Mental Health Commission

ANNUAL REPORT 2018

including Report of the Inspector of Mental Health Services

MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

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Chairperson's Statement

John Saunders
Chairperson

In 2018, the Mental Health Commission initiated a comprehensive and collaborative stakeholder engagement process to develop a new strategic plan. 'Protecting People's Rights' clearly sets out the Commission's strategic goals to the end of 2022. It is the first plan under our revised Mission 'to regulate and engage to promote, support and uphold the rights, health and well-being of all people who access mental health and decision support services'. The plan ensures that upholding and protecting human rights underpins every aspect of our work while also developing an organisation that is responsive to a rapidly changing external environment.

2018 also saw the creation of a clear pathway for the establishment of Ireland's Decision Support Service (DSS), which we hope, when commenced, will be the 'gold standard' for decision support services in Europe. Our aim, in collaboration with and supported by the Department of Justice and Equality, is to deliver a service which puts Ireland to the forefront of vindicating human rights and ensuring the citizen has a service focused on their needs. The DSS will play a key role in delivering the much needed and long-awaited reforms introduced by the Assisted Decision Making (Capacity) Act of 2015. The 2015 Act emphasises personal 'will and preferences', ensuring respect for the rights of a person and supporting them in autonomous decision-making and advance planning.

The Commission welcomes the development and implementation of Sláintecare. This programme is vital to the transformation of our health and social care services and is essential to ensure our mental health services provide timely and integrated access to services. It also creates a trajectory of hope and a platform for informed national and strategic investment in mental health services. However, while policy creates hope, the evidence gathered by the Commission and set out in this report indicates that it is only well-governed, well-managed and well-resourced services that deliver for the public.

It is evident from the 2018 Annual Report that the level of change in our mental health service provision is uncoordinated, ad hoc and slow. A top level view of our work in 2018 indicates three sustained and key challenges for the mental health care system in Ireland. First, we must put in place a system of governance that drives best practice across the whole country. There are geographical pockets of good practice. However, governance within the HSE now needs to ensure that these good practices are replicated across all parts of the country. Second, the specialist in-patient approved centres must be up to standard, thereby ensuring that every person everywhere in Ireland has access to and enters a place of hope and healing. Finally, the Government needs to continue moving the treatment and recovery model to specialist professional community care. The Commission welcomes and recognises the investment in primary care units, which are modern, inclusive and form a base for outreach in the community.

However, given the findings of the Inspector of Mental Health Services, it is clear that a planned, costed and funded capital investment programme is required to bring a significant number of HSE buildings up to date, make them fit for purpose and ensure that they are registrable.

In 2018, the Inspector of Mental Health Services continued to examine the quality of service provided in 24-hour community residences. The findings indicate that there are very vulnerable people living in unregulated 'community residences'. While regulation now protects older persons and people with disabilities living in community residential settings, it does not protect the more than 1,200 people who live in State-provided mental health community residences.

The Commission continues to advocate for strong mental health legislation and policy reform to ensure a reliable, efficient and safe mental health care system in Ireland. In that regard, 2018 was a significant year for the rights of people who are involuntarily detained. Legislation was passed preventing detention orders of 12 months' duration and ensuring that patients, if involuntarily detained on orders of up to six months, are entitled to an additional review by a Mental Health Tribunal if still detained after three months. This is an extra human rights' safeguard for patients, which the Commission welcomes. In addition, we have committed to informing policy across mental health care services. It is in this context of driving improvement and protecting people's rights that in 2018 we collaborated with HIQA to develop new adult safeguarding standards.

From a human rights perspective, the use of seclusion and restrictive practices in a dignified, safe and legal way is a priority that must be tackled. Furthermore, services for children and adolescents require improvement in many areas.

In 2019 the Commission will continue to work towards ending any lingering legacy of disrespect around mental health services, ensure that there is parity and take all relevant actions to ensure that all people are treated equally and in accordance with the law, regardless of their geographical location or health issues.

As an independent public body charged with driving high-quality and safe mental health care in Ireland, the Commission is responsible for delivering its mandate in an open, transparent, effective and cost-efficient manner. I wholeheartedly thank all the Executive and staff of the Commission for their hard work and commitment during 2018 and I thank all members of the Board for the advice and direction they provided. I also thank the Minister of State for Mental Health and Older People and the Minister for Justice and Equality and the officials in the Department of Health and in the Department of Justice and Equality for all their support during 2018.

This report shows that Ireland has a way to go to ensure that all persons have access to appropriate mental health care in all parts of Ireland. However it also shows that some parts of Ireland and some service providers are getting things right. This report evidences that the Mental Health Commission will play its part with all stakeholders to realise our vision of an Ireland with the highest quality mental health and decision support services underpinned by a person's human rights.

John Saunders
Chairperson

Chief Executive's Review

John Farrelly
Chief Executive

The Mental Health Commission has a function in law 'to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services'. In fulfilling this role in 2018, we continued to work with services that put the person first while also targeting low quality services and using our regulatory powers to intervene. To ensure the Commission is responsive, open and inclusive, we are committed to creating stronger, deeper relationships to deliver our statutory mandate, promote standards and mitigate risk. We also recognise and report on all improvements as well as deficits. As a proportionate, independent risk-based regulator, the Commission delivered a programme of regulation during 2018 which promoted both quality and safety.

The programme of registration, inspection and monitoring continued to hold providers to account, while the publication of our national reports and regular inspections created a transparency that enabled the public and stakeholders to clearly understand both the strengths and weaknesses of mental health care in their own geographic location. In tandem with inspection, we continued to receive, analyse and risk-assess information in relation to approved centres which enabled targeted and proportionate intervention.

The evidence and statistics in this report indicate an increase in the placement of children and adolescents in adult mental health units. However, the placement of any child in any adult unit indicates a gap in service provision.

A child or adolescent's first introduction to mental health care should not be through a service or building that is not specifically equipped to deal with their needs.

Despite compliance trends slowly moving in the right direction at a national level, there are a significant number of approved centres which have – on a consistent and sustained basis – failed to provide the most basic and fundamental aspects of a service, such as privacy and cleanliness. There is no justification for some of the low levels of compliance evidenced in this report. It points to significant flaws in governance and management within our mental health services. The Commission will continue to work with providers but it is difficult to see how some of the lowest compliant centres could be registered in the future without significant improvement.

The Commission is also charged with operating the review process for vindicating the rights of patients who are involuntarily detained. We want service users, and their loved ones, to know that these review processes are independent and exist to ensure they are receiving high quality and safe mental health services. We thank all the panel members and independent consultant psychiatrists who contributed to ensuring that the law was applied to all involuntary detentions. The Mental Health Tribunals are a key mechanism by which the Irish State ensures people's rights are vindicated. There was a 4 per cent increase in admission orders between 2017 and 2018 and a 13 per cent increase over the last five years.

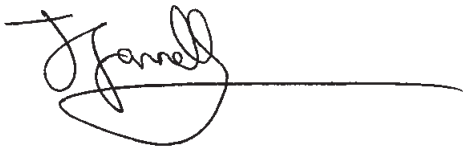
However, applications for involuntary admission from family members are down by 6 per cent to 38 per cent of all applications. This decrease is welcomed as the effects that these types of applications have on family members and loved ones can be damaging.

Our Constitution is clear that no citizen shall be deprived of his/her personal liberty save in accordance with law. Indeed, the law requires that mental health treatment be humane, therapeutic and recovery orientated. The data in this report clearly indicates a systemic risk developing in relation to the physical restraint and seclusion of patients in approved centres. In 2018, the Commission initiated a first ever prosecution under the Mental Health Act 2001 on foot of findings that some patients were deprived of basic dignity and human rights by being secluded in a dirty, malodorous, badly lit and badly ventilated room. Unfortunately, based on the data, the pattern of poor practice in relation to seclusion and physical restraint is not limited to one or two centres but is more widespread. The Commission has commenced a process to ensure that the system changes and becomes compliant with the rules.

In 2018, the Commission began expanding its operations in preparation for the commencement of the new Decision Support Service. Key to delivering our functions is a strong corporate operations service and a modern digital infrastructure that will support person-centred delivery whilst reducing red tape and the regulatory burden for individuals and providers of services. In 2018, we continued to strengthen our corporate operations and corporate governance structure to deliver our objectives and ensure accountability and transparency in our operations. We also continue to review our operating models and approach to strengthen our internal capacity, ensure value for money and harness and develop the expertise of our staff.

I am conscious that a refresh of 'A Vision for Change' is nearing completion. Indeed, the work carried out over the last decade, in particular the closing of the majority of old, large institutions, must be recognised. The task now is to push on and develop high-quality, community-based services. An agreed, clear policy direction is to be welcomed and it will assist all stakeholders to develop and improve our mental health services.

I sincerely thank all those in the Commission and in our mental health services who continue to work tirelessly to improve the standard of care in Ireland.



John Farrelly
Chief Executive

2018 in Brief

44
Enforcement Actions

51
Registration Conditions Attached

84
Child Admissions to Adult Units

54
Inspections Of 24-Hour Nurse Supervised Residences

79%
National Compliance With Regulations

64
Annual Regulatory Inspections

2,002
Mental Health Tribunal Hearings

2,435
Involuntary Admissions to Approved Centres

€3 million
allocated to the implementation of the Decision Support Service

3,000
Estimated number of Wards of Court that will exit Wardship and become part of the Decision Support Service

220,000
adults in Ireland who require some level of support to help them to make decisions

Who We Are

The Mental Health Commission

The Mental Health Commission is an independent statutory body established under the provisions of the Mental Health Act 2001. The remit of the commission incorporates the broad spectrum of mental health services for all ages in all settings.

In addition, under the provisions of the Assisted Decision Making (Capacity) Act 2015, the Commission is responsible for establishing the Decision Support Service to support decision-making by and for adults with capacity difficulties.

Vision, Mission and Values

Our Vision 2019-2022

The highest quality mental health and decision support services underpinned by a person's human rights.

Our Mission 2019-2022

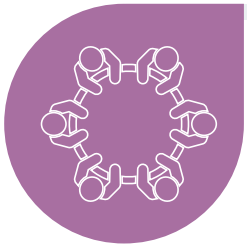
Regulate and engage to promote, support and uphold the rights, health and well-being of all people who access mental health and decision support services.

Strategic Objectives 2019-2022

The 12 months that this report is concerned with was the final year of our 2016-2018 Strategic Plan. During the year we embarked on significant stakeholder engagement to support the development of our new Strategy. The 2019-2022 Strategy - entitled 'Protecting People's Rights' - has five strategic objectives:

Strategic Objective 1

Promote and uphold human rights to meet our responsibilities and remit under national and international legislation.



Strategic Objective 2

Implement the Commission's legislative mandate and pursue appropriate changes to the Mental Health Act 2001, the Assisted Decision Making (Capacity) Act 2015 and other relevant legislation.

Strategic Objective 3

Promote awareness of and confidence in the role of the Mental Health Commission.

Strategic Objective 4

Develop an organisation that is responsive to the external environment and societal changes.

Strategic Objective 5

Develop an agile organisation with an open and inclusive culture.

Mental Health Commission Members (April 2017 – April 2022)

Name
John Saunders

Position Type
Chairperson

Name
Aaron Galbraith

Position Type
Member

Name
Catherine O'Rorke

Resigned
07/08/2018

Position Type
Member

Name
Colette Nolan

Position Type
Member

Name
Francis Xavier Flanagan (Dr)

Position Type
Member

Name
Jim Lucey (Dr)

Position Type
Member

Name
Margo Wrigley (Dr)

Position Type
Member

Name
Michael Drumm (Dr)

Position Type
Member

13 – MAXIMUM NUMBER OF APPOINTMENTS

6 FEMALE
46%

7 MALE
54%

Name
Ned Kelly

Position Type
Member

Name
Niamh Cahill

Position Type
Member

Name
Nicola Byrne

Position Type
Member

Name
Patrick Lynch

Position Type
Member

Name
Rowena Mulcahy

Position Type
Member

**Mr Tómas Murphy became a member of the Commission in January 2019, replacing Ms Catherine O'Rorke.*

Secretary to the Board (Commission) & Chief Risk Officer
Ms Orla Keane

Chair of Audit & Risk Committee
Mr Patrick Lynch

Chair of the Legislation Committee
Ms Rowena Mulcahy

Senior Management Team at the Commission

Chief Executive
John Farrelly

Inspector of Mental Health Services
Dr. Susan Finnerty

Head of Legal Services and Division Lead, Mental Health Tribunals
Orla Keane

Director of Standards & Quality Assurance
Rosemary Smyth

Chief Operations Officer
Simon Murtagh

Director of Decision Support Service
Áine Flynn

What We Do

Regulatory Process

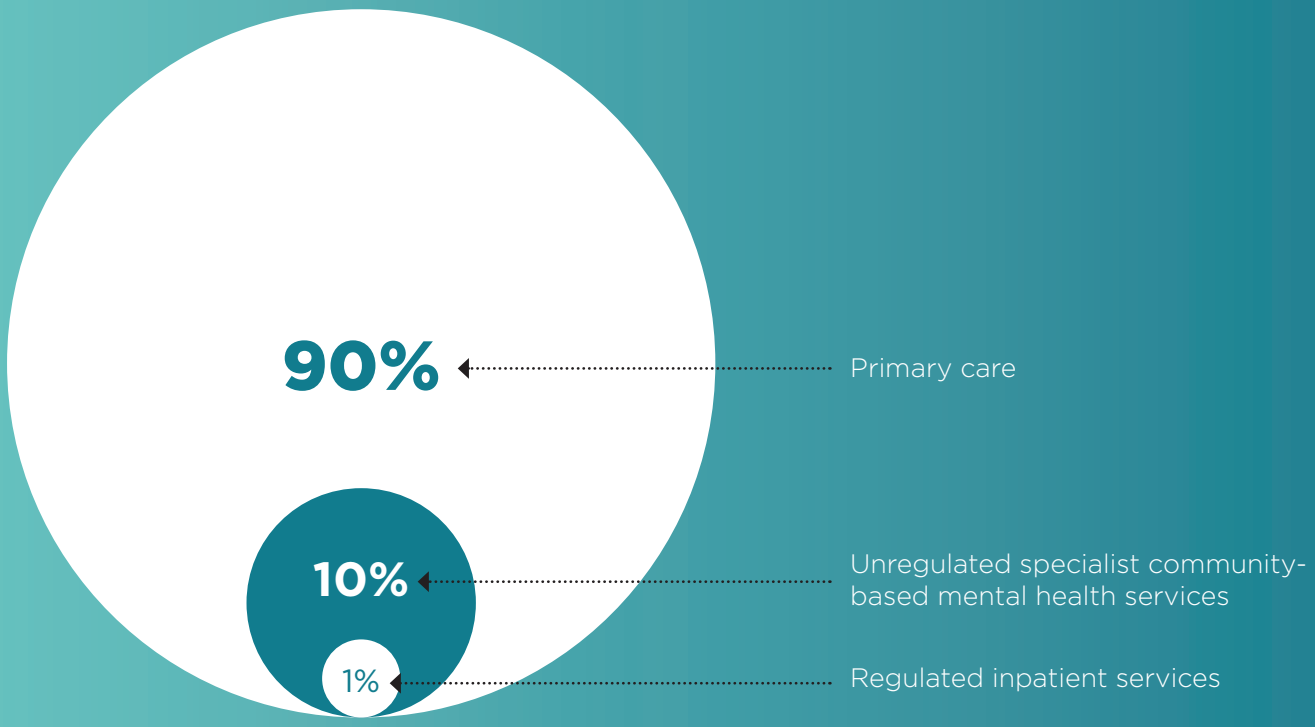
One of the Commission's core functions is to regulate and regularly inspect in-patient mental health facilities ('approved centres'). Our regulatory process includes a cycle of registration, inspecting and monitoring services to ensure high standards and good practices in the delivery of care and treatment.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

We are a responsive regulator, which means we uphold the principles of consistency, proportionality, accountability, transparency and targeting. Responsive regulation promotes capacity building and self-assessment within services and uses enforcement measures as a last resort.

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 monitor services and promote safe and high quality care.

Regulated mental health services make up a small percentage of services in Ireland. Most specialist community mental health services e.g. day hospitals, community residences and community mental health teams are not regulated.

FIGURE 1. DISTRIBUTION OF MENTAL HEALTH SERVICES



Registration

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

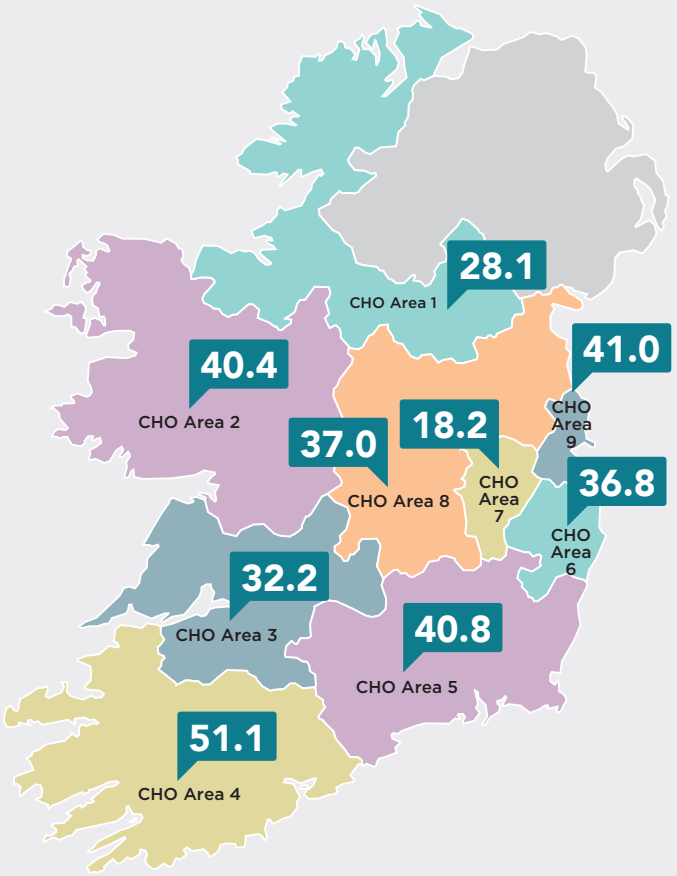
Registration as an approved centre lasts for a period of three years, after which time the service must apply to continue registration.

As part of a registration application, 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.

We register and regulate a wide range of in-patient services, including:

- Acute adult mental health care
- Continuing mental health care
- Psychiatry of later life
- Mental health rehabilitation
- Forensic mental health care
- Mental health care for people with intellectual disability
- Child and adolescent mental health care (CAMHS)

FIGURE 2. HSE BEDS BY 100,000 POPULATION



At the end of 2018, there were **64** approved centres registered with the Commission. During the year there were two closures and two new registrations.

The full **Register of Approved Centres** is available on the Commission website: www.mhcirl.ie/registration.

At the end of 2018, there were **2,770** in-patient beds in approved centres across the country. A breakdown of beds per 100,000 population across the HSE Community Healthcare Organisation (CHO) areas is set out in Figure 2.

There were **102** CAMHS beds nationally; 62 in Dublin, 20 in Galway and 20 in Cork.

There were **704** adult beds in the independent sector, of which 696 were in Dublin.

There were also **103** registered forensic beds and **124** mental health intellectual disability (MHID) beds. These beds were located in Dublin, with a national catchment.

Inspection

The Inspector of Mental Health Services visits and inspects every approved centre at least once a year. Following inspection, the Inspector prepares 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.

On inspection, the Inspector rates compliance against:

- 31 Regulations
- Part 4 of the Mental Health Act 2001
- 4 Codes of Practice
- 2 Statutory Rules

The Inspector also assesses the quality of the service against the four pillars of the Judgement Support Framework:

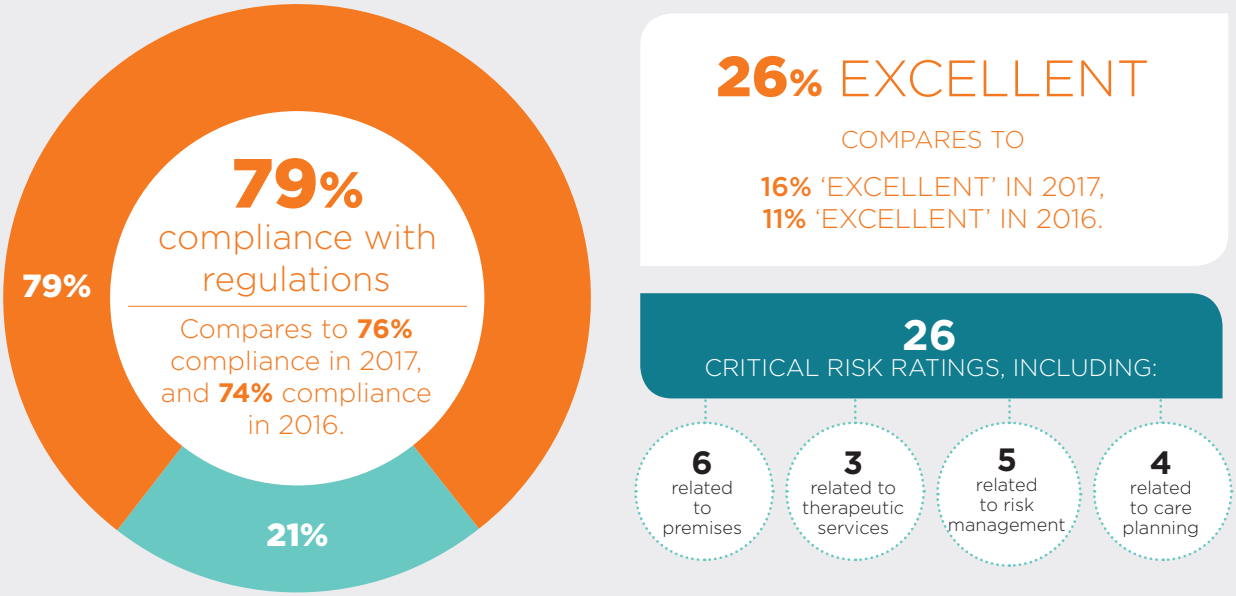
- Processes
- Training
- Monitoring
- Implementation

Based on compliance with the relevant legislative requirements, the Inspector makes a compliance rating of 'Compliant' or 'Non-Compliant'. Based on adherence to the criteria set out in the Judgement Support Framework, the Inspector makes a Quality Assessment of 'Excellent', 'Satisfactory', 'Needs Improvement' or 'Inadequate'.

In 2018, there were **64** annual regulatory inspections of regulated approved centres. There were **two** focused inspections. In addition, there were **54** inspections of unregulated 24-hour nurse supervised community residences.

Further detail can be found in the Report of the Inspector of Mental Health Services on page 58.

FIGURE 3. 2018 INSPECTION FINDINGS



Compliance Monitoring

We collect and analyse compliance data by individual service, by sector/CHO area, and nationally, to identify areas of good practice and areas of concern.

While enforcement processes address the critical risks and serious incidents, compliance monitoring focuses on the overall trends over time. The Commission does not look solely at whether an individual service has increased or decreased in compliance, as this does not tell us very much (for example, if a service 'decreases' from 97% to 95% compliance). Instead, the aim of compliance monitoring is to focus on the majority of services consistently improving year on year.

Table 1 gives the breakdown of all services' compliance with regulations across three years (2016-2018). The table is colour-coded to indicate poor compliance, moderate compliance, and good compliance. The table shows significant progress across this time period, with **32** services achieving good compliance and no service with poor compliance in 2018. This compares with **24** services achieving good compliance and 5 services with poor compliance in 2017.

While we consider that there are still too many services consistently achieving 'moderate compliance' with little improvement, it is positive to see the overall trends on an upward trajectory.

Areas of concern

Despite compliance trends moving in the right direction, there are a number of areas of concern, some of which include the most basic and fundamental aspects of a service, such as privacy, cleanliness, and receiving a general physical health check from a doctor.

While we recognise that some areas of concern will require time to address, for example, where significant building works are required), there is no justification for the ongoing low levels of compliance in other areas.

Areas of good practice

A number of areas showed consistently high compliance across all services. These include resident identifiers (100%), food and nutrition (92%) and complaints procedures (92%). We also saw a notable improvement in risk management (up 22%) and operational policies (up 15%).

AREAS OF CONCERN

9% **Staffing:** staff training, access to health and social care services e.g. psychology, social work

30% **Premises:** poor decorative condition, structural risks, cleanliness

42% **General health:** Full physical assessment undertaken every 6 months

53% **Privacy**: Resident details on noticeboards, inadequate privacy screens

53% **Records:** Loose pages, not complete, in good order and easily retrievable

AREAS OF GOOD PRACTICE

100% **Children's Education:** Continuity of education services within the approved centre

100% **Resident Identifiers:** Appropriate identifiers used prior to medication and treatments

100% **Religion:** Religious practice facilitated in line with residents' expressed wishes

98% **Visits:** Clear and appropriate visiting times, private areas for visits

97% **Property:** Property accounted for on admission and kept safe within the service

2018 Approved Centre Compliance with Regulations

The following table shows the percentage compliance with regulations for all regulated services across a three-year period (2016-2018). The services are ranked from highest to lowest compliance for 2018.

Less than 60% compliant

Between 60% and 80% compliant

80% compliant and over

TABLE 1. APPROVED CENTRE RANKED COMPLIANCE WITH REGULATIONS 2016-2018.

Approved Centre	CHO/Sector	% Compliance 2018	% Compliance 2017	% Compliance 2016
Willow Grove	CAMHS	**100**	100	93
St Edmundsbury	Independent	**100**	96	100
St Patrick's Hospital	Independent	**97**	100	90
Linn Dara	CAMHS	**97**	97	80
Eist Linn	CAMHS	**94**	87	90
Tearmann Ward	3	**93**	82	62
Lois Bridges	Independent	**93**	79	82
Cappahard Lodge	3	**93**	71	79
St Brigid's Hospital, Ardee	8	**93**	64	66
Sycamore Unit	9	**90**	90	82
Maryborough Centre	8	**90**	74	83
Merlin Park	CAMHS	**90**	74	70
Cois Dalua	Independent	**90**	Not open	Not open
Deer Lodge	4	**89**	80	Not open
Owenacurra	4	**89**	75	61
Ashlin Centre	9	**87**	84	77
AAMHU Galway*	2	**87**	80	67
Central Mental Hospital	National Forensic	**87**	80	80
An Coillin	2	**86**	89	86
AIPU, St Vincent's	CAMHS	**86**	72	86
St John of God Hospital	Independent	**84**	84	87
Cluain Lir Care Centre	8	**83**	86	86
Highfield Hospital	Independent	**83**	86	69
St Michael's Unit	4	**83**	72	76
St Vincent's Hospital	9	**83**	72	63
DOP Roscommon	2	**83**	52	72
Creagh Suite	2	**82**	93	82
St Davnet's Hospital	1	**82**	72	66
DOP Portlaoise	8	**80**	90	83
Phoenix Care Centre	9	**80**	74	80
Sligo/Leitrim Inpatient Unit	1	**80**	70	60
St Joseph's IDS	National ID	**80**	67	57
Jonathan Swift Clinic	7	**79**	55	72
Bantry General Hospital	4	**77**	87	80

Approved Centre	CHO/Sector	% Compliance 2018	% Compliance 2017	% Compliance 2016
Vergemount	6	**77**	79	67
St Loman's Hospital	8	**77**	77	77
AMHU Cork	4	**77**	73	77
Newcastle Hospital	6	**77**	70	67
APU Cavan	1	**74**	83	67
Carraig Mór Centre	4	**74**	77	80
APU Ennis	3	**73**	90	63
AMHU Mayo	2	**73**	83	80
DOP Waterford	5	**73**	77	57
Bloomfield	Independent	**73**	77	83
Haywood Lodge	5	**73**	74	73
Lakeview Unit	7	**73**	67	73
O'Casey Rooms	9	**72**	83	76
Wood View	2	**72**	76	66
St Aloysius Ward	9	**72**	70	53
Sliabh Mis	4	**72**	67	71
APU 5B Limerick	3	**72**	60	52
Teach Aisling	2	**72**	59	66
Selskar House	5	**71**	93	93
DOP Connolly	9	**70**	77	80
Drogheda DOP	8	**70**	70	87
St Finbarr's Hospital	4	**69**	70	46
St Anne's Unit	2	**68**	86	93
APU Tallaght	7	**68**	74	60
DOP Letterkenny	1	**67**	60	83
St Canice's Hospital	5	**64**	68	61
St Otteran's Hospital	5	**63**	57	73
Elm Mount Unit	6	**62**	69	77
St Stephen's Hospital	4	**62**	66	55
DOP St Luke's	5	**60**	57	73

**The DOP Galway closed in 2018 and reopened on new premises as AAMHU Galway*

TABLE 2. PERCENTAGE COMPLIANCE BY CHO AND SECTOR 2016-2018

CHO/Sector	% Compliance 2018	% Compliance 2017	% Compliance 2016
CAMHS	**93**	86	84
Independent	**88**	87	85
CHO 3	**83**	76	64
CHO 8	**82**	77	80
CHO 9	**79**	79	73
CHO 2	**78**	77	77
CHO 4	**77**	74	68
CHO 1	**76**	71	69
CHO 7	**73**	65	68
CHO 6	**72**	73	68
CHO 5	**68**	71	72

TABLE 3: COMPLIANCE WITH REGULATIONS 2017-2018

Regulation	2018	2017
4: Resident identifiers	**100%**	98%
5: Food and nutrition	**92%**	86%
6: Food safety	**86%**	91%
7: Clothing	**88%**	91%
8: Property and possessions	**97%**	88%
9: Recreational activities	**92%**	91%
10: Religion	**100%**	100%
11: Visits	**98%**	92%
12: Communication	**95%**	98%
13: Searches	**91%**	86%
14: Care of the dying	**95%**	89%
15: Individual care planning	**58%**	52%
16: Therapeutic services	**73%**	77%
17: Children's education	**100%**	89%
18: Transfers	**84%**	92%
19: General health	**42%**	72%
20: Information	**91%**	88%
21: Privacy	**53%**	55%
22: Premises	**30%**	25%
23: Medication	**52%**	47%
24: Health and Safety	**100%**	100%
25: CCTV	**78%**	61%
26: Staffing	**9%**	6%
27: Maintenance of records	**53%**	42%
28: Register of residents	**67%**	53%
29: Policies	**95%**	80%
30: Mental Health Tribunals	**98%**	91%
31: Complaints	**92%**	84%
32: Risk management	**72%**	50%
33: Insurance	**100%**	100%
34: Certificate of registration	**100%**	97%

TABLE 4: FULL COMPLIANCE WITH STATUTORY RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001 2017-2018

Instrument	2018	2017
Rules on ECT	**58%**	77%
Rules on Seclusion	**33%**	19%
Rules on Mechanical Restraint	**50%**	75%
Consent procedures (Part 4)	**81%**	59%

TABLE 5: FULL COMPLIANCE WITH CODES OF PRACTICE 2017-2018

Code of Practice	2018	2017
Physical Restraint	**19%**	31%
Admission of Children	**11%**	25%
ECT	**64%**	57%
Admission, Transfer, Discharge	**25%**	6%

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, health and well-being of residents, or where there has been a failure to address an ongoing area of non-compliance.

All 'critical-risk' issues are considered by the Commission's Regulatory Review Committee. Enforcement most commonly arises out of inspection findings, quality and safety notifications, and ongoing monitoring.

Enforcement actions available to the Commission are set out in the enforcement model pyramid at Figure 4 below. Enforcement actions range from requiring a Corrective and Preventative Action plan (at the lower end of enforcement) to removing an approved centre from the register or pursuing prosecution (at the higher end of enforcement).

Enforcement actions

The Commission took **44** enforcement actions against incidents, events and serious concerns arising in 2018. These actions related to **23** approved centres. This compares with **23** enforcement actions in 2017.[1] One reason for the higher number of actions is down to the increased collection of high-quality compliance data across a number of years, leading to enforcement taken based on trends of ongoing non-compliance.

During 2018, enforcement included:

- **26** Immediate Action Notices relating to 34 serious concerns
- **3** Regulatory Compliance Meetings
- **1** Prosecution

The majority of enforcement actions (73%) arose out of annual regulatory inspections.

Other enforcement actions arose out of quality and safety notifications, compliance monitoring and focused inspections.

In addition, 10 new registration conditions were attached to five approved centres during 2018. These are set out in the next section.

Enforcement actions related to core areas of service provision which impacted on the safety, well-being or human rights of residents. They included:

- **4** Consent procedures
- **7** Safety hazards (including overcrowding)
- **2** Cleanliness of premises
- **4** Provision of therapeutic services
- **4** Care planning
- **5** Inadequate facilities

FIGURE 4. ENFORCEMENT MODEL

1 The 2017 annual report included follow up to SREs as enforcement actions. These have been excluded for reporting purposes.

Registration Conditions

The Commission may attach conditions to an approved centre's registration (similar to a penalty or endorsement on a driver's licence). Conditions may relate to an aspect of the operation of an approved centre, but are usually related to individual care planning, medication, premises maintenance, staff training and risk management.

Registration conditions allow the Commission to closely monitor plans to address non-compliances. They do this by:

- Setting additional reporting requirements (e.g. audit reports, training records)
- Requiring certain actions (e.g. building works, developing protocols)
- Prohibiting certain actions (e.g. direct admissions)

It is an offence to breach a condition of registration.

As at the end of 2018, there were **51** conditions attached to **30** approved centres. The conditions were applied in the following areas:

13 Premises maintenance

12 Care planning

10 Staff training

3 Medication management

2 Risk management

3 Plan for closure

8 Other

Conditions attached

Ten new registration conditions were attached to 5 approved centres during 2018:

- Department of Psychiatry, Connolly Hospital
- St Aloysius Ward, Mater Misericordiae University Hospital
- Acute Mental Health Unit, Cork University Hospital
- Le Brun House and Whitethorn House, Vergemount Mental Health Facility
- Lois Bridges

Conditions removed

During 2018, 11 conditions were removed due to the approved centre demonstrating compliance in the relevant area, or due to the approved centre closing.

Conditions were removed from the following approved centres due to achieving compliance:

- Acute Psychiatric Unit, Cavan General Hospital
- Department of Psychiatry, Midland Regional Hospital, Portlaoise
- Department of Psychiatry, University Hospital Waterford
- St Ita's Ward, St Brigid's Hospital
- Units 2, 3, 4, 5, and Unit 8 (Floor 2), St Stephen's Hospital

Quality and Safety Notifications

Approved centres and other community mental health services are required to submit Quality and Safety Notifications to the Commission. There are 16 Quality and Safety Notifications in total, which relate to:

- **Adverse events** (e.g. serious reportable events, incidents and deaths)
- **Regulated practices** (e.g. ECT and restrictive practices)
- **Areas that the Commission closely monitors** (e.g. child admissions, overcapacity)

The Commission closely monitors and analyses trends for these notifications. We also produce annual reports on regulated practices, which can be found on our website.

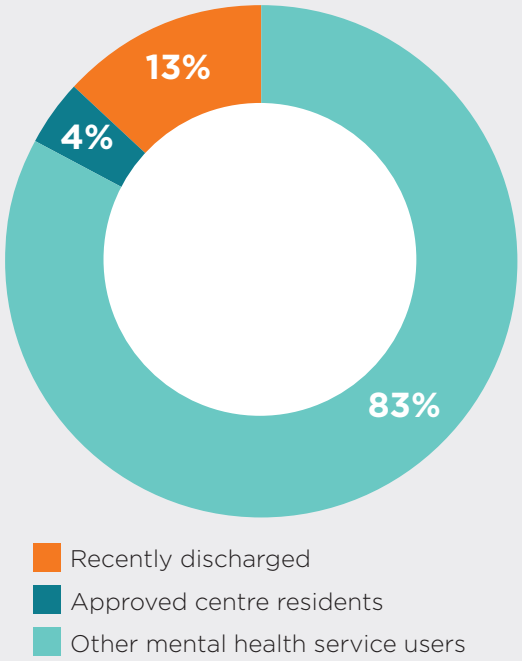
Deaths

In 2018, **533** deaths of people using mental health services were reported to the Commission. 171 of these related to regulated services (approved centres), while 362 related to other community mental health services.

Death by suicide may only be determined by a Coroner's inquest, which may take place a number of months after the death.

However, 184 deaths were reported to us by the service as 'suspected suicides'. Figure 5 shows the percentage of deaths reported as suspected suicides, broken down by service type.

FIGURE 5. SUSPECTED SUICIDES BY SERVICE TYPE



Serious Reportable Events

All mental health services are required to notify the Commission of Serious Reportable Events (SREs, HSE 2015). In 2018, **32** SREs were reported to the Commission, **27** of these related to residents of approved centres. Table 6 shows the number of reported SREs, broken down by SRE category.

TABLE 6. SERIOUS REPORTABLE EVENTS REPORTED BY CATEGORY

SRE category	Description	Number reported
Care Management Event (4I)	Stage 3 or 4 pressure ulcers	6
Environmental Event (5D)	Serious disability associated with a fall	14
Criminal Event (6C)	Sexual assault on a patient or other person	12

Child admissions

The Commission closely monitors the admission of children and young people (under the age of 18) to in-patient mental health services. The total number of admissions of young people to approved centres in 2018 was **408**. This compares with a total of 439 admissions in 2017 and 509 in 2016.

Admissions to adult approved centres

Children and young people should not be admitted to adult units except in exceptional circumstances. The reason for the majority of admissions to adult units is due to an immediate risk to the young person or others, or due to the lack of a bed in a specialist CAMHS unit.

There are only CAMHS units in three counties nationally, and they generally do not take out-of-hours admissions. Children and young people in crisis are left with the unacceptable 'choice' between an emergency department, general hospital, children's hospital, or an adult in-patient unit.

In 2018, there were **84** admissions to **18** adult units. This compares with 82 admissions to 21 adult units in 2017.

11 of those admissions were for less than 48 hours.

Admissions to child and adolescent approved centres

There are six specialist CAMHS units nationally; four in Dublin, one in Cork and one in Galway.

In 2018, there were **324** admissions to these units. The average duration of admission was 57 days (based on discharge information provided for 304 admissions).

Involuntary child admissions

The District Court has to authorise the involuntary admission of a child. In 2018, there were 18 involuntary admissions orders of children to approved centres, pursuant to Section 25 of the Mental Health Act. This included:

- **5** orders to adult units
- **13** orders to CAMHS units

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

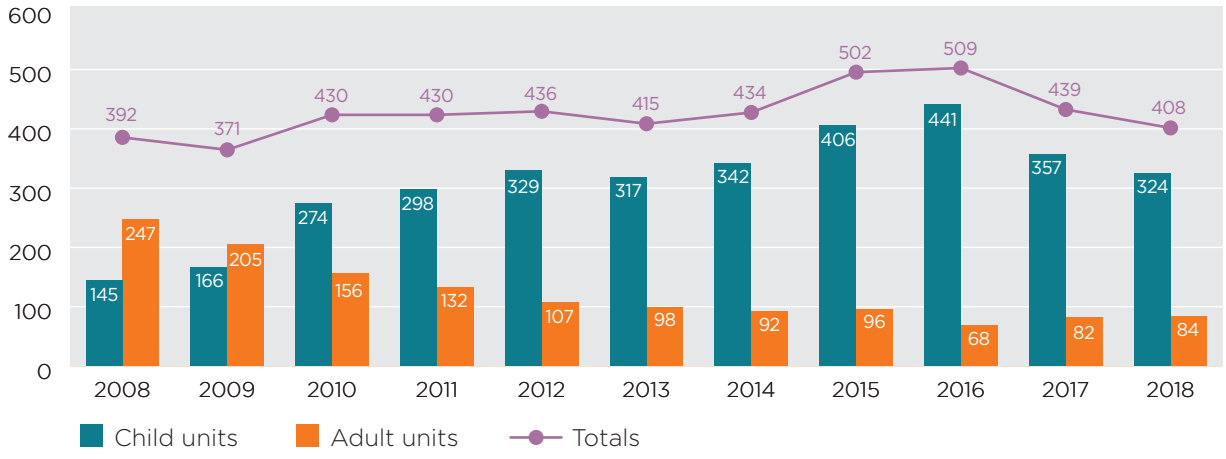
Age and gender of child admissions

In 2018, 62% of all child admissions were female.

TABLE 7. AGE OF CHILD ADMISSIONS TO ADULT AND CHILD UNITS

Age	Adult unit	CAMHS unit
17	45	99
16	31	97
15	6	65
14	2	37
13 and under	0	26

FIGURE 6. CHILD ADMISSIONS BY UNIT TYPE (ADULT OR CHILD) FROM 2008 TO 2018



Quality Improvement

The Commission has a mandate to foster high standards and good practices in the delivery of mental health care. 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 analysis, issuing guidance and developing evidence based standards, rules and codes of practice to improve service delivery and service user experience.

We also utilise quality improvement methodologies in the review of our own internal processes.

During 2018, our key activities under our Quality Improvement functions included a national in-patient census, a new suite of Quality & Safety Notification Forms, the development of a new Comprehensive Information System and the collaborative development of National Standards for Adult Safeguarding, together with HIQA.

Collaborative Working

Submissions

During 2018, we provided submissions or comment on a number of draft standards, frameworks, strategies and position papers, including but not limited to:

- Oversight Group for 'A Vision for Change' Review
- Joint Oireachtas Committee on the Future of Mental Health Care
- Policing Authority Policing Priorities for 2019
- Draft HSE Adult Safeguarding Policy
- Draft NMBI Standards for Registered Nurses and Midwives on Medication Administration
- Draft HIQA Guidance on a Data Quality Framework for Health and Social Care
- HRB Research Priorities for Ireland's Health Care System
- DYCA National Strategy of Children and Young People's Participation in Decision Making

Committees, Advisory Groups and Interest Groups

During 2018, we participated in a number of groups to contribute to the development of standards, share learnings and gain international insights, including:

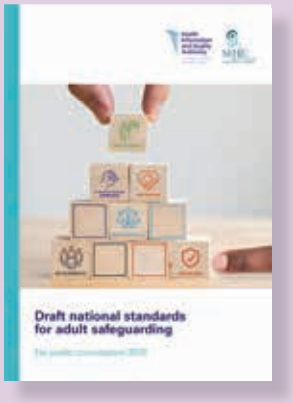
- National Clinical Effectiveness Committee
- International Foundation for Integrated Care, Healthcare Regulators Interest Group
- International Healthcare Regulators Forum
- National Safeguarding Committee
- National Standards for Infection Prevention and Control in Community Services Advisory Group
- HIQA Expert Advisory Group on Restrictive Practices
- HIQA Advisory Group for Human Rights Based Approach to Health and Social Care
- National Healthcare Quality Reporting System Governance Committee

Adult Safeguarding

During 2018, we continued to develop - jointly with HIQA - national standards for adult safeguarding for health and social care services. National standards for adult safeguarding will promote a consistent approach to preventing and responding to harm when it does occur.

Key work undertaken with HIQA in 2018 included:

- A background document (including a systematic literature review), and a review of national and international adult safeguarding practices.
- An Adult Safeguarding Seminar attended by over 220 delegates: 'Promoting Rights, Health and Well-being'.
- Extensive stakeholder engagement, including an advisory group, focus groups and a public consultation.



Comprehensive Information System

During 2018, we continued to develop our new Comprehensive Information System (CIS), which will enable a coordinated, organisation-wide, secure system which supports our core functions.

As well as an internal information and process management system, the CIS will provide a direct interface with mental health services, allowing authorised individuals to log on to the system for key interactions with the Commission, including: registration applications, 'Comment and Review' of inspection reports, CAPAs, Quality and Safety Notifications and notifications in respect of involuntary admissions.

During 2018, we continued extensive development and testing. We held workshops with services and held on-site training at the Commission, as well as familiarisation sessions with services at their premises in Dublin and Galway. We went 'live' with the CIS for registration processes in December and will continue development in 2019.

Quality and Safety Notifications

Regulated services are required to submit Quality and Safety Notifications to the Commission in relation to adverse events (deaths and serious incidents), regulated practices (restraints and ECT) and areas we closely monitor (e.g. child admissions).

As part of the CIS project, and in light of the GDPR regulations, we undertook a review of our quality and safety notification forms. We updated our forms to include a standardised format and standard questions which improve ease of use and minimise the collection of personal data.

We undertook workshops and a targeted consultation with services on the revised forms and received constructive feedback which informed the final product.

We also updated our Guidance on Quality and Safety Notifications. The updated forms and guidance can be found on our website www.mhcirl.ie.

2018 National In-patient Census

28 NOVEMBER

2,345 RESIDENTS
65 APPROVED CENTRES

47% **52%**

LENGTH OF ADMISSION

52% less than three months

41% over six months

29% over 2 years

18% over 5 years

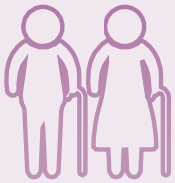
10% persons in acute adult beds for longer than 6 months

84% national occupancy rate

2% Wards of Court

13% involuntary

81% voluntary



33% over 65

PRIMARY DIAGNOSIS

39% Schizophrenia disorders

19% Depressive disorders

12% Organic disorders (including dementia)

7% Mania

4% Personality disorder

Youngest resident **12 years** of age

Oldest resident **101 years** of age

Notes: On 28 November 2018 the Commission conducted an in-patient census across all of its regulated in-patient mental health services (approved centres). This included all residents who were in-patient in the unit, absent without leave, on approved leave, or transferred to another facility (e.g. a general hospital) but not discharged.

Responses were received from all 65 approved centres that were on the Register of Approved Centres as of midnight on the 28 November 2018. The census information was submitted by each service on a standard form on an excel spreadsheet and was stored securely at the Commission and available to a limited number of designated personnel. A process of data validation was undertaken and services contacted in relation to any queries.

The information gathered on the census will be used to inform the Commission of the resident profile across in-patient services.

Mental Health Tribunals

2018 was a significant year in progressing the rights of both persons who are voluntarily in approved centres and patients who have been involuntarily detained.[1]

Key Changes

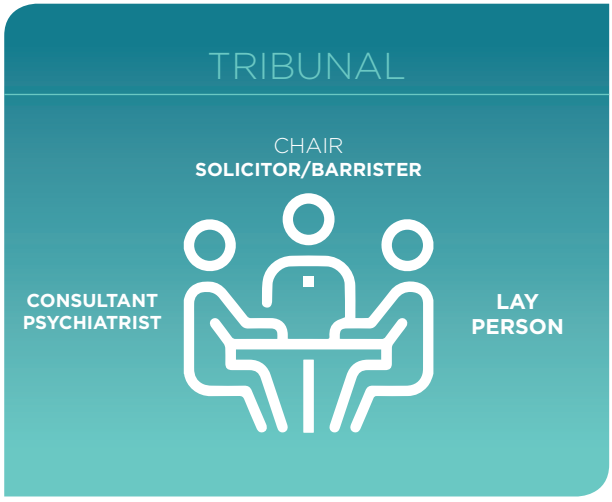
- Patients can no longer be involuntarily detained on orders for up to 12 months.
- Patients, if involuntarily detained on orders for up to six months, are entitled to an additional review by a tribunal if still detained after three months.
- The orders which can be considered by the Circuit Court have been expanded.
- The very limited basis upon which a voluntary patient can be prevented from leaving an approved centre has been clarified.

1 This progress was a result of a number of Court decisions.

Introduction

Under the Mental Health Act 2001 (the 2001 Act), every adult who is involuntarily detained in an approved centre shall have their detention order reviewed by a mental health tribunal (tribunal). This is a core requirement in protecting and upholding patients' human rights.

The 2001 Act sets out how this mandatory system of independent review operates. The independent review must be carried out by a tribunal within *21 days* of the making of the order. The tribunal is made up of three people – a solicitor/barrister as chair, a consultant psychiatrist and another person, often referred to as a lay person.



As part of this process, the Commission assigns each patient a legal representative (covered by legal aid) but, if they so wish, a patient can also appoint their own private solicitor. The Commission also arranges for the patient to be reviewed by an independent consultant psychiatrist, whose report is provided to their legal representative and the tribunal.

Parties who may be in attendance at the tribunal are the patient (who may not always attend), the patient's legal representative (if the patient wants them to attend) and the patient's treating consultant psychiatrist.

Involuntary Admission

A person can only be admitted to an approved centre and detained there if he or she is suffering from a mental disorder (as defined in section 3 of the 2001 Act).

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

In such cases, the admission order is made by a consultant psychiatrist on a statutory form (Form 6 or 13). If detained on a Form 6, the form must be accompanied by other statutory forms which include an application form (Forms 1, 2, 3, or 4) and a recommendation form by a registered medical practitioner (Form 5).

The initial order detaining a patient, known as an *admission order*, is for a maximum of *21 days*. The detention can be extended by a further order, known as a *renewal order*, the first of which can be for a period up to three months and the second for a period up to six months.

A renewal order can only be made after the consultant who is responsible for the patient reviews the patient and decides that he or she is still suffering from a mental disorder. A consultant psychiatrist, when making an order for up to three or six months, does not have to make it for the full period and must use their clinical judgement to decide what is appropriate. Each of these orders are also sent to a tribunal to be reviewed.

Up to October 2018, a patient could be detained on an order for up to 12 months. An Act was passed in 2018 which prevented orders for up to 12 months being made and it also made a change regarding orders of up to six months (this was following a court decision).[2]

The 2018 Act required all patients on orders up to six or 12 months (second or subsequent renewal orders), as of 8 October 2018, to be reviewed by their responsible consultant psychiatrist. If the patient was suffering from a mental disorder, an order was to be made. These were known as *replacement renewal orders*. All such orders were to be reviewed by a tribunal within 21 days of the date of the order.

A total of 97 orders were made and a total of 96 hearings took place. These replacement renewal orders have not been included in the 2018 statistics.

Of importance is that if a patient is detained on an order for up to six months (a second or subsequent renewal order) he or she is now entitled to an additional review by a tribunal if still detained after three months. This is an **extra safeguard** for patients.

In 2018 the following orders were made:

- **1,825** admission orders from the community
- **610** admission orders by way of re-grading
- **963** renewal orders for a period up to 3 months
- **151** renewal orders for a period up to 6 months[3]
- **104** renewal orders for a period up to 12 months (such orders no longer exist).

There was a 4% increase in admission orders between 2017 and 2018. Of note is that there has been a 13% increase in admission orders over the last five years.

Tribunal Hearings

A tribunal must sit within 21 days of an order being made. A total of 2002 tribunals took place in 2018.[4] In Figure 12 on page 40, it can be seen on what day of that 21-day period tribunals were heard in 2018.[5]

In 2018;

- **1,711** orders were revoked before hearing,
- **2,002** orders went to hearing, and
- **225** orders were revoked at hearing.

The Report of the Expert Review Group in December 2014 recommended that reviews by tribunals should be carried out within 14 days of the order being made. In 2018, 86% of hearings took place between days 15 and 21. The Commission will have to consider how best to implement such a change if it becomes law.

2 AB-v-the HSE and others:- 3 May 2018 – following which the Mental Health (Renewal Orders) Act 2018 was enacted and commenced.
3 The 97 Replacement Renewal Orders received in October 2018 have not been included in this figure.
4 The 96 hearings for Replacement Renewal Orders have not been included in this figure.
5 Hearings heard/concluded after the 21 days relate to hearings that were extended (as allowed under the Act) or relate to section 28 hearings heard after an order is revoked.

Orders revoked before hearing:

A consultant psychiatrist responsible for a 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, 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 reasonably 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 – written notice to this effect. When a patient's order is revoked, they may leave the approved centre or they may agree to stay to receive treatment on a voluntary basis. In 2018, **46% of all orders** were revoked before a tribunal hearing.

Section 28 tribunal hearings:

If an order is revoked before a tribunal hearing, the patient can still decide to have a tribunal. This is commonly referred to as a section 28 tribunal. Of the 1,711 orders revoked before hearing, there were 39 requests for section 28 tribunals, of which 30 proceeded to an actual hearing. This is a very small percentage (1.8%) of the orders revoked before hearing.

The Commission has stated that, in its opinion, it is not clear what a tribunal is to decide at a section 28 hearing. Some comments were made on section 28 by the Supreme Court in a recent decision but the matter was not dealt with in any detail.[6]

Orders revoked at hearings:

As noted on the previous page, the number of orders revoked at a tribunal was 225, which was 11% of those that went to hearing. This shows an increase of 1% from 2017.

During 2019, the Commission plans to review the breakdown of why these orders are revoked at hearing and provide additional information to the public in the 2019 Annual Report.

Voluntary to involuntary

There was an important court decision in 2018 relating to the rights of voluntary patients. The court highlighted that voluntarism is a cornerstone of our system of medical treatment.

Currently, if a voluntary patient indicates a wish to leave an approved centre, they can be detained if certain staff are of the opinion that the patient is suffering from a mental disorder. A detailed process must be undergone before this can happen which includes the requirement that the person must be reviewed by their responsible consultant psychiatrist and a second consultant psychiatrist.

As noted, there were 610 such admissions notified to the Commission in 2018.

Age and gender

Analysis of age and gender was completed on the figures for episodes of involuntary admission in 2018 (see tables 5, 6 and 7).

- People aged 35-44 had the highest number of involuntary admissions at **22%** in comparison to 2017 where the highest number of involuntary admissions was in the 25-34 age group at 23%.
- Those aged over 65 had a decrease in involuntary admissions to **15%** down 2% from 2017.
- **54%** of total involuntary admissions were male. However, there were more female admissions in all age groups over 45.

6 IF-v-MHT heard on 21 March 2019 and judgment dated 29 May 2019.

TABLE 8. ANALYSIS BY GENDER AND AGE OF 2018 INVOLUNTARY ADMISSIONS

Age	Male	Female	% gender
18 – 24	221	98	69% male
25 – 34	308	186	62% male
35 – 44	293	243	55% male
45 – 54	190	224	54% female
55 – 64	133	177	57% female
65 and over	159	203	56% female
Total	**1,304**	**1,131**	**54% male**

TABLE 9. ANALYSIS BY GENDER AND ADMISSION TYPE OF 2018 INVOLUNTARY ADMISSIONS

Gender	Form 6	Form 13	Total	%
Female	804	327	1,131	46%
Male	1,021	283	1,304	54%
Total	**1,825**	**610**	**2,435**	**100%**

TABLE 10. ANALYSIS BY GENDER, AGE AND ADMISSION TYPE OF 2018 INVOLUNTARY ADMISSIONS

Age	Form 6	Form 6 Female	Form 6 Male	Form 13	Form 13 Female	Form 13 Male	Total	%
18 – 24	215	55	160	104	43	61	319	13%
25 – 34	375	131	244	119	55	64	494	20%
35 – 44	418	176	242	118	67	51	536	22%
45 – 54	304	157	147	110	67	43	414	17%
55 – 64	234	133	101	76	44	32	310	13%
65 and over	279	152	127	83	51	32	362	15%
Total	**1,825**	**804**	**1021**	**610**	**327**	**283**	**2,435**	**100%**

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.

They key changes to the 2018 figures show that applications by family members are down by 6%; applications by authorised officers are up by 2%; applications by Garda Siochána are up by 1%; and applications by 'any other person' are up by 3%.[7]

The Commission welcomes the decrease in applications by family members but remains concerned about the effects that these types of applications have on family members and loved ones.

FIGURE 7. ANALYSIS OF APPLICANTS FOR INVOLUNTARY ADMISSION FROM THE COMMUNITY IN 2018

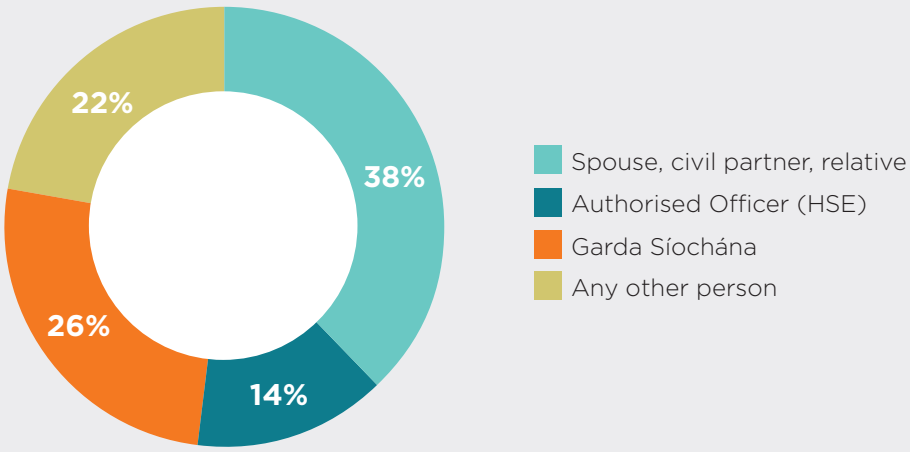
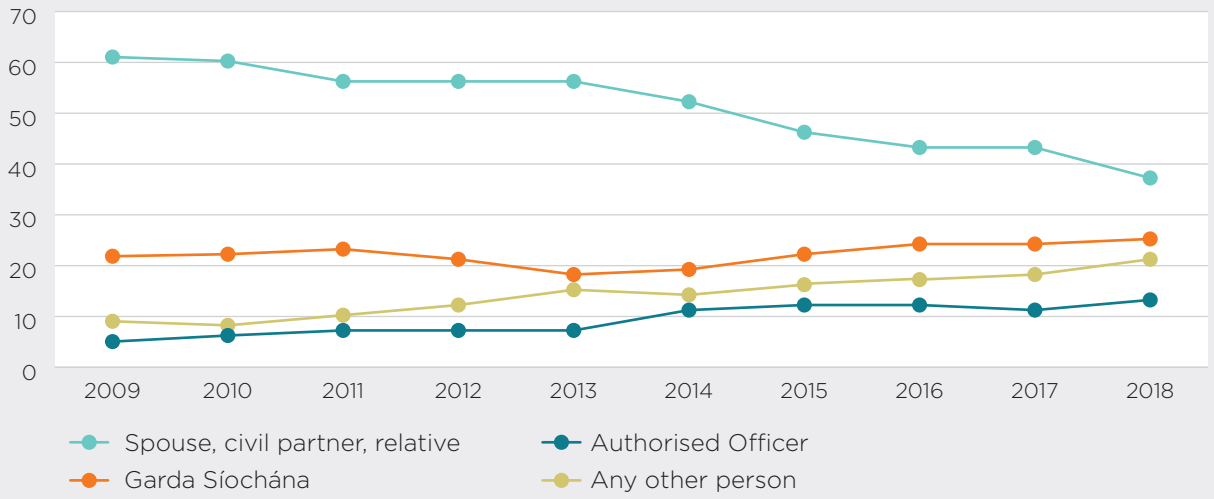


FIGURE 8. ANALYSIS OF APPLICANTS FOR INVOLUNTARY ADMISSION FROM COMMUNITY FROM 2009 TO 2018



7 'any other person' is very broad and can include a doctor in an A&E Department.

Circuit Court Appeals

Patients can appeal the decision of a tribunal to the Circuit Court. However, the appeal does not consider the decision of the tribunal. Exactly what the Circuit Court can consider in relation to certain orders (those that have been revoked or extended by the time appeal comes up for hearing have been extended) is an issue on which the Supreme Court recently made a decision.

The Supreme Court held that a renewal order extends the life of an admission order, therefore when someone has appealed the decision of a tribunal in relation to an admission order, which is then extended by a renewal order, the appeal can still proceed as the focus of the appeal is the current state of the patient and whether the patient is or is not suffering from a mental disorder.[8]

The Commission was notified of 142 Circuit Court appeals in 2018. This is consistent with the numbers received in recent years with the exception of 2017 when 120 such appeals were received. Of the 142 appeals received in 2018, 27 appeals proceeded to full hearing. This is in comparison to 21 in 2017 and 35 in 2016.

The issue of whether the Circuit Court should be allowed to deal with matters other than the issue of mental disorder has been the subject of some discussion. The Commission would advocate for the expansion of the matters with which the Circuit Court can deal. This would enhance the rights of persons detained in approved centres. Furthermore, as these Courts are local, they are more accessible. In addition, the Commission's legal aid scheme is available to patients wishing to bring Circuit Court appeals.

8 Appeal to Supreme Court in the case of IF-v-MHT heard in March 2019 and judgment dated 29 May 2019.

Mental Health Tribunal Activity

Please note that Replacement Renewal Orders and associated tribunal hearings have been excluded from the relevant graphs and tables (Figure 11: Comparison of renewal orders, Figure 12: Breakdown of hearings over 21 day period 2018 and Figure 13: Number of hearings and % of orders revoked at hearing 2018).

FIGURE 9. MONTHLY INVOLUNTARY ADMISSIONS 2018

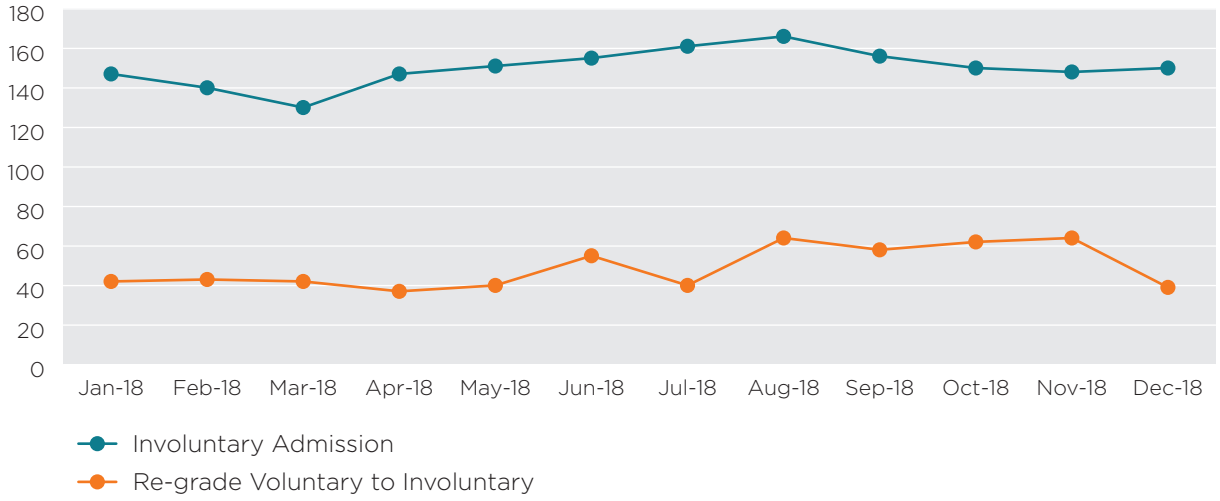


FIGURE 10. COMPARISONS OF TOTAL INVOLUNTARY ADMISSIONS 2014-2018

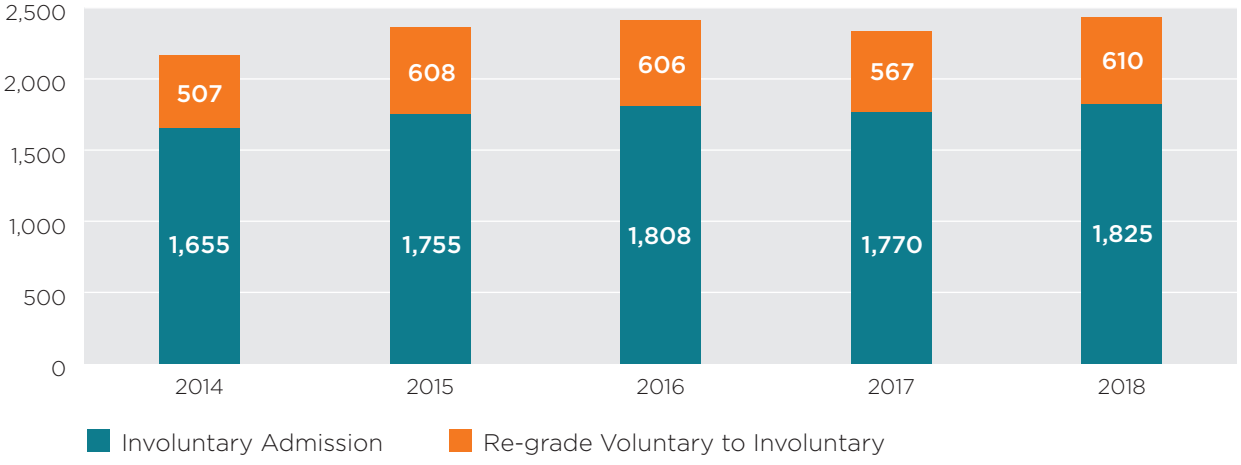


FIGURE 11. COMPARISON OF RENEWAL ORDERS 2009-2018

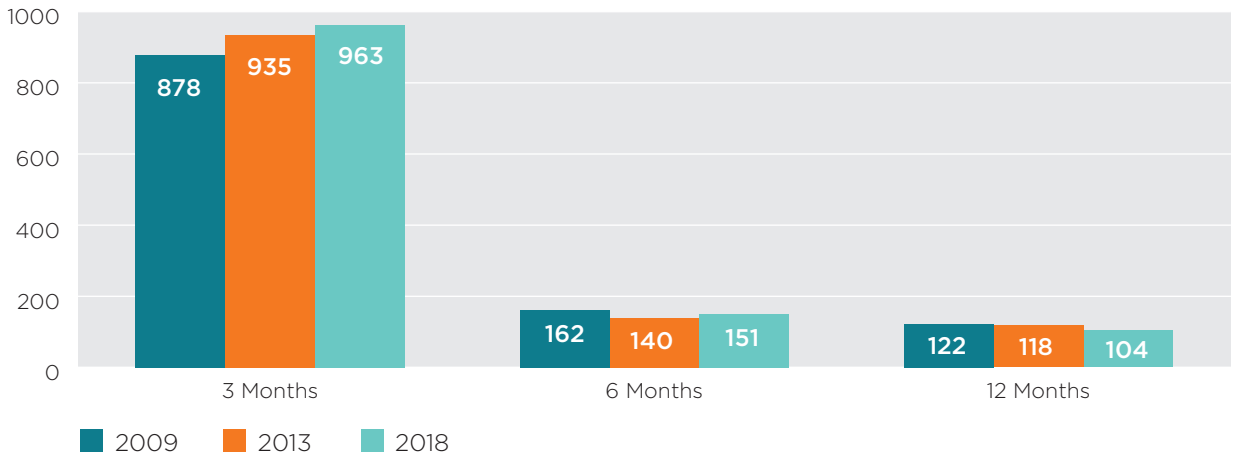


TABLE 11. INVOLUNTARY ADMISSION RATES FOR 2018 (ADULT) BY CHO AREA AND INDEPENDENT SECTOR[1]

	Involuntary Admissions	Re-grade Voluntary to Involuntary	Total Involuntary Admission Rate	Population
CHO1	161	53	214	389,266
CHO2	199	56	255	442,972
CHO3	124	24	148	380,206
CHO4	270	100	370	676,638
CHO5	163	41	204	504,709
CHO6	106	33	139	378,175
CHO7	162	73	235	686,483
CHO8	211	36	247	612,102
CHO9	291	108	399	606,097
Independent Sector[2]	138	86	224	N/A
TOTAL (Exclusive of Independent sector)	**1,687**	**524**	**2,211**	**4,676,648**
TOTAL (Inclusive of Independent sector)	**1,825**	**610**	**2,435**	**4,676,648**

1 Population figures taken from CSO Census 2016. Detailed analysis of involuntary admission rates for 2018 per approved centre is provided on the Mental Health Commission website www.mhcirl.ie.
2 There are six independent approved centres.

FIGURE 12. BREAKDOWN OF HEARINGS OVER 21 DAY PERIOD 2018

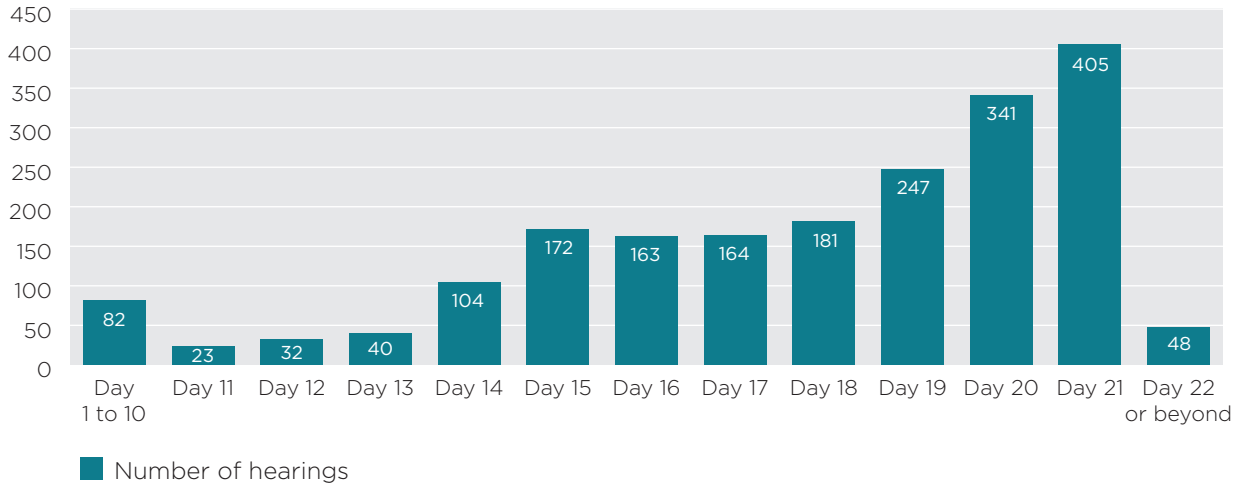


FIGURE 13. NUMBER OF HEARINGS AND % OF ORDERS REVOKED AT HEARING 2018

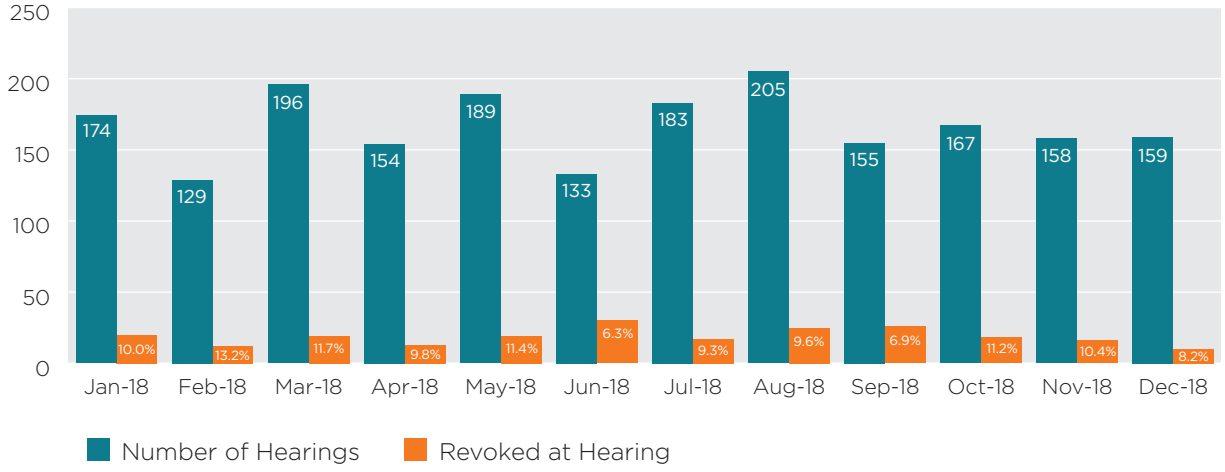
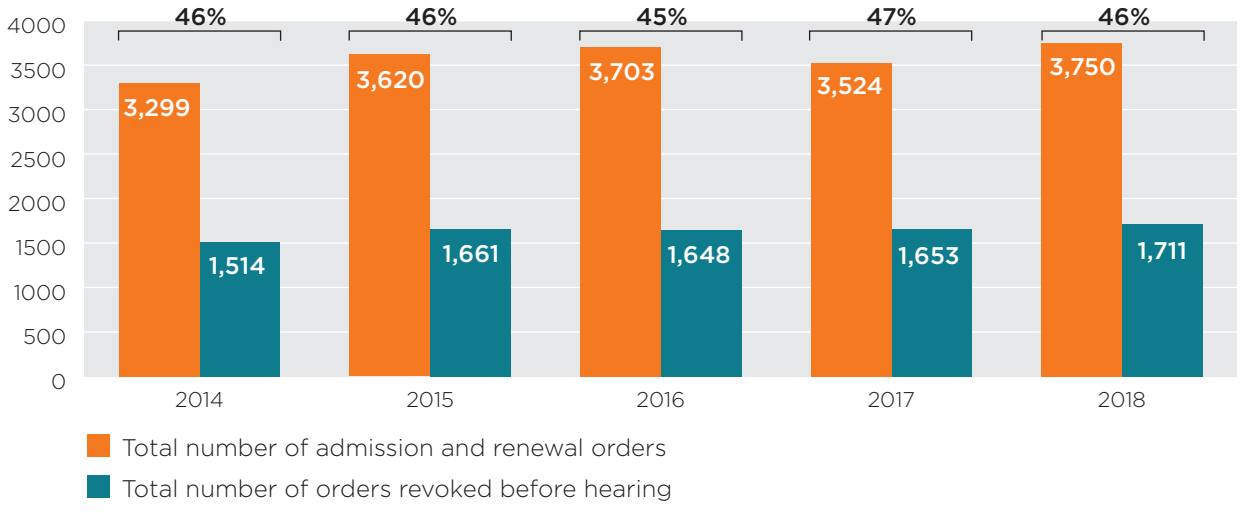


FIGURE 14. NUMBER OF ORDERS REVOKED BEFORE HEARING BY RESPONSIBLE CONSULTANT PSYCHIATRISTS FOR YEARS 2014 TO 2018



Decision Support Service

The Decision Support Service (DSS) is an essential service for all adults who have difficulties with decision-making capacity. This may include people with an intellectual disability, mental illness or acquired brain injury, as well as people with age-related conditions who may need supports to make decisions.

During 2018, we continued work to establish the Decision Support Service within the Commission. The Decision Support Service is provided for under the Assisted Decision Making (Capacity) Act 2015 ('2015 Act'). The 2015 Act is a significant piece of reforming human rights legislation which provides a modern statutory framework for supported decision-making.

The 2015 Act establishes a statutory time-specific and issue-specific assessment of capacity and sets out important guiding principles, emphasising privacy, autonomy, and minimal intervention.

The supports provided for and monitored by the Decision Support Service will help to ensure that people are afforded the fundamental human rights to make their own decisions as far as possible about their personal welfare and their property and affairs.

In 2018, Ireland ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). Key requirements of Article 12 of the UNCRPD include:

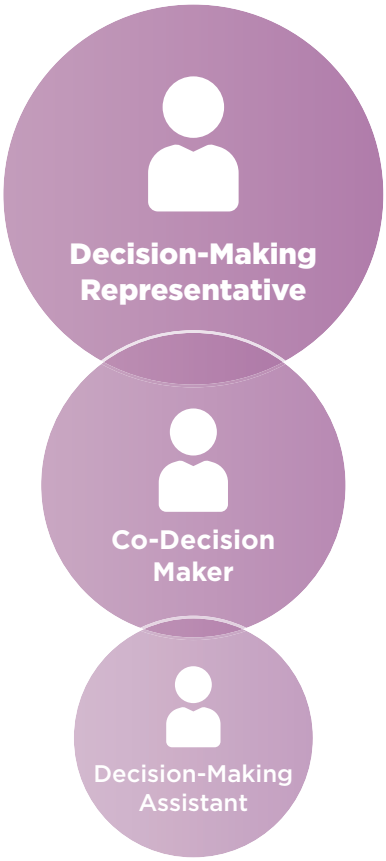
- Persons with disabilities have the right to recognition everywhere as persons before the law.
- Persons with disabilities should enjoy legal capacity on an equal basis with others in all aspects of life.
- Appropriate measures should be taken to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
- All measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. These safeguards must respect the will and preference of the person.
- Appropriate measures should be taken to ensure the equal rights of persons with disabilities to own or inherit property, to control their own financial affairs.

The establishment of the Decision Support Service and the commencement of the 2015 Act are central to compliance with UNCRPD.

The Decision Support Service will also act as Ireland's Central Authority for the Hague Convention of the International Protection of Adults. In December 2018, the Director attended a European Commission-Hague Convention Joint Conference on the Cross-border Protection of Vulnerable Adults in Brussels and presented on the 2015 Act and the steps towards ratification of the Convention.

Who needs the Decision Support Service?

The 2015 Act sets out three different tiers of supports that could be provided to a relevant person who is faced with capacity challenges.



At the lowest end of supports, the person may appoint a Decision-Making Assistant to obtain and explain information and to help the person make and express a decision. At the next level is a Co-Decision Maker, who again, provides support and information, but also makes the decision jointly with the relevant person.

At the top end is a Decision-Making Representative, who is appointed by the Circuit Court to make certain decisions on the relevant person's behalf. Ideally, this will be someone close to the relevant person.

The Act also provides improved tools for advance planning so that adults with capacity can provide for a time in the future when they might lose capacity. They can do so by way of an Enduring Power of Attorney and Advance Healthcare Directive.

At all levels, the decision supporters must abide by Guiding Principles and respect the relevant person's will and preferences. There are varying requirements around registration and reporting duties depending on the level of the arrangement.

While we all are presumed to have capacity, it is estimated that there could be over 220,000 adults in Ireland who require some level of support to help them to make decisions. In some cases, the 2015 Act requires that certain people must be notified if a decision support arrangement needs to be registered with the Decision Support Service. As such, the reach of the Decision Support Service will potentially be very extensive.

Implementing the Decision Support Service

During 2018, extensive work was undertaken in preparation for a fully operational Decision Support Service. This included organisational design, scoping the service, project governance, scoping ICT infrastructure, defining the regulatory framework, undertaking stakeholder engagement and mapping out our customer journeys.

As part of the planning and implementation of the Decision Support Service, five key design principles (see Figure 15) were agreed to inform all stages of the Decision Support Service design and operationalisation.

FIGURE 15. DESIGN PRINCIPLES FOR THE DECISION SUPPORT SERVICE

A number of successful recruitment campaigns were undertaken later in 2018 to fill key roles in the new Decision Support Service structure, as well as within the wider Commission to ensure appropriate operation supports are in place.

Codes of Practice

During 2018, significant work was advanced in the development of a number of Codes of Practice for decision supporters and certain categories of professionals, e.g. healthcare professionals, legal and finance professionals. A large body of work was carried out by the National Disability Authority with the input of relevant technical experts and five draft Codes were provided to the Director of the Decision Support Service in November 2018. In addition, the Advance Healthcare Directives Multi-Disciplinary Working Group commissioned by the Minister for Health submitted three draft codes to the Director in December 2018.

The Director will review the draft Codes and undertake a public consultation before the final codes are published with Ministerial approval. This work will continue in 2019.

FIGURE 16. ESTIMATE ENGAGEMENT OF ADULT POPULATION WITH DECISION SUPPORT SERVICE

220,000

Adults may have arrangements with the Decision Support Service

Engagement with stakeholders to raise awareness

The 2015 Act is largely not yet commenced. However, certain sections have been commenced, which include the appointment of the Director to allow for the establishment of the Decision Support Service. The Director was appointed in October 2017 and has a number of specific functions and responsibilities set out under Part 9 of the 2015, including providing information and promoting public awareness.

The Director undertook significant engagement with stakeholders in 2018, to provide information about the Decision Support Service, and to listen to the views of people who are likely to be affected by the Decision Support Service (Figure 17 below).

The Decision Support Service is represented on these external committees

- HIQA Advisory Group: Guidance on a Human Rights-Based Approach to Care and Support in Health and Social Care Settings
- Standards Advisory Group Joint HIQA-MHC National Standards for Adult Safeguarding
- Safeguarding Ireland
- Expert Review Group 'Promoting Assisted Decision Making in Acute Care Settings' (PADMACS) Project (UCD)
- Inter Departmental Steering Group for the Implementation of the Decision Support Service (Department of Justice and Equality and the Department of Health)

FIGURE 17. ORGANISATIONS THE DIRECTOR OF THE DECISION SUPPORT SERVICE ENGAGED WITH IN 2018

University College Cork School of Law
Protecting and Enhancing the Rights of Vulnerable Adults and Older People (August). Medical Profession Dealing with Issues of Capacity & Consent & the implications of the Assisted Decision Making(Capacity) Act 2015 (October)

University of Limerick School of Law
School of Medicine Seminar

UCD – Health Sciences (Assisted Decision Making in Acute Care)

RCSI
Annual Conference Masterclass (March)

University College Dublin Psychology
Expert panel (April) and Presentation to Gerontology (May)

UCD Sutherland School of Law
Workshop (August)

NUIG – Centre for Disability Law & Policy
Voices – "Silenced, Alone, Powerless: My Life as a Ward of Court in Ireland" workshop and book launch (October)

Department of Health

Nursing Homes Ireland
Annual Conference (November)

Institute of Hospice & Palliative Care
Palliative Care & Disabilities seminar (June)

Irish Hospice Foundation
Planning for the future: Conversations and Challenges Conference (October)

Safeguarding Ireland
Roundtable on Advocacy (October)

College of General Practitioners

Irish Association of Social Workers
IASW National Social Work Conference 2018: Keeping Adults Safe: Rights, Risks and Vulnerability (May)

NMBI

Department of the Taoiseach

Four Jurisdictions Capacity and Guardianship Conference

Department of Justice Equality and Law Reform

HQIA Safeguarding Standards Advisory Group
Safeguarding seminar (May)

Office of the Wards of Court

IHREC

EC-HCCH Joint Conference on the Cross-border Protection of Vulnerable Adults

Courts service

National Disability Association

Office of the General Solicitors for Wards of Court & Minors

Law Society of Ireland

Professional Training

Mental Health and Capacity Committee of the Dublin Solicitors Bar Association (September)

Law Society's Human Rights Committee Annual Conference (October)

Sage

Nothing about you/ without you: Protecting and enhancing the rights of vulnerable adults and older people (May) Preparing for Commencement – ADM (Capacity) Act 2015 (June)

Inclusion Ireland

A.G.M. & Seminar (June)

National Advocacy Service

Independent advocacy meeting (July)

Family Carers

Workshop (April)

Daughters of Charity

A New Model: Pathway to Implementation of the Decision Support Service Daughters of Charity Presentation (December)

Society of Financial Planners Ireland

Society of Financial Planners Ireland Annual Conference (September)

Association of Compliance Officers Ireland

Understanding the Implications of the Assisted Decision-Making Capacity Act 2015 for Financial Services (July)

Banking & Payments Federation

Institute of Banking

Understanding the Implications of the Assisted Decision-Making Capacity Act 2015 for Financial Services

Governance

Introduction

The Members of the Mental Health Commission (the Commission) are the governing body of the organisation. The Commission has 13 Members (including the Chairman) who are appointed by the Minister for Health. Section 35 of the Mental Health Act 2001 (the 2001 Act) provides for the composition of the Commission. In December 2015, the Commission's remit was extended to include the establishment of the Decision Support Service under the provisions of the Assisted Decision (Making) Capacity Act 2015 (the 2015 Act).

2018 was the first full 12 months for the current Commission Members, who were mostly appointed in April 2017. Details of the Commission's membership and meeting attendance for 2018 are provided on page 56 of this Report.

During 2018, the Commission had two standing committees, the Audit and Risk Committee and the Legislation Committee. Details of both Committees can be found on page 57. In late 2018, the Commission established a third Committee called the Quality Improvement Committee.

Corporate Governance within the Mental Health Commission

The Commission is committed to attaining the highest standard of Corporate Governance within the organisation. Continuing to develop a culture which supports and drives high standards was central to the work programme undertaken by Members and the Executive in 2018.

On 1 September 2016, the 2016 Code of Practice for the Governance of State Bodies (the 2016 Code) became the definitive corporate governance standard for all commercial and non-commercial state bodies in Ireland. Its provisions supersede the standards previously issued in October 2001 and May 2009 by the Department of Finance. The 2016 Code consists of one main standard and four associated Code requirement and guidance documents. The Code was updated in November 2017 with a Guide for Annual Financial Statements and the Annual Report.

Agencies were given 12 months following the launch of the 2016 Code of Practice to action and implement the provisions. The Commission has adopted the 2016 Code and has put procedures in place to ensure compliance with the provisions of the Code. Except for a few provisions, the Commission is substantially compliant with the 2016 Code. All reporting requirements for 2018 have been met.

Key Governance Activities in line with the requirements of the Code undertaken during 2018

Board Effectiveness

In line with good governance, the Commission undertook a self-assessment survey in Quarter 4 2018. This was considered by the Commission Members at its meeting in January 2019 and a report on actions was produced.

The Audit and Risk Committee (ARC) and Legislation Committee also undertook self-assessments for 2018. The details of the assessment were discussed by the ARC Members at its meeting in March 2019 and any issues arising are to be actioned. The details of the Legislation Committee have also been considered. Furthermore, the ARC in 2018 agreed that one of the Internal Audits for 2019 would be an audit on the Commission compliance with the 2016 Code.

In line with the 2016 Code of Practice, the Commission's overarching responsibilities are:

- 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
- to monitor the overall management of the organisation

In 2018 the 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
- Significant amendments to the pension benefits of the Chief Executive and Staff

Corporate Governance

The Corporate Governance Manual for the Commission was updated in May 2017. This is undergoing further review which shall be completed in 2019.

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

For the year ended 31 December 2018, 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. The Commission is to produce a dedicated Code of Conduct for Commission Members in 2019.

Business & Financial Reporting

The Department of Health allocation to the Commission for 2018 was €14.174 million. The outturn for 2018 in the Mental Health Commission was €14.423 million. The principle reason for the variance was as a result of a High Court decision in 2017 relating to orders up to 12 months, which was appealed and the Court of Appeal delivered its decision in 2018. This decision resulted in amending legislation resulting in additional orders and reviews by tribunals. The Commission was in ongoing communication with the Department of Health in relation to this matter to include the costs impact.

The Department of Justice and Equality allocation for the Decision Support Service work programme for 2018 was €3 million (all of the funds were not drawndown).

Key areas of expenditure related to the statutory functions as set out in the 2001 Act including the provision of Mental Health Tribunals, the regulation of Approved Centres (community residences) and the establishment of the Decision Support Service.

Other expenditure related to staff salaries, rent, professional fees, ICT and related technical support. Third party support contracts continue to be managed to ensure value for money and service delivery targets are met.

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

Furthermore, the Commission can confirm that it adhered to the Public Spending

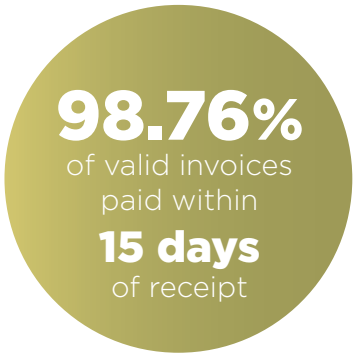
Code and the Government travel policy requirements. The Commission did not make any payments in relation to non-salary related fees.

The Commission has included a statement on the system of internal control in the format set out in the 2016 Code in the unaudited Financial Statements for 2018.

The Commission approved the draft unaudited Financial Statements and agreed that they are a true and fair view of the Commission's financial performance and position at year end. The unaudited Annual Financial Statements for 2018 was submitted to the Comptroller and Auditor General (C&AG) as per Section 47 of the Mental Health Act 2001 and the 2016 Code. 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. The Audit and Risk Committee specifically addressed with the C&AG's office the need to have the audit of the Financial Statements completed earlier in order that the finalised audited Financial Statements could be included in the Annual Report. The C&AG committed to earlier audit in 2019 of the 2018 Financial Statements.

Prompt Payment of Account legislation

The Commission complied with the requirements of the Prompt Payment of Accounts legislation and paid 98.76% 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 Audit and Risk Committee held four meetings in 2018 and its Annual Report 2018 was provided to the Commission in March 2019. 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")
4. Risk Management
5. Governance and Internal Control
6. Personnel Performance Management

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 2018, the Commission adhered to the three main principles of governance: openness, integrity and accountability.

A significant part of the work programme of the Audit and Risk Committee is the oversight role it plays in the Risk Management process for the organisation. 2018 was the first full year of a revised Risk Management process, which introduced a number of key improvements to the manner in which risk was reported by the organisation. The ARC welcomed the changes made.

The risk environment is considered monthly by the Senior Management Team; it is an item on the agenda for each Commission meeting; and it is on the agenda for each ARC meeting.

Internal Audit and Control

The internal control system includes all the policies and procedures adopted by management to assist in achieving the 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

The Chief Executive (with the Senior Management team) provided the Commission with the relevant assurances on the adequacy and appropriateness of the internal control system.

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.

The Audit and Risk Committee at each of its meetings reviewed any draft Internal 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 2018-2020 Audit Plan. The ARC noted that management were using their best endeavours to address the various recommendations. The Audit Plan is reviewed annually depending on any issues that may arise (and specifically any risk issue). The Internal Auditors proposed the Internal Audits for 2019, based on the risk profile in 2018, and those internal audits were agreed by the Audit and Risk Committee at its meeting in November 2018.

Relations with Oireachtas, Minister and Department of Health

Governance meetings with officials from the Department of Health and the Executive took place in March, June, September and December 2018.

Oversight and Performance Delivery Agreements were signed for 2018.

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.

Information Management Technology (ICT)

The key focus for ICT within the Commission is to provide an innovative and resilient framework of Information Services to support all aspects of the Commission's business. This includes the implementation and configuration of corporate IT systems, as well as supporting the underlying technology.

During 2018, the Commissioned improved its network security (with increased focus on ransomware threats) and upgraded 60% of the Commission's desktops and laptops.

The Commission is developing a computerised Comprehensive Information System (CIS) which will support the Commission's core functions. The system is a web application which is accessed securely in a similar way to internet banking. Substantial work was undertaken in 2018 to advance this project.

Two of the five modules are currently live with all Applications for Registration and Approved Centre Inspections for 2019 being recorded on the CIS system. The remaining three modules are scheduled to go-live by the end of 2019.

Human Resources

The Human Resources function supports the employees of the Commission throughout their employment life cycle.

We acknowledge our employees as a pivotal resource of the Mental Health Commission and recognise and appreciate the diverse expertise, professionalism and commitment of employees.

Recruitment

In 2018, the Commission saw significant changes in the overall organisational structure. Further to the receipt of sanction from the Department of Health and Department of Justice and Equality, the headcount in the Mental Health Commission increased from 31 to 49 employees – a total increase of 58%.

By the end of 2018, the Commission saw the beginning stages of the recruitment for the DSS which comprised 5 posts, to support the establishment of this new service. In total by the close of 2018 the Mental Health Commission had 49 employees.

The promotion of equality, diversity and inclusion is reflected in our compliance with equality legislation. As an organisation, we ensure equal opportunities for all those that apply for posts advertised by the Commission, with gender balance being maintained on all our recruitment panels.

Performance Management

To help our employees grow and develop, a Performance Management Development System (PMDS) is in place to support the achievement of a positive performance and development culture. In 2018, performance management compliance was at 100%.

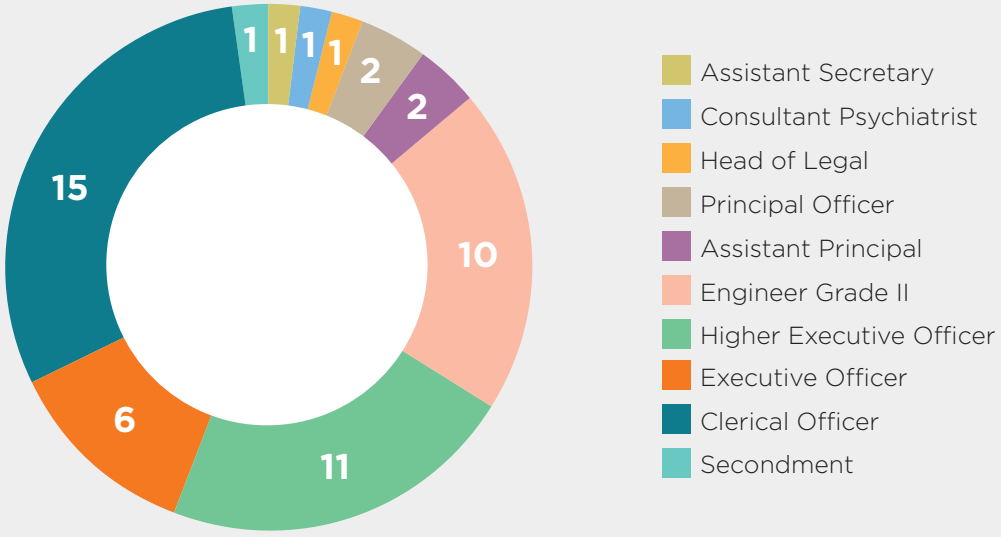
A comprehensive induction programme was rolled out for new employees of the Commission in 2018.

All new employees are also given a one-to-one induction and information packs on the commencement of their employment.

Employee Wellness

An Employee Assistance Programme (EAP) is a purpose built service, provided by an external provider, which offers a free, professional service for employees to resolve personal or work related concerns, which may affect a person's well-being and their performance in the workplace.

FIGURE 18. BREAKDOWN OF EMPLOYEES BY GRADE AS OF 31/12/18



Statistical returns from 2018 detail that 18 out of 49 employees availed of the service (37% employees in total engaged with the service in 2018).

The Commission is committed to supporting the well-being of its employees.

Supports for Employees with Disabilities

The Commission provides a positive working environment and, in line with equality legislation, promotes equality of opportunity for all employees. The National Disability Authority (NDA) has a statutory duty to monitor the employment of people with disabilities in the public sector each year, the target for which is 3%. In 2018, the Commission reported a rate of 3.92%.

Employee census update forms were made available to all employees in order to update the record on the number of employees with disabilities in the Commission. 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 and Safety

The Commission is committed to ensuring the well-being of its employees by maintaining a safe place of work and ensuring compliance with all requirement pursuant to the Safety, Health and Welfare at Work Act 2005 (as amended and/or updated). In 2018, the Commission undertook a full ergonomic assessment for all staff and has implemented all of the recommendations.

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

For the year ended 31 December 2018, 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 2018.

Freedom of information/ Data Protection

General Data Protection Legislation (GDPR)

The General Data Protection Regulation and the Data Protection Act 2018 came into effect on 25 May 2018. This required significant work to be done by the Commission. The Commission had all relevant policies in place prior to 25 May 2018 as well as many other actions. In the third quarter of 2018, an Internal Review of GDPR Compliance in the Commission took place. The recommendations made were incorporated into a GDPR Compliance Plan, which is reviewed and updated monthly as actions are completed. It also resulted in the establishment of an Information Governance Group. Its purpose is to address – amongst other issues – Data Protection and Freedom of Information matters throughout the Commission on an ongoing basis.

Freedom of Information/ Data Protection Statistics

In 2018, the Commission received 21 requests under the Freedom of Information Act 2014. A further 4 were carried over from 2017. Of the 25, 14 requests were granted, 5 were part-granted, 3 were withdrawn, 2 were refused and 1 case was open as of year-end.

There were two requests for information under the Data Protection Act 2018.

Most requests for information are received from persons who have been involuntarily detained in approved centres. A typical request is for information on a mental health tribunal at which that particular individual's involuntary detention was considered. Access to such information is not only a discrete legal entitlement; it forms part of the Commission's delivery on our strategic objective to uphold human rights. The fact that requests from those who have been involuntarily detained tend to be made under Freedom of Information provisions rather than Data Protection may be because of freer access to health-related information under Freedom of Information.

Energy Reporting

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

The Commission is fully committed to the 2020 Vision in relation to reaching verifiable energy-efficiency savings of 33%. In 2018, the Commission consumed 138,415kWh of energy, consisting of 79,807 kWh of electricity and 58,608 kWh of Gas.

Maastricht Returns

In 2018, 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, the Commission may still employ "mandated persons" as defined in the 2015 Act. A Register of Mandated Persons within the Commission is maintained and was updated during 2018. The Commission's Policy for Reporting of Child Protection and Welfare Concerns has been in place since January 2018. No events were reported to the Commission during 2018.

TABLE 12. MENTAL HEALTH COMMISSION MEETING ATTENDANCE 2018

Mental Health Commission Meeting Attendance 2018												
Commission Member	**25 & 26.01.18**	**15.02.18**	**11.03.18**	**19.04.18**	**17.05.18**	**21.06.18**	**19.07.18**	**20.09.18**	**18.10.18**	**15.11.18**	**13.12.18**	**Total**
John Saunders	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	11/11
Jim Lucey	Y 26.01	Y	Y	Y	Y		Y	Y		Y		8/11
Patrick Lynch	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	10/11
Catherine O'Rorke	Y	Y	Y	Y			Y					5/8
Ned Kelly	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		10/11
Aaron Galbraith	Y	Y	Y	Y			Y	Y	Y			7/11
Xavier Flanagan	Y 25.01.	Y	Y	Y	Y	Y	Y	Y	Y		Y	10/11
Colette Nolan	Y		Y	Y		Y	Y		Y			6/11
Niamh Cahill	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	10/11
Rowena Mulcahy	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	10/11
Margo Wrigley	Y	Y	Y	Y		Y		Y	Y	Y	Y	9/11
Michael Drumm	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	10/11
Nicola Byrne	Y	Y		Y	Y		Y	Y	Y	Y	Y	9/11

Commission Committees

The Chairman is an 'Ex Officio' Committee Member.
(CM = Commission Member and EM = External Member)

Audit and Risk Committee

TABLE 13. MEMBERSHIP AND MEETINGS 2018:

Committee Member	March	June	September	November
Patrick Lynch (CM)	✔	✔	✔	✔
Catherine O'Rorke (CM)[1]	✔	✘	–	–
Dr James Lucey (CM)	✔	✔	✘	✘
Nicola Byrne (CM)	✔	✔	✔	✔
Joseph Campbell (EM)[2]	✘	✘	–	–
Ciara Lynch (EM)	✘	✔	✔	✔
Moling Ryan (EM)	✔	✔	✔	✔
Mairead Dolan (EM)[3]	–	–	✔	✔

Legislation Committee

TABLE 14. MEMBERSHIP AND MEETINGS 2018

Committee Member	February	April	July	November
Rowena Mulcahy (CM)	✔	✔	✔	✔
Ned Kelly (CM)	✔	✔	✔	✔
Michael Drumm (CM)	✔	✔	✘	✔
Mary Donnelly (EM)	✔	✔	✔	✔

Quality Improvement Committee

TABLE 15. MEMBERSHIP AND MEETINGS 2018

Committee Member	September (11/9)	(29/9)
Margo Wrigley (CM)	✔	✔
Nicola Byrne (CM)	✔	✔
Aaron Galbraith (CM)	✔	✔

1 Catherine O'Rorke resigned from Commission in August 2018.
2 Joseph Campbell resigned between the March and June meetings.
3 Mairead Dolan replaced Mr Campbell and attended her first meeting in September 2018.

Report of the Inspector of Mental Health Services

MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

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 see if they are compliant with the Mental Health Act 2001 (Approved Centres) Regulations 2006[1] ("the Regulations"), Rules[2] and Codes of Practice[3] and any other issues relating to the care and treatment of residents in the approved centres (these documents can be found on the Mental Health Commission website: 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 also 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;

(d) Any other matter that the Inspector considers appropriate that have arisen from the review.

The Inspector has a multidisciplinary team of assistant inspectors and administrative staff to assist in the inspections. In 2018, this team had 10 assistant inspectors.

The Inspectorate is part of a wider Regulatory Team whose functions include Registration, Inspection, Enforcement and Monitoring.

1 Mental Health Act 2001 (Approved Centres) Regulations 2006 (S.I. No. 551 of 2006)
2 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
3 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

What did we inspect in 2018?

- We inspected all **64 approved centres** under the Regulations, Rules and Codes of Practice
- We inspected **54 community residences** that were staffed 24 hours a day
- We carried out focused inspections to follow-up on enforcement actions or where there were issues of concern
- We met with the management teams of the Rehabilitation and Recovery teams in all nine Community Mental Health Services to obtain an oversight of the State's rehabilitation and recovery services
- We carried out a review of physical health in a sample of residents with enduring mental illness in continuing care units
- We also met with service users and peer advocacy 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

All our reports are published on our website: mhcirl.ie.

What Did We Find?

Compliance

Acute approved centres provide in-patient 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 continuing care units where residents live, often for many years or permanently. Most mental health services are provided in community settings, but these facilities are not regulated.

Overall, there has been an increase of 3% in compliance with regulations, from 76% in 2017 to 79% in 2018.

TABLE 1. TOP 5 APPROVED CENTRES IN COMPLIANCE WITH REGULATIONS IN 2018:

Approved Centre	Hospital Type	Percentage Compliance
Willow Grove	CAMHS	100
St. Edmundsbury	Independent	100
St. Patrick's Hospital	Independent	97
Linn Dara	CAMHS	97
Eist Linn	CAMHS	94

CAMHS – Child and Adolescent Mental Health Services

TABLE 2. LOWEST 5 APPROVED CENTRES IN COMPLIANCE WITH REGULATIONS IN 2018:

Approved Centre	Community Healthcare Organisation (CHO) area	Percentage Compliance
St. Canice's Hospital	CHO 5	64
St. Otteran's Hospital	CHO 5	63
Elm Mount Unit	CHO 6	62
St. Stephen's Hospital	CHO 4	62
Department of Psychiatry Kilkenny	CHO 5	60

Premises

There was a **5% increase in compliance** with Regulation 22 Premises from 25% in 2017 to 30% in 2018. However, many approved centres (70%) remained dirty, malodorous and poorly maintained.

St Stephen's Hospital Cork

- The approved centre was not clean and maintained in good structural and decorative condition.
- There was not sufficient outdoor space for residents to access.
- The approved centre had an inadequate number of showers and bathrooms having regard to the number and mix of residents in the approved centre.
- The premises were not adequately ventilated as the approved centre was not clean or free from offensive smells.
- Infection control guidelines had not been followed in relation to decontamination of the environment.
- A programme of renewal of the fabric and decoration of the premises was not undertaken as some chairs had burns from cigarettes and one was very worn.
- Minimisation of ligature points to the lowest practicable level was not undertaken as no ligature audit had been undertaken in some units.

Woodview, Galway

- The premises had not been maintained in good structural and decorative condition.
- Cracked and peeling paint was observed on windowsills, skirting boards, and walls and decaying wood was not replaced.
- The premises were not adequately lit in some of the bedrooms and external areas of the approved centre.
- The premises were not adequately ventilated; two toilets were malodorous.
- A programme of renewal of the fabric and decoration of the premises had not been developed and implemented and there were no records of such programmes.

Department of Psychiatry, Kilkenny

- The seclusion room was not clean, as there was evidence of hair, hardened food, and other dirt on the floor of the room. There were drinks stains on walls and windows in the room.
- At the time of inspection, the approved centre felt overheated, lacked airflow and ventilation, despite the windows being opened.
- A number of toilets had evidence of dirt around the bases.
- The oven in the occupational therapy kitchen was dirty.
- The corridors were dirty.
- There were cigarette butts on the ground inside and outside the approved centre.

Six approved centres' non-compliance with Regulation 22 Premises was rated as a critical risk. During all of these inspections, the inspectors directed that an immediate deep clean of the premises take place. Further enforcement action also took place. A further 60% of non-compliance with Regulation 22 Premises were rated as high risk.

This is not to say that there has not been some improvement. New approved centres such as the Department of Psychiatry in Drogheda, the Acute Mental Health Unit in Galway and Deer Lodge in Killarney are state of the art buildings and are spacious, respect residents' privacy and have facilities for recreation and therapies. Sliabh Mis in Killarney is undergoing extensive renovations.

A number of approved centres remained 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, Vergemount Mental Health Facility, St Catherine's Ward in St Finbarr's Hospital in Cork, and Jonathan Swift Clinic in St James's Hospital.

Staffing of approved centres

Most approved centres continued to struggle to ensure that they were staffed safely and adequately at all times. There is a national shortage of mental health staff and this was evident in most approved centres. Many providers use agency staff to fill vacancies and absences. Where this is the case, residents' experience and continuity of care can be affected. In the worst cases, it could affect safety – particularly in 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. This was despite active recruitment programmes. All this affects the access of people with mental illness to appropriate therapies and increases the reliance on a medical model of care. Some approved centres had no or very little 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.

Individual care plans

59% of approved centres were compliant with the Regulation on individual care planning.

The Regulations for approved centres require that each resident in an approved centre has an individual care plan. Regulation 15 defines an individual care plan and each individual care plan must contain the elements described in the definition:

> A documented set of goals developed, regularly, reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation.

The HSE describes an individual care plan thus:

> An individual care plan is a treatment plan agreed between the service user and the Mental Health Team on what will be done to address the service user's mental health difficulties. A key worker is allocated to work with the service user to develop a plan of care that outlines how the service user and mental health team can work together to build on strengths and address the difficulties.

In 2012, the Mental Health Commission issued guidance to help mental health services in developing and maintaining individual care plans.[4]

There has been some improvement in compliance in Regulation 15 Individual Care Plan from 2016-2018, from the low baseline of 23 approved centres compliant in 2016, to 38 in 2018.

However, there have been ongoing challenges in turning care planning into a live, person-centred, recovery-focused, and fully participative process, even where all requirements of the regulation are met.

There were a number of reasons why approved centres were not compliant with Regulation 15 Individual Care Plans.

FIGURE 1. APPROVED CENTRE COMPLIANCE WITH REGULATION 15: INDIVIDUAL CARE PLAN

4 Guidance Document on Individual Care Planning Mental Health Services. Mental Health Commission 2012

Of great concern is non-compliance due to the lack of resident involvement in their own care plan.

*There needs to be greater understanding that we develop care plans **with** the resident, reflecting their goals and strengths, and not **for** them.*

Seclusion

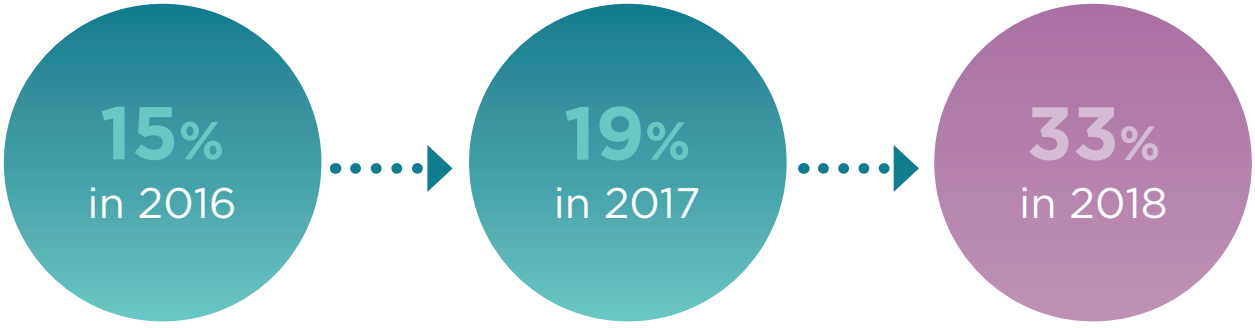
Twenty-seven approved centres continued to use seclusion in 2018. Seclusion is when a patient is involuntarily confined in a room or area and is physically prevented from leaving, usually by a locked door but also by staff blocking the door. The seclusion room is usually bare apart from a special mattress. Heat, light and ventilation are controlled from outside the room. The use of seclusion in psychiatric in-patient units is controversial and is highly regulated. The use of seclusion in Ireland can only be carried out under Rules Governing the Use of Seclusion and Mechanical Restraint. In total, 67% of approved centres that used seclusion were non-compliant with the Rules in 2018, an improvement since 2017 when 81% of approved centres that used seclusion were non-compliant. In other words, people were being secluded in mental health units in contravention of the law and therefore in contravention of human rights.

The primary goal of seclusion in inpatient psychiatry is to maintain the safety of everyone in the treatment environment. It is not a treatment in itself. Seclusion can be seen as a negative experience by individuals because risks to patients can be severe, such as re-traumatisation of people who have a history of trauma, loss of dignity, and damage to therapeutic relationships. However, failing to use seclusion in emergency situations can also result in adverse outcomes to the individual or to others in the environment. During seclusion, the patient has no social interaction apart from nursing and medical staff doing checks and he or she is constantly observed. To all intents and purposes, it is solitary confinement, with no distractions, no therapy and no recreational activities.

Over the past decade, a clear consensus has emerged that restraint and seclusion are safety interventions of last resort and that the use of these interventions can and should be reduced significantly. The Mental Health Commission is committed to the reduction of both the frequency and duration of seclusion and restraint episodes in approved centres and in 2014 developed a strategy for the reduction of seclusion and restraint.[5]

In practice, the decision to use seclusion should only be made where the balance between the potential risks of seclusion and any other intervention, such as prolonged physical restraint, indicates that it would be safer to use seclusion. There must be robust assessment of risks, which must take into account all available information.

FIGURE 2. COMPLIANCE WITH THE RULES GOVERNING THE USE OF SECLUSION 2016-2018



5 Seclusion and Restraint Reduction Strategy. Mental Health Commission December 2014

It is of interest that some approved centres catering for acutely ill patients do not have seclusion facilities and have not requested them, whereas other approved centres seclude service users for lengthy periods of time. Reasons for not using seclusions may include better staffing levels, more reliance on emergency medication, more staff training, more use of physical restraint or use of alternative strategies in dealing with violent and aggressive behaviour.

Seclusion should only be used for the shortest time possible; lengthy periods of seclusion are counter-therapeutic. Approved centres must inform the Inspector if seclusion is extended beyond 72 hours. In 2018, there were 73 episodes where seclusion was used for more than 72 hours continuously. There were also 35 incidents where a patient was secluded seven or more times in seven days.

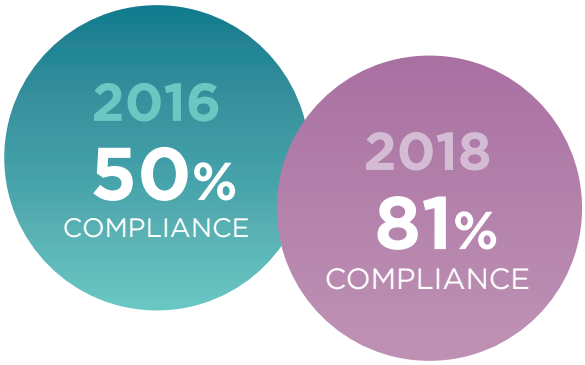
TABLE 3: EPISODES WHERE SECLUSION WAS USED FOR MORE THAN 72 HOURS CONTINUOUSLY

Approved Centre	Number of seclusion episodes lasting over 72 hours	Range of length of seclusion episodes
Central Mental Hospital	29	72 – 1,708 hours
Drogheda Department of Psychiatry	7	72 – 216 hours
St. John of God Hospital & Cluain Mhuire	5	73 – 98 hours
Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital	4	185 – 717 hours
Phoenix Care Centre	5	84 – 475 hours
Department of Psychiatry, St Luke's Hospital	6	97 – 331 hours
Ashlin Centre	4	112 – 164 hours
Avonmore & Glencree Units, Newcastle Hospital	2	97 – 120 hours
Adult Acute Mental Health Unit, University Hospital Galway	2	74 – 126 hours
Adult Mental Health Unit, Mayo University Hospital	2	85 – 267 hours
Department of Psychiatry, Midland Regional Hospital, Portlaoise	1	128 hours
St. Vincent's Hospital	1	99 hours
Sligo/Leitrim Mental Health In-patient Unit	1	78 hours
Department of Psychiatry, Connolly Hospital	2	80 – 92 hours
Acute Mental Health Unit, Tallaght Hospital	1	74 Hours
St Aloysius Ward, Mater Hospital	1	92

Compliance with Part 4 of the Mental Health Act

Section 60 of Part 4 of the Mental Health Act 2001 specifies that the administration of medicine to an adult patient who is detained for longer than three months cannot be continued unless the patient gives consent in writing or the medicine is approved by the treating consultant psychiatrist and authorised by another consultant psychiatrist, on a Form 17 (Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent). Compliance with Part 4 of the Mental Health Act is assessed during inspections.

In 2016, in response to concerns about assessment of capacity to consent to psychiatric treatment, the Mental Health Commission issued guidance for approved centres with regard to Part 4 of the Mental Health Act – Consent to Treatment in order to increase compliance. This guidance has led to a dramatic improvement in compliance with Part 4 of the Mental Health Act: from 50% compliance in 2016 to 81% compliance in 2018.



In the four approved centres that were non-compliant, the reason was failure to assess capacity of the patient to consent to treatment.

Physical Restraint

Physical restraint is defined as the use of physical force by one or more persons for the purpose of preventing the free movement of a resident's body when he or she poses an immediate threat of serious harm to self or others.[6] Physical restraint should only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. Physical restraint is a traumatic experience for the resident. For a resident on a psychiatric ward, being physically restrained by staff is not only humiliating and distressing, but can also be dangerous – even life-threatening.

In 2014 the Mental Health Commission developed a strategy for reducing the use of seclusion and restraint.[7]

Fifty-two (81%) of approved centres used physical restraint in 2018. Of these, 19% were compliant with the Code of Practice on Physical Restraint. In 43% of non-compliant approved centres, there was no physical examination following the episode of restraint. This is required by the Code of Practice on Physical Restraint due to the risk of injury to the resident. 48% of approved centres had not trained all staff in prevention and management of aggression and violence.

6 Code of Practice on the Use of Physical Restraint in Approved Centres. Mental Health Commission 2009
7 Seclusion and Restraint Reduction Strategy. Mental Health Commission December 2014

2018 Themed Reports

24-hour supervised residences for people with mental illness

Since 1984, the process of "deinstitutionalisation" in Ireland has led to developing supported accommodation services to enable people with mental health problems to live in the community instead of large psychiatric hospitals. A range of provisions were developed, including residential facilities that are staffed 24 hours a day. 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 would decrease. This has not been the case. In 2005, there were 127 24-hour supervised residences. In 2018, 13 years later, 118 24-hour supervised residences remained. The policy of housing people with mental illness in such facilities has continued, with the number of people residing in them remaining relatively stable over many years, currently just over 1,200. *A Vision for Change* outlines a requirement of approximately 30 places per 100,000 population.

In 2018, the second year of our current three-year programme of inspections, we inspected 54, 24-hour supervised residences across a number of Community Healthcare Organisations.

We found that:

- 57% of residences offered all residents single room accommodation and one residence had 4-person bedrooms
- In residences with shared rooms, 91% had no privacy between beds or within the bedrooms
- Only 46% of residences were in good physical condition and 19% required urgent maintenance and refurbishment
- A rehabilitation team provided services for 61% of residences. In these residences it was more likely that the residents would have a multidisciplinary care plan in which they had involvement
- There was no access to a kitchen to make tea, coffee or snacks in 33% of residences
- Residents were unable to lock their bedroom doors in 88% of residences

There is evidence that rehabilitation and recovery teams, although insufficient in number and staffing, have made progress in providing services to people in the residences. However, there is an insufficient number of rehabilitation and recovery teams, and a lack of adequate staffing of these teams to provide a comprehensive service. Assessments are now carried out to assess residents' needs but many of these needs are unmet due to lack of resources. Only 43% of residences provided multidisciplinary individual care plans for their residents.

There has been little progress in addressing the rights of people with mental illness who live in 24-hour supervised community residences. The number of residents and the number of residences have not decreased significantly since 2005. Needs assessments indicate that if the appropriate resources were in place, many could move to smaller more independent accommodation but this is not happening, due in part to lack of appropriate housing, not enough rehabilitation teams and inadequate staffing of rehabilitation teams.

The lack of privacy in the residences was of serious concern. We found that 43% of residences did not provide single room accommodation for all residents. A startling and disturbing finding was that 91% of residences that had shared rooms did not provide any privacy (not even curtains between the beds) within the shared bedrooms. This is in clear breach of the right to privacy and is unacceptable in any healthcare facility.

There are continuing breaches of human rights in 24-hour supervised residences:

- The right to privacy
- The right to a clean well maintained accommodation
- The rights of service users to choose where they would like to live
- The right to independent living with appropriate supports
- The right to access appropriate care and treatment through access to rehabilitation and recovery services

All the 1,200 people resident in these residences have enduring mental illness or intellectual disability. They often have severe, complex mental health problems, such as schizophrenia, with associated cognitive difficulties that impair their organisational 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.

Over a number of years, the Mental Health Commission has called for these residences to be regulated. Regulation would allow the Mental Health Commission to enforce changes where deficits and risks are found, protect the human rights of people living in these residences and help mental health services to provide care and treatment in accordance with best practice standards.

We will inspect the remaining 24-hour supervised residences in our three-year inspection cycle in 2019. This will complete an extensive review of all such residences over a three year period, looking in detail at residents' human rights, autonomy, care and treatment and physical condition of residences.

Physical Health in people with a severe mental illness

People with a severe mental illness will typically die between 15 and 20 years earlier than someone without a mental illness and their physical illnesses are largely preventable.

The excess mortality rates in persons with severe mental illness are largely due to modifiable health risk factors. Therefore, the monitoring and treatment of these factors should be a part of clinical routine care of the psychiatrist and GP.

The recent National Institute for Health and Clinical Excellence (NICE) guidelines on schizophrenia recommend that 'GPs and other primary healthcare professionals should monitor the physical health of people with schizophrenia at least once a year'.[8] The table shows the minimum monitoring that should be carried out at least yearly for people with severe mental illness, and especially those who are taking antipsychotic medication.

TABLE 4. MONITORING REQUIREMENTS FOR RESIDENTS ON ANTIPSYCHOTIC MEDICATION AT LEAST ANNUALLY

Family history
Personal medical history
Dietary intake
Activity level and exercise
Use of tobacco and alcohol or other substances
Cardiovascular disease (CVD) risk
Blood pressure
Dental health
Weight gain and obesity using body mass index (BMI); waist circumference, (WC)
Fasting blood levels of glucose or HbA1c
Fasting blood levels of lipids, especially triglycerides and high-density lipoprotein (HDL)-cholesterol
Prolactin levels (depending upon the individual psychotropic agent[9])
Liver function tests, blood count, thyroid hormone, electrolytes
Electrocardiographic (ECG) parameters[10] [11]

In 2017, during our inspections of in-patient mental health units, we found that the compliance for Regulation 19 General Health[12] had decreased from 75% to 73%. In addition, it was obvious that monitoring of the physical health of people with severe mental illness – who were in hospital for more than six months – was not in line with best practice and did not meet international guidelines. In view of this, in early 2018, we added the specific monitoring required to the guidance for approved centres in achieving compliance with regulations, the *Judgement Support Framework*.

During the 2018 inspections, we found again that there was poor adherence by the mental health services to best practice guidelines referenced above and also to Regulation 19 General Health. While most doctors carried out a physical examination every six months for each resident, none carried out adequate monitoring in accordance with regulations and best practice guidelines. We found that only 42% of approved centres were compliant with Regulation 19 General Health and for 97% of those centres, one of the reasons included was insufficient monitoring. Further review of 100 patients in 10 inpatient units found that none of them had sufficient monitoring to identify cardiac disease or its precursors.

These findings are of serious concern and show that residents in long-term care in mental health in-patient units are not adequately monitored for serious physical illness, which they have a higher risk of developing than the general population.

Another serious finding in this review was that there was widespread **lack of access to essential healthcare** such as physiotherapy, dietetics, speech and language therapy and seating assessments in the centres reviewed. These services are available to the rest of the population in the community and in

8 National Institute for Health and Clinical Excellence Clinical Guideline 82. Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care (update). London: NICE, 2009.
9 Taylor D, Paton C, Kerwin R. The Maudsley Prescribing Guidelines (9e) London: Informa Healthcare, 2007.
10 Marc De Hert et al. Physical illness in patients with severe mental disorders.II. Barriers to care, monitoring and treatment guidelines, plus recommendations at the system and individual level WPA Action Plan 2008-2011 (World Psychiatry 2011;10:138-151)
11 Lester et al. (2012) Positive Cardio-metabolic Health Resource: an intervention framework for patients with psychosis on antipsychotic medication. Royal College of Psychiatrists. London.
12 S.I. No. 551 Mental Health Act 2001 (Approved Centres) Regulations 2006

general hospitals but are refused in many cases to residents in continuing care mental health units. This constitutes a breach of human rights and is discriminatory. I found a significant number of residents who had been assessed as needing these services but had no access to them.

The report of this review was published in May 2019 and can be found here: https://www.mhcirl.ie/Inspectorate_of_Mental_Health_Services/Themed_Reports/

Rehabilitation and Recovery Services

The purpose of specialist rehabilitation services is to deliver effective rehabilitation and recovery to people whose needs cannot be met by less intensive mainstream adult mental health services. The focus is on the treatment and care of people with severe and complex mental health problems who are disabled and often distressed, and who are or would otherwise be high users of in-patient and community services. The aim is to promote personal recovery, while accepting and accounting for continuing difficulty and disability. Despite developments in mental health interventions and services that provide early intervention to people presenting with psychosis, around 20% of people entering mental health services will have particularly complex needs that require rehabilitation and intensive support from mental health services over many years.[13]

This group often require lengthy admissions and ongoing intensive support from rehabilitation and other mental health services to live in the community successfully after discharge. Despite being a relatively small group, they absorb around 25-50% of the total health and social care budget for people with mental health problems.[14]

What does a good rehabilitation service look like?

- Inpatient and community based rehabilitation units
- Community rehabilitation teams
- Supported accommodation services
- Services that support service users' occupation and work
- Advocacy services
- Peer support services
- Robust arrangements for liaison with primary and secondary care services to monitor and manage physical health comorbidities

All three specialist in-patient rehabilitation units are provided by the private sector. Two are situated in Dublin in Highfield Hospital and Bloomfield Hospital. The other is in a remote area of Co Cork. They provide a service to the HSE nationally. This has resulted in service users receiving treatment for up to two years at great distance from their locality. It means that they do not remain under the care of their local rehabilitation team, they are far away from family, friends and local support in their own community and there is the potential of disjointed care. I encountered some deficits with the specialist rehabilitation units in continuing contact with the local services and planning for discharge and an attitude of "out of sight, out of mind" from some of the local services.

13 Craig, T., Garety, P., Power, P., et al (2004) The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis. BMJ, 329: 1067-71.
14 Killaspy, H., Marston, L., Green, N. et al. (2016) Clinical outcomes and costs for people with complex psychosis; a naturalistic prospective cohort study of mental health rehabilitation service users in England. BMC Psych, 16:95.

We have a large number of people living in highly supported residential units and in-patient continuing care. Many of these people have grown old in the mental health services and have social and behavioural features of institutionalisation. Most have not received a rehabilitation services at any stage of their illness. Others are younger with differing needs and require focused rehabilitation services to promote a more independent life, with an occupation and social outlets. These rehabilitation services are hard to provide when there are less than half the teams that should be in place and these are, for the most part, inadequately staffed.

What should a rehabilitation team look like?

- One consultant psychiatrist
- 10-15 psychiatric nurses for Assertive Outreach Nursing Team
- Mental health support workers
- Two occupational therapists
- Two social workers
- Two clinical psychologists
- Cognitive behaviour therapist/ psychotherapist
- Addiction counsellor
- Additional staff:
  – Domestic skills trainer
  – Creative/recreational therapists

A Vision for Change 2006

What is the current provision of rehabilitation services in Ireland?

A Vision for Change in 2006 recommends 39 teams nationally. However, the population of Ireland has increased by 11.1% to 4.76 million (2016 census). There are now 47.5 teams required to provide a comprehensive national rehabilitation service.

Others are placed in what is sometimes restrictive care in residential and nursing homes that may have little emphasis on the promotion of independent living skills. These people are at risk of living out their lives in these settings. For yet another group of people the lack of access to a local rehabilitation service means remaining at home with their families and being reliant on the care and support of increasingly elderly relatives in circumstances of unacknowledged distress.

Proper access to rehabilitation services can be summarised in the broad headings below.[15]

Localisation

A rehabilitation service should be close to its clients, their families and workers who know them.

Personalisation

A local service can be tailored to the needs of the individuals it is for and respond to a change in need.

Choice

A person should be able to remain living in their community of origin if that is their wish.

15 Faculty report FR/RS/1Faculty of Rehabilitation and Social Psychiatry of the Royal College of Psychiatrists November 2009. Edited by Paul Wolfson, Frank Holloway and Helen Killaspy

TABLE 5. *A VISION FOR CHANGE* RECOMMENDS ONE TEAM PER 100,000 POPULATION

Community Healthcare Organisation (CHO)	Population	Number of teams	Recommended number of teams as per A Vision for Change
CHO 1	391,281	2	4
CHO 2	453,109	3	4.5
CHO 3	384,988	2	4
CHO 4	690,575	2	7
CHO 5	510,333	3	5
CHO 6	393,239	0	4
CHO 7	697,644	3	7
CHO 8	615,258	2	6
CHO 9	621,405	3	6
Total		**20**	**47.5**

Mental health and safety

There will always be people with complex needs who need longer hospital stays in a more specialist environment for engagement and treatment, sometimes for as long as 2-3 years.

I found some excellent initiatives within the rehabilitation services. There have been appointments of peer support workers, provision of recovery services that are co-produced through Advancing Recovery in Ireland (ARI), the provision of IPS[16] and housing officers. A model of care for rehabilitation has been developed. There are local initiatives, again co-produced, which aim to promote social integration and reduce stigma, provide education and training. Even in the two areas that do not have any rehabilitation services, there is evidence of nursing staff providing a recovery-focused input and liaising with external agencies to provide appropriate rehabilitation services.

There is a long way to go to provide an acceptably comprehensive service for those that are often vulnerable, distressed and struggling with enduring mental illness, but there are signs that we are moving in the right direction.

16 IPS Supported Employment is an evidence-based approach to supported employment for people who have a severe mental health difficulty.

Conclusion

There has been a move towards improvement in overall compliance with regulations from 76% to 79% since 2016. Some areas such as compliance with individual care plans, seclusion and consent to treatment have shown a definite improvement, albeit from a low base. While compliance with regulation 22 Premises has also improved, there was a serious concern with hygiene and maintenance in a significant number of approved centres. The degree of dirtiness and shabbiness is unacceptable and has significant risks in infection control. It also shows disrespect for patients' dignity.

We remain concerned about the condition of supervised community residences and the disregard for human rights of the people who live there. This concern is heightened by the fact that these residences are not regulated, leaving residents open to the risk of abuse.

About 20% of people entering mental health services will have particularly complex needs that require rehabilitation and intensive support from mental health services over many years. The provision of rehabilitation services nationally are not adequate, both in number of teams and staffing within the teams. We are concerned about the lack of community rehabilitation residential services and the fact that specialist in-patient rehabilitation services are being provided out of area; in one case, without appropriate staffing, training or programmes. However, there is evidence that there is a lot of work being done to mitigate against this in local services and that a model of care for rehabilitation services is currently being rolled out by the HSE.

The level of disregard for the physical health of people who are long-stay in our mental health units is alarming. Comprehensive physical examination, appropriate monitoring, testing and diagnosis are the concern of every doctor, no matter what their speciality. People with severe and enduring mental illness have a higher risk of death and serious illness due to cardiovascular disease (CVD). There is no excuse for not monitoring for CVD and its risk factors with tests that are relatively inexpensive and easy to perform.

MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

Waterloo Exchange,
Waterloo Road, Dublin 4,
D04 E5W7

T +353 1 636 2400
F +353 1 636 2440
E info@mhcirl.ie

www.mhcirl.ie