



WORKING TOGETHER
FOR QUALITY MENTAL
HEALTH SERVICES

Mental Health Commission
Annual Report 2015

Including Report of the Inspector
of Mental Health Services



MHC

Coimisiún | Mental Health
Meabhair-Shláinte | Commission

Our Vision

WORKING TOGETHER FOR QUALITY MENTAL HEALTH SERVICES

We will continue to work collaboratively with our stakeholders to create this shared vision and deliver real change in our mental health services. We will continue the alignment of strategies and processes in the mental health domain with the aim of achieving quality mental health services.

Our Mission

Our Mission is to safeguard the rights of service users, to encourage continuous quality improvement, and to report independently on the quality and safety of mental health services in Ireland.

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Chairman's Foreword

I am pleased to present the 2015 Annual Report of the Mental Health Commission which includes the report of the Inspector of Mental Health Services.

Strategic Development

During 2015 the Commission, in association with the Executive, undertook a strategic review in preparation for the development of a new Strategic Plan for 2016 - 2018. This work involved both internal and external stakeholders and the Commission wishes to acknowledge and thank all those who participated in this important exercise.

The Strategic priorities of the Mental Health Commission for 2016 - 2018 are;

- Promoting the continuous improvement and reform of mental health services and standards
- Fostering an integrated person-centred approach for service users
- Encouraging the development of future focused services
- Developing our people, processes and systems internally

Policy

The national mental health policy, A Vision for Change, is in place since 2006. The core concepts of the policy are recovery, person centeredness, partnership, user and family involvement and the delivery of multidisciplinary community based services.

As referred to in last year's report there is now a degree of congruence between national mental health policy and the aspirations and objectives of the HSE Mental Health Divisional Operational Plan. There is considerable commitment to the policy both at national and regional level. This commitment is evident in the statutory, voluntary and independent sectors.

The implementation of policy to date is still reliant on innovative and imaginative leadership at regional and local levels. The Commission is conscious that there is a great deal of activity, clinically and administratively, and all levels of service provision need to work towards adherence to the Vision for Change policy. Notwithstanding this commitment, this report of the Commission shows that much needs to be done to ensure the delivery of consistent, timely and high quality services in all geographic regions and across the full range of clinical programmes and age groups.

I have referred in previous years to the absence of any independent monitoring of A Vision for Change policy. This situation has remained unchanged since 2013. Additionally, there is now a need to formally review the implementation of the policy ten years on from its launch. Specific consideration needs to be given to the increased population size and changed demographic in Ireland since 2006 as well as reviewing models of service.

Resources

The Commission welcomed the €35 million budget allocation in 2015 for revenue spending on the development of additional mental health services with an emphasis on supporting the development of specialist community mental health teams. The Commission is cognisant that the current level of expenditure on mental health as a proportion of overall health expenditure is still less than the 8.24% target (based on 2005 figures) envisaged in Vision for Change.

The Commission notes that the HSE's 2015 Mental Health Division Plan states that the services were operating with a staffing level of circa 75% of the Vision for Change recommended number. In 2015 there was funding for an additional 700 WTEs. Regrettably, the Commission notes the continuing difficulties of recruitment of specific professional staff. This is a situation that requires action as a matter of urgency if we are to achieve full staffing of mental health teams across the country.

The Commission is also pleased to see the continued progress towards ending the use of outdated and unsuitable buildings to provide inpatient services. The Commission stresses the need for the continued development of community mental health services to replace traditional models of inpatient care.

Recovery Services

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. Notwithstanding the stated commitment by the Mental Health Division of the HSE to the Advancing Recovery in Ireland programme and the Service User, Carer and Family Engagement Action, 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 therapy, and other multidisciplinary team members. This situation persists ten years after the adoption of A Vision for Change and reflects to a large extent the combined effect of poor manpower planning, lack of change in professional training schemes, the impact of public service expenditure reductions, delays in the process of recruitment and more recently, as referred to above, a shortage of appropriately trained staff.

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 Commission is of the view that there needs to be a greater focus on corporate culture change to bring about the required systematic shift towards recovery in service provision.

Standards

The Commission is also concerned regarding a number of specific areas of service provision where, in 2015 standards fell below what is acceptable.

During 2015 there were five areas identified by the Commission of significant non-compliance. These were individualised careplanning, privacy, staff training, safety of premises and the control and administration of medication. Some of these issues, such as individual care planning and privacy, have been recurrent themes for a number of years and need to be addressed if we are to demonstrate the provision of high quality services. In addition to the above, a significant percentage of applicable approved centres (43%) were found to have breached the rules on seclusion. These breaches had the potential to pose serious risk to the safety and wellbeing of service users.

Involuntary admissions

The Commission is concerned at the increase in the number of involuntary admissions - in 2015 there were 2,363 admissions compared with 2,162 in 2014. This represents a 9% increase.

Whilst the Commission cannot identify the precise reasons for such an increase, it is worth noting that modern mental health policy and practice suggests that admission to inpatient care and, in particular, involuntary admission, should be a last resort intervention. All community based interventions should be considered and implemented prior to the decision to admit voluntarily and involuntarily.

Additionally, the Commission is concerned at the preponderance of involuntary admissions where the family and Gardai are the primary applicants (23% and 47% respectively). This is a cause for concern and requires a review of the operation of the Authorised Officer Scheme as is proposed in the Expert Group Report.

Other specific concerns of the Commission include the use of security personnel to restrain individuals in a small number of cases. Questions arise about the appropriateness of using security personnel in what is a controlled clinical intervention.

Community Residences

In 2015, the Commission reported on its work to promote quality improvement in 24 hour staffed community residences

Following review of the relevant inspection reports, the Commission requested quality improvement plans (QIP) for 20 residences to address standards in the Quality Framework, as well as recommendations that the Inspector of Mental Health Services had made. Several services were also requested to outline how they were delivering a service in line with A Vision for Change, the national policy on mental health services. Services were requested to outline actions being taken or planned, timeframes for completion, and persons responsible for implementation of any quality improvement actions and initiatives taking place within the service.

During 2015 the Commission continued to be concerned about specific issues related to these residences. There is a fundamental issue of identifying precisely the number of residences and people living in such residences. Despite repeated discussions with the HSE, no agreement has been reached on this issue. Additionally, the Commission is concerned that some of these residences are too large, have poor physical infrastructure, are institutional in nature and lack individualised care plans.

Admissions, Transfers and Discharge

In relation to younger service users, there is still a most unsatisfactory situation whereby children are being admitted to adult units, there were 95 such admissions in 2015. It should be noted that there is a Commission code of practice, accepted by the HSE stating that inappropriate admissions of children to adult units should not take place. Additionally, there needs to be a focus on the full implementation of the Vision for Change recommendations on residential and community based services for children and adolescents.

The Commission is also concerned by the continued decline in compliance with the codes of practice governing admission, transfer and discharge. The reports of the Inspector indicate instances where residents are transferred or discharged early to make room for new admissions. This situation points to the need for a more coherent responsive bed management policy and perhaps, a review of the required number of beds to serve the present population. Pressure to admit is also reflective of the ability or otherwise of services to maintain people in their own community.

Legislation

The final report of the group tasked with the review of the Mental Health Act 2001, was published in December 2014 and I alluded to this in last year's report. Unfortunately, draft legislation has not been progressed to bring about the changes envisaged in the review. The exception is the passing of legislation in December 2015 to remove the word 'unwilling' from the Mental Health Act. The effect of this is that a person who expresses his or her unwillingness to receive ECT or to have medication administered to him or her after a period of three months will have his or her opinion respected. This is a long overdue and welcome legislative change.

Similarly, the Commission acknowledges the enactment of the Assisted Decision Making (Capacity) Act 2016 and notes particularly the powers conferred on the Commission regarding the Office of the Director of Decision Support Services. The Commission looks forward to working with the relevant government departments to implement this part of the Act.

Conclusion

The Commission is concerned that there are serious issues to be addressed in relation to the admission of children to adult services.

Additionally, much work remains to be done to change service culture and to refocus on the full delivery of A Vision for Change. Services must be accessible, comprehensive, responsive and timely. Now more than ever, there is a need to address systemic issues which prevent the delivery of services and the development of newer, more appropriate ones.

The Commission is supportive of government policy to ensure that the necessary resources and support are put in place to allow the full realisation of policy and an operational plan for a recovery focussed, clinically excellent service that provides for and fully involves, service users and their families in all aspects of service delivery and development.

Finally, I would like to thank the members of the Commission for supporting me in my role 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

2015 marked the final year in the timeframe of the Mental Health Commission's (the Commission) 2013-2015 Strategic Plan.

During the year we continued to evolve with an emphasis on working in partnership with others to inform and influence mental health policy and practice, to regulate approved centres, report on the quality of mental health services and to protect the interests of persons who are detained in approved centres under the Mental Health Act 2001. Our work during the year was directed and guided by the Strategic Plan 2013-2015 set down by the Commission who specified the following four outcomes focussed strategic priorities for the three year period:

1. Safeguarding human rights and incorporating these principles in all our work;
2. Supporting the development of high standards and good practices in the delivery of mental health services and supporting good quality care;
3. Promoting service user – centred and recovery oriented services;
4. Strengthening the profile of the Mental Health Commission and mental health services.

Details of how we achieved our strategic priorities are provided throughout this Report.

In the Commission our Values are fundamental to the way we work and are the foundation stone upon which we build our progress. These values are accountability and integrity, dignity and respect, confidentiality, empowerment, quality and recovery. Accountability assists us to operate at all times in a fair and transparent manner and take responsibility for our actions; dignity and respect underlines the importance of how we treat each other within the organisation and also all those with whom we come into contact during the course of our work; confidentiality helps us to behave with the highest level of professionalism; empowerment underlines our approach to facilitation of autonomy for service users; quality ensures our focus is always on the attainment of quality mental health service provision and recovery is about ensuring our work focusses on strong equal participation of service users and services providers. Of course, teamwork is key and in a small organisation like the Commission it is particularly important that we learn from each other as in its absence we could not achieve our objectives.

Regulation of mental health services is a key core activity of the Commission. Regulation comprises of registration, inspection and enforcement activities. One of the statutory functions of the Inspector of Mental Health Services is to inspect all approved centres at least annually and report on the inspections and also on the quality of mental health services. In addition, the Inspector may visit and inspect other mental health services, however the Commission does not have a statutory enforcement role for such services. The approved centre inspection reports provide information that is used by the Standards and Quality Assurance team to carry out the enforcement component of regulation. Our role as a regulator is to look at mental health services and ensure they are providing a high quality service. To do this successfully, as well as being outward looking we also have to look inwards at our own approach and ask ourselves how we as an organisation can evolve to continue to support services in reaching compliance with statutory regulations, rules and codes of practice and, most importantly, to achieve high quality mental health service provision. We decided to focus on providing better guidance and assistance to services, making our systems and processes more transparent. Our efforts culminated in the development of the Judgement Support Framework (JSF) which is a guidance document to assist approved centres to meet statutory minimum standards and also support continuous quality improvement by setting out, for each regulation, its purpose, the processes and training that should be in place to support the regulation, the monitoring requirements to ensure the regulation is being implemented appropriately and the types of evidence that should be available to the Inspector.

This resulted in inspections commencing mid-year with the Inspector and Assistant Inspectors looking for evidence of compliance and quality improvements through interviews with staff and residents in approved centres; observation of the premises, facilities and operational practices and also review of various documents. The subsequent regulatory enforcement actions taken in respect of areas of non-compliance comprised of requests for the provision of corrective and preventative action plans and the issuing of immediate action notices details of which are provided within the Report.

Ongoing monitoring of the conditions attached to the registration of approved centres requiring the monthly submission of mandatory audits of individual care plans (ICP's) to the Commission, resulted in eight out of nine approved centres achieving compliance with the statutory regulation regarding ICP's. Of note is that four of the eight approved centres concerned were rated by the Inspector as excellent achievement.

We acknowledge that in the interest of fairness all approved centres must be inspected in a consistent manner. The introduction of new processes, and the JSF in July, meant that some approved centres were subject to unannounced inspection within a very short space of time although the legal requirements were unchanged. We are acutely aware of the need to continuously listen to others and act on feedback we receive from services users and their advocates telling us about their care as well as from mental health service providers and other stakeholders who inform our work. We made a commitment to carry out a review of the revised processes and JSF once the 2015 inspections were completed. We advised that the review would be carried out in early 2016 and that, based on the feedback received, we would continue to enhance our activities in this important area. I look forward to reporting on progress in this area in the 2016 annual report. Internationally there is an increasing understanding that quality improvement requires a whole systems approach with the various stakeholders working together. We, as the regulator of mental health services will continue to play our part in enabling this.

Our role in ensuring that every person who is admitted as an involuntary patient has an automatic entitlement to review by a mental health tribunal, an examination by an independent consultant psychiatrist and the appointment of a legal representative continued throughout the year. Our mental health tribunals' team ensured that 1,944 hearings took place. There was a 9% increase in the involuntary admission rate during the year and a detailed breakdown of the independent review system is also included in the report. Of course, it would not have been possible to implement the independent review system without the assistance of the legal representatives, chairpersons, consultant psychiatrists and other persons (referred to as lay persons) that populate the mental health tribunal panels and other associated panels. We thank them for their assistance and commitment to providing such services to the Commission and most importantly to the patients that we support.

None of the above activities could function effectively without the provision of the appropriate infrastructure, which falls in under the umbrella of our corporate services team and is outlined in some detail within the report. At the time of writing we await the provision of the audited 2015 financial statement of accounts and it will be made publically available on our website upon receipt. However, you will note in the report that our outturn for 2015 was €12.731 million and our non-capital allocation was €12.750 million.

2016 will be a particularly busy year for the Commission with the enactment of the Assisted Decision-Making (Capacity) Act 2015 in December 2015. The Decision Support Service under this Act will fall within the remit of the Commission. The range of functions that will be carried out by the Director of the Decision Support Service and his or her team are extensive and significant planning and resources will be required. We look forward to working with the relevant government departments and playing our part to bring about the commencement of this important statute.

I offer thanks to the Commission's management teams and staff for their hard work and dedication.

I also offer thanks to Mr John Saunders the Chairman and Members of the Commission for their governance and support and for developing a new strategic plan to guide us through the period 2016-2018.

Finally, we could not do what we do without the inputs and expertise of a wide range of stakeholders. We are grateful, as ever, for your support.



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 the Regulator for mental health services in Ireland as provided for under the provisions of the Mental Health Act 2001.

The Commission is an independent statutory body which was established in April 2002. The Commission's 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). Our remit includes the broad spectrum of mental health services including 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 Commission's additional responsibilities under the 2001 legislation 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 (Electroconvulsive Therapy), seclusion and mechanical restraint; and
- Developing Codes of Practice to guide people working in the mental health services.

The Mental Health Commission has 13 Members, including the Chairman, who are appointed by the Minister 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 five years.

- The current Commission was appointed in April 2012 and their term of appointment will stand until April 2017.
- Eleven meetings of the Commission were held in 2015, one of which was a two-day meeting (June). Commission Members attendance at meetings in 2015 was recorded as follows:

MEMBER	Jan 22	Feb 18	Mar 20	Apr 24	May 14	Jun 25/26	Jul 01	Sep 18	Oct 16	Nov 12	Dec 11	Total Meetings
Dr Michael Byrne	•		•	•	•			•	•	•	•	8/11
Dr Maeve Doyle	•	•	•		•	•	•	•	•	•		9/11
Dr Xavier Flanagan	•	•	•	•	•	•		•	•		•	9/11
Ms Pauline Gill			•	•	•	•	•	•		•	•	8/11
Dr Mary O'Hanlon*						•	•	•	•	•	•	6/6
Mr Ned Kelly	•	•	•	•	•	•	•	•	•	•	•	11/11
Dr Mary Keys	•	•	•	•	•	•		•	•	•	•	10/11
Ms Colette Nolan			•		•	•		•		•	•	6/11
Ms. Yvonne O'Neill	•	•	•		•	•		•	•	•	•	9/11
Ms Catherine O'Rorke	•	•	•	•	•	•	•	•	•	•	•	11/11
Ms Patricia O'Sullivan Lacy	•	•		•	•	•	•	•	•	•	•	10/11
Mr John Redican												0/11
Mr John Saunders	•	•	•	•	•	•	•		•	•	•	10/11

* Dr. Mary O'Hanlon was appointed to the Commission on 19th May, 2015

Mental Health Commission Members (at time of appointment)

April 2012 – April 2017



Mr. John Saunders
Chairman
Director
Shine



Dr. Mary O'Hanlon*
Consultant Psychiatrist -
Health Service Executive Dublin
Mid-Leinster



Dr. Maeve Doyle
Consultant Child and 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)



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



Mr. Ned Kelly
Director of Nursing
Health Service Executive South



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



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



Ms. Colette Nolan
Chief Executive Officer
Irish Advocacy
Network



Ms. Yvonne O'Neill
Head of Planning, Performance and Programme Management
HSE Mental Health Services

** Dr. Anne Jeffers resigned from the Commission in January 2015 and Dr. Mary O'Hanlon was appointed to the Commission by Minister Lynch in May 2015.*

Mental Health Commission Committee(s)

During 2015 the Mental Health Commission had two Standing Committees, the Audit Committee and the Legislation Committee.

The Membership of the Audit Committee is made up of Commission Members (CM) and External Members (EM).

Audit Committee (2015)

Ms. Patricia O’Sullivan Lacy (Chair) (CM), Ms. Catherine O’Rorke (CM), Mr. Ned Kelly (CM), Ms. Pauline Gill (CM), Mr. John Redican (CM), Ms. Noreen Fahy (EM), Mr. Joseph Campbell (EM).

The Audit Committee held four meetings in 2015 with attendance recorded as follows:

Committee Member	21st January	18th March	26th May	17th September	Total Meetings
Mr. Joseph Campbell	•		•		2/4
Ms. Patricia O’Sullivan Lacy (Chair)	•		•	•	3/4
Ms. Noreen Fahy		•		•	2/4
Mr. Ned Kelly		•	•	•	3/4
Ms. Catherine O’Rorke	•	•	•		3/4
Ms. Pauline Gill	•	•			2/4
Mr. John Redican					0/4

Legislation Committee (2015)

Membership of the Legislation Committee is made up of Commission Members (CM) and Executive (E). Dr. Mary Keys (Chair) (CM), Mr. Ned Kelly (CM), Ms. Patricia O’Sullivan Lacy (CM), Ms. Pauline Gill (CM), Mr. David Hickey (E), Ms Marina Duffy (E), Dr. Maeve Doyle (CM).

Management Team

- › Ms. Patricia Gilheaney - Chief Executive
- › Dr. Patrick Devitt, Inspector of Mental Health Services to May 2015
- › Dr Susan Finnerty / Dr. Fionnuala O’Loughlin - Acting Inspector(s) of Mental Health Services. May – December 2015 alternating
- › Ms. Rosemary Smyth - Director Standards & Quality Assurance and Director Training & Development
- › Mr. Ray Mooney - Director Corporate Services
- › Mr. David Hickey - Director Mental Health Tribunals and Legal Affairs

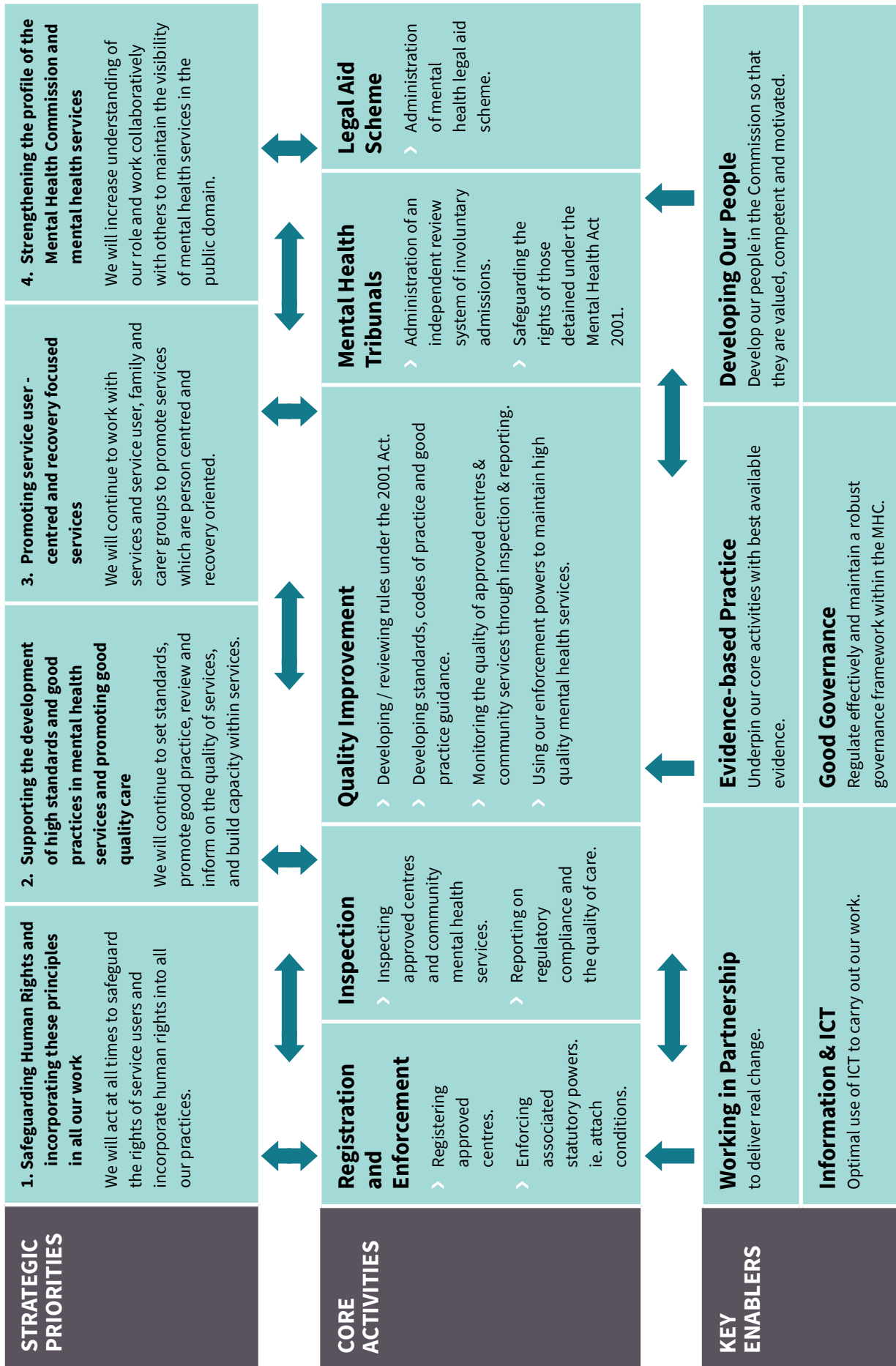
Mental Health Commission Core Activities

The Mental Health Commission’s work programme is focused on five core activities.

- › 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.

The Annual Report is structured by our core activities, our collaborative work and key enablers with links to the Commission’s strategic priorities for 2013 - 2015 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.



**Concluding Year for
our Strategic Plan
2013 – 2015**

Concluding Year for our Strategic Plan 2013 – 2015

2015 marked the final year in the timeframe of the Commission's 2013 – 2015 Strategic Plan. The Plan mapped the strategic direction for the organisation from 2013 to 2015 with an emphasis on the Commission's core activities.

The Strategic Plan set out four outcome focused Strategic Priorities for the three year period.

Strategic Priorities 2013 – 2015

1 Safeguarding human rights and incorporating these principles in all our work

We will act at all times to safeguard the rights of service users and incorporate human rights into all our practices.

2 Supporting the development of high standards and good practices in mental health services and promoting good quality care

We will continue to set standards, promote good practice, review and inform on the quality of services, and facilitate the building of capacity within services through education and information.

3 Promoting service user - centred and recovery oriented services

We will continue to work with services and service users, family and carer groups to promote services which are person-centred and recovery-oriented.

4 Strengthening the profile of the Mental Health Commission and mental health services

We will increase understanding of our role and work collaboratively with others to maintain both the visibility of the Mental Health Commission and of mental health services in the public domain.

Details of how the Commission achieved its strategic objectives in 2015 are provided from page 19 to 53 of this Report.

Planning for the 2016 – 2018 Strategic Period

During 2015 the Commission began its planning and work programme for the development of the 2016 – 2018 Strategic Plan. Consultation took place in the form of workshops which were held with the Commission Members and staff. Feedback was also sought from a wide range of our Stakeholders.

The Draft Strategic Plan was presented, considered and approved by the Commission at their December meeting. Subsequent to this meeting, the Draft Plan was furnished to Ms. Kathleen Lynch, T.D., Minister of State at the Department of Health in line with provision 2.15 of the *Code of Practice for the Governance of State Bodies (2009)*.

The Guiding Principles and Core Values of the Organisation

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
- › Mental Health (Amendment) Act 2015
- › 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 & 2014
- › Data Protection Acts 1988 & 2003

Values

The Commission is committed to operating in a manner that demonstrates our core values.

- › **Accountability and Integrity:** We will operate at all times in a fair and transparent manner and take responsibility for our actions.
- › **Dignity and Respect:** We will show dignity and respect for those using services and those providing them.
- › **Confidentiality:** We will handle confidential and personal information with the highest level of professionalism and we will take due care not to disclose information outside of the course of that required by law.
- › **Empowerment:** Our goal is to empower stakeholders (service users, families, carers, service providers and general public) through our work.
- › **Quality:** We aim to provide a quality service to all our stakeholders through use of evidence informed practices and by adopting a responsive regulatory approach.
- › **Recovery:** Our work will be at all times oriented towards recovery, encouraging and focusing on strong, equal partnerships between service users, families and carers and service providers.

The background is a solid teal color with a pattern of fine, parallel diagonal lines. Overlaid on this are several large, overlapping circles in various shades of teal, creating a layered, abstract effect.

Realising our Strategic Plan and Priorities Core Activities 2015

Regulation

The Mental Health Act 2001 (“2001 Act”) provides the Commission with a range of powers to register approved centres and to ensure that such centres meet and maintain certain statutory and regulatory requirements. Our registration, compliance and enforcement procedures are designed to protect the health, welfare and safety of all residents accessing inpatient mental health services. The following section sets out changes to the Register of Approved Centres; national compliance levels of approved centres with the 2001 Act, regulations, rules and codes of practice; and our regulatory response to areas of non-compliance identified in 2015, including areas identified on inspection.

Registration

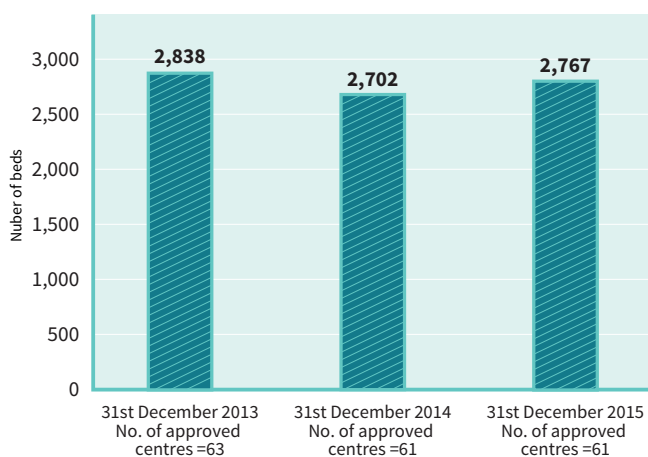
Registration of Approved Centres

It is a statutory requirement for all in-patient mental health facilities to be registered as approved centres by the Commission. This requirement applies to all ‘centres’: hospitals and in-patient facilities providing care and treatment to persons suffering from a mental illness or disorder.

The number of approved centres registered as at 31st December 2015 was 61 and the overall number of in-patient beds in these approved centres was 2,767. Compared to the figures as at 31st December 2014, there was no net change in the number of approved centres, and a 2.4% increase in the overall number of in-patient beds (65 beds). Figure 1 sets out the combined in-patient bed capacity as at 31st December 2013, 2014 and 2015.

While there was no net change to the number of approved centres on the Register as at the end of 2015, three approved centres closed during 2015, and three approved centres were registered for the first time in 2015. The approved centres were:

Figure 1 - *Number of approved centres and combined bed capacity as at 31st December 2013, 2014 and 2015*



Approved centre closures

> Aurora Unit, St Joseph’s Hospital, Limerick

This approved centre, which had a condition attached to its registration requiring closure by no later than 12th April 2015, closed on 9th March 2015. The centre had six residents at the time of closure, with one resident transferring to another approved centre and the remaining five residents transferring to community mental health services in the locality.

> South Lee Mental Health Unit, Cork University Hospital

This approved centre closed on 5th August 2015 following the transfer of residents and services to the new approved centre: Acute Mental Health Unit, Cork University Hospital.

> Linn Dara Child & Adolescent Mental Health In-patient Unit, St Loman’s Hospital, Dublin

This approved centre closed on 14th December 2015 following the transfer of residents and services to the new approved centre: Linn Dara Child & Adolescent Mental Health In-patient Unit, Cherry Orchard Hospital.

Approved centre new registrations

> Acute Mental Health Unit, Cork University Hospital

This approved centre was purpose built to replace the South Lee Mental Health Unit, Cork University Hospital. It was registered on 4th February 2015 and opened on 5th August 2015 to facilitate the closure of South Lee Mental Health Unit.

> Le Brun House & Whitethorn House, Vergemount Mental Health Facility

Le Brun House and Whitethorn House had been inspected during 2014 as a community residence and the Inspector’s report stated that both facilities functioned as ‘centres’ rather than community residences. An application for registration as an approved centre was subsequently received and reviewed, with the units being registered together as an approved centre on 9th February 2015.

› Linn Dara Child & Adolescent Mental Health In-patient Unit, Cherry Orchard Hospital, Dublin 10

This facility was purpose built to replace the Linn Dara Child & Adolescent In-patient Unit in St Loman's Hospital, Dublin 20. It was registered and opened on 10th December 2015 to facilitate the closure of the Linn Dara unit in St Loman's Hospital.

Expiration of Registration

The registration of an approved centre is valid for three years from the date of registration. If the registered proprietor wishes to continue the registration after that time, he/she must apply to the Commission to register the centre for another three year period.

An approved centre's registration may also cease if the registered proprietor changes. Where this happens, the new proprietor must apply to the Commission to register the centre for another three year period.

During 2015, the Commission registered seven existing approved centres for a further three year period. Six approved centres were required to make new applications for registration as the three year period for which they were registered in 2012 expired in 2015. In addition, one approved centre: St Aloysius Ward, Mater Misericordiae University Hospital, was required to submit a new application for registration because of a change in registered proprietor. Table 1 details these seven approved centres and the dates on which they were registered.

Table 1 - *Approved centres ongoing registration in 2015*

Approved Centre	Date of Registration
Adolescent In-patient Unit, St Vincent's Hospital	29 January 2015
Highfield Hospital	30 March 2015
Haywood Lodge	23 April 2015
Linn Dara Child & Adolescent In-patient Unit, St Loman's Hospital	11 May 2015
St Bridget's Ward & St Marie Goretti's Ward, Cluin Lir Care Centre	31 May 2015
St Aloysius Ward, Mater Misericordiae University Hospital	25 September 2015
Department of Psychiatry, Connolly Hospital	7 December 2015

Compliance

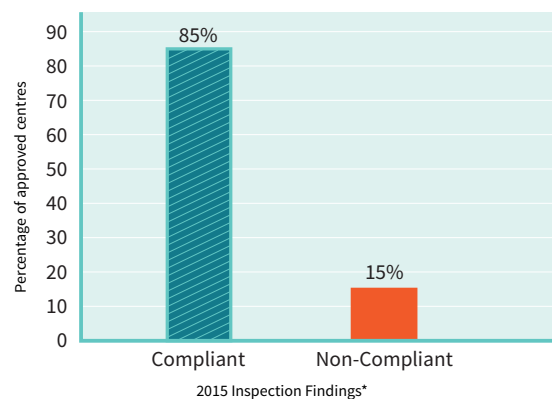
The compliance of approved centres with 31 regulations, two statutory rules and six codes of practice made under the 2001 Act as well as Part 4 of the 2001 Act (together referred to as the "legislative requirements") was determined by the Inspector of Mental Health Services following the annual regulatory inspection of approved centres in 2015.

In 2015, approved centres were assessed as being 'compliant – excellent achievement', 'compliant – good achievement', 'non-compliant – poor achievement', 'non-compliant – negligible achievement' or 'not-applicable' with each of the legislative requirements. The Inspector also assessed the risk level of each non-compliant legislative requirement. Ratings of risk were determined as 'low', 'moderate', 'high' or 'critical'.

National compliance of approved centres in 2015

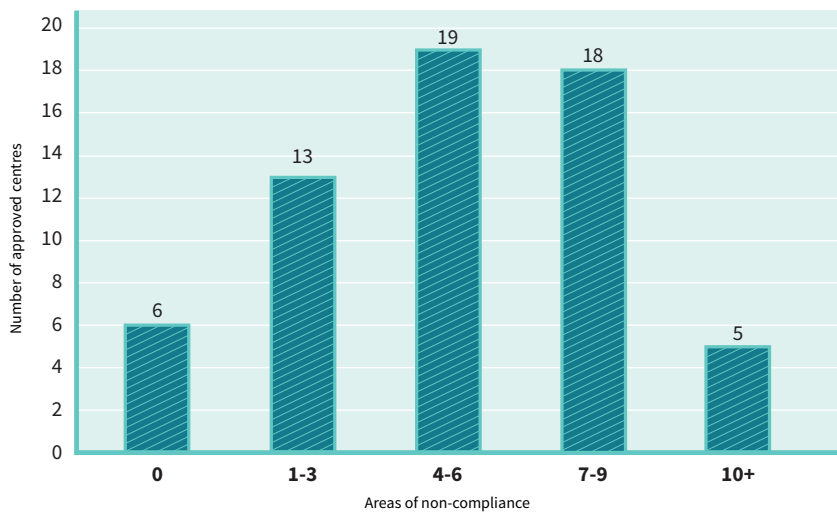
Sixty-one approved centres were inspected in the 2015 regulatory inspection cycle. Data from the 2015 inspection reports were collated to present the national level of compliance with legislative requirements.

Figure 2 - *Overall national compliance with legislative requirements 2015*



* Findings of 'not applicable' were not included in overall compliance percentages.

Figure 3 - Findings of non-compliance per approved centre 2015



There were a total of 1830 (85%) findings of compliance with legislative requirements across all approved centres (including ‘compliant – good achievement’ and ‘compliant – excellent achievement’). Conversely there were a total of 324 (15%) findings of non-compliance across all approved centres (including ‘non-compliant – poor achievement’ and ‘non-compliant – negligible achievement’). Note: 347 legislative requirements were deemed not-applicable for assessment and were therefore not factored into the overall national compliance levels.

As presented in Figure 3, 6 of the 61 approved centres (9.8%) were rated as compliant with all legislative requirements (zero findings of non-compliance). These approved centres were:

- Clonfert Ward, St Brigid’s Hospital, Ballinasloe
- Highfield Hospital
- Lois Bridges

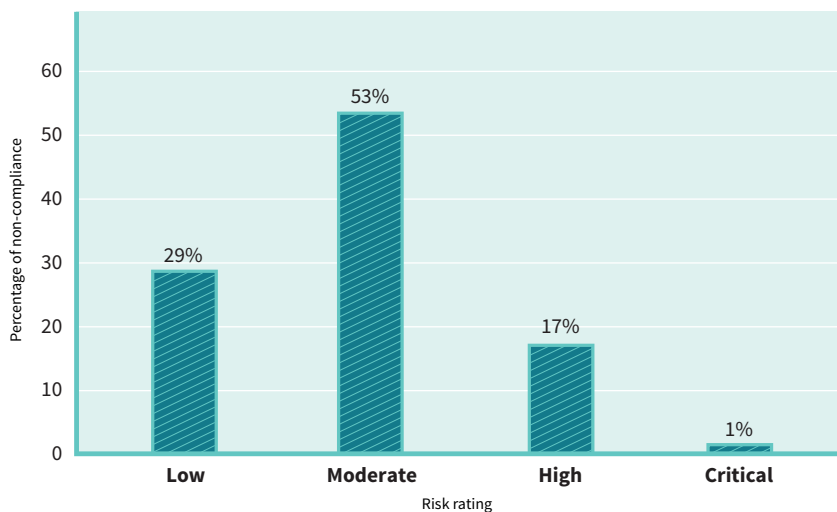
- St Edmundsbury Hospital
- St Patrick’s University Hospital
- Willow Grove Adolescent Unit, St Patrick’s University Hospital.

Thirteen (21%) approved centres were rated as non-compliant with 1-3 legislative requirements. 19 (31%) were rated as non-compliant with 4-6 legislative requirements. 18 (30%) were rated as non-compliant with 7-9 requirements and 5 (8.2%) were rated as non-compliant with 10 or more (range 11-15) requirements.

Risk is assessed by weighting the impact of the non-compliance against the likelihood of the non-compliance reoccurring. Where the reoccurrence is ‘highly likely’ and the impact is ‘significant’ the risk is rated as ‘critical’.

As presented in Figure 4, 94 (29%) of the 324 non-compliant legislative requirements were rated as low risk; 173 (53%) were rated as moderate risk; 55 (17%) were rated as high risk; and 2 (1%) were rated as critical risk.

Figure 4 - Risk level of non-compliance 2015



Compliance with regulations

The Mental Health Act 2001 (Approved Centres) Regulations 2006 are legal requirements that all approved centres must adhere to. They set out the minimum standards that approved centres must meet to protect the health, welfare and safety of residents. Figures 5 to 12 below present the national levels of compliance and non-compliance with regulations in 2015.

Figure 5 - *Compliance with Regulations 2015*

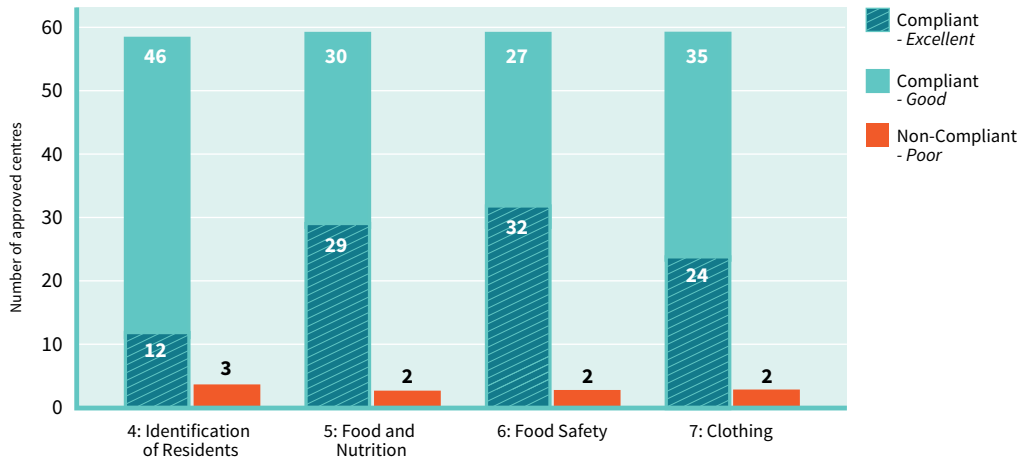


Figure 6 - *Compliance with Regulations 2015*

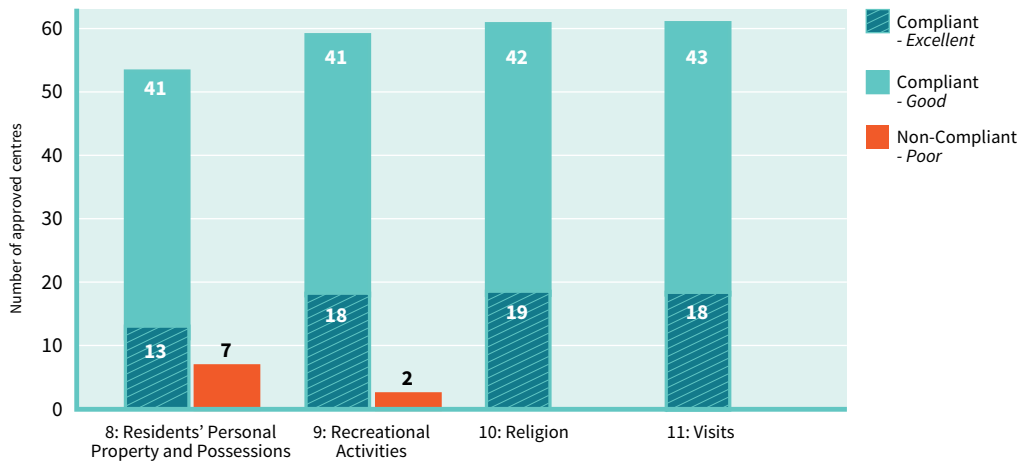
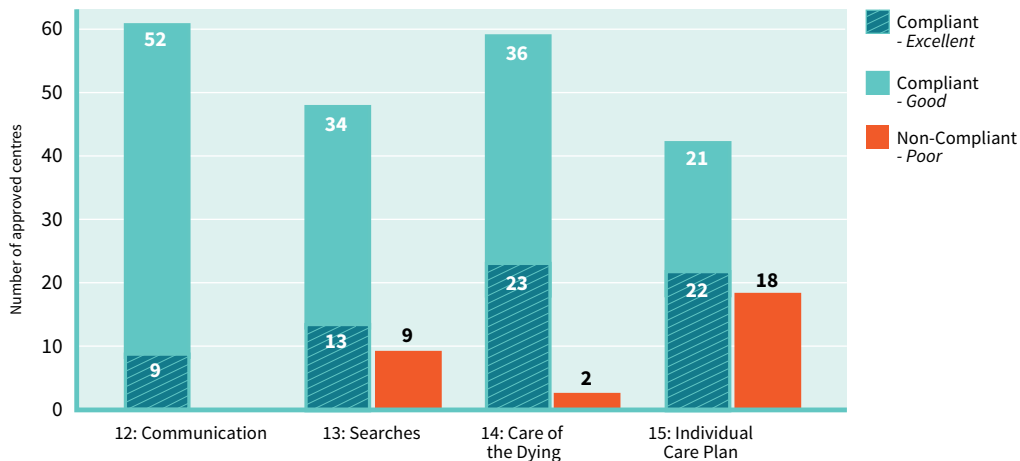
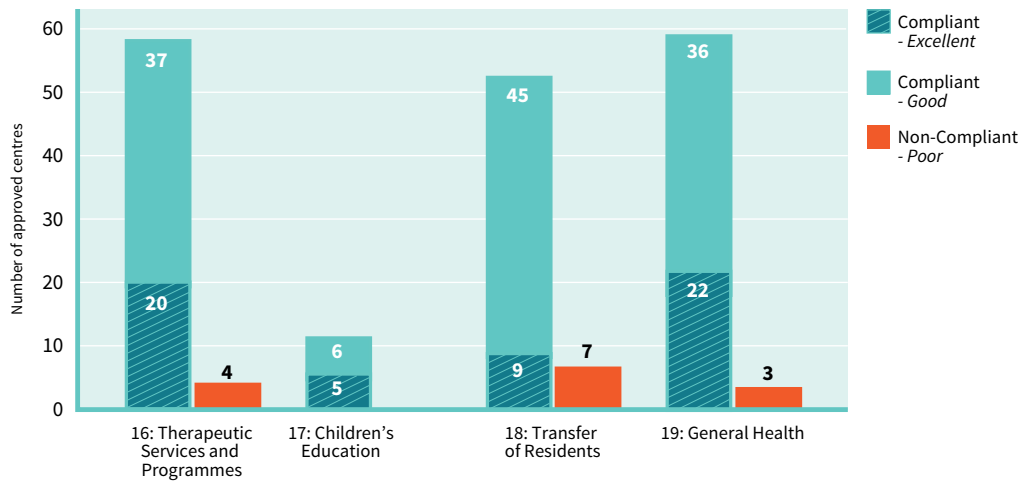


Figure 7 - *Compliance with Regulations 2015*



Note: Regulation 13: 5 approved centres rated not applicable n = 56.

Figure 8 - **Compliance with Regulations 2015**



Note: Regulation 17: 50 approved centres rated not applicable n = 11.

Figure 9 - **Compliance with Regulations 2015**

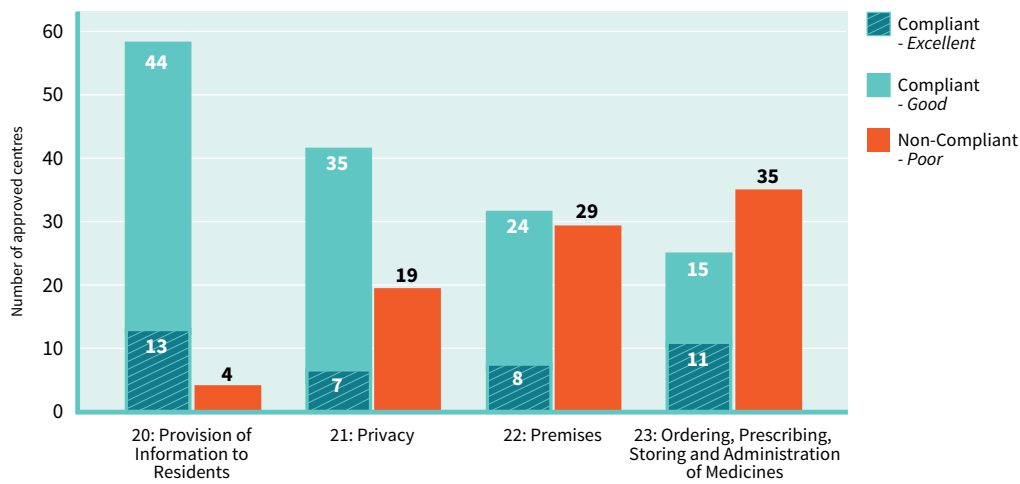
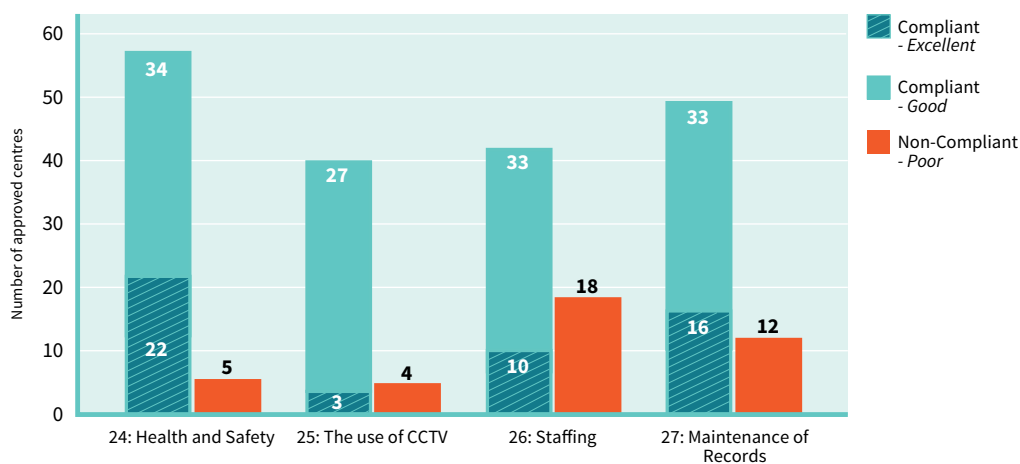
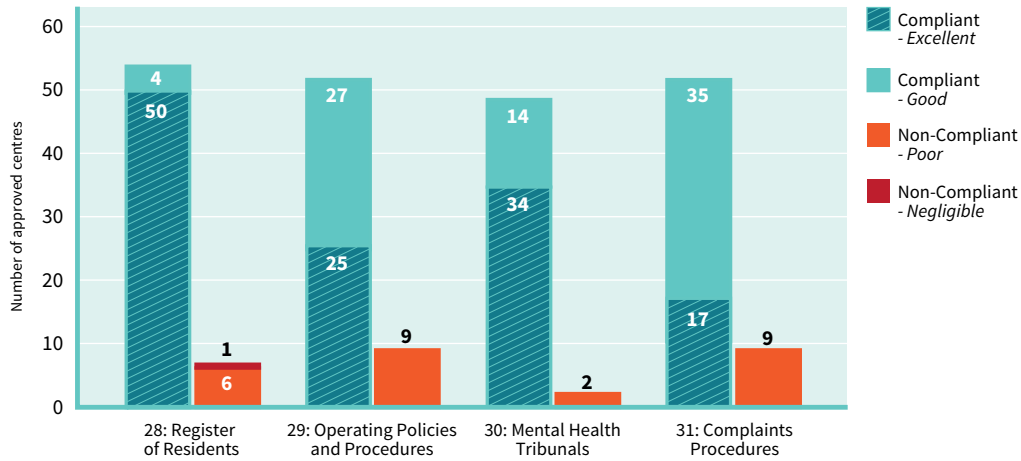


Figure 10 - **Compliance with Regulations 2015**



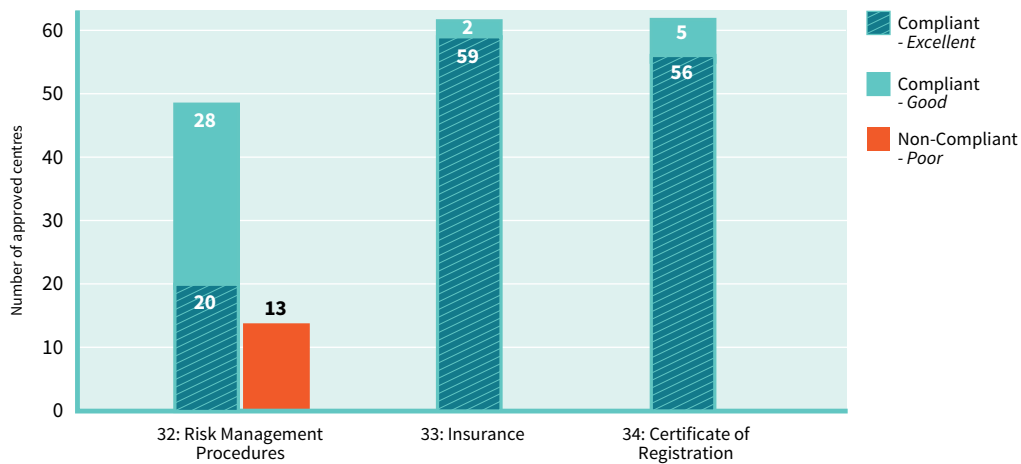
Note: Regulation 25: 27 approved centres rated not applicable n = 34.

Figure 11 - **Compliance with Regulations 2015**



Note: Regulation 30: 11 approved centres rated not applicable n = 50.

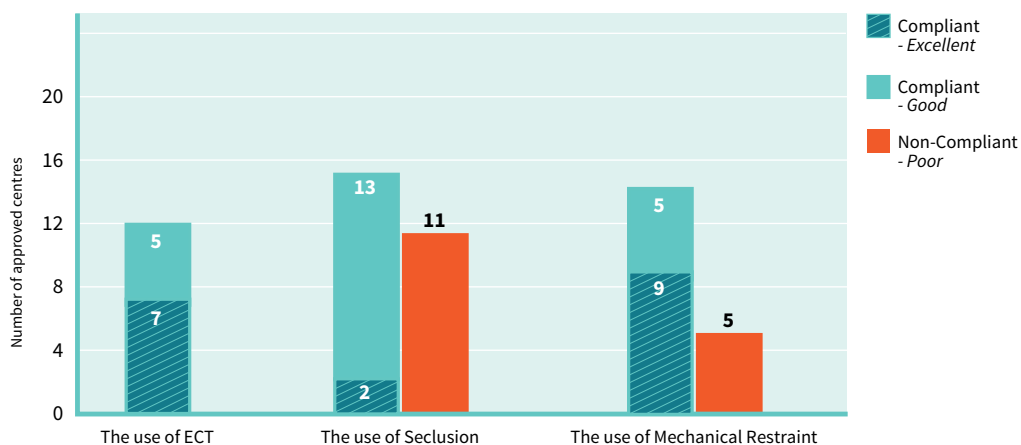
Figure 12 - **Compliance with Regulations 2015**



Compliance with rules

The Mental Health Act 2001 requires the Commission to make rules governing the use of electro-convulsive therapy (ECT) for involuntary patients (Section 59) and rules governing the use of seclusion and mechanical means of bodily restraint on a resident (Section 69). Figure 13 below presents the national level of compliance and non-compliance with rules in 2015.

Figure 13 - **Compliance with Rules 2015**



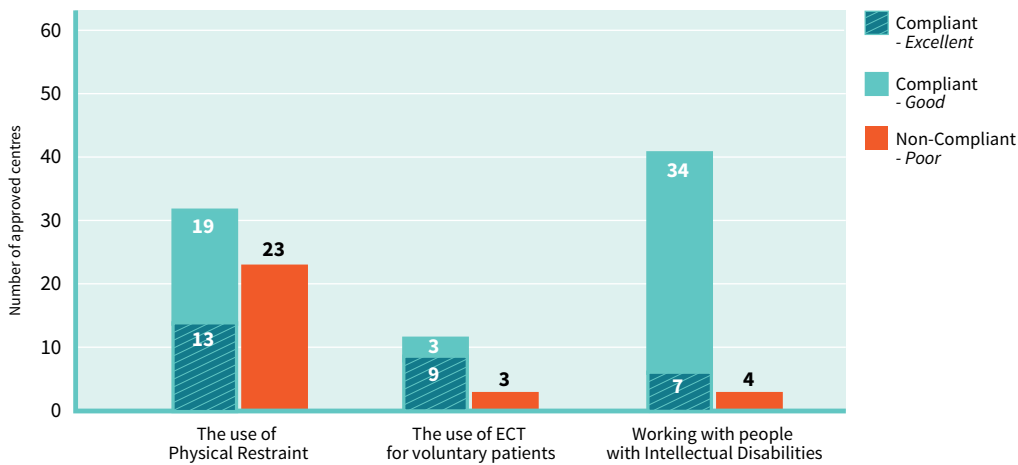
Note: The use of ECT: 49 approved centres rated not applicable n = 12; The use of Seclusion: 35 approved centres rated not applicable n = 26; The use of Mechanical Restraint: 42 approved centres rated not applicable n = 19.

Compliance with codes of practice

The Mental Health Act 2001 obliges the Commission to prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in mental health services.

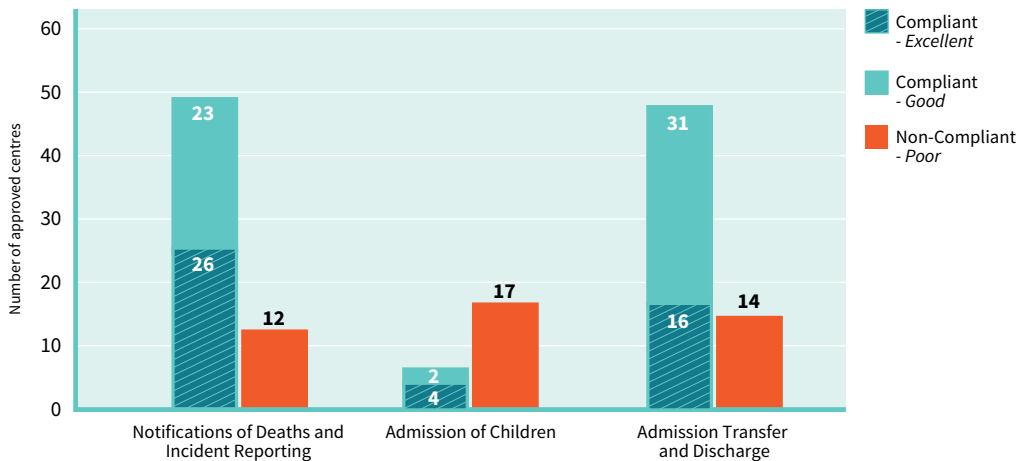
There are six codes of practice for the following: The Use of Physical Restraint; The Use of ECT for Voluntary Patients; Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities; Notification of Deaths and Incident Reporting; Admission of Children; and Admission, Transfer and Discharge. Figures 14 to 15 below present the national level of compliance and non-compliance with codes of practice in 2015.

Figure 14 - Compliance with Codes of Practice 2015



Note: The use of Physical Restraint: 6 approved centres rated not applicable n = 55; The use of ECT for voluntary patients: 46 approved centres rated not applicable n = 15¹; Working with people with Intellectual Disabilities: 16 approved centres rated not applicable n = 45.

Figure 15 - Compliance with Codes of Practice 2015



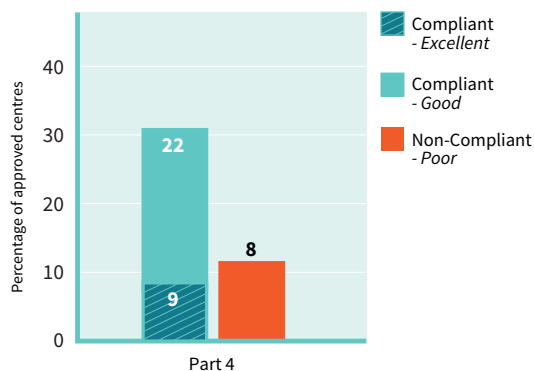
Note: Admission of Children: 38 approved centres rated not applicable n = 23.

1 14 approved centres had ECT facilities. One approved centre which did not have ECT facilities and which transferred resident(s) to another approved centre for ECT was assessed on inspection for compliance against applicable aspects of the Code of Practice.

Compliance with Part 4 of the Mental Health Act 2001

Part 4 of the 2001 Act sets out requirements for obtaining consent to treatment for involuntary patients. Section 60 and Section 61 of the 2001 Act set out the legal requirements for providing medication to involuntary patients for over three months and for providing medication where the patient is unable or unwilling to consent. Figure 16 below presents the national level of compliance and non-compliance with Part 4 in 2015.

Figure 16 - 2015 compliance with Part 4 of the Mental Health Act 2001



Note: Part 4: 22 approved centres rated not applicable $n = 39$.

Areas of high and low compliance

The legislative requirements with the highest percentage compliance (95-100%) and lowest percentage compliance (less than 75%) are set out in Tables 2 and 3.

As evident from table 2, national compliance with 15 legislative requirements was between 95-100%. As a new compliance rating system was introduced in 2015, the data could not be compared against 2014 ratings.

As evident from table 3, 9 legislative requirements had a compliance rating of 75% or lower (i.e. over a quarter of approved centres were found non-compliant with the legislative requirement).

One regulation had less than 50% overall compliance: Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines. The high number of non-compliant findings reflects a focus from the Inspector on ensuring that approved centres are implementing appropriate prescription practices; in particular the use of Medical Council Registration Numbers.

Table 2 - Highest percentage compliance

Legislative requirement	Percentage Compliance
Regulation 10: Religion	100%
Regulation 11: Visits	100%
Regulation 12: Communication	100%
Regulation 17: Children's Education	100%
Regulation 33: Insurance	100%
Regulation 34: Certificate of Registration	100%
Rule: Governing the use of ECT	100%
Regulation 5: Food and Nutrition	97%
Regulation 6: Food Safety	97%
Regulation 7: Clothing	97%
Regulation 9: Recreational Activities	97%
Regulation 14: Care of the Dying	97%
Regulation 30: Mental Health Tribunals	96%
Regulation 4: Identification of Residents	95%
Regulation 19: General Health	95%

Note: Percentage compliance excludes 'not applicable' ratings.

Table 3 - Lowest percentage compliance (highest non-compliance)

Legislative requirement	Percentage Compliance
Code of Practice: Admission of Children	26%
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	42%
Regulation 22: Premises	52%
Rule: Governing the use of Seclusion	57%
Code of Practice: The Use of Physical Restraint	58%
Regulation 21: Privacy	69%
Regulation 15: Individual Care Plan	70%
Regulation 26: Staffing	70%
Rule: Governing the use of Mechanical Restraint	74%

Note: Percentage compliance excludes 'not applicable' ratings.

One code of practice had less than 50% overall compliance: Code of Practice: The Admission of Children. The high number of non-compliant findings are associated with admissions of children to approved centres for adults. Of the 17 findings of non-compliance, 16 related to child admissions to adult units.

The 52% level of compliance for Regulation 22: Premises reflects, amongst other factors, premises that were not purpose built for the provision of mental health services; premises with insufficient or inadequate facilities; and premises with ligature anchor points. Approved centres who were undertaking works to address issues with their premises were found non-compliant when the substantive issue had not been addressed at the time of inspection. The Commission closely monitors the progress of works to ensure issues relating to the safety of premises are being addressed, and that residents' safety and wellbeing are being protected while works are underway.

The Code of Practice on the Use of Physical Restraint had a compliance rating of 58% (23 out of 55 approved centres were found to be non-compliant).

The most common reasons for non-compliance with this code of practice were: Inadequate documentation of episodes of restraint and lack of up-to-date staff training in the prevention and management of violence and aggression. Other common reasons for non-compliance included: lack of documentation of a medical review within three hours of the episode of restraint; next of kin not being informed; and the use of security staff to assist in episodes of restraint.

The Rules Governing the Use of Seclusion had a compliance rating of 57% (11 out of 26 approved centres were found to be non-compliant). 35 approved centres did not use seclusion in 2015. There were a range of reasons and no apparent trends for non-compliance in this area. Reasons for non-compliance included: Inability to directly observe the resident (instead relying on a mirror or CCTV); an inadequate policy; lack of up to date training in the prevention and management of violence and aggression; insufficient seclusion facilities; and inadequate documentation.

The breakdown of the risk level for the legislative requirements with highest levels of non-compliance is presented in Figures 17 to 20 below.

Figure 17 - Risk levels of legislative requirements with highest overall non-compliance

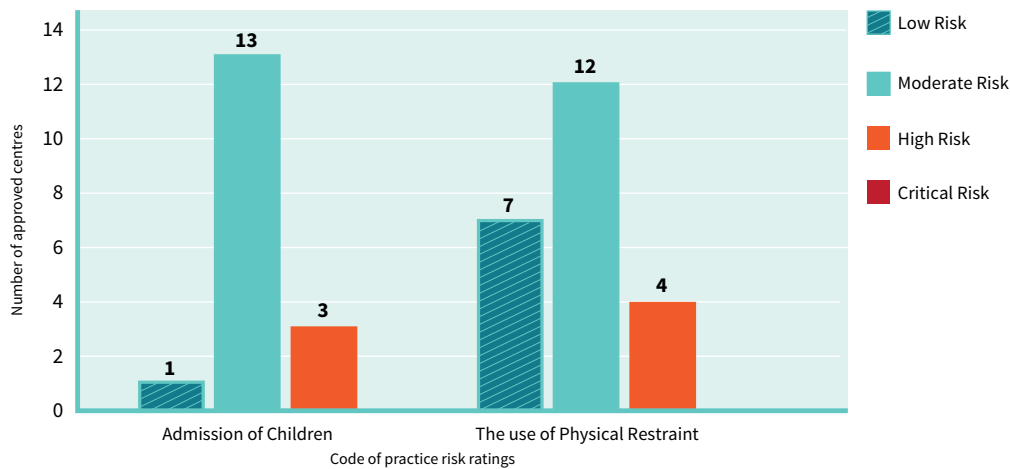


Figure 18 - Risk levels of legislative requirements with highest overall non-compliance

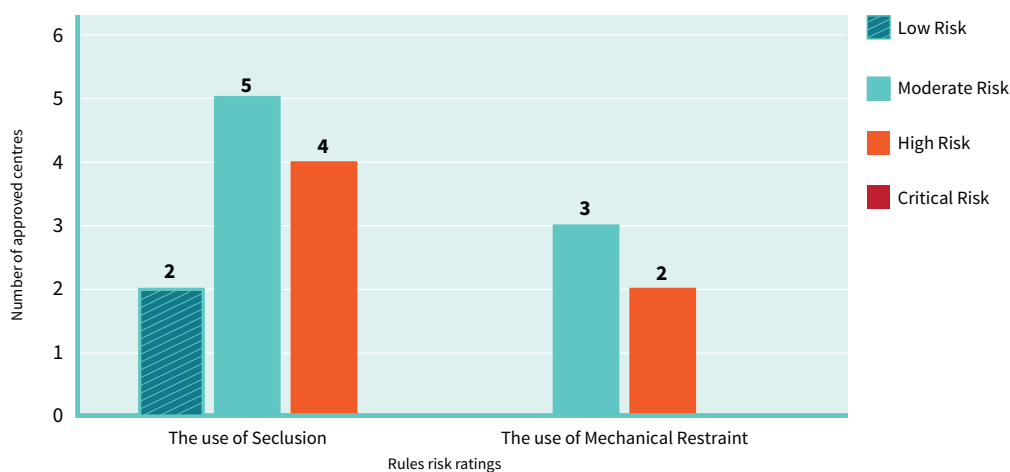


Figure 19 - Risk levels of legislative requirements with highest overall non-compliance

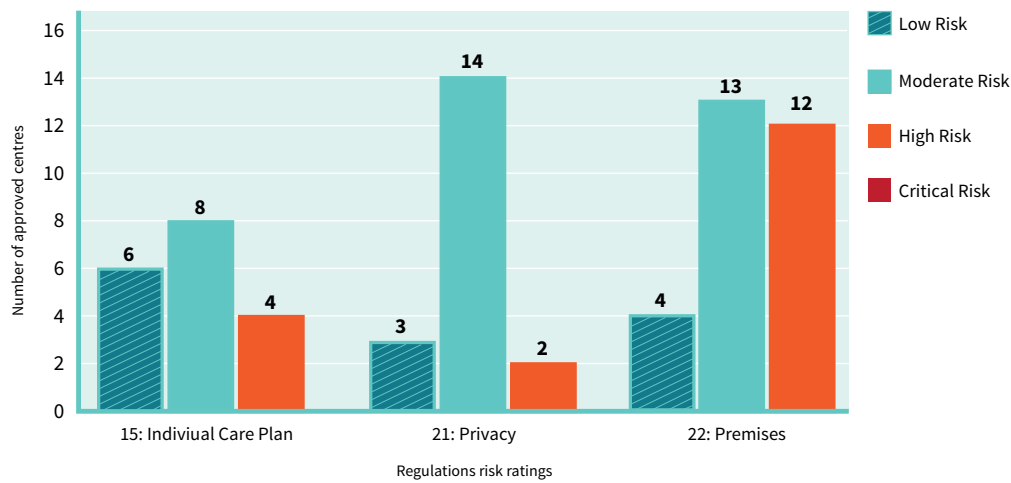
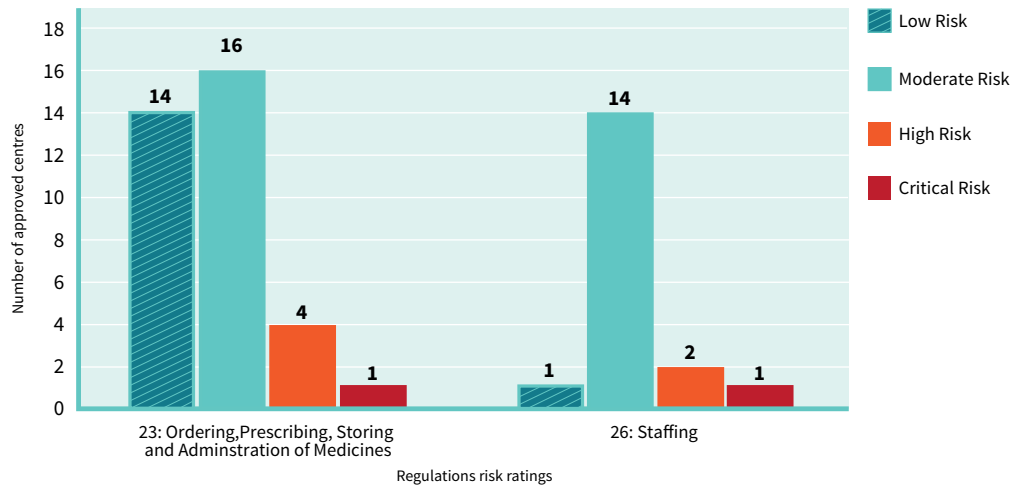


Figure 20 - Risk levels of legislative requirements with highest overall non-compliance



As presented in Figures 17 to 20, a rating of ‘moderate risk’ was most frequently determined for the legislative requirements with highest levels of non-compliance. Two regulations received one rating of ‘critical risk’: Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines and Regulation 26: Staffing.

Enforcement

The Commission adopts a responsive approach to regulation. This means that where an approved centre is non-compliant with the 2001 Act, regulations, rules or codes of practice under the 2001 Act, we are responsive to the approved centre’s conduct and behaviour when deciding what regulatory actions to take. We endeavour to support all approved centres to comply with all legislative requirements and to improve the quality of services provided.

In 2015 the Commission reviewed and updated our regulatory enforcement procedures. Our first response is to support approved centres to identify and implement a plan of actions to address the non-compliance and mitigate against the non-compliance reoccurring: a corrective and preventative action.

Where an approved centre fails to adequately address an area of non-compliance, or where a non-compliance poses a significant risk to patients’ safety and wellbeing, the Commission may take further escalating enforcement actions as follows in Figure 21 below.

Corrective and Preventative Action Plan

As set out in Figure 3 (page 22) (findings of non-compliance per approved centre 2015), 55 out of 61 approved centres were found to be non-compliant in one or more areas in the 2015 inspection cycle. These approved centres were requested to provide a corrective and preventative action plan (CAPA) for each area of non-compliance identified.

We reviewed each plan and returned 28 (51%) CAPAs which were not specific, measurable, realistic, achievable and time-bound (SMART) to approved centres for revision. Where an approved centre’s CAPAs were found to be unacceptable following two revisions (three reviews), the unacceptable CAPAs were published as submitted and further enforcement action was taken.

Table 4 - CAPA review process – acceptance of CAPAs

CAPA Review	Approved Centres	Percentage (of total)
First Review		
Acceptable	27	49%
Unacceptable	28	51%
Second Review		
Acceptable	17	31%
Unacceptable	11	20%
Third Review		
Acceptable	9	16%
Unacceptable	2	4%

Non-compliance critical risk

As set out in Figure 4 (Risk Level of Non-compliance 2015) there were two non-compliant areas where the risk was assessed as ‘critical’. Table 5 provides details of the non-compliance and the actions taken in response to the assessed risk.

Figure 21 - Regulatory Enforcement Actions



Table 5 - *Critical-risk non-compliance*

Approved Centre	Non-compliance	Response
Department of Psychiatry, Midland Regional Hospital, Portlaoise	Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines.	A notice of serious concern was sent to the approved centre. The approved centre submitted a specific plan to address non-compliances. The implementation of this plan is being monitored on an ongoing basis.
St Aloysius Ward, Mater University Hospital	Regulation 26: Staffing.	The Inspector undertook a focused inspection at the approved centre. A contingency plan is in place to mitigate against reoccurrence.

Table 6 - *Immediate Action Notices issued to approved centres*

Approved Centre	Non-compliance	Response
Department of Psychiatry, Midland Regional Hospital, Portlaoise	Breach of Part 4 of the Mental Health Act 2001.	Ongoing implementation and monitoring of immediate action plan.
	Breach of Condition of Registration in relation to Regulation 15: Individual Care Plan.	Ongoing implementation and monitoring of immediate action plan.
	Failure to provide effective CAPA plan.	Acceptable CAPA plan provided.
Acute Psychiatric Unit, University Hospital Ennis	Breach of Condition of Registration in relation to the transfer of residents to alleviate bed shortages.	Ongoing implementation and monitoring of immediate action plan.
St. Stephen's Hospital	Failure to provide effective CAPA plan.	Acceptable CAPA plan provided.
Cluain Lir Care Centre	Failure to provide effective CAPA plan.	Acceptable CAPA plan provided.

Immediate Action Notice

Where an approved centre fails to provide or implement an effective CAPA, or where the non-compliance poses a significant risk to patients' safety and wellbeing, the Commission may issue a formal Immediate Action Notice, directing action to be carried out within a specified timeframe. Immediate Actions Notices issued on the foot of non-compliances identified in 2015 are set out in table 6 above.

Registration Conditions

The 2001 Act affords the Commission a range of statutory enforcement powers, including the attaching of conditions to an approved centre's registration. This step may be taken by the Commission where it deems the attaching of a condition to be an appropriate step to protect the welfare or safety of residents.

In 2015, the Commission did not attach any new conditions. As at 31 December 2015, there were a total of 14 conditions attached to the registration of 12 approved centres.

The Commission reviews the conditions attached to registrations upon receipt of the Inspector's inspection report. As at 31 December 2015 the inspection reports for 10 of the 12 approved centres with conditions attached had not been finalised and therefore the conditions had not been reviewed at that date. The inspection reports for O'Connor Unit, St Finan's Hospital and Sycamore Unit, Connolly Hospital had been received; their conditions of registration were reviewed and were not revoked.

A full breakdown of the conditions attached to approved centre registrations as at 31 December 2015 is provided for in Table 7.

Table 7 - *Conditions attached to approved centre registrations as at 31 December 2015*

Approved centre	Summary of conditions(s) attached	Effective date
Acute Psychiatric Unit, Cavan General Hospital	The Commission must be notified in advance of the administration of electro-convulsive therapy (ECT). The notification must include the proposed date and confirmation that the relevant requirements regarding staffing have been met.	19 August 2014
Acute Psychiatric Unit, University Hospital Ennis	<ul style="list-style-type: none"> ➤ Full compliance must be achieved with Regulation 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. Ongoing audits of compliance with Regulation 15 must be carried out on an ongoing basis, with monthly reports to be submitted to the Commission. ➤ The transfer of residents to another approved centre to alleviate bed shortages is prohibited. ➤ All residents must be accommodated in suitable sleeping accommodation that ensures the privacy and dignity of residents is respected. 	1 March 2014
Cappahard Lodge	Full compliance must be achieved with Regulation 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. Ongoing audits of compliance with Regulation 15 must be carried out on an ongoing basis, with monthly reports to be submitted to the Commission.	1 October 2014
Department of Psychiatry, Midland Regional Hospital, Portlaoise	Full compliance must be achieved with Regulation 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. Ongoing audits of compliance with Regulation 15 must be carried out on an ongoing basis, with monthly reports to be submitted to the Commission.	1 March 2014
Department of Psychiatry, St Luke's Hospital	Full compliance must be achieved with Regulation 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. Ongoing audits of compliance with Regulation 15 must be carried out on an ongoing basis, with monthly reports to be submitted to the Commission.	1 March 2014
Department of Psychiatry, University Hospital Galway	Full compliance must be achieved with Regulation 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. Ongoing audits of compliance with Regulation 15 must be carried out on an ongoing basis, with monthly reports to be submitted to the Commission.	1 March 2014
O'Connor Unit, St Finan's Hospital	The direct admission of residents is prohibited unless for respite care in accordance with the person's individual care and treatment plan.	1 March 2014
Selskar House, Farnogue Residential Healthcare Unit	Ongoing audits of compliance with Regulation 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 must be carried out on an ongoing basis, with monthly reports to be submitted to the Commission.	18 December 2014

Approved centre	Summary of conditions(s) attached	Effective date
Sligo/Leitrim Mental Health In-patient Unit	Training to be delivered as per the training plan submitted to the Mental Health Commission. Reports on the progress of the training plan must be submitted to the Commission on a quarterly basis.	1 March 2014
St Davnet's Hospital - Blackwater House	The Commission requires quarterly progress reports on the development of replacement facilities.	1 March 2014
St Ita's Ward and Unit One, St Brigid's Hospital, Ardee	Full compliance must be achieved with Regulation 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. Ongoing audits of compliance with Regulation 15 must be carried out on an ongoing basis, with monthly reports to be submitted to the Commission.	19 August 2014
Sycamore Unit, Connolly Hospital	Full compliance must be achieved with Regulation 26 (Staffing) of the Mental Health Act 2001 (Approved Centres) Regulations 2006.	6 June 2013

Quarterly Progress Reports

Quarterly progress reports were received from three approved centres during 2015 as part of the conditions that were attached to each centre's registration.

The premises of two approved centres; Blackwater House, St. Davnet's Hospital, Monaghan and Aurora Unit, St Joseph's Hospital, were found not to be fit for purpose as mental health facilities. As such, quarterly reports on the closure of the approved centres were required from the registered proprietors. Progress reports were received for both approved centres and Aurora Unit, St Joseph's Hospital closed in March 2015.

For one approved centre: Sligo/Leitrim Mental Health In-patient Unit, progress reports on staff training were requested and received. The approved centre was found to be compliant with Regulation 26: Staffing in its annual regulation inspection.

Individual Care Plan Audits

Monthly reports on individual care plan (ICP) audits were received from nine approved centres during 2015 as part of the conditions that were attached to each approved centre's registration. The reports were reviewed and monitored; further information was requested from approved centres, as required. Table 8 shows a breakdown of approved centres that submitted monthly compliance audits and their compliance ratings from their annual regulatory inspections.

Table 8 - *Compliance ratings of approved centres submitting ICP audits*

Approved centre	2015 compliance rating
Acute Psychiatric Unit 5B, University Hospital Limerick	Compliant: Excellent Achievement
Acute Psychiatric Unit, University Hospital Ennis	Compliant: Excellent Achievement
Cappahard Lodge	Compliant: Excellent Achievement
Department of Psychiatry, Midland Regional Hospital, Portlaoise	Non-Compliant: Poor Achievement
Department of Psychiatry, St Luke's Hospital	Compliant: Excellent Achievement
Department of Psychiatry, University Hospital Galway	Compliant: Good Achievement
St Ita's Ward and Unit One, St Brigid's Hospital, Ardee	Compliant: Good Achievement
Selskar House, Farnogue Residential Healthcare Unit	Compliant: Good Achievement

Revocation of registration conditions

The Commission may revoke a registration condition where it is satisfied that the requirements of the condition have been met or the circumstances that led to the condition being attached have been addressed.

In 2015, the Commission formally revoked two registration conditions. In addition, one condition expired when the approved centre to which the condition was attached closed. The approved centres are:

› **St Vincent's Hospital, Fairview, Dublin 3**

This approved centre had a condition requiring the closure of one of the approved centre's wards by 31st December 2014. The Commission was informed in January 2015 that the ward has closed on 19th December 2014. A proposal to revoke the condition was issued in accordance with the provisions of the 2001 Act, and the condition was revoked on 14th February 2015.

› **Acute Psychiatric Unit 5B, University Hospital Limerick**

This approved centre had a condition requiring full compliance with Regulation 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. The condition also required clinical audits of compliance with Regulation 15 and monthly reports on the results of the audits. The approved centre was found compliant with Regulation 15 in its annual regulatory inspection. A proposal to revoke the condition was issued in accordance with the provisions of the 2001 Act, and the condition was revoked on 19th November 2015.

› **Aurora Unit, St Joseph's Hospital, Limerick**

This approved centre had a condition requiring closure by no later than 12th April 2015. The registered proprietor confirmed that the approved centre had closed on 9th March 2015, and the condition expired when the approved centre was removed from the Register of Approved Centres.

Regulatory Compliance Report

In addition to the above enforcement actions, a number of Regulatory Compliance Reports (RCRs) were received in the first two quarters of 2015 relating to enforcement action from 2014 inspection reports. These were reviewed and monitored where necessary.

An RCR was requested under the previous regulatory enforcement process in situations where the overall risk posed to resident safety and welfare due to issues of non-compliance was deemed to be minor. The reports required management to outline the actions planned or already implemented to achieve full compliance, the person(s) responsible for implementing the change, and the timeframes for completion of actions.

Community Residences

Twenty inspections took place of 24 hour nurse-staffed residences in 2015. Following review of the inspection reports, the Commission requested Quality Improvement Plans (QIP's) from all the residences inspected. Services were asked to provide a QIP to address the standards in the Quality Framework for Mental Health Services and outline how the recommendations made by the Inspector were to be implemented.

Thirteen of the 20 community residences' were requested to provide QIP's relating to redevelopment work or replacement accommodation in line with Vision for Change. One QIP related to the safety and welfare of residents, this residence continues to be monitored on an ongoing basis. A service decided to close a community residence where it was reported by the Inspector that the premises was unsuitable. The Commission sought a breakdown of where each resident was relocated and confirmation that transfers were in accordance with residents assessed needs.

Other specific recommendations' made by the Inspector that were addressed in the returned QIP's related to care planning, physical health, complaints, advocacy, medication, rent and fire safety.

Quality Improvement

Quality Improvement

One of the Commission's functions under the 2001 Act is to promote the development and maintenance of good practices and high standards in mental health services. It is also part of the Commission's mission to encourage continuous quality improvement in the delivery of mental health services.

A key component in developing good practices and improving the delivery of services is the collection and analysis of information on activity within mental health services. Approved centres and other mental health services are required to submit quality and safety notifications as defined by the Mental Health Commission, as per the Mental Health Act 2001. These notifications include information on admission of children, notification of deaths of service users, incidents including serious reportable events, administration of electroconvulsive therapy and use of seclusion and restraint.

Quality and safety notifications are used by the Commission to support the regulatory process. In line with a risk-based regulatory approach, data from approved centres are risk rated by the Commission and any that are rated as critical are escalated for immediate enforcement action. Quality and safety notification data are used to prepare a risk profile for each approved centre which is used to inform the inspection process. The Commission also reports publicly on national data through annual activity data reports (on electroconvulsive therapy and seclusion and restraint) and in our annual report. Activity data on admissions of children and death notifications are included below.

Activity Data

Admission of Children under the Mental Health Act 2001

The Mental Health Commission has been collecting and reporting on data in relation to the admission of children² to approved centres since 2007. In particular, we monitor admissions of children to adult units and have consistently highlighted the lack of sufficient child and adolescent in-patient and day hospital facilities.

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. This addendum placed tighter restrictions on the admission of children to adult facilities and stated that "no child under 18 years is to be admitted to an adult unit in an approved centre from 1st December 2011." It was emphasised that the above provisions should be followed except in 'exceptional circumstances'.

Admission of Children in 2015

In 2015, the Commission was notified of 501 admissions³ to approved centres⁴. This represented a 16% increase on the total number of admissions reported in 2014 (432⁵). Of the 501 admissions, 95 (19%) were to 21 adult units and 406 (81%) were to six child units.

Figure 22 shows that there has been a year-on-year increase in the total number of child admissions nationally in the three-year period from 2013 to 2015 with 415 admissions in 2013, 432 admissions in 2014 and 501 admissions in 2015. It also includes a breakdown of the number of admissions to adult units and to child units in each year.

The number of child admissions to adult units nationally has been relatively consistent over the last three years ranging from 90 to 98 admissions. There were 95 child admission to adult units in 2015 which represents a slight increase in the number of admissions in comparison to 2014 (90). However, there was an overall increase in the total number of child admissions in 2015 and therefore the proportion of admissions to adult units decreased slightly in 2015 (19.0%) in comparison to 2014 (20.8%). In 2013, 23.6% of admissions were to adult units.

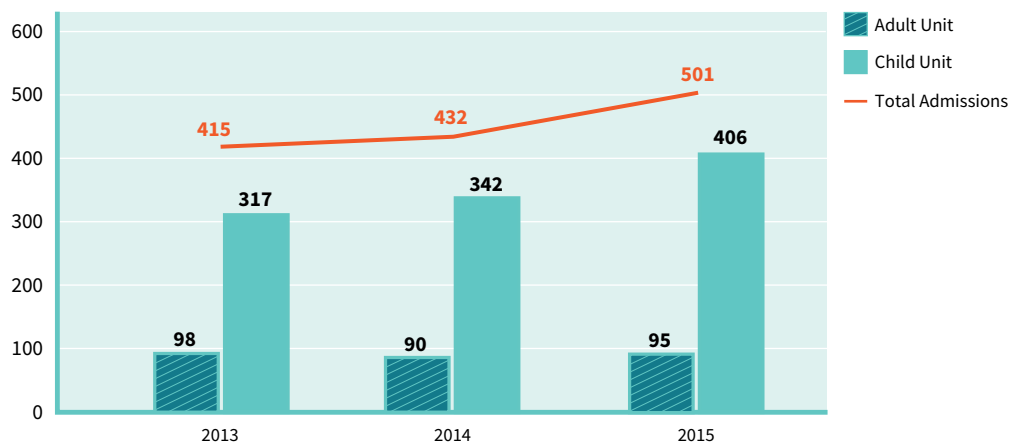
2 The Mental Health Act 2001 Section 2(1) defines a "child" as a person under the age of 18 years other than a person who is or has been married.

3 Number of admissions does not equate number of children admitted. A child may be admitted on more than one occasion and to more than one approved centre over the course of reporting year. In the absence of a national unique patient identifier, it is not possible to accurately report on the number of children admitted nationally in a reporting year.

4 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).

5 2014 data was updated since publication of the 2014 Annual Report as a result of cross validation with the Health Research Board 2014 data, in line with the terms of our Memorandum of Understanding.

Figure 22 - Admissions of children. Unit Type. 2013, 2014, 2015. Numbers



Furthermore, Figure 22 shows that there has been a steady increase in the number of child admissions to child units over this three-year period. There were 317 admissions of children to child units in 2013, 342 in 2014 and 406 in 2015. In 2013, 76.4% of admissions were to child units in comparison to 81.0% in 2015.

Circumstances of Admissions to Adult Units

When a child is admitted to an adult unit, specific details must be submitted to the Commission, outlining the circumstances of the admission including the 'reason for the admission'; 'what efforts have been made to admit the child to an age appropriate approved centre' and whether requirements that the Commission have identified for any adult unit admitting a child are in place. The information provided below is based on information provided, by the service.

In 2015, the reason for admission for over one-third (35.8%) of child admissions was 'immediate and serious risk to self and/or others'. No bed available in an age appropriate centre' was indicated for 19.0% of admissions and a combination of both 'serious risk' and 'no age appropriate bed' was the reason indicated for 38.9% of admissions. 'Other reason' accounted for 6.3% of admissions.

For the majority of admissions (89.5%), the service indicated that efforts were made to admit the child to an age appropriate approved centre. For the remaining 10.5% of admissions approved centres indicated that efforts were not made to admit to an age appropriate approved centre. The reasons for this included: 'admissions late at night'; 'crisis admissions'; 'previous refusal to admit from a child unit' and the 'child being close to 18 years of age at the time of admission'.

Out of the 95 admissions to adult units 26 admissions (27.4%) resulted in the child being discharged and admitted to a child unit as soon as a bed became available. This is similar to the proportion reported in 2014 (23.3%) but lower than in 2013 (31.6%). The average duration of these 26 admissions to adult units, where the child was subsequently admitted to a child unit once a bed was available, was six days.

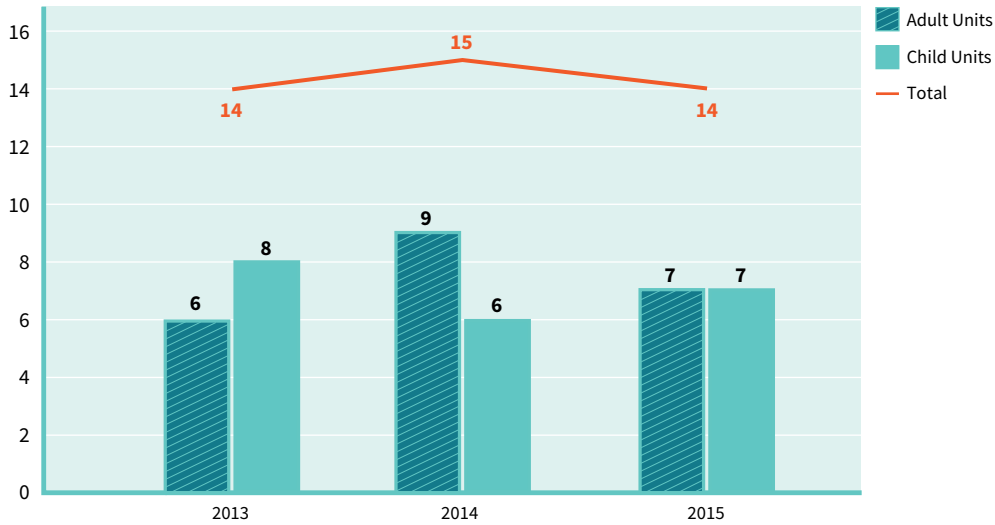
Section 2.5 of the *Code of Practice Relating to Admission of Children under the Mental Health Act 2001* identifies provisions which should be in place in any adult unit which admits children. Based on information provided by approved centres, it appears that there are particular challenges in relation to providing 'age appropriate advocacy services' and 'age appropriate activities and facilities' with over 50% of admission forms indicating 'no' in relation to these two requirements.

Child 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 2015, there were 14⁶ Section 25 Orders for involuntary admission to approved centres. Figure 23 shows this is consistent with the number of Section 25 Orders reported in previous years with 15 Orders in 2014 and 14 Orders in 2013. It also provides a breakdown of involuntary admissions of children by unit type. In 2015, half, (7/14) of the involuntary admissions were to adult units and the remaining seven admissions were to child units. In 2014 the majority, (9/15) involuntary admissions were to adult units and in 2013 slightly more, (8/14) involuntary admissions were to child units than to adult units.

6 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 2015, in both cases the admission was initially to an adult unit.

Figure 23 - Section 25 Orders (involuntary admission of children) by Unit Type. 2013, 2014, 2015. Numbers.



A total of 14 children were the subject of a Section 25 Order in 2015. Five children were 15 years of age or under, four children were 16 years of age and five were 17 years of age.

Age and Unit Type

In 2015, 36.7% (184) of child admissions related to children who were 15 years of age or younger, 27.8% (139) admissions related to children who were 16 years of age and the remaining 35.5% (178) of admissions related to children who were 17 years of age at the time of admission.

Figure 24 provides a comparison of admissions to adult units and child units by age in 2015. It shows that the majority of admissions in each age group were to child units.

A small proportion 4.9% (9/184) of admissions of children who were 15 years of age or under were to adult units. In contrast, a larger proportion of 16 and 17 year olds were admitted to adult units, 24.5% (34/139) and 29.2% (52/178) respectively.

In 2015, children admitted to adult units were more likely to be older than those admitted to child units. The mean age of children admitted to adult units was 16.4 years old (median = 17 years of age) and the mean age of those admitted to child units was 15.5 years old (median = 16 years of age).

Gender and Unit Type

In 2015, the majority, 60.3% (302/501) of child admissions were female and 39.7% (199/501) were male.

Figure 24 - Admissions of children. Age and Unit Type. 2015. Percentages.

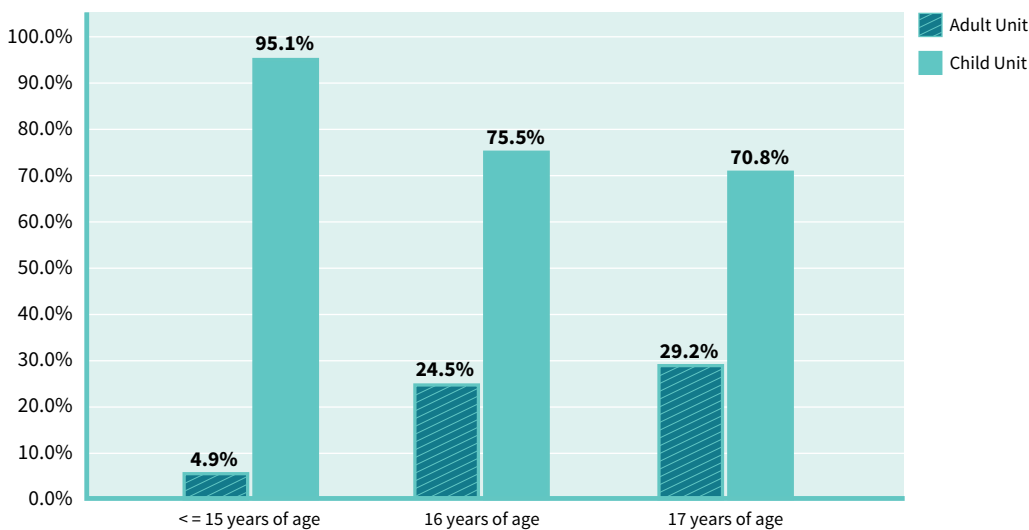
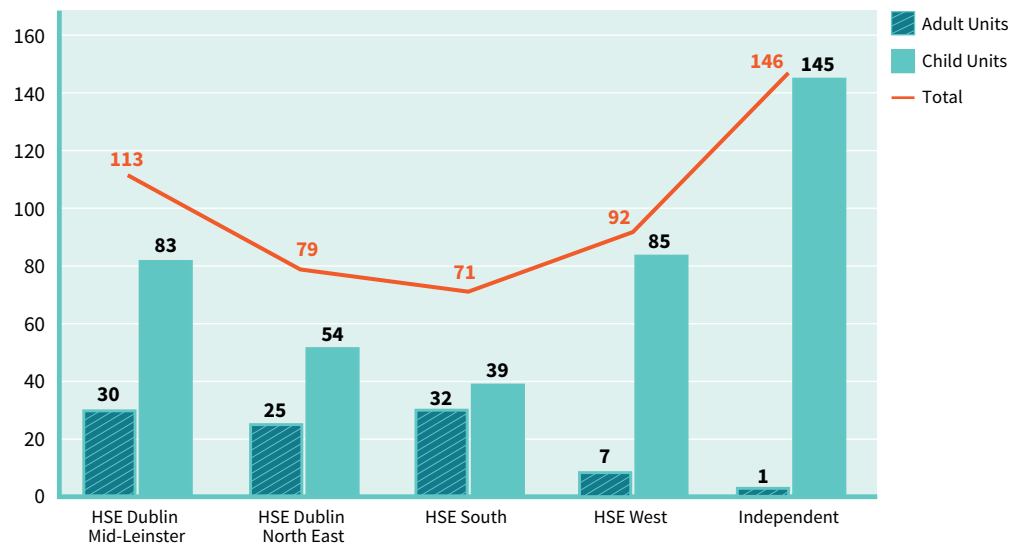


Figure 25 - Admissions of children. Service Provider and Unit Type. 2015. Numbers



Only 11.6% (35/302) of female admissions were to adult units and 88.4% were to child units. In contrast almost one third, 30.2% (60/199) of male admissions were to adult units.

Duration of Admission

The mean duration of admission⁷, for all child admissions in 2015 was 48 days (median = 38 days). This is slightly shorter than in 2014 when the average duration was 54 days (median = 42 days).

In 2015, the average length of stay in child units was significantly longer than in adult units, with a mean duration of 57 days (median = 48 days) in child units in comparison to nine days (median = 4 days) in adult units. The duration of admission to both child units and adult units in 2015 was slightly shorter than in 2014 when the mean duration of admission in child units was 66 days (median = 55 days) and 10 days (median = 5 days) in adult units.

There were four admissions to adult units where the child turned 18 years of age during their admission. All four remained on the unit as voluntary adult patients after they turned 18 years old. The duration of admission for these four admissions ranged from one day to 47 days.

Admissions by Service Provider⁸

Children were admitted to 21 adult units and six child units (one in each of the four HSE Areas and two⁹ in the independent sector) nationally in 2015.

Figure 25 shows the number of admissions to child units and adult units in each of the four HSE Regions and to units in the independent sector in 2015.

The majority, 70.9% (355) of all child admissions, in 2015, were to HSE operated approved centres. Almost three-quarters, (73.5%) of child admissions to HSE operated services were to child units and 26.5% were to adult units. Approved centres in HSE Dublin Mid-Leinster reported the highest number of child admissions (113), with 30 admissions to seven adult units and 83 admissions to the child unit. HSE West recorded the second highest number of admissions (92), with seven admissions to four adult units and 85 to the child unit. There were 79 admissions in HSE Dublin North East, 25 to five adult units and 54 to the child unit. HSE South recorded the lowest number of admissions of the four HSE Areas (71). There were 32 admissions to four adult units and 39 admissions to the child unit.

In three of the four HSE Areas, the number and proportion of admissions to child units far out-weighted admissions to adult units. However, in HSE South the number and proportion of admissions to adult units and the child unit were almost equal, 45.1% (32) and 54.9% (39) respectively.

In 2015, 29.1% (146) of admissions were to approved centres operated by Independent Service Providers.

7 Length of stay figures for 2015 concern those children who were admitted in 2015 and discharged at the time of writing this report in April 2016. Figures are based on 490/501 admission records.

8 A breakdown of admissions by service provider is based on the location of the unit and not the child's home address. A child can be admitted to a unit outside of their region and a large number of child admissions annually are to services operated by Independent Service Providers.

9 This includes the Ginesa Suite, a 12-bed CAMHS unit in St John of God Hospital which is a registered approved centre.

Almost all, 145/146 admissions, in the independent sector, were to two child units; Willow Grove Adolescent In-patient Unit, St Patrick's University Hospital and Ginesa Suite, St John of God Hospital. There was one admission of a child to an adult unit in the independent sector in 2015. The 145 admissions to the two child units accounted for 28.9% of all admissions nationally and 35.7% of admissions to child units. This is in keeping with the pattern in previous years; in 2014, 32.6% of all child admissions were to these two child units and in 2013 31.4% of all admissions were to these units.

Notes regarding child admission data

Under the terms of our Memorandum of Understanding with the Health Research Board (HRB), we cross reference our child admission data annually. If any discrepancies arise, approved centres are contacted for clarification and validation.

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

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

Notification of Deaths

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

Section 2(b) of the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting requires that 'All sudden, unexplained deaths¹⁰ 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 March 2014, the scope of the Code of Practice was expanded to include that all sudden and unexplained deaths of any person availing of a mental health service¹¹ are required to be notified to the Mental Health Commission.

The Commission received a total of 437 death notifications from mental health services in 2015. The section below reports on the number of death notifications received from approved centres in relation to residents and people who were recently discharged and from other mental health services. It also provides a breakdown of the proportion of death notifications that related to sudden, unexplained deaths. Death by suicide may only be determined by a Coroner's inquest; therefore it is not possible for the Mental Health Commission to report on how many of the sudden and unexplained deaths reported in 2015 were due to suicide.

In 2015, approved centres notified the Commission of 125 deaths which related to individuals who were a resident of an approved centre at the time of their death. Based on information provided by the service, 10.4% (13/125) of death notifications related to sudden unexplained deaths. Over half (8/13) of these sudden, unexplained deaths occurred when the resident was on authorised leave from the approved centre, four occurred subsequent to the resident absconding from the unit and one occurred in an approved centre.

Approved centres returned a further 42 death notifications to us in 2015; 41 pertained to persons who were recently discharged (within four weeks of the date of death) from an approved centre and one death notification concerned an individual who was a former in-patient (had been discharged more than four weeks prior to their date of death and was not availing of any other mental health service at the time of their death). Of these 42 death notifications 66.7% (28/42) included information to suggest that the death was a sudden unexplained death, for 26.2% (11/42) death was either due to natural illness or disease and on the remaining three forms the service indicated that the cause of death was unclear.

The Commission was notified of 270 deaths from community mental health services in 2015.

¹⁰ A sudden and unexplained death' refers to an unexpected death that may have been a suicide or that has occurred in suspicious circumstances as a result of violence or misadventure on the part of others or from any cause other than natural illness or disease.

¹¹ Mental Health Services include but are not limited to Day Hospitals, Day Centres, 24 Hour Staffed Community Residences and Other Mental Health Services such as out-patient departments, resource centres, group homes, out-reach teams, home-based treatment teams and other service types.

Based on information provided by the service, 63.3% (171/270) of death notifications related to sudden, unexplained deaths. In a small proportion, 6% (16/270) of cases the service indicated that the cause of death was unclear. For the remaining 30.7% (83/270) of death notification forms the death was either due to natural illness or disease and there was no requirement for the service to notify the Commission of these deaths.

Inspection and Regulatory Processes

A review of the MHC regulatory processes was conducted in 2015. A new inspection and regulatory process was introduced which included the publication of a Judgement Support Framework. The Framework incorporates national and international best practice under each relevant section of the legislative requirements. The Framework was developed as a guidance document to assist approved centres to comply with the Mental Health Act 2001 (Approved Centre) Regulations. The framework also provides guidance for approved centres regarding the matters which the Office of the Inspector of Mental Health Services shall address during the course of its annual inspections and may address during the course of any other focused inspections. The Framework also promotes the continuous improvement of the quality of services provided to residents of approved centres.

The Framework was published in July 2015. Prior to its publication the Commission held six national information sessions on the revised inspection and regulatory enforcement process and framework for approved centres as follows:

- › Monday 29th June, 2015 Merlin Park University Hospital, Galway.
- › Tuesday 30th June, 2015 HSE Model Business Park, Model Farm Road, Cork.
- › Friday 3rd July, 2015 Ashling Hotel, Dublin 8.
- › Tuesday 7th July, 2015 Ballymun Civic Centres.

Two sessions were held per day one in the morning and one in the afternoon. A total of 282 senior mental health services clinical staff and management attended.

International Society for Quality in Healthcare - International Accreditation Programme

The Commission applied for organisational accreditation to the International Society for Quality in Healthcare (ISQua) in 2014. Preparatory work took place in 2015 for ISQua's International Accreditation Programme (IAP).

This included process mapping, policy development and associated training in preparation for an onsite organisational survey to be conducted by a survey team from ISQua as part of the IAP. A Quality Management System, in line with the ISQua Guidelines and Standards for External Evaluation Organisations, was developed to assist in the accreditation process.

Joint Standards for the Notification and Management of Patient Safety Incidents Mental Health Commission and the Health Information Quality Authority

Following the publication of the Chief Medical Officer's Report, into the HSE Midland Regional Hospital, Portlaoise Perinatal Deaths, in February 2014, recommendation 14 proposed that the Health Information and Quality Authority (HIQA) should develop national standards for the conduct of reviews of adverse incidents. Further to this, the Health Information and Patient Safety Bill 2015 and the proposed Department of Justice and Equality Bill on Periodic Payment Orders (to include Open Disclosure Provisions) allow for the development of joint standards by the Commission and HIQA on the reporting of patient safety incidents (including serious reportable events (SRE's)) and on open disclosure. Following discussions with the Department of Health in 2015 it was agreed that the Commission and HIQA would develop joint standards for the notification and management of patient safety incidents which comprise the three elements:

- › Reporting of patient safety incidents (including serious reportable events (SREs))
- › Open disclosure
- › The conduct of reviews of patient safety incidents.

Health Act 2007 (Part 14) and Protected Disclosures Act 2014

A protected disclosure was made to the Commission under the Provisions of Part 14 of, Health Act 2007. The concern related to the safety and welfare of residents in a community residence. The Acting/Inspector of Mental Health Service was requested by the Commission to carry out a focused inspection.

The Inspection Report was published in 2015 and a Quality Improvement Plan was requested by the Commission. In light of the concerns notified to the Commission, implementation of the plan continues to be monitored on an ongoing basis, with particular regard to ensuring the safety of the residents.

Mental Health (Amendment) Act 2015

The Mental Health Amendment Act was signed by the President on the 25th December, 2015. The Commission progressed work on updating relevant rules, codes of practice and associated documents to reflect the amendments prior to the Commencement Order coming into effect in February, 2016.

Assisted Decision Making (Capacity) Act 2015

The Assisted Decision Making (Capacity) Act 2015 was signed by the President on Wednesday 30th December, 2015.

The Decision Support Service under the Assisted Decision-making Capacity Act 2015 will be under the remit of the Mental health Commission. The Commission will engage with the Department of Health regarding the implications of this legislation at the earliest opportunity in 2016.

Targeted Intervention Report

In March 2014, the Commission decided to instigate a Targeted Intervention in relation to mental health services in Carlow/Kilkenny and South Tipperary. A Targeted Intervention includes a review, an implementation plan for recommendations and a follow-up inspection to verify that required actions have been taken.

The initiative was prompted by concern within the Commission over the safety of mental health service users in the catchment area, and over the clinical governance and control of those services, arising from a number of deaths and other incidents between January 2012 and March 2014. The Commission chose this process to ensure that recommendations were actually implemented, and that their implementation was verified.

The targeted intervention team made 19 recommendations. A subsequent inspection and correspondence with the service established that 12 of these recommendations have been implemented, with implementation of the other seven underway. The full quality improvement initiative report was published in July 2015 is available on the Mental Health Commission's website.

Mental Health Commission Training Events

The Commission contributed to the following training events in 2015:

1. Circuit Court Section 19, Mental Health Act Appeals: The Role & Responsibilities of the Psychiatrist - College of Psychiatrists of Ireland and the Mental Health Commission.
2. Professional Certificate in Acute Mental Health Interventions - University College Dublin.
3. Certificate in the Application of Mental Health Legislation to Practice – Health Service Executive.
4. Training for HSE Authorised Officers in relation to MHA 2001– Health Service Executive.
5. Meeting the requirements of the Mental Health Act 2001 in Mental Health Services for HSE Non-Clinical Staff – Health Service Executive.
6. The Principles of Responsive Regulation and its Contribution to Quality Improvement – Webinar, International Society for Quality in Healthcare.

Independent Review System Mental Health Tribunals

Independent Review System Mental Health Tribunals

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 admission¹². This independent review is performed by a mental health tribunal during each period of detention. This section of the report provides a comparative analysis of 2015 involuntary admissions and their review by mental health tribunals, with previous years.

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

Involuntary Admission (Adults) 2015

Analysis was completed on the number of adults who were involuntarily admitted pursuant to Sections 9, 10, and 14 of the Act in 2015.

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 (Forms 1, or 2 or 3 or 4) and a recommendation by a registered medical practitioner (Form 5). There were 1,755 Form 6, Admission Orders, notified to the Commission in 2015.

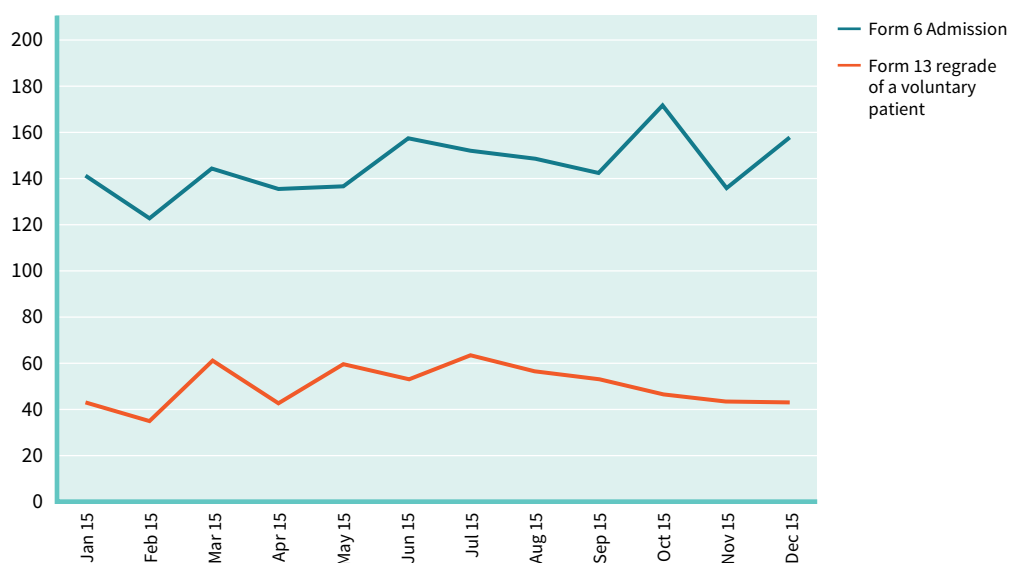
Detention of a Voluntary Patient (2015)

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 statutory Form 13, *Certificate & Admission Order to Detain a Voluntary Patient (Adult)*, signed by two consultant psychiatrists. There were 608 such admissions notified to the Commission in 2015.

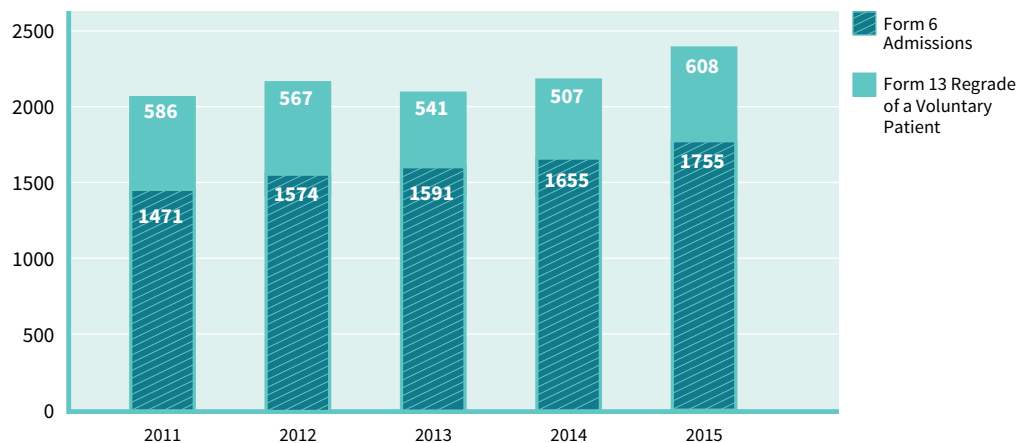
Comparisons 2011 - 2015

Figure 26 below summarises on a monthly basis both the above categories of involuntary admission for 2015, 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 of 124 to 172 per month, and the number of Form 13 orders fall within a range of 35 to 63 per month.

Figure 26 - *Monthly involuntary admissions 2015*



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

Figure 27 - *Comparisons of total involuntary admissions 2011 – 2015*

Comparison was made between the number of involuntary admission orders in 2015 and the orders in the previous four years. Figure 27 above summarises these comparisons on an annual basis and shows an increase of 4% from 2011 to 2012, no change from 2012 to 2013, a 1% increase from 2013 to 2014 and a 9% increase between 2014 and 2015.

A total of 44 patients had three or more involuntary admissions in 2015.

Table 9 below provides further details of involuntary admission rates for 2015 by HSE region and independent sector, with rates per 100,000 of total population.

Table 9 - *Involuntary admission rates for 2015 (adult) by HSE region and independent sector*

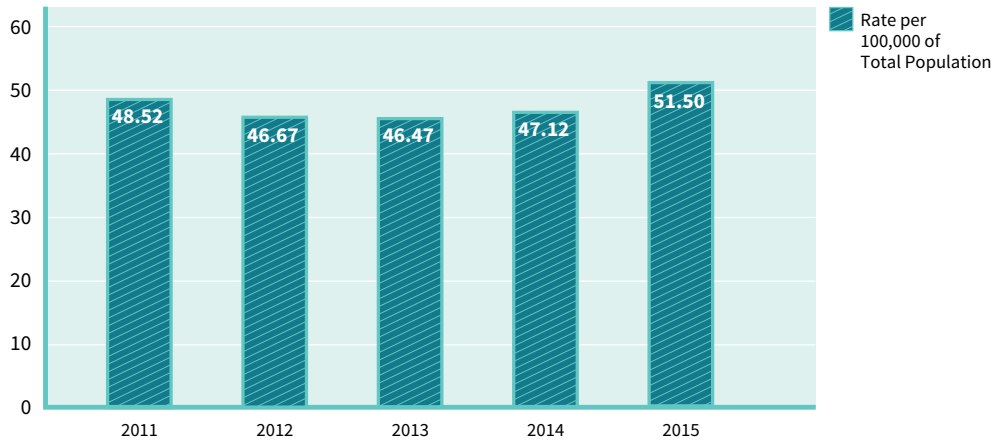
	Form 6	Form 13	Total Involuntary Admission Rate	Population*	Involuntary Admission Rate per 100,000 total population
HSE West	423	114	537	1,084,304	49.52
HSE South	427	126	553	1,133,858	48.77
HSE Dublin North East	377	157	534	1,018,535	52.42
Total HSE Dublin Mid Leinster	417	118	535	1,351,555	39.58
Independent Sector	111	93	204	N/A	N/A
TOTAL (Exclusive of Independent sector)	1,644	515	2,159	4,588,252	47.05
TOTAL (Inclusive of Independent sector)	1,755	608	2,363	4,588,252	51.50

*Population figures taken from CSO census 2011.

Detailed analysis of involuntary admission rates for 2015 by Approved Centre is provided on the Mental Health Commission web-site 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 28 below for the years 2011 to 2015.

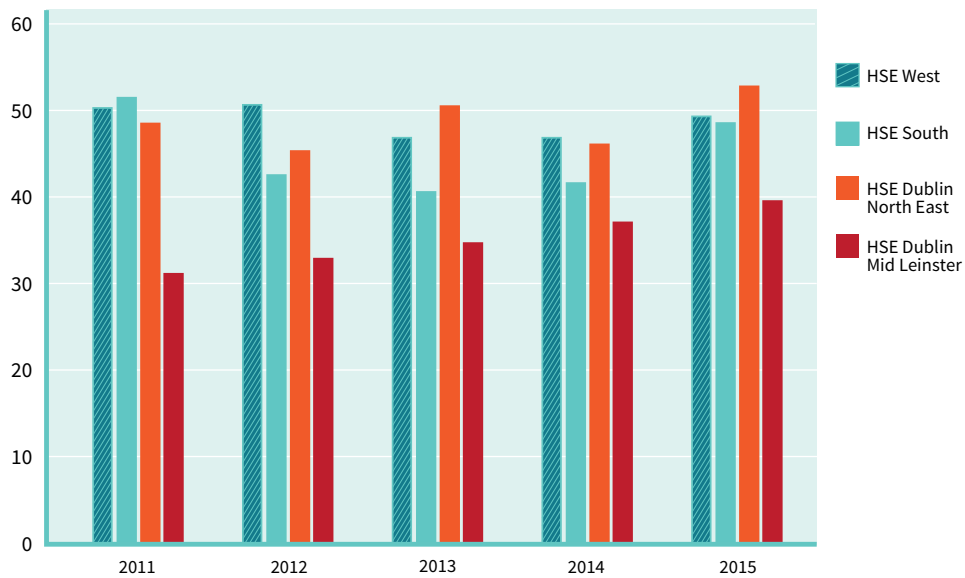
Figure 28 - *Ireland’s Involuntary Admission Rates per 100,000 of total population for the years 2011 to 2015**



*Population figures taken from CSO census 2011.

Figure 29 below further analyses involuntary admission rates per 100,000 of population for the years 2011 to 2015 by HSE Region.

Figure 29 - *Involuntary Admission Rates per 100,000 of population for the years 2011 to 2015 by HSE Region*



Age and Gender

Analysis of age and gender was completed on the figures for episodes of involuntary admission in 2015. Tables 10 and 11 below summarise these findings.

Table 10 - *Analysis by age - involuntary admissions 2015 (adults)*

AGE	FORM 6	FORM 13	TOTAL	%
18 - 24	208	106	314	13%
25 - 34	372	154	526	22%
35 - 44	360	103	463	19%
45 - 54	269	101	370	16%
55 - 64	207	67	274	12%
65 and over	339	77	416	18%
Total	1755	608	2363	100%

Table 11 - *Analysis by gender - involuntary admissions 2015 (adults)*

GENDER	FORM 6	FORM 13	TOTAL	%
Female	746	312	1058	45%
Male	1009	296	1305	55%
Total	1755	608	2363	100%

Type of Applicant

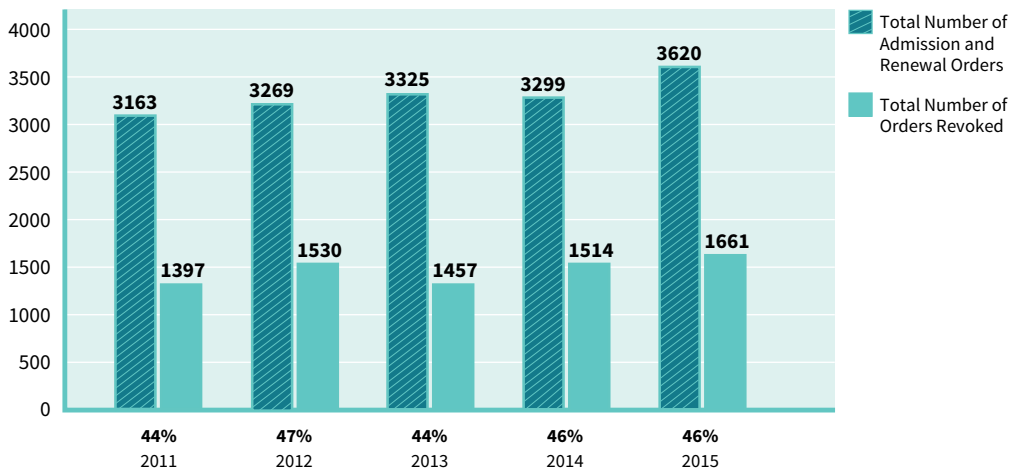
Analysis was undertaken of the categories of persons who applied for a person to be involuntarily admitted under Section 9 of the Act in 2015. Table 12 below summarises this analysis.

Table 12 - *Analysis of applicant: involuntary admissions 2015 (adults)*

FORM	TYPE	TOTAL 2015	%
1	Spouse,Civil Partner,Relative	831	47%
2	Authorised Officer	231	13%
3	Garda Síochána	404	23%
4	Any Other Person	289	17%
	TOTAL	1755	100%

Comparison of the 2014 figures for type of applicant with the 2015 figures shows the number of applicants by spouse/relative has decreased from 53% to 47%, authorised officer has increased from 12% to 13%, Garda Síochána has increased from 20% to 23% and any other person has increased from 15% to 17%. 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.

Figure 30 - **Number of orders revoked before hearing by Responsible Consultant Psychiatrists under the provisions of Section 28 for years 2011 to 2015**



Revocation by Responsible Consultant Psychiatrist

Section 28 provides that the consultant psychiatrist responsible for the patient shall revoke an order where they become of the 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, notice to this effect (statutory Form 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 1,661 such instances in 2015. The patient may leave the centre at this stage or stay to receive treatment on a voluntary basis. Figure 30 above shows the number of orders revoked before hearing by responsible consultant psychiatrists under the provisions of Section 28 for years 2011 to 2015.

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, also appointed by the Commission, will have been completed. There were 1,944 hearings in 2015. Hearings were monitored by the Commission as to when in the 21 day period of the order the mental health tribunal occurred. Figure 31 below shows the breakdown of hearings over the 21 day period of the relevant order.

Figure 31 - **Breakdown of hearings over 21 day period 2015**

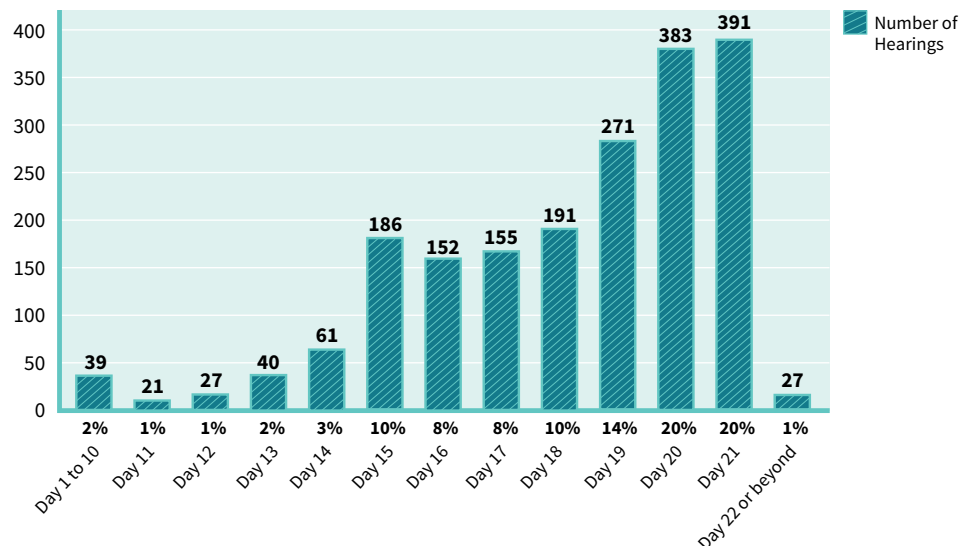
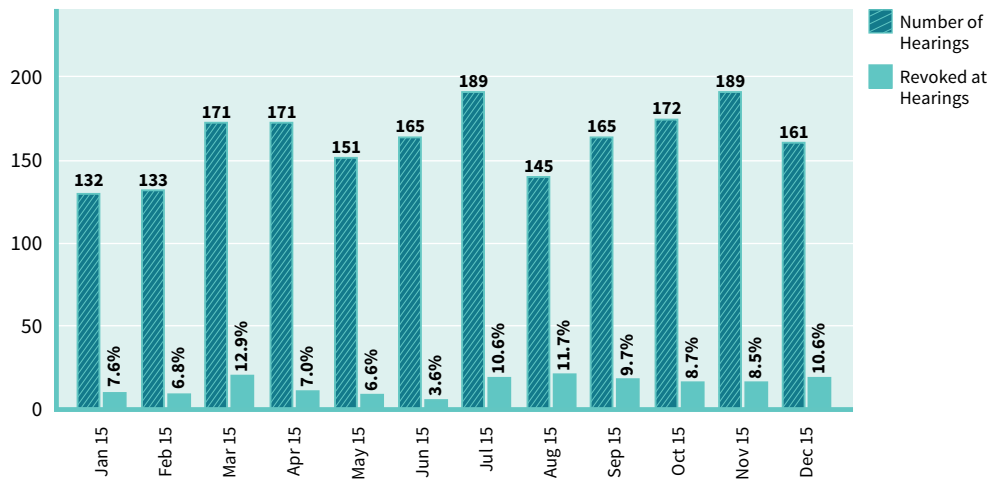


Figure 32 - *Number hearings and % of orders revoked at hearing 2015*

It is important to note that hearings that took place on Day 22 or beyond were in relation to orders 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).

Orders Revoked at Hearing

Analysis was undertaken of the number of orders revoked at a mental health tribunal in 2015. Figure 32 above shows the number of hearings on a month by month basis for 2015 and the number of orders revoked (%) in each month. In total, 9% of orders reviewed by mental health tribunals in 2015 were revoked. This shows a 1% increase in comparison with the percentage of orders revoked at hearing in 2014.

Appeals Pursuant to Section 19 of the Mental Health Act, 2001

Section 19 (1) of the Mental Health Act, 2001 provides:

“A patient may appeal to the Circuit Court against a decision of a 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.”

Section 19(16) of the Act provides:

“No appeal shall lie against an order of the Circuit Court under this section other than an appeal on a point of law to the High Court.”

The Commission was notified of 144 Circuit Court appeals in the period from 1 January to 31 December 2015. Of that number, 30 appeals proceeded to full hearing.

The Commission notes the continuing trend in the number of Circuit Court appeals being brought on behalf of patients and also in the numbers proceeding to full hearing since Part II of the Act was commenced on the 1st of November 2006. 48 appeals were brought in 2008, 46 were brought in 2009, 67 were brought in 2010, 87 were brought in 2011, 116 appeals were brought in 2012, 121 were brought in 2013 and 145 were brought in 2014.

In compliance with S.I. 11/2007, Circuit Court Rules (Mental Health) 2007, the Mental Health Tribunal is the respondent to these appeals notwithstanding that the ‘order’ which ‘is’ under appeal is the order of the responsible consultant psychiatrist detaining the patient. The High Court has held on a number of occasions that the question to be determined by the Circuit Court is whether the patient ‘is’ suffering from a mental disorder on the date of the hearing. In *DH v. The President of the Circuit Court and Others*¹³ Mr. Justice Charlton stated at paragraph 19:

“The legislative purpose behind section 19 of the Mental Health Act, 2001, is to allow those patients who are still detained, following a hearing before a Mental Health Tribunal, to have the condition of their mental health reviewed before a Judge of the Circuit Court. It is not to engage in an historical analysis. Whether there would be a point, or would not be a point, to such an historical analysis is irrelevant given the express wording of the section. I am obliged to give grammatical and ordinary sense to the use of the present tense in s. 19, and to the choice given to the Circuit Court of either affirming an admission or renewal order, or revoking it.”

This approach was confirmed by the High Court in *E.G. v. Mental Health Tribunal and Others*¹⁴. As such, the reasoning and conclusions of the Mental Health Tribunal are irrelevant to determining the appeal. The patient and the responsible consultant psychiatrist together with the approved centre are the interested parties.

The Commission’s legal aid scheme is available to patients wishing to bring appeals under section 19, irrespective of whether those appeals are likely to be successful. The Commission is also liable for the costs of defending such appeals on behalf of the Mental Health Tribunals. Heretofore, the Commission has always granted legal aid to a patient wishing to bring an appeal under section 19. The Commission considers this approach to be in line with its function of protecting “the interests of persons detained in approved centres under this Act”¹⁵.

The Commission notes recommendations 71 and 72 of the Report of the Expert Group on the Review of the Mental Health Act 2001 in relation to Circuit Court Appeals.

Recommendation 71:

Grounds for appeal to the Circuit Court should be amended such that the onus of proof as to the existence or otherwise of a mental illness that meets all the criteria for detention falls on the approved centre rather than the patient as is currently the case.

Recommendation 72:

S.I. 11/2007, Circuit Court Rules (Mental Health) should be amended to reflect the fact that the approved centre should be the respondent in cases brought before the Court and the Mental Health Commission’s potential involvement should be as a Notice Party.

13 [2008] IEHC 160

14 Unreported High Court (O’Neill J.), 20 December 2013

15 Section 33(1) of the Mental Health Act, 2001

External Environment and MHC Collaboration

External Environment and MHC Collaboration

Expert Group Review on the Mental Health Act 2001

The Chief Executive of the Commission was a member of the Expert Group established by Ms Kathleen Lynch TD, Minister for Primary Care, Social Care (Disabilities & Older People) and Mental Health. The group concluded their work in 2014, which was presented to Minister who published the 'Report of the Expert Group on the Review of the Mental Health Act 2001' in March 2015. The report and its authors support the policy set out in 'A Vision for Change', and have made a total of 165 recommendations that will help bring legislation in line with that policy.

Medication Safety Forum

The Commission continues to be represented on the Medication Safety Forum, hosted by the Department of Health. The aim of the Forum is implementing the medication safety recommendations of the Report of the Commission on Patient Safety.

HSE Serious Reportable Events Governance Group

The Commission participated in establishing a framework for the reporting of Serious Reportable Events (SREs), the defined list of SREs and associated guidance was published by the HSE, in January 2015.

Quality and Qualifications Ireland

The Commission was invited to participate on a panel of experts to undertake the validation assessment of a 'Certificate in Basic Cognitive Behavioural Skills for Nurses', Level 8. Quality and Qualifications Ireland's (QQI's) role is to validate training and education programmes and to quality assure providers of education and training.

National Strategy on Children and Young People's Participation in Decision-Making 2015 - 2020

The Department of Children and Youth Affairs launched the first National Strategy on Children and Young People's Participation in Decision-making (2015 – 2020) in June, 2015. The goal of the strategy is to ensure that children and young people have a voice in their individual and collective everyday lives across the five national outcome areas set out in Better Outcomes, Brighter Futures:

The National Policy Framework for Children and Young People 2014 – 2020. The Commission was invited to contribute to its development and provided feedback to areas of responsibility assigned to the Commission within the report.

National Office for Suicide Prevention

"Connecting for Life – Ireland National Strategy to Reduce Suicides 2015 – 2020" was published in June 2015. The Chief Executive of the Commission was a member of the Strategic Planning Oversight Group for the Strategy and also chaired the Practice Improvement Advisory Group. A representative from the Commission was a member of the National Standards in Suicide Prevention Working group, whose remit was to develop standards based on the strategy.

National Healthcare Quality Reporting System

The Department of Health published the first annual report of the National Healthcare Quality Reporting System in March 2015. The aim of the report was to provide information on the quality and safety of health care services that can be easily understood and used by patients, members of the public, policy makers, and service providers. The Commission is represented on the governance committee.

National Clinical Effectiveness Committee

The National Clinical Effectiveness Committee's (NCEC's) mission is to provide a framework for national endorsement of clinical guidelines and audit to optimise patient and service user care. The NCEC has a remit to establish and implement processes for the prioritisation and quality assurance of clinical guidelines and clinical audit so as to recommend them to the Minister for Health to become part of a suite of National Clinical Guidelines and National Clinical Audit. Fourteen National Clinical Guidelines have been published to date.

National Standards for Clinical Practice Guidance were launched at the National Patient Safety Conference on the 12th November 2015. The purpose of this document is to provide standards for health care staff developing evidence-based clinical practice guidance for health care. The development of these standards builds on existing frameworks such as the Quality Framework for Mental Health Services.

It is expected that the HSE and all health care organisations will develop all new and updated guidance in line with these national standards. The standards are intended to support and complement existing standards and all new and updated guidance should be aligned to these national standards.

The Commission was represented on the committee and continues to contribute to the NCEC's work programme. Mental Health Services are required to take cognisance of the guidelines, which the Inspector of Mental Health Services monitors when inspecting approved centres, if appropriate.

Gay and Lesbian Equality Network

A representative from the Commission continued to sit on the Gay and Lesbian Equality Network (GLEN) research advisory group in 2015. The focus of the study, which commenced in 2014, was on mental health and suicidal behaviour of LGBT people in Ireland. As part of this two-part project, surveys and interviews were conducted throughout 2015. Findings are due to be published in early 2016.

Healthcomplaints.ie Governance Committee

The healthcomplaints.ie initiative was launched in 2011 by the Ombudsman's office as a way to signpost the public as to how to raise a concern or to make a complaint about health and social care services and service providers in Ireland. The governance committee was established in 2011 to oversee the initiative and to strive to keep information and, in particular, information on the website up to date and accurate. In 2015, the Chief Executive of the Commission passed the chairing of the Governance group to the Ombudsman.

National Incident Management System Implementation Group

A representative from the Commission sat on the National Incident Management System (NIMS) Phase I Implementation Steering Group. The group was responsible for overseeing phase one implementation of the NIMS system nationally. The group concluded its work in December 2015.

Key Enablers

Key Enablers

Expenditure

The non-capital allocation to the Mental Health Commission for 2015 was €12.750 million. The outturn for 2015 in the Mental Health Commission was €12.731 million.

Key areas of expenditure related to the statutory functions as set out in the Mental Health Act 2001 including the provision of Mental Health Tribunals and inspection of Approved Centres and other locations where mental health services are provided. Additional expenditure related to staff salaries, legal fees, office rental, ICT technical support and development. Third party support contracts continue to be managed to ensure value for money and service delivery targets are met.

The accounts for 2015 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 Commission website www.mhcirl.ie as soon as they are available.

Prompt Payment of Account legislation

The Commission complied with the requirements of the Prompt Payment of Account Legislation and paid 96.41% 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 / Data Protection

During 2015 the Mental Health Commission received 18 requests under the Freedom of Information Act 2014. Of these, 11 requests were granted, seven requests were refused and one request remained open at the end of the year.

There were no requests for, or breach of information under the Data Protection legislation.

Energy Reporting

The Public Sector has been challenged to reach verifiable energy-efficiency savings of 33%. This target requires management commitment at the highest level and the involvement of all public sector staff.

The Commission is fully committed to the 2020 Vision in relation to reaching verifiable energy-efficiency savings of 33%. The Commission has been working with the Sustainable Energy Authority of Ireland (SEAI) since taking on this challenge in early 2014 when we were required to submit all of our energy data as far back as 2009.

To date we have achieved energy-efficiency savings of 15.8% based on our 2009 starting point showing that we are half way to achieving our 33% target. To put this into perspective, the Commission is the 126th best performer out of all 439 Public Bodies involved, whose average energy savings was 4.4%, 11.4% less than that of the Commission's.

In 2015 the Commission consumed 154,819kWh of energy, consisting of 66,623kWh of electricity and 88,197kWh of heating oil. This is a reduction in energy consumption of 22.8% compared to 2014 and 40.2% compared to our 2009 baseline. This reduction is as a result of the refurbishment works that were completed in Quarter 1 of 2015 which incorporated energy saving measures as recommended by an energy report produced by the SEAI at the request of the Commission.

The Commission remains determined to achieve the 33% target by 2020.

ICT

The Commission issued an invitation to tender for Information Technology Managed Support Services and for proposals to update the current ICT systems across the organisation. The successful completion and developments arising from this tender will lead to an enhanced ICT system in the Commission.

During 2015 the Commission was advised that the online payment system used by Mental Health Tribunal Panel Members and Commission staff would no longer be supported by a public sector third party. Plans were put in place to move this system in-house in early 2016.

Staff in the Commission

During 2015 the Corporate Services Division engaged in a number of recruitment campaigns which saw the introduction of a Finance Officer and other administration staff in addition to a number of Assistant Inspectors of Mental Health Services.

Following the completion of a tendering process, the Commission began work with external consultants on an organisational review to ensure that it is positioned appropriately to efficiently address its statutory mandate now and in the medium to long term. The current structure was established prior to the implementation in full of the Mental Health Act 2001 in 2006 and the functions of the Commission have evolved over time. The final Report of this review is due in early 2016.

The organisational review coincides with the development of the Commission's Strategic Plan 2016 – 2018 and is a proactive initiative to map resources to functions to maximise current capacity and identify gaps that require augmentation to ensure the Commission is positioned to deliver its strategic objectives to 2018.

Developing our People

In 2015 the Commission continued to support staff by way of training and development programmes to assist them in the performance of their roles within the Commission. The Commission also commenced a programme of health promotion events for staff which was well received.

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 the regulations and orders under the Safety, Health and Welfare at Work Act, 2005.

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. The National Disability Authority (NDA) has a statutory duty to monitor the employment of people with disabilities in the public sector each year. Staff census update forms were made available to all staff in order to update the record on the number of staff with disabilities in the Commission. The Commission's 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 are an integral component of all Commission 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.

Research

NUI Galway – Research Programme Grant Scheme
Research Project: *“A Prospective evaluation of the operation and effects of the Mental Health Act 2001 from the viewpoints of services users and health professionals”*.

A short no cost extension was granted to the above project in 2015 which is now due for completion in April 2016.

MHC/RCSI Research Collaboration
Research Project: *“ECT and Seclusion in Clinical Mental Health Practice in Ireland”*

The above project concluded in 2015 with a presentation made at the March Commission meeting.

Contacting the Mental Health Commission

Mental Health Commission / Coimisiún Meabhair-Shláinte

St. Martin's House
Waterloo Road
Dublin 4
D04 E5W7
Tel: (+353) 01 6362400
Fax: (+353) 01 6362440
Email: info@mhcirl.ie
Website: www.mhcirl.ie

Solicitors:

Arthur Cox Solicitors
Earlsfort Centre
Earlsfort Terrace
Dublin 2
D02 CK83
Tel: (+353) 01 6180000
Fax: (+353) 01 6180618
Website: www.arthurcox.com

Accountants:

Crowleys DFK
16/17 College Green
Dublin 2
D02 V078
Tel: (+353) 01 6790800
Fax: (+353) 01 6790805
Website: www.crowleysdfk.ie

Auditors:

Office of Comptroller and Auditor General
3A Mayor Street Upper
Dublin 1
Tel: (+353) 01 8638600
Website: www.audgen.gov.ie

Report of the Inspector of Mental Health Services

The Inspector of Mental Health Services term of office expired in May 2015. Pending the filling by the Commission of the post on a substantive basis, two of the Assistant Inspectors who met the eligibility qualification criteria for Inspector i.e. (a Consultant Psychiatrist, Section 50, Mental Health Act 2001) were appointed on a rotational basis during 2015 as Interim Inspector.

This Report was prepared by:

Dr. Fionnuala O'Loughlin (Interim Inspector during 2015)

Dr. Susan Finnerty (Interim Inspector during 2015).

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Introduction

The functions and duties of the Inspector of Mental Health Services are set out in sections 51 and 52 of the Mental Health Act 2001 (“the Act”).

The Act includes a provision to visit and inspect every approved centre at least once in each year and to furnish a report in writing to the Mental Health Commission on the compliance by approved centres with any Code of Practice, Regulations made under section 66 of the Act, Rules made under sections 59 and 69, and the provisions of Part 4 of the Act on Consent to Treatment. Approved centres are hospitals or other in-patient facilities for the care and treatment of people suffering from a mental illness or mental disorder and which are registered with the Mental Health Commission.

Inspections are carried out to determine compliance with Mental Health Act 2001 (Approved Centres) Regulations 2006¹⁶ (“the Regulations”), Rules¹⁷ and Codes of Practice¹⁸ and any other issues relating to the care and treatment of residents in the approved centres (these documents may be found on the Mental Health Commission website: <http://www.mhcirl.ie>). The Inspector may also inspect any other service, where mental health services are being delivered under the direction of a consultant psychiatrist.

Inspections in 2015

In 2015, the Mental Health Commission developed and published a Judgement Support Framework as a guidance document to assist approved centres to comply with the Regulations, Rules and Codes of Practice. The Judgement Support Framework also promotes continuous improvement of the quality of services provided to residents of approved centres. The Judgement Framework provides clarity and transparency in relation to the inspection process.

In 2015, a total of 61 approved centres were inspected by the Inspector of Mental Health Services and inspection team.

The inspection team is multidisciplinary and in 2015 comprised psychiatrists, mental health nurses, occupational therapists, social worker, service user representative and researcher. All inspections of approved centres in 2015 were unannounced.

Compliance with Regulations

In 2015, six approved centres were compliant with all applicable Regulations, Rules, Codes of Practice and Part 4 of the Act Consent to Treatment. These were:

- › Highfield Hospital, Dublin 9
- › Lois Bridges, Sutton, Dublin 13
- › Clonfert Ward, St Brigid’s Hospital, Ballinafe, Co Galway
- › St Edmundsbury Hospital, Lucan, Co Dublin
- › St Patrick’s University Hospital, Dublin 8
- › Willow Grove Adolescent Unit, St Patrick’s University Hospital, Dublin 8

St Edmundsbury Hospital and Willow Grove Adolescent Unit had complied with all applicable Regulations, Rules and Codes of Practice for three consecutive years.

All approved centres achieved compliance with the following Regulations:

- › Regulation 10 Religion
- › Regulation 11 Visits
- › Regulation 12 Communication
- › Regulation 33 Insurance
- › Regulation 34 Certificate of Registration

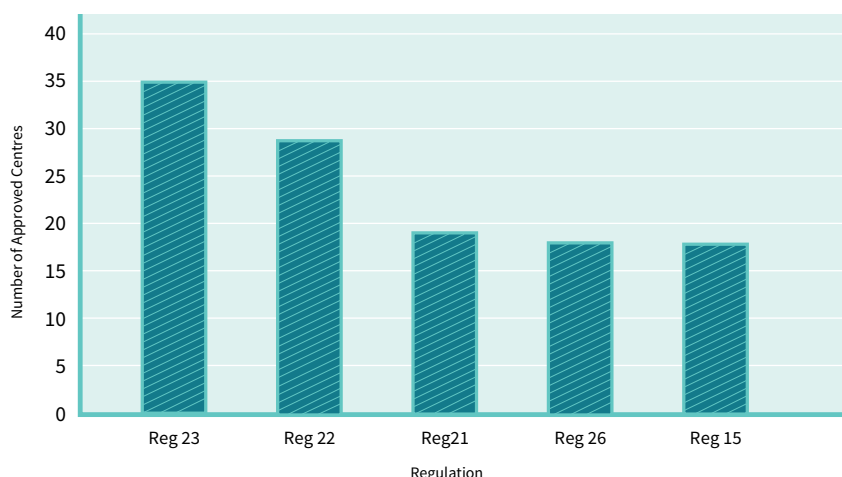
Where the regulation was applicable, all approved centres achieved compliance with Regulation 17 Children’s Education.

¹⁶ Mental Health Act 2001 (Approved Centres) Regulations 2006 (S.I. No. 551 of 2006)

¹⁷ Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint. Mental Health Commission Rules Governing the Use of Electro-Convulsive Therapy (ECT). Mental Health Commission

¹⁸ Code of Practice relating to Admission of Children under the Mental Health Act 2001. Mental Health Commission
Code of Practice on the Use of Physical Restraint in Approved Centres. Mental Health Commission
Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. Mental Health Commission
Code of Practice on Admission, Transfer and Discharge to and from an approved centre. Mental Health Commission
Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities. Mental Health Commission
Code of Practice on the Use of ECT for Voluntary Patients. Mental Health Commission Code of Practice on the Use of Physical Restraint. Mental Health Commission

Figure 1 - *Non compliance with regulations*



Reg 23 Ordering, Prescribing, Storing and Administration of Medicine; Reg 22 Premises; Reg 21 Privacy; Reg 26 Staffing; Reg 15 Individual Care Plan.

The graph above shows the five Regulations with which approved centres were most frequently non-compliant in 2015.

Regulation 15 Individual Care Plan

Since the introduction of Regulations governing the operation of approved centres in 2006, there has been a consistent failure of compliance with the Regulation on individual care plans. In the Regulations, an individual care plan is defined “*Individual care plan*” means a documented set of goals developed, regularly reviewed and updated by the resident’s multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation. Services failed to be compliant with this Regulation if all aspects of the care plan were not addressed. The most common reason for non-compliance was the absence of specified goals in the care plan. Other reasons included a lack of multi-disciplinary team input in the care plan and a lack of clarity on the necessary resources to implement the individual’s care plan. In 2015, 18 (30%) approved centres were non-compliant with this Regulation and, in all but two approved centres, all residents had an individual care plan.

Regulation 26 Staffing

The Regulation on staffing requires that staff have access to education and training. 18 approved centres (30%) failed to achieve compliance with this Regulation.

In the majority of cases (12 approved centres), the reason for non-compliance was a lack of evidence that staff had access to training to enable them to provide care and treatment in accordance with best contemporary practice. A lack of appropriate skill mix of staff was apparent in four approved centres and, in one instance, there was a serious concern about the projected staffing level for an acute approved centre. This was reported to the Regulatory Review Committee in the Mental Health Commission and enforcement action was taken.

Regulation 21 Privacy

Privacy, with due regard for the safety of residents in an approved centre, is a basic human right and, for the most part, approved centres provided facilities which offered privacy. However, 19 approved centres (31%) did not adequately provide for privacy for their residents. The main reason for this was a lack of privacy in the sleeping accommodation. Residents in five approved centres were accommodated in large dormitory-style bedrooms. Notwithstanding the fact that beds had surround curtains, this arrangement was not conducive to privacy for residents and was not acceptable in a 21st century healthcare facility.

In contrast to the older approved centres, all new approved centres have been constructed with consideration for privacy and residents were accommodated in single, mainly en suite bedrooms. In all, 14 approved centres provided such accommodation in 2015 and included approved centres in Cork University Hospital, Phoenix Care Centre and the Ashlin Unit in Beaumont Hospital. All five approved centres for the admission of children and adolescents provided accommodation in single bedrooms.

Regulation 22 Premises

In previous years, the Inspector has reported on the number and condition of approved centres dating back to the 19th century still in operation. At the end of 2013, there were 15 approved centres dating from the 19th century in operation. This number is decreasing each year and, at the end of 2015, there were three such approved centres in operation.

The approved centres in buildings dating to the 19th century still in operation in 2015 were:

- › Central Mental Hospital, Dundrum, Dublin (94 beds)
- › St Fintan's Hospital – Ward 6, Portlaoise, Co Laois (30 beds)
- › Blackwater House in St Davnet's Hospital, Co Monaghan (20 beds)

Other approved centres located in the grounds of 19th century asylums included:

- › Admission Ward and St Edna's Ward, St Loman's Hospital, Mullingar
- › St Aidan's Ward and Grangemore, St Otteran's Hospital, Waterford
- › St Gabriel's Ward, St Canice's Hospital, Kilkenny
- › O'Connor Unit, St Finan's Hospital, Killarney

Notwithstanding the decrease in the use of 19th century buildings as approved centres, the level of compliance with this Regulation was disappointing. 29 approved centres (48%) did not comply with all the requirements of the regulation. The most common reason for non-compliance was the degree to which ligature anchor points within the approved centre (10 approved centres) had not been addressed and, therefore, continued to pose a risk to patient safety. However, it was evident in many approved centres that work had been carried out or was ongoing to address the presence of ligature anchor points. Other reasons which contributed to the failure to reach compliance included an institutional layout and a poor state of repair of the building. In two approved centres, a lack of adequate showering facilities resulted in non-compliance. It was difficult to understand how a mental health service could stand over the provision of only two showers for 32 residents (one of which was out of order on the first day of inspection) in one approved centre and in another approved centre, the provision of one shower for 25 residents.

Regulation 23 Ordering, Prescribing, Storing and Administration of Medicines

This Regulation requires the service to have appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines. 35 approved centres (57%) did not comply with this Regulation. The reason for non-compliance in the vast majority of cases (80%) was the failure of medical practitioners to record their Medical Council Registration Numbers (MCRN) on prescriptions.

Approved Centres' Compliance with Rules

Rules Governing the Use of ECT for Involuntary Patients and Use of Seclusion and Mechanical Means of Bodily Restraint, developed by the Mental Health Commission in accordance with sections 59(2) and 69(2) of the Act, are included in the inspection of all approved centres, when applicable.

ECT

There was full compliance with the Rule on ECT, when ECT was administered to involuntarily detained patients, as determined on inspections.

Seclusion

Seclusion is defined, in the Rule developed by the Mental Health Commission, as *"the placing or leaving of a person in any room alone, at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving"*. Where seclusion is used, a room is designated and fitted out as a seclusion room, which is only used for this purpose. In 2015, less than half of all approved centres (46%) had seclusion facilities.

Ten (36%) of the approved centres which had seclusion facilities were found to be in breach of the Rule on seclusion and, in three approved centres, the seclusion facilities were not in use at the time of inspections due to their current unsuitability for use. These were:

- › Acute Psychiatric Unit 5B, Limerick
- › CAMHS In-patient Unit, Merlin Park, Galway
- › Linn Dara Child and Adolescent Unit, Cherry Orchard, Dublin

In three approved centres, the reason for the breaches was the presence of a 'blind spot' in the seclusion room. This meant that a resident in seclusion could not be directly observed by nursing staff for the first hour of seclusion, which is a requirement of the Rule.

Other causes of non-compliance were a failure to carry out a medical review within four hours of seclusion and a failure to complete documentation in respect of the episode of seclusion.

The Mental Health Commission published a Seclusion and Restraint Reduction Strategy in 2014¹⁹ with the aim of reducing the frequency of seclusion and restraint, to encourage the use of evidence-based best practice and achieve an improved service experience for both the recipient and providers of mental health services. The Inspector promotes this strategy and encourages its use in decreasing restrictive practices.

Mechanical Restraint

For the purpose of the Rule governing the use of mechanical restraint, mechanical means of bodily restraint is defined as *“the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a patient’s body”*. Part 5 of the Rules states that *“the use of mechanical means of bodily restraint on an ongoing basis for enduring risk of harm to self or others may be appropriate in certain clinical situations and must be used only to address an identified clinical need”*. In essence, this means the use of lap belts or other such restraint to prevent a resident falling and causing harm to themselves.

Mechanical restraint under Part 5 of the Rules, was used in 17 approved centres in 2015; 12 of these approved centres (70%) were approved centres for the continuing care of residents. When mechanical restraint was used, compliance was generally good with a compliance rate of 70%. The failure to complete documentation in respect of the orders for mechanical restraint was responsible for the finding of non-compliance. A further approved centre used mechanical restraint when indicated under Part 5, but it had not been used since the previous inspection in 2014.

In addition, only one approved centre, the Central Mental Hospital, used mechanical restraint for the immediate threat of serious harm to self or others (Part 4 of the Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint). This was the use of handcuffs for transportation of patients only. The Central Mental Hospital was compliant with the Rule.

Sections 60 and 61 of the Mental Health Act 2001 (Administration Of Medicine) Consent to Treatment

Sections 60 of the Mental Health Act 2001 specify that the administration of medicine to a detained patient for longer than three months cannot be continued unless the patient gives consent in writing or is approved by the treating consultant psychiatrist and authorised by another consultant psychiatrist. Section 61 of the Mental Health Act 2001 specifies that where a child is detained for a continuous period of three months under section 25 of the Act, the administration of medication shall not be continued unless the consultant psychiatrist responsible for the care and treatment of the child approves the administration of medication and that it is authorised on a specified form by another consultant psychiatrist. In 22 of the 61 approved centres (36%), this section of the Act did not apply as there were no detained patients in the approved centres at the time of inspection.

Of the 39 approved centres where detained patients were administered medicine for longer than three months, 31 were compliant with section 60 or 61.

The reasons for non-compliance were a failure to provide evidence of written consent by the patient, an authorisation form which had lapsed or a failure to specify on the authorisation form the medicine prescribed for the patient.

Approved Centre Compliance with the Codes of Practice

Code of Practice on the use of Electro-Convulsive Therapy for Voluntary Patients

During the inspections in 2015, it was determined that there were ECT facilities in 14 approved centres, i.e. 23% of all approved centres. ECT had not been administered in two of these approved centres since the inspections of 2014: Acute Psychiatric Unit, Cavan General Hospital and Acute Psychiatric Unit, University Hospital, Ennis.

Of the 12 approved centres that had administered ECT in the interval since the previous inspections, 9 (75%) were compliant with the Code of Practice. In the three approved centres which were not compliant with the Code of Practice, the reasons included a lack of evidence of physical examination of the resident prior to ECT, lack of training of the ECT nurse and a failure to record an assessment of capacity to consent to anaesthesia.

19 Seclusion and Restraint Strategy 2014. Mental Health Commission

Code of Practice on the use of Physical Restraint

Aggression can occur in psychiatric inpatient care and its frequency towards healthcare professionals is well documented²⁰. Physical restraint of a resident may have to be used in an approved centre where a resident is at risk of harming themselves or others. Physical restraint refers to *'the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident's body'*²¹.

Of the 56 approved centres that used physical restraint in 2015, 42% were non-compliant with the Code of Practice. There were a number of different reasons for non-compliance in 2015. Documentation was inadequate in 69% of non-compliant approved centres, and included failure of the consultant psychiatrist to sign the clinical practice form; incomplete forms; and forms not located in the clinical file. The Code of Practice states that all uses of physical restraint should be clearly recorded, as soon as is practicable, on the Clinical Practice Form for Physical Restraint.

In 31% of approved centres non-compliant with the Code of Practice, the resident did not have a physical examination as required by the Code of Practice.

In 44% of approved centres, which were not compliant with the Code of Practice, not all staff were trained in prevention and management of violence and aggression, including how to physically restrain an individual. As in 2014, due to staffing problems there were difficulties in releasing staff for training. The importance of training in the use of physical restraint should not be underestimated, due to the risk of injury to both residents and staff²². Security personnel participated in the physical restraint of a resident in 38% of approved centres.

Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting

This Code of Practice requires approved centres to report the death of any resident to the Mental Health Commission within 48 hours. In addition, a summary of incidents is required to be reported to the MHC on a six-monthly basis and the approved centre policy on risk management must identify the risk manager for the approved centre.

Twelve approved centres (20%) were not compliant with the Code of Practice in 2015. The reasons for the non-compliance included reporting of a death outside the timeframe specified (three approved centres), failure to identify the risk manager in the policy (three approved centres) and failure to provide a six-monthly summary of incidents (two approved centres). In one case, the summary report did not accurately reflect the range of incidents in the approved centre, which led to a breach of the Code of Practice.

Code of Practice on Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities

This Code of Practice was developed to provide guidance to approved centres where residents with an intellectual disability, in addition to a mental illness, are admitted. The Code of Practice was not applicable in 17 approved centres because, at the time of inspection in 2015, no resident had an intellectual disability and a mental illness.

Only four approved centres (2%) were not compliant with the Code of Practice; the reasons for this were a lack of staff training in the area of intellectual disability (two approved centres) and the lack of a policy on the care and treatment of residents with an intellectual disability.

Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre

The Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre provides guidance on the criteria which facilitate entrance to and exit from an approved centre. The Code specifically references a number of Regulations with which approved centres must comply; a breach of these Regulations results in a failure to comply with the Code of Practice.

On inspections in 2015, most approved centres were compliant with the Code of Practice; 14 approved centres (23%) were not compliant. The most frequent causes for non-compliance were a breach of the specified Regulations (four approved centres) and a lack of adequate documentation in relation to residents transferred to another approved centre or facility (four approved centres). One approved centre (Acute Psychiatrist Unit, University Hospital, Ennis) was in breach of a condition which prohibits the transfer of residents to another approved centre to alleviate bed shortages.

20 Physical restraint: in defence of the indefensible? The Eileen Skellern Lecture 2014: Duxbury JA *Psychiatr Ment Health Nurs*. 2015 Mar;22(2):92-101.

21 Code of Practice on the Use of Physical Restraint. Mental Health Commission 2009

22 Manual restraint and shows of force: The City-128 study Len Bowers, Marie Van Der Merwe, Brodie Paterson and Duncan Stewart *International Journal of Mental Health Nursing* (2012) 21, 30-40

Admission of Children to Adult Approved Centres

A Vision for Change, the national mental health policy, recommended that children up to the age of 18 years who required in-patient mental health services should be admitted to dedicated child and adolescent in-patient units. The Mental Health Commission set out in the Code of Practice Relating to Admission of Children under the Mental Health Act 2001 that, from December 2011, no admission of a child under the age of 18 years to adult units was to take place.

If, due to exceptional circumstances, an admission of a child to an adult approved centre takes place in contravention of the above, the approved centre must submit a detailed report on a specified clinical practice form to the Mental Health Commission.

In 2015 there were four publicly provided child and adolescent approved centres nationally:

Table 1

Approved centre	Number of registered beds*
Eist Linn, Cork	20
Child and Adolescent In-patient Unit, Merlin Park Galway	20
Adolescent In-patient Unit, St Vincent's Hospital, Dublin	12
Linn Dara, Dublin	12
TOTAL	64

* Number of beds registered with the Mental Health Commission.

Linn Dara moved to Cherry Orchard and was registered with 24 beds on 15 December 2015. By 31 December 2015, there were 78 publicly-funded registered child and adolescent inpatient beds nationally.

Willow Grove, an independent provider in St Patrick's Hospital Dublin, had 14 beds in 2015 and St John of God Hospital had a dedicated Child and Adolescent Mental Health Service (CAMHS) in-patient unit with 12 beds, giving a total of 26 independent CAMHS beds.

Twenty-six approved centres were compliant with the Codes of Practice relating to Admission of Children under the Mental Health Act 2001. The majority were non-compliant due to the absence of age appropriate therapies, activities and facilities for providing inpatient care for children. Four out of five CAMHS approved centres were compliant with the code of practice.

The Adolescent In-patient Unit, St Vincent's Hospital was not compliant, as 69% of staff had not received training in *Children First* guidelines.

Mental health services are required to notify the Mental Health Commission on a specified form in the event of a child being admitted to an adult approved centre. In 2015, there were 95 admissions of children to adult approved centres. This compares to previous years as follows:

Table 2

Year	Number of admissions of children to adult approved centres
2012	106
2013	98
2014	90
2015	95

It is disappointing that there was an increase in 2015 in the number of children admitted to adult approved centres and access to child and adolescent inpatient beds remained a problem for some mentally ill children throughout 2015.

The number of children admitted to individual adult approved centre is as follows:

Table 3

Community Healthcare Area (CHO)	Population ²³	Number of admissions of children to the adult approved centre
CHO 1 (Donegal, Sligo/Leitrim/West Cavan)	389,048	7
CHO 2 (Galway, Roscommon and Mayo)	445,356	1
CHO 3 (Clare, Limerick, North Tipperary)	379,327	4
CHO 4 (Kerry, North Cork, North Lee, South Lee, West Cork)	664,533	12
CHO 5 (South Tipperary, Carlow/Kilkenny, Waterford and Wexford)	497,578	20
CHO 6 (Wicklow, Dun Laoghaire and Dublin South East)	364,464	4
CHO 7 (Kildare/West Wicklow/Dublin West/Dublin South City and Dublin South West)	674,071	9
CHO 8 (Laois/Offaly, Longford/Westmeath, Louth and Meath)	592,388	20
CHO 9 (Dublin North, Dublin North Central and Dublin North West)		1
TOTAL		95

While there were 64 registered CAMHS beds nationally, CAMHS approved centres were requested to provide the Inspector with the number of operational beds in their centre each month. The number of operational CAMHS beds available at the end of each quarter in 2015 was as follows:

Table 4

Approved centre	No. of registered beds	No. of operational beds Jan 2015	No. of operational beds Apr 2015	No. of operational beds July 2015	No. of operational beds Dec 2015
Eist Linn, Cork	20	12	12	12	12
Child and Adolescent In-patient Unit, Merlin Park Galway	20	20	20	20	20
Adolescent In-patient Unit, St Vincent's Hospital	12	9	11	12	12
Linn Dara, Dublin*	12	14	14	14	14
TOTAL	64	55	57	58	58

* Linn Dara moved to Cherry Orchard and was registered by the Mental Health Commission as an approved centre with 24 beds on 15 December 2015.

Independent CAMHS Units	No. of registered beds	No. of operational beds Jan 2015	No. of operational beds Apr 2015	No. of operational beds July 2015	No. of operational beds Dec 2015
Willow Grove (approved centre)	14	10	12	7	13 (end of Nov)
Ginesa Suite (Part of St John of God approved centre)	12	12	11	5	10

There was a total of 501 admissions of children in 2015 and 19%, or nearly one-fifth, of these admissions were to adult approved centres. In 75% of admissions of children to an adult unit, the admitting team attempted unsuccessfully to source a CAMHS inpatient bed. In all cases the team were told by the various CAMHS that there were no available beds or that emergency admissions were not accepted. However, on all dates that children were admitted to adult approved centres, there were bed vacancies in one or more of the CAMHS approved centres, ranging from one vacancy to 19 vacancies. One CAMHS approved centre, Adolescent In-patient Unit, St Vincent's Hospital operated with between three and seven beds from June 2015 to mid-August, despite being registered for 12 beds. From October to mid-December it operated at two thirds or less of its 12-bed capacity. During these periods, children from local areas were admitted to adult units.

It is unclear why these vacant beds were not made available instead of admitting children to adult units. It appears that there are difficulties in accessing beds outside of office hours or that a CAMHS team is not available out of hours. The lack of provision of emergency assessment by a CAMHS team of children presenting to emergency departments and adult units, and the lack of emergency CAMHS beds may be contributing to the continuing high number of admissions of children to adult units. Other reasons may include geographical location of the CAMHS units with parents unwilling to admit their child to a CAMHS unit at some distance from their home. However, this was evident in only one admission, according to completed notification forms. As sleeping accommodation in CAMHS inpatient units are single rooms (apart from one double room in one CAMHS approved centre), it would appear that gender issues are not a major barrier to admission.

The HSE was invited to provide an update on how the issue of child admissions to adult approved centres was being addressed, and it provided the following information: The HSE launched the CAMHS Standard Operating Procedure in June 2015, which mapped out the role and function of CAMHS, both from a community and in-patient perspective. A CAMHS Service Improvement Lead was appointed to address the admissions of children to adult approved centres. The Lead is notified of all admissions of young people to adult units at the time of admission and prioritises such cases with the local responsible CAMHS in-patient unit.

A weekly referrals teleconference call takes place between the four in-patient CAMHS units which includes the CAMHS Service Improvement Lead. This forum reviews all referrals to each of the CAMHS units and identifies available beds across the country. It also highlights when a child/young person is placed in an adult approved centre and identifies a lead CAMHS unit to progress admission screening assessment in such cases. The impact of the strategy will be assessed in 2016.

The practice of admitting children to adult psychiatric units is unacceptable in all but the most urgent of circumstances. The lack of access to reported vacant beds in the CAMHS units suggests that improvements are required in the areas of bed management, communication between adult and CAMHS services, provision of a 24-hour emergency CAMHS service in all CHOs and fully resourcing the CAMHS community service.

Community Residences

Since the policy document Planning for the Future was published in 1984, 24-hour supervised residences have opened to accommodate patients who had resided in large old hospitals, often for many years. During that time, people with long-term mental illness were also admitted from the community and acute psychiatric units to these residences, which provide a mixture of continuing care and rehabilitation. In 2014, there were ninety-nine 24-hour supervised residences with approximately 1,300 residents²⁴. The HSE Mental Health Division Operational Plan for 2015 stated that there were one hundred and seven 24 hour supervised community residences ("high support community residences").

Under the Mental Health Act 2001, the Inspector can visit these residences and report on his or her findings and the mental health services can be requested to provide a quality improvement plan. However, under the current legislation, these residences are not subject to regulation by the Mental Health Commission. The Expert Group established by Minister Kathleen Lynch to review the Mental Health Act 2001 made the following recommendation:

The new Act should give the Mental Health Commission specific powers to make standards in respect of all mental health services and to inspect against those standards. The Standards should be made by way of regulations and the regulations should be underpinned by way of primary legislation.

24 Mental Health Commission Annual Report 2014 Including Report of the Inspector of Mental Health Services - http://www.mhcirl.ie/Publications/Annual_Reports/

25 Convention for the Rights of People with Disabilities United Nations. 2006

As there are upwards of one thousand people living in these residences and receiving 24-hour mental health care, it is essential that all mental health services and community residences in particular, be regulated.

The Convention on the Rights of Persons with Disabilities (CRPD) guarantees all human rights and fundamental freedoms to all persons with disabilities (Ireland has signed but not ratified the Convention). It promotes a social model of disability and outlines general principles which include respect for individual autonomy and independence of persons, and full and effective participation and inclusion in society. In respect of living arrangements, Article 19 of the Convention affirms the right of persons with disabilities to live in the community and among other things to have the opportunity to choose their place of residence and where and with whom they live.

In 2015, twenty 24-hour supervised residences were inspected. The reports of these inspections can be found on the Mental Health Commission website²⁶. The location of the residences inspected are shown in Table 5 below.

Table 5

Community Healthcare Organisation (CHO)	Number of residences
CHO 9 (Dublin North, Dublin North Central and Dublin North West)	4
CHO 2 (Galway, Roscommon and Mayo)	5
CHO 7 (Kildare/West Wicklow/Dublin West/Dublin South City and Dublin South West)	3
CHO 6 (Wicklow, Dun Laoghaire and Dublin South East)	1
CHO 8 (Laois/Offaly, Longford/Westmeath, Louth and Meath)	3
CHO 1 (Donegal, Sligo/Leitrim/West Cavan)	2
CHO 5 (South Tipperary, Carlow/Kilkenny, Waterford and Wexford)	2
TOTAL	20

Size of Residences

In 2006, *A Vision for Change*²⁷ recommended that 24-hour supervised residences should have a maximum of ten places to foster a non-institutional environment. In 2014, there were ninety-nine 24-hour nurse supervised residences across the country, and there were 1,314 persons living in these residences. Fifty-eight percent of these residences had more than 10 beds²⁸. The Health Service Executive report on accommodation for people with disabilities, *Time to Move on from Congregated Settings*, recommends that the home-sharing arrangement should be confined to no more than four residents in total and that those sharing accommodation have, as far as possible, chosen to live with the other three people²⁹.

The number of beds in each residence inspected in 2015 is shown in Table 6 below. Fifty-five percent of residences inspected in 2015 had more than 10 beds and 40% had more than 13 beds.

Table 6

Number of beds	Number of residences	Percentage
5-7 beds	5	25%
8-10 beds	4	20%
11-13 beds	3	15%
14-16 beds	4	25%
17-19 beds	3	15%

Large residences tend to be institutional in environment and practices, increase the risk of stigma and limit individuals' choices.

Physical Environment of the Residences

It is important to be aware that people with long-term mental illness live in these residences, often for many years. Therefore, these residences should be fit for habitation and provide a homely comfortable environment. Nearly half of the residences inspected were found to be in poor condition, which is unacceptable. Examples of findings from the inspections (reports are available on the Mental Health Commission website) include:

26 http://www.mhcirl.ie/Inspectorate_of_Mental_Health_Services/Other_MHS_Inspection_Reports/

27 *A Vision for Change*. Report of the Expert Group on Mental Health Policy 2006

28 Mental Health Commission Annual Report 2014 Including Report of the Inspector of Mental Health Services

29 *Time to Move on from Congregated Settings: A Strategy for Community Inclusion: Report of the Working Group on Congregated Settings*. Health Service Executive June 2011

“The overall state of the residence was poor. External brickwork and piping was poorly maintained and internally the premises looked worn....It was apparent that in a number of (bed)rooms that storage space was inadequate as residents were obliged to store personal property in bags on the floor”

“The residence was old and in a poor state of repair. There was evidence of structural damage to the premises which staff reported was the result of subsidence. It was in urgent need of redecoration, with peeling paint in several places, ... One bathroom light fitting was dirty, as was the kitchen in places. A toilet seat was broken. One bedroom was not being used because a leaking roof had caused damage to the ceiling”

“Although the residence looked well from the outside, well laid out with a pleasing front garden, the internal physical structure was mostly drab, dreary and depressing. There was one bathroom and toilet upstairs and a downstairs toilet. Both of these rooms were damp and dilapidated with peeling paint from both the walls and ceilings.....In the downstairs bedroom, situated below the window balcony of the room above, there was peeling paint on the walls around the window area; this was reported to be as a result of a problem from leaking and dampness seeping through from the outside upstairs balcony. All bedrooms and internal rooms were in need of painting, refurbishment and repair apart from the main sitting rooms and the kitchen and dining rooms which at best could be described as old-world or quaint,. The interior living conditions of the community residence in their present state were not suitable for the accommodation of residents.”

Deficits in other residences included broken bathroom tiles, chipped and flaking paintwork, deteriorating woodwork and rotting wood, persistent damp and mould on a bathroom ceiling.

Only six out of the 20 residences inspected were described as in good decorative order, comfortable and homely.

A number of residences were institutional in function and environment. For example, chairs lined up against the walls in a row, bedrooms devoid of personal possessions, locked shower facilities, residents not allowed to lock their wardrobes or bedroom doors.

Only seven (35%) of the residences had exclusively single bedrooms. Twelve residences had double bedrooms; ten of these had no provision for individual privacy. One residence had two four-bed rooms. The inability to provide residents with a single room impacts on their privacy³⁰ and dignity.

In the larger residences, the meals were cooked off-site and transported to the residence. Otherwise, staff prepared meals in the residence. In eight residences, the residents could participate in cooking or cook their own meals. Tea and coffee were freely available in nine residences. In three residences, there was no access by residents to the kitchen, limiting any move towards more independent living.

Involvement in the Local Community

Overall, there was good involvement in community activities such as attending bingo, coffee shops, libraries and cinema. In three residences, engagement in the local community was very limited.

Charges

Charges applied to residents for board, utilities and food varied considerably across Community Healthcare Organisations (CHOs) and even within CHOs. See Table 7 below:

Table 7

Amount resident charged per week	Number of residences	Percentage
€60-80	7	35%
€81-100	5	25%
€101-120	0	-
€121-140	0	-
€141-160	2	10%
Means tested (range: €70 -€140)	6	30%

In 14 residences, it did not appear that residents were means tested for charges and each resident paid the same charge. Charges varied for residents within the same CHO area. Charges for residents in one CHO varied between residences, from €90 to €148.

The Health (Amendment) Act 2005 allows the HSE to charge a person for long stay in-patient services. This includes people residing in long-stay institutions, or community residences where nursing or medical care is provided. Clients receiving in-patient services on premises where nursing care is provided on a 24-hour basis, are charged a weekly rate based on assessed weekly income. The maximum charge is €175 per week and applies to those whose weekly income is assessed at the level of €208 or more³¹.

30 A survey and evaluation of community residential mental health services in Ireland. Mental Health Commission 2007

31 S.I. No. 382/2011 - Health (Charges for In-Patient Services) (Amendment) Regulations 2011

Individual Care Plans

Table 8

Individual Care Plans	Number of residences
Multidisciplinary input	9
Medical and nursing only	8
No ICP	3

In 17 residences (85%) ICPs were in operation, but only 53% of these residences had multi-disciplinary input. In seven of these residences, the resident was involved in developing and reviewing his/her ICP. In 11 residences, the ICPs were reviewed at least every six months.

Fifteen residences had therapeutic programmes available externally in community workshops and day centres; eight of these residences also had therapeutic programmes available in the residences. In three residences, the residents had no therapeutic activities available to them either internally or externally.

Physical Health

Patients with severe mental illnesses, particularly schizophrenia and chronic mood disorders, demonstrate a higher prevalence of metabolic syndrome or its components compared with the general population. Many residents in community residences are on long-term psychotropic medication, which may also contribute to the risk of metabolic syndrome. Metabolic syndrome consists of central obesity, elevated blood pressure, hypertriglyceridaemia, low serum levels of high-density lipoprotein (HDL) cholesterol and high serum levels of fasting glucose leading to Type 2 diabetes³². Metabolic syndrome is a major public health problem that has been recognised to be a global epidemic by the World Health Organization (WHO)³³. Based upon the increased risk of metabolic syndrome in these residents, baseline and periodic medical evaluations should become a standard component in ongoing clinical assessment, which should take place yearly³⁴. In ten of the 20 residences inspected in 2015, the residents had a six-monthly medical check with their GP, while in six residences, there were annual medical checks for residents. In four residences, the residents did not attend scheduled medical checks and only attended the GP when they became unwell. All residents were registered with a GP.

In summary, many of the residences inspected were too big, in poor condition and institutional. There was limited multidisciplinary input in over 50% of residences inspected. Some residents had no care plans or any meaningful activities to occupy them during the day. Many 24-hour supervised residences were failing to provide opportunities for the optimal recovery and rehabilitation of their client population, as outlined for them in *A Vision for Change*, which is now 10 years in operation. Recovery in this context “reflects the belief that it is possible for all service users to achieve control over their lives, to recover their self-esteem, and move towards building a life where they experience a sense of belonging and participation.” The guiding principles relevant to the housing needs of individuals with mental health difficulties should include citizenship (equity of access), community care, including specialist mental health support, coordination of supports and inclusiveness³⁵. The provision of community residential care for vulnerable mentally ill people, who may not be in a position to articulate their wishes, must be on an equal basis with other citizens, and such provision should be a priority.



Dr Fionnuala O'Loughlin
Interim Inspector of Mental Health Services (2015)
Medical Council Number: 008108



Dr Susan Finnerty
Interim Inspector of Mental Health Services (2015)
Medical Council Number: 009711

32 Metabolic syndrome in psychiatry: advances in understanding and management Cyrus S. H. Ho, Melvyn W. B. Zhang, Anselm Mak, Roger C. M. *Advances in Psychiatric Treatment* Mar 2014, 20 (2) 101-112

33 Potenza MV, Mechanick JI (2009) *The metabolic syndrome: definition, global impact, and pathophysiology. Nutrition in Clinical Practice*, 24: 560-77

34 Maudsley Prescribing Guidelines 12th Edition Taylor D, Paton C, Kapur S. 2015

35 Addressing the Housing Needs of People using Mental Health Services: A Guidance Paper. Multiagency Advisory Group for HSE National Vision for Change Working Group 2012

Notes

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Mental Health Commission

Mental Health Commission
Coimisiún Meabhair-Shláinte

St. Martin's House,
Waterloo Road, Dublin 4
D04 E5W7

Tel: +353 1 6362400

Fax: +353 1 6362440

Email: info@mhcirl.ie

Website: www.mhcirl.ie

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