Coimisiún Meabhair-Shláinte | Mental Health Commission

Mental Health Commission

Annual Report

Including Report of the Inspector of Mental Health Services

2017

Contents

Chairman's Foreword

Introduction

In reviewing the contents of this report and particularly the report of the Inspector of Mental Health Services, the Commission is dismayed at the pattern of issues that have been consistently highlighted in Annual Reports dating back to 2012.

These issues include;

- The inappropriate admission of children into adult mental health in-patient services.
- Inadequate staffing and variable funding in community child and adolescent mental health services, leading to unacceptable waiting times, and forcing young people into emergency services.
- The continuing inability of some services to put in place an individualised care plan and therapeutic programme, which are the cornerstone of a recovery focussed person centred service as per national policy.
- The widespread use of restrictive practices such as seclusion and physical restraint as a normalised behaviour in services which lack sufficient numbers of staff and/or appropriately trained staff.
- The fundamental and careless lack of attention to basic issues such as dirty and dilapidated premises, which do not ensure adequate privacy and where there has been a disappointing drop in compliance from already low levels.
- The provision of services to vulnerable people with long-term mental illness who are accommodated in 24-hour community residences that are not subject to regulatory oversight.

There is a glaring and inconsistent pattern of standards in service provision. The lack of any real progress and commitment on these matters undermines the fundamental human rights of people using mental health care services.

Due to a failure by Government to update the statutory powers of the Commission, more and more people are now using unregulated mental health care services (outside of the Approved Centres) leading to a significant risk of neglect and abusive incidents occurring.

The Commission is now calling on the Government with the Health Service Executive, as the statutory provider of services, to initiate a major transformation programme to deal with the service issues highlighted in this and previous reports of the Commission.

Reform of the 2001 Act is now urgently needed and the Commission urges that the Department of Health takes heed of our commentary in this area to ensure the provision and regulation of a modern mental health service in Ireland.

If this does not happen Ireland will continue to provide a level of unsafe and substandard services, which are not aligned to best practice and breach the fundamental rights of a vulnerable group of people who require such services.

Strategic Development

During 2017, the Commission in association with the Executive continued its work in accordance with the Mental Health Act 2001 and under the direction of its Strategic Plan. The Strategic Plan reflects the statutory requirements of the Mental Health Act 2001 and the Assisted Decision-Making (Capacity) Act 2015, and it accounts for the envisaged changes to the Mental Health Act 2001.

The strategic priorities of the Mental Health Commission for 2016 – 2018 are as follows:

1. Promoting the continuous improvement and reform of mental health services and standards.

2. Fostering an integrated person-centred approach for service users.
3. Encouraging the development of future-focused services.
4. Developing our people, processes and systems internally.

During 2017 the Commission has continued to emphasise the human rights of mental health service users across all of its core functions. All services users should be involved in decisions about their care and be supported to exercise their legal capacity. Mental health service users should not be subjected to undue restrictions and should have access to basic general health services. Residents should have access to adequate living standards in in-patient settings where their privacy and dignity is respected at all times.

These basic rights should be assumed in any modern mental health service and is the minimum we should expect for ourselves, our family and loved ones.

Policy

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

The Commission notes the continued endeavours of the Government, the statutory and independent service providers and the voluntary sector in the implementation of the policy. This report, as in previous Commission reports, indicates 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*, a situation that has remained unchanged since 2013. I also referred in last year's report to the need to formally review the implementation of the policy ten years on from its launch. The Commission welcomes the publication during 2017, by the Department of Health of an evidence review of best practice in the development and delivery of mental health services. Specific consideration needs to be given to Ireland's growing population and changing demographics since 2006, areas of none or partial implementation and a review of models of service.

The Commission is aware of a review group established to consider progress in the implementation of Vision for Change. However, the MHC has not received any formal communication from the Department of Health in this matter. This is a cause of concern, given the key statutory role the MHC has in overseeing the quality of mental health service delivery.

Resources

The Commission welcomed the €35 million budget allocation in 2017 for spending on additional mental health services. 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 *A Vision for Change*.

The Commission is also conscious of the continued difficulties in maintaining and increasing staff levels in mental health services. From its inspections, it is aware of the significant effect this has on the quality and quantity of services that can be provided. Given the labour-intensive nature of mental health care services, it is imperative that this matter is addressed with urgency if full staffing of mental health teams across the country is to be achieved.

Recovery-Orientated Mental Health Services

Since its establishment, the Commission has seen significant changes in the provision of mental health services, but challenges remain in terms of the delivery of high-quality, recovery-oriented services. Although staff understand the concept of "recovery," it is not evident that this translates into recovery-focused care, particularly in relation to the development of individual care plans.

Chairman's Foreword

It is concerning that while compliance has increased, just a small minority of approved centres had individual care plans that were recovery-centred, with strong service user involvement and multi-disciplinary input.

The Commission welcomes the continued rollout of the Advanced Recovery Initiative, which involves service users in their own recovery. ARI seeks to contribute to the development of a recovery-oriented service away from a linear medical model. However, a fundamental change in attitudes and behaviours is still required. All staff delivering mental health services must be trained in recovery competencies, work in partnership with service users and their families and work cohesively with other mental health professionals to provide an integrated, responsive and person-centred service in a timely and appropriate manner. This cultural shift requires more than the development of a recovery framework. It demands a significant restructuring of the model of service delivery such that the bio-psychosocial model espoused in *A Vision for Change* is put into place.

The Commission is of the view that there needs to be an emphasis on changing the corporate culture to bring about the required systematic shift towards recovery in service provision.

In this regard, it will continue to focus on the need for individualised, recovery-oriented services that place service users and family members at the centre of all activity.

Compliance with Regulations

During 2017, the Commission identified numerous areas of significant non-compliance. The Regulations with the lowest levels of compliance were related to staffing, premises, maintenance of records and medication practices. In 2017, less than half approved centres were found to be compliant in these areas. There has been little improvement in these four areas since 2016, with the exception of maintenance of records.

There were also concerns with individual care planning, privacy, the availability of therapeutic activities in continuing care facilities, and breaches of rules on seclusion. Many of these issues have been recurring themes for a number of years and must be addressed to ensure the provision of high-quality services.

The main reason for non-compliance with Staffing was staff not being trained in the four mandatory training areas set out in the Judgement Support Framework: Basic Life Support, Management of Aggression and Violence, Fire Safety and the Mental Health Act 2001. We do however recognise the challenges in implementing this requirement and the efforts made by services to achieve this requirement over the past year.

The most common reasons for non-compliance with premises is the inadequate facilities and the presence of ligature points.

In 2017, 62 of 64 approved centres were found to be non-compliant with one or more legislative requirement in their annual regulatory inspection. The Commission sought plans to address areas of non-compliance and monitored the implementation of these plans on an ongoing basis.

Involuntary Admissions

In 2017, there were 2,337 involuntary admissions compared to 2,414 in 2016, representing a 3% decrease. Looking at the total number of admissions for the period 2012 – 2017, there has been an incremental increase in annual admission rates, from 2,141 in 2012 up until 2016, and a decrease between 2016 and 2017. It is worth noting that modern mental health policy and practice suggests that admission to in-patient care, especially involuntary admission, should be a last resort intervention. All community-based interventions should be considered and implemented prior to the decision to admit, whether on a voluntary or involuntary basis. There are many issues around involuntary admissions which have been a cause of concern for at least 5 years. One of these is the provision of authorised officers to conduct involuntary admissions.

Family members continue to be the most prevalent applicant at 44% of all involuntary admissions. Looking at the longitudinal pattern the Commission is pleased to note that the rate of involuntary admissions where family members are the primary applicants has reduced from 69% in 2007 to 44% in 2017. This trend needs to continue into the future.

Community Residences

The Commission continues to have concerns about 24-hour staffed community residences, which are providing care to a large cohort of vulnerable people with long-term mental illness. The residences have been found to be accommodating too many people, to have poor physical infrastructure, to be institutional in nature and to lack individual care plans. A major issue is that the residences are not regulated. Although the Mental Health Act permits the Inspector to visit and inspect "any other premises where mental health services are being provided", community residences are not subject to regulation by the Mental Health Commission.

The Commission is undertaking a three year inspection of all 24-hour staffed community residences. The Inspection of 43 residences in 2017 has already been published.

Once again this report highlighted glaring issues around the size of the residences, the limitation of staffing, the absence of privacy and space, the poor repair of buildings and the degree of institutional care provided in these homes.

Many of the people living in 24-hour community residences are ex-patients of the large institutions closed over the last 20 years. This is a very vulnerable population of people, and the emerging patterns from the inspections is that they are a forgotten group of people who are living their lives in less than satisfactory conditions.

It is recommended in the Report of the Expert Group on the Review of the Mental Health Act 2001 that community services should be registered and inspected. The Commission is of the view that the regulation of 24-hour staffed community residences must be prioritised as a matter of urgency.

Child and Adolescent Mental Health Services

A most unsatisfactory situation still prevails, whereby children are being admitted to adult in-patient units. There were 82 such admissions to 19 adult units in 2017 compared to 68 in 2016. The admission of any child to an adult service is unsatisfactory. A contributory factor to the continued admission of children to adult units is a shortage of operational beds in dedicated child units.

A significant influence is the inability of CAMHS Units to admit children after hours thereby forcing admissions to adult care services. This trend has been prevalent for many years and is not only an unsatisfactory situation for the child and his or her family but is also a clear breach of the human rights and dignity of the child.

This matter has been a concern to the Commission for many years. It needs to be urgently addressed by the Government, the Department of Health and the HSE.

In 2017, the Commission has also highlighted serious concerns in community child and adolescent mental health services (CAMHS). The Inspector found community CAMHS teams to be inadequately staffed and to have considerable variation in funding depending on their geographic region. There was also notable variation in waiting lists for CAMHS referrals and in the provision of emergency cover.

While CAMHS should be focused on children and young adults with severe mental illness, the staffing deficits in primary care have meant that children and young adults with mild to moderate mental illness are also reliant on CAMHS services.

Chairman's Foreword

Legislation

The final report of the group tasked with the review of the Mental Health Act 2001 was published in December 2014, which I alluded to in previous reports. Unfortunately, draft legislation has not been progressed to bring about the changes envisaged in the review, with one exception: the passing of the Mental Health (Amendment) Act in December 2015 to remove the word "unwilling" from Section 60 of the Act.

The Commission welcomes the various private members' bills seeking to amend the 2001 Act. The Courts have also focused on a number of sections of the Act in recent cases and suggested that the scope of some sections might be reconsidered. While these interventions are important, the Commission's view is it would be more effective and efficient in the long term, to bring forward a single bill encompassing all of the recommendations. The Government has announced recently that the Heads of a Bill are expected to be significantly progressed by end of September 2018.

Given the length of time since the original Mental Health Act was passed and the ever-changing, modern mental health policy and practice environment, it is now a matter of urgency that the legislative changes are made.

Ireland is now faced with a situation where mental health services catering to the majority of service users and their families are not subject to independent regulation and standards.

Decision Support Service

During 2017 work has continued towards the operationalisation of the Decision Support Service (DSS). The establishment of the DSS extends the remit of the Commission beyond mental health services to include all relevant persons in Ireland who may require supported decision making.

The DSS also extends beyond decisions about healthcare and includes decisions about welfare, property and finances. The DSS will provide a framework which will include a range of decision making supports and will regulate the individuals who are providing support to people with capacity difficulties.

The Commission continued to attend at monthly meetings of the Inter-Departmental Steering Group which was established to advance the implementation of the DSS. In these meetings the Commission emphasised the importance of a properly structured and resourced DSS with a robust legislative foundation.

The Commission has been working in tandem with the Department of Health and Department of Justice and Equality to set up the infrastructure in preparing for full implementation of the DSS by the 1st quarter of 2020.

Following a recruitment campaign by the Public Appointments Service from April to June 2017, a Director of the DSS was selected and commenced in post at the beginning of October 2017.

Conclusion

The Commission is concerned that there are serious human rights issues to be addressed in relation to the admission of children to adult services and the shortage of operational beds for young service users. Additionally, the Commission is concerned about the long waiting times for those children referred to child and adolescent mental health services.

It is also concerned about the 1300 vulnerable people with long-term mental illness who are accommodated in 24-hour community residences, that are not subject to regulatory oversight.

Fundamentals in in-patient settings, such as individual care plans, privacy, the provision of therapeutic activities in continuing care facilities, and staff training are also areas that require urgent attention. There continues to be fundamental shortfalls in compliance with basic hygiene, physical repair and space restrictions within many services.

The 2017 inspections have once again highlighted the inappropriate use of seclusion and physical restraint in services which have become in many instances the normalised response to managing difficult and challenging behaviours in the absence of sufficient and skilled staff.

There continues to be a chronic shortage of staff and appropriately trained staff. Notwithstanding this the Commission is acutely aware that the frontline staff presently operating services are highly motivated and working under extreme pressure to meet the demands made on the service.

The Commission is aware of other issues of access to approved centres which warrant attention by service providers. This includes inter alia; policies of having to access mental health services via accident and emergency units, which do not always have appropriately trained mental health staff, and difficulties in gaining admission to approved centres, as well as perceived early discharges.

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, it is necessary to address systemic issues that hamper the delivery of services and the development of newer, more appropriate ones.

Progress in many significant areas has either been non-existent or slow, leading to the continued provision of poor quality services for people who use mental health services and their family members.

Reform of the Mental Health Act 2001 is now a matter of urgency as significant numbers of people are now using unregulated mental health care day and residential services. This situation increases dramatically the risk of abusive or neglectful incidents occurring.

The Commission is concerned that over the last 5 years there has been a consistent pattern in the operation of mental health services; year on year similar issues such as the inconsistent use of individual care plans, the admission of children into inappropriate adult services, as well as issues of compliance with regulations of privacy and medication continue to be highlighted in inspection reports. This continuing trend is worrying and indicates a lack of interest and motivation by Government and services providers to make meaningful change. The Commission is strongly of the view that there is apparently little heed given to the commentary of the Commission by the Department of Health, or Health Service Executive.

The Commission will continue its work of supporting the rights of individuals and families who use mental health services and seek to ensure that the services provide the highest quality of service provision in line with best practice, and to which they are entailed as a basic human right.

Finally, I want thank the members of the Commission for supporting me in my role as Chairman. I would also like to thank the Commission's Chief Executive, Patricia Gilheaney and current Interim Chief Executive, Rosemary Smyth, the senior management team and all of the Mental Health Commission staff for their support and commitment.

John Saunders
Chairman

Chief Executive's Introduction

This Annual Report represents an overview of our work over the past year, the second year into our Strategic Plan, 2016 to 2018. This report provides details on our core functions, including the Report of the Inspector of Mental Health Services and the Director of the Decision Support Service (DSS). This introduction gives an overview of how we have progressed our Strategic Priorities during 2017.

2017 marked a year of significant change for the Commission. The remit of the Commission was widened in 2016 to include the functions of the Decision Support Service as laid out in the Assisted Decision Making (Capacity) Act 2015. In 2017, we progressed the establishment of the DSS within the Commission by securing additional accommodation to facilitate the service and the appointment of the Director of the DSS, who joined us on 2 October 2017. We also attended monthly Inter-Departmental Steering group meetings to advance the implementation of the DSS.

Our Strategic Plan was revised in 2017 to incorporate the additional functions under the Assisted Decision Making (Capacity) Act 2015. The provisions in this legislation extend beyond mental health services to include all relevant persons who may require support in decision making.

While we continue to be directed by our Strategic Priorities as set out in our Strategic Plan 2016 -2018, we now endeavour to make a significant contribution to the lives of people who will be availing of the DSS.

Ensuring high standards and good practice in the delivery of mental health services is one of our core functions. We are committed to playing a significant role and contribution in ensuring mental health services are safe and of a high quality. Most importantly, people using the services have a right to receive high quality person centered care that uphold their human rights. During 2017, we continued to embed changes in our regulatory processes following a comprehensive review in 2015. More than 50% of our approved centres made applications for a further registration period. We introduced a new robust system for registering centres, and as a result we registered 72% of those approved centres with registration conditions.

In 2017, we identified a general trend of improvement in services' compliance with regulatory requirements. It is encouraging to see progress, particularly in the number of services attaining a quality rating of excellent. However, there has been little improvement in some areas such as the provision of staff training and the overall maintenance of premises, which is of great concern to us.

We commenced a three-year research project in 2017, which involves using data from 2016-2018 compliance levels and attainment of quality ratings to assess the effectiveness of the Judgement Support Framework in promoting quality improvement in approved centres. To support quality improvement, we provided further guidance to approved centres and developed a variety of templates to assist services in reporting on registration conditions and self-assessing on compliance.

In collaboration with HIQA, we published the National Standards for the Conduct of Reviews of Patient Safety Incidents. The aim of these standards are to promote an open culture in acute hospitals under HIQA's remit and mental health services to ensure that services act in a transparent, standardised and person-centred way to review patient safety incidents and learn from them. We have embarked on conducting a further set of joint standards on 'safeguarding adults at risk'.

The aim of these standards will be to promote and uphold human rights and safeguard those most vulnerable in our society. We were actively involved in the National Safeguarding Committee throughout 2017 and we hosted the launch of their review of current practice in the use of wardship for adults in Ireland.

In keeping with our mandate, we ensure all those who are involuntary detained have their detention reviewed to make sure that service users' rights are protected. We organise mental health tribunals for persons who are involuntarily detained, ensuring that they occur within the statutory timelines. Further details on mental health tribunals can be found within this report.

In 2017, the High Court found that Part 2 of the Mental Health Act 2001 was incompatible with Article 5.4 of the European Convention on Human Rights in that it does not provide persons who are detained under a 12 month order with an entitlement to initiate a review of their detention once their rights have been exhausted under the provisions of the current legislation. Subsequently, the Court of Appeal found that the section of the 2001 Act relating to orders up to 6 and up to 12 months was unconstitutional. Amending legislation has to be introduced by the Government in 2018. We continue to advocate for shorter duration renewal orders to make sure that there is a more frequent review of patients who are detained.

The Commission took a number of key steps to ensure its commitment to achieving compliance with the requirements of the 2016 Code of Practice for the Governance of State Bodies by maintaining a high standard work programme by both the members and the executive.

A full review of all our internal policies and procedures commenced during the year. The work we commenced to re-design our ICT systems in 2016 was paused for a period during 2017 for a review, which resulted in some improvements to the project plan. Significant progress has now been made. It is anticipated we will commence engagement on the roll out of the system with all relevant stakeholders in 2018.

2017 saw significant changes to our organisational structure. We welcomed the Head of Legal Services and the Director of the DSS, we also saw the loss of several integral post holders in the Commission, resulting in an annual turnover of over 21%. At the beginning of 2017, we submitted an Independent Report on our organisational structure to the Department of Health (DoH) for their review and approval of proposed staffing requirements. We had been seeking an increase in resources since 2008; the report acknowledged that the original structure of the Commission was only designed to make the organisation operational.

After some deliberation, the DoH sanctioned 32 posts, of which 16 were replacement posts and two were to commence the establishment of the DSS.

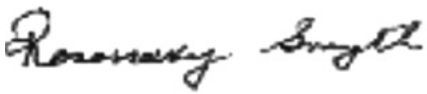
However, it was 2017 before we were in a position to embark on a recruitment process, prioritising the positions needed to ensure we had sufficient resources to complete our statutory requirement to inspect all approved centres during 2018. The recruitment campaigns will continue in 2018 to fill the posts approved. We will commence business analysis to identify the appropriate infrastructure to support and carry out our existing and additional functions.

2018 will be a busy year for the Commission in not only achieving our current strategic priorities, but also the significant changes in the organisation with the ongoing establishment of the DSS. We embrace and look forward to the associated challenges. We will continue to work with the relevant government departments to progress the full commencement of the Assisted Decision Making (Capacity) Act 2015, by the 1st quarter of 2020.

I would like to thank all of my colleagues in the executive, the Inspector of Mental Health Services, the Director of DSS and all our staff for their support and continued commitment to achieving our business objectives throughout the year. I would like to commend everybody who despite significantly constrained resources, were innovative in looking at ways to work most effectively and efficiently to fulfil our mandate.

I would also like to extend my thanks to the Mr John Saunders, the Chairman and members of the Commission for their governance, strategic direction and support that they provided.

Finally, I would like to pay a particular tribute to Ms Patricia Gilheaney, for her leadership, guidance and support as Chief Executive of the Commission since 2010, and prior to that for her key role in establishing and operationalizing the Commission from 2003. Patricia has taken up an exciting and challenging new role and the staff of the Commission wish her well in her future endeavours.



Rosemary Smyth
Interim Chief Executive

2017 IN REVIEW

1113 **QUALITY AND SAFETY** NOTIFICATIONS RECEIVED

2337 **INVOLUNTARY** ADMISSIONS TO APPROVED CENTRES

76% **NATIONAL COMPLIANCE** WITH REGULATIONS

57 **ENFORCEMENT** ACTIONS

64 ANNUAL REGULATORY INSPECTIONS **5 FOCUSED INSPECTIONS**

50 **REGISTRATION CONDITIONS** ATTACHED

1633 CORRECTIVE AND PREVENTATIVE **ACTION PLANS**

82 **CHILD ADMISSIONS** TO ADULT UNITS

€3 MILLION allocated to implementation of the Decision Support Service

43 INSPECTIONS OF **24-HOUR NURSE SUPERVISED** RESIDENCES

1867 MENTAL HEALTH **TRIBUNAL** HEARINGS

35 REGISTRATIONS OF APPROVED CENTRES **RENEWED**

Strategic Priorities 2016-2018

- 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

Vision and Mission

OUR VISION

Our vision is a quality mental health service that is founded on the provision of recovery based care, dignity and autonomy for service users.

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.

Who we are and what we do

The Mental Health Commission is the regulator for mental health services in Ireland.

We are an independent statutory body which was established in April 2002. The regulatory functions and process for independent review of involuntary admissions came into effect following full commencement of the 2001 Act, in 2006.

In 2017, we welcomed the establishment of the Decision Support Service (DSS) within the Mental Health Commission. The DSS extends the remit of the Commission beyond mental health services to include all relevant persons in Ireland who may require supported decision-making.

The Commission's main functions are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to protect the interests of persons admitted and detained under the 2001 Act.

Our core functions are set out on this page and are supported by our Corporate Services team.

Regulatory Process

Monitoring mental health services and the registering and inspection of approved centres in line with legal requirements. We are a responsive regulator and use data collected to take a risk based approach.

Mental Health Tribunals

Protecting the human rights and interests of persons detained for care and treatment; specifically through ensuring the independent review of involuntary admission orders by a Mental Health Tribunal.

Decision Support Service

Maximising autonomy for all relevant persons requiring support to make decisions about their healthcare, property and finances. Regulating individuals who are providing a range of supports to people with capacity difficulties.

Quality Improvement

Encouraging continuous quality improvement; fostering high standards and good practices in the delivery of mental health services. Issuing guidance and developing evidence based standards to improve service delivery and service user experience.

Regulatory Process

One of the Commission's core functions is to regulate and regularly inspect in-patient mental health facilities. Our regulatory process includes a cycle of licensing, inspecting and monitoring services to ensure high standards and good practices in the delivery of care and treatment. Our regulatory process is risk based, using the best available information to ensure a targeted, proportionate and timely approach.

People in Ireland have the right to expect high quality person-centred mental health care for them and their loved ones that upholds their human rights and provides them with the care and treatment they need. This is why we supervise and promote safe and high quality care.

Registration

All in-patient facilities who provide care and treatment to people suffering from mental illness or disorder must be registered by the Commission.

We consider information about how the facility is run, the profile of residents, how it is financed, how it is staffed and how those staff are governed. The application also seeks information about the premises and the types of services that are provided. For new applicants, the application requires information on how the facility intends to comply with regulations.

Registration as an approved centre lasts for a period of three years, after which times the service must apply to continue registration.

In 2017, 35 of our approved centres were up for registration. We reviewed our procedures and implemented revised registration processes including a new application form and new supporting documentation.

We introduced a more robust review process which included the review of a service's latest inspection report, Corrective and Preventative Action Plans (CAPAs), compliance data, notifications, and enforcement data over the registration period. We also reviewed key templates used by the service to determine the likelihood of compliance with standards, such as their individual care plan template, medication prescription and administration record (MPAR), and consent form.

As a result of these processes, we registered 26 approved centres with 50 registration conditions. 9 services were registered with no conditions.

For most conditions we included a regular reporting requirement to allow us to monitor compliance and progress over time. There was 92% compliance with reporting requirements

2017 Registration Conditions

- 12x premises maintenance
- 12x individual care planning
- 9x staff training
- 3x risk management
- 4x closure
- 4x medication management
- 6x other targeted conditions

A full list of registered approved centres and registration conditions is available in Appendix 1.

64 approved centres

2778 in-patient beds
(down **13** from 2016)

1 closure and **1** new registration

50 conditions on **26** approved centres

Inspection

64 approved centres inspected

5 focused inspections

893 non-compliant findings

individual reasons for non-compliance

The Inspector of Mental Health Services is required to visit and inspect every approved centre at least once a year. Following inspection, the Inspector prepared a report on the findings of the inspection. Each service is given an opportunity to review and comment on any of the content or findings prior to publication.

All reports can be found on the Commission's website at www.mhcirl.ie/Inspectorate_of_Mental_Health_Services/. The full report of the Inspector of Mental Health Services is included later in this report.

On inspection, the Inspector rates compliance against:

31 REGULATIONS

6 CODES OF PRACTICE

2 STATUTORY RULES

The Inspector assesses the quality of services against the four pillars of the Judgement Support Framework: Processes, Training and Education, Monitoring and Evidence of Implementation.

PROCESSES

Supports and systems to ensure consistent implementation: Policies, protocols and procedures.

TRAINING

Training and education requirements to ensure staff understand the processes.

MONITORING

How to monitor and measure implementation: Review, audit and analysis.

IMPLEMENTATION

Evidence of implementation made available to the inspector and for self-assessment.

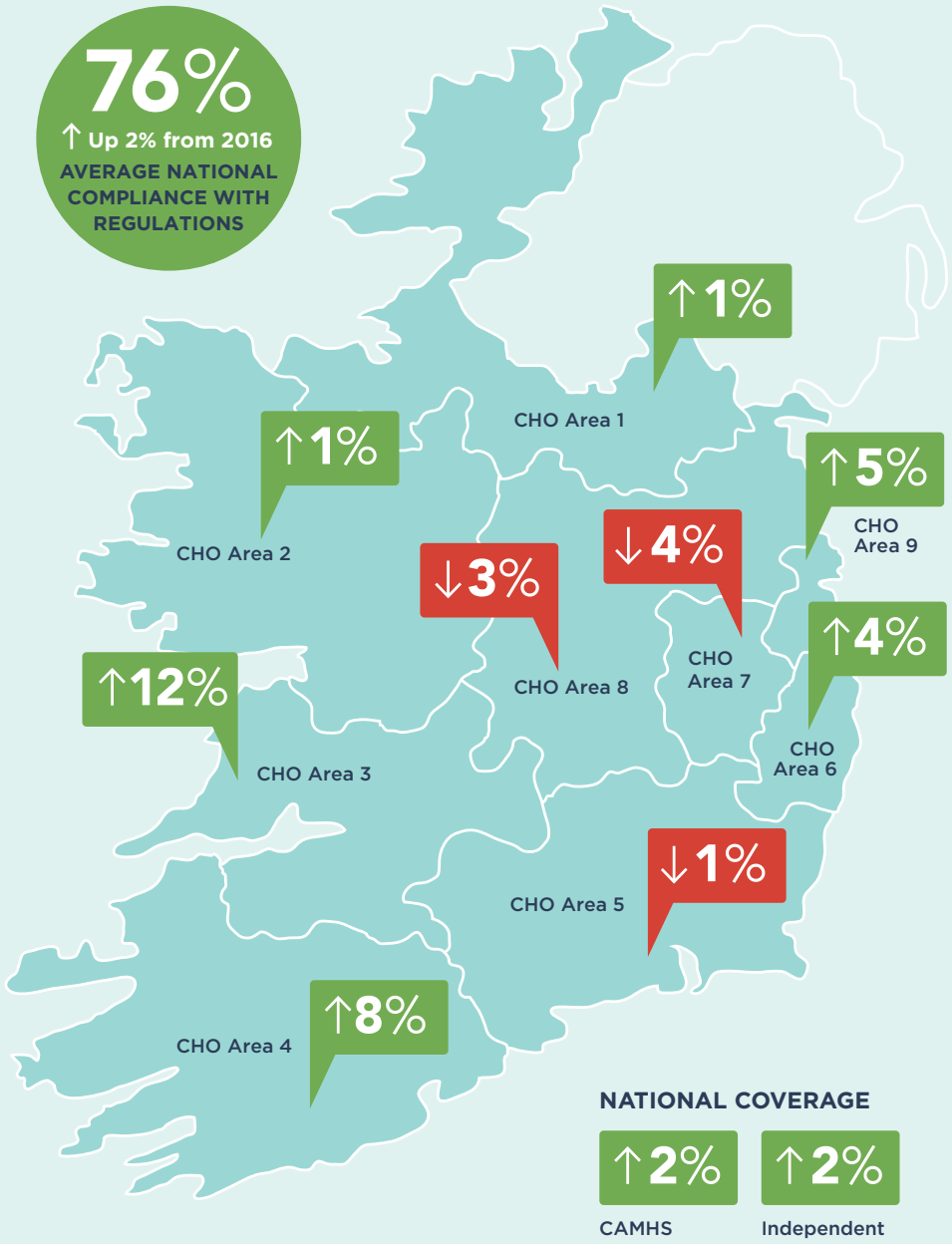


Fig. 1 The National Picture Change in Compliance in 2017 Compared with 2016

Compliance

We monitor findings made by the Inspector to identify trends and to agree plans with services to address findings of non-compliance. In 2017, we identified a general trend of **improvement** in services' compliance with Regulatory requirements.

- Nationally and regionally, there was an improvement in compliance with Regulations, including improvement in six of the nine HSE Community Healthcare Organisations (CHOs) (Fig. 3).
- There was an improvement in the majority of areas addressed by the Regulations, including improvement in compliance with Individual Care Planning, Maintenance of Records, and Recreational Activity requirements (Fig. 3).
- There was an improvement in services' quality assessment ratings, particularly in the level of services attaining a quality rating of Excellent (Fig. 2).

These findings present a positive baseline from which we will continue to monitor compliance and provide encouragement to services.

Fig. 2 Quality Assessment 2016-2017

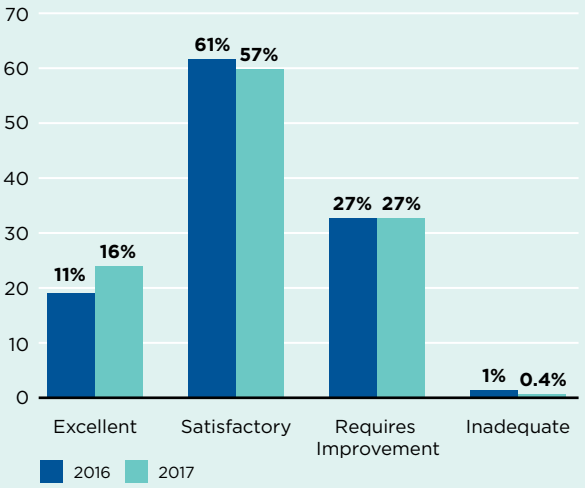
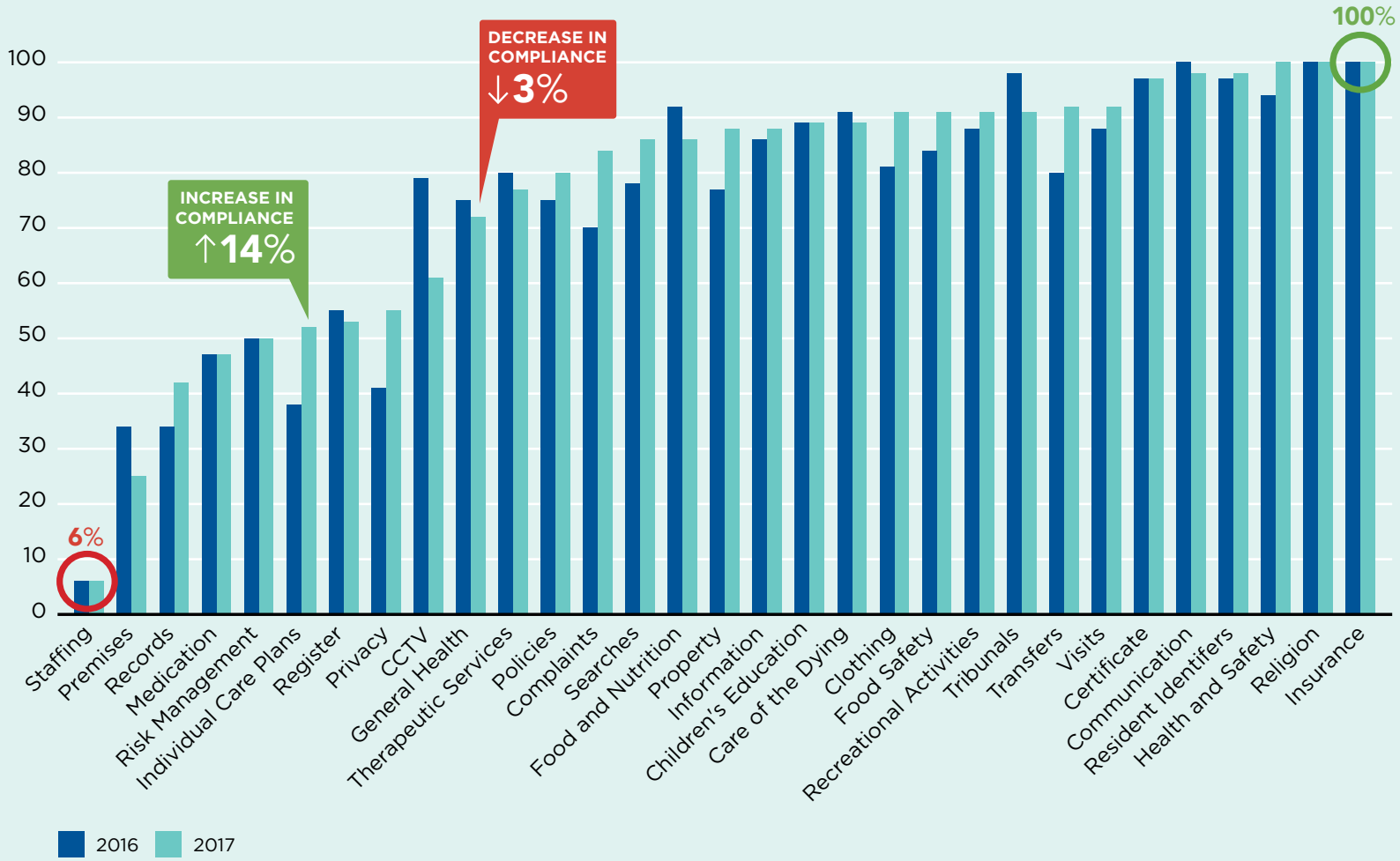


Fig. 3 Overall approved centre compliance with regulations 2016-2017



Areas of Concern

The Regulations with the lowest levels of compliance were related to staffing, premises, maintenance of records and medication practices. In 2017, less than half approved centres were found to be compliant in these areas. There has been little improvement in these four areas since 2016, with the exception of maintenance of records (Table 1).

Table 1 Areas of Low Compliance 2016 – 2017

Regulation	2016	2017
26: Staffing	6%	6%
22: Premises	34%	25%
27: Records	34%	42%
23: Medication	47%	47%

The main reason for non-compliance with **Staffing** was staff not being trained in the four mandatory training areas set out in the Judgement Support Framework:

- Basic Life Support
- Management of Aggression and Violence
- Fire Safety
- Mental Health Act 2001

We recognise the challenges in implementing this requirement and the efforts made by services to achieve this requirement over the past year.

The most common reasons for non-compliance with **Premises** related to the general condition of premises, inadequate facilities and the presence of ligature points.

While we recognise that some issues relating to the structure of the facility and premises may require significant work and take time to fix, it is a concern that there has been a decrease in compliance in this area.

Addressing Non-compliant Findings

In 2017, 62 of 64 approved centres were found to be non-compliant with one or more legislative requirements in their annual regulatory inspection.

An approved centre can be non-compliant with each Regulation for a varying number of reasons; the number of individual non-compliant findings with Regulations per approved centre ranged from one to 30 (the average was 14). The total number of non-compliant findings with Regulations for all 62 approved centres was 893.

We requested and reviewed corrective and preventative action (CAPA) plans from services, for each non-compliant finding. We monitored the implementation of these plans on an ongoing basis.

For a full breakdown of individual approved centres' compliance with Regulations see Appendix 2.

25%

compliance with Regulation 22: Premises

1633

individual CAPA plans agreed with services

57
enforcement actions for
28 approved centres

13 Immediate Action Notices

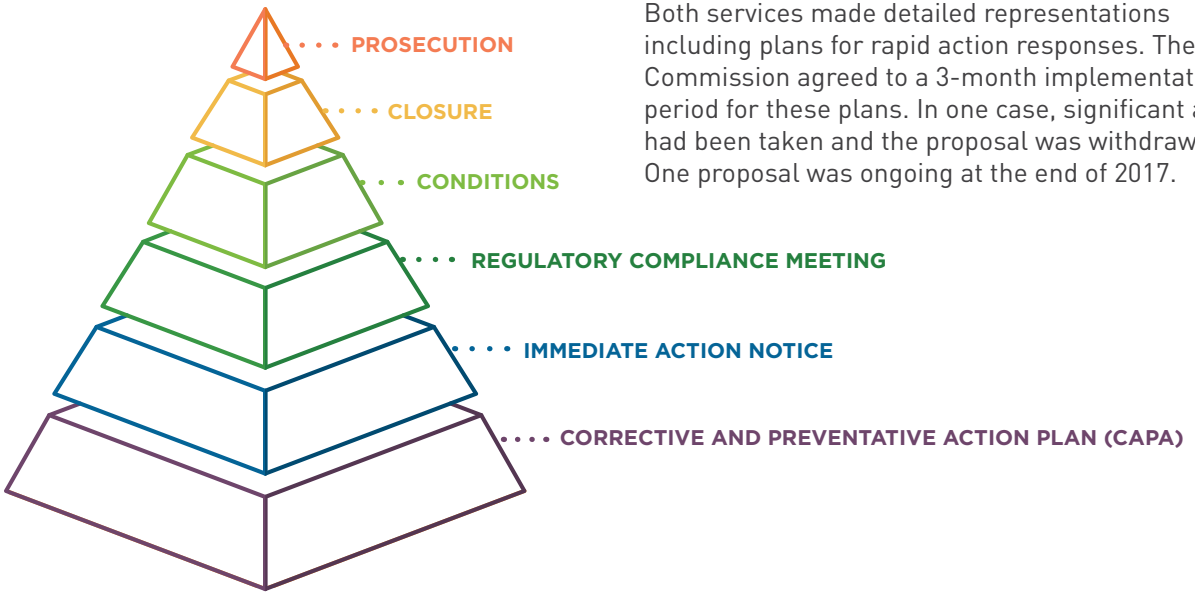
5 Regulatory Compliance Meetings

2 closure proposals

Enforcement

Enforcement action is taken where we are concerned that an element of care and treatment provided in an approved centre may be a risk to the safety, wellbeing or human rights of service-users. The intention of enforcement action is not to punish services, but to push them towards high standards in the provision of mental health services.

Our primary concern is always the people receiving care and treatment in mental health services. However, we know that staff also want to work for services offering high quality person-centred care. Our pyramid of enforcement actions is pictured below.



Where standards have not been met, it is the responsibility of the Commission to enforce the Mental Health Act 2001 in a fair, proportionate and consistent manner.

In 2017, we took 57 enforcement actions in relation to **28** approved centres. **34** of these related to Serious Reportable Events (SREs). We were concerned to receive 8 reports of Grade 3 or 4 pressure ulcers in approved centres; this is an unacceptable standard of care.

Other reasons for enforcement included inadequate staffing, inadequate therapeutic programmes, inadequate consent procedures, and unsafe, unhygienic and inappropriate premises.

We issued closure proposals in 2017 following serious and repeated non-compliances in 2 services. Both services made detailed representations including plans for rapid action responses. The Commission agreed to a 3-month implementation period for these plans. In one case, significant action had been taken and the proposal was withdrawn. One proposal was ongoing at the end of 2017.

Quality and Safety Notifications

Child admissions to adult units

Children and teens (>18 years) should not be admitted to adult units except in exceptional circumstances. As specialist Child and Adolescent Mental Health Services (CAMHS) in Ireland do not take out-of-hours admissions, children in crisis can be left with the unacceptable 'choice' of being cared for in the emergency department of a general hospital, or an adult in-patient unit.

The Commission continues to highlight the lack of CAMHS community and in-patient services and the detrimental effect this has on the mental health and wellbeing of young people in Ireland.

In 2017, **82** children were admitted to **21** adult units.

The most common reason reported for the admission of a child to an adult unit was an immediate risk to self or others combined with the unavailability of a bed in a child unit.

Child admissions to CAMHS units

In 2017, 357 children were admitted to six CAMHS units, for an average duration of 65 days (based on discharge information provided to the Commission for 330 admissions).

Involuntary Child Admissions

In 2017, there were 28 involuntary admission orders of children to approved centres, pursuant to Section 25 of the Mental Health Act 2001, including:

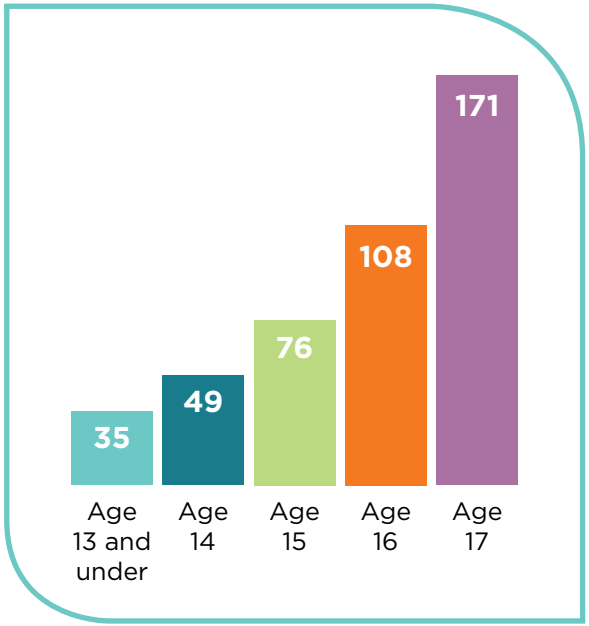
- **4** orders to adult units,
- **24** orders to CAMHS units.

In addition, there was one High Court Order for the admission of a child to an adult unit.

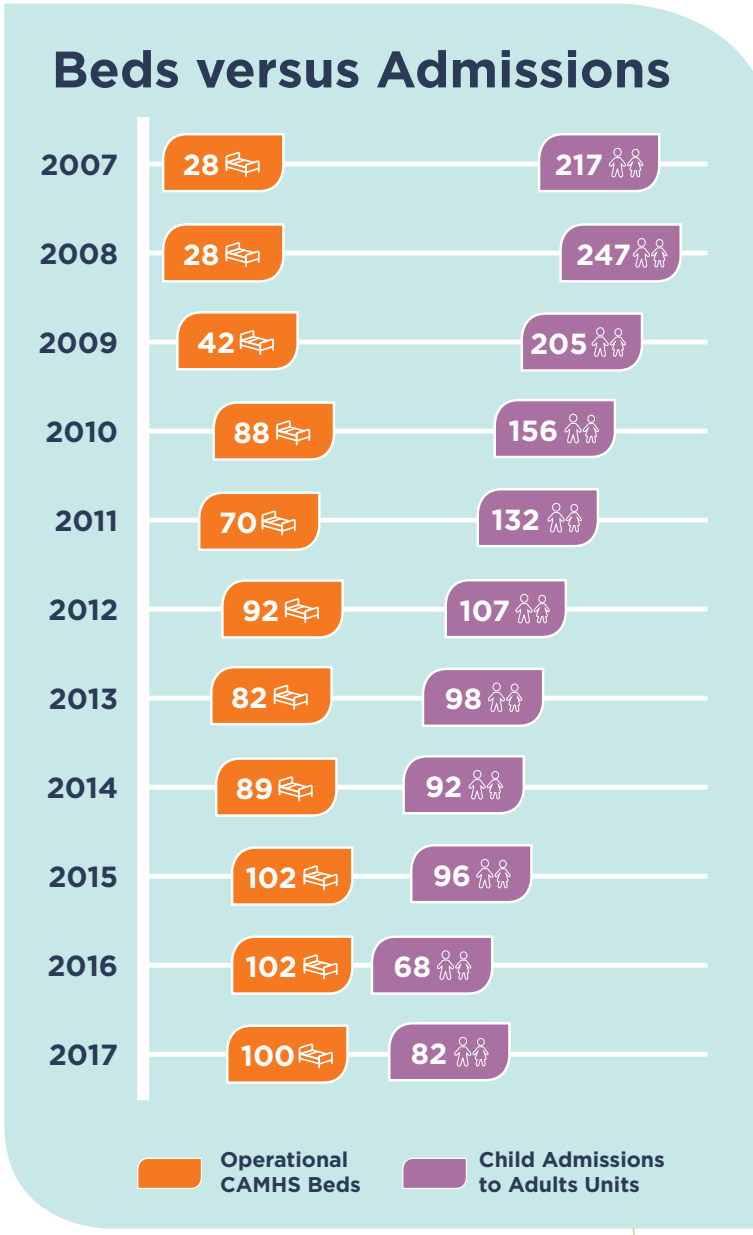
Age and Gender of Child Admissions

- **59% of child admissions to all units were female.**

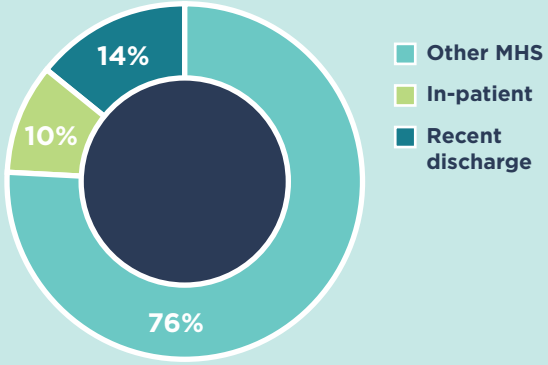
The age of children admitted to all units (CAMHS and adult units) is presented below. For more information on child admissions see Appendix 4.



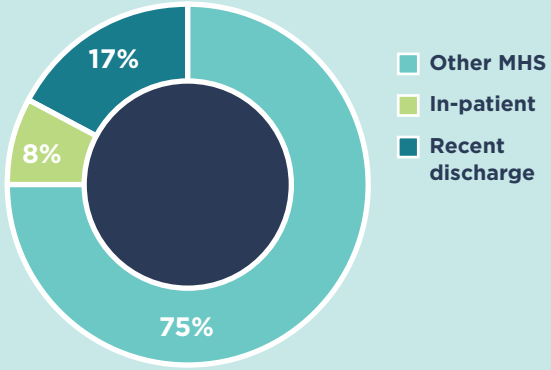
Beds versus Admissions



Sudden and unexplained deaths by service type



Deaths reported as suspected suicide by service type



Reported deaths

Mental Health Services are required to report deaths of service users to the Commission. Services must report:

- *Any* death of a resident in an approved centre
- The *sudden and unexplained death* of a person availing of a mental health service (e.g. outpatient, day centre, community residence etc.).

Sudden and unexplained deaths are an unexpected death from any cause other than natural illness or disease, this includes suspected suicide and deaths that occurred in suspicious circumstances which may be have been the result of violence or misadventure, that have been referred to the Coroner or Garda.

It is not possible for us to report the number of sudden and unexplained deaths that were due to suicide, as death by suicide may only be determined by a Coroner's inquest. However, we can report the number of deaths which were considered to be a 'suspected suicide' by the service.

The categorisation of the cause of death was based on qualitative information provided by services, the standard of which varied based on information available to the service at the time of reporting. Therefore, these findings should be interpreted with caution.

In 2017, **427** deaths were reported to the Commission. Based on the information available at the time of reporting, it was not possible to categorise 38 of these deaths. Of the 389 categorised deaths there were:

- **177** deaths due to natural causes
- **212** sudden and unexplained deaths, of which **153** were suspected suicides.

Sudden and unexplained deaths

We analyse sudden and unexplained deaths according to the mental health service the person was availing of prior to their death. We look at in-patient services, persons recently discharged from in-patient services, and 'other' mental health services.

Half (13) of the suspected suicide deaths of individuals who were recently discharged from an in-patient service died within 1 week of their discharge; however, services are more likely to be aware of deaths occurring closer to the discharge date and therefore may be more likely to be reported.

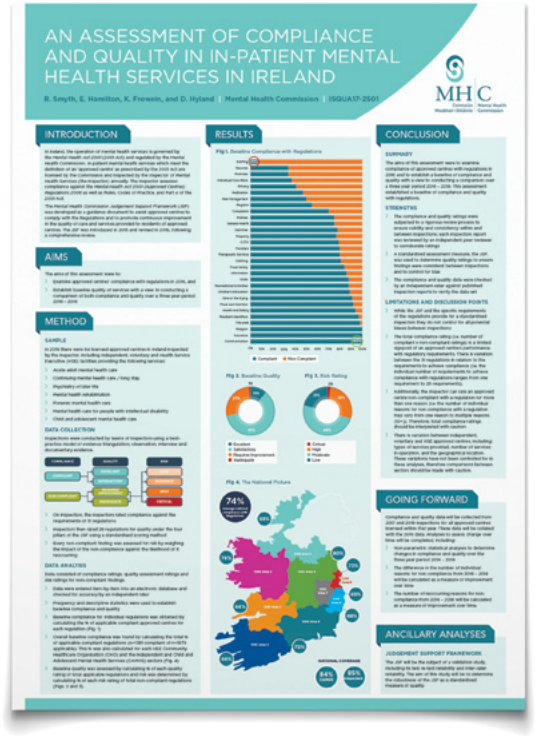
- **9** deaths of approved centre residents reported as suspected suicides occurred while the person was on leave or absent without leave
- **66%** of all deaths reported as suspected suicides were male.

For further information on deaths (by service provider) please see Appendix 3.

Quality Improvement

At the Commission we have a mandate to foster high standards and good practices in the delivery of mental health services. We encourage recovery-based person-centred care that promotes service-user autonomy and upholds their human rights.

We contribute to a culture of continuous quality improvement by conducting research, issuing guidance and developing evidence based standards, Rules and Codes of Practice to improve service delivery and service user experience.



Research in 2017

In 2017, the Commission commenced a three year research project, using data from 2016-2018, conducting a comparison of both compliance and quality in approved centres to assess the effectiveness of the Judgement Support Framework in promoting quality improvement.

Guidance in 2017

A minor, technical review was undertaken following the 2016 inspection cycle with the purpose of identifying errors, duplications and ambiguities in the Judgement Support Framework. Guidance for services in relation to compliance with Part 4 of the Mental Health Act 2001 was incorporated into the Framework.

Standards in 2017

In October 2017 the Commission and the Health Information and Quality Authority (HIQA) published standards for the conduct of reviews of patient safety incidents. The standards promote an open culture and aim to ensure that services act in a transparent, standardised and person-centred way to review patient safety incidents and learn from them.

Service-user Voice

In 2017, the Inspector of Mental Health Services introduced a service-user questionnaire, which is provided to service-users during an inspection. The questionnaire gives service-users an opportunity to provide feedback on their experience of the service, which is an important way to hear the service-user voice, particularly if they do not feel comfortable speaking with an inspector. These finding are used to inform the inspection reports.

Submission to the Seanad Public Consultation Committee

In 2017 the Commission was invited to attend and provide a submission to the Seanad Public Consultation Committee in respect of the Mental Health (Amendment) Bill 2016. The Commission provided data to the Committee on child admissions to adult units, and reiterated the Commission's view that any admission of a child to an adult in-patient unit should be in exceptional circumstances only.

Committees and Advisory Groups

The Commission was represented on a number of Committees in 2017, including the National Safeguarding Committee, National Healthcare Quality Reporting System Committee and National Clinical Effectiveness Committee. We attended the Open Policy Debate on the Review of the Child Care Act 1991.

We were represented on the Advisory Group for the development of National Standards for infection prevention and control in community settings. We were also on the working group for the review of the HSE complaints policy Your Service Your Say.

Templates to promote quality improvement

In 2017 we developed templates to report on the results of audits against a number of our approved centre regulations. These templates were originally developed as a reporting mechanism for registration conditions, however they have been circulated more widely as they provide a useful 'checklist' for services to self-assess compliance with regulations. Report templates are available for:

- Individual Care Planning
- Premises Maintenance
- Medication Management
- Staff Training

Safeguarding Adults

In 2017, the Commission commenced development of National Standards for safeguarding adults at risk. These Standards will be jointly developed with HIQA and will provide a framework for best practice in safeguarding adults in all health and social care settings. Work on these standards will continue in 2018.

Collaborations, Presentations and Conferences

- **We presented at a joint conference on the Role of the Family in Promoting Recovery, jointly hosted by Shine and the College of Psychiatrists of Ireland**
- **We presented research at the ISQua 34th International Conference**
- **We peer reviewed abstracts for the Scientific Committee for the ISQua 34th International Conference**
- **We presented to the Norwegian Committee to Assess Laws relating to the Use of Coercion in the Health and Care Sector**
- **We hosted the launch of the National Safeguarding Committee's Review of Current Practice in the Use of Wardship for Adults in Ireland**
- **We provided a report on our actions in relation to the 2nd Annual Report of the Implementation of the National Strategy on Children and Young People's Participation in Decision Making**
- **We were advisors to the 10th European Congress on Violence in Clinical Psychiatry**

Collaborative Working

Health Service Executive

- National Office for Suicide Prevention
- Quality Assurance and Verification
- National Mental Health Division
- Quality and Service User Safety Team
- National Safeguarding Committee

State Bodies

- Legal Aid Board
- Tusla

Service Users and Carers

- Irish Advocacy Network
- Mental Health Reform
- Shine

Department of Health

- Mental Health Division
- National Patient Safety Office
- National Clinical Effectiveness Committee
- Medication Safety Forum
- National Healthcare Quality Reporting System Committee

Other Government Bodies

- Department of Children and Youth Affairs
- Department of Justice and Equality

Regulatory Bodies

- Health Information and Quality Authority (HIQA)
- Regulation and Quality Improvement Authority RQIA Northern Ireland

Research and Training

- Health Research Board
- College of Psychiatrists of Ireland
- University College Dublin
- St John of God Community Services

We work in partnership with a number of organisations, agencies and bodies

Mental Health Tribunals

One of the Commission's core functions is to ensure the independent review of involuntary admissions by a mental health tribunal.

Under the Mental Health Act 2001, everyone who is involuntarily admitted to an approved centre has their case reviewed by a mental health tribunal. The tribunal involves a group of trained and independent people who look at the involuntary admission to decide if it followed the requirements in the Act and makes sure the service-user's rights are protected.

The 2001 Act introduced a mandatory system of independent reviews in relation to each order made relating to the involuntary admission of an adult.

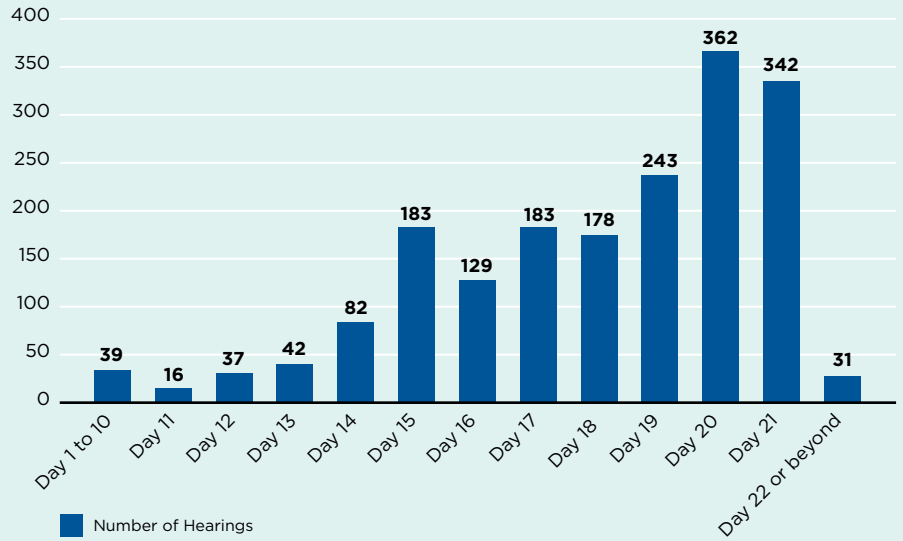
This independent review must be carried out by a mental health tribunal within 21 days of the making of the order. The mental health tribunal is a made up of a solicitor / barrister as chair, a consultant psychiatrist and another person, often referred to as a lay person. The review is a limited review dealing primarily with whether the person is still suffering from a mental disorder or not.

Adults are reviewed by an independent consultant psychiatrist and the Commission assigns free legal representation for their hearing during their period of involuntary detention.

There were **1,867** hearings in 2017.

We monitor the 21 day period of the order to ensure the independent review happens within this timeframe. The majority of mental health tribunals continued to take place at the end of the 21-day period. (Figure 4).

Fig. 4 Breakdown of Hearings over 21 day period 2017



Involuntary Admission

A person can only be admitted to an approved centre and detained there on the grounds that he or she is suffering from a mental disorder.

An involuntary admission of an adult can occur in two ways - an involuntary admission or a re-grading from a voluntary patient to an involuntary patient.

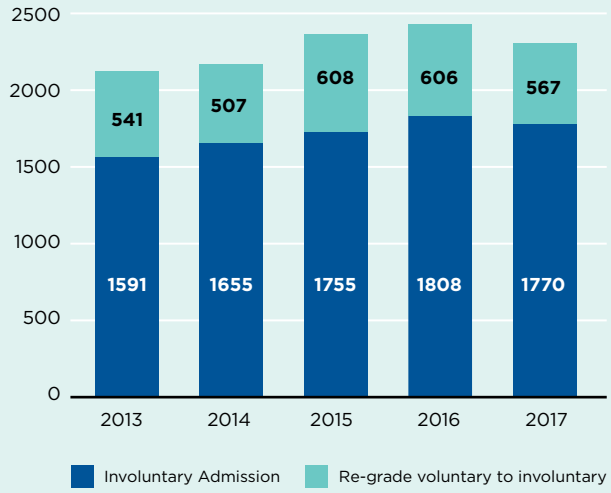
In such admissions the admission order is made by a consultant psychiatrist on statutory Form 6, Admission Order, which must be accompanied by an application (Forms 1, 2, 3, or 4) and a recommendation by a registered medical practitioner (Form 5).

There was a total of **1,770** Form 6, Admission Orders, notified to the Commission in 2017.

The initial order detaining a patient, known as an admission order, is for a maximum of 21 days.

A patient can then be detained on a further order, known as a renewal order, the first of which can be for a period up to three (3) months, the second for a period up to six (6) months and the third a period up to twelve (12) months.

Fig. 5 Comparisons of total involuntary admissions 2013-2017



All orders thereafter can be for a period up to (12) months. The consultant psychiatrist when making the order does not have to make it for the full period and has a discretion to make it for a lesser period depending on their expert clinical judgement.

In 2017 of the total renewal orders made –

- 908 were for a period up to three months,
- 139 were for a period up to six months, or
- 140 were for a period up to 12 months.

Re-grading of Voluntary Patient to an Involuntary Patient

The 2001 Act 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 **567** such admissions notified to the Commission in 2017.

A total of 51 patients had three or more separate involuntary admissions in 2017, the same number as in 2016.

Comparison was made between the number of involuntary admission orders in 2017 and the orders in the previous 4 years. There was a year on year increase in orders made each year up until 2016. There was a 3% decrease between 2016 and 2017 (Fig. 5).

In 2017, the High Court[1] found that pursuant to section 5 of the European Convention on Human Rights Act 2003 that Part 2 of the Mental Health Act 2001 was incompatible with Article 5.4 of the European Convention on Human Rights in so far as it does not provide persons who are detained under a 12 month renewal order (made pursuant to section 15(3) of the 2001 Act) with an entitlement to initiate a review of their detention following the expiry or exhaustion of their rights pursuant to section 18 and section 19 of the said 2001 Act.

The Commission continues to advocate for shorter duration renewal orders to ensure the regular review of patients' care and capacity.

1 A.B. - v – The Clinical Director of St. Loman's. The Courts found that the section of the 2001 Act relating to orders up to 6 and up to 12 months was unconstitutional. Amending legislation has to be introduced by the Government in 2018.

70%

of the total involuntary admissions age 18-24 were **male.** However, there were more **female admissions** in all age groups **45** and over

44%

of applications are still made by spouse, civil partner or a relative

Age and Gender

Analysis of age and gender was completed on the figures for episodes of involuntary admission in 2017.

- People aged 25-34 had the highest number of involuntary admissions at 23% in comparison to 2016 where the highest number of involuntary admissions was in the 35-44 age group at 22%.
- Those aged 65 + had an increase in involuntary admissions to 17% up 2% from 2016.
- 53% of the total involuntary admissions were male. However, there were more female admissions in all age groups 45 + and over.

Table 2 Analysis by Gender - Involuntary Admissions 2017

Age	Male	Female	% gender
18 – 24	200	87	70% male
25 – 34	321	207	61% male
35 – 44	261	241	52% male
45 – 54	155	201	56% female
55 – 64	119	163	58% female
65 +	179	203	53% female

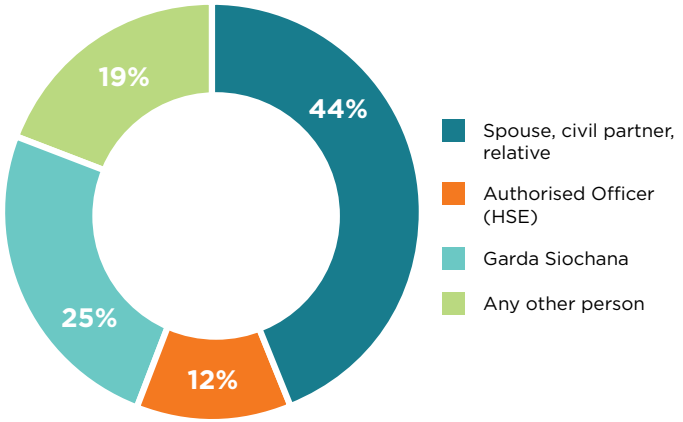
Who makes the application to detain?

As part of our analysis, we collect data on who makes the application for the involuntary admission of an adult to an approved centre.

2017 figures show the only change from 2016 is applications by authorised officers decreasing by 1% and 'any other person' increasing by 1%.

The Commission is disappointed to see that applications by family remained at 44% in 2017. We remain concerned about the effects of making these types of applications on family members and loved ones.

Fig. 6 Analysis of Applicant: Involuntary Admissions 2017 (adults)



Revocation by Responsible Consultant Psychiatrist

The consultant psychiatrist responsible for the patient must revoke an order if they become of the opinion that the patient is no longer suffering from a mental disorder. In deciding whether to discharge a patient, after the order is revoked, the consultant psychiatrist has to balance the need to ensure that the person is not inappropriately discharged and that the person is only involuntarily detained for so long as is reasonable necessary for their proper care and treatment.

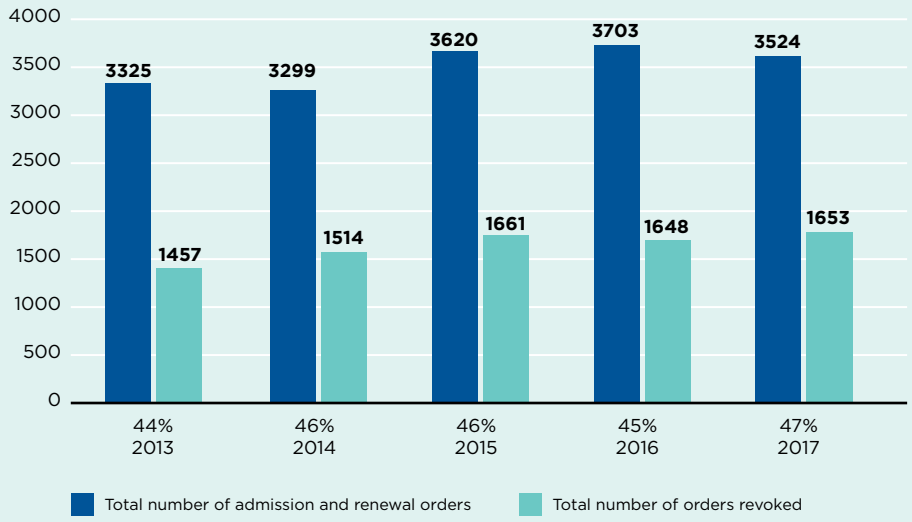
Where the responsible consultant psychiatrist discharges a patient under the 2001 Act they must give to the patient concerned, and his or her legal representative, notice to this effect. When a patient's order is revoked they may leave the approved centre or they may agree stay to receive treatment on a voluntary basis.

The total number of orders revoked by a responsible consultant psychiatrist in 2017 were **1,653**. This amounts to 47% of all the orders (admission and renewal orders) made. See Figure 7.

Orders Revoked at Hearing

The number of orders revoked at a mental health tribunal was 181, which represents 10% of total orders. This shows no change to the percentage of orders revoked at hearing in 2016.

Fig. 7 Number of Orders Revoked before Hearing by Responsible Consultant Psychiatrists under the Provisions of the Act for Years 2013 to 2017



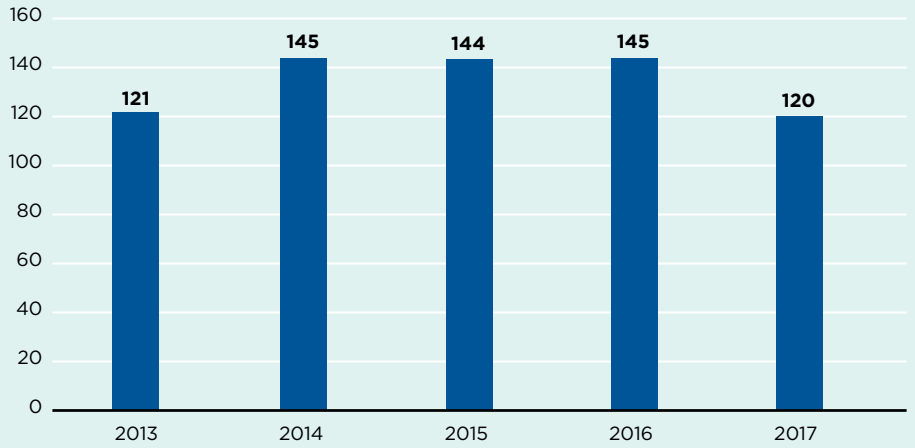
Circuit Court Appeals

Patients can appeal to the Circuit Court against a decision of a mental health tribunal under Section 19 of the 2001 Act.

The Commission was notified of 120 Circuit Court appeals in 2017. Of those, 21 appeals proceeded to full hearing in comparison to 35 in 2016. The Commission's legal aid scheme is available to patients wishing to bring Circuit Court appeals.

The Commission is the nominated party to defend these appeals under the Court Rules. The number of appeals brought in the last 5 years is set out in Fig. 8.

Fig. 8 Number of Circuit Court Appeals 2013 to 2017



Governance and Key Enablers

The four pillars of key governance are Values, Purpose, Performance and Developing Capacity. At the Commission, we are committed to reaching the highest standard of Corporate Governance in line with the Code of Practice for the Governance of State Bodies (2016).

We are supported in delivering our core statutory functions through key enablers such as ICT, finance and human resources.

Governance and Key Enablers

The Members of the Commission are the governing body of the organisation. The Commission has 13 Members including the Chairman all of whom are appointed by the Minister for Health. The composition of the Commission is provided for under the provisions of Section 35 of the Mental Health Act 2001.

2017 marked the end of the 5-year term of office for the previous Commission (2012 – 2017) and also marked the appointment of the organisation's fourth Commission (2017 – 2022). Details of the previous and current Commission Members as well as attendance at meetings during 2017 can be found at Appendix 6.

During 2017 the Commission had two Standing Committees, the Audit and Risk Committee and the Legislation Committee. Details of both the previous and current Committees can be found in Appendix 6. In addition, the Commission established a Working Group of the Commission Members and the Executive to ensure compliance with the Code of Practice for the Governance of State Bodies 2016 ("the 2016 Code").

Corporate Governance within the Commission

The Commission is committed to reaching the highest standard of Corporate Governance within the organisation. This was central to the work programme undertaken by Members and the Executive in 2017.

On 1 September 2016, the 2016 Code became the definitive corporate governance standard for all commercial and non-commercial state bodies in Ireland.

Agencies were given 12 months following the launch of the 2016 Code of Practice to action and implement the provisions. In line with this timeline, the Commission's senior management team, with assistance from outsourced financial advisors, commenced a gap analysis to compare the MHC's current adopted policies, procedures, and practices to provisions in the 2016 Code and to identify gaps (if any) which required action. The Report was completed in June 2017.

Following this, the 2016 Code Working Group was established, whose work is continuing. The Commission has adopted the 2016 Code, has put procedures in place to ensure compliance with the provisions of the Code and confirmed this to the Department of Health (DOH). Except for a small number of provisions that are a work in progress at year end, the Commission is significantly compliant with the 2016 Code. All reporting requirements for 2017 have been met.

Key Governance Activities in line with the requirements of the Code

Board Effectiveness

An Induction programme was undertaken with the newly appointed Commission Members in May (and again in November and December for the Members who were not appointed until later in the year) 2017 in line with the provisions of the revised 2016 Code.

In line with good governance the Commission undertook a self-assessment survey in Quarter 4 2017. This was welcomed as an opportunity to focus and reflect on the work programme for the coming year which will be the first full year in office for the new members.

The Audit and Risk Committee (ARC) also undertook a self-assessment survey for the period August to December 2017. It has been agreed that an external evaluation of the ARC and the Commission will be done in 2019. Further details of the work programme of the ARC are provided below.

Corporate Governance

The Corporate Governance Manual for the Commission was updated in May 2017. The overarching responsibilities are as follows: -

- to define the vision and strategic direction of the organisation;
- to ensure the organisation fulfils its statutory functions;
- to define the internal control mechanisms for the organisation to safeguard public resources; and
- to monitor the overall management of the organisation.

Specific responsibilities of the Commission Members include: -

- Adoption of the Commission's Strategic Plan, Annual Business Plan and Annual Budget;
- Approval of significant acquisitions, disposals and retirement of assets of the organisation;
- Approval of any borrowings by the Commission, subject to the approval of the Minister for Expenditure and Public Reform (Section 41);
- Approval of annual report and other reports requested by the Minister (Section 42);
- Approval of annual financial statements;
- Appointment of the Audit and Risk Committee;
- Review of the organisation's system of internal controls;
- Appointment, remuneration and assessment of and succession planning for the Chief Executive; and
- Significant amendments to the pension benefits of the Chief Executive and Staff.

The current Commission has committed to a further review of the Corporate Governance Manual in 2018, which will expand on certain issues.

Code of Conduct, Ethics in Public Office, Additional Disclosures of Interests by Board Members and Protected Disclosures

For the year ended 31 December 2017, the Commission can confirm that a Code of Conduct for the Board and staff members was in place and adhered to. Furthermore, all Commission Members and relevant staff members complied in full with their statutory responsibilities under the Ethics in Public Office legislation.

Business & Financial Reporting

The non-capital allocation to the Mental Health Commission for 2017 was €14.274m. The outturn for 2017 in the Mental Health Commission was €13.541 million.

Key areas of expenditure related to the statutory functions as set out in the 2001 Act including the provision of Mental Health Tribunals, the registration, inspection and regulation of approved centres (in-patient mental health facilities). 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.

An allocation of €300,000 was made available from the Department of Justice and Equality for 2017. In October 2017, it was announced that €3 million would be allocated to fund the continuing implementation of the DSS in 2018

The Commission can confirm that all appropriate procedures for financial reporting, internal audit and asset disposals were carried out.

Furthermore, the Commission can confirm that it adhered to the Public Spending Code and the Government travel policy requirements were complied with in all respects. The Commission did not make any payments in relation to non-salary related fees.

The Commission has included a statement on the system of internal control (as per the 2016 Code) in the unaudited Financial Statements for 2017, which have been sent to the Department, of which this includes where a breach of this system has been identified, and an outline of the steps that will be taken to guard against such a breach occurring in future.

The Commission approved the draft unaudited Financial Statements in 2018 and agreed that they are a true and fair view of the Commission financial performance and position at year end. The unaudited Annual Financial Statements for 2017 was submitted to the Comptroller and Auditor General as per Section 47 of the Mental Health Act 2001 and the 2016 Code. This included details of the Commission's pension scheme. 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 95% 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.

Audit and Risk Committee (ARC)

The previous ARC provided an Annual Report in March 2017, which included its work for 2016 and the first quarter of the 2017. This report was produced to the Commission in March 2017. The current ARC had three meetings in 2017 and its Annual Report relates to the period May to December 2017.

The report addresses all issues required under the 2016 Code to include –

1. Stakeholder Relationships
2. Monthly Management Accounts
3. Budget
4. Annual Financial Statements and External Audit Internal Audit ("IA")
5. Risk Management
6. Governance and Internal Control
7. Personal Performance Management

At its meeting in October 2017, a number of key documents were presented for review, comment and approval, they included

1) Revised Charter / Terms of Reference
2) Work Plan for 2018
3) Internal Audit Charter
4) Internal Audit Plan.

The relevant documents were brought to the Commission at its meeting in November 2017 and approved.

Risk Management

The effective management of organisational risk requires robust control processes to support management in achieving the Commission's objectives and in ensuring the efficiency and effectiveness of operations. In carrying out its risk management responsibilities during 2017, the Commission adhered to the three main principles of governance: openness, integrity and accountability.

A significant part of the work programme of the ARC is the oversight role it plays in the Risk Management process for the organisation. The ARC highlighted that a critical component of the control environment is the process by which an organisation manages its risk profile. With that in mind, a significant work programme was commenced in July 2017, in relation to amending the format of the Risk Register, the Risk Policy, the Risk Appetite and the associated documents.

Arising from the review and updating of the risk documentation, the structure relating to risk is a lot clearer. Risk appears on the Senior Management Agenda once a month, it is on the Agenda for each Commission meeting and on the Agenda for each ARC (which will meet a minimum of four times a year).

Furthermore, the ARC identified three key risks for the MHC –

1) Reported lack of resources within the Commision and the impact of same,

2) Reported concerns in relation to the commencement of the operation of the Decisions Support Service and the impact of same, and

3) Review of the Mental Health Act 2001

Internal Audit and Control

The internal control system includes all the policies and procedures (internal controls) adopted by Management to assist in achieving their objective of ensuring, as far as practicable, the orderly and efficient conduct of the organisation's activities, including adherence to internal policies, the safeguarding of assets, the management of risk, the prevention and detection of fraud and error, the accuracy and completeness of the accounting records and the timely preparation of reliable financial information. Senior Management has the key responsibility for ensuring an adequate and appropriate internal control system.

The ARC at each of its meetings reviewed any draft Audit Reports (with Management's responses) that were presented. In addition, an Internal Audit Update was provided at each meeting in relation to the Audits carried out pursuant to the 2015-2017 Audit Plan. The ARC noted that Management were using their best endeavours to address the various recommendations. The ARC acknowledged that a lack of resources impacted on the ability to address certain matters. Furthermore, new measures were implemented in 2017 with regard to how best to progress audit recommendations.

The ARC at its meeting in October agreed an Audit Plan for the three years 2018-2020. This plan shall be reviewed annually depending on any issues that may arise specifically any risk issues.

The control environment means the overall attitude, awareness and actions of management and staff regarding internal controls and their importance in the organisation. The control environment encompasses the management style, and corporate culture and values shared by all employees. It provides the background against which the various other controls are operated.

Relations with Oireachtas, Minister and Department of Health

Governance meetings with Officials from the Department of Health and the Commission Executive took place in April, September, October and December in 2017.

Furthermore, the Commission signed both the Oversight Agreement and Performance Delivery Agreement in December 2017.

The Commission had no legal disputes with any other State agency or Government body. In addition, the Commission did not make any payments in the settlement of any legal disputes.

Remuneration and Superannuation

During 2017 the Commission finalised a Superannuation Scheme for the organisation. The associated documentation was submitted and adopted by the Department of Health and the Department of Public Expenditure and Reform. The new Scheme is now operational.

Information Management Technology (ICT)

In 2017, the Commission continued in the work programme started in 2016 to re-design the ICT systems for key certain areas in the organisation. An extensive work plan was rolled out for 2017 focused on further design elements and implementation. This project was paused for a number of reasons from July to October 2017. During this period certain changes were made and the project was recommenced in November 2017. Since re commencement significant progress has been made. The project was ongoing at year-end.

Staff in the Commission

Developing our People

2017 saw significant changes to the organisational structure of the Mental Health Commission, two fundamental roles were appointed, Head of Legal Services and the Director of the Decision Support Services.

The Mental Health Commission has been seeking an increase in resources since 2008. In 2017 32 vacancies (of which 16 were replacement posts) were confirmed.

Fig. 9 Turnover Reason Breakdown

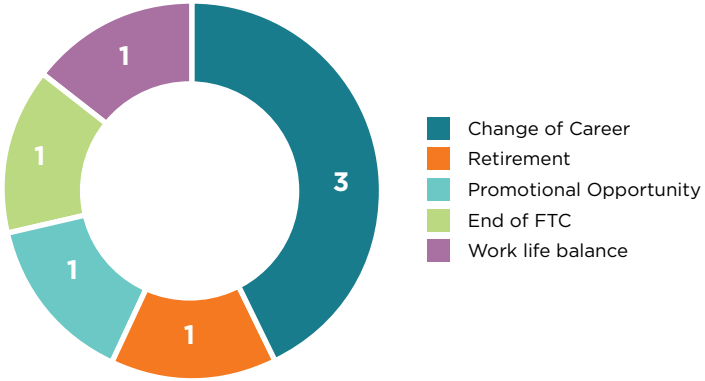
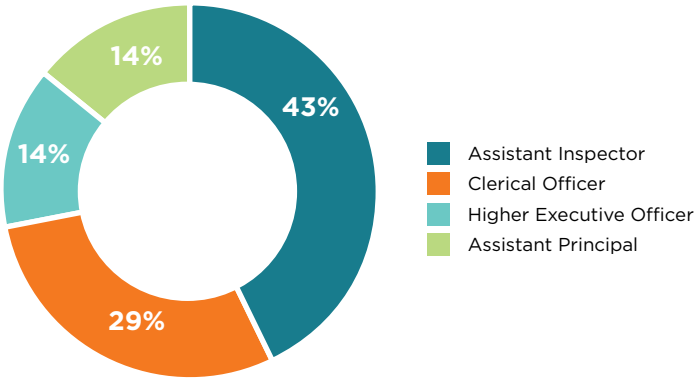


Fig. 10 Turnover by Grade



The recruitment of these posts was led by an external recruitment provider further to a tender process for our recruitment services. It is expected that these campaigns will continue into 2018.

By the end of 2017, we saw the beginning stages of the recruitment for both the Assistant Inspector and the Technical Report Drafters posts, which comprised 12 positions.

In 2017 we also saw the loss of several integral post holders in the Commission, resulting in an annual turnover percentage of 21.21%. These leavers were across the organisation.

Exit interviews were conducted with all leavers as part of the leaving process. Change of career dominated reasons for leaving in 2017.

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. Our census results for 2017 were provided to the Department of Health and will be included in a report published by the National Disability Authority (NDA).

It is the policy of the Commission to ensure that relevant accessibility requirements for people with disabilities are an integral component of all of our 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.

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

In 2017, the Commission had procedures in place for the making of protected disclosures in accordance with the relevant legislative requirements. There were no protected disclosures reported to the Commission during 2017.

Freedom of information / Data Protection

In 2017, the Commission received 23 requests under the Freedom of Information Act 2014. Of these, requests 14 were granted, two were referred to another agency, 2 were part-granted, 2 requests were refused and three of the cases were open as of year-end.

There were 2 requests for information under Data Protection legislation in 2017.

The Mental Health Commission report data breaches to the Office of the Data Protection Commissioner during 2017, the details of which are included in the unaudited Financial Statements for 2017.

General Data Protection Legislation

The Data Protection Legislation in Ireland will be amended by EU Regulation 2016/679. The Commission was in communication with the Department of Health and notified them that due a lack of resources and funding that it would not be compliant with the Regulations as of May 2018. The Commission has a plan of action in place and it will continue to work towards compliance during 2018.

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 (as amended and/or updated). In 2017, we undertook to update our Health and Safety Statement and carry out a Risk Assessment. This work was ongoing at year end.

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.

At the Commission, we are fully committed to the 2020 Vision of reaching verifiable energy-efficiency savings of 33%.

In 2017 the Commission consumed 84,534 kWh of energy, consisting of 74,928 kWh of electricity and 9606 kWh of Gas.

We remain determined to achieve this 33% target by 2020 and are committed in continuing to investigate and implement more measures to ensure that this target is met.

Maastricht Returns

In 2017, the Commission complied with the requirement to submit a Maastricht Return to the Department of Health.

Children First

The Children First Act 2015 was commenced on 11 December 2017. The Commission is not a "relevant service" as defined in the 2015 Act. However, we have a small number of staff who are "mandated persons" as defined in the 2015 Act. Before year end 2017 all mandated persons within the Commission underwent mandatory training and register of same was maintained. The Commission introduced a new Policy which was finalised and circulated to staff – A Policy for the Reporting of Child Protection and Welfare Concerns.

Decision Support Service

Maximising autonomy for all relevant persons requiring support to make decisions about their personal welfare, property and affairs. Regulating individuals who are providing a range of supports to people with capacity difficulties.

Decision Support Service

During 2017 work has continued towards the operationalisation of the Decision Support Service (DSS). The establishment of the DSS extends the remit of the Commission beyond mental health services to include all relevant persons in Ireland who may require supported decision-making.

The DSS also extends beyond decisions about healthcare and includes decisions about welfare, property and finances.

The DSS will provide a framework which will include a range of decision-making supports and will regulate the individuals who are providing support to people with capacity difficulties.

Assisted Decision-Making (Capacity) Act 2015

The Assisted Decision-Making (Capacity) Act 2015 [2015 Act] provides for the establishment within the Commission of the DSS. The 2015 Act is a reforming piece of human-rights based legislation.

The key changes which the 2015 Act introduces are:

- abolition of the Wards of Court system
- a statutory functional (time-specific, issue-specific) assessment of capacity
- a three-tier framework for supported decision-making
- guiding principles which promote will and preference rather than best interests
- changes to the procedures around Enduring Powers of Attorney
- statutory recognition of Advance Healthcare Directives

The Commission acknowledges the cultural shift brought about by the 2015 Act and welcomes the move towards a new system which has the 'relevant person' at its centre.

The Commission is aware that the existing paternalistic system of substituted decision-making is incompatible with our current human rights obligations, including the guarantee contained in UNCRPD that

"...persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life" (Art 12.2)

The Commission considers it a privilege to be entrusted with a project of this scale and significance.

Work in progress

The Commission has continued to attend at monthly meetings of the Inter-Departmental Steering Group which was established in 2016 to advance the implementation of the DSS. In these meetings we have emphasised the importance of a properly structured and resourced DSS with a robust legislative foundation.

An allocation of €300,000 was made available from the Department of Justice and Equality for 2017. In October 2017, it was announced that €3 million would be allocated to fund the continuing implementation of the DSS in 2018.

Following a recruitment campaign by the Public Appointments Service from April to June 2017, a Director of the DSS was selected and commenced in post at the beginning of October 2017.

The Assistant Principal who was seconded from the Department of Justice from June 2016 to July 2017 prepared an overview of the project to date and a detailed briefing for the incoming Director.

Functions of the Director of the DSS

The 2015 Act is largely not yet commenced. Sections which have been commenced include Section 95 which set out the functions of the Director. These include:

- Providing information and promoting public awareness
- Supervising compliance by interveners
- Investigating complaints
- Maintaining a register of decision-making agreements
- Approving draft Codes of Practice
- Acting as the Central Authority for the Hague Convention on the International Protection of Adults

In 2017, the Director commenced wide-ranging stakeholder engagement with civil society groups, healthcare, social work, financial and legal professionals, with academia and with the public sector, including Court Services.

The Director and the Chief Executive of the Commission have been appointed to the National Safeguarding Committee.

Codes of Practice

Work has continued on the codes of practice which are being developed under the Section 103 of the 2015 Act for decision supporters and for certain categories of professionals. This work has been carried out by the National Disability Authority under contract to the Department of Justice. Under Part 8 of the Act a separate Ministerial Working Group established by the Minister of Health has continued to develop Codes of Practice in relation to Advance Healthcare Directives.

The Director and the Commission have been apprised of progress in relation to all draft codes. When they are completed, the Director will review the draft codes and a mandatory consultation period will follow before the final codes are published with the approval of both Ministers.

MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

Report of the Inspector of Mental Health Services

2017

Contents

What does the Inspector of Mental Health Services do?

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"). Inspections are carried out in approved centres to determine compliance with Mental Health Act 2001 (Approved Centres) Regulations 2006[2] ("the Regulations"), Rules[3] and Codes of Practice[4] 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).

Approved centres are hospitals or other in-patient facilities for the care and treatment of people experiencing a mental illness or mental disorder and which are registered with the Mental Health Commission.

The Inspector can inspect any other mental health facility, which is under the direction of a consultant psychiatrist.

The Inspector must also carry out a review of the mental health services in the State and give a report to the Mental Health Commission. This national review must include: (a) a report on the care and treatment given to people receiving mental health services; (b) anything that the inspector has found out about approved centres or other mental health services; (c) the degree to which approved centres are complying with codes of practice; and (d) any other matter that the Inspector considers appropriate that have arisen from the review.

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

3 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

4 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

Introduction

Mental health services need to give people the help and support they need, when they need it and where they need it and the service provided must be of high quality. To do this and to meet the expectations from the public, the mental health sector must overcome a considerable set of challenges – high demand, workforce shortages, unsuitable buildings and financial restrictions.

Mental health does not have a very high profile, in government, in the public domain or within healthcare provision. Yet mental health problems account for 13% of the burden of disease (WHO 2008). The Mental Health Commission gives an estimate of €3 billion for the cost to Ireland of poor mental health (2% of GNP)[5]. The budget for mental health is low, compared to many European countries, at approximately 6% as a proportion of the overall health budget. Stigmatisation is still a major problem, despite real efforts to address this and the fact that people are being encouraged to talk openly about their mental health and to share their experiences[6,7]. This stigmatisation is particularly true for people with severe mental illness such as schizophrenia or bipolar illness. The Mental Health Act 2001 is outdated and requires considerable changes[8]. Community mental health services, including residential care, are not regulated. There is overcrowding in some approved centres and long waiting times for many child and adolescent mental health services (CAMHS). There are serious staff shortages throughout the mental health sector. Despite this, in most mental health services, we found enthusiastic staff in all disciplines, who were motivated, professional and provided excellent care and treatment for people who experienced mental ill-health.

During our inspections, we found examples of good and excellent care. In these services, we found that staff were skilled and appropriately trained, service users were involved in planning their care, and there was a multidisciplinary approach to care.

"The best services have improved their quality of care, working in partnership with the service users, empowering their staff and looking for opportunities to improve the quality of care they give."

These outstanding mental health services – like St Patrick's Mental Health Services – provide care that is excellent. They have leaders, both at senior and ward level, who deliver person centred care and foster a multidisciplinary approach. However, we also found too much poor care, lack of a person-centred and recovery approach and far too much variation in quality and access across different services.

More than 30 years after introduction of the policy to close large institutions[9], we were concerned to find examples of outdated and sometimes institutionalised care both in approved centres and residential units. We found that these approved centres and residential units are in fact long-stay wards that institutionalise residents, rather than a step on the road back to recovery and a more independent life in the person's home community. In a number of cases we found that the HSE did not employ enough staff with the right skills to provide the high-quality, intensive rehabilitation care required to support recovery, resulting in people failing to fulfil their potential to regain control of how they live their lives.

5 *The Economics of Mental Health Care in Ireland* (2008) Mental Health Commission.

6 St Patrick's Mental Health Services. Annual Mental Health Survey 2017

7 *What is stigma? A guide to understanding mental health stigma.* See Change The National Mental Health Stigma Reduction Partnership.

8 Report of the Expert Group Review of the Mental Health Act 2001 (2015)

9 Planning for the Future 1984

Long-term care in hospitals and large 24-hour supervised residences not only results in people's isolation and institutionalisation, but is also very expensive.

Some services continue to provide over-restrictive care that is not tailored to each person's individual needs and not based on risk assessment. We are concerned about the great variation across the country in how often staff physically restrain and seclude patients whose behaviour they find challenging. This wide variation is present even between approved centres that admit the same patient group. We also found evidence of blanket restrictions such as banning mobile phones or locking bedroom doors during the day to prevent access. These practices will be scrutinised further in 2018.

The majority of staff that we encountered in mental health services cared about the people who used their services. With very few exceptions, staff were observed to have relationships with their patients that were respectful and compassionate. We were impressed by staff who work in challenging situations, in unsuitable or poorly maintained buildings and where there is insufficient staff, and still continued to treat people with kindness and respect. Where mental health staff could do better as caring professionals is by engaging patients as real partners in their care. In too many services, care plans do not reflect the service user's voice.

What did we inspect in 2017?

In 2017, we inspected all 64 approved centres. We also inspected 43 community residences that were staffed 24 hours a day.

We met with the management teams of the Child and Adolescent Mental Health Services (CAMHS) in all nine Community Healthcare Organisations (CHOs) to obtain an oversight of the State's CAMHS services. We also met with service user groups and representatives to get a perspective of mental health services from those who experience such services.

We published inspection reports for approved centres and community residences on the Mental Health Commission website during 2017.

In 2018, as in previous years, we will be only able inspect approved centres and a very small number of community residences with our current staffing levels. Most mental healthcare is provided in the community but we have not been given the staffing resources to inspect community services.

What did we find?

We found a number of issues about which we were concerned :

- The considerable variation between approved centres in how frequently staff use restrictive practices, physical restraint and seclusion to de-escalate challenging behaviour
- The impact of staffing shortages
- The lack of person-centred care in approved centres
- Poor physical environments in some approved centre
- Lack of access to Child and Adolescent Mental Health Services
- 24-hour supervised community residences that were too large, in poor condition and institutionalised

We found a number of good practices:

- Staff were observed to have relationships with their patients that were respectful and compassionate
- Some services have improved their quality of care, working in partnership with the people whose care they deliver, empowering their staff and looking for opportunities to improve the quality of care they give
- There were good examples of staff being attentive to the physical health needs of patients. In some cases, staff also actively promoted a healthy lifestyle.

Highest Compliance

Approved Centre	# non-compliant
St Patrick's Hospital	0
Willow Grove CAMHS Unit	0
St Edmundsbury Hospital	1
Creagh Suite Ballinasloe	4
Linn Dara CAMHS Unit	3
Sycamore Unit, Connolly Hospital	5
Selskar House Wexford	5
Highfield Hospital	5

Lowest Compliance

Approved Centre	# non-compliant
Department of Psychiatry Letterkenny	20
Department of Psychiatry Roscommon	19
Unit 5B Limerick	18
Teach Aisling Castlebar	16
Jonathan Swift Clinic	16
Sliabh Mis, Tralee	15
St Joseph's Intellectual Disability Service	15
Lakeview Unit, Naas	15

Approved Centres

Acute approved centres provide services for acutely unwell people whose mental health conditions are such that they cannot be treated and supported safely or effectively at home. As bed numbers have reduced and the threshold for admission has increased, only those people who need intensive treatment and care are admitted to hospital. Other approved centres are long-stay units where patients[10] spend considerable time, years in many cases.

We found that there was a wide variation in compliance with Regulations, Rules and Codes of Practice across approved centres. We saw an improvement in national compliance of approved centres with regulation; up 2% from 2016. We also note an increase in the quality rating of excellent; up 5% since 2016.

Some services performed particularly well with five or less non-compliances with Regulations, Rules and Codes of Practice.

In addition, services that needed to improve had made real progress where they have taken on board our findings, provided corrective and preventative action plans and committed to tackle problems proactively and learn from other services.

However, there are a substantial number of approved centres that need to improve the quality of care they provide. There were a number of approved centres that had 15 or more non-compliances. These approved centres have struggled to improve compliance levels over a number of years.

A full breakdown of all approved centres, including 2016 and 2017 compliance ratings, is available in Appendix 2.

Restrictive practices

Restrictive practices include seclusion, mechanical restraint and physical restraint. These are highly regulated. However, there are subtler forms of restrictive practices that we encountered as we inspected approved centres.

Blanket restrictions are ward 'rules' that are applied to every patient on a ward and are not justified on the basis of an assessment of the risk posed to or by each individual patient. These might include blanket bans on the use of mobile phones or the practice of searching all patients on return from leave, including those who pose no realistic risk of bringing banned items onto the ward. Such practices can contravene the 'least restriction' principle and potentially result in a greater likelihood of aggressive behaviour.

10 For the purpose of this reports patients include both voluntary and involuntary patients

Among some of the restrictive practices we found were:

- Locked entrance and exit door to the unit
- Locked bedrooms and ensuite toilets
- Having to stay in a certain area of the unit
- No access to an outside space
- Limited access to the patient's own mobile phone
- No keys to their own bedrooms
- No keys to wardrobes
- No access to make a cup of tea, coffee or snack
- Searching patients' property on return from leave

Across all mental health services, we found great variation between approved centres in how frequently staff use seclusion and physical restraint to manage challenging behaviour. We noted that in those approved centres where the level of restraint is low or where they have reduced it over time, staff have been trained in the specialised skills required to anticipate and de-escalate behaviours or situations that might lead to aggression or self-harm.

Seclusion

We have particular concerns about the frequency of use and the length of time that people spend in seclusion in approved centres.

When a patient is confined in a room or area against their will and is physically prevented from leaving, usually by a locked door, this is termed seclusion. According to the Rules Governing the Use of Seclusion, seclusion is only meant to be used as a last resort:

Seclusion is used in rare and exceptional circumstances and only in the best interests of the patient when he or she poses an immediate threat of serious harm to self or others. Services must be able to demonstrate that they are attempting to reduce the use of seclusion. This includes considering all other interventions to manage a patient's unsafe behaviour before deciding to use seclusion.

A seclusion room is bare apart from a special mattress. Heat, light and ventilation are controlled from outside the room and communication is through an intercom system. Patients in seclusion are regularly checked by nursing and medical staff. Patients, male and female, are sometimes dressed in "refractive clothing", which is a dress made of safety material and which compromises patients' dignity. Medical and nursing staff must fill a register outlining the duration and circumstances of the seclusion episode and this, along with seclusion records and clinical files, is inspected by the inspection team to ensure that the approved centre is complying with legal requirements.

12% compliance with the rules on seclusion

> We have particular concerns about the frequency of use and the length of time that people spend in seclusion in approved centres.

Some, but not all, nursing staff in approved centres, are trained in management of aggression and violence, which should reduce the need for seclusion and other restrictive practices. Lack of this appropriate and mandatory training is likely to contribute to the risk of a patient being secluded.

Twenty-seven approved centres used seclusion in 2017.

Thirty percent of approved centres catering for acutely ill patients do not have seclusion facilities and have not sought to provide them. We continue to question: Why do some acute mental health facilities use seclusion, often for lengthy periods, while others can manage distress, agitation, aggression by other means that are more respectful of human rights?

Reasons for not using seclusion may include better leadership, higher staffing levels, more staff training, more reliance on emergency medication, more use of physical restraint or use of alternative strategies in dealing with violent and aggressive behaviour.

In 2017, 22 (88%) approved centres which used seclusion, did not comply with the Rules Governing the Use of Seclusion. The reasons were varied. In some, the seclusion room was unsafe, dirty or lacked privacy for the patient in seclusion. This had been highlighted in previous inspections and no improvement had been made. In others, the seclusion register was incorrectly completed. In one case, the CCTV image of the person in seclusion could be seen by the public outside the approved centre.

The use of seclusion in psychiatric in-patient units is controversial. It is, to all intents and purposes, solitary confinement for someone who is severely mentally ill, often distressed, aggressive and agitated. The reason for using seclusion should be to maintain the safety of everyone in the treatment environment and for no other reason. Seclusion is not a treatment in itself, and is often counter-therapeutic. During seclusion, the patient has no social interaction apart from nursing and medical staff doing checks and he or she is constantly observed. There are no therapies and no recreational activities. Seclusion can be seen as a negative experience by patients. It can also damage therapeutic relationships, re-traumatise people who have a history of trauma or abuse, it can cause fear and it causes loss of dignity. Isolation can worsen psychiatric symptoms, such as hallucinations, anxiety, paranoia and depression.

The decision to use seclusion should only be made where the balance between the potential risks of seclusion is weighed against the risks to the patient and/or others if the patient had not been secluded and all other alternatives have been exhausted. Therefore, there must be robust assessment of risks, which must take into account all available information.

Seclusion should only be used for the shortest time possible. The Rules Governing the Use of Seclusion state that: *Seclusion is not prolonged beyond the period which is strictly necessary to prevent immediate and serious harm to the patient or others.* Approved centres must inform us if seclusion is extended beyond 72 hours or where there are seven consecutive seclusion episodes in seven days.

Long duration and high frequency seclusion

- There were 47 notifications of seclusion exceeding 72 hours
- There were 22 notifications of where a patient was secluded seven times in seven days.

We noted a decrease in frequency and duration of seclusion in one service: The Department of Psychiatry, Portlaoise, which was previously amongst the highest users of seclusion. This shows that focused and persistent efforts alongside strong leadership can be effective in reducing the use of seclusion

It is clear, from a human rights perspective, that restraint and seclusion are safety interventions of last resort, should be carried out within a legal framework and should only be used for the shortest time possible. The use of these interventions can and should be reduced significantly. The Mental Health Commission, in 2014, developed a strategy for reduction of seclusion and restraint[11]. We found very little evidence that there were action plans to reduce the use of seclusion.

11 *Seclusion and Restraint Reduction Strategy.* Mental Health Commission December 2014

Physical restraint

Physical restraint is where there is direct physical contact by healthcare staff where the intention is to prevent or restrict movement of the body (or part of the body) of another person. It should only be used when that person poses an immediate threat of serious harm to self or other. Physical restraint should be used only when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.

In all circumstances, the least restrictive restraint that is effective should be used and restraints should never be used for the sake of convenience. It is essential that healthcare workers understand and follow proper protocol and procedures when restraining a patient to ensure safety and dignity of the patient and that they are adequately trained in restraint techniques as well as negotiation and de-escalation. For a service user in an approved centre, being physically restrained by staff is humiliating and distressing, but it also entails the risk of physical injury or even death.

In 2017, 41 (69%) approved centres which used physical restraint were non-compliant with the Code of Practice on Physical Restraint. Reasons for non-compliance included incorrect completion of the clinical practice form, policy deficits, and, of greater concern, failure to physically examine the patient after an episode of physical restraint. Lack of training in prevention and management of violence and aggression is still a concern where healthcare staff untrained in safe restraint techniques are restraining patients. However, there is evidence that much has been done in this area to ensure that relevant staff have appropriate training.

As in 2016, I draw attention to the fact that the Mental Health Act 2001 does not allow for the making of Rules for physical restraint, with the result that there cannot be enforcement if there is non-adherence to the Code of Practice on Physical Restraint. Protection for service users during physical restraint would be increased if there was a statutory basis for governing physical restraint.

"All approved centres where restrictive interventions are used should have in place a restrictive intervention reduction programme which can reduce the incidence of violence and aggression and ensure that alternatives to restrictive interventions are used."

Such programmes should be planned in the context of robust governance arrangements, a clear understanding of the legal context for restrictive interventions, including human rights principles, and effective training for staff.

41 approved centres used physical restraint in 2017

31% compliance with physical restraint

This represents a **9% increase** from 2016

25%

compliance with premises

This represents a **9% decrease** from 2016

Physical Environment

Increasingly, admission wards and psychiatric intensive care units (PICUs) are high-risk environments. Some acute and one PICU unit are in buildings that were not designed to meet the needs of such a patient group. They often have fixtures and fittings that are potential ligature anchor points for patients at risk of suicide, and their layout means that nurses cannot easily observe all areas. There was evidence that most services were addressing these, but in a significant number of approved centres, these ligature anchor points remained.

Some approved centres cannot be modified to eliminate all these features. This makes it even more important that staff assess and actively manage and mitigate risks in the ward environment. This was sometimes not the case. An example is one independent acute service where senior staff had inadequate knowledge of ligature risks and were unable to identify them appropriately.

A number of approved centres have been built in the last few years and have a high standard of accommodation, with ample space, single bedrooms, adequate therapy space and have minimised ligature anchor points. These include Drogheda Department of Psychiatry, Phoenix Care Centre and Acute Mental Health Unit Cork University Hospital. However, a number of inpatient facilities were not designed to meet the needs of the group of patients that are admitted to approved centres. We identified a number of approved centres that had dormitory accommodation. In the 21st century, service users, many of whom have not agreed to admission, should not be expected to share sleeping accommodation with strangers – some of whom might be agitated and distressed. This arrangement does not support people's privacy or dignity.

"A disturbingly high number of approved centres were dirty, with associated implications for infection control."

These included approved centres with dirty bathrooms, stained fixtures, cigarette butts littering garden spaces and dirty windows. In a number of approved centres, the inspectors requested an immediate deep clean of areas to reduce the risk of infection. Many more were in urgent need of maintenance and repair: peeling paint, damaged plaster, dampness, mould, foul smelling toilets and bathrooms. There was little evidence of routine and regular maintenance, resulting in units that had become worn and shabby.

Five approved centres had no or extremely limited access to an outside space, either because there was none or because the access to it was locked. This meant that the people in these approved centre had little access to fresh air or exercise.

In the Department of Psychiatry in Roscommon, there was a 15 minute access to a very small caged area every hour and non-smokers had to share this with smokers. Other approved centres, especially the newer ones, had suitable and well-tended gardens and courtyards.

A number of approved centres, were completely unsuitable and not fit for purpose. This included Blackwater House in Monaghan, the Acute Mental Health Unit in Sligo, St Otteran's Hospital in Waterford, Teach Aisling in Mayo, Vergemount Mental Health Facility, and Jonathan Swift Clinic in St James's Hospital.

Staffing

"Most approved centres struggled to ensure that they were staffed safely and adequately at all times."

There is national shortage of mental health nurses and this was evident in most approved centres. The shortage is greater in some parts of the country than others. The resulting negative effect on morale can create a cycle of increasing sickness and staff turnover that can be difficult to break. Many provider agency staff to fill vacancies and absences. This can work well, provided the nurses who are filling in know the patients, their nursing colleagues and the unit routine.

If not, patients' experience and continuity of care can be affected, as a number of residents in approved centres told us. In the worst cases, it could affect safety – particularly on units where safety was already compromised by a poor physical environment.

There were few mental health teams where there was a full complement of multidisciplinary staff as outlined in *A Vision for Change*. Occupational therapists, psychologists and social workers were often shared across teams. Maternity leave was not covered and vacancies were unfilled. All this affects the access of people with mental illness to appropriate therapies and increases the reliance on a medical model of care. There is some realisation of the importance of occupational therapy in approved centres and we saw a significant number of approved centres where there was a dedicated occupational therapist. Others had no input from an occupational therapist, which added to isolation, institutionalisation, boredom and challenging behaviour, particularly where people where in approved centres for long periods of time.

The number of staff trained in mandatory training (fire safety, Basic Life Support, prevention and management of aggression and violence, and the Mental Health Act) has increased, although there is still some way to go. Again, lack of staffing resources causes difficulty in releasing staff for training.

Person-centred care

In person-centred care, multidisciplinary professionals work collaboratively with people who use services. Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care. It is coordinated and tailored to the needs of the individual. Crucially, it ensures that people are always treated with dignity, compassion and respect.[12]

This might seem a common sense vision for any form of health care, but it is not standard practice. Often, health care does 'to' or 'for' people rather than 'with' them, finds it difficult to include people in decisions, and views people's goals only in terms of particular clinical outcomes.

People with mental illness, like all other ill people, want to have a say in how they are treated and what they would like to happen.

"We found a disturbing absence of person-centred care in many approved centres and a marked lack of recovery based treatment."

12 *Person-centred care made simple,* October 2014, Health Foundation.

The basis for person-centred care is the individual care plan, which all people in approved centres must have under the Regulations. Individual care plans should be developed by the multidisciplinary team and the person with mental illness together. The goals should be relevant to the person, meaningful, reflect recovery aims, be achievable and resources made available to achieve the person's goals.

We found that too many individual care plans that did not meet these standards. There was an increase of compliance of 14% since 2016 in individual care plans, which showed that some services were working hard to achieve compliance. However, we noted that, while some approved centres were technically compliant by meeting the requirement of regulation, the individual care plans in these approved centres were not always person-centred or recovery based.

Blanket restrictions, outlined above, where all mobile phones are taken away from people in approved centres; where there is no access for anyone to the sleeping area or bedroom during the day; where all residents in an approved centre are locked into specific areas; where there is no access for anyone to an outside space; where people cannot avail of water, tea of coffee when they wish, are not person-centred and respectful. They are, in fact, a breach of human rights.

Twenty-nine (45%) of approved centres were non-compliant with the Regulation on Privacy. In most cases, there was little awareness among staff and management that this was a breach of human rights or that it was disrespectful to residents. The fact of not being able to undress in private, or go to the toilet in private or have privacy in a shared bedroom in some approved centres, is unacceptable. In some cases, names, dates of admission, legal status and other information about residents was clearly displayed on a board and visible to the public.

Physical care

"We had concerns about physical care of people in some approved centres: lack of access to services such as speech and language assessments and therapy, physiotherapy and occupational therapy."

In one approved centre, people had no access to speech and language, physiotherapy, occupational therapy, social work, psychology or even a consultant psychiatrist. This was despite an urgent need for these therapies and staff. Staff in some approved centres consistently failed to ensure that patients had physical health checks, or to record this. Some showed poor general monitoring of physical health including for patients with long-term conditions.

Overall, compliance in the Regulation on Physical Health decreased by 3% from 2016. On the other hand, we have seen good examples of staff being attentive to the physical health needs of patients, such as carrying out regular physical health checks and organising GP services to provide primary care services for residents. In some cases, staff also actively promoted a healthy lifestyle; for example, by giving nutritional advice, facilitating national screening programmes and smoking cessation. However, this was not always the case.

Child and Adolescent Mental Health Services

Eight percent of Irish children have a moderate to severe mental health difficulty, and 2% of children at any point in time will require specialist mental health intervention.[13] Child and Adolescent Mental Health Services (CAMHS) provide assessment, care and treatment, both in hospital and in the community, for children and young people with severe mental illness. Increasingly, CAMHS has had to provide services for mild and moderate mental distress due to the lack of primary care psychology services.

CAMHS in-patient units

In Ireland, there are four public in-patient CAMHS units with a total of 76 registered beds, although some of these may not be operational at any given time. Staffing shortages have periodically closed in-patient CAMHS beds. On occasion, complex needs of some young people have necessitated the closure of some beds to care for these young people in a safe setting.

The Adolescent In-patient Unit in St Vincent's Hospital in Fairview is funded by the HSE for 12 beds but only provided 8 beds until December 2017, when the bed complement increased to 10. In order to increase access to HSE in-patient CAMHS beds, there is a telephone conference once a week to prioritise children and young people who require in-patient services and to map vacant beds in the system. Young people cared for in adult mental health units are deemed high priority.

There are 26 private CAMHS beds, Willow Grove in St Patrick's Mental Health Service and Ginesa Suite in St John of God Hospital. Both are national services. The HSE fund these two services to provide beds when there are no vacant beds in the HSE. St Patrick's Mental Health Services also have a CAMHS outpatient clinic in Lucan and Cork.

The admission of children to adult mental health units increased in 2017. Since 2012, there has been an 23% decrease in numbers.

Table 3 Number of admissions of children to adult units 2012-2017

2012	2013	2014	2015	2016	2017
106	98	90	95	68	82

Concerns about CAMHS in-patient units in 2017

- **Young people often had to be admitted to CAMHS units at considerable distances from their homes and families. This can make it difficult for them to maintain close contact with their families and for families to participate in treatment.**

  For example, from Letterkenny to the nearest CAMHS in-patient unit in Galway, is a round trip of 500 km.

- **Three of the five CAMHS approved centres used seclusion.**
- **It was often difficult for referral agencies to source a bed in CAMHS units even when beds were empty.**
- **The process of sourcing a bed, especially in an emergency situation was frustrating, time-consuming and often resulted in a young person being admitted to an adult mental health unit.**

13 Irish College of Psychiatrists; 2005: *A Better Future Now: Position Statement on Psychiatric Services for Children and Adolescents in Ireland.*

Fig. 11 Number of children admitted to adult units in 2017 by CHO

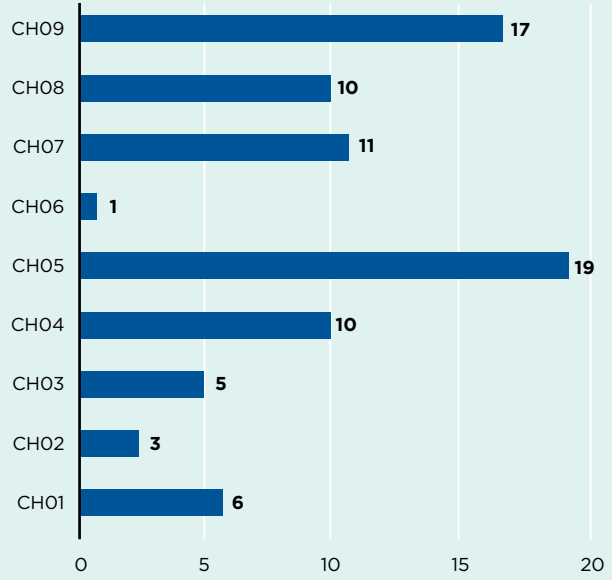
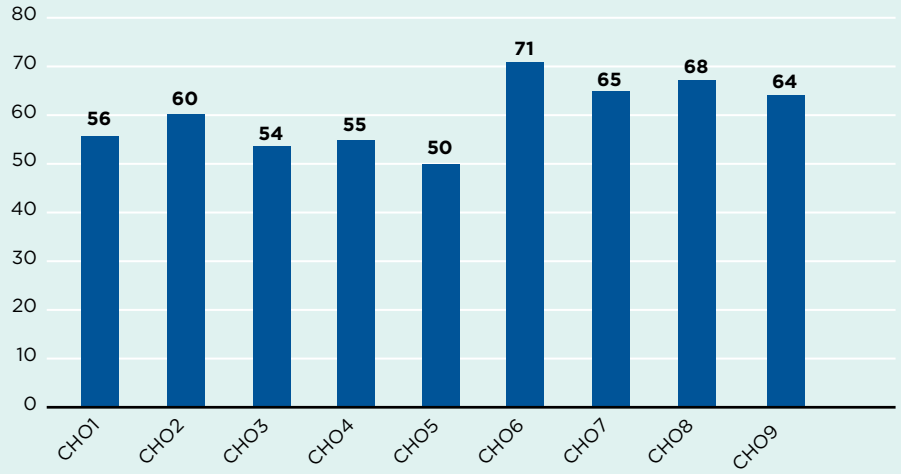


Fig. 12 Staffing of CAMHS teams as % of A Vision for Change recommendations by CHO



Eleven children were treated abroad during 2017, because of lack of appropriate services in Ireland.

Community CAMHS

We found community CAMHS teams inadequately staffed. A Vision for Change gives recommendations for adequately staffed community CAMHS teams.

Overall, staffing of CAMHS teams is only 60% of that recommended by A Vision for Change.

CHOs were requested to provide information on funding for CAMHS services in their areas.

Funding per capita for young people under the age of 18 varies considerably across CHO, from €40 in CHO 5 to €92 in CHO2.

With approximately **2,400** children and young people with mental health disorders on the waiting list for CAMHS in 2017, over **200** were waiting for more than a year. We enquired into waiting times for CAMHS appointments in each CHO.

Overall, the CHOs reported that most emergency cases were assessed within 72 hours and urgent cases within 2 weeks. CHO2 had no waiting list, while children and young people in CHO 8 could wait for up to 15 months for their initial assessment.

"Waiting times for non-urgent cases varied between 3 months to 15 months depending on CHO."

In CHOs 3, not all young people aged 17 were accepted for community treatment by CAMHS and their clinical care was provided by the adult mental health services. An audit carried out by the HSE in May 2017 showed that 93.8% of CAMHS teams were seeing 16 year olds and 78.1% were seeing 17 year olds. Twenty-two percent of CAMHS did not accept 16 or 17 year olds to their service.

The provision of emergency cover was varied across the CHOs and within the CHOs. Seventy percent of CAMHS teams provide an out-of-hours service. CHOs 6, 7, 8 and 9 did not provide an out-of-hours service to all Emergency Departments in general hospitals in their area. This resulted in a young person being assessed and treated by an adult mental health team, with no access to CAMHS until office hours resumed.

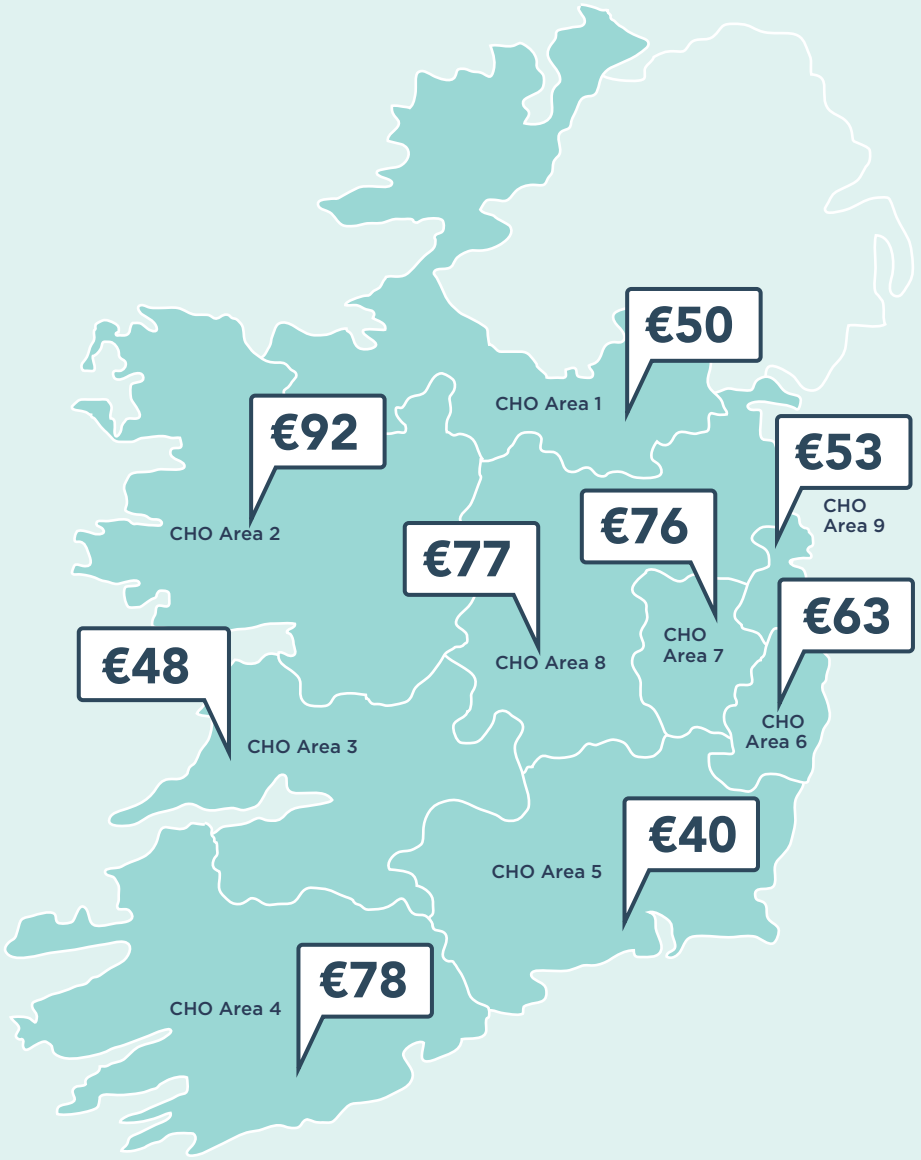


Fig. 13 Funding per capita for young people under the age of 18 by CHO

CAMHS should be available for children and young adults with severe mental illness. Mild and moderate mental distress should be assessed and treated in primary care. However, there is considerable staffing deficit in primary care psychologists. There are plans to recruit primary care psychologists in 2018.

The absence of adequate services for children and young people with an intellectual disability or Autistic Spectrum Disorder (ASD) has meant that children with these difficulties are referred to CAMHS. This all adds to the lengthy waiting times for children and young people with severe mental illness. Investment in primary care psychology and family counselling, intellectual disability services and ASD services would undoubtedly have a positive effect on waiting lists for CAMHS.

Jigsaw, a primary care service for young people with mental health difficulties

Jigsaw, the National Centre for Youth Mental Health provides a primary care service for young people from 12 to 25 years. It receives 94% of its funding from the HSE to provide this service. Donations and fundraising provides 6% of funding. Ninety- four percent of expenditure is in service development. They have 13 sites nationwide and provide brief intervention and support for young people with mild to moderate mental health difficulties.

Staffing is multidisciplinary with psychology, social work, occupational therapy and nursing. Young people are referred by GPs, CAMHS and through self-referral. Waiting times for appointments is 2-3 weeks. For young people with more severe mental health difficulties, Jigsaw refer to CAMHS specialist services, notifying the young person's GP of the referral. Although the HSE Standard Operating Procedure states that Jigsaw can make direct referrals to CAMHS, some CAMHS do not accept these referrals, instead insisting that the young person go to their GP for a referral. This causes delays and puts another step in the process that is already difficult for the young person and their family.

Education and information is provided by Jigsaw to schools, GPs and CAMHS. The organisation also hold Youth Mental Health Workshops and also train young people to become Peer Educators in schools. Each local Jigsaw service has a Youth Advisory Panel.

Jigsaw provide a much needed primary care service for young people with mild to moderate mental health difficulties. It has easy and acceptable access to its services for both young people and their families. There is excellent involvement by young people in the organisation. It is disappointing that some CAMHS services refuse to accept referrals from Jigsaw, which runs counter to a seamless and person-centred pathway for young people with mental health difficulties.

Developments in CAMHS

There is an awareness in the HSE that CAMHS provision has sometimes fallen short of best standards. A number of initiatives are in progress to try to address some of these deficits:

- There is a Standard Operating Procedure in CAMHS that was developed in 2015, and this is currently being reviewed by a CAMHS review group, which includes service users and families.
- Clinical Directors in CAMHS will be appointed to all CHOs in 2018. There will also be a lead nurse, health and social care professional and lead manager as part of the governance structure.
- There is now a joint protocol between mental health services and Tusla. This includes quarterly meetings for discussion of contentious cases. Referrals to Tusla had been identified as problematic in some CHOs.
- There will twenty extra CAMHS in-patient beds in the new Children's Hospital. Eight beds will be for young people with eating disorders. There will also be 10 CAMHS Forensic beds in the Central Mental Hospital in Portrane. By 2022, there will be 106 CAMHS in-patient beds.
- Advocacy services for young people in CAMHS are being developed. Willow Grove and Ginesa Suite already provide an advocacy service. The HSE will be piloting an advocacy service in the CAMHS in-patient unit in Galway in 2018.
- There will be recruitment of primary care psychologists in 2018.

24-hour nurse supervised residences

The process of "deinstitutionalization" over recent decades in Ireland has led to developing supported accommodation services to enable people with mental health problems to live in the community rather than hospital. A range of accommodation has been developed, including facilities that are staffed 24 hours a day, as well as residences that are less intensively staffed, shared group homes and Outreach, where staff who are based off-site visit service users in their own individual or shared homes, providing support of flexible intensity. As well as facilitating service users who had been long-stay patients in psychiatric hospitals, 24-hour supervised residences now also accommodate people who have been discharged from both long-stay and acute mental health care services.

Ideally, there should be a "care pathway", where people move from hospital to highly supported accommodation, graduating to more independent settings as they gain skills and confidence. However, at present, there is a serious lack of lack of provision of suitable accommodation options and rehabilitation and recovery staff to enable service users to move through the different stages of recovery and progress towards the goal of independent community based living. Many people have to remain in highly supported accommodation.

Concerns about a lack of rehabilitative ethos in the community residences have led to assertions that mental health services have undergone a process of "trans-institutionalization" rather than deinstitutionalization[14]. The number of places in supervised and supported housing, in most, but not all, of European countries is increasing, showing an ongoing although not consistent trend, toward increasing provision of institutionalized mental health care across Europe[15].

Of particular concern are the 24-hour nurse supervised residences. *A Vision for Change* in 2006 outlines a requirement of approximately 30 places per 100,000 population and that these residences should have a maximum of ten places to foster a non-institutional environment. It was anticipated that once the housing needs of the cohort of former long stay hospital service users has been catered for, the requirement for the current level of 24 hour high support accommodation will decrease.

118 24-hour supervised residences

Over **1300** beds

> "It is concerning that some of our most vulnerable citizens, many of whom have spent decades in psychiatric hospitals, are now being accommodated in unregulated, poorly maintained residences, that are too big, are institutionalised, in some cases restrictive, and are not respectful of their privacy, dignity and autonomy."

14 Helen Killaspy. Supported accommodation for people with mental health problems. World Psychiatry. 2016 Feb; 15(1): 74–75.)

15 Mental health care institutions in nine European countries, 2002 to 2006. Priebe S, Frottier P, Gaddini A, Kilian R, Lauber C, Martínez-Leal R, Munk-Jørgensen P, Walsh D, Wiersma D, Wright D. Psychiatr Serv. 2008 May;59(5):570

The HSE in its Guidance Document *Addressing the Housing Needs of People Using Mental Health Services* in 2012 stated that "as community based secondary mental health services develop, the need for the current accommodation resources in mental health services (such as high, medium and low support community residences and group homes) should diminish. These resources should then become available to the rehabilitation and recovery team". However, it would appear that rehabilitation and recovery services have to increase *before* people can move to less supported accommodation, in order to provide the necessary skills to enable people to move to more independent living.

Unfortunately, the number of 24-hour supervised residences has not significantly decreased. In 2005, there were 127 24-hour supervised residences[16]. In 2017, 12 years later, 118 24-hour supervised residences remained. While the number of rehabilitation teams has (insufficiently) increased, it has little or no impact in the overall number of high support residential facilities.

As we had failed for 2015 and 2016 to get an accurate list centrally from the HSE, we sought information from each CHO individually in 2017. Again, when we came to inspect 24-hour residences in 2017, this information was inaccurate. The operational plan for the mental health services 2017 from the HSE has inaccurate information about numbers of 24-hour supervised residences, which are termed High Support Hostels in the plan.

Lack of basic information about number of residences and number of people in these residences results in inability to plan. There can obviously be no clear strategy for appropriate placement, rehabilitation and future care for people other than to let them stay indefinitely in what are mostly large institutionalised residences with little prospect of improving their situation or partaking of a recovery process. This is almost entirely due to lack of planning, lack of appropriate accommodation and inadequate rehabilitation services.

Given the difficulty in obtaining accurate figures from the HSE, there appeared to be 118 24-hour supervised residences in the mental health services with over 1,300 beds. All the people resident in these residences have enduring mental illness or intellectual disability. They are a vulnerable group of people who are at risk of abuse. They often have severe, complex mental health problems, such as schizophrenia, with associated cognitive difficulties that impair their organizational skills, motivation and ability to manage activities of daily living. The support they need to live successfully in the community is mainly of a practical nature, including assistance to manage their medication, personal care, laundry, shopping, cooking and cleaning. Most residents are unemployed, socially isolated, and many do not participate in civil and political processes. The residences are not regulated, which is a serious deficiency, leading to the risk of abuse and substandard living conditions and treatment.

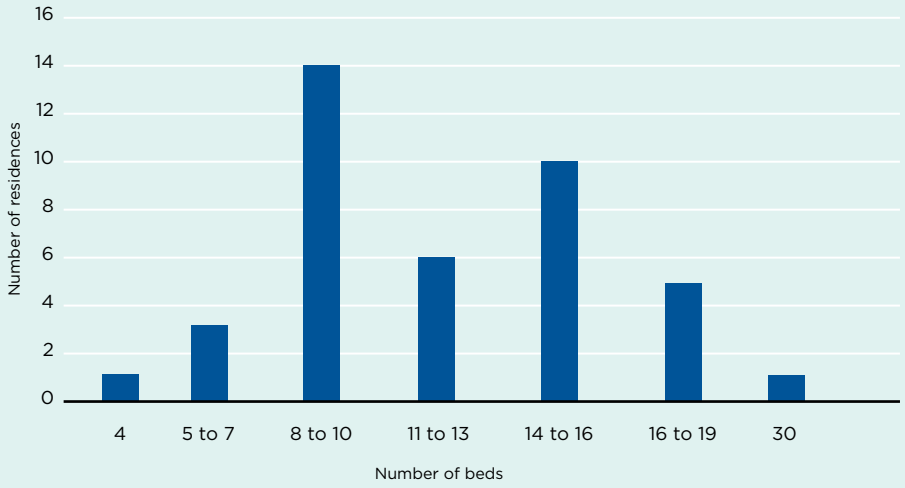
In 2017, we inspected 43 24-hour supervised residences. This was the first year of a rolling 3-year programme of inspection of all 24-hour supervised residences. This cohort of residences showed that the majority (58%) had more than 10 beds, the maximum number of beds recommended in *A Vision for Change*. The HSE's own 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 a total of four residents.[17]

We found that 58% of residences had more than 10 beds.

16 Annual Report of the Inspector of Mental Health Services 2005. Mental Health Commission

17 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

Fig. 14 Number of beds in 24-hour supervised residences



Spotlight on 24-hour nurse supervised residences

- Only **59%** of residences offered all residents single room accommodation and two residences had 4-person bedrooms.
- In residences with shared rooms, **58%** had no privacy between beds or within the bedrooms.
- Only **44%** of residences were in good physical condition and **19%** required urgent maintenance and refurbishment.
- A rehabilitation team provided services for **51%** of residences. In these residences it was more likely that the residents would have a multidisciplinary care plan in which they had involvement.
- Residents were not free to leave in **14%** of residences, which had locked doors.
- There was no access to a kitchen to make tea, coffee or snacks in **44%**.
- Residents were unable to lock their bedroom doors in **77%** of residences.
- Some residents partook of community activities and there was evidence of social inclusion in **67%**.

Conclusion

There is much to be concerned about in the national mental health services. There is lack of adequate budgets to staff mental health teams to provide basic mental health care, buildings that are run-down or not fit for purpose, tolerance of continued institutionalisation of vulnerable people with mental illness, long waiting times for assessment and treatment for young people in CAMHS.

As Inspector of Mental Health Services, I am duty-bound to report the problems that we have found on our inspections and in the national mental health services, and we will continue to report whenever we encounter poor care.

However, it is important not to lose sight of the very many positive messages in our reports. We have shown that mental health services can improve, despite the considerable pressures they face. We have seen the enthusiasm and professionalism of staff, in what are sometimes difficult and challenging circumstances. We have seen managers working hard to provide quality services where there are financial restrictions and recruitment difficulties. We have also seen an improvement in regulation compliance of approved centres nationally.

The importance of person-centred care cannot be over-stated. Person-centred care is a way of thinking and doing things so that people using mental health services are equal partners in planning, developing and monitoring care to make sure it meets their needs. It is about considering people's wishes, values, family and social circumstances and lifestyles, seeing the person as an individual, and working together to develop appropriate solutions to their needs. This involves working with people and their families to find the best way to provide their care. It is about doing things with people, rather than 'to' them.

We would like to see more involvement of service users in their care, more respect for privacy, dignity and autonomy of service users, less restrictive practices in caring for service users and better maintained and cleaner buildings in which service users reside. Making sure that people are involved in and central to their care is now recognised as a key component of developing high quality mental healthcare.

Dr Susan Finnerty MCRN: 009711
Inspector of Mental Health Services

Appendices

Appendix 1: Approved Centres by Region and Bed Number

Area / Sector	Geographical Location	Bed Number*	Approved Centre [name as registered]
CHO Area 1	Cavan, Donegal, Leitrim, Monaghan and Sligo	25	Acute Psychiatric Unit, Cavan General Hospital
		34	Department of Psychiatry, Letterkenny University Hospital
		20	Rehab and Recovery Mental Health Unit, St John's Hospital Campus
		32	Sligo/Leitrim Mental Health In-patient Unit
		20	St Davnet's Hospital - Blackwater House
CHO Area 2	Galway, Mayo and Roscommon	32	Adult Mental Health Unit, Mayo University Hospital
		22	An Coillín
		22	Department of Psychiatry, Roscommon University Hospital
		45	Department of Psychiatry, University Hospital Galway
		12	St Anne's Unit, Sacred Heart Hospital
		14	Creagh Suite, St Brigid's Healthcare Campus
		10	Teach Aisling
		21	Wood View
CHO Area 3	Clare, Limerick and North Tipperary	42	Acute Psychiatric Unit 5B, University Hospital Limerick
		39	Acute Psychiatric Unit, Ennis Hospital
		32	Cappahard Lodge
		15	Tearmann Ward, St Camillus' Hospital

Area / Sector	Geographical Location	Bed Number*	Approved Centre [name as registered]
CHO Area 4	Cork and Kerry	50	Acute Mental Health Unit, Cork University Hospital
		18	Carraig Mór Centre
		18	Centre for Mental Health Care and Recovery, Bantry General Hospital
		40	Deer Lodge
		29	Owenacurra Centre
		34	Sliabh Mis Mental Health Admission Unit, University Hospital Kerry
		21	St Catherine's Ward, St Finbarr's Hospital
		50	St Michael's Unit, Mercy University Hospital
		93	Units 2, 3, 4, 5, and Unit 8 (Floor 2), St Stephen's Hospital
CHO Area 5	Carlow, Kilkenny, South Tipperary, Waterford and Wexford	44	Department of Psychiatry, St Luke's Hospital
		44	Department of Psychiatry, University Hospital Waterford
		40	Grangemore Ward & St Aidan's Ward, St Otteran's Hospital
		40	Haywood Lodge
		20	Selskar House, Farnogue Residential Healthcare Unit
		20	St Gabriel's Ward, St Canice's Hospital
CHO Area 6	Dun Laoghaire, Dublin South East and Wicklow	52	Avonmore and Glencree Units, Newcastle Hospital
		39	Elm Mount Unit, St Vincent's University Hospital
		52	Le Brun House & Whitethorn House, Vergemount Mental Health Facility
CHO Area 7	Dublin South City, Dublin South West, Dublin West, Kildare and West Wicklow	52	Acute Psychiatric Unit, Tallaght Hospital
		51	Jonathan Swift Clinic
		29	Lakeview Unit, Naas General Hospital
CHO Area 8	Laois, Longford, Louth, Meath, Offaly and Westmeath	44	Admission Unit and St Edna's Unit, St Loman's Hospital
		46	Department of Psychiatry, Midland Regional Hospital, Portlaoise
		46	Drogheda Department of Psychiatry
		30	Maryborough Centre, St Fintan's Hospital
		42	St Bridget's Ward & St Marie Goretti's Ward, Cluain Lir Care Centre, St Mary's Campus
		20	St Ita's Ward, St Brigid's Hospital

Area / Sector	Geographical Location	Bed Number*	Approved Centre [name as registered]
CHO Area 9	Dublin North City and County	44	Ashlin Centre
		47	Department of Psychiatry, Connolly Hospital
		25	O'Casey Rooms, Fairview Community Unit
		54	Phoenix Care Centre
		15	St Aloysius Ward, Mater Misericordiae University Hospital
		45	St Vincent's Hospital
		25	Sycamore Unit, Connolly Hospital
Independent Service Provider	All located in Dublin	114	Bloomfield Hospital
		110	Highfield Hospital
		7	Lois Bridges
		52	St Edmundsbury Hospital
		183	St John of God Hospital
		241	St Patrick's University Hospital
CAMHS	Dublin, Galway and Cork	10	Adolescent In-patient Unit, St Vincent's Hospital, Dublin
		20	Child and Adolescent Mental Health In-patient Unit, Merlin Park University Hospital, Galway
		20	Eist Linn Child and Adolescent In-patient Unit, Cork
		24	Linn Dara Child and Adolescent Mental Health In-patient Unit, Cherry Orchard Hospital Campus
		14	Willow Grove Adolescent Unit, St Patrick's University Hospital, Dublin
National Specialist Services	All located in Dublin	103	Central Mental Hospital – National Forensic Mental Health Service
		124	St Joseph's Intellectual Disability Service, St Ita's Hospital

Notes: *Bed numbers: registered beds as at 31 December 2017. CHO = Community Health Organisation, Health Service Executive. CAMHS = Child and Adolescent Mental Health Service.

Appendix 2: Approved Centres Ranked by Compliance with Regulations

Over half of all Approved Centres demonstrated an increase in percentage compliance from 2016 to 27 (54%). The Acute Psychiatric Unit, Ennis Hospital (CHO Area 3) displayed the highest percentage increase across all Approved Centres (+24%). 48% of Approved Centres achieved percentage compliance above the national average (76%).

Increase in % compliance 2016-2017
Decrease in % compliance 2016-2017
No change in % compliance 2016-2017

Rank	Approved Centre	Sector	2017 % Compliance	2016 % Compliance
1	St Patrick's University Hospital	Independent	100	90
1	Willow Grove Adolescent Unit, St Patrick's University Hospital	CAMHS	100	93
2	Linn Dara Child and Adolescent Mental Health In-patient Unit	CAMHS	97	80
3	St Edmundsbury Hospital	Independent	96	100
4	Creagh Suite, St Brigid's Healthcare Campus	CHO Area 2	93	82
4	Selskar House, Farnogue Residential Healthcare Unit	CHO Area 5	93	93
5	Acute Psychiatric Unit, Ennis Hospital	CHO Area 3	90	63
5	Department of Psychiatry, Midland Regional Hospital, Portlaoise	CHO Area 8	90	83
5	Sycamore Unit, Connolly Hospital	CHO Area 9	90	82
6	An Coillín	CHO Area 2	89	86
7	Centre for Mental Health Care and Recovery, Bantry General Hospital	CHO Area 4	87	80
7	Eist Linn Child and Adolescent In-patient Unit	CAMHS	87	90
8	St Anne's Unit, Sacred Heart Hospital	CHO Area 2	86	93
8	St Bridget's Ward and St Marie Goretti's Ward, Cluain Lir Care Centre	CHO Area 8	86	86
8	Highfield Hospital	Independent	86	69
9	Ashlin Centre	CHO Area 9	84	77
9	St John of God Hospital	Independent	84	87
10	Acute Psychiatric Unit, Cavan General Hospital	CHO Area 1	83	67

Rank	Approved Centre	Sector	2017 % Compliance	2016 % Compliance
10	Adult Mental Health Unit, Mayo University Hospital	CHO Area 2	83	80
10	O'Casey Rooms, Fairview Community Unit	CHO Area 9	83	76
11	Tearmann Ward, St Camillus' Hospital	CHO Area 3	82	62
12	Department of Psychiatry, University Hospital Galway	CHO Area 2	80	67
12	Deer Lodge	CHO Area 4	80	Not Open
12	Central Mental Hospital	National - Forensic	80	80
13	Le Brun House and Whitethorn House, Vergemount Mental Health Facility	CHO Area 6	79	61
13	Lois Bridges	Independent	79	82
14	Carraig Mór Centre	CHO Area 4	77	80
14	Department of Psychiatry, University Hospital Waterford	CHO Area 5	77	57
14	Admission Unit and St Edna's Unit, St Loman's Hospital	CHO Area 8	77	77
14	Department of Psychiatry, Connolly Hospital	CHO Area 9	77	80
14	Bloomfield Hospital	Independent	77	83
15	Wood View	CHO Area 2	76	66
NATIONAL AVERAGE 76%				
16	Owenacurra Centre	CHO Area 4	75	61
17	Haywood Lodge	CHO Area 5	74	73
17	Acute Psychiatry Unit, Tallaght Hospital	CHO Area 7	74	60
17	Maryborough Centre, St Fintan's Hospital	CHO Area 8	74	83
17	Phoenix Care Centre	CHO Area 9	74	80
17	Child and Adolescent Mental Health In-patient Unit, Merlin Park University Hospital	CAMHS	74	70
18	Adult Mental Health Unit, Cork University Hospital	CHO Area 3	73	77
19	St Davnet's Hospital, Blackwater House	CHO Area 1	72	66
19	St Michael's Unit, Mercy University Hospital	CHO Area 4	72	76

Rank	Approved Centre	Sector	2017 % Compliance	2016 % Compliance
19	St Vincent's Hospital	CHO Area 9	72	63
19	Adolescent In-patient Unit, St Vincent's Hospital	CAMHS	72	86
20	Cappahard Lodge	CHO Area 3	71	79
21	Sligo/Leitrim Mental Health In-patient Unit	CHO Area 1	70	60
21	Avonmore and Glencree Units, Newcastle Hospital	CHO Area 6	70	67
21	Drogheda Department of Psychiatry	CHO Area 8	70	87
21	St Aloysius Ward, Mater Misericordiae University Hospital	CHO Area 9	70	53
22	St Catherine's Ward, St Finbarr's Hospital	CHO Area 4	69	46
22	Elm Mount Unit, St Vincent's University Hospital	CHO Area 6	69	77
23	St Gabriel's Ward, St Canice's Hospital	CHO Area 5	68	61
24	Sliabh Mis Mental Health Admission Unit, University Hospital Kerry	CHO Area 4	67	71
24	Lakeview Unit, Naas General Hospital	CHO Area 7	67	73
24	St Joseph's Intellectual Disability Service	National - ID	67	57
25	Units 2, 3, 4 and Unit 8 (Floor 2), St Stephen's Hospital	CHO Area 4	66	55
26	Rehab and Recovery Mental Health Unit, St John's Hospital Campus	CHO Area 1	64	68
26	St Ita's Ward, St Brigid's Hospital	CHO Area 8	64	66
27	Department of Psychiatry, Letterkenny University Hospital	CHO Area 1	60	83
27	Acute Psychiatric Unit 5B, University Hospital Limerick	CHO Area 3	60	52
28	Teach Aisling	CHO Area 2	59	66
29	Department of Psychiatry, St Luke's Hospital	CHO Area 5	57	73
29	Grangemore Ward and St Aidan's Ward, St Otteran's Hospital	CHO Area 5	57	73
30	Jonathan Swift Clinic	CHO Area 7	55	72
31	Department of Psychiatry, Roscommon University Hospital	CHO Area 2	52	72

Notes: Rank range 1 – 31; CHO = HSE Community Healthcare Organisations; CAMHS = Child and Adolescent Mental Health Service.

Appendix 3: Further Information on Deaths

Table 4 Number of Sudden and Unexplained Deaths by Service Provider

Service Provider	Approved Centre In-Patient	Recently discharged from an Approved Centre (4 weeks)	Mental Health Service User (e.g. outpatient)	Total	Reported by the Service to be 'Suspected Suicide'	
CHO Area 1	1	3	16	20	15	75%
CHO Area 2	1	1	18	20	13	65%
CHO Area 3	1	6	16	23	22	96%
CHO Area 4	3	6	26	35	25	71%
CHO Area 5	1	4	21	26	19	73%
CHO Area 6	3	2	18	23	15	65%
CHO Area 7	1	1	18	20	18	90%
CHO Area 8	2	2	10	14	8	57%
CHO Area 9	2	2	13	17	8	47%
Independent	7	3	4	14	10	71%
National Forensic	0	0	0	0	0	-
National ID	0	0	0	0	0	-
Totals	**22**	**30**	**160**	**212**	**153**	**72%**

Notes: Sudden and Unexplained deaths as categorised by the Commission based on qualitative information reported by services; Deaths of service users of Child and Adolescent Services (CAMHS) are reported within the relevant service provider category; CHO = HSE Community Healthcare Organisations; National ID = National Intellectual Disability Service.

Appendix 4: Further Information on Child Admissions

Fig. 15 Gender of Child Admissions

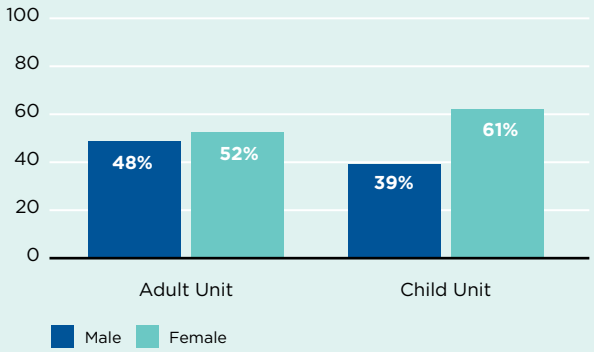


Fig. 16 Age of Child Admissions

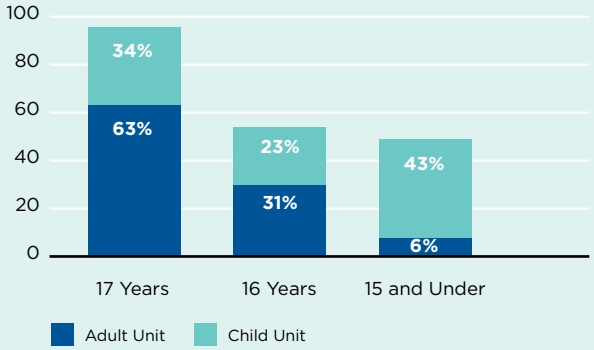


Fig. 17 Average Duration of Child Admissions

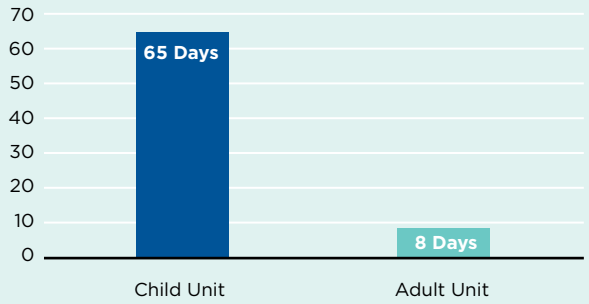
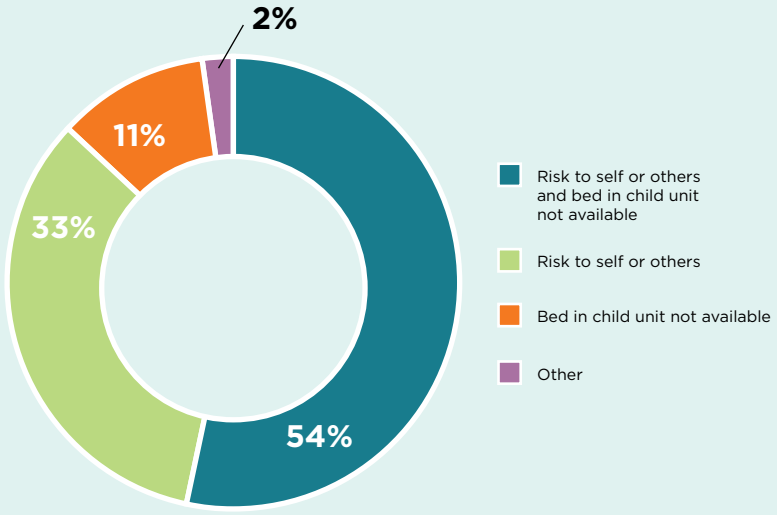


Fig. 18 Reason for Child Admissions to Adult Units



Appendix 5: Further Information on Tribunal Activity

Table 5 Involuntary Admission Rates for 2017 (Adult) by CHO Area and Independent Sector with Rates per, with 100,000 of Total Population

Sector	Involuntary Admissions	Re-grade Voluntary to Involuntary	Total Involuntary Admission Rate	Population[1]	Involuntary Admission Rate per 100,000 total population
CHO Area 1	138	41	179	389,266	45.98
CHO Area 2	199	41	240	442,972	54.17
CHO Area 3	123	37	160	380,206	42.08
CHO Area 4	252	94	346	676,638	51.13
CHO Area 5	144	43	187	504,709	37.05
CHO Area 6	115	30	145	378,175	38.34
CHO Area 7	198	69	267	686,483	38.89
CHO Area 8	188	48	236	612,102	38.55
CHO Area 9	283	89	372	606,097	61.37
Independents[2]	130	74	204	N/A	N/A
National Intellectual Disability Service	0	1	1	N/A	N/A
TOTAL (Exclusive of Independent sector and National Intellectual Disability Service)	**1,640**	**492**	**2,132**	**4,676,648**	**45.58**
TOTAL (Inclusive of Independent sector and National Intellectual Disability Service)	**1,770**	**567**	**2,337**	**4,676,648**	**49.97**

Notes:

1 Population figures taken from CSO census 2016. Detailed analysis of involuntary admission rates for 2017 by Approved Centre is provided on the Mental Health Commission web-site www.mhcirl.ie

2 There are six independent approved centres

Fig. 19 Monthly Involuntary Admissions 2017

The number of Form 6 orders fall within a range of 131 to 176 per month, and the number of Form 13 orders fall within a range of 31 to 61 per month, see figure below.

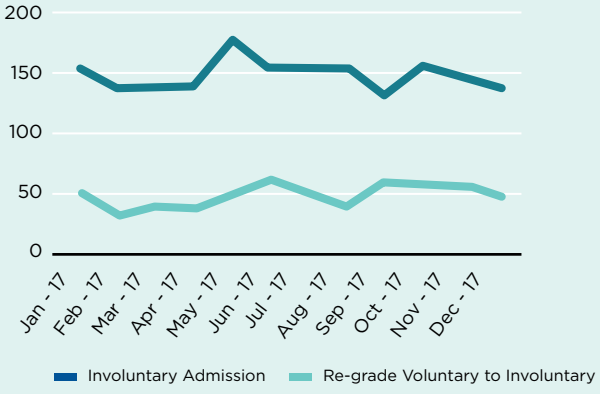


Fig. 20 Involuntary Admission Rates per 100,000 of Total Population for the Years 2013 to 2017

Analysis of involuntary admission rates per 100,000 of total population, including involuntary admissions to independent sector approved centres' as shown in the figure below for the years 2013 to 2017.

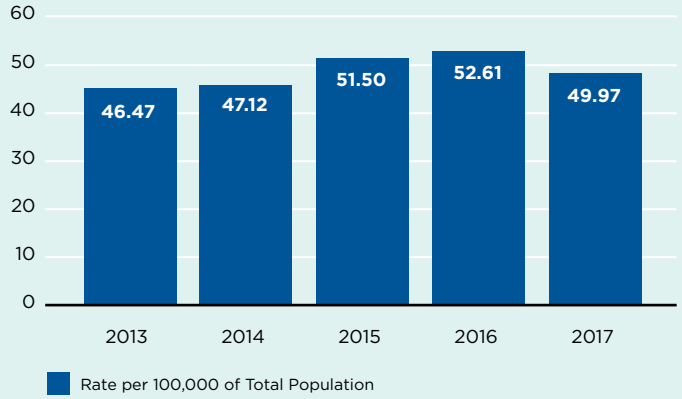


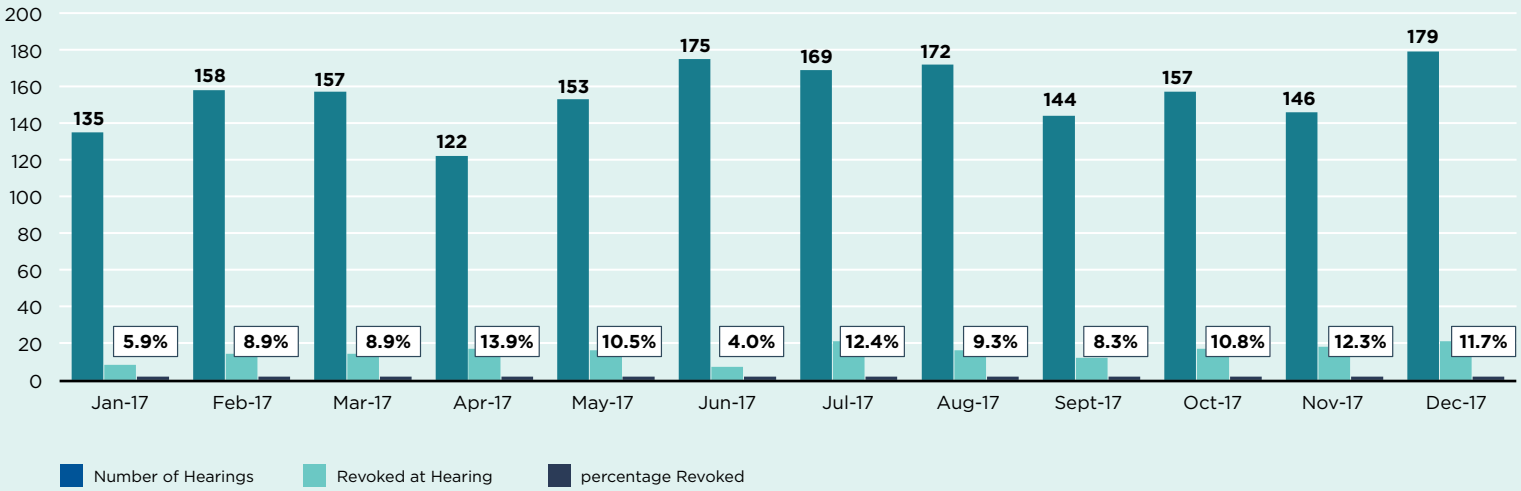
Table 6 Analysis by Age - Involuntary Admissions 2017

Age	Total Form 6	Form 6 Female	Form 6 Male	Total Form 13	Form 13 Female	Form 13 Male	Total Forms	Total % by age
18-24	201	56	145	86	31	55	287	12
25-34	398	139	259	130	68	62	528	23
35-44	385	173	212	117	68	49	502	21
45-54	281	152	129	75	49	26	356	15
55-64	203	113	90	79	50	29	282	12
65+	302	152	150	80	51	29	382	17
Total	**1770**	**785**	**985**	**567**	**317**	**250**	**2337**	**100**

Table 7 Analysis by Gender - Involuntary Admissions 2017

Gender	Form 6	Form 13	Total Forms	Total % by gender
Female	785	317	1101	47
Male	985	250	1236	53
Total	**1770**	**567**	**2337**	**100**

Fig. 21 Number of Hearings and % of Orders Revoked at Hearing 2017



Appendix 6: Mental Health Commission - Membership and Attendance at Commission Meetings and Committee Meetings

Table 8 Mental Health Commission Members (April 2017 – April 2022)

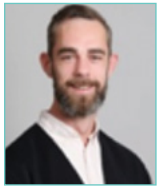
Name	**John Saunders**
First Appointed	**05.04.2012**
Reappointed	**05.04.2017**
End of Term	**04.04.2022**
Position Type	**Chairman**
Basis of Appointment	*Nominated by* **Shine / The Wheel**
	Appointed by **Minister for Health**

13 Maximum Number of Appointments

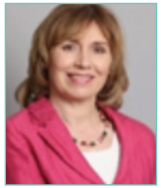
6 (46%) Female

7 (54%) Male

Secretary to the Board (Commission):
Ms Orla Keane
Head of Legal Services, Mental Health Commission



Name	**Aaron Galbraith**
First Appointed	**05.04.2017**
Reappointed	
End of Term	**04.04.2022**
Position Type	**Member**
Basis of Appointment	*Nominated by* **The Children's Rights Alliance**
	Appointed by **Minister for Health**



Name	**Catherine O'Rorke**
First Appointed	**05.04.2012**
Reappointed	**05.04.2017**
End of Term	**04.04.2022**
Position Type	**Member**
Basis of Appointment	*Nominated by* **Mental Health Nurse Managers of Ireland**
	Appointed by **Minister for Health**

Name	**Margo Wrigley (Dr)**
First Appointed	**05.04.2017**
Reappointed	
End of Term	**04.04.2022**
Position Type	**Member**
Basis of Appointment	*Nominated by* **The Irish Hospital Consultants Association**
	Appointed by **Minister for Health**

Name	**Collette Nolan**
First Appointed	**05.04.2012**
Reappointed	**05.04.2017**
End of Term	**04.04.2022**
Position Type	**Member**
Basis of Appointment	*Nominated by* **Irish Advocacy Network**
	Appointed by **Minister for Health**

Name	**Francis Xavier Flanagan (Dr)**
First Appointed	**05.04.2012**
Reappointed	**05.04.2017**
End of Term	**04.04.2022**
Position Type	**Member**
Basis of Appointment	*Nominated by* **The Irish College of General Practitioners**
	Appointed by **Minister for Health**

Name	**James Lucey (Dr)**
First Appointed	**05.04.2017**
Reappointed	
End of Term	**04.04.2022**
Position Type	**Member**
Basis of Appointment	*Nominated by the* **College of Psychiatrists of Ireland**
	Appointed by **Minister for Health**

Name	**Michael Drumm (Dr)**
First Appointed	**05.04.2017**
Reappointed	
End of Term	**04.04.2022**
Position Type	**Member**
Basis of Appointment	*Nominated by* **The Psychological Society of Ireland**
	Appointed by **Minister of State for Mental Health and Older People**

Name	**Ned Kelly**
First Appointed	**05.04.2012**
Reappointed	**29.09.2017**
End of Term	**04.04.2022**
Position Type	**Member**
Basis of Appointment	*Nominated by* **Mental Health Nurse Managers of Ireland**
	Appointed by **Minister for Health**

Name	**Niamh Cahill**
First Appointed	**31.10.2017**
Reappointed	
End of Term	**04.04.2022**
Position Type	**Member**
Basis of Appointment	*Nominated by* **Minister for Health following PAS Process**
	Appointed by **Minister for Health following PAS Process**

Name	**Patrick Lynch**
First Appointed	**05.04.2017**
Reappointed	
End of Term	**04.04.2022**
Position Type	**Member**
Basis of Appointment	*Nominated by* **HSE**
	Appointed by **Minister for Health**

Name	**Nicola Byrne**
First Appointed	**05.04.2017**
Reappointed	
End of Term	**04.04.2022**
Position Type	**Member**
Basis of Appointment	*Nominated by* **The Irish Association of Social Workers**
	Appointed by **Minister for Health**

Name	**Rowena Mulcahy**
First Appointed	**26.09.2017**
Reappointed	
End of Term	**04.04.2022**
Position Type	**Member**
Basis of Appointment	*Nominated by* **Minister for Health following PAS Process**
	Appointed by **Minister for Health following PAS Process**

Table 9 January - March 2017 (previous) Commission Members Attendance at Meetings

Commission Member	January 20.01.17	February 24.02.17	March 24.03.17	Total
Dr Michael Byrne	Y	Y	Y	3/3
Dr Maeve Doyle	Y		Y	2/3
Dr Xavier Flanagan	Y		Y	2/3
Ms Pauline Gill	Y	Y	Y	3/3
Dr Mary O'Hanlon	Y	Y		2/3
Mr Ned Kelly	Y	Y	Y	3/3
Dr Mary Keys	Y	Y	Y	3/3
Ms Colette Nolan	Y		Y	2/3
Ms. Yvonne O'Neill	Y	Y	Y	3/3
Ms Catherine O Rorke	Y		Y	2/3
Ms Patricia O Sullivan Lacy	Y	Y	Y	3/3
Mr John Redican				0/3
Mr John Saunders (Chair)	Y		Y	2/3

Table 10 May - December 2017 (current) Commission Members Attendance at Meetings

Commission Member	May 30.05.17	July 03.07.17	Sep 05.09.17	Oct 04.10.17	Nov 09.11.17	Dec 01.12.17	Dec 13.12.17 Extraordinary Meeting Teleconference	Total
Mr John Saunders	Y	Y	Y	Y	Y	Y	Y	7/7
Dr Margo Wrigley	Y	Y	Y	Y	Y			5/7
Dr James Lucey		Y	Y	Y	Y	Y		5/7
Dr Michael Drumm		Y	Y	Y	Y	Y	Y	6/7
Dr Xavier Flanagan	Y		Y	Y	Y	Y		5/7
Mr Aaron Galbraith		Y			Y		Y	3/7
Ms Nicola Byrne	Y	Y	Y	Y	Y	Y	Y	7/7
Ms Colette Nolan		Y		Y		Y		3/7
Mr Patrick Lynch		Y	Y	Y	Y	Y	Y	6/7
Ms Catherine O Rorke	Y	Y	Y	Y	Y	Y	Y	7/7
Mr Ned Kelly *(L.A.)				Y	Y	Y	Y	4/4
Ms Rowena Mulcahy* (L.A.)					Y	Y	*Due to an MHC IT issue RM did not receive the meeting notification	2/3*
Ms Niamh Cahill *(L.A.)					Y	Y	Y	3/3

Notes: L.A. = Late Appointment

Table 11 Commission Committees - Membership and Meeting Attendance

Audit and Risk Committee

Chief Risk Officer: Ms Orla Keane *(Mental Health Commission)*

Chair of Audit and Risk Committee: Mr Patrick Lynch

January - March 2017			
Committee Member		**March**	**Attendance**
Patricia O'Sullivan Lacy	CM	Y	1/1
Joseph Campbell	EM	-	0/1
Ned Kelly	CM	Y	1/1
Catherine O'Rorke	CM	Y	1/1
Pauline Gill	CM	Y	1/1
John Redican	CM	-	0/1
Ciara Lynch	EM	Y	1/1

July - December 2017[1]					
Committee Member[2]		**August**	**October**	**November**	**Attendance**
Patrick Lynch	CM	Y	Y	Y	3/3
Catherine O'Rorke	CM	Y	Y	Y	2/3
James Lucey	CM	Y	Y	Y	3/3
Nicola Byrne[3]	CM	-	-	Y	1/1
Joseph Campbell	EM	Y	Y	Y	3/3
Ciara Lynch	EM	Y	Y	Y	3/3
Moling Ryan	EM	X	X	Y	1/3

Notes:

The Chairman is an 'Ex Officio' Committee Member.

CM = Commission Member, EM = External Member.

1 The Members of the Committee were appointed in July 2017.

2 Collette Nolan (CM) was initially appointed to the Committee but due to other commitments she requested to step down.

3 Nicola Byrne (CM) was appointed to replace Collette Nolan at the November Commission meeting.

Legislation Committee

Chair of Legislation Committee: Ms Rowena Mulcahy

January - March 2017			
Committee Member		**January**	**Attendance**
Mary Keys	CM	Y	1/1
Ned Kelly	CM	Y	1/1
Patricia O'Sullivan Lacy	CM	Y	1/1
Pauline Gill	CM	Y	1/1
Maeve Doyle	CM	-	0/1

November - December 2017[4]			
Committee Member		**December**	**Attendance**
Rowena Mulcahy	CM	-	0/1
Ned Kelly	CM	Y	1/1
Michael Drumm	CM	Y	1/1
Mary Donnelly	EM	-	1/1
John Saunders Ex Officio	CM	Y	1/1

Notes:

4 The Members of the Committee were appointed in November 2017.

Table 12 Working Groups - Membership and Meeting Attendance

Governance Working Group

April - December 2017			
Working Group Member	**October**	**December**	**Attendance**
John Saunders	Y	Y	2/2
Margo Wrigley	Y	Y	2/2
Catherine O'Rorke	Y	Y	2/2

Table 13 Senior Management Team

Mental Health Commission (including the Decision Support Service)	
Chief Executive	Ms Patricia Gilheaney
Inspector of Mental Health Services	Dr Susan Finnerty
Head of Legal Services	Ms Orla Keane[1]
Director of Standards and Quality Assurance and Training and Development	Ms Rosemary Smyth
Director Corporate Services	Mr Ray Mooney[2]
Director Decision Support Services	Ms Aine Flynn[3]

Notes:

1 Took up office on 24.05.2017

2 Vacant from October 2017 due to retirement

3 Took up office on 04.10.2017

Table 14 Statutory Reporting Requirements

Freedom of Information Act 2014
Data Protection Act 1998 to 2018
Protected Disclosures Act 2014 - Part 14 Health Act 2007
Safety Health & Welfare at Work Act 2005
Prompt Payments Act 1997
Disability Act 2005
Children First
Maastricht Returns
Energy Reporting (SEAI)

Mental Health Commission

Mental Health Commission
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