Irish Journal of Psychological Medicine (2025), **42**, 15–20
doi:10.1017/ipm.2024.32

CAMBRIDGE UNIVERSITY PRESS

Original Research

Use of restrictive practices in approved mental health centres in Ireland: consideration of five years of national data

James V. Lucey[1,2,3], Gary Kiernan[3], John Farrelly[3], Aisling Downey[3] and Pawel Stepala[3]

[1]Royal College of Surgeons in Ireland, Dublin, Ireland, [2]Trinity College Dublin, Dublin, Ireland and [3]The Mental Health Commission, Waterloo Exchange, Dublin, Ireland

Abstract

Objective: To evaluate the rates of use of restrictive practices (RPs), such as seclusion and physical restraint, in approved mental health centres (ACs) in Ireland.

Methods: Examination of data reported to the regulator of mental health in Ireland, the Mental Health Commission (MHC), and the Health Research Board (HRB).

Results: There has been a substantial reduction in RP use in Irish ACs between 2018 and 2022.

Conclusions: The MHC welcomes this reduction in RP use and considers several possible reasons for this data.

Keywords: Approved centres (ACs); mental health care; restrictive practice (RP)

(Received 21 February 2024; revised 1 June 2024; accepted 20 June 2024; First Published online 16 October 2024)

Introduction

Application of restrictive practices (RPs) such as seclusion and restraint within an approved mental health centre (AC) should be 'humane respectful and for the shortest period' (National Institute for Health and Care Excellence (NICE), 2015). Strategies to reduce the use of RP have proven effective in ACs (Bowers et al., 2015, Chua et al., 2021, Celofiga et al., 2022). International best practice recommendations emphasise human rights and consensus-based approaches to achieve further reductions (De Cuyper et al., 2023). Nevertheless, in certain settings and in high-risk situations, RPs continue to be used and may be unavoidable (Chieze et al., 2019, Perers et al., 2022). This paper is the first to compare RP rates in Irish ACs over a five-year period.

The Mental Health Commission (MHC) is the regulator of mental health services in Ireland. It is an independent statutory body established in accordance with the Mental Health Acts 2001–2018 (Mental Health Act) with responsibility for the establishment and maintenance of high standards and good practices in Irish mental health services. The MHC has a duty to enhance the protection of individuals admitted to Irish ACs, including those detained under the Mental Health Act.

A limited number of RP is regulated by the MHC, thus ensuring that ACs adhere to specific rules and codes of practice published by the commission. These include rules on the use of seclusion and a code of practice on the use of physical restraint (Mental Health Commission, 2009a, 2009b).

According to the MHC, physical restraint is "the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident's body when he or she poses an immediate threat of serious harm to self or others". Seclusion means "the placing or leaving of a person in any room alone, at any time, day, or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving" (Mental Health Commission, 2009a, 2009b).

RPs may only be used when a person poses an immediate threat of serious harm to self or others. Section 69(2) of the Mental Health Act stipulates that the use of seclusion is only permitted in accordance with the rules produced by the MHC, where its use is necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others. The rules on seclusion, which were applicable to the given period, advise that it must only be " . . . used in rare and exceptional circumstance and only in the best interests of the patient when he or she poses an immediate threat of serious harm to self or others". (Mental Health Commission, 2009a). Similarly, the MHC Code of Practice on the Use of Physical Restraint in place during 2018–2022 states that the use of physical restraint should only be used "in rare and exceptional circumstances and only in the best interests of the resident when he or she poses an immediate threat of serious harm to self or others."

Each AC must report data on its activities, including use of RP, to the MHC on an annual basis. The availability of this database enabled this 5-year analysis.

Method

We examined anonymised data reported to the MHC on RP use within all Irish ACs over a five-year period. The data shown are taken from reports made by ACs to the MHC between 2018 and 2022

Corresponding author: James V. Lucey; Email: jim.lucey@mhcirl.ie

Cite this article: Lucey JV, Kiernan G, Farrelly J, Downey A, and Stepala P. (2025) Use of restrictive practices in approved mental health centres in Ireland: consideration of five years of national data. *Irish Journal of Psychological Medicine* **42**: 15–20, https://doi.org/10.1017/ipm.2024.32

Table 1. Number of admissions to approved centres and total number of inpatient bed days (by year)

Year	Number of admissions	Total number of inpatient bed days	Number of approved centres
2022	16,136	732,254	67
2021	15,723	718,906	66
2020	15,391	746,646	68
2019	16,710	829,911	66
2018	17,000	895,206	67
Change 2018-2022	−5%	−18%	–

Source: Health Research Board 2018–2022.

Table 2. Number of persons secluded and rate per secluded patient

Year	Number of persons secluded	Rate per secluded patient	Number of ACs that used seclusion
2022	620	2.63	26
2021	645	1.9	27
2020	699	2.8	27
2019	653	2.6	28
2018	760	2.4	27
Change 2018-2022	−18%	+ 9.5%	–

Source: Mental Health Commission Ireland, Restrictive Practices Activity Reports 2018–2022.

inclusive. These are presented for all ACs combined. This RP data refers to all episodes of seclusion and physical restraint used across 26 counties. We recorded total RP numbers and calculated RP rates per 1000 occupied bed days and per 100,000 members of the population. We then compared these data over 5 years from 2018 to 2022.

Results

The total number of admissions to Irish ACs fell by 5% over five years (ranging from 17,000 admissions in 2018 to 16,136 in 2022). Total admission days fell by 18% (from a peak of 895,206 bed days in 2018 to 732,254 bed days in 2022). (See Table 1)

The number of ACs using restrictive practices fell from 55 in 2018 to 47 in 2022. The number of approved centres using seclusion did not change substantially over this period ($N = 27$, range 28–26) (See Table 2).

The number of individual residents restrained fell by 21% (from 1207 in 2018 to 1078 in 2022). The total number of physical restraint episodes fell by 48% (from a high of 5665 events in 2018 to 2945 events in 2022). The rate of restraint episodes per 1000 occupied bed days fell from 6.3 per 1000 in 2018 to 4 per 1000 in 2022. The rate of restraint per 100,000 population also fell from 110 in 2018 to 57.2 in 2022. (See Table 3).

The total number of residents secluded fell by 18% (from 760 in 2018 to 620 in 2022). The total number of seclusion episodes fell by 24% (from 1799 in 2018 to 1364 in 2022). There was a fall of 5% in the rate of seclusion per 1000 occupied bed days (from 2 per 1000 in 2018 to 1.9 per 1000 in 2022) and a fall of 30% in the seclusion rate per 100,000 population (from 37.8 in 2018 to 26.5 in 2022). (See Table 4). The rate of seclusion per secluded resident has risen by 9.5 %. (from 2.4 episodes per secluded patient to 2.63 in 2022). (See Table 2).

The mean (SD) age of residents secluded within Irish ACs remained static at 45 (1) years. Secluded residents were marginally younger at 36 (2) years compared to residents who were restrained 41 (1) years. (See Table 5). The gender profile of residents admitted to Irish ACs remained equipoised throughout five years, and while males and females were physically restrained in almost equal measures, males remained twice as likely to experience an episode of seclusion compared to females admitted to an Irish AC. (See Table 6).

The duration of RP episodes did not change substantially over the period. Most episodes of restraint remain of short duration (58.9% of restraints in 2022 were for less than 5 minutes), and the proportion of lengthy restraints (> 30 minutes) has fallen from 1.1% in 2018 to 0.3% in 2022. (See Table 7). The duration of seclusion episodes has remained static. In 2022, 22% of seclusions persisted

Table 3. Number of episodes of physical restraint including restraint rate per 100,000 population and restraint rate per 1000 occupied bed days (by year)

Year	Number of restraint episodes	Restraint rate per 1000 occupied bed days	Restraint rate per 100,000 population[1]
2022	2,945	4	57.2
2021	3,460	4.8	72.7
2020	3,990	5.3	83.8
2019	5,029	6	105.6
2018	5,665	6.3	119
Change 2018-2022	−48%	−36.5%	−52%

Table 4. Number of episodes of seclusion, including seclusion rate per 100,000 population and seclusion rate per 1000 occupied bed days (by year)

Year	Number of seclusion episodes	Seclusion rate per 1000 occupied bed days	Seclusion rate per 100,000 population
2022	1,364	1.9	26.5
2021	1,176	1.6	24.7
2020	1,840	2.5	38.65
2019	1,719	2	36.1
2018	1,799	2	37.8
Change 2018-2022	−24%	−5%	−30%

Table 5. Profile of persons secluded and physically restrained compared to the overall inpatient population: mean age (in years)

Year	All inpatient admissions	Secluded persons	Physically restrained persons
2022	45.8	36	41
2021	45	39	41
2020	45	39	42
2019	45	37	41
2018	45	36	42

Source: Mental Health Commission, Restrictive Practices Activity Reports 2018–2022; Health Research Board 2018–2022.

https://doi.org/10.1017/ipm.2024.32 Published online by Cambridge University Press

Table 6. Profile of persons secluded and physically restrained compared to the overall inpatient population: gender

Year	All inpatient admissions	Secluded persons	Physically restrained persons
2022	Female: 51% Male: 49% Other: -	Female: 35% Male: 65% Other: -	Female: 48% Male: 52% Other: -
2021	Female: 51% Male: 49% Other: -	Female: 34% Male: 66% Other: -	Female: 46% Male: 54% Other: <1%
2020	Female: 50% Male:50% Other: -	Female: 38% Male: 62% Other: <1%	Female: 48% Male: 52% Other: <1%
2019	Female: 49% Male: 51% Other: -	Female: 33% Male: 67% Other: -	Female: 46% Male: 54% Other: -
2018	Female: 50% Male: 50% Other: -	Female: 35% Male: 65% Other: -	Female: 51% Male: 49% Other: -

Source: Mental Health Commission, Restrictive Practices Activity Reports 2018–2022; Health Research Board 2018–2022.

Table 7. Duration of physical restraint episodes (by year)[1]

Year	< 5 minutes	5–15 minutes	16–30 minutes	Over 30 minutes
2022	58.9%	31.8%	9%	0.3%
2021	63.4%	27.9%	7.5%	1.1%
2020	54.4%	38.4%	7.1%	0.2%
2019	48.6%	39.5%	11.3%	0.6%
2018	52.7%	38.2%	7.9%	1.1%

Source: Mental Health Commission Ireland, Restrictive Practices Activity Reports 2018–2022.
[1]In some instances, the percentages do not add up to 100% due to rounding.

Table 8. Duration of seclusion episodes

Year	Less than 4 hours	4–8 hours	>8–24 hours	>24–48 hours	>48–72 hours	Over 72 hours
2022	22%	22%	34%	10%	5%	7%
2021	24%	21%	34%	11%	4%	6%
2020	20%	18%	49%	7%	2%	4%
2019	29%	28%	29%	7%	3%	4%
2018	31%	22%	28%	10%	4%	5%

Source: Mental Health Commission Ireland, Restrictive Practices Activity Reports 2018–2022.

Table 9. Total number of restrictive practice (RP) episodes (physical restraint and seclusion), including rate per 100,000 population and rate per 1000 bed days (by year)

Year	Number of RP episodes	RP rate per 1000 occupied bed days	RP rate per 100,000 population
2022	4,309	5.9	83.7
2021	4,636	6.5	97.4
2020	5,830	7.8	122.45
2019	6,748	8.1	141.7
2018	7,464	8.3	156.8
Change 2018-2022	−42%	−29%	−47%

for less than 4 hours, but 7% were for more than 72 hours. (See Table 8).

The total number of restrictive practice episodes (calculated by combining episodes of restraint with episodes of seclusion) fell from 7464 restrictive practice events in 2018 to 4309 in 2022. The rate of restrictive practices per 1000 occupied bed days fell by 29% (from 8.3 in 2018 to 5.9 in 2022). The rate of restrictive practices per 100,000 population fell by 47% (from 156.8 in 2018 to 83.7 in 2022). (See Table 9).

Discussion

RPs such as seclusion and physical restraint have been a feature of psychiatric practice since its very beginning (Abderhalden et al., 2006). In modern times, the negative physical and psychological consequences for those subjected to RP have been acknowledged (Chieze et al., 2019). RPs are recognised as being inconsistent with principles ensuring human rights (World Health Organisation, 2019).

Although RPs are never therapeutic in themselves, they may be justified in an emergency, such as where serious threat to life arises because of mental illness. Following extensive consultation with experts and stakeholders, the MHC published a strategy for RP reduction in Irish Mental Health Services (Mental Health Commission, 2014). MHC rules and code of practice on RPs were published in 2009 and more recently revised (Mental Health Commission, 2022b). Our data suggest that application of these standards in Irish ACs correlates with a reduction in RP.

Comparing the rates of RPs with those in other jurisdictions

Comparison of RP rates across centres and across nations remains problematic. There have been calls for a common set of international measures so that finer comparisons within and between countries can be made (Savage et al., 2024). The types and definitions of reported coercive practices vary considerably. For example, some jurisdictions do not differentiate "restraint" into physical restraint and mechanical restraint. Additionally, there are discrepancies in how rates are reported, with countries and states measuring rates of RPs per 1,000 occupied bed days and/or rates per 100,000 population, for example. The MHC has been called to address some of these difficulties in its publications (Duffy 2023). In this analysis, we have presented the data as total numbers of RP events experienced in the total numbers of residents. At the same time, we have calculated the rates of RP per 1000 bed days and per 100,000 population. (See Tables 10–12)

We have not calculated the rates of RP per region or per CHO. We cannot rule out the possibility that reduction in seclusion and, or restraint is associated with the emergence of other effects, such as the use of chemical restraint.

Recently published analysis (Te Pou, 2022) demonstrates that Ireland is below average in terms of its use of seclusion in adult inpatient units; it ranked fourth lowest in the use of seclusion per 10,000 occupied bed days out of nine jurisdictions during 2022. Ireland's seclusion rate was lower than New Zealand, Australia, England, Northern Ireland, and Sweden, and higher than the Netherlands, Wales, and Scotland.

In terms of physical restraint, the rate of RP per 1,000 occupied bed days is lower than in comparable jurisdictions (England and

https://doi.org/10.1017/ipm.2024.32 Published online by Cambridge University Press

Table 10. Number of persons physically restrained and rate per restrained patient (by year)

Year	Number of persons physically restrained	Rate[2] per restrained patient	Number of ACs that used physical restraint
2022	1,078	2.7	47
2021	1,145	3	47
2020	1,211	3.3	48
2019	1,144	4.4	58
2018	1,207	4.7	55
Change 2018-2022	−21%	−42.6%	–

Source: Mental Health Commission Ireland, Restrictive Practices Activity Reports 2018–2022.

Table 11. Profile of persons physically restrained (by age group)[1]

Year	<18	18–29	30–39	40–49	50–59	60–69	70+
2022	4.1%	28.6%	21.0%	17.2%	9.8%	8.7%	8.6%
2021	2.9%	29.6%	20.8%	17.9%	12.2%	8.2%	8.4%
2020	4.6%	22.5%	23.4%	17.1%	13.6%	10.1%	8.7%
2019	4.1%	26.9%	19.5%	17.9%	15.7%	8.8%	7%
2018	5.6%	24.3%	19.1%	20.1%	13.7%	8.5%	8.7%

Source: Mental Health Commission, Restrictive Practices Activity Reports 2018–2022.
[1]In some instances, the percentages do not add up to 100% due to rounding.

Table 12. Profile of persons secluded (by age group)[1, 2, 3]

Year	<18	18–29	30–39	40–49	50–59	60–69	70+
2022	1.4%	36.5%	24.9%	21%	10.3%	3.3%	2.6%
2021	1.9%	30.9%	26.7%	20.3%	12.9%	5.1%	2.3%
2020	2.4%	27.8%	28%	19.1%	12.1%	7.8%	2.8%
2019	4.1%	26.9%	19.6%	17.9%	15.7%	8.8%	7%
2018	3.7%	33%	27.1%	21.8%	8.7%	4.2%	1.4%

Source: Mental Health Commission, Restrictive Practices Activity Reports 2018–2022.
[1]In some instances, the percentages do not add up to 100% due to rounding.
[2]Calculations based on the 2016 Census population of 4,761,865 (2018-2021 inclusive) and on the 2022 Census population of 5,149,139 (2022).
[3]Rate: The average number of times a person was physically restrained has reduced from 4.7 episodes per restrained patient in 2018, to 2.7 episodes per restrained patient in 2022.

Australia). Ireland had a restraint rate per 1,000 occupied bed days of 4 in 2022 and 4.8 in 2021. In contrast, England reported 17 restraints per 1,000 occupied bed days in August 2021 (Care Quality Commission, 2021), while Australia published a rate of 10 physical restraint events per 1,000 bed days in 2022/2023 (Australian Institute of Health and Welfare, 2024).

The question remains whether the fall in RP as identified is a real effect or simply an artefact of a reduction in the numbers of admissions, along with a fall in the numbers of bed days and a fall in the numbers of centres using RP? The years of the pandemic also intervened, and it is possible that clinical behaviours mandatory during that period also had some effect.

Nevertheless, there are several reasons to conclude that the level of RP use has fallen. The first prosecution under the Mental Health Act occurred in early 2019 on foot of an inspection in 2018. The registered proprietor was convicted of failing to ensure adherence to the regulations comply with the rules governing the use of seclusion and mechanical means of bodily restraint (The Irish Times 2019). While the rules and code governing RPs during the subsequent five-year period remained static, the numbers of centres achieving full compliance with these standards rose substantially. Compliance with the rules and code in centres using seclusion rose from 33% in 2018 to 83% in 2022 and in centres using restraint from 19% in 2018 to 82% in 2022 (Mental Health Commission, 2023b).

Along with more effective regulation, improved training on human rights and initiatives aimed at improving the quality of care in Irish ACs may also have had a positive effect.

Consequences of the use of RPs

The MHC has considered the consequences of the use of RPs, such as seclusion and physical restraint. In 2022, it conducted a public consultation (Mental Health Commission, 2022b) on the use of such interventions, including with people who had direct experience of being subjected to seclusion and/or physical restraint in an Irish AC. The MHC also commissioned in-depth evidence review (Mental Health Commission, 2022c) to inform the review of the code of practice on the use of physical restraint and the rules governing seclusion and mechanical means of bodily restraint in inpatient mental health services.

The results of the MHC's public consultation with service users who had experience of RPs were revealing. There was general agreement that the trauma experienced because of seclusion or restraint had a subsequent negative impact on their recovery. During consultation service, users described feeling 'controlled', 'abused', 'frightened', 'anxious', 'angry', 'helpless', 'disempowered', 'humiliated', 'vulnerable', and 'disrespected', when seclusion or restraint was used. "It *[seclusion] was traumatising for me. People should be offered counselling afterwards . . . you are still in shock at what happened to you".* Another service-user described: *"If in life you find yourself in a distressing situation, you need to talk to someone . . . instead you are locked up . . . seems like a punishment rather than a treatment and that is a long way from being person-centred."* The use of seclusion or restraint was reported as leading to a "*lack of trust*" and a "*. . . change in dynamics . . . you now feel threatened by the staff that are supposed to be taking care of you . . . you think these people have absolute power over you".* One service user described: *"There is a huge power imbalance when you are being restrained and going forward . . . dealing with the staff who restrained you."* One service user spoke of their experience of lengthy seclusion (three weeks): "*It felt lonely and isolated in the seclusion room . . . I missed social interaction . . . staff should communicate with the person in seclusion . . . through a closed door . . . so they know that they aren't forgotten about*". Another commented: "*When you are in seclusion there is nothing to read or see . . . You're just alone with your thoughts . . . this isn't the best thing [for me] . . . it's important to be able to speak to someone you can trust when in [seclusion] . . . maybe have some sort of communication device so you can talk to a family member or advocate . . . that would ground you and calm you.*" Another service user detailed how she was "*. . . put in a gown in a padded cell so there is no way to harm yourself. Heavy, woolly thing - horrible. You don't feel like a person in that environment . . . it is dehumanising, rights are taken*" (Mental Health Commission, 2022b).

In summary, the evidence reviews (Mental Health Commission, 2022c) found evidence that restrictive practices can cause

https://doi.org/10.1017/ipm.2024.32 Published online by Cambridge University Press

deleterious physical and psychological consequences (Chieze et al., 2019) for those subjected to them. Eight themes from the integrative review by Cusack et al (2018) summarise the negative impact of physical restraint upon those subjected to it: Trauma/retraumatisation due to the incident itself or retraumatised due to past trauma, distress, fear, feeling ignored, control, power, and dehumanising. Fear, anxiety, post-traumatic stress disorder, powerlessness, abandonment, distrustfulness or loneliness, punishment, maltreatment, anger, rage, resentment, depression, impotence, sadness, humiliation, degradation, shame, loss of freedom, and coercion. Similar findings were also identified by Aguilera-Serrano et al. (2018) in 24 of the 26 papers in their systematic review.

The emotional impact of seclusion in 10 of 11 papers examined in the evidence review was identified as negative. This included intense effect, emotional impact, emotional experiences, loneliness, autonomy, fear, anger, frustration, powerlessness, and sadness. The environmental experience of seclusion and the process of being placed in seclusion (disrobing and the locking of the door) were described as frightening, humiliating, and dehumanising and resulted in sensory deprivation and problems relating to lack of access to meet basic needs. The seclusion experience can also result in or exacerbate symptoms such as agitation, hallucinations, delusions, and the effects of sensory deprivation (Mellow et al., 2017).

Future research

There is a need for examination of whether efforts to reduce or eliminate the use of RPs in Irish inpatient mental health units have proven successful (particular in the period post January 2023 when the MHC introduced revised rules and codes of practice and a requirement of mandatory reporting of each use of RP within three working days). The MHC-commissioned evidence review identified a dearth of research on the physical risks associated with physical restraint and the impact of the use of restraint/seclusion on older people and in children/adolescents. This paper has focused on the use of seclusion and physical restraint. Additional research that looks at the use of other forms of restrictive practices in approved centres in Ireland would be welcomed.

Conclusion

International policy and best practice is increasingly focused on a human rights approach to care and treatment, and several jurisdictions are introducing measures to reduce or eliminate restrictive practices from their mental health services, having regard to the evidence that shows the harmful physical and psychological consequences of RPs.

The data presented in this paper suggest that a substantial reduction in RP has occurred in Irish ACs, and this is to be welcomed. Further progress is expected with increased emphasis on a human rights approach to Irish acute mental healthcare.

Evidence of this momentum is to be found in the MHC's introduction of revised rules governing the use of seclusion and a revised code of practice on the use of physical restraint, which came into effect on 1 January 2023. The regulator now requires that each approved centre recognises the inherent rights of a person to personal dignity and freedom in accordance with national and international human rights instruments and legislation. It also requires that every approved centre that uses, or permits the use of, seclusion/physical restraint develops and implements a reduction policy that clearly documents how the approved centre aims to reduce, or where possible eliminate, the use of seclusion/physical restraint within the approved centre. Furthermore, the MHC has made training in trauma-informed care and human rights (including the legal principles of restrictive interventions) mandatory for staff.

Henceforth, every episode of seclusion/physical restraint will be reported to the MHC within three working days, and the regulator will actively follow up with the service in relation to the use of these RPs.

RP data will be analysed and published with a greater focus on national and international best practice.

Financial support. None.

Competing interests. None.

Ethical standards. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. The authors assert that the local ethics committee has determined that ethical approval for publication of this *service evaluation* was not required by their local ethics committee.

References

Abderhalden C, Hahn S, Bonner Y, Galeazzi G (2006). 'Users' perception and views on violence and coercion in mental health. In *Violence in Mental Health Settings: Causes, Consequences, Management* (ed. DRichter ed. and R Whittington), pp. 69–92. Springer New York: New York, NY.

Aguilera-Serrano C, Guzman-Parra J, Garcia-Sanchez JA, Moreno-Küstner B, Mayoral-Cleries F (2018). Variables associated with the subjective experience of coercive measures in psychiatric inpatients: a systematic review. *The Canadian Journal of Psychiatry* **63**, 129–144. https://doi.org/10.1177/0706743717738491

Australian Institute of Health and Welfare (2024). *Seclusion and Restraint in Mental Health Care*. https://www.aihw.gov.au/mental-health/topic-areas/seclusion-and-restraint.

Bowers L, James K, Quirk A, Simpson A, Stewart D, Hodsoll J (2015). Reducing conflict and containment rates in acute psychiatric wards: the safewards cluster randomized controlled trial. *International Journal of Nursing Studies* **52**, 1412–1422. https://doi.org/10.1016/j.ijnurstu.2015.12.006

Care Quality Commission (2021). *Restraint, Segregation and Seclusion Review: Progress Report*. https://www.cqc.org.uk/publications/themes-care/restraint-segregation-seclusion-review-progress-report-december-2021.

Celofiga A, Plesnicar BK, Koprivsek J, Moskon M, Benkovic D, Kumperscak HG (2022). Effectiveness of de-escalation in reducing aggression and coercion in acute psychiatric units. A cluster randomized trial. *Frontiers in Psychiatry* **13**, 856153. https://doi.org/10.3389/fpsyt.2022.856153

Chieze M, Hurst S, Kaiser S, Sentissi O (2019). Effects of seclusion and restraint in adult psychiatry: a systematic review. *Frontiers in Psychiatry* **10**, 1–19. https://doi.org/10.3389/fpsyt.2019.00491

Chua JD, Bellonci C, Sorter MT (2021). Treatment of childhood emotion dysregulation in inpatient and residential settings. *Child and Adolescent Psychiatric Clinics of North America* **30**, 505–525. https://doi.org/10.1016/j.chc.2021.04.004

Cusack P, Cusack FP, McAndrew S, McKeown M, Duxbury J (2018). An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings. *International Journal of Mental Health Nursing* **27**, 1162–1176. https://doi.org/10.1111/inm.12432

De Cuyper K, Vanlinthout E, Vanhoof J, Van Achterberg T, Opgenhaffen T, Nijs S, Peeters T, Put J, Maes B, Van Audenhove C (2023). Best practice recommendations on the application of seclusion and restraint in mental health services: An evidence, human rights, and consensus-based approach. *Journal of Psychiatric and Mental Health Nursing* **30**, 580–593. https://doi.org/10.1111/jpm.12890

https://doi.org/10.1017/ipm.2024.32 Published online by Cambridge University Press

Duffy RM (2023). The limitations of MHC's report on seclusion and restraint, and suggestions for future reports. *Irish Journal of Psychological Medicine* **40**, 300–301. https://doi.org/10.1017/ipm.2020.23

Health Research Board (2023). *National Psychiatric Inpatient Reporting System (NPIRS) Annual Report on the Activities of Irish Psychiatric Units and Hospitals, 2022*. Dublin, Ireland.

Health Research Board (2022). *National Psychiatric Inpatient Reporting System (NPIRS) Annual Report on the Activities of Irish Psychiatric Units and Hospitals, 2021*. Dublin, Ireland.

Health Research Board (2021). *National Psychiatric Inpatient Reporting System (NPIRS) Annual Report on the Activities of Irish Psychiatric Units and Hospitals, 2020*. Dublin, Ireland.

Health Research Board (2020). *National Psychiatric Inpatient Reporting System (NPIRS) Annual Report on the Activities of Irish Psychiatric Units and Hospitals, 2019*. Dublin, Ireland.

Health Research Board (2019). *National Psychiatric Inpatient Reporting System (NPIRS) Annual Report on the Activities of Irish Psychiatric Units and Hospitals, 2018*. Dublin, Ireland.

Mellow A, Tickle A, Rennoldson M (2017). Qualitative systematic literature review: the experience of being in seclusion for adults with mental health difficulties. *Mental Health Review Journal* **22**, 1–15. https://doi.org/10.1108/MHRJ-04-2016-0007

Mental Health Commission (2022a). *The Use of Restrictive Practices in Approved Centres. Activity Report 2021*. Mental Health Commission: Ireland.

Mental Health Commission (2022b). *Consultation Report: Revision of the Rules and Code of Practice Relating to the Use of Seclusion, Mechanical Means of Bodily Restraint, and Physical Restraint in Approved Centres*. https://www.mhcirl.ie/sites/default/files/2022-09/MHC_ConsultationReport.pdf.

Mental Health Commission (2022c). *Evidence Reviews to Inform the Review of the Code of Practice on the Use of Physical Restraint and the Rules Governing Seclusion and Mechanical Means of Bodily Restraint in Inpatient Mental Health Services*. https://rcsi.com/dublin/-/media/feature/media/download-document/dublin/about/schools-faculties-and-departments/faculty-of-nursing-and-midwifery/evidence-review-restrictive-practices.pdf.

Mental Health Commission (2023a). *The Use of Restrictive Practices in Approved Centres. Activity Report 2022*. Mental Health Commission: Ireland.

Mental Health Commission (2023b). *Mental Health Commission Annual Report 2022*. Mental Health Commission: Ireland.

Mental Health Commission (2021). *The Use of Restrictive Practices in Approved Centres. Activity Report 2020*. Mental Health Commission: Ireland.

Mental Health Commission (2020). *The Use of Restrictive Practices in Approved Centres. Activity Report 2019*. Mental Health Commission: Ireland.

Mental Health Commission (2019). *The Use of Restrictive Practices in Approved Centres. Activity Report 2017 and 2018*. Mental Health Commission: Ireland.

Mental Health Commission (2014). *Seclusion and Restraint Reduction Strategy*. Mental Health Commission: Ireland.

Mental Health Commission (2009a). *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*. Dublin.

Mental Health Commission (2009b). *Code of Practice on the Use of Physical Restraint in Approved Centres*. Dublin.

National Institute for Health and Care Excellence (NICE) (2015). *Violence and Aggression: Short-term Management in Mental Health, Health, and Community Settings*. https://www.nice.org.uk/guidance/ng10.

Perers C, Bäckström B, Johansson BA, Rask O (2022). Methods and strategies for reducing seclusion and restraint in child and adolescent psychiatric inpatient care. *Psychiatric Quarterly* **93**, 107–136. https://doi.org/10.1007/s11126-021-09887-x

Savage MK, Lepping P, Newton-Howes G, Arnold R, Staggs VS, Kisely S, Hasegawa T, Reid KS, Noorthoom EO (2024). Comparison of coercive practices in worldwide mental healthcare: overcoming difficulties resulting from variations in monitoring strategies. *BJPsych Open* **10**, e26. https://doi.org/10.1192/bjo.2023.613

Te Pou (2022). *Seclusion Data Indicators: Key Performance Indicator Literature Review*. https://www.mhakpi.health.nz/wp-content/uploads/2022/12/Seclusion-KPI-evidence-udpate-November-22.pdf.

The Irish Times (2019). *HSE Fined Over Condition of KILKENNY PSYCHIATRIC UNIt*. https://www.irishtimes.com/news/crime-and-law/courts/district-court/hse-fined-over-condition-of-kilkenny-psychiatric-unit-1.3806055.

World Health Organisation (2019). *Strategies to End Seclusion and Restraint. WHO Quality Rights Specialized Training - Course Guide*. https://www.who.int/publications/i/item/9789241516754.

https://doi.org/10.1017/ipm.2024.32 Published online by Cambridge University Press