

Mental Health Commission Annual Report 2020



Including the Report of the Inspector
of Mental Health Services



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Chairperson's Statement



John Saunders
Chairperson



2020 was a year of significant challenge, change and loss due to the COVID-19 global pandemic. This annual report evidences how the Mental Health Commission (MHC) and our staff ensured that all our functions and obligations were fulfilled in 2020. I wish to commend all staff in the MHC and in our mental health services who continued to provide a service during this most testing of times. I also wish to offer my condolences to all people who lost loved ones to the virus.

In 2020, in the context of COVID-19, the MHC remained focused on our 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'.

The MHC welcomes the determination and resolve of the Minister for Mental Health and Older People, Mary Butler TD, to progress new and reforming legislation. The MHC was invited to comment on the draft Heads of Bill to amend the Mental Health Act, 2001. We established a working group, which was chaired by our General Counsel and included the Inspector of Mental Health Services and the MHC's Director of Regulation. This group worked with the Commission's Legislation Committee to provide a detailed, evidenced-based, person-centred, and rights-based submission to the Department of Health. A synopsis of our recommendations can be found in the appendices to this report (page 64).

A key strategic priority for the MHC is the establishment of Ireland's Decision Support Service (DSS). In October 2020, overall responsibility for the implementation and commencement of the Assisted Decision Making (Capacity) Act of 2015 was transferred from the Department of Justice and Equality (DJE) to the newly established Department of Children, Equality, Disability, Integration and Youth (DCEDIY). We continue to work with Government to deliver a service which will put Ireland to the forefront of protecting human rights and ensures that personal will and preferences, respect for the rights of a person, supported decision-making and advance planning become part of Irish culture.

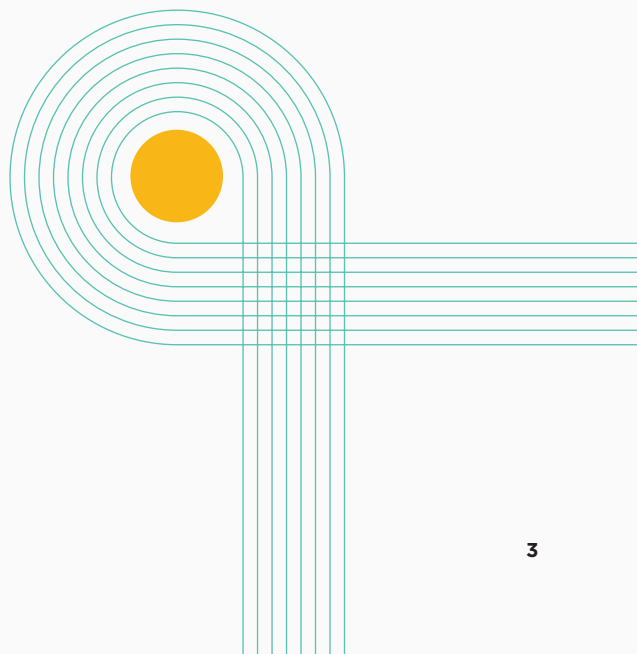
In 2020, we dedicated significant time and resources to establishing the DSS. Over the course of the year, a full programme of work on the establishment project, comprising six workstreams and 28 sub-projects continued despite remote working. We continued to expand our communications and stakeholder engagement as we moved towards full commencement of operations in mid-2022.

The MHC is also charged with operating mental health tribunals - the review process for vindicating the rights of involuntary patients. Being involuntarily detained in an approved centre is a very difficult experience for any individual and the global pandemic in 2020 heightened this challenge. In 2020, we developed and implemented a work plan to ensure that all tribunals occurred and that all detentions complied with the strict statutory rules and time limits. I thank all the panel members, independent consultant psychiatrists, legal representatives, and mental health act administrators who worked to ensure that the law was applied during the pandemic.

In 2020, the MHC welcomed the publication of 'Sharing the Vision', Ireland's revised mental health strategy. The pandemic highlighted in stark terms the need for a modern, well-staffed, holistic mental health service. The strategy, if funded and implemented, creates a structure so that mental health services are built up in the community with the goal of having a stepwise integrated primary, secondary and specialist mental health care system so that no individual falls through the cracks at their time of greatest need. The strategy, in tandem with proposed new legislation, sets a solid base from which to enhance and expand mental health service provision. The MHC anticipates that the proposed expansion of regulation will also ensure that appropriate oversight occurs to ensure better and safer services are delivered in our communities.



John Saunders
Chairperson



Chief Executive's Review



John Farrelly
Chief Executive



In 2020, the COVID-19 global pandemic emerged as the most significant public health threat for over a century. The MHC, in collaboration with the HSE and Department of Health, researched and established a monitoring system to identify and mitigate risks in 1,300 approved mental health centres and community residences. Data from notifications and more than 2,500 monitoring calls were collated and analysed to initiate rapid local responses and provide information to the National Public Health Emergency team (NPHE).

In the peak months of April and May, services came under severe and relentless pressure. The collaborative, flexible and committed effort of all involved contributed significantly to protecting the life, health and welfare of patients and residents. Our work, as set out in this annual report, may help to elucidate lessons and opportunities as we continue to transform mental health care.

The pandemic and resultant public health guidelines changed work practices in approved centres. Many services operated significantly under-capacity in accordance with infection prevention and control measures. Additionally, certain regulatory functions were altered during the pandemic, including the pausing of certain aspects of compliance monitoring and all inspections conducted were announced and agreed with services in advance. Furthermore, in early 2020, the MHC had applied 109 new conditions to the registration of 36 centres to mitigate persistent noncompliance mainly around premises, staffing and care planning.

All the above led to less enforcement and improved compliance in 2020. The MHC took 17 enforcement actions relating to 13 approved centres, compared with 40 enforcement actions in 2019. There were 58 instances of overcapacity, compared to 208 in 2019. There were 27 admissions of children to nine adult units, compared with 54 admissions to 15 adult units in 2019. The pandemic highlighted the requirement to improve or replace premises which, at 55%, had the lowest level of compliance nationally compared with all other regulations. While the physical restraint of patients declined, the number of times patients were secluded increased. This is a worrying trend and part of the reason why we are reviewing the rules on seclusion and seeking the views of stakeholders and the public on this matter.

The level of compliance with individual care planning also remains worryingly low, particularly since the whole point of a service is to support the individual and involve them in their care. Although individual care plans were provided for almost all inpatient mentally ill people, the quality of the plans was poor. This is despite the fact that patients have a legal right to a care plan and to be involved in developing and reviewing it with the support of their families and advocates.

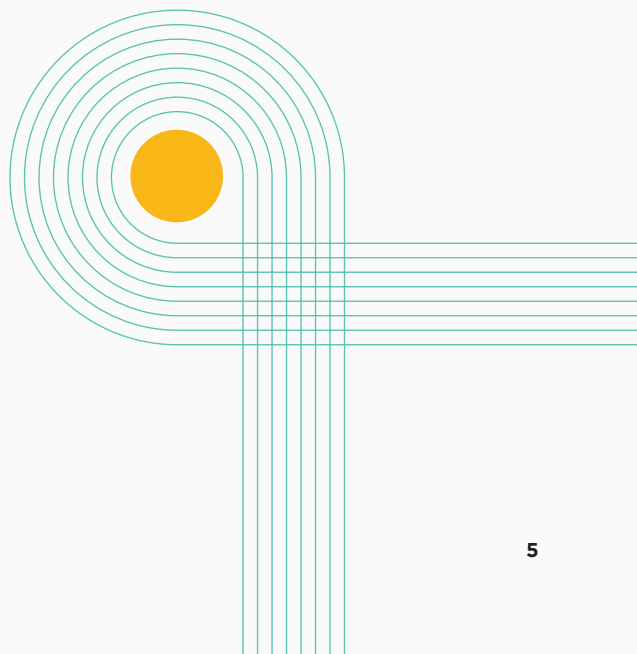
In 2020, significant work occurred to ensure that the rights of involuntarily detained persons were vindicated by way of maintaining tribunals during COVID-19. Initially tribunals took place remotely by teleconference. However, following a feasibility study and pilot project, videoconferencing was rolled out in all centres. Despite these successes, the MHC is anxious to resume face to face hearings as soon as it is safe to do so.

It is also worth noting that there were 1,919 admission orders for involuntary detention from the community in 2020. The largest amount of orders (32%) were initiated by An Gardaí. It was concerning to see the applications by authorised officers decrease and those from An Gardaí increase for the second year in a row. It is even more concerning that this occurred during COVID-19 when persons requiring treatment might have been even more vulnerable and intervention by An Gardaí could have caused more distress. The Expert Review Group Report in March 2015 on amendments required to the 2001 Act strongly advocated that all applications should be made by authorised officers. The MHC, in its submission to the Department of Health in March 2020, supported this recommendation and I hope that this matter is scrutinised closely by both health and justice officials.

In conclusion, I want to thank the executive leadership team and staff of the MHC for all their work in 2020. I also want to thank the Board Members and the various Board Committees who both supported and held the Executive to account in 2020.



John Farrelly
Chief Executive



2020 in Brief



17

Enforcement Actions



109

new conditions attached to 36 approved centres



89%

compliance with regulations nationally



2,657

Inpatient beds



58

Instances of overcapacity in 2020



27

child admissions to nine adult units. This compares with 54 admissions to 15 adult units in 2019.



586

deaths of people using mental health services were reported to the MHC. 207 of these related to approved centres and 379 related to other community mental health services.



1,946

Mental Health Tribunal Hearings



1,919

Involuntary Admissions to Approved Centres



24

Requests for Additional Reviews



100%

of hearings took place within statutory timelines



32%

of applications for involuntary admission were from Garda Síochána



181

services were contacted at least once a week from April to June. For the remainder of the year services reporting cases were contacted weekly



Over 2,500

COVID-19 related calls made to services



3

approved centres registrations were expedited



35

concerns were escalated



€5.77 million

Allocated to implementation of the Decision Support Service



2022

The 2015 Act will be commenced and the DSS will open its doors in 2022



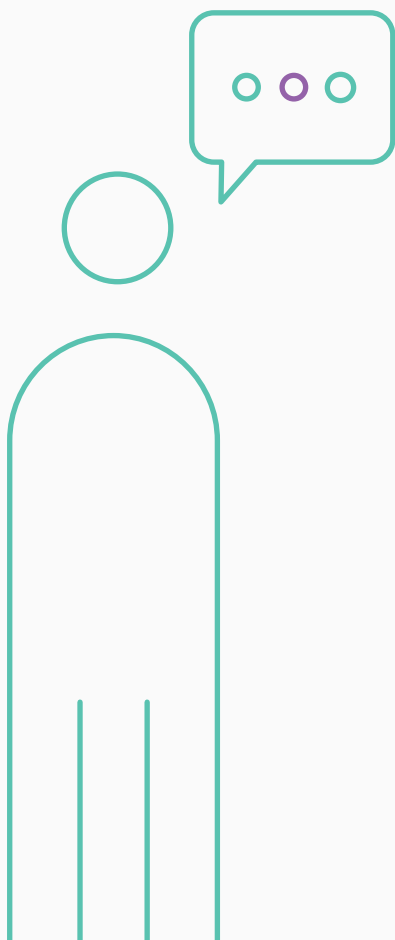
Who We Are

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The Mental Health Commission

The Mental Health Commission (MHC) is an independent statutory body established under the provisions of the Mental Health Act 2001. The remit of the MHC 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 MHC 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.

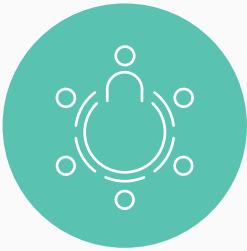


Strategic Objectives 2019-2022



Strategic Objective 1

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



Strategic Objective 2

Implement the MHC'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 MHC.



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 are known as the Commission and are the governing body of the organisation. The Commission has 11 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 MHC'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 2020 can be found in Appendix 1, 2 and 3 on pages 62-63.

During 2020, the Commission had two Standing Committees. These were the Finance, Audit and Risk Committee, and the Legislation Committee.

Details of both Committees can be found in Appendix 2 and 3 on pages 62-63.



John Saunders

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

Position Type: Chairperson

Basis of Appointment: *Nominated by Shine/The Wheel*
Appointed by the 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



Patrick Lynch

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

Position Type: Member

Basis of Appointment: *Nominated by the HSE and*
Appointed by the Minister for Health



Members (continued)



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 the Minister for Health



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 the Minister of State for Mental Health and Older People



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 the Minister for Health



Ned Kelly

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

Position Type: Member

Basis of Appointment: *Nominated by* the 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 the 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* the Mental Health Nurse Managers of Ireland and *Appointed by* the Minister of State for Mental Health and Older People

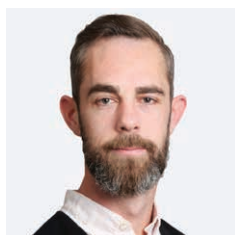


John Hillery (Dr)

First Appointed 02/11/2020 End of Term 04/04/2022

Position Type: Member

Basis of Appointment: *Nominated by* the College of Psychiatrists in Ireland; appointed by the Minister of State for Mental Health and Older People



Aaron Galbraith

Appointed 05/04/2017 Resigned 09/04/2020

Position Type: Member

Basis of Appointment: *Nominated by* the Children's Rights Alliance
Appointed by the Minister for Health



Francis Xavier Flanagan (Dr)

Reappointed 05/04/2017 Resigned 16/07/2020

Position Type: Member

Basis of Appointment: *Nominated by* the Irish College of General Practitioners
Appointed by the Minister for Health

Additional Roles

Orla Keane

Secretary to the Commission (Board)

Patrick Lynch

Chair of Finance, Audit & Risk Committee (FARC)

Rowena Mulcahy (resigned as Chair in February 2021)

Chair of the Legislation Committee

Simon Murtagh

Chief Risk Officer

Notes

Mr Aaron Galbraith resigned in April 2020 and was replaced by Fionn Fitzpatrick in February 2021.

Mr Francis Xavier Flanagan resigned in July 2020 and was replaced by John Cox in February 2021.

Senior Leadership Team



↳
John Farrelly
Chief Executive



↳
Áine Flynn
Director, Decision Support Service



↳
Orla Keane
General Counsel for the MHC (DSS)



↳
Gary Kiernan
Director of Regulation



↳
Dr Susan Finnerty
Inspector of Mental Health Services



↳
Simon Murtagh
Chief Operations Officer

Notes

Director of Standards and Quality Assurance, Rosemary Smyth, retired in September 2020.



What We Do

Regulatory Process

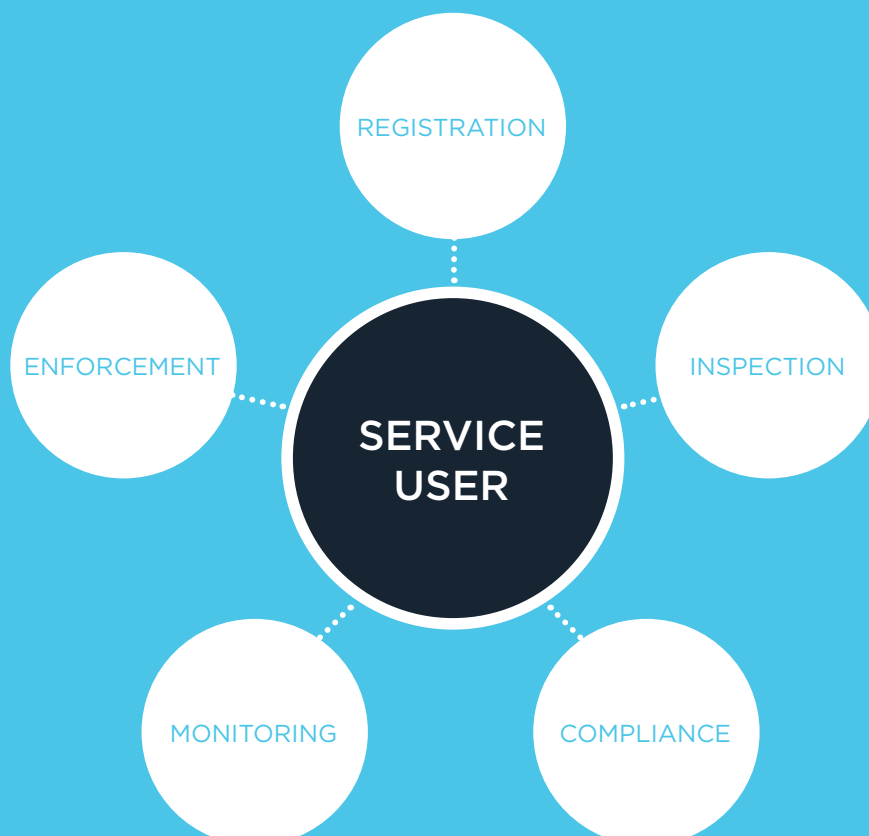
One of the MHC’s core functions is to regulate and regularly inspect inpatient mental health facilities known as ‘approved centres’.

Our regulatory process includes a cycle of registration, inspecting, compliance monitoring, and enforcement to ensure high standards and good practices in the delivery of care and treatment to service users. We take a risk based and intelligence-led approach to our regulatory practices.

We uphold the principles of responsive regulation, including being consistent, transparent, targeted, proportionate, and accountable.

We promote capacity building and self-assessment within services and aim to use our enforcement powers as a last resort.

Fig 1: MHC model of regulation



Registration

All inpatient facilities that provide care and treatment to people who have a mental illness or disorder must be registered by the MHC as an approved centre. Registration as an approved centre lasts for a period of three years, after which the service must apply to re-register.

As part of a registration application, we consider information about how the facility is run, the profile of residents, 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 inpatient services, including:

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

At the end of 2020, there were **66** approved centres registered with the MHC. During the year there were five new registrations, five approved centre closures, and 34 approved centres were re-registered.

At the end of 2020 there were 2,657 inpatient 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 **713** adult beds in the independent sector, of which 697 were in Dublin.
- There were also **103** registered forensic beds and **79** 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 MHC's website.

New Registrations

There were five approved centres registered during 2020. They were as follows:

- Aidan's Residential Healthcare Unit, Waterford
- Brandon Unit, Portrane, Dublin
- Blackwater House, Monaghan
- Grange Unit, Waterford
- Acute Mental Health Unit, Sligo University Hospital

All of the units above provided residents with single room, en-suite accommodation in modern, purpose-built facilities.

Due to the COVID-19 outbreak, the MHC developed a streamlined registration processes for inpatient mental health facilities. This ensured that new facilities could be quickly registered to allow residents to transfer out of shared or dormitory accommodation. However, services were still required to demonstrate to the MHC that the premises were suitable and would meet all regulatory requirements.

Closures

Five approved centres also closed during 2020, as new facilities were opened in their place, or they were only operating temporarily to facilitate the management of COVID-19 or refurbishment works in other approved centres. They were as follows:

- St Aidan's Ward, St Otteran's Hospital.
- Brandon Unit, Portrane, Co Dublin.
- St Davnet's Hospital, Monaghan.
- Sligo/Leitrim Mental Health Inpatient Unit.
- Grange Unit, Waterford.



Inspection

The Inspector of Mental Health Services visits and inspects every approved centre at least once each year. The Inspector prepares a report on her findings following the inspection. Each service is given an opportunity to review and comment on any content or findings prior to publication.

On inspection, the Inspector rates compliance against:

- 31 Regulations
- Part 4 of the Mental Health Act 2001
- Three Statutory Rules
- Four 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', or 'Satisfactory', and 'Needs Improvement' or 'Inadequate'.

Prior to the onset of the COVID-19 pandemic in 2020, there were 12 annual regulatory inspections of approved centres, all of which were unannounced.

On 13 March 2020, annual regulatory inspections of approved centres were paused due to the impact of the pandemic. On 14 July 2020, annual regulatory inspections of approved centres recommenced under a streamlined inspection process. The streamlined inspection process aimed to reduce the risk of disease transmission through shorter onsite components of the inspection and limiting the number of inspectors attending on site.



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.

66 approved centres were inspected in 2020, 12 of which were completed before the suspension of annual regulatory inspections on 13 March due to the COVID-19 pandemic. These approved centres were inspected against all regulatory requirements and the Judgement Support Framework Version 5.1, under the usual annual regulatory inspection process, while two were announced inspections.

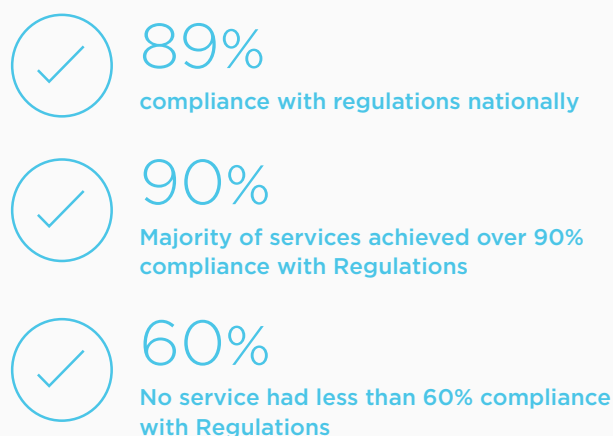
The remaining 54 approved centres were inspected from 14 July, when the inspections of services recommenced, to the end of the year. These 54 approved centres were inspected under a revised inspection process and framework to control for the risk of transmission of COVID-19 in line with public health guidance. All inspections were announced. These approved centres were inspected against all regulatory requirements including the regulations, rules, codes of practice and Part 4 of the Mental Health Act and a revised Judgement Support Framework *Special Edition, For Use During the COVID-19 Pandemic July - December 2020* (henceforth referred to as 'the revised JSF').

The revised JSF allowed for the assessment of compliance against the strict wording of the regulation. Quality assessments against the four pillars (policy, training and education, monitoring, and evidence of implementation) were not included and, therefore, no quality ratings were awarded. The revised JSF also provided that a service would not be deemed non-compliant with a regulatory requirement where there was evidence that the failure to meet the requirement was directly related to the service following public health guidance and/or the management of a COVID-19 outbreak. In addition, the inspection of certain regulatory requirements was not completed due to the impact of the pandemic on services' ability to comply. For example, staff training under Regulation 26 was not assessed.

Having regard to the adjustments made in 2020, comparative analysis of compliance with previous years or between services was not completed, nor is it advised.

The MHC recommends interpreting the findings included in this section with caution, owing to the impact of the pandemic and changes to the inspection process and framework.

Key findings:



Areas of Good Practice

Overall compliance with regulations and regulatory requirements was high. The majority of regulations showed consistently high rates of compliance (over 80%) and 10 regulations were complied with by all 66 approved centres. These included identification of residents, recreational activities, and children's education.

Areas of concern

Areas that continue to be of concern include individual care planning and premises, as both regulations' compliance rates were below 60%. A further six regulations' compliance levels were below 80%. These were general health, privacy, medication management, staffing, maintenance of records and risk management procedures.



In addition, the levels of compliance for five rules and codes of practice were below 80%. These were admission of children; seclusion; admission, transfer and discharge; physical restraint; and use of electroconvulsive therapy. There was 0% compliance with the code of practice on the admission of children to approved centres as services did not provide age appropriate facilities and programmes of activities to children admitted to adult units.

Critical risks

In 2020, there were 23 instances of non-compliance that received a critical risk rating. This means that there was a high likelihood of continued non-compliance and a high impact on the safety, rights, health or wellbeing of residents.

The critical risks included those related to therapeutic services (5), premises (4), privacy (3), staffing (2), maintenance of records (2), and seclusion (2).

The MHC follows up on all areas of concern and critical risks through our enforcement process.

2020 Approved Centre Compliance with Regulations

Key:

Less than 60% compliant
Between 60% - 80% compliant
80% compliant and over

Table 1: Approved Centres' Compliance with Regulations - During Pandemic

Approved Centre	Sector/CHO	% Compliance
CAMHS, Merlin Park University Hospital	CAMHS	100
Willow Grove Adolescent Unit, St Patrick's University Hospital	CAMHS	100
Selskar House, Farnogue Residential Healthcare Unit	5	100
St Patrick's University Hospital	Independent	100
Aidan's Residential Healthcare Unit	5	100
St Bridget's Ward & St Marie Goretti's Ward, Cluain Lir Care Centre	8	100
Acute Psychiatric Unit, Cavan General Hospital	1	100
Haywood Lodge	5	100
Acute Psychiatric Unit, Tallaght Hospital	7	100
St Edmundsbury Hospital	Independent	100
Teach Aisling	2	100
Deer Lodge	4	100
Lois Bridges	Independent	100
St Gabriel's Ward, St Canice's Hospital	5	100
Phoenix Care Centre	9	97
Bloomfield Hospital	Independent	97
Department of Psychiatry, St Luke's Hospital	5	97
Cois Dalua	Independent	97
Linn Dara Child & Adolescent Mental Health Inpatient Unit, Cherry Orchard	CAMHS	97
Avonmore & Glenree Units, Newcastle Hospital	6	93
Adolescent Inpatient Unit, St Vincent's Hospital	CAMHS	93
Department of Psychiatry, Roscommon University Hospital	2	93
Acute Psychiatric Unit 5B, University Hospital Limerick	3	93
Adult Acute Mental Health Unit, University Hospital Galway	2	93

Approved Centre	Sector/CHO	% Compliance
O'Casey Rooms, Fairview Community Unit	9	93
St John of God Hospital	Independent	93
St Anne's Unit, Sacred Heart Hospital	2	93
Drogheda Department of Psychiatry	8	93
Sliabh Mis Mental Health Admission Unit, University Hospital Kerry	4	93
An Coillín*	2	93
St Joseph's Intellectual Disability Service	ID	93
Ashlin Centre*	9	90
Eist Linn Child & Adolescent Inpatient Unit	CAMHS	90
St Vincent's Hospital	9	90
Creagh Suite*	2	90
Blackwater House	1	90
Grangemore Ward, St Otteran's Hospital	5	90
Adult Mental Health Unit, Sligo University Hospital	1	90
Department of Psychiatry, Letterkenny University Hospital	1	90
Maryborough Centre, St Fintan's Hospital*	8	90
Centre for Mental Health Care & Recovery, Bantry General Hospital	4	90
Lakeview Unit, Naas General Hospital	7	90
Tearmann Ward, St Camillus' Hospital*	3	89
Department of Psychiatry, University Hospital Waterford	5	87
Ginesa Suite, St John of God Hospital	CAMHS	87
Admission Unit & St Edna's Unit, St Loman's Hospital	8	87
Jonathan Swift Clinic	7	86
Elm Mount Unit, St Vincent's University Hospital	6	86
Highfield Hospital*	Independent	83
St Michael's Unit, Mercy University Hospital	4	83
Cappahard Lodge*	3	82
St Ita's Ward, St Brigid's Hospital	8	82
Acute Mental Health Unit, Cork University Hospital	4	80
Adult Mental Health Unit, Mayo University Hospital	2	80
Owenacurra Centre*	4	79
Carraig Mor Centre	4	77
Department of Psychiatry, Midland Regional Hospital, Portlaoise	8	77
Central Mental Hospital	Forensic	77
Units 2, 3, 4, and Unit 8 (Floor 2), St Stephen's Hospital	4	76
St Catherine's Ward, St Finbarr's Hospital*	4	75
St Aloysius Ward, Mater Misericordiae University Hospital	9	72
Wood View*	2	72
Department of Psychiatry, Connolly Hospital*	9	70
Le Brun House & Whitethorn House, Vergemount	6	68
Sycamore Unit, Connolly Hospital*	9	68
Acute Psychiatric Unit, Ennis Hospital	3	67

Note: * denotes the 12 approved centres which were inspected prior to the suspension of inspections due to the COVID-19 pandemic.

Table 2: Compliance with Regulations - During Pandemic

Regulation	% Compliance
Regulation 4: Identification of Residents	100
Regulation 5: Food and Nutrition	94
Regulation 6: Food Safety	95
Regulation 7: Clothing	98
Regulation 8: Personal Property & Possessions	92
Regulation 9: Recreational Activities	100
Regulation 10: Religion	100
Regulation 11: Visits	97
Regulation 12: Communications	98
Regulation 13: Searches	97
Regulation 14: Care of the Dying	100
Regulation 15: Individual Care Plan	59
Regulation 16: Therapeutic Services and Programmes	88
Regulation 17: Children's Education	100
Regulation 18: Transfers	94
Regulation 19: General Health	65
Regulation 20: Provision of Information to Residents	100
Regulation 21: Privacy	71
Regulation 22: Premises	55
Regulation 23: Medication	71
Regulation 24: Health & Safety	98
Regulation 25: Use of CCTV	86
Regulation 26: Staffing	71
Regulation 27: Maintenance of Records	76
Regulation 28: Register of Residents	94
Regulation 29: Operating Policies and Procedures	100
Regulation 30: Mental Health Tribunals	100
Regulation 31: Complaints Procedures	95
Regulation 32: Risk Management Procedures	77
Regulation 33: Insurance	100
Regulation 34: Certificate of Registration	100

Table 3: Compliance with Statutory Rules and Part 4 of the Mental Health Act 2001 - During Pandemic

Instrument	% Compliance
Rules on ECT	77
Rule on Seclusion	61
Rules on Mechanical Restraint (Part 5)	86
Consent Procedures (Part 4)	84

Table 4: Compliance with Code of Practice - During Pandemic

Code of Practice	% Compliance
Physical Restraint	76
Admission of Children	0*
ECT	86
Admission, Transfer and Discharge	70

* This Code of Practice is applicable in respect of adult services which admit children. Nine such services were inspected and all were found to be non-compliant with the Code. Reasons for non-compliance included services not providing age appropriate facilities and programmes of activities.

Enforcement

Enforcement action is taken where we are concerned that the 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 by the provider to address an ongoing area of non-compliance.

All critical risk issues are considered by the MHC’s Regulatory Review Committee. Enforcement actions most commonly arise out of inspection findings, quality and safety notifications, and compliance monitoring.

Enforcement actions available to the MHC are set out in Figure 2. 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 and/or pursuing prosecution.

Enforcement actions

The MHC took **17** enforcement actions in response to incidents, events, and serious concerns arising in 2020. These actions related to **13** approved centres. This compares with 40 enforcement actions in 2019, 44 enforcement actions in 2018, and 23 enforcement actions in 2017.

The lower number of enforcement actions in 2020 is likely the result of several factors, including the COVID-19 pandemic and resultant changes to work practices in approved centres. By way of example, we know that several services operated significantly under-capacity in accordance with infection prevention control measures. Additionally, certain regulatory functions were altered during the pandemic. The submission of reports on the implementation of corrective and preventative action plans were paused, and all inspections were announced.

During 2020, enforcement actions included:

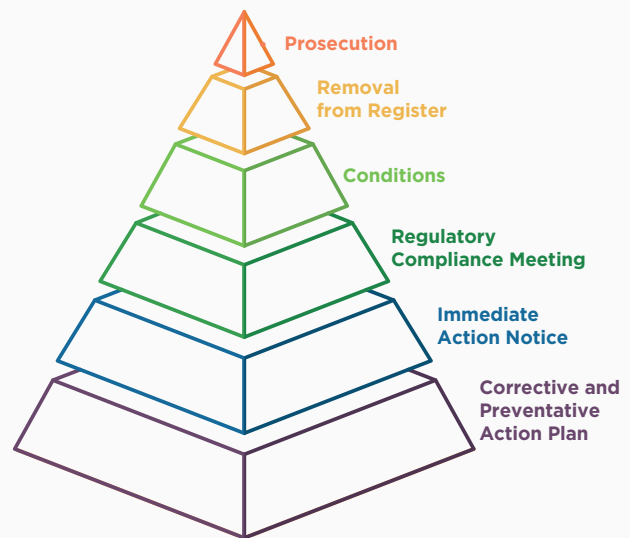
- **11** Immediate Action Notices, relating to 15 serious concerns
- **Five** Regulatory Compliance Meetings
- **One** Condition Proposal¹

All but one enforcement action arose from regulatory inspections conducted by the Inspectorate division. One enforcement action arose as a result of information obtained from an approved centre during compliance monitoring.

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

- **Five** relating to the provision of therapeutic services and programmes
- **Five** relating to concerns about the premises of the approved centre
- **Two** relating to the Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint

Figure 2: MHC Enforcement Model



¹ This condition is distinct from the 115 conditions attached as part of registration or re-registration. This condition was subsequently attached in 2021.

Registration Conditions

The MHC may attach conditions to an approved centre's registration. The most common reason to attach conditions to the registration of an approved centre is continued non-compliance with a regulation or a statutory rule.

The MHC uses conditions to closely monitor and ensure action is taken in respect of areas of concern. It is an offence to breach a condition.

Conditions attached

In 2020, **109** new conditions were attached to the registration of **36** approved centres. This compares to 14 conditions attached to the registration of nine approved centres in 2019.

At the end of 2020, there were **115** conditions attached to **42** approved centres, compared to 57 conditions attached to 35 approved centres in 2019. The most common conditions attached are presented in Table 5.

This notable increase in the amount of conditions attached is attributed to ongoing non-compliance in key areas of concern.

Conditions attached in 2020:

- Set additional reporting requirements (e.g. audit report and training records)
- Required certain actions (e.g. building works and developing protocols)
- Prohibited certain actions (e.g. direct admissions).

Most conditions require that monthly or quarterly reports be submitted to the MHC, which allows for regular monitoring. There were 395 condition monitoring reports submitted by services in 2020.

To allow health services to prioritise their resources in providing safe and appropriate care during the COVID-19 pandemic, the MHC suspended condition reporting.

Table 5: Breakdown of conditions attached in 2020

Month of decision to attach	Number of conditions attached	Number of approved centres
January	0	0
February	90	25
March	5	2
April	0	0
May	1	1
June	3	1
July	1	1
August	0	0
September	5	3
October	4	3
November	0	0
December	0	0

Table 6: Areas to which conditions were attached in 2020

Area to which conditions were attached	Number of conditions attached
Regulation 22: Premises	38
Regulation 26: Staffing	30
Regulation 15: Individual Care Plan	12
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	6
Regulation 27: Maintenance of Records	5
Regulation 32: Risk Management Procedures	6
Closure of approved centre	6
Regulation 19: General Health	3
No new admissions	2
Regulation 21: Privacy	1

Quality and Safety Notifications

Approved centres and other community mental health services are required to submit Quality and Safety Notifications to the MHC. There are 16 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 MHC closely monitors** (e.g. child admissions and overcapacity)

The MHC closely monitors these notifications. We review, and where appropriate, follow up with the services to ensure that specific actions have been taken to safeguard the wider resident group or that relevant learnings have since been incorporated into service practice.

In addition, we analyse these for trends and use these data to inform our regulatory practices. We also produce annual activity reports on regulated practices, which can be found on our website.

Adverse events

Deaths

In 2020, **586** deaths of people using mental health services were reported to the MHC. **207** of these related to approved centres and **379** related to other community mental health services. This compares to 563 deaths in 2019, 166 of which were residents in approved centres and 397 of which were related to other community mental health services.

Death by suicide may only be determined by a Coroner's inquest, which may take place several months after the death. However, **151** total deaths were reported to us by services as a "suspected suicide" and 39 of these related to residents of approved centres. This compares to 168 in 2019. A breakdown of the deaths reported to us is provided in Table 7.

Serious reportable events

All mental health services are required to notify the MHC of Serious Reportable Events (SREs, HSE 2015).

In 2020, **46** SREs were reported to the MHC, **35** of which related to residents of approved centres, while **11** related to other community mental health services. In 2019, there were 41 SREs reported in respect of 37 approved centres. Table 8 shows the number of reported SREs, broken down by SRE category.

Table 7: Breakdown of deaths reported by type of death and service

Type of Death Reported	Approved Centre	Other Mental Health Service	Total
Death was sudden	41	90	131
	20%	24%	22%
Death was not sudden	119	115	234
	57%	30%	40%
Death was a suspected suicide	39	112	150
	19%	30%	26%
Unknown	8	62	70
	4%	16%	12%
Total deaths	207	379	586

Table 8: Serious Reportable Events reported by category

SRE category	Description	Number reported
Environmental Events (5D)	Serious disability associated with a fall	26
Criminal Events (6C)	Sexual assault on a patient or other person	9
Care Management Events (4I)	Stage 3 or 4 pressure ulcers	7
Patient Protection Events (3C)	Sudden unexplained deaths or injuries which result in serious disability	4
Total		46

Regulated Practices

The MHC produces annual activity reports on the use of ECT and restrictive practices of seclusion, physical restraint, and mechanical restraint. Below is a high-level overview of the information which will be presented in greater detail in these reports when published.

ECT

In 2020 there were 300 programmes of ECT for 240 residents in 16 approved centres. A programme may involve up to 12 individual treatments. In 2020 there were a total of 2248 individual ECT treatments. 1863 treatments took place with the patient's consent, and 55 programmes of ECT included at least one treatment without consent.

This compares to 395 programmes of ECT for 286 residents in 2019. In 2019, there were 3124 individual treatments. 2621 of these took place with the patients consent, and 62 programmes of ECT included at least one treatment without consent.

Seclusion

In 2020 there were 1840 episodes of seclusion involving 643 residents in 28 approved centres. The shortest episode reported was 10 minutes, while the longest was 2424 hours and 30 minutes. The MHC received 56 notifications from 10 approved centres of episodes of seclusion that lasted longer than 72 hours.

This compares to 1719 seclusion episodes involving 653 residents in 28 approved centres in 2019. In 2019, the shortest episode was 30 seconds and the longest was 3837 hours. In 2019, there were 61 episodes of over 72 hours.

Physical restraint

In 2020 there were 4055 episodes of physical restraint involving 1168 residents in 52 approved centres. This compares to 5019 episodes involving 1443 residents in five approved centres in 2019.

Mechanical Restraint

In 2020 10 patients were restrained in two services Under Part 4 of Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint - Use of Mechanical Means of Bodily Restraint for Immediate Threat of Serious Harm to Self or Others.

Of the two approved centres that reported use of mechanical restraint, the national forensic mental health service, (the Central Mental Hospital), reported 16 episodes on nine patients with a minimum duration of two hours and a maximum duration of 2.40 hours. The other service reported 150 episodes on one resident with a minimum duration of 1.15 minutes and maximum duration of 953.20 hours.

This compares to 18 episodes involving eight patients in one service with a total duration of 34.58 hours in 2019.

Areas that the MHC closely monitors

Overcapacity

There were **58** instances of overcapacity reported in 2020 by approved centres. An approved centre is at 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.

The 58 instances of overcapacity related to the following five approved centres:

- AMHU, Mayo University Hospital
- DOP, Roscommon University Hospital
- DOP, University Hospital Waterford
- Drogheda Department of Psychiatry
- Sliabh Mis, University Hospital Kerry

AMHU, Mayo University Hospital and DOP, Roscommon University Hospital reported 53 of the 58 instances of overcapacity. The MHC engaged with services reporting overcapacity to ensure surge management plans were in place and to address the systemic causes of overcapacity.

Twelve of the notifications received referenced the use of leave beds as a means of accommodating overcapacity. A further 32 notifications refer to beds being available in the unit, likely also as the result of residents on leave. The Inspector of Mental Health Services considers this to constitute poor practice as patients may need to return from leave at any point and require their bed and further treatment.

This figure of 58 compares to 208 instances in 2019. The MHC expects that the COVID-19 pandemic and resultant service reconfigurations have contributed to the significant reduction in reported instances of overcapacity between 2019 and 2020. Bed capacity was reduced in many services to enable implementation of COVID-19 infection prevention and control guidance.

Child admissions

The MHC closely monitors the admission of children and young people under the age of 18 to inpatient mental health services.

The total number of admissions of children and young people to approved centres in 2020 was 486. This compares with a total of 497 admissions in 2019 and 408 in 2018.

Admissions to adult approved centres

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

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

In 2020, there were 27 admissions to nine adult units as presented in Table 9. This compares with 54 admissions to 15 adult units in 2019. Eight of those admissions in 2020 were for less than 48 hours, compared to 23 admissions for less than 48 hours in 2019.

This is part of a trend over the last number of years where the numbers of admissions of children to adult units has fallen dramatically.

In 2009 there were more children admitted to adult units than CAMHS units. However, in 2020 only 5.6% of child admissions were to adult units, the lowest number since records began.

While this is part of an overall decline in child admissions to adult units, it is a significant drop on 2019, when 54 children were admitted to adult units accounting for 11% of child admissions. Part of this decline may relate to changed admission and isolation practices in response to the COVID-19 pandemic. However, based on the currently available data, it is not possible to determine a direct causal relationship.

Table 9: Child admissions to Adult Units

Rank	Approved Centre	No. Admissions
1	Sliabh Mis Mental Health Admission Unit, University Hospital Kerry	10
2	Department of Psychiatry, University Hospital Waterford	6
3	Department of Psychiatry, Connolly Hospital	5
4	St Michael’s Unit, Mercy University Hospital	1
5	Acute Psychiatric Unit, Cavan General Hospital	1
6	Acute Psychiatric Unit, Ennis Hospital	1
7	Acute Mental Health Unit, Cork University Hospital	1
8	Department of Psychiatry, Midland Regional Hospital, Portlaoise	1
9	Department of Psychiatry, Letterkenny University Hospital	1

Admissions to child and adolescent approved centres

There are six specialist Child and Adolescent Mental Health Service (CAMHS) units nationally: four in Dublin, one in Cork, and one in Galway.

In 2020, there were **459** admissions to these units. The average duration of admission was 40 days (based on discharge information provided for 442 admissions).

Involuntary child admissions

The District Court is required to authorise the involuntary admission of a child. In 2020, there were **39** involuntary admissions orders of children to approved centres, pursuant to Section 25 of the Mental Health Act.

This included:

- Two orders to adult units
- 37 orders to CAMHS units

In addition, there were:

- <5 High Court Orders for the admission of a child to a CAMHS unit, to an adult unit or admission of a Ward of Court to an adult unit
- Seven admissions of a Ward of Court to a CAMHS Unit.

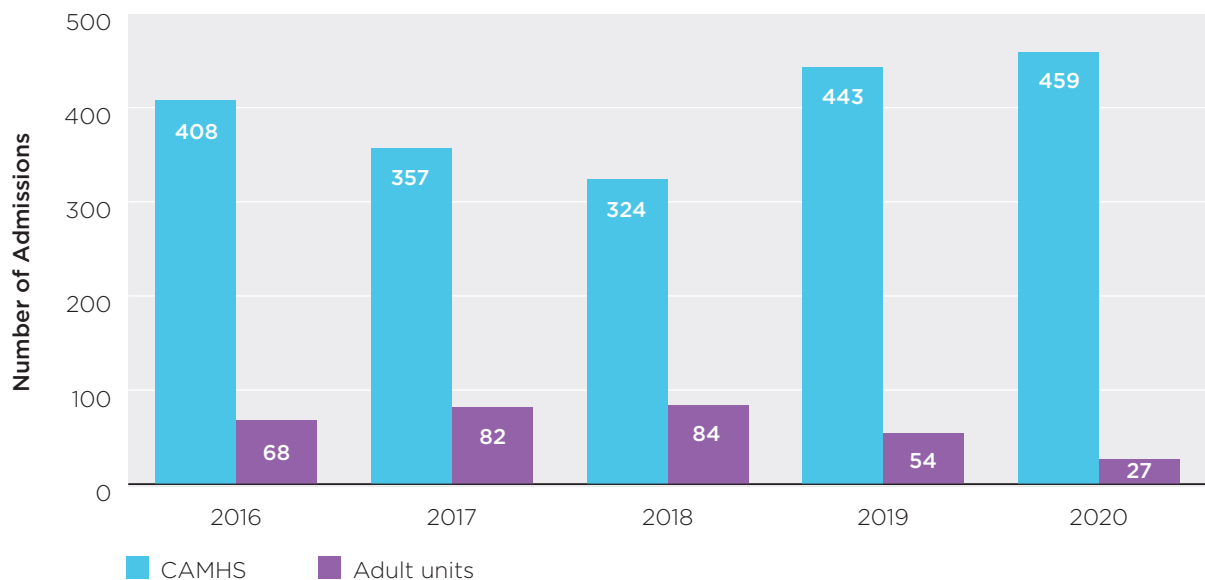
Age and gender of child admissions

In 2020, 72% of all child admissions were female, this compares to 65% in 2019. The youngest resident was 10 years of age as presented in Table 10.

Table 10: Admissions to Adult and CAMHS approved centres by age in 2020

Age	Adult	CAMHS
17	11	148
16	14	103
15	<5	94
14	0	75
13 and under	0	39

Figure 3: Child admissions to Adult and CAMHS approved centres for the past 5 years





Quality Improvement

The MHC 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 use quality improvement methodologies in the review of our own internal processes.

During 2020, our key activities under our Quality Improvement functions included the development, together with HIQA, of an e-learning module to support the implementation of the National Standards for Adult Safeguarding and the publication of the Access to Acute Mental Health Beds in Ireland discussion paper.

Publications

The MHC published several documents throughout 2020. These documents range from informative activity reports to quality standards.

- Individual Care Planning: 2016-2018 in Review
- Access to Acute Mental Health Beds: A discussion paper analysing bed availability for adults, including international comparisons
- COVID Paper 1: Supervising, monitoring and supporting Irish residential mental health services during COVID-19
- The Use of Restrictive Practices in Approved Centres: Activity Report 2019
- The Administration of Electroconvulsive Therapy in Approved Centres: Activity Report 2019.

Collaborative working

Submissions

During 2020, the MHC provided submissions or comments on several draft standards, frameworks, strategies, and position papers, including but not limited to:

- Health Service Executive on their Corporate Plan
- Law Reform Commission on a Regulatory Framework for Adult Safeguarding
- Department of Justice on the Gender Implications of the COVID-19 Pandemic
- Department of Children and Youth Affairs on the Child and Youth Participation Framework
- Department of Health on Adult Safeguarding Mapping
- HIQA on Draft Recommendations on the Implementation of a National Electronic Patient Summary in Ireland

Committees, advisory groups and interest groups

During 2020, the MHC participated in several groups to contribute to the development of standards, share learnings and gain international insights, including:

- COVID-19 NPHET Subgroup - Vulnerable People
- Dialogue Forum on the role of voluntary organisations in publicly funded health and social care services
- Oireachtas Special Committee on COVID-19 Response
- National Clinical Effectiveness Committee
- National Healthcare Quality Reporting System Governance Committee

E-Learning module to support the national standards for adult safeguarding

The MHC and the Health and Information Quality Authority (HIQA) jointly published National Standards for Adult Safeguarding in 2019. 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 Standards also provide a common language to describe adult safeguarding and to help those using services to understand what they should expect.

In 2020, the implementation of these Standards was supported by the launch of an e-learning module, entitled: *National Standards for Adult Safeguarding: Putting the standards into practice*. The online learning module was developed to help front-line staff implement the standards and assess their own work against them. The module is hosted on HSELand.

COVID-19 monitoring

In September 2020 the MHC published the first of a series of papers outlining the response of the regulator and mental health services to the COVID-19 pandemic. The purpose of this paper was to set out the role of the MHC's regulatory team in supervising, monitoring, and supporting services in the management and mitigation of COVID-19 in residential mental health services.

The MHC also reviewed preliminary data and observations gathered from Irish mental health services during the COVID-19 pandemic, seeking to share learnings and developments to ensure that services were prepared to the utmost degree possible for any further surges.

Work on a second paper on COVID-19 began in late 2020. Data relating to staff and resident cases were validated with services to give a complete picture of the progression of the first 'wave' of the disease within Irish mental health services between March and July 2020. The paper (which was published in June 2021) also includes examples of innovative practices implemented by services in response to the pandemic.

Access to acute mental health beds in Ireland

In early 2020 the MHC published the above 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 MHC set up a Quality Improvement Committee in 2018. The Committee, with the approval of the MHC, 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 provides a comprehensive picture of access to acute inpatient 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 used 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 MHC in November 2018.

National Standards for the Care and Support of Children Using Health and Social Care Services

In 2020 the MHC commenced a collaboration with the Health Information and Quality Authority (HIQA) on the development of joint National Standards for the Care and Support of Children using Health and Social Care Services.

The standards will provide a common language and framework for all health and social care services working with children to promote integrated working across services and improve the experience and outcomes of children using these services.

The standards will promote clarity, consistency, and continuity within and between services, and will focus services on the child first, rather than on the individual service needs. This is the first time a set of standards are focused on the needs of a whole population across health and social care services.

The standards will set out the responsibilities of both health and social care providers when they are working to care for, and support children.

The MHC and HIQA will undertake extensive stakeholder engagement to inform the development of the standards, meeting with children and families with experience of health or social care services, as well as advocates, front-line staff, management and policymakers.

COVID-19

The MHC faced a new challenge in 2020 with the emergence of COVID-19 and the resultant impact on mental health services, staff, and residents. The MHC responded rapidly to the risk posed by COVID-19 in residential mental health settings and expediently adapted and updated processes to evaluate and respond to emerging and developing situations throughout 2020.

Regulatory response

In March 2020, the MHC paused several regulatory functions in response to the pandemic and in acknowledgement of the significant burden being placed on the health service. This included the suspension of annual regulatory inspections of mental health services on 13 March and the pausing of several routine compliance reporting requirements between 25 March and 8 June.

The MHC developed and implemented a plan to recommence inspections of approved centres in line with public health advice and which aimed to protect the safety of residents and staff of approved centres and staff of the MHC by limiting the risk of COVID-19 transmission.

The plan reduced the amount of time spent on site in approved centres by Inspectors and limited the number of Inspectors on site, while ensuring that compliance with all regulations, rules and codes of practice were assessed. Where onsite work was required, protocols to reduce the risk of COVID-19 disease progression were implemented. Under these provisions, the inspections of approved centres resumed on 14 July.

New registrations

Three new approved centres were registered in 2020 as a direct response to the pandemic. One approved centre was opened temporarily to facilitate the reconfiguration of the Central Mental Hospital, and the registrations of St Aidan's Residential Healthcare Unit and Blackwater House were expedited to allow residents to move from shared accommodation to single occupancy rooms.

COVID-19 monitoring in mental health services

In April 2020, The Department of Health (DoH) wrote to the MHC requesting a risk assessment of mental health services based on disease progression, environment, and staffing levels. Mental health services were considered potentially high-risk settings, due to the prevalence of infection and higher risks for persons over 60 years of age; those with underlying medical conditions; and those residing in high contact, congregated environments.

In response to the DoH's request, the MHC undertook a rapid review of available national and international guidance in relation to long term care provided in residential settings and developed a risk assessment framework to objectively assess and record the level of risk in residential mental health services (approved centres and 24-hour nurse-staffed community residences).

The regulatory team commenced weekly monitoring with 181 services on 7 April to 14 June. This monitoring included an assessment against the risk framework, as well as monitoring of disease progression among residents and staff, testing and access to personal protective equipment (PPE).

In response to the national reduction in COVID-19 cases, the MHC adapted its monitoring approach and implemented a risk based model; from 15 June services which reported a suspected or confirmed case among residents or staff were contacted weekly, and a new specific COVID-19 Monitoring Team was established in October which was dedicated to the monitoring of COVID-19.

The MHC's Regulatory Management Team (RMT), which included the Inspector of Mental Health Services and the Director of Standards and Quality Assurance (from April to end November, who was then superseded by the Director of Regulation in December) met weekly to oversee COVID-19 monitoring.

Risks and concerns identified during monitoring calls were escalated to the RMT. In turn, the RMT would identify and escalate concerns to the HSE - seeking appropriate plans and mitigation - or to the Department of Health, as appropriate. A total of 35 escalations were made, consisting of one or more of the concerns detailed in Table 11.

Table 11: Breakdown of escalation concerns

Escalation reasons	Number
Outbreak	17
Staffing Issues	8
PPE	2
Delay in Test Results	5
Other	10

The MHC worked closely with the HSE and the DoH and established a governance structure to ensure issues and risks were identified and escalated appropriately. This included a weekly reporting mechanism and the establishment of a tripartite governance forum between the three bodies.

NPHEH COVID-19 subgroup: vulnerable people

The MHC was a member of the NPHEH Subgroup on Vulnerable People which was established in March 2020. The purpose of the sub-group was to provide oversight and assurance about the measures and actions that needed to be taken to protect vulnerable groups from the impacts of COVID-19.

Oireachtas special committee

The MHC made a submission to the Oireachtas Special Committee on COVID-19 Response in July 2020. Observations informed by our data collection were made on the following: recommending non-COVID-19 care and services, a catch-up programme for same, mental health and wellbeing, additional capacity in the health service and the need for additional testing availability at that time. The submission is available on our website.

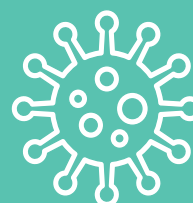
Health Protection Surveillance Centre and Department of Health

The MHC engaged with the Department of Health in relation to the recommencement of inspections and the ongoing process for same. The MHC also engaged with the HSE in relation to Health Protection Surveillance Centre (HPSC) guidance for mental health services.

The MHC’s COVID-19 monitoring continued throughout 2020. Further information about this work is documented in the MHC’s ‘COVID-19 Paper 1: supervising, monitoring, and supporting Irish residential mental health services during COVID-19’ which is available on our website.



From April to June all 181 services were contacted at least once a week. For the remainder of the year, services reporting cases were contacted weekly



Over 2,500 COVID-19 related calls made to services



3 approved centres registrations were expedited



35 concerns were escalated



Mental Health Tribunals

Introduction

Being involuntarily detained in an approved centre is a very difficult experience for any individual. The global pandemic in 2020 heightened this difficulty.

On 2 March 2020, the Mental Health Tribunal (MHT) team commenced work on a plan for COVID-19 (COVID) to ensure that it could continue to meet its obligation to vindicate the rights of those persons involuntarily detained, specifically the review of every detention order detaining a person and to comply with the strict statutory time limits in the legislation.

This was a difficult and unsettling time for the MHT team, due to the uncertain and rapidly changing situation. Each day outbreaks were being confirmed in approved centres, a number of treating consultant psychiatrists and mental health act administrators tested positive for COVID, had to quarantine and were unavailable to work, and many panel members were concerned (due to elderly parents, underlying conditions, sick children and other reasons) about going into approved centres. By the second week in March 2020, the MHT team was beginning to face problems assigning members to cases/hearings to review detention orders due to all the above and the fast pace at which matters were developing.

At this point, we were already in contact with the Department of Health (DOH) and the HSE (the main provider of mental health services in the State) to agree a plan of action to ensure that tribunals would continue to take place regardless of COVID. In that regard, the MHT team already had a protocol for holding remote tribunals in Red Weather Alert situations following Storm Ophelia and Storm Emma. This formed the basis of the action plan for COVID.

From 9 March to 17 March, the MHT team developed a plan for remote hearings to be held by phone (and all the ancillary matters related to this). We worked closely with the DOH and the HSE on legislative amendments that were required for remote hearings and continued to communicate with our stakeholders. Requests for amendments were made by all three bodies.

Legislative amendments were made to the Mental Health Acts 2001-2018 (the 2001 Act) by way of the Emergency Measures in the Public Interest (COVID-19)

Act 2020. This assisted and supported the MHC in ensuring that tribunals would continue to vindicate the rights of those persons involuntarily detained. Concerns were voiced during the Dail debates over some of the amendments which were made. The MHC would have welcomed an opportunity at the time to discuss these concerns and explain the rationale for the amendments. The MHC believes that the amendments made reflected the realities of what was happening on the ground and that the measures were taken to ensure that as few as possible changes were made to the tribunal process. Many of the legislative amendments were not used thanks to the work of the MHC and all the relevant stakeholders. The most notable measures that were not used included the introduction of one-member panels (all cases have been heard by a three-person panel) and the appointment of a consultant psychiatrist not on the MHC panel (all appointments have been persons on the MHC panels). It is regrettable that a few entities published reports on the impact of these amendments in early 2021 without any consultation with the MHC as to what happened in practice². We are glad to say other organisations did liaise with the MHC and acknowledged the good work that was done³.

The first remote tribunal took place on 18 March 2020 and all tribunals took place remotely as and from 31 March 2020⁴. To assist with the remote process, guidance was issued to all tribunal panel members⁵. This was updated several times based on feedback received and in support of the practical operation of the remote tribunals. In addition, there were a number of new procedures internally to ensure the effective operation of remote hearings by the MHT team, which resulted in considerable additional work for the MHT team and other stakeholders.

The MHT team published a leaflet for persons involuntarily detained explaining how tribunals would operate during COVID⁶. In addition, a booklet for persons involuntarily detained was issued by the MHT team entitled **Know Your Rights⁷. Know Your Rights** is available in nine languages both in booklet and audio form. This booklet was introduced further to consultation with relevant patient groups and we are very much obliged for their input during this period.

2 <https://www.ihrec.ie/app/uploads/2021/02/Irelands-Emergency-Powers-During-the-COVID-19-Pandemic-25022021.pdf>

3 <https://www.mentalhealthreform.ie/COVID-19/>

4 Please note that video call tribunals were introduced in December 2020 and as of May 2021 almost all tribunals are held via video call subject to the patient's agreement.

5 <https://mhcirl.ie/sites/default/files/2021-03/Guidance%20Document%20for%20MHTs%20COVID-19%20V.9%2012%20March%202021.pdf>

6 <https://www.mhcirl.ie/what-we-do/mental-health-tribunals/information-patients/information-involuntary-patient-COVID-19>

7 <https://www.mhcirl.ie/what-we-do/mental-health-tribunals/information-patients/information-involuntary-patients>

The MHT team is proud of the work it has done to ensure involuntarily detained persons continued to have their rights vindicated by way of tribunals during COVID. The MHC is the only quasi-judicial body in the State to have a 100% record for its hearings in 2020.

The MHT team conducted a feasibility study on videoconferencing for tribunal hearings and a subsequent pilot project in late 2020. This was followed by the commencement of rollout of videoconferencing to all approved centres⁸. It is regrettable that a lack of co-ordinated approach by Government and state bodies to the provision of IT supports, services and resources within and across health services had a considerable impact on the implementation of videoconferencing. The MHC would have benefitted from more guidance and support in this matter.

The COVID journey continues but there is light at the end of the tunnel. The MHC are anxious to resume face to face hearings as soon as it is safe to do so. In the interim, the MHT team wishes to thank the persons involuntarily detained for their patience, we know this has not been an easy time for them, and to all of the other stakeholders for their assistance, support – mental health act administrators, treating consultant psychiatrists, independent consultant psychiatrists, legal representatives, tribunal panel members and many others.

Mental Health Tribunals

Under 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 MHC 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 MHC's panel appointed to them or the patient may appoint their own private solicitor.

The MHC also arranges for the patient to be reviewed by an independent consultant psychiatrist, whose report is provided to their legal representative and the tribunal.

Parties who may be in attendance at a 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. A sample was taken of 45 hearings in 2019 (15 from April, June, and October) and 73% of patients attended their hearing. An equivalent sample was taken in 2020 and 82% of patients attended their hearing. Therefore, it would appear that COVID had no impact on patients attending their tribunal hearing albeit remotely.

Involuntary Detention (admission and renewal orders)

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 (but can be for a lesser period) and the second for a period up to six months (and again this can be for a lesser period).

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 2020, the following orders were made:

- 1,919 admissions orders from the community
- 513 admissions orders by way of re-grading
- 900 renewal orders for a period up to three months
- 310 renewal orders for a period up to six months

⁸ This was progressed with almost all approved centres conducting video conferencing by 30 April 2021

Between 2019 and 2020, there was a 2% increase in admission orders and a 2% decrease in renewal orders

Figures 1-3 and Table 1 in the Mental Health Tribunal 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.

In 2020, there were 253⁹ patients who were eligible to seek an additional review of which:

- Twenty-four (24) requests were received for additional review.
- One (1) order was revoked before the hearing took place.
- Four (4) requests were withdrawn by the patient.
- Nineteen (19) hearings took place with eighteen orders (18) orders affirmed and one (1) order revoked.

The requests received represent 9% of the total number of patients eligible for an additional review, which is considerably less than what the MHC expected.

In the 2019 Annual Report, it was stated that the MHC was going to review the reason for low take up. Where possible, we were to speak with patients/patient advocates to see if patients are fully aware of this right and if more needs to be done by the MHC to make them aware of the right. In 2020, the following measures were taken:

- An information leaflet was issued to involuntarily detained persons setting out their right to an additional review.
- A measure was inserted into the MHT IT system, CIS, to automatically flag to legal representatives when a right to an additional review arises to ensure they speak to their client and outline their rights to an additional review.

- The MHT guidance documents were updated to refer to the right of an additional review and to ensure that tribunals refer patients to their right where relevant.

Unfortunately, we were not able to engage directly with those involuntarily detained due to COVID but hope that we can do so during 2021.

Tribunal Hearings

3,642 orders were made in 2020 and of those it is noted:

- 1,791 orders were revoked before hearing – 49%
- 1,946 orders went to hearing – 51%
- 223 orders were revoked at hearing

During COVID-19

As of Tuesday 31 March 2020, all mental health tribunals (tribunals) were held remotely. A guidance document was issued to all panel members in relation to the holding of tribunals by way of phone call.

All tribunals consisted of a three-person panel and the amendment in the emergency legislation allowing for a one-member panel was not required once the tribunals were commenced remotely.

Due to the additional work involved with organising remote phone tribunals by both the MHT team and the approved centres, a limit was placed on the number of tribunals to be held per day and the time when those tribunals could take place.

Emphasis was placed on patient confidentiality and data protection and the MHC required the following:

1. All panel members, legal representatives, and approved centres to continue to apply data protection legislation and procedures.
2. When working from their office or from home all parties need to do so in a room away from other people as it was imperative that confidentiality and privacy be maintained at all times.
3. All paperwork in their office or at home must be kept in a secure locked location.
4. All paperwork should be stapled together rather than clipped or left in loose pages.
5. All applications and devices relating to MHC work when not in use must be fully turned off.
6. All emails to the MHC with sensitive patient data were to be encrypted/password protected¹⁰.

⁹ This figure differs from the figure of 310 renewal orders for a period of six months noted above. There are a number of reasons for this difference. For further information please contact the MHT team.

¹⁰ In August 2020 the MHT team moved to a new IT system (CIS) which includes a number of new features. CIS allows the user to upload documents directly. Previously, certain documents had to be password-protected and emailed to the MHC. The new IT system has a number of built in data protection measures in terms of passwords and encryption.

The MHC's DPO was involved at all stages of the process.

The MHC revised several of its statutory forms to align with the remote tribunals namely the Form 8 – decision of the mental health tribunal, Form 9 – decision of the mental health tribunal to extend by 14 days and the Record of Proceedings.

Detailed instructions were provided to each of the key stakeholders. Examples include:

A. Mental Health Act Administrators (MHAAs)

1. Extracts from patient records at the time of the detention order were provided to the ICP and LR and up to date records were provided to all when the MHT was to carry out its review (e.g. the patient records were to be uploaded to Comprehensive Information System (CIS) – the MHC's online system – either by 5 pm the day before the tribunal or 10 am on the day of the tribunal if the tribunal is on a Monday or a Tuesday after a bank holiday). Pre-COVID patient's records were not sent to the MHC and would have been reviewed by all of the parties in the approved centre.
2. The MHAA organised within the approved centre for appropriate facilities to be made available to the patient so that he/she could attend the tribunal if he/she wished –
 - a. Where the tribunal was proceeding by way of teleconference call, a dedicated telephone was to be made available to the patient.
 - b. Where the tribunal was proceeding by way of videoconference call, a laptop/tablet/desktop with camera/microphone was to be made available to the patient and the patient's RCP.
 - c. Privacy was ensured for the patient attending such hearings¹¹.
3. The MHAA accommodated both LRs and ICPs in relation to the making of video calls – via WhatsApp or otherwise – to the patient.
4. The MHAA arranged for a copy of the decision of the tribunal to be given to the patient once the patient had spoken to their legal representative.

B. Responsible Consultant Psychiatrists (RCPs)

1. RCPs were to make themselves available to be interviewed by the ICP as per pre-COVID requirements but this could be done remotely.

2. The RCP provided a report to the tribunal. If the RCP was attending the tribunal that report could be a short pro forma report. If the RCP was not attending the tribunal, he/she had to set out in full the basis as to why he/she believed the patient continued to suffer from a mental disorder as per section 3 of the Mental Health Act 2001. This report was to be provided "no earlier than the day before the date" of the relevant tribunal.
3. The RCP had to attend the tribunal save that he/she could not attend for COVID-19 reasons.
4. RCPs, if attending the tribunal, were to be available for the entire tribunal, which included the delivery of the tribunal decision. If, for some exceptional reason, the RCP was not able to attend for the delivery of the decision, the RCP had to provide the Chair with contact details for the on-call consultant to ensure that the decision was communicated to the approved centre.

C. Legal Representatives (LRs)

1. The patient and/or his or her legal representative was entitled to provide a written submission to the tribunal.
2. The legal representative ensured the patient was aware of the decision of the tribunal, when that was done, the legal representative would contact the MHAA who would ensure that a copy of the decision was given to the patient.
3. Legal representatives were to raise issues with the MHC if they were having any difficulties getting access to their client by phone or otherwise.

D. Independent Consultant Psychiatrists (ICPs)

1. The ICP was to carry out all the same functions as per pre COVID-19 procedures save that it was done remotely. If the ICP was unable to carry out the examination of the patient due to COVID-19, this was to be expressly addressed in the ICP report setting out the attempts made and the reasons it was not possible.
2. ICPs were requested not to save the patient records on their desktop/laptop or other devices.
3. ICPs were asked where possible to make an attempt to speak to the patient by way of video call where possible and the approved centres were asked to facilitate the calls/videos where possible in terms of access to a phone/video and to ensure privacy.

¹¹ All these matters may seem obvious but not all patients have their own room, not all approved centres have appropriate facilities and in a number of cases the dedicated tribunal room was reallocated to infection control during COVID. The MHC needed to ensure that these rights of confidentiality and privacy continued to be respected. The issue of premises in approved centres was addressed by the Inspector of Mental Health Services in a recent report <https://www.mhcirl.ie/publications/report-physical-environments-mental-health-inpatient-units>.

E. Three Member Tribunal

1. On the day of the tribunal, or the evening before, the members were sent the patient records and other documents.
2. The tribunal convened by way of conference call (teleconference or videoconference, as appropriate) one hour in advance of the scheduled hearing time as per pre-COVID-19 procedures to discuss the case and any issues arising.
3. The Chair of the tribunal managed the phone or video call.
4. The Chair uploaded the Decision with the full Record of the Proceedings to CIS, which was then checked by the MHT team.
5. The tribunal members were requested not to save any patient records on their desktop/laptop or other devices.

Orders revoked before tribunal

A consultant psychiatrist responsible for a patient must revoke an order if they become of the opinion that the patient is no longer suffering from a mental disorder.

In deciding whether to discharge a patient, the consultant psychiatrist has to balance the need to ensure that the person is not inappropriately discharged 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. 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 must be explained to the patient by the responsible consultant psychiatrist and other members of the patient's treating team. Please refer to **Figure 5** in the Appendices.

Orders revoked at tribunal

A total of 1,946 orders were reviewed by a tribunal and of those 223 were revoked (i.e. 11% of the cases that went to hearing were revoked). This is 1% lower than in 2019. **Figure 6** in the Appendices provides a further breakdown of these revocations. In relation to those revocations:

- 57% did not meet the criteria in section 3 of the 2001 Act.
- 32% 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 i.e. non-compliance with statutory provisions.
- 7% are a combination of the two above i.e. 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.
- 4% were classed as "other".

Therefore, 39% of revocations related to issues of non-compliance, which is not acceptable¹².

Of the 32% of revocations solely due to issues of non-compliance the following should be noted:

- A number of cases had two or more issues of non-compliance
- Approx. 50% of the cases related to errors on the patient notification form
- Approx. 20% of cases related to errors on the admission orders (be it from the community or a regrading)
- Approx. 13% of cases related to errors on the renewal orders
- Approx. 17% of cases related to errors on the recommendation forms.

(Note – All of the above forms are completed by a consultant psychiatrist save the recommendation, which is completed by a general medical practitioner.)

Tribunals for transfers to the CMH

There was one tribunal to seek the transfer of a patient to the CMH in 2020. The proposal to transfer was authorised by the tribunal.

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 1,791 orders revoked before hearing, there were 29 requests for Section 28 tribunals of which 19 proceeded to an actual hearing. This is a very small percentage (1%) of the orders revoked before hearing.

The MHC has stated that, in its opinion, it is not clear what a tribunal is to decide at a section 28 tribunal. The MHC in its submission to the DOH in March 2020 has sought for section 28 to be reviewed and its purpose clarified to assist persons involuntarily detained, those representing them and the tribunal members.

¹² The MHC is organising a series of events with the relevant stakeholders to address these issues of non-compliance.

Time between making the order and the tribunal

The Report of the Expert Review Group in March 2015 recommended that reviews by tribunals should be carried out within 14 days of the order being made. In 2020, 91% of hearings took place between Days 15 and 21. The MHC in its submission to the DOH in March 2020 agreed with this recommendation and is already putting measures in place to ensure that this is achievable.

Admissions from the community

There were 1,919 admission orders from the community in 2020 and one of the issues which the MHC considers each year is who makes these applications.

The key changes in the 2020 figures compared to 2019 are that applications by family members are down by 5% and applications by authorised officers are down by 1% but applications by An Garda Síochána are up by 4% with applications by 'any other person' up by 2%¹³. Please refer to Figure 4 and Figure 5 in the Appendices.

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

- It welcomes the continued decrease in applications by family members.
- It is disappointed by the reduction in applications by authorised officers (see below).
- It is very concerned about the increase in applications by the Gardaí.
- It is difficult to assess fully the applications by other persons as these include doctors in Emergency Departments, which would in many cases be considered appropriate.

The Expert Review Group, which published its Report in March 2015 on amendments required to the 2001 Act¹⁴, strongly advocated that all applications should be made by authorised officers. The MHC in its submission to the DOH in March 2020 supported this recommendation and outlined a number of additional requirements to ensure this could happen. The MHC is concerned to see the applications by authorised officers go down when those by the Gardaí has gone up, for the second year in a row. This is even more concerning that this happened during a period of time when such persons might have been even more vulnerable and intervention by the Gardaí could have caused more distress. The MHC wishes to be clear that it is in no way critical of the Gardaí who made these applications.

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.

There were 513 such admissions notified to the MHC in 2020.

Age and gender

Analysis of age and gender for episodes of involuntary admission in 2020 show the following:

- 81% of involuntary admissions of people aged 18-24 category were male.
- People aged 35-44 had the highest number of involuntary admissions at 23% (up 1% from 2019).
- 56% of the total involuntary admissions were male.
- However, there were more female admissions in the age groups over 45.

See Tables 2,3 and 4 in the Appendices for further detailed information.

Quality improvement

The MHT team introduced a number of measures in 2018 aimed at improving the quality of services provided by the MHT team, panel members assigned to mental health tribunals and approved centres. These were expanded in 2019 and 2020. There are now audits across three main areas:

- The work of the MHT team.
- The decision of the tribunals.
- Issues arising in approved centres of which we are aware.

Audit on the work of the MHT team:

The team conducts 13 audits on the services provided by the team and by panel members who are assigned to mental health tribunals. Some items of interest from these audits are:

- From a sample of 392 independent consultant psychiatrist reports, 100% were submitted within 14 days of the making of an order.
- Patients may choose a different solicitor from the MHC's panel of legal representatives than the one that was assigned to their case. 27 patients chose to be represented by another legal representative from the panel.

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

14 <https://www.gov.ie/en/publication/637ccf-report-of-the-expert-group-review-of-the-mental-health-act-2001/>

- Patients are also entitled to be represented by their own private solicitor or represent themselves under the Constitution. Two patients chose a private solicitor to represent them and two chose to represent themselves.

Audit of the tribunal decisions:

The audit covers a variety of issues and some of the key findings are as follows:

- 120 decisions over a 12-month period were reviewed.
- 17 orders revoked of which
 - 13 did not meet the criteria in section 3
 - 3 due to an issue of non-compliance
 - 1 other (decision related to an issue outside the remit of the MHT).
- 23 of the 120 patients did not attend the hearing and this does not take into account those that do not attend for the decision.

Audit relating to the approved centres:

This audit is done on a quarterly basis following which reports are sent to the individual approved centres.

66 issues were logged. Of note:

- 76% 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 6% 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 reduction of the number of issues reported in the 2020 in comparison with 2019. 66 issues were recorded in 2020 in comparison with 89 issues recorded in 2019. This is notwithstanding COVID-19. Credit must be given to the consultants and MHAAs for this reduction.

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 the court will consider whether or not the patient is suffering from a mental disorder as of the date of the appeal. If the order is revoked by the Court, this will extend to the renewal order even it is not specifically the subject of the appeal to the court.

The MHC was notified of 156 Circuit Court appeals in 2020. This is consistent with the numbers received in recent years except for 2017 when 120 such appeals were received.

Of the 156 appeals received in 2020:

- 19 appeals proceeded to full hearing.
- 18 were affirmed by the Court.
- 1 was revoked by the Court.

In 2019, 33 cases went to a full hearing and in 2018, 27 cases went to a full hearing. One possible reason for the reduction in hearings is COVID-19 but this is not clear. The MHC did confirm to legal representatives that it would accommodate all such hearings remotely or in person.

The MHC in its submission to the DOH to amend the 2001 Act recommended a number of legal and practical amendments in relation to Circuit Court appeals and section 19 of the 2001 Act. The two key amendments were:

1. The expansion of the remit of the Circuit Court to deal with compliance issues which the tribunal considers. This should assist patients and reduce the need to go to the High Court; and
2. The MHC recommended that the approved centre be the respondent to the proceedings as the detainer. The current position is wholly unsatisfactory as the MHC is dealing with these appeals for the tribunal and in doing so is calling the RCP to give evidence i.e. in effect the MHC is having to present evidence to the court on the ongoing detention of the patient, which as the regulator for the approved inpatient facility is not appropriate. The matter now needs to be addressed in the primary legislation and thereafter an amendment to the Court Rules. The MHC also requested that the tribunal should not be a notice party but that the MHC should be notified of the appeal and the outcome for the purposes of its records regarding involuntarily detained patients.

In addition, the MHC supports the proposal that the burden of proof in relation to appeals should lie with the approved centre as the detainer and not the patient.

Mental Health Tribunal Information

Appendices

Figure 1: Monthly Involuntary Admissions 2020

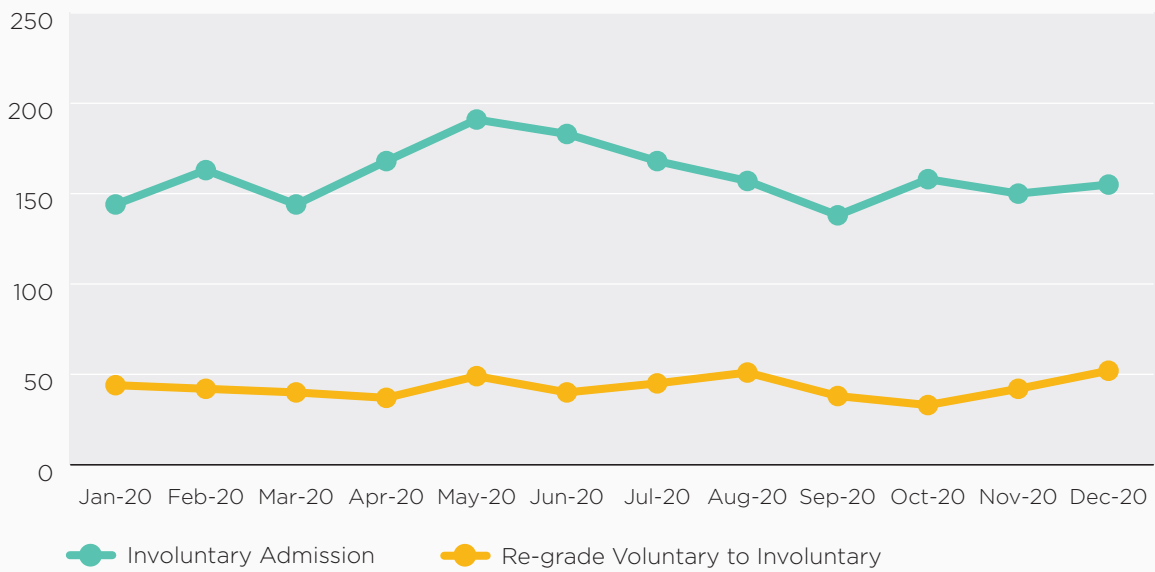


Figure 2: Comparisons of total involuntary Admissions 2016-2020

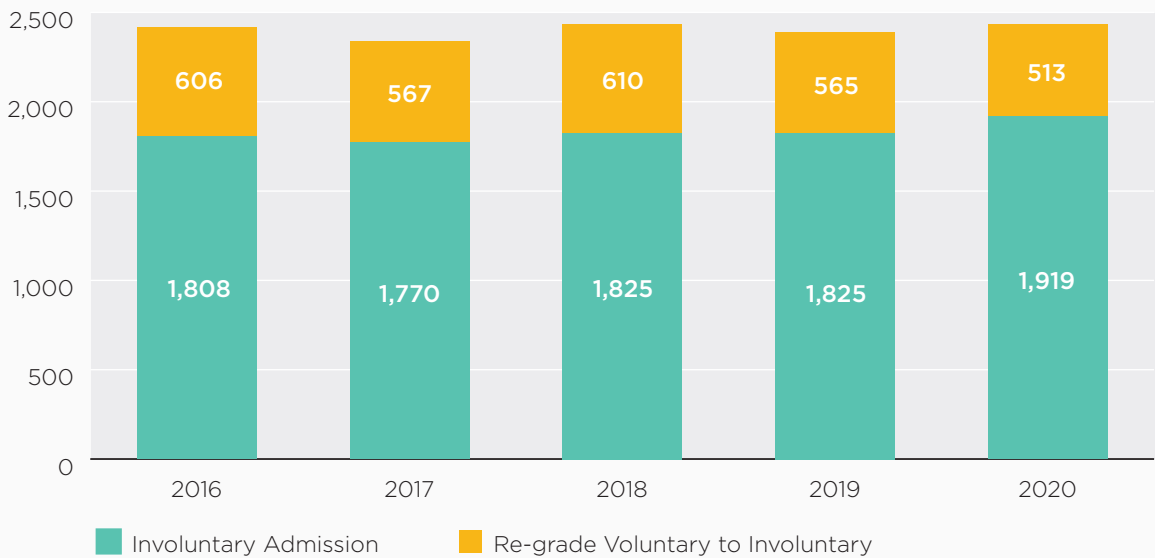


Figure 3: Comparison of renewal orders 2016-2020

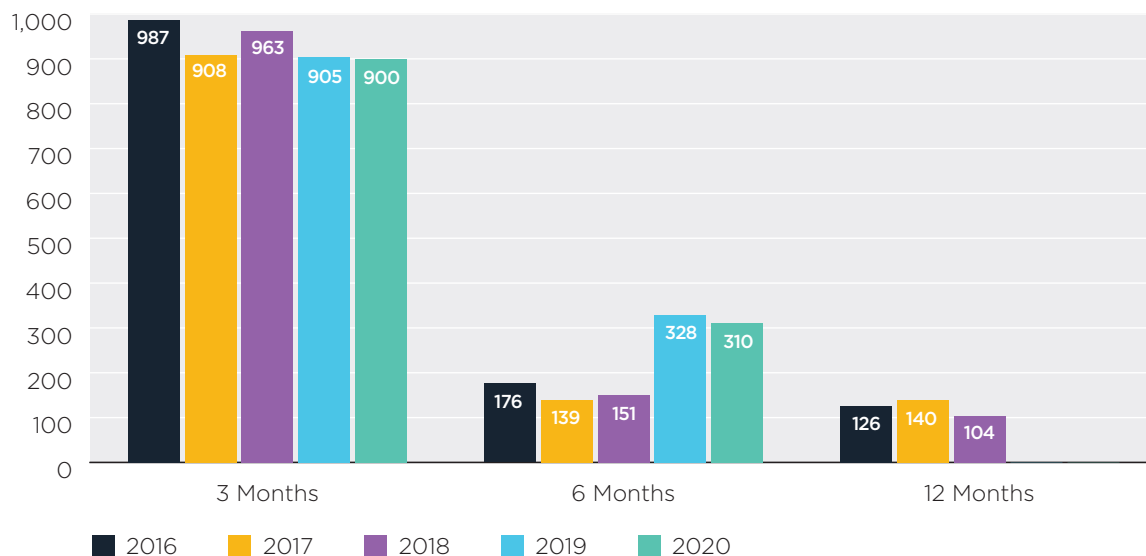


Table 1: Involuntary Admission Rates for 2020 (Adult) by CHO Area and Independent Sector

	Involuntary Admissions	Re-grade Voluntary to Involuntary	Total Involuntary Admission Rate
CHO1	151	29	180
CHO2	207	34	241
CHO3	119	41	160
CHO4	308	81	389
CHO5	161	51	212
CHO6	155	24	179
CHO7	201	59	260
CHO8	228	27	255
CHO9	304	99	403
Independent Sector ¹⁵	85	68	153
TOTAL (Exclusive of Independent sector)	1,834	445	2,279
TOTAL (Inclusive of Independent sector)	1,919	513	2,432

¹⁵ There are seven independent approved centres.

Figure 4: Analysis of Applicants for Involuntary Admissions from the Community in 2020

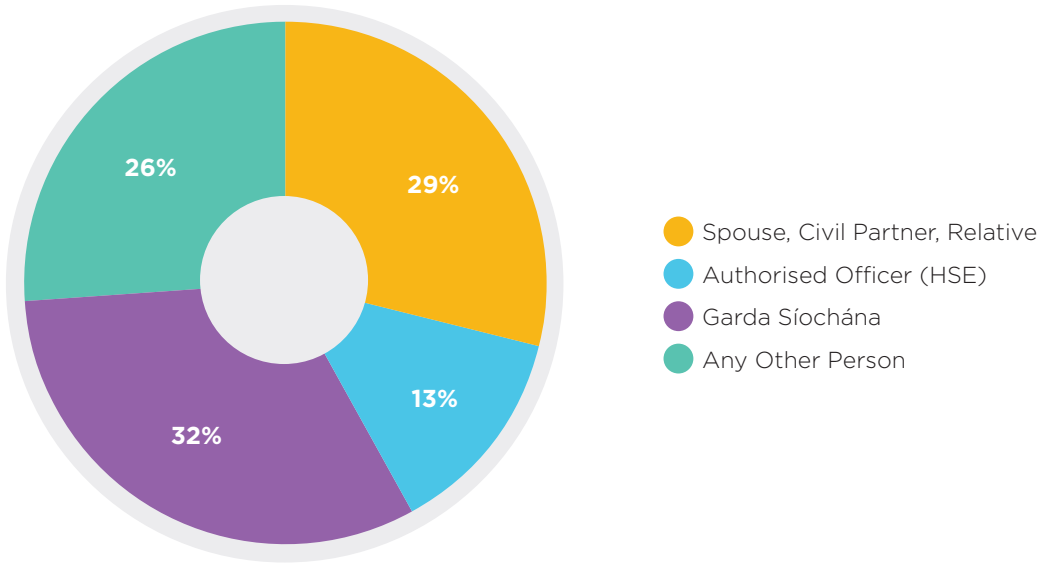


Figure 5: Analysis of Applicants of Involuntary Admissions from Community from 2011 to 2020

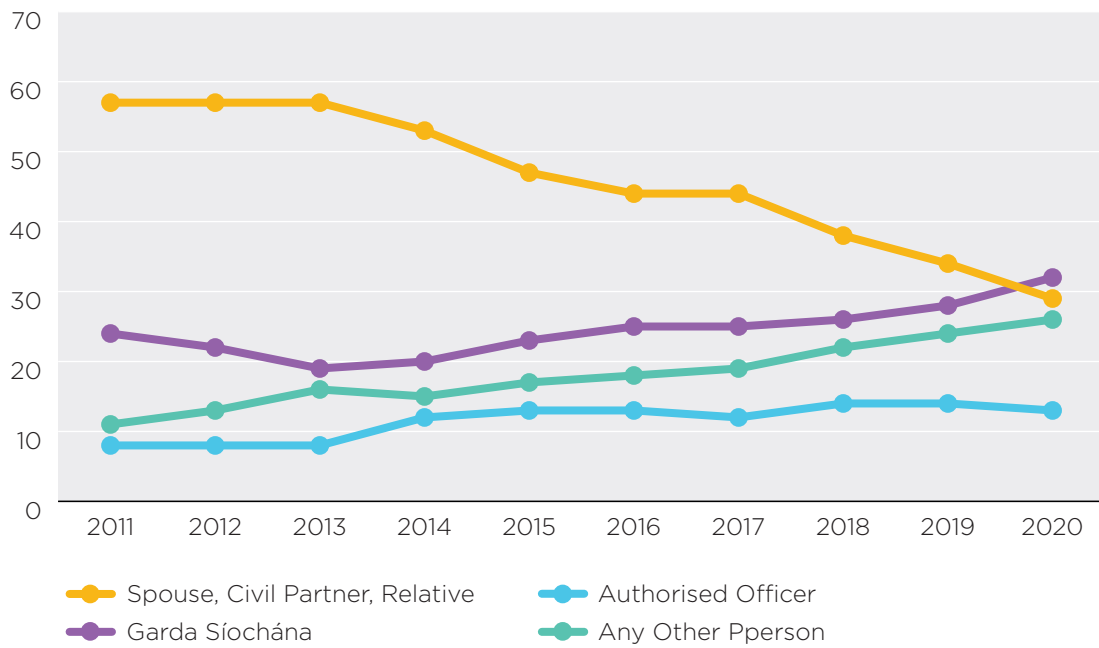


Figure 6: Breakdown of Hearings in 2020 over 21 day period¹⁶

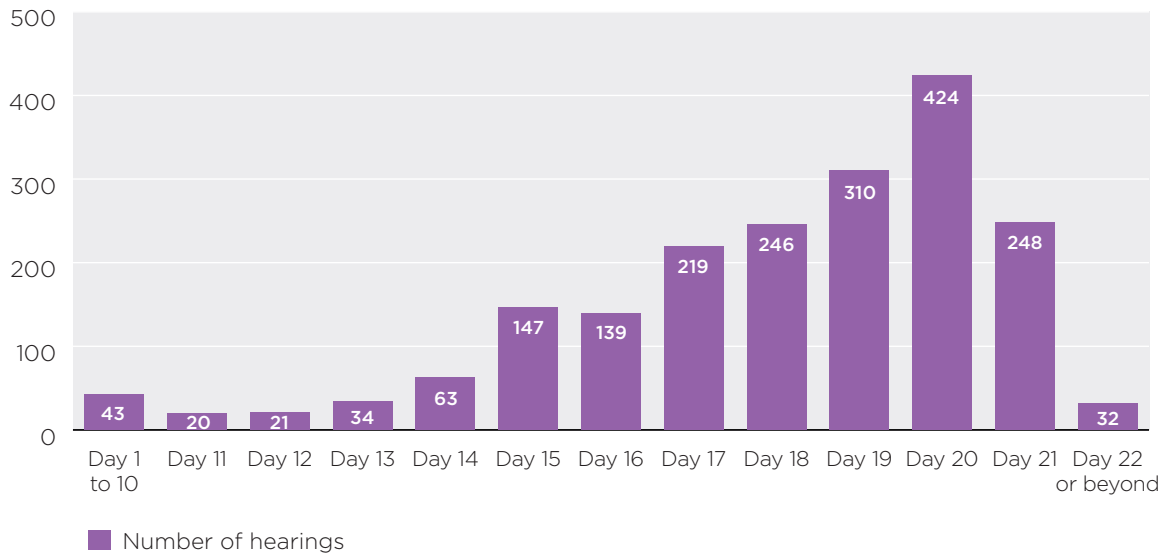
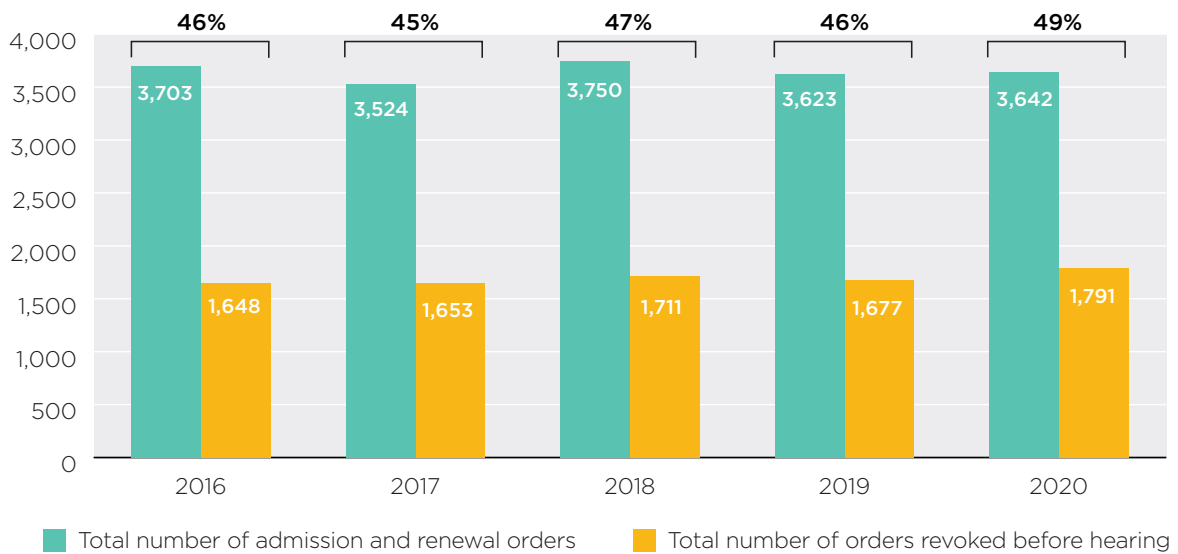


Figure 7: Number of Orders Revoked before Hearing by Responsible Consultant Psychiatrists for Years 2016 to 2020



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

Figure 8: Number of hearings and % of orders revoked at hearing 2020

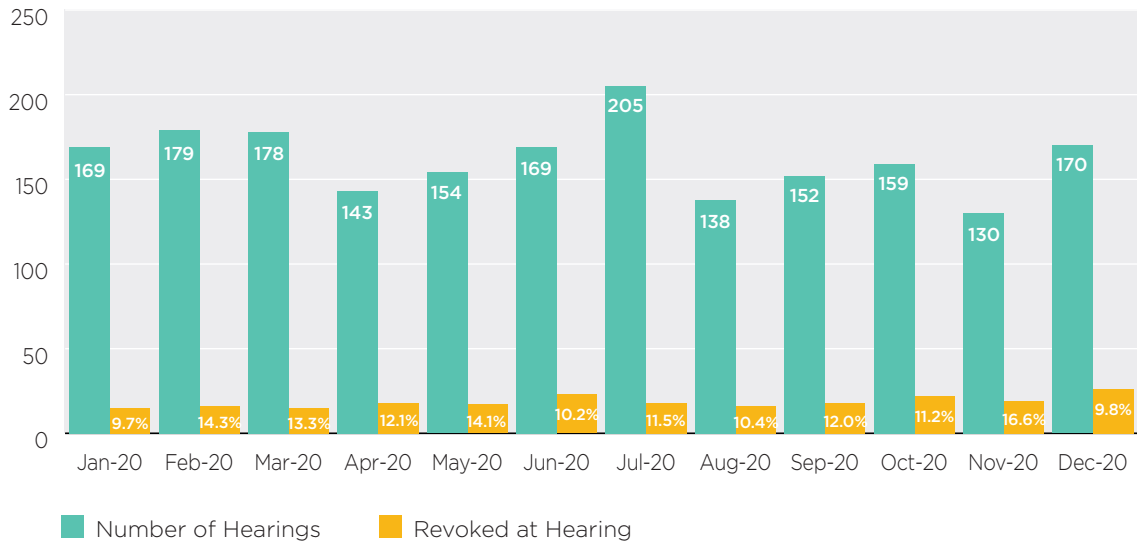


Table 2: Analysis by Gender and Age of 2020 Involuntary Admissions

Age	Male	Female	% gender
18 - 24	215	51	81% male
25 - 34	376	189	67% male
35 - 44	269	233	54% male
45 - 54	204	242	54% female
55 - 64	126	186	60% female
65 +	161	180	53% female
Total	1,351	1,081	56% male

Table 3: Analysis by Gender and Admission type of 2020 Involuntary Admissions

Gender	Form 6	Form 13	Total	%
Female	826	255	1,081	44%
Male	1,093	258	1,351	56%
Total	1,919	513	2,432	100%

Table 4: Analysis by Gender, Age and Admission type of 2020 Involuntary Admissions

Age	Form 6	Form 6 Female	Form 6 Male	Form 13	Form 13 Female	Form 13 Male	Total	%
18 - 24	212	35	177	54	16	38	266	11%
25 - 34	441	132	309	124	57	67	565	23%
35 - 44	399	181	218	103	52	51	502	21%
45 - 54	365	193	172	81	49	32	446	18%
55 - 64	238	146	92	74	40	34	312	13%
65 and over	264	139	125	77	41	36	341	14%
Total	1,919	826	1093	513	255	258	2,432	100%



seirbhís tacaíochta
cinnteoireachta

decision support service

Countdown to Commencement

Despite the considerable challenges and adjustments faced by all as a result of the COVID-19 pandemic, 2020 was a year of significant progress for the Decision Support Service (DSS) as we continued to prepare for commencement of the Assisted Decision-Making (Capacity) Act 2015 (2015 Act).

During 2020, as we turned to remote working, we continued to implement our business objectives, with a key focus on all of the various milestones required to operationalise the DSS. We commenced work developing our ICT system which will be the main point of interaction with a range of DSS users and stakeholders, including panel members, the courts and people entering into decision support arrangements.

In October, overall responsibility for the implementation and commencement of the 2015 Act transferred from the Department of Justice to the newly established Department of Children, Equality, Disability, Integration and Youth (DCEDIY).

We worked constructively with the Department of Justice and later with the DCEDIY to gain clarity on amendments to the 2015 Act and aspects of the DSS that must be set by Regulations.

During 2020, a costed timebound plan for commencing the DSS was agreed to by the Department of Justice and the Inter-Departmental Steering Group for the commencement of the DSS. Additional funding of €2.27 million, bringing the allocation to a total of €5.77 million, was announced in October as part of Budget 2021. This additional resourcing was warmly welcomed and will play a key role in ensuring the much-needed service opens its doors on time.

DCEDIY has publicly stated its commitment to commence the 2015 Act in full and for the DSS to open in June 2022. This commitment gives certainty to all stakeholders and provides a clear date to work towards.

Despite this progress a number of external dependencies remain. These dependencies require the DSS to proceed on the basis of certain assumptions, for example, in relation to the final amended Act, regulations, and court processes.

The readiness of the DSS is not the only precondition to commencement of the Act. Coordinated preparation across all affected sectors is essential to implement the important reforms brought about by the 2015 Act.

By mid-2020, the importance of informed consent and lack of existing legal frameworks for people unable to consent was highlighted as part of the procedures developed by the HSE in relation to the COVID-19 vaccine. At the DSS, the relevant person is always our focus, and as such we welcomed the practical approach which places the person's will and preferences at the centre at all times.

2021 marks 150 years since the Lunacy Regulation (Ireland) Act 1871 was introduced. It remains more important than ever that we commence this essential service.

Engaging with our stakeholders

The 2015 Act has wide-ranging effects for stakeholders across a number of sectors. The DSS has an important statutory role to play in promoting awareness and understanding of the 2015 Act and continued to do so in 2020, engaging with stakeholders through new digital channels.

Readiness for commencement of the 2015 Act is much broader than just the establishment of the DSS; organisations, professionals, and potential users of the DSS need to start taking steps now to get ready.

The DSS team priorities in 2020:



Relevant person

The relevant person is the key stakeholder of the DSS and the 2015 Act. Following commencement, the relevant person will have access to a range of supports to exercise their decision-making capacity.



Friends, family and carers

Loved ones and carers currently operate in a 'grey area' and are not recognised as a legal supporter or decision-maker unless by way of an enduring power of attorney. Following commencement, the new decision support arrangements will provide certainty for these roles.



Finance and legal sectors

Following commencement, professionals will need to implement procedures for interacting with decision supporters and for interacting with clients who may face capacity challenges.



Courts and justice sector

Following commencement, a new scheme of legal aid will be available for the relevant person. Wards of court will transition out of wardship and the Circuit Court will have new responsibilities under the 2015 Act.



Health and social care sector

The 2015 Act has wide-ranging effects on healthcare professionals and healthcare service providers. There are particular implications for residential care facilities and consent to treatment.

2020 ENGAGEMENTS

Banking and Payments Federation
 Cairde
 Camphill Communities of Ireland
 Competition and Consumer Protection Commission
 Courts Service
 Department of Children, Equality, Disability, Integration and Youth
 Department of Health
 Department of Justice
 Department of Social Protection
 HSE National Office for Human Rights and Equality Policy
 HSE National Safeguarding Office
 Inclusion Ireland
 Irish Advocacy Network
 Irish Human Rights and Equality Commission
 Irish Penal Reform Trust
 Law Reform Commission
 Mental Health Reform
 National Disability Authority
 Neurological Alliance Ireland
 Nursing Homes Ireland
 Safeguarding Ireland
 Society of Trust and Estate Practitioners
 St. John of God Research Foundation

Our Work in 2020

Service design

During 2020 we continued to develop our policies, procedures and supporting materials for DSS functions in preparation for commencement. When operational, the DSS will have the following core business functions:

- Registration of decision support arrangements
- Supervision and monitoring of decision supporters
- Register searches
- Establishment and maintenance of expert panels
- Investigation and resolution of complaints
- Query management
- Recognition of international decision support arrangements.

Demand forecasting

In September 2020, we commenced a project to estimate potential and likely future users of the DSS. There is no single data source of adults in Ireland who have capacity challenges and may benefit from decision-making supports. As such, we accessed a wide range of data sources and commenced analysis to identify potential user cohorts.

ICT project

The DSS ICT project was approved by the Department of Justice in April 2020. Design and development of the new DSS ICT system, which will include an online portal, case management system and searchable arrangements register, formally commenced in 2020.

The DSS is committed to establishing an accessible, user-friendly system which will enable people to register decision support arrangements, submit monitoring reports, search the register, ask questions, and make complaints.

Codes of Practice

The National Disability Authority (NDA) and the Health Service Executive (HSE) were tasked by the Departments of Justice and Equality and Health respectively with drafting Codes of Practice. The DSS is reviewing the draft codes to ensure they align with operational policies and procedures that have been developed in detail throughout the DSS implementation programme. The DSS will conduct a public consultation prior to seeking Ministerial approval for publication of these codes of practice. The public consultation will commence when there is clarity on amending legislation and relevant regulations.

Organisational design

During 2020, we continued to develop our team and shifted focus to how the DSS will operate following go-live. This included identifying the key roles and grades that will be required to deliver our core functions. We also began working on a training strategy focused on the induction and ongoing development of our team.

Panel recruitment

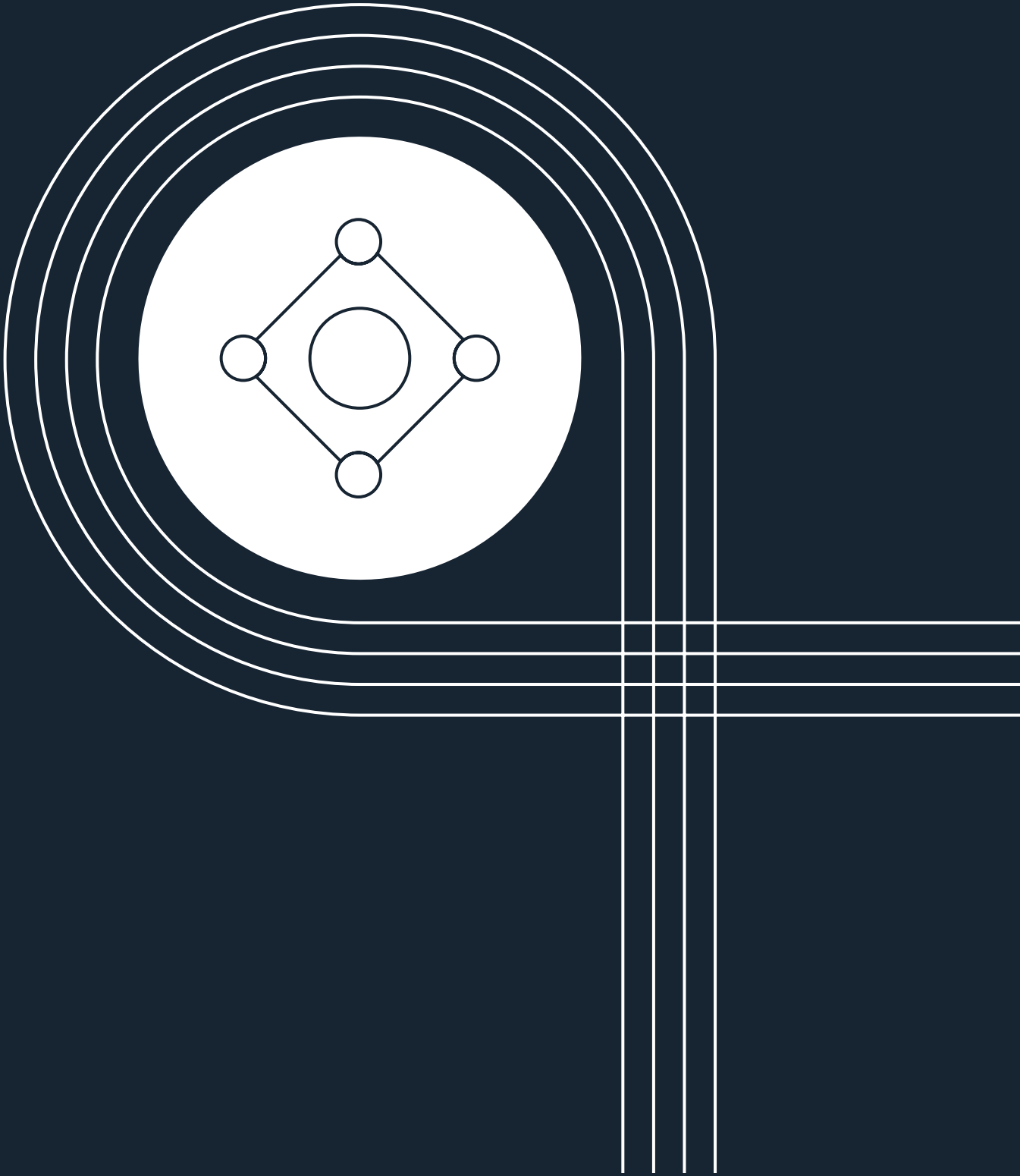
Panel members will play a key role in the future operations of the DSS, including assisting in its supervisory functions. Codes of Practice and terms and conditions will define the role and responsibilities of the different types of panel members.

During 2020, the DSS actively engaged with the relevant departments on the terms and conditions for panel members. In addition, there has been ongoing engagement with the Courts Service to establish processes relating to requests for panel members and the notification of court orders (court friends and decision-making representatives).

DSS website

The new DSS website www.decisionsupportservice.ie was launched in 2020, meeting an important statutory obligation under Section 95(1)(j) of the 2015 Act.

The website is a key tool for promoting understanding and awareness of the changes brought about by the 2015 Act, as well as for engaging with future DSS users.



Governance

Corporate Governance within the MHC

The MHC is committed to attaining and maintaining 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 requirements and guidance documents. The 2016 Code was updated in November 2017 with a Guide for Annual Financial Statements and in September 2020 with an Annex on Gender Balance, Diversity and Inclusion.

The MHC has procedures in place to ensure compliance with the provisions of the Code. All reporting requirements for 2020 have been met.

As required under the 2016 Code, the MHC has a formal schedule of matters specifically reserved for its decision to ensure the direction and control of the MHC. These reserved functions include planning and performance functions, MHC committees, financial transactions, internal controls and risk management. The reserved functions are reviewed by the MHC every second year. In addition to this, the MHC also has a Scheme of Delegation in place to ensure that the organisation can carry out all of its statutory functions effectively and that senior management are confident that they have the delegated authority to carry out their statutory functions and make decisions.

Key Governance Activities in line with the requirements of the Code undertaken during 2020

Board effectiveness

In line with good governance, the MHC undertook a self-assessment survey for 2020. This was considered by the MHC Members at a meeting in February 2021. In addition to this, in November 2019, consistent with governance best practice and the requirements of the the 2016 Code, the MHC engaged external providers to independently conduct a Board effectiveness review and to report on its findings and recommendations. This report was presented at the MHC meeting in April 2020. A set of actions arising from the report was agreed to be taken forward with a view to further improving the effectiveness of the MHC and its committees. The MHC has taken ownership of these actions, which have been monitored and updated throughout 2020.

The Finance, Audit and Risk Committee (FARC) and the Legislation Committee also undertook self-assessments for 2020.¹⁷

Gender balance in the MHC membership

As at 31 December 2020, the MHC had 4 (30%) female and 7 (54%) male members, with 2 (16%) positions vacant. Therefore, the MHC does not meet the Government target of a minimum of 40% representation of each gender in the membership of State Boards. However, the MHC does meet the statutory requirements set out in the Mental Health Acts 2001-2018. In order to address and improve gender balance on the Board, the Chair of the MHC provided details of the current gender balance of the MHC to the Minister of State for Mental Health and Older People, who is responsible for appointing the MHC Members¹⁸.

Code of Conduct, Ethics in Public Office, Additional disclosures of interest by board members and protected disclosures

For the year end 31 December 2020, the MHC confirms that a code of conduct was in place and adhered to. Furthermore, all MHC Members and relevant staff members complied in full with their statutory responsibilities under the Ethics in Public Office legislation.

Committees

The Legislation Committee met six times in 2020. The focus of its work was the MHC's review of the Heads of Bill to amend the Mental Health Acts 2001-2018 as received from the Department of Health (DOH) in 2020. A comprehensive submission was made to the DOH in March 2020 followed by a separate submission in June 2020 on the proposed new Part to the Act relating to children. The Committee also met later in the year to address queries raised by the DOH in relation to its submissions. The Legislation Committee provided reports to the MHC following all of its scheduled meetings.

The FARC held four meetings in 2020 and its Annual Report was provided to the MHC in March 2021. The report considered the following:

1. Stakeholder Relationships
2. External Audit (C&AG)
3. Annual Financial Statements for 2019
4. Internal Audit – There were 3 internal audits completed with their reports approved by the FARC in 2020 as follows:
 - i. Report on the Review and Effectiveness of Internal Financial Controls
 - ii. Review of Risk Management Processes
 - iii. Review of Resource Planning and Deployment Processes

¹⁷ The details of the self-assessment were discussed by the FARC at its meeting in March 2021 and by the Legislation Committee at its meeting in January 2021.

¹⁸ In February 2021, two new MHC members were appointed. As a result of this recent appointment, the MHC now has 5 (38%) female and 8 (62%) male members.

Two further audits were done in 2020 with those reports being considered by the FARC at its first meeting in 2021:

- i. Procurement Review
- ii. Review of Internal Financial Controls

5. Management Accounts and Budget for 2020
6. Risk Management
7. Governance and Internal Control/Internal Financial Control with additional assurances and provisions having been put in place
8. Protected Disclosures
9. FARC Performance Management

Risk management

The effective management of organisational risk requires robust internal control processes to be in place to support the senior leadership team in achieving the MHC's objectives and in ensuring the efficiency and effectiveness of operations.

In carrying out its risk management responsibilities in 2020, the MHC adhered to three main principles of governance:

1. Openness
2. Integrity
3. Accountability

A significant part of the work programme of the FARC is the oversight role it plays in the risk management process for the organisation. The risk environment and the updating of the corporate risk register is considered quarterly by the senior leadership team and the FARC reviews the risk register presented by management at each of its meetings and reports its findings to the MHC. Risk is a standing item on the agenda for each MHC meeting and the Chief Risk Officer reports on any significant events affecting the working environment of the MHC at each meeting.

Relations with Oireachtas, Minister and Department of Health

Governance meetings with officials from the Department of Health and the Executive took place in May, July, October and December 2020. Oversight and Performance Delivery Agreements were signed for 2020. The MHC met with the officials from the Department of Children, Equality, Disability, Integration and Youth (the new parent department for the Decision Support Service) in relation to the governance mechanisms required to be put in place once the Decision Support Service commences operations.

The MHC had no legal disputes with any other State agency or Government body save in its role as a regulator of approved centres.

Energy reporting

In 2020, the MHC consumed 143,416kWh of energy, consisting of 63,348kWh of Electricity and 80,068kWh of Gas. Our EnPI (Energy Performance Indicator) was 52.1% better than 2019.

As per Government advice in relation to COVID-19, the majority of staff in the MHC have been working remotely, contributing to the reduction in our energy consumption in 2020.

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

For the year ended 31 December 2020, the MHC had procedures in place for the making of protected disclosures in accordance with the relevant legislative requirements. No protected disclosures were reported to the MHC during 2020.

Maastricht Returns

In 2020, the MHC 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 MHC is not a "relevant service" as defined in the 2015 Act. However, the MHC may still employ "mandated persons" as defined in the 2015 Act. A register of mandated persons within the MHC is maintained and was updated during 2020. The MHC's Policy for Reporting of Child Protection and Welfare Concerns has been in place since January 2018. No events were reported to the MHC during 2020.

Business & financial reporting

The Department of Health's total allocation to the MHC for 2020 was €14.832m. The outturn for 2020 in the MHC was €13.8m. Due to COVID-19 there were cost savings related to general expenses and a reduction in travel and subsistence claims for Mental Health Tribunals as tribunal hearings were held remotely.

The MHC received an additional €0.034m from the Department of Health as a Capital grant to fund the purchase of new ICT equipment mainly to ensure that staff could work remotely.

The Department of Justice and Equality's allocation for the Decision Support Service establishment programme for 2020 was €3.5 million. From October 2020, funding was transferred to the Department of Children, Equality, Disability, Integration and Youth. In 2020, €3.26 million was drawn down by the Decision Support Service (€1.8 million from the Department of Justice and €1.46 million from the Department of Children, Equality, Disability, Integration and Youth).

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 MHC can confirm that all appropriate procedures for financial reporting, internal audit and asset disposals were adhered to. Furthermore, the MHC can confirm that it adhered to the Public Spending Code and the Government travel policy requirements. The MHC did not make any payments in relation to non-salary related fees.

The MHC approved the draft unaudited Financial Statements and agreed that they are a true and fair view of the MHC's financial performance and position at year end.

The MHC 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 2020. The onset of the COVID-19 pandemic in early 2020, and the resulting public health advice and safety measures, rapidly and fundamentally changed the working practices of the MHC with remote and virtual working becoming the norm for most MHC staff. The MHC has monitored the developments closely, looking to mitigate the risks that may affect the MHC's business operations, staff and stakeholders. Actions taken by the MHC early in the pandemic ensured that all statutory functions continued to be delivered throughout 2020.

The unaudited annual financial statements for 2020 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 2020 annual audited financial statements of the MHC will be published on the website as soon as they are available.

Prompt Payment of Account legislation

The MHC complied with the requirements of the Prompt Payment of Accounts legislation and paid 99.88% 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 website.



Information Management Technology (ICT)

The key focus for ICT within the MHC is to provide a resilient framework of information services to support all aspects of the MHC's business. This includes the implementation and configuration of corporate IT systems, as well as supporting the underlying technology. During 2020, the MHC upgraded its ICT infrastructure including servers and laptops to support remote working. All laptops are running the latest operating system. Penetration testing was conducted on firewalls and applications.

In 2020, the MHC moved to Microsoft 365 in line with the DPER guidance on cloud services. The Comprehensive Information System (CIS) was completed for Mental Health Tribunals and it now serves all the divisions which were within scope.

Procurement commenced for the provision of a new storage area network and host servers. These are scheduled for completion in 2021.

Stakeholder engagement

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

The vision for communications is that the MHC 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.

To that end, we planned in 2020 to host several town hall events across the country to inform about the MHC's remit and to hear from members of the public, their views, and experiences of mental health services. Our first town hall event was held in Wexford in February 2020. With the onset of the pandemic and lockdown in March 2020, unfortunately we hosted only one of these events.

The pandemic accelerated a need for our stakeholder engagement to move into the digital sphere. In January 2020, we launched a Twitter account for the MHC. We used videos to accompany the launch of many of our reports which outlined the major findings in an accessible format.

After initiating the project to develop a website for the Decision Support Service in 2019, the website www.decisionsupportservice.ie was launched in the summer of 2020. It was designed with involvement from service users and with accessibility at the centre of the site's design and development.

After the successful launch of the DSS website, the focus moved towards redesigning the website for the MHC, ensuring it was more accessible. By the end of 2020, the process of migrating content to the new site had begun, with a view to launching by the end of the first quarter of 2021.

The communications team facilitated stakeholder engagement at Commission meetings with presentations made by Cairde, the Irish Hospice Foundation - an important DSS stakeholder - and Pavee Point, who gave a presentation on mental health in the Travelling community.

The year of 2020 was defined by COVID-19 and at the height of the crisis we tried as much as possible to keep our stakeholders and the public informed of the situation within mental health services.

In 2021, the communications team will continue to promote the work of the MHC and the DSS, and work to engage with key stakeholders on all issues that concern or relate to mental health and decision support services.

Human resources

Our people are our greatest resource. The Human Resources function plays a significant role in developing positive business culture and improving employee engagement and productivity. Treating our employees fairly and providing them with opportunities to grow assists the MHC to achieve its mission, business objectives and strategy.

Traditionally, HR in the MHC focused on recruitment, resignations and pay reviews. However, the function now covers a much wider remit, including, but not limited to, the following duties:

- Long term strategies for staff growth and development
- Recruitment - a total headcount of 67 as of 31 December 2020. Turnover rate for the year in total was 10%, with a total of seven leavers throughout the course of 2020
- Inductions and exit interviews carried out
- Oversee completion of Performance Management and Development System (PMDS)
- Prepare and process bi-weekly payroll
- Administration of pension queries - current and historical
- Employee benefits
- Monitoring and compliance of HR legislative requirements
- Training and development
- Policy & procedure development and review
- Employee wellness

- Statutory reporting for several agencies such as, Central Statistics Office Reports, National Disability Authority, Department of Health and the Department of Public Expenditure and Reform
- Employment advice

Performance management

The Performance Management and Development System (PMDS) was successfully carried out in 2020 for all eligible employees and HR assisted with moving the performance reviews to a virtual setting during the COVID-19 pandemic. This system continues to strengthen in 2021 with the planned delivery of PMDS training for all people managers. This training will focus on upskilling people managers to spot opportunities for development when giving performance evaluations.

Employee wellness

2020 saw the continued growth of the MHCs wellness programme WorkWell. Since the COVID-19 pandemic, WorkWell has been adapted to the remote working environment and a key aspect of WorkWell 2020 was to remain oriented and further embed ourselves within the needs of our current diverse employee base. A key driver for WorkWell 2020 was addressing several of the results from the General Staff Survey 2019 and tailoring the wellbeing facets to the feedback from the HR Schedule of Events 2019 survey. As a result of this feedback, many initiatives were delivered in 2020.

These include:

- Fika friday
- Pilates
- Step challenge
- Food sharing
- Easter chocolate appeal
- MHC cookbook
- Lunchtime yoga
- Remote walking group
- Mindfulness moment
- Workwell remote survey
- Wildflower gift
- Evening relaxation session
- Resilience seminar
- Mental Health Ireland workshop
- Book club
- Christmas tips and tricks

As the 'WorkWell' programme continues to develop, we will continue to use wellbeing research to provide the overarching structure to the initiative. The MHC has joined a wellness network with other departments and agencies that will share and collaborate on wellbeing initiatives and recommendations. An employee wellness survey will continue to drive the intention of the WorkWell programme to ensure we are meeting the current and changing staff wellbeing needs. This will result in the organisation benefitting from the application of a successful and supportive wellness programme that has employee mental health and wellbeing at the forefront.

Employee Assistance Service

The MHC'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. This service is accessible 24 hours a day, 7 days a week, 365 days a year.

Remote working

The COVID-19 pandemic saw all employees being transitioned over to a remote working arrangement.

Throughout the pandemic, the MHC has continued to follow Department of Health guidelines on safe working arrangements. A COVID-19 response team was established in 2020 and has been responsible for overseeing the supply of equipment to employees, working closely with IT and the Health and Safety Officer to ensure all possible safety measures are in place.

Payroll & Pension

2020 was a successful year for payroll despite the pandemic and remote working arrangements impacting other areas of work practices. All 26 pay runs were executed on time without any delay.

In 2020, there were two circulars issued from the Department of Public Expenditure and Reform that affected employees' salaries. The January circular saw a 0.5% increase apply to certain salary bands with an October circular providing a 2% increase. Both increases were applied successfully and on time to every applicable employees' pay cycle.

Supports for Employees with Disabilities

The HR team provides an Access Officer to ensure that the MHC provides a progressive working environment and, in line with equality legislation, promotes equality of opportunity for all employees. The Access Officer ensures the safety, health and welfare of people who may be members of such groups. The MHC takes into consideration the recommendations of the National Disability Authority (NDA) in ensuring the recruitment strategy; orientation/integration in the workplace; professional progression; workplace accommodation/equipment and health, safety, and welfare at work for people with disabilities.

The 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.

HR is responsible for the statutory reporting, both quantitatively and narratively to the NDA. In 2020, through the response of the NDA staff census returns, the MHC reported a rate of 5.48% of their employee base as having a disability.

Training and development

2020 saw a high number of training activities delivered that provided upskilling, confidence and competence in job roles and work practices.

Recruitment

Following receipt of sanction from both the Department of Health and the Department of Justice and Equality, the MHC's recruitment drive saw the engagement of 11 new permanent employees and 10 temporary employees in 2020.

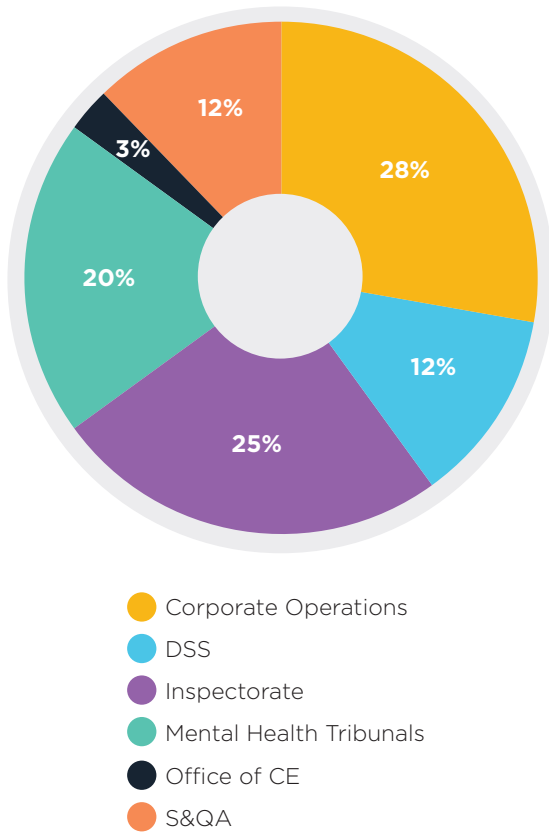
Leavers

HR continue to conduct exit interviews when employees leave the MHC to get a deeper look at the workplace culture, reasons for leaving and to access the overall employee experience.

Joiners

A comprehensive induction programme was conducted for all new employees of the MHC in 2020 and was delivered remotely to accommodate staff working remotely during the pandemic.

Figure 1: Headcount as at 31 December 2020



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 MHC 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 MHC - including issues pertaining to Data Protection and Freedom of Information.

Requests

In 2020, seven Data Subject Access Requests were made under data protection legislation. At year end, no cases remained open.

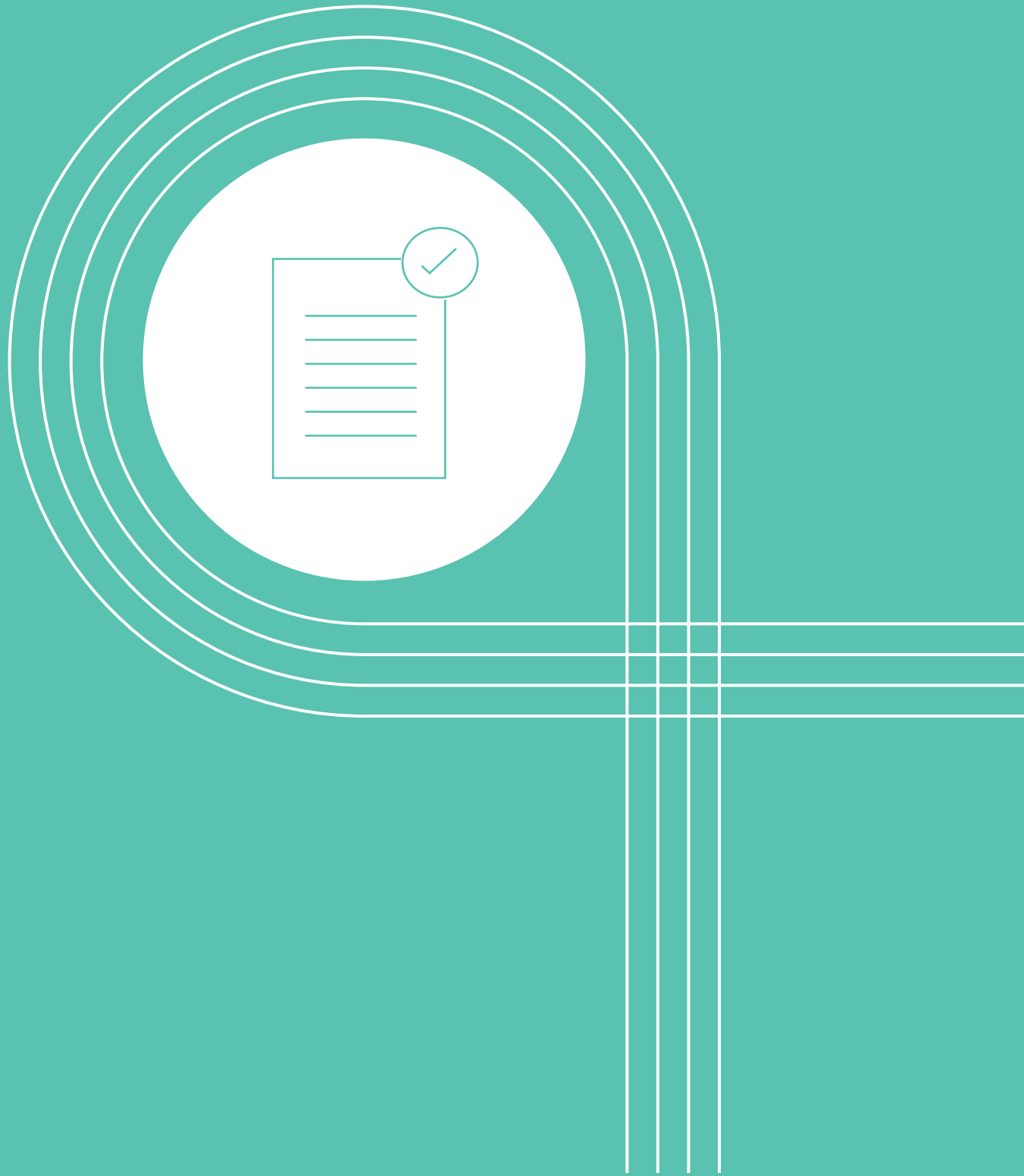
Freedom of information

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

Requests

In 2020, the MHC received 23 requests under the Freedom of Information Act 2014 with no requests carried over from 2019. Of the 23 requests, 12 were granted, one was part-granted, two were withdrawn, none were transferred and seven were refused. At year end, one case 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 MHC's delivery on, and commitment to, its strategic objective to uphold human rights.



Appendices

Appendix 1 – MHC Membership and Meeting Attendance 2020

No	Name	30/01	20/02	21/02	06/03	26/03 ¹⁹	16/04	21/05	18/06	30/06 ²⁰	16/07	17/09	15/10	19/11	17/12	Total
1	John Saunders	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	14/14
2	Colette Nolan	N	Y	Y	Y	N	Y	Y	N	N	Y	N	N	N	N	6/14
3	Dr Margo Wrigley	Y	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	11/14
4	Dr Michael Drumm	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	14/14
5	Ned Kelly	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	13/14
6	Tómas Murphy	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	12/14
7	Nicola Byrne	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	14/14
8	Patrick Lynch	Y	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	12/14
9	Rowena Mulcahy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	14/14
10	Jack Nagle	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	13/14
11	Dr John Hillery ²¹	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Y	Y	2/2
12	Dr Xavier Flanagan ²²	Y	Y	N	Y	Y	Y	Y	Y	N	Y	n/a	n/a	n/a	n/a	8/10
13	Aaron Galbraith ²³	N	N	N	N	N	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0/5

Appendix 2 – Finance, Audit and Risk Committee Membership and Meeting Attendance 2020²⁴

Name	06/03/20	24/06/20	25/09/20	27/11/20	Total
Patrick Lynch (Chair) (CM)	Y	Y	Y	Y	4/4
Nicola Byrne (CM)	Y	Y	Y	Y	4/4
Tomas Murphy (CM)	Y	Y	Y	Y	4/4
Ciara Lynch (EM)	Y	Y	Y	Y	4/4
Kevin Roantree (EM) ²⁵	n/a	n/a	Y	Y	2/2
Richard O'Farrell (EM) ²⁶	n/a	n/a	Y	Y	2/2
Mairead Dolan (EM)	Y	Y	Y	Y	4/4
Moling Ryan (EM) ²⁷	Y	n/a	n/a	n/a	1/1

19 Additional Meeting held in 2020.

20 Additional Meeting held in 2020.

21 Dr John Hillery was appointed in November 2020.

22 Dr Xavier Flanagan resigned in July 2020.

23 Aaron Galbraith resigned in April 2020.

24 CM = MHC Member and EM = External Member.

25 Appointed June 2020.

26 Appointed June 2020.

27 Resigned June 2020.

Appendix 3 – Legislation Committee Membership and Meeting Attendance 2020

Name	07/01/20	07/02/20	12/05/20	18/05/20	14/09/20	12/10/20	Total
Rowena Mulcahy (Chair) (CM)	Y	Y	Y	Y	Y	Y	6/6
Ned Kelly (CM)	Y	Y	Y	Y	Y	Y	6/6
Michael Drumm (CM)	Y	Y	Y	Y	Y	Y	6/6
Teresa Blake (EM)	Y	Y	Y	Y	Y	Y	6/6
Mary Donnelly (EM) ²⁸	Y	N	Y	Y	Y	Y	5/6

28 M Donnelly provided written comments to the Committee in relation to the matter discussed at the meeting which she could not attend.

Appendix 4 – Review of the Heads of Bill to amend the Mental Health Act 2001-2018 (the 2001 Act)

The MHC was provided with an opportunity by the Department of Health (DOH) to provide input into the Heads of Bill to amend the 2001 Act. It is an opportunity, which the MHC took very seriously, given the importance of its functions under the 2001 Act, its Strategic Plan for 2019-2022 and the changing face of mental health in Ireland today.

The Heads of Bill (Heads) were provided to the MHC in July 2019 (save for section 25 of the 2001 Act, which was provided in August 2019). On receipt of the Heads, the MHC established an Executive Working Group (WG), the Terms of Reference for which were approved by the Senior Leadership Team and the MHC in July 2019. There then followed a series of meetings of the WG in relation to each Part of the Heads. The WG then arranged for separate meetings with the MHC's Legislation Committee (LC) in relation to each Part of the Heads. The LC then reviewed each Part with the WG and further to amendments being made the Submissions were presented to the Commission for review, comment and approval. The first Submission was made to the DOH in March 2020 and the second Submission relating to the new Part for Children was made in June 2020. The MHC has liaised with the DOH since then on various queries that have arisen.

The MHC took a practical person-centred approach when reviewing the Heads, which will apply to mental health services and its users for some time into the future. The MHC also recommended that its oversight role be increased across the mental health services

The review was an extensive piece of work. Therefore, we have set out below a few of the key Recommendations made by the MHC.

1. Extending the remit of the MHC's Regulatory Function

Of note is that the regulatory aspect of the MHC's role received very little consideration by the Expert Review Group who presented their final report in December 2014. The MHC sought to address that in its March 2020 Submission.

The amendments proposed are in accordance with the MHC's Strategic Plan 2019-2022, in particular, that all mental health services in the State should be regulated by the MHC. This is required for a variety of reasons but primarily to ensure:

1. Appropriate services are being provided at all levels of mental health services,
2. Best practice is being applied in all areas of mental health services, and
3. Standardisation and parity of health services for all users.

The MHC recommended that mental health services be divided into three categories for the purposes of regulation, with different commencement dates in order that the change in the regulatory system can be done on a phased basis. The three categories are as follows:

1. **Approved inpatient facility**, currently approved centres with some minor proposed changes to the regulatory process which exists,
2. **Approved community residence**, which are similar to nursing homes. The DOH has indicated its support for the full regulation of these services, and
3. **Approved community mental health services**, this includes all community services/all services other than 1 and 2 above, referred to in A Vision for Change, provided by mental health teams working in the community.

2. Guiding Principles

Currently, the principle of best interests (section 4 of the 2001 Act) applies to all decisions concerning care and treatment under the 2001 Act. This principle has been deemed to be overly paternalistic and is to be replaced by the concept of guiding principles.

The concept of guiding principles was introduced in the Assisted Decision-Making Capacity Act 2015 (the 2015 Act) from the relevant European Conventions. However, the 2015 Act differs in terms of its functions to those in the 2001 Act, therefore the guiding principles in the Heads needed to be amended to address the services and persons to which it will relate.

While the MHC welcomed the intention of the Mental Health (Amendment) Act 2018 (passed but not commenced), the MHC does not believe that it will work in practice. Therefore, the MHC undertook a significant amount of work in draft guiding principles which could operate in practice for all the relevant stakeholders. It is recommended that the revised guiding principles shall relate to those with capacity - be they voluntary or involuntary - and that if a person does not have capacity that the guiding principles in the 2015 Act shall apply.

In order for the guiding principles to be fully implemented, various consequential amendments require to be made in the legislation.

Of importance, is that the guiding principles must be understood by persons using the mental health services. Currently, they are very legalistic, and it may be difficult for the ordinary person to decipher. The MHC appreciates the constraints in drafting legislation but would propose that a Guide or Code would be issued to assist all those using the mental health services.

3. Involuntary detention

There are a few points of note:

- **Criteria for detention:** There are two key departures – firstly, the phrase mental disorder will no longer be used and secondly, a person will no longer be involuntarily detained solely on the ground of “risk”. Furthermore, it is proposed that an express provision be inserted into the Act that a person cannot be detained in an approved centre just because it is a safe environment.
- **Authorised Officer:** The MHC welcomed the expansion of this role and recommended that there be specific eligibility criteria for those who can be authorised officers, all of whom should undergo specialised training.
- **Admission via the Gardaí:** The MHC recommended some significant changes with the result that no applications for admission should be made by the Gardaí, instead, if someone is taken into custody the Gardaí should be required to contact an authorised officer. Furthermore, the MHC recommended very specific and reduced time periods be inserted into the Act with regard to the length of time a person should be in the custody of Gardaí.
- **Assisted Admissions:** The MHC believes that there is a lack of oversight and governance in relation to this role and has made recommendations to address this.
- **Involuntary admissions:** The MHC has sought to strengthen the requirement, in that the consultant psychiatrist must not simply have to consult with another healthcare professional but the other healthcare professional shall carry out their own assessment, which shall be recorded in the person’s file and in the admission order, which shall be considered by the review board.
- **Transfers to Central Mental Hospital:** The MHC has been concerned about the delay in transferring persons from other approved inpatient facilities to the CMH. Therefore, it recommended that if a proposal to transfer is approved by a review board, and not successfully appealed by the person, that the transfer should occur within 3 months. The MHC believes that the failure to do so is having an adverse impact on the detained persons and local approved inpatient facilities. The MHC also recommended for the purpose of good governance, accountability and oversight requirements and in the interests of transparency, that the CMH should provide to the MHC (as the Regulator of such service) a report every 3 months, providing details of the status of the persons detained in the CMH under the 2001 Act and the status of all of the pending applications for transfer to the CMH.

4. Mental Health Tribunals (to be renamed review boards)

Some of the key recommendations are

- The patient should be free to decide whether to attend the review board or not and this should not be a matter for the RCP/review board to decide.
- An express obligation should be placed on approved inpatient facilities/review boards to facilitate the attendance of patients at review boards. This is covered in the current Regulations but in very broad terms.
- It was recommended by the Expert Review Group that decisions of the review boards be published. This issue has been repeatedly raised at seminars hosted by the MHC and others. The MHC has included a new subsection in the Heads to address this requirement. This provision will require additional resources and expenditure if it is to be fully implemented.

5. Consent/capacity to consent/where there is no capacity

This was a complex area and fundamental changes were recommended. Issues considered were the 2015 Act, the changes in the area of consent and the rights-based approach advocated by the UNCRPD/the EU Courts. It is important that there is clarity relating to the process and that the rights of the person are vindicated and respected at all stages. The proposed amendments shall require a major cultural change.

Of particular importance, the MHC recommended that a consultant psychiatrist cannot override the decision of a decision-making representative, attorney or designated healthcare representative where they have the relevant power to make a decision.

The MHC recommended that a new section be inserted to address life-saving treatment. This would align with general medical hospitals and other such facilities where life-saving treatment is required but consent cannot be obtained. The MHC acknowledges that there is no express legislative provision dealing with consent in general hospitals and that common law is applied.

6. Section 60 A – Bodily restraint and seclusion

The MHC has recommended there be a separate and distinct Part of the Act relating to restrictive practices separate to the Part relating to consent to treatment and medication. The MHC restrictive practices include – Seclusion, Physical restraint, Mechanical restraint and Chemical restraint. The MHC also recommended that there be separate Rules relating to each restrictive practice and the breach of each would be an offence subject to a fine or a conviction.

7. New Part relating to Children

The MHC welcomed the new Part dedicated to Children and made a number of recommendations:

- That each child should be appointed a legal representative from the beginning of an involuntary detention process to its conclusion. The MHC is of the view that this is the best way to ensure that the voice of the child is heard. The MHC could extend its legal aid scheme to deal with the appointment of such legal representatives. Such appointments would also provide continuity when a child turns 18 and is dealt with under the adult Parts of the Act.
- The MHC as the regulator of mental health services in Ireland is concerned about the lack of oversight it currently has in relation to section 25 applications. Therefore, the MHC recommended that if an application is made to involuntarily detain a child that notice of the application should be given to the MHC, together with copies of all orders made, and that the MHC would be entitled to make representations where it considers appropriate.
- The MHC notes that there was no dedicated expertise on child care law, child psychiatry or child mental health on the Expert Review Group and recommended that the DOH seek such expertise to ensure that the Heads are fit for purpose now and for the next 10/20 years.
- The MHC recommended that the new Part be a standalone Part not reliant on any of the provisions in the Child Care Acts. A number of the provisions of the Child Care Acts are not appropriate in relation to applications for the involuntary detention of children.
- The MHC recommended that the DOH needs to review each section and the position as it relates to those under 16 and then those aged 16 years and older and how the issues for each are required to be addressed. In addition, the DOH needs to consider the position of the parents in relation to children aged 16 years and older; how the parents can continue to be involved where the decision to consent or refuse treatment rests with the child.
- The MHC noted the importance of the provision of information to children and their parents and made a number of recommendations. Furthermore, the MHC believes that the provision of this information must be in a language and format which is easily understood by all.
- The MHC recommended the participation of the child in all proceedings. During the current health crisis, the courts started using video links to allow parties to participate in cases. The MHC is of the opinion that these learnings should be taken and adopted as part of future practice. Video links from approved inpatient facilities would be an excellent way of having a child participate in the proceeding while not having to attend court, which can be intimidating for a child. This would ensure that the voice of the child is heard.

Report of the Inspector of Mental Health Services



By Dr. Susan Finnerty,
Inspector of Mental
Health Services





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Who we are

The Inspector of Mental Health Services has a statutory role under the Mental Health Act 2001 and is appointed by the MHC to carry out inspections of mental health services nationally. The Inspector has a multi-disciplinary team of assistant inspectors, technical writers, a researcher, and administrative staff to assist in the inspections.

The Inspectorate is part of a wider Regulatory team whose functions include registration, inspection, enforcement, and monitoring.

What we do

The functions and duties of the Inspector of Mental Health Services are set out in sections 51 and 52 of the Mental Health Act 2001 ("the Act"). Inspections are carried out in approved centres to see if they are compliant with the Mental Health Act 2001 (Approved Centres) Regulations 2001 ("the Regulations"), Rules, Codes of Practice, and any other issues relating to the care and treatment of residents in the approved centres (these documents can be found on the MHC website: www.mhcirl.ie).

Approved centres are hospitals or other inpatient facilities for the care and treatment of people experiencing a mental illness or mental disorder and which are registered with the MHC.

The Inspector can also inspect any other mental health facility that is under the direction of a consultant psychiatrist. This includes community residences; however, as these are not regulated by the Act, the MHC has no enforcement powers with regard to these facilities.

The Inspector must also carry out a review of the mental health services in the State and give a report to the MHC. This national review must include:

- A report on the care and treatment given to people receiving mental health services.
- Anything that the Inspector has learned or discovered about approved centres or other mental health services.
- The degree to which approved centres are complying with codes of practice.
- Any other matter that the Inspector considers appropriate that have arisen from the review.

What we did in 2020

- We inspected all 66 approved centres under the regulations, rules, and codes of practice.
- We inspected four community residences that were staffed 24 hours a day.
- We carried out one focused inspection to follow-up where there were issues of concern.

- We published inspection reports for approved centres and community residences on the MHC website.
- We published a national review of Mental Health Services for Older People in Ireland.
- We carried out a national review of the premises where mental health services are delivered and published a report of the review.
- We met with service users and contacted peer advocacy representatives to get their perspective on mental health services.
- We received and followed up submitted issues of concern from service users, carers, mental health staff, and the general public.

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

COVID-19

During February and March 2020, COVID-19 emerged as the greatest public health crisis that Ireland has faced for over a century. Inpatient mental health services are high-risk settings in a pandemic as they are high contact, congregated environments where the majority of residents are over 60 and have a higher prevalence of underlying medical conditions. There were cases and suspected cases of COVID-19 in staff and residents of mental health facilities as well as other care homes and hospitals across the country. Mental healthcare providers and staff have had to balance the priority of reducing the risk of COVID-19 transmission in services with the importance of maintaining a focus on the needs and rights of individuals in their care.

Following the emergence of the pandemic, approved centres and community residents ceased visits from family and friends in an effort to control the spread of the virus. These measures had a huge impact on service users, with some residents confined to their rooms, social events and outings cancelled, and communal areas in the facility, such as dining rooms and sitting rooms, closed due to physical distancing. Limitations on social contact during lockdown increased loneliness and stress. Seeing others grow seriously ill from COVID-19 in the approved centres increased anxiety and worry. Relatives contacted us to say they worried about how their relatives were receiving care in inpatient facilities; how they would cope without the regular support of friends and family; or to express their distress or confusion about why their loved ones were confined to their rooms rather than being able to move around freely.

The speed and scale of the pandemic required mental health care providers to respond in novel ways. The pandemic accelerated the adoption of a number of innovations, such as therapy sessions moving to remote consultations; staff helping people to access family and friends by providing them with digital devices for video calling and contact; and clinical and management meetings being held online. However, many of these innovations excluded those without access to digital services, or who were unable or reluctant to use such technology. Arrangements and planning for those who are vulnerable to digital exclusion must not be overlooked in the rush to prioritise online options.

In April 2020, the Department of Health requested the MHC provide a risk assessment of COVID-19 in mental health services based on disease progression, environment, and staffing levels. Risks and concerns identified during monitoring were escalated to the HSE, seeking appropriate plans and mitigation or to the Department of Health, as appropriate. Further details are given in the following report, which can be accessed on the MHC website: *COVID-19 PAPER 1 Supervising, monitoring and supporting Irish residential mental health services during COVID-19* (mhcir.ie)

Following consultation with the Director of Public Health, inspections were suspended from March to July 2020. Inspections resumed under strict public health restrictions, which included spending shorter amounts of time in approved centre; limiting the number of inspectors on site; the wearing of PPE, maintaining social distancing; and using digital technology where possible, while ensuring that compliance with all regulations, rules, and codes of practice were assessed. All inspections from July 2020 were announced, which differed from preceding years where most inspections were unannounced.

We have consistently raised the inappropriate design of mental health facilities, including the ongoing use of shared bathrooms, and sleeping accommodation. These concerns were brought into sharp focus during the COVID-19 pandemic. As a result of this, there was a concerted effort by services to provide single room accommodation or to reduce the number of residents in each bedroom. This was achieved by re-purposing other rooms and reducing the number of residents in the approved centre. The opening of three modern approved centres with single en-suite bedrooms was expedited to replace outdated multi-bedroom units.

Some confusion about testing and re-testing for COVID-19 and regional variations in testing were noted. There were also some initial delays in obtaining adequate PPE for some approved centres.

Access to therapeutic services and programmes were initially restricted, but as the pandemic progressed, therapists and clinicians began to use virtual technology to maintain contact and provide therapies for their patients.

What we found during inspections:

Levels of compliance with regulations	Number of approved centres	Percentage of approved centres
100% compliance	14	21%
90-99% compliance	28	42%
80-89% compliance	12	18%
70-79% compliance	9	14%
Below 70% compliance	3	5%

We found areas of good practice:

- There was a significant improvements in monitoring of patients' physical health.
- Approved centres were compliant with COVID-19 restrictions and protocols.
- Staff were caring and professional, and quickly adapted to working in different ways to keep people safe during the pandemic.
- Hygiene in approved centres had improved in 2020.

We found areas that require improvement:

- That 47% approved centres had ligature anchor points that required urgent attention.
- That 41% of services did not develop comprehensive individual care plans with the residents in the approved centre.
- Some approved centre facilities were not suitable to provide a mental health service.

Year	2016	2017	2018	2019	2020
Average compliance with regulations	74%	76%	79%	78%	89%

It must be noted that the majority of inspections were announced in 2020 (as a result of restrictions relating to the COVID-19 pandemic), which was not the case in previous years. Twelve approved centres had an unannounced inspection prior to the onset of the pandemic, while the remaining 54 approved centres' inspections were announced. In addition, the inspection of some parts of regulatory requirements was not completed due to the impact of the pandemic on services' ability to comply; for example, staff training under Regulation 26 was not assessed.

Critical risks

Each non-compliance is risk rated as a low, moderate, high, or critical risk.

Critical risk means that there was a high likelihood of continued non-compliance and a high impact on the safety, rights, health, or wellbeing of residents.

In 2020, there were 23 non-compliances that received a critical risk rating. These included:

Therapeutic Services and Programmes	5
Premises	4
Privacy	3
Staffing	2
Maintenance of records	2
Seclusion	2
Admission, Transfer and Discharge	1

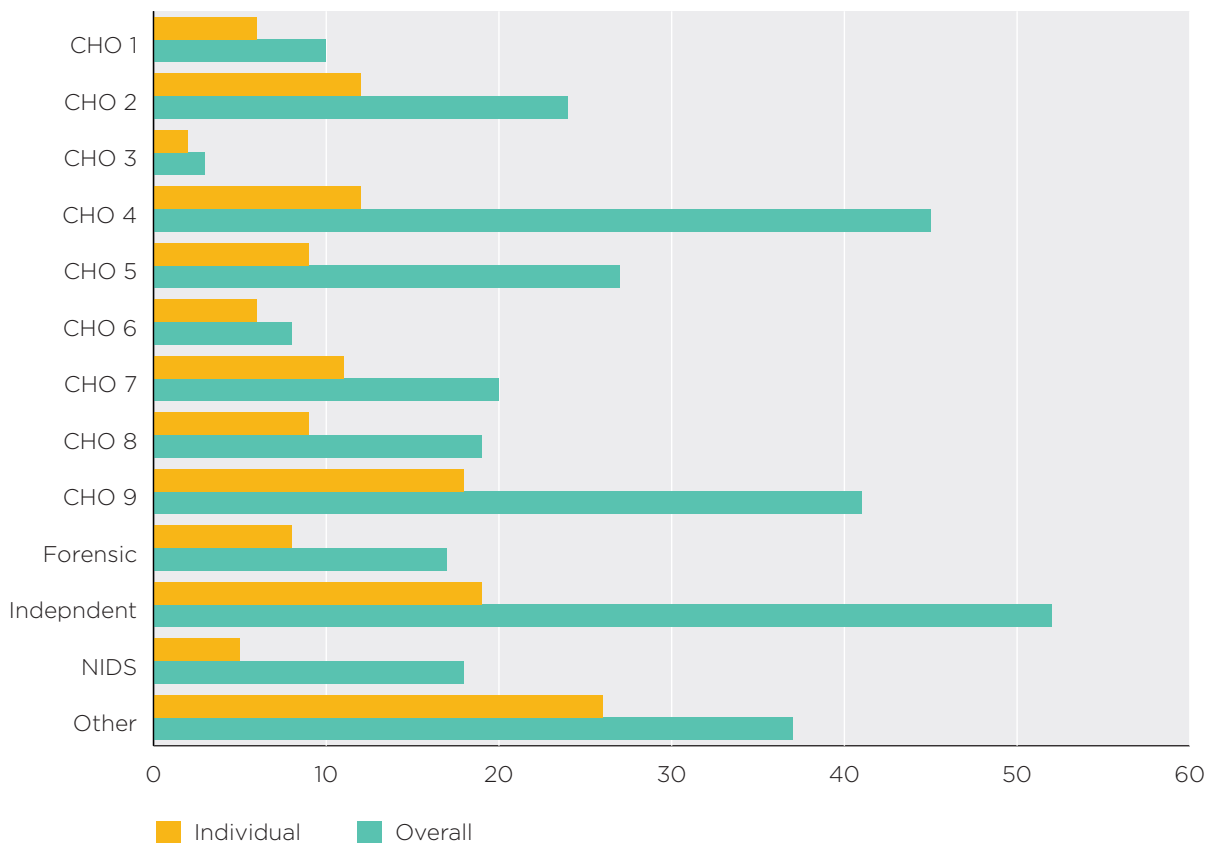
Other critical risks in non-compliance included: individual care plan (1); Consent to treatment (1); residents' personal property (1); and medication management (1).

Submitted issues of concern 2020

The MHC does not have the legal power to investigate complaints; however, if an issue of concern about a specific service is received by the MHC, it is directed to the Submitted Issues of Concern Committee, consisting of the Inspector of Mental Health Services, Director of Regulation, and an administration team. Each issue is considered and acted upon immediately and/or taken under consideration during the next inspection of that service. An issue of concern is a report from a member of the public and must relate to the health, wellbeing, or safety of a person in receipt of mental health services. The MHC provides direction on how best to get the support, advice or information required and may follow-up concerns with the appropriate mental health service.

The committee reviewed 321 individual concerns in 2020. These concerns pertained to 143 individuals.

Figure 1: Number of concerns - Per CHO



A Submitted Issue of Concern can have multiple themes.

Theme	Number
Related to the care and treatment of a resident	53
Related to the conditions in an approved centre	45
Related to doctors or nurses	28
Related to COVID-19	19
Related to a Mental Health Tribunal	15
Related to a community residence	11
Related to a housing issue	9
Related to children's access to services	9
Related to a GP	7
Related to a Freedom of Information request	3
Other issues	54

Other issues included access to computers, requests to change consultant psychiatrist, requests for information, lack of response to a complaint by the mental health service, and individual specific queries.

The MHC welcomes views and concerns from the public about the mental health services and we can be contacted through our website.

Regulations

Individual care plans

Everyone using mental health services has the right to a care plan that is personal to them. They also have the right to be involved in developing their care plan, to know what is in their care plan, and to be involved in reviewing their care plan. The Mental Health Act 2001 (Approved Centres) Regulations 2001 enshrine that right and compliance with the Regulations is inspected every year.

A care plan describes the care, treatment, and interventions that a person should receive, to ensure that they get the right care at the right time. It is a written record (either electronic or paper-based) of needs, goals, actions, and responsibilities, which can be used and understood by individuals receiving care, their relatives/carers, and others as appropriate. The care plan is based on a 'template' that defines the areas the care plan covers. Some templates are very simple and focus on the essentials of care, e.g. mobility and nutrition, while others can be very detailed.²⁹

Current NICE³⁰ guidelines state that "people using mental health services [should] develop a care plan with mental health and social care professionals, and [be] given a copy with an agreed date to review it." The Royal College of Psychiatrists in its Standards for Inpatient Units states that every patient must have a written care plan reflecting their individual needs, and that staff members actively seek to collaborate with patients and their carers (with patient consent) when developing the care plan. The care plan must clearly outline:

- 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.³¹

29 Mental Welfare Commission for Scotland. Person Centred Care Plans Good Practice Guide 2019

30 NICE. Service user experience in adult mental health services. Quality standard [QS14]. 2011. <https://www.nice.org.uk/guidance/qs14/chapter/quality-statement-8-care-planning>.

31 Standards for Inpatient Mental Health Services, Second edition, 2017 Royal College of Psychiatrists

On our inspections, we regularly find that the quality and level of participation by service users varies considerably, noting, in particular, the lack of engagement by mental health services with care planning as a meaningful process. It is a common finding in Ireland, but also in comparable jurisdictions, that care planning is seen as a bureaucratic and administratively burdensome process by mental healthcare professionals. It is important to note that the Regulations set a basic standard in relation to care planning. Regulation 15: Individual Care Plan requires that “each resident has an individual care plan”. This means that not only does every resident need to have a care plan in place, but that each care plan is assessed against nine separate elements (ten elements for children).³² Many mental health professionals struggle to develop comprehensive care plans for their patients through collaborative multi-disciplinary care planning and clearly need more guidance to achieve this. Some of the constraints and challenges in trying to develop and review individual care plans include a lack of resources, short ward stays, risk behaviours, limited capacity, and a focus on medical treatment.

The benefits of a care plan include:^{33 34 35}

- The identification of problems and setting of realistic goals which can then be worked towards and achieved.
- Service user and providers become more focused on the individual's needs.
- Service users become more involved in the care planning process, thus fostering a sense of commitment and responsibility in achieving their personal health and social goals.
- Continuity of care among the relevant disciplines becomes more streamlined.
- Better definition of roles and distribution of tasks among team members.
- The use of planned interactions to support evidence-based care.
- Providing clinical case management services for complex patients.
- Ensuring regular follow-up by the care team.

A care plan should:

- Incorporate examples of the individual's views, opinions, wants, and goals in terms of their care.
- Be driven by the individual's view of what improvement will look like.
- Be produced collaboratively but show clear separation regarding actions for professionals and the individual.
- Be produced in collaboration and with the contribution of other professionals.
- Contain carer views and their role and expectations in care delivery.
- Be accessible in a format that is meaningful to the person, e.g. use pictures where these would help understanding, increase size of font for those with poor vision; have two versions of the care plan, one for the formal record and another that is tailored for the individual's own use.
- Display a method of having the person sign/agree their care plan and indicators of ownership.
- Be accessible to other care providers and health care professionals.

*From Mental Welfare Commission for Scotland
Person Centred Care Plans*

An individual care plan should, at a minimum, consider:

- Finance and money
- Accommodation
- Personal care and physical wellbeing
- Psychological interventions
- Education and training
- Work and occupation
- Parenting or caring relationships
- Social, cultural, or spiritual beliefs
- Medical and other forms of treatment.

The Mental Health (Wales) Measure 2010

32 Individual care planning 2016-2018 in review MHC January 2020.

33 MHC Guidance Document on Individual Care Planning Mental Health Services 2012.

34 HSE Individual Care Plans, HSE.ie.

35 Care planning, involvement and person-centred care, Social Care Institute for Excellence.

In 2020, there was a marginal improvement in the compliance with Regulation 15: Individual Care Plans.

Year	2016	2017	2018	2019	2020
Compliance with Regulation 15: Individual Care Plans	36%	52%	58%	52%	59%

Reasons for non-compliance with Regulation 15 Individual care plans	Percentage of non-compliant centres
Lack of multidisciplinary input	71%
Lack of service user involvement	15%
Inappropriate or absence of goals	53%
No documentation of interventions	37%
No identification of resources required	39%
No individual care plan developed within 7 days of admission	11%

Most approved centres had more than one reason for non-compliance.

General health

People with a serious mental illness typically die 15-20 years earlier than someone without a mental illness and their physical illnesses are largely preventable and treatable. These illnesses include obesity, diabetes, cardiovascular disease, and lung disease. It is vital, therefore, that services encourage residents to adopt a healthy lifestyle and monitor and treat physical illness³⁶.

Regulation 19: General Health requires that approved centres monitor residents' physical health at least every six months. Best evidence shows that the following parameters should be checked:

Regulation 19: General Health
Family and personal medical history
Dietary intake
Activity level and exercise
Use of tobacco or other substances
Blood pressure
Weight, body mass index (BMI), waist circumference
Dental health
Blood glucose levels
Blood lipids
Prolactin, if indicated
Liver function tests
Electrocardiogram (ECG)
Examination of all body systems

Metabolic syndrome is a cluster of the most dangerous heart attack risk factors: diabetes and raised fasting glucose, abdominal obesity, abnormal blood lipids and high blood pressure. Patients with severe mental illness are at twice the risk of developing metabolic syndrome compared with the general population.³⁷ To prevent, monitor, and treat this condition, people on antipsychotic medications need regular monitoring of various parameters including waist circumference, body mass index (BMI), blood pressure, blood sugar, blood lipids, and electrocardiogram (ECG)³⁸.

In 2018, due to the concern at the lack of adherence to international guidelines and best practice in monitoring physical health of those with severe mental illness, the MHC issued guidance to approved centres as to what was required. Although improvement was slow initially, in 2020 there was an improvement in compliance with Regulation 19 and we found that services were increasingly using best practice guidelines in monitoring residents' physical health. However, it remains unacceptable that medical staff fail to adequately monitor the physical health of people with severe mental illness.

	2018	2019	2020
Regulation 19: General Health	42%	42%	65%

36 Physical Health of People with Severe Mental illness. Dr Susan Finnerty. Mental Health Commission MHC 2018 (mhcirl.ie).

37 Bressington DT et al. The prevalence of metabolic syndrome amongst patients with severe mental illness in the community in Hong Kong - a cross sectional study. BMC Psychiatry 13(2013) p 87.

38 Physical Health of People with Severe Mental Illness, Dr Susan Finnerty, Mental Health Commission MHC 2019.

Restrictive practices

Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient’s movement, liberty and/or freedom to act independently in order to: take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and end or reduce significantly the danger to the patient or others³⁹.

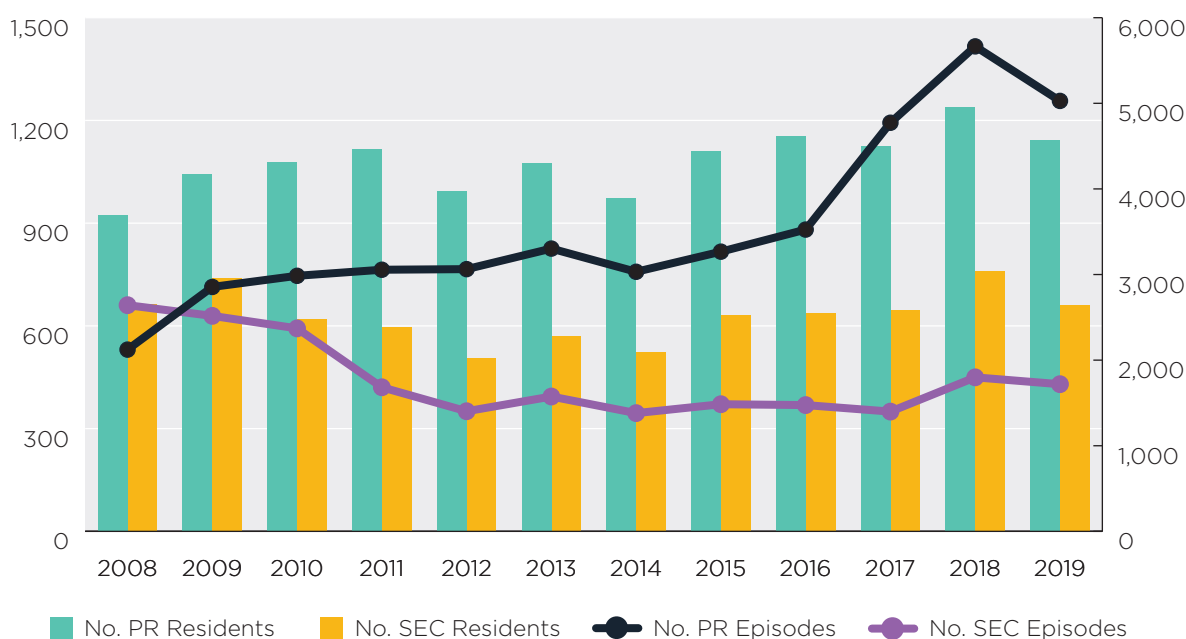
These measures limit several fundamental human rights, such as liberty of choice or movement, autonomy, and physical integrity. By definition, an intervention is legitimate only if a direct benefit for the patient is scientifically proven⁴⁰. However, little data exists on the real benefit of restrictive practices regarding efficiency, efficacy, or effectiveness. No controlled studies exist that evaluate the value of seclusion or restraint in those with serious mental illness and there are reports of serious adverse effects of these techniques in qualitative reviews⁴¹.

Reducing restrictive practices in mental health settings is an issue of national importance. Intervention that compromises a person’s liberty is very serious and should only ever be used as a last resort. We know that there is no evidence of a therapeutic benefit associated with the use of restrictive practices and there is also limited evidence of restrictive practices reducing violent and aggressive behaviours.

Compared to non-exposure, seclusion and restraint have harmful physical and psychological consequences for patients, including Post-Traumatic Stress Disorder (PTSD), revival of previous trauma, increased length of stay, hallucinations, and negative emotions, particularly feelings of punishment and distress^{42 43 44}.

There was a 19% reduction in physical restraint episodes between 2019 and 2020. However, there was a 7% increase in the use of seclusion in the same period.

Figure 2: Number of episodes of physical restraint; episodes of seclusion; residents physically restrained; and residents secluded, 2008-2019



Mental Health Commission MHC The use of Restrictive Practices in Approved Centres Activities report 2019

39 Mental Health Act (UK) Code of Practice 2015.

40 Gupta M. Ethics and evidence in psychiatric practice. *Perspect Biol Med* (2009) 52(2):276-88. doi: 10.1353/pbm.0.0081.

41 Sailas E, Fenton M. Seclusion and restraint for people with serious mental illnesses. *Cochrane Database Syst Rev* (2000) (2), CD001163. doi: 10.1002/14651858.CD001163.

42 Sagduyu K, Hornstra RK, Munro S, Bruce-Wolfe V. A comparison of the restraint and seclusion experiences of patients with schizophrenia or other psychotic disorders. *Mo Med* (1995) 92(6):303-7.

43 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.

44 Tooke SK, Brown JS. Perceptions of seclusion: comparing patient and staff reactions. *J Psychosoc Nurs Ment Health Serv* (1992) 30(8):23-6.

In 2014, the MHC published a *Seclusion and Restraint Reduction Strategy (MHC, 2014)*, for the purposes of achieving significant reductions in the use of seclusion and physical restraint, while also ensuring resident and staff safety. The National Institute for Clinical Excellence (NICE) have the following guidance:

- Use a restrictive intervention only if de-escalation and other preventive strategies, including p.r.n. [as required] medication, have failed and there is potential for harm to the service user or other people if no action is taken. Continue to attempt deescalation throughout a restrictive intervention.
- Do not use restrictive interventions to punish, inflict pain, suffering or humiliation, or establish dominance.
- Ensure that the techniques and methods used to restrict a service user:
 - Are proportionate to the risk and potential seriousness of harm.
 - Are the least restrictive option to meet the need.
 - Are used for no longer than necessary.
 - Take account of the service user's preferences, if known and it is possible to do so.
 - Take account of the service user's physical health, degree of frailty, and developmental age.

Violence and aggression: short-term management in mental health, health and community settings
NICE guideline [NG10] Published date: 28 May 2015

Seclusion

Seclusion is defined in the Rules as “the placing or leaving of a person in any room alone, at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving”⁴⁵.

Seclusion is in direct contradiction to the movement towards increased patient autonomy and choice, taking a ‘least restrictive’ approach, and recognising the importance of allowing patients to guide their own recovery⁴⁶. Bearing all this in mind, it may seem somewhat surprising that seclusion remains ethically justified as a part of everyday clinical practice⁴⁷.

A Cochrane review of seclusion and restraint was unable to find any controlled trials of seclusion in the 2,155 citations found by literature review and could not therefore find any evidence-based support for the benefits of secluding patients⁴⁸. A Cochrane review of containment strategies in psychiatric practice was also negative and could not find evidence to support their use. Both reviews caution against the use of seclusion on the basis of a lack of evidence⁴⁹.

Seclusion in Ireland is highly regulated under the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*. In 2020, 28 approved centres used seclusion and, of these, 61% were compliant with the Rules.

Mechanical restraint

Mechanical restraint is defined by the *Rules Governing the Use of Seclusion and Mechanical Restraint* as “the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a patient’s body”. These include arm and leg cuffs, mittens, and straps.

Since the commencement of the Mental Health Act in 2001, until 2020, there has been no report of the use of mechanical restraint under Part 4 of the Rules in any approved centre except the Central Mental Hospital, where handcuffs are sometimes used for the transportation of patients to and from the hospital.

45 Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint MHC.

46 Davidson, L (2005) Recovery, self management and the expert patient – changing the culture of mental health from a UK perspective. *Journal of Mental Health* 14: 25-35.

47 Newton-Howes, G. (2013). Use of seclusion for managing behavioural disturbance in patients. *Advances in Psychiatric Treatment*, 19(6), 422-428. doi:10.1192/apt.bp.112.011114.

48 Sailas E, Fenton M. Seclusion and restraint for people with serious mental illnesses. *Cochrane Database Syst Rev* (2000) (2), CD001163. doi: 10.1002/14651858.CD001163.

49 Muralidharan, S, Fenton, M (2006) Containment strategies for people with serious mental illness. *Cochrane Database of Systematic Reviews* 3: CD002084.

However, in 2020, there was prolonged mechanical restraint under Part 4 of the Rules of a young person over several months in an approved centre, with the use of arm and leg restraints, (using “soft cuffs”). This was to prevent staff from being harmed and to reduce frequent episodes of seclusion and physical restraint that the young person had undergone. The MHC expressed ongoing concern to the approved centre and HSE about the continued use of arm and leg restraints on a child and engaged an expert in Child and Adolescent Forensic Mental Health Services to review the case. The approved centre was subject to an annual inspection and a focused inspection to monitor the situation. The centre also had to submit daily reports to the MHC about the length and frequency of mechanical restraint, as well as other records. On inspection, the centre was found to be non-compliant with the *Rules Governing the Use of Mechanical Restraint*.

The National Institute of Health and Care Excellence (NICE) state the following: *Do not use mechanical restraint in children. Healthcare provider organisations should ensure that, except when transferring young people between medium- and high-secure settings (as described below), mechanical restraint in young people is used only in high-secure settings (on those occasions when young people are being treated in adult high-secure settings),and with support and agreement from a multidisciplinary team that includes a consultant psychiatrist in child and adolescent mental health services*⁵⁰.

The UK guidelines *Reducing the Need for Restraint and Restrictive Intervention* clearly states that “every child and young person has a right to be treated with respect and dignity, and deserves to have their needs recognised and be given the right support” and that “restrictive intervention should only be used when absolutely necessary, in accordance with the law and clear ethical values and principles which respect the rights and dignity of children and young people, and in proportion to the risks involved. It can never be a long-term solution”⁵¹.

Some children and young people with mental health difficulties may react to distressing or confusing situations by displaying behaviours which may be harmful to themselves and others, and they are at heightened risk of restrictive intervention to minimise the impact of their behaviour on them and on other people. Children and young people, their families, and carers have said that restraint and restrictive intervention are traumatising. The personal costs to children and young people’s development and welfare and to staff from the use of restraint are well documented⁵².

Using positive behaviour support and other alternatives, which can de-escalate challenging behaviour and tackle the reasons for it at source, should be the preferred approach. Mechanical restraint should be avoided wherever possible, and proactive, preventative, non-restrictive approaches adopted in respect of behaviour that challenges.⁵³

The Inspector is seriously concerned about the introduction of mechanical restraint (Part 4) as a restrictive practice in Ireland’s mental health services, and even more so that mechanical restraint was used to manage the behaviour of a young person. Mechanical restraint is traumatic, countertherapeutic, and dehumanising and has no place in a person-centred recovery focused mental health service, let alone in the care and treatment of a young person.

Physical restraint

Physical restraint is defined in the *Code of Practice on the Use of Physical Restraint in Approved Centres* as “the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident’s body when he or she poses an immediate threat of serious harm to self or others”.

The use of physical restraint varies between approved centres and CHOs/service providers. At a national level, physical restraint is used more frequently and widely than seclusion. The frequency of physical restraint use on admitted patients in mental health settings ranges from 3.8% to 51.3% worldwide. In Ireland, physical restraint was used in 89% of approved centres in 2019 and the rate of episodes of physical restraint was 105.6 per 100,000.⁵⁴ The frequency of use of physical restraint in mental health settings varies greatly in different approved centres.

50 Violence and aggression: short-term management in mental health, health and community settings (Managing violence and aggression in children and young people) NICE guideline [NG10] Published date: 28 May 2015

51 Reducing the Need for Restraint and Restrictive Intervention *Children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings* Published: 27 June 2019 HM Government (UK)

52 Nielson S et al. Physical restraint of children and adolescents in mental health inpatient services: A systematic review and narrative synthesis *Journal of Child Health Care* 2020

53 1 Children’s Views on Restraint, reported by the Children’s Rights Director for England (Ofsted, 2012); Mental health crisis care: Physical Restraint in Crisis (MIND, 2012). https://www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf

54 MHC. The use of restrictive practices in approved centres. Activity report 2019

Patients with mental illness may pose critical risks to themselves and others. Patients with severe mental disorders sometimes have a high level of agitation or aggression due to their illness. Healthcare staff generally apply alternative approaches, such as de-escalation techniques and crisis management, to alleviate critical risks posed by an acutely mentally ill patient. Nevertheless, physical restraint is implemented when alternatives fail to resolve the situation in order to prevent harm to the patient or others.

While it has been argued that restraint is necessary for patient and staff safety, its use has negative consequences. Patients and staff report feeling distressed, fearful, angry, anxious, and frustrated,⁵⁵ and that restraint is damaging to the therapeutic relationship, damaging to patient relationships with services, and incompatible with caring values⁵⁶. Being physically restrained by staff as a patient on a psychiatric ward is not only humiliating and distressing, it can also be dangerous – even life-threatening. However, there is tension in mental health care between this desire to reduce restraint and the need to provide and maintain a safe environment.

Restraint-related injury or harm

Psychosocial injury

- Including post-traumatic stress disorder and damage to therapeutic relationships.

Soft-Tissue injury

- Including injury to skin, muscles, ligaments, and tendons.

Articular or bony injury

- Including injury to joints and bones.

Respiratory restriction

- Including compromise to airway, bellows mechanism, and gaseous exchange, which results in respiratory crisis or failure.

Cardiovascular compromise

- Including compromise to the heart and the peripheral vascular system.

Under Regulation 26, all staff must be trained in prevention and management of violence and aggression, which must include training in holds and restraint positions to minimise injuries. Under no circumstances should staff take part in physically restraining a patient without this training.

55 approved centres used physical restraint and 76% of these were compliant with the *Code of Practice on the Use of Physical Restraint*.

Year	2016	2017	2018	2019	2020
Compliance with the Code of Practice on the Use of Physical Restraint	22%	31%	19%	50%	76%

As this code of practice is for guidance and cannot be enforced, the Inspector strongly recommends that the Mental Health Act provides for rules governing the use of physical restraint.

Overviews

Mental health services for older people

In 2020, we published a report about mental health services for older people (MHSOP) in Ireland⁵⁷. Approximately 15% of adults aged 60 and over suffer from a mental illness, including depression, dementia, anxiety, alcohol dependence, and schizophrenia. In this age group, physical illness is more common and includes heart disease, loss of mobility, lung disease, chronic pain, and frailty. Other considerations include lack of appropriate accommodation, loneliness, bereavement, and financial difficulties. It is, therefore, obvious that there must be an integration of all services for older people, i.e. alignment and collaboration between the care sectors. Currently, this integration varies widely across the country, resulting in the duplication of services and a lack of access to healthcare and support services.

Despite the increasing elderly population, we are currently not providing a nation-wide, comprehensive mental health service for older people. We have highly trained and committed specialist clinicians, yet we have only 66% of the recommended number of specialist teams, which themselves are only staffed at an overall level of 54%.

55 Bonner, G., Lowe, T., Rawcliffe, D. & Wellman, N. (2002). Trauma for all: A pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. *Journal of Psychiatric and Mental Health Nursing*, 9, 465-473.

56 Wynn, R. (2004). Psychiatric inpatients' experiences with restraint. *The Journal of Forensic Psychiatry & Psychology*, 15, 124-144.

57 Mental Health Services for Older People, Dr Susan Finnerty, MHC 2020 MHC (mhci.ie)

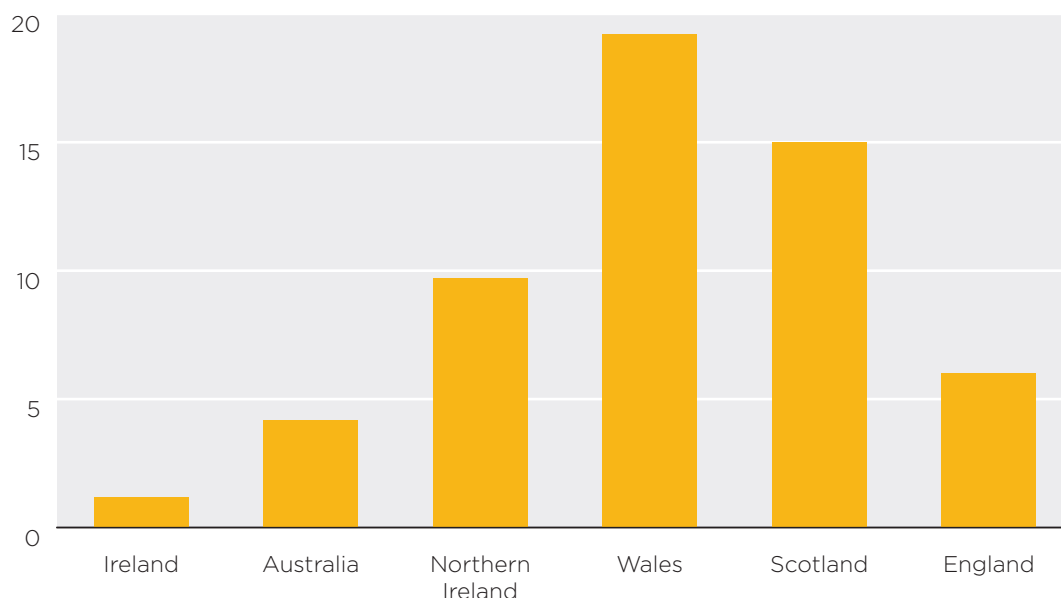
Community Healthcare Organisation	Percentage of recommended staffing of MHSOP teams
CHO 1	75%
CHO 2	73%
CHO 3	37%
CHO 4	31%
CHO 5	61%
CHO 6	51%
CHO 7	63%
CHO 8	52%
CHO 9	57%
Total	54%

Day hospitals assist in maintaining people living at home while providing assessment and treatment, but there are only 0.26 day hospital places per 10,000 population over 65. There is a lack of community supports, such as respite care and home care packages, which increases the probability of dependence on costly residential care.

There are 1.2 dedicated acute mental health beds for older people per 100,000, compared with 6 per 100,000 in England and 9.7 in Northern Ireland. The delivery of inpatient mental health care to older people in general adult mental health units, rather than in dedicated units, constitutes a risk to their safety and does not meet their therapeutic needs.

	Acute beds for older persons per 100,000 population	Source
England	6	NHS 2018
Scotland	15	Scottish inpatient census (2018)
Wales	19.2	Statistics Wales (2018)
Northern Ireland	9.7	Northern Ireland Department of Health (2018)
Australia	4.2	Australian Institute of Health and Welfare (2018)
Ireland	1.2	MHC (2019)

Figure 3: Acute beds for older persons per 100,000 population



The presence of mental illness in elderly general hospital admissions is common and includes depression, delirium, and dementia. Liaison psychiatry services in acute general hospitals are needed to address the mental health needs of people being treated primarily for physical health problems and symptoms. Apart from two areas in Dublin, there are no liaison teams and the needs of this population are met by already stretched community teams.

The COVID-19 pandemic presents further difficulties for the mental health of older people. In addition to carrying the highest mortality and morbidity risk from COVID-19, they also experience social distancing, isolation, and a heightened perception of the risk of death and illness. Isolation is strongly linked to depression, anxiety, and cognitive decline, and reduces resilience factors such as self-worth, sense of purpose, and feeling valued. Access to appropriate mental health services and other supports is essential. Given the congregate nature of inpatient and residential units, elderly residents are at high risk of being affected by respiratory pathogens like COVID-19. A strong infection prevention and control program is critical to protect both residents and healthcare personnel. Mental health services must endeavour to provide more single en-suite accommodation in residential and acute mental health care to prevent progression of the disease.

An effective mental health service for older people requires a managed network of services across a wide spectrum of care, with the exact components of the care pathway determined by need. Improved older people's mental health services will ensure that older people with mental health problems have their needs met so that their quality of life, choices, and independence are enhanced now and into the future.

Premises

In 2020, we completed a national review of the inpatient premises and looked at the reasons for non-compliance with Regulation 22: Premises⁵⁸.

Service users need spaces where they have privacy and areas where they can engage with staff, meet visitors, socialise with other service users, participate in leisure activities (watching TV, listening to music, and indoor games, for example), and develop a sense of community. Providing a safe and therapeutic environment for service users, staff and visitors is integral to the provision of clinical care. It is particularly important to consider the impact that ward size and layout, service user numbers, and population mix will have on the therapeutic environment and on safety.

Over many years, mental health inpatient units have struggled to comply with Regulation 22: Premises, achieving a maximum compliance level of 33% between 2017-2019. The reasons for non-compliance are varied but include the presence of ligature anchor points, lack of cleanliness, poor decorative and maintenance standards, poor ventilation, presence of hazards, and insufficient or unsuitable furniture.

	2017	2018	2019	2020
Non-compliant with Regulation 22: Premises	75%	67%	69%	45%

Reasons for non-compliance	2017 %	2018 %	2019 %	2020 %
Presence of ligature anchor points	67%	44%	38%	47%
Unclean premises	31%	30%	27%	17%
Lack of maintenance and decoration	54%	63%	47%	58%
No programme of maintenance	42%	49%	16%	11%
Lack of space for residents	19%	14%	13%	33%
No outdoor space	15%	5%	4%	4%
Poor ventilation	27%	37%	16%	19%
Insufficient or unsuitable furniture	21%	28%	16%	30%
Presence of hazards	13%	12%	16%	27%

The buildings of many mental health units are not appropriate for delivering mental health care. Many are converted from other healthcare buildings and are unsuitable as mental health facilities, with long corridors, poor lines of sight, cramped living and sleeping space, multi-occupancy bedrooms, and small sitting rooms. Many acute facilities have no dedicated beds for older people.

58 A report on Physical Environments in Mental Health Inpatient Units, Dr Susan Finnerty, MHC. (mhcir.ie)

Single bedrooms with private bathrooms may be the single most important design intervention for facilitating privacy and reducing crowding stress and aggression in inpatient psychiatric wards. Considerable research on apartments and correctional facilities has shown that the number of persons sharing a bedroom or cell reliably correlates with higher crowding stress, reduced privacy, more aggressive behaviour, illness complaints, and social withdrawal⁵⁹. Research on psychiatric inpatient wards suggests a strong association between multi-occupancy bedrooms and social withdrawal⁶⁰.

There is a limited supply of single, en-suite bedrooms in mental health inpatient facilities in Ireland. There are three acute mental health units that have all single, en-suite bedrooms. A further two acute mental health units have 75% and 92% single, en-suite accommodation respectively. In the inpatient mental health facilities that provide long term accommodation for mostly older persons, 32% provide exclusively single bedroom accommodation. One inpatient facility has a dormitory of nine beds.

There is a consensus view in Europe and North America that single rooms in hospitals are important in preventing and controlling healthcare associated infections. Single rooms facilitate family involvement in patient care and increase the opportunities for treatment at the bedside. They enable better bed management, abolish gender bed blocking, and lead to fewer patient transfers.

Maintaining a safe, clean and hygienic environment and minimizing microbial contamination of surfaces, items, and equipment within the health care environment is increasingly recognized as an essential approach to reducing the risk of health care-associated infections for all patients, residents, visitors, and staff within health care settings.

The COVID-19 pandemic has demonstrated that, in Ireland, some mental health buildings are not fit for purpose, both across the community and inpatient estate. Many buildings have been designed to address safety concerns, such as fire, self-harm, and violence, but not infection prevention and control. It is paramount that mental health services prevent transmission of the virus in inpatient settings. People who have a mental illness are also more likely to have poorer physical health than the general population, making them more susceptible to the virus.

It is important that the physical healthcare infrastructure is fit for purpose and provides adequate bed spacing, isolation, and single room capacity that minimises the spread of infections, including multidrug-resistant microorganisms. It is essential that the service complies with all aspects of maintaining cleanliness and safety of the physical environment in line with relevant legislation and best practice for the prevention and control of healthcare-associated infections.

It is encouraging to note that a small number of new mental health units opened in the last 4-5 years meet the requirements of the regulation and also have single en-suite bedrooms with plenty of space internally and externally. However, many unsuitable buildings remain which will require considerable funding to either replace or bring to an acceptable standard.

Conclusion

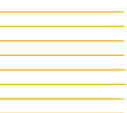
Overall compliance with Regulations, Rules, and Codes of Practice in approved centres continued to improve in 2020. In the majority of approved centres, staff are engaged with the regulatory processes and endeavoured to be compliant with the regulatory framework. This is encouraging and shows a willingness to strive for a quality service.

Many mental health facilities are ageing and have suffered from years of neglect and lack of funding. This has resulted in many mentally ill people living in or receiving treatment in unsuitable, run-down approved centres. We now find ourselves in the position where a large amount of funding is required across the country to render facilities acceptable for mental health care and treatment. The standard of newly built mental health facilities is high, but the number of these is few and funding for remaining essential new builds and extensive renovations remains low and difficult to attain.

Although inpatients care plans are provided for almost all inpatients, the quality is poor in most approved centres. There is a failure by many consultant psychiatrists as clinical leads to ensure that inpatients have an individual care plan that enables recovery, and involves the person in caring for their own mental health. Multi-disciplinary team members are sometimes slow to attend care plan meetings and assist in developing a meaningful care plan. Nursing staff cannot develop and review care plans in isolation and yet this is often the case. People in approved centres have a legal right to a care plan and to be involved in developing and reviewing it. They and their families, as well as agencies that support and advocate for them, should insist that each person has a meaningful care plan, that is owned by them and that is their manual for recovery.

59 V.C. Cox, P.B. Paulus, G. McCain Prison crowding research: The relevance for prison housing standards and a general approach regarding crowding phenomena *American Psychologist*, 39 (10) (1984), pp. 1148-1160

60 W.H. Ittelson, H.M. Proshansky, L.G. Rivlin Bedroom size and social interaction of the psychiatric ward J. Wohlwill, D. Carson (Eds.), *Environment and the social sciences*, American Psychological Association, Washington, DC (1972), pp. 95-104

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In 2020, we published a report about mental health services for older people (MHSOP) in Ireland. Approximately 15% of adults aged 60 and over suffer from a mental illness, including depression, dementia, anxiety, alcohol dependence, and schizophrenia as well as physical illness. They may also suffer from lack of appropriate accommodation, loneliness, bereavement, and financial difficulties. It is essential that services for older people are integrated to provide a holistic, joined-up approach. With a deficit in the number of specialist teams and lack of resources within those teams, we are not currently providing a nation-wide, comprehensive mental health service for older people.

The use of mechanical restraint on a child is a concerning development in Ireland. Mechanical restraint in children or adults has not been a practice since the introduction of the Mental Health Act 2001, apart from transport to and from the National Forensic Mental Health Services in the Central Mental Hospital. International guidelines recommend that it is not used in children. The Inspector strongly recommends that mechanical restraint does not become part of the delivery of mental health services in either children or adults.

COVID-19 has been very difficult for service users, in particular those who were admitted to or resident in approved centres. As well as battling with mental illness, residents also suffered from isolation, lack of visitors, a decrease in therapies available, fear and anxiety and COVID-19 infection itself. Staff worked extremely hard, not only to prevent and manage infection but also to provide alternative ways of providing therapies and care. This work continues into 2021.



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