Working together for quality mental health services

Mental Health Commission Annual Report 2012 Including Report of the Inspector of Mental Health Services

Our Vision

Working together for quality mental health services

Our 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

I am pleased to present the 2012 Annual Report of the Mental Health Commission which includes the report of the Inspector of Mental Health Services. The present Commission took office in April 2012.

At the heart of Irish Government Policy as espoused in A Vision for Change are concepts such as recovery, person centeredness, partnership, user and family involvement and the delivery of multidisciplinary community based services. It is my opinion that much of the implementation to date has been achieved by innovative and imaginative clinical and administrative leadership at regional and local levels. There is considerable commitment to the policy. Despite these actions the policy is being implemented unevenly and inconsistently across the country and there is a requirement for innovative actions to be supported and reinforced by strong corporate governance at national level.

In June 2012 the second independent monitoring group, which monitored the implementation of the policy, came to the end of its term creating a vacuum which has yet to be filled. As per the recommendations in A Vision for Change, the last monitoring group recommended a review of the implementation of *a Vision for Change*, and the Commission enthusiastically supports this.

Of course financial resources are required to ensure the policy is implemented. The Commission welcomed the €35 million budget allocation for revenue spending in 2012 on the development of community mental health teams, a core element of A Vision for Change. We were disappointed that the filling of the required posts was then delayed until December 2012, but welcome the fact that this money appears to have been preserved, and in addition to the €35 million allocated for 2013 means that €70 million is now allocated for spending on community mental health teams in 2013.

Since 2007, staffing in mental health services has been reduced by the implementation of recruitment embargoes and employment moratoriums. Whilst these instruments are undoubtedly effective in reducing the bottom line cost of services, they are rather blunt in terms of planning and developing comprehensive community mental health services. The medium and long term effect of such policies is to endanger the delivery of confident and responsive community based services as envisaged in A Vision for Change. This situation needs to be reversed by the continued allocation of new revenue for the full development of community mental health teams and concomitant services. This would require a change in approach to recruitment to ensure that all allied health professionals with a special interest in mental health are recruited as opposed to the current geographical selection process.

Of course we are aware too that more than €70 million has been lost due to public service expenditure reductions. However the net effect of these reductions and the allocation of new funding is the shifting of resources from old to new services. The Commission is supportive of this modification in spending priorities.

The incoming Commission is also pleased to see the continued progress towards ending the use of outdated and unsuitable buildings to provide inpatient services. There continued to be a reduction in the bed capacity in the older approved centres in 2013. There were 1,352 beds in such premises at the end of 2009, while there were just 394 at the start of 2013. This trend is to be welcomed, and the Commission stresses the need for the continued development of community mental health services to replace traditional models of inpatient care.

The concept of recovery – that mental health services are designed to assist in a person's recovery rather than simply to "manage" their illness – is now well understood. Implementation of it is uneven, however. The information provided in this report points to a serious deficiency in the development and provision of recovery oriented mental health services. Service delivery is still largely delivered by medical psychiatric and mental health nursing staff. There is still a significant absence of psychology, social work, occupational, and other multidisciplinary team members.

In order for a fully developed recovery oriented service to be delivered there needs to be a cultural shift in how we deliver services away from a linear medical model towards a more holistic bio-psychosocial one. There needs to be a change in attitudes and behaviours so that all staff delivering mental health services are trained in recovery competencies, work in a partnership style with service users and their families and work cohesively with other mental health professionals to provide an integrated, responsive and person centred service that responds to the needs of individuals and their families in a timely and appropriate manner. The development of a systematic recovery initiative 'Advancing Recovery in Ireland' by the HSE is a promising one.

Appointments to the posts of Directors Designate have been made within the HSE. The Commission welcomes in particular the appointment of Director Designate of Mental Health Services although it is concerned about the lack of clarity vis a vis the strategic and operational responsibilities of the post and its relationship with other management structures.

The Commission is also concerned regarding a number of specific areas of service provision which impinge on human rights and where, in 2012, standards fell below what is acceptable.

In principle, for example, it is accepted that each service user should have their own individualised care plan, designed to assist in their recovery. In practice, not all mental health services have developed and are using standardised multidisciplinary care plans.

The extent of the continued usage of seclusion and physical restraint is unacceptable.

The Mental Health Commission has recently published a report on ECT activity for 2011. The Commission is still concerned that ECT can be administered to detained persons against their will.

In relation to younger service users, there is still a most unsatisfactory situation whereby children are being admitted to adult units – there were 106 such admissions in 2012.

The Minister of State is currently conducting a review of the Mental Health Act 2001, with a view to enhancing compliance with international human rights legislation. The Commission is very supportive of this process and looking forward to working within the jurisdiction of an amended Act.

There are other areas where progress remains slow and is a cause of frustration. Mental capacity legislation, now to be called "assisted decision making legislation", is promised. At the time of writing it has been announced that the legislation will be brought before the cabinet before end of June 2013. Similarly Ireland's name remains absent from the list of signatories of the UN Convention on the Rights of People with Disabilities.

Finally, I would like to thank the members of the Commission for supporting me in my first year as Chairman. I would like to thank the Chief Executive Patricia Gilheaney, the senior management team and all of the Mental Health Commission staff for their support and commitment to the Commission.

John Saunders

Chairman

Chief Executive's Introduction

This is the eleventh Annual Report of the Mental Health Commission, and it includes the Report of the Inspector of Mental Health Services for the year ended December 31st 2012 in accordance with Section 42 of the Mental Health Act 2001.

The Annual Report sets out the programme of work we undertook in 2012 and the progress made towards achieving our strategic objectives as set out in our Strategic Plan 2009-2012.

Having consulted widely with stakeholders in the third quarter of 2012 as part of the planning process for our new Strategic Plan, we recognised that a greater understanding of our remit and core activities was required. Therefore, the 2012 Report is structured by our Core Activities, (i) Registration and Enforcement, (ii) Quality Improvement, (iii) Mental Health Tribunals and Legal Aid Scheme and (iv) Inspection.

In relation to our commitment to safeguarding the best interests and human rights of service users, the report provides data on involuntary admission rates to approved centres in 2012 and comparisons of admissions over the past six years since the full commencement of the Mental Health Act 2001. Data is also provided in relation to the admission of children and the use of Electro Convulsive Therapy and Seclusion and Restraint.

The findings of the Inspector of Mental Health Services were utilised by the Commission to inform decisions in relation to the registration of approved centres.

An overview of the achievement of Business Plan 2012 objectives is available at Appendix 1 of this report.

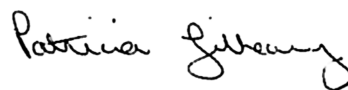
The MHC net non-capital allocation for 2012 was €14.7 million. During the year the Executive was particularly mindful of the severe pressure on public finances and set out to continue to operate in the most efficient and effective manner possible, striving to deliver greater efficiencies and cost savings.

In 2012 the Executive continued to operate within the Moratorium on Recruitment and Promotion in the Public Sector, the Public Service Agreement 2010-2014 and the Public Service Reform Plan (Department of Public Expenditure and Reform, October 2011). The Commission operated throughout 2012 with a depleted management team. I am aware that the attainment of the Business Plan objectives set by the Commission in 2012 would not have been possible without the drive, enthusiasm, flexibility and commitment of my colleagues across the organisation. I appreciate their continued support.

Together we look forward to the year ahead, we are committed to protecting the interests of persons detained in approved centres, facilitating the continued improvement in the quality of mental health service provision, particularly community mental health services and ensuring that mental health is high on the public health agenda.

I would like to thank the outgoing Chairman Dr Edmond O Dea and the current Chairman Mr John Saunders and the Members of the Commission for their support of the Executive.

I also wish to acknowledge the support of Mr Luke Mulligan, Mr Colm Desmond, and officials in the Mental Health Unit, Department of Health.



Patricia Gilheaney

Chief Executive

Mental Health Commission
Who we are and What we do

Mental Health Commission - Who we are and What we do

The Mental Health Commission is responsible for regulating and monitoring mental health services in Ireland as defined by the Mental Health Act 2001.

The Commission was established in April 2002. We are an independent statutory body and our functions are set out in the Mental Health Act 2001. Our main functions are to promote, encourage and foster high standards and good practices in the delivery of mental health services and to protect the interests of patients who are involuntarily admitted and detained *(Section 33(1), Mental Health Act 2001)*.

The Commission's remit includes general adult mental health services, as well as mental health services for children and adolescents, older people, people with intellectual disabilities and forensic mental health services.

The Mental Health Act 2001 also outlines the additional responsibilities of the Commission. These include:

- Appointing persons to mental health tribunals to review the detention of involuntary patients and appointing a legal representative for each patient;
- Establishing and maintaining a Register of Approved Centres i.e. we register inpatient facilities providing care and treatment for people with a mental illness or mental disorder.
- Making Rules regulating the use of specific treatments and interventions i.e. ECT (Electro-convulsive Therapy), seclusion and mechanical restraint; and
- Developing Codes of Practice to guide people working in the mental health services.

Mental Health Commission Members - April 2012 – April 2017

Mr. John Saunders
Chairman

Director – Shine

Dr. Anne Jeffers
Consultant Psychiatrist – Health Service Executive West

Dr. Maeve Doyle
Consultant Child & Adolescent Psychiatrist – Health Service Executive Dublin North East

Dr. Mary Keys
Lecturer NUI Galway

Dr. Michael Byrne
Principal Psychology Manager – Health Service Executive West

Dr. Xavier Flanagan
General Practitioner Clane, Co. Kildare

Mr. John Redican
National Executive Officer – National Service User Executive (NSUE)

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

Mr. Ned Kelly
Director of Nursing – Health Service Executive South

Ms. Catherine O'Rorke
Director of Nursing Health Service Executive Dublin North East

Ms. Colette Nolan
Chief Executive Officer – Irish Advocacy Network

Ms. Patricia O'Sullivan Lacy
Barrister-at-Law

Ms. Pauline Gill
Principal Social Worker Health Service Executive National Forensic Mental Health Service

The Mental Health Commission consists of 13 Members, including the Chairman, who are appointed by the Minster for Health. The composition of the Commission is laid down in Section 35, Mental Health Act 2001. Members of the Commission hold office for a period not exceeding 5 years.

The current Commission was appointed on 5th April 2012. The first quarter of 2012 represented the final term of office of the second Commission (5th April 2007 – 4th April 2012) under the Chairmanship of Dr. Edmond O'Dea.

Ten Meetings of the Mental Health Commission were held in 2012, two of which were two-day meetings (March & June). Commission Members attendance at meetings in 2012 was recorded as follows:

Mental Health Commission (Term of appointment) 05.04.07 – 04.04.12	2012
Dr. Edmond O'Dea (Chairman)	4/4
Mr. Brendan Byrne	4/4
Ms. Marie Devine	4/4
Dr. Brendan Doody	3/4
Mr. Padraig Heverin	4/4
Dr. Martina Kelly	0/4
Dr. Mary Keys	4/4
Dr. Eamonn Moloney	2/4
Ms. Patricia O'Sullivan Lacy	4/4
Mr. John Redican	3/4
Mr. Martin Rogan	3/4
Mr. John Saunders	2/4
Ms. Vicki Somers	1/4

Mental Health Commission (Term of appointment) 05.04.12 – 04.04.17	2012
Mr. John Saunders (Chairman)	6/6
Dr. Michael Byrne	4/6
Dr. Maeve Doyle	5/6
Dr. Xavier Flanagan	5/6
Ms. Pauline Gill	6/6
Dr. Anne Jeffers	5/6
Mr. Ned Kelly	6/6
Dr. Mary Keys	4/6
Ms. Catherine O'Rorke	5/6
Ms. Patricia O'Sullivan Lacy	6/6
Mr. John Redican	5/6
Mr. Martin Rogan	4/6
Ms. Colette Nolan	3/6

Mental Health Commission Committees & Working Groups 2012

In 2012 there were two standing Committees of the Commission, the Audit & Finance committee whose membership consists of Commission Members (CM), Executive (E) and External Members (EM) and a Legislation Committee which has both Commission (CM) and Executive (E) members.

The Chairman of the Commission is an Ex Officio member of all Committees and Working Groups established by the Commission.

Audit & Finance Committee

Ms. Patricia O'Sullivan Lacy (Chair) (CM), Ms. Catherine O'Rorke (CM), Mr. Ned Kelly (CM), Mr. John Redican (CM), Ms. Noreen Fahy (EM), Mr. Declan Lyons (EM).

Legislation Committee

Dr. Mary Keys (Chair) (CM), Ms. Pauline Gill (CM), Mr. John Redican (CM), Dr. Anne Jeffers (CM), Ms. Patricia O'Sullivan Lacy (CM), Ms. Patricia Gilheaney (E), Ms. Rosemary Smyth (E), Ms. Marina Duffy (E). Ms. Ulla Quayle (E) provided administrative support to the Committee.

During 2012 the Commission established two working groups, a Governance Working Group and a Strategic Plan Working Group.

Governance Working Group

Mr. Ned Kelly (Chair) (CM), Ms. Catherine O'Rorke (CM), Mr. John Redican (CM), Ms. Marina Duffy (E), Ms. Ulla Quayle (E) provided administrative support to the working group.

Strategic Plan Working Group

Ms. Catherine O'Rorke (Chair) (CM), Mr. Ned Kelly (CM), Dr. Michael Byrne (CM), Mr. Martin Rogan (CM), Ms. Patricia Gilheaney (E), Ms. Marina Duffy (E), Ms. Ulla Quayle (E) provided administrative support to the working group.

Commission Executive

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

The Inspector of Mental Health Services, appointed by the Commission, is required to visit and inspect every approved centre at least annually and may visit and inspect any other premises were mental health services are being provided as he deems appropriate. The Inspector furnishes a report in writing to the Commission on an annual basis and it is contained in the Commission's Annual Report as the Report of the Inspector of Mental Health Services.

Management Team

Ms. Patricia Giheaney – Chief Executive

Dr. Gerry Cunningham – Director Mental Health Tribunals (Retired in January 2012)

Ms. Patricia Gilheaney – Acting Director Mental Health Tribunals (From February 2012)

Dr. Patrick Devitt – Inspector of Mental Health Services

Mr. Ray Mooney – Director Corporate Services

Ms. Rosemary Smyth – Director Training & Development

Ms. Rosemary Smyth – Interim Director Standards & Quality Assurance (From February 2012).

Core Activities of the Mental Health Commission

The Mental Health Commission's work programme is focused on five core activities. These include:

- Registration and Enforcement
- Inspection
- Quality Improvement
- Mental Health Tribunal Reviews
- Managing the Legal Aid Scheme.

All of our core activities reflect the Commission's statutory functions. We also engage in collaborative work with external stakeholders as a means of realising these statutory functions. A number of key enablers also allow the Commission to function as an effective organisation.

This year's annual report is structured by our core activities, our collaborative work and key enablers with links to the Commission's strategic priorities for 2009 – 2012 highlighted. The core activity of inspection is presented separately in the Report of the Inspector of Mental Health Services which forms the second part of this report.

Core Activities of the Commission

The Commission's work programme is focused on five core activities (i) Registration & Enforcement (ii) Inspection, (iii) Quality Improvement (iv) Mental Health Tribunals, (v) Legal Aid Scheme.

	Our Core Activities	
Regulation	Registration and Enforcement	Registering approved centres. Enforcing associated statutory powers e.g. attaching conditions.
	Inspection	Inspecting approved centres and community mental health services. Reporting on regulatory compliance and the quality of care.
	Quality Improvement	Developing and reviewing rules under the Mental Health Act 2001. Developing standards, codes of practice and good practice guidance. Monitoring the quality of service provision in approved centres and community services through inspection and reporting. Using our enforcement powers to maintain high quality mental health services.
Independent Reviews	Mental Health Tribunal Reviews	Administering the independent review system of involuntary admissions. Safeguarding the rights of those detained under the Mental Health Act 2001.
	Legal Aid Scheme	Administering of the mental health legal aid scheme.

Strategic Plan
2009 - 2012

Strategic Plan 2009 – 2012

The timeframe of the third Strategic Plan for the Mental Health Commission concluded at the end of 2012. The plan chartered the direction and focus of the Commission over the past four years.

The Strategic Plan 2009 – 2012 timeframe coincided with a time of unprecedented economic adversity which brought great challenges for the public sector in general including the Mental Health Commission.

The Six Strategic Priority areas identified in the plan were as follows:

Strategic Priorities 2009 – 2012

1. 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' assessed needs.

2. 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 2001 Act.
- The Commission will continue to monitor Rules and Codes of Practice issued pursuant to the provisions of the 2001 Act.
- Promote and support advances in legislation to protect the human rights of vulnerable people.

3. 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.

4. 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.

5. Social Inclusion & Active Citizenship

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

6. Efficiency of 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.

During 2012 the Commission established a Strategic Plan working group to plan and develop the fourth Strategic Plan for the organisation. In quarter three 2012, the group consulted with a wide range of stakeholders to ascertain their views on the new plan. The group was delighted to have the opportunity to get direct feedback on the work of the Commission and how this impacts on our stakeholders. At the end of 2012 work on the plan was concluding. The Strategic Plan 2013 – 2015 will be published in 2013.

Guiding Principles and Core Values of the Mental Health Commission

The ethos and culture of an organisation is developed through its Guiding Principles and Core Values. The work of the Commission is especially guided by the principles articulated 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 the Rights of Persons with Disabilities
- 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

Our Values

Accountability and Integrity

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

Dignity and Respect

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

Confidentiality

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

Empowerment

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

Quality

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

Achieving Together

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

How we progressed our Strategic Plan and Priorities through our Core Activities in 2012

Regulation

Registration and Enforcement

The Commission's registration and enforcement activities primarily relate to maintaining the Register of Approved Centres and using our statutory powers to attach conditions to the registration of approved centres where necessary.

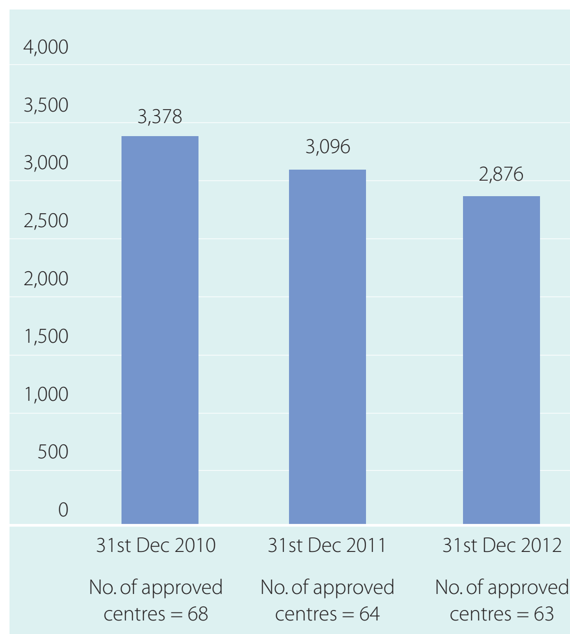
Register of Approved Centres

The Commission continues to maintain the Register of Approved Centres in accordance with its statutory functions, as set out in Section 64 of the Mental Health Act 2001.

The number of approved centres in the Register of Approved Centres on 31st December 2012 was 63. These 63 approved centres had a combined bed capacity of 2,876 beds. When compared to the figures on 31st December 2011, there was a 7.1% (n=220) reduction in the combined bed capacity during 2012.

Figure (1) details the total number of approved centres and the combined bed capacity on 31st December for each of the years 2010, 2011 and 2012.

Figure 1. Number of Approved Centres and combined bed capacity on 31st December in 2010, 2011, & 2012



A copy of the information held in the *Register of Approved Centres*, including an up-to-date list of all approved centres, is available on the Commission's website at www.mhcirl.ie/registration.

Changes to the Register of Approved Centres

During 2012, four new centres were added to the Register of Approved Centres and five centres were removed. Tables 1 and 2 detail these changes.

Table 1. Approved Centres Added to the Register of Approved Centres

Approved Centre Name & Address	Date Entered in the Register
Highfield Hospital, Swords Road, Whitehall, Dublin 9	30th March 2012
Heywood Lodge, Heywood Road, Clonmel, Co Tipperary	23rd April 2012
Linn Dara Child & Adolescent In-patient Unit, St Loman's Hospital, Palmerstown, Dublin 20	11th May 2012
St Bridget's Ward & St Marie Goretti's Ward, Cluain Lir Care Centre, St Mary's Campus, Longford Road, Mullingar, Co Westmeath	31st May 2012

Table 2. Approved Centres Removed from the Register of Approved Centres

Approved Centre Name & Address	Date Removed from the Register
Highfield Private Hospital, Swords Road, Whitehall, Dublin 9	4th April 2012
Hampstead Private Hospital, Hampstead, Glasnevin, Dublin 9	11th April 2012
Warrenstown Child & Adolescent In-patient Unit, Blanchardstown Road, Blanchardstown, Dublin 15	31st May 2012
St Michael's Unit, South Tipperary General Hosptial, Clonmel, Co Tipperary	17th July 2012
St Luke's Hospital, Clonmel, Co Tipperary	26th July 2012

The centres detailed in Table 2 were removed from the Register following the transfer of the centre's mental health service to other facilities as follows:

- The services in Highfield Private Hospital and Hampstead Private Hospital were transferred to the newly registered approved centre, Highfield Hospital;
- The service in Warrenstown Child & Adolescent In-patient Unit was transferred to the newly registered approved centre, Linn Dara Child & Adolescent In-patient Unit;
- The service in St Michael's Unit, South Tipperary General Hospital was transferred to the Department of Psychiatry, St Luke's Hospital, Kilkenny; and
- The service in St Luke's Hospital, Clonmel, was transferred to the newly registered approved centre, Heywood Lodge, and community based mental health services in the area.

Expiration of Registration

Under Section 64 of the 2001 Act, a centre's period of registration is three 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 or she must apply to the Commission for registration. The period of registration of two approved centres expired during 2012 and both centres applied for registration and were subsequently registered.

Continuous Quality Improvement

The Commission's Standards and Quality Assurance Division monitors approved centres' compliance with regulations, rules, and codes of practice made under the 2001 Act, as reported by the Inspector of Mental Health Services.

The Standards & Quality Assurance Division received reports from the Inspector of Mental Health Services for 62 approved centres in 2012.

Of these, two approved centres achieved full compliance with all applicable articles of the regulations, rules, and codes of practice. The centres were:

- Hawthorn Unit, Connolly Hospital, and
- Willow Grove Adolescent Unit, St Patrick's University Hospital.

Where the Report of the Inspector of Mental Health Services shows that a centre does not achieve full compliance with all applicable regulations, rules, and codes of practice, the Commission requests a Statutory Compliance Report (SCR) which must set out how full compliance will be achieved. The SCR must also indicate the timeframes for completion of relevant actions and the person responsible for achieving compliance.

SCRs were requested in writing from the majority of approved centres that did not achieve full compliance with all applicable articles of the regulations, rules, and codes of practice. Fifteen centres were requested to attend face-to-face meetings to present and discuss their Statutory Compliance Reports where the Commission had greater concerns over compliance with regulations, rules, and codes of practice.

These SCRs, in conjunction with the Reports of the Inspector of Mental Health Services, form the basis of the Commission's ongoing review of each approved centre's registration.

Conditions Attached to the Registration of Approved Centres

The Commission may attach conditions to the registration of approved centres in relation to the carrying on of the centre concerned, and other such matters as the Commission considers appropriate.

The Commission first notifies the registered proprietor in writing of its proposal to attach a condition, and the reason(s) for the proposal. The registered proprietor then has 21 days to make representations to the Commission and the Commission must consider these representations before making a decision.

Notification of the decision is issued to the registered proprietor in writing. The proprietor may appeal the Commission's decision to the District Court within 21 days of receiving notification of the decision, and the Commission must be notified of any such appeal.

During 2012, the Commission attached conditions to the registration of nine approved centres, as shown in Table 3. None of the decisions to attach conditions to the registration of approved centres during 2012 were appealed to the District Court.

Table 3. Summary of conditions attached to the registration of Approved Centres during 2012

Approved Centre	Summary of conditions attached
Bloomfield Care Centre – Donnybrook, Kylemore, & Owendoher Wings	• Full compliance with Article 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 must be achieved by 31st August 2012. • Full compliance with Article 16 (Therapeutic Services & Programmes) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 must be achieved by 31st August 2012. • Full compliance with Article 26 (Staffing) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 must be achieved by 30th November 2012. These conditions were attached with effect from 8th August 2012.
Department of Psychiatry, Connolly Hospital	• Full compliance must be achieved with Article 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. This condition was attached with effect from 7th December 2012.
Department of Psychiatry, University Hospital Galway	• Full compliance must be achieved with Article 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. This condition was attached with effect from 6th November 2012.
Jonathan Swift Clinic, St James' Hospital	• The approved centre must develop written procedures on the operation of the Mental Health Act 2001. • The approved centre must develop a training curriculum on the Mental Health Act 2001, and associated rules and codes of practice. These conditions were attached with effect from 26th November 2012.
Lakeview Unit, Naas General Hospital	• Renovation works to increase the number of showers must be completed by 29th February 2012. • Full compliance with the Rules Governing the Use of Seclusion & Mechanical Means of Bodily Restraint must be achieved by 31st January 2012. These conditions were attached with effect from 9th January 2012.
South Lee Mental Health Unit, Cork University Hospital	• Full compliance with Article 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 must be achieved by 31st March 2012. This condition was attached with effect from 8th February 2012.
St Finan's Hospital	• The closure of St Peter's Ward must be achieved by 30th September 2012. This condition was attached with effect from 18th April 2012.
St John of God Hosptial Limited	• Full compliance with Article 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 must be achieved by 30th June 2012. This condition was attached with effect from 9th May 2012.
St Michael's Unit, Mercy University Hospital	• Full compliance with Article 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 must be achieved by 31st March 2012. This condition was attached with effect from 1st February 2012.

As of 31st December 2012, there were a total of 23 conditions attached to the registration of 12 approved centres.

In addition to the nine approved centres that had conditions attached to their registration during 2011, conditions that were attached to the registration of four approved centres in 2011 remained in place at the end of 2012. Three of these four approved centres are St Brendan's Hospital, St Ita's Hospital, Portrane, Donabate, Co Dublin and St Loman's Hospital, Mullingar, Co Westmeath. In addition to the condition that was attached to the registration of St Finan's Hospital in 2012, two conditions were attached to its registration in 2011 which remain in place. Details of conditions attached to the registration of approved centres in 2011 are available in the 2011 Annual Report.

Compliance with conditions attached to the registrations of approved centres is reviewed by the Commission on an ongoing basis. Where the Commission is in receipt of evidence that a condition has been met, such as contents of the Reports of the Inspector of Mental Health Services or confirmation from the registered proprietor, the Commission may propose to revoke the condition, in accordance with the procedures set out in the 2001 Act.

National Levels of Compliance with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Rules and Codes of Practice

The Commission presents data each year on national levels of compliance with the regulations, rules and codes of practice as reported by the Inspector of Mental Health Services. These data allow for short term and medium term trends in compliance levels in approved centres to be observed. This year's annual report compares compliance levels for 2012 with those reported in 2011. It also shows compliance data for the regulations for 2007, which was the first year that approved centres were inspected against the regulations.[1]

In 2012, the Inspectorate inspected approved centres against all of the Mental Health Act 2001 (Approved Centres) Regulations 2006. In 2011 however, the Inspectorate focused on assessing compliance with specific articles that approved centres breached in 2010 as well as re-inspecting compliance against 9 articles for all approved centres as follows: 15 (Individual Care Plan); 16 (Therapeutic Services and Programmes); 17 (Children's Education); 18 (Transfer of Residents); 19 (General Health); 20 (Provision of Information to Residents); 21 (Privacy); 22 (Premises); and 26 (Staffing). Comparisons between compliance levels in 2011 and 2012 can only be made therefore for these nine articles.

Figures 2 (a) – (c) inclusive show national levels of compliance with these nine articles for the years 2012, 2011 and 2007. The data show that between 2011 and 2012, levels of compliance in approved centres nationally decreased for seven of the nine articles and increased for the other two articles. The two Articles for which large decreases in full compliance were recorded were Article 21 (Privacy) and Article 20 (Provision of Information to Residents). Full compliance with Article 21 (Privacy) was achieved by 65% of approved centres in 2011 but this fell to 48% of approved centres in 2012. Full compliance with Article 20 (Provision of Information to Residents) was achieved by 63% of approved centres in 2012 compared to 79% of centres in 2011.

1. In 2007, the Inspector reported compliance as follows: Yes or No. In 2011 and 2012, the Inspector reported compliance as follows: Fully Compliant, Substantially Compliant, Compliance Initiated, and Not Compliant.

Figure 2 (a). Comparison of the national levels of full compliance with articles 15 to 17[2, 3] of the regulations for 2007, 2011, and 2012

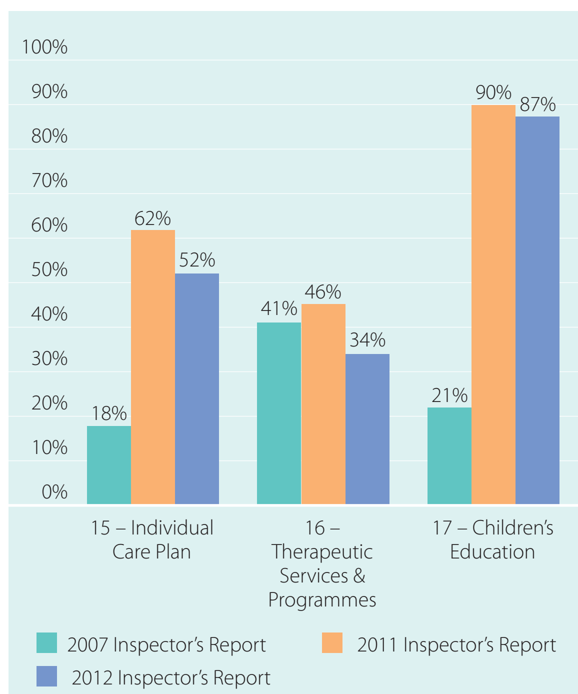


Figure 2 (c). Comparison of the national levels of full compliance with articles 21, 22, and 26[5] of the regulations for 2007, 2011, and 2012

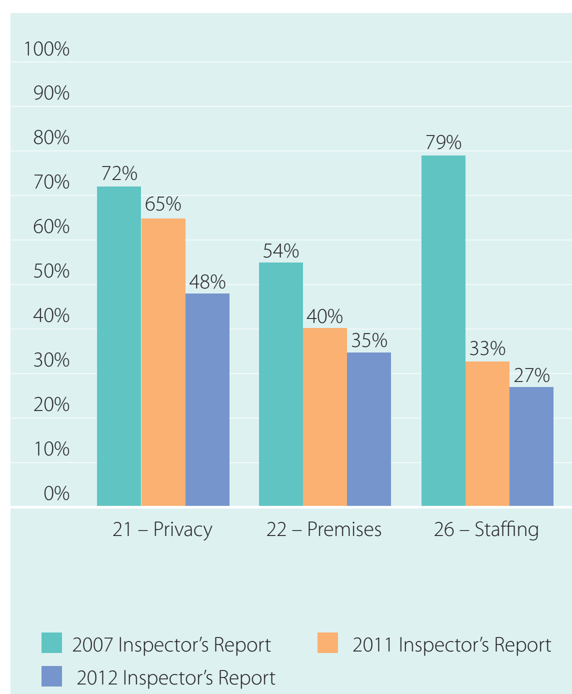
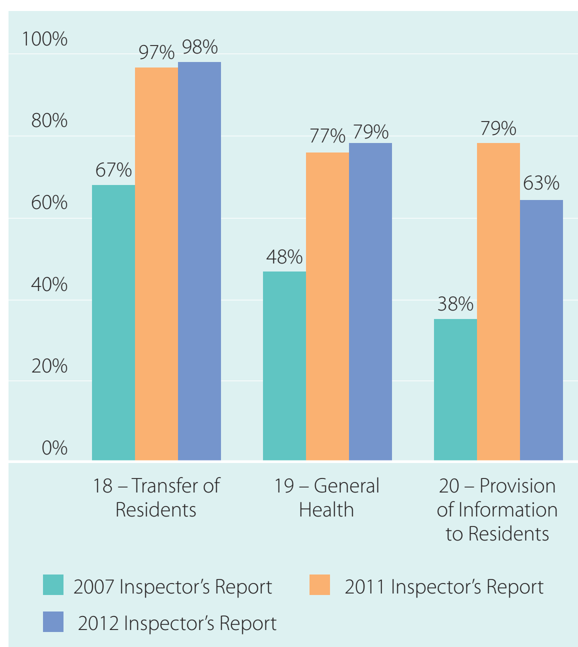


Figure 2 (b). Comparison of the national levels of full compliance with articles 18 to 20[4] of the regulations for 2007, 2011, and 2012



2. The levels of full compliance with Articles 15 and 16 are based on 61 approved centres in 2007, 63 approved centres in 2011 and 62 approved centres in 2012.
3. The levels of full compliance with Article 17 are based on 34 approved centres in 2007, 29 approved centres in 2011 and 27 approved centres in 2012.
4. The levels of full compliance with Articles 18, 19, and 20 are based on 61 approved centres in 2007, 63 approved centres in 2011 and 62 approved centres in 2012.
5. The levels of full compliance with Articles 21, 22, and 26 are based on 61 approved centres in 2007, 63 approved centres in 2011 and 62 approved centres in 2012.

National Levels of Compliance with Rules and Codes of Practice

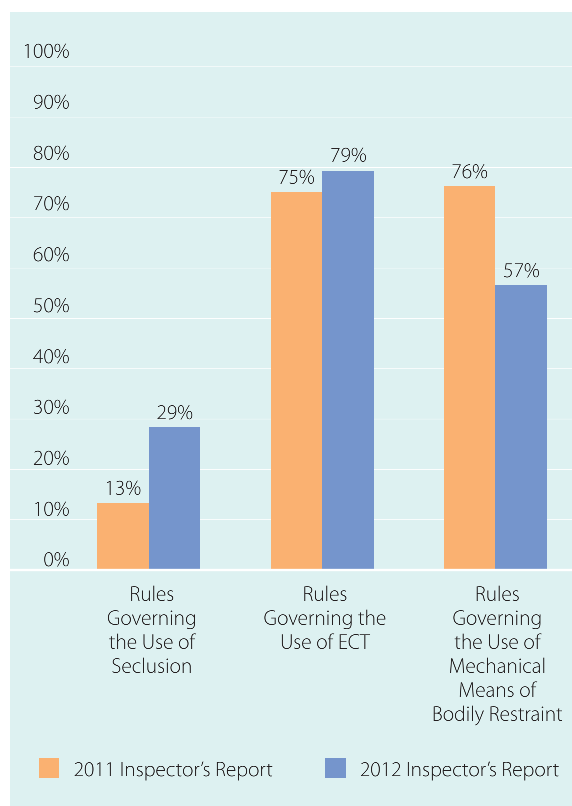
Pursuant to Sections 59(2), 69(2) and 33(3)(e) of the Mental Health Act 2001, the Commission has published a number of rules and codes of practice as follows:

- Version 2 of the *Rules Governing the Use of Electro-Convulsive Therapy* came into effect on 1st January 2010.
- Version 2 of the *Rules on the Use of Seclusion and Mechanical Means of Bodily Restraint* came into effect on 1st January 2010 and were amended on 1st March 2011 by way of an addendum.
- The *Code of Practice Relating to the Admission of Children Under the Mental Health Act 2001* came into effect on 1st November 2006 and was amended on 1st July 2009 by way of an addendum.
- The *Code of Practice for Mental Health Services on Notification of Deaths & Incident Reporting* came into effect on 1st November 2008.
- The *Code of Practice on Admission, Transfer & Discharge* to and from an Approved Centre came into effect on 1st January 2010.
- The *Code of Practice – Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities* came into effect on 1st January 2010.
- Version 2 of the *Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients* came into effect on 1st January 2010.
- Version 2 of the *Code of Practice on the Use of Physical Restraint in Approved Centres* came into effect on 1st January 2010.

Figure 3 compares levels of full compliance with the different Commission Rules as reported by the Inspector between 2011 and 2012. The Section 69 (2) Rules concern both seclusion and mechanical restraint. Compliance levels are presented separately for the Rules Governing the Use of Seclusion and for the Rules Governing the Use of Mechanical Means of Bodily Restraint.

Figure 3 shows that full compliance with the Rules Governing the Use of Seclusion was achieved by 29% of approved centres in 2012, which was an increase compared to 2011 when just 13% of approved centres were fully compliant with these Rules. There was a small increase in the percentage of approved centres achieving full compliance with the Rules Governing the Use of ECT from 75% in 2011 to 79% in 2012. There was a notable decrease, however, in the percentage of approved centres achieving full compliance with the Rules Governing the Use of Mechanical Means of Bodily Restraint. Levels of full compliance fell from 76% of approved centres nationally in 2011 to 57% of approved centres in 2012.

Figure 3. Comparison of the national levels of full compliance with the rules[6, 7, 8] for 2011 and 2012



6 The levels of full compliance with the Rules Governing the Use of Seclusion are based on 30 approved centres in 2011 and 28 approved centres in 2012.

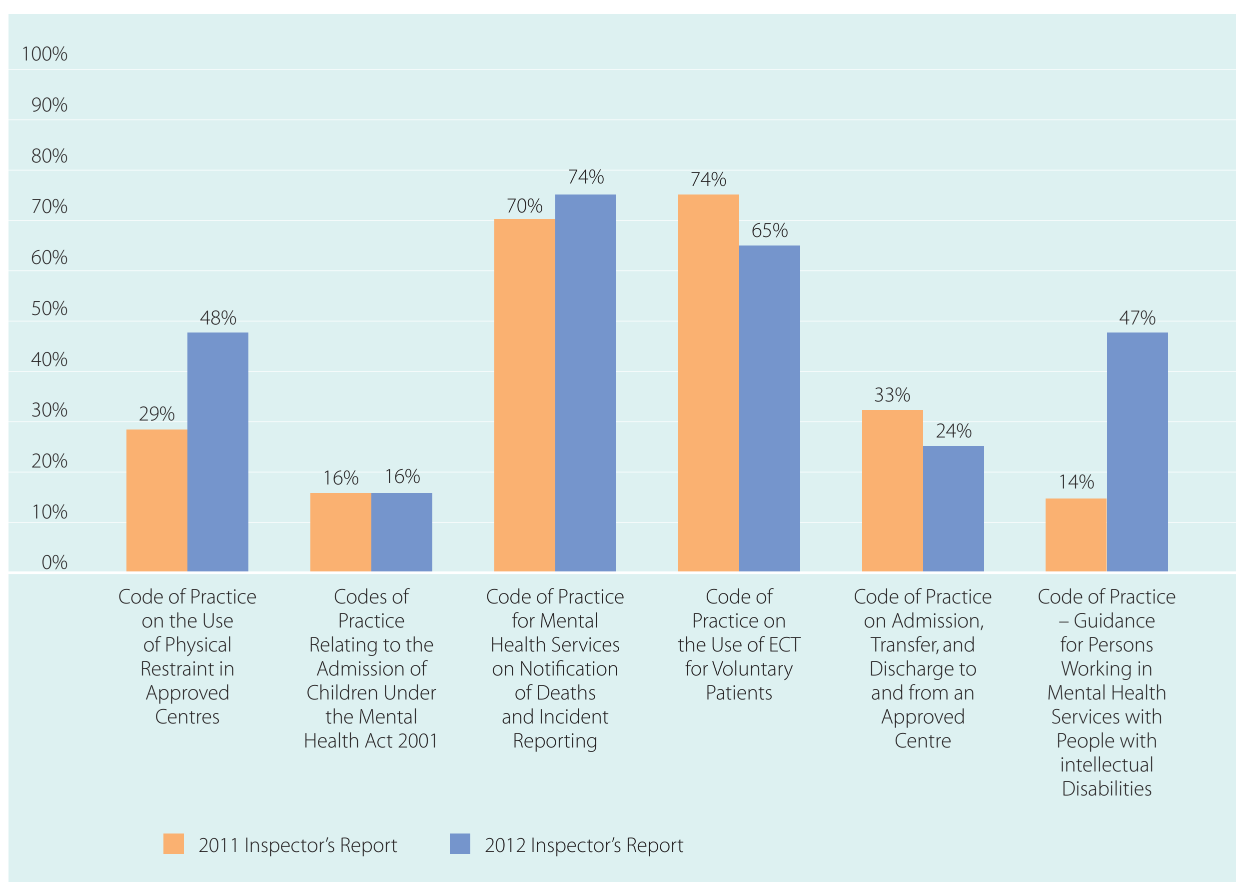
7 The levels of full compliance with the Rules Governing the Use of Electro-Convulsive Therapy are based on 16 approved centres in 2011 and 14 approved centres in 2012.

8 The levels of full compliance with the Rules Governing the Use of Mechanical Means of Bodily Restraint are based on 21 approved centres in 2011 and 14 approved centres in 2012.

Figure 4 shows levels of full compliance in 2011 and 2012 for the six codes of practice that have been issued by the Commission. Compared to 2011, national levels of compliance in 2012 increased for three codes of practice, decreased for two codes but remained the same for the Code of Practice Relating to the Admission of Children under the Mental Health Act 2001.

There were especially large increases in national levels of compliance with two codes of practice. The percentage of approved centres achieving full compliance with the Code of Practice Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities increased from 14% to 47%. There was also a jump from 29% to 48% in the percentage of approved centres who were fully compliant with the Code of Practice on the Use of Physical Restraint in Approved Centres.

Figure 4. Comparison of the national levels of full compliance with the codes of practice[9, 10, 11, 12, 13, 14] for 2011 and 2012



9 The levels of full compliance with the Code of Practice on the Use of Physical Restraint in Approved Centres are based on 52 approved centres in 2011 and 54 approved centres in 2012.

10 The levels of full compliance with the Code of Practice Relating to the Admission of Children Under the Mental Health Act 2001 are based on 31 approved centres in 2011 and 32 approved centres in 2012.

11 The levels of full compliance with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting are based on 63 approved centres in 2011 and 62 approved centres in 2012.

12 The levels of full compliance with the Code of Practice on the Use of Electro-Convulsive Therapy are based on 19 approved centres in 2011 and 20 approved centres in 2012.

13 The levels of full compliance with the Code of Practice on Admission, Transfer, and Discharge, to and from an Approved Centre are based on 63 approved centres in 2011 and 62 approved centres in 2012.

14 The levels of full compliance with the Code of Practice – Guidance for Persons Working in Mental Health Services with People With Intellectual Disabilities are based on 58 approved centres in 2011 and 57 approved centres in 2012.

Quality Improvement

Quality Improvement

The Commission's quality improvement activities are directly related to our statutory function "to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services". Our efforts to bring about quality improvements are multifaceted and include inspections of mental health services which are detailed separately in the Report of the Inspector of Mental Health Services. We also collect and publish data on activity within mental health services to drive improvements. This includes the publication of child admissions data for example which highlights the continued admission of children to adult units. During 2012, we sought to enhance care and treatment planning by issuing a guidance document upon the conclusion of the National Mental Health Services Collaborative Project. We detail these and other quality improvement initiatives that took place in 2012 below.

Data on Admission of Children under the Mental Health Act 2001

The Mental Health Commission collects and reports on data in relation to the admission of children[15] to approved centres. We present key points in relation to the admission of children in 2012 in this annual report. A more detailed report on child admissions data is available on our website.

Admission of Children in 2012

In 2012, the Commission was notified of 428 admissions of 357 children to approved centres.[16] The total number of admissions of children has been consistent over the last three years with 430[17] such admissions in 2011 and 430 admissions in 2010.

In December 2011, Section 2.4.1 c) of the Addendum to the Code of Practice Relating to Admission of Children under the Mental Health Act 2001 came into effect. It states that apart from exceptional circumstances:

> *2.4.1 c)*
> *"No child under 18 years is to be admitted to an adult unit in an approved centre from 1st December 2011."*

In 2012, there were six child units compared to three such units in 2008. This increased provision has contributed to a decline in the number of admissions of children to adult units. Admissions of children to adult units, nevertheless, continued in 2012. There were 106 such admissions in 2012 which corresponds to one quarter (24.8%) of all child admissions. It is encouraging that there continues to be a year-on-year decline in the proportion of child admissions that are to adult units. In 2011, 30.7% (132/430) of all child admissions were to adult units and the corresponding percentage in 2008 was 63.0% (247/392). Progress on this issue must continue so that all children who require in-patient mental health services receive such services in age appropriate settings.

The 106 admissions to adult units in 2012 occurred in 24 approved centres. The remaining 322 child admissions were to the six child and adolescent units.

When a child is admitted to an adult unit, the approved centre is required to inform the Commission of the reason for the admission. In 2012, 'no age appropriate bed available' was indicated as a reason for admission in 84% (89/106) of admissions to adult units.

In 2012, in 22.6% (24/106) of admissions, to adult units, the child was discharged from an adult unit and admitted to a child unit when a bed became available. In 2011, only 9.1% (12/132) of admissions to adult units resulted in a discharge from the adult unit and a subsequent admission to a child unit.

15. 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.

16. 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).

11. The number of admissions in 2011 has been updated since the publication of the Mental Health Commission's 2011 Annual Report (April 2012). Updated child admission data were returned by two approved centres as a result of cross validation with the Health Research Board's 2011 child admission data.

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. In 2012, there were 18 Section 25 Orders for the involuntary admission[18] of 15 children to approved centres. This represents a slight decrease in the 21 Section 25 Orders that were notified to us in 2011. Four of these involuntary admissions were to adult units and 14 admissions were to child units.

Five of the 15 children who were the subject of a Section 25 Order were 15 years of age or under, three were 16 year olds and seven were 17 year olds.

In the case of three of the 18 involuntary admissions, the child was initially admitted as a voluntary patient but their legal status changed to involuntary during their admission.

Data on Notification of Deaths and Incident Reporting

Mental health services report to the Commission on deaths and incidents in services as provided for in the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. Summary information on these reports is presented here. A more detailed report on data on deaths and incident reporting is available on our website.

Deaths in 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.

In 2012, 45 approved centres notified the Commission of 174 deaths. Based on the information reported to us, 10.9% of notifications (19) related to sudden, unexplained deaths.[19]

Deaths in Community Mental Health Services (CMHS)[20]

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 in accordance with Section 2 (b) of the Code.

All death notifications are forwarded to the Inspector of Mental Health Services in accordance with our standard operating procedures. The Inspector of Mental Health Services examines all death notifications. In cases suggestive of suicide or violent death he requests that a review is carried out by the service and a copy sent to him. These reviews are 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.

In 2012, the Commission was notified of 90 deaths from community mental health services. For 38 of these deaths, physical illness was indicated as the cause of death and so it did not appear that a sudden, unexplained death had occurred.

Incident Reporting

In accordance with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, approved centres also provide the Commission with six-monthly summary incident reports. These reports are made available to the Inspectorate to inform inspections.

18. If a child was discharged from one approved centre and admitted to another approved centre under a single Section 25 Order this was only reported as one involuntary admission. There were two such admissions in 2012.
19. A death is categorised as a 'sudden, unexplained death' by the Mental Health Commission on review of the circumstances surrounding the death, indicated by the service, on the death notification form. Where the circumstances suggest a likely suicide, missing patients, violence or any circumstance where negligence or malpractice may have been a factor the death is categorised as a sudden, unexplained death.
20. Community Mental Health Services include Day Hospitals, Day Centres, 24 Hour Staffed Community Residences and Other Mental Health Services (includes out-patient departments, resource centres, group homes, out- reach teams and other service types).

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 in annual activity reports. These reports provide a current picture of activity both within individual services and at national level and are intended to inform the quality improvement process within mental health services. The most recent reports, which relate to 2011, are available on our website.

Your Views of Inpatient Mental Health Services Inpatient Survey 2011

In 2011, the Commission carried out a national survey, in partnership with the Irish Society for Quality and Safety in Healthcare, to ascertain the views of service users recently discharged from approved centres across Ireland. Over 700 individuals nationally took part in the survey. The findings were published in February 2012. Each of the 28 participating approved centres was also provided with an individual report on the findings from their service. This survey will enable services to benchmark their performance nationally with other approved centres. It was intended that approved centres would then identify where improvements are needed and put in place appropriate quality initiatives. The full report of the survey's findings and an executive summary are available on our website.

The National Mental Health Services Collaborative (NMHSC)

The National Mental Health Services Collaborative (NMHSC) project commenced in November 2009 and ran for a period of 18 months. The collaborative project was a quality improvement initiative designed to facilitate the implementation of mental health policy in the area of individual care and treatment planning. It was underpinned by a formal agreement between four sponsoring organisations, the Health Service Executive (HSE), Mental Health Commission (MHC) and two independent mental health providers, St Patrick's University Hospital and St. John of God Hospital. As a means of spreading the results of the NMHSC, the Sponsors hosted a national symposium on 'Individual Care Planning: Enabling the Paradigm shift to Recovery Focussed Care - Lessons from the National Mental Health Services Collaborative' on the 7th February 2012. The Symposium was attended by 380 delegates from across the spectrum of mental health services. Feedback provided by delegates was very positive. Minister Kathleen Lynch T.D., Minister of State with responsibility for Mental Health attended the Symposium in the afternoon to address delegates. The Collaborative evaluation report was also published on the day and can be downloaded from the Commission's website.

Guidance Document on Individual Care Planning Mental Health Services

A Guidance Document on Individual Care Planning for Mental Health Services was published in April 2012. This guidance document came about as a result of one of the recommendations made in the evaluation report of the National Mental Health Services Collaborative.

It is intended that this document will assist service users and health care providers to devise individual care plans for all service users of mental health services in Ireland and to facilitate meeting the requirements of Articles 15 and 16 of the Mental Health Act 2001(Approved Centres) Regulations 2006.

Response to the Task Force Report on the Child and Family Support Agency

On foot of the publication of the Task Force Report on the establishment of a Child and Family Support Agency in July 2012, the Commission established a sub group to prepare a response to the report. We were concerned with the implications of recommendations of the Task Force for the quality of child and adolescent mental health services. Our response contained a number of recommendations for progressing the delivery of better services to meet the mental health needs of vulnerable young people. The response was issued to the Department of Health and also the Department of Children and Youth Affairs in December 2012 and can be found on our website.

Lesbian, Gay, Bisexual and Transgender (LGBT) Service Users

The Commission commenced collaborative work with the Gay and Lesbian Equality Network (GLEN) in 2012 to develop a guidance document for staff working in mental health services on issues affecting LGBT service users. The need for this guidance arose from Irish research that identified increased mental health risk among LGBT people, and younger people in particular. It also arose out of the need to increase awareness amongst health professionals of LGBT persons' mental health problems. This document is due for publication in 2013.

Seclusion and Physical Restraint Reduction Strategy

After preparing a knowledge review and associated draft seclusion and physical restraint reduction strategy, the Commission carried out a written consultation exercise from June to September 2012 where we sought the views of stakeholders on the strategy. Fifty-two responses were submitted which were representative of all major stakeholder groups. The Commission will publish a consultation report which summarises the feedback we received in early 2013.

Statutory Rules

The Department of Health requested the Commission to prepare and publish Section 59(2) Rules Governing the Use of ECT (Electro-convulsive therapy) and Section 69(2) Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint as Statutory Instruments. The Legislation Committee progressed this matter during 2012 and the associated work programme will be finalised in 2013.

Independent Review

Mental Health Tribunals and Legal Aid Scheme

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[21]. This Independent Review is performed by a mental health tribunal during each period of detention. The Commission now has six complete years of data relating to involuntary admissions activity. This section of the report provides analysis of 2012 involuntary admissions and their review by mental health tribunals, and comparisons with previous years.

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 solely on the grounds that he or she is suffering from a mental disorder as defined in the Act.

Involuntary Admission (Adults) 2012

Analysis was completed on the number of adults who were involuntarily admitted using the provisions of sections 9, 10, & 14 of the Act in 2012. 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 1574 Form 6 *Admission Orders* notified to the Commission in 2012.

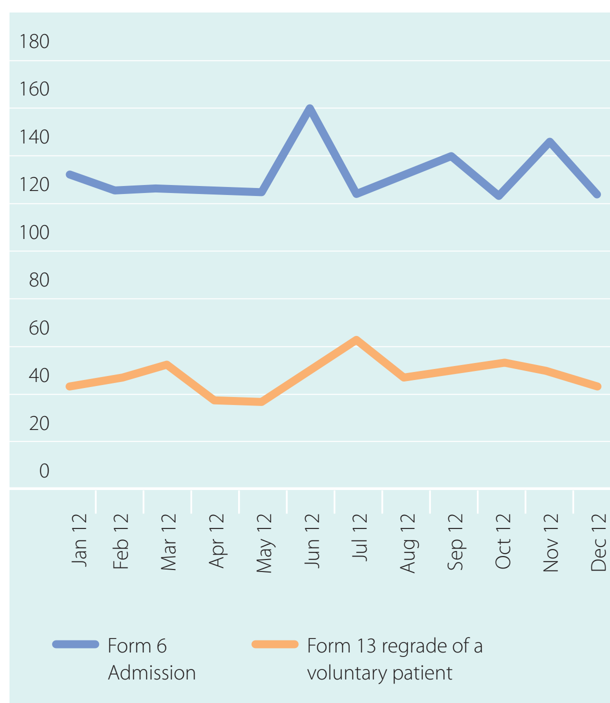
Detention of a Voluntary Patient (2012)

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 567 such admissions notified to the Commission in 2012.

Comparisons 2007 - 2012

Figure 5 summarises on a monthly basis both the above categories of involuntary admission for 2012, 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 122 to 159 per month, and the number of Form 13 orders fall within a range from 37 to 62 per month.

Figure 5. Monthly Involuntary Admissions 2012



21. An episode is a patient's unbroken period of involuntary admission

Comparison was made of 2012 involuntary admission activity with that for a number of previous years. Figure 6 summarises these comparisons on an annual basis and shows a decrease of 6% from 2007 to 2008, an increase of 1% from 2008 to 2009, a decrease of 4% from 2009 to 2010, an increase of 5% from 2010 to 2011and an increase of 4% from 2011 to 2012. Admission activity in 2012 has returned to a similar level as 2007. A total of 40 patients had three or more involuntary admissions in 2012.

Table 4 provides further analysis of involuntary admission rates for 2012 by HSE region and independent sector, with rates per 100,000 of total population.

Figure 6. Comparisons of Total Involuntary Admissions 2007 – 2012

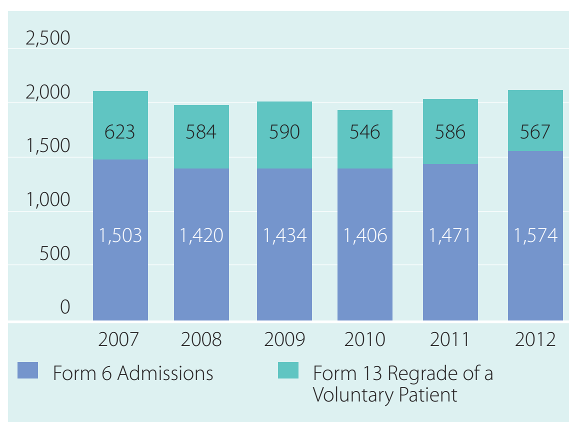


Table 4. Involuntary Admission Rates for 2012 (ADULT) by HSE region & independent sector

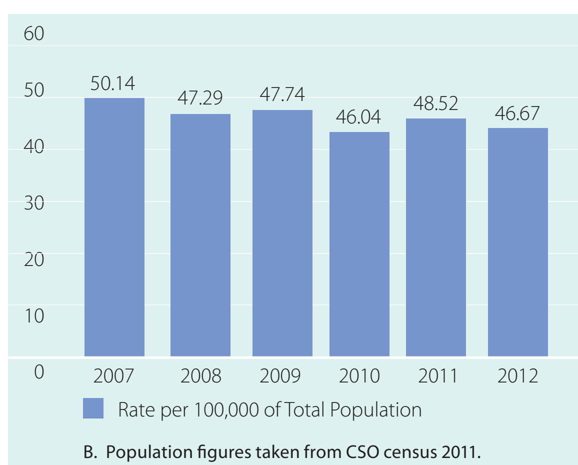
	Form 6	Form 13	Total Involuntary Admission Rate	Population [22]	Involuntary Admission Rate per 100,000 total population
HSE West	420	131	551	1,084,304	50.82
HSE South	373	107	480	1,133,858	42.33
HSE Dublin North East	331	126	457	1,018,535	44.87
Total HSE Dublin Mid Leinster	345	97	442	1,351,555	32.70
Independent Sector	105	106	211	N/A	N/A
Total (Exclusive Of Independent Sector)	1469	461	1,930	4,588,252	42.06
Total (Inclusive Of Independent Sector)	1574	567	2,141	4,588,252	46.67

22 Population figures taken from CSO census 2011. Please note that populations in the HSE regions have been adjusted to allow for admissions in Approved Centres from catchment areas in other HSE regions

Detailed analysis of involuntary admission rates for 2012 by Approved Centre is provided on the Mental Health Commission website www.mhcirl.ie.

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 7 below for the years 2007 to 2012.

Figure 7. Ireland's Involuntary Admission Rates per 100,000 of total population[B] for the years 2007 to 2012



B. Population figures taken from CSO census 2011.

Figure 8 below further analyses involuntary admission rates per 100,000 of population for the years 2007 to 2012 by HSE Region.

Figure 8. Involuntary Admission Rates per 100,000 of population for the years 2007 to 2012 by HSE Region

Age and Gender

Analysis of age and gender was completed on the figures for episodes of involuntary admission in 2012. Tables 5 and 6 summarise these findings.

Table 5. Analysis By Age - Involuntary Admissions 2012 (Adults)

Age	Form 6	Form 13	Total	%
18 – 24	155	78	233	11%
25 - 34	325	136	461	21%
35 - 44	350	119	469	22%
45 - 54	288	92	380	18%
55 - 64	212	73	285	13%
65 and	244	69	313	15%
Total	1,574	567	2,141	100%

Table 6. Analysis By Gender - Involuntary Admissions 2012 (Adults)

Gender	Form 6	Form 13	Total	%
Female	688	296	984	46%
Male	886	271	1,157	54%
Total	1,574	567	2,141	100%

Type of Applicant

Analysis was undertaken of the categories of persons who applied for a recommendation for a person to be involuntarily admitted under section 9 of the Act in 2011. Table 7 summarises this analysis.

Table 7. Analysis Of Applicant: Involuntary Admissions 2012 (Adults)

Form Number	Type	Number	%
1	Spouse, Civil Partner, Relative	901	57%
2	Authorised Officer	127	8%
3	Garda Síochána	336	22%
4	Any Other Person	210	13%
	Total	1,574	100%

Comparison of the 2007 figures for type of applicant with the 2012 figures shows the number of applicants by spouse/relative has fallen from 68% to 57%, authorised officer has risen from 7% to 8%, Garda Síochána has risen from 16% to 22% and any other person has risen from 9% to 13%. 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.

Revocation by Responsible Consultant Psychiatrist

Section 28 provides that the consultant psychiatrist responsible for the patient shall 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 1,530 such instances in 2012. The patient may leave the centre at this stage or stay to receive treatment on a voluntary basis. Figure 9 shows the number of orders revoked before hearing by responsible consultant psychiatrists under the provisions of section 28 for years 2007 to 2012.

Figure 9. Number of orders revoked before hearing by Responsible Consultant Psychiatrists under the provisions of Section 28 for years 2007 to 2012

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 another 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 privately) and an independent medical examination by a consultant psychiatrist, appointed by the Commission, will have been completed. There were 1,790 hearings in 2012. 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. Figure 10 shows the breakdown of hearings over the 21 day period of the relevant order.

It is important to note that hearings that took place on Day 22 or greater are in relation to orders that have been extended by tribunal or orders that were revoked and a hearing subsequently took place at the request of the patient (Section 28, Mental Health Act 2001).

Figure 10. Breakdown of hearings over 21 day period 2012

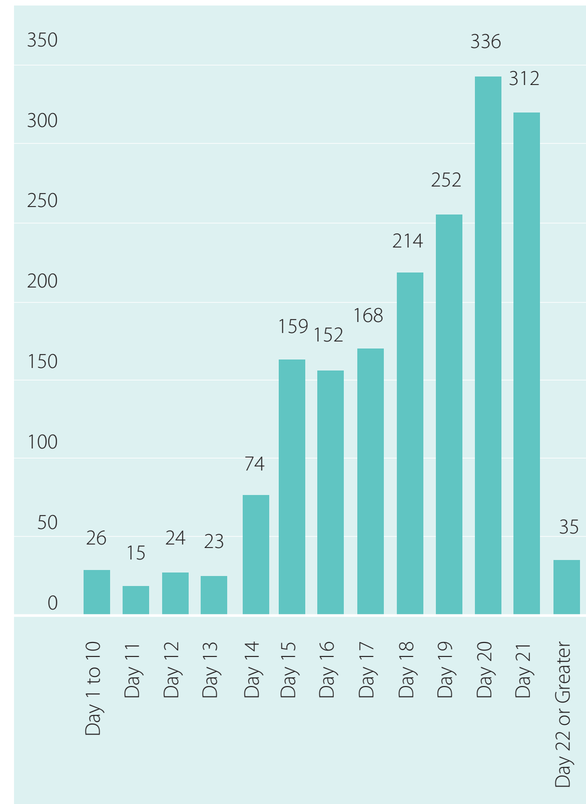
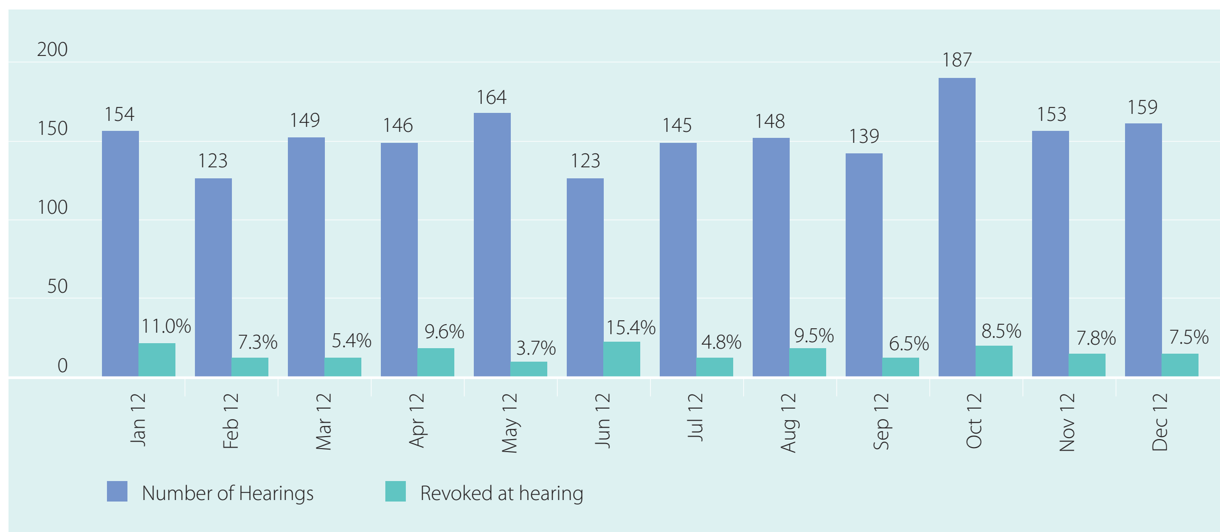


Figure 11. Number hearings and % of Orders Revoked at hearing 2012



Orders Revoked at Hearing

Analysis was undertaken of the number of orders revoked at a mental health tribunal in 2012. Figure 11 shows the number of hearings on a month by month basis for 2012 and the percentage of orders revoked in each month. In total, 8% of orders reviewed by the mental health tribunal in 2012 were revoked. This showed a 'no change' situation to the percentage of orders revoked at hearing in 2011.

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 have a mental disorder and is detained. The Commission was notified of 116 Circuit Court appeals in the period from 1 January to 31 December 2012 (This compares to 87 such notifications in 2011). 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 (n = 17), all of the Orders were affirmed by the Circuit Court.

External Environment and MHC Collaboration

External Environment and MHC Collaboration

In addition to our core activities, the Commission collaborates with key external stakeholders as a means of realising our statutory functions and engaging on issues in the wider health domain. We participate in working groups, make policy submissions and support key goals such as reducing the stigma and discrimination experienced by people with mental illness through our partnership in *See Change*, the National Mental Health Stigma Reduction Partnership. We are also represented on the Expert Group on the Review of the Mental Health Act 2001. More information on these and other collaborative projects are detailed below.

Review of Mental Health Act 2001

In August 2012 the Chief Executive of the Commission was appointed as a member of the Expert Group established by Ms. Kathleen Lynch, T.D., Minister of State, Department of Health and Department of Justice, Equality and Defence with responsibility for Disability, Equality, Mental Health & Older People to review the Mental Health Act 2001. The Chief Executive was a Member of the preceding Steering Group which prepared its Interim Report in April 2012. The Steering Group Report identified key areas to be further examined and proposed a range of recommendations on the Review of the Act. The Steering Group Interim Report was referred to the Expert Group for the second and substantive phase of the Review. The work of the Expert Group was underway during quarter four of 2012.

The Terms of Reference of the Expert Group are:

1. To examine each of the recommendations of the Interim Report on the review of the Mental Health Act 2001, and
    - propose which recommendations can be agreed without further assessment or modification,
    - establish which recommendations require further analysis before being finalised and reach conclusions in respect of the issues concerned,
    - make decisions on those areas where the Steering Group had offered choices rather than specific recommendations.
2. To consider Departmental proposals for amending the Mental Health Act which pre-dated the Steering Group report and recommend a course of action in respect of those matters.
3. To examine any further specific issues which may be referred to the Expert Group by the Minister.
4. To ensure that the recommendations of the Expert Group take account of any Capacity legislation published in the meantime and be consistent with such legislation and existing criminal law insanity legislation, which is also under review at this time.
5. To conclude its deliberations and submit final report to the Minister by end March 2013.

Capacity Legislation

Since its establishment the Mental Health Commission has been highlighting the urgent need for Capacity Legislation to be enacted. In February 2012 Dr. Mary Keys, Chair of the Commission's Legislation Committee and the Chief Executive met with the Joint Oireachtas Committee on Justice, Defence and Equality to outline the Commission's views on any forthcoming Capacity legislation. The meeting took the format of an 'open session/presentation' at which a number of other stakeholders in the mental health area were also in attendance. The Report on hearings in relation to the Scheme of the Mental Capacity Bill was published in May 2012 and is available at www.oireachtas.ie

It is expected that the new Capacity Bill will be published in 2013.

A Vision for Change

2012 represented a seven year milestone in the implementation timeframe of 'A Vision for Change' Ireland's national mental health policy. It also marked the conclusion of the three year work programme of the Policy's second Independent monitoring group. It is the Commission's view that the absence of independent monitoring of A Vision for Change needs to be addressed without delay. During 2012 the Commission has continued to emphasise that a streamlined structure with proper governance by way of a separate, semi-autonomous Mental Health Services Directorate within the Health Service Executive is required if the policy is to be effectively implemented. For HSE services, the introduction of the clinical care programmes for mental health which are due to be implemented in 2013 are to be welcomed as they will focus services on both process and quality improvement.

In 2012 the Commission also welcomed the special Governmental allocation of €35 million provided primarily to further strengthen Community Mental Health Teams in both adult and children's mental health services, to advance activities in the area of suicide prevention, to initiative the provision of psychological and counseling services in primary care, especially for people with mental health problems and to facilitate the re-location of mental health service users from institutional care to more independent living arrangements in their communities. The approval of 414 posts to implement these packages was also a welcome development.

It was disappointing to note that only a proportion of posts were filled by the end of 2012, however, it is encouraging that the €35 million allocated for this purpose in 2012 is being made available in 2013 in addition to the 2013 allocation.

Advisory / Working Groups

The Commission Executive were involved in several collaborative projects with other organisations and stakeholders in 2012 and sat on associated working groups. These included the 'healthcomplaints' initiative involving a group of organisations working in health and social care, standards advisory groups established by the Health Information and Quality Authority (HIQA) and working groups established by the Health Service Executive.

Submissions

The Commission made a number of submissions to government departments, statutory bodies and the HSE over the year on matters of relevance to our statutory remit and relating to the provision of health and social care services. These included submissions contributing to the review of the Criminal Law (Insanity) Acts 2006 and 2010 and to the review of the Nursing Homes Support Scheme, Fair Deal.

See Change

In 2012 the Mental Health Commission continued to be a 'partner organisation' with 'See Change'. See Change is an alliance of organisations working together through the National Stigma Reduction Partnership to bring about positive change in public attitudes and behavior towards people with mental health problems.

See Change works in lots of locations and in different ways to maximize the effectiveness of the campaign. The pillars of the campaign are; community and grass roots; in the workplace; partner activity; and public engagement.

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.

Further information on 'See Change' can be accessed at www.seechange.ie

National Patient Safety Advisory Group

A National Patient Safety Advisory Group (NPSAG) was established in 2011 to facilitate the process of continuing to drive the patient safety agenda forward at national level and to provide for continuity of high level engagement of the stakeholders that worked together on the implementation of the Patient Safety Commission's Report and the launch of the Patient

Safety First Initiative.

The Chief Executive of the Mental Health Commission Commission was appointed as a member of this group by Dr. James Reilly, T.D, Minister for Health.

The Terms of Reference of the NPSAG are as follows:

1. To support the Minister and the Department in providing national leadership on patient safety and quality.
2. To advise on the development of policy in the area of patient safety and quality as requested by the Minister.
3. To provide a forum for dialogue and discussion of important patient safety issues at national level as requested by the Minister from time to time.
4. To provide a national forum for the discussion and sharing of members' experiences, concerns and learning in relation to patient safety.
5. To advise the Minister and the Department and service providers of any new or emerging patient safety issues that come to its attention.
6. To advise on high level patient safety indicators for adoption at national level and comment on their implementation.
7. To act as trustees for the 'Patient Safety First' brand through ongoing advice and oversight in relation to website content and activities undertaken under this heading.
8. To oversee the implementation of the recommendations of the Commission on Patient Safety and Quality Assurance.

National Clinical Effectiveness Committee

The Chief Executive of the Commission was appointed as a member of the National Clinical Effectiveness Committee by Dr. James Reilly, T.D. Minister for Health in 2010.

The aim of the committee is to provide a framework for national endorsement of clinical guidelines and audit to optimise patient care, within the Irish health system, both public and private.

The Terms of Reference of the NCEC are as follows:

- Apply criteria for the prioritisation of clinical guidelines and audit for the Irish health system.
- Apply criteria for quality assurance of clinical guidelines and audit for the Irish health system.
- Disseminate a template on how a clinical guideline and audit should be structured, how audit will be linked to the clinical guideline and how and with what methodology it should be pursued.
- Recommend clinical guidelines and national audit, which have been quality assured against these criteria, for Ministerial endorsement within the Irish health system.
- Facilitate with other agencies the dissemination of endorsed clinical guidelines and audit outcomes to front-line staff and to the public in an appropriate format.
- Report periodically on the implementation of endorsed clinical guidelines.

Health, Social Care and Regulatory Forum

The Chief Executive of the Commission is a Member of the Health, Social Care and Regulatory Forum.

The Terms of Reference of the Forum are:

1. To enhance the overall practice by sharing knowledge and experience of Health, personal social services and regulation in Ireland
2. Explore opportunities to harmonise certain business processes, share best practice and facilitate coordination where appropriate.
3. Act as a steering group for specific work projects agreed by the forum.
4. Provide advice on legislation to address anomalies or gaps as required.

Medication Safety Forum

The Mental Health Commission continues to be one of the stakeholders of the Medication Safety Forum which was established in 2008. The main aim of the Forum 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.

Our Key Enablers

Key Enablers

Good Governance

We continue to demonstrate good governance by reviewing and assessing internal systems, policies and processes to ensure they are effective and of high quality.

Expenditure

The non-capital allocation to the Mental Health Commission for 2012 was €14.7 million. The outturn for 2012 in the Mental Health Commission was €13.165 million.

Key areas of expenditure included Statutory Functions i.e. Mental Health Tribunals, Legal Aid Scheme, Inspections, staff salaries, legal fees, office rental, ICT technical support and development and research projects. Third party support contracts continue to be managed to ensure value for money and service delivery targets were met.

The accounts for 2012 have been submitted to the Comptroller and Auditor General as per Section 47 of the Mental Health Act 2001. The annual audited financial statements of the Mental Health Commission will be published on the Mental Health website www.mhcirl.ie as soon as they are available.

Audit Committee

The Mental Health Commission Audit Committee met on four occasions in 2012 to conduct its business. Issues addressed by the Audit Committee include Financial Statements for 2011, Budget 2012, Accounts Procedures, Report from Service, Training for Audit Committee, Risk Register, Rolling Budget Reports 2012, Mental Health Commission's Code of Business Conduct for Staff, Fraud Policy Overview, Review of Internal Financial Controls and the Audit Committee Quarterly Reports.

Prompt Payment of Account legislation

The Commission complied with the requirements of the Prompt Payment of Account legislation and paid over 94% of valid invoices within 15 days of receipt. In order to meet this target strict internal timelines are in place for the approving of invoices. Details of the payment timelines are published on the Commission's website.

Freedom of Information

During 2012 the Mental Health Commission received thirty six requests under the Freedom of Information Acts (1997 and 2003). Of these eighteen were granted seven were part-granted, twelve requests were withdrawn and one request carried forward from 2011 was completed.

Data Protection

One request for information was received in 2012 under the Data Protection Act and this request was granted.

Health and Safety

The Commission is committed to ensuring the well-being of its employees by maintaining a safe place of work and by complying with relevant employment legislation including the Safety, Health and Welfare at Work Act, 2005. and the Safety, Health and Welfare at Work (General Application) Regulations, 2007

Information and ICT

We published and disseminated information online and in other formats that related to the work of the Commission. We sought to maximise the use of information communication technology (ICT) in order to enhance our work and practices.

- Enhancements were made to the on-line payment system used by the Mental Health Tribunal Panel Members.
- The Secure Messaging System was introduced to the majority of Approved Centres in 2012.
- ICT Security policies and procedures were revisited and rewritten to ensure applicability with new developments in technology and to ensure compliance with legislation.
- Disaster recovery plans were updated and tests successfully carried out to ensure the Mental Health Commission can fulfill its statutory mandate in the event of an untoward incident rendering our systems in St Martin's House inoperable.

Developing Our People

We will develop our people in the Commission so that they feel valued, motivated and are equipped with the necessarily skills to deliver on our strategic priorities.

In line with our 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.

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).

It is the policy of the Mental Health Commission to ensure that relevant accessibility requirements for people with disabilities is an integral component of all Commision processes.

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 coordinating assistance and guidance to persons with disabilities accessing the services provided by the Commission.

Evidence-Informed Practice

We will use available international and national evidence and research to underpin all of our regulatory practices and oversight activities.

Research Projects

In 2012 and in a challenging fiscal environment the Commission continued to fund three existing Research Programmes.

One project which maintained funding under the Commission's former Research Scholarship Scheme, is a three year project being undertaken by Mr. Niall Turner. The project title is:

> A clinical trial of supported employment (SE) and the Workplace Fundaments Module (WFM) with people diagnosed with schizophrenia spectrum disorders

The Academic Host Institution for the above project is University College, Dublin.

A second project is funded under the Commission's former Research Programme Grant Scheme. Professor Colm McDonald is the Lead Applicant for this project with University College Galway being the Host Institution. Professor McDonald's project title is:

> A prospective evaluation of the operation and effects of the Mental Health Act 2001 from the viewpoints of service users and health professionals

2012 represented the second year of this four year project.

Work continued to progress in 2012 pertaining to a PhD Research Programme Collaboration between the Mental Health Commission and the Royal College of Surgeons in Ireland. Two Clinical Research Scientists Dr. Selena Pillay and Mr. Stephen Shannon are working on a three year project as part of this programme. The project title is:

An analysis of the use of ECT and Seclusion in Clinical Mental Health Practice in Ireland.

Quarter three 2012 represented the first year of the project being completed.

Additional Information

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Fax: (+353) 01 6790805
www.crowleysdfk.ie

Auditors:

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

Appendix 1 :

Table 1: Overview of achievement of Business Plan 2012 Objectives

Strategic Priority (2009-2012)		Number of associated objectives in 2012	Number completed	Detail of objective(s) not completed	Reason
1	Service users and their families are active participants in the care process	10	9	Evaluation of MHC/ISQSH inpatient perception project with a view to rolling it out on a regular basis in inpatient and community settings	Priority given to objectives that fulfill statutory requirements due to depletion of staffing resources throughout 2012[23]
2	The human rights and best interests of all persons who use mental health services are respected and protected.	16	11	3 objectives associated with the preparation of Statutory Instruments.	Substantially complete for finalisation in early 2013
				2 objectives associated with seclusion and restraint reduction strategy	Stakeholder consultation complete. Consultation report and associated action plan for Members consideration in January 2013.
3	The quality of mental health services is consistent with best international standards	OIMHS[24]: 19	16	3 objectives associated with completion of 8 whole service evaluations	Whole service evaluations - detail involved in carrying out the evaluations was more than expected therefore 4 were completed.
		Executive:15	13	2 objectives associated with preparation of activity reports	Verification of data from services received later than requested. Report(s) preparation in progress and for completion in January 2013.
4	The needs and rights of people with mental illness are addressed in an integrated and cohesive manner within the wider health domain.	OIMHS: 5	4	1 meeting with stakeholder group deferred.	
		Executive: 10	9	Scoping exercise with external partners to develop a suite of key performance indicators for mental health services deferred	

23 This reason is applicable to all SP objectives not completed by end 2012

24 Office of the Inspector of Mental Health Services

Strategic Priority (2009-2012)		Number of associated objectives in 2012	Number completed	Detail of objective(s) not completed	Reason
5	Public understanding of mental illness is enhanced, stigma is diminished and public attitudes are increasingly respectful.	9	9	N/A[25]	N/A
6	The Mental Health Commission is viewed as an efficient organisation with the interests of people with serious mental illness or mental disorder at the forefront of all our activities.	50	41	2 objectives associated with PMDS	Delayed due to depletion of senior staffing resources
				2 objectives associated with OIMHS working with Executive to develop an agreed dataset for the OIMHS	Delayed due to depletion of senior staffing resources.
				1 objective associated with Feasibility study to establish electronic registration system	Staffing as above
				1 objective relates to post implementation review of RADAR	Postponed to 2013 as full implementation was commenced later in the year than planned
				2 objectives relate to Reviews of operational matters	Not possible due to depleted staff resource and subsequent reprioritisation
				1 objective relates to the development of fourth MHC Strategic Plan	Currently work in progress by Committee and nearing completion.

25 N/A: not applicable

Report of the Inspector of Mental Health Services 2012

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The following 2012 Reports of the Inspector of Mental Health Services are available on the Commission's website at www.mhcirl.ie

A CD of the Commission's Annual Report 2012 and the Report of the Inspector of Mental Health Services is also available from the Commission.

HSE Dublin Mid-Leinster

- Acute Psychiatric Unit, AMNCH, Tallaght
- Central Mental Hospital
- Department of Psychiatry, Midland Regional Hospital, Portlaoise
- Elm Mount Unit, St. Vincent's University Hospital
- Jonathan Swift Clinic, St. James's Hospital
- Lakeview Unit, Naas General Hospital
- Newcastle Hospital
- St. Fintan's Hospital
- St. Loman's Hospital, Mullingar

HSE Dublin North East

- Acute Psychiatric Unit, Cavan General Hospital
- Blackwater House and Ward 15, St. Davnet's, Hospital, Monaghan
- Department of Psychiatry, Connolly Hospital
- Department of Psychiatry, Our Lady's Hospital, Navan
- Hawthorn Unit, Connolly Hospital
- Joyce Rooms, Fairview Community Unit, Griffith Court, Philipsburgh
- O'Casey Wing, St. Vincent's Hospital, Fairview
- St. Aloysius Ward, Mater Misericordiae University Hospital
- St. Brendan's Hospital, (Units O, 3A, 3B and 8A)
- St. Brigid's Hospital, Ardee, (Unit One and St. Ita's Ward)
- St. Ita's Hospital – Mental Health Services
- St. Joseph's Intellectual Disability Services
- St. Vincent's Hospital, Fairview
- 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
- Heywood Lodge, Heywood Road, Clonmel
- O'Connor Unit - East & West Wings, Killarney (formerly St Finan's Hospital)
- South Lee Adult Mental Health Unit, Cork University Hospital
- St. Finbarr's Hospital
- St. Gabriel's Ward, St. Canice's Hospital
- St. Michael's Unit, Mercy Hospital Cork
- St. Otteran's Hospital
- St. Senan's Hospital
- St. Stephen's Hospital

HSE West

- Acute Psychiatric Unit 5b, Midwestern Regional Hospital, Limerick
- Acute Psychiatric Unit, Midwestern Regional Hospital, Ennis
- Adult Mental Health Unit, Mayo General Hospital
- An Coillín
- Cappahard Lodge
- Department of Psychiatry, County Hospital Roscommon
- Department of Psychiatry, Letterkenny General Hospital
- Department of Psychiatry, University Hospital Galway
- Sligo/Leitrim Mental Health In-patient Unit
- St Anne's Unit, Sacred Heart Hospital, Castlebar
- St. Brigid's Hospital, Ballinasloe
- St. Joseph's Hospital, Limerick
- Teach Aisling, Castlebar
- Tearmann Ward and Curragour Ward, St. Camillus' Hospital

Independent Service

- Bloomfield Care Centre – Donnybrook, Kylemore, Owendoher & Swanbrook Wings
- Highfeld Hospital
- Lois Bridges
- St. Edmundsbury Hospital
- St. John of God Hospital Limited
- St. Patrick's University Hospital

Child and Adolescent Services

- Adolescent In-patient Unit, St. Vincent's Hospital
- Child and Adolescent Mental Health Unit, Merlin Park University Hospital
- Eist Linn Child and Adolescent Mental Health Inpatient Services
- Linn Dara Child & Adolescent In-patient Unit, St Loman's Hospital, Palmerstown
- Willow Grove Adolescent Unit, St. Patrick's University Hospital

Whole Service Evaluation Reports 2012

- Dublin North Central
- Kildare West Wicklow
- Waterford
- Limerick

24 Hour Nurse Staffed Community Residences

- Ashford House, Longford
- Avonree House, Kilrush
- Cherryfield House, Killarney
- Bramble Lodge, Newbridge
- Edgewater House, Mullingar
- Hazel Heights, Ballinasloe
- Glenavon House, Athlone
- Inisgile, Limerick
- Larine House, Maynooth
- New Strand House, Limerick
- Riverview, Ballinasloe
- St. Colman's House, Macroom
- St. Mary's Residence, Drogheda
- Solas Nua, Mallow
- The Moorings, Point Road, Dundalk
- Unit 9A, Merlin Park, Galway

Child and Adolescent Mental Health Services

- CAMHS Team Limerick
- CAMHS Team Kildare
- CAMHS Team Waterford

Community Mental Health Services

- South Wexford CMHS
- City Sector Team, Waterford
- Marino Clontarf Sector Team
- Marino Tolka Sector Team
- North Kildare Community Mental Health Team

Day Centre

- 87 St. Lawerence Road
- Activation Therapy Unit (ATU), St Otteran's Hospital, Waterford
- Iniscara Day Centre, Limerick
- Newport House, Dungarvan
- Whitestown House, Kilcock

Day Hospital

- Brook House Day Hospital, Waterford
- Cellbridge Day Hospital
- Crannog Day Hospital, Fairview
- Iona Day Hospital, Fairview
- Psychiatry of Old Age, St. Vincent's Hospital, Fairview
- St Anne's Day Hospital, Limerick
- St Joseph's Adolescent & Family Service, St. Vincent's Hospital, Fairview

Forensic Community Mental Health Team

- Forensic CMHT, Limerick

Home Based Treatment Teams

- North Kildare Home Service Team

Medium Support Community Residence

- 87 St. Lawerence Road

National Overview Meeting Reports 2012

- National Overview Occupational Therapy
- National Overview Social Work
- National Overview Service User, Carer, Family Representative, Consumer Panels and Advocacy Groups
- National Overview Psychology

Outpatient Services

- City Sector, Waterford
- Cellbridge Outpatients Department
- Newport Outpatients Services, Dungarvan
- Psychiatry of Old Age, Outpatient Department, Waterford
- Sector B, Limerick

Psychiatry of Old age (POA) Team

- Waterford and South Kilkenny POA
- Psychiatry of Old Age Team, Limerick

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

2012 has been a difficult year for Ireland's Mental Health Services and in particular for staff attempting to maintain high quality of care in an environment of squeezed resources and general uncertainty.

Despite a number of perennial problem areas such as:

- Insufficient attention to governance;
- Number and variety of staffing;
- Inadequate understanding of the values underpinning mental health legislation and policy;
- A weak conceptual grasp of individual care planning,

Ireland's mentally ill can still be reasonably assured of a reasonably satisfactory standard of treatment in a caring and compassionate manner. Most of those receiving treatment, however, will be offered the more traditional medicalised version rather than that propounded in A Vision for Change.

The key concepts in A Vision for Change are:

- Patient/service user centrality;
- Recovery and multi-disciplinary working primarily in a community setting;
- Less emphasis on inpatient treatment

These concepts are still not universally applied.

The main structure which would remedy these problems, a Directorate of Mental Health Services with executive and budgetary powers, providing a streamlined, unified vision and mission, is still not in place.

2. Basis of this review

This review is based on the work of the Inspectorate throughout 2012. This is presented in tabular form in the appendix to this report.

The Inspection Process

All approved centres were visited, inspected and reported upon during the year according to the Act. Again, all inspections were unannounced and a number of approved centres were re-visited when various issues of non-compliance were identified (see table 1, appendix).

A number of areas of immediate concern were communicated directly to the Mental Health Commission Executive and immediate action was taken.

Approved Centres were asked to complete a self-assessment with respect to the rules, regulations and codes of practice in advance of inspection. Following inspection, a feedback session was held at which a general discussion took place with respect to initial impressions. Draft reports were completed and forwarded to the approved centres for factual correction.

Second drafts incorporating agreed aspects of the factual correction were prepared and forwarded to the Mental Health Commission Executive who, having studied the reports, took appropriate action.

The second draft reports were sent to the Quality, Proof-Reading and Editing Committee where certain amendments with respect to consistency and style were implemented. This Committee also deals with aspects of consistency across reports and the general quality of reports. This information is fed back to the Inspectorate at Regular Meetings to attempt to continuously improve the process.

The final version 3 reports are sent to the Mental Health Commission according to the Act and reports are published by the Mental Health Commission on the website http://www.mhcirl.ie/Inspectorate_of_Mental_Health_Services/

The Inspectorate has devised certain standards with respect to timeliness of completion of various phases of the process in order to provide reports as soon as feasible.

Through the process of inspection, the Inspectorate's aim is to achieve an improvement in the quality of care and treatment of mental health services. Much of this is achieved through ongoing dialogue with service providers and clinicians.

According to the Mental Health Act 2001, in addition to the compulsory annual inspection of approved centres, the Inspectorate may also inspect any mental health service.[26]

In that respect, the Inspectorate seeks to gather as much information as possible regarding the totality of mental health services through inspections of day hospitals, day centres, 24-hour community residences as well as whole service evaluations (see tables 2 and 3, appendix).

In 2010/2011 approved centres were inspected against the core (most important) aspects of the regulations, rules and codes of practice and given credit when self-assessed as compliant or had previously been compliant with a particular regulation. In order to eliminate any possible complacency, all regulations, rules and codes of practice were inspected during 2012.

As in previous years, a number of national overview meetings were conducted. In 2012, the national mental health services were examined from the following perspectives:

- Service user/carer and advocate views of the mental health services;
- Mental health services social workers;
- Mental health services clinical psychologists;
- Mental health service occupational therapists.

National overview meetings offer the opportunity to cross-reference emerging themes and to corroborate impressions gained at individual locations throughout the year.

From all of the above information, it appeared to us that many of the issues encountered could be grouped under two main themes, governance and human rights.

26. 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, Mental Health Act 2001.

3. Governance issues in 2012

3.1 A Director/Directorate of Mental Health Services has still not been appointed

Comment: This appointment has been recommended by several agencies with interest in the mental health services, in particular, Mental Health Reform.

The rationale for this structure has been well-rehearsed, but can be summarised by stating that a clear vision and mission with stream-lined paths of accountability are essential to counteract muddled thinking and wide variations in practice across the country.

Such a Directorate has the potential to provide a higher quality of service with more efficient use of resources.

3.2 Executive Clinical Directors (ECD's)

In any Directorate of Mental Health Services, the Executive Clinical Directors would play an important role as leaders of multi-disciplinary management team operating according to A Vision for Change with a population of around 300,000.

Currently, uncertainty abounds regarding the re-appointment of the original tranche of ECD's. A theme which emerged from our national overview meetings of health and social care professionals (HSCP's) was that management had now become even more centralised and less open to disciplines other than psychiatry and nursing. Largely because of financial considerations, decisions were being postponed and held up more centrally.

3.3 Staffing

An important aspect of good governance is the provision of adequate numbers and variety of staff to deliver according to established high standards.

- Nursing staff numbers continue to dwindle;
- Health and social care professionals (HSCP's) are recruited from national panels at junior level sometimes with little interest in the area of mental health;
- It is becoming increasingly difficult to recruit both in terms of numbers and quality. Some Consultant Psychiatrists say that they are no longer able to rely on the quality of their Non-Consultant Hospital Doctors (NCHD's) as previously. This, in turn, causes a knock-on effect in terms of fulfilment of other responsibilities. We have been told that a "brain drain" currently exists with respect to NCHD's.

A shortage of staff gives rise to transfer of staff from community duties to inpatient duty often at short notice for short periods. This results in problems of continuity of care within the approved centre and in the community and takes the focus away from community treatment.

3.4 Training and Supervision of Staff

Across all clinical disciplines, partly because of a lack of balance between senior and junior staff, junior staff receive inadequate supervision and opportunities for professional development.

Training opportunities are also limited and during some of our inspections, we were shocked by the lack of understanding of basic aspects of mental health legislative requirements.

We welcome registration of HSCP's and the likely requirement of specific continuous professional development.

3.5 Mental Health of Staff

Mental Health staff at present are under enormous pressure and are themselves at risk of mental ill-health. This is a matter that should be addressed by the Occupational Health Departments of the various agencies.

3.6 Compliance

Overall compliance with regulations, rules and codes of practice in 2012 can only be regarded as fair with no significant improvement on previous years.

We were dismayed to discover several examples of inadequate and absent individual care plans, of non-compliance with aspects of the Mental Health Act with respect to involuntary admission and the requirement of Section 60 with respect to medicating without consent. Although clinicians were operating in conditions where administrative staff had been reduced, some had failed to proactively ensure that their legal responsibilities were met.

It was in this area that the most glaring effects of inadequate governance were exposed.

3.7 Risk Management

A core principle of good clinical governance is that the safety of patient/service users and staff and the reputation of the institution are protected by a robust risk management process.

This involves careful assessment of the risk (for example, violence) with respect to previous history, current clinical condition and external factors. It is vitally important that this risk assessment is continuously updated and easily communicated to all staff.

It is not enough to identify the risk; a management plan should be initiated and carefully monitored.

Even with careful and prudent risk-assessment and management, because of the often unpredictable nature of human behaviour, adverse events will occur. These should be expeditiously and carefully analysed through a process such as root cause analysis and results quickly disseminated.

The Inspectorate expects to pay particular focus to this important area on inspections in 2013.

3.8 Family Involvement in the Risk Assessment and Management Process

It is vitally important that families of patients/service users are involved as early as possible in the risk assessment and management process. Even in situations where the patient/service user does not wish clinical information to be given to family members, it is still reasonable to seek and accept important relevant information from family members where possible. It is often the case that a close family member will have important information which will impinge on the assessment of risk.

In the case of an adverse event, family should be involved as much as is practicable in the review of clinical care and systems of care.

In the whole area of mental health, which has enormous implications for the quality and nature of relationships, it is vitally important and good practice to engage with families in terms of mutual support.

3.9 Geographical Variations

We are aware through our inspections and through information gathered at national overview meetings, that wide variations exist across the country with respect to several aspects of practice. While the well-known maxim "variation is the enemy of quality" is helpful in the quality assurance of manufacturing, it would be reasonable to allow for a degree of individual variation in a field of such complexity and subtlety as mental health. However, the degree of variation in Irish mental health practice goes beyond even this allowance.

It has been pointed out in our national reviews that variation and practice depends largely on the particular practice style of the Consultant Psychiatrist. Other factors include geographical considerations and history of the development of the services and resources.

Again, a robust system of governance with frequent auditing of practice is essential here.

3.10 Documents/Records

The condition of medical records in many of the approved Centres was poor.

Good governance also involves the maintenance of good records, not just as a protection in the event of a legal action, but also to provide continuity of communication and care to the patient/service user.[27]

The issue was raised with us regarding the confidentiality of psychiatric records which are integrated with general medical records in general hospitals. It is reasonable to assert that the content of a psychiatric record in many cases may be more sensitive than that of a general medical record and that widening the "ring of confidentiality" to the general hospital at large, weakens the certainty that information will not be leaked. This confidentiality issue is even more important in the case of electronic records.

On the topic of electronic records, several advantages are evident, in particular in terms of access to records remotely allowing for continuity of care between various centres of practice. There is still scope, however, for improvement in the immediate accessibility of key aspects of the medical record so that a new staff member or a staff member filling in for an illness absence can easily become acquainted with a particular patient/service user's condition and care plan.

3.11 Assessment

Proper governance arrangements would include proper provision for out-of-hours assessments.

Allowing the practice where an individual with perceived difficulties can self-present on a "walk-in" basis, to an approved centre for an ad hoc assessment does not reflect good practice and is more likely to lead to a default admission without appropriate rigour.

If those who govern the services are serious about providing a primarily community-based mental health service, then all assessments should be provided in the community mainly during working hours, but also out of hours.

3.12 Use of Medication

This is an important area of governance which had not been audited sufficiently on a systematic basis though an increasing number of centres now audit medication use. The guidelines issued recently by the College of Psychiatry of Ireland on the use of benzodiazepines are welcomed.

3.13 Child and Adolescent Mental Health Services

While the development of new inpatient centres for child and adolescent mental health services is welcomed, there appears to be a lack of clarity around and inadequate provision for those in particular aged 16 and 17, requiring acute admission. In 2012, there were 106 admissions of this age group to adult approved centres.

Good governance systems would quickly pick up this information and would be flexible enough to readjust the system such that beds could be made available exclusively for the acute underage admissions.

It is our impression that CAMHS health and social care professionals could be more usefully employed sharing their time between inpatient units and the community.

27. Medical Council's Ethical Guide – Section C – Medical records and Confidentiality

3.14 Examples of Good Governance

Two areas in particular deserve to be highlighted in respect of the methodical manner in which the mental health services were reorganised in the face of closure of the old asylums in their areas. These were Wexford/Waterford and South Tipperary/Kilkenny/Carlow.

With patient methodical management and involvement of staff at all levels in planning, a successful transition has taken place from the old psychiatric centres with the closure of St. Luke's and St. Michael's in Clonmel and the closure to acute admissions at St. Senan's in Enniscorthy.

Another example of good governance is the St. Patrick's University Hospital group which achieved very high compliance rates. St. Patrick's has also introduced an outcome document in which activity levels and analysis of the various operations are presented in readable, informative style.

4. Human Rights Issues 2012

4.1

The publication of the steering group report on the review of the mental health act emphasised the importance of a human rights approach to legislation and practice.

Further, discussions around the preparation of a capacity bill are also developing an increased focus on the issue of human rights.

These are ground-breaking developments and in the words of Professor Wayne Martin of the University of Exeter in his address to the Amnesty International Legal Capacity and Mental Health Workshop (26/11/2012) "The eyes of the world are on Ireland how it develops its capacity legislation".

These developments owe a significant debt of gratitude to the work of Amnesty International, who, with the use of a recent grant, brought the issue of human rights in mental health services centre stage.

Apart from Amnesty International, other organisations have tirelessly pushed the cause of those with mental illness, in particular, the Mental Health Reform conglomerate, NSUE and SHINE. The development of Consumer Panels around the country by NSUE is welcomed.

Approaching the delivery of mental health services from a human rights perspective will be an important philosophical adjustment which should impact positively on the quality of care and treatment. The concept of universal human rights can be understood in relatively simple terms and can cause clinicians to think twice with respect to particular treatments or approaches with particular patient/service users.

For example, understanding and respecting the liberty rights of a patient/service user and recognising that curtailment of these rights requires the closest scrutiny of procedure and process might mean that clinicians will pay more attention to these matters.

In addition, the human right to bodily integrity must be taken into account when assessment is made of the mental capacity of an individual to give or withhold consent to a particular treatment, e.g., medication or ECT.

Current thinking in this area is that decision-making should be supported by an appropriate person other than those providing care to allow a sense of objectivity and also to allow maximum expression of the patient/service user's preferences.

4.2

The concept of recovery can be understood in terms of the human right to autonomy and self-fulfilment of the individual.

4.3 Individual Care Planning

Nowhere in our mental health services is the concept of the essential dignity, autonomy and right to self-fulfilment of the individual more enshrined than in the individual care plan. Here, according to the Mental Health Act regulations, the patient/service user participates in planning his own treatment. This treatment takes into account his personality, his cultural context, his family, his preferences, aspirations and desires. Treatment is not of an illness or of a diagnosis. Treatment is identifying what aspects of the mental health services can be incorporated into a person's life to enhance that life largely by that person's own definition (but with some objective standards necessarily incorporated along with family input).

Perhaps if Individual Care Plans were seen in that context, the attitude that these are a "paperwork nuisance" might be less prevalent.

Although full multi-disciplinary teams frequently do not exist, the onus is on individual members of the care team to assert and advocate for the human rights of individuals with respect to having an individual care plan[28].

4.4 Seclusion and Physical Restraint

From a human rights perspective, seclusion and physical restraint are an even higher order of deprivation of liberty. In order to justify this, the rationale must be thoughtfully calculated and documented accordingly. A patient/service user subsequently looking for a rationale can have his concerns assuaged if this is present. If, instead, he is presented with a loose thinking verbal set of reasons an understandable sense of paranoia could easily develop.

4.5 Advocacy

Protection of human rights is a matter which requires committed advocacy on the ground. The presence of advocates in all approved centres allows the ventilation of issues which otherwise would not come to attention. It is extremely important that advocacy services are maintained and properly resourced with access to ongoing training.

5. Conclusions

1) Ireland's mental health services are stagnant and perhaps have slipped backwards in 2012.
2) While it is difficult to be optimistic regarding an increase in resources, the opportunity exists to re-frame the approach to mental health services from the point of view of good governance and protection of human rights.
3) Good governance requires clean administrative structures, clear vision, mission, measurement and accountability.
4) A human rights approach to practice requires education in human rights theory, a change of philosophical focus and a commitment to maintain beneficial change.
5) With these approaches, Ireland's mental health services with a strong philosophical foothold can achieve some stability in these turbulent times.
6) Improvements in governance and in human rights awareness will not be costly in terms of utilisation of resources and will, in all likelihood, if clear in focus, give rise to significant efficiencies.
7) We all want to see a mental health service, which does not dominate individuals with mental health problems, but rather supports them towards their own recovery and alleviates distress and suffering. This service should reflect the complexity of mental health issues with the use of multi-disciplinary teams and the importance of preserving autonomy through the maximal use of community services.

28 In 2012, the Inspectorate wrote to individual Consultant Psychiatrists to inform them when their patient/service users did not have an Individual Care Plan

Appendix

Table 1 Approved Centres Inspections 2012

	Approved Centre	Date of Inspection	Date of Night Inspection	Date of Re-Inspection
1.	Acute Psychiatric Unit 5B, Midwestern Regional Limerick	16 April 2012	_	_
2.	Acute Psychiatric Unit, AMNCH, (Tallaght) Hospital	03 May 2012	_	_
3.	Acute Psychiatric Unit, Cavan General Hospital	12 June 2012	_	_
4.	Adult Mental Health Admission Unit, Kerry General Hospital	17 October 2012	_	_
5.	Acute Psychiatric Unit, Midwestern Regional Hospital, Ennis	21 March 2012	_	23 October 2012
6.	Adolescent In-Patient Unit, St. Vincent's Hospital	04 September 2012	_	_
7.	Adult Mental Health Unit, Mayo General Hospital	19 June 2012	18 June 2012	20 November 2012
8.	An Coillín	20 June 2012	_	20 November 2012
9.	Bloomfield Care Centre-Donnybrook, Kylemore, Owendoher and Swanbrook Wings	14 February 2012	_	_
10.	Cappahard Lodge	22 March 2012	_	_
11.	Carraig Mór Centre	18 July 2012	_	_
12.	Central Mental Hospital	23, 24 and 25 September 2012	_	_
13.	Centre for Mental Health Care and Recovery, Bantry General Hospital	14 August 2012	_	_
14.	Child and Adolescent Mental Health In-patient Unit, Merlin Park University Hospital Galway	02 October 2012	_	_
15.	Department of Psychiatry, Connolly Hospital	03 April 2012	_	_

Table 1 Approved Centres Inspections 2012

	Approved Centre	Date of Inspection	Date of Night Inspection	Date of Re-Inspection
16.	Department of Psychiatry, County Hospital, Roscommon	24 April 2012	_	_
17.	Department of Psychiatry, Midland Regional Hospital, Portlaoise	28 March 2012	27 March 2012	_
18.	Department of Psychiatry, Our Lady's Hospital, Navan	30 May 2012	_	_
19.	Department of Psychiatry, Letterkenny General Hospital	21 February 2012	_	_
20.	Department of Psychiatry, St. Luke's Hospital, Kilkenny	12 June 2012	_	_
21.	Department of Psychiatry, University College Hospital Galway	1 May 2012	_	_
22.	Department of Psychiatry, Waterford Regional Hospital	25 June 2012	_	08 November 2012
23.	Eist Linn Child and Adolescent In-Patient Unit	02 October 2012	_	_
24.	Elm Mount Unit, St. Vincent's University Hospital	16 February 2012	_	_
25.	Hawthorn Unit, Connolly Hospital	03 April 2012		_
26.	Heywood Lodge, Clonmel	08 August 2012	_	_
27.	Highfield Hospital	23 August 2012	_	_
28.	Jonathan Swift Clinic	20 September 2012	_	_
29.	Joyce Rooms, Fairview Community Unit	21 February 2012	_	_
30.	Lakeview Unit, Naas General Hospital	21 May 2012	_	_
31.	Lois Bridges	24 April 2012	_	_

Table 1 Approved Centres Inspections 2012

	Approved Centre	Date of Inspection	Date of Night Inspection	Date of Re-Inspection
32.	Newcastle Hospital	1 March 2012	_	_
33.	O'Casey Rooms, Fairview Community Unit	27 September 2012	_	_
34.	Sligo/Leitrim Mental Health In-Patient Unit	24 May 2012	_	_
35.	South Lee Mental Health Unit, Cork University Hospital	18 July 2012	_	_
36.	St. Aloysius Ward, Mater Misericordiae University Hospital	20 March 2012	_	_
37.	St. Anne's Unit, Sacred Heart Hospital	19 June 2012	_	_
38.	St. Brendan's Hospital	15 May 2012	_	_
39.	Unit One and St. Ita's Ward, St. Brigid's Hospital, Ardee	29 May 2012	_	_
40.	St. Brigid's Hospital, Ballinasloe	21 August 2012	_	26 November 2012
41.	St. Gabriels Ward, St. Canice's Hospital	13 June 2012	_	_
42.	St. Davnet's Hospital –Blackwater House	13 June 2012	_	_
43.	St. Edmundsbury Hospital	11 September 2012	_	_
44.	St. Finan's Hospital- O'Connor Unit (East and West Wings)	16 October 2012	_	_
45.	St. Finbarr's Hospital	30 August 2012	_	_
46.	St. Fintan's Hospital, Portlaoise	28 March 2012	27 March 2012	_
47.	St. Ita's Hospital-Willowbrook and	15 May 2012	_	_
48.	St. John of God Hospital Limited	13 and 14 November 2012	_	_

Table 1 Approved Centres Inspections 2012

	Approved Centre	Date of Inspection	Date of Night Inspection	Date of Re-Inspection
49.	St. Joseph's Hospital, Limerick	16 April 2012	_	_
50.	St. Joseph's Intellectual Disability Services	28 February 2012	_	_
51.	St. Loman's Hospital, Mullingar	1 May 2012	_	_
52.	St. Michael's Unit, Mercy University Hospital	18 July 2012	_	_
53.	St. Otteran's Hospital	25 June 2012	_	_
54.	St. Patrick's University Hospital	20 and 21 November 2012	_	_
55.	St. Senan's Hospital	24 July 2012	_	_
56.	St. Stephen's Hospital	31 May 2012	_	_
57.	St. Vincent's Hospital, Fairview	03 September 2012	_	_
58.	Sycamore Unit, Connolly Hospital	03 April 2012	_	_
59.	Teach Aisling	19 June 2012	18 June 2012	19 November 2012
60.	Tearmann Ward, St. Camillus' Hospital	17 April 2012	_	_
61.	Linn Dara	10 October 2012	_	_
62.	Willow Grove Adolescent Unit, St. Patrick's University Hospital	10 October 2012	_	_

Details of the Changes to the Register of Approved Centres during 2012 are available on page 21 of the Report. The Summary of Conditions attached to the registration of Approved Centres during 2012 are available on page 23.

Table 2 Other Mental Health Services Inspections 2012

	Other Mental Health Service	Name	Date of Inspection
1.	Medium Support Community Residence	87, St. Lawrence Road, Clontarf	4 September 2012
2.	24 Hour Nurse Staffed Support Community Residence	Ashford House, Longford	11 September 2012
3.	24 Hour Nurse Staffed Community Residence	Avonree, Clare	1 November 2012
4.	24 Hour Nurse Staffed Community Residence	Bramble Lodge, Newbridge	22 May 2012
5.	24 Hour Nurse Staffed Community Residence	Cherryfield House, Kerry	22 November 2012
6.	24 Hour Nurse Staffed Community Residence	Edgewater House, Mullingar	18 October 2012
7.	24 Hour Nurse Staffed Community Residence	Glenavon House, Athlone	11 September 2012
8.	24 Hour Nurse Staffed Community Residence	Hazel Heights, Ballinasloe	21 August 2012
9.	24 Hour Nurse Staffed Community Residence	Inisgile, Limerick	17 April 2012
10.	24 Hour Nurse Staffed Community Residence	Larine House, Maynooth	22 May 2012
11.	24 Hour Nurse Staffed Community Residence	New Strand House, Limerick	18 April 2012
12.	24 Hour Nurse Staffed Community Residence	Riverview Community Residence, Ballinasloe	21 August 2012
13.	24 Hour Nurse Staffed Community Residence	Solas Nua, Bantry	20 August 2012
14.	24 Hour Nurse Staffed Community Residence	St. Colman's Residence, Macroom	17 July 2012
15.	24 Hour Nurse Staffed Community Residence	St. Mary's Residence, Drogheda	10 July 2012
16.	24 Hour Nurse Staffed Community Residence	The Moorings, Dundalk	10 July 2012

Table 2 Other Mental Health Services Inspections 2012

	Other Mental Health Service	Name	Date of Inspection
17.	24 Hour Nurse Staffed Community Residence	Unit 9A, Merlin Park, Galway	3 October 2012
18.	Child and Adolescent Mental Health Services Team	Waterford	27 June 2012
19..	Child and Adolescent Mental Health Services Team	South Kildare	22 May 2012
20.	Child and Adolescent Mental Health Services Team	Limerick	12 April 2012
21.	Home Based Treatment Team	North Kildare	22 May 2012
22.	Day Hospital	Brook House, Waterford	26 June 2012
23.	Day Hospital	Celbridge	22 May 2012
24.	Day Hospital	Crannog Day Hospital, Dublin North City	4 September 2012
25.	Day Hospital	Iona Day Hospital, Dublin North City	4 September 2012
26.	Day Hospital	St. Anne's, Limerick	18 April 2012
27.	Day Hospital	St. Joseph's Adolescent and Family Service, Dublin North City	3 September 2012
28.	Day Hospital	Psychiatry of Old Age, St. Vincent's Hospital, Fairview	5 September 2012
29.	Day Centre	ATU, St. Otteran's Hospital, Waterford	26 June 2012
30.	Day Centre	87 St. Lawrence Road, Clontarf	4 September 2012
31.	Day Centre	Inis Cara, Limerick	19 April 2012
32.	Day Centre	Newport, Dungarvan, Co. Waterford	26 June 2012
33.	Day Centre	Whitestown House, Kilcock	22 May 2012

Table 2 Other Mental Health Services Inspections 2012

	Other Mental Health Service	Name	Date of Inspection
34.	Outpatient Department	Celbridge	22 May 2012
35.	Outpatient Department	Newport, Dungarvan, Co. Waterford	26 June 2012
36.	Outpatient Department	Psychiatry of Old Age, Dungarvan, Co. Waterford	26 June 2012
37.	Outpatient Department	City Sector, Waterford	26 June 2012
38.	Psychiatry of Old Age Team	Waterford	26 June 2012
39.	Psychiatry of Old Age Team	Limerick	17 April 2012
40.	Forensic Team	Limerick	17 April 2012
41.	Sector Team	North Kildare	22 May 2012
42.	Sector Team	Sector B, Limerick	17 April 2012
43.	Sector Team	Marino Clontarf	5 September 2012
44.	Sector Team	Marino Tolka	5 September 2012
45.	Sector Team	City Sector Team, Waterford	26 June 2012
46.	Sector Team	South Wexford Community Mental Health Team	25 July 2012

Table 3 Whole Service Evaluations 2012

	Whole Service Evaluations	Dates of Inspections
1.	Limerick	Week 16 April 2012
2.	Waterford	Week 25 June 2012
3.	Dublin North Central	Week 3 September 2012
4.	Kildare West Wicklow	Week 21 May 2012

Table 4 National Overview Meeting Reports 2012

	National Overview Meetings	Date of Meeting
1.	Social Work	22 October 2012
2.	Service User, Family/Carer and Advocacy Group Involvement in mental health Services	23 October 2012
3.	Psychologists	5 November 2012
4.	Occupational Therapist	19 November 2012

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