2010

MENTAL HEALTH COMMISSION **ANNUAL REPORT**
Including
REPORT OF THE INSPECTOR OF MENTAL HEALTH SERVICES

COIMISIÚN MEABHAIR-SHLÁINTE **TUARASCÁIL BHLIANTÚIL**
Lena n-áirítear
TUARASCÁIL AN CHIGIRE UM SHEIRBHÍSÍ MEABHAIR-SHLÁINTE

MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

MENTAL HEALTH COMMISSION ANNUAL REPORT 2010

Including

REPORT OF THE INSPECTOR OF MENTAL HEALTH SERVICES

The principal functions of the Mental Health Commission, as defined by the Act, shall be 'to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under this Act'.

Mental Health Act 2001 Section 33 (1)

Vision

Working together for quality mental health services

Mission

To raise to the best international standards the quality of mental health services provided in Ireland and to protect the interests of all people who use mental health services*

* "mental health services" means services which provide care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist".
Section 2, Mental Health Act 2001.

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CHAIRMAN'S FOREWORD

The year 2010 saw the Mental Health Commission being very active in pursuit of its statutory role against a very difficult economic background. We are now at the half way point in the ten year timetable envisaged for the implementation of A Vision for Change, and we have not seen the fundamental changes envisaged when the document was written.

This is deeply disappointing in light of the fact that all stakeholders – service users, government, staff and management – are fully committed to the principles underlying it. Its core proposal is the reorientation of the delivery of mental health services away from the old style model of institutional care to community based services.

Such a reorientation is international best practice but in the case of Ireland the poor condition of some of our approved centres gives an added urgency to the need to make this change. It is therefore very heartening to see that in its programme for government entitled 'Government for National Recovery' the incoming coalition has given commitments to:

- Ring fencing €35m a year for the development of community mental health teams and services;
- Establishing a cross-departmental group to integrate good mental health policy into other areas;
- Endeavouring to end the practice of placing children and adolescents in adult wards; and
- Bringing in new legislation on mental capacity in line with the UN Convention on the Rights of Persons with Disabilities to ensure the greatest degree of autonomy for people with intellectual disabilities or with mental illnesses.
- Reviewing the Mental Health Act.

Without new community mental health services, the switch from older institutions cannot take place at the pace required. Therefore the commitment of €35 million a year for this purpose, while less than we believe is needed is very welcome during difficult economic times.

The unprecedented rate of staff retirement from the mental health services means that in the past one to two years 20% of nurse staffing in many areas has been lost. The current moratorium on public service recruitment often results in staff being withdrawn from community services in order to plug gaps in inpatient units. This further militates against the move from institutional to community care that we all want.

It is important to note too that even within existing resources there are dramatic changes that can be led by health service management and staff. Some examples were shown by the HSE who improved and developed services in response to the imposition of conditions by the Mental Health Commission on certain acute inpatient units in 2010. This showed that while we wait and hope for funding to develop new community services, there is a lot of change that can be brought about, and that change makes a profound difference to the quality of life and the prospects for recovery of service users and their families.

It was in this context that the Commission continued with its regulatory role in 2010. The Inspectorate of Mental Health Services inspected all approved centres in 2010. The reports of these inspections cover the quality of care and treatment of patients in mental health services across the country as well as their adherence to the Mental Health Act 2001.

While we may well impose stringent conditions on some centres as we did in 2010, our initial approach is always to engage with the centre in question and work with them towards a resolution of the issues identified by the Inspector.

However as we have demonstrated in 2010 the Commission has the power to deregister or impose conditions or restrictions on centres which are consistently in breach of the regulations and will enforce them where appropriate.

The continued admission of children and adolescents to adult mental health wards has long been a concern of the Commission, and we are pleased to see reference to this issue in the programme for government. In 2009 we amended the Code of Practice in this area to set a timetable for the ending of the admission of children under 18 years of age to adult units, except in very exceptional circumstances. This envisages that by the end of 2011 no child under 18 years is to be admitted to an adult unit in an approved centre. During 2010 we also commissioned Dr. Sally Bonnar, Child & Adolescent Psychiatrist to undertake a Review of the Admission of Children to Adult Mental Health Wards in Ireland. Dr. Bonnar completed her work in late 2010 and her report is available on the Commission's website.

The Commission is disappointed to note that since 2007, the number of applications for involuntary admission to approved centres by authorised officers has remained static at just 7% of all involuntary admissions, while the number of applications by members of An Garda Siochána has risen from 16% to 23%. We recognise that An Garda Siochána members are called upon regularly to respond to possible emergency situations. However visible Garda involvement in involuntary admissions of patients can both alarm and stigmatise vulnerable people and their families and should only happen when there is no alternative course of action available.

Finally I would like to warmly welcome our new Chief Executive Patricia Gilheaney to her post. Patricia takes over on an interim basis from Hugh Kane who retired in December 2010. Hugh brought enormous dedication, energy and drive to the Commission's work during his tenure. Patricia comes to the job from the post of Director of Standards and Quality Assurance within the Commission and brings a deep understanding of and commitment to the standards required of a modern mental health service. I and the Commission wish them both well for the future.

Dr. Edmond O'Dea
Chairman

INTRODUCTION – CHIEF EXECUTIVE OFFICER

I am pleased to introduce the ninth Annual Report of the Mental Health Commission including the Report of the Inspector of Mental Health Services for the period ending 31st December 2010.

I am delighted to be able to report that the Commission had a very active year. This report details the range of activities that were undertaken during the year to progress the Mental Health Commission's six strategic priorities as outlined in our Strategic Plan 2009 – 2012.

Our first Strategic Priority relates to service users, families and carers. The initiatives undertaken in 2010 include the development of a self-advocacy toolkit for young people the Headspace Toolkit; a National Mental Health Services Collaborative to develop and implement individual care and treatment plans to support recovery for all persons availing of mental health services; and in collaboration with members of the Health and Social Care Regulatory Forum we developed a Framework for Public and Service User Involvement in Health and Social Care Regulation.

Our second strategic priority addresses Human Rights and Best Interests. In this section of the report we provide detailed information regarding mental health tribunals activity; training and development of tribunal members and the national rates of compliance with Rules and Codes of Practice.

Our third strategic priority relates to quality mental health services. An outline of the work undertaken during 2010 in relation to the registration of approved centres is detailed in this section. We also provide information on approved centres that had conditions attached to their registration/licence during the year.

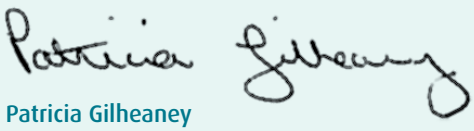
Our fourth strategic objective addresses the wider mental health domain. The Commission is of the strong view that efficient effective mental health services are provided by multidisciplinary mental health teams. In March, we published a resource paper entitled "Teamwork Within the Mental Health Services in Ireland". The aim of the paper is to provide teams with an understanding of what contributes to successful team working, identify some of the pitfalls and also to assist in developing creative solutions for more effective team working. This section of the report also includes the Commission's view that implementation of government policy on mental health Vision for Change requires a semi-autonomous mental health services directorate to drive through the changes required.

The extensive work undertaken in relation to social inclusion and active citizenship, and also in further enhancing the organisational efficiency of the Commission, are captured under strategic priorities five and six.

All of these achievements would not be possible without the work and dedication of the many stakeholders with whom we work, in particular, service user and carer organisations, mental health professionals and the mental health section of the Department of Health and Children.

I commend strongly the work of the executive within the Commission; they are committed, enthusiastic and passionate about the work that we do. On the 30th December we said farewell to our Chief Executive Hugh Kane who led the team during 2010. During his year with us Hugh continued to raise the profile of the work of the Commission. We wish him success in the future.

Finally, I would like to thank the members and executive of the Commission for the support that they have given me as Chief Executive on an interim basis, since December 31. We look forward to 2011 and the challenges ahead.



Patricia Gilheaney
Chief Executive Officer
(appointed on an interim basis with effect from 31 December 2010)

MENTAL HEALTH COMMISSION MEMBERS

(April 2007–2012) (Position at time of appointment).

Dr. Edmond O'Dea
Chairman
Principal Psychologist
Health Service Executive
West

Mr. Brendan Byrne
Director of Nursing
Carlow/Kilkenny Mental
Health Services

Ms. Patricia O'Sullivan Lacy
Barrister-At-Law
Appointed June 2010 to replace Ms. Emile Daly who resigned in Dec 2009

Ms. Marie Devine
Bodywhys

Dr. Brendan Doody
Consultant Child
Psychiatrist
Health Service Executive
Dublin Mid-Leinster

Mr. Padraig Heverin
Clinical Nurse Manager II
Mayo Mental Health
Services

Dr. Martina Kelly
General Practitioner

Dr. Mary Keys
Lecturer
NUI Galway

Dr. Eamonn Moloney
Consultant Psychiatrist
Health Service
Executive South

Mr. Martin Rogan
Assistant National
Director –
Mental Health
Health Service
Executive

Mr. John Saunders
National Director
Schizophrenia Ireland

Mr. John Redican
Chief Executive Officer
Irish Advocacy Network

Ms. Vicki Somers
Principal Mental Health
Social Worker
Health Service Executive
Kildare/West Wicklow
Mental Health Services

The Commission consists of 13 people, including the Chairman, who are appointed by the Minister for Health and Children. The composition of the Commission is as follows:

- A person who has had not less than 10 years experience as a practising barrister or solicitor in the State ending immediately before his or her appointment to the Commission
- Three shall be representative of registered medical practitioners (of which two shall be consultant psychiatrists) with a special interest in or expertise in relation to the provision of mental health services
- Two shall be representative of registered nurses whose names are entered in the division applicable to psychiatric nurses in the register of nurses maintained by An Bord Altranais under section 27 of the Nurses Act, 1985
- One shall be representative of social workers with a special interest in or expertise in relation to the provision of mental health services
- One shall be representative of psychologists with a special interest in or expertise in relation to the provision of mental health services
- One shall be representative of the interest of the general public
- Three shall be representative of voluntary bodies promoting the interest of persons suffering from mental illness (at least two of whom shall be a person suffering from or who has suffered from mental illness)
- One shall be representative of the chief executives of the health boards
- Not less than four shall be woman and not less than four shall be men

Members of the Commission shall hold office for a period not exceeding 5 years.

Eleven meetings of the Mental Health Commission were held in 2010, two of which were teleconferences.

Commission Members attendance at meetings was recorded as follows:

Dr. Edmond O'Dea 11/11	Mr. Brendan Byrne 11/11	Ms Marie Devine 9/11
Dr. Brendan Doody 7/11	Mr. Padraig Heverin 9/11	Dr. Martina Kelly 4/11
Dr. Mary Keys 10/11	Dr. Eamonn Moloney 6/11	Mr. John Redican 8/11
Mr. Martin Rogan 8/11	Mr. John Saunders 7/11	Ms. Vicki Somers 6/11
Ms. Patricia O'Sullivan Lacy 4/6 *appointed June 2010*		

MENTAL HEALTH COMMISSION

Mental Health Commission

MENTAL HEALTH COMMISSION

The Mental Health Commission is an independent statutory body, which was established in April 2002 under the provisions of the Mental Health Act, 2001.

The Mental Health Act 2001 specifies the principal functions of the Commission are which are to promote, encourage, and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres (Section 33 (1)).

The Commission incorporates the broad spectrum of mental health services including general adult mental health services, mental health services for children and adolescents, older people, people with learning disabilities and forensic mental health services.

GUIDING VALUES AND PRINCIPLES OF THE MENTAL HEALTH COMMISSION

The guiding principles and core values of an organisation define its ethos and culture.

VALUES

Accountability and Integrity: The Commission is committed to expressing these values by operating at all times with probity and in a transparent manner.

Empowerment: The Commission recognises that empowerment lies through the provision of information, training and education in an accessible manner.

Dignity and Respect: The Commission respects the dignity of those in contact with us and responds with courtesy and consideration.

Quality: The Commission is committed to striving for continuous quality improvement in all its activities.

Confidentiality: The Commission pledges to handle confidential and personal information with the highest level of professionalism and to take due care not to release or disclose information outside the course of that necessary to fulfil our legal and professional requirements

Achieving Together: The Commission is committed to collaboration for improvement through ongoing partnership, consultation and teamwork.

PRINCIPLES

The Mental Health Commission is guided in particular by the principles enunciated in the:

- Mental Health Act 2001
- European Convention for the Protection of Human Rights and Fundamental Freedoms
- European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
- United Nations Universal Declaration of Human Rights
- United Nations Convention on the Rights of the Child
- United Nations Convention against Torture and other Cruel and Inhuman or Degrading Treatment or Punishment
- United Nations Convention on Persons with Disability
- International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights
- United Nations Principles for the Protection of Persons with a Mental Illness and for the Improvement of Mental Health Care
- European Convention on Human Rights Act 2003
- Disability Act 2005
- Equal Status Acts 2000 – 2004
- Child Care Act 1991
- Childrens Act 2001
- Freedom of Information Acts 1997 & 2003
- Data Protection Acts 1988 & 2003

MENTAL HEALTH COMMISSION COMMITTEES 2010

The Mental Health Commission has established a number of committees to advise on a range of issues. Members of the Commission also participate in committees that are established.

The Chairman of the Commission, Dr. Edmond O'Dea sits on the Mental Health Services Committee, and Research Committee. Dr. O'Dea also contributes to the work programme of other committees as he considers appropriate.

AUDIT COMMITTEE

Mr. Declan Lyons (Chair) (EM), Ms. Vicki Somers (CM), Mr. Padraig Heverin (CM), Mr. Brendan Byrne (CM), Mr. John Redican (CM).

WORLD MENTAL HEALTH DAY 2010

Ms. Marie Devine (Chair) (CM), Mr. Brendan Byrne (CM), Dr. Martina Kelly (CM), Ms. Rosemary Smyth (E), Ms. Marina Duffy (E).

CHILD & ADOLESCENT MENTAL HEALTH SERVICES COMMITTEE

Dr. Brendan Doody (Chair)(CM), Ms. Vicki Somers (CM), Mr. Martin Rogan (CM), Ms. Marie Devine (CM), Mr. Hugh Kane (E), Ms. Patricia Gilheaney (E), Dr. Susan Finnerty (E), Ms. Rhona Jennings (E).

FORENSIC MENTAL HEALTH SERVICES COMMITTEE

Mr. Padraig Heverin (CM), Mr. John Saunders (CM), Mr. Brendan Byrne (CM).

MENTAL HEALTH COMMISSION RESEARCH COMMITTEE

Professor Patrick Wall (Chair) (EM), Dr. Jim Campbell (EM), Ms. Elizabeth Brosnan (EM), Dr. Patricia Clarke (EM), Dr. Elizabeth McKay (EM), Dr. Eadbhard O'Callaghan (EM), Dr. Dermot Walsh (EM), Dr. Claire Collins (EM), Dr. Fiona Keogh (EM), Mr. Paddy McGowan (EM), Ms. Veronica Ranieri (EM), Professor Agnes Higgins (EM), Dr. Edmond O'Dea (CM), Dr. Patrick Devitt (E), Dr. Eucharia Meehan (EM), Mr. Hugh Kane (E), Ms. Marina Duffy (E).

ASSISTED ADMISSIONS COMMITTEE

Mr. Padraig Heverin (Chair) (CM), Mr. Brendan Byrne (CM), Dr. Eamonn Moloney (CM), Dr. Martina Kelly (CM), Mr. Ronan Browne (NSUE) (EM), Ms. Catherine Bourke (Shine) (EM), Mr. Hugh Kane (E), Ms. Marina Duffy (E).

MENTAL HEALTH SERVICES COMMITTEE

Dr. Brendan Byrne (Chair) (CM), Mr. Padraig Heverin (CM), Dr. Edmond O'Dea (CM), Mr. John Redican (CM), Mr. John Saunders (CM), Mr. Hugh Kane (E), Ms. Marina Duffy (E).

COMMITTEE ON SCHEME FOR MENTAL CAPACITY BILL

Dr. Mary Keys (Chair) (CM), Mr. John Saunders (CM), Mr. John Redican (CM), Ms. Vicki Somers (CM), Mr. Martin Rogan (CM), Mr. Hugh Kane (E).

CM=Commission Member, EM=External Member, E=Executive Member

ORGANISATIONAL STRUCTURE

The Mental Health Act 2001 provides for the appointment of a Chief Executive Officer for the Commission and the Inspector of Mental Health Services.

The Chief Executive Officer (CEO), appointed by the Commission, has responsibility for the overall management and control of the administration and business of the Commission. The Chief Executive Officer is the accountable officer for the organisation.

Mr. Hugh Kane, Chief Executive Officer, resigned with effect from 30th December, 2010. Ms. Patricia Gilheaney was appointed Chief Executive Officer on 31st December, 2010 on an interim basis.

Dr. Patrick Devitt is the Inspector of Mental Health Services. The principal responsibilities of the Inspector of Mental Health Services include, visiting and inspecting approved centres and other premises where mental health services are being provided as per Sections 51-53 Mental Health Act 2001, carrying out annual reviews of mental health services in the State and furnishing a report to the Commission as per Section 51 Mental Health Act 2001

The Mental Health Act also provides for the appointment of Assistant Inspectors of Mental Health Services.

MENTAL HEALTH COMMISSION STAFF 2010 (END OF YEAR).

Office of the Chief Executive Officer

Ms. Patricia Gilheaney – CEO
(appointed on an interim basis 31st December, 2010)

Ms. Marina Duffy

Ms. Ulla Quayle

Mental Health Tribunals Division

Dr. Gerry Cunningham – Director

Ms. Sandra Curran

Dr. Enda Dooley

Dr. Fiona Fenton

Mr. Kevin Foley

Dr. Maria Frampton

Mr. Andrew Goodwin

Ms. Deirdre Hanratty

Dr. Eugene Hill

Mr. Simon Horne

Ms. Emer Kelly

Dr. Evelyn McCabe

Ms. Erica McCluskey

Dr. Eugene Morgan

Dr. Maria Morgan

Dr. Maria Moran

Ms. Eilis Scully

Dr. Dermot Walsh

Standards and Quality Assurance Division

Ms. Patricia Gilheaney – Director

Mr. Derek Beattie

Ms. Deirdre Hyland

Mr. Adrian Murtagh

Ms. Lisa O'Farrell

Mr. Brian O'Sullivan

Office of Inspector of Mental Health Services

Dr. Patrick Devitt – Inspector of Mental Health Services

Mr. Paul Collins

Ms. Patricia Doherty

Dr. Susan Finnerty

Ms. Maeve Kenny

Mr. Sean Logue

Dr. Fionnuala O'Loughlin

Ms. Helena Moloney

Ms. Orla O'Neill

Ms. Colette Ryan

Training and Development Division

Ms. Rosemary Smyth – Director

Ms. Ulla Quayle

Corporate Services Division

Mr. Ray Mooney – Director

Ms. Marie Higgins

Ms. Joanna Macklin

Ms. Monica Martin

Mr. Mathew Morenigbade

MENTAL HEALTH COMMISSION

HOW WE PROGRESSED THE STRATEGIC PLAN 2009–2012 DURING 2010

Mental Health Commission

STRATEGIC PRIORITY ONE 2009-2012
Service Users, Families & Carers

- Policy and Planning: service users and their families and carers are involved in a significant way, locally and nationally.
- Individual Care Planning: service users and their families and carers are actively involved in planning the care required to meet each individual service users's assessed needs.

SERVICE USER EMPOWERMENT/ INVOLVEMENT

The Mental Health Commission recognises the importance of service user involvement in mental health care and treatment and has identified this as one of its strategic priorities for 2009 – 2012. In line with this priority, the Commission produced several service user related publications in 2010.

FRAMEWORK FOR PUBLIC AND SERVICE USER INVOLVEMENT IN HEALTH AND SOCIAL CARE REGULATION

The Mental Health Commission is a member of the Health and Social Care Regulatory Forum. The Forum published a *Framework for Public and Service User Involvement in Health and Social Care Regulation in Ireland* in January 2010. The Commission evaluated the involvement of the public and service users in its work in 2010 and developed a draft action plan of ways the public and service users could be greater involved in its work during 2011 and 2012.

NATIONAL SERVICE USER EXECUTIVE (NSUE)

The National Service User Executive is one of the Mental Health Commission's key stakeholders and during 2010 the Commission continued to work in collaboration with NSUE on a number of projects. The Executive of the Commission meet on a quarterly basis with representatives from NSUE, with meetings held in January, April, July and October 2010.

Tripartite meetings were also held with representatives from NSUE and HSE in September and November 2010 to facilitate discussion on areas of mutual interest and concern.

HEADSPACE TOOLKIT FOR YOUNG PEOPLE

The Commission developed a rights and self advocacy toolkit for young people availing of inpatient mental health services entitled the "Headspace Toolkit" in 2009. The toolkit was published in December 2009 and officially launched in the Base Youth Centre in Ballyfermot in February 2010 by former Minister of State for Disability and Mental Health, John Moloney TD, and former Minister for Children, Barry Andrews, TD.

NATIONAL INPATIENT PERCEPTION PROJECT

The Commission commenced work on a national inpatient perception project in 2010 in partnership with the Irish Society for Quality and Safety in Healthcare which aims to find out the views of service users who have been recently discharged from inpatient mental health services. Approximately 30 approved centres are involved in the project which will run into 2011.

NATIONAL MENTAL HEALTH SERVICES COLLABORATIVE

The National Mental Health Services Collaborative (NMHSC) commenced in November 2009. The NMHSC is a quality improvement initiative between the Mental Health Commission (MHC) and Health Service Executive (HSE), in partnership with St. Patrick's University Hospital (SPUH) and St. John of God Hospital (SJOG).

The aim of this collaborative is to develop and implement individual care and treatment plans to support recovery in accordance with Standard 1.1 of the Quality Framework for Mental Health Services in Ireland (MHC, 2007) over 18 months. In addition teams will also achieve15 of the other standards during the process. The project is using the 'Breakthrough Collaborative approach' developed by the Institute of Health Care Improvement (IHI) in the United States. The Breakthrough Collaborative Approach was chosen as the preferred methodology as it involves selecting one single issue and setting measurable targets to ensure that change is achieved in a set timeframe. This approach has been widely used to drive change in health services and to ensure that modern best practice enunciated in policy is implemented in practice.

The NMHSC has four distinct phases:

- Initiation (November 2009 – January 2010)
- Pre-planning (February2010 – April 2010)
- Action (May 2010 – April 2011)
- Summative (May 2011 – July 2011)

Each phase has a set time frame and actions to be completed.

TEAMS

Eleven multidisciplinary teams (MDT) were identified by the service providers and include teams from each region within the HSE (N=8), St. Patrick's University Hospital (N=1) and St. John of God Hospital (N=2). The teams are working across a variety of clinical settings and age groups including community mental health teams, day hospitals and inpatient units.

- Wexford South Sector Community Mental Health Team
- Eist Linn, Child and Adolescent In patient Unit, Cork
- Ennis Community Mental Health Centre
- Galway/South Connemara Community Mental Health Team
- Department of Psychiatry, Navan (Navan Sector Team)
- Swords Day Hospital
- St. Vincent's University Hospital, Baggott Street Community Mental Health Team
- Lucan Child and Adolescent Community Mental Health Team
- St. Patrick's University Hospital Team
- St. John of God Hospital
  - Adolescent Team
  - Psychosis Team

A team consists of service users, carers and mental health professionals. Key to the project is the active inclusion of service users and carers in all aspects of the collaborative.

1

STRATEGIC PRIORITY ONE
Service Users, Families & Carers

GOVERNANCE

The project is underpinned by a formal agreement between the four main sponsoring organisations. This agreement was signed by the respective Chief Executive Officers on 22nd January 2010. The NMHSC is governed by a Steering Group consisting of 19 people including the senior managers from the main sponsoring organisations, service user, carer, professional and academic leaders and policy makers.

A project manager was seconded in November 2009 to oversee the project. The post holder reports to the Director of Standards and Quality Assurance, MHC and to the Steering Group. From the Steering Group a MDT clinical lead group was formed to advise the project manager and liaise with their own professional groups on the progress within the collaborative.

INITIATION PHASE

During the initiation phase a knowledge review on care planning was completed and key learning points were identified. This review was distributed to all participants in advance of a one day stakeholder reference group meeting held in February 2010. 130 people attended.

Each of the 11 MDT Teams mapped the service users' journey from referral to discharge from treatment and from this constraints and duplications in the process were identified. Each team was able to identify a change idea. Teams were required to set clear measurable goals linked to the overall national goal.

Each team has a project facilitator who links in with the project manager on a regular basis.

During the pre planning phase a number of measurement tools were identified by the teams for use during the project. These were:

- Teamwork within Mental Health Services in Ireland (Resource Tool Kit, MHC, 2010)
- Recovery Resource Toolkit (MHC 2007)
- Service user Questionnaire (NMHSC 2010)

Data was collected at the start of the project (May 2010), midpoint (November 2010) and will be collected at the end of the process (April 2011). Feedback was provided to the teams on completion of the tools for discussion and to assist in planning new SMART goals.

LEARNING SETS

A key component of the collaborative methodology is learning sets. The core purpose of learning sets is to promote a collaborative style of learning and provide an opportunity for each team to assess its progress. In 2010 three learning sets were held in May, October and December. A further learning set is scheduled for 2011. Outside of the learning sets teams are encouraged to collaborate so as to continue sharing and learning from each other.

JOINT STATEMENT MENTAL HEALTH COMMISSION AND AN BORD ALTRANAIS

An Bord Altranais and the Mental Health Commission issued a joint statement regarding the documentation of professional nursing practice within an integrated multidisciplinary care record in November. The key outcome of this statement is that An Bord Altranais reiterates its requirement for registered nurses to effectively document a comprehensive nursing assessment and in addition, that it is the responsibility of the registered nurse to be centrally involved in ensuring that nursing care and evaluation is demonstrated and operationalised within the multidisciplinary care plan specific to the needs of the patient/client/service user.

INDEPENDENT EVALUATION

An Independent evaluation was commissioned as part of the overall project plan. The evaluation commenced in May 2010 and will conclude in July 2011 with the publication of a report.

STRATEGIC PRIORITY TWO 2009-2012
Human Rights & Best Interests

- A commitment to Human Rights is embedded in all aspects of the Commission's and mental health service providers' policy and practice.
- The Commission will continue to arrange reviews of involuntary admission in compliance with the Mental Health Act 2001.
- The Commission will continue to monitor Rules and Codes of Practice issued pursuant to the provisions of the Mental Health Act 2001.
- Promote and support advances in legislation to protect the human rights of vulnerable people.

MENTAL HEALTH TRIBUNALS

Procedures for Involuntary Admission (Adults)

The 2001 Act introduced provisions for a system of free legal representation for adults and independent reviews during their episode of involuntary admission[1]. This is performed by a mental health tribunal during each period of detention. This part of the 2001 Act was commenced on 1 November 2006. The Commission now has four complete years of data relating to involuntary admissions activity. This section of the report provides analysis of 2010 involuntary admissions and their review by mental health tribunals, and comparisons with previous years.

It is important to note that the 2001 Act has provisions for two methods of initiating detention; an *Admission Order,* (Form 6) and a *Certificate & Admission Order to detain a Voluntary Patient (Adult),* (Form 13). A person may be admitted to an approved centre and detained there on the grounds that he or she is suffering from a mental disorder as defined in the Act.

Involuntary Admission (Adults) 2010

Analysis was completed on the number of adults who were involuntarily admitted using the provisions of sections 9, 10, & 14 of the Act in 2010. In such admissions the admission order is made by a consultant psychiatrist on statutory Form 6, *Admission Order*, which must be accompanied by an application (Form 1, 2, 3, or 4) and a recommendation by a registered medical practitioner, (Form 5). There were 1,406 Form 6 *Admission Orders* notified to the Commission in 2010.

DETENTION OF A VOLUNTARY PATIENT; SECTION 24, MENTAL HEALTH ACT 2001 (2010)

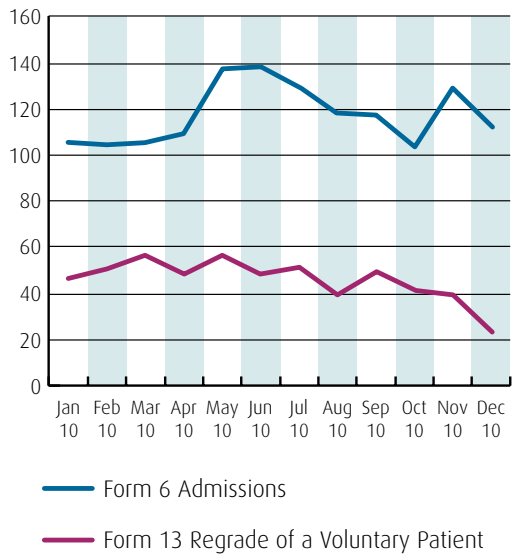
Section 24 of the Mental Health Act 2001 outlines the procedures relating to a decision to re-grade a voluntary patient to involuntary status. In such admissions the admission order is made on a statutory form, Form 13 *Certificate & Admission Order to Detain a Voluntary Patient (Adult)*, signed by two consultant psychiatrists. There were 546 such admissions notified to the Commission in 2010.

[1] An episode is a patient's unbroken period of involuntary admission.

COMPARISONS 2007 - 2010

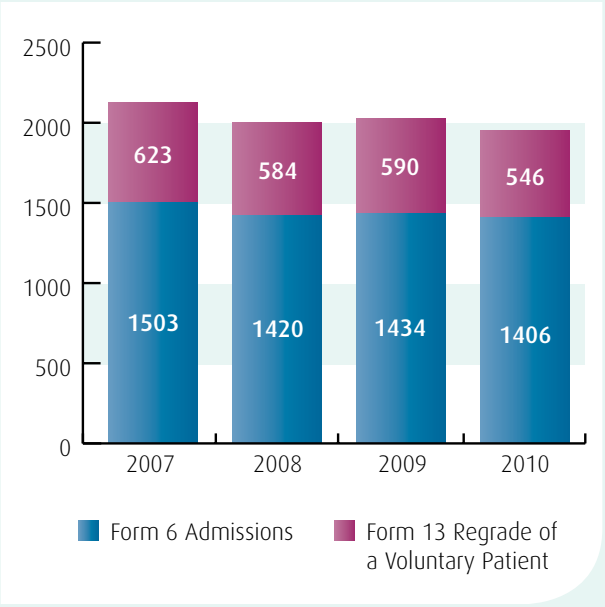
Figure 1 below summarises on a monthly basis both the above categories of involuntary admission for 2010, i.e. – Form 6 *Admission Orders,* and Form 13, *Certificate & Admission Order to Detain a Voluntary Patient (Adult).* The number of Form 6 orders fall within a range from 103 to 138 per month, and the number of Form 13 orders fall within a range from 23 to 56 per month.

Figure 1: Monthly Involuntary Admissions 2010: Form 6 Admission Orders, and Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)



Comparison was made of 2010 involuntary admission activity with that for a number of previous years. Figure 2 below summaries these comparisons on an annual basis and shows a decrease of 6% from 2007 to 2008, an increase of 1% from 2008 to 2009 and a decrease of 4% from 2009 to 2010. From 2007 to 2010 there has been a decrease of 8%.

Figure 2: Comparisons of Total Involuntary Admissions 2007–2010



Form 6 Admission Order. Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)

Further comparison of 2007 with 2010 shows the decrease in activity is accounted for by a 6% decrease in Form 6 *Admission Orders,* and a 12% decrease in the Form 13, *Certificate & Admission Orders to Detain a Voluntary Patient (Adult).*

Tables 1(a)-1(e) below provide further analysis of involuntary admission orders in 2010 by approved centre, by HSE region, and for the independent sector.

Table 1(a): Involuntary Admissions by HSE Regions 2010 (Adults)

HSE WEST	County	Form 6[a]	Form 13[a]	Total
Ballytivnan Sligo/Leitrim Mental Health Services	Sligo	28	14	42
St. Conal's Hospital Letterkenny	Donegal	0	0	0
Acute Psychiatric Unit Carnamuggagh Letterkenny	Donegal	46	20	66
Department of Psychiatry County Hospital Roscommon	Roscommon	13	4	17
St. Brigid's Hospital Ballinasloe	Galway	23	13	36
Department of Psychiatry University College Hospital	Galway	48	16	64
Acute Psychiatric Unit 5B Midwestern Regional Hospital	Limerick	76	12	88
St. Josephs Hospital	Limerick	0	0	0
Tearmann Ward & Curragour Wards St. Camillus Hospital	Limerick	0	1	1
Acute Psychiatric Unit Midwestern Regional Hospital Ennis	Clare	38	11	49
Orchard Grove Ennis	Clare	0	1	1
Adult Mental Health Unit Mayo General Hospital Castlebar	Mayo	74	8	82
An Coillin Castlebar	Mayo	0	0	0
TOTAL HSE WEST		**346**	**100**	**446**

[a] Form 6 Admission Order. Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)

Table 1(b): Involuntary Admissions by HSE Regions 2010 (Adults)

HSE SOUTH	County	Form 6[a]	Form 13[a]	Total
St. Finan's Hospital Killarney	Kerry	1	0	1
Acute Mental Health Admission Unit Kerry General Hospital Tralee	Kerry	57	5	62
South Lee Mental Health Unit, Cork University Hospital	Cork	77	24	101
St. Michael's Unit Mercy Hospital	Cork	59	25	84
St. Stephen's Hospital Glanmire	Cork	29	8	37
Carraig Mor Centre	Cork	6	3	9
Centre for Mental Health Care & Recovery Bantry General Hospital	Cork	16	11	27
St. Dympna's	Carlow	0	1	1
St. Canice's	Kilkenny	1	1	2
Department of Psychiatry St. Luke's Hospital	Kilkenny	26	8	34
St. Luke's Hospital Clonmel	Tipperary	1	0	1
St. Michael's Unit South Tipperary General Hospital Clonmel	Tipperary	45	11	56
St. Senan's Hospital Enniscorthy	Wexford	51	12	63
Department of Psychiatry Waterford Regional Hospital	Waterford	42	15	57
St. Otteran's Hospital	Waterford	2	1	3
TOTAL HSE SOUTH		**413**	**125**	**538**

[a] Form 6 Admission Order. Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)

Table 1(c): Involuntary Admissions by HSE Regions 2010 (Adults)

HSE DUBLIN NORTH EAST	County	Form 6[a]	Form 13[a]	Total
Acute Psychiatric Unit Cavan General Hospital	Cavan	21	5	26
St. Davnet's Hospital Monaghan	Monaghan	9	9	18
Department of Psychiatry Our Lady's Hospital Navan	Meath	27	12	39
St. Brigid's Hospital Ardee	Louth	34	10	44
ST. Vincents Hospital Fairview	Dublin	54	39	93
St. Ita's Hospital Mental Health Services Portrane	Dublin	34	29	63
Acute Psychiatric Unit, St. Aloysius Ward Mater Misericordiae Hospital	Dublin	27	10	37
St. Brendan's Hospital	Dublin	18	9	27
Department of Old Age Psychiatry Sycamore Unit Connolly Hospital	Dublin	0	0	0
Department of Psychiatry Connolly Hospital	Dublin	39	17	56
TOTAL DUBLIN NORTH EAST		**263**	**140**	**403**

[a] Form 6 Admission Order. Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)

Table 1(d): Involuntary Admissions by HSE Regions 2010 (Adults)

HSE DUBLIN MID LEINSTER	County	Form 6[a]	Form 13[a]	Total
Jonathan Swift Clinic	Dublin	41	21	62
Acute Psychiatric Unit AMNCH	Dublin	46	37	83
Elm Mount Unit St.Vincent's University Hospital	Dublin	52	4	56
Lakeview Unit Naas General Hospital	Kildare	36	13	49
St. Loman's – Palmerstown	Dublin	0	1	1
Department of Psychiatry Midland Regional Hospital Portlaoise	Laois	39	5	44
St. Loman's Hospital Mullingar	Westmeath	60	12	72
Newcastle Hospital	Wicklow	25	8	33
TOTAL HSE DUBLIN MID LEINSTER		**299**	**101**	**400**

[a] Form 6 Admission Order. Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)

Table 1(e): Involuntary Admissions Independent Sector 2010 (Adults)

INDEPENDENT SECTOR	County	Form 6[a]	Form 13[a]	Total
St. John of God Hospital Stillorgan	Dublin	56	43	99
St. Patrick's Hospital Dublin	Dublin	27	36	63
St. Edmundsbury Hospital Dublin	Dublin	0	0	0
Highfield Hospital	Dublin	0	1	1
Bloomfield	Dublin	2	0	2
TOTAL INDEPENDENT SECTOR		**85**	**80**	**165**

[a] Form 6 Admission Order. Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)

Table 2 below shows Total Involuntary Admission Rates for 2010 (Adult) by HSE region and independent sector, with rates per 100,000 of total population.

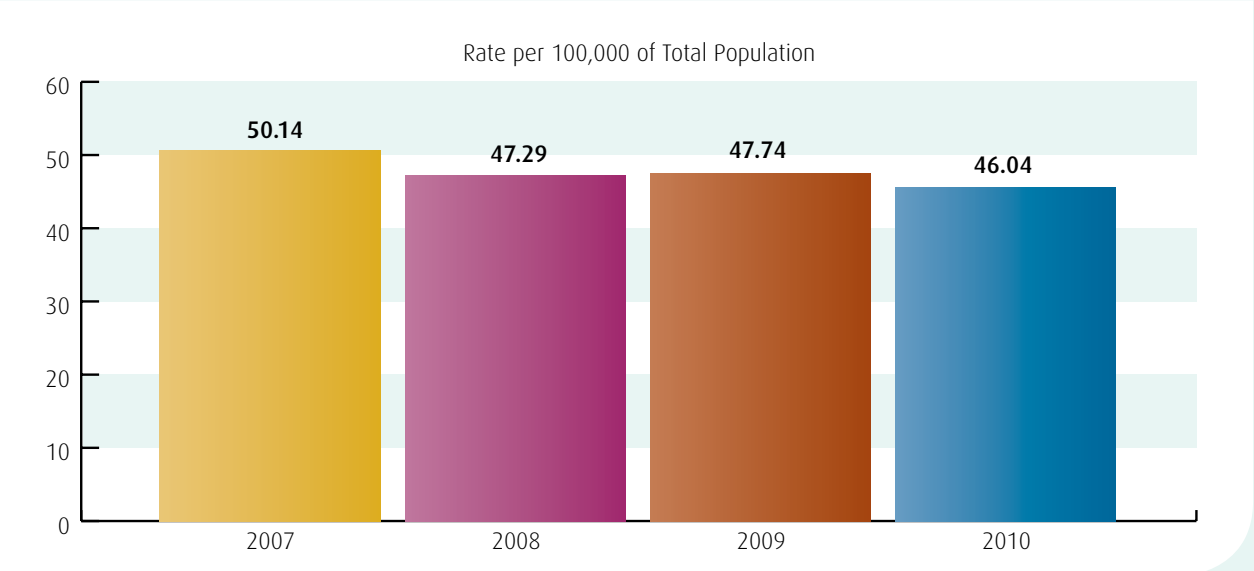
Table 2: Total Involuntary Admission Rates for 2010 (Adult) by HSE Region & Independent Sector

	Total Involuntary Admission Rate 2010 (ADULT)	Population[A]	Involuntary Admission Rate per 100,000 Total Population
HSE WEST	446	1,012,413	44.05
HSE SOUTH	538	1,081,968	49.72
HSE DUBLIN NORTH EAST	403	928,619	43.40
TOTAL HSE DUBLIN MID LEINSTER	400	1,216,848	32.87
INDEPENDENT SECTOR	165	N/A	N/A
TOTAL (Exclusive of Independent sector)	**1,787**	**4,239,848**	**42.15**
TOTAL (Inclusive of Independent sector)	**1,952**	**4,239,848**	**46.04**

[A] Population figures taken from CSO census 2006

Analysis of Ireland's involuntary admission rates per 100,000 of total population, including involuntary admissions to independent sector approved centres, is shown in Figure 3 below for the years 2007 to 2010.

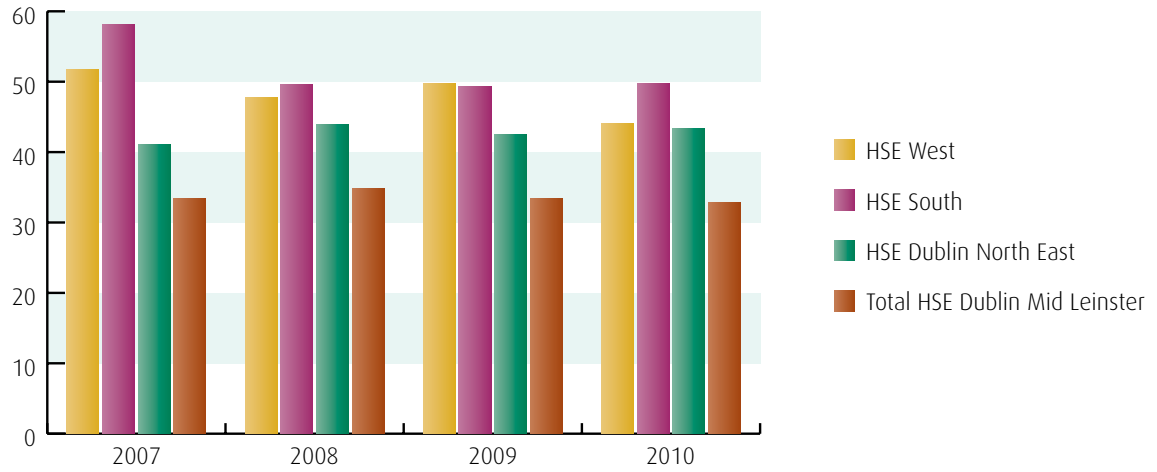
Figure 3: Ireland's Involuntary Admission Rates per 100,000 of Total Population B for the Years 2007 to 2010.



[B] Population figures taken from CSO census 2006

Figure 4 below further analyses involuntary admission rates per 100,000 of population for the years 2007 to 2010 by HSE Region.

Figure 4: Involuntary Admission Rates per 100,000 of population for the years 2007 to 2010 by HSE Region



AGE AND GENDER

Analysis of age and gender was completed on the figures for episodes of involuntary admission in 2010. Tables 3 and 4 below summarise these findings.

Table 3: Analysis by Age – Involuntary Admissions 2010 (Adults)

Age	Form 6	Form 13	Total	%
17-18	0	0	0	0%
18 – 64	1,184	486	1,670	86%
65 and over	222	60	282	14%
TOTAL	**1,406**	**546**	**1,952**	**100%**

Table 4: Analysis by Gender – Involuntary Admissions 2010 (Adults)

Gender	Form 6	Form 13	Total	%
Female	619	264	883	45%
Male	787	282	1,069	55%
TOTAL	**1,406**	**546**	**1,952**	**100%**

TYPE OF APPLICANT

Analysis was undertaken of the categories of persons who applied for a person to be involuntarily admitted under section 9 of the Act in 2010. Table 5 below summarises this analysis.

Table 5: Analysis of Applicant – Involuntary Admissions 2010 (Adults)

Form Number	Type	Number	%
1	Spouse/Relative	852	61%
2	Authorised Officer	97	7%
3	Garda Síochána	324	23%
4	Any Other Person	133	9%
	TOTAL	**1,406**	**100%**

Comparison of the 2007 figures for type of applicant with the 2010 figures shows the number of applicants by spouse/relative has fallen from 69% to 61%, authorised officer has remained at 7%, Garda Síochána risen from 16% to 23% and any other person remained at 9%. An authorised officer is an officer of the HSE who is of a prescribed rank or grade and who is authorised to exercise the powers conferred on authorised officers by section 9 of the Act.

DIAGNOSIS

When the episode of involuntary admission is ended by the responsible consultant psychiatrist revoking the order the psychiatrist is requested to provide details to the Commission of the patient's diagnosis using ICD-10 diagnostic groups on statutory Form 14, *Revocation of an Involuntary Admission or Renewal Order.* Details of diagnoses reported to the Commission in 2010 are summarised in Table 6 below.

Table 6: ICD 10 Diagnostic Groups Coded at Close of Episode (Adults) 2010

ICD-10 diagnostic groups	ICD-10 Code	Number of Episodes	Number of Episodes (%)
1. Organic Disorders	F00-F09	81	7.09%
2. Alcoholic Disorders	F10	30	2.62%
3. Other Drug Disorders	F11-F19, F55	51	4.36%
4. Schizophrenia, Schizotypal and Delusional Disorders	F20-F29	563	49.26%
5. Depressive Disorders	F31.3, F31.4, F31.5, F32, F33, F34.1, F34.8, F34.9	90	7.87%
6. Mania	F30, F31.0, F31.1, F31.2, F31.6, F31.7, F31.8, F31.9, F34.0	273	23.81%
7. Neuroses	F40-F48	21	1.84%
8. Eating Disorders	F50	1	0.09%
9. Personality and Behavioural Disorders	F60-F69	21	1.84%
10. Intellectual Disability	F70-F79	7	0.61%
11. Development Disorders	F80-F89	0	0
12. Behavioural and Emotional Disorders of Childhood	F90-F98	See children sections	
13. Other Diagnosis	F38, F39, F51-F54, F59, F99	7	0.61%
TOTAL		**1,145**	**100%**

It is of interest to note that the diagnostic group with the highest rates of involuntary admission is the grouping *"Schizophrenia, Schizotypal & Delusional Disorder"*s followed by that for *"Mania"*. This is similar to the findings for 2007, 2008 and 2009.

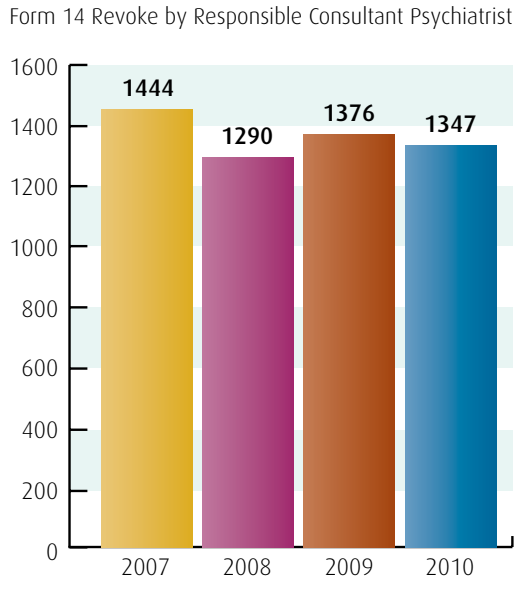
2

STRATEGIC PRIORITY TWO
Human Rights & Best Interests

REVOCATION BY RESPONSIBLE CONSULTANT PSYCHIATRIST

Section 28 provides the consultant psychiatrist responsible for the patient with the option to revoke an order where they become of opinion that the patient is no longer suffering from a mental disorder as defined in the Act. Where the responsible consultant psychiatrist discharges a patient under section 28 they must give to the patient concerned and his or her legal representative a notice to this effect, a statutory form number 14, *Revocation of an Involuntary Admission or Renewal Order.* Analysis of orders revoked by the responsible consultant psychiatrist under the provisions of section 28 shows that there were 1,347 such instances in 2010. The patient may leave the centre at this stage or stay to receive treatment on a voluntary basis. Figure 5 below shows the number of orders revoked by responsible consultant psychiatrists under the provisions of section 28 for years 2007 to 2010.

Figure 5: Number of Orders Revoked by Responsible Consultant Psychiatrists under the Provisions of Section 28 for years 2007 to 2010



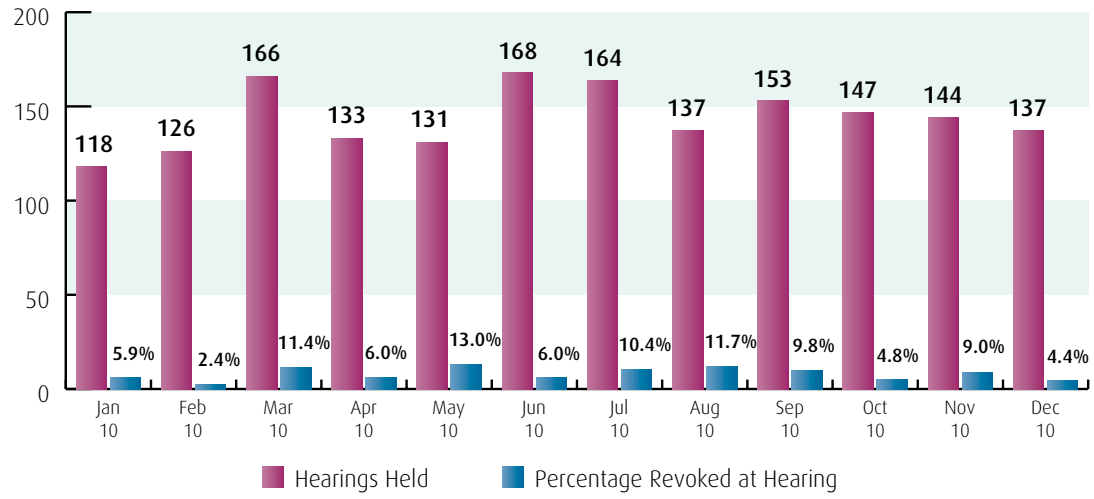
INDEPENDENT REVIEW BY A MENTAL HEALTH TRIBUNAL

The Mental Health Act 2001 provides for the patients' right to an automatic independent review of an involuntary admission. Within 21 days of an admission (or renewal) order, a three person mental health tribunal consisting of a lawyer as chair, a consultant psychiatrist and an other person review the admission (or renewal) order. Prior to the independent review, a legal representative is appointed by the Mental Health Commission for each person admitted involuntarily (unless s/he proposes to engage one) and an independent medical examination by a consultant psychiatrist, appointed by the Commission, will have been completed. In 2010 the Mental Health Commission was notified of 1,406 involuntary admission orders, 546 orders re-grading a voluntary patient to involuntary and 1,102 renewal orders. There were 1,724 hearings in 2010. Hearings for involuntary admission orders were monitored by the Commission as to when in the 21 day period of the order the mental health tribunal occurred. In 2010 sixty three per cent of hearings occurred at or before day eighteen of the order.

ORDERS REVOKED AT HEARING

Analysis was undertaken of the number of orders revoked at a mental health tribunal in 2010. Figure 6 below shows the number of hearings on a month by month basis for 2010 and the number of orders revoked (%) in each month. In total, 8% of orders reviewed by the mental health tribunal in 2010 were revoked.

Figure 6: Number Hearings & % of Orders Revoked at Hearing 2010



CASES BROUGHT BEFORE THE COURTS

Circuit Court Appeals

Section 19(1) of the 2001 Act states that a patient may issue an appeal to the Circuit Court against a decision of a mental health tribunal to affirm an order made in respect of him or her on the grounds that he or she is not suffering from a mental disorder. The appeal can only be made or proceed if the patient continues to be detained. The Commission were notified of 68 Circuit Court appeals in the period from 1 January to 31 December 2010. Some of these cases did not proceed as the orders detaining the patients were revoked by the responsible consultant psychiatrist prior to the hearing of the appeal or the patient did not wish to proceed for whatever reason. In relation to the cases that did go to hearing, all of the Orders were affirmed by the Circuit Court.

High Court Cases

Pursuant to Section 19 (16) of the Mental Health Act 2001, a patient is entitled to appeal a decision of the Circuit Court on a point of law. There were two such appeals filed in 2010. Both were withdrawn by the patients.

Judicial review is a method developed at common law to enable an individual who is the subject of a government / statutory action to challenge the legality of that action in the Courts. The decision must have been made by a body or persons, with legal or statutory authority to determine questions affecting the rights of citizens and having the duty to act judicially. Judicial review is brought in relation to both legislative and executive actions. These reviews are heard by a Judge in the High Court and can be appealed to the Supreme Court. It is a discretionary remedy. Once such case was issued in 2010 where the Commission was a party but was subsequently withdrawn by the patient.

The Commission was a party in High Court proceedings (issued in 2009) concerning an application pursuant to Section 73 of the Mental Health Act 2001 which came on for hearing in 2010. The Section 73 application as brought by the patient was successful. The case was compromised before it came on for full hearing. This was the first Section 73 application. (A Section 73 application is an application to the High Court to seek leave to bring proceedings in relation to a matter concerning the Mental Health Act 2001.)

Neither the Commission nor a mental health tribunal were a party to a Supreme Court appeal or hearing during 2010.

SERVICE DEVELOPMENT

The Mental Health Tribunals Division made a number of enhancements to its IT systems in 2010 that improve efficiency and reduce costs in line with Government policy. An extension was made to the Commission's on-line Mental Health Tribunal Secure Messaging Centre to allow St. Patrick's University Hospital to access documentation relating to its Mental Health Tribunals, thus reducing postage and courier costs and providing speedier access. Other approved centres are being shown this development with a view to extending this service to other sites. The on-line Mental Health Tribunal Secure Messaging Centre was also modified to flag instances when orders are revoked before hearing to reduce the cost of cancelled hearings.

An extensive recruitment process for chairpersons, consultant psychiatrists and lay persons was carried out in partnership with the Public Appointments Service and successfully completed by 1 November 2010.

A new information leaflet was designed with service user input and is now in use. This is sent to each patient when we are notified they are the subject of an involuntary admission or when their status is re-graded from voluntary to involuntary.

MULTIPLE INVOLUNTARY ADMISSIONS

The Mental Health Commission holds an extensive data base of involuntary admissions in Ireland from commencement of the Mental Health Act (2001) in 2006. In the period since commencement there has been an overall reduction in the number of voluntary and involuntary admissions to Irish psychiatric hospitals and units. However, the use of involuntary admission remains at around 10% of all admissions. Examination of the data held by the Commission indicates that a number of patients (n=121) have had multiple involuntary admissions (defined as patients having three or more involuntary episodes in a calendar year). The Commission carried out more empirical analysis of the data relating to these 121 patients, to determine if there were any trends or commonality regarding their demographic characteristics, length of episode, and diagnoses. Seven percent (n=569) of involuntary admission orders in the period from commencement to end 2010 relate to these 121 patients, i.e. to 2% of all involuntary patients in the period. Within this group of patients it was found that they are predominantly male (59%), often have a diagnosis of schizophrenia, or schizotypal and delusional disorders (57%), or mania (20%), are most often in the age band 22-64 (80%) and often live in rural counties. This analysis does not include the number of voluntary admissions in the period for these patients as this information is not available to the Commission on an individualised basis. Commission data is being further analysed and when this is completed these findings will be published.

TRAINING AND DEVELOPMENT – MENTAL HEALTH TRIBUNAL MEMBERS

The Training and Development Division contributed to the recruitment process for Mental Health Tribunal Members which took place during 2010.

Following on from the recruitment process, the Training and Development Division developed, prepared and

delivered three induction training programmes for Mental Health Tribunal Members in preparation for their specific role. The programmes were delivered in October/November 2010. These were:

- Induction programme for new Mental Health Tribunal Panel Members
- Revision programme for Mental Health Tribunal Panel Members recruited and trained in 2009 but not appointed to the panels
- Induction programme for Mental Health Act 2001 Section 17 Independent Medical Examiners

All programmes were accredited by their relevant professional bodies.

Panel members were kept updated by the distribution of information and materials throughout the year.

RULES, CODES AND GUIDANCE

Rules

The Commission issued two revised sets of Rules which came into effect in January 2010. They were the:

- Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint, Version 2
- Rules Governing the Use of Electro-convulsive Therapy, Version 2

Codes of Practice

The Commission issued two revised Codes of Practice which came into effect in January 2010. They included the:

- Code of Practice on the Use of Physical Restraint in Approved Centres, Version 2
- Code of Practice on the Use of Electro-convulsive Therapy, Version 2

The Commission also issued two new codes of practice which came into effect in January 2010. They were as follows:

- Code of Practice – Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities
- Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre

GUIDANCE ON MENTAL HEALTH ACT 2001

The Commission commenced work on developing a Code of Practice on the Mental Health Act 2001 during 2010 arising out of the recommendation of the *Report on the Operation of Part 2 of the Mental Health Act 2001* in line with Section 42(4) of the Act. An external consultation process took place between March and May 2010 during which the views of key stakeholders were sought as to the areas of the Act on which they felt guidance would be useful.

An initial draft of a Code of Practice was prepared based on the findings of the consultation. After reviewing this initial draft and further examining the appropriateness of developing guidance on each of the key themes highlighted in the consultation, it became clear that there were very few areas on which it was appropriate to develop guidance in the form of a Code of Practice. The Commission also considered that the development of a Code of Practice on the Act may be more appropriate following the review of the 2001 Act during 2011. Therefore, the Mental Health Commission decided not to proceed with the development of a Code of Practice on the Act at this time.

ACTIVITY DATA: ADMISSION OF CHILDREN

Since its establishment, the Mental Health Commission has consistently highlighted the lack of sufficient Child and Adolescent in-patient and day hospital facilities. We continue to hold the view that the provision of age appropriate mental health services for children and adolescents must be addressed as a matter of urgency. In situations where children are admitted to adult units out of necessity, the provisions of the *Code of Practice Relating to Admission of Children under the Mental Health Act 2001* apply and these include a requirement to notify the Commission of such admissions.

Adult units in approved centres are requested to notify the Commission of the admission of a child within 72 hours of the child's admission under provision 2.5(m) of the code. Child units in approved centres are requested to send us a monthly report on admissions.

Admission of Children in 2010

In 2010, the Commission was notified of 429 admissions of children[2] to approved centres[3]. This represents a 16% increase on the number of admissions reported in 2009 (371)[4]. There were 155 admissions to adult units and 274 admissions to child units.

Admission of Children to Adult Units

In 2010, 36% of admissions (n=155) were to adult units. There was a 24% decrease in admissions of children to adult units in 2010, in comparison to 2009. Admissions to adult units decreased in all areas except HSE Dublin North East where there was a 94% increase in the number of admissions between 2009 and 2010.

Table 7 provides a breakdown of admissions of children to adult units, by service provider, from 2007 to 2010.

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2 The Mental Health Act 2001 Section 2(1) defines a *"child"* as a person under the age of 18 years other than a person who is or has been married.

3 Includes approved centres for adults (adult units), approved centres for children and adolescents (child units) and a child and adolescent unit in an approved centre which also admits adults (child unit).

4 Since publication of the 2009 Annual Report the Commission was notified of six additional child admissions that occurred in 2009, five to adult units and one to a child unit.

Table 7: Adult Units. Number of Admissions of Children and Number of Units by Service Provider. 2007, 2008, 2009 and 2010

Service Provider	2007	2008	2009	2010
HSE Dublin Mid Leinster	32 (7 adult units)	53 (7 adult units)	50 (7 adult units)	28a (7 adult units)
HSE Dublin North East	28 (6 adult units)	33 (8 adult units)	16 (7 adult units)	31 (5 adult units)
HSE South	71 (10 adult units)	71 (9 adult units)	65 (8 adult units)	49 (8 adult units)
HSE West	53 (7 adult units)	57 (8 adult units)	47 (8 adult units)	40 (8 adult units)
Independent	33 (2 adult units)	33 (1 adult unit)	27 (1 adult unit)	7 (1 adult unit)
TOTAL	**217 (32 adult units)**	**247 (33 adult units)**	**205 (31 adult units)**	**155 (29 adult units)**

[a] Includes one admission under Section 15(2) of the Criminal Law Insanity Act 2006 to the National Forensic Service.

Admission of Children to Child Units

There was a 65% increase in admissions of children to child units in 2010, in comparison to 2009. In 2010, the child unit in HSE South reported a substantial increase in admissions on what was reported in 2009; this was attributable to the fact that this unit was only operational for the month of December in 2009. There was a 125% increase in admissions to child units in the Independent Sector in 2010, from 2009, which was likely to be due to the opening of a new child unit in this sector in early 2010.

Table 8 provides a breakdown of admissions of children to child units, by service provider, over the four-year period from 2007 to 2010.

Table 8: Child Units. Number of Admissions of Children and Number of Units by Service Provider. 2007, 2008, 2009 and 2010

Service Provider	2007	2008	2009	2010
HSE Dublin Mid Leinster	46 (1 child unit)	42 (1 child unit)	44 (1 child unit)	38 (1 child unit)
HSE Dublin North East	- (No child unit)	- (No child unit)	29 (1 child unit)	34 (1 child unit)
HSE South	- (No child unit)	- (No child unit)	4 (1 child unit)	43 (1 child unit)
HSE West	20 (1 child unit)	34 (1 child unit)	33 (1 child unit)	33 (1 child unit)
Independent	69 (1 child unit)	69 (1 child unit)	56 (1 child unit)	126 (3 child units a)
TOTAL	**135 (3 child units)**	**145 (3 child units)**	**166 (5 child units)**	**274 (7 child units)**

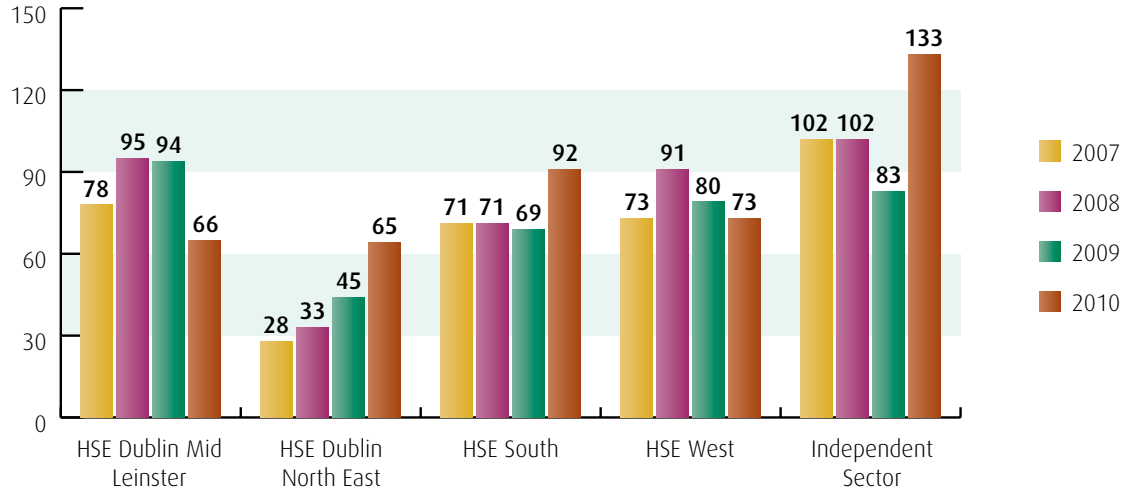
[a] Includes The Haven Children's Residential Unit, which only admitted children in January 2010 and did not have any admissions for the remainder of the year

Admissions by Service Provider

Figure 7 compares the number of admissions to approved centres (adult and child units) in 2007, 2008, 2009 and 2010 by service provider.

There was a decrease in the total number of admissions of children to approved centres in HSE Dublin Mid-Leinster and HSE West between 2009 and 2010. There was an increase to units in all other areas, with the largest increase in the independent sector. Admissions to approved centres in HSE Dublin North East have increased annually in the period from 2007 to 2010.

Figure 7: Number of Child Admissions by Service Provider in 2007, 2008, 2009 and 2010.



Involuntary Admissions

There are provisions under Section 25 of the Mental Health Act 2001 in relation to the involuntary admission of children that require the HSE to make an application to the District Court. Details of the involuntary admission process are provided in the *Code of Practice Relating to the Admission of Children under the Mental Health Act 2001.*

There were 14 involuntary admissions[5] of children to approved centres in 2010. Thirteen were made under Section 25 of the Mental Health Act 2001 and one was made under Section 15(2) of the Criminal Law (Insanity) Act 2006.

This represents a slight increase on the number of involuntary admissions reported in 2009 (n=10). In contrast to previous years, the majority of involuntary admissions were to child units (n=11). In relation to one involuntary admission that was initially to an adult unit, the child was transferred to a child unit during the period of the Section 25 Order.

[5] If a child was transferred from one approved centre to another approved centre under a single Section 25 Order this was only reported as one involuntary admission. There were three such instances in 2010.

Table 9 shows involuntary admissions by year and by unit type in the period from 2007 to 2010.

Table 9: Involuntary Admissions by Unit Type 2007-2010

Year	Adult Units	Child Units	Total
2007	3	-	3
2008	6	2	8
2009	7[a]	3	10
2010	3[b]	11	14
TOTAL	**19**	**16**	**35**

[a] includes one admission under S18(1) of the Child Care Act 1991

[b] includes one admission under S15(2) of the Criminal Law Insanity Act 2006

Admissions by Age and Unit Type

An *Addendum to the Code of Practice relating to the Admission of Children under the Mental Health Act 2001* was issued in 2009. It prohibited

a) the admission of children under 16 years of age to adult units in approved centres from 1st July 2009 and

b) the admission of children under 17 years of age to adult units in approved centres from 1st December 2010.

Part **a)** of the addendum was applicable in the period from January to November 2010. In that time, four adult units reported 13 admissions of children under 16 years of age, this is slightly more than in all of 2009. In two cases, the children were admitted to an adult unit but were transferred to a child unit and remained there until they were discharged. The majority of admissions, of children under 16 years of age, in 2009 and 2010 were to the same adult unit in an approved centre in HSE West.

Part **b)** of the addendum was applicable from 1st December 2010; there were no admissions of children under 17 years of age to adult units in December.

There was a large increase in the number of admissions of 16 and 17 year olds to child units in 2010, almost double the number of such admissions reported in 2009.

Table 10 summarises the number of admissions by age and unit type in 2007, 2008, 2009 and 2010.

Table 10: Numbers of Admissions by Age and Unit Type for 2007, 2008 and 2009

	2007		2008		2009		2010	
Age	Adult Unit	Child Unit	Adult Unit	Child Unit	Adult Unit	Child Unit	Adult Unit	Child Unit
≤15 years of age	14	99	24	90	12	89	13	122
16 and 17 years of age	203	36	223	55	193	77	142	152
TOTAL (admissions by unit Type)	**217**	**135**	**247**	**145**	**205**	**166**	**155**	**274**

Gender

In 2010 there were slightly more female admissions 53% (229), than male admissions 47% (200). This is similar to the breakdown of gender reported since 2007.

Additional Information regarding child admission data

The Commission cross references the child admissions data received from approved centres with data reported to the Health Research Board (HRB). If any discrepancies arise, approved centres are contacted for clarification and validation.

The number of admissions of children reported here may differ from those reported by the HRB for the following reasons:

- The HRB reports on the legal status of children on admission, whereas the Commission captures change in legal status from voluntary to involuntary throughout the period of admission and reports on such admissions once as an involuntary admission
- The Commission's data on admissions of children only includes the admissions of children as defined in the Mental Health Act 2001. Section 2(1) states that *"child"* means a person under the age of 18 years other than a person who is or has been married. The HRB report on admissions of persons under 18 years of age irrespective of their current or previous marital status

REVIEW OF THE ADMISSION OF YOUNG PEOPLE TO ADULT MENTAL HEALTH FACILITIES

In August 2010 the Mental Health Commission commissioned Dr. Sally Bonnar, a Child & Adolescent Psychiatrist based in Dundee, Scotland to undertake a Review of the Admission of Young People to Adult Mental Health Wards in Ireland. The Terms of Reference for the Review were as follows:

1. To examine the factors contributing to the admission of children under 16s in 2010 to:
   a) Adults units in Approved Centres
   b) General paediatric units
2. To examine the challenges for providers in meeting the mental health needs of those under 18 years in the context of the addendum to the Mental Health Commission Code of Practice for the admission of children
3. To present a report of findings and recommendations to the Mental Health Commission

Dr. Bonnar submitted her final Review report in December 2010 which was considered and approved by the Commission at its meeting of 9th December, 2010. The report is available on the Commission's website at *www.mhcirl.ie*

NOTIFICATION OF DEATHS

Approved Centres

Approved Centres are required to notify the Commission of the death of any resident of an approved centre in accordance with Article 14(4) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and Section 2.2 of the *Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting.*

In 2010, 42 approved centres notified the Commission of 162 deaths. Based on the information reported to us, 14% of notifications (n=22) related to sudden unexplained deaths. A breakdown of death notifications by service provider is provided in Table 11.

Table 11: Number of Approved Centres that Notified Deaths and Number of Death Notifications by Service Provider in 2008, 2009 and 2010.

Year	2008		2009		2010	
Service Provider	Number of Approved Centres	Number of death notifications	Number of Approved Centres	Number of death notifications	Number of Approved Centres	Number of death notifications
HSE Dublin Mid Leinster	7	21	6	22	6	16
HSE Dublin North East	7	40	8	32	8	30
HSE South	13	54	13	65	11	57
HSE West	8	32	11	23	9	25
National Intellectual Disability Service	1	5	1	6	1	6
National Forensic Service	-	-	-	-	1	1
Independent	6	27	6	24	6	27
TOTAL	**42**	**179**	**45**	**172**	**42**	**162**

Day Hospitals, Day Centres and 24 Hour Staffed Community Residences

All sudden, unexplained deaths of persons attending a day hospital or a day centre, or living in 24 hour staffed community residences, should be notified to the Commission within 7 days of the death occurring (Section 2 (b) *Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting*).

In 2010, the Commission was notified of 75 deaths in this category. Based on the information provided, it was not apparent in all instances that a sudden unexplained death had occurred.

Table 12 provides a breakdown of this information by HSE administrative area.

Table 12: Number of Death Notifications Submitted by Day Hospitals, Day Centres, 24-hour Staffed Community Residences and Other Mental Health Services by HSE Area. 2008, 2009 and 2010

HSE Dublin Mid Leinster	2008	2009	2010
24 Hour Staffed Residence	6	6	3
Day Centre	1	2	1
Day Hospital	4	5	2
Other Mental Health Service	5	6	15
TOTAL	**16**	**19**	**21**

HSE Dublin North East	2008	2009	2010
24 Hour Staffed Residence	7	7	2
Day Centre	1	1	3
Day Hospital	2		2
Other Mental Health Service	1	1	6
TOTAL	**11**	**9**	**13**

HSE South	2008	2009	2010
24 Hour Staffed Residence	10	8	9
Day Centre	4	2	1
Day Hospital	7	4	5
Other Mental Health Service	1	7	4
TOTAL	**22**	**21**	**19**

HSE West	2008	2009	2010
24 Hour Staffed Residence	20	17	10
Day Centre	3	8	5
Day Hospital	4	3	6
Other Mental Health Service	3	2	1
TOTAL	**30**	**30**	**22**

Other Mental Health Service: Includes out-patient department, resource centre, group home, out-reach team and other service types

Inspector of Mental Health Services

All death notifications were forwarded to the Inspector of Mental Health Services in accordance with our standard operating procedures. The Inspector of Mental Health Services examined all death notifications and in cases suggestive of suicide or violent death requested a review be carried out by the service and a copy sent to the Inspectorate. These reviews were analysed to identify opportunities for improvement in patient safety, care and treatment and to form part of the ongoing dialogue between the Inspectorate and services.

INCIDENT REPORTING

In accordance with the *Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting,* approved centres provided us with six-monthly summary reports of all incidents that occurred in the centre. The reports received were made available to the Inspectorate to inform inspections.

In the absence of a national incident reporting taxonomy and given the wide variation in incident reporting systems used by mental health services it was not possible to report on these data at a national level.

The Commission on Patient Safety and Quality Assurance was established by the Minister for Health and Children in 2007 to develop clear and practical recommendations to ensure that safety and quality of care for patients is paramount within our healthcare system. Their report – Building a Culture of Patient Safety – was published in 2008 and approved by Government in January 2009. The report contains 134 recommendations including 18 which address the reporting, managing and learning from adverse events. An Implementation Steering Group and a number of working groups were established to implement the recommendations of this report. The Commission was represented on the Adverse Events Working Group by the Director of Standards and Quality Assurance and the Policy Subgroup by the Policy Officer in 2010.

DATA ON THE USE OF ELECTRO-CONVULSIVE THERAPY (ECT), SECLUSION, MECHANICAL RESTRAINT AND PHYSICAL RESTRAINT

Approved Centres are required to return data on the use of ECT, seclusion, mechanical means of bodily restraint and physical restraint under the respective Rules and Codes of Practice issued in accordance with the Mental Health Act 2001. The Commission collects and reports on the above data to provide a current picture of activity both within individual services and at national level and to inform the quality improvement process.

Due to delays during the data validation process, it was not possible to publish the 2009 activity reports in 2010 as intended; they will be published in early 2011.

SCHEME OF MENTAL CAPACITY BILL 2008

During 2010 the Mental Health Commission continued to highlight the urgent need for capacity legislation to be enacted in Ireland. Members of the Commission and the Executive met with representatives from the Department of Justice and Law Reform in November 2010 to discuss progress on the drafting of the next stage of the Bill and to again bring to the fore the pertinent issues which had formed the basis of the Commission's 2009 submission on the Bill.

EUROPEAN COMMITTEE FOR THE PREVENTION OF TORTURE AND INHUMANE OR DEGRADING TREATMENT OR PUNISHMENT (CPT)

The European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment (CPT) visited Ireland in January 2010. During their visit the CPT met with Members of the Commission and Executive and held a separate meeting with the Inspector of Mental Health Services. Subsequent to the visit, in October 2010 the Commission made a submission to the Department of Health and Children in response to the section of the CPT's report focused on Seclusion and Restraint.

STRATEGIC PRIORITY THREE 2009-2012
Quality Mental Health Services

- The scope and process of inspection and reporting is effective in enhancing both compliance and commitment to continuous quality improvements and is a catalyst for change.
- To facilitate and support implementation of the quality improvement standards for mental health services in Ireland. (Quality Framework for Mental Health Services in Ireland, MHC 2007).
- To continue to support mental health services research to build knowledge that leads to practical ways of improving services.
- To promote and support the development of a national mental health information system.

One of the principal overarching functions of the Mental Health Commission, as specified within the provisions of the Mental Health Act 2001, is to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services. (Section 33(1), Mental Health Act, 2001).

The Commission's mandate encompasses the broad spectrum of mental health services in Ireland.

INSPECTOR OF MENTAL HEALTH SERVICES

Section 51, Mental Health Act 2001 specifies the functions of the Inspector of Mental Health Services. In 2010, in line with its statutory mandate the Inspectorate of Mental Health Services visited and inspected every approved centre and visited and inspected a number of other premises where mental health services were being provided and which were deemed appropriate to inspect.

The 2010 Inspector's annual review of mental health services in Ireland is detailed in the second report of this Book. The detailed approved centre inspection reports are contained in books 2-6 on CD Rom and are published on the Mental Health Commission website *www.mhcirl.ie*

REGISTER OF APPROVED CENTRES

One of the Commission's key functions is to maintain the *Register of Approved Centres* (Section 64, Mental Health Act 2001). Section 62 of the 2001 Act defines a centre as "a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder" and the term does not solely refer to centres that are admission units.

Under Section 63 of the 2001 Act, a centre cannot operate unless registered with the Mental Health Commission. To maintain awareness of the legal requirement for facilities that meet the definition of 'centre' to register with the Commission, advertisements were placed in three national newspapers in March and October 2010.

Two facilities ceased operating as centres during 2010 and were removed from the Register of Approved Centres in accordance with Article 36 (Closure of an Approved Centre) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. These facilities were:

- Unit 9A, Merlin Park University Hospital, which was removed from the Register on 16th May 2010
- St. Conal's Hospital, which was removed from the Register on 18th June 2010

EXPIRATION OF REGISTRATION

Under the provisions of the 2001 Act, a centre's period of registration shall usually be 3 years from the date of registration. Where the registered proprietor of a centre proposes to carry on the centre immediately after the period of registration expires, he/she must apply to the Commission for registration.

The period of registration of 18 approved centres expired during 2010. One of the centres was Unit 9A, Merlin Park University Hospital, which ceased operating as a centre and was removed from the Register when its period of registration expired on 16th May 2010. The remaining 17 centres applied for registration in accordance with Section 64(9) of the 2001 Act and were entered in the Register of Approved Centres as follows:

- Palmerstown View, Stewart's Hospital; registered on 1st March 2010
- Acute Psychiatric Unit, Carnamuggagh; registered on 13th April 2010
- St. Dympna's Hospital; registered on 17th May 2010
- St. Aloysius Ward, Mater Misericordiae University Hospital; registered on 17th May 2010
- An Coillín; registered on 17th May 2010
- St. Loman's Hospital, Palmerstown; registered on 17th May 2010
- St. Finbarr's Hospital; registered on 17th May 2010
- St. Finan's Hospital; registered on 17th May 2010
- St. John of God Hospital Limited; registered on 17th May 2010
- Bloomfield Care Centre – Donnybrook, Kylemore, Owendoher, & Swanbrook Wings; registered on 17th May 2010
- St. Joseph's Intellectual disability Services; registered on 17th May 2010
- Hampstead Private Hospital; registered on 25th May 2010
- Highfield Private Hospital; registered on 25th May 2010
- St. Edmundsbury Hospital; registered on 25th May 2010
- St. Anne's Child & Adolescent Unit; registered on 25th May 2010
- Teach Aisling; registered on 31st May 2010
- Sycamore Unit, Connolly Hospital; registered on 6th June 2010

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ADDITIONS TO THE REGISTER OF APPROVED CENTRES

Four new centres were entered in the Register of Approved Centres during 2010:

- Lois Bridges, Sutton, Dublin 13. This centre was entered in the Register on 19th January 2010 and conditions were attached to the registration.
- Willow Grove Adolescent Unit, St. Patrick's University Hospital, Dublin 8. This centre was entered in the Register on 30th April 2010.
- Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital. This centre was entered in the Register on 9th December 2010 and a condition was attached to the registration.
- Eist Linn Child & Adolescent In-patient Unit. This centre was entered in the Register on 22nd December 2010 and a condition was attached to the Registration.

The total number of Approved Centres at 31st December 2010 was 68. An up to date list of all approved centres entered in the Register of Approved Centres is available in the *Registration of Approved Centres* section of the Commission's website, *www.mhcirl.ie.*

CONTINUOUS QUALITY IMPROVEMENT

As part of the Commission's standard operating procedures, the Standards and Quality Assurance Division requested each approved centre to provide an implementation plan to address the areas of non-compliance, if any, with the Articles of the Regulations, Rules, and Codes of Practice identified by the Inspector of Mental Health Services.

The Implementation Plan must detail (i) the actions already undertaken to fully address the areas of non-compliance identified in the Inspector's Report, (ii) the actions that will to be taken to fully address the areas of non-compliance and (iii) the time-frame(s) for completion. To assist the process, a Standardised Implementation Plan Template is issued to each approved centre.

The Standards & Quality Assurance Division received Inspector's Reports for 67 approved centres. Out of this number, 62 Reports identified areas of non-compliance with the Articles of the Regulations, Rules, or Codes of Practice.

The five approved centres deemed fully compliant with the Articles of the Regulations, Rules, and Codes of Practice by the Inspector of Mental Health Services in 2010 were:

- Adolescent In-patient Unit, St. Vincent's Hospital
- Lois Bridges
- St. Edmundsbury Hospital
- St. Patrick's University Hospital
- Willow Grove Adolescent Unit, St. Patrick's University Hospital

CONDITIONS ATTACHED TO THE REGISTRATION OF APPROVED CENTRES

In 2010, the Commission attached conditions to the registration of 8 approved centres. These approved centres were:

- Acute Psychiatric Unit, Carnamuggagh, Letterkenny, Co. Donegal

  The condition attached required full compliance to be achieved with Article 15 (Individual Care Planning) of the Regulations within three months of the condition being attached.

  This condition was attached with effect from 11th June 2010.

- Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital, Galway

  The condition attached stated that the maximum number of residents who can be accommodated is nine, and set out the bedrooms that these residents can be accommodated in.

  The condition was attached with effect from the centre's date of registration, 9th December 2010.

- Eist Linn Child & Adolescent In-patient Unit, Bessborough, Cork

  The condition attached stated that the maximum number of residents who can be accommodated is 12, and set out the bedrooms that these residents can be accommodated in.

  The condition was attached with effect from the centre's date of registration, 22nd December 2010.

- Lois Bridges, Sutton, Dublin 13

  The conditions attached stated that the maximum number of residents who can be accommodated is 6, and that works notified to the Commission on 22nd December 2009 are carried out prior to opening.

  These conditions were attached with effect from the centre's date of registration, 19th January 2010.

- St. Aloysius Ward, Mater Misericordiae University Hospital

  The condition attached required full compliance to be achieved with the Rules Governing the Use of Mechanical Means of Bodily Restraint.

  The condition was attached with effect from 19th July 2010.

- St. Senan's Hospital, Enniscorthy, Co. Wexford

  The conditions attached required (i) the cessation of the admission of children by 30th June 2010, (ii) the cessation of the admission of residents to St. Clare's Ward and St. Anne's Ward by 28th February 2011, and (iii) full compliance with the Rules Governing the Use of Seclusion within three months of the condition being attached.

  These conditions were attached with effect from 11th June 2010.

- St. Brendan's Hospital, Dublin 7

  The conditions attached required (i) the cessation of admission to Units 3A and 3B of residents from the Finglas and Cabra sectors of the community

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within three months of the condition being attached, (ii) the transfer from Units 3A and 3B to Pine Unit, Connolly Hospital of residents from the Finglas and Cabra sectors of the community within three months of the condition being attached, and (iii) full compliance with the Rules Governing the Use of Seclusion within three months of the condition being attached.

These conditions were attached with effect from 11th June 2010.

In September 2010, the Commission received written confirmation from the Registered Proprietor that the residents of Units 3A and 3B from Finglas and Cabra were transferred to the newly opened Pine Unit in Connolly Hospital. The Proprietor also confirmed that persons from Finglas and Cabra were now admitted to the Pine Unit in Connolly Hospital, instead of Units 3A and 3B of St. Brendan's Hospital.

The Inspector's 2010 Report for St. Brendan's Hospital states that the centre is fully compliant with the Rules Governing the Use of Seclusion.

St. Ita's Hospital, Portrane, Donabate, Co. Dublin

The conditions attached, and the dates the conditions were attached, are as follows:

- The admission of children must cease by 30th June 2010. This condition was attached with effect from 11th June 2010.
- The admission of residents to the Acute Units must cease by 28th February 2011. This condition was attached with effect from 11th June 2010.
- Ward 9 is required to be permanently closed by 17th December 2010. This condition was attached with effect from 24th November 2010.
- Ward 8 must be refurbished by 17th December 2010. This condition was attached with effect from 24th November 2010.
- Unit 1 – Female and Unit 1 – Male are required to be permanently closed by 28th February 2011. This condition was attached with effect from 30th November 2010.

In December 2010, the Commission received written confirmation from the Registered Proprietor that Ward 9 had closed.

Where a proposal was made to attach a condition to a centre's registration, or to enter a centre in the Register with a condition attached to its registration, correspondence was issued to the Registered Proprietor in accordance with the provisions of Section 64(11) and Section 64(12) of the Mental Health Act 2001.

These Sections afford the Registered Proprietors of the centres the right to make representations to the Commission within 21 days of receipt of the correspondence and the Commission must take these representations into consideration before making a decision. Under Section 65, the registered proprietor may also appeal the Commission's decision to the District Court within 21 days of receiving notification of the decision.

As of 31st December 2010, 12 of the 68 approved centres entered in the Register of Approved Centres had conditions attached to the registration.

NATIONAL LEVELS OF COMPLIANCE WITH THE MENTAL HEALTH ACT 2001 (APPROVED CENTRES) REGULATIONS 2006

The Mental Health Act 2001 (Approved Centres) Regulations 2006 came into effect on 1 November 2006. Compliance with the regulations is linked with registration as an approved centre. Therefore approved centres are obliged to comply.

This report provides a comparison of compliance in 2010 with 2009 based on the findings of the Inspector of Mental Health Services as provided to the Mental Health Commission.

In 2010, full compliance[6] was 90% or more for the following 20 articles:

- Article 13 – Searches (100%)
- Article 14[7] – Care of the Dying (100%)
- Article 30[8] – Mental Health Tribunals (100%)
- Article 34 – Certificate of Registration (100%)
- Article 4 – Identification of Residents (99%)
- Article 7 – Clothing (99%)
- Article 8 – Residents' Personal Property and Possessions (99%)
- Article 10 – Religion (99%)
- Article 12 – Communication (99%)
- Article 23 – Ordering, Prescribing, Storing & Administration of Medicine (99%)
- Article 28 – Register of Residents (99%)
- Article 33 – Insurance (99%)
- Article 5 – Food & Nutrition (97%)
- Article 18 – Transfer of Residents (96%)
- Article 11 – Visits (64%)
- Article 24 – Health & Safety (94%)
- Article 25[9] – Use of Closed Circuit Television (92%)
- Article 6 – Food Safety (91%)
- Article 31 – Complaints Procedure (91%)
- Article 29 – Operating Policies and Procedures (90%)

[6] The 2009 and 2010 Inspector's Reports grade compliance as follows: fully compliant, substantially compliant, compliance initiated, or not compliant.

[7] The level of compliance with Article 14 in 2010 is based on 66 approved centres. The Inspector's Reports stated that Article 14 was not applicable in one centre in 2010.

[8] The level of compliance in with Article 30 in 2009 and 2010 is based on 55 approved centres. The Inspector's Reports stated that Article 30 was not applicable in 9 approved centres in 2009 and in 12 centres in 2010.

[9] The level of compliance with Article 25 is based on 36 approved centres in 2009 and 2010. The Inspector's Reports stated that Article 25 was not applicable in 28 centres in 2009 and in 31 centres in 2010.

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In 2009, compliance was 90% or more for the following 12 articles:

- Article 10 – Religion (100%)
- Article 30[10] – Mental Health Tribunals (100%)
- Article 34 – Certificate of Registration (100%)
- Article 4 – Identification of Residents (98%)
- Article 33 – Insurance (97%)
- Article 14 – Care of the Dying (97%)
- Article 7 – Clothing (95%)
- Article 8 – Residents' Personal Property & Possessions (95%)
- Article 12 – Communication (94%)
- Article 13 – Searches (94%)
- Article 25[11] – Use of Closed Circuit Television (92%)
- Article 18 – Transfer of Residents (92%)

In 2010, full compliance was less than 50% for the following four articles:

- Article 26 – Staffing (28%)
- Article 16 – Therapeutic Services and Programmes (34%)
- Article 15 – Individual Care Plan (42%)
- Article 22 – Premises (42%)

This compares to 2009, where compliance was less than 50% for the following four articles:

- Article 26 – Staffing (27%)
- Article 16 – Therapeutic Services & Programmes (27%)
- Article 15 – Individual Care Plan (33%)
- Article 22 – Premises (44%)

The largest improvements in compliance in 2010 were as follows:

- Article 6 – Food Safety (70% in 2009, 91% in 2010)
- Article 28 – Register of Residents (81% in 2009, 99% in 2010)
- Article 29 – Operating Policies and Procedures (78% in 2009, 90% in 2010)
- Article 17 – Children's Education (78% in 2009, 89% in 2010)

[10] See footnote 3.
[11] See footnote 4.

However a disimprovement in compliance in 2010 with Article 19 (General Health) is noted falling from 83% in 2009 to 73% in 2010.

In relation to Article 15 (Individual Care Plan) compliance in 2007 was 18%. This improved to 33% in 2008, remained at 33% in 2009 and improved once again to 42% in 2010.

Full national compliance data comparing 2010 with 2009 is provided in figure 8(a) – (d) inclusive.

Figure 8(a): Comparison of the National Levels of Compliance with Articles 4 to 14 of the Regulations for 2009 and 2010

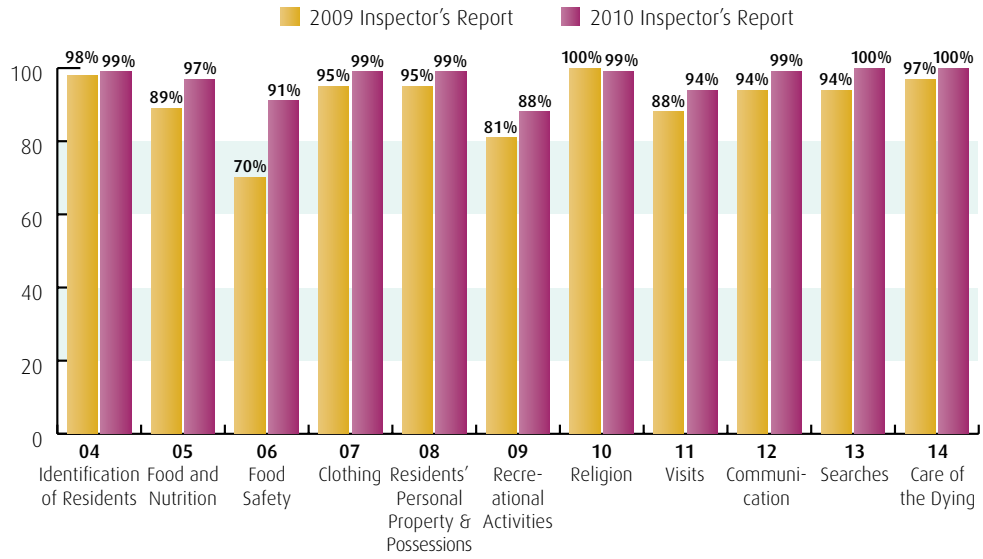


Figure 8(b): Comparison of the National Levels of Compliance with Articles 15 to 20 of the Regulations for 2009 and 2010

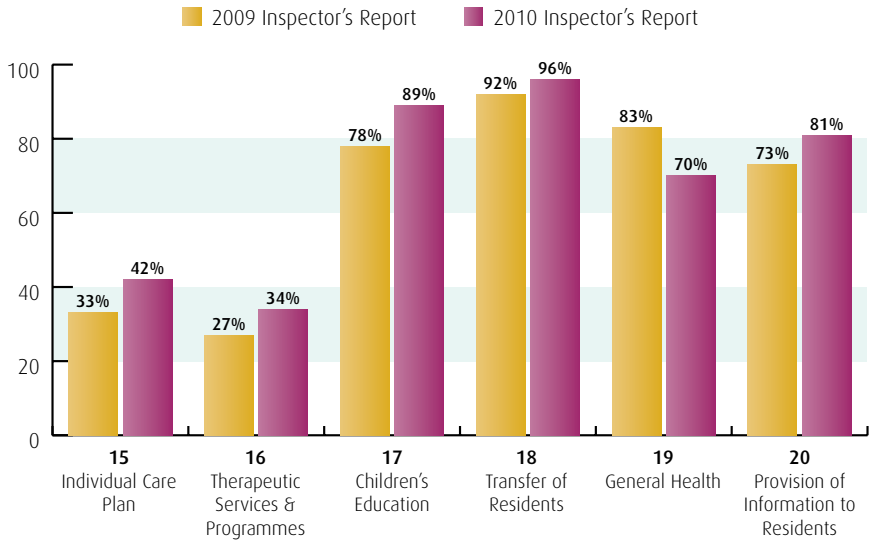


Figure 8(c): Comparison of the National Levels of Compliance with Articles 21 to 26 of the Regulations for 2009 and 2010

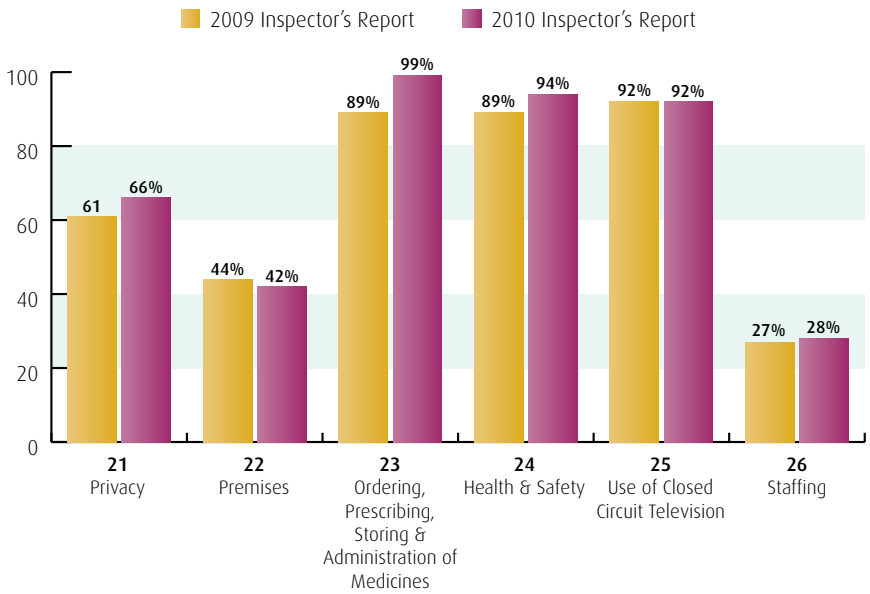
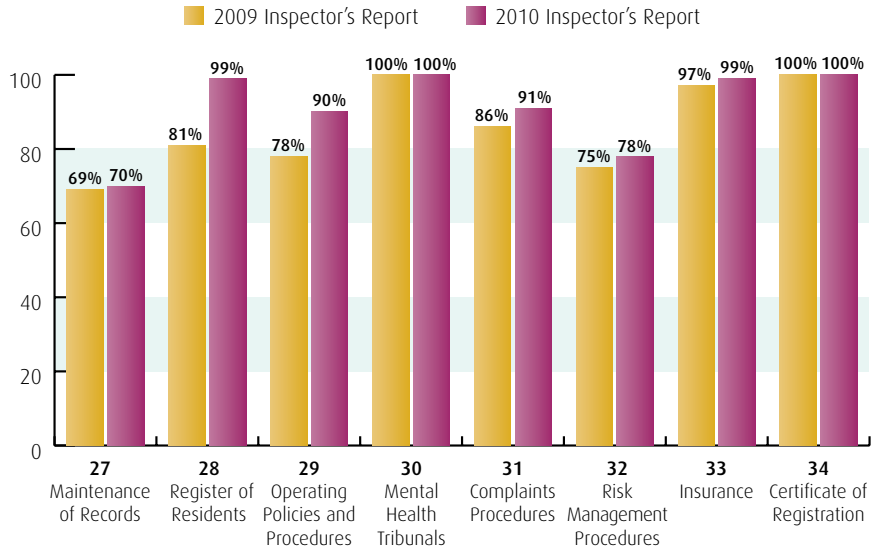


Figure 8(d): Comparison of the National Levels of Compliance with Articles 27 to 34 of the Regulations for 2009 and 2010.



NATIONAL LEVELS OF COMPLIANCE WITH RULES AND CODES OF PRACTICE

Pursuant to Sections 59(2), 69(2) and 33(3)(e) of the Mental Health Act 2001, the Commission has published a number of rules and codes of practice.

In 2010, the Inspectorate inspected compliance with two sets of rules and six codes of practice. Both sets of rules and two codes of practice were revised effective from 1st January 2010. Another two codes of practice were introduced effective from 1st January 2010.

Figures 9(a) to 9(i) illustrate the national levels of compliance in 2010 with these rules and codes.

Figure 9(a): Levels of Compliance in 2010 with the Rules Governing the Use of Seclusion (n=67)

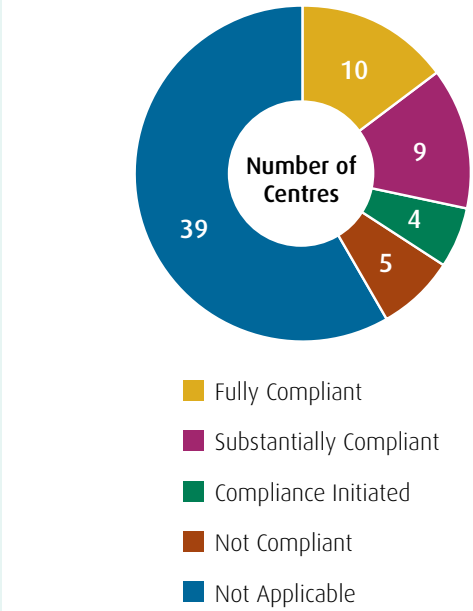


Figure 9(b): Levels of Compliance in 2010 with the Rules Governing the Use of Mechanical Means of Bodily Restraint (n=67)

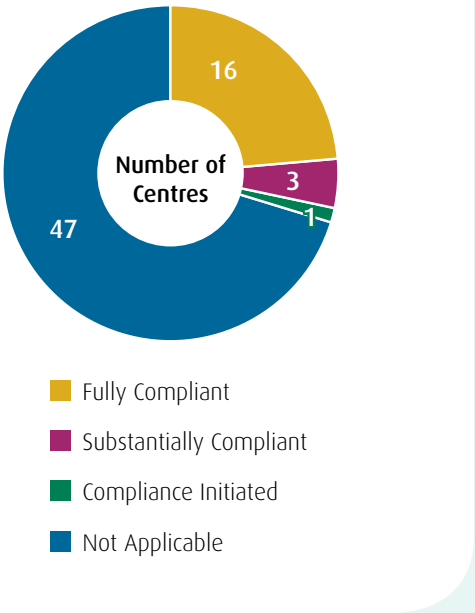


Figure 9(c): Levels of Compliance in 2010 with the Rules Governing the Use of ECT (n=67)

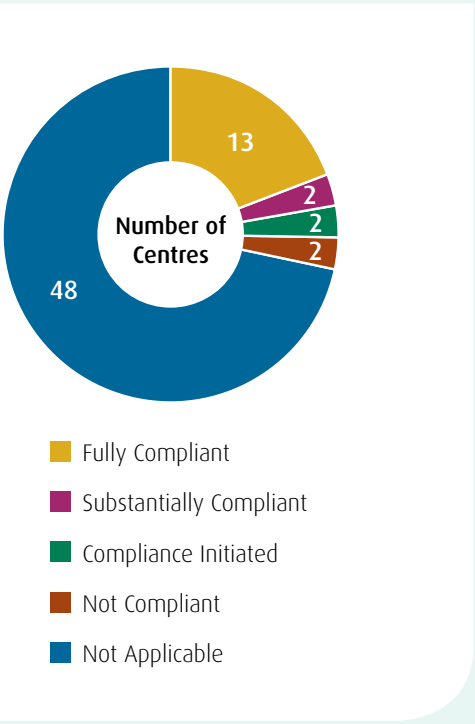


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Figure 9(d): Levels of Compliance in 2010 with the Code of Practice on the Use of ECT for Voluntary Patients (n=67)

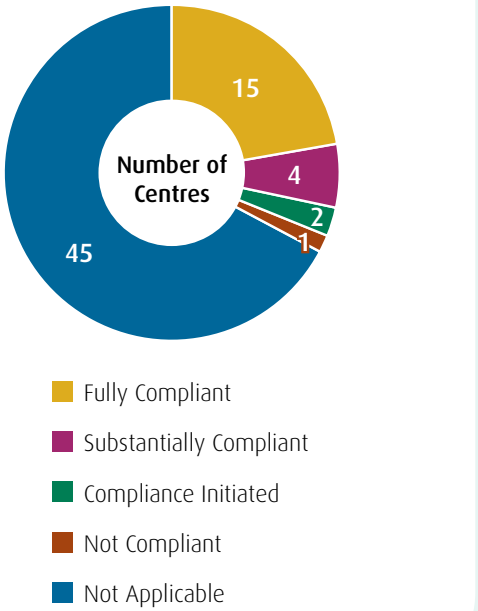


Figure 9(f): Levels of Compliance in 2010 with the Code of Practice on the Admission of Children Under the Mental Health Act 2001 (n=67)

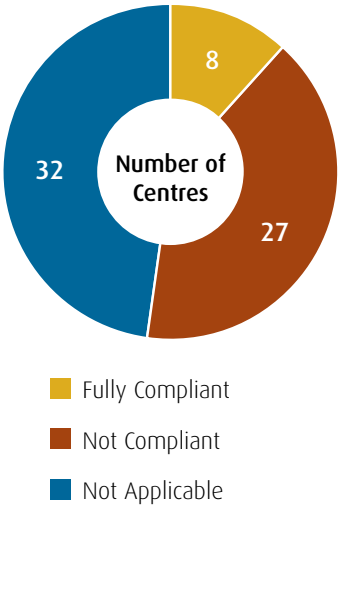


Figure 9(e): Levels of Compliance in 2010 with the Code of Practice on the Use of Physical Restraint in Approved Centres (n=67)

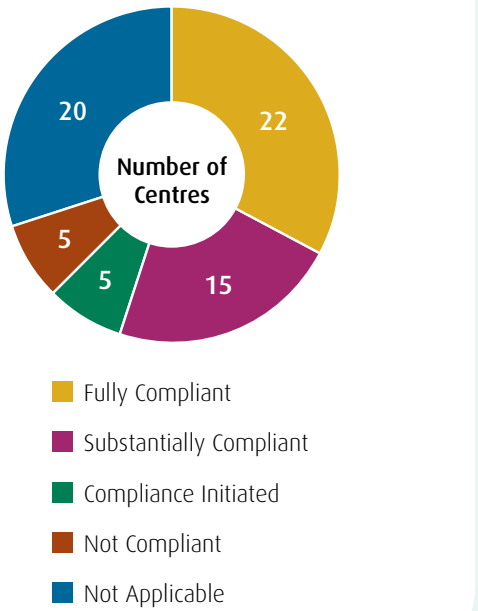


Figure 9(g): Levels of compliance in 2010 with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting (n = 67)

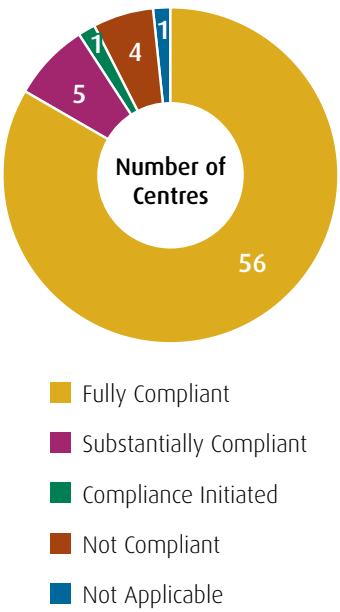


Figure 9(h): Levels of Compliance in 2010 with the Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre (n = 67)

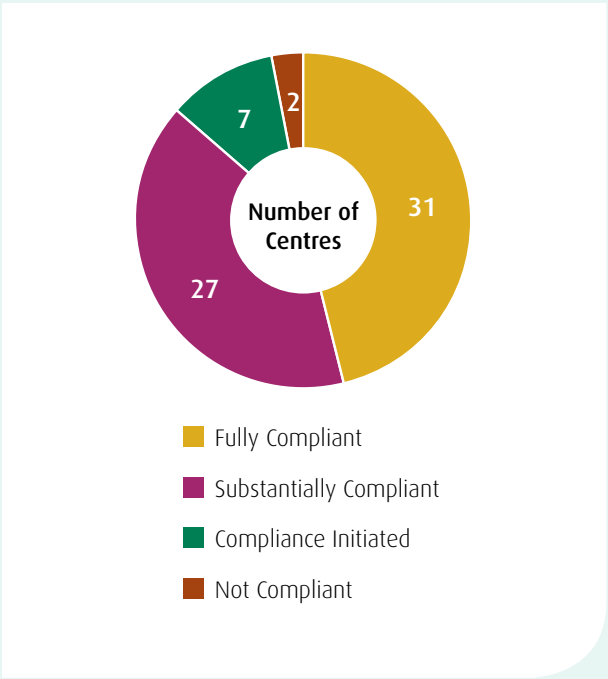
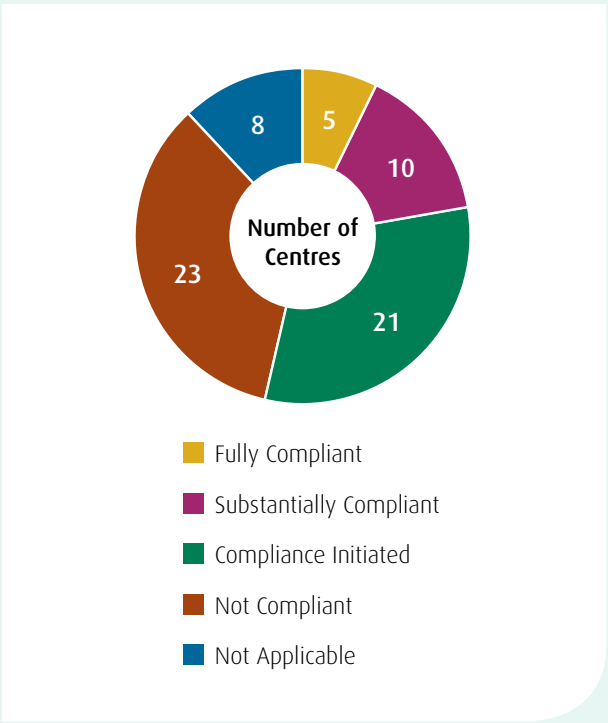


Figure 9(i): Levels of Compliance in 2010 with the Code of Practice – Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities (n = 67).



E-LEARNING

The e-learning programme continues to be monitored and managed by the Training and Development Division. During 2010 a number of new trainers have been added to the Mental Health Commission trainer resource area of the programme.

TRAINING AND DEVELOPMENT STRATEGY

A scoping study on 'Current Education and Training for Professionals Working in the Mental Health Services in Ireland' was conducted by Trinity College Dublin in 2009, on behalf of the Mental Health Commission. This report was published in hard copy and on the MHC website and circulated to all relevant stakeholders in September 2010.

Discussions have commenced with the Higher Education Authority regarding progressing the recommendations outlined in the report.

SUPPORTING MENTAL HEALTH SERVICES RESEARCH

2010 was the fifth year of the Commission's current Research Strategy work programme. Over the past five years the Commission has highlighted the need for mental health services research and its centric importance to the development of high quality mental health services. One of the four action plans, which are outlined in the strategy, is the need to build capacity within the system for mental health services research to be undertaken. Three other action plans detailed are: recording and disseminating knowledge and best practice in mental health services, creating links and collaborating research standards in mental health and setting the mental health agenda.

RESEARCH COMMITTEE

The Mental Health Commission's research committee was established in March 2005. The work of the Committee is focused on three key areas (i) making recommendations on the research to be commissioned or carried out by the Mental Health Commission (ii) reviewing research projects commissioned or carried out by the Mental Health Commission and (iii) considering any other matters that may be referred to the Research Committee from time to time by the Commission.

The Research committee held three meetings and one teleconference during 2010.

At the time of publication of this report the Commission was notified of the untimely passing of Professor Eadbhard O'Callaghan. Professor O'Callaghan made a considerable contribution to the work of the Commission's Research Committee and will be greatly missed by his fellow Committee members and within the wider mental health services.

RESEARCH PROJECTS

During 2010 the Mental Health Commission was funding the following projects under its Research Scholarship Scheme, the first three of which will be issuing final reports to the Commission in quarter one of 2011. The last study undertaken by Mr. Turner is due for completion in Q4 2012.

- Dr. Siobhán Ní Bhríain (Academic Host Institution: Trinity College): Measurement of needs in the HSE-SWA: A Measure of Needs and Correlation with Intervention in Home and Community-based Services in General Adult Psychiatry and Psychiatry of Later Life

- Professor Stiofán de Burca (Academic Host Institution : University of Limerick): Adult Community Mental Health Teams: Determinants of Effectiveness

- Dr. Ena Lavelle (Academic Host Institution: Royal College of Surgeons in Ireland) : Rehabilitation and Recovery Services in Ireland: a multicentre study to investigate current service provision, characteristics of service users and 18 month outcomes for those with and without access to these services

- Mr. Niall Turner (Academic Host Institution: University College Dublin): A clinical trial of supported employment (SE) and the Workplace Fundamentals Module (WFM) with people diagnosed with schizophrenia spectrum disorders

In 2010 the Commission also approved funding for the following study under the MHC Research Programme Grant Scheme.

- Professor Colm McDonald (Academic Host Institution: University College Galway): A Prospective Evaluation of the Operation and Effects of the Mental Health Act 2001 from the Viewpoint of Service Users and Mental Health Professionals.

Professor McDonald's study is due to commence in early 2011.

Also in 2010 a collaboration between the Mental Health Commission and the Royal College of Surgeons in Ireland was agreed which will be facilitated through the establishment of a joint PhD Research programme.

It is expected that following a studentship selection process the work of this programme will begin in mid 2011.

STRATEGIC PRIORITY FOUR 2009-2012
Wider Mental Health Domain

- The work of relevant state agencies and other organisations within the wider mental health domain is informed by the Commission's strategy and national government policy on mental health, *A Vision for Change*.

A VISION FOR CHANGE

2010 represented the 5th year of the implementation timeframe for *A Vision for Change*, Ireland's national mental health policy. Central to the ethos of *Vision for Change* is the re-orientation of the delivery of mental health services from an institutional model of care to specialist community care and treatment based on the biological, psychological and social factors that may contribute to a person's mental illness. Implementation remained slow during 2010, however, there was some positive progress made. The Commission used its statutory powers to drive progress by imposing stringent conditions on three of the older institutions following the Report of the Inspector of Mental Health Services in 2009.

The principles underpinning *Vision for Change* require cultural change, emphasis on service user involvement and a recovery focused approach. It must be noted that not all elements of *Vision for Change* require additional resources and in the current economic climate the focus must be on delivering change which is achievable i.e. to focus on the core elements and the delivery of patient focused safe services.

Since the publication of *Vision for Change* the Commission has continued to highlight the importance of the establishment of a National Mental Health Services Directorate with multi-disciplinary representation. It is regrettable that 2010 has not seen the real and fundamental change required at this key juncture of the policy timeframe. The Commission had the opportunity in November 2010 to provide a written submission to the Independent Monitoring Group outlining its assessment of progress to-date.

TRAINING PROGRAMMES FOR RELEVANT STAKEHOLDERS

The Training and Development Division engaged with relevant stakeholders to identify training needs and to develop and deliver training programmes. These included:

- A joint training workshop designed, prepared and delivered with the Office of the Ombudsman took place on 22nd October 2010. The aim of the programme was to raise awareness of the role and function of each organisation and explore means of working collaboratively.
- A certificate programme in Capacity and Mental Health Law with the Law Society commenced in November 2010.
- The Mental Health Commission and the College of Psychiatry of Ireland jointly developed and delivered a training programme on Management of Children and Adolescents who Present to Adult Services for Consultant Psychiatrists' and Senior Registrars. The aim of the programme

was to equip consultant psychiatrists and Senior Registrars with the skills to deal with children and adolescents who present at adult mental health services. The course took place on 23rd April 2010 and it was accredited by the College of Psychiatry of Ireland.

- The Mental Health Commission and the College of Psychiatry of Ireland also jointly developed and delivered a training programme on Mental Health Tribunal Skills for Responsible Consultant Psychiatrists' working in approved centres. The aim of the programme was to equip Consultant Psychiatrists, who are responsible for detained persons, with the skills required to perform competently at Mental Health Tribunals. The course took place on 14th May 2010 and it was accredited by the College of Psychiatry of Ireland.

- Mental Health Act training provided throughout the year to service providers as requested, which also included undergraduate students.

RECRUITMENT, INDUCTION, TRAINING AND DEVELOPMENT PROJECT GROUP

This project group was established by the Health and Social Care Regulatory Forum. The terms of reference for the group were as follows:

1. Establishing a faculty across the Regulators from which we could share expertise and resources in a planned way where possible

2. Undertaking joint tenders for similar activities to provide a more cost effective solution where applicable

3. Begin to undertake joint initiatives where appropriate

A survey was conducted by this group to identify what current policy, procedures and initiatives exist or are planned by the different regulators in health and social care, in the areas of recruitment, induction, training and education, and organisational development. The findings suggested that there were education, training and development initiatives that could be shared. A project initiation document for developing an "Education, Training and Development Faculty" across the health and social care regulatory organisations was prepared by the group and the Report and any subsequent actions handed over to the Health and Social Care Regulatory Forum Human Resources Group.

TEAMWORK WITHIN THE MENTAL HEALTH SERVICES IN IRELAND

In March 2010 the Mental Health Commission published a Resource Paper entitled "Teamwork Within the Mental Health Services in Ireland". The Resource Paper followed on from the Commission's 2006 Discussion Paper. The aim of the resource paper is to equip individuals and teams to:

- Understand what contributes to successful teamworking and identify some of the pitfalls

- Develop creative solutions for more effective teamworking

The paper includes an audit tool to enable mental health teams to assess whether their teamworking practices are promoting quality of care standards that not only meet stakeholder expectations but also offer the kind of service that the team can be proud of. The resource paper is available on the Commission's website at *www.mhcirl.ie*

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STRATEGIC PRIORITY FOUR
Wider Mental Health Domain

COLLABORATIVE WORKING

The Commission has been involved in several inter-organizational working groups in 2010. These included the following:

- DOHC Working Group and sub group on Adverse Event Reporting – represented by the Director Standards & Quality Assurance
- HIQA: National Standards for Quality and Safety Advisory Group – represented by the Director Standards & Quality Assurance

The Commission also contributed to the following external consultation by way of a written submission:

- Department of Health and Children: *Towards a Restraint Free Environment in Nursing Homes*

STRATEGIC PRIORITY FIVE 2009-2012
Social Inclusion & Active Citizenship

- To challenge the barriers experienced by people with a mental illness to social inclusion and active citizenship.

SEE CHANGE

See Change is Ireland's national programme working to positively change social attitudes and behaviour so that there is a reduction in stigma and discrimination associated with mental health problems, ensuring that everyone enjoys the same rights on an equal basis. The aims and objectives of the See Change programme are:

1. Create an environment where people can be more open and positive in their attitudes and behaviour towards mental health
2. Promote greater understanding and acceptance of people with mental health problems
3. Create greater understanding and knowledge of mental health problems and of health services that provide support for mental health problems
4. Reduce stigma associated with mental health problems and challenge discrimination

The Training and Development Division represents the Mental Health Commission in the partnership and on the See Change advisory committees.

IRISH MENTAL HEALTH RECOVERY EDUCATION CONSORTIUM

The Training and Development Division represented the Mental Health Commission on the advisory group of the Irish Mental Health Recovery Education Consortium (IMHREC). Having come to a close on 31st March 2010, the purpose of the IMHREC consortium was to develop, deliver and evaluate a mental health recovery education programme, using the Wellness Recovery Action Planning (WRAP) approach during the course of 2009. The learning programme was designed to enable its participants to consider and adopt the WRAP recovery principles into their own lives and/or practice in order to achieve their own goals within a philosophy of recovery. The programme commenced with one day conferences and was followed with the facilitated learning programmes across three regional hubs in 2009 and was followed by a "Recovery Café" in February 2010. The final report on the independent evaluation of the project was published in 2010 and is available on the IMREC website.

The project was extremely well received and delivered Mental Health Recovery and WRAP training to almost 200 graduates across the country, 67 of whom are now qualified Mental Health Recovery and WRAP Facilitators who will be continuing to disperse the learning of the project now that it has finished.

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STRATEGIC PRIORITY FIVE
Social Inclusion & Active Partnership

The role of the Mental Health Commission was to advise and support the consortium in the design, delivery and evaluation of the mental health recovery and WRAP education programme. The Mental Health Commission approached IMREC regarding connecting in with the graduates of the Mental Health Recovery and WRAP Programme to assist in roll out of the National Mental Health Services Collaborative.

MEDICATION SAFETY FORUM

The Mental Health Commission was one of the stakeholder groups of the Medication Safety Forum which was set up and facilitated by HIQA in 2008. The terms of reference of the group was to provide those with an interest in the medication use process or in medication safety in Ireland an opportunity to come together to discuss relevant national issues and developments.

In keeping with the recommendation of the Commission on Patient Safety and Quality Assurance (CPSQA), regarding the establishment of clear communication structures between all bodies with a stake in the medication use process or medication safety, it was agreed that the Medication Safety Forum could be harnessed to assist with the implementation of the medication safety project's objectives. The terms of reference of the Medication Safety Forum evolved to allow the group to actively contribute to the implementation of the CPSQA report recommendations.

The main aim of the Medication Safety project is to develop initiatives that will improve the safety of medication prescribing, dispensing and administration and improve the safe use of medicines in all hospital, community and home settings.

The Medication Safety Forum Work Programme is progressing 28 projects in total. One of the projects led by the Mental Health Commission is a "Review of the use of Psychotropic Medication in Inpatient Psychiatric Units in 2010". As part of the annual inspection of approved centres by the Inspectorate of Mental Health Services copies of medication sheets were obtained from each unit inspected in 2010. The number of prescriptions for each psychotropic medication was calculated and recorded. The overall results are published in this report and will also be communicated to the forum for the purposes of progressing one of the objectives "Safe uses of Medicines – Initiatives addressing the safe use of medicines in High Risk Population".

NATIONAL DISABILITY ADVISORY COMMITTEE

The Mental Health Commission continues to contribute to the National Disability Advisory Committee, established by the Department of Health and Children for the purposes of:

- Provide a forum to inform policy at national level in relation to services for people with disabilities
- Form part of the overall monitoring mechanism in relation to the implementation of the National Disability Strategy in so far as it relates to the health services
- Advise the Minister for Health and Children on progress in the implementation of the Disability Act 2005 within the health services

COMPLAINTS AND ENQUIRIES

A steering group for a Joint Initiative on Complaints in Health and Social Care led by the Office of the Ombudsman was established in September 2010. The group comprises the Mental Health Commission, other members of the Health and Social Care Regulators' Forum, the HSE, the Citizens Information Board and service user representatives. The purpose of this group is to raise public awareness in the following areas:

1. Members of the public will know how to make a complaint or raise a concern/issue about health and social services
2. Members of the public can access easily understood information that describes the unique and contrasting roles of various bodies
3. Members of the public can access assistance in making their complaint/raising a concern

The steering group have identified five projects that could proceed at minimal cost and that will raise public awareness. A number of sub committees have been established to progress these projects. The projects are as follows:

- A dedicated web portal regarding how to make a complaint/raise a concern about health or social care services
- An informational leaflet and booklet
- A training manual for staff and advocates
- Updating of individual member websites to link with the Initiative outcomes
- A launch for the Initiative that will generate publicity

INTERNATIONAL INITIATIVE FOR MENTAL HEALTH LEADERSHIP (IIMHL)

The International Initiative for Mental Health Leadership (IIMHL) is a "Government-to-Government" initiative with seven participating Governments. The purpose of the initiative is to work towards improving mental health services by supporting innovative leadership processes. The Mental Health Commission was one of the hosts of the International Initiative for Mental Health Leadership annual (IIMHL) Exchange and Network meeting which took place from 17th to 21st May 2010. The Mental Health Commission hosted a two day exchange programme with a number of visiting leaders who signed up to attend the programme.

The Mental Health Commission was one of the partners supporting the exchange and conference and the Training and Development Division represented the Mental Health Commission on the steering group.

Following the exchange, the Mental Health Commission submitted an article for publication to the IIMHL Special Edition of the International Journal of Leadership in Public Services which is published after every leadership exchange.

WORLD MENTAL HEALTH DAY

World Mental Health Day is an international event which is annually held on 10th October. Each year there is a different theme which raises awareness about mental health and wellbeing. The 2010 World Mental Health Day campaign focused on *"Mental Health and Physical Illness"*. The Mental Health Commission marked the event by issuing a press release to all media stakeholders and worked in conjunction with MS Ireland and the Irish Heart Foundation in order to highlight the importance of the day.

STRATEGIC PRIORITY SIX 2009-2012
Efficiency of the MHC as an Organisation

- To maintain and enhance the Mental Health Commission's systems and processes to ensure the provision of a quality service by the Mental Health Commission.
- To continue to promote a culture within the organisation which reflects deep commitment to the Commission's stated values.
- To ensure that the Mental Health Commission is staffed by well trained, competent and committed people.
- To foster widespread understanding of the role and functions of the Mental Health Commission.

EXPENDITURE

The non-capital allocation to the Mental Health Commission for 2010 was €18.19 million from the Department of Health and Children. This figure was revised following discussion with the Department of Health and Children during the year as projected levels of expenditure in a number of areas did not proceed as expected. The provisional outturn for 2010 is €13,255,673.

Key areas of expenditure included Mental Health Tribunal's, staff salaries, legal fees, office rental, I.T technical support and development and research projects. Third party support contracts continued to be managed to ensure value for money and service delivery targets were met. The accounts for 2010 will be submitted to the Comptroller and Auditor General as per Section 47 of the Mental Health Act 2001. Following approval by the Comptroller and Auditor General the annual audited financial statements of the Mental Health Commission will be available on the Mental Health Commission website *www.mhcirl.ie.*

AUDIT COMMITTEE

The Mental Health Commission Audit Committee met on 4 occasions in 2010 to conduct its business. Issues addressed by the Audit Committee included the report on the internal audit review of internal financial controls, the report from the Comptroller and Audit General on the Mental Health Commission's financial statements for 2009, revised corporate governance framework, review of the Mental Health Commission's expenditure in 2010, and approval of the Whistle Blowing Charter for the Commission. Recommendations from the above reports were reviewed and incorporated into current procedures.

During 2010, the Commission carried out a review of operational policies and procedures in light of the revised Code of Practice for the Governance of State Bodies and has taken appropriate steps to ensure compliance.

FREEDOM OF INFORMATION

During 2010 the Mental Health Commission received 18 requests under the Freedom of Information Acts (1997 and 2003). Of these 17 were granted and 1 request was withdrawn.

DATA PROTECTION

1 request for information was received under the Data Protection Act in 2010. This request was granted.

INFORMATION COMMUNICATION TECHNOLOGY (ICT)

During 2010 the Mental Health Commission continued to enhance its existing ICT systems in order to improve the quality of data and increase efficiency in the area of Mental Health Tribunal scheduling. The Mental Health Commission also enhanced management reporting in the area of payments.

A project to replace out of warranty hardware for critical systems in the Mental Health Commission was initiated in 2010. IT Security policies were revisited to ensure applicability with new developments in technology and to ensure compliance with legislation or changes in legislation.

Disaster Recovery Plans were enhanced and tests carried out to ensure capability of the Mental Health Commission to fulfil its statutory duty under the Mental Health Act 2001 in the event of an untoward incident rendering our systems in St. Martin's House inoperable.

Steps were taken to improve the Records Management Policy in the Commission.

Extension of the Secure Messaging Centre to one Approved Centre was progressed in 2010 in preparation for further roll out in 2011.

HEALTH & SAFETY

The Mental Health Commission has reviewed and updated its Health and Safety statement. The annual health and safety Inspection was carried by the Safety Representative and all recommendations made were completed in 2010. Meetings were held on a regular basis with the Commission's staff Safety Representatives and the Safety Officer. Manual Handling training was carried out.

The Mental Health Commission has a number of proactive measures in place to protect staff health and wellbeing such as:

- Flu vaccination available to staff
- Fire Warden and First Aid training
- Personal Evacuation Egress Plans (PEEP) are made available to staff
- Ergonomic workstation assessments available to staff
- VDU eyesight test and eye tests made available to staff

STAFF DEVELOPMENT & TRAINING

In line with its strategic plan the Commission continued to support staff and ensure maximum staff engagement; by maintaining a programme of staff training and development in order to encourage learning and professional development for all staff.

The Commission enhanced the Performance Management Development System in 2010 to incorporate a competency scoring system directly related to staff training needs. The personal development and training plans, developed under the Performance Management and Development System, are the primary mechanism for submitting training requests to Corporate Services. In 2010 21% of the Commission staff received Study Assistance.

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STRATEGIC PRIORITY SIX
Efficiency of the MHC as an Organisation

SUPPORTS FOR STAFF WITH DISABILITIES

The Commission provides a positive working environment and in line with equality legislation, promotes equality of opportunity for all staff. Staff census update forms were made available to all staff, to update the record on the number of staff with disabilities.

The census results were included in a report published by the National Disability Authority (NDA).

When necessary the Commission has provided specialist equipment and /or measures to staff that require same to assist in their work. It is the policy of the Mental Health Commission to ensure that relevant accessibility requirements for people with disabilities are included in all stages of the tendering processes the Commission enters into.

In line with the Disability Act 2005, the Commission has in place an Access Officer. The Access Officer is responsible, where appropriate, for providing or arranging for and co-ordinating assistance and guidance to persons with disabilities accessing the services provided by the Commission.

ADDITIONAL INFORMATION

CONTACTING THE MENTAL HEALTH COMMISSION:

Mental Health Commission/Coimisiún Meabhair-Shláinte
St Martin's House, Waterloo Road, Dublin 4
Tel: (+353) 01 6362400 Fax: (+353) 01 6362440
Email: info@mhcirl.ie
Website: www.mhcirl.ie

Solicitors:
Arthur Cox
Earlsfort Centre
Earlsfort Terrace
Dublin 2
Tel: (+353) 01 6180000
Fax: (+353) 01 6180618
www.arthurcox.com

Accountants:
Crowleys DFK
16/17 College Green
Dublin 2
Tel: (+353) 01 6790800
Fax: (+353) 01 6790805
www.crowleysdfk.ie

Auditors:
Office of Comptroller and Auditor General
Treasury Block
Dublin Castle
Dublin 2
Tel: (+353) 01 6031000
Fax: (+353) 01 6031010
www.audgen.gov.ie

IRISH WEBSITES

Government Organisations

Department of Health & Children	www.dohc.ie
Government of Ireland	www.gov.ie
Public Service Information	www.citizensinformation.ie.

Health Service Executive

Health Service Executive	www.hse.ie
The Health Service Reform Programme	www.healthreform.ie

Independent & State Research Bodies/Organisations

The Economic and Social Research Institute	www.esri.ie
Health Research Board	www.hrb.ie
Irish Research Council for the Humanities & Social Sciences	www.irchss.ie
Irish Social Science Data Archive	www.ucd.ie/issda
National Institute of Health Sciences	www.nihs.ie
Irish Council for Bioethics	www.bioethics.ie

Mental Health Professional Organisations and Health Professional Organisations

The College of Psychiatry of Ireland	www.irishpsychiatry.ie
Association of Occupational Therapists of Ireland	www.aoti.ie
Irish Association of Social Workers	www.iasw.ie
Irish College of General Practitioners	www.icgp.ie
The National Council for the Professional Development of Nursing and Midwifery	www.ncnm.ie
National Service Users Executive	www.nsue.ie
The Psychological Society of Ireland	www.psihq.ie
Irish Association of Speech and Language Therapists	www.iaslt.ie

Mental Health Organisations and Advocacy Organisations

The Alzheimer Society of Ireland	www.alzheimer.ie
Aware	www.aware.ie
Bodywhys	www.bodywhys.ie
GROW	www.grow.ie
Headstrong	www.headstrong.ie
Inclusion Ireland	www.inclusionireland.ie
Irish Advocacy Network	www.irishadvocacynetwork.com

Mental Health Reform	www.mentalhealthreform.ie
Mental Health Ireland	www.mentalhealthireland.ie
Samaritans	www.dublinsamaritans.ie
Shine	www.shineonline.ie
STEER	www.steermentalhealth.com
The Irish Association of Suicidology	www.ias.ie

Other

Age & Opportunity	www.olderinireland.ie
Amnesty International - Irish Branch	www.amnesty.ie
Simon Communities of Ireland	www.simon.ie
Focus Ireland	www.focusireland.ie
Health Information & Quality Authority	www.hiqa.ie
HSE Libraries Online	www.hselibrary.ie
Irish Human Rights Commission	www.ihrc.ie
Irish Society for Quality & Safety in Healthcare	www.isqsh.ie
Law Reform Commission	www.lawreform.ie
National Federation of Voluntary Bodies	www.fedvol.ie
National Office for Suicide Prevention	www.nosp.ie
Ombudsman for Children's Office	www.oco.ie

Registration Bodies

An Bord Altranais	www.nursingboard.ie
Medical Council	www.medicalcouncil.ie

Staff Representative Organisations

IMPACT	www.impact.ie
Irish Hospital Consultants Association	www.ihca.ie
Irish Medical Organisation	www.imo.ie
Irish Nurses and Midwives Organisation	www.inmo.ie
Psychiatric Nurses Association of Ireland	www.pna.ie
SIPTU	www.siptu.ie

State Bodies

National Disability Authority	www.nda.ie
Office of the Minister for Children and Youth Affairs	www.omc.gov.ie

EUROPEAN, INTERNATIONAL, REFERENCE AND UK WEBSITES

European

Council of Europe	www.coe.int
HOPE	www.hope.be
Health – EU Portal	http://ec.europa.eu/health-eu/index_en.htm

International

United Nations – Human Rights	www.un.org/rights/
World Health Organization	www.who.int
World Federation for Mental Health	www.wfmh.org

Reference Sites

Guidelines International Network	www.g-i-n.net
The International Society for Quality in Healthcare	www.isqua.org
National Institute for Health and Clinical Excellence	www.nice.org.uk
The Cochrane Collaboration	www.cochrane.org

UK

Department of Health UK	www.dh.gov.uk
Medical Research Council	www.mrc.ac.uk
Mental Health Alliance	www.mentalhealthalliance.org.uk
Mental Health Foundation	www.mentalhealth.org.uk
Mental Welfare Commission for Scotland	www.mwcscot.org.uk
NHS Choices	www.nhs.uk
Health Information Resources	www.library.nhs.uk
The Royal College of Psychiatrists	www.rcpsych.ac.uk
SANE	www.sane.org.uk
Social Care Online	www.scie-socialcareonline.org.uk
Centre for Mental Health	www.centreformentalhealth.org.uk

2010

REPORT OF THE INSPECTOR OF MENTAL HEALTH SERVICES 2010

TUARASCÁIL AN CHIGIRE UM SHEIRBHÍSÍ MEABHAIR-SHLÁINTE

MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

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Elm Mount Unit, St Vincent's University Hospital
Jonathan Swift Clinic, St. James's Hospital
Lakeview Unit, Naas General Hospital
Lakeview Unit, Naas General Hospital – *Night Inspection*
Lakeview Unit, Naas General Hospital – *Re-Inspection*
Newcastle Hospital
St. Fintan's Hospital
St. Loman's Hospital, Mullingar
St. Loman's Hospital, Mullingar – *Night Inspection*
St. Loman's Hospital, Palmerstown

HSE DUBLIN NORTH EAST

Acute Psychiatric Unit, Cavan General Hospital
Department of Psychiatry, Connolly Hospital
Department of Psychiatry, Our Lady's Hospital, Navan
St. Aloysius Ward, Mater Misericordiae University Hospital
St. Brendan's Hospital
St. Brigid's Hospital, Ardee
St. Davnet's Hospital – Wards 4, 8 and 15
St. Ita's Hospital – Mental Health Services
St. Joseph's Intellectual Disability Services
St. Vincent's Hospital
Sycamore Unit, Connolly Hospital

HSE SOUTH

Acute Mental Health Admission Unit, Kerry General Hospital
Carraig Mór Centre
Centre for Mental Health Care and Recovery, Bantry General Hospital
Department of Psychiatry, St. Luke's Hospital Kilkenny
Department of Psychiatry, Waterford Regional Hospital
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Orchard Grove
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Highfield Private Hospital
Lois Bridges
Palmerstown View, Stewart's Hospital
St. Edmundsbury Hospital
St. John of God Hospital Limited
St. John of God Hospital Limited – *Re-inspection*
St Patrick's Hospital

CHILD AND ADOLESCENT SERVICES

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The Haven Children's Residential Unit
St. Anne's Child and Adolescent Mental Service, Galway
Warrenstown Child & Adolescent In-patient Unit
Willow Grove Adolescent Unit, St. Patrick's University Hospital

24 HOUR NURSE STAFFED COMMUNITY RESIDENCES

Ardamine House, Wexford
Ashbrook House, Leitrim
Ashford House, Longford
Cherryfield House, Killarney
Gallen House, Dublin
Glenmalure House, Blackrock Road, Cork
Knockroe House, Castlerea, Co. Roscommon
Quilca, Dublin
The Treatment Centre, Swinford
Unit 9B, Merlin Park Galway
Unit D, Vergemount, Dublin
Weir House, Cork Street, Dublin
Woodvale, Monaghan

HOME BASED TREATMENT TEAMS

Mayo Home Based Treatment Team
Monaghan Home Based Treatment Team

DAY HOSPITALS

Birr Day Hospital
Brook House, Waterford
Centre for Living, Blackrock
Connolly Norman House, Dublin
Day Hospital, Cavan General Hospital
Day Hospital, Ennis
Lincarra Day Hospital, Bray
Park View House Day Hospital, Letterkenny
Ravenscourt Day Hospital, Cork
Ros na Suan, Roscommon
St. Michael's Day Hospital, Castlebar, Co. Mayo
Tevere Day Hospital, Limerick

CRISIS HOUSE

Greenbanks Crisis House, Carlow

PRISONS

Forensic Psychiatric Service, Mountjoy Prison

NATIONAL OVERVIEW OF SERVICE USER, FAMILY/CARER AND ADVOCACY INVOLVEMENT IN MENTAL HEALTH SERVICES 2010

National Overview of Mental Health Services for Older People Report 2010
National Overview of Liaison Services 2010
National Overview of Service User, Family/Carer and Advocacy Involvement in Mental Health Services

SUPER CATCHMENT AREA REPORTS 2010

Carlow/Kilkenny/South Tipperary
Cavan/Monaghan/Louth/Meath
Donegal/Sligo/Leitrim/West Cavan
Dublin North
Dublin North West/Dublin North Central
Dublin West/South West/South City
Dun Laoghaire/Dublin South East and Wicklow (Including Drug Treatment Board)
Galway/Mayo/Roscommon
Kildare West Wicklow, Laois/Offaly and Longford/Westmeath
North Lee/North Cork
South Lee/West Cork/Kerry
Waterford/Wexford
TABLES: Super Catchment Area Services and Teams
TABLES: Super Catchment Area Staffing

THEMED REPORTS 2010

Article 15 Individual Care Plans Compliance 2010
Care Pathways 2010 Dublin Mid-Leinster
Care Pathways 2010 West
Overview of Rates of Compliance in Announced and Unannounced Inspections 2009 and 2010
Medication Report 2010
Overview of Inspections of Day Hospitals 2010
Overview of Inspections of 24 hour Residences 2010
Psychological Therapies Report 2010

NATIONAL REVIEW OF MENTAL HEALTH SERVICES 2010

MENTAL HEALTH ACT, 2001, SECTION 51:

The principal functions of the Inspector shall be:

(b) In each year, after the year in which the commencement of this section falls, to carry out a review of mental health services in the state and to furnish a report in writing to the Commission (The Mental Health Commission) on –

(i) the quality of care and treatment given to persons in receipt of mental health services,

(ii) what he or she has ascertained pursuant to any inspections carried out by him or her of approved centres or other premises where mental health services are being provided,

(iii) the degree and extent of compliance by approved centres with any code of practice prepared by the Commission under section 33(3)(e), and

(iv) such other matters as he or she considers appropriate to report on arising from his or her review.

1. INTRODUCTION

This is the seventh report of the Inspectorate of Mental Health Services as established under the Mental Health Act, 2001, and the fourth year in which approved centres were inspected against the rules, regulations, codes of practice and conditions.

Ireland's mental health services are still standing, but groggily so having taken a number of serious financial punches during the year.

Throughout the country, three topics dominated during inspections. The first was the unprecedented rate of staff retirement, in particular nurses (in many areas, 20 per cent of nurse staffing has been lost in the last year or two). The second was reduced resources and the third referred to the increased number of referrals to the specialist mental health services directly related to the economic recession.

For the most part, however, dedicated staff continue, to the best of their abilities, to cater for the needs of service users/patients.

As in any crisis, there was a range of responses from outright demoralisation to increased focus on resource-neutral improvements.

Some services got better, most remained the same and some disimproved.

The transition from Victorian-era buildings to modern settings continued slowly with reduced numbers residing in the old institutions.

2. INSPECTION 2010

Over and above the minimal statutory requirement to visit, inspect and report on all approved centres see pages 97-102 Appendix – Tables 1-5 list of Approved Centres and other components of Irish Mental Health Services inspected in 2010.

In addition, the Inspectorate continued the policy of follow-up of various reported incidents with a view to encouraging a culture of reflection and accountability and ultimately to improvement in services.

Incidents of prolonged seclusion were also the subject of meetings and correspondence with a number of approved centres.

The project arising out of the Section 55 Inquiry in the Clonmel Mental Health Services was also monitored.

3. THE INSPECTORATE OF MENTAL HEALTH SERVICES

Under Sections 50 and 54 of the Mental Health Act 2001, the Inspectorate is appointed by the Mental Health Commission (the Commission). The principal functions are outlined in Section 51 as stated at the beginning of this document.

The Inspectorate operates independently. The Commission, as one of its functions, regulates mental health services on the basis of Inspection reports and other factors.

Regulatory action may include removal of an approved centre from the register or the imposition of conditions on the registration.

When matters of serious concern arise during an inspection, the approved centre and the CEO of the Commission are informed immediately and, in most case, immediate appropriate remedial action takes place.

Matters of intermediate level of concern are managed by ongoing interaction between the Inspectorate and the particular approved centre to achieve the desired improvement. This may involve a number of re-inspections, mainly focused on areas of concern.

The Inspectorate and the Commission have established a close, collaborative relationship in order to provide a more comprehensive and understandable picture of improvements or otherwise within services over time.

Failure to improve may also attract the attention of a condition on registration.

Particular focus is placed during inspections on adherence to these conditions.

Over and above such technical aspects, the Inspectorate sees its role as that of catalyst to the changing of attitudes, opening of minds and ultimately to the improvement of services.

4. ENCOURAGING DEVELOPMENTS 2010

4.1 Following the imposition of a condition by the Mental Health Commission on St. Brendan's Hospital, acute admissions from the community no longer take place. Admissions now are to the Pine Unit at Connolly Hospital.

4.2 Plans are now well advanced for the establishment on the St. Brendan's campus of two new modern units.

4.3 Again, following the imposition of conditions by the Commission, plans are also well advanced at St. Senan's Hospital to cease acute admissions.

4.4 At St. Ita's Hospital, acute admissions will no longer take place to the present inappropriate admission wards from early 2011.

4.5 In addition, the long-sought acute psychiatric unit at Beaumont Hospital appears to be nearing realisation with building due to commence shortly.

4.6 Overall, a satisfactory building programme has taken place in various locations throughout the country.

4.7 Individuals with intellectual disabilities are no longer housed in the inappropriate setting of St. Luke's Hospital, Clonmel.

4.8 The project team arising out of the Section 55 Inquiry Report of Clonmel continues to operate effectively and is bolstered by the addition of €20 million in funding. This project has now become integrated into a wider "super catchment" project which will involve a reduction of acute beds to the numbers recommended in *A Vision for Change* and the addition of home-based treatment teams, community nurse units, day hospitals and crisis housing.

4.9 Last year's Inspectorate Report made favourable comment on the appointment of the 14 Executive Clinical Directors (ECD's). The progress made in establishing "super-catchment" governance structures as envisaged in *A Vision for Change*, has been slow, but encouraging nonetheless.

4.10 Provision of Child and Adolescent Mental Health Service (CAMHS) beds in more suitable facilities in Galway and in Cork is welcomed.

4.11 The establishment of 11 beds in Willow Grove Child and Adolescent Service at St. Patrick's Hospital is also welcomed.

4.12 The second national audit of CAMHS services organised by Dr. Brendan Doody of the HSE is a positive development and one which should be emulated by other aspects of the services.

4.13 More training on the concepts of recovery and service user/patient involvement is taking place in a greater number of areas throughout the country.

4.14 A number of approved centres achieved full compliance with the rules, regulations and codes of practice. These were St. Stephen's Hospital in Cork, St. Patrick's Hospital in Dublin and St. Edmundsbury Hospital in Dublin.

4.15 Achieving this platform will allow the Inspectorate in 2011 to look for and encourage more sophisticated quality improvement activities in these centres.

4.16 *Inpatient Specialisation* – A number of centres have adopted the practice (some on a pilot basis) of managing inpatient services by dedicated consultants/teams. On a theoretical basis at least, this should obviate the chaos which can ensue when a large number of teams (sometimes up to 10) are admitting to a particular psychiatric unit.

The practice should also more easily allow the adoption of and compliance with a coherent and consistent set of unit policies. With better organisation and less chaos, less violent incidents should occur.

This is little in the way of an evidence base yet that this system will yield particular benefits. However, data on this practice should be published and debate should ensue[1].

4.17 The development of the residential unit at Knockamann at St. Joseph's Hospital Portrane (for the intellectually disabled) was finally opened in 2010 and is an excellent example of how these services should be organised in the future.

4.18 The "See-Change" initiative to reduce the stigma of mental illness is welcomed.

4.19 We welcome the joint statement of the An Bord Altranais and the Commission which states that nursing care plans (which, in general, are excellent) need not exist independently and can be incorporated into the multi-disciplinary team individual care plan. There is a reasonable expectation that this development will result in improvement of individual care plans in general.

4.20 We welcome the National Mental Health Services Collaborative (NMHSC) on Individual Care Planning and look forward to the results next year.

[1] Burns, T., *The Dog that Failed to Bark*, Psychiatrist 2010, **34**, 361-3.

5. OPPORTUNITIES

All crises provide opportunities. In this particular crisis, opportunities exist for clear thinking regarding mission and what services should be provided under the rubric of mental health services as defined under the Mental Health Act 2001[2].

Services which are not essential to this mission can be pruned. Clear policies can be developed with respect to admission and early discharge. Acute beds in excess of those recommended in *A Vision for Change* can be reduced in number and staff re-deployed to provide community-based services.

Clinicians will be obliged to realign their practices more closely with *A Vision for Change* with primary focus on community treatment and with hospitalisation only as a last resort.

Executive Clinical Directors now have the supervisory power to lay down clear guidelines and policies with respect to criteria for admission, discharge, acceptance into the service and monitoring of quality and performance.

[2] "Mental Health Services means services which provide care and treatment to persons suffering from a mental illness or mental disorder and under the clinical direction of a Consultant Psychiatrist."

6. AREAS OF CONCERN 2010

6.1 The continued absence within the HSE of a Mental Health Services Directorate with full executive and budgetary powers is still problematic for the proper governance of the services and impedes badly needed change.

Mental health services have been traditionally neglected, need radical reform/ modernisation, are chronically under-resourced and deal with individuals with severe conditions which adversely affect themselves, their families and society.

A blueprint for change is already in place, *A Vision for Change (2006)*. To implement it, a system of stream-lined, focused governance should be in place.

6.2 *Individual Care Plan* – The existence and quality of Individual Care Plans remains disappointing. In many cases, this is a mere "paper exercise" and, in some cases, we found deliberate decisions not to implement the plans.

In the 2009 Inspectorate Report, we highlighted[3] the whole area of care planning and provided examples of satisfactory templates.

The concept of service user/patient involvement in the preparation of the plan is still weakly understood.

The absence of proper care planning is emblematic of the failure by a number of teams (and in this regard, a small number of Consultant Psychiatrists must shoulder the responsibility as leaders of multi-disciplinary care teams) to embrace the philosophical underpinnings of a modern mental health service. These are patient-centeredness, recovery, multi-disciplinary teamwork, and primarily community-based services.

6.3 We have received numerous reports throughout the country from advocates and service users/patients of their dissatisfaction with the absence of inpatient therapeutic activities or planned recreational activities.

Therapeutic activities should be linked to the care plan, should be individualised and focused on specified goals. Progress towards these goals should be measured.

Without care planning and associated therapeutic input, hospitalisation is largely custodial and focused narrowly on physical treatments.

[3] http://www.mhcirl.ie/Publications/Annual_Reports/MHC_AR09.pdf

6.4 The practice of using the beds of the mental health services indiscriminately and as a default for the generally vulnerable, but not mentally ill, or worse, for those who would abuse the service for their own ends, is a cause for concern.

The beds in approved centres should be for the exclusive use of those with serious mental illness whose symptoms cannot be managed safely in the community.

The practice of admitting children with social problems to psychiatric beds referred to in last year's report, remains prevalent.

Lack of proper discrimination is a disservice to those genuinely mentally ill service users/patients requiring focused treatment and contributes to unnecessary lengths of hospital stay.

6.5 An unfortunate casualty of funding reductions is the difficulty in maintaining mandatory training. The national training in ECT provided by St. Vincent's University Hospital has not been funded centrally and its continuation is in doubt.

6.6 *Community Nursing Units* – The development of these units as alternatives to the old buildings is welcome and should provide improvement in physical infrastructure and lay-out for residents. However, they should not become mini-institutions in the community and former custodial and patronising attitudes should not continue.

6.7 The incidence of violent episodes in approved centres is reported to us as increasing. We have found that risk assessments and management are, in general, not sufficiently thorough or comprehensive.

6.8 An increasing difficulty exists throughout the country in the placement of "civilly dangerous" service users/patients. These are individuals who have no criminal charges, but have a strong history of violence in the context of mental illness and are known to be violent. We have discovered examples of security personnel on duty around the clock monitoring those considered "dangerous". If such personnel require to be on acute units, this should be for serious and rare situations. Proper training in control and restraint and in dealing with people with mental health problems should be provided.

A number of services have reported to us dissatisfaction with the inability of the forensic services to provide for this type of individual.

It has been suggested that a national forum comprising the forensic service and civil mental health services throughout the country be established to lay down transparent and reasonable criteria for placement in forensic rehabilitation.

6.9 The absence of the four Intensive Care Rehabilitation Units (ICRU) as recommended in *A Vision for Change,* of course, compounds this problem. There is an increasing body of opinion within community psychiatry that ICRU's should be managed by the local community services with close liaison with the national forensic services obviously very important.

6.10 The practice of seclusion and mechanical physical restraint varies widely throughout the country.

Seclusion and restraint should be measures of last resort and their long-term use cannot be regarded as therapeutic.

The Inspectorate monitors seclusions longer than 72 hours and more than 7 episodes in 7 days and has noticed an increase in the frequency of these practices.

We have also noticed carelessness regarding the completion of seclusion forms. This carelessness must reflect an indifference to or at least a lack of understanding of the threat to the human rights and the dignity of the person subjected to these practices and the importance of strict adherence to the "letter of the law".

6.11 We have found examples of glaring ignorance of aspects of the Mental Health Act.

Recently, we discovered a number of examples of flouting of Section 60 of the Mental Health Act[4]. Many nurses have expressed frustration that it seems to be their responsibility "to chase the doctors..."

Lack of respect for the Act can only be interpreted as lack of respect for service users/patients.

6.12 Some approved centres, especially of a more long-stay nature, have arranged that local General Practitioners provide the physical care and treatment of the residents. This in itself is an excellent arrangement.

However, too often we have seen medical notes which have not been integrated with the general body of progress notes. This practice is dangerous, in breach of regulations and should be discontinued.

6.13 At our National Meeting for Liaison Mental Health Services, we discovered there were large areas of the country where no formal liaison service is provided. Rather, local community psychiatrists heroically "help out" their hospital medical colleagues on an ad hoc basis without proper funding.

6.14 The attendance of adults and children with acute mental health problems at hospital emergency departments as a first port of call appears to be on the increase. These service users/patients should be seen whenever possible at community mental health centres for initial assessment even on a 24/7 basis.

It is not the role of the liaison mental health services to provide an emergency service for community mental health services. Confusion in this regard causes service user/patients inappropriate inconvenience (with long waiting times in emergency departments) and, in some cases, inappropriate treatment.

6.15 We were surprised by the workload in psychiatry of old age which is accounted for by liaison services. This is an area which should be carefully audited and appropriate services planned according to need.

[4] S 60 refers to the requirement for second opinion for those receiving medication without consent for 3 months.

6.16 We remain concerned that in times of financial crisis, the "communitisation" process is being reversed in some instances. Staff shortages in approved centres have been staunched by redeployment of community staff.

6.17 We remain concerned at the number of children, aged 16 and 17, who attend adult emergency departments and who are admitted on an acute basis to adult approved centres. This signifies a gap in the CAMHS Services with respect to the provision of acute services for children. Liaison with private approved centres catering for this vulnerable age group might provide a solution to their placement in adult beds.

6.18 We are concerned with reports from advocacy groups that "sometimes staff are too busy to talk..."

The provision of mental health services is fundamentally a human interaction. All mental health staff should have core competency in and protected time for basic psychotherapy.

6.19 The under-provision of expertise in dealing with the difficulties caused by substance abuse/dependence in mental health settings, is a disservice to service user/patients and causes difficulties in managing services.

6.20 Inadequate number of and filling of community mental health multi-disciplinary teams continues to be a source of worry.

6.21 Apart from some pockets, there is still widespread ignorance of the principles of recovery.

It should be a condition of continued registration of mental health professionals that competence in the area of recovery is demonstrated in theory and in practice.

6.22 We have noted high rates of prescribing of sedative medications in many centres.[5] Prescribing practices should be continually audited against best practice.

[5] See 2010 Inspectorate report on Prescribing on *www.mhcirl.ie*

7. IMPLEMENTING *'A VISION FOR CHANGE'* (2006)

This document represents a major shift in the philosophical approach to mental health and the provision of mental health services.

Although *Vision* contains many concrete and excellent prescriptive recommendations with respect to structures and numbers, implementation will not occur without clear focus on and understanding of a number of basic principles, the most important of which are:

BASIC PRINCIPLES:

7.1 The person with a mental condition requiring intervention is the most important element in the whole enterprise.

7.2 People with serious mental conditions can recover and lead fulfilled lives.

7.3 The essence of a dignified fulfilled life is a reasonable degree of respect and personal autonomy.

7.4 The process of institutionalisation can rob people of these essential human rights.

7.5 Where possible, treatment should be, as much as possible, in the community.

7.6 Mental health needs are complex and involve an intricate interplay of biological, social, psychological, cultural and spiritual factors.

7.7 These can only be addressed by a multi-disciplinary team working in harmony.

7.8 The primary aim of the mental health services is not necessarily to remove symptoms or cure illnesses, but to facilitate and promote the autonomous improvement of the lives of those with mental illness.

7.9 The overall greater good of society and individuals with mental health problems will be best served by careful identification, management and judicious tolerance of risk.

HOW CAN THESE PRINCIPLES BE ADOPTED WITHIN THE HSE?

There are a number of essential conditions for this type of change:

1) A major investment in change management expertise.

2) A streamlined structure with proper governance. This must involve a separate Mental Health Services Directorate.

3) Harnessing the natural leadership within the organisation at more local levels.

CONSULTANT PSYCHIATRISTS:

Much should be expected of Consultant Psychiatrists in terms of leadership. By law, individuals cannot be admitted involuntarily to approved centres without the signature of a Consultant Psychiatrist. Similarly, the decision to discharge is usually that of the Consultant Psychiatrist.

Consultant Psychiatrists can be the solution to the current impasse in the modernisation of services.

Put simply, if Consultant Psychiatrists admitted less and discharged more quickly, the number of acute beds recommended in *A Vision for Change* would soon be realised.

The counter-argument, often used, is that hospital beds cannot be emptied until the full range of community-type services are in place. This is unlikely to happen, even in a resource-plenty environment as it will require duplication of services.

Rather, if beds are closed, former inpatient staff can and must now be redeployed to operate in the community, first in day hospitals and then by use of home-based treatment teams.

With patient explanation and support for carers and families, the expectation of an automatic admission to hospital can be neutralised. Families and service users/patients will soon see that community-based services are more humane, provide greater autonomy and, importantly, mitigate the loss of social skills.

Of course, merely deploying current staff working in unnecessary acute units will not give rise overnight to a "perfect" service. It will still be decidedly imperfect until the proper range and extent of multiple disciplines are provided. However, this arrangement will be less imperfect than the current one whereby with 1300 acute beds *(A Vision for Change recommends 650),* at any given time, it could be said that 650 service users/patients are not receiving appropriate treatment.

The difficulties involved in achieving this change in mentality among Consultant Psychiatrists should not be underestimated. Much training and re-training, argument and debate will be required.

But, it is not impossible. In Ireland today, there are many examples of Consultant Psychiatrists who practice along these lines.

There are two important groups who can change the philosophical stance of the majority of Consultant Psychiatrists: the ECD Group who should set and implement operational standards and the College of Psychiatry in Ireland, the professional representational body, which should support and provide the necessary training.

By making a firm commitment to overhaul old practices with respect to admission/discharge and to focus on nationally agreed, clear, identifiable and auditable criteria for admission, one of the philosophical underpinnings of *A Vision for Change,* i.e., communitisation, could be achieved.

Although patronising attitudes can still be perpetrated in the community, it is more likely in a community setting that the seeds of recovery will receive more daylight and will be more likely to flourish.

A matter which will arise in any debate on how to achieve a primarily community based service will be the current treatment afforded to those "private" service users/patients whose primary component of care is hospital with minimal outpatient or community involvement.

8. CONCLUSIONS

8.1 The philosophical change required to implement *A Vision for Change* in Ireland's Mental Health Services has not yet occurred.

8.2 A number of encouraging developments have taken place during 2010 reflecting efforts to improve the services.

8.3 Of the number of concerns identified, many, at their core, represent an as-yet inadequate grasp and commitment to the principles underlying *A Vision for Change*.

8.4 Deep attitudinal change can only occur by commitment to change management, adequate governance infrastructure and the persuasion of local opinion leaders.

8.5 This requires a semi-autonomous Mental Health Services Directorate with strong executive and budget powers.

8.6 During a financial crisis, it is imperative that the human rights and the dignity of vulnerable members of society are protected.

8.7 A financial crisis offers the opportunity for clearer thinking with respect to priorities.

ACKNOWLEDGEMENTS

The major task of completion of the 2010 Inspection reports was only achieved by the dedication and commitment of all members of the Inspectorate team, inspecting and administrative, whose contribution is greatly appreciated. Thanks are also due to all staff members of mental health services both clinical and administrative without whose cooperation the inspection reports would not have been achieved. Particular thanks are due to Colette Ryan, Senior Administrator of the Inspectorate.

Dr. Patrick Devitt
Inspector of Mental Health Services
MCN: 04321
January 2011

Postscript: The Commitment in the March 2011 Programme for Government to "ring fence" €35 million for community mental health services is most welcome. Maximum value from this important investment will require a National Director and Directorate of Mental Health Services with executive and budgetary powers.

APPENDIX

Table 1: Approved Centres Inspections 2010

Approved Centre	Date of Inspection	Date(s) of Re-Inspection	Announced/ Unannounced visit
Acute Psychiatric Unit, Kerry General Hospital	23 June 2010	–	Unannounced
Acute Psychiatric Unit 5B, Midwestern Regional Limerick	15 April 2010	–	Announced
Acute Psychiatric Unit, AMNCH	23 March 2010	–	Unannounced
Acute Psychiatric Unit, Carnamuggagh	16 June 2010	–	Unannounced
Acute Psychiatric Unit, Cavan General Hospital	6 May 2010	–	Announced
Acute Psychiatric Unit, Midwestern Regional Hospital, Ennis	8 September 2010	–	Unannounced
Adolescent In-Patient Unit, St. Vincent's Hospital	10 June 2010	–	Announced
Adult Mental Health Unit, Mayo General Hospital	24 February 2010	2 June 2010	Unannounced
An Coillín	24 February 2010	–	Unannounced
Ballytivnan Sligo/Leitrim Mental Health Services	13 October 2010	–	Announced
Bloomfield Care Centre- Donnybrook, Kylemore, Owendoher and Swanbrook Wings	11 February 2010	–	Unannounced
Cappahard Lodge	9 September 2010	–	Unannounced
Carraig Mór Centre	22 September 2010	–	Announced
Central Mental Hospital	7 October 2010	–	Unannounced
Centre for Mental Health Care and Recovery	24 June 2010	–	Unannounced
Child and Adolescent Mental Health In-Patient Unit, St. Stephen's Hospital	8 April 2010	–	Unannounced
Department of Psychiatry, Connolly Hospital	11 May 2010	–	Announced
Department of Psychiatry, County Hospital, Roscommon	7 April 2010	–	Announced
Department of Psychiatry, Midland Regional Hospital, Portlaoise	1 April 2010	–	Unannounced
Department of Psychiatry, Our Lady's Hospital, Navan	9 March 2010	–	Announced
Department of Psychiatry, St. Luke's Hospital, Kilkenny	4 August 2010	–	Announced

Approved Centre	Date of Inspection	Date(s) of Re-Inspection	Announced/ Unannounced visit
Department of Psychiatry, Waterford Regional Hospital	22 April 2010	–	Announced
Elm Mount Unit, St. Vincent's University Hospital	22 July 2010	–	Announced
Hampstead Private Hospital	9 February 2010	–	Unannounced
Highfield Private Hospital	9 February 2010	–	Unannounced
Jonathan Swift Clinic	3 November 2010	–	Unannounced
Lakeview Unit, Naas General Hospital	16 (night inspection) and 17 June 2010	7 September 2010	Unannounced
Lois Bridges	15 July 2010	–	Announced
Newcastle Hospital	18 February 2010	–	Unannounced
Orchard Grove	9 September 2010	–	Unannounced
Palmerstown View, Stewart's Hospital	3 February 2010	–	Unannounced
Psychiatric Unit, University College Hospital Galway	19 May 2010	–	Unannounced
South Lee Mental Health Unit, Cork University Hospital	21 September 2010	19 October 2010 (night inspection) and continued on 20 October 2010	Revisit Unannounced
St. Aloysius Ward, Mater Misericordiae University Hospital	7 July 2010	–	Announced
St. Anne's Child and Adolescent Unit, Galway	20 May 2010	–	Unannounced
St. Anne's Unit, Sacred Heart Hospital	2 June 2010	–	Unannounced
St. Brendan's Hospital	15 June 2010	–	Unannounced
St. Brigid's Hospital, Ardee	8 April 2010	–	Announced
St. Brigid's Hospital, Ballinasloe	18 May 2010	–	Unannounced
St. Canice's Hospital	4 August 2010	–	Announced
St. Conal's Hospital, Letterkenny *	16 June 2010	–	Unannounced
St. Davnet's Hospital – Wards 4, 8 and 15	5 May 2010	–	Announced
St. Dympna's Hospital	5 August 2010	–	Unannounced
St. Edmundsbury Hospital	16 March 2010	–	Announced
St. Finan's Hospital	24 June 2010	14 December 2010	Unannounced
St. Finbarr's Hospital	22 September 2010	–	Announced
St. Fintan's Hospital, Portlaoise	1 April 2010	–	Unannounced
St. Ita's Hospital-Mental Health Services	14 July 2010	–	Announced
St. John of God Hospital Limited	10 August 2010	18 November 2010	Revisit Unannounced

Approved Centre	Date of Inspection	Date(s) of Re-Inspection	Announced/ Unannounced visit
St. Joseph's Hospital, Limerick	14 April 2010	21 October 2010	Revisit Unannounced
St. Joseph's Intellectual Disability Services	14 July 2010	–	Announced
St. Loman's Hospital, Mullingar	1 June 2010 (night inspection) and 2 June 2010	–	Unannounced
St. Loman's Hospital, Palmerstown	23 March 2010	–	Unannounced
St. Luke's Hospital, Clonmel	28 January 2010 (night inspection)	19 August 2010	Unannounced January
St. Michael's Unit, Mercy University Hospital	23 September 2010	–	Announced
St. Michael's Unit, South Tipperary General Hospital	28 January 2010 (night inspection)	19 August 2010	Unannounced January
St. Otteran's Hospital	20 April 2010	–	Announced
St. Patrick's University Hospital	11 March 2010	–	Announced
St. Senan's Hospital	21 April 2010	–	Announced
St. Stephen's Hospital	7 April 2010	–	Unannounced
St. Vincent's Hospital, Fairview	9 June 2010	–	Announced
Sycamore Unit, Connolly Hospital	13 May 2010	–	Announced
Teach Aisling	24 February 2010	–	Unannounced
Tearmann Ward and Curragour Ward, St. Camillus' Hospital	24 March 2010	–	Unannounced
The Haven Children's Residential Unit	9 February 2010	–	Unannounced
Warrenstown Child and Adolescent In-Patient Unit	16 February 2010	–	Unannounced
Willow Grove Adolescent Unit, St. Patrick's University Hospital	3 November 2010	–	Announced

* Following receipt of correspondence by the Mental Health Commission St. Conal's Hospital, Letterkenny was removed from the Register of Approved Centres on 8 July 2010.

Table 2: Other Mental Health Services Inspections 2010

Other Mental Health Service	Name	Date of Inspection	Announced/ Unannounced Visit
24 Hour Nurse Staffed Community Residence	Ardamine, Gorey, Wexford	21 April 2010	Announced
24 Hour Nurse Staffed Community Residence	Ashbrook, Leitrim	14 October 2010	Announced
24 Hour Nurse Staffed Community Residence	Ashford House, Longford	2 June 2010	Unannounced
24 Hour Nurse Staffed Community Residence	Cherryfield House, Killarney	23 June 2010	Unannounced
24 Hour Nurse Staffed Community Residence	Treatment Centre, Swinford, Mayo	25 February 2010	Unannounced
24 Hour Nurse Staffed Community Residence	Gallen House, Howth Road, Dublin	9 June 2010	Announced
24 Hour Nurse Staffed Community Residence	Glenmalure House, Cork	21 September 2010	Announced
24 Hour Nurse Staffed Community Residence	Knockroe House, Castlerea, Roscommon	8 April 2010	Announced
24 Hour Nurse Staffed Community Residence	Quilca, Dublin South City	29 September 2010	Announced
24 Hour Nurse Staffed Community Residence	Unit D, Vergemount, Clonskeagh	21 October 2010	Announced
24 Hour Nurse Staffed Community Residence	Unit 9B, Merlin Park University Hospital, Galway	19 May 2010	Unannounced
24 Hour Nurse Staffed Community Residence	Weir Home, North West Dublin	25 March 2010	Announced
24 Hour Nurse Staffed Community Residence	Woodvale, Monaghan	5 May 2010	Announced
Care Pathway	East Location	4 November 2010	Announced
Care Pathway	West Location	10 September 2010	Announced
Crisis House	Greenbanks, Carlow	27 May 2010	Announced
Home Based Treatment Team	Mayo	25 February 2010	Unannounced
Home Based Treatment Team	Monaghan	5 May 2010	Announced
Day Hospital	Birr, Co. Offaly	31 March 2010	Announced
Day Hospital	Ravenscourt, Cork	21 September 2010	Announced
Day Hospital	Cavan	5 May 2010	Announced
Day Hospital	Centre for Living, Cluain Mhuire, Blackrock, Dublin	10 August 2010	Announced
Day Hospital	Connolly Norman House, NCR, Dublin	16 March 2010	Announced
Day Hospital	Park View House, Donegal	17 June 2010	Unannounced
Day Hospital	Ennis, Clare	9 September 2010	Unannounced

Other Mental Health Service	Name	Date of Inspection	Announced/ Unannounced Visit
Day Hospital	Ros Na Suan, Roscommon	6 April 2010	Announced
Day Hospital	Tevere, Limerick	15 April 2010	Announced
Day Centre	Lincara Day Centre, Bray	25 March 2010	Announced
Day Hospital	St. Michael's Castlebar, Mayo	25 February 2010	Unannounced
Day Hospital	Brook House, Waterford	21 April 2010	Announced
Prison Service	Mount Joy Prison	6 April 2010 and meeting held on 11 June 2010	Announced

Table 3: Super Catchment Area Meetings 2010

Super Catchment Area Meeting	Date of Meeting
Kildare West Wicklow/Laois/Offaly and Longford/Westmeath	22 June 2010
Galway, Mayo and Roscommon	29 June 2010
Cavan/Monaghan/Louth/Meath	6 July 2010
Dublin North Central/Dublin North West	13 July 2010
Waterford/Wexford	27 July 2010
Donegal, Sligo/Leitrim and West Cavan	7 September 2010
Carlow/Kilkenny and South Tipperary	14 September 2010
South Lee, West Cork and Kerry	20 September 2010
North Cork/North Lee	21 September 2010
Limerick, North Tipperary and Clare	28 September 2010
Dublin West, South West and Dublin South City	5 October 2010
Dun Laoghaire, Dublin South East and Wicklow	2 November 2010
North Dublin	16 November 2010
Super Catchment Area Data Tables	–

Table 4: National Overview Meetings 2010

National Overview Meetings	Date of Meeting
Liaison Mental Health Services	9 November 2010
Mental health Services for Older People	23 November 2010
Service User, Family/Carer and Advocacy Involvement in mental health Services	30 November 2010

Table 5: Themed Reports 2010

Themed Reports
Medication
Overview of Inspections of Day Hospitals
Overview of Inspections of 24 Hour Nurse Staffed Community Residences
Overview of Rates of Compliance in Announced and Unannounced Inspections in 2009 and 2010
Psychological Therapies
Compliance with Article 15 Care Planning Table