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

Public Consultation

06 March 2026

Background

Established in 2002, the Mental Health Commission (MHC) is an independent statutory body responsible for regulating mental health services in Ireland. Its primary function is to promote, encourage, and foster the maintenance of high standards and good practices in the delivery of mental health services and to protect the interests of people detained under the Mental Health Acts 2001-2018 (the 2001 Act).

At present, the MHC regulates 67 approved centres providing inpatient care and treatment to people with a mental health difficulty and as part of its regulatory remit the MHC currently inspects against rules governing the use of seclusion and mechanical restraint, and a code of practice on the use of physical restraint. The MHC's rules and codes of practice adopt a human rights and person-centred approach to the regulation of these practices.

The number of episodes of seclusion and physical restraint has been decreasing in approved centres in Ireland since 2018 the rate of decline accelerated following the implementation, by the MHC, of revised human rights-based rules and code of practice which came into effect on 1 January 2023. The number of episodes of seclusion and physical restraint has fallen by 62% since 2018, with a notable 91% decrease in the use of these restrictive practices on children[i]. The use of mechanical restraint continues to be very rare.

Mental Health Bill 2024

Following the December 2025 amendments to the Mental Health Bill 2024 which aim to expand the MHC's remit to provide for the regulation of pharmacological restraint (previously referred to as 'chemical restraint'), the MHC is currently in the early stages of developing a code of practice on the use of pharmacological restraint. It is envisaged that it will be inspected against from 1 January 2027.

Section 33(3)(e) of the 2001 Act (the current legislation) provides for the MHC to "prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services". The code of practice on the use of pharmacological restraint will be applicable to all inpatient mental health services ("approved centres") in the public, voluntary and independent sectors including services for children and adolescents, adults, older persons, persons with an intellectual disability and a mental health difficulty and forensic mental health services.

The code of practice will pave the way for requirements which come into effect following enactment of the Mental Health Bill 2024.

Definition

The Mental Health Bill defines 'pharmacological restraint' as:

the administration of medication to a person where the only purpose of such administration is to—

(a) control the person's behaviour, or

(b) restrict, prevent or limit the person's freedom of movement or access to his or her own body,

but does not include the administration of medication that is for the purposes of treating or ameliorating his or her mental disorder".

Note: It is acknowledged by the MHC that the use of pharmacological restraint is a complex matter which requires careful consideration of human rights. The code of practice on the use pharmacological restraint will relate to the administration of medication to control the person's behaviour, or restrict, prevent or limit the person's freedom of movement. Whilst the MHC does not support the routine use of pharmacological restraint, it recognises that, in exceptional circumstances and as an emergency measure where there is an immediate threat of serious harm to the person or to another person, its use may be unavoidable. The use of pharmacological restraint should be proportionate to the immediate threat, be the least restrictive practice possible in the circumstances, for the shortest duration possible and where there is no safe alternative for the person.

The MHC does not have an oversight role in the prescribing of medications as this is a matter of clinical decision-making and is outside the scope of the code of practice. However, the MHC recognises that the use of medication to control behaviour or restrict a person's movement in an emergency is a significant intervention, which has potentially serious consequences for the person. Therefore, the code of practice will seek to ensure that its use has robust oversight, the human rights of the person are upheld, and the restraint is undertaken with the most extreme caution with the safety of the person during and after the restraint paramount.

The purpose of this survey is to help the MHC to identify key areas that the code of practice should address.

As part of this consultation, we would like to hear from all relevant stakeholders. We especially want to hear from people who have experience of using mental health services in Ireland, those close to them, and staff who work in mental health services.

We will carefully assess all responses received and use the information gathered, along with other available evidence (including an in-depth evidence review and advice received from the Expert Advisory Group and the MHC's Stakeholder Forum), to develop the code of practice. The MHC will publish a consultation report alongside the code of practice.

Please note, the closing date for this consultation is **5pm Tuesday 7 April 2026**.

While we encourage respondents to complete the survey using the online form, completed surveys may also be returned to standards@mhcirl.ie or by post to: Standards and Quality Assurance, Mental Health Commission, Waterloo Road, Dublin 4 D04 E5W7

For queries, or to request a word version or physical copy of the survey, please contact standards@mhcirl.ie or by telephoning us on 01 636 2400.

Data Protection and Freedom of Information

The MHC will only collect contact information during this consultation for the purposes of verifying an organisation's feedback. If you have any concerns regarding your data, please contact the MHC's Information Governance Manager at dpfoi@mhcirl.ie. Please note that the MHC is subject to the Freedom of Information (FOI) Act and the statutory Code of Practice in relation to FOI. Following the consultation, we will include the names and types of organisations that submitted feedback to us, we will not publish the names of individuals who provide feedback. For that reason, it would be helpful if you could inform us if you regard the information you have provided us as being confidential or commercially sensitive.

Support

Please note that the MHC appreciates and recognises that a public consultation process can be difficult for some people. With that in mind, we would like to direct anyone in need of support to: Urgent Help and Support | Mental Health Commission (mhcirl.ie)

This page provides key links and contact details for services and organisations that offer immediate or urgent support, and to organisations that offer general and specialised ongoing support.

Concerns

If you have an issue of concern about a particular service, you can report that concern to us. For more information, visit: Report a Concern | Mental Health Commission (mhcirl.ie)

Question 1

Are you providing us feedback as:

- An individual
- On behalf of an organisation. *For verification purposes, please provide the name of the organisation and a name and phone number/official email address for a contact person within the organisation:*

AsIAm

Question 2.

Are you commenting as:

☐ A person who has used, or is currently using, mental health services in Ireland

☐ A friend, family member, or carer of a person who has used, or is currently using, mental health services in Ireland (Please specify)

☐ A staff member or other person working in mental health services

☐ A staff member or representative of an organisation. This might include people working for a government department or an advocacy group.

(Please specify your role)

Senior Policy Officer

☐ Other (please specify)

Question 3.

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

AsIAm welcomes the opportunity to engage with the Mental Health Commission on their Public Consultation on their Code of Practice on the use of pharmacological restraint in inpatient mental health services. As Ireland's Autism Charity and a Disabled Persons Organisation, AsIAm advocates for a Code of Practice on the use of pharmacological restraint that needs to be rooted in a rights-based, neuro-affirmative and trauma-informed approach. The Code must be consistent with Ireland's obligations under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). The Code should recognise that all people, including those experiencing mental distress have an inherent right to dignity, autonomy and bodily integrity, and to be free from violence, coercion and inhuman and degrading treatment, and to legal capacity to make informed decisions relating to their healthcare and wellbeing.

Realising these standards requires a paradigm shift away from medicalised and pathologised approaches to treatment, towards recognising a person's autonomy, legal capacity, and expressed will and preferences as central in all decisions relating to their mental health care and support needs. In this context, pharmacological restraint cannot be seen as a neutral clinical intervention, but one which carries risks to the dignity, autonomy and wellbeing of Autistic people and which departs from their human rights.

Recent debates, including with the Mental Health Bill and with the Additional Protocol to the Oviedo Convention, highlight the serious risks of making amendments to regulatory frameworks that seek to legitimise coercion and restrictive practices in mental health. Organisations, including the European Disability Forum, Mental Health Europe and Mental Health Reform, have warned that taking these approaches risk further entrenching involuntary treatment and embedding coercive practices within our mental health system, putting Ireland in contravention of the UNCRPD.

In this regard, the Code must both regulate pharmacological restraint and explicitly recognise its use as a harmful practice that restricts the rights of Autistic and Disabled people, including those with mental health or psychosocial disabilities, with a clear commitment to reducing and eventually eliminating these practices over the longer term. The principle of last resort must be interpreted narrowly: restraint should only be considered where there is an immediate and serious risk of harm, and where all possible alternatives have been exhausted.

Importantly, the Code must embed the principles of non-discrimination, autonomy, dignity and bodily integrity, and that any interventions used by clinical professionals without the person's free and informed consent risk causing serious harm or injury and infringe the rights of Autistic and Disabled people under Articles 14, 15, 16 and 17 of the UNCRPD. The CRPD Committee and wider UN system have made clear that involuntary treatment, even when

framed as medically necessary, can breach the Convention.

Evidence from the Autistic community's experiences with Child and Adolescent Mental Health Services (CAMHS) in Ireland underscores the urgency of these principles, particularly where Autistic people may be discriminated against. Young people frequently present to services in crisis, following prolonged periods where they may be refused access to the supports they need or experience discrimination in accessing services. These also include long waiting times to being seen by clinicians and to being inappropriately prescribed medication to make up for shortfalls in therapeutic supports. In this regard, the use of pharmacological restraint often reflects structural shortcomings within mental health services and fails to meet an Autistic person's support needs. This underscores the importance of embedding prevention and early support as core principles of the Code, and that the Commission discourages the use of psychotropic medication to restrain an Autistic person.

For these reasons, as members of Mental Health Reform, AsIAm supports their calls for cultural change within mental health services, to help build a modern, rights-based mental health system in Ireland, where meeting the needs of Autistic people means that services should maintain therapeutic environments that support people based on collaboration, mutual respect and which prioritise the use of non-coercive forms of treatment. We also support Mental Health Reform's call that people who have been subject to restrictive practices be central to the Code's development, implementation and ongoing monitoring and review.

AsIAm believes that the Code should be grounded in the following approach:

- **Human rights and dignity:** Pharmacological restraint must be framed as an exceptional derogation of a person's rights, and the person's dignity, autonomy, bodily integrity, privacy must be core to every decision made about their treatment, and any review or monitoring therein.
- **Safety:** The person's physical and psychological safety, as well as the prevention of any avoidable harm or injury, must be a primary consideration at all stages of any use of pharmacological restraint. For Autistic people, this should include their own individual experience of safety, their history of any traumatising or adverse experiences, and their right to be free of coercive practices and from inhuman and degrading treatment.
- **Last resort and least restrictive:** Pharmacological restraint should only be used when there is an immediate and serious risk of harm, when all other deescalation and non-restrictive options have been tried or are clearly inappropriate, and when it is the least restrictive option in that moment.
- **Proportionality and necessity:** The type and dose of medication administered must be proportionate and not be used as a form of punishment or controlling the person.
- **Time-limited and closely monitored:** Pharmacological restraint should be for the shortest possible time, with criteria for when its effect is considered to have ended and when a full review must occur. The findings of the Halpin and Maskey Reports into CAMHS services in Kerry highlight the consequences of inadequate oversight and governance mechanisms which exposed many children across Kerry to harm and psychological distress through the over-prescription of powerful psychotropic medication. Continuous monitoring must be carried out by appropriately trained and qualified staff, with the appropriate competencies to assess the treatment's physical and psychological impact on the person.

- **Person-centred and trauma-informed:** Any use of pharmacological restraint should consider the person's preferences, trauma, culture, and communication needs. The code should explicitly require trauma-informed practice and recognition that restrictive practices can potentially retraumatise Autistic people needing support.
- **Accountability and governance:** Strong governance and oversight, mandatory reporting and data collection should underpin the governance around the use of pharmacological restraint.
- **Reduction and eventual elimination:** The Code should explicitly align with the broader goal of reducing and, where possible, eliminating restrictive practices over time.
- **Informed consent:** The Code should require that clinicians seek the informed consent of the person wherever they have capacity, even in crisis situations. Where their capacity is impaired, staff must make every effort to explain what is happening, why, and what alternatives exist. The person's advance healthcare directives, their expressed will and preferences, and crisis plans must be central to decision-making. Consent must not be seen as a one-off event but an ongoing process of communication, respect, and partnership between the person receiving treatment and clinicians and staff involved in their care and wellbeing.
- **Transparency:** The Code should require clear documentation of the clinician's reasoning why pharmacological restraint was need and used in this situation, any alternatives that were attempted, medication used, and ongoing monitoring of the person. Transparency must also involve open communication with the person themselves (including their families, nominated persons or supporters) and clinicians and staff, including during the event and a meaningful debrief afterwards, as well as transparent reporting at service and system levels to support monitoring and reduction processes.

Question 4.

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)?

A rights-compliant Code of Practice must ensure that human rights are protected across the life course and focus on preventing situations in which restraint is considered in the first instance. Protecting human rights in this context requires a proactive, person-centred, and neuro-affirmative approach that recognises distress as a response to unmet need.

Prior to any use of pharmacological restraint, services must be required to adopt a proactive, preventative approach grounded in individualised, person-centred mental health supports grounded in their will and preferences. This includes identifying and responding to the triggers that cause an Autistic person to feel anxious or distressed, meeting an Autistic person's communication support needs, and effective de-escalation strategies. It also requires providing reasonable accommodations, including the use of information in accessible formats and facilitating the use of Augmentative and Alternative Communication, and ensuring access to supports that meet the person's communication, sensory, and emotional support needs. For Autistic and Neurodivergent people, this includes sensory supports, predictable environments, and accessible communication.

A rights-based approach must also require that informed consent is sought wherever possible, even during crisis situations. When a person's decision-making is impaired, every effort must still be made to explain what is happening in an accessible and supportive manner. Advance directives, crisis plans, and previously expressed preferences must play a central role. The Code should require clear documentation that all non-restrictive alternatives - including de-escalation, any adjustments to the sensory environment, and relational supports - have been attempted and exhausted

During any use of restraint, it is important to recognise that the use of coercion itself may constitute a violation of human rights, particularly where it overrides the individual's will and preferences. This reinforces the need for the Code to treat pharmacological restraint not as a neutral clinical tool, but as a measure carrying inherent ethical and legal risks. This reinforces the need for a clear threshold for immediate and serious risk of harm necessary for pharmacological restraint, strict limitations in duration and scope, continuous monitoring, and clear communication throughout, and the immediate cessation once the risk of harm subsides. The use must be time-limited and proportionate and preserve the Autistic person dignity and bodily integrity.

Safeguards must prioritise the person's dignity, bodily integrity, and personal experience of safety. Staff should be required to communicate clearly and calmly throughout, explaining what is happening and why, even where the person is highly distressed. Communication must be trauma-informed, non-threatening, and respectful, with an explicit prohibition on derogatory, stigmatising, or coercive language, including threats of further restraint. Medication should be administered in as private a setting as possible, with due regard to cultural, gender, and personal preferences. Continuous monitoring of physical health, including vital signs and potential side effects, must be mandatory, with clear escalation procedures in place. Only appropriately trained and competent staff should be permitted to authorise and administer pharmacological restraint.

Following the use of restraint, robust review and accountability mechanisms are essential. This should include requiring the clinician to formally report incidents when restraint is used, meeting with the individual, allowing them opportunities to decide on their preferences relating to their future care and wellbeing. Autistic people's experiences with CAMHS highlights that restraint can be deeply distressing and, in some cases, retraumatising, with long-term impacts on wellbeing, trust and engagement with mental health services. Addressing this requires mandatory monitoring and reporting of incidents and allowing individuals to access advocacy and complaints mechanisms.

All incidents must be formally documented and subject to multidisciplinary review, including if the treatment was necessary and proportionate, whether the person's rights were restricted more than necessary, and what could be done differently. Data should be collected and analysed as part of restraint reduction strategies both organisationally and across the mental health system.

Access to independent advocacy and effective complaints mechanisms is essential to ensure accountability and to support individuals in exercising their rights. With the person's consent, families or nominated supporters should be involved in post-incident review and future planning.

Question 5.

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

The safe and rights-compliant use of pharmacological restraint is dependent on the knowledge, skills and values of staff. As such, the Code of Practice must set a high threshold for the experience and training required, with a clear emphasis on prevention, human rights, and person-centred, neuro-affirmative care.

Staff involved in the use of pharmacological restraint must have appropriate clinical qualifications and have received requisite training and professional development in human rights, neuro-affirmative practice and trauma-informed care and person-centred approaches. Only appropriately qualified professionals should be permitted to authorise pharmacological restraint. Authorisation should be restricted to registered medical practitioners with demonstrable expertise in psychopharmacology and an understanding of the risks associated with emergency sedation, including over-sedation, drug interactions, and polypharmacy.

All staff involved in the use of pharmacological restraint must receive comprehensive training grounded in a human rights-based framework, including Ireland's obligations under the United Nations Convention on the Rights of Persons with Disabilities. This training should ensure a clear understanding of key principles such as autonomy, legal capacity, necessity, proportionality, and the requirement to use the least restrictive alternative. It should also support staff to critically reflect on the ethical implications of coercion in clinical practice.

Training should prioritise prevention and de-escalation, equipping staff to recognise distress as a response to unmet support needs and focus on accessible communication, emotional regulation and wellbeing support. This includes developing skills in verbal and non-verbal de-escalation, emotional regulation support, and early identification of distress, as well as the use of environmental and sensory strategies to prevent escalation. Staff should be trained to use accessible and inclusive communication approaches, including working with individuals who use Augmentative and Alternative Communication.

A strong emphasis must also be placed on neuro-affirmative and trauma-informed practice, including the direct involvement of Autistic people in co-designing approaches to mental health and crisis support, and centring Autistic-led practice in mental health. Staff must understand the experiences of Autistic and neurodivergent individuals, including sensory processing differences, communication styles, and environmental triggers. Without this there is a significant risk that distress will be misinterpreted and seen as a behaviour that challenges or must be managed by restrictive practices, rather than affirmatively supporting the person throughout the process.

Staff should also receive training in trauma-informed support, including an understanding of trauma, power dynamics and the potential for restrictive practices to retraumatise Autistic and Disabled people accessing services. This should include collaborative safety-planning, relationship-based care and supporting the person to make decisions as to their support preferences and their mental health care.

Training must also include clinical competencies related to pharmacological restraint, including side-effects of medication used, monitoring requirements, managing adverse side effect, as well as the risks of over-sedation and polypharmacy, and how mental health interacts with physical health and neurodevelopmental differences. They should also include

building cultural competence in supporting Autistic people, communication differences, language barriers and how intersecting identities may influence their experiences of mental health and distress, particularly for people who may be at increased risk of restrictive practices.

Finally, the Code should require ongoing supervision, reflective practice, and continuous professional development. Staff should be supported to engage in structured debriefing following incidents, to reflect on decision-making, and to contribute to service-level learning and quality improvement. The overall aim of training should be to reduce reliance on restraint and promoting rights-based neuro-affirmative alternatives that uphold the person's dignity, autonomy and wellbeing.

Question 6.

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

Pharmacological restraint should never be used in situations where an Autistic person is not at an immediate or serious risk of harm. Its use in situations of distress arising from unmet support needs, inaccessible environments, or communication barriers is fundamentally incompatible with a rights-based approach to mental health care set out in the UNCRPD.

For Autistic and neurodivergent people, their experience of distress can be attributed to sensory overload, overwhelming environments and situations, unmet communication needs and a lack of access to supports. The use of pharmacological restraint in these situations reflects a failure of services to appropriately respond to a person's needs and should never be used on the basis of a person being Autistic. A rights-based Code of Practice must make clear that distress alone - including agitation, anxiety, withdrawal, or verbal expressions of upset, distress or frustration – can never justify the use of pharmacological restraint in the absence of an immediate and serious risk of harm.

The Code should prohibit the use of pharmacological restraint in circumstances even where services are under pressure. It should never be used for reasons of staff expediency, inadequate staffing or as a response to structural or environmental shortcomings within services. It must also never be used as a form of punishment, control or as a response to non-compliance. The use of restraint as a response to an Autistic person that is acting in a disruptive but not dangerous manner, or in situations where de-escalation and other non-coercive approaches have not been fully exhausted, cannot be justified.

Pharmacological restraint should not be used where there are situations that would make its use unsafe or disproportionate, such as underlying health conditions, co-occurring physical or chronic health conditions or where there are medical contraindications, including allergies or dual diagnosis. It should also not be used as a substitute for appropriate assessment and treatment, particularly where there may be an underlying health condition involved.

The use of pharmacological restraint on the basis of a person's disability, including where a person is Autistic, Neurodivergent or has an intellectual disability, must be explicitly prohibited. Disabled people may be at increased risk of restrictive practices, including overmedication and polypharmacy, and this risk must be actively mitigated using clear

safeguards within the Code. There has been growing evidence on the impact of the negative impact that restraint has on both Autistic children and staff. For example, reports by HIQA have repeatedly identified the use of restrictive practices in disability services and highlighted the need for stronger oversight and accountability mechanisms, and to develop a rights-based approach focused on reducing restraint. Similarly, the European Committee for the Prevention of Torture has raised concerns about prescribing practices in Irish mental health settings, including the use of PRN medication in ways that may amount to de facto chemical restraint.

Caution must apply in relation to children and people whose capacity to make decisions may be affected. In these cases, the Code should place a significantly higher threshold for any use of pharmacological restraint, with a clear presumption against its use. It should never be employed as a substitute for meaningful engagement or supports aimed at meeting their support needs.

Finally, the Code must respect the person's will and preferences, including any advance healthcare directives or previously expressed wishes regarding medication. Where a person has clearly indicated that they do not wish to receive specific medications, these preferences should be upheld to the greatest extent possible, and any departure from them must be subject to the highest level of scrutiny and justification.

Question 7.

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

Robust safeguards are vitally important to ensuring the safety, dignity, wellbeing and human rights of people in any circumstance where pharmacological restraint is used. These safeguards must be framed within a broader commitment to reducing and eliminating the use of pharmacological restraint and restrictive practices and ensure that systems are accountable and orient towards cultural and structural change. A rights-based Code of Practice must therefore ensure that safeguards operate not only at the point of intervention, but across individual, team, and organisational levels.

At the point of use, strict clinical safeguards are necessary. Pharmacological restraint must be subject to a clear authorisation process, led by a named responsible clinician, with explicit documentation of the rationale, alternatives attempted, and the expected duration of the intervention. Its use must be time-limited, proportionate, and in line with evidence-based protocols, with clearly defined maximum dosage thresholds and criteria for cessation.

Prior to administration, a comprehensive assessment of the person's physical health must be undertaken. This should include a review of medical history, identification of pre-existing conditions, current medications, and individual risk factors. These factors must inform clinical decision-making, including dose adjustments and the selection of the least risky pharmacological option, in order to minimise the risk of adverse outcomes such as over-sedation.

During and immediately after administration, continuous monitoring is essential. This should include standardised observation protocols for vital signs and side effects, with clearly defined escalation pathways and access to emergency medical support. The environment in

which the intervention takes place must also be safe and appropriate, minimising risks such as falls, aspiration, or injury. Only staff with appropriate training and competence in both psychopharmacology and physical health monitoring should be involved in administering and overseeing pharmacological restraint.

Safeguards must extend beyond the immediate clinical intervention to include post-incident review and learning. Every use of pharmacological restraint should be formally recorded and subject to timely multidisciplinary review, including consideration of whether the intervention was necessary and proportionate, whether all alternatives were appropriately explored, and what could be done differently in future. Attention should be paid to avoiding cumulative sedation and polypharmacy through a review of the individual's ongoing medication.
A structured debrief with the individual should be a core requirement, providing an opportunity for the person to share their experience, have the impact of the intervention acknowledged, and inform future care planning. With the person's consent, families or nominated supporters should be involved in this process, recognising that they may play a key role in understanding the individual's needs and identifying more appropriate responses in future situations. Access to independent advocacy and clear, accessible complaints mechanisms must also be guaranteed to ensure that individuals can exercise their rights and seek redress where necessary.

At a **service and system level**, strong governance and accountability mechanisms are critical. This should include mandatory reporting of all incidents, standardised data collection, and regular auditing of frequency, patterns, and outcomes. Autistic people and people with lived experience in reviewing policies, training content, and aggregating data, and in co-producing policies aimed at meeting the need of these communities.

Question 8. 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 robust and rights-based Code of Practice on pharmacological restraint must be informed by international human rights standards, lived experience, interdisciplinary expertise, and evidence-based research. It is essential that the Mental Health Commission engages with a broad and diverse range of stakeholders to ensure that the Code reflects best practice and responds to the realities of those most affected by restrictive practices.

At an international level, the Code should be grounded in the principles and obligations set out in the United Nations Convention on the Rights of Persons with Disabilities, which provides a clear framework for understanding autonomy, legal capacity, dignity, and freedom from coercion. European-level policy and advocacy, including the work of the European Disability Forum and Mental Health Europe, also offers important analysis on the human rights implications of restrictive practices and the need for their reduction and elimination.

The Mental Health Commission should engage closely with Disabled Persons Organisations (DPOs) and representative advocacy groups, ensuring that the voices of those most impacted by pharmacological restraint are central to the development of the Code. This includes Autistic-led organisations such as AsIAm, as well as organisations representing people with intellectual disabilities, mental health difficulties, and other disabilities, including Inclusion Ireland and Mental Health Reform.

Engagement should also extend to organisations supporting individuals with specific communication access and support needs, including those using Augmentative and Alternative Communication, as well as DPOs representing the Deaf community such as Irish Deaf Society, and organisations representing Disabled women and girls, including Disabled Women Ireland. Broader independent living and rights-based organisations, such as Independent Living Movement Ireland, should also be included in this engagement and consultation.

Given the intersectional nature of access to mental health services, it is also important to engage with organisations representing marginalised and underrepresented communities, including Traveller and Roma organisations, migrant and refugee support organisations, LGBTQIA+ youth organisations, and groups supporting care-experienced young people and those involved with Tusla. These communities face well-documented barriers in accessing Child and Adolescent Mental Health Services and may be disproportionately impacted by restrictive practices.

The Code should also be informed by the expertise of equality and human rights bodies, including the National Disability Authority and the Irish Human Rights and Equality Commission, which provide critical oversight and guidance on rights-based approaches. Engagement with professional bodies is also essential to ensure that the Code is both practical and evidence informed. This includes the Psychological Society of Ireland, and the Irish Association of Counsellors and Psychotherapists, as well as representative bodies for occupational therapists, speech and language therapists, and social workers, and the Royal College of Psychiatrists in Ireland. Input from general practitioners and community mental health professionals should also be sought, particularly those with lived experience of these practices. Importantly, engagement should include Autistic clinicians and professionals with lived experience, as well as those with expertise in neuro-affirmative and trauma-informed practice, including international experts and sectoral groups like Autistic Doctors International.

Academic and research expertise should further inform the Code, including engagement with universities and research centres specialising in disability rights, youth mental health, and trauma-informed care, such as the Centre for Disability Law and Policy at the University of Galway.

Finally, the Mental Health Commission should ensure meaningful engagement with people with lived experience, including individuals who have been subject to restrictive practices, as well as their families and supporters. Their perspectives are essential to understanding the real-world impact of pharmacological restraint and to identifying practical alternatives. Engagement should also extend to regulators and oversight bodies, such as HIQA and the Ombudsman, as well as peer support organisations and community-based services working on alternatives to coercion, including crisis houses and community-led supports. Incorporating this breadth of expertise and lived experience will be critical to developing a Code of Practice that is not only clinically sound, but also rights-based, inclusive, and capable of driving meaningful cultural and systemic change within mental health services in Ireland.

Question 9.

Any additional thoughts or comments?

The use of pharmacological restraint must be understood within the broader context of the barriers Autistic people face in accessing mental health supports. Autistic people's experiences reflect that in many situations restrictive practice is often used to deal with situations that are exacerbated by unmet need, long waiting times, having their experiences dismissed or not feeling supported during crisis situations. For many Autistic people, feeling distressed or crisis situations can also be linked to their experiences of sensory overload, Autistic burnout, or not feeling understood or supported, particularly during crisis situations. Addressing these underlying issues is essential to reducing reliance on pharmacological restraint. Illustrating this, AsIAm's Same Chance Report found that 66% of respondents sometimes, often or always have difficulties with accessing mental health supports. 70% of community members also felt that they needed mental health and wellbeing supports to live independently in the community.

Evidence reviewed by the Mental Health Commission highlights the lack of robust evidence supporting the effectiveness of restrictive practices, alongside well-documented risks of psychological and physical harm. The absence of international consensus on best practice further reinforces the need for a neuro-affirmative, rights-based approach. Research also highlights significant variation in the use of restrictive practices, with higher rates observed in child and adolescent services, underscoring the importance of strong governance, consistent monitoring, and consistency across national standards. Evidence further indicates that early identification of distress, environmental triggers, and unmet needs, alongside relational and de-escalation approaches, can significantly reduce the need for clinicians to use restrictive practices.

The development of this Code of Practice takes place within a wider international context in which there is increasing recognition that coercion in mental health care is incompatible with human rights standards, including the UNCRPD. Concerns raised during the debates for the Mental Health Bill, particularly in relation to expanding the basis for involuntary treatment reinforces the need for developing a rights-based Code of Practice which supports an Autistic person's wellbeing and recognises their dignity, autonomy and capacity, and their full ability to exercise their human rights and participation in decisions relating to the wellbeing and mental health support needs under the UNCRPD.

A meaningful Code of Practice must therefore do more than regulate the use of pharmacological restraint. It must set a clear direction towards its reduction and, where possible, elimination, supported by investment in therapeutic approaches, community-based supports, and rights-based, person-centred support which centres the experiences of Autistic people and marginalised communities and is responsive in meeting their care needs.

In this regard, there is a clear need for a **system-wide review of sedation practices** across mental health services in Ireland. At present, there is limited clarity and consistency in how services distinguish between therapeutic sedation, rapid tranquillisation, and pharmacological restraint. Without a comprehensive national picture, it is difficult to assess the true scale and impact of these practices. Concerns raised by the European Committee for the Prevention of Torture in its review of Irish services highlight the risks associated with the inappropriate use of PRN (as-needed) medication, including overmedication, chemical restraint, and insufficient oversight. A structured national review would enable the Mental Health Commission to better understand how sedation is used in practice, identify where it may function as a de facto restrictive practice, and develop clearer definitions, thresholds, and safeguards.

This review should examine any difference in treatment across services and clinical settings, assess whether sedation is being used in place of non-restrictive alternatives, and consider the extent to which it may be compensating for structural issues such as staffing pressures or a lack of therapeutic supports. Crucially, it should centre the lived experiences of individuals who have been subject to these practices, including people with psychosocial disabilities.

The Code of Practice must also address the ambiguity in the definition of pharmacological restraint. While the Mental Health Bill defines it based on the intention behind the use of medication, in practice the distinction between treatment and restraint is often unclear. The same medications used for therapeutic purposes can, in certain contexts, limit autonomy, control or supress behaviour, or render a person unable to meaningfully engage. PRN medication may contribute to cumulative sedation that effectively functions as restraint, regardless of its stated purpose.

For this reason, the Code should recognise that the effects of medication on the individual are as important as the intent behind its use. Where medication results in over-sedation, loss of agency, or inability to communicate, it should be understood and regulated as a restrictive practice. This requires clear thresholds, enhanced monitoring, and comprehensive documentation of both the intended purpose and the observed impact of medication on the person's autonomy and capacity.

Finally, the Code should explicitly prohibit the use of threats of pharmacological restraint. The suggestion that medication may be administered to enforce compliance constitutes a form of psychological coercion and can be deeply distressing and traumatising, particularly for individuals with prior experiences of restrictive practices. Such threats undermine trust, escalate distress, and create coercive environments, even where medication is not ultimately administered. Prohibiting this practice would send a clear signal that coercion has no place in a rights-based mental health system and would reinforce the importance of communication, de-escalation, and collaborative approaches.

Register for future engagement opportunities

If you are interested in participating in further engagement (e.g. taking part in an online focus group) with us about the development of the code of practice, please include your contact details in the box below, or email standards@mhcirl.ie

Adrian Carroll, Senior Policy Officer, AsIAm

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THANK YOU FOR TAKING THE TIME TO COMPLETE THIS SURVEY.

[i] Declining restrictive practice in approved centres in Ireland: improving quality of care through the adoption of a human rights-based approach | Irish Journal of Psychological Medicine | Cambridge Core