not be used to treat an informal patient who has the capacity to refuse treatment and who has done so. • The decision to use restraint should be discussed first with the clinical team and should be properly documented and justified in the patient's notes **Post RT** • Following the administration of rapid tranquillisation, the patient's condition and progress should be closely monitored (not specified) • Subsequent records should indicate the reason for the use of rapid tranquillisation and provide a full account of both its efficacy and any adverse effects observed or reported by the patient.
NICE Guidance Restrictive interventions for managing aggression in adults (2022 p. 8)	Rapid Tranquillisation	• Specific protocols around medication to be prescribed and under what conditions outlined throughout. **Pre RT:** • Issues for consideration prior to prescribing include pre-existing conditions, possible interactions with other medications, possible response to the RT, potential interactions with other prescribed medication and maximum daily dosages. **Post RT:** • Side effects • Physical observations: Pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness • At least every hour until there are no further concerns about their physical health status.

		• Every 15 minutes if the BNF maximum dose has been exceeded or the Service User: appears to be asleep or sedated, has taken illicit drugs or alcohol has a pre-existing physical health problem or has experienced any harm as a result of any restrictive intervention. **RT during seclusion:** • To be undertaken with caution following the recommendations above • Be aware of and prepared to address any complications associated with RT • Ensure the Service User is observed within eyesight by a trained staff member • Undertake a risk assessment • Consider ending the seclusion when rapid tranquillisation has taken effect.
Scotland Rights Risks and Limits to Freedom, Mental Welfare Commission for Scotland (2021 p. 30)	**Medication as restraint**	**Pre RT** • A full and clear multi-disciplinary assessment of the symptoms of disturbance and their causes is essential before drug treatment of disturbed behaviour is considered. • In most cases drug treatment can be avoided unless there is a clear underlying cause, such as a medical condition, depression, fixed delusions, severe anxiety or emotional lability • There are enormous variations in individual responses to drugs and in some cases a process of 'trial and error' will have to be used. The role of the doctor is central to this. • Consent to be considered under the appropriate legislation. **Administration of RT** • The giving of medication, for whatever reason, without the consent or knowledge of the individual is potentially an assault and should only be considered in exceptional cases. **Post RT** • In most cases drug treatment can be avoided unless there is a clear underlying cause, such as a medical condition, depression, fixed delusions, severe anxiety or emotional lability • Side effects must be carefully monitored

Wales
(Mental Health Act 1983 Code of Practice Review for Wales, Welsh Government, 2016 p.190)
	Use of medication: Rapid Tranquillisation	**Pre RT**
		• Behaviours that challenge should only be controlled by rapid tranquilisation after careful consideration, risk assessment and as part of an agreed care and treatment plan
		• Local protocols should be in place covering all aspects of rapid tranquillisation. Should include:
		  ○ Legal issues
		  ○ Advanced statements/directives
		  ○ Patients physical condition and history
		  ○ Post RT monitoring to be put in place
		Administration of RT
		• Restraint may be used to administer medication, to an unwilling patient, where there is legal authority to treat the patient without consent. It should never be used unless there is such legal authority

Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021)	Chemical restraint	**Pre CR** • circumstances under which CR can be considered outlined and efforts required to avoid **Administration of CR:** • Distinction made between CR and RT here. RT can be administered parenterally if patient will not take oral **Post CR:** • All episodes of CR or RT must have a formal incident review for each episode of administration Issues relating to administration of medication which is not intended to be CR but results in a restrictive result raised here. 3 positive steps recommended to support a review of here.
South Australia	Chemical restraint	**Pre CR**

'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021).		• Only for use in an emergency and when all other efforts have failed • Must be a CR service best practice protocol (regularly reviewed) describing the clinical indications for each medication, contraindications, progressive escalation and the level of physical monitoring required. • Must be a procedure for administration and monitoring • Long term CR prohibited • Authorisation by paramedic, medical practitioner or nurse practitioner **Administration of CR** • Paramedic, medical practitioner, nurse practitioner **Post CR** • Post monitoring commensurate with the risks and other restrictive practices • Debriefing of patient and staff • Review: The treatment team will meet with senior clinicians of the unit to review the incident the next day and to prepare plans to reduce and eliminate this intervention for the particular person who was chemically restrained or other persons in similar circumstance • Incident report to be completed post IM or IV CR

Table 23 Management of RT or CR by Jurisdiction

6.4 Other Restrictive Practices

This section will review the extended categorisation of restrictive practices outside of seclusion, physical restraint, mechanical restraint and chemical restraint, already discussed in this review. The aim is to provide the MHC with a precis of the approaches taken by the international comparators around what is considered restrictive practice and what are the key issues considered in their use. The documents used to inform this section are those recommended by the International Experts for each jurisdiction as identified in the previous section on Table 4 and as follows:

Jurisdiction	Document
England	Code of Practice, Mental Health Act 1983 (DoH, 2015)
Scotland	Use of Seclusion: Good Practice Guide (MWC, 2019) Rights Risks and Limits to Freedom, Mental Welfare Commission for Scotland (2021)
Wales	Mental Health Act 1983 Code of Practice Review for Wales (Welsh Government, 2016) Reducing Restrictive Practices Framework: A framework to promote measures and practice that will lead to the reduction of restrictive practices in childcare, education, health and social care settings for people of all ages. (2021)
Northern Ireland	Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021)
South Australia	'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021)
New Zealand	Guidelines on the use of Seclusion (2010) New Zealand Standard NZS 8134:2021: Health and Disability Services Standard

6.4.1 What is considered restrictive practice?

The term restrictive practice is a relatively new one in the context of Mental Health Services. It characterises a group of interventions or practices commonly used historically to manage difficult or challenging behaviours presenting in the context of inpatient care. International comparators have attempted to make clear what constitutes restrictive practice within their jurisdiction from both a narrow perspective (restraint and seclusion) and a broad perspective (coercion, locked doors etc). However, wherever a restrictive practice has been identified, they are regulated and/or governed by standards or guidance accordingly. Jurisdictions adopting an overarching restrictive practice approach include England, Northern Ireland and Wales (in the most recent 2021 document). The remaining jurisdictions have identified restrictive measures individually with corresponding definitions and requirements for use. Restraint and seclusion have been robustly discussed and critiqued using a similar approach, as such only restrictive practices outside of physical restraint, mechanical restraint and seclusion will be addressed here. Available definitions and restrictive practices referred to in the Jurisdictional documents are presented in Table 24.

As evidenced in Table 24, restrictive practices given attention in the various jurisdictions vary considerably outside of physical restraint, mechanical restraint and seclusion. Those that are subjected to regulation or guidance vary between a minimum of seclusion and restraint up to nine practices identified as restrictive in nature. Those jurisdictions that consider the wider aspects of restriction in practice, consider the human rights and person-centred issues in a broader sense and any action or intervention that may contravene these needs careful consideration. These practices may be clearcut or not so obvious as indicated in the Scottish Rights, Risks and Limits to Freedom document (MWC, 2021). These are referred to as 'softer' methods of limiting freedom such as verbal control, psychological pressure or social exclusion which can be as restrictive in nature as actual physical restrictive practices. An example provided includes unfriendly, brusque or bullying attitudes by staff which do not encourage individuals to ask for help to move to another room or go to the toilet- these can be seen as having a restraining effect on the freedom of movement of the individual concerned (SWC, 2021 p.7). The Northern Ireland draft standard (Gov NI 2021 p. 9) echoes this approach and views restrictive practice from those that are obvious (physical restraint and seclusion) to those that are less obvious, including coercion and psychological measures like controlling how often and for how long someone watches television.

To mitigate against uncertainty, confusion or dilemmas on the issue, the Northern Ireland draft standard (Gov NI, 2021) identifies a framework to support staff deliberations around what constitutes a restrictive practice and to identify not only the least restrictive means of dealing with presenting challenging behaviours, but a positive approach to intervening (RCN, 2017). This is a commendable approach which anchors critical review and reflection by practitioners within a Human Rights framework and empowers an alternative less restrictive, more positive approach. This kind of approach should be given consideration within the Irish context. Furthermore, the NI Draft Standard proposes that 'organisations must identify and include all potentially restrictive interventions, including those that are not always obvious' (p.9). This approach also warrants consideration in the Irish context as it would provide a clear pathway for staff to ensure that restrictive practices are considered across the spectrum of care practices and will support the wide scale culture change that is needed to reframe current practices.

Jurisdiction and Source	Definitions of Restrictive Practice	Restrictive Practices Outlined
England (Code of Practice MHA 1983 (2016 p. 290)	Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to: • take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and • end or reduce significantly, the danger to the patient or others.	Enhanced observation Physical restraint Mechanical restraint, Rapid tranquillisation Seclusion Long-term segregation
Scotland Rights Risks and Limits to Freedom, Mental Welfare Commission for Scotland (2021)	Definitions by individual practice	Direct physical restraint Direct mechanical restraint Locking the doors Wandering technology Video surveillance Passive alarms Medication as restraint Indirect limits to freedom

Wales (Mental Health Act 1983 Code of Practice Review for Wales, Welsh Government, 2016) Reducing Restrictive Practices Framework A framework to promote measures and practice that will lead to the reduction of restrictive practices in childcare, education, health and social care settings for people of all ages. (2021 p.3)	Definitions by practice 'Restrictive practices are a wide range of activities that stop individuals from doing things that they want to do or encourages them to do things that they don't want to do. They can be very obvious or very subtle.' (Care Council for Wales, 2016)1 This term covers a wide range of activities that restrict people. It includes: • physical restraint • chemical restraint • environmental restraint • mechanical restraint • seclusion or enforced isolation • long term segregation • coercion	Observation Restraint Use of medication (includes RT) Seclusion Locked doors Physical restraint Chemical restraint Environmental restraint Mechanical restraint Seclusion or enforced isolation Long term segregation Coercion
Northern Ireland Draft Regional Policy on the use of Restrictive Practices in Health and Social Care Settings And Regional Operational Procedure for the Use of Seclusion (2021 p.5, p.8)	Restrictive Practice is an umbrella term that refers to the entire range of interventions that are considered restrictive and which infringe a person's rights. Restrictive practices are those that limit a person's movement, day to day activity or function Also definitions by practice	Environmental Psychological Coercion Observation Restraint Clinical holding Mechanical restraint Chemical restraint Seclusion
South Australia 'A standard to reduce where possible the use of restraint and seclusion as applied under the MHA 2009', (Gov SA, 2021).	Definitions by practice	Mechanical restraint Physical restraint Chemical restraint Seclusion Acknowledgement that there is a broad range of other restrictive practices that may occur- not identified
New Zealand New Zealand Standard NZS 8134:2021: Health and Disability Services Standard Governance issues (2021)	Definition by practice	Seclusion Restraint

Table 24 Restrictive Practices and Definitions by Jurisdiction

6.4.2 International comparators principles and restrictive practices

All jurisdictions clearly identify underpinning philosophical or values-based principles to the issue. Every jurisdiction adopts a human rights approach or baseline to varying degrees, with the rights to freedom, dignity and autonomy consistently referred to. In addition to consideration of human rights, some jurisdictions have added other baseline values or approaches which set the tone for what is expected in practice. In addition to human rights issues as the framework for consideration of restrictive practice, the Scottish document highlights the need for a caring ethos and the Code of Practice for the Mental Health Act 1983 (Wales) (2016) adopts a preventative stance requiring alternatives to restrictive practices and providing specific good practice guidance on options to do so.

Similarly, the Northern Ireland Draft Standard is underpinned by the principle of early intervention and positive practice to minimise and eliminate the occurrence of restrictive practices and to promote the principle of least restriction.

Consideration should be given in the Irish Context to the explicit identification of a Human Rights (HR) Framework to support all issues relating to the use of restrictive practices in clinical practice. The Scotland document is a good example of how to approach HR issues in this context. However equally good examples can be found in the other jurisdictions. In addition to the framework, other underpinning principles can be identified in accordance with the Irish approach to mental health care. Examples of these in the international context include, the principles of early intervention, least restriction and positive practice.

6.4.2.1Approaches to identified restrictive practices

The majority of the comparator jurisdictions provide an overview of restrictive practices, the principles to underpin all deliberations and actions, the policy and procedural issues common to all as well as restriction specific guidance. There are some elements within this that allow for service provider discretion, for example authorisation of physical restraint (England). It is possible to synthesise all of the guidance to identify a robust framework for the development of guidelines on restrictive practices. Reflective of existing approaches, this framework considers seclusion, restraint, mechanical restraint and chemical restraint to be the practices requiring mandatory policy and procedures within the legislative framework as evident in the comparable jurisdictions. The wider restrictive practices for consideration, and associated requirements are identifiable and together provide a robust approach which can support the development of regulatory and/or practice guidance within the Irish context (see Fig. 20).

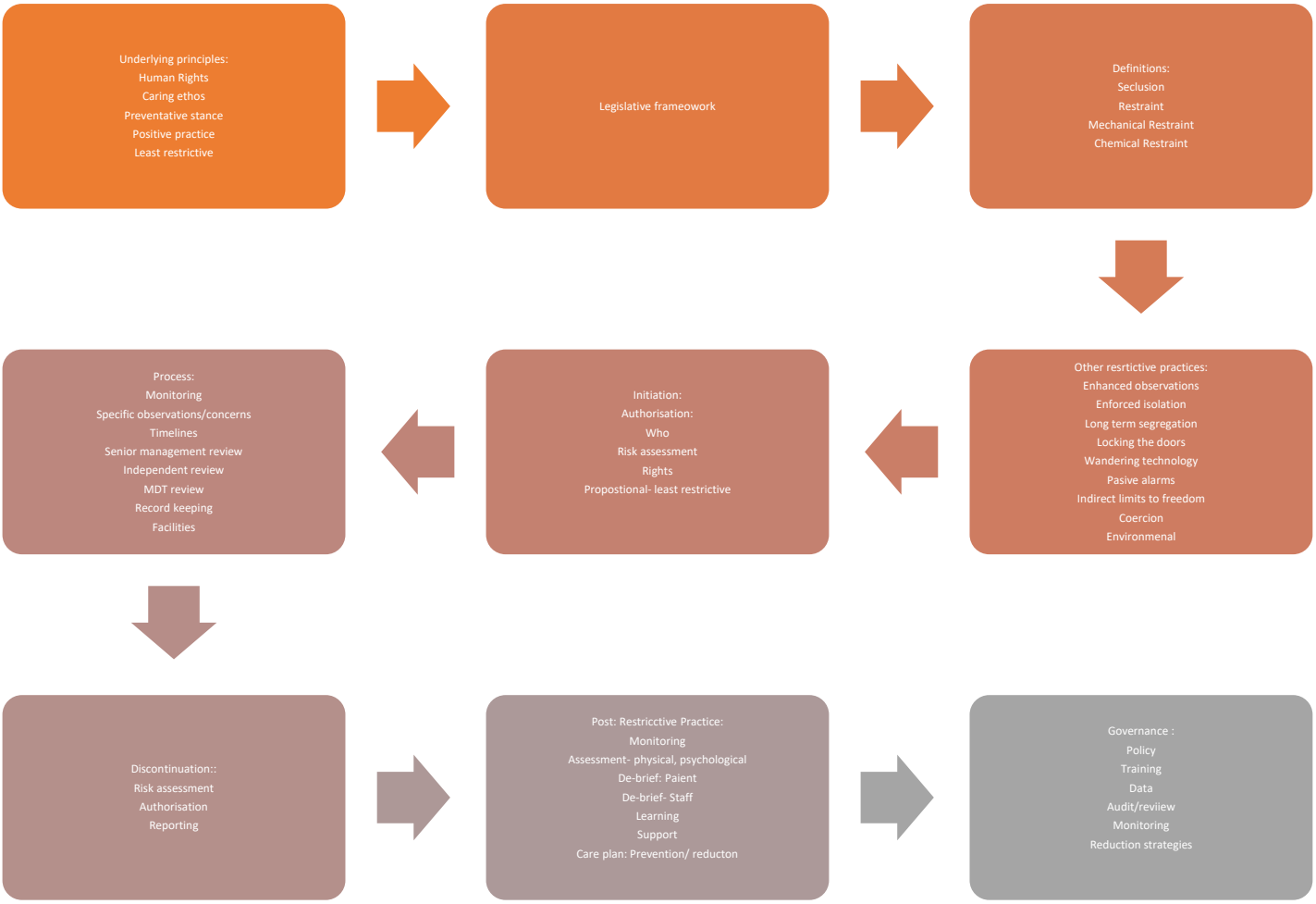


Figure 20 Framework for the development of guidance on restrictive practices, synthesised from comparator jurisdictions

7 Summary of Sections

7.1 Background and Irish Context

Over the past two decades there has been an increasing interest in restrictive practices, in particular, seclusion, physical restraint, mechanical restraint and chemical restraint. This interest has been impelled by international imperatives (UN, 1991; UN, 2006; WHO, 2019) which have required a focus on restrictive practices which impact on human rights. Additionally, evidentiary developments delineating issues around the use of these measures, including factors precipitating and impact, have changed the frame of reference for restrictive practices. Moreover, the potential physical and psychological iatrogenic harm associated with seclusion, physical restraint and mechanical restraint is now well noted (Cheize, Hurst et al 2019). Together, these imperatives have resulted in an international and national agenda around the reduction and elimination of restrictive practices, in particular seclusion, physical restraint and mechanical restraint.

Within the Irish context the Mental Health Commission (MHC) has provided regulatory and practice guidance on the use of seclusion and mechanical means of bodily restraint (MHC 2009) and physical restraint (2009). Following extensive consultation with experts and stakeholders, a strategy for the reduction of seclusion and restraint in Irish Mental Health Services was published in 2014 (MHC, 2014). This strategy had a strong evidence base and provided services with a suite of actions designed to support reduction in the use of seclusion and restraint. However, despite this, seclusion and restraint remains a feature of Irish Mental Health Care and there has been little difference in reporting trends over time. In fact, the MHC reports on activity on the use of seclusion and restraint in approved centres show that physical restraint has increased in the intervening period.

To this end and in the context of the review of the MHA (2001), the MHC is reviewing the evidence and international practices associated with restrictive practices in order to progress a contemporary evidence- based approach to the issue in Ireland, that is commensurate with evidentiary, international and national legislative imperatives.

7.4 International Review

Comparator jurisdictions were limited to allow for review in the given timeframe and were identified for the purpose of this review by the MHC oversight group. These jurisdictions were England, Scotland, Wales, Northern Ireland, South Australia and New Zealand. The process for review involved local jurisdictional experts and a desktop review of documents recommended as essential to the remit of this review.

All jurisdictions adopt a Human Rights approach and have a focus on reduction of restrictive practices to varying degrees. Furthermore, each jurisdiction has published important national guidance around restrictive practice either in final draft or complete for implementation in 2021. These documents have provided a wealth of evidence and best practice-based information to support changes in the Irish context.

Considerations for the Irish context are identified by jurisdiction. They can be broadly summarised as follows:

- Consider values-based approach to legislation and guidance. Minimum but not limited to Human Rights.
- Consider providing guidance and evidence around antecedents of different challenging behaviours resulting in restrictive practices.
- Consider adding chemical restraint for regulation in the Irish context. Consider adding other restrictive practices such as increased observations and search.
- Consider some of the good practice approaches to debriefing to strengthen the Irish approach.
- Consider progressing the issue of advanced statements in the mental health context.
- Consider service user led approaches to monitoring of data and processes.

7.5 Literature

A review of the evidence associated with restrictive practices was presented by inpatient population as follows:

- Reduction systematic reviews
- Reduction studies
- CAMHS
- Acute Inpatient
- Forensic
- Mental health care for older people inpatient (MHCOP)
- Other

A total of 102 papers were included in this review. Each section was subjected to thematic analysis. Based on the findings in each section, considerations for Ireland were identified from the evidence at the end of each section in no particular order.

The evidence associated with seclusion and restraint reduction supports the need for a multi-intervention or 'bundled' approach at all organisational levels. This is likely to be more effective when implemented through a Quality Improvement Project (QIP) process which allows for local specific issues relating to restrictive practices and change management to be addressed.

Evidence associated with the identified mental health specialist categories was broadly similar and overall can be categorised into antecedents of restrictive practices, restrictive practices and the consequences of restrictive practices. Broadly speaking there is little change in the findings over time, however there is more of a focus on patient related precipitating factors. This may be due to the availability and exploitation of large databases of electronic records relating to restrictive practices.

The majority of the evidence originates from the adult inpatient category. It is noted that evidence from Mental Healthcare of Older People (MHCOP) is severely limited within the time parameters and that there is a dearth of evidence associated with young people and children's (CAMHS) experiences of restrictive practices.

Considerations for Ireland from the literature can be broadly summarised as follows:

- Consider a 3-tier approach to seclusion and restraint reduction (national, organisational and local).
- Consider the use of QIP related approach to reduction of restrictive practices.
- Consider approaches to support an evidence-based approach to proportionality and least restrictive means of managing aggression.
- Consider supervisory requirements for restrictive practices to be Registered Nurses.
- Consider engagement models as a means of avoiding and/or minimising restrictive practices.
- Consider prioritising funding for research into MHCOP and CAMHS around experiences of restrictive practices.
- Consider progressing advanced directives in relation to restrictive practices in mental health and further developing de-briefing processes in line with findings.
- Consider providing an evidence-based suite for interventions to support staff to avoid restrictive practices.

7.3 Critical Review of Rules Governing Seclusion and Mechanical Means of Bodily Restraint and Code Governing Use of Physical Restraint in Approved Centres

Critical documents identified by the jurisdictional experts were reviewed and a comparative analysis against the Irish rules was undertaken. The review is timely in the sense that all jurisdictions have adopted a Human Rights Approach to varying degrees. There is an absence of such an approach in the Irish context.

Overall, the Irish guidance, codes and rules are reflective of good evidence in the area. However, the Rules and Code are limited in areas relating to underpinning Human Rights principles. Furthermore, there is an absence of independent review in the Irish context which is fairly extensively adopted in the International Jurisdictions. Monitoring measures need to be strengthened in the light of findings and there needs to be a constant focus on reduction or minimising the restrictive practices, expanding the focus from an organisational approach.

7.4 Other Restrictive Practices

Categorisation of restrictive practices varies by Jurisdiction. However, seclusion, restraint, mechanical restraint (where used) and chemical restraint are consistently regulated. There is a clear move towards identifying wider restrictive practices common in mental healthcare. These include locked doors, observation, search etc. Of note, Scotland is moving towards a zero-observation policy with the intention of refocusing supportive interventions in practice. Processes to encourage critical reflection on the use of these practices in the context of Human Rights are being developed in some Jurisdictions. It was possible to synthesise the best elements of jurisdictional approaches into a framework to support the development and review of restrictive practices. This includes specific actions and strictures in areas including underpinning principles, initiation, monitoring, post restrictive practice and governance. This may support the MHC in deliberations around specific issues to be considered in providing guidance or regulation for restrictive practices.

7.5 Limitations of the Review

Every effort has been made to undertake this review according to best practice and academic rigor within the time and resources available. However, there are some limitations to this review:

- Literature search parameters: Due to the size of the final cohort of papers for review and the time available for the review the timeline parameters had to be halved for the patient related cohorts of the study.
- Jurisdiction comparators: Due to the time available to undertake the review the jurisdictional comparators had to be prioritised to six.
- One primary reviewer: This review was undertaken by one primary reviewer. The limitations of this were mitigated by the use of quality assessment tools, monitoring by an Oversight Group and an independent academic review.

7.6 Next Steps

It is hoped that this review will provide valuable evidence, best practice and international insights to support the MHC in its deliberations on restrictive practices. This report will be submitted to the Oversight Group to be considered alongside consultative processes and contextualised to the Irish setting for actionable strategies for the review of restrictive practices in Ireland.

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Author/s	Year	Title	Type of review	Review focus	Nos of studies included	Key findings
Johnson	2010	**Violence and Restraint Reduction Efforts on Inpatient Psychiatric Units**	Integrative	Violence, Restraint	46 Research & QIPs	Efforts that are focused only on restraint/seclusion reduction seem to be more effective than efforts that are focused only on aggression/violence reduction. The authors recommended a more flexible approach to training focusing on core principles through the development of leadership and group discussion, with a build-up of content from week to week.
Scanlan	2010	**Interventions to reduce the use of seclusion and restraint in inpatient psychiatric settings: what we know so far, a review of the literature**	Integrative	Seclusion and restraint	29 papers evaluating 23 programmes	7 strategy types can reduce restraint and seclusion: 1. Policy change / leadership: National/local directives. 2. Use of external review committee/debriefing 3. Use of data and- benchmarks 4. Training strategies have focused on supporting skill development and attitudinal change. Formal training to increase de-escalation and crisis management skills is considered essential 5. Consumer/family involvement- empowerment, advocacy 6. Issues in staff ratio/staff response teams 7. Programme/elements change: A range of ward or unit level changes to support S&R reduction. 8. Other changes include: (i) implementation of early intervention strategies and least-restrictive crisis management approaches (almost all programmes); (ii) use of sensory approaches to care (iii) modifying the environment (iv) increasing involvement in day programmes (v) changing the ward routine; (vi) implementing token economies
Stewart, et al.	2010	**A Review of Interventions to Reduce Mechanical Restraint and Seclusion among Adult Psychiatric Inpatients**	Narrative	Mechanical restraint and seclusion	36	The majority of the studies were retrospective and were comprised of numerous interventions. It was not possible to identify which intervention was more effective over another. However, some recurring interventions alone or used in combination with another, were identified as part of successful efforts including: 1. Introduction of outcome measures- occurrences and time 2. Restraint and/or seclusion policies 3. Staffing changes 4. Staff training 5. Review procedures 6. Crisis management initiatives. The authors also found evidence that substitution of one containment measure for another resulted in a reduction of the former- substituting restraint or seclusion for each other or for alternative forms of containment (medication in particular).
Bak, et al.	2012	**Mechanical Restraint—Which Interventions**	Systematic	Mechanical restraint	59	Limited evidence. Interventions ranked on a matrix as likely to succeed- 1= high degree of certainty and 5 highly unlikely -reporting 1 (high degree of certainty of success), 2

		Prevent Episodes of Mechanical Restraint? —A Systematic Review				(degree of certainty of success) and 3 (may or may not succeed. 27 interventions. No intervention achieved a score of 1. 1. No interventions 2. introducing validated risk assessment systems, including systems of care interventions 3. CBT through patient involvement and empowerment 3. Combined interventions: Patient participation, patient education, staff education, programmatic changes, high level administrative endorsements, cultural changes, data analysis 3. Implementation of patient centred care with increased degree of patient positive involvement in their care 3. Better staff training: longer, more staff participation, different involving educational methods, high quality content, diversity of topics 3. Higher educated staff 3. More experienced staff
Goulet, et al.	2017	**Evaluation of seclusion and restraint reduction programs in mental health: A systematic review**	Systematic	Seclusion and restraint	23	Key reduction interventions were identified as follows: • Leadership evident in 22 of the 23 papers: Specifically around Organisational (protocols, internal policies, and clinical clarification of mission and values); Unit: Use of champions, participatory approach • Training Staff evident in 21 of the 23 papers: Specifically content around De-escalation, changing philosophies of care. Patients: anger management techniques • Post seclusion and restraint review evident in 19 of the 23 studies: Types of review included Internal, with patient, team, organisation • Patient involvement evident in 16 of the 23 papers: Means of achieving this specifically identified as: Care plans, peer support workshops, partnership on management committees • Prevention of aggression interventions or tool identified in 16 of the 23 studies, including De-escalation, communication, safety plan, risk assessment tool • Therapeutic environment was identified as an intervention in 16 of the 23 studies: This included Warm environment, colours, plants, rugs; Single en-suite rooms, recreational facilities- garden, sports • Huckshorns Core Six Strategies for Seclusion and Restraint Reduction (2014) identified as having the most reliable evidence to as a seclusion and restraint reduction programme. • Safewards, new model for reducing conflict and containment- still not sufficient evidence to support the model but emerging evidence is promising.
(Allen, Fetzer et al.)	2018	**Decreasing physical restraint in acute inpatient psychiatric hospitals**	Systematic review	Restraint: Manual Mechanical	3	• Multiple interventions implemented in each of these successful programmes: • All three studies included Staff training and de-escalation as interventions • Two of the studies implemented debriefings after restraint episodes, implemented patient specific crisis management plans or tools • One study initiated a Crisis response team, increased reporting, sharing of data, implementation of restraint chairs

						• One study implemented a Crisis response team alongside a requirement for prior authorization from the medical director before applying restraints.
(Hirsch and Steinert)	2019	**Measures to avoid coercion in psychiatry and their efficacy**	Narrative synthesis	Seclusion and Restraint	90	Scientifically evaluated treatment programmes to reduce coercion: • Safewards • Six Core Strategies • Engagement model Effective single intervention studies: • Environment: 9 studies; 7 reported a reduction in coercive measures • Organisation: 11 studies: 6 reported a reduction in coercive measures • Staff training: 13 studies: 9 reported a reduction in coercive measures • Psychotherapy: 5 studies: 5 reported a reduction in coercive measures • Risk assessment: 5 studies: 5 reported a reduction in coercive measures • Debriefing: 2 studies: 2 reported a reduction in coercive measures • Advance directive: 1 study, did not report a reduction in coercive measures 38 studies reporting complex multi-faceted interventions: 37 studies reported a reduction in coercive measures.
(Väkiparta, Suominen et al.)	2019	**Using interventions to reduce seclusion and mechanical restraint use in adult psychiatric units: An integrative review**	Integrative review	Seclusion and mechanical restraint	28	Interventions found to proactively reduce seclusion on adult psychiatric units: • Environmental interventions: Use of regulations, closed units opened, Introduction of PICU, focus on recovery, Availability of cultural services, High staff to patient ration, Availability of a single room, Use of personal alarm system • Staff training: Relating to challenging patient behaviour, preventative measures, seclusion, evidence-based practice, therapeutic interventions • Treatment planning: Individualised care plan, information used in care planning, Identification of patients triggers, identification of patient's interventions, involvement in treatment planning, adjustment of treatment plans All staff involved in treatment planning • Use of information; Information on seclusion utilised, information utilised in planning changes, Identification of seclusion alternatives • Risk assessment: Assessment of patient's behavioural changes, use if specific assessment tool, review of risk assessment, introduction of safety meetings, use if seclusion review. Interventions to proactively decrease use of mechanical restraint on adult psychiatric inpatient units: • Mechanical restraint regulations: Introduction of new regulations • Therapeutic environment: Therapeutic care environment, No crowding • Staff training: Challenging behaviour, Mechanical restraint, preventative measures, staff factors, therapeutic interventions • Treatment planning: Use of individual care planning, identification of triggers, identification of patient's helpful interventions, patient involvement in treatment planning

						• Review of mechanical restraint risks: Information on mechanical restraint utilised, information on mechanical restraint alternatives, assessment of patient related risk, documentation of risk assessment, introduction of safety meetings, use of mechanical restraint review.
(Baker, Berzins et al.)	2021	**Nonpharmacological interventions to reduce restrictive practices in adult mental health inpatient settings: The COMPARE systematic mapping review**	Mapping review	Restrictive practices: Restraint, sedation, mechanical restraint, injecting of sedating drugs, constant observation	175	• 150 unique interventions found: Majority aimed to reduce seclusion or restraint or both, 11 aimed to reduce PRN medication, none targeted rapid tranquillisation. • Most interventions had multiple procedures- numbers of interventions used together ranged between 2 and 10. • Intervention themes identified- applied either singularly or in groups (referred to as families): 1. Staff focused, Including training, role models 2. Alternatives: Including sensory, activities 3. Incident: Including debriefing, data review, rapid response team 4. Service User: Including care planning, risk assessment 5. Organisation: including increased staffing, nursing changes, communication, policy changes, Service User involvement • Most common were: 1. Educating staff 2. Changing the environment to prevent incidents 3. Giving staff feedback about incidents • Behaviour changes techniques identified in studies reporting statistically significant findings (in ranked order) s: 1. Instruction on how to perform the behaviour 2. Problem-solving 3. Restructuring the social environment 4. Action-planning 5. Framing/reframing 6. Antecedents 7. Prompts 8. Feedback on outcomes of behaviour 9. Social support (practical) 10. Adding objects to the environment

Author/s	Year	Title	Type of study	Location	Study focus	Study Question	Population: Adult, CAMHS, Forensic, MHCOP, All	Intervention	Key findings
(Andersen, Kolmos et al.)	2017	**Applying sensory modulation to mental health inpatient care to reduce seclusion and restraint: a case control study**	Case control	Denmark	Forced medication and mechanical (belt) restraint	Using sensory modulation to reduce forced medication and restraint	Acute adult. 2 similar psychiatric units. 17 beds and a seclusion room.	Broset Violence Checklist (BVC) used on both units prior to project. Control unit intervention: Self-administered Adolescent For patients in non-acute state: Adult Sensory Profile (ASP). Acute state: Observed Sensory Integration when stable ASP. Inventory (SII) staff training, individualised plans by 2 dedicated OTs in collaboration with MDT. Training all staff: theory in sensory integration, ASP assessment, use of sensory equipment. Plus, for OTs: planning sensory interventions. Sensory modalities and room available. Individual or group focus depending on assessed need and level of agitation. Programme exclusively used for patients with previous exposure to seclusion or restraint or those with signs of SM disfunction. 40 assessments and 40 plans.	Belt restraints and forced medication reduced by 42% overall (38% belt restraints, 46% forced medication) in the project unit compared to the control unit. When looked at separately the differences failed to reach statistical significance at 5%.
(Blair, Woolley et al.)	2017	**Reduction in seclusion and restraint in an inpatient psychiatric setting**	Pre-post study design PILOT	USA	Seclusion and restraint *(def not present)* Reduction of violence and aggression	Evaluation of an intervention designed from evidence-based literature on reducing violence/aggression to decrease seclusion and restraint	All. 120 bed psychiatric facility in a large urban hospital	Baseline data gathered year prior to intervention. Intervention over 1 year- all consecutive admissions (N=8029). Comparison before and after, frequency and duration of S/R events. Intervention: • Routine use of Broset Violence Checklist (BVC) (Dr on admission, Nurses every shift throughout hospitalization)- checklist for staff interventions added- verbal de-escalation, diverting activity, reduced stimulation, sensory modulation/comfort measures,	52% reduction in seclusion rates- achieved statistical significance (p<.01). However mean seclusion duration increased by 34% (statistically significant at <p.01) Restraint events *(no definition provided therefore unclear what kind of restraint)* reduced by 6% - not statistically significant. Mean restraint duration increased by 35% (statistically significant at <p.01)

								medication, continuous supervision, S/R. Checklist required for all S/R events. • Mandated staff education in crisis intervention and trauma informed care. Content: (TM 2-day programme based on trauma informed model of care- goal to reduce staff interactions which may exacerbate trauma reactions in patients); de-escalation, new method of nursing assignments to maximise staff presence in the milieu • Increased frequency of physician re-assessment of the need for S/R every two hours • Formal administrative review of S/R events: Medical and Nursing Director to examine all episodes of S/R using standard template to determine if formal administrative review was needed. • Environmental enhancements (examples given; assessment on admission for personal coping strategies, comfort rooms to support sensory modulation, areas with calming lights, sensory items, music)	
(Hochstrasser, Frohlich et al.)	2018	**Long- term reduction of seclusion and forced medication on a hospital-wide level: Implementation of an open-door**	Longitudinal observational study	Switzerland	Seclusion and forced medication, (physical restraint defined as mechanical restraint but not included)	Examine if the introduction of an open-door policy is associated with the reduction of the frequency of seclusion and the frequency of forced medication.	Presumed adult (mean age 45.4-46.9 over the course of the study).	Implementation of an open-door policy to 6 previously closed wards and change programme aimed at positive patient centred and recovery-oriented care.	Controlled for confounders: age, sex, marital status, nationality, housing situation, occupational situation, main diagnosis, type of entry, type of admission, triage to an open or closed ward at admission. Over the six-year period there was a steady decline in number of episodes for both seclusion and Forced Medication and additionally duration for seclusion. Seclusion:

		policy over 6 years							Percentage of cases with at least one seclusion went from 8.2% (N=2924) to 3.5% (N=2803) = 239 episodes to 97. Forced medication: The percentage of cases with at least 1 Forced Medication decreased from 2.4% (N=2924) to 1.2% (N=2803) = 70 episodes to 35.
(Mann-Poll, Smit et al.)	2018	**Long term impact of a tailored seclusion reduction program: Evidence for change?**	Longitudinal cohort study	Netherlands	Seclusion	Long term study examining the impact on seclusion before, during and after the implementation of a SRP over ten years	Adult and MHCOP (>60yrs) 5 wards- 3 adult admission, 1 elderly admission, 1 long stay.	Dynamic in nature. Started with 2 admission wards and added the remainder after 3 years. 12 interventions identified. Top down-bottom-up approach. Leadership focus. Staff on each ward were empowered to choose a package of interventions from the 12 as suited to their ward. These had flexibility to be amended as required. The 12 interventions summarised: 1. All staff committed to the prevention of seclusion being a goal of the ward 2. Weekly team meetings with an external supervisor also covering seclusion figures 3. Team training: Prevention of aggression, risk assessment, dealing with conflict 4. Individual job coaching following team training (specifics not outlined) 5. Proactive approach to detecting behaviour preceding aggression-use of information from the patient, family, community team to develop specific signalling plans 6. Clear boundaries and limitations with regards to acting out behaviour was communicated to patients on admission 7. At involuntary admission-dangerousness criteria were re-	The study was able to retrospectively identify three phases namely: 1. Preparing and implementation (4 years) 2. Project phase (3 years- SRP implemented) 3. Consolidation period (3 years) (Analysis over phase 2 and 3) Overall, 73% reduction in events (statistically significant at p<0.0001). Overall, 80% reduction in duration (statistically significant at p<.0001). Increase of 20% in the last 2 years. The most important change occurred in phase 2. No significant changes in forced medication were reported over the period.

								evaluated in the context of the admission 8. First admission- information was gathered to develop specific observation signalling plans- aimed at early detection of behaviour preceding aggression 9. Agreement with the patient on treatment plans seen as important in identifying behaviour preceding aggression 10. Family participation as a main component of treatment 11. Family morning to establish family participation 12. All MDT members had important input into treatment plans • 2 comfort rooms opened on the long stay ward after 3 years	
(Allen)	2018	**Decreasing duration of mechanical restraint episodes by increasing Registered Nurse assessment and surveillance in an acute psychiatric hospital**	QIP	USA	Mechanical restraint	QIP to decrease duration of mechanical restraint 3rd PDSA cycle in an existing project over 4 years. This cycle over 3 months.	Adult, CAMHS (MHCOP unclear)	Direct observation by a Registered Nurse of a person in mechanical restraint for the duration of the restraint was introduced as the standard of nursing care on 8 units. QIP interventions noted: PDSA Cost benefit analysis Organisational gap analysis	Overall duration of Mechanical Restraints s on Part 3 pilot Units decreased by 44% after 3 months (4 adult units and CAMHs). Breakdown: Adult pilot units: decreased by 15% CAMHS 14-18 unit: 70% reduction CMHS <14 unit: 100% reduction Duration of Mechanical Restraints on Part 2 pilot Units decreased by 15% on adult units and 70% on the CAMHs unit. Duration decreased by 30% on the adult units and all units from previous stages plus part 3: overall reduction of 33%
(Eblin)	2019	**Reducing seclusion and restraints on the inpatient child and adolescent behavioural unit: A quality improvement study**	QIP	USA	Seclusion and restraints (def not present)	Quality improvement study to reduce seclusion and restraints in a 14 bed CAMHS unit	CAMHS	• Hospital goal to achieve zero restraints • Root cause analysis 1. Barriers identified as lack of guidelines for least restrictive measures prior to S/R, S/R use based on staff judgement, at risk patients received	Overall, the project reported a 55% reduction post intervention in Seclusion and Restraint Seclusion: 62% reduction Restraints: 18% 29% decline in mean duration for both interventions *Small sample size (n=7 pre and post intervention)

								standard treatment, debriefings not performed. Bundled intervention of: • Behavioural modification plans (Behaviour intervention plan template) for patients at risk of seclusion or restraints • Patient debriefing tool to be used after each episode of S/R • Decision making algorithm for initiation of S/R • 3 one-hour education sessions (unit interventions; JC and CMS standards of practice; instruction on interventions and timelines; goals of QIP). Training was optional – 90% attended. Additional materials through staff email • Data collection	
(Lau, Brackmann et al.)	2020	**Aims to Reduce Coercive Measures in Forensic Inpatient Treatment: A 9-Year Observational Study**	Longitudinal, observational, dynamic cohort study	Germany	Coercive measures: Seclusion, restraint (mechanical) and forced medication	Longitudinal cohort study evaluating the change process for reduction of coercive measures over a 9-year period- for seclusion and restraint duration and rate.	Forensic Large inpatient forensic clinic- 79 beds, 1 maximum security ward, 2 locked medium to low security wards and one low security open ward.	Rates of coercion over a 9-year period following implementation of a change process including 6 areas: 1. Obligation to follow guidelines 2. Establishment of detailed documentation to control the process of the coercion order (responsible physician, controlling nursing staff, frequency of control visits, reports of the patient's condition, detailed risk assessment and documentation. 3. Accompanying the patient in restraint continuously 4. Increasing frequency of control visits from twice daily to two hourly	Overall decrease in episodes of restraint from 35 episodes in year 1 to 6 episodes in Year 6. No reduction in forced medication. Changes were noted in the order of coercive measures from the beginning of data collection- it was more common to resort to restraint than Forced Medication in the first two years and the reverse in the following years. Seclusion: There was already a downward trend prior to the intervention. From the intervention date the rate fluctuated, the rate in the final year was a reduction of 18.4% from the date of the intervention. Restraint: Fluctuations noted over the period, with an increase over two consecutive years, however overall reduction by final year was 4%. Forced Medication: No negative trend found.

								5. Obliging staff to use other strategies to avoid coercion such as intensifying 1:1 care etc 6. Mandatory training in de-escalation for all nursing and medical staff at beginning of employment with yearly refreshers. 7. Data reports on the progress and impact of 1-6	
(Mann-Poll, Noorthoorn et al.)	2020	**Three pathways of seclusion reduction programs to sustainability: Ten years follow up in psychiatry**	Dynamic cohort study	Netherlands	Seclusion	Dynamic cohort study to analyse the differences in sustainability of SRPs in three different institutes with different SRPs over the same 10 years with particular focus on the 3 years period FOLLOWING three funding waves provided by the government.	Not stated. 3 psychiatric institutes with 37 participating inpatient wards.	Institute 1: Shared vision policy with a goal of seclusion free treatment. Continuity of SRP for the full 10 years. Top/down bottom/up approach. Multi-faceted programme: Focus on education and professionalisation; team training aimed at prevention of aggression; Risk assessment; dealing with conflict. Team cohesion, weekly team meetings supervised by external team supervisor. Family appreciated as a main component. Institute 2: Personal engagement policy. Years 2 and 3- ward initiatives and building of a PICU. Year 8 onwards engagement model- consultation team, second opinion. Ward professionals encouraged to be involved and developed their own ward strategies. Continuity of plan from years 3 to 9. Institute 3: Leadership years 4 to 6- and focus of medical director from year 6. Engagement model years 6-9- Personal management policy and ward initiatives similar to institute 2. Then forced medication policy. Year 7 change in strategy to top-down approach- audits, weekly seclusion event analysis, early intervention with medication- forced medication	All institutes showed a continuous reduction in seclusion rates. Institute 1: Significant reduction over the SRP years with the largest reduction seen in years 3 and 4. However, increase in duration noted (71%). Sustainability: Project ended in year 9- assumption was that project was complete. Institute 2: Fluctuating rates during the complete project time. Overall, 21% reduction in number and duration. Sustainability: Steering group evaluating seclusion rates continued but SRP ended- assumption was that project was complete. Institute 3: Significant reduction of seclusion over time. 68% reduction in events and duration. Unclear if replaced by FM policy change in year 7 as data not gathered. SRP continued after funding ended. All three achieved a decline in number of events with institute 3 increasing duration alongside this. Sustainability after SRPs end needs to be considered.

								prioritised over other coercive measures.	
(Shields and Busch)	2020	**The effects of centres for Medicare and Medicaid inpatient psychiatric facility quality program on the use of restraint and seclusion**	Quasi experimental- difference in difference design	USA	Seclusion and restraint	1. To examine whether facilities implementing the IPFQR program for the first time will have greater improvement pre and post implementation compared to those already reporting the measures in the pre IPFQR program TJC. 2. Examine the moderating role of ownership and whether non-profits will be more responsive than for profits given lack of financial incentive.	All over a 6-year reporting period. 1841 facilities.	IPFQR Program	1. 48.96% reduction in duration of restraint and 53.4% for seclusion 2. No evidence of ownership being associated with changes in restraint or seclusion 3. The program did not result in zero rates for either.
(Haefner, Dunn et al.)	2021	**A quality improvement project using verbal de-escalation to reduce seclusion and patient aggression in an inpatient psychiatric unit**	QIP- quasi experimental design	USA	Seclusion Aggression	Evaluation of the impact of the implementation of a named educational programme on seclusion and aggression	Not stated. 37 bedded psychiatry unit in a mid-sized urban area.	• Named TM training programme focussing on team strategies for de-escalation of patient aggression that can lead to seclusion. 2 steps; Step 1- 3 1-hour self-learning computer modules and Step 2- in class demonstration of de-escalation techniques. • Posters summarising the education placed in Nurses' station, staff lounge and report room.	• Pre and post tests show a clinical reduction in seclusion from 23 to 15 but did not achieve statistical significance. • Pre and post tests show a reduction in nursing documented episodes of patient aggression from 67 to 39- achieving statistical significance at p=.0.024.

								• Laminated card with de-escalation techniques attached to staff ID badges. • Unit leadership supportive • MDT approach	
(Orlick)	2021	**Reducing the use of physical and chemical restraint through enhanced de-escalation training in adult inpatient psychiatry**	QIP	USA	Physical restraint Chemical restraint	1. Evaluated whether teaching de-escalation techniques combined with simulation exercises reduces the number of seclusions and restraint and involuntary intramuscular psychotropic medication (IIPM) 2. Evaluated if staff attitude towards restraint and seclusion changed after undergoing the training and if this contributed to seclusion and restraint reduction.	Acute adult	• One hour training module supplementing existing CPI training • Training included: Combined Safewards soft words and talk down techniques with the 10 strategies of de-escalation developed as part of project BETA (Richmond, Berlin et al. 2012) • Dual instrument: ○ Confidence coping with aggression scale, CCPAI, (Thackrey 1987) ○ Staff attitude toward coercion survey, SCAS (Husum, Bjorngaard et al. 2008) ○ pre and post survey (20-day interim) also investigated changes in staff attitudes and confidence regarding de-escalation techniques as a result of the training.	• 83.7% completion of the pre and post survey instrument • Staff reported being significantly more confident in handling incidents of aggression (M = 83.76 to M = 87.64; p = .028) • De-escalation training changed staff attitudes regarding the offensive nature of coercion to a minor extent (M = 18.48 to M = 19.46), did not achieve statistical significance. • Reduction in use of IM medication unclear • Seclusion 28 days pre intervention 0; 20 days post intervention 1 • Number of behavioural health emergencies (BHEs) 28 days pre intervention 36; 20 days post intervention 14.

Author/s	Year	Title	Type of study	Location	Study focus	Study Question and Instruments used	Population: Adult, CAMHS, Forensic, MHCOP, All	Key findings
(Payne-Gill, Whitfield et al.)	2021	**The relationship between ethnic background and the use of restrictive practices to manage incidents of violence or aggression in psychiatric inpatient settings**	Observational	UK	Physical restraint (defined as with and without prone), seclusion and rapid tranquillisation	To assess the relationship between ethnicity and restrictive practices	**ALL** Analysis of routine data collected over 3 years of patients subjected to restrictive practices following an incident of aggression or violence	• Top 10% of Service Users most frequently involved in incidents accounted for 50% of all incidents. The bottom 40% of Service Users, who were involved in just one incident each account for just 9% of all incidents. • Incident characteristics: 10515 of inpatient aggression or violence involving 2350 patients over the study period. • Physical restraint distinguished between prone (face down on a surface) or not prone • Physical restraint (not prone) most common restrictive practice (30.5%) • Seclusion (13.9%) • Prone restraint (14.7%) • Rapid tranquillisation (16.7%) • Patient under MHA (84.3%) • Incidents were categorised as Severe (.4%), Moderate (40.3%), Low (41.6%), No adverse outcome (17.6%). • Incident target were categorised as: Targeting staff (38.7%), challenging behaviour (37.8%), targeting Service Users (20.7%), damage to property (2.9%) • Under 18s (10.5%) were involved in incidents (20.1%) more often than other groups. • Physical restraint (not prone): Black Caribbean Service Users more likely to be physically restrained than white Service Users • Physical restraint with prone: Black African Service Users overrepresented in prone restraint (number not evident); Black Caribbean Service Users 55% greater odds of being subjected to prone restraint • Seclusion: Black African Service Users and Black "Other' (not within the categories identified) Service

								Users almost twice the odds of being secluded than white Service Users. • Incidents rated C or above more likely to result in seclusion; Black Other (40.5%) and Black African (47.6%) Service Users were involved in category C incidents or above. • Black Caribbean Service Users over 65% (older age profile than white Service Users) were more likely to be secluded. • Service Users with a mixed ethnic background twice the odds of being secluded than white Service Users • Rapid Tranquillisation: No association between ethnicity and rapid tranquillisation
(O'Callaghan, Plunkett et al.)	2021	**The association between perceived coercion on admission and formal coercive practices in an inpatient psychiatric setting**	Quantitative	Ireland	Coercive practices (Seclusion and physical restraint)	1.To determine the relationship between perceived coercion on admission and coercive practices, specifically seclusion and restraint 2. To determine if there is a relationship between perceived coercion on admission and age, gender, and diagnosis *Perceived coercion on admission was assessed retrospectively **Instruments:** Scale for assessment of positive symptoms of schizophrenia (SAPs) (Andreason, 1983) Scale for assessment of negative symptoms (SANs) (Andreason, 1994) Mini mental state examination (MMSE) (Folstein, Folstein and McHugh, 1975) GAF (American Psychiatric Association, 1994)	Adult N=107 Participants (purposive sampling) admitted to a service over a 30-month period. 27.1% involuntary.	• Perceived coercion on admission was significantly associated with involuntary status (p = .001); female gender (p = .040); positive symptom of schizophrenia (p = .049) • Perceived procedural injustice on admission significantly associated with fewer negative symptoms of schizophrenia (p =.006); involuntary status (p = .008); cognitive impairment (p = .014) and female gender (p = .015). • Patient experience of seclusion and restraint during their admission was not associated with perceived coercion on admission, negative pressures on admission, perceived procedural injustice on admission, affective reactions to hospitalization on admission or total AES score.

						McArthur admission experience survey (AES) (Gardner et al, 1993)		
(Hammervold, Norvoll et al.)	2021	**Post-incident reviews (PIR) after restraints—potential and pitfalls Patients' experiences and considerations**	Qualitative	Norway	Restraint	To explore patients' perceptions of post incident reviews (PIRs) in relation to participation and potential for care improvement and restraint prevention	Adults (N = 8)	• Patients experiences of PIRs varied • Experience of being strengthened, processing the restraint incident, and developing new coping strategies • Experience of the PIR as meaningless, feeling like an object and longing for living communication and closeness
(Beames and Onwumere)	2021	**Risk factors associated with use of coercive practices in adult mental health inpatients: A systematic review**	Systematic Review		Coercive practices: Physical restraint (Defined as physically holding a person), seclusion, chemical, environmental, mechanical, or psychological restraint or seclusion	To examine the evidence concerning risk factors associated with the use of coercive practices in adults admitted to inpatient services	Adult 20 studies	4 Risk Categories (ranged between 1 and 17 across the studies reported): 1. Patient socio-demographics- gender, age, and ethnicity most frequently examined. 2. Patient clinical: diagnosis, symptom severity, functioning and factors pertaining to features of the hospital admission 3. Staff: socio demographic, physical stature 4. Organisational factors: ward environment, the hospital itself Types of coercive practices reported: 7 discrete forms: 1. Seclusion 2. Restraint 3. Chemical restraint 4. Isolation (placement in an isolated closed ward) 5. Level of privilege 6. Transfer to PICU 7. Time out Exposure to coercive practice is a product of multi factorial risks. Younger age, male gender, ethnic minority, symptom severity and a mood disorder diagnosis associated with measures. Poor methodological quality and heterogenous findings and the fact that practices are not applied uniformly across services means it was not possible to identify any single variable as a robust risk factor for CP.
(Varpula, Välimäki et al.)	2020	**Nurses' perceptions of risks for occupational**	Qualitative	Finland	Seclusion and mechanical	To describe the risks for occupational hazards in	Adult	4 Themes for occupational hazards identified: 1. Patient-induced

		hazards in patient seclusion and restraint practices in psychiatric inpatient care: A focus group study				patient seclusion and mechanical restraint practices	One psychiatric hospital. Focus groups with a total of 32 Nurses	2. Staff-induced: staff described that their own actions or negligence can contribute to the risks, physical impairments 3. Organisation-induced: Decisions at organisational level related to training and staffing. Processes can improve occupational safety- particularly up to date practices and safe use of S&R 4. Environment-induced: The seclusion room itself-design, ergonomics, inconvenient working positions, cement floors, size of room, slippery floors, materials (wooden door cases) that can be used as weapons, sound- echo. Equipment- slippery shoes, equipment for restraint (beds, belts) heavy and difficult to use, proximity of equipment, outdated personal alarms or alarms that do not work inside seclusion rooms.
(Scheeres, Xhezo et al.)	2020	**Changes in voluntary admission and restraint use after a comprehensive tobacco-free policy in inpatient psychiatric health facilities**	Retrospective pre-post method	USA	Voluntary admission and restraint	1. To examine the feasibility of implementing a tobacco-free policy in multiple inpatient psychiatric health facilities in a large, urban setting among Medicaid recipients 2. To examine changes in behavioural problems, treatment access, and NRT use following implementation of a tobacco-free policy using administrative data, as measured by seclusion and restraint incidents, involuntary and voluntary admissions, and NRT prescriptions.	14 inpatient facilities	• Seclusion and restraint did not differ post intervention • Low use of the Nicotine Replacement Therapy (NRT) •

(Staggs, V)	2020	**Predictors of seclusion and restraint following injurious assaults on psychiatric units**	Retrospective cohort	USA	Seclusion and restraint defined as 1.Device restraint (e.g., blanket wrap, vest, wrist -waist 2. Hold (e.g., therapeutic hold) 3. Pharmacological restraint	To describe the use of seclusion and restraint following injurious assault by psychiatric patients in US hospitals	Adult and Geriatric inpatient: 747 units in 482 hospitals 156 study months	3519 injurious assaults resulting in seclusion 7108 injurious assaults resulting in one or more types of restraint- these numbers include 995 resulting in both seclusion and restraint. Device restraints most common, followed by pharmacological restraints and then physical holds Seclusion and all three types of restraint were less likely to be used in Geriatric Units Seclusion was more common in locked units Device restraint more common in unlocked unit Hospital: Seclusion used more frequently in academic medical centres and teaching hospitals. Non-teaching hospitals had the highest rates of all three types of restraint. Seclusion and restraint were lower in Government funded hospitals whereas pharmacological restraint was most common in for-profit hospitals. Strongest predictors were assault characteristics. All restraints and seclusion were less likely following sexual assault. Odds for all measures increased with a one person increase in the number injured. Similarly, an increase in level of injury severity (mild, moderate, major, death) increased the odds of seclusion, device restraint and hold. No meaningful change in odds ratio for pharmacological restraint regardless of injury level. Assaultive patient characteristics: involuntary status associated with higher seclusion, device restraint and hold. Episodes of seclusion and restraint were 20% shorter for patients in teaching hospitals compared to non-teaching hospitals. Episodes were markedly longer in federal hospital than in non-federal government facilities. Hospitals in metropolitan settings reported 30% longer time spent in seclusion. Device restraints were 30-43% shorter for geriatric patients and 21% shorter for females than for males.

(Reen, Bailey et al.)	2020	**Systematic review of interventions to improve constant observation on adult inpatient psychiatric wards**	Systematic review		Constant Observations: Two types: Control and Care	To describe and categorise all interventions relevant to constant observations	Adult 16 studies	• 16 studies evaluated 13 interventions designed to reduce or change the focus of constant observations • Outcome measures were variable however specific to restrictive practices*:* Protocol to engage patients at low risk of self-harm and aggression as opposed to immediate close observations reduced aggression and restrictive practices. Replacing control-based observation with care-based observations reduced restrictive practices, self-harm, absconding and aggressive incidents. Reviewing where staff were based on the ward reduced the use of close observations especially at night. • Interventions: *Changes to team:* Strongest impact on constant observations was achieved by adjusting teams and teamwork. *Staff education and training*- how to undertake and assess for constant observations *Record keeping and assessment:* Information about the patient, reason for observation level, factors that may help reduce observation level, personalised care plans *Involving patients in care:* Patients encouraged to contribute to discussions about their observation levels, patients suggest interventions to be used when adapting constant observation levels *Physical environment:* Sensory modulation tools for agitated patients, locking rooms with high incident rates, strategically placing staff around the ward.
(Nielsen, Milting et al.)	2020	**Increased use of coercive procedures and prolonged hospitalization in compulsory admitted psychotic patients, who refuse antipsychotic medication**	Retrospective observational cohort	Norway	Coercive procedures: Forced medication	To examine whether the delay in initiation of involuntary medication (3 days whilst a complaint is being processed under legislation) results in a change in the rate of coercive measures.	34 consecutively admitted involuntary patients with schizophrenia.	• 23 patients consented to antipsychotic treatment immediately. • 11 opted to complain under the legislation. These patients were subjected to 6.8% more coercive measures or forced sedative medication compared to the other patents. • Length of stay was 2.3 times longer for the complaining patients than those who accepted medication immediately on admission.
(Mangaoil, Cleverley et al.)	2020	**Immediate Staff Debriefing Following**	Scoping review		Seclusion and mechanical restraint	1. How has the use of immediate post-	Adult (acute and forensic)	• Often linked to seclusion and restraint reduction programmes- particularly the 6 Cs (Huckshorn, 2014)

		Seclusion or Restraint Use in Inpatient Mental Health Settings: A Scoping Review				seclusion debriefing by Nurses in adult inpatient mental health settings been defined and/or operationalized in the academic and gray literature. 2. What are the core components of immediate post seclusion and restraint debriefing by Nurses in adult inpatient settings	31 Academic Articles 11 Gray literature	• Learning opportunity to prevent recurrence of violence resulting in coercive practices • Education and training highlighted as important in the context of seclusion and restraint reduction, risk management, training to improve de-escalation. • Components: Organised as a series of actions rather than separate or discrete events. 1. Staff discussion where they can only express emotions or opinions about the seclusion or restraint event in an open and blame free environment 2. Identification of patient and staff behaviours that preceded seclusion or restraint and revising the care plan as required 3. Formal and executive debriefings provide more in- depth analysis of seclusion and restraint where the focus is not on the immediate emotional or psychological support to staff but more on how the organisation as a whole can find other support for staff who have who have experienced or witnessed violence • Need for documentation – debriefing framework and clear documenting of the debriefing itself. • Monitoring of quality of debriefing
(Laukkanen, Kuosmanen et al.)	2020	**Seclusion, restraint, and involuntary medication in Finnish psychiatric care: a register study with root-level data**	Cross sectional	Finland	Containment: seclusion, restraint, involuntary medication	To examine psychiatric Nurse managers attitudes towards containment methods • Instrument: ACMQ (Bowers et al 2004)	Adult Inpatient psychiatric Nurse managers (N=90)	• Most negative attitudes towards net bed and mechanical restraint. • Most positive attitudes towards PRN medication and intermittent observation • PRN medication, intermittent observations, PICU and constant observations were the most accepted containment methods • Least accepted: Net bed, mechanical restraint, IM medication • Most effective: IM medication, mechanical restraint, PICU, constant observation • Least effective: Net bed • Most dignified: PRN medication, intermittent observation, constant observations • Least dignified: Net bed, mechanical restraint, IM medication • Safest for staff: PRN medication, PICU

								• Safest for patients: Intermittent observations, PRN Medication • Unsafe for staff: Net bed, physical restraint, open area seclusion • Unsafe for patients: Net bed, mechanical restraint, physical restraint • Most prepared to use: Intermittent observations, constant observation, PRN medication • Least prepared to use: Net bed and mechanical restraint • Work experience negatively associated with attitudes towards open area seclusion
(Laukkanen, Kuosmanen et al.)	2020	**Seclusion, restraint, and involuntary medication in Finnish psychiatric care: a register study with root-level data**	Retrospective register study	Finland	Seclusion, mechanical and physical restraint, and involuntary medication	To analyse data relating to seclusion, restraint, and involuntary medication on the National Register over a period of one year	Specialized psychiatric care (adult, CAMHs) 200 wards across 22 organisations.	• Most frequently used restrictive measure was seclusion, followed by involuntary medication. • Mechanical restraint and physical used more infrequently • Heavy use of restrictive measures focussed on a minority of wards • Variations in use of seclusion, restraint, and involuntary medication evident between different wards
(Hammervold, Norvoll et al.)	2020	**Post-incident reviews- a gift to the Ward or just another procedure? Care providers' experiences and considerations regarding post-incident reviews after restraint in Mental Health Services. A qualitative study**	Qualitative	Norway	Restraint	1. What are the professional care providers experiences and considerations regarding the use of post incident reviews (PIRs) in practice 2. What do professionals see as the benefits and challenges of PIRs	19 interprofessional staff	Patients' voices strengthen PIRs potential to improve and may also contribute to restraint prevention. 3 Overarching Themes: 1. Potential to improve the quality of care though: • Knowledge of other perspectives and solution • Increased ethical and professional awareness • Emotional and relational processing. 2.Tensions between the potential to improve quality of care and struggling to get hold of the patients voices in the encounter 3. Opportunity to prevent the use of restrain use and reflection on action provides an opportunity to review antecedents, action taken and alternative measures
(Doedens, Vermeulen et al.)	2020	**Influence of nursing staff attitudes and characteristics on the use of coercive measures in acute Mental Health**	Systematic review		Coercive measures: Seclusion, restraint	1. What are the attitudes of psychiatric Nurses towards the use of coercive measures 2. Which individual or team nursing	Acute adult 76 studies	Attitudes towards containment: 2 major themes: 1. Treatment paradigm versus 2. safety paradigm: The belief that patients experience therapeutic benefits from the use of coercion. The belief that the patient undergoing coercive measures experiences negative consequences, but coercive measures are

		Services—a systematic review				characteristics are associated with the use of coercive measures and with the attitudes of Nurses towards coercive measures in acute Mental Health Services		necessary to maintain safety for patients and staff members. • Need for less intrusive alternative interventions • Influence of nursing staff characteristics inconclusive
(Digby, Bushell et al.)	2020	**Implementing a Psychiatric Behaviours of Concern emergency (Psy-BOC) team in an acute inpatient psychiatry unit: Staff perspectives**	Qualitative	Australia	Restraint, seclusion	To examine the opinions of multidisciplinary team on the implementation of the Psy-BOC initiative	Adult 2 adult psychiatric inpatient units 5 Focus groups	4 main themes: 1. Identifying deterioration; Identifying warning signs, impact of illicit drug use, knowing/not knowing the patient 2. Responding to the BOC; Managing the problem, talking with the patient, administering medication, calling for help 3. Staff reactions: Safety in numbers, vulnerability, reaction to Psy-BOC, management response 4. Barriers: The environment, time constraints, lack of education, PSY-BOC shortcomings • Introduction of the BOC was associated with a reduction in restrictive practices and staff harm-frontline staff did not believe that this was causal.
(W. Haugom, Ruud et al.)	2019	**Ethical challenges of seclusion in psychiatric inpatient wards: a qualitative study of the experiences of Norwegian mental health professionals**	Qualitative	Norway	Seclusion (note definition is accompanied with staff)	To examine how clinical staff in psychiatric inpatient wards describe and assess the ethical challenges of seclusion	ALL 57 inpatient wards 149 detailed descriptions of seclusion on 57 psychiatric wards	• Seclusion episodes between 1 hr and 168 days • Mean days 17, median 10 • Main finding- The relationship between treatment and control during seclusion produces ethical challenges. 3 Categories: 1. The staff has a desire to provide good treatment during seclusion. 3 Subcategories I. The staffs' loyalty to the treatment plan is important for performing good seclusion. II. A separate seclusion area is important for the quality of treatment during seclusion. III. The staff experience is that patients are mainly negative towards seclusion. 2. The need for control provides treatment dilemmas during seclusion. 3 subthemes: I. The need for control provides treatment dilemmas during seclusion.

								II. Threats and risk of violence make safety a priority over self-determination. III. Voluntary seclusion is coercion without specific legal basis. 3. It is challenging to work with patients being secluded. 3 sub themes: I. Being 'in seclusion' places a psychosocial strain on staff II. It is burdensome to work with patients when optimal solutions are lacking. III. Restrictions provide a basis for reflection.
(Verbeke, Vanheule et al.)	2019	**Coercion and power in psychiatry: A qualitative study with ex-patient**	Qualitative	Belgium	Coercion: Seclusion/segregation	The aim is to propose an interactional model of the relational aspects of coercion that enhances theoretical understanding based on assumptions of patients	12 discharged patients	• Theme 1: Segregation. I. Being seen through the lens of being a patient. Personality traits were considered a symptom rather than someone's way of being. Challenges to house rules or coercive practices seen as a symptom of illness II. Us and them: The one-sided focus on being a patient led to a segregation which spilt patients and staff. • Theme 2: De-subjectivation I. Patients: Parts of their subjectivity (other than patient) were neglected e.g., mother, independent person. This led to them feeling cut off from children, families etc. II. Staff: Seen as a group rather than part of a group. Coercion often part of the protocol and rules. The mental health worker is perceived as a less humane person, purely implementing a technique in standardised fashion. Staff also became de-subjectivated- referred to as them or they. • Theme 3: Power resides in interactions. I. Broken contact II. Captured in silence- lack of communication a core feature in the power dynamic. • Theme 4: Positive encounters. Most participants eventually found help that they defined as non-coercive.

(Sampogna, Luciano et al.)	2019	**Perceived Coercion Among Patients Admitted in Psychiatric Wards: Italian Results of the EUNOMIA Study**	Cohort	Italy	Coercive measures: Restraint, seclusion, forced medication	To identify socio-demographic and demographic predictors of the levels of perceived coercion Instruments: • MacArthur Admission Experience Survey (AES, Gardner et al, 1993) • Clients' assessment of treatment (CAT, Priebe and Grutyer, 1995) • Cantril Ladder of Perceived Coercion Scale (Cantrill, 1965) • Global assessment of functioning (GAF: Gardner et al, 1993) • Brief Psychiatric Rating Scale (BPRS: APA, 1994) Three assessments T0- first 7 days of admission: AES T1- after 1 month: Cantril T3- after three months: CAT, Cantril	Not clear Total Sample N = 294 Three assessments T0- first 7 days of admission T1- after 1 month T3- after three months	• Involuntary admission, being male, being older and less satisfied with received treatments are associated with higher levels of perceived coercion • Majority of patients admitted (56%; n = 165) were voluntarily admitted and suffered from psychosis (62.7%) • 78.6% had been previously admitted • Compulsorily admitted patients were more frequently male, with higher levels of positive and manic/hostility symptoms and lower depression/anxiety symptoms • At T0 Patients reported high levels of perceived coercion • At T2: Patients reported higher levels of satisfaction were those who reported lower levels of coercion on admission • 28.6% (n = 84) participants reported to have received one or more coercive measures during hospitalization: 22.4% (n = 66) experienced forced medication 8.8% (n = 26) were physically restrained 6.8% (n = 20) patients were isolated from other patients
(Välimäki, Yang et al.)	2019	**Trends in the use of coercive measures in Finnish psychiatric hospitals: a register analysis of the past two decades**	Retrospective register analysis	Finland	Coercive measures: Seclusion, limb restraints, forced injection and physical restraint	To examine trends in the national register of variance of any coercive measure as well as the other four specified coercive measures over a twenty-year period and to investigate the trends among care providers and regions.	294 patients from 5 Psychiatric Hospitals Severe mental disorders Patients were assessed three times: 1. Within first 7 days after admission 2. After 1 month 3. After 3 months	• Dataset of 226,498 patients admitted over 20-year timeframe- 505169 treatment periods • Prevalence of coercive measures was 9.8%. Small decrease noted 2010-14 • The overall prevalence of coercive measures was Seclusion (6.9%); Limb restraints (3.8%); forced injection (2.6%) and physical restraints (0.8%) • Use of limb restraints showed a downward trend over time- all others no change • Geographic and care provider variations notes • Significantly lower overall prevalence of seclusion and limb restraints used on female patients compared to males.

								• Higher prevalence of forced injection in females compared to males • No gender difference for physical restraints
(Stepanow, Stepanow et al.)	2019	**Narrative Case Notes Have the Potential to Predict Seclusion 3 Days in Advance: A Mixed-Method Analysis**	Mixed methods retrospective case-control study.	Switzerland	Seclusion	Investigate precursors of seclusion in narrative case notes in a group of patients with seclusion in comparison to a control group without seclusion. Instruments: • Modified overt aggression scale (MOAS, Knoedler, 1989) • Positive and negative symptoms scale-excited component (PANSS-EC, Montoya et al 2011) • Clinical global impression – severity of aggression scale (CGI-A, Huber et al, 2007)	Adult	• Patients in the case group showed more aggressive behaviour (assessed with MOAS, PANSS-EC, and CGI-A tools). Increase of aggression scores from day -3 to 0 became evident in the case group for all quantitative measures • Qualitative analysis revealed 112 variables per observational day- 400 variables in total. Main focus of analysis: Staff subjectivity, terms describing patients' behaviour, terms associated with risk assessment, sleep behaviour, demanding behaviour, requests, high contact frequency and non-compliance. • Staff subjectivity: Descriptions grouped into provoked or arduous behaviour, anxiety. Pejorative terms, enthusiastic and compassionate • Terms describing patients' behaviours in the case group were described significantly more often in the case group than in the control group. Significantly more negative valence potentially related to problematic behaviour: Examples: agitated (most frequently represented term), irritable, loud/screaming, obtrusive, restless, threatening, dysphoric, insulting/cursing, aggressive, bizarre/foolish, provocative. • Risk assessment: Expressions such as threatening, unpredictable were used more often before an aggressive or escalation in the case group. Threatening showed increased use in the lead up to seclusion. • Sleep behaviour: Patients in the case group showed significantly more sleep irregularities- in particular insomnia, in the days before seclusion. • High contact frequency of patients with staff was documented in the case group- requests to leave, cigarettes, food at inappropriate times, refusing medication more often- no significant differences between regarding frequency of requests that were fulfilled between both groups.

								• Predictors following logistic regression terms in the categories Unpredictable, sleep irregularities and manageable were potential predictors of seclusion.
(Narita, Inagawa et al.)	2019	**Factors associated with the use and longer duration of seclusion and restraint in psychiatric inpatient settings: a retrospective chart review**	Retrospective chart review	Japan	Seclusion and restraint (Not separated- referred to as SR)	To examine factors that may affect the use and duration of seclusion and restraint in psychiatric inpatient settings	Adult and MHCOP - 4 acute wards over three months 213 patients- 58 experienced SR	• 27.2% (n = 58) out of 213 patients experienced SR. • Various diagnoses: Dementia in Alzheimer's Disease, mental disorders due to brain damage, schizophrenia, schizoaffective, bipolar affective, depressive episode, mild mental retardation, hyper-kinetic disorder. • Mean number if SR days was 17.5. Reasons for SR included psychomotor agitation, suicidal ideation, self-harm, harmful behaviour to others, risk of falls, self-extraction of catheters. Dementia and depressive disorder were associated with longer duration of SR. • Dementia, history of epilepsy and the use of antipsychotics significantly increased the odds of PR
(Mårtensson, Johansen et al.)	2019	**Dual diagnosis and mechanical restraint—A register-based study of 31,793 patients and 6562 episodes of mechanical restraint in the Capital region of Denmark from 2010–2014**	Retrospective national register analysis	Denmark	Mechanical restraint	To investigate whether patients with dual diagnosis have a higher risk of being mechanically restrained compared to patients with only psychiatric diagnosis	ALL over a four-year period	Note: Dual diagnosis defined as: Co-occurrence of diagnosis of harmful use of dependency and psychiatric diagnosis • 31793 patients admitted 85736 times over the four years. 6.8% of these patients experienced being mechanically restrained 6538 times. • 23% of all admissions had a diagnosis of dual diagnosis. • Patients with dual diagnosis more likely to be mechanically restrained compared to patients with only psychiatric diagnoses or only other substance use diagnosis. • However, with adjustment for characteristics of patients, patients with substance related diagnoses only were the most likely to be mechanically restrained.
(Laukkanen, Vehvilainen-Julkunen et al.)	2019	**Psychiatric nursing staffs' attitudes towards the use of containment methods in psychiatric inpatient care: An integrative review**	Integrative review	Finland	Containment- PRN medication, physical restraint, intermittent observation, seclusion, timeout, intramuscular medication, transfer of patient to a locked ward (PICU), mechanical	To identify, analyse and synthesise the available research on psychiatric nursing staffs' attitudes towards containment methods in inpatient psychiatric care.	24 Studies	• Nurses' attitudes towards containment methods have continuously become more negative over the last decades. • Nurses have negative feelings such as frustration and regret regarding the use of containment methods • Nurses identified restraint, seclusion, and PRN medication to be the most commonly used measures

					restraint, constant observations, net bed, and open area seclusion			• Main reasons for use: violence, self-harm, behavioural control of the patients • Nurses recognised patients' negative feelings and reactions to the use of coercion.
(Lai, Jury et al.)	2019	**Variation in seclusion rates across New Zealand's specialist Mental Health Services: Are sociodemographic and clinical factors influencing this?**	Retrospective national register data	New Zealand	Seclusion	To examine the extent to which variation in seclusion rates could be explained by the sociodemographic and clinical differences between populations admitted to adult inpatient services	Adult over 1 year	• 828 admissions with one or more seclusions-overall rate 7.7% (N of total admissions 10717) • Rates for each district health board (DHB) ranged between 2.2% and 23.3%. • When comparing between DHBs that had low and high seclusion rates, the findings indicated that age, ethnicity (Māori/non- Māori) DHBs or clinical diagnoses did not significantly explain the variance in seclusion rates. • It is likely to be differences in clinical practices, organisational culture across units.
(Kersting, Hirsch et al.)	2019	**Physical Harm and Death in the Context of Coercive Measures in Psychiatric Patients: A Systematic Review**	Systematic review		Coercive measures: *Restraint:* physical (manual holding), mechanical (1, 4, 5 and 11 point), mechanical (chair restraint), mechanical (bed rails) and vest restraint *Seclusion:* separating the patient in a locked room *Forced medication:* Meaning oral or parenteral (IV or IM) application of medication by force or by definite psychological pressure, e.g., announcing forced parenteral medication if medication is not immediately taken orally	To examine harmful or fatal adverse effects of coercive interventions in psychiatry and estimate expected frequencies of these adverse events depending on the use of different measures	67 papers	• In most cases only one type of harm was examined in the context of only one or a few different coercive measures • Death was the most frequent harm documented in 42 studies: o Cause of death- cardiopulmonary arrest in 17 studies whereby positional asphyxia or heart failure was not mentioned by default and overlaps were common o Asphyxia caused by strangulation was mentioned in 10 studies o Pulmonary embolism in 8 studies o Other causes: Suicide, bleeding to death, hemoperitoneum resulting from restraints, sudden unexpected death as well as asphyxia caused by chokehold o 5 studies documented increased mortality without being able to deduce direct causality • Second most frequently analysed harm: VTE in 14 studies, DVT in 8 studies, PE in 12 studies with the consequence of death in 8 studies. • Harm in the form of physical injuries/physical traumata was reported in 8 studies encompassing minor skin lesions, pressure sores, bruises, lacerations, contusions, fractures, head injuries and not further specified injuries.

								• 4 studies increased though not significant risk of falling • Self-injury in seclusion • 4 deaths by burning in mechanical restraint- three patients set the restraint on fire with the intention to escape and 1 accidental death caused by inflamed oxygen ignited by a cigarette.
(Jury, Lai et al.)	2019	**People who experience seclusion in adult mental health inpatient services: An examination of health of the nation outcome scales scores**	Retrospective national register dataset	New Zealand	Seclusion	1. Examine the association between HoNOS items and seclusion 2. Adjust for covariate factors associated with seclusion and 3. Examine the adjusted association	Adult inpatient over 1 year	• 842 people of 11341 admitted to adult inpatient services experienced one or more episodes of seclusion. Overall rate 7.42%. 63% of seclusion episodes occurred within 48 hours of admission. • All HoNOS items except item 5 were significantly associated with seclusion • Item 1 was strongest factor (overactive, aggressive, disruptive, or agitated behaviour). 14.02% of people with clinically significant scores on item 1 were secluded compared to 2.5% of people without. • 11% of people with clinically significant scores on item 6 (problems with hallucinations and delusions) were secluded compared with 4.08% of people without clinically significant scores • 10.38% of people with clinically significant scores on item 3 (problems with drinking or drug use) compared to 5.44% without • Item 2 (problems with non-accidental self-injury) 3.9% of people with clinically significant scores were secluded compared to 9.59% of people without • 4.11% of people with clinically significant scores in item 7 (problems with depressed mood) compared to 10.97% without. • People who were secluded were slightly younger (35.28 V 36.87), and had longer length of stay (27.44 v 14.38 nights) • People who experienced seclusion were more likely to be male, under compulsory treatment, and Māori or Pasifika peoples. • Comprehensive assessment is an essential activity prior to or on admission
(Jacob, Holmes et al.)	2019	**Convergence and divergence: An analysis of mechanical restraints**	Qualitative	Canada	Mechanical restraint	1. To gain access to the bodily phenomenon of being placed in mechanical restraints	Adult 21 Nurses 19 patients	Nurses and patients' experiences were analysed and themed separately then reanalysed and combined into 5 Themes: 1. Context of care

						2. To give voice to the intimate experiential understanding of this experience 3. Through phenomenological interpretation to understand the subjective processes and meaning making of this experience		2. Meaning of quality of care 3. Emotional reactions and Nurse-patient relationship 4. Meeting the needs 5. Need for alternatives
(Hu, Muir-Cochrane et al.)	2019	**An examination of the incidence and nature of chemical restraint on adult acute psychiatric inpatient units in Adelaide, South Australia**	Descriptive quantitative design	Australia	Chemical restraint	To examine chemical, restrain use in 12 adult inpatient wards as follows: • Prevalence rates of chemical restraint • Characteristics of chemically restrained consumers • Characteristics of chemical restraint events • Medication used • Reasons for chemical restraint • Interventions prior to/during chemical restraint events Instrument: Severity assessment code (SAC, Southern Health, 2018)	Adult 12 acute psychiatric units over 12 months	• Severity assessment code (SAC) reporting the overall severity levels of chemical restraint events was documented for each event • 166 events involving 110 consumers • More males (n = 69; 57.3%) than females • 120 admissions to all units involving chemical restraint, 103 out of 110 experienced 1 chemical restraint during admission. • 97% of events were reported as SAC level 3 (moderate risk) with the remainder at SAC level 4 (low risk) • Schizophrenia, schizotypal and delusional disorders were the prominent diagnoses of those restrained • Most events occurred between three-time blocks: 1400-14.59; 16.00-16.59; 21.00-21.59 • Two most common medications used were: Anti-psychotic medication: olanzapine (used in half of the events where medications were listed) followed by zuclopenthixol acetate (13%) and quetiapine (5%) Benzodiazepines: Clonazepam (35%), Lorazepam (18%) and midazolam (8%). • IM alone represented 90.4% of administrations • Oral alone 1.7%). 52 events recorded offering oral tablets to consumers first • 114 events did not have medication route information. • Higher proportion pf admissions where chemical restraint was used involved males rather than females (marginal significance) • Mean age of those restrained 33.52 years

								• 57.3% had a diagnosis involving schizophrenia, schizotypal, delusional disorders, mood disorders • 15.4% had a recorded diagnosis of bipolar affective disorder or were experiencing a manic episode • 11.8% mental disorders due to psychoactive substance use • Reasons for chemical restraint: 270 reasons for 166 chemical restraint events Intrusive behaviour, verbal abuse, or disruption (42.6%) Actual threat of physical aggression (22.2%) Aggression or damage to property (14.1%) To administer treatment under the MHA (11.5%)
(Hazewinkel, de Winter et al.)	2019	**Text Analysis of Electronic Medical Records to Predict Seclusion in Psychiatric Wards: Proof of Concept**	Retrospective Cohort	Netherlands	Seclusion	To explore the feasibility of text mining analysis in the Electronic Medical Records (EMR) to eventually help reduce the use of seclusion in psychiatry	Adult, acute and non-acute 4-year period- all nursing and medical notes	• Frequently used concepts in the two weeks prior to seclusion identified by text mining. • 2816 patient notes, 60% male and 40% female, Mean age 41 years. 23% (n = 656) of the patients were secluded • 67590 notes and reports- 57381 belonged to non-secluded patients and 10209 belonged to secluded patients • Main diagnosis of secluded patients: Schizophrenia (32%; n = 967); Mood disorders (25%; n = 767) and other psychiatric disorders (22%; n = 672) • 1500 most meaningful concepts were generated • Of these 115 seem to typically precede seclusion for 14 days • These were grouped as follows: 1. Phrases that accompany reasons for seclusion 2. Other containment measures used in psychiatric practice 3. Implementing seclusion 4. The working environment of nursing staff 5. Non-specific terms • Over half of the concepts evident in the full 14 days prior to seclusion were present in days 14-7 • Exploratory study determined that it is feasible to use EMR and text mining. However, a model needs to be built, trained, and tested before becoming an evidence based clinical decision-making tool.

(Guzmán-Parra, Aguilera-Serrano et al.)	2019	**Experience coercion, post-traumatic stress, and satisfaction with treatment associated with different coercive measures during psychiatric hospitalization**	Quasi experimental	Spain	Coercive measures: Involuntary medication mechanical restraint and both combined	To analyse the patient's perceived coercion, symptoms of post-traumatic stress and subjective satisfaction with the hospital treatment associated with the use of involuntary medication, mechanical restraint, and a combination of both. **Instruments:** Perceived coercion: Coercion Experience Scale (CES, Bergk et al 2010) Event related stress: Davidson trauma scale (DTS, Davidson et al, 1997) Satisfaction with treatment: Client's assessment of treatment (CAT, Priebe et al 1995)	Adult 2 inpatient units 111 participants	• Higher perceived coercion in the combined measures group • 12.65 (5 involuntary medication, 4 mechanical restraints and 5 combined measures) were noted to have a score higher than the cut off for the DTS indicating event related post-traumatic stress disorder • Participants who experienced combined measures and mechanical restraint had higher DTS scores than those who had received involuntary medication • Patient satisfaction with treatment: Patients who experienced the combined measures were less satisfied with treatment than those who had received involuntary medication. No statistical significance with mechanical restraint group
(Gleerup, Østergaard et al.)	2019	**Seclusion versus mechanical restraint in psychiatry—A systematic review**	Systematic review		Seclusion and mechanical restraint	To review studies comparing seclusion and mechanical restraint	14 papers	11 studies using a subjective outcome measure (patient preference/emotions) were in favour of seclusion whilst 3 studies using an objective outcome measure (duration of coercion/need to transfer to another coercive measure) favoured mechanical restraint
(Danielsen, Fenger et al.)	2019	**Predicting mechanical restraint of psychiatric inpatients by applying machine learning on electronic health data**	Cohort	Denmark	Mechanical restraint	To investigate whether MR occurring in the first 3 days following admission could be predicted based on the analysis of electronic health data available after the first hour of admission	5050 patients with 8869 admissions 100 patients experienced MR between 1 hour and 3 days after admission	• Data were extracted from three databases: The electronic health record system, the registry of coercive measures in psychiatric treatment and the Danish Psychiatric Central Research Register. Information was linked at the level of the individua • Criteria made clear for 'case admissions'. • 86 predictors identified, the final, model used 45 predictors. The two most important predictors were categorical: admission type (voluntary; involuntary because of danger; involuntary because of urgent need for treatment) and Broset Violence Checklist. • The Random Forest Model achieved a sensitivity of 56% at 94% specificity when validated using an independent test set.

								• Out of the ten most important predictors, 9 were derived from clinical notes. Involuntary admission, BVC score, somatic comorbidity, sparse/non coherent verbal response and non-informative verbal response, abnormal behaviour, threatening behaviour, good social status, suicidal ideation – car crash, persecutory ideation
(Chieze, Hurst et al.)	2019	**Effects of Seclusion and Restraint in Adult Psychiatry: A Systematic Review**	Systematic review		Seclusion and restraint	To explore effects of seclusion and restraint on psychiatric inpatients	35 papers	• Evidence that seclusion and restraint have deleterious physical or psychological consequences • Evidence that negative effects have consistently been found across studies: PTSD, medication need, increased length of stay and DVT. However, one study suggested a beneficial quality of life. • Estimation of post-traumatic stress disorder incidence after intervention varies from 25%-47% • Effectiveness and adverse effects of seclusion and restraint seem to be similar • Compared to forced medication seclusion seems to be better accepted. While restraint seems to be less tolerated' • Therapeutic interaction appears to have a positive influence on coercion perception
(Askew, Fisher et al.)	2019	**What are adult psychiatric inpatients' experience of seclusion: A systematic review of qualitative studies**	Systematic review		Seclusion			• Published research may have flaws with the quality of analysis, mainly due to limited researcher reflexivity • Four themes: Patients feel vulnerable, neglected, and abused, disconnected from the experience and that it is dangerous to their mental health
(Odgaard, Kragh et al.)	2018	**The impact of Modified Mania Assessment Scale (MAS-M) implementation on the use of mechanical restraint in psychiatric units**	Historical cohort study	Denmark	Mechanical restraint	To examine the association between the use of the Danish assessment tool for psychiatric inpatients diagnosed with mania (MAS-M) and mechanical restraint	Adult 218 patients, 74 scored for the MAS-M	• No significant association between the MAS-M and mechanical restraint.
(Mielau, Altunbay et al.)	2018	**The influence of coercive measures on patients' stances towards psychiatric institutions**	Quantitative	Germany	Coercive measures: Forced medications, mechanical restraint. seclusion	To determine the impact, quantitative aspect, and subjective experience of CI in patients' attitudes towards psychiatry.	Adult 79 patients with psychosis and bipolar disorders	• The manner in which coercion is subjectively experienced has direct influence on patients' perceptions of psychiatry • 55 Male; 24 Female

						Instruments: Coercion experience scale (CES, Bergk et al 2010), Admission Experience Survey (AES, Gardner et al, 1998) Global assessment of functioning (GAF, APA, 2000) Schedule of unawareness of illness (SAI, David et al 1992) Beck Cognitive Insight Scale (BCIS, Beck et al 2004).		• Main diagnoses: Schizophrenia (62%; n = 49); Schizoaffective (16.5%; n = 13) and bipolar disorder (20.3%; n = 16). • 65.8% of patients had between 1 and 10 previous hospital admissions, average duration of illness was 13.03yrs. • 51 patients experienced forced medications: 39 experienced mechanical restraint and 31 experienced seclusion • The subjective rather than quantitative or illness related variables bear influence on patients' future expectations of the psychiatric system as help or harm. • Factual variables associated with CI (previous experience of and type and number of) showed no significant associations with patients' stances
(Krieger, Moritz et al.)	2018	**Patients' attitudes towards and acceptance of coercion in psychiatry**	Exploratory naturalistic	Germany	Seclusion, mechanical restraint, forced medication, involuntary hospitalisation, seclusion, video surveillance	To examine patients' attitudes towards and understanding of previously experienced coercive measures as well as their preferences related to coercive measures and possible alternatives **Instruments:** Brief psychiatric rating scale (BPRS, Overall and Gorham,1962) Global assessment of functioning (GAF, American Psychiatric Association, 1989), BECK depression inventory 2 (Beck et al 1996) Patient health Questionnaire (PHQ-9 Lowe et al, 2002) Insight Scale (IS, Birchwood et al, 1994)	Adult, 3 acute wards 213 patients who had experienced coercion against 51 in control group.	• 'Non-invasive measures'- seclusion were better accepted than 'invasive measures', mechanical restraint forced medication. • Forced medication and mechanical restraint were less well accepted than involuntary hospitalisation, seclusion, or video surveillance. • The CI group: The main diagnosis were schizophrenia spectrum disorder 71.1%; substance abuse and intoxication 10%, affective disorder including bi-polar disorder 12.8%, personality 3.3%, other diagnosis 2.8%. • All patients in the CI group were admitted involuntarily. During the current admission 36.6% (n = 78) had experienced mechanical restraint, 15% (n = 32) had been isolated, 14.1% (n = 30) had been given forced medication and 9.4% (n = 20) had been monitored via video. 19.7% experienced two additional measures and 3.8% experienced three measures. • Most participants could be classified as seriously ill according to BPRS cut offs and had a low level of functioning according to the GAF. Both groups showed low insight levels, however insight was significantly lower in the CI group. • The majority of patients experienced negative emotions such as helplessness or desperation during

						Attitudes towards coercion scale (Krieger et al, 2017)		the measures. 40% reported feeling indifferent and positive emotions such as sense of safety and release were experienced during an involuntary hospitalization. • Patients expressed the highest level of understanding for involuntary admission (49%), least understanding of forced medication (13%) followed by both seclusion and mechanical restraint (both 24%), Understanding of forced medication, seclusion and mechanical restraint increased over the period of the admission.
(Khatib, Ibrahim et al.)	2018	**Re-building trust after physical restraint during involuntary psychiatric hospitalization**	Cross sectional	Israel	Physical restraint	To identify the elements which might best minimize the negative consequences of restriction of inpatients and the therapeutic alliance	Adult 15 participants who had experienced restraint during their last involuntary hospitalisation	3 major themes: 1. Issues related to time lapses: Duration of the restriction played a crucial role in the patients experience of the restriction. Descriptions of the passage of time being slow, feeling more emotional than usual and focussed on being untied. Being untied by staff restored calmness and trust- in contradiction to the aim of the restraint. Feelings of helplessness and descriptions of being at the mercy of the Nurses for release demonstrated traumatic experiences. The majority of participants mentioned the importance of contact with a staff member as soon as possible upon restraint. Patients described the experience of being tied in a room alone as awful, terrifying, felt like they were going to die, a nightmare. The experience of feeling degraded and humiliated was offset against the presence of a caring staff member. 2. Physical conditions during restraint. The sub themes here related to the staffs influence on the physical conditions in the venue. Most of the participants mentioned that replacement of bedding suitability of temperature and ventilation and the extent of comfort and posture when tied or otherwise restrained. The restoration of trust in the staff was dependent on the level of concern or interest they had for the patient in those areas.

								3. Issues related to the quality of the interaction with staff: Two polar sub themes of supportive and accusing. Supportive verbal expressions by staff improved a harsh experience whereas accusing interactions contributed to a negative and traumatic experience.
(Hotzy, Theodoridou et al.)	2018	**Machine learning: An approach in identifying risk factors for coercion compared to binary logistic regression**	Quantitative	Switzerland	Coercion: all	To define risk factors and test machine learning algorithms for their accuracy in the prediction of the risk to being subjected to coercive measures	Adult 393 involuntarily hospitalised patients. 170 experienced coercion.	In a model with 18 risk factors which were available on admission, the algorithm identified 120 out of the 170 patients which had experienced coercion and 174 out of 223 without. In a model with 18 risk factors available after discharge, the logistic regression algorithm identified 121 out of 170 with and 176 out of 223 without coercion. Machine learning algorithms are comparable to binary logistic regression and show promise for further research on risk factors relating to coercion in psychiatry.
(Gowda, Lepping et al.)	2018	**Restraint prevalence and perceived coercion among psychiatric inpatients from South India: A prospective study**	Prospective cohort study	India	Physical restraint, forced pharmacological treatments (chemical restraints and involuntary medications), isolation, seclusion, and ECT	To study the prevalence of restraint in an Indian psychiatric inpatient unit, and to examine the level of perceived coercion correlating to various forms of restraint **Instruments:** Coercion ladder (measure subjective coercion) (Gowda et al 2017) Mac Arthur perceived coercion scale (MAES, Gardner et al 1993) Iowa coercion questionnaire (ICQ, Moser et al 2004)	Adult 200 random number sampling	All participants were interviewed within three days of admission and three days of discharge • In 65.5% one or more restraint measures were used • Physical restraints were used in 20% • Chemical restraints were used in 58% of the sample- most common restraint used • Seclusion 18% • Involuntary medication 32% • Perceived coercion was higher in patients who were subjected to restraints during admission compared to those who had not. • Male gender, being married, a rural background, low socioeconomic status, mood disorder and alcohol or drug dependence were associated with higher risk of exposure to physical and chemical restraint.
(Goulet, Larue et al.)	2018	**A pilot study of "post-seclusion and/or restraint review" intervention with patients and staff in a mental health setting**	Participatory case study	Canada	Seclusion, Restraint	To develop and evaluate a post seclusion and/or restraint review (PSRR) intervention implemented in an acute psychiatric care unit.	12 staff members and 3 patients	3 phases to the intervention: 4. 5 months: Development of the intervention: Immersion in the setting, individual interviews, and development of the PSRR 5. 3 months: Implementation: Informative presentations, adjustment of the intervention.

								6. 6 months: Evaluation: Individual interviews, SR prevalence over 195 admissions • In the evaluation phase 9 out of 12 SR incidents had a PSRR. • Length of intervention 10-30 mins • PSRR was integrated into practice with the patient • However, it was less integrated into practice with the healthcare team- reasons outlined were: 1. It was only considered relevant if the SR was perceived as difficult 2. It called into question the quality of relationships between staff members Qualitative findings: • Nurses felt able to explore the patients' feelings during the PSRR • This contributed to restoration of the therapeutic relationship • PSRR with the treatment team was perceived as a learning opportunity • Use of seclusion and time spent in seclusion were significantly reduced 6 months after introduction of the PSRR Quantitative findings: • 21% of patients 6 months pre intervention were secluded • 10.4% 6 months post PSRR were secluded • This was statistically significant for seclusion and the intervention • However, it was not statistically significant for restraint and the intervention
(Goulet and Larue)	2018	**A case study: Seclusion and restraint in psychiatric care**	Participatory case study	Canada	Seclusion, restraint	To understand the context in which seclusion and restraint practices are employed based on the perceptions of staff and inpatients in a psychiatric ward	Adult 11 staff participants (all professions) 6 patient participants	A multifactor decision- making influence model (Larue et al 2009) was used to guide the documentation of the context in which SR practices occur, the interview framework and the analysis. Main themes influencing seclusion and restraint management: • Patient characteristics: etiology of violence, difficult experience • Staff characteristics: feelings of safety, rationalisation of seclusion use • Environmental characteristics: Staff described feeling unsafe in the environment

								• Explicit standards such as hospital protocol and Implicit standards such as ward rules. Prevention of aggressive behaviour: Alternatives to SR and its consequences: • Alternatives to SR are embedded in practice • SR is a last resort • Patient debriefing was informal and not systematic • PSRR objectives and themes • Methods varied among staff • Staff debriefing took place only in exceptional circumstances • SR or aggression management? There was no team debriefing if no problems were encountered during the SR event
(Fukasawa, Miyake et al.)	2018	**Relationship between the use of seclusion and mechanical restraint and the Nurse-bed ratio in psychiatric wards in Japan**	Cross sectional	Japan	Seclusion and mechanical restraint	To clarify the effect of the Nurse-to-bed ratio on the use of seclusion and restraint in Japanese general psychiatric wards, controlling for patient characteristics and ward-level characteristics. It was hypothesized that seclusion and restraint are less likely to be used in a ward with more Nurses. **Instrument:** Global assessment of functioning (GAF, American Psychiatric Association, 1989),	Adult and MHCOP Data from electronic records on 113 wards of 23 hospitals over a two-year period	Analysed relationships between number of Nurses per 10 beds in each ward and the use of seclusion and mechanical restraint, controlling for the patients age, sex, diagnosis, voluntary versus involuntary admission, prescribed dose of antipsychotics, severity of symptoms, length of stay, ward characteristics including ward size, location (urban or rural), and type of ward (acute or not). • 101013 admissions analysed. • Admissions exposed to at least one episode of seclusion in first 90 days was 36.7% (n = 3679) and mechanical restraint was 14.9% (1496) • Median time in seclusion in the first 90 days was 224hrs • Median time in mechanical restraints in the first 90 days was 143hrs. • Patients secluded were more likely to be male, young, diagnosed with schizophrenia or related disorders and admitted involuntarily • Mechanical restraint more likely to be used in over 65yrs • Mean hospital stay for patients secluded and mechanically restrained was longer • GAF score in people secluded was lower • Seclusion was more likely to be used in wards with more beds, more Nurses, in acute wards and in urban areas.

								• Odds ratios of the numbers of Nurses per 10 beds for the use of seclusion and mechanical restraint were 2.36 and 1.74 respectively • Seclusion and restraint were used more frequently on wards with more Nurses
(Dahan, Levi et al.)	2018	**The impact of 'being there': Psychiatric staff attitudes on the use of restraint**	Survey design	Israel	Restraint, mechanical restraint	To explore differences in attitudes towards restraint in psychiatry based on level of exposure of staff members to incidences of restraint	Population: Not clear Staff- all disciplines 43% response rate (n = 143) 1 hospital, 260 beds, 4 acute units and 4 chronic units- 35 patients in each ward	Instrument: Demographic questionnaire and attitudes towards mechanical restraint (Gelkopf et al 2009) • 32% (n = 46) were not present during an incident of restraint in the past year • 68% (97) were present • Of those present 35% did not participate (NP) and 65% were present and participated (PNP) • Predominance of women in the study- however, when the characteristics were compared across groups of presence and participation in incidences of restraint, the PP group was predominantly male • Significant differences in attitudes towards restraint based on the proximity to incidents of restraint • Among those present in incidents of restraint, those who physically participated saw them more as a means to achieve security and order and less humiliating and offending compared to those present but not physically participating in restraint.
(Cusack, Cusack et al.)	2018	**An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings**	Integrative review		Physical Restraint	To explore the physical and psychological impact of physical restraint for people receiving in-patient Mental Health Care.	10 papers	8 themes 1. Trauma/re-traumatisation: Due to the incident itself or retraumatised due to past trauma. 2. Distress 3. Fear 4. Feeling ignored 5. Control 6. Power 7. Calm 8. Dehumanising conditions Physical restraint in some instances can and does lead to physical and/or psychological harm.
(Cullen, Bowers et al.)	2018	**Factors associated with use of psychiatric intensive care and seclusion in adult**	Case control	UK	PICU and Seclusion	To determine the demographic, clinical and behavioural predictors of both PICU and seclusion	Adult 2 Cohorts: PICU Cohort: All patients transferred from general adult to	Data derived from electronic medical records of patients Demographic and clinical factors and behavioural precursors occurring 3 days prior to PICU transfer or seclusion episode were extracted from the medical records.

		inpatient Mental Health Services					PICU over a 5year period (N=986) and 994 controls who were non PICU transfers. Seclusion Cohort: Comprising all seclusion episodes occurring in PICU wards over the same period (N = 990) and a randomly selected group of patients who were not secluded (N= 1032)	• PICU cases were significantly likely to be younger in age, have a diagnosis of bipolar disorder and be involuntary compared to those not transferred. • The strongest predictors of transfer to PICU were incidents of physical aggression towards others or objects and absconding or attempts to abscond • Female sex and longer time since admission were associated with lower odds of transfer • Secluded patients were more likely to be younger and legally detained compared to non-secluded patients. • Female sex increased the odds of seclusion • Likelihood of seclusion decreased with time since admission • Precursors to seclusion included restraint, shouting and involuntary status
(Barnett, Kusunzi et al.)	2018	**Factors associated with the use of seclusion in an inpatient psychiatric unit in Lilongwe, Malawi**	Retrospective chart review	Malawi	Seclusion	To calculate the frequency of seclusion in patients hospitalised in an inpatient psychiatric unit in Malawi and identify factors associated with its use	1 year – 419 records reviewed.	• 30.3% (n = 127) of admissions were secluded • Male patients had increased odds of being secluded (OR 2.22 p = 0.02) • Presenting to the unit in mechanical restraint had increased odds of being secluded (OR 2,22 p = <.01) • No other statistically significant variables • Limitation: missing data but extent of this not identified
(Aguilera-Serrano, Guzman-Parra et al.)	2018	**Variables Associated With the Subjective Experience of Coercive Measures in Psychiatric Inpatients: A Systematic Review**	Systematic review		Coercive measures: Mechanical restraint, seclusion, forced medication	To present evidence regarding factors that may influence the patients subjective experience of an episode of mechanical restraint, seclusion or forced medication	34 papers	• Considerable heterogeneity among studies in terms of coercive measures experienced by participants and study designs. • Main findings are the attitudes of professionals and patients' interactions with the staff. • Respect and humane treatment by staff were associated with a more favourable perceptions of coercion. • Themes identified: • Provision of information, presence of or interaction with staff, and adequacy of communication with professionals influenced the subjective experience of the coercive measure. The presence of staff during the process of the measure can make the coercive measure less aversive. Adequate communication or conversely lack of communication can also influence the experience of coercive measures

								• The environment of the psychiatric ward including comfort, furniture, the physical environment, wearing own clothes, the presence of personal objects. The regulated use of bathrooms, pronounced activity, the ward atmosphere, hostile environment, and privacy • Respect, humane treatment, and support from staff • Debriefing • Individual characteristics of patients • Characteristics of experiences raised by coercive measures: Predominantly negative (26 studies): Fear, anxiety, post-traumatic stress disorder, powerlessness, abandonment, distrustfulness or loneliness, punishment, maltreatment, anger, rage, resentment, depression, impotence, sadness, humiliation, degradation, shame, loss of freedom or coercion. Conversely 6 studies found some positive experiences Feeling that the measure was helpful, beneficial, or necessary, calming, time for reflection or rest, safety or sense of control and prevention of violence or a place to express emotion.
(Wilson, Rouse et al.)	2017	**Is restraint a 'necessary evil' in Mental Health Care? Mental health inpatients' and staff members' experience of physical restraint**	Qualitative	UK	Physical restraint	To improve understanding of the experience of restraint for patients and staff with direct experience and witnesses.	13 patients-current or former who had witnessed or experienced physical restraint 22 staff who had witnessed or been involved in physical restraint	• Overarching theme: Is restraint a necessary evil? • Subthemes: 1. It's never very nice: Predominantly negative emotional or relational outcomes reported. 2. But it's got to be done: Whilst restraint was never nice it is a necessary evil, last resort used to deal with safety concerns Distressing and fear-inducing for patients, staff, and witnesses Dehumanising and feelings of loss of control for patients Difficult aspect of staff job, contrary to the caring nature of it Negative effect on patient staff relationships

(van de Sande, Noorthoorn et al.)	2017	**Associations between psychiatric symptoms and seclusion use: Clinical implications for care planning**	Cross sectional	Netherlands	Seclusion	To investigate the association between the sores of three structured observation tools and seclusion. The tools: • Level of functioning: The Kennedy Axis V (K-Axis-V Kennedy, 2003) • Symptoms: The Brief Psychiatric Rating Scale (BPRS, Overall and Gorham, 1988) • Dysfunctional behaviours: The social disfunction and aggression scale (SDAS, Wistedt et al. 1990) • Coercive interventions: Argus Scale (Janssen et al 2011)	Adult 4 comparable psychiatric wards Total admissions 1383 of 878 adults over 24 months. N = 370	• There are dynamic and static factors related to seclusion • Dynamic: violent behaviour, current substance abuse, suspiciousness, and negativism • Static: Ethnicity, Diagnosis of substance abuse disorder • 22% (n = 193) of the patients admitted were subjected to seclusion • 6% 1 seclusion episode, 10% 2 seclusion episodes and 6% more than two episodes. • 79% of all assessments were completed/retrieved • Secluded patients were usually younger, more often from an ethnic background, had a diagnosis of bipolar disorder. Less often had personality disorder or a depressive disorder. • Seclusion was *not* linked to involuntary admission • Mean length of stay for patients who were secluded was longer • The findings show that in the week prior to seclusion patients assessments sowed lower psychological functioning and social skills, violence to self or others, medical impairment. Treatment motivation showed dysfunctional scores in the same week, positive, negative, and manic symptoms as well as conceptual disorganization showed elevated scores also in the week prior to seclusion.
(Thomsen, Starkopf et al.)	2017	**Risk factors of coercion among psychiatric inpatients: a nationwide register-based cohort study**	Cohort	Denmark	Coercion: Compulsory admission, involuntary detention, restraint and forced treatment.	To identify the people at risk of coercion in psychiatric services	All All psychiatric inpatients in Denmark (N = 112, 233) over a five-year period.	• 21.9% of inpatients were exposed to a coercive measure • Patients with organic mental disorder (fivefold elevated odds and 12-fold elevated odds of forced treatment), mental retardation or schizophrenia had the highest risk of being subjected to a coercive measure. • Risk was highest on first admission for all coercive measures and decreased with every subsequent admission • Patients who had received outpatient care in the preceding year were more likely to be subjected to a coercive measure. • Socio economic variables associated with increased risk of coercion were male, highest level of education, unemployed or had parents who were

								unemployed, lower social class, immigrants from low- and mid-income countries, Over the age of 51 years • Early retirement, being married and having children were associated with decreased risk of being coerced
(McLeod, King et al.)	2017	**Ethnic disparities in the use of seclusion for adult psychiatric inpatients in New Zealand**	National dataset analysis	New Zealand	Seclusion	To investigate the disparities in seclusion between Māori and non-Māori non-Pacific (nMnP) adults in mental health inpatient Units in NZ	Adult 2 years 1944 Māori admissions for 1245 individuals 5295 nMnP admissions for 3454 individuals	• Māori psychiatric inpatients are 39% more likely to experience a seclusion episode than nMnP adults • Māori male and female admissions were significantly more likely to be secluded than nMnP of the same gender • Patterns of duration were similar between Māori and nMnP seclusion episodes • Māori patients were younger than nMnP patients • Involuntary patients more likely to experience seclusion
(Pettit, Bowers et al.)	2017	**Acceptability and use of coercive methods across differing service configurations with and without seclusion and/or psychiatric intensive care units**	Cross sectional design	UK	Manual restraint	To compare across different service configurations (with seclusion/without seclusion; with PICU/without PICU) the acceptability of containment methods to acute wards staff and the speed of initiation of manual restraint Instruments: • Attitudes towards containment questionnaire (ACMQv2 Bowers et al 2007) • The Moylan progression of aggression tool (MPAT Moylan, 2009)	Adult 207 staff across 8 hospitals over 1 year	• PICU, intermittent observations and PRN medications received the highest approval ratings • Mechanical restraint and net beds received the lowest approval ratings • Open area seclusion, mechanical restraint and seclusion showed the greatest variability in approval scores • Access to seclusion room was associated with greater approval as a methods of containment • The availability of PICU was not statistically associated with any containment method acceptability score • MAPAT time to restraint was not associated with demographic information or details of current post • MAPAT timings were inversely associated with seclusion availability but were not associated with seclusion availability

(Pawlowski and Baranowski)	2017	**How patients' characteristics influence the use of coercive measures**	Longitudinal perspective observational study	Poland	Coercive measures Physical coercion: physical restraint; forced medication; mechanical restraint and seclusion	Identify sociodemographic and clinical characteristics of patients that were associated with coercion during hospital treatment	Adult and older persons One hospital over one year. Six inpatient wards. Total treated N =1476 (778 Male and 698 Female)	• 15% (n = 226) were subjected to coercion on a total of 405 occasions • Most frequent form of coercion- mechanical restraint (47.2%). • Most frequently exposed to coercion diagnosis: Schizophrenia, schizotypal, delusional disorders • Factors associated with the use of direct coercion: male, young, mental disorders arising from misuse of psychoactive drugs, involuntary admission, and the use of direct coercion in the past.
(Mellow, Tickle et al.)	2017	**Qualitative systematic literature review: The experience of being in seclusion for adults with mental health difficulties**	Qualitative systematic review		Seclusion	To investigate the lived experience of seclusion for adults with mental health difficulties	11 papers	• Papers were of mixed quality and findings • Seclusion has the potential to cause iatrogenic harm, particularly where interactions with nursing staff are not experienced as compassionate • The actions of nursing staff when implementing seclusion may cause iatrogenic harm • 5 Themed categories: Emotional impact of seclusion: 10 of 11 papers identified this as negative. This included intense effect, emotional impact, emotional experiences, loneliness, autonomy, fear, anger, frustration, powerlessness, and sadness 2 papers found that some participants reported positive effects of the seclusion experience. This included relief, feeling secure enough to get some sleep. Environmental experience of seclusion: Sensory deprivation, problems relating to lack of access to meet basic needs. The process of seclusion in terms of disrobing and the locking of the door were described a frightening, humiliating, and dehumanising. Cognitive and behavioural responses to being in seclusion: Described as a response to seclusion or being exacerbated by seclusion: agitation, hallucinations, delusions, and the effects of sensory deprivation. Making sense of the seclusion experience: For many the experience was understood as a form of punishment and was described as a dehumanising experience. The participants understanding or lack of understanding was a factor.

								Interactions with staff: Interactions with staff were seen as important and could be identified as positive or negative. Positive interactions: clear communication, support, understanding. Negative interactions: poor quality interactions, lack of communication or concern
(McKenna, McEvedy et al.)	2017	**Association of methamphetamine use and restrictive practices in an acute adult inpatient mental health unit: A retrospective cohort study**	Retrospective cohort	Australia	Restrictive practices: Seclusion, physical restraint, mechanical restraint.	To describe the incidences of restrictive practices and the association of methamphetamine use at an acute inpatient mental health unit	Adult and older persons 1 Unit over a three-month period (N = 232 consecutive admissions)	• 10.8% (n = 25) of all admissions were subjected to a restrictive intervention. • Methamphetamine use was either self-reported or detected by saliva test for 30.6% (n = 71) of consumers. • Methamphetamine use and restrictive intervention in the ED were predictors of restrictive practices in the MH service • The use of restrictive practices on the unit was uncommon- 73.2% of people with methamphetamine use did not experience a restrictive intervention. • Those who did experience restrictive practices (n = 18/25): 23 episodes of seclusion, 20 episodes of physical restraint, one episode of mechanical restraint.
(Fletcher, Spittal et al.)	2017	**Outcomes of the Victorian Safewards trial in 13 wards: Impact on seclusion rates and fidelity measurement**	Before and after design with a comparison group	Australia	Seclusion	To assess the impact of implementing Safewards on seclusion	Adult and adolescent inpatient: 13 wards Comparator wards: 31	• Adherence to the model was good • Seclusion rates were reduced by 36% in Safewards trial wards compared to non-trial wards by the 12 month follow up period • No change in seclusion rates in the comparator wards
(Chavulak and Petrakis)	2017	**Who experiences seclusion? An examination of demographics and duration in a public acute inpatient mental health service**	Descriptive	Australia	Seclusion	To investigate the use of seclusion and who was secluded amongst patients presenting with psychotic symptomology: • Length, duration, and admission route of seclusion episodes	Adult and older person acute 655 acute crisis admissions over 1 year	• 79 individuals experienced seclusion 200 times • 45% (n = 96) were within the legally acceptable 4-hour duration • 33.3% experienced seclusion once • Age range 17-74 years, mean age 36 years. • 66% in the age backet 18-39yrs and the same number were male • Half identified housing as unknown and 27% lived independently • 75% had never been married • Two distinct groups:

								Those secluded for short periods of time irregularly Those who experienced lengthier seclusion events and/or those experiencing multiple seclusion events during their inpatient stay
(Beaglehole, Beveridge et al.)	2017	**Unlocking an acute psychiatric ward: the impact on unauthorised absences, assaults, and seclusions**	Before and after design	New Zealand	Seclusion	To evaluate whether shifting to an unlocked environment was associated with higher rates of adverse events, including unauthorised absence violent incidents and seclusion	Adult acute	• Seclusion dropped by 53% • Unauthorised absences increased by 58% • A small incidence in violent incidents was recorded but it was not statistically significant

Author/s	Year	Title	Type of study	Location	Study focus	Study Question	Population: Adult, CAMHS, Forensic, MHCOP, All	Key findings
(Askew, Fisher et al.)	2020	**Being in a seclusion room: The forensic psychiatric patients inpatients perspective.**	Qualitative	UK	Seclusion: Patient experience	The forensic inpatients experience of being in the seclusion and the specific psychological needs of Service Users	Forensic adult: (N=7)	Patient experience: 4 themes • Intense fear: Frightening experience • Not getting the care I need: Feelings of neglect, being left, the nature of the room- cold, no blanket etc • I am being abused: Staff actions were sometimes interpreted as abusive- physical, and sexual (including observations during use of the bathroom). • Power struggle: Participants were vulnerable and experienced a loss and gain of power throughout the seclusion. Staff had power over the seclusion experience and the duration of it. Participants sought to either to behave in a docile manner or to display behaviours which restored their power.
(Jalil, Huber et al.)	2020	**The role of interpersonal style in aggression and its containment in a forensic mental health setting: A correlational and pseudoprospective study of patients and nursing staff**	Correlational pseudoprospective	UK	Aggression Containment: Restraint, Seclusion	To measure the self-reported anger and reciprocally rated interpersonal styles in order to explore the relationship between a complementary and anticomplementary Nurse-patient interaction styles with aggression (patients) and with involvement in in restraint and seclusion (Nurses)	Forensic adult N=150 patients and N=65 Nurses.	• Positive association between patients self-reported anger and staff ratings of patients' hostile interpersonal style. • Positive association between Nurses self-reported anger and the patients rating of the key-workers dominant, but not hostile interpersonal style. • Patients' hostile-dominant interpersonal style and association with inpatient aggression and containment-partially supported • Aggressive patients had significantly more anger than non-aggressive- anger was a statistically significant predictor variable. • Patients self-reported anger predicted being subjected to restraint only. • A hostile interpersonal style predicted being subjected to physical restraint followed by seclusion • No staff variable predicted involvement in physical restraint with or without seclusion • Deviation from complementarity in relationship dyads did not predict both patient aggression and patients being subjected to containment.

Kennedy et al	2020	**To devise and validate a tool for clinicians and secure hospitals to assess necessity and proportionality between restrictive practices including de-escalation, seclusion, restraint, forced medication and others.**	Retrospective observational cohort study-proof of concept	Ireland	Violence and restrictive practices	Data to support development of DRILL and overall model: Focus on antecedent context with corresponding interventions using daily risk assessment tools and context decision pathways: ladders	Adult Forensic	• A system for measuring adverse behaviour and corresponding continuum of restrictive interventions. Interventions were proportionate to seriousness of harmful behaviours. The system includes: • (Ladders represent the continuum of behaviour or interventions) • Previous day assessment using DASA to inform the newly developed, validated evidence-based DRILLs for the following day: Behaviour ladders (5 ordinal scales: Violence, self-harm, risk to others, absconding and non-compliance) and corresponding intervention ladders. (8 ordinal scales: de-escalation, observations, personal searches, extra medication, situational coercion, manual restraint, seclusion and mechanical restraint). • Useful for supporting proportionality of interventions
(Gunther, Kirchebner et al.)	2020	**Identifying direct coercion in a high-risk subgroup of offender patients with schizophrenia via machine learning algorithms**	Retrospective study design	Switzerland	Coercion: Restraint (physical, mechanical) Seclusion Involuntary medication	To use machine learning for analysis of 569 potential predictors of coercive measures in a cohort of inpatient forensic offender patients to identify more subtle and detailed predictors of coercion.	Adult forensic. 358 offender patients	• The model correctly classified the 'not having experienced coercion' with 72.87% sensitivity • The model correctly classified and identified the 'experienced coercion' with 73.68% specificity. • Best identifiers out of a set of 569 potential variables in order of statistical significance: o Threat of violence and actual violence towards other during inpatient admission o Direct coercive measures in the past o Poor impulse control and uncooperativeness at admission o Prescription of haloperidol during treatment o The total PANSS (Positive and Negative Symptoms Scale) score on admission o Daily cumulative olanzapine equivalent dosage on discharge o Hostility on admission o Legal prognosis as estimated by a team of forensic psychiatrists upon discharge based upon all available material in the patient's file.
(Flammer, Frank et al.)	2020	**Freedom restrictive coercive measures in forensic psychiatry**	Cross sectional	Germany	Coercion: Seclusion, mechanical restraint, room confinement	Data from cohort of inpatient forensic patients in 8 forensic facilities were gathered and analysed for type and duration of	Adult forensic N=1431	• Seclusion: Forensic: 22.6% of cases were subjected to seclusion General Psychiatry: (N=115011) 2.9% subjected to 9716 seclusion episodes • Mechanical restraint:

						coercive measures, number according to diagnosis and cumulated number of days of treatment. These were compared to the same type of data from general psychiatry		Forensic: 3.8% of cases were subjected to mechanical restraint General psychiatry: 4.7% were subjected to 17131 • Room confinement: Forensic: 13.2% subjected to room confinement General psychiatry: 0% Not used • Involuntary medication: Forensic: 1.9%; .2 emergency and .2 court order. General psychiatry: .07 emergency and .06 by court order. • Use of seclusion in general hospital was 8 times higher than in forensic psychiatry • Use of mechanical restraint in general psychiatry slightly lower. • Use of involuntary medication in forensic hospitals was three times higher but still low >3%.
(Tingleff, Hounsgaard et al.)	2019	**Forensic psychiatric patients' perceptions of situations associated with mechanical restraint: A qualitative interview study**	Qualitative	Denmark	Mechanical restraint	Examine patient perceptions of MR before and after, meaning ascribed to the event by patients and perceptions of factors that affect use and duration.	Forensic Adult N=20	The measure seen as a process of before, during and after, Four similar themes in 2 linked typical patterns: Patterns of protest and pattern of illness: Pattern of protest: 1. Overt protest reactions (Before MR, antecedent) Characterised by patients anger and frustration which is reflected in violence threats or aggression towards staff- arising from conflict- examples given unit rules, discussions about medication. Exacerbated when patients perceived that staff declined to enter a dialogue or refused to understand patients' perceptions or ignored an approach- resulting in patient feeling inferior to staff. 2. Overt protest reaction/Silent protest reaction (At the point of MR) Further exacerbated at point of MR. – fighting, feeling surrounded, overpowered, subjected to holding by staff members. Feelings of humiliation, - exacerbated by lack of emotional engagement by staff. Silent protest characterised by 'false calmness' as a way of coping and repressing actual feelings of anger, frustration and sadness. Reports of giving up fighting the staff to avoid risking a charge of a violent offence or because they know it would not result in their desired outcome. 3. Overt protest reaction/Silent protest reaction (During the period of MR) Overt: Anger frustration

								characterised by shouting and being threatening towards staff. Staff reactions gave rise to exacerbation of the protest- particularly directed towards the observing member of staff or the Dr who had minimal communication or no communication with the patient. Prolonging MR perceived as a misuse of power. Participants were angry at being forcibly medicated or forced to eliminate body wastes in the presence of staff during the MR. Eventually the patient replaced the protest with a false act of calmness in silent protest, suppressing anger or giving up resisting. 4. Silent protest reaction (After MR). Patients perceived that the decision to end the MR depended on whether it suited the staff or not. Patients considered that their relationships with staff had changed as a result of MR, felt mistrust, avoided contact with staff and followed staff rules to avoid further conflict and subsequent MR. Patients described it as difficult to maintain silent protest and that eventually anger and frustration could explode resulting in further MR. Patients perceived that staff avoided providing them with information on how to appeal the restraint, the reasons for the restraint and a dialogue to avoid further restraint. Conversely some patients felt genuinely calm following the MR without the need for overt protest- patients perceived a positive impact and 'had learned from their mistakes'. Pattern of Illness: 1. Illness related behaviour (Before MR/Antecedents) Patients perceived their own behaviour to eb caused by illness as an antecedent to MR: Extent of risk posed to themselves or others as a result of their illness. Lack of insight reported which resulted in overt protest reactions. 2. Overt protest reaction (At the point of MR) Patients perceived their actions and reactions to be as a result of their illness. In addition, they resisted and displayed overt reactions against the restrictions of free movement. Through a process of receiving medication and time in the MR they felt genuinely calm. Staff could contribute to this through the use of small talk, calming and encouraging communication.

								3. Illness related behaviour/Overt protest reaction/Genuinely calm (During the period of MR) Through a process of receiving medication and time in the MR they felt genuinely calm. Staff could contribute to this through the use of small talk, calming and encouraging communication. 4. Genuinely calm (After MR) Patient acknowledged the need for the MR episode, staff acted to care for them. This realisation could be self or though debriefing when staff provided an explanation for the MR and its duration.
(Nielsen, Gildberg et al.)	2018	**Forensic mental health clinician's experiences with and assessment of alliance regarding the patient's readiness to be released from mechanical restraint**	Qualitative	Denmark	Mechanical restraint	To report on the clinician patient alliance during MR and how parameters of the alliance are assessed regarding readiness to be released from MR	Forensic; 28 clinicians	• A personal alliance with the patient before MR forms the basis for entering, observing, and assessing the clinician-patient alliance during MR • According to clinicians' patients felt safe by having a connection with the clinician during MR • Assessment of the alliance for release: patients' insight into understanding of the present situation, knowledge of the patients' habitual state, prior experiences of being around the patient and observations of their current state. • Patients psychiatric condition and to what extent this overrode or made contact or cooperation difficult or whether the patient seemed stable. • Patients' insight into or understanding of the present situation. Ability to talk about the present situation, insight into the need for restraint and motivation to move on facilitated clinician patient co-operation. Lack of insight and communication made it difficult to negotiate release. Where a patient was unable to understand the present situation clinicians also assessed whether the patient understood the behaviour required of them to be released from MR. • Patients' ability to co-operate and have contact-provided clinicians with an assessment of the patients current understanding and situation and the extent to which they would be able to keep to agreements made. Predictability and contact stability was important to the clinician's assessment. Fluctuation in behaviour had a negative impact on the decision to discontinue MR and vice versa.

								• Overall team assessment- the range of alliances between the patient and the various clinicians gave rise to different assessments of the patient which were gathered (total quality alliance) into an overall assessment for release.
(Griffiths, Roychowdhury et al.)	2018	**Seclusion: the association with diagnosis, gender, length of stay and HoNOS-secure in low and medium secure inpatient mental health service**	Retrospective cohort study	UK	Seclusion	Compare the characteristics of secluded and non-secluded patients admitted to secure wards: HoNOS, length of stay, gender, age, and diagnosis and if the presence or absence of seclusion affects the entry to discharge change I the HoNOS secure scores amongst 4 diagnostic groups: Asperger's syndrome, paranoid schizophrenia, organic personality disorder.	Forensic low secure (n=347)	• 96 patients (27.6%) experienced at least one seclusion even, 251 experienced no seclusion. • Overall, no gender difference in whole cohort • Higher proportion of men in the non-secluded emotionally unstable PD group • Secluded (Mean 30.8) patients were significantly younger (Mean 35.2) than those not. • Secluded/not secluded by diagnosis: Paranoid schizophrenia (126; 28), Emotionally unstable PD (64; 32), Asperger's Syndrome (34;15), Organic PD (27;21). • Ranked: Organic PD group (44%), Emotionally unstable PD (33%) and paranoid schizophrenia (18%) • Length of stay did not differ between secluded and non-secluded groups • HoNOS total amount of change from admission to discharge was not different in the two groups- recovery not delayed. Rate if improvement was higher in secluded group with borderline PD. • Paranoid schizophrenia: Presence of seclusion appears to adversely affect the sub scales on personal and emotional wellbeing. • Organic PD: No difference in scores across the secluded and non-secluded- this cohort had the highest number of seclusions • Asperger's Syndrome No link between the HoNOS scores and seclusion rates • HoNOS- secure clinical and secure subscales can measure clinically meaningful change across diagnostic groups when used as a total scores comparing admission and discharge. The presence or absence of seclusion impacts on these scores and there is a complex relationship between diagnosis, seclusion v non seclusion and HoNOS scores. • More research needed

Author/s	Year	Title	Type of study	Location	Study focus	Study Question	Population: Adult, CAMHS, Forensic, MHCOP, All	Key findings
(Geng, Jiang et al.)	2021	**Elevated Rates of Restraint and Seclusion in Child and Adolescent Psychiatric Inpatients in China and Their Associated Factors**	Survey design: MM (semi structured interviews, review of records for specific variables)	China	Rates of seclusion and restraint (physical and mechanical- not defined pr distinguished)	To investigate the rate of restraint and seclusion in child and adolescent psychiatric inpatients and their associated factors	CAMHS N = 196 from 41 provincial tertiary hospitals over a 14-day period.	• Official national survey • Rates: 28.6% (n = 56) restraint; 11.7% (n = 23); 22 patients exposed to both. 6 patients more than half of the restraint events; 4 more than half of seclusion events. • More likely to have been hospitalised on an involuntary basis (p<.01) • Manic or aggressive on admission (p<.01) • More frequent aggression during hospitalisation (p<.001) • Lower Global assessment of functioning (GAF) score om admission (p<.01)
(Nielsen, Bray et al.)	2021	**Physical restraint of children and adolescents in mental health inpatient services: A systematic review and narrative synthesis**	SR: Narrative		Physical restraint only	• Which children and adolescents are being physically restrained in inpatient Mental Health Services • Why children and adolescents are being physically restrained in child and adolescent Mental Health Services • The consequences for children and adolescents of reported physical restraint use in inpatient Mental Health Services	CAMHS 16 quantitative studies	• No data on children's first-hand experiences of restraint • Combination of patient (intrinsic) and environmental (extrinsic) factors lead to restraint of children and adolescents in Mental Health Services • Who: Younger children >13yrs; Males, Females greater risk of multiple restraints; Diagnosis- developmental disorder, psychotic disorder, externalising and internalising disorder, multiple co-morbid diagnoses increased likelihood; History- multiple previous inpatient admissions, history of trauma, self-harm, and aggression • Why: Risky behaviours- agitation, aggression, threats, staff directed assault, self-harm, opposition, disinhibition, absconsion; Admission status- emergency and voluntary; Timing- Incidents more prevalent at the start of the week, afternoon, and evenings and during longer admissions. Incidents generally decrease over the course of an admission, spike after initial 'honeymoon period, potential for clusters- one incident sparks another • Consequences: Physical injury- Potential relationship between increased risk of physical injury. Psychological- associated with lack of therapeutic

								effect, potentially worsening behaviours, little known about adverse effects associated with children and adolescents. • Most studies recognise there may be underreporting • 4 studies reported multiple interventions attempted prior to physical restraint (as needed medication before 35%, other interventions not noted) • 5 studies report that use of physical restraint is partly determined by staff familiarity with policies (not specified) • Time- as time progresses threshold for staff using physical restraint increases- interventions focus on most dangerous behaviours • Staff lack of familiarity with child's cultural background- misperceptions around dangerousness leading to miscommunication and mistrust from both perspectives • Children and adolescents from minority backgrounds have a higher proportion of unmet mental health needs, have more serious symptoms on admission and are at higher risk of physical restraint
(Perers, Bäckström et al.)	2021	**Methods and Strategies for Reducing Seclusion and Restraint in Child and Adolescent Psychiatric Inpatient Care**	SR		Seclusion and restraint (inc mechanical restraint) reduction	2010-2020 methods and strategies for reducing seclusions and restraints in child and adolescent inpatient psychiatric units	CAMHS: 18 studies	• Multi component trauma informed initiatives (4 papers), 3 based on the six core strategies, strengths-based initiatives • CPS and CFCC: Included additional interventions such as animal assisted therapy, mindfulness group for adolescents, DBT and Acceptance and Commitment Therapy (ACT) • Behavioural Management Programmes: Category of interventions grounded in social learning and applied behaviour analysis. Mixed results dependent on the interventions- can be seen as rule enforcing etc. Traditional rewards and consequences can result in increased conflict between patients and staff. Significantly less patients had seclusion or restraints during the BMP period. • Modified Positive Behavioural Interventions and Supports (M-PBIS)- 3-tiered approach- significant decrease in mean seclusion rate, % of patients placed in seclusion or restraint, means duration of restraint ad % of patients who received any PRN.

								○ Universal interventions: establishing staff commitment, defined set of positively worded expectations, how to meet these and reward system for positive behaviour ○ Targeted problem-solving conversations with selected patients ○ Functional behaviour assessments and individualised behaviour plans for those who continued to have problems after 1 and 2 • BMP: For children with ADHD and oppositional defiant disorder (ODD)- points system, social reinforcement, time-out, parent training • Behavioural modification plans- Address issues such as problem behaviour, replacement behaviour, positive rewards, negative consequences. • Sensory rooms as single intervention: Study 1: Seckman (2017) Reduction in incidents of restraint (26.5%) and seclusion (32.8%) and reduced frequency of aggression Study 2: West et al (2017) Statistically significant reduction in distress – greatest reduction among adolescents with a history of aggression Study 3: Bobier et al (2015) Statistically significant decrease in seclusion episodes 6 months after, slight decrease in full restraint episodes (not statistically significant) • Milieu Nurse assignment as single intervention: Changes in shift assignments, allocation of Nurses to meet the needs of the group as a whole (as opposed to individually)- create an environment of structure, safety, consistency, empathy, as well as administering PRN medications and executing/updating client treatment plans- enabled early interventions- statistically significant decrease in average monthly restraint rate from 72.9 to 7.5 restraints per 1000 client days
(Yurtbasi, Melvin et al.)	2021	**Nurse and patient factors: Predicting seclusion in adolescent psychiatric units**	Retrospective nested Case control	Australia	Seclusion	To identify Nurse and patient variables that are predictive of seclusion.	CAMHS Comparison of 72 pm shifts on which seclusion occurred	• Increased seclusion predicted by: Lower Nurse patient ratio, more male Nurses on shift, presence of agency/temporary Nurses on shift, greater combined years of MH experience, lower total HoNOSCA subscale

							to 216 pm shifts on which no seclusion occurred over a 3-year period. One adolescent inpatient unit.	score. Unique predictors increasing risk of seclusion: number of male Nurses, presence of temporary/agency Nurses. Greater number of female Nurses decreased risk of seclusion.
(Vidal, Reynolds et al.)	2020	**Risk Factors for Seclusion in Children and Adolescents Inpatient Psychiatry: The Role of Demographic Characteristics, Clinical Severity, Life Experiences and Diagnoses**	Quantitative: Case controlled retrospective analysis	USA	Seclusion	To understand the risk factors for seclusion in a sample of children and adolescents admitted to an inpatient psychiatric facility.	CAMHS 1 unit 4-year period- N= 1986	Predictors of seclusion: • Demographic: Younger age, male, black race, prior admission, Patients with public medical insurance • Clinical severity: Disruptive behaviour, readmission • Diagnostic characteristics: Bipolar and related disorder, depression, trauma, and stress disorders • History of physical abuse
Carlson, Chua et al.	2020	**Behaviour Modification Is Associated with Reduced Psychotropic Medication Use in Children with Aggression in Inpatient Treatment: A Retrospective Cohort Study**	Retrospective cohort	USA	Psychotropic Medication use in children with aggression	Examine rates of PRN Psychotropic medication before and after a BM was discontinued.	CAMHS 10 bedded unit. N = 661 in 5 cohorts over 10 years admitted for aggressive behaviour. PRN use per 1000 days was the primary outcome measure. Predictors: BMP status, CAP oversight, diagnosis, age, length of stay, neuroleptic use.	Children admitted for aggression: high rates of externalising disorder (79%), low rates of mood (27%), anxiety disorders (21%) and significantly high rates of PRN and S&R (p<.001). Rate of PRN use was significantly lower during the BMP programme than when it was absent. Higher PRN use was predicted by BMP absence, half time CAP oversight, neuroleptic treatment, young age.
(Furre, Falk et al.)	2017	**Characteristics of adolescents frequently restrained in acute psychiatric units in Norway: a nationwide study**	Retrospective cohort	Norway	Restraint: Mechanical, physical holding and Pharmacological Seclusion	To examine the type, reason, and duration of restraint episodes	CAMHS National study (16units, 3 years) 4099 adolescents admitted- 267 experienced restraint.	6.5% (n=267) of the sample experienced restraint. 59% girls, 13% immigrant background, psychotic disorders 12%, affective disorders 22%, neurotic and stress related disorders 20%, externalising disorders 28% and no diagnosis 18%. Total pf 2277 episodes: 13.6% MR, 1.6% Pharmacological restraint, 5.9% seclusion, 78.7% physical holding, .4% no description.

								13.4% was mechanical restraint, 1.6% was pharmacological restraint, 5.9% were seclusion and 78.7% were physical holding. Median number of restraint per patient was 2. Most common reason was harm to others (53.2%). Self-harm (21.7%); Damaging property (16.5%); running away (13.90; 11.2% acting out. Patients restrained for harming others or self were restrained for significantly longer than other. Duration mean: Mechanical restraint 3.5hrs, seclusion 30 mins, physical holding 10mins.
(Seckman, Paun et al.)	2017	**Evaluation of the use of a sensory room on an adolescent inpatient unit and its impact on restraint and seclusion prevention**	QIP	USA	Restraint and seclusion	Effects of a sensory room intervention on seclusion and restraint, staff/patient relationships and patient aggressive behaviours	CAMHS 20 bedded unit	PDSA used Staff training and procedures for use of the room Data 6 months pre and 6 months post: Restraint: 26.5% reduction Seclusion: 32.8% reduction All aggression types reduced except destruction of property which increased by 23.6% Duration: steady downward trend expect for 2 months- further analysis suggests this was due to 3 outliers.

Author/s	Year	Title	Type of study	Location	Study focus	Study Question	Population: Adult, CAMHS, Forensic, MHCOP, All	Key findings
(Chieze, Kaiser et al.)	2021	**Prevalence and risk factors for seclusion and restraint in old-age psychiatry inpatient units**	Retrospective cohort	Switzerland	Coercion: Seclusion, forced medication, four- and five-point mechanical restraints, seat belts, holding tables, abdominal bed holding belts, bedrails, anti-wandering devices, forced medication	Identify the risks of coercion in elderly	MHCOP over one year	• 16.4% (n=81) of admissions were prescribed at least one coercive measure • Seclusion most prescribed (77.4%) followed by restraint (16.7%) including bedrails (n = 6), chair-tiding (n =6), bed-tiding (n = 4) and immobilization (n = 1). • More men than women subjected to coercive measures, involuntary status, longer length of stay, organic and bipolar patients more likely to experience coercive measures. • Risk was higher is separated/divorced and married people than single/living alone • Age reduced risk of coercion, risk increases with increased number of hospitalisations • Increased with the item 1 rating on the HoNOS

Author/s	Year	Title	Type of study	Location	Study focus	Study Question	Population: Adult, CAMHS, Forensic, MHCOP, All	Key findings
(Funayama and Takata)	2020	**Psychiatric inpatients subjected to physical restraint have a higher risk of deep vein thrombosis and aspiration pneumonia**	Retrospective cohort	Japan	Mechanical restraint (Physical Restraint: Defined as applied to the upper extremities- not chest or shoulder vest)	To assess differences between the two groups with respect to the occurrence of medical complications	Adult N=1308 Restraint n= 110 No Restraint n= 1198 1 Psychiatric Unit	• The Restraint group had substantially higher risk for DVT, and aspiration pneumonia compared to the non-PR group • Protocol for use of restraint identified incusing preventative measures • Bedridden status and poor psychiatric functioning also affected the incidence of DVT and pneumonia
(Nielsen, Bech et al.)	2019	**Construct validity of the Mechanical Restraint – Confounders, Risk, Alliance Score (MR-CRAS): a new risk assessment instrument**	Field study test of instrument	Denmark	Mechanical restraint	To investigate construct validity the subscales of the MR-CRAS constituted separate subscales and needed further revisions.	Forensic: 16 units, 379 Forensic clinicians on 88 patients, 143 episodes for the research	• Minor alteration and clinical validation- considered a valid tool

(Nielsen, Lea et al.)	2017	**'Mechanical restraint—confounders, risk, alliance score': testing the clinical validity of a new risk assessment instrument**	Assessment and pilot of instrument	Denmark	Mechanical restraint	To assess the clinical validity of the MR-CRAS	Forensic	• Excellent face and content validity • Perceived as a comprehensible, useable, risk assessment instrument

Author/s	Year	Title	Type of study	Location	Study focus	Study Question	Intervention	Key findings
Robins et al	2021	Definition and measurement of physical and chemical restraint in long-term care: A systematic review	Systematic review		Physical and chemical restraint definitions	To identify thematic elements within definitions of physical and chemical restraint, compare explicit and implicit definitions, and synthesise reliability and validity of studies examining physical and/or chemical restraint use in long term care	86 Papers 86 discussed physical restraint, 20 of these also discussed chemical restraint. 51 explicit definitions of physical restraint 4 explicit definitions of chemical restraint	7 themes 1. Restraint method 2. Setting resident is restrained in 3. Stated intent 4. Resident capacity to remove/control 5. Caveats and exclusions 6. Duration 7. Frequency or number 8. Consent and resistance In relation to chemical restraint: Themes from explicit definitions: Restraint method- the medication class (no specific medications identified) Stated intent- The intent to control behaviour, reported in 3 of the four definitions. Any drug prescribed out of organisational convenience (1 study). Themes from implicit definitions: Restraint method- medication classes n= 16. Stated intent- control behaviour (n=2), inappropriate use (n=1), without supporting diagnosis (n=2)
Muir - Cochrane, Oster and Grimmer	2020	International research into 22 years of use of chemical restraint	Systematic review		Chemical restraint (CR)	To summarise the research published over 22 years, identify trends and gaps in knowledge, and highlight these areas for new research to inform practice.	311 relevant primary studies	Lack of clarity about the most effective application of CR Def: Chemical restraint (CR) also known as rapid tranquillisation is the forced (non-consenting) administration of medications to manage uncontrolled aggression, anxiety or violence in people who are likely to harm to themselves or others. Clear distinction between consenting and non consenting- non consenting being the differentiating factor. Themes: (30.2%) Medications used for CR (effectiveness, choices, comparisons, safety) (12.2%) Patient perspectives of CR (retrospective attitudes of patients to involuntary IM meds, 4 papers- patient and

								health worker perspectives about coercion involving CR (11.6%) Ward practices and policies. (Changed ward practices and their influence on coercive practices, such as open and closed wards. Regulations and guidelines for practice and different service configurations. (10.6%) Clinician perspectives of CR: Nurses experiences with patient aggression, physicians experiences with coercion, current practices on managing aggression (8.7%) Precursors or pathways to aggression (5.8%) Patient characteristics
Muir Cochrane et al	2020	Prevalence of the use of chemical restraint in the management of challenging behaviours associated with adult mental health conditions: A meta analysis	Meta analysis		Chemical restraint (CR)	To synthesise the international prevalence of chemical restraint for non-consenting adults	48 papers	Median prevalence of ay restraint: 21.2% Median prevalence of those chemically restrained of all the people restrained: 43.1% Median of chemical restraints for all admissions: 7.4% Significant decrease in use of CR over time 18 definitions of CR- common themes: a description of the use of medication, whether it was administered forcibly with or without consumers consent, to control agitated or violent behaviours associated with mental health disorders that endangered themselves or others. 16 of the 18 papers agreed that chemical restraint was a risk management strategy as opposed to therapeutic intervention. Prevalence of CR: 32 papers reported on 302602 consumers who presented to services over 779 months. 49765 of these had been restrained chemically to manage agitation and/or violent behaviours. – CR reported for 9.1% of the overall dataset. Most common route IM (75.2%) followed by Iv (21.5%) then oral (3.3%).
Nash et al	2018	Rapid tranquilization: An audit of Irish Mental Health Nursing Practice	Descriptive survey design	Ireland	Rapid tranquilization			Rapid tranquilisation is a form of restrictive practice Conventional and controversial intervention in the therapeutic management of risk in mental health settings

								Rapid tranquillization (RT) also referred to as involuntary medication, forced medication or coerced medication is an example of a restrictive practice (RCN, 2013).

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5. Help and Hindrances to Completion of Psychiatric Advance Directives - the url is: https://doi.org/10.1176/appi.ps.202000080
6. The hui [*Ō tātou hiranga/What matters to us: Shared decision-making and advance care planning virtual hui*, HQSC] 2 December 2020: A MAP for mental health: giving consumers a voice in their care planning.
7. A webinar in in September is available at: https://youtu.be/FMPW5kKWkbQ