Mental Health Commission Annual Report 2019

Including Report of the Inspector of Mental Health Services

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Chairperson's Statement

Now is the Time for Real Reform.

2019 represented the first year of the Commission's sixth strategic plan. 'Protecting People's Rights', which was formally launched in February, set out our strategic priorities 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 wellbeing of all people who access mental health and decision support services'. 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.

A key strategic objective for the Commission for many years has been the reform and updating of mental health legislation. In July 2019, the Commission was invited to comment on the Heads of Bill to amend the Mental Health Act, 2001. The Commission established a Working Group of the Executive, led by our Head of Legal Services, who worked with the Commission's Legislation Committee (including external representatives) reviewed the Heads of Bill taking into account the findings of the report of the Expert Review Group of December 2014, all of the developments in the intervening period together with information collated by the Commission.

A practical person-centred and rights-based approach was adopted with numerous changes proposed. The following are some of the key changes:

- Ensure parity of mental health issues to general health issues.
- Extend Commission remit to cover residential and community services.

John Saunders
Chairperson

- Extend the remit of the mental health tribunals and those of the circuit court for the benefit of patients.
- Reform the provisions relating to consent and the administration of medication.
- Reform of the Regulations relating to approved centres and care plans.

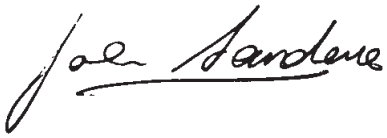
A second strategic priority for the Commission is the establishment of Ireland's Decision Support Service (DSS), which we hope, when commenced, will set a 'gold standard' for decision support services in Europe. Our aim, in collaboration with and supported by the Department of Justice and Equality, is to deliver a service which puts Ireland to the forefront of protecting human rights and ensuring long-awaited reforms introduced by the Assisted Decision Making (Capacity) Act of 2015 which emphasises personal 'will and preferences', respect for the rights of a person, and supporting autonomous decision-making and advance planning.

In 2019, the new DSS senior management team was recruited, a tender process was initiated for the development of our digital system, and extensive communications and stakeholder engagement took place. A key reminder of the need to expedite the service is the fact that 1,250 people have been taken into an outdated wardship system since the initial legislation was first passed at the end of 2015. This fact alone tells us that we have to stay focused on delivery of this modernising, essential human rights-based service.

The Commission believes that Ireland, at this critical juncture, has the opportunity to address the issues that continue to afflict our mental health services. The current Covid-19 pandemic has highlighted in stark terms the need for a modern, well-staffed, holistic community-based mental health service. This can only occur when mental health is appropriately prioritised. As per the evidence of the Inspector of Mental Health Services, this and previous Commissions have been continuously forced to highlight that the current system is ad hoc, sporadic, lacks integration, and much of the mental health interventions are still linked to institutional care instead of community.

The Commission recognises that Slaintecare provides the key principles for reform of health care. However, there is a need for a detailed, funded, evidenced-based policy to create community-based, holistic, integrated mental health care that meets people at the earliest point in their mental health experience and ensures national governance and oversight so that primary, secondary and specialist care are integrated. This approach is pivotal to ensuring that no individual falls through the cracks at their time of greatest need. Now is the time for real reform.

Finally, I would like to thank the Minister of State for Mental Health and Older Persons, the Minister for Justice and Equality, the relevant department officials and my fellow Commission Members and staff for their dedication in 2019.



John Saunders
Chairperson

Chief Executive's Review

As a proportionate, independent risk-based regulator, the Mental Health Commission delivered a programme of regulation during 2019 which promoted both quality and safety.

John Farrelly
Chief Executive

Over the course of 2019, we continued to work with services that put the person first while also targeting low-quality services and using our regulatory and enforcement powers to intervene.

While our ongoing programme of registration, inspection and monitoring continued to hold providers to account, the widespread publication of our reports ensures that the public and our key stakeholders clearly understood both the strengths and weaknesses of mental health care in their own geographic location.

In 2019, overall compliance by approved centres with Regulations was 78%. We welcome the year-on-year improvement, since the introduction of our guidance document, the 'Judgement Support Framework', in the percentage of services achieving quality ratings of 'excellent'.

In 2019, the Commission took 40 enforcement actions against 31 Approved Centres in response to critical risks in areas of practices relating to premises, staffing and the privacy and dignity of residents. The Commission secured its first ever prosecution under the Mental Health Act 2001 last year on foot of findings that 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 that services become increasingly compliant with the rules.

It is clear that a significant amount of premises are no longer suitable and need to be replaced. Of the 45 non-compliant approved centres, 15 (33%) were non-compliant with the Regulation because they were unclean. In addition, 23 centres (49%) were non-compliant due to poor structural or decorative condition.

We also introduced a requirement in 2019 for providers to notify us of instances of overcrowding. We received notification of 208 instances of overcapacity related to 13 approved centres. These facts - in tandem with the publication of the 'Access to Acute Mental Health Beds in Ireland' discussion paper - clearly indicate the need to upgrade or replace a significant number of in-patient units and also to begin to put in place modern community mental health services.

What is once again clear from this report is that the continued non-compliance in key areas of care points to a deficit in

governance at national level within our mental health services. To truly provide a comprehensive national service, governance from board down to service user level must urgently be revised to ensure that whatever system we have in place is continually progressed and improved upon, and the same low standards are not repeated ad nauseam.

There were 54 child admissions to 15 adult units. This compares with 84 admissions to 18 adult units in 2018. This is in keeping with a trend where child admissions to adult units have fallen year-on-year for the past 10 years. We welcome this trend. However, it is very important that 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 support their needs.

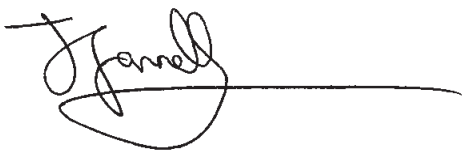
The Commission is also charged with operating the review process (mental health tribunal process) for vindicating the rights of patients who are involuntarily detained. We want service users, and their loved ones, to know that these review processes are independent and exist to ensure that they are receiving high quality and safe mental health services. We thank all the panel members, independent consultant psychiatrists, legal representatives and mental health act administrators who contributed to ensuring that the law was applied to all involuntary detentions.

From January 2019, if a patient is detained on an order for up to six months, he or she is entitled to an additional review by a tribunal if still detained after three months. This is an extra safeguard for patients. The request for an additional review must come from the patient or his/her legal representative. All other reviews are mandatory. Only 16% of the total number of patients eligible for an additional review sought one. The uptake is considerably less than expected. In 2020, the Commission is going to review the reason for this, to include speaking with patients and their advocates to see what more can be done to make patients aware of their rights.

Towards the end of 2019, the Commission and the Health and Information Quality Authority (HIQA) jointly published the National Standards for Adult Safeguarding. These standards set the bar for ensuring we provide safe and effective care while absolutely protecting and vindicating the rights of the people we serve.

At a corporate level, we continued to digitalise our regulatory functions, including registration applications and the submission of our Quality and Safety Notifications. This digital approach both lessens the burden on providers and also enables real time data collection and analysis in order to identify and mitigate risks in our mental health system.

In conclusion, I am conscious that we are publishing this report during the greatest pandemic to affect our nation. I want to thank all the clinical staff, management and providers of services for their work. I also want to sincerely thank all of the staff of the Commission who have worked tirelessly to protect patients at this time.



John Farrelly
Chief Executive

2019 in Brief

40
Enforcement Actions

57
Registration conditions attached to 35 approved centres

78%
National Compliance With Regulations

2,703
In-patient beds

208
Instances of overcapacity in 2019

54
Child Admissions to Adult Units of which 23 were for less than 48 hours

563
Deaths of people using mental health services reported to the Commission. 166 related to approved centres, and 397 related to community mental health services.

2,024
Mental Health Tribunal Hearings

2,390
Involuntary Admissions to Approved Centres

39
Requests for Additional Reviews

65
Annual Regulatory Inspections (5 Announced 60 Unannounced)

18
Inspections of unregulated 24-Hour Nurse Staffed Residences

5
Focused Inspections

€3.5 million
Allocated to implementation of the Decision Support Service

1,250
People taken into Wardship since ADMA 2015 was passed

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.

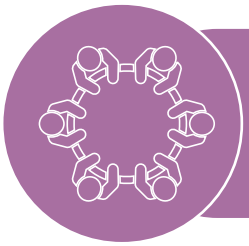
Our Mission 2019-2022

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

Strategic Objectives 2019-2022

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 and its Members (April 2017 – April 2022)

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).

Details of the Commission's membership and meeting attendance for 2019 can be found in Appendix 1, 2 and 3 page 57.

During 2019, the Commission had two Standing Committees, the Finance, Audit and Risk Committee and the Legislation Committee. It also formed a Quality Improvement Group who commenced work on a discussion paper in relation to Access to Acute Mental Health Beds in Ireland.

Details of both Committees can be found in Appendix 2 and 3, page 57.

Members

John Saunders
Reappointed 05/04/2017 End of Term 04/04/2022

Position Type: Chairman
Basis of Appointment: *Nominated by* Shine/The Wheel
Appointed by Minister for Health

Aaron Galbraith
Appointed 05/04/2017 End of Term 04/04/2022[1]

Position Type: Member
Basis of Appointment: *Nominated by* The Children's Rights Alliance
Appointed by Minister for Health

Colette Nolan
Reappointed 05/04/2017 End of Term 04/04/2022

Position Type: Member
Basis of Appointment: *Nominated by* Irish Advocacy Network
Appointed by Minster for Health

1 Mr Galbraith resigned in April 2020.

Members (continued)

Michael Drumm (Dr)
First Appointed 05/04/2017 End of Term 04/04/2022

Position Type: Member
Basis of Appointment: *Nominated by* The Psychological Society of Ireland
Appointed by Minister of State for Mental Health and Older People

Francis Xavier Flanagan (Dr)
Reappointed 05/04/2017 End of Term 04/04/2022

Position Type: Member
Basis of Appointment: *Nominated by* The Irish College of General Practitioners
Appointed by Minister for Health

Jim Lucey (Dr)
First Appointed 05/04/2017 Resigned November 2019

Position Type: Member
Basis of Appointment: *Nominated by* The College of Psychiatrists in Ireland
Appointed by Minister for Health

Margo Wrigley (Dr)
First Appointed 05/04/2017 End of Term 04/04/2022

Position Type: Member
Basis of Appointment: *Nominated by* The Irish Hospital Consultants Association *Appointed by* Minister for Health

Ned Kelly
Reappointed 29/09/2017 End of Term 04/04/2022

Position Type: Member
Basis of Appointment: *Nominated by* Mental Health Nurse Managers of Ireland
Appointed by The Minister for Health

Nicola Byrne
First Appointed 05/04/2017 End of Term 04/04/2022

Position Type: Member
Basis of Appointment: *Nominated by* The Irish Association of Social Workers
Appointed by Minister for Health

Rowena Mulcahy
First Appointed 26/09/2017 End of Term 04/04/2022

Position Type: Member
Basis of Appointment: *Nominated and appointed by* The Minister for Health following PAS Process.

Niamh Cahill
First Appointed 31/10/2017 Resigned June 2019

Position Type: Member
Basis of Appointment: *Nominated and appointed by* The Minister for Health following PAS Process

Patrick Lynch
First Appointed 05/04/2017 End of Term 04/04/2022

Position Type: Member
Basis of Appointment: *Nominated by* The HSE *Appointed by* Minister for Health

Jack Nagle
First Appointed: 23/12/2019 End of Term 04/04/2022

Position Type: Member
Basis of Appointment: *Nominated and appointed by* The Minister for Health following PAS Process

Tómas Murphy
First Appointed: 15/01/2019 End of Term 04/04/2022

Position Type: Member
Basis of Appointment: *Nominated by* Mental Health Nurse Managers of Ireland and *Appointed by* Minister of State for Mental Health & Older People.

Additional Roles

Secretary to the Commission (Board)
Orla Keane

Chair of Finance, Audit & Risk Committee (FARC)
Patrick Lynch

Chair of the Legislation Committee
Rowena Mulcahy

Chief Risk Officer
Simon Murtagh

Notes

Ms Catherine O'Rourke resigned in August 2018 and was replaced by Mr Tómas Murphy in January 2019.

Ms Niamh Cahill resigned in June 2019 and was replaced by Mr Jack Nagle in December 2019.

Dr Jim Lucey resigned in November 2019 and new appointment awaited.

Senior Management Team at the Commission

Chief Executive
John Farrelly

Inspector of Mental Health Services
Dr. Susan Finnerty

Director of Standards and Quality Assurance and Training and Development
Rosemary Smyth

Head of Legal Services and Mental Health Tribunals Lead
Orla Keane

Director Decision Support Service
Áine Flynn

Chief Operations Officer
Simon Murtagh

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 licensing, inspecting and monitoring services to ensure high standards and good practices in the delivery of care and treatment. Our regulatory process is risk-based, using the best available information to ensure a targeted, proportionate and timely approach.

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**.

Fig 1.
MHC model of regulation

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 (acute and continuing care)
- Mental health rehabilitation
- Forensic mental health care
- Mental health care for people with intellectual disability
- Child and adolescent mental health care (CAMHS)
- Eating disorder treatment centre

At the end of 2019, there were **65** approved centres registered with the Commission. During the year there was one new registration and 20 approved centres were re-registered.

During 2019, the Commission commenced a significant registration project in advance of the new registration cycle, in which 28 approved centres were due for re-registration in early 2020. The purpose of the project was to systematically gather relevant information to support the re-registration process.

At the end of 2019, there were **2,703** in-patient beds in approved centres across the country.

There were **98** CAMHS beds nationally: 62 in Dublin, 20 in Galway and 16 in Cork.

There were **687** adult beds in the independent sector, of which 679 were in Dublin.

There were also **103** registered forensic beds and **96** mental health intellectual disability (MHID) beds. These beds were located in Dublin, with a national catchment.

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

Figure 2.
Key figures 2019

Inspection

The Inspector of Mental Health Services visits and inspects every approved centre at least once each year. Following an inspection, the Inspector prepares a report on her findings. 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
- 2 Statutory Rules
- 4 Codes of Practice

The Inspector also assesses the quality of each 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'. Additionally, based on the service's 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 2019, there were **65** annual regulatory inspections of regulated approved centres, of which **5** were announced and **60** were unannounced. In addition, there were **18** inspections of unregulated 24-hour nurse-staffed community residences, and 5 focused inspections.

Further detail can be found in the Report of the Inspector of Mental Health Services on page 60.

The Judgement Support Framework was introduced in 2015 and with it a new method for measuring approved centres' regulatory compliance. The below figure shows the levels of compliance over the four-year period since the introduction of the Judgement Support Framework. It demonstrates that there has been a year-on-year increase in approved centre compliance with the regulations over the four-year period.

Figure 3.
Compliance With Regulations 2016-2019

2019	**78%** compliance	**33%** rated excellent	**22** critical risks
2018	**79%** compliance	**26%** rated excellent	**26** critical risks
2017	**76%** compliance	**11%** rated excellent	**20** critical risks
2016	**74%** compliance	**16%** rated excellent	**13** critical risks

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. Figure 4 shows average compliance by sector and CHO area. In 2019, the highest average compliance with regulations was in the CAMHS sector. The lowest average compliance was in CHO 7.

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 is not very informative (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.

In 2019 the overall national compliance with regulations decreased slightly to 78%, down from 79%.

Areas of good practice and improvements

Compliance is also monitored across the different regulations and regulatory requirements to track improvements and to highlight potential areas of concern. The full breakdown is set out in Table 2 below.

A number of areas showed consistently high compliance across all services, including resident identifiers (100%), health and safety (100%) and communication (97%). Notable improvements included a 13% improvement in compliance in the Register of Residents (80%), a 5% improvement in complaints, and 5% improvement in therapeutic programmes and services. There was a 1% improvement in *Regulation 22: Premises*, which had been an area of concern in previous years.

Areas of concern

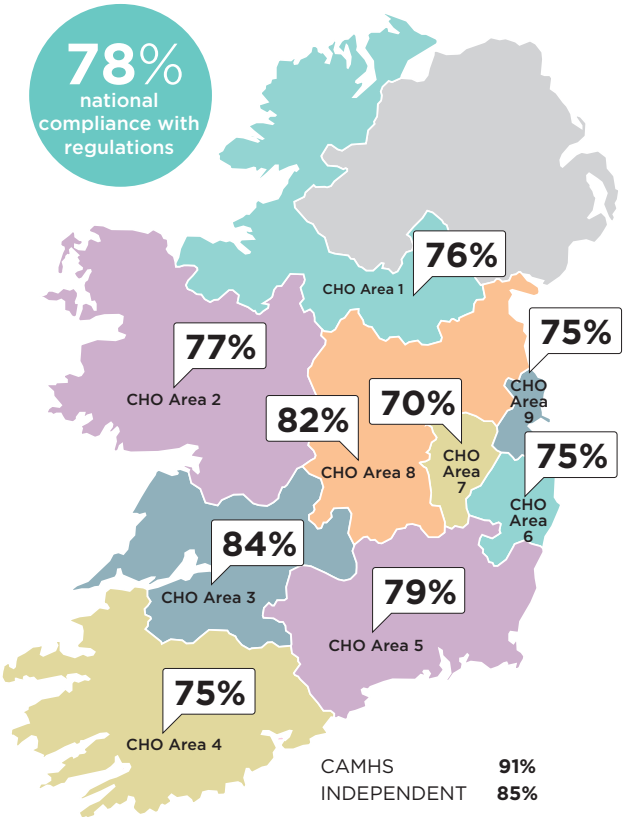
Areas that continue to be of concern, include *Regulation 26: Staffing*, which fell to 8% compliance in 2019, and *Regulation 19: General Health*, relating to the physical health of residents, which includes receiving general health screenings from a doctor, which remained at 42% compliance.

Critical risks

In 2019, there were 22 areas of non-compliance that received a critical risk rating. This means there was a high likelihood of continued non-compliance and a high impact on the safety, rights, health or wellbeing of residents.

Critical risks included privacy (6), premises (5), therapeutic programmes and services (3), and staffing (2).

Figure 4.
Average compliance with regulations by CHO and sector'



2019 Approved Centre Compliance with Regulations

Tables 1 and 2 give the breakdown and ranking of all services' compliance with regulations across three years (2017-2019), and are separated based on inspections that were announced and those that were unannounced.

The tables are colour-coded to indicate **poor** compliance, **moderate** compliance and **good** compliance. The tables shows consistency in the compliance levels of a number of approved centres across this time period, with **27** services achieving good compliance, and **1** service with poor compliance in 2019. This compares with **27** services achieving good compliance and no service with poor compliance in 2018.

Less than 60% compliant
Between 60% and 80% compliant
80% compliant and over
Not open

Table 1.
Approved Centre Compliance With Regulations, 2017-2019 (Announced Inspections 2019) – Ranked by Compliance

Approved Centre	CHO/Sector	2019	2018	2017
St Edmundsbury	Independent	100%	100%	96%
St Patrick's Hospital	Independent	100%	97%	100%
Willow Grove	CAMHS	97%	100%	100%
Tearmann Ward	3	96%	93%	82%
Linn Dara	CAMHS	93%	97%	97%

Table 2.
Approved Centre Compliance With Regulations, 2017-2019 (Unannounced Inspections 2019) – Ranked by Compliance

Approved Centre	CHO/Sector	2019	2018	2017
AIPU St Vincent's	CAMHS	97%	86%	72%
An Coillin	2	97%	86%	89%
Creagh Suite	2	97%	82%	93%
Cappahard Lodge	3	93%	93%	71%
Bloomfield	Independent	90%	73%	77%
Haywood Lodge	5	90%	73%	74%
Cluain Lir	8	90%	83%	86%
DOP Roscommon	2	90%	83%	52%
Lois Bridges	Independent	89%	93%	79%
Bantry General Hospital	4	87%	77%	87%
Merlin Park	CAMHS	87%	90%	74%
St Loman's Hospital	8	87%	77%	77%
Maryborough Centre	8	86%	90%	74%
St Canice's Hospital	5	86%	64%	68%
Deer Lodge	4	83%	89%	80%
Phoenix Care Centre	9	83%	80%	74%
Highfield	Independent	83%	83%	86%

Approved Centre	CHO/Sector	2019	2018	2017
St Vincent's Hospital	9	83%	83%	72%
Wood View	2	83%	72%	76%
St Davnet's Hospital	1	82%	82%	72%
Sycamore Unit	9	82%	90%	90%
Vergemount	6	82%	77%	79%
AMHU Cork	4	80%	77%	73%
AMHU Mayo	2	80%	73%	83%
DOP Portlaoise	8	80%	80%	90%
DOP St Lukes	5	80%	60%	57%
Eist Linn	CAMHS	80%	94%	87%
APU Cavan	1	79%	74%	83%
Owenacurra	4	79%	89%	75%
Selskar House	5	79%	71%	93%
St Anne's Unit	2	79%	68%	86%
St Brigid's Hospital	8	79%	93%	64%
Ginesa Suite	Independent	77%	Not open	Not open
Lakeview Unit	7	77%	73%	67%
Newcastle Hospital	6	77%	77%	70%
Jonathan Swift Clinic	7	76%	79%	55%
Teach Aisling	2	76%	72%	59%
APU Ennis	3	73%	73%	90%
Ashlin Centre	9	73%	87%	84%
Central Mental	National Forensic	73%	87%	80%
Cois Dalua	Independent	73%	89%	Not open
DOP Letterkenny	1	73%	67%	60%
Drogheda DOP	8	73%	70%	70%
APU 5B Limerick	3	72%	72%	60%
St Michael's Unit	4	72%	83%	72%
St Stephen's Hospital	4	72%	62%	66%
St John of God Hospital	Independent	71%	84%	84%
AAMHU Galway	2	70%	87%	80%
Carraig Mor	4	70%	74%	77%
Sligo/Leitrim	1	70%	80%	70%
St Otteran's Hospital	5	70%	63%	57%
St Aloysius Ward	9	69%	72%	70%
St Joseph's IDS	National ID	69%	80%	67%
O'Casey Rooms	9	68%	72%	83%
Sliabh Mis	4	68%	72%	67%
DOP Connolly	9	67%	70%	77%
DOP Waterford	5	67%	73%	77%
Elm Mount Unit	6	66%	62%	69%
St Finbarr's Hospital	4	64%	69%	70%
APU Tallaght	7	57%	68%	74%
National Average 78%				

**Ginesa Unit was inspected as part of St John of God hospital in 2017 and 2018.*

Compliance by regulatory requirement

The below table sets out compliance with Regulations in 2019. It is grouped under the categories included in the *Mental Health Act 2001 (Approved Centres) Regulations 2006*: General Care and Welfare, Care of Residents, Premises, Staffing, Records, and Other Provisions, and includes the percentage increase or decrease of compliance from 2018 to 2019.

In 2019, 21 of the 31 applicable regulations on average had a high level of compliance, while the 7 regulations relating to staffing, premises, privacy, general health, medication practices, maintenance of records and individual care planning, saw poor compliance among the approved centres inspected. In general, the level of compliance of services with regulations was similar in 2019 as in 2018, with a very slight decline in 2019. This is seen in the decreased average national compliance from 79% to 78%. This indicates that, while results have remained substantially consistent, there is still room for improvement.

In 2019, there were notable increases in compliance with the Rules on Mechanical Restraint (Part 5) and the Codes of Practice relating to Physical Restraint and Admission, Transfer and Discharge.

However, there was a decrease in compliance with the Rules on Seclusion from an already low level of compliance. The main reasons for non-compliance were reported as: inadequate or incomplete recording of the seclusion episode; the seclusion room being unclean; and suitability and safety of the seclusion facilities.

There was also a decrease in compliance with the Code of Practice on the Admission of Children. However, this Code of Practice was only applicable in 14 approved centres in 2019, down from 18 in 2018. The main reasons for non-compliance were reported as: adult approved centres not having age-appropriate facilities or activities for child residents.

Less than 60% compliant
Between 60% and 80% compliant
80% compliant and over
Not open

Table 3.
Compliance With Regulations 2018-2019

Regulation		2019 compliance	2018 compliance	Change (%)
GENERAL CARE AND WELFARE				
4	Identification of Residents	100%	100%	No change
5	Food and Nutrition	91%	92%	-1%
6	Food Safety	88%	86%	+2%
7	Clothing	95%	88%	+8%
8	Property	91%	97%	-7%
9	Recreational activities	95%	92%	+3%
10	Religion	100%	100%	No change
11	Visits	97%	98%	-1%
12	Communication	97%	95%	+2%
13	Searches	92%	91%	+1%

Regulation		2019 compliance	2018 compliance	Change (%)
14	Care of the Dying	100%	95%	+5%
CARE OF RESIDENTS				
15	Individual Care Plan	52%	58%	-6%
16	Therapeutic services	78%	73%	+5%
17	Children's Education	88%	100%	-12%
18	Transfers	88%	84%	+4%
19	General Health	42%	42%	No change
20	Provision of Information	97%	91%	+6%
21	Privacy	49%	53%	-4%
PREMISES				
22	Premises	31%	30%	+1%
23	Medication	54%	52%	+2%
24	Health and Safety	100%	100%	No change
25	CCTV	71%	78%	-7%
STAFFING				
26	Staffing	8%	9%	-1%
RECORDS				
27	Maintenance of Records	52%	53%	-1%
28	Register	80%	67%	+13%
29	Policies	89%	95%	-6%
OTHER PROVISIONS				
30	Mental Health Tribunals	93%	98%	-5%
31	Complaints	97%	92%	+5%
32	Risk Management	69%	72%	-3%
33	Insurance	100%	100%	No change
34	Certificate	97%	100%	-3%

Table 4.
Compliance With Statutory Rules And Part 4 Of The Mental Health Act 2001 2018-2019

Instrument	2019	2018	Change (%)
Rules on ECT	45%	58%	-13%
Rules on Seclusion	21%	33%	-12%
Rules on Mechanical Restraint (Part 5)	76%	50%	+26%
Consent procedures (Part 4)	87%	81%	+6%

Table 5.
Compliance With Codes Of Practice 2018-2019

Code of Practice	2019	2018	Change (%)
Physical Restraint	50%	19%	+31%
Admission of Children	7%	11%	-4%
ECT	81%	64%	+17%
Admission, Transfer, Discharge	46%	25%	+21%

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 wellbeing 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 pyramid in Figure 5. 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.

Enforcement actions

The Commission took **40** enforcement actions against incidents, events and serious concerns arising in 2019. These actions related to **31** approved centres. This compares with 44 enforcement actions in 2018 and 23 enforcement actions in 2017.[2]

The higher number of actions in 2018 and 2019 relates to the increased and improved collection of high-quality compliance data which enables enforcement actions to be taken in respect of trends of on-going non-compliance.

During 2019, enforcement included:

- **16** Immediate Action Notices relating to 20 serious concerns
- **24** Regulatory Compliance Meetings

The relatively high number of Regulatory Compliance Meetings held relates to the Registration Project, as referred to in the Registration section of this report. Twenty-one pre-registration Regulatory Compliance Meetings took place on site at each approved centre and focused on whether sufficient corrective and preventative actions had been implemented within the service.

45% of enforcement actions arose from regulatory inspections conducted by the Inspector of Mental Health Services. 43% of enforcement actions arose from compliance monitoring and in particular pre-registration compliance monitoring.

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

- **7** relating to the premises of the approved centre
- **4** relating to staffing concerns, including staff knowledge of the Rules and Codes
- **4** relating to the privacy and dignity of residents

Figure 5.
Mental Health Commission Enforcement Model

2 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). The most common reason to attach a condition to the registration of an approved centre is due to ongoing and/or high-risk non-compliance with a regulation or statutory rule.

It is an offence to breach a condition of registration.

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)

The majority of conditions currently attached to facilities require monthly or quarterly reports submitted to the commission on a standardised template. This allows the commission to closely monitor the condition requirement.

As at the end of 2019, there were **57** conditions attached to **35** approved centres. The most common conditions were attached in the following areas:

- **18** Mandatory staff training
- **14** Premises maintenance
- **10** Individual care planning
- **3** Medication
- **3** Closure

Conditions attached

In 2019, **14** new registration conditions were attached to **9** approved centres during 2019:

- Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital
- Drogheda Department of Psychiatry
- Eist Linn Child & Adolescent In-patient Unit
- Lois Bridges
- Maryborough Centre, St Fintan's Hospital
- St Catherine's Ward, St Finbarr's Hospital
- St Joseph's Intellectual Disability Service
- Teach Aisling
- Woodview

Conditions removed

During 2019, **7** conditions were removed due to the approved centre demonstrating compliance in the relevant area.

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

- St Aloysius Ward, Mater Misericordiae Hospital
- Deer Lodge
- Department of Psychiatry, University Hospital Waterford
- Lakeview Unit, Naas General Hospital
- St Ita's Ward, St Brigid's Hospital
- St Michael's Unit, Mercy University 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 2019, **563** deaths of people using mental health services were reported to the Commission. **166** of these related to regulated services (approved centres), while **397** 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, **168** deaths were reported to us by the services as 'suspected suicides'.

563	Total deaths in mental health services
166	Deaths in approved centres
168	Deaths reported as suspected suicides

Serious Reportable Events

All mental health services are required to notify the Commission of Serious Reportable Events (SREs, HSE 2015). In 2019, **41** SREs were reported to the Commission. **37** of these related to residents of approved centres, 4 related to other community mental health services. 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
Environmental Event (5D)	Serious disability associated with a fall	11
Criminal Event (6C)	Sexual assault on a patient or other person	9
Care Management Event (4I)	Stage 3 or 4 pressure ulcers	8
Criminal Event (6D)	Death or serious injury/disability	5
Patient Protection Events (3C)	Sudden unexplained deaths or injuries which result in serious disability	5
Other		2
Patient Protection Events (3B)	Patient death or serious disability associated with a patient absconding	1
Total		**41**

Overcapacity

There were **208** instances of overcapacity in 2019. An approved centre is considered to be overcapacity if the number of residents accommodated in the unit at 12am on that day exceeds the number of beds the approved centre is registered for.

These 208 instances of overcapacity related to **13** approved centres. **Five** approved centres reported **194** of the 208 instances of overcapacity:

- Department of Psychiatry, University Hospital Waterford
- Sliabh Mis Mental Health Admission, University Hospital Kerry
- Adult Mental Health Unit, Mayo University Hospital
- Department of Psychiatry, St Luke's Hospital
- Department of Psychiatry, Roscommon University Hospital

When outlining reasons for overcapacity, **115** notifications referenced one or more emergency admissions. Other reasons included voluntary or involuntary admissions, no available discharges, and returns from leave.

The Commission actively engaged with approved centres reporting overcapacity in order to ensure that effective surge management plans were in place and to address the systemic causes of overcapacity.

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 2019 was **497**. This compares with a total of 408 admissions in 2018 and 439 in 2017.

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 are 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 do not take out-of-hours admissions, with the exception of Merlin Park and Linn Dara. 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.

CAMHS Unit	County	Sector	Age of admission
Merlin Park	Galway	HSE	<18
Eist Linn	Cork	HSE	<18
Linn Dara	Dublin	HSE	<18
Ginesa Unit	Dublin	Private	16-17
Willow Grove	Dublin	Private	16-17
AIPU St Vincent's	Dublin	Voluntary	16-17

In 2019, there were **54** admissions to **15** adult units. This compares with 84 admissions to 18 adult units in 2018.

23 of those admissions were for less than 48 hours, compared to only 11 admissions for less than 28 hours in 2018.

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 2019, there were **443** admissions to these units. The average duration of admission was **50** days (based on discharge information provided for 431 admissions).

Involuntary child admissions

The District Court has to authorise the involuntary admission of a child. In 2019, there were 32 involuntary admissions orders of children to approved centres, pursuant to Section 25 of the Mental Health Act. This included:

- **2** orders to adult units
- **30** orders to CAMHS units

In addition, there was one High Court Order for the admission of a child into an adult unit. There were **three** young people admitted to CAMHS units as Wards of Court and **one** admitted to an adult unit as a Ward of Court.

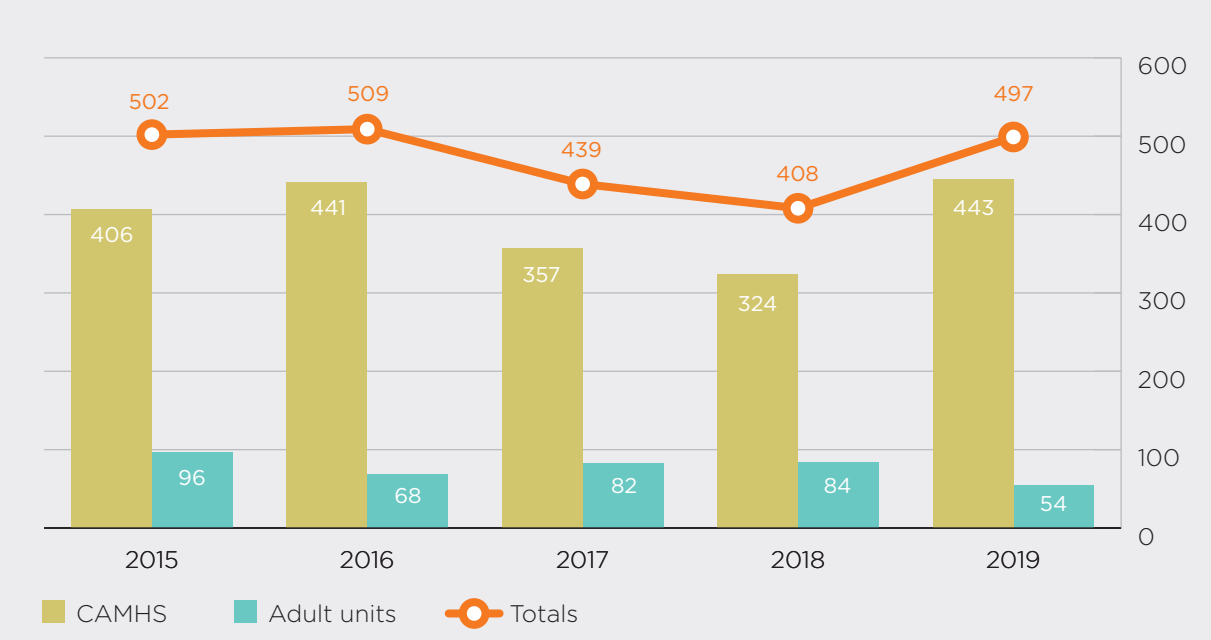
Age and gender of child admissions

In 2019, 65% of all child admissions were female. The youngest resident was 11 years of age.

Table 7.
Age of Child Admissions to Adult and Child Units

Age	Adult unit	CAMHS unit
17	32	153
16	16	118
15	6	89
14	0	54
13 and under	0	29

Figure 6.
Child admissions by unit type (adult or child) from 2015 to 2019



Quality Improvement

The Commission has a mandate to foster high standards and good practice in the delivery of mental health care. We encourage the delivery of recovery-based, person-centred services which promote and uphold the human rights of those receiving care and treatment.

We contribute to a culture of continuous quality improvement by conducting analysis, issuing guidance and developing evidenced-based standards, rules and codes of practice to improve service delivery and the experience of those accessing services.

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

During 2019, our key activities under our Quality Improvement functions included the development and launch, together with HIQA, of National Standards for Adult Safeguarding and the launch of the Comprehensive Information System (CIS).

Publications

The Commission published a number of documents throughout 2019 and into early 2020. These documents range from informative activity reports to quality standards.

- Mental Health Commission Strategy 2019-2022
- The Use of Restrictive Practices in Approved Centres: Activity Report 2017 & 2018
- The Use of Electro-Convulsive Therapy in Approved Centres: Activity Report 2017 & 2018
- Quality and Safety Notifications – Guide to the Revised Forms
- National Standards for Adult Safeguarding

Access to Acute Mental Health Beds in Ireland

During 2019, the Commission worked to finalise a discussion paper which presents the findings from a review of the provision of adult acute mental health beds in Ireland. As part of its strategic commitment, the Commission set up a Quality Improvement Committee in 2018. The Committee, with the approval of the Commission, entered into a joint working agreement with University College Dublin to undertake a review into access to acute mental health beds in Ireland.

The discussion paper aims to provide a comprehensive picture of access to acute in-patient services including the number of acute beds, their ratio with respect to population, the availability of age related acute mental health beds for those over 65 years and the availability of continuum-of-care resources. The paper uses data provided during the registration process of approved centres, as well as data collected during a census on bed occupancy which was carried out by the Commission in November 2018.

Collaborative Working

Submissions

During 2019, the Commission provided submissions or comments on a number of draft standards, frameworks, strategies and position papers, including but not limited to:

- CORU Standards of Proficiency for Social Workers
- HIQA Scoping Consultation on National Standards for Children's Social Services
- HIQA Information Management Services
- HSE Corporate Plan
- Health Products Regulatory Authority Strategic Plan

Committees, Advisory Groups and Interest Groups

During 2019, the Commission participated in a number of groups to contribute to the development of standards, share learnings and gain international insights, including:

- BMJ International Forum on Quality in Healthcare, Glasgow
- Joint Oireachtas Committee on Health
- European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
- National Office for Suicide Prevention
- Dialogue Forum on the role of voluntary organisations in publicly funded health and personal social services
- National Safeguarding Committee
- National Clinical Effectiveness Committee
- HIQA Advisory Group for Human Rights Based Approach to Health and Social Care

National Standards for Adult Safeguarding

In 2019, the Mental Health Commission and the Health and Information Quality Authority (HIQA) jointly published National Standards for Adult Safeguarding. The Standards' development process included a comprehensive review of national and international evidence, focus group participation and a public consultation, engagement with the Department of Health and ultimate approval by the Minister for Health. The Standards were launched by the Minister in December 2019 and are available on our website.

All adults have a right to be safe and to live a life free from harm. Having National Standards for Adult Safeguarding in place allows for a consistent approach to preventing and responding to harm if it does occur. The Standards outline a way of working for health and social care services and support the development of a culture which ensures safeguarding is a fundamental part of service provision.

The Commission and HIQA have developed a number of additional resources to support the implementation of the Standards.

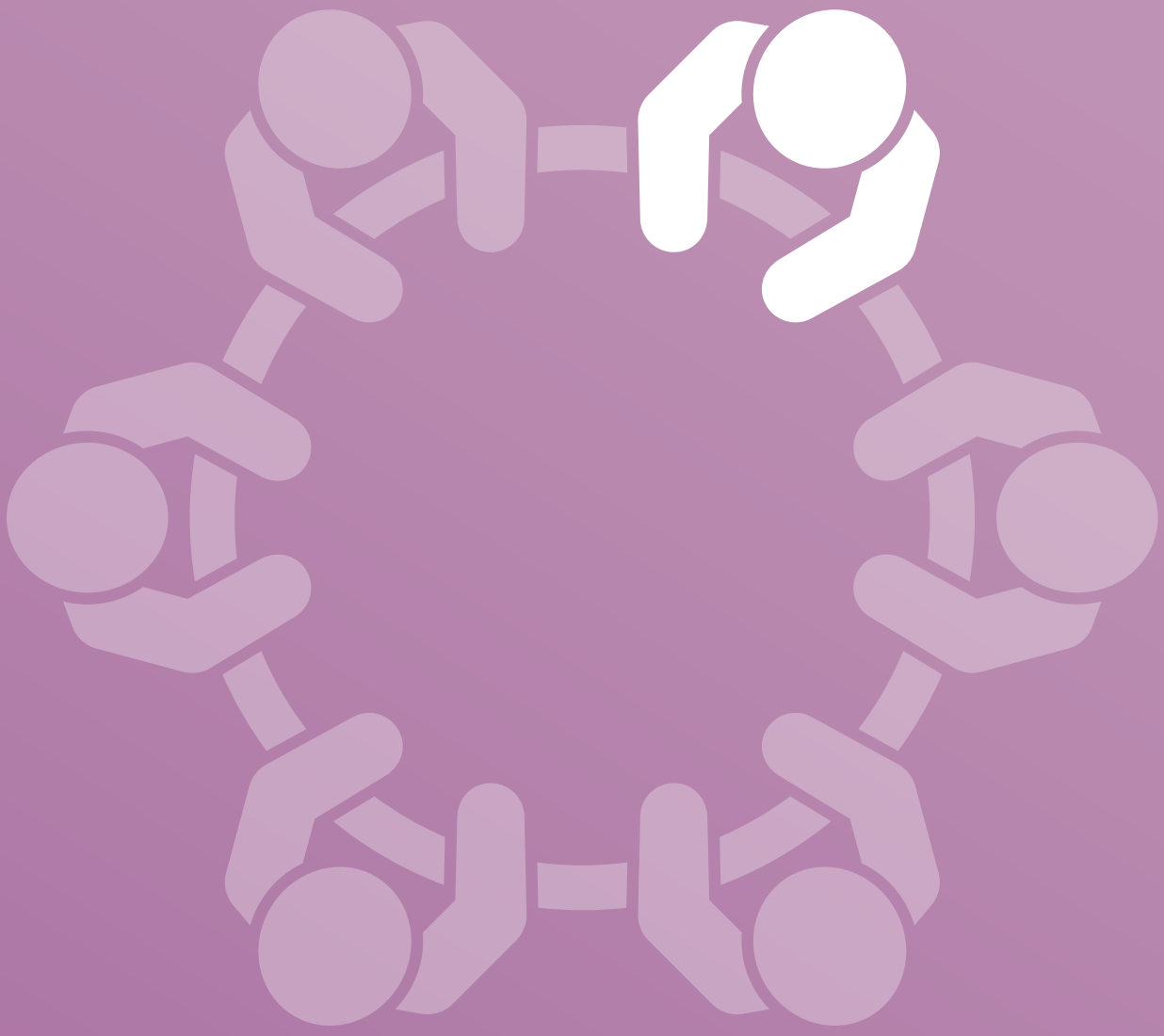
Comprehensive Information System

The Commission launched the Comprehensive Information System (CIS) in 2019. CIS is a coordinated, organisation-wide, secure system which supports the core functions of the Commission. CIS enables internal information and process management while also providing mental health services with an interface which facilitates paperless communication with the Commission. The following processes are now conducted through CIS: registration applications, 'Comment and Review' of inspection reports, the submission of Corrective and Preventative Action Plans (CAPAs), and the submission of Quality and Safety Notifications.

In the last quarter of 2019, the Commission provided in-person training for approved centre staff who would be engaging with the Quality and Safety Notification process on CIS. This was supplemented by a number of comprehensive training manuals and videos which are available on our website.

The Commission is continuing the roll-out of CIS to further functions and notifications, including the work of the Tribunals division and the submission of information in relation to ECT and restrictive practices in approved centres.

Mental Health Tribunals



Introduction

There was a number of court decisions during 2019, which enhanced the rights of persons involuntarily detained in that they had real and practical impact for the patient.

One such case[3] found that a patient is still entitled to appeal an admission order even if that order has been extended by a renewal order. If that appeal is upheld and the court revokes the admission order, the whole detention is revoked.

In another case[4], the Supreme Court emphasised that the voice of the relevant person must be heard in the process by stating:

"It is essential that the voice of the individual be heard in the process, and if she cannot speak for herself then some person must be found, who is not otherwise involved in any dispute, who can speak for her... This is in fact the most striking feature of all of the litigation and all of the court-mandated procedures to date – that it has proceeded to this point on the basis of arguments between third parties, and decisions of courts, as to what [the patient]. wants and what is in her best interests, without her voice being heard."

Although the decision in this case applied to those in hospitals and nursing homes, the message applies to all vulnerable persons to include those in residential mental health services.

The above two cases highlighted the need for the Mental Health Act 2001 to be amended, a matter which did progress in 2019. The Heads of Bill for the Mental Health Act 2001 were given to the Commission in July 2019 for review over a six month period.

General Information

Under the Mental Health Act 2001 (the 2001 Act), every adult who is involuntarily detained in an approved centre shall have their detention order referred to a mental health tribunal (tribunal) to be reviewed. 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 may seek to have another solicitor from the Commission's panel appointed to them and the patient may 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.

3 IF -v- MHT and others 29 May 2019 The Supreme Court found that a renewal order extends the life of an admission order and a renewal order "...does not replace or of itself authorise detention of the patient. The basis for detention remains the admission order, albeit extended."

4 A.C. & Ors v Cork University Hospital and Ors & A.C. v Fitzpatrick and Ors 17 October 2019.

Parties who may be in attendance at the tribunal in addition to the tribunal members 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 the person is 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 signed 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.

In 2019, the following orders were made:

- **1,825** admissions orders from the community
- **565** admissions orders by way of re-grading
- **905** renewal orders for a period up to three months
- **328** renewal orders for a period up to six months

There was a 2% reduction in admission orders and a 1% increase in renewal orders between 2018 and 2019.

Figures 9-11 and Tables 8,9,10 and 11 in the Appendices provide detailed information on admission and renewal orders.

Additional Reviews

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. It also made a change regarding orders of up to six months.

If a patient is detained on an order for up to six months (a second or subsequent renewal order), he or she is entitled to an additional review by a tribunal if still detained after three months. This is an extra safeguard for patients. This right to seek an additional review came into effect on 8 January 2019 and can be sought by the patient or their legal representative.

From 8 January 2019 to 7 January 2020, there were 234 patients who were eligible to seek an additional review. Of these, we would note:

- Thirty nine (39) requests were received for hearing.
- Three (3) orders were revoked before the hearing took place.

- Two (2) requests were withdrawn by the patient.
- Thirty four (34) hearings took place with thirty three (33) orders affirmed and one (1) order revoked.

The requests received represent 16% of the total number of patients eligible for an additional review, which is considerably less than what the Commission expected.

In 2020, the Commission is going to review the reason for the low take up. Where possible, we will speak with patients/patient advocates to see if patients are fully aware of this right and if more needs to be done by the Commission to make them aware of the right.

Tribunal Hearings

A tribunal must sit within 21 days of an order being made. A total of 2,024 tribunals took place in 2019. In Figure 12 in the Appendices, it can be seen on what day of that 21 day period tribunals were heard.

In 2019:

- 1,677 orders were revoked before hearing
- 2,024 orders went to hearing
- 245 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 2019, 88% of hearings took place between Days 15 and 21. The Commission agrees with this recommendation and will ensure that this is achievable before it becomes law.

Orders revoked before hearing:

A consultant psychiatrist responsible for a patient must revoke an order if he/she becomes 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 with the need to ensure that the person is only involuntarily detained for so long as is reasonable necessary for their proper care and treatment.

Where the responsible consultant psychiatrist discharges a patient under the 2001 Act, they must give to the patient concerned, and his or her legal representative, written notice to this effect. The Commission would note that this is not always done or not done in timely manner. 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. All of this should be explained to the patient by the responsible consultant psychiatrist and other members of the patient's team. In 2019, 46% of all orders were revoked before a tribunal hearing. Please refer to Figure 13 in the Appendices.

Section 28 tribunals:

If an order is revoked before a tribunal, the patient can still decide to have a tribunal. This is commonly referred to as a *Section 28 tribunal*. Of the 1,677 orders revoked before hearing, there were 34 requests for Section 28 tribunals of which 24 proceeded to an actual hearing. This is a very small percentage (1.4%) 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 tribunal. Some comments were made on Section 28 by the Supreme Court in a decision in 2019 but the matter was not dealt with substantively.[5]

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

Orders revoked at tribunals:

As noted above, the number of orders revoked at a tribunal was 245, which was 12% of those that went to hearing. This shows an increase of 1% from 2018. Figure 14 in the Appendices provides a further breakdown of these revocations.

There was a total of 245 orders revoked at tribunal in 2019 which can we divided up as follows:

- 65% did not meet the criteria in section 3 of the 2001 Act
- 29% did not comply with one of the relevant sections listed in section 18 (1)(a)(i) (or equivalent) and this affected the substance of the order
- 4% did not meet the criteria in section 3 and did not comply with one of the relevant sections in section 18 (1)(a)(i) (or equivalent) and this affected the substance of the order
- 2% were classed as 'other' (for example – two revocations were related to section 26 issues).

Voluntary to Involuntary

If a voluntary patient indicates a wish to leave an approved centre they can be detained if the 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 fact that the person must be reviewed by their responsible consultant psychiatrist and a second consultant psychiatrist.

As noted, there were 565 such admissions notified to the Commission in 2019.

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.

The key changes in the 2019 figures compared to the previous year are that applications by family are down by 4%; applications by authorised officers remain the same; applications by Garda Síochána are up by 2%; and applications by 'any other person' are up by 2%[6].

The Commission would note the following in relation to these findings:

- It welcomes the decrease in applications by family.
- It is concerned about the increase in applications by the Gardaí.
- As applications by other persons may include doctors in Emergency Departments, this might not represent a surprising increase.
- In terms of authorised officers, the fact that the figures has remained the same is disappointing.

The Commission holds that all applications could be made by authorised officers. There would have to be a change in law and in practice in order to accommodate this proposal, which is supported by the vast majority of interest groups.

6 Other person is very wide and can include a doctor in an A&E department.

Figure 7.
Analysis of Applicants for Involuntary Admissions from the Community in 2019

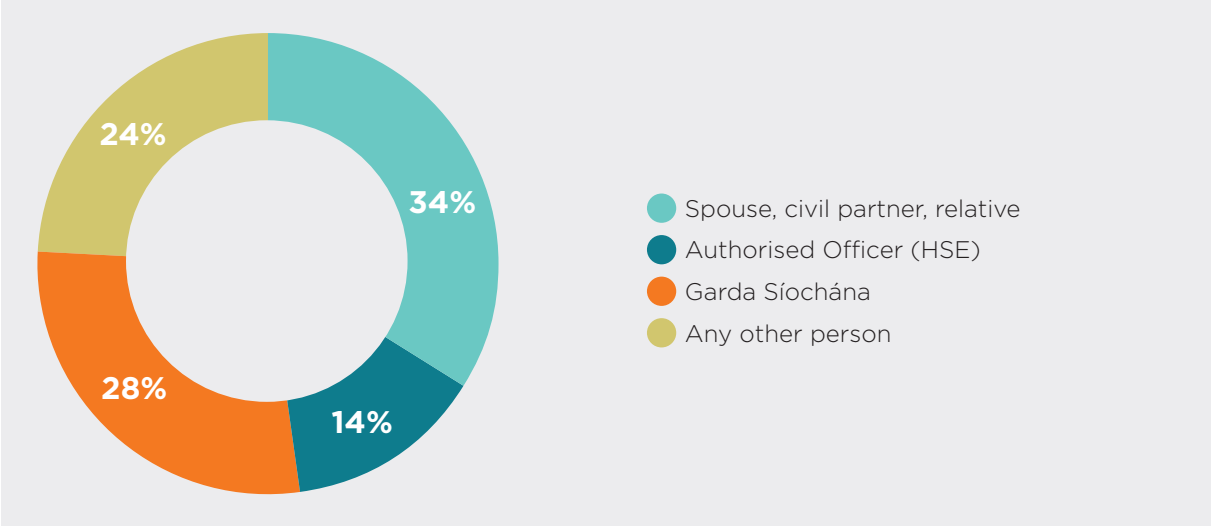
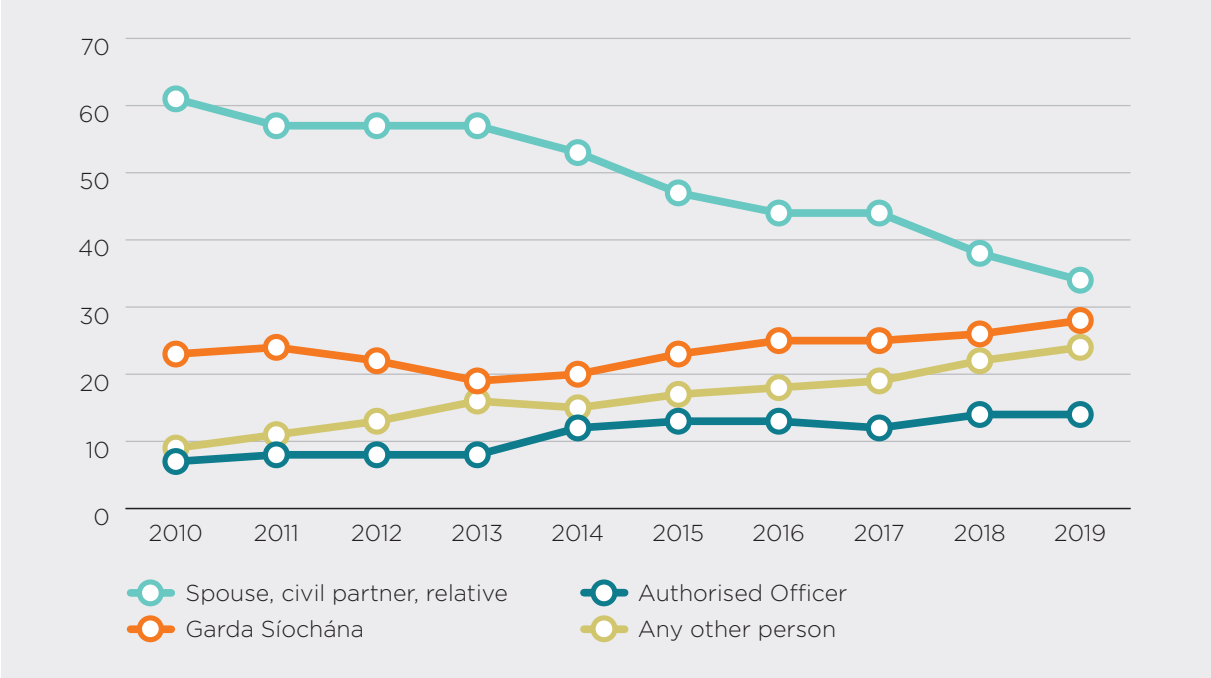


Figure 8.
Analysis of Applicants of Involuntary Admissions from Community from 2010 to 2019



Age and Gender

- Analysis of age and gender for episodes of involuntary admission in 2019 show the following: People aged 35-44 had the highest number of involuntary admissions at 22% (same as 2018).
- Those aged over 65 had a decrease in involuntary admissions to 14% (down 1% from 2018).
- 54% of the total involuntary admissions were male. However, there were more female admissions in the age groups over 55.

See tables 9, 10 and 11 in the Appendices for further detailed information.

Quality Improvement

The Mental Health Tribunals Division introduced a number of measures in 2018 that were aimed at improving the quality of services provided by the Tribunals Division and by Panel Members who are assigned to mental health tribunals. These were expanded in 2019 and included the implementation of internal audits on the Tribunals team, panel members and approved centres, and the provision of regular information updates based on the findings of these audits.

Key measures included the introduction of a formal log of issues relating to each approved centre, which comes to the attention of the Tribunals Division throughout the year. Reports were provided on a quarterly basis and at year end to approved centres regarding all issues that arose that needed to be addressed.

Eighty-nine (89) issues were logged. Of note:

- 43% of the issues were in relation to revocations of orders that were signed and received on the day of the patient's tribunal hearing, some at the time the tribunal was due to commence.
- Forms received later than the statutory 24-hour timeline accounted for 10% of issues, with consequences for the validity of the detention in some of those cases.

The impact of the audit and the reporting of same was seen in the reduction of issues reported in the second half of the year. Sixty-six issues were recorded in the first six months of the year and this reduced to 23 issues recorded in the second half of the year.

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. The Circuit Court considers the issue of mental disorder as of the date of the appeal.

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 its focus is on the current state of the patient and whether or not they are suffering from a mental disorder (the IF case as referred to above).

The Commission was notified of 153 Circuit Court appeals in 2019. This is consistent with the numbers received in recent years with the exception of 2017 when 120 such appeals were received.

Of the 153 appeals received in 2019, 33 appeals proceeded to full hearing. This is an increase in comparison to 27 in 2018 and 21 in 2017.

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.

Mental Health Tribunal Information
Appendices

Figure 9.
Monthly Involuntary Admissions 2019

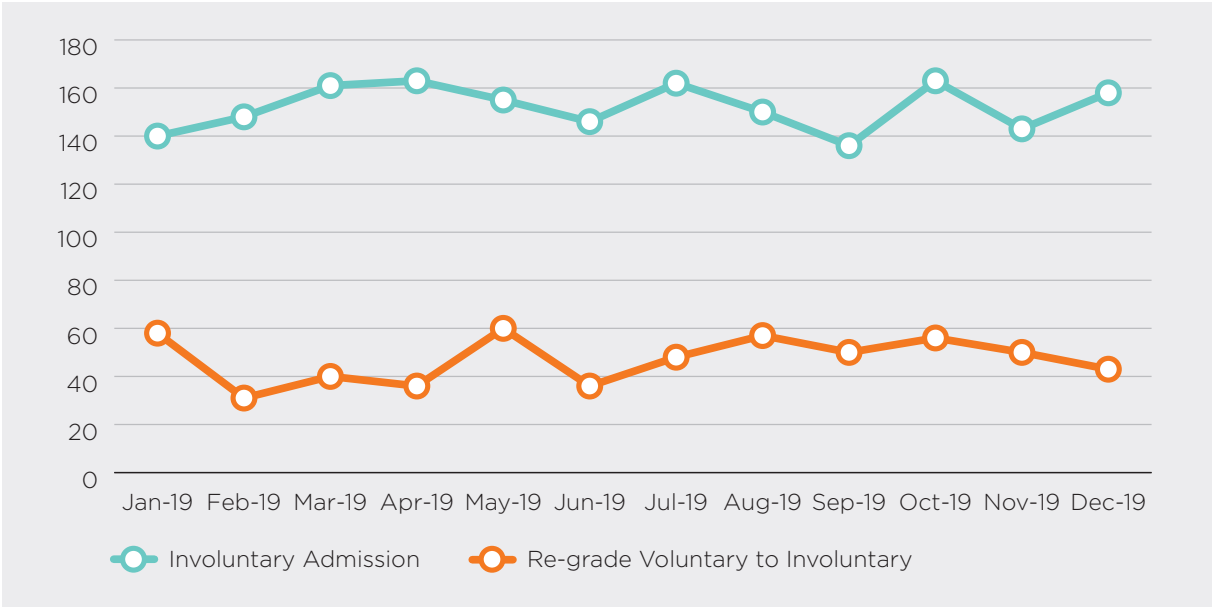


Figure 10.
Comparisons of total Involuntary Admissions 2015-2019

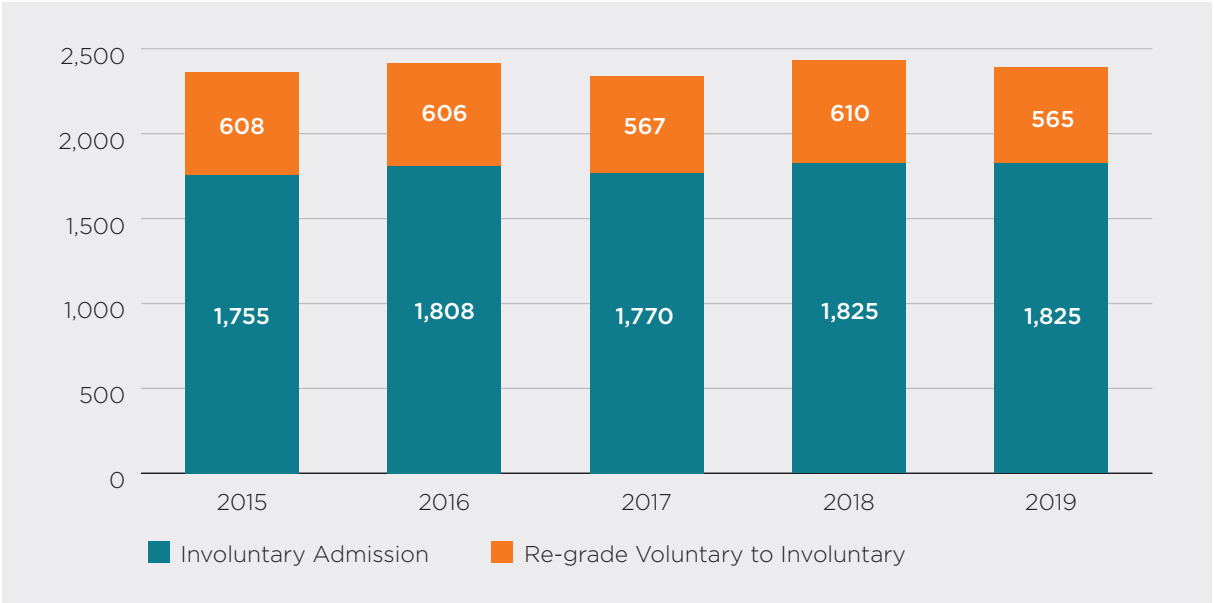


Figure 11.
Comparison of Renewal Orders 2015-2019

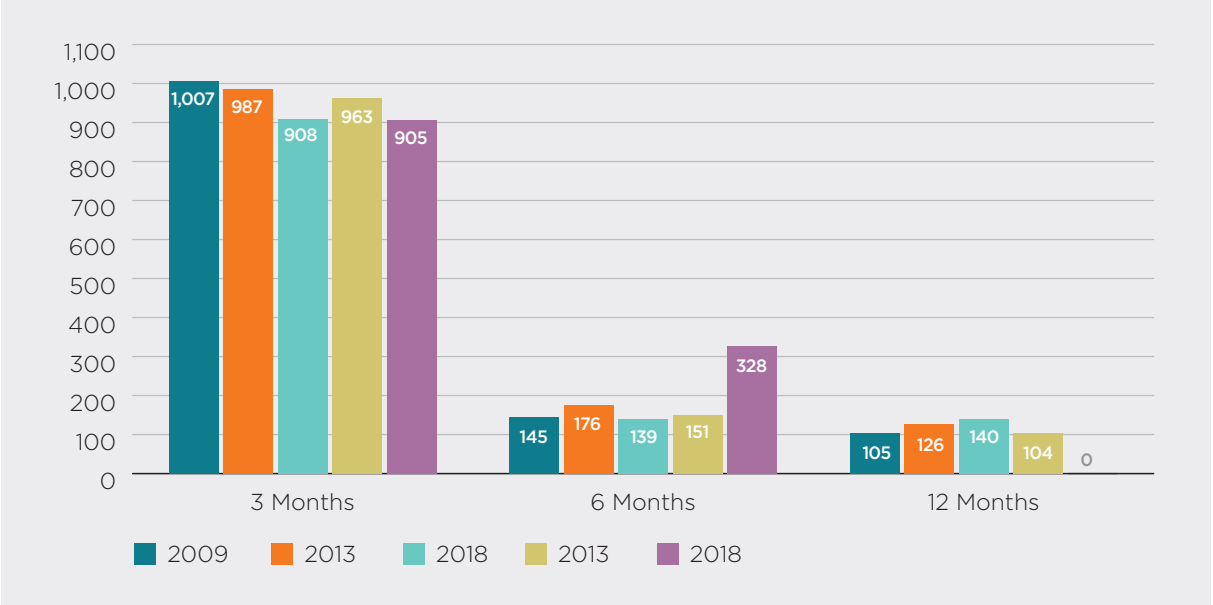


Table 8.
Involuntary Admission Rates for 2019 (Adult) by CHO Area and Independent Sector[7]

	Involuntary Admissions	Re-grade Voluntary to Involuntary	Total Involuntary Admission Rate
CHO1	153	40	193
CHO2	203	42	245
CHO3	116	24	140
CHO4	296	84	370
CHO5	128	48	176
CHO6	137	34	171
CHO7	211	76	287
CHO8	209	35	247
CHO9	296	104	400
Independent Sector[8]	76	78	154
TOTAL (Exclusive of Independent sector)	**1,749**	**487**	**2,236**
TOTAL (Inclusive of Independent sector)	**1,825**	**565**	**2,390**

7 Detailed analysis of involuntary admission rates for 2019 per Approved Centre is provided on the Mental Health Commission website www.mhcirl.ie
8 There are seven independent approved centres.

Figure 12.
Breakdown of Hearings in 2019 over 21 day period[9]

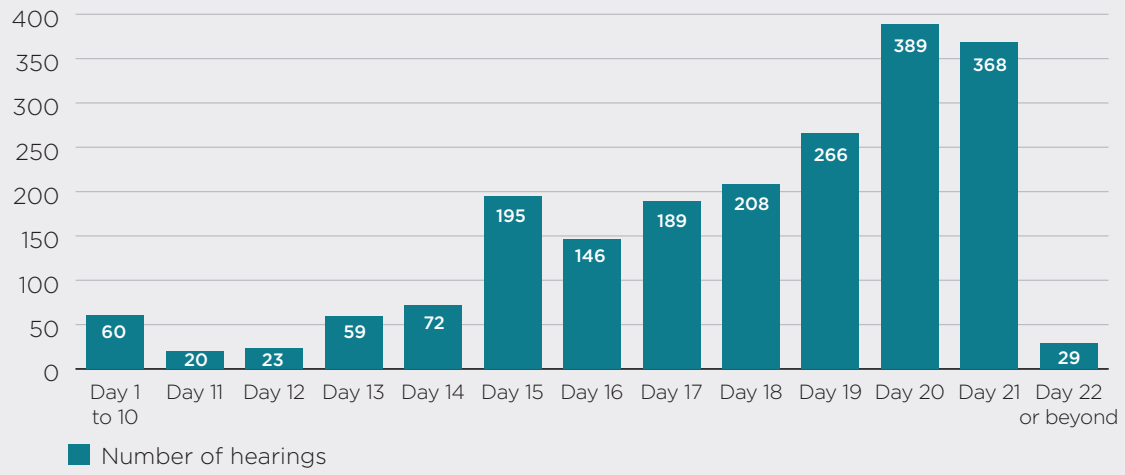


Figure 13.
Number of Orders Revoked before Hearing by Responsible Consultant Psychiatrists for Years 2015 to 2019

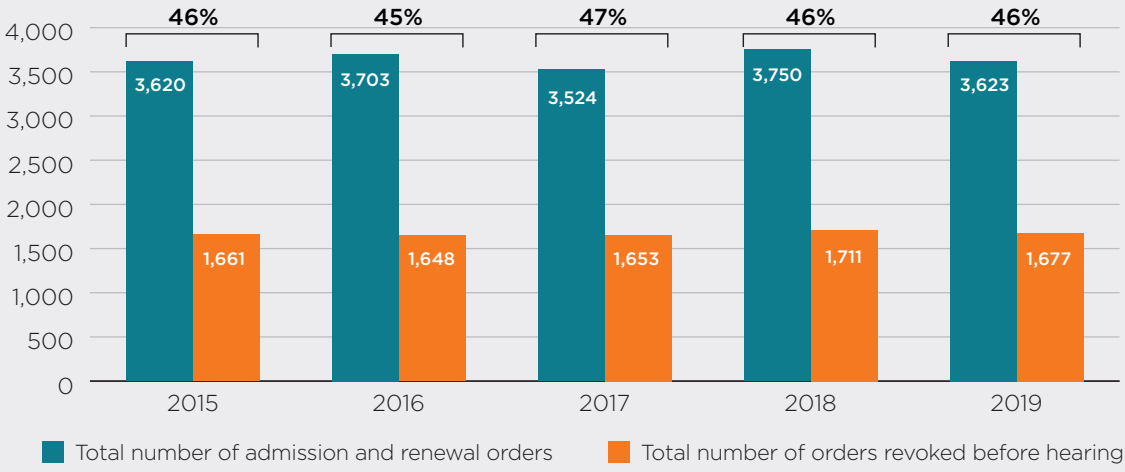
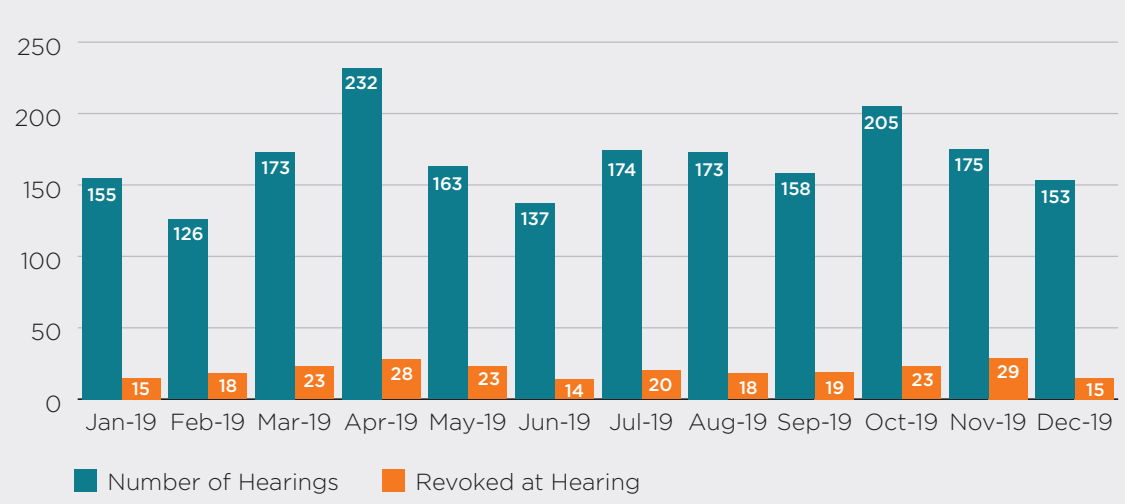


Figure 14.
Number of Hearings and of Orders Revoked at Hearing 2019



9 In relation to the hearings heard after the 21 days these relate to hearings that were extended (as allowed under the Act) or relate to section 28 hearings after an order is revoked.

Table 9.
Analysis by Gender and Age of 2019 Involuntary Admissions

Age	Male	Female	% gender
18-24	206	90	70% male
25-34	314	185	63% male
35-44	289	233	55% male
45-54	233	223	51% male
55-64	126	166	57% female
65+	131	194	60% female
Total	**1299**	**1091**	**54% male**

Table 10.
Analysis by Gender and Admission type of 2019 Involuntary Admissions

Gender	Form 6	Form 13	Total	%
Female	821	270	1,091	46%
Male	1,004	295	1,299	54%
Total	**1,825**	**565**	**2,390**	**100%**

Table 11.
Analysis by Gender, Age and Admission type of 2019 Involuntary Admissions

Age	Form 6	Form 6 Female	Form 6 Male	Form 13	Form 13 Female	Form 13 Male	Total	%
18-24	205	56	149	91	34	57	296	12%
25-34	381	134	247	118	51	67	499	21%
35-44	408	182	226	114	51	63	522	22%
45-54	363	176	187	96	50	46	414	19%
55-64	218	121	97	71	42	29	310	12%
65 and over	250	152	98	75	42	33	362	14%
Total	**1,825**	**821**	**1004**	**565**	**270**	**295**	**2,390**	**100%**

seirbhís tacaíochta cinnteoireachta

decision support service

Decision Support Service year in review

Over the last year we worked to progress the 2019 Business Plan for the Decision Support Service (DSS), with a particular focus on the project to operationalise the DSS upon full commencement of the Assisted Decision Making (Capacity) Act 2015.

In 2019, our focus was:

- Engaging with a wide range of stakeholders to provide information and promote readiness for commencement.
- Developing the operational structures necessary to deliver an accessible, person-centred service, including an appropriate IT system.
- Reviewing Codes of Practice drafted by the National Disability Authority and Health Service Executive working groups.
- Gaining clarity on amendments to the 2015 Act and aspects of the DSS that must be set by Regulations made by the Department of Justice and Equality and Department of Health.
- Building a new DSS website.
- Growing our team.

While good progress was made against our business objectives in 2019, there were a number of external dependencies which impacted on our ability to fully deliver our business plan. During 2019, external dependencies prevented us from gaining clarity on our regulatory framework, on funding for the DSS commencement programme, and on an approach for cross-organisational working.

Towards the end of 2019, significant progress was made collaboratively with the Department of Justice and Equality and the Department of Health towards agreeing a costed, time-bound plan for commencement that all interested parties could work towards. Key outstanding issues included clarity on fundamental aspects of the 2015 Act and Regulations from the Department of Health which will define important aspects of the legal framework for advance healthcare directives.

Four years on, the 2015 is still not fully commenced. The effect of this is that **each year**:

- **100s** of people continue to be taken into wardship
- **1000s** of people remain vulnerable to financial and other abuse
- **100,000s** of people lack the formal frameworks to plan ahead, and to be supported to the fullest extent to make decisions about their own lives

Over 1250 people have been made Wards of Court since the 2015 Act was passed. In its landmark judgment in *AC and Others v. Cork University Hospital and Others* in October 2019, the Supreme Court commented that the voice of the ward was insufficiently heard in the wardship process and that it lacked certain fundamental safeguards for the interests of the proposed ward.

In 2020, Ireland will report on its compliance with the United Nations Convention on the Rights of Persons with Disabilities, following ratification in March 2018. The full commencement of the 2015 Act and operationalisation of the DSS plays a key role in the State's compliance with the Convention.

Getting everyone ready for supported decision-making

In 2019 we met with, presented to, worked with and consulted a wide range of stakeholders across over 40 events, workshops, forums and meetings.

	People experiencing capacity difficulties, their families, family carers, loved ones and chosen representatives.
	Psychiatrists, gerontologists, speech and language therapists, anaesthesiologists, GPs, social workers, intellectual disability service providers, nursing home proprietors, mental health providers, Department of Health, HIQA, HSE, National Rehabilitation Hospital, Safeguarding teams.
	Lawyers, Legal Aid Board, Department of Justice and Equality, An Garda Síochána, The Courts Service, Law Society of Ireland, Office of the Wards of Court.
	Banks, Society of Financial Planners Ireland, Central Bank, ComReg, Banking and Payments Federation.
	Advocates, activists, voluntary bodies, NGOs academics and universities. Inclusion Ireland, Sage, Mental Health Reform, AsIAm, IHREC, National Disability Authority, Citizens Information Board.

In November 2019, together with the HSE Assisted Decision-Making and Consent Office and UCC School of Law, we hosted two events on the 2015 Act. One event was hosted on 20 November 2019 in Croke Park and explored specific impacts for mental health services. The second event was hosted over 28-29 November 2019 in UCC and covered implications for the wider health sector.

In 2019 the Director submitted an article to the journal of the Irish College of General Practitioners 'A cultural shift in the human rights of healthcare'. The Director also contributed to a review published by BMC Health Services Research 'What are the mechanisms that support healthcare professionals to adopt assisted decision-making practice? A rapid realist review'

Key messages we delivered in our stakeholder engagement in 2019:

- Readiness for the 2015 Act is bigger than the DSS and requires significant planning and implementation from the health and social care sector, finance sector, legal sector and Courts Services among many others.
- We all need to act now to be ready for commencement.
- Proper resourcing is required both for the operationalisation of the DSS, as well as for training, education and proper preparedness for the 2015 Act across all sectors.
- The 2015 Act gives legal footing and certainty to many concerning 'grey areas', such as treatment without consent, role of next-of-kin and management of the financial affairs of persons experiencing capacity difficulties.
- The Wardship system is a blunt instrument that continues to deprive thousands of people of the right to make decisions about their life and is long overdue for reform.

Getting operational

Our people

During 2019, we filled a number of key roles within the DSS to support the Director in her functions, including establishing the management team of Senior Case Manager, Senior Panel Manager and Senior Complaints and Investigations Manager. At the end of 2019, the DSS team had grown to a team of nine, including the Director, and continues to be supported by the Commission's Corporate Operations Team.

Service design

In 2019, we continued the detailed design of core processes for the DSS, including the application and registration of decision support arrangements, monitoring of decision supporters, establishing expert panels and a complaints and investigations function.

IT system

During 2019, we developed a detailed request for tender (RFT) for a DSS IT system that would include a public facing portal, case management system and searchable register. It is essential that this IT system has the highest levels of both user accessibility and privacy. We engaged with external experts to evaluate and award this tender. In addition we provided the RFT to the Department of Justice and Equality's ICT Governance Group for their consideration and review.

DSS brand and logo

We developed and launched our new logo and visual identity.

DSS website

During 2019, we awarded a tender for the development of a new website for the DSS. The website project commenced in late 2019 and will go live in 2020. This is a requirement under the 2015 Act and will play a key role in promoting awareness and understanding of the Act.

Codes of Practice

The National Disability Authority (NDA) and HSE were tasked by the Department of Justice and Equality and Department of Health respectively to develop draft Codes of Practice for the guidance of persons affected by and undertaking functions under the 2015 Act. During 2019, the final draft Codes of Practice were submitted to the DSS by the NDA and HSE.

Learning from others

We engaged with established supported decision-making bodies in Canada, England and Scotland to learn from their experiences. We also reached out to other sectors and organisations who work closely with the public to learn about their procedures and infrastructure. Most importantly, we engaged with potential future users of the DSS. We will continue to engage with and learn from these key stakeholders in 2020.

Governance

Corporate Governance within the MHC

The Commission is committed to attaining the highest standard of corporate governance within the organisation.

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. 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. The Commission has procedures in place to ensure compliance with the provisions of the Code. All reporting requirements for 2019 have been met.

Key Governance Activities in line with the requirements of the Code undertaken during 2019

In line with good governance, the Commission undertook a self-assessment survey for 2019. This was considered by the Commission Members at its meeting in February 2020. In addition the Commission Members engaged external providers to carry out an external review of the Commission's effectiveness. This was not complete as of 31 December 2019.[10] Both documents shall inform a plan of action for the Commission Members for the next few years. The Finance, Audit and Risk Committee (FARC) and Legislation Committee also undertook self-assessments for 2019[11].

Corporate Governance

A number of corporate governance documents were introduced or updated in 2019 as follows:

Corporate Governance Manual – updated

Reserved Functions of the Commission – updated

Scheme of Delegation (with Register of Delegations) – new

Code of Conduct for the Commission Members – new

Customer Charter – new

Protected Disclosures Policy (Internal Workers) – updated

Protected Disclosures Policy (External Workers) – updated

All of the above were all reviewed and updated in accordance with best practice and the 2016 Code. They were also reviewed and amended further to input from the Senior Management Team and the Commission Members.

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

For the year ended 31 December 2019, 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 produced a dedicated Code of Conduct for Commission Members in 2019.

10 The Report was completed following discussion at the Commission meeting in April 2020.
11 The details of the assessment were discussed by the FARC Members at its meeting in March 2020 and by the Legislation Committee at its meeting in May 2020.

Committees

The Legislation Committee held six meetings in 2019 and the main focus of its work plan was the Commission's review of the Heads of Bill to amend the Mental Health Act 2001. The draft Submission was presented to the Commission at its February meeting.

The Finance, Audit and Risk Committee held four meetings in 2019 and its Annual Report 2019 was provided to the Commission in March 2020. The Report considered the following:

1. Stakeholder Relationships
2. External Audit (C&AG)
3. Annual Financial Statements for 2018
4. Internal Audit – there were 4 internal audits completed in 2019, as follows:
   - Report on the Review and Effectiveness of Internal Financial Controls
   - Review of compliance with the Code of Practice for the Governance of State Bodies 2016
   - Review of IT Governance
   - Review of Regulatory Processes (Monitoring and Enforcement)
5. Management Accounts & Budget for 2019
6. MHC ICT Projects
7. Decision Support Services
8. Policies
9. Risk Management
10. Governance and Internal Control/Internal Financial Control
11. Controls maturity assessment
12. Protected Disclosures

Business & Financial Reporting

The Department of Health's total allocation to the Commission for 2019 was €14.4 million. The outturn for 2019 in the Mental Health Commission was €14.237 million.

The Commission received an additional €0.026m from the Department of Health as a Capital grant to fund the purchase of new ICT equipment.

The Department of Justice and Equality's allocation for the Decision Support Service work programme for 2019 was €3.5 million (only €2.7 million was drawn down due to external factors causing delays to the DSS project).

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 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. Finance policies in the areas of asset management, banking, procurement procedures and accounting procedures were updated and approved by the Commission in 2019.

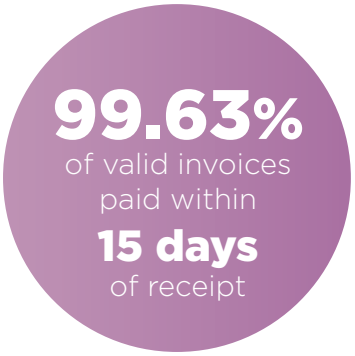
Furthermore, the Commission can confirm that it adhered to the Public Spending Code and the Government travel policy requirements. The Commission did not make any payments in relation to non-salary related fees.

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 2019.

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 2019 were 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 as soon as they are available.

Prompt Payment of Account legislation

The Commission complied with the requirements of the Prompt Payment of Accounts legislation and paid 99.63% 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.



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 2019, the Commission adhered to the three main principles of governance: openness, integrity and accountability. A significant part of the work programme of the Finance, Audit and Risk Committee is the oversight role it plays in the risk management process for the organisation. The risk environment is considered monthly by the Senior Management Team and it is an item on the Agenda for each Commission meeting.

A comprehensive review is done each quarter by the Senior Management Team, reviewed by the FARC and then presented for review and discussion at the next Commission 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 accounts.

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 FARC 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 FARC noted that management was using its 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 the 2020 based on the risk profile in 2019 and those internal audits were agreed and added to by the FARC at its meeting in November 2019.

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, October and December 2019. Oversight and Performance Delivery Agreements were signed for 2019. The Commission commenced discussions with the Department of Justice and Equality in 2019 in relation to what governance mechanisms are required to be put in place once the Decision Support Service commences operation.

The Commission had no legal disputes with any other State agency or Government body save in its role as a regulator of approved centres. In that regard, one of the approved centres was successfully prosecuted by the Commission in 2019. The Commission did make a contribution toward costs in the settlement of one case.

Information Management Technology (ICT)

The key focus for ICT within the Commission is to provide a 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 2019, the Commission upgraded its ICT infrastructure including desktops, laptops and backup broadband lines. All desktops and laptops are now running the latest operating system. Penetration testing was conducted on firewalls and applications.

Procurement was completed for the provision of both mobile phones and USB broadband dongles. These have been rolled out to staff to support agile working.

The Comprehensive Information System (CIS) was completed for Standards and Quality Assurance and the Inspectorate. Substantial work was undertaken in 2019 to advance this system for use by the Tribunals division also. The CIS application is scheduled for completion in 2020.

In 2019, the Commission commenced a review of Cloud services for its existing and future ICT systems, as a replacement for traditional servers. The review was conducted in line with the DPER guidance on Cloud services "Cloud Computing Advice Note" issued in October 2019. Further consideration will be given to Cloud services in 2020.

Energy Reporting

In 2019, the Commission consumed 206,383kWh of energy, consisting of 101,975 kWh of electricity and 104,408 kWh of Gas.

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

For the year ended 31 December 2019, 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 2019.

Maastricht Returns

In 2019, 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 2019. 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 2019.

Stakeholder Engagement

The Commission put in place its first in-house communications function in early 2019.

The objective of the communications team is to proactively contribute towards the realisation of the organisation's strategic objectives by helping to drive awareness of the Commission, and by effectively communicating about the Decision Support Service (DSS).

By employing an in-house communications team, the Commission recognised that it had an opportunity to develop a comprehensive, distinct and innovative communications strategy that would chart a course for the Commission to develop a new way of communicating with its stakeholders.

That communications strategy was developed in early summer, and set out some of the key communications objectives and actions for the Commission over the following four years. It supports the overall strategic direction of the Commission, and was informed by its mission, vision and values, along with conversations and correspondence from key stakeholders, including mental health service users, service providers, staff, media and the Irish public.

The vision for communications is that the Commission is recognised by its stakeholders as a strong, independent, compassionate and transparent organisation that puts the voice and human rights of the service user at the very heart of its communications.

In order to work towards that vision, the communications team set about heavily promoting the work of the Commission – and primarily our key reports – through traditional media channels. Media coverage of the Commission and its regulatory work across 2019 was therefore significantly enhanced compared to previous years.

In an effort to boost face-to-face interaction with key stakeholders, the communications team also organised various launches and events that were, in total, attended by more than 900 people from over 60 organisations. These events included the launch of the MHC 2019-2022 Strategic Plan, the 2018 MHC Annual Report; two public 'Town Hall' events in Cork and Galway; and the launch of the National Standards for Adult Safeguarding with HIQA.

In addition the communications team set up the Commission Members Stakeholder Initiative in 2019, a formal process of stakeholder engagement between service users and the Commission.

The communications team also developed several key documents during the year to underpin the development of an elevated digital presence for the Commission in the coming years. These included a digital communications strategy, a social media roadmap, and a social media policy. The team also established a LinkedIn account at the start of the year, and launched a Twitter account at year end.

The development of a new Commission website, and the development of website for the DSS – projects that are both overseen and managed by the communications team – together represent the most crucial digital project in the lifespan of the Commission. The DSS website project commenced towards the end of the year and will be launched in 2020. The MHC website project will commence during 2020.

With regard to the DSS, the communications team supported the team over the course of the year and arranged the hosting of a briefing for Oireachtas members at Government Buildings towards the end of the year. The team also supported the DSS with events in Dublin and Cork, held in collaboration with the HSE and UCC.

In 2020, the communications team will continue to drive promotion of the Commission's work, and work to engage with key stakeholders on all issues that concern or relate to the Commission.

Human resources

The Human Resources function supports the employees of the Commission throughout their employment life cycle. Employees of the Commission are a fundamental resource and their diverse expertise, professionalism and commitment is appreciated.

The Commission continuously strives for excellence in the work environment and recognises that the success of the organisation is dependent on the skills and capabilities of its employees.

Performance Management

The Commission is dedicated to the training and development of employees by implementing processes and systems to achieve organisational objectives. To foster a culture of growth and advancement, a Performance Management Development System (PMDS) is in place to support the achievement of positive performance and professional development.

A comprehensive induction programme was conducted for new employees of the Commission in 2019 to ensure an inclusive transition into the employ of the Commission.

General Staff Survey 2019

The general staff survey 2019 was conducted by an external provider to ensure the highest standards in objectivity and impartiality. The survey was comprehensive and the findings were presented to all employees. The data compiled has been used to inform HR changes and challenges, and will further serve as a baseline for evaluation of the general staff survey 2020.

Employee Wellness

2019 saw the implementation of a new wellness programme for the Commission's employees called 'Work Well'. The main focus of the plan was to embed the programme within the needs of our current diverse employee base. The key driver of the WorkWell 2020 programme of events will be to address some of the fundamental findings from the General Staff Survey 2019 and tailoring wellbeing programmes and events towards addressing these.

By investing in the health and wellbeing of MHC employees we have the potential to improve productivity, reduce absenteeism, increase engagement and enhance job satisfaction.

With an increasingly competitive marketplace (both within the Irish public sector itself and across sectors) it is imperative that the Mental Health Commission is branded as a great place to work, of which employee wellbeing is a key aspect. We aim to attract, and retain, the best talent to achieve the organization's strategic goals and keep our key talent well throughout the course of their careers with us.

The framework employed to design the WorkWell initiative was the '5 Ways to Wellbeing' framework (promoted within Ireland by Mental Health Ireland). It is comprised of a 5 step evidence-based action plan that promotes positive wellbeing and functioning for members of society, both within and outside of the workplace. Our initiatives ran on a monthly basis, and each one fell within at least one of the five action categories:

Connect

- Lavender plant provided to each member of staff for tending to in the office space or at home.
- A remembrance tree at Christmas for staff members to hang the name of someone they would like to take the time to remember over the festive season.

Be Active & Healthy

- Weekly pilates classes.
- Monday morning fruit baskets.

Take notice

- A "Pay it forward" initiative, which saw employees thanking a colleague anonymously with small gestures over a period of time.

Keeping learning

- A book nook was established in employee spaces where books can be exchanged, with a 'take a book, leave a book' approach taken.
- Noticeboards were established in employee spaces to promote healthy activities – e.g. walking 10,000 steps per day and details of the Employee Assistance Programme available.
- A lunchtime talk by a member of the Kidney Association on the topic of 'Organ Donation'.

Give

- Shoebox appeal in conjunction with the Inner City Helping Homeless (ICHH) charity in Dublin.

As the 'WorkWell' programme continues to develop, we will continue to use wellbeing research to provide the overarching structure to the initiative. By completing this research on an annual basis, we aim to meet current and changing staff wellbeing needs. This will result in the organisation benefitting from the application of a successful and supportive wellbeing programme.

The Commission's Employee Assistance Programme (EAP), which is provided by an external provider, offers a free, professional service for employees and their families to resolve personal or work related concerns, which may be affecting a person's wellbeing and their performance in the workplace.

Supports for Employees with Disabilities

The Commission provides a progressive 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 on an annual basis. The Government has committed to increasing the public service employment target for persons with disabilities on an incremental basis from a minimum of 3% to a minimum of 6% by 2024.In 2019, through the issues of staff census returns, the Commission reported a rate of 5.88% of their employee base as having a disability.

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 health and wellbeing of its employees by maintaining a safe place of work and ensuring compliance with all requirements pursuant to the Safety, Health and Welfare at Work Act 2005 (as amended and/or updated).

Recruitment 2019

The Commission's organisational structure continued to build on the expansion that occurred during 2018. Following receipt of sanction from both the Department of Health and the Department of Justice and Equality, the Commission's headcount increased from 49 employees at the start of January 2019 to 68 employees at the end of December 2019 (an increase of 38.8% overall). A large portion of this increase was seen in the Corporate Operations and DSS divisions. Employee headcount peaked at 72 during August 2019, with a headcount of 68 as at 31 December 2019. Turnover rate for the year in total was 17.9%, with a total of 12 leavers throughout the course of 2019.

Freedom of information/Data Protection

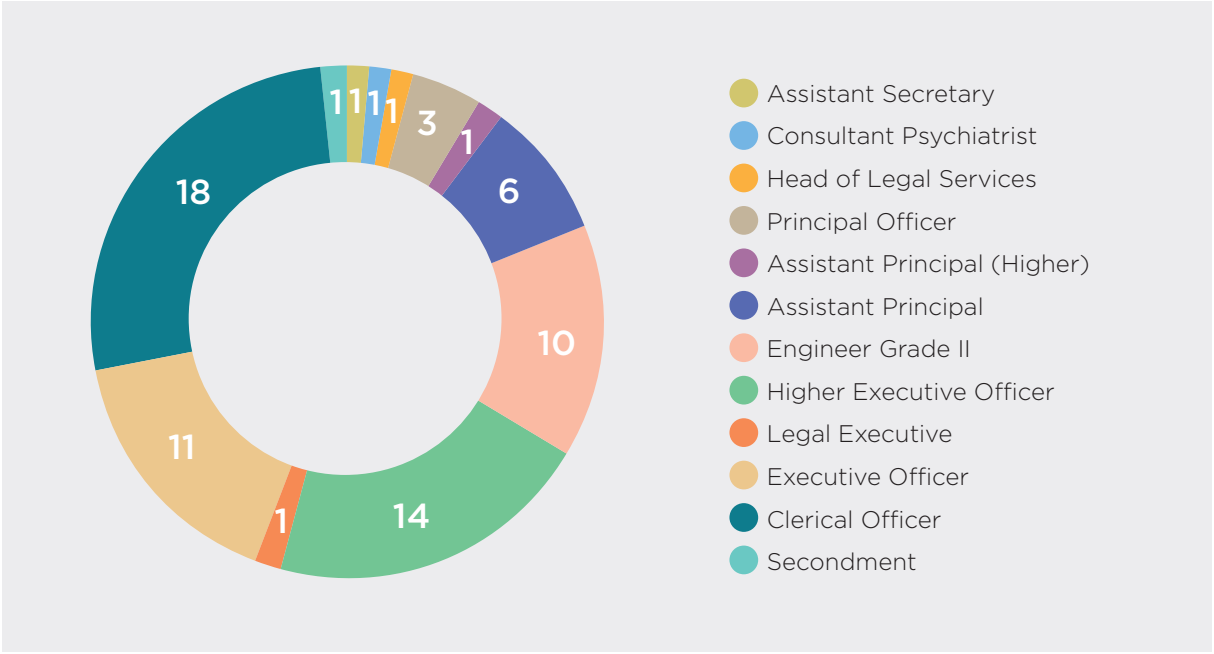
Data Protection

The General Data Protection Regulation (GDPR) and the Data Protection Act 2018 came into effect in 2018. Since then, the Commission has carried out work required and updated its policies within this legislative context. It has produced and implemented a GDPR compliance plan on an organisation-wide basis. Throughout the year, it convenes an Information Governance Group to address information matters on behalf of the Commission – including issues pertaining to Data Protection and Freedom of Information.

Requests

In 2019, 8 Data Subject Access Requests were made under data protection legislation. At year-end, one case remained open.

Figure 15.
Headcount as at 31 December 2019



Freedom of Information

Under the Freedom of Information Act 2014, the Commission is a designated FOI body. In compliance with this legislation, it provides its Freedom of Information Publication Scheme on its website and processes requests for information on a continuing basis.

Requests

In 2019, the Commission received 27 requests under the Freedom of Information Act 2014. A further one was carried over from 2018. Of the 28 requests, 9 were granted, 2 were part-granted, 6 were withdrawn, 3 were transferred and 8 were refused. At year-end, no cases remained open.

The majority of requests for information processed under the data protection legislation or the Freedom of Information Act 2014 are from persons who have been involuntarily detained in Approved Centres. A typical request is for information on a Mental Health Tribunal at which that person's involuntary detention was considered. Access to such information is not only a legal entitlement, it forms part of the Commission's delivery on, and commitment to, its strategic objective to uphold human rights.

Appendices

Appendix 1.
Mental Health Commission Membership and Meeting Attendance 2019

Mental Health Commission Meeting Attendance 2019												
Commission Members	**16/17.01**	**21.02**	**21.03**	**18.04**	**16.05**	**20.06**	**18.07**	**19.09**	**17.10**	**21.11**	**19.12**	**Total**
John Saunders (Chair)	Y	Y	N	N	Y	Y	Y	N	Y	Y	Y	**8/11**
Jim Lucey	N	Y	Y	N	Y	N	N	Y	N	NA	NA	**4/10**
Patrick Lynch	Y	Y	Y	Y	N	Y	Y	Y	Y	N	Y	**9/11**
Ned Kelly	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**11/11**
Aaron Galbraith	N	Y	Y	Y	Y	N	Y	N	N	N	N	**5/11**
Xavier Flanagan	Y	N	N	N	Y	Y	Y	N	Y	Y	Y	**7/11**
Colette Nolan	Y	Y	Y	N	Y	Y	N	Y	Y	Y	N	**8/11**
Rowena Mulcahy	Y	Y	Y	N	Y	N	Y	Y	Y	Y	Y	**9/11**
Margo Wrigley	Y	N	Y	N	Y	Y	Y	N	Y	Y	Y	**8/11**
Michael Drumm	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**11/11**
Nicola Byrne	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	**9/11**
Tomas Murphy	NA	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	**9/10**
Niamh Cahill	Y	Y	Y	Y	N	NA	NA	NA	NA	NA	NA	**4/5**

Appendix 2.
Finance, Audit And Risk Committee Membership And Meetings 2019[12]

Finance, Audit and Risk Committee Attendance 2019					
Committee Members	**04.03**	**01.07**	**06.09**	**29.11**	**Total**
Patrick Lynch (Chair) (CM)	Y	Y	Y	Y	**4/4**
Moling Ryan (EM)	Y	Y	N	Y	**3/4**
James Lucy (CM)	Y	Y	N	NA	**2/3**
Nicola Byrne (CM)	N	Y	Y	Y	**3/4**
Ciara Lynch (EM)	Y	Y	Y	Y	**4/4**
Mairead Dolan (EM)	Y	Y	Y	Y	**4/4**
Tomas Murphy (CM)	Y	Y	Y	Y	**4/4**

Appendix 3.
Legislation Committee Membership and Meetings 2019

Legislation Committee Meeting Attendance 2019							
Committee Members	**11.02**	**02.09**	**07.10**	**05.11**	**02.12**	**17.12**	**Total**
Rowena Mulcahy (Chair) (CM)	Y	Y	Y	Y	Y	Y	**6/6**
Mary Donnelly (EM)	Y	Y	Y	Y	Y	Y	**6/6**
Michael Drumm (CM)	Y	Y	Y	Y	Y	Y	**6/6**
Ned Kelly (CM)	Y	Y	Y	Y	N	Y	**5/6**
Teresa Blake(EM)[13]	NA	Y	Y	Y	Y	Y	**5/5**

12 CM = Commission Member and EM = External Member.
13 Teresa Blake was appointed in July 2019.

Report of the Inspector of Mental Health Services

By Dr. Susan Finnerty,
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 determine whether or not they are compliant with the Mental Health Act 2001 (Approved Centres), Regulations 2006[14] ("the Regulations"), Rules[15], and Codes of Practice[16], as well as any other issues relating to the care and treatment of residents in the approved centres.

Registered with the Mental Health Commission, approved centres **are hospitals or other in-patient facilities for the care and treatment of people experiencing a mental illness or mental disorder**. 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. Other services include continuing care units where residents live, often for many years or permanently.

Approved centres and continuing care units only make up 1% of all mental health services in the country. The other 99% are provided in community settings and are not regulated. Though the Inspector can inspect any other mental health facility that is under the direction of a consultant psychiatrist, the Mental Health Commission does not have the legal power to enforce any required changes.

As part of their duties, the Inspector must also carry out a national review of the mental health services in the State and provide a report of their findings to the Mental Health Commission. This national review must include:

a) A report on the care and treatment given to people receiving mental health services;

b) Anything that the inspector has found out about approved centres or other mental health services;

c) The degree to which approved centres are complying with codes of practice, and;

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

The Inspector is supported by the Inspectorate; a team that includes assistant inspectors, technical writers, and administrative staff. The Inspectorate is part of a wider Regulatory Team whose functions include registration, inspection, enforcement, and monitoring.

The Inspector wishes to acknowledge the work done by the inspectorate team during 2019.

14 Mental Health Act 2001 (Approved Centres) Regulations 2006 (S.I. No. 551 of 2006).
15 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.
16 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 2019?

In 2019:

- We inspected all **65 approved centres** using the Regulations, Rules, and Codes of Practice;
- Out of the 65 approved centre inspections, there were **five** announced inspections. The announced inspections were undertaken in approved centres which had the most compliances with regulations, rules and codes of practice in 2018;
- We inspected **22 community residences**;
- We carried out **five** focused inspections to follow-up on enforcement actions or when there were issues of concern;
- We met with the management and clinical teams of Mental Health Services for Older People (MHSOP) in all **nine** Community Mental Health areas and in **four** independent providers of mental health services;
- We carried out a review of the premises in which in-patient mental health services are delivered;
- We met with service users and peer advocacy representatives to get their perspectives on mental health services; and;
- We published all inspection reports of approved centres and community residences on the Mental Health Commission website.

All of our reports can be accessed on our website: http://www.mhcirl.ie.

What did we find?

We found a number of **issues of concern**:

- The considerable variation in how staff of approved centres use restrictive practices, physical restraint, and seclusion to de-escalate challenging behaviour.
- The poor quality in monitoring the physical health of residents.
- The impact of staffing shortages.
- The failure to provide all residents with a meaningful individual care plan.

We found a number of **good practices**:

- Staff were observed to be kind, compassionate, and caring towards residents.
- Most approved centre staff and management engaged well with the regulatory process.
- The best services improved their quality of care by working in partnership with the service users, empowering their staff, and looking for opportunities to improve the quality of care they give.

Compliance with Regulations, Rules, and Codes of Practice in Approved Centres

In 2019, we found that compliance with regulations remained similar to 2018, at 78%. It was disappointing that the modest improvements made since 2016 did not continue.

Year	2016	2017	2018	2019
Average compliance	74%	76%	79%	78%

However, some individual approved centres made considerable progress in improving quality and safety for residents and in their compliance with all regulatory requirements, including regulations, rules, codes of practice and Part 4 of the Mental Health Act 2001:

Table 1.
Approved centres with highest overall compliance levels

Most compliant				
Approved Centre	**Community Healthcare Organisation (CHO)**	**Hospital Type**	**Inspection Type**	**Percentage Compliance 2019**
St Patrick's Hospital, Dublin	Independent	General Adult Mental Health Services	Announced	100%
Creagh Suite, Ballinasloe	CHO 2	Mental Health Services for Older People	Unannounced	97%
Willow Grove, Dublin	Independent	CAMHS	Announced	97%
St Edmundsbury, Lucan	Independent	General Adult Mental Health Services	Announced	97%
Tearmann Ward, Limerick	CHO 3	Mental Health Services for Older People	Announced	97%

**CAMHS – Child and Adolescent Mental Health Services*

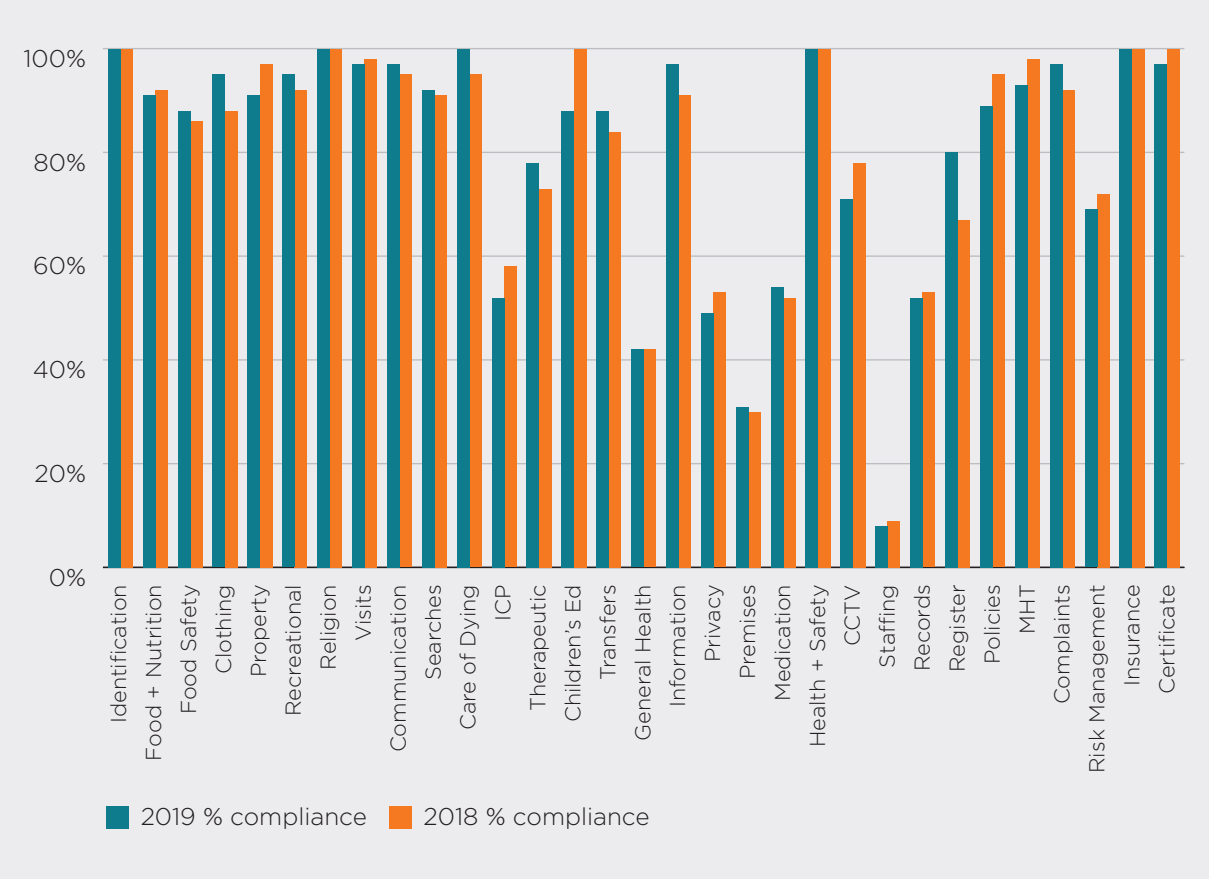
Others struggled to achieve compliance above 60%:

Table 2.
Approved centres with lowest overall compliance levels

Least compliant				
Approved Centre	**CHO area**	**Hospital Type**	**Inspection Type**	**Percentage Compliance 2019**
Acute Psychiatric Unit Tallaght	CHO 7	Acute General Adult	Unannounced	56%
Department of Psychiatry Waterford	CHO 5	Acute General Adult	Unannounced	57%
Sliabh Mis, Tralee	CHO 4	Acute General Adult	Unannounced	58%
Department of Psychiatry, Connolly Hospital, Dublin	CHO 9	Acute General Adult	Unannounced	59%

The following figure shows the percentage compliance with each individual regulation in 2019 compared against percentage compliance in 2018.

Figure 1.
Approved centre compliance with regulations 2018-2019



Some regulations saw low levels of compliance across approved centres, including those that are essential to a resident's wellbeing, such as Individual Care Plans (Regulation 15), General Health (Regulation 19), and Medication (Regulation 23).

Table 3.
Regulations with low levels of compliance

Regulation	2018 compliance	2019 compliance	Change (%)
Staffing (Regulation 26)	9%	8%	↓1%
Premises (Regulation 22)	30%	31%	↑1%
General Health (Regulation 19)	42%	42%	No change
Medication (Regulation 23)	52%	54%	↑2%
Privacy (Regulation 21)	53%	49%	↓4%
Maintenance of Records (Regulation 27)	53%	52%	↓1%
Individual Care Plan (Regulation 15)	58%	52%	↓6%

Table 4.
Regulations with high levels of compliance

Regulation	2018 compliance	2019 compliance	Change (%)
Identification (Regulation 4)	100%	100%	No change
Religion (Regulation 10)	100%	100%	No change
Health + Safety (Regulation 24)	100%	100%	No change
Insurance (Regulation 33)	100%	100%	No change
Care of the Dying (Regulation 14)	95%	100%	↑5%
Visits (Regulation 11)	98%	97%	↓1%
Communication (Regulation 12)	95%	97%	↑2%

Individual Care Plans

Regulation 15, Individual Care Plans, states that each resident in an approved centre must have an individual care plan. It defines an individual care plan as:

'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.'

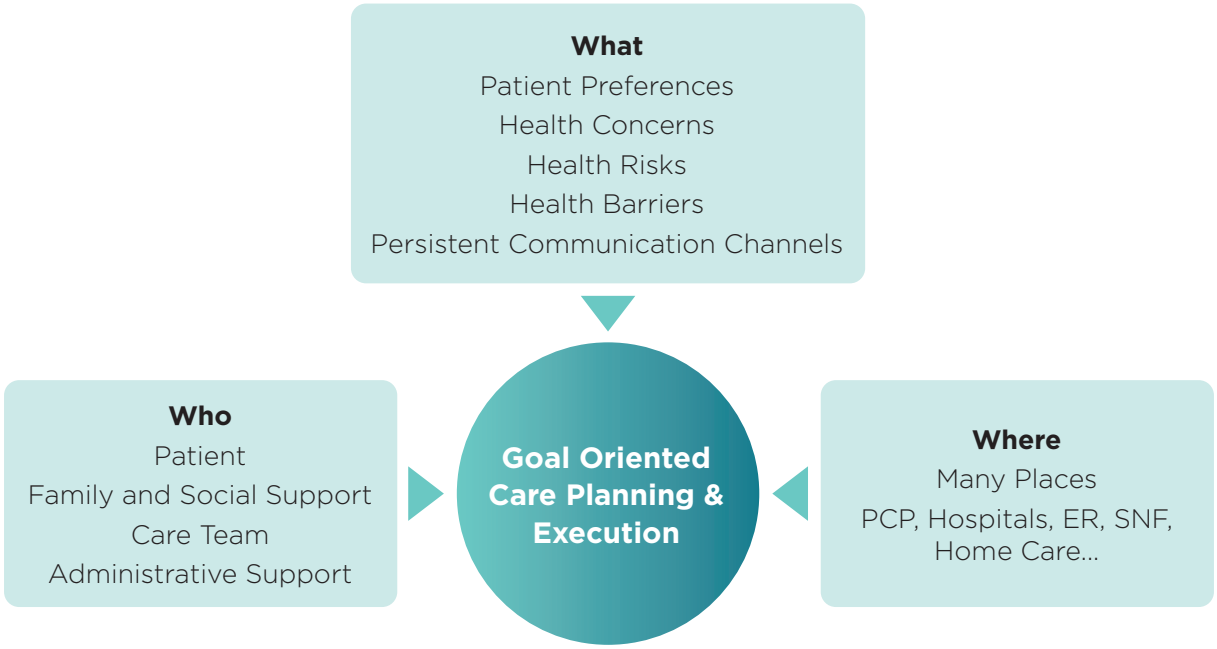
In other words, a care plan is:

'A plan that describes in an easy, accessible way the needs of the person, their views, preferences and choices, the resources available, and actions by members of the care team, (including the service user and carer) to meet those needs. It should be put together and agreed with the person through the process of care planning and review[17].'

The National Institute for Health and Care Excellence (NICE) guidance states that:

"people using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it"[18].

The individual care plan must be easily understood and used by colleagues should the person coordinating the care not be present, and so it must include enough information to effectively implement the plan.



17 Care Coordination Association website on: www.cpaa.org.uk
18 Quality Standard for Service User experience in adult mental health (QS14) December 2011 NICE Quality Statement 8.

Every patient has a written care plan, reflecting their individual needs.

Staff members actively seek to collaborate with patients and their carers (with patient consent) when developing the care plan.

The care plan clearly outlines:

- Agreed intervention strategies for physical and mental health;
- Measurable goals and outcomes;
- Strategies for self-management;
- Any advance directives or statements that the patient has made;
- Crisis and contingency plans;
- Review dates and discharge framework.

The patient (and their carer, with the patient's consent) are offered a copy of the care plan and the opportunity to review this.

Standards for Inpatient Mental Health Services Second edition, 2017
Editors: Jen Perry, Lucy Palmer, Peter Thompson, Adrian Worrall, Rob Chaplin
Publication Code: CCQI260

Good care planning includes:

Busy acute approved centres have large numbers of teams but limited resources to develop or review care plans. It has been commented to the Inspector that care plans do not reflect "what happens on the ground" and that too many staff resources are spent developing and reviewing care plans, reducing the amount of time spent with residents. This has led to a great deal of frustration and disappointment within the approved centres when the standard of the regulation is not met.

Goals need to be:

Specific: goals need to be clear and specific, not general or vague.

Measurable: Patients should be able measure their progress.

Attainable: Patients should be encouraged to set goals and objectives they can meet. Goals should be challenging but also realistic.

Relevant: Goals and objectives should be relevant to the issues listed in the treatment plan.

Time-bound: Goals and objectives must have a deadline. Goals might be considered short-term or long-term.

A robust factor in promoting mental health recovery and wellbeing is effective goal setting. There is strong evidence that working towards clearly defined goals, which the resident has set for themselves, improves outcomes across a wide variety of illness states and therapy types, and helps to build and strengthen the therapeutic alliance[19 20].

Goal setting works best when the person working towards the goal chooses what they want to achieve. The more confidence an individual has in their capacity to undertake and execute a task, the more likely they are to be successful[21].

19 Clarke SP, Oades LG, Crowe TP, et al. (2006) Collaborative goal technology: Theory and practice. Psychiatric Rehabilitation Journal 30(2): 129-136.
20 Schrank B, Bird V, Rudnick A, et al. (2012) Determinants, self-management strategies and interventions for hope in people with mental disorders: Systematic search and narrative review. Social Science & Medicine 74: 554-564.
21 Mann T, de Ridder D, Fujita K. (2013) Self-regulation of health behavior: Social psychological approaches to goal setting and goal striving. Health Psychology 32(5): 487-498.

Compliance in 2019 – Individual Care Plans

In 2019, in each approved centre, the inspectorate examined a sample of 10 individual care plans, in line with the definition provided in Regulation 15 and outlined on page 65. We found that just 52% of approved centres were compliant with this regulation. This compares with previous years as shown in figure 2.

Of approved centres who were non-compliant with this regulation, 74% did not develop appropriate goals for residents. In some individual care plans there were no goals documented, in other care plans "Big Picture" goals were stated. These included "maintain physical health, "improve mental health", "get accommodation". In one case, the goal was documented as "remains irritable".

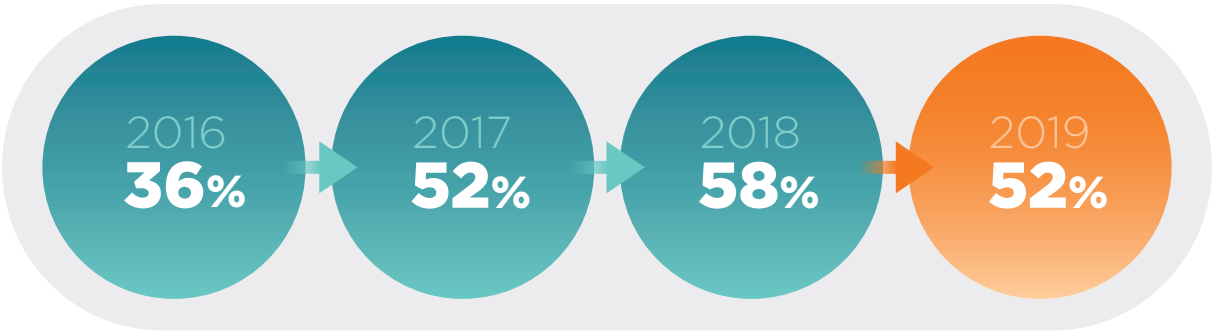
One could consider the lack of training a factor in poor care planning practice. However, most approved centres have provided training in care planning for their staff. This training may need to be reviewed and standardised.

Leadership in the care planning process is important. If clinical leads do not "agree with" individual care planning, there is little chance that meaningful care plans will be developed and reviewed. As most approved centres have doctors that are training in psychiatry, there is every risk that poor care planning practice will be perpetuated.

Continued poor compliance with Regulation 15: Individual Care Plan needs to be tackled on a number of fronts:

1. **Change of culture**: The patient's individual care plan should be seen as the blueprint for their care pathway. It should be viewed as the patient's care plan, not the clinician's.
2. **Training**: Training needs to incorporate theoretical and experiential learning with regular refresher courses. There should be regular audits of the training and demonstrable learning from those audits.
3. **Leadership in care planning**: Clinical leads must be supportive and engage in the care planning process.
4. **Availability of clinical staff**: It is well recognised that shortage of clinical staff leads to a lack of involvement by clinicians in care planning development and review. The very minimum should be that any clinical staff involved in assessment and review of patients are present at the care planning meetings.

Figure 2.
Individual care plan compliance 2016-2019



5. **Regular feedback from service users**: For the most part, patients are aware whether or not they have an individual care plan. Mental health lobby groups, support groups, and advocates have repeatedly stated that residents want individual care plans. Patients should be encouraged to engage fully and to view their care plan as an essential part of their assessment and treatment while in hospital and beyond.
6. **End-to-end journey**: A patient's individual care plan should follow the patient throughout their mental health service journey and not just begin or end at the doors of the in-patient mental health unit.

Physical Care for Persons with Severe Mental Illness

In May 2019, I published a themed report on the Physical Health of Persons with Severe Mental Illness.[22] This report outlined the increased risk of ill health and early mortality associated with severe mental illness, in particular the increased incidence of metabolic syndrome associated with antipsychotic treatment.

It remains a fact that in the 21st century people with a mental illness will die between 15-20 years earlier than their peers in the general community, in many cases due to preventable physical illnesses. As citizens, people with mental illness have the same rights as everyone else and are entitled to an expectation of living long and healthier lives. Failure to facilitate this is both stigmatising and discriminatory.

Figure 3.
Individual care plan relation between person and care professional

22 https://www.mhcirl.ie/File/MHC_PhysicalHealthReport.pdf

The report highlighted that, for a variety of reasons, this cohort of the population did not have access to various aspects of physical healthcare on an equitable basis to other citizens. To a significant extent, the lack of initiative and associated apathy with long-standing psychotic illness contributed to both an unhealthy lifestyle and an avoidance of engagement with physical health care services.

It has been noted internationally, however, that factors within the health system contribute to this discrepancy in engagement. The historic separation of physical and mental healthcare within the organisation of our health system has led to a situation where specialist mental health training and the associated practice standards arising has, to a certain degree, lost sight of the 'whole' patient and the need to consider both mental and physical factors in the genesis and continuation of mental illness.

In addition to training and recognition issues, the long term under-resourcing of mental health within the overall health budget has contributed to a lack of dedicated resources and facilities within the mental health system for the provision of physical healthcare.

Such was the concern at the repeated identification during the inspection process of inadequate standards of health monitoring, particularly in continuing care locations, that changes were introduced in early 2018 in the guidance for approved centres in achieving compliance with regulations (the Judgement Support Framework (JSF)).

These changes required a more systematic physical review to be undertaken for residents who were over six months in approved centres. They also required that, where residents were in receipt of antipsychotic medication, appropriate biochemical checks to monitor possible development of the metabolic syndrome be undertaken in line with best practice.

International best practice recommendations, as outlined by the National Institute for Clinical Excellence in the UK [23] and the World Health Organisation[24], indicate that people with severe mental illness should be offered regular physical health monitoring. At minimum, residents in continuing care should have a regular six-monthly assessment of their physical health needs. In particular, given the well-established association between chronic illness and poor diet, inadequate physical activity levels, and weight gain, it is recommended that physical reviews give specific focus to:

- Family history of illness;
- Personal medical history;
- Weight gain and obesity utilising waist circumference (WC) and Body Mass Index (BMI);
- Activity level and exercise pattern;
- Cigarette and alcohol consumption;
- Blood Pressure;
- Dental health screening.

In addition, where a resident is prescribed antipsychotic medication, steps should be taken from the outset to screen, identify, and monitor the potential development of the metabolic syndrome, a combination of high blood pressure, diabetes, and obesity. It is characterised by increased waist circumference, persistent high blood pressure, high blood triglycerides with low levels of HDL ('good' cholesterol), and insulin resistance.

While not unique to mental illness, there is a now well documented association between the use of antipsychotics (particularly second generation antipsychotics) and the development of metabolic syndrome. It is estimated that over a third of patients with schizophrenia will develop metabolic syndrome with detrimental effect on their health and life span.

23 https://www.nice.org.uk/guidance/cg178
24 https://www.who.int/mental_health/evidence/guidelines_physical_health_and_severe_mental_disorders/en/

In addition to the regular health assessment outlined above, good practice recommendations advise that patients being prescribed antipsychotic medication should have, on at least an annual basis, the following:

- Fasting blood glucose or HbA1c;
- Fasting blood lipids, particularly triglycerides and high density lipoprotein (HDL);
- Prolactin levels (depending on the individual antipsychotic agent);
- Liver function tests;
- Thyroid hormone, and;
- Electrocardiogram (ECG).

These steps have been considered necessary to refocus the attention of mental health teams on the need to place a greater priority on physical care issues. Over the last two years, since the changed requirements were introduced in early 2018, the inspection process has sought to promote a more intensive and structured physical review process. Many services have now put in place a more systematic and structured physical review template covering many, if not all, of the issues outlined above. Nevertheless, the inspection process during 2019 has identified an on-going failure to systematically record and document various aspects (weight, waist circumference, BMI, substance use, dental health screening) fundamental to the overall review of physical health in the context of mental illness and, particularly, the use of various medications with known association with metabolic syndrome.

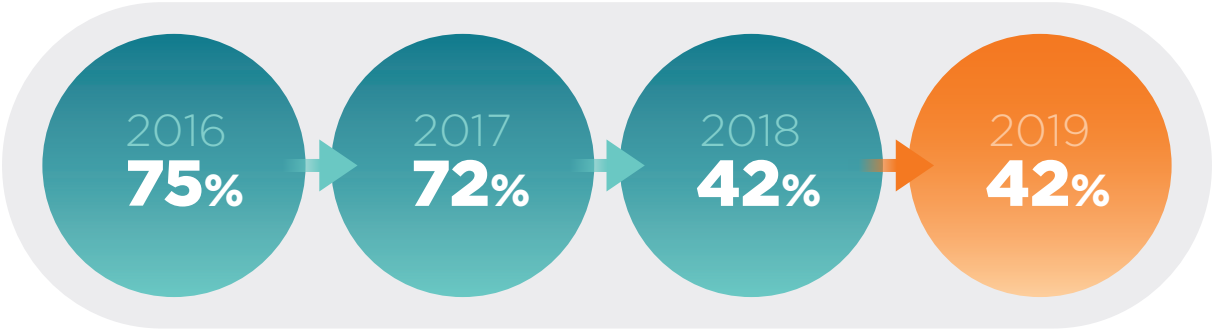
The requirements specified in the JSF should be considered as a minimum and services are encouraged to promote physical wellbeing through the development and availability of ancillary services such as dietetics, speech and language, physiotherapy, and seating assessment on an equitable basis to elsewhere in the health system.

Compliance in 2019 – General Health

Following the addition of specific monitoring requirements, introduced in early 2018, the inspection process has focussed on the comprehensiveness of the physical assessment process and associated documentation. During 2019, a total of 12 approved centres (18% of the total) achieved a rating of 'Excellent' in relation to compliance with Regulation 19: General Health.

During the 2019 inspections, we found that there was an on-going failure to meet best practice guidelines. Only 42% of approved centres were compliant with Regulation 19: General Health. There was no improvement to the corresponding figure in 2018 (42%), despite the fact that all services have had a further year to take account of the best practice requirements outlined in the JSF and to adjust their operational processes and resource provision to meet the requirements.

Figure 4.
General health compliance 2016-2019



Notwithstanding the development in many cases of examination templates to assist and facilitate the review of physical status and documentation of findings, it is a source of major concern that in the majority of cases of non-compliance there was failure to systematically document fundamental issues relevant to the health status of the residents such as weight, waist circumference, body mass index (BMI). Other issues, such as nutritional status, smoking status, and assessment of dental health, were inconsistently documented. These failures indicated a systematic inconsistency in the review of physical monitoring processes.

In particular, there has been a review of the processes implemented in continuing care (non-acute) approved centres where residents, often an older age cohort with a variety of associated health issues, are domiciled for considerable periods of time. In these locations, it is reasonable to expect that the physical health needs of residents will be prioritised with associated operational and resource processes implemented to ensure that residents have access to resources on an equitable basis to other citizens.

There were two issues of particular concern in continuing care situations: 1) the failure to undertake and systematically document a full physical review on a six-monthly basis, and; 2) where residents were prescribed antipsychotic medication on a long-term basis, the undertaking of appropriate physical and biochemical screening to monitor and minimise potential effects of the metabolic syndrome.

Sixteen (57%) of the total of 28 approved centres whose primary focus was continuing care failed to comply with the requirements of this regulation.

In nine approved centres with a focus on continuing care, difficulties were noted in relation to access to various services (dietetics, speech and language, physiotherapy, etc.) on an equitable basis to citizens in the wider community.

It is disappointing to report that the failures outlined in this report repeat concerns previously documented in both my previous Annual Report and in the Thematic Report on the Physical Health of Persons with Severe Mental Illness published in May 2019. The findings and concerns reflect international experience that persons with mental illness receive a poorer standard of physical health care than their peers in the community with consequent morbidity and excess mortality.

I would expect that the findings in these various reports will be used by services to promote and improve the resourcing and operation of physical health processes within the mental health structure. It was notable that during 2019 a number of services had developed comprehensive templates for the documentation of physical health processes but had failed to ensure that they were consistently implemented.

Success in this respect will be demonstrated not only by a decrease in the excess morbidity and mortality currently prevalent in this population but by a promotion of healthy living through improved diet, promotion of physical activity, and promotion of strategies to lessen tobacco and alcohol consumption among this vulnerable population.

58% non-compliance with General Health in Continuing Care (non-acute) units.

95% failed to document that assessment was completed for all residents that had been in hospital for over six months.

39% failed to assess residents for metabolic syndrome.

Maintenance of Records

Medical records are of prime importance because of the information they contain. High-quality information underpins the delivery of safe, high-quality, and evidence based healthcare for patients. Information is most valuable when it is accurate, up-to-date, and accessible when it is needed. An effective records management system ensures that information is properly managed, is available whenever and wherever there is a justified need for that information, and in whatever medium it is required and which is compliant with the relevant legislation.

Function of Medical Records[25]:

1. Maintains the history of patient care.
2. Records decisions relating to the care plan of the individual.
3. Supports the workflow of clinical and administrative functions in the hospital for clinicians and staff.
4. Supports the communication with external sources of medical information such as laboratory and radiology departments as well as consultations and referrals with colleagues
5. Justifies care delivery in the context of legislation, professional standards guidelines, evidence, research and professional and ethical conduct.
6. Records decisions relating to the care plan of the individual.
7. Supports the workflow of the clinical and administrative functions within the hospital for clinicians and staff.
8. Supports the communication with external sources of medical information such as laboratory and radiology departments as well as consultations and referrals with colleagues.
9. Justifies care delivery in the context of legislation, professional standards, guidelines, evidence, research and professional and ethical conduct.

Medical records include patient healthcare records (electronic or paper based), X-ray and imaging reports, output and images, photographs and other images, as well as scanned records.

- The patient's complete medical record should be available at all times during their stay in hospital.
- Every page in the medical record should include the patient's name and identification number.
- The contents of the medical record should have a standardised structure and layout.
- Documentation within the medical record should reflect the continuum of patient care and should be viewable in chronological order.
- Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma.
- Every entry in the medical record should be dated, timed (24-hour clock), legible, and signed by the person making the entry. The name and designation of the person making the entry should also be legibly printed against their signature. Deletions and alterations should be countersigned, dated, and timed.
- Entries to the medical record should be made as soon as possible after the applicable event (e.g. change in clinical state, ward round, investigation) and before the relevant staff member goes off duty. If there is a delay, the time of the event and the delay should be recorded.

25 Healthcare Records Management: National Hospitals Office Code of Practice, 2007.

- Every entry in medical records should identify the most senior healthcare professional present (who is responsible for decision-making) at the time the entry is made.
- On each occasion the consultant responsible for the patient's care changes, the name of the new responsible consultant and the date and time of the agreed transfer of care should be recorded.
- An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four days for acute medical care or seven days for long-stay continuing care, the next entry should explain why.
- The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital.
- Advanced Decisions to refuse treatment, consent, cardio-pulmonary resuscitation decisions must be clearly recorded in the medical record.[26]

Compliance in 2019 – Maintenance of Records

In 2019, 30 (52%) approved centres were non-compliant with Regulation 27: Maintenance of Records. Apart from a small number of approved centres who have developed their own electronic record keeping, there is no move to electronic medical records. Medical records, therefore, can become bulky, untidy, and cause difficulty in retrieving relevant information. Pages become loose, which causes difficulties in maintaining secure information and keeping records in logical sequence. This has repercussions for good communication, confidentiality, and safety of the patient.

Reasons for non-compliance	
Records had loose pages.	58%
Records were oversized and bulky.	21%
Records were not in good order.	29%
Records were not in logical sequence and/or finding information was difficult.	68%
Records were not dated and/or timed.	23%
Records did not document 2 patient identifiers.	21%
Records were not stored in a secure location.	19%

Regulation 22 – Premises

Much of the policy context with regard to premises in mental health care focuses on the de-institutionalisation of organisations in order to provide mental health care in the community setting. The effects of the built environment on mental wellbeing are well established[27]. By contrast, the impact of poor architecture on mental health is well researched.

However, the exact nature of what constitutes a 'good environment' for acute, inpatient mental health care is less clear. Ulrich et al. in 2018 describe a ward with stress reducing design features that include:

- The reduction of crowding stress (single rooms, communal areas with ample space);
- Reduction of environmental stress (noise reducing design);
- Stress reducing positive distractions (garden accessible to patients, nature window view), and;
- Design for observation from a central location[28].

26 Generic medical record keeping standards Royal College of Physicians, 2015.
27 Christenfeld R et al How physical settings affect chronic mental patients. Psychiatric Quarterly 60: 253-264 (198).
28 Ulrich, R. S., Bogren, L., Gardiner, S. K., & Lundin, S. (2018). Psychiatric ward design can reduce aggressive behavior. *Journal of Environmental Psychology*, 57, 53-66.

The importance of hygiene and maintenance, as well as privacy and spaciousness to residents in terms of hospital layout is acknowledged in academic literature[29], and that moving to a purpose-built mental health facility has a positive impact upon the atmosphere of a ward[30].

Regulation 22 Premises has been used as the basis for the inspection of Irish approved centre premises since the inception of the Mental Health Act (2001).

Compliance levels over past 5 years

In 2015, 52% of approved centres were compliant with Regulation 22 Premises. Inspection findings in 2015 included buildings that were not fit for purpose and the availability of insufficient or inadequate facilities. 2016 saw a reduction in compliance levels, to 34%. Poor maintenance, a lack of cleanliness and the presence of ligatures all featured as reasons for non-compliance with the regulation. In 2017, only 25% of approved centres were compliant with Regulation 22 Premises, a 9% drop from 2016. Non-compliant premises were assessed as unsafe, dirty, inappropriate, and in need of maintenance. In five centres residents had no or limited access to an outside garden or courtyard. Access to routine and regular maintenance was also noted as an issue.

In 2018, there was a slight increase in compliance with the regulation whereby 30% of approved centres were compliant; 70% remained dirty, malodorous, and poorly maintained. Six approved centres were non-compliant, risk rated critical, and had 13 conditions to registration applied.

Compliance in 2019 – Premises

In total, 45 (69%) approved centres were non-complaint with Regulation 22: Premises, and of those 5 (11%) were risk rated as critical.

Of the 45 non-compliant approved centres, 15 (33%) approved centres were non-compliant with the Regulation because they were unclean. Findings included: a dirty seclusion room; unclean bathroom facilities, including discarded cigarette butts; litter in outdoor areas, and; kitchen areas that appeared contaminated. Urine soaked panels and floors were also observed. Offensive odours were observed in nine facilities: toilets, bathrooms, bedrooms, and communal rooms all presented as malodorous over the course of the 2019 inspections.

In addition, 23 (49%) approved centres were non-compliant due to poor structural or decorative condition, including: peeling paint; chipped floor coverings and damaged ceilings; broken showers; cigarette burn marks; holes in walls where fixtures had been removed, and; a cracked glass ceiling. Ten approved centres were not adequately lit, heated, or ventilated.

Figure 5.
Premises compliance 2016-2019

29 Cspike E et al. Design in Mind: eliciting service user and frontline staff perspectives on psychiatric ward design through participatory methods. Journal of Mental Health 25(2)114-21.
30 Nicholls D et al The value of purpose built mental health facilities: Use of the Ward Atmosphere Scale to gauge the link between milieu and physical environment. International Journal of Mental Health Nursing August 2015 Issue 4.

Eight approved centres did not have a programme of routine maintenance, which had implications for the upkeep of the buildings and was a factor in some cases of non-compliance. Twenty-five approved centres were not developed or maintained with due regard to the specific needs of residents and patients: 17 of these included the continued presence of ligature points. Insufficient access to toilet facilities and a lack of space, including outdoor space, was evident in six of these approved centres. A lack of access to personal space was also observed, including the provision of six bedded dormitories containing beds that were located too closely together.

Code of practice on Physical Restraint

Residents with mental illness may sometimes pose critical risks to themselves and others. Mental health clinicians generally apply alternative approaches, such as de-escalation techniques and crisis management, to alleviate any critical risks posed by a resident. Nevertheless, compulsory intervention is implemented when alternatives have been exhausted. Physical restraint is the use of physical force by one or more persons for the purpose of preventing the free movement of a resident's body when they pose an immediate threat of serious harm to either themselves or others. Physical restraint should only be used when less restrictive interventions have been determined to be ineffective in protecting the patient, a staff member, or others from harm. Physical restraint is a traumatic, humiliating, and distressing experience for the resident, as well as posing a physical risk. In 2014, the Mental Health Commission developed a strategy for reducing the use of seclusion and restraint.

The current literature on physical restraint strongly suggests that seclusion and restraint have deleterious physical or psychological effects. The incidence of Post-Traumatic Stress Disorder (PTSD) after seclusion or restraint ranges from 25% to 47%[31], especially in patients with past traumatic events The main diagnoses associated with the use of seclusion or restraint are schizophrenia, schizoaffective disorder or bipolar (manic) disorder. Seclusion and restraint are mostly associated with negative emotions, particularly feelings of punishment and distress and there is little evidence for any protective or therapeutic effects of seclusion and restraint.[32] [33]

Therapeutic interaction seems to influence perceptions of coercion and could help to avoid negative effects when coercive measures are not avoidable.[34]

Factors associated with fatality during restraint[35]:

- Neck holds*
- Restraint in a prone position*
- Obstruction of nose and/or mouth*
- Hyperflexion
- Obesity
- Heart disease
- General ill health
- Exhaustion
- Sedation without supervision

**Not permitted in Ireland under the Code of Practice on the Use of Physical Restraint*

31 Fugger G, Gleiss A, Baldinger P, Strnad A, Kasper S, Frey R. Psychiatric patients' perception of physical restraint. Acta Psychiatr Scand (2016) 133(3):221-31.
32 Chieze M, Hurst S, Kaiser S, Sentissi O Effects of Seclusion and Restraint in Adult Psychiatry: A Systematic Review Front. Psychiatry, 2019.
33 Guzmán-Parra J, et al. Experience coercion, post-traumatic stress, and satisfaction with treatment associated with different coercive measures during psychiatric hospitalization. Int J Ment Health Nurs (2018) 448-56
34 Keski-Valkama A, Koivisto A-M, Eronen M, Kaltiala-Heino R. Forensic and general psychiatric patients' view of seclusion: a comparison study. J Forensic Psychiatry Psychol (2010) 21(3):446-61.
35 Paterson B, Bradley P, Stark C, et al. Deaths associated with restraint use in health and social care in the UK. The results of a preliminary survey. J Psychiatr Ment Health Nurs 2003;10:3-15.

The Royal College of Psychiatrists' guidelines emphasise pre-emptive action, as does the British Institute of Learning Disability, in order to avoid the need, wherever possible, for the physical restraint of service users.

Compliance in 2019 – Physical Restraint

Fifty-eight (89%) of approved centres used physical restraint in 2019, five more approved centres than in 2018. Of these, 50%% were compliant with the Code of Practice on Physical Restraint[36], a significant improvement since 2016 when the rate of compliance was 22%.

In 21% of non-compliant approved centres, there was no physical examination following an episode of restraint, which was the main reason for non-compliance.

Over the past number of years, I have drawn attention to the fact that the Mental Health Act 2001 does not allow for the making of Rules for physical restraint, with the result being that there can be no enforcement should non-adherence to the Code of Practice on Physical Restraint occur. Protection for service users during physical restraint would be increased if there was a statutory basis for governing the use of physical restraint.

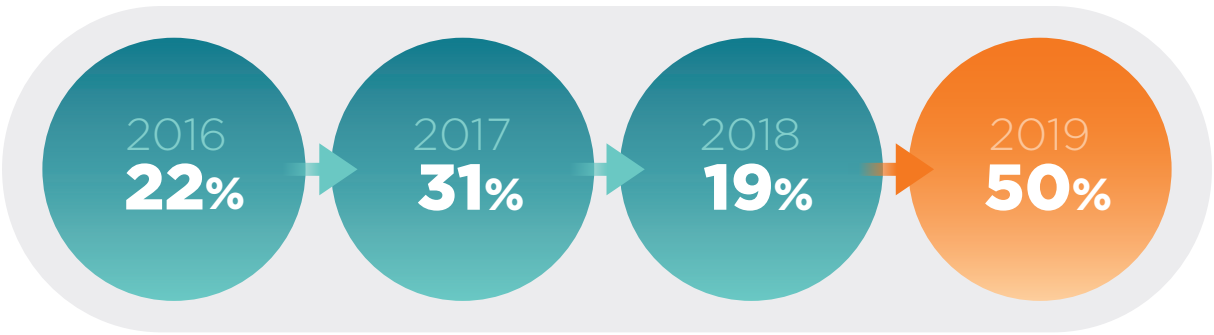
Seclusion

Seclusion occurs when a service user is involuntarily confined in a room or area and is physically prevented from leaving, usually by a locked door. A 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 highly regulated. The use of seclusion in Ireland is governed by Rules, which are secondary legislation.

The primary goal of seclusion in in-patient psychiatry is to maintain the safety of everyone in the treatment environment. It is not a treatment in and of itself and can be seen as a negative experience by individuals. Because risks to service users can be severe, such as re-traumatisation of people who have a history of trauma, as well as the 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.

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 both seclusion and restraint episodes in approved centres and, in 2014, it developed a strategy for reduction in incidents of seclusion and restraint.[37]

Figure 6.
Physical restraint compliance 2016-2019



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

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 assessments of risks, which must take into account all available information.

Reasons for not using seclusion may include better staffing levels, more reliance on emergency medication, more staff training, or 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 possible time. Approved centres must inform the Inspector if seclusion is extended beyond 72 hours.

Long and repeated periods of seclusion are counter-therapeutic. During seclusion, the service user has no social interaction apart from the nursing and medical staff that periodically conduct checks as well as constant observation.

Compliance in 2019 – Seclusion

Out of 65 approved centres, 28 (43%) used seclusion and had seclusion facilities. One-third of acute approved centres did not use seclusion. Three out of six CAMHS units used seclusion, two did not use seclusion, and one used seclusion facilities in the adjacent adult approved centre. Out of the approved centres that used seclusion, 21% were compliant. The reasons for non-compliance were varied as can be seen from Table 5.

Table 5.
Seclusion 2019 reasons for non-compliance

Seclusion room dirty and/or malodorous	23%
Seclusion room had hazards	27%
Patient was not reviewed in accordance with the Rules	27%
Patient not given adequate information about their seclusion	27%

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 a second consultant psychiatrist, on a Form 17 (Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent). For the period of hospital stay up to three months, a detained patient may be administered medication if they do not have the capacity to consent, without any second opinion or review. An adult is presumed to have capacity unless proven otherwise.

Compliance with Part 4 of the Mental Health Act is inspected 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 87% compliance in 2019 in the 38 applicable approved centres.

24-hour supervised community residences

In 1984, a report on psychiatric services, *Planning for the Future*, recommended the development of 24-hour staffed high support hostels for residents who could be relocated from large psychiatric hospitals as they closed. The hostels were mainly seen as residences for 'new long-stay' patients. Since then, there has been a growing number of 24-hour supervised residences that, over time, have been increasingly used for relocating residents with complex needs from in-patient acute mental health care into the community.

A Vision for Change, the 2006 Mental Health Policy, stated that these community residences were often little more than replacements for long-stay wards in their size and absence of rehabilitation programmes. It recommended that 24-hour supervised residences should have a maximum of 10 places to foster a non-institutional environment and that nursing staff in these residences should be predominantly involved in therapeutic activities with residents rather than with domestic or administrative activities. The HSE's own report on accommodation for people with disabilities, *Time to Move on from Congregated Settings*, recommends that the home-sharing arrangement should be confined to no more than a total of four residents.[38]

Table 6.
Inspections of 24-hour supervised residences in 2019

CHO	Residences inspected in 2019
CHO2	1
CHO 3	3
CHO 4	4
CHO 5	9
CHO 8	1
Total	**18**

In 2019, out of 18 residences inspected, 33% had more than ten beds. Two residences had 14 or more beds. It is difficult to see these large residences as anything but wards in the community, with all the disadvantages of institutional living. There were only two residences with fewer than seven beds.

Table 7.
Number of beds in 24-hour supervised residences in 2019

Number of beds	Number of residences	%
5-7	2	11%
8-10	10	55%
11-13	4	22%
14-16	1	6%
20-22	1	6%
Total	**18**	**100%**
Percentages of residences with ten beds or less		67%
Percentage of residences with more than ten beds		33%

Sixty-nine percent of bedrooms in the 18 residences inspected were single rooms, though most were not en suite. 46% of shared rooms had no privacy between beds.

Table 8.
Number of 24-hour supervised residences with shared accommodation 2019

Sleeping accommodation	Number	%
All single rooms	126	79%
Self-contained Flats	4	2%
Shared (2 beds)	28	18%
Shared (3 beds)	2	2%
Shared (4 beds or more)	0	0%
Shared rooms without privacy	13	43%
Total number of rooms	**160**	
Total number of shared rooms	**30**	

There were two residences in which the condition of the building was poor and a further nine residences for which the building required improvement. In these cases, regular maintenance was difficult to obtain and there were lengthy waiting times for urgent repairs.

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

Table 9.
Condition of 24-hour supervised residences 2019

Condition of residence	Number of residences	%
Poor condition	2	11%
Needs improvement	9	50%
Good condition	7	39%

CHO 3

"Each of the two-bedded rooms did not have adequate screening to ensure resident's privacy and dignity, as the screens did not fully enclose the resident's areas. The male downstairs toilet was missing floor tiles. The flooring throughout the majority of the house was cracked and lifting which posed a potential trip hazard. The black leather couches and chairs within the sitting room were considerably scuffed and peeling. The front and back door were single glazed.... the windows and doors were dated, draughty and offered limited security... There were no current plans in motion to address these issues. Reportedly, there were plans for the single glazed windows to be replaced; however, no definite timeline was provided for this work."

CHO 5

"Residents were accommodated in nine single bedrooms which each had a sink, safe, TV, and were simply furnished. Bathroom facilities were shared and included six toilets, one of which was an assisted toilet. There... (was) an exercise bike, stereo, and a door entering out onto the garden. All bedrooms were homely and residents could personalise their rooms. Residents' artwork was displayed throughout the residence. There was a large enclosed garden, with potted plants and seating. Residents were growing fruit and vegetables. The property had been renovated. A shower room had been added, and new sitting room furniture had been purchased."

CHO 5

"The residence was not kept in a good state of repair. Internal walls were marked, cabinet doors were chipped, and one bedroom wardrobe did not have a door. The fixtures and fittings within the premises were old and dated. While a cleaning schedule was implemented within the residence, the premises was not observed to be clean and free from offensive odours. This included dust and dirt within the kitchen and a strong, stale odour in the hall... the open risers on one of the staircases was identified as a significant risk. The back garden was overgrown, requiring maintenance, and the sloped path to the unused poly-tunnel was a hazard as it was covered in moss. The uneven flooring in the sitting room was also identified as a hazard. The premises was painted within the past three years. Recent installations included closed circuit television and house alarm. There were no further plans for renovations or refurbishment".

A *Vision for Change* recommended that rehabilitation and recovery teams have responsibility for those physical resources appropriate to the needs of their service users, such as community residences. *A Vision for Change* observed that the need for 24-hour staffed residences would decrease once the cohort of former long-stay hospital service users had been accommodated. The move to clinical care by rehabilitation teams remained slow, with a little over half of the residences having specialist rehabilitation input.

Table 10.
Clinical teams in 24-hour supervised residences 2019

Clinical Team Responsible	Number of Residences	%
Rehabilitation	10	56%
General Adult Mental Health	7	39%
Intellectual Disability	0	0%
Shared (Rehabilitation and General Adult)	1	6%

In these 18 residences, we can see that the problems associated with congregated settings and lack of rehabilitation continue. There are too many residents in each residence, there is an insufficient number of single rooms with en suite facilities, and just over one-third are in good condition. The purpose of providing this type of accommodation appears to be one of containing as many residents as possible at the lowest possible cost. Lack of provision of regular or urgent maintenance, lack of resources in the provision of rehabilitation input, and having two or more people sharing bedrooms with no privacy is unacceptable.

I will be publishing the overall report for the three year rolling programme (2017-2019) and am once again calling for the regulation of community residences for people with mental health difficulties.

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