



Our Rights
and
Medication

Our Rights and Medication

Public Consultation on the development
of a Code of Practice on the use of
pharmacological restraint in inpatient
mental health services and the revision
of the MHC's Seclusion and Restraint
Reduction Strategy 2014



CONSULTATION RESPONSE

.....



7 April 2026



www.ourrightsandmedication.ie

Acknowledgements

This document was drafted on behalf of the Our Rights and Medication (ORAM) Group by Marge Lysaght, Advocacy Programme Co-Ordinator for the Social Health and Education Project (SHEP). SHEP's Independent Advocacy Programme hosts and is a member of ORAM. Thank you to ORAM members who provided input and feedback on this submission, with particular thanks to Deirdre Lillis.

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Transparency Statement

Artificial intelligence tools were used to support the design, formatting and editorial presentation of this publication. All policy positions, recommendations and written content have been developed, reviewed and approved by the Our Rights and Medication (ORAM) Group and reflect the collective expertise of its members, as well as ORAM values, commitments and working principles.



About the Our Rights and Medication Advocacy Group

The Our Rights and Medication (ORAM) Advocacy Group is a network of experts by experience, advocates, academics and practitioners hosted by the SHEP Advocacy Programme. In line with the principles of the Assisted Decision Making (Capacity) Acts 2015 and 2022 and human rights-based practice we want everyone to know (particularly people with disabilities and older people) that they have choices and rights around the medication they are prescribed. We want health and social care professionals to feel empowered to support people to exercise their rights around their medication. And we want to work with others to ensure that clinical guidance on the prescribing of psychotropic medication in all healthcare settings becomes a reality.

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About the Consultation

On 6 March 2026, the Mental Health Commission (MHC) opened a public consultation to inform two related pieces of work: the development of a new Code of Practice on the use of pharmacological restraint in inpatient mental health services, and the revision of the MHC's *Seclusion and Restraint Reduction Strategy 2014*. The consultation closed on 7 April 2026.

The development of the Code follows the Mental Health Bill 2024, under which the MHC is required, for the first time, to regulate the use of pharmacological restraint. Amendments made to the Bill in December 2025 extended the Commission's remit to cover this area. The Bill has since been enacted as the Mental Health Act 2026. The MHC also prepares and reviews codes of practice under section 33(3)(e) of the Mental Health Act 2001, following consultation with relevant bodies.

The Code will apply to approved centres, which are inpatient mental health services in the public, voluntary and independent sectors. These include child and adolescent, adult, older persons, intellectual disability and forensic mental health services. At the time of the consultation, the MHC regulated 67 approved centres and expected to inspect services against the new Code from 1 January 2027.

The MHC invited responses through two surveys: **Survey 1** on the development of the Code of Practice, and **Survey 2** on the revision of the Seclusion and Restraint Reduction Strategy. The Commission was particularly keen to hear from people with experience of mental health services, the people close to them, and staff. Responses will be considered alongside an evidence review, advice from an Expert Advisory Group and input from the MHC's Stakeholder Forum, and the MHC has said it will publish a consultation report alongside the final Code and revised Strategy.

This document sets out ORAM's response to both surveys, as submitted to the MHC. Each section follows a question asked in the consultation, with the responses to Survey 1 followed by the responses to Survey 2.

Introduction

ORAM welcomes the Mental Health Commission's decision to develop a Code of Practice on the use of pharmacological restraint in inpatient mental health services and to revise the *Seclusion and Restraint Reduction Strategy 2014*. We believe this work is both essential and long overdue.

Since 2019, ORAM members have raised concerns about the use of medication in ways that can restrict a person's rights, autonomy and participation in decisions about their own care. Our work has consistently highlighted the need for greater transparency, stronger safeguards, meaningful accountability and a clear commitment to human rights in every decision involving medication. The development of this Code provides an important opportunity to address these issues and to establish a clear rights-based framework for practice.

ORAM is a unique group bringing together people with lived experience of health and social care services, family members, advocates, professionals, academics and organisations with a shared commitment to promoting rights in relation to medication. Some members have lived experience themselves of enduring restrictive practices, including pharmacological restraint. Others have supported people whose rights have been affected through inappropriate medication practices, lack of informed consent, or exclusion from decisions about their own care. These experiences reflect the realities faced by people across a range of health and social care settings and continue to shape the work of ORAM today.

The principles underpinning this Code are the same principles that have guided ORAM since it was established in 2019. Respect for human rights, informed consent, supported decision-making, independent advocacy, participation, dignity and the least restrictive approach are at the heart of our work. We believe that every person has the right to understand the medications they are prescribed, to have their will and preferences respected, to receive appropriate support to make decisions, and to be protected from coercive and unjustifiable restrictive practices.

We believe that no person should be subjected to forced medication simply because they are distressed, disabled, in crisis or perceived as difficult to manage. Medication administered without free and informed consent is among the most serious forms of coercive intervention that can be imposed on an individual. It strikes at the heart of the rights to autonomy, bodily integrity, dignity and equality before the law. A rights-based system must begin from the presumption that every person has the right to direct decisions about their own body and healthcare, with support where required, and that any departure from this principle demands the highest level of scrutiny, accountability and legal safeguard.

We also recognise the significant commitment shown by the Mental Health Commission in bringing forward this consultation. Developing a Code of Practice specifically addressing pharmacological restraint acknowledges an area of practice that has often lacked clear definition and consistent oversight. It provides an opportunity to strengthen protections for individuals while supporting services to deliver care that is safer, more transparent and more firmly grounded in human rights.

This submission reflects ORAM's collective experience, knowledge and commitment to improving practice. It draws on the expertise of people with lived experience alongside

advocates and professionals to develop practical recommendations that are grounded in human rights, evidence and everyday experience.

We hope the final Code will provide more than guidance. It should become a meaningful driver of cultural and systemic change, ensuring that pharmacological restraint is recognised as a serious rights-limiting intervention, used only in genuinely exceptional and unavoidable circumstances, where all other less restrictive options have been exhausted, subject to robust safeguards and accountability, and always with the dignity, autonomy and rights of the person at its centre.

Survey 1

The development of a Code of Practice on the use of pharmacological restraint in inpatient mental health services

Q1. What principles should guide the code of practice on the use of pharmacological restraint?

The Code of Practice should be grounded in a human rights-based approach, aligned with the UNCRPD, other human rights legislation, and underpinned by existing Irish legislative, policy, and regulatory frameworks, including the Assisted Decision-Making (Capacity) Acts 2015 and 2022, the HSE National Consent Policy (2018), professional ethical guidance, and HIQA's human rights-based approach (FREDA principles).

Autonomy and assumed capacity

Individuals must be recognised as decision-makers in their own right, with the right to direct their own care.

This requires:

- always presuming capacity and avoiding assumptions based on disability, diagnosis, or communication differences
- actively supporting the person to express their will and preferences, including through accessible communication, appropriate supports, and sufficient time
- ensuring that supported decision-making is prioritised and that substitute decision-making is not used where participation can be supported
- recognising that even where support needs are high, the person's will and preferences must remain central to all decisions, including those relating to medication

Free and informed consent

Consent must be understood as an ongoing, supported, and meaningful process, not a one-off event.

This requires:

- providing information that is accessible, clear, and tailored, including the purpose of medication, potential benefits, risks, side effects, and alternatives

- ensuring that consent is freely given, without coercion, pressure, or influence arising from service limitations, power imbalances, system pressures or other factors
- ensuring individuals have real and meaningful choices, including access to non-pharmacological alternatives
- recognising the person's right to refuse or withdraw consent at any time, and ensuring this is respected in practice

Least restrictive practice

Least restrictive practice must be demonstrated in practice, not stated in principle.

This requires:

- ensuring that non-pharmacological approaches are actively attempted, appropriately resourced, and given sufficient time to be effective
- recognising that congregated and institutional settings increase the likelihood of restrictive practices, and that progressing decongregation and access to community-based, person-centred supports is essential to achieving least restrictive practice and reducing harmful restrictive practices
- limiting pharmacological restraint to exceptional circumstances only, where there is an **immediate and serious risk of harm (i.e. imminent and likely harm, not distress, non-compliance, or hypothetical risk)** and all appropriate alternatives have been explored and found to be ineffective in that moment
- ensuring any use is:
 1. proportionate to the level of risk
 2. the least restrictive option available
 3. for the shortest time necessary
- ensuring that pharmacological restraint is **not used in response to distress alone, 'behaviours of concern', refusal of care, or as a substitute for adequate staffing, training, or environmental supports**
- requiring services to demonstrate ongoing reduction in the use of restrictive practices, supported by monitoring, oversight, and regulatory accountability

Dignity, bodily integrity, and FREDA (fairness, respect, equality, dignity and autonomy) principles

These principles must be embedded in everyday practice.

This requires:

- treating each person with dignity and respect, recognising them as an individual rather than defining them by behaviour or diagnosis
- ensuring communication is accessible, supported, and non-paternalistic, particularly where individuals communicate differently or require assistance
- upholding equal standards of care and consent for all individuals

- recognising that administering medication without consent represents a serious interference with bodily integrity, requiring clear justification, strong safeguards, and regulatory oversight

Definition and prohibition of pharmacological restraint

The Code must provide a clear and enforceable definition of pharmacological restraint and explicitly prohibit its inappropriate use.

Pharmacological restraint should be defined as the use of medication:

- for the primary purpose of altering or controlling behaviour
- without a clear, evidence-based clinical indication
- or as a response to environmental, organisational, or service limitations, including staffing constraints or lack of appropriate supports

The Code should clearly state that:

- medication must not be used as a form of behavioural management.
- the use of medication must always reflect a clearly identified clinical need, distinct from behavioural control.
- the use of medication solely or primarily to alter or control behaviour is not therapeutic, and may constitute pharmacological restraint and a serious human rights violation under national and international legislation and conventions.

To ensure accountability, the Code should require:

- mandatory identification, recording, and justification of all instances of pharmacological restraint
- clear documentation of:
 1. rationale and evidence of medical need in urgent or exceptional situations (i.e. immediate and serious risk of harm).
 2. alternatives attempted and the basis for decision-making.
 3. consent processes.
 4. duration of use, which must be the shortest possible and clearly defined.
- ensuring that any use is **time-limited, with defined frequent review points, and subject to timely review by an appropriately senior clinician.**
- ensuring that PRN (as required) medication is **not used in a manner that results in ongoing or repeated restraint without formal review and oversight.**
- mandatory reporting of all instances that meet the definition of pharmacological restraint at both service and regulatory level

Person-centred and participation

Care must be grounded in a person-centred approach, where the individual is an active participant in their own care.

This requires:

- ensuring meaningful involvement of the person in all decisions about their care and treatment, including medication.

- recognising and prioritising the person's will and preferences as the primary driver of decision-making.
- ensuring that the involvement of family members, supporters, or professionals is guided by and accountable to the person's wishes.
- creating environments where individuals are supported and empowered to:
 1. participate
 2. ask questions
 3. express concerns
 4. influence decisions
 5. have autonomy over decisions related to their medication
 6. and give or withdraw consent
- ensuring that participation is **meaningful in practice**, including through the provision of time, supports, independent advocacy support and appropriate environments

Right to independent advocacy free from conflict of interest

Access to independent advocacy is essential and must be recognised as a core component of rights-based practice, not an optional support.

The Code should require that:

- individuals have access to independent advocacy that is free from conflicts of interest, meaning the advocate is not employed by or accountable to the service providing care
- advocacy is available, as a right, in all cases where pharmacological restraint is being considered, used, or reviewed.
- individuals are proactively informed of their right to advocacy in accessible ways that suit their communication needs.
- advocacy services are **adequately resourced and accessible in a timely manner to ensure effectiveness in practice**.
- advocates are enabled to:
 1. support individuals to understand information and express their will and preferences.
 2. participate in care planning and review processes.
 3. access relevant information (with consent or on a vital interest basis where consent is not possible).
 4. and challenge decisions where necessary.

Accountability, transparency, and regulatory oversight

The Code must ensure that all use of pharmacological restraint is subject to robust scrutiny, transparency, and enforcement.

This requires:

- mandatory identification, recording, and justification of all use
- comprehensive documentation of:
 1. rationale.

2. Alternative, non-pharmacological, supports attempted.
 3. consent processes.
 4. duration of use.
- mandatory reporting at both service and regulatory level.
 - integration of pharmacological restraint into inspection frameworks, quality assurance systems, and safeguarding processes.
 - establishment of clear regulatory oversight, including authority to:
 1. monitor prescribing patterns.
 2. identify areas of concern.
 3. and require corrective action.
 - development of national data systems to track use, identify trends, and address inequities
 - requiring that **every instance is followed by a structured post-incident review**, which must:
 1. involve the individual and their advocate where appropriate
 2. examine contributing factors, including environmental and organisational issues
 3. identify actions to reduce the likelihood of recurrence
 - requiring services to **identify and address systemic drivers**, including staffing levels, skill mix, environmental factors, and availability of supports

Summary

For the Code of Practice to be effective, it must:

- clearly define and explicitly limit pharmacological restraint.
- prohibit the use of medication for behavioural control.
- embed autonomy, consent, dignity, and least restrictive practice in all decisions.
- ensure access to independent advocacy is protected and supported.
- require time-limited use, review, and post-incident learning.
- address systemic and organisational drivers of restrictive practices.
- recognise and address structural drivers of restrictive practices, particularly the continued use of congregated settings.
- and establish strong systems of accountability, reporting, and regulatory oversight.

Without this level of clarity, there is a significant risk that pharmacological restraint will remain normalised, under-recognised, and insufficiently regulated across services.

Q2. How can the code of practice ensure that the human rights of the person are upheld prior to, during, and after the use of the restraint (for example the dignity of the person)?

To uphold human rights in practice, the Code must embed clear, enforceable safeguards before, during, and after any use of pharmacological restraint, ensuring the protection of **autonomy, dignity, bodily integrity, and participation at each stage**.

At every stage, access to independent advocacy, free from conflict of interest, must be recognised as a core safeguard to ensure that the person's will, preferences, and rights are protected

Before use

This stage is critical to upholding autonomy, informed consent, and the person's right to participate in decisions affecting their care.

The highest and clearly evidenced threshold must be met before pharmacological restraint is considered.

The Code should require:

- demonstrable evidence that non-pharmacological approaches have been actively explored, appropriately resourced, and exhausted, including environmental, behavioural, communication, and therapeutic supports
- consideration of environmental and systemic factors, including whether the setting itself (e.g. congregated or institutional environments) is contributing to distress or escalation, and whether alternative, less restrictive environments are required
- a clear understanding of the person as an individual, including:
 1. their history, preferences, and known triggers
 2. their communication style and support needs
 3. and any existing care or crisis plans
 4. their Advance Healthcare Directive if they have one
- ensuring the person:
 1. receives accessible, understandable information about the proposed intervention, including purpose, risks, and alternatives
 2. is supported to make informed decisions, with appropriate supports for different communication needs
 3. is given time and appropriate conditions to consider their options
 4. has access to independent advocacy, particularly where there is disagreement, uncertainty, or risk of restrictive intervention

- ensuring that involvement of family members or supporters is guided by the person's will and preferences and does not override their rights
- ensuring that supported decision-making measures are actively implemented in line with legal obligations
- proactively informing the person of their right to independent advocacy and facilitating access where required

Documentation must clearly record:

- the specific, imminent and immediate risk of harm being addressed and how it has been measured as meeting the required threshold
- the rationale, clearly distinguishing it from behavioural management
- all alternatives attempted and why they were unsuccessful or not feasible
- the consent process, including supports provided and the person's response
- confirmation that advocacy was offered and/or accessed
- why the intervention is considered necessary, proportionate, and the least restrictive option available

During use

This stage engages the person's rights to dignity, bodily integrity, and freedom from inhuman or degrading treatment.

Any use of pharmacological restraint must be strictly limited, carefully monitored, and carried out in a manner that preserves dignity and minimises harm.

The Code should require:

- ensuring the intervention is:
 1. proportionate to the level of immediate and serious risk
 2. used only in urgent or emergency circumstances
 3. the least restrictive option available
 4. and time-limited, with clear criteria for ending its use
- maintaining the person's dignity, comfort, and safety, including:
 1. respectful, clear, and reassuring communication
 2. explanation of what is happening in a way the person can understand
 3. sensitivity to distress, fear, or confusion
- ensuring staff remain present, responsive, and accountable, and do not withdraw support after administering medication
- providing continuous clinical monitoring, including:
 1. physical health (e.g. vital signs, adverse reactions)

2. level of sedation
3. psychological wellbeing and distress

- ensuring that any continuation of the intervention is actively reviewed in real time, rather than continuing by default
- where feasible, ensuring the person continues to have access to support and representation, including advocacy support

After use

This stage is essential to uphold the person's rights to accountability, participation, and remedy, including recognition of their experience.

Post-incident processes are essential to ensure accountability, learning, and the prevention of recurrence.

The Code should require:

- ensuring the person has the opportunity and support to:
 1. express their views and experiences
 2. be listened to and taken seriously
 3. and have their perspective inform future care planning
- ensuring the person is treated with dignity following the event, including acknowledgement of their experience, distress, or harm, and appropriate follow-up support
- ensuring access to independent advocacy, particularly to:
 1. support the person in understanding what occurred
 2. assist them in expressing concerns or complaints
 3. and support their participation in review processes
- conducting a meaningful multidisciplinary critical review, which examines and documents:
 1. whether the intervention was necessary and justified
 2. whether the person's rights were upheld, including consent, dignity, and participation
 3. whether alternatives could have been used
 4. and what changes are required to prevent recurrence
- reporting this review to an appropriate regulatory body (e.g. MHC, HIQA) to ensure oversight and accountability
- developing a clear, actionable plan to:
 1. address unmet needs or contributing factors (e.g. communication, environment, supports)
 2. strengthen non-pharmacological approaches
 3. and reduce reliance on restrictive practices

- ensuring ongoing and regular medication review, including:
 1. reassessment of clinical need
 2. consideration of dose reduction or discontinuation
 3. transition to less restrictive alternatives wherever possible
- recording and reporting the incident within:
 1. service-level governance systems, and
 2. regulatory oversight frameworks, to ensure accountability and system-wide learning
- ensuring that advocacy services can engage with review and oversight processes, where appropriate and with the person's consent

Role of independent advocacy across all stages

The Code should explicitly recognise that independent advocacy is a critical safeguard at every stage, not an optional support as all forms of restraint including pharmacological restraint are in clear breach of human rights-based practice.

This means:

- advocacy must be independent of the service providing care, free from conflict of interest
- individuals must be informed of their right to advocacy in accessible ways
- access to advocacy must be facilitated proactively, not left to the individual to arrange
- advocates must be enabled to:
 1. support communication and decision-making
 2. attend relevant meetings
 3. access information (with consent)
 4. and challenge decisions where necessary

Independent advocacy is essential to:

- support the person to have a voice in decisions made about their care
- address power imbalances
- ensure that consent is real and meaningful
- support individuals who may otherwise be excluded from decision-making
- and identify and challenge inappropriate or coercive practices, including pharmacological restraint

Summary

To uphold human rights, the Code must ensure that:

- **before restraint**, autonomy, informed consent, and participation are respected
- **during restraint**, dignity, safety, and bodily integrity are protected
- **after restraint**, accountability, participation, and learning are guaranteed
- pharmacological restraint is only used in exceptional, clearly justified circumstances (defined as above; imminent serious harm or danger)
- the person is informed, supported, and involved at every stage

- independent advocacy is available and embedded throughout
- and every use is subject to robust review, accountability, and learning

Without these safeguards, there is a significant risk that pharmacological restraint will continue to be used in ways that undermine autonomy, dignity, and fundamental human rights.

Q3. What experience should staff be required to have, and what training should they undertake to apply pharmacological restraint?

The use of pharmacological restraint represents a serious and potentially rights-breaching intervention. It should therefore only be undertaken by staff who are not only clinically competent, but who are demonstrably skilled in rights-based, person-centred practice and in the use of non-pharmacological alternatives.

The Code of Practice should make clear that the ability to administer medication is not sufficient. Staff must have the knowledge, skills, experience, and values required to ensure that pharmacological restraint is used only in exceptional, justified, and rights restricted compliant circumstances.

The Code should also distinguish between the competencies required for **prescribing, authorising, and administering** pharmacological restraint, ensuring that each role has clearly defined training, accountability, and decision-making responsibilities.

Core experience requirements

Staff involved in decisions about or administration of pharmacological restraint should have:

- demonstrable experience in delivering person-centred, rights-based care, including respect for autonomy, dignity, and will and preferences.
- practical, supervised experience in the use of non-pharmacological interventions, including:
 1. de-escalation techniques.
 2. communication strategies.
 3. behavioural and environmental supports.
- experience in recognising and responding to distress, trauma, and unmet need, rather than defaulting to behavioural control approaches.
- competence in supported decision-making, including working with individuals with different communication needs.
- an understanding of the risks, harms, and long-term impacts associated with psychotropic medication and restrictive practices.

Staff should not be involved in the use of pharmacological restraint unless they can demonstrate relevant supervised experience in applying these approaches in practice.

Importantly, staff must be able to demonstrate that they can **prevent and reduce reliance on pharmacological interventions**, not simply administer them.

Mandatory training requirements

Training must be **mandatory, standardised, practical, and regularly refreshed**, and should apply to all staff involved in prescribing, decision-making, or administration. Staff must demonstrate competence in practice, not just attendance at training, before being permitted to participate in the use of pharmacological restraint.

Human rights and legal frameworks

Staff must be trained in:

- the UNCRPD and human rights-based approaches to care
- the Assisted Decision-Making (Capacity) Acts 2015 and 2022, including supported decision-making in practice
- the HSE National Consent Policy, with a clear focus on informed and voluntary consent
- the application of FREDa principles (Fairness, Respect, Equality, Dignity, Autonomy)
- HIQA and MHC guidance on advocacy and human rights-based approaches to health and social care

Training must explicitly focus on how these frameworks apply in real-world situations, particularly in crisis and emergency contexts.

Supported decision-making and communication

Staff must be equipped to:

- support individuals to understand information and express their will and preferences.
- use and adapt to different communication methods.
- recognise when additional supports, including independent advocacy, are required.
- avoid substituting their own judgement for that of the person where support can enable participation.

Alternatives to pharmacological restraint

A central requirement of training should be the ability to prevent the need for pharmacological restraint.

Staff must be trained in:

- de-escalation techniques and crisis prevention.
- Positive Behaviour Support (PBS) and understanding behaviour as communication.
- trauma-informed approaches, recognising the impact of past experiences on current distress.
- environmental and relational approaches to reducing distress.
- identifying and responding to unmet needs (e.g. pain, fear, communication barriers)

Training should emphasise that pharmacological restraint is a **last resort and a failure of earlier supports**, not a routine response.

Medication knowledge and ethical prescribing

Staff must have a clear understanding of:

- the purpose, effects, and risks of medications used in restraint contexts.
- potential side effects and adverse reactions, including reduced function, over-sedation, and long-term impacts and increased risk of stroke or death.
- principles of safe prescribing, monitoring, and de-prescribing.
- the distinction between therapeutic use and pharmacological restraint.

They must also understand that:

- medication must not be used for behavioural control or convenience.
- all use must be clinically justified and evidence based.

Recognition and prevention of pharmacological restraint

Training must explicitly address:

- what constitutes pharmacological restraint
- how such practices can become normalised within services
- the ethical and human rights implications of such use
- the responsibility of staff to identify, question, and challenge inappropriate use

Advocacy, safeguarding, and speaking up

Staff must be trained to:

- Support the fundamentals of advocacy
- understand the role and importance of independent advocacy.
- support individuals to access independent advocacy services.
- recognise situations where advocacy is particularly necessary (e.g. potential breaches of human rights based practice including all forms of restraint and decision where consent has not been given, disagreement, high-risk decisions, conflict of interests).
- raise concerns and challenge practice where medication use may be inappropriate or rights are at risk.

Training should also address:

- organisational culture-acceptance of medication as a means to control behaviour.
- ensuring staff can speak up without fear of repercussions.

Ongoing competency and accountability

The Code should require that:

- training is not a one-off requirement, but part of ongoing professional development.
- staff competency is assessed in practice, not just through attendance.
- supervision, reflective practice, and multidisciplinary learning are embedded in service delivery.
- services demonstrate that staff are:
 1. using alternatives effectively
 2. applying rights-based approaches
 3. and reducing reliance on pharmacological restraint over time

Summary

To ensure safe and rights-compliant practice, the Code must require that staff:

- have relevant, supervised experience in person-centred and non-pharmacological approaches before being involved in pharmacological restraint.
- understand and apply human rights, consent, and supported decision-making in practice
- are trained to prevent, recognise, and challenge pharmacological restraint.
- and are supported to work in environments that prioritise person-centred, non-restrictive care.

Without this level of experience, training, and accountability, there is a significant risk that pharmacological restraint will continue to be used in place of appropriate supports, undermining the rights and wellbeing of those receiving care.

Q4. In your view, in which circumstances, if any, should pharmacological restraint never be used in an emergency?

The Code must provide a **clear and narrow definition of “emergency”** to prevent misuse or over-interpretation.

An emergency should be defined as a situation where there is an **immediate, imminent, and serious risk of physical harm to the person or others**, which cannot be safely managed through less restrictive means at that time.

Serious harm should be defined as an immediate and imminent risk of significant physical injury that cannot be safely prevented through less restrictive means, and must not include distress, refusal of care, or non-imminent or speculative risks.

It must not include situations arising from distress, unmet need, behavioural presentation, service pressures, or organisational limitations.

The Code must make clear that the presence of urgency does not remove the obligation to uphold human rights, and that pharmacological restraint can only ever be considered where it is a **necessary, proportionate, and last-resort response** to such clearly defined risk.

Pharmacological restraint should **never be used, including in emergency situations**:

- where there is **no immediate, imminent, and serious risk of physical harm**
- as a response to **distress, unmet needs, trauma, or communication differences**
- where **appropriate non-pharmacological alternatives have not been actively attempted**, where feasible
- due to **staffing pressures, environmental limitations, or lack of appropriate services or supports**

- for **convenience, behavioural control, or as a substitute for appropriate care**
- without **clear, evidence-based clinical justification**
- where the person's **will and preferences are known but not respected**, except where there is a lawful, necessary, and proportionate justification in line with human rights standards
- as a form of **punishment, coercion, or compliance management**

The Code should further recognise that pharmacological restraint is a **coercive intervention**, particularly where used alongside other restrictive practices such as physical restraint. The use of such interventions can represent a **significant breach of trust** and carries risk of both **physical harm (including over-sedation and adverse reactions)** and **psychological harm (including fear, trauma, and loss of dignity)**.

Guidance developed based on evidence, from international human rights bodies, including the United Nations Committee on the Rights of Persons with Disabilities, regulatory reports such as those of Health Information and Quality Authority, and clinical guidance from National Institute for Health and Care Excellence, consistently demonstrates that restrictive practices, including pharmacological restraint, are associated with **increased risk of harm, reduced quality of care, and erosion of trust**, particularly where used in the absence of appropriate supports.

The Code should explicitly state that such uses, even in emergency contexts, are not therapeutic, may constitute pharmacological (chemical) restraint, and risk serious violations of the person's **dignity, autonomy, and bodily integrity**.

Q5. What safeguards should the code of practice contain to ensure the safety of the person during and after the restraint?

The use of pharmacological restraint constitutes a **serious interference with fundamental human rights**, including the rights to **dignity, bodily integrity, autonomy, liberty, and freedom from inhuman or degrading treatment**.

Under international human rights law, including the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), healthcare must be provided on the basis of **free and informed consent**, with full respect for the person's will and preferences. The use of pharmacological restraint, particularly where it is non-consensual or used to control behaviour, amounts to a **violation of these rights**.

In addition, pharmacological restraint carries a **significant risk of iatrogenic harm**, including adverse drug reactions, over-sedation, reduced functioning, and psychological harm such as fear, trauma, and loss of trust.

Safeguards are therefore not solely clinical requirements, but **essential human rights protections**, including ensuring access to an **effective remedy where rights may have been breached**.

The Code of Practice must set out clear, enforceable safeguards during and after any use of pharmacological restraint, ensuring both **the safety of the person and the protection of their rights**.

During restraint

The Code must require:

- continuous clinical monitoring, including observation of vital signs, level of sedation, and any adverse reactions
- staff presence and active supervision at all times, ensuring the person is not left unattended
- that the intervention is time-limited, with clear criteria for ending its use and ongoing real-time review
- that the person's dignity, comfort, and safety are maintained through respectful communication and minimisation of distress
- clear escalation procedures where any deterioration or risk to the person's health is identified

After restraint

The Code must require:

- a structured post-incident review, involving the person and their advocate where appropriate, examining necessity, proportionality, and whether alternatives could have been used
- examination of environmental and structural factors, including whether congregated or institutional settings contributed to the use of restraint, and identification of actions to reduce reliance on such settings where appropriate
- ongoing clinical review, including reassessment of medication, monitoring for delayed effects, and consideration of dose reduction or discontinuation
- access to independent advocacy to support the person in understanding what occurred and participating in review and complaints processes
- **accessible, timely, and effective complaints mechanisms as part of the person's right to remedy**, ensuring that:
 1. the person is proactively informed of their right to make a complaint about a pharmacological restraint in a way they can understand
 2. supports are provided to enable the person to engage in the complaints process (including advocacy)
 3. complaints are taken seriously, investigated independently where appropriate, and responded to within clear timeframes
 4. outcomes of complaints lead to corrective action, accountability, and service improvement
- accessible and effective systems for **raising concerns and safeguarding**, for both individuals and staff, including escalation where local responses are inadequate
- mandatory recording and reporting of each incident, including rationale, duration, and outcomes
- regulatory oversight, including monitoring of prescribing practices and service-level use
- national data collection to identify patterns, risks, and areas requiring improvement

Summary

Safety requires both immediate clinical safeguards and robust systems of accountability, oversight, and **access to remedy**, grounded in the protection of human rights.

Without these safeguards, there is a significant risk of avoidable harm, including iatrogenic harm, and of practices that violate dignity, autonomy, and bodily integrity.

Q6.

Please indicate any policy documents/evidence/initiatives we should consider when developing the Code of Practice and/or key individuals/organisations the MHC could engage with during this consultation. We may invite them to take part in future interviews

The development of a Code of Practice on pharmacological restraint should be firmly grounded in existing human rights, legal, and policy frameworks in Ireland, alongside national clinical guidance and emerging evidence on prescribing practices.

These frameworks already establish clear standards in relation to autonomy, consent, dignity, equality, and least restrictive care. The key issue is not the absence of standards, but the need to translate and consistently apply them in everyday prescribing practice, particularly in relation to psychotropic medication.

Key policy and legal frameworks

International

- United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), including:

- Article 12 (legal capacity and supported decision-making)
- Article 17 (bodily integrity)
- Article 25 (free and informed consent in healthcare)
- Article 15 (freedom from ill-treatment, including chemical restraint)

These establish that psychotropic medication must never substitute for appropriate supports or undermine autonomy and dignity.

National

- Assisted Decision-Making (Capacity) Acts 2015 and 2022
- HSE National Consent Policy (2018)

- Medical Council Guide to Professional Conduct and Ethics (2016)
- Equal Status Acts (2000–2018) and Disability Act (2005)

Together, these frameworks establish that prescribing practices must be rights-based, person-centred, and accountable.

National clinical guidance and initiatives

National Clinical Guideline 21 (NCG21) should be recognised as a key evidence-based foundation. It represents a shift away from medication-led care and includes:

- prioritisation of non-pharmacological interventions.
- emphasis on informed consent and supported decision-making.
- requirements for clear clinical justification and documentation.
- regular review and de-prescribing.

The Code should also consider:

- the **work of the project team that developed NCG21**, including their expertise in implementation, behavioural alternatives, and prescribing governance.
- the opportunity to extend NCG21 principles beyond dementia care into a **cross-sector, rights-based prescribing framework**.

In addition, the Code should take account of:

- the **ORAM Rights and Medication Charter (The Our Rights and Medication Group www.ourrightsandmedication.ie)**, which sets out the rights of individuals in relation to medication use, consent, and participation in decision-making.

Supporting evidence base

National and international evidence consistently highlights:

- overuse of psychotropic medication without clear clinical indication.
- gaps in consent and supported decision-making.
- variability in prescribing practices and oversight.
- reliance on medication in the absence of adequate supports.

International evidence further demonstrates that effective reduction of restrictive practices requires:

- investment in non-pharmacological supports.
- workforce training.
- robust data systems.
- and strong regulatory oversight.

Evidence also demonstrates that congregated and institutional settings are associated with increased use of restrictive practices, including pharmacological restraint, reinforcing the importance of decongregation and community-based models of care.

Key organisations and stakeholders for engagement

To ensure the Code is practical, rights-based, and implementable, the MHC should engage with:

- individuals with lived experience, including people who have been subject to pharmacological restraint.
- family members and supporters.
- independent advocacy organisations.
- **ORAM (The Our Rights and Medication Group)**
- **HIQA (Health Information and Quality Authority)**
- **HSE (including mental health, disability, and older persons services)**
- the **National Dementia Office** and those involved in NCG21 development and implementation,
- professional bodies (e.g. Medical Council, Nursing and Midwifery Board of Ireland),
- clinical experts in psychiatry, geriatrics, intellectual disability, and pharmacy.
- safeguarding and rights organisations.

Engagement with the NCG21 project team would provide valuable insight into translating guidance into practice and addressing barriers to reducing reliance on psychotropic medication. Although it is a clinical and not rights based guideline.

Overall position

The Code of Practice should:

- be firmly grounded in existing human rights and legal frameworks.
- recognise NCG21 as a strong, evidence-based foundation for rights-aligned prescribing.
- incorporate initiatives such as the ORAM Rights and Medication Charter.
- and build a comprehensive, cross-sector framework for the use of psychotropic medication

This approach would:

- reduce inappropriate use of pharmacological restraint.
- promote consistent, rights-based practice across services.
- and ensure prescribing decisions are guided by clinical need, informed consent, and the least restrictive option.

Without this alignment and engagement, there is a significant risk that existing standards will remain inconsistently applied, and that harmful practices such as chemical restraint will persist.

Any additional thoughts or comments?

While the development of a Code of Practice on pharmacological restraint is an important and necessary step, it is essential to recognise that **Codes of Practice are not, in themselves,**

legally binding and may function primarily as guidance unless supported by appropriate legislative and regulatory mechanisms.

There is a significant risk that, without clear enforcement provisions, the standards set out in the Code will be applied inconsistently, and practices such as pharmacological restraint may continue without adequate accountability. In this context, there is a real risk that the Code will lack practical effect or “teeth” unless it is clearly embedded within enforceable legal and regulatory frameworks.

The Code should therefore be explicitly linked to existing and future legislation to ensure that:

- compliance with the Code is subject to regulatory oversight, inspection, and enforcement
- breaches of the Code, particularly where they result in harm or rights violations, are identifiable and actionable
- clear consequences are in place for non-compliance, including regulatory sanctions and, where appropriate, legal liability

Consideration should be given to how legislation can:

- underpin the status of the Code within **inspection, registration, and licensing frameworks**
- **require services to demonstrate compliance as a condition of operation** and ongoing regulation
- and **establish enforceable consequences** where serious or repeated breaches occur, including escalation pathways where harm or rights violations arise

In addition, careful consideration must be given to the **scope and applicability of the Code across different sectors and legal frameworks**. Pharmacological restraint is not confined to one setting, and occurs across:

- mental health services, including approved centres
- disability services
- residential care settings for older persons
- and broader health and social care environments

A cross-sector approach is essential to ensure that the rights to **dignity, autonomy, bodily integrity, equality, and non-discrimination** are protected consistently, regardless of where a person receives care. These rights are universal and must not vary depending on service type. In practice, this requires that individuals are:

- recognised as decision-makers, with their will and preferences respected
- supported to give free and informed consent
- protected from coercion and restrictive practices
- supported to maintain their physical and psychological integrity
- and able to access effective remedy and accountability where their rights are not upheld

Without such alignment, there is a risk of fragmented standards, unequal protection of rights, and gaps in accountability across services.

The **language used within the Code is also critically important** and should reflect a human rights-based approach. The Code should avoid overly medicalised or deficit-based language, including terminology that defines individuals primarily by “disorder”, “illness”, or “challenging behaviour”.

Instead, the Code should adopt language that:

- recognises the person first, rather than defining them by diagnosis or condition
- reflects the individual as a **rights-holder**, not solely a recipient of care
- emphasises **distress, unmet need, and context**, rather than reducing experiences to symptoms or behaviours
- avoids framing that may implicitly justify coercive or restrictive practices

Moving away from a purely clinical or medical framing is essential to ensure that pharmacological restraint is not normalised as a treatment response, but is instead recognised as a **serious, rights-limiting intervention requiring strict safeguards**.

Overall, without clear legislative underpinning, cross-sector consistency, and a shift toward rights-based language and practice, there is a significant risk that the Code will remain aspirational rather than operational, limiting its effectiveness in preventing inappropriate use of pharmacological restraint and protecting the rights of individuals.

Survey 2

The revision of the MHC's Seclusion and Restraint Reduction Strategy 2014

Q1. What key areas should the revised reduction strategy focus on?

The revised strategy should be grounded in a human rights-based approach, aligned with the UNCRPD and existing Irish legal and policy frameworks, and focused on the reduction and, where possible, elimination of restrictive practices across all services.

A human rights-based approach requires that individuals are recognised as **rights-holders**, not passive recipients of care, and that safeguards such as access to independent advocacy are understood as **rights**, necessary to support participation, consent, and the exercise of legal capacity.

The strategy should prioritise a structured, evidence-informed approach, consistent with National Clinical Guideline 21 (NCG21), based on assessment, prevention, intervention, and review.

Prevention and early intervention

Restrictive practices should be prevented through proactive, person-centred supports.

This requires:

- comprehensive, ongoing assessment of the person's needs, preferences, health status, and environment
- early identification of triggers for distress, including pain, confusion, communication barriers, and environmental factors
- timely and appropriate responses to prevent escalation

Understanding distress and unmet need

Distress should be understood as meaningful and responsive to context.

This requires:

- recognising behaviour as communication
- identifying underlying causes, including physical health, mental health, trauma, or environmental stressors
- avoiding default responses based on risk or control

Autonomy and supported decision-making

Individuals must be recognised as decision-makers in their own right.

This requires:

- embedding supported decision-making in all care processes
- ensuring the person's will and preferences guide interventions
- ensuring access to independent advocacy as a **right**, to support participation and decision-making

Non-pharmacological, person-centred interventions

Non-pharmacological approaches must be the first-line response.

This requires:

- implementation of structured, individualised supports based on assessed need
- ensuring interventions are available, resourced, and consistently applied
- regular review of effectiveness and adjustment of supports

Reduction and elimination of restrictive practices

The strategy must move beyond reduction alone to elimination.

This requires:

- setting clear expectations and measurable targets
- requiring services to demonstrate ongoing reduction
- ensuring restrictive practices are used only as a last resort

Workforce capability and culture change

Practice must shift from control-based to rights-based approaches.

This requires:

- training in rights based practice, trauma-informed, person-centred care
- support for reflective practice and supervision
- leadership that promotes non-restrictive approaches

Data, monitoring, and accountability

Reduction must be measurable and transparent.

This requires:

- national data systems to track use and outcomes
- mandatory reporting and review of all restrictive practices
- integration into inspection and regulatory frameworks

Cross-sector consistency

Standards must apply equally across all services.

This requires:

- alignment across mental health, disability, older persons, and wider health and social care
- consistent definitions, thresholds, and safeguards

Q2. What alternatives could be used instead of restrictive interventions?

The strategy should prioritise non-pharmacological, person-centred alternatives that address the underlying causes of distress rather than attempting to control behaviour. These must be implemented as first-line responses, in line with National Clinical Guideline 21 (NCG21).

This requires:

Comprehensive assessment and identification of underlying causes

- systematic assessment of pain, discomfort, infection, delirium, medication side effects, or sensory impairment
- identification of psychological distress, trauma, loneliness, or fear
- understanding environmental triggers, including noise, overcrowding, and unfamiliar settings.

De-escalation and relational approaches

- calm, clear, and respectful communication
- continuity of care and use of familiar staff
- allowing sufficient time and space for the person to process and respond
- avoidance of confrontation and reduction of stimuli

Trauma-informed approaches

- recognition of triggers linked to past experiences
- avoidance of practices that may retraumatise
- promotion of safety, trust, and predictability

Positive Behaviour Support (PBS)

- development of behaviour support plans based on functional assessment
- identification of triggers and early warning signs

- implementation of proactive and preventative strategies
- support for alternative coping strategies where appropriate

Environmental and sensory interventions

- reduction of noise, crowding, and overstimulation
- adjustment of lighting, temperature, and layout
- provision of quiet or low-stimulation spaces
- use of sensory supports

Meaningful activity and engagement

- structured, meaningful activities based on the person's interests
- support for social interaction and reduction of isolation
- maintenance of routine and familiarity

Communication supports

- use of accessible communication methods and support tools
- ensuring staff understand the person's communication style and seek to support it
- allowing additional time and support for communication

Individualised care and crisis planning

- development of personalised care plans reflecting the person's will and preferences
- co-produced (with person at risk of restrictive practice) crisis prevention plans
- clear guidance for staff on early intervention strategies

Family, supporter, and independent advocacy involvement

- involvement of family members or supporters in line with the person's wishes
- ensuring access to independent advocacy as a **right**, to support participation and decision-making
- shared understanding of needs and preferences

Staffing and service-level supports

- adequate staffing levels and appropriate skill mix
- consistent staff allocation
- access to multidisciplinary input

Ongoing review and adaptation

- monitoring effectiveness of interventions
- adapting supports based on response
- continuous reduction in reliance on restrictive practices

Restrictive practices should be understood as a failure of earlier supports, not a routine or acceptable intervention.

Q3. What, in your opinion, are the biggest challenges or barriers to the reduction of restrictive practices in services?

The barriers to the reduction of restrictive practices are primarily **systemic, cultural, and organisational**, rather than arising from individual staff practice alone. Without addressing these underlying factors, restrictive practices will continue to be used despite policy commitments to reduce them.

This includes:

Organisational culture and acceptance of restrictive practices

Restrictive practices are often normalised within services and understood as necessary or inevitable, particularly in risk-averse environments.

This requires:

- recognising and addressing cultures that prioritise control, compliance, or risk avoidance over rights
- challenging the perception that restrictive practices are therapeutic or protective
- promoting a culture where restrictive practices are understood as a last resort and a failure of earlier supports, rather than a routine response

Dominance of a medical model of care

Service provision is often grounded in a medical or deficit-based model, where individuals are viewed primarily as patients or recipients of care rather than as rights-holders.

Change to this requires:

- shifting to a **human rights-based approach**, where individuals are recognised as rights-holders with autonomy and agency
- moving away from approaches that prioritise diagnosis, compliance, or behavioural control
- ensuring care is guided by the person's **will, preferences, and lived experience**, rather than solely by clinical judgement

Lack of understanding of restrictive practices and their impact

There is often limited understanding of what constitutes restrictive practices, particularly pharmacological restraint, and of the harm they may cause.

This requires:

- clear, consistent definitions of restrictive practices across all services
- increased awareness of the **physical, psychological, and iatrogenic harms**, including trauma and loss of trust

- recognition that such practices may constitute **serious interferences with human rights**, including dignity, autonomy, and bodily integrity

Gaps in training, supervision, and support for staff

Staff are frequently not equipped with the knowledge, skills, or support required to implement effective alternatives.

This requires:

- comprehensive training in de-escalation, trauma-informed care, Positive Behaviour Support, and supported decision-making
- ongoing supervision, reflective practice, and multidisciplinary support
- ensuring staff are supported to respond to distress and complexity without reliance on restrictive practices

Gaps in information, understanding, and support for individuals at risk of restraint

Individuals who are at risk of experiencing restrictive practices are often not supported to understand their rights or to participate meaningfully in decisions affecting them.

This requires:

- accessible information on rights, consent, and restrictive practices
- support to enable individuals to understand, question, and influence decisions
- access to independent advocacy
- recognition of individuals as **active participants and rights-holders**, rather than passive recipients of care

Lack of supports for individuals at risk of restraint

Restrictive practices are more likely where an individual's needs are not adequately understood or met.

This requires:

- access to person-centred, rights based, non-pharmacological supports
- development of individualised care and crisis prevention plans
- early identification and response to distress, unmet need, and environmental triggers

Resource constraints and service limitations

Insufficient staffing, inappropriate environments, and lack of access to alternatives contribute directly to the use of restrictive practices.

This requires:

- adequate staffing levels and appropriate skill mix
- environments that support de-escalation, comfort, and safety
- investment in non-pharmacological interventions and supports

Lack of accountability, oversight, and consequences

There is often insufficient oversight of restrictive practices and limited consequences where they are used inappropriately, allowing practices to continue without effective challenge.

This requires:

- mandatory identification, recording, and reporting of all restrictive practices
- robust regulatory oversight, inspection, and monitoring of use at service and system level
- clear governance structures to review use and identify patterns of concern
- transparency and access to data to support accountability
- clear and enforceable consequences where restrictive practices are used inappropriately, including escalation where harm or rights violations occur

Fragmentation and inconsistency across services

Different standards across mental health, disability, older persons, and other services result in unequal protection of rights.

This requires:

- consistent definitions, thresholds, and safeguards across all sectors
- alignment of policy, regulation, and practice across services

Power imbalances and limited access to advocacy

Individuals may not be supported to participate in decisions or to challenge restrictive practices.

This requires:

- access to independent advocacy
- support for individuals to express their will and preferences
- accessible mechanisms to raise concerns and challenge decisions
- ensuring access to independent advocacy as a **right**, enabling individuals to exercise their legal capacity, participate in decisions, and challenge restrictive practices

Without addressing these **cultural, structural, and systemic barriers**, including the lack of accountability and oversight and the need to recognise individuals as **rights-holders rather than passive recipients of care**, there is a significant risk that restrictive practices will remain embedded within services, regardless of policy or strategy commitments to reduce or eliminate them.

Q4. How can services practically sustain / embed the reduction and, where possible, the elimination of restrictive practices?

Sustained reduction and, where possible, elimination of restrictive practices requires **system-wide, embedded change**, supported by leadership, accountability, and a clear commitment to

a **human rights-based approach**. Reduction cannot rely on isolated initiatives, but must be integrated into everyday practice, governance, and culture.

This requires:

Leadership, governance, and accountability

Reduction must be driven and sustained at organisational level.

This requires:

- clear leadership commitment to the reduction and elimination of restrictive practices
- defined governance structures with responsibility for oversight and review
- clear lines of accountability at all levels of the organisation
- ensuring that restrictive practices are recognised as **serious incidents requiring scrutiny and response**

Designated responsibility at service and team level

Reduction must be owned and actively managed in practice.

This requires:

- identification of a **designated person or lead** responsible for restrictive practice reduction within each service or team
- clear responsibility for monitoring use, ensuring review, and progressing reduction actions
- integration of this responsibility into supervision, performance, and governance structures

Reporting, monitoring, and real-time visibility

Reduction must be measurable, transparent, and actively monitored.

This requires:

- mandatory identification, recording, and reporting of all restrictive practices
- collection of consistent, high-quality data on type, frequency, duration, and context
- use of **real-time or near real-time data** at service level (e.g. team or ward level) to support immediate awareness and response
- regular review of data within teams to identify patterns, risks, and opportunities for early intervention

Targets and continuous reduction

Reduction must be actively pursued and demonstrated over time.

This requires:

- setting clear, measurable targets for reduction and, where possible, elimination
- requiring services to demonstrate ongoing progress
- linking reduction targets to service performance and accountability frameworks

Regulatory oversight and enforcement

Reduction must be supported by external oversight and accountability.

This requires:

- integration of restrictive practices into inspection and regulatory frameworks
- monitoring of compliance with standards and guidance
- clear consequences where inappropriate use is identified
- alignment with legislative frameworks to ensure enforceability

Embedding a human rights-based approach

Reduction depends on a fundamental shift in how care is understood and delivered.

This requires:

- embedding respect for **autonomy, dignity, bodily integrity, and participation** in all aspects of care
- recognising individuals as **rights-holders first**, rather than passive recipients of care
- ensuring that decision-making is guided by the person's will and preferences
- supporting access to independent advocacy
- ensuring access to independent advocacy as a **core safeguard and right**, embedded in practice and governance, not dependent on service discretion

Culture change and attitudinal shift

Sustainable reduction requires a shift away from control-based approaches.

This requires:

- challenging cultures that normalise restrictive practices
- promoting rights values of respect, inclusion, and person-centred care
- ensuring staff understand restrictive practices as a **last resort and a failure of earlier supports**
- leadership that models and reinforces non-restrictive practice

Training, supervision, and reflective practice

Staff must be supported to change practice in meaningful ways.

This requires:

- ongoing training in de-escalation, trauma-informed care, and supported decision-making
- structured supervision and multidisciplinary support
- embedding **reflective practice**, including learning from incidents and near misses
- creating safe environments for staff to reflect, question, and improve practice

Access to alternatives and supports

Reduction is not possible without viable alternatives.

This requires:

- ensuring availability of non-pharmacological, person-centred interventions
- adequate staffing levels and appropriate skill mix
- access to multidisciplinary and specialist supports

Co-production and involvement of people with lived experience

Reduction efforts must be informed by those directly affected.

This requires:

- involving individuals with lived experience in service design, review, and improvement
- co-producing care plans and prevention strategies with the person
- ensuring feedback from individuals informs service-level learning

Learning, review, and continuous improvement

Each use of restrictive practice must inform change.

This requires:

- structured post-incident review involving the person and, where appropriate, their advocate
- identification of contributing factors and missed opportunities for prevention
- review of both incidents and **near misses where restraint was avoided**, to identify effective interventions
- implementation of actions to reduce recurrence and embed learning

Without sustained leadership, designated accountability, real-time monitoring, and a shift toward a **rights-based, person-centred culture**, there is a significant risk that restrictive practices will continue to be used as routine responses, rather than being reduced and, where possible, eliminated

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

The revised strategy should be grounded in existing **human rights, legal, policy, and evidence-based frameworks**, and should focus on aligning and operationalising these to support the **reduction and, where possible, elimination of restrictive practices**.

This includes:

Human rights and legal frameworks

The strategy must align with international and national human rights obligations.

This requires consideration of:

- United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), including rights to legal capacity, bodily integrity, free and informed consent, and freedom from ill-treatment
- Assisted Decision-Making (Capacity) Acts 2015 and 2022

- HSE National Consent Policy (2018)
- relevant equality and disability legislation

These frameworks establish that care must be **rights-based, person-centred, and grounded in autonomy, dignity, and consent**, including access to **supports such as independent advocacy** to enable participation in decision-making.

National clinical guidance – National Clinical Guideline 21 (NCG21)

The strategy should explicitly recognise National Clinical Guideline 21 (NCG21) as a key foundation for reducing reliance on pharmacological and restrictive interventions.

This requires:

- building on NCG21 principles, including **non-pharmacological approaches as first-line interventions**
- embedding requirements for **assessment, identification of underlying causes, and person-centred interventions**
- strengthening implementation of **review, de-prescribing, and monitoring practices**
- extending NCG21 beyond dementia care into a **cross-sector framework**
- engagement with the **NCG21 project team** to support implementation and system learning

National policy, regulation, and advocacy safeguards

The strategy should reflect existing national standards and statutory safeguards, including the role of independent advocacy.

This requires consideration of:

- Health Information and Quality Authority (HIQA) standards and guidance, which require access to advocacy and a human rights-based approach
- the Mental Health Act 2001, including provisions relating to complaints processes and patient safeguards, supported by access to advocacy
- Mental Health Commission rules, codes, and the Seclusion and Restraint Reduction Strategy (2014)
- national safeguarding policies and frameworks

These frameworks recognise that **access to independent advocacy is a core safeguard**, supporting participation, consent, and the ability to challenge restrictive practices.

Rights-based initiatives and advocacy perspectives

The strategy should incorporate initiatives that centre the voice and rights of individuals.

This requires consideration of:

- the **ORAM Rights and Medication Charter**, which articulates rights in relation to medication, consent, and participation <https://ourrightsandmedication.ie/human-rights-charter>
- advocacy-led and lived experience-informed initiatives

These reinforce the need to recognise individuals as **rights-holders, supported by independent advocacy**, rather than passive recipients of care.

International evidence and guidance

The strategy should be informed by international best practice.

This requires consideration of:

- World Health Organization guidance on rights-based care and reduction of coercion
- National Institute for Health and Care Excellence (NICE) guidance on restrictive practices and behavioural support

These frameworks recognise that access to independent advocacy is a **core human rights safeguard and a right**, necessary to support participation, consent, and accountability, including the ability to challenge restrictive practices and access remedy.

Data, research, and system learning

The strategy should be informed by evidence on the use and impact of restrictive practices.

This requires:

- consideration of research on the **physical, psychological, and iatrogenic harms** associated with restrictive practices
- use of national data on prescribing and restrictive practices
- learning from inspection, audit, and review processes

Summary

The revised strategy should **align, integrate, and operationalise existing frameworks**, including embedding **access to independent advocacy as a core safeguard across all services**.

Without this alignment, there is a significant risk that existing standards—including those relating to advocacy, participation, and consent—will remain inconsistently applied, and that restrictive practices will continue despite policy commitments to reduce them.

Any additional thoughts or comments?

The effectiveness of the revised strategy will depend on how it is **implemented, resourced, and enforced in practice**, rather than on the articulation of principles alone.

There is a significant risk that, without clear mechanisms for implementation, the strategy will remain aspirational, and that restrictive practices—including pharmacological restraint—will continue to be used in practice.

This requires:

Implementation, resourcing, and system alignment

The strategy must be supported by clear implementation structures and adequate resourcing.

This requires:

- dedicated funding to support the delivery of **non-pharmacological, person-centred**

alternatives

- investment in staffing, training, and multidisciplinary supports
- alignment with regulatory, inspection, and governance frameworks to ensure implementation is monitored and enforced

Without investment in alternatives, there is a significant risk that restrictive practices will continue to be used in place of appropriate supports.

Embedding non-pharmacological and non-restrictive approaches

The strategy must ensure that non-pharmacological approaches are not only recommended, but **available, accessible, and prioritised in practice**.

This requires:

- ensuring services have the capacity to deliver preventative, person-centred supports
- embedding these approaches as **first-line responses**, rather than optional interventions
- monitoring their use and effectiveness as part of service oversight

Decongregation and service model reform

The continued use of restrictive practices is closely linked to **institutional models of care**.

This requires:

- prioritising and progressing **decongregation**, ensuring individuals are supported to live in community-based, person-centred settings
- recognising that congregated and institutional environments increase the likelihood of restrictive practices
- aligning the strategy with national policy commitments on community inclusion

Evidence, including findings from the EQUIP research programme, demonstrates that **off-label and inappropriate prescribing is more prevalent in institutional settings**, reinforcing the need for structural reform alongside practice change.

Addressing prescribing practices and system drivers

The strategy must recognise that restrictive practices are often driven by system pressures rather than individual need.

This requires:

- addressing over-reliance on psychotropic medication, including off-label prescribing
- ensuring prescribing is based on clear clinical need, informed consent, and regular review
- strengthening oversight of prescribing patterns at service and national level

Accountability and enforcement

The strategy must include clear mechanisms to ensure accountability.

This requires:

- defined responsibilities for implementation at service and system level
- monitoring of compliance through inspection and regulation
- clear consequences where restrictive practices are used inappropriately

Rights-based approach and cultural change

The success of the strategy depends on a fundamental shift in how individuals are understood and supported within services.

This requires:

- recognising individuals as **rights-holders**, not passive recipients of care
- embedding autonomy, dignity, bodily integrity, and participation in all aspects of care
- moving away from institutional and purely medicalised models toward **person-centred, community-based supports**

Use of rights-based, non-reductive language

The language of the strategy is critical and must reflect a human rights-based approach.

This requires:

- avoiding reductive or deficit-based language that defines individuals by “disorder”, “illness”, or “behaviour”
- ensuring language does not frame distress in ways that justify coercive or restrictive practices
- recognising the person first, and describing experiences in the context of **distress, unmet need, and environment**
- reinforcing the person as a **rights-holder**, rather than an object of care or control

The use of rights-based language is not merely stylistic; it shapes how practice is understood and delivered and is essential to preventing the normalisation of restrictive practices. This must be reflected not only in language but in practice, including the consistent recognition of independent advocacy as a **right integral to the exercise of autonomy, participation, and access to remedy**, rather than an optional service.

Summary

For the strategy to be effective, it must move beyond policy commitments and ensure **implementation, resourcing, accountability, and cultural change**, alongside **structural reform**, including decongregation.

Without this, there is a significant risk that restrictive practices will remain embedded within services, particularly in institutional settings, and that non-pharmacological alternatives will not be realised in practice.



About ORAM

The Our Rights and Medication (ORAM) Advocacy Group is a network of experts by experience, advocates, academics and practitioners hosted by the SHEP Advocacy Programme.

In line with the principles of the Assisted Decision Making (Capacity) Acts 2015 and 2022 and human rights-based practice we want everyone to know (particularly people with disabilities and older people) that they have choices and rights around the medication they are prescribed.

We want health and social care professionals to feel empowered to support people to exercise their rights around their medication.

And we want to work with others to ensure that clinical guidance on the prescribing of psychotropic medication in all healthcare settings becomes a reality.



Contact



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**Promoting human rights,
informed consent and
the least restrictive approaches
to medication and care.**