mhc
coimisiún meabhair - shláinte
mental health commission

Mental Health Commission Annual Report 2021

Including the report of the Inspector of Mental Health Services

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This report may be cited as follows: 'Mental Health Commission 2021 Annual Report (2022), Mental Health Commission, Dublin, Ireland.'

CHAIRPERSON'S STATEMENT

Dr John Hillary
Chairperson

Over the past number of years, the Mental Health Commission (MHC) has been deeply engaged in the implementation of its 2019-2022 strategy titled 'Protecting People's Rights'.

This strategic document was the first under our revised mission to 'regulate and engage to promote, support, and uphold the rights, health and wellbeing of all people who access mental health and decision support services'. The new strategy is a critical document as it continually directs the MHC to uphold and protect human rights in every aspect of our work while also developing an organisation that is responsive to a rapidly changing external environment.

In 2022, we will engage with service users and all other stakeholders to develop our strategic objectives until 2028. This approach will ensure that the MHC remains responsive, transparent, and inclusive, thereby creating stronger and deeper relationships to deliver our statutory mandate and foster and encourage higher standards of care.

The MHC welcomes the development and continued implementation of 'Sharing the Vision', the State's national mental health policy. This document offers a trajectory of hope and, critically, a platform for integration of, and an informed strategic investment in, the State's mental health services.

We also welcome the significant work to progress a new mental health act. As part of the MHC's current strategy, we listed as an action the pursuit of the expansion of our remit to include the regulation of community services and we are delighted that this has been agreed to by Government. We are confident that the expansion of our regulatory powers will ensure that appropriate oversight occurs to ensure that better and safer services are delivered in our communities.

Throughout 2021, the MHC undertook intensive work to establish Ireland's first ever Decision Support Service (DSS). Our aim, in collaboration with and supported by the Department of Children, Equality, Disability, Integration and Youth, is to deliver a service that puts Ireland to the forefront of vindicating human rights and ensuring that all citizens have a service that is focused on their will and preferences. The DSS will play an integral role in delivering the much needed and long-awaited reforms introduced by the Assisted Decision Making (Capacity) Act 2015.

The MHC holds the view that there is a shared agenda and consensus to deliver better mental health and decision support services in Ireland. The MHC will continue to play its part, with all stakeholders, to realise our vision of an Ireland with the highest quality mental health and decision support services underpinned by a person's human rights. I want to thank all the staff of the MHC for their hard work

Throughout 2021, the MHC undertook intensive work to establish Ireland's first ever Decision Support Service (DSS).

and commitment during 2021. I also want to thank all members of the Board for their advice and direction and especially to Mr John Saunders who filled the role of Chairperson for the last 10 years.

Finally, I wish to thank the Minister for Mental Health, Mary Butler, and the Minister for Disability, Anne Rabbitte, for all the support that they and their officials provided to the MHC during 2021.

John Hilary
Chairperson

CHIEF EXECUTIVE'S REVIEW

John Farrelly
Chief Executive

The key challenge in 2021 for all stakeholders in the mental health sector was to help ensure that as many people as possible received appropriate mental health care and that the rights of all persons involuntarily detained were vindicated during the COVID-19 pandemic. A collaborative, evidence-driven approach between the MHC, the Department of Health and the HSE contributed in no small part to supporting services and service users during what was an unprecedented health crisis.

The MHC has a function in law 'to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services. With the service user at the centre of our work, we delivered a programme of regulation in 2021 which targeted risk and promoted quality and safety in services. Our programmes of registration, inspection, monitoring, and enforcement continued to hold providers to account. The publication of both national and individual centre inspection reports ensured a transparency for the public to clearly understand both the strengths and weaknesses of inpatient mental health services.

The MHC is also custodian of the process for vindicating the rights of patients who are involuntarily detained. We want service users to know that we are independent. We exist to vindicate their rights at all times. On a positive note, all professionals and centre staff worked hard to ensure each person received a tribunal during COVID-19. However, it was very disappointing to see that applications made

by HSE 'authorised officers' to involuntary detain patients remained at the same level as the previous year, while applications by An Garda Síochána continued to increase.

This report also shows that there has been a continued upward trend in compliance with approved centre regulations. Approximately 89% of approved centres achieved an 80% rate of compliance or higher, compared to 82% of services in 2020. Only seven services had a compliance rating lower than 80% in 2021, and no individual service had a regulation compliance rate lower than 68%. This is very welcome, and we commend all clinical staff and management who delivered these improvements.

However, a top-level view of our work in 2021 shows a gap emerging between independent providers and the HSE particularly in relation to premises and individualised care planning. While we recognise the investment in premises to date, the current approach to structural improvements in a significant number of HSE centres is inadequate. To ensure every person in Ireland has equal access to a consistent quality of care a targeted, funded strategic capital investment programme is required for our public system.

Once again, our inspection team has found that there is inadequate engagement by services with care planning in a meaningful way. The level of compliance with the associated regulation has been consistently low for many years, something that is largely down to the lack of input by multidisciplinary teams. This is an area that services need to come to terms with if we are to truly achieve an appropriate standard of individualised patient care.

However, a top-level view of our work in 2021 shows a gap emerging between independent providers and the HSE particularly in relation to premises and individualised care planning.

To address the findings set out in this report, the need for enhanced leadership and governance is essential. It is imperative if we are to achieve the delivery of the wide-ranging and innovative actions set out in 'Sharing the Vision' over the next 10 years.

Finally, I would like to thank all the staff of the MHC and Board members who continue to work tirelessly to deliver on our mission at a time of great change in Irish society.

John Farrelly
Chief Executive

2021 in Brief

42
Enforcement Actions

28
Requests for Additional Reviews

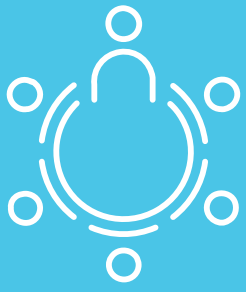
3
new conditions attached to 3 approved centres

2,549
Involuntary Admissions to Approved Centres

64%
of Approved Centres had over 90% compliance with each of the 31 mental health regulations

35%
of applications for involuntary admission were from An Garda Síochána

471
deaths of people using mental health services were reported to the MHC. 174 of these related to approved centres and 297 related to community mental health services.



1,910
Mental Health Tribunals

January

had the highest COVID-19 cases with 948 cases

2,657

Inpatient beds

May

the lowest COVID-19 cases with 32 cases reported

64

Instances of overcapacity in 2021

€5.7m

allocated in Budget to support implementation of DSS

32

child admissions to 11 adult units. This compares with 27 admissions to 9 adult units in 2020.

66

DSS stakeholder groups engaged with

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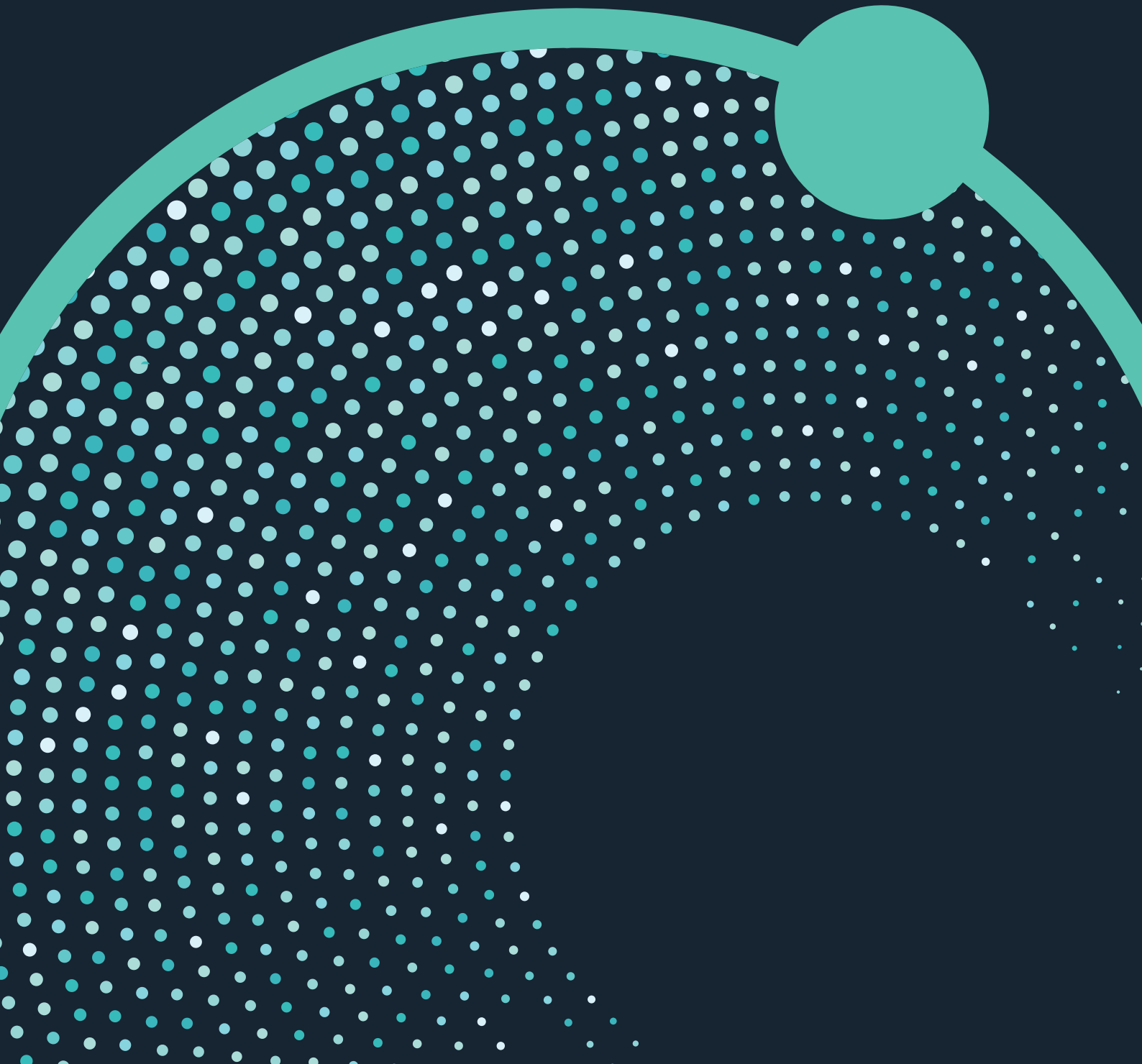
mental health commission

Who We Are



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.

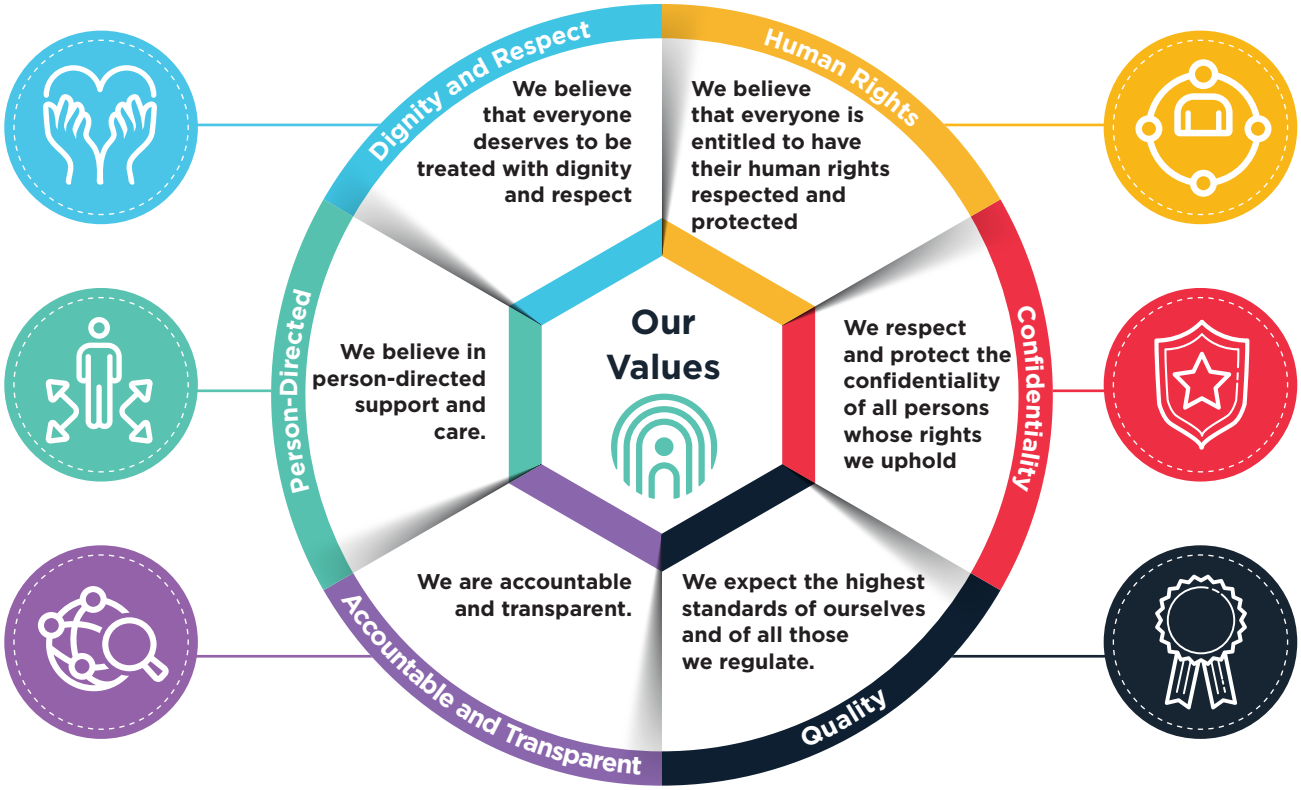
Vision, Mission and Values

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 (MHC) are known as the Commission and are the governing body of the organisation. The Commission has 13 Members, including the Chairperson, 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 (DSS) under the provisions of the Assisted Decision (Making) Capacity Act 2015 (the 2015 Act).

Details of the Commission's membership and meeting attendance for 2021 can be found in Appendix 1, 2 and 3 on pages 69-70.

During 2021, 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 69-70.

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

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

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

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

Tomás 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. 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

Fionn Fitzpatrick

First Appointed 12/02/2021
End of Term 04/04/2022

Position Type: Member

Basis of Appointment: Nominated by the Voluntary Sector. Appointed by the Minister of State for Mental Health and Older People.

John Cox (Dr)

First Appointed 12/02/2021
End of Term 04/04/2022

Position Type: Member

Basis of Appointment: Nominated by the Irish College of General Practitioners. Appointed by the Minister of State for Mental Health and Older People.

Additional Roles

Secretary to the Commission:
Orla Keane

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

Chair of Legislation Committee
Rowena Mulcahy (resigned as Chair in February 2021)
Michael Drumm (Dr) (appointed as Chair in July 2021)

Chief Risk Officer:
Simon Murtagh

Senior Leadership Team at the MHC

Chief Executive
John Farrelly

General Counsel
Orla Keane

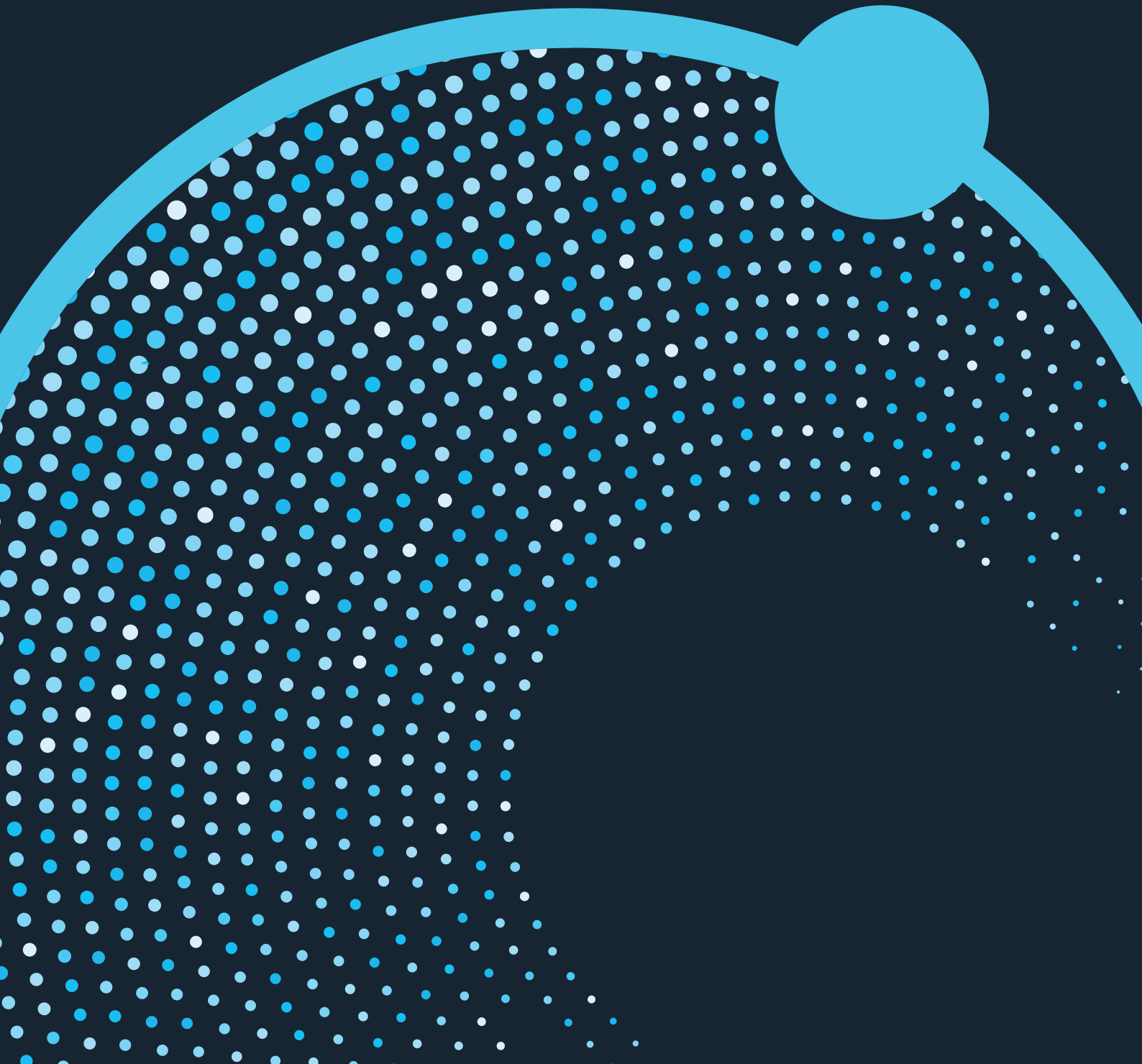
Inspector of Mental Health Services
Dr Susan Finnerty

Director, Decision Support Service
Áine Flynn

Director of Regulation
Gary Kiernan

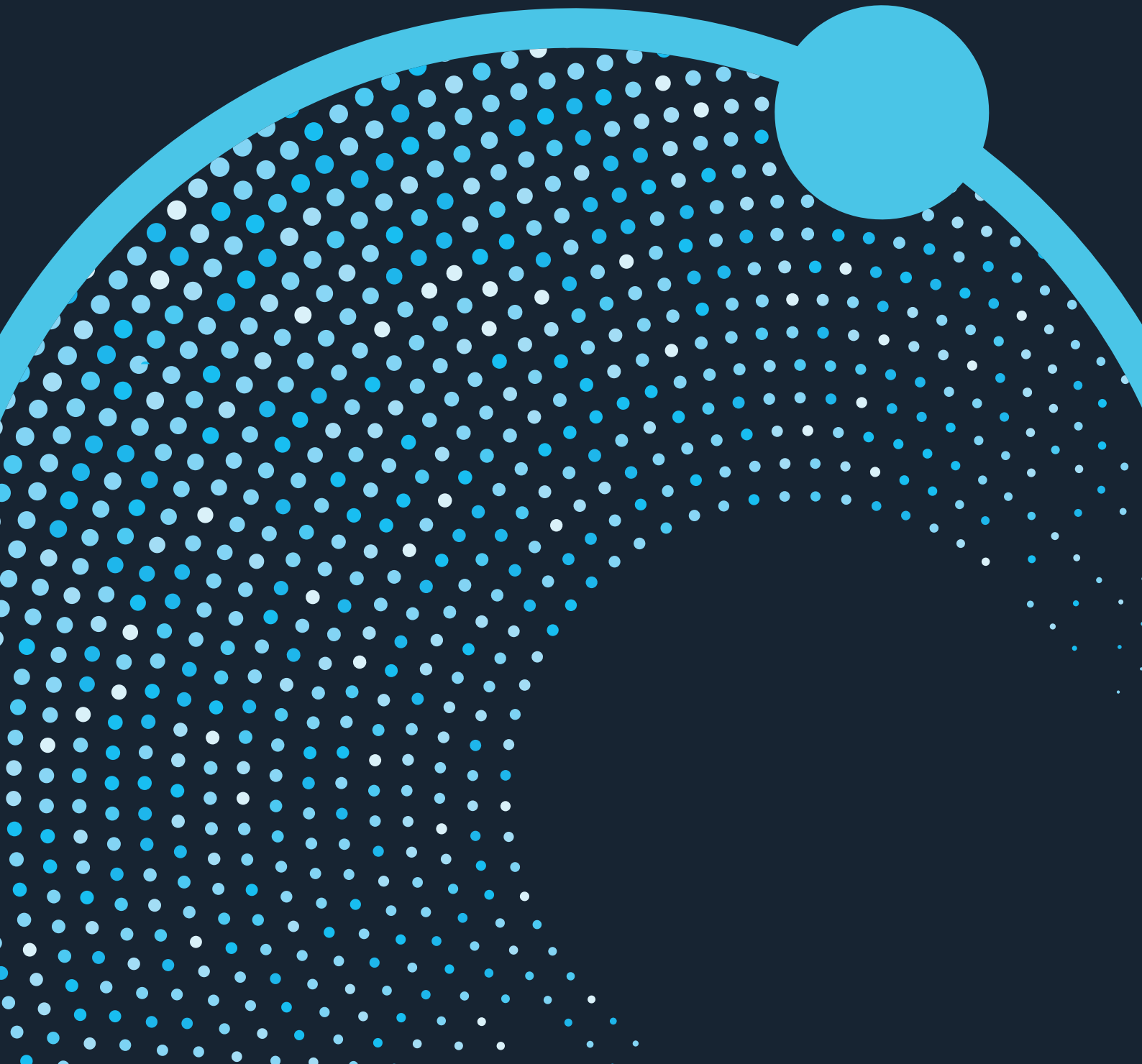
Chief Operations Officer
Simon Murtagh

What We Do



> Our work includes regulating inpatient mental health services; protecting the interests of people who are involuntarily admitted; and setting standards for high quality and good practices across mental health services.

Regulatory Process



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.

Figure 1: *MHC model of regulation*

Registration

All inpatient facilities that provide care and treatment to people who have a mental illness or disorder must apply to 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, the MHC considers information about how the facility is run, the profile of residents, how it is staffed and how those staff are recruited and trained. The application also seeks information about the premises and the types of services that are provided.

The MHC registers and regulates 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 2021, there were 67 approved centres registered with the MHC. During the year there were two new registrations, one approved centre closure, and 10 approved centres were re-registered.

At the end of 2021 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 786 adult beds in the independent sector, of which 770 were in Dublin. Although open but not providing inpatient services in 2021, the National Eating Disorders Recovery Centre had an allocation of six beds.
- There were also 106 registered forensic beds and 91 mental health intellectual disability (MHID) beds. These beds were in Dublin, with a national catchment.

The full Register of approved centres is available on the MHC's website.

New Registrations

There were two new approved centres registered during 2021:

- Silver Lodge, Tullamore, Co. Offaly
- National Eating Disorders Recovery Centre, Co. Dublin

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

Closures

Maryborough Centre, St Fintan's Hospital was closed and removed from the register, following a request from the registered proprietor, to accommodate planned refurbishment works in 2021. The service moved, temporarily, to Silver Lodge.

In addition, there were no beds available throughout 2021 in the approved centre referred to as the Sycamore Unit in Connolly Hospital. This was on foot of arrangements put in place by the HSE to accommodate reconfiguration for Covid-19 management.

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 comments on any content or findings prior to publication.

On inspection, the Inspector rates the compliance against:

- 31 Regulations
- Part 4 of the Mental Health Acts 2001-2018
- 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 relative 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'.

Due to the impact of the COVID-19 pandemic, the quality rating was not used for 2021 inspections. The revised Judgement Support Framework for 2021 is discussed in more detail in the Compliance Monitoring section on page 20.

Compliance Monitoring

The MHC collects, monitors and analyses compliance data by individual service, by sector and or CHO area, and nationally to identify areas of good practice and areas of concern.

Due to the COVID-19 pandemic, all approved centres in 2021 continued to be inspected under a revised inspection process and framework to control for the risk of transmission of COVID-19, in line with public health guidance. The Judgment Support Framework is a key document which informs how compliance is assessed on inspection. In 2021, a revised 'Judgement Support Framework Special Edition, For Use During the COVID-19 Pandemic' ('the revised JSF') was used to inspect each approved centre against all regulatory requirements including the regulations, rules, codes of practice and Part 4 of the Mental Health Act. Sixty-six of the 67 registered approved centres were inspected in 2021 using the revised JSF. The Sycamore Unit, Connolly Hospital had no beds available in 2021 and therefore was not subject to inspection.

The revised JSF required an assessment of compliance against the strict wording of the regulations. However, quality assessments against the four pillars (policy, training and education, monitoring, and evidence of implementation) were not included and, therefore, quality ratings were not awarded as part of the 2021 inspection cycle. Reduced sample sizes were also used by inspectors to determine service compliance. In addition, the revised JSF 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. Furthermore, the inspection of certain regulatory requirements, which fall under some parts of individual regulations, was not completed due to the impact of the pandemic on services' ability to comply. For example, staff education and training under Regulation 26(4) was not assessed in 2021.

It should be noted that prior to 13th March 2020 and the COVID-19 pandemic, approved centres were inspected against all regulatory requirements and quality criteria in accordance with 'Judgement Support Framework Version 5.1'.

Having regard to the inspection adjustments made in March 2020, which also impacted all inspections carried out in 2021, 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.

For further information on individual service inspection reports, as well as the revised JSF and JSF Version 5.1, please go to the MHC website www.mhcirl.ie.

Key Findings

74% regulations with over 90% compliance nationally

64% individual services that achieved over 90% compliance with Regulations

68% no service had less than 68% compliance with Regulations

Areas of Good Practice

Overall, compliance with the 31 regulations improved in 2021 in comparison to 2020. Approximately 89% of approved centres achieved an 80% rate of compliance or higher with the regulations in 2021, compared to 82% of services in 2020. Only seven services had a compliance rate lower than 80% in 2021, and no individual service had a regulation compliance rate lower than 68%. In comparison, 12 approved centres had a compliance rate lower than 80% in 2020, and the lowest compliance rate in 2020 was 67%.

There was a marked difference in levels of compliance achieved across the HSE's Community Healthcare Organisations (CHOs).

In 2021, CHO 5 (97%) had the highest compliance rate with regulations on average across each of its services, while CHO 4 had the lowest average

compliance rate (82%). The average compliance rate across services operated by independent providers was 95.2%.

In addition, 25 (81%) of the regulations had an approved centre compliance rate of 80% or higher in 2021. Eleven regulations (32%) were fully complied with by all 66 approved centres, including food/nutrition, recreation, care of the dying and children's education. In 2020, 77% of regulations had a compliance rate of 80% or higher, and full compliance by services was achieved with 10 regulations.

In relation to compliance with the five statutory rules and Part 4 of the Mental Health Act 2001, compliance rates did not fall below 80% across all applicable services in 2021. In 2020, two rules fell below 80% compliance, namely the rules on electro-convulsive therapy (ECT) and seclusion. Statutory rules cover the use of ECT, seclusion, mechanical restraint, as well as consent and leave. It should be noted that these rules do not apply to all approved centres.

Compliance rates with three of the four codes of practice did not fall below 70% across applicable services in both 2021 and 2020. These codes relate to the use of physical restraint, ECT for voluntary patients, and admission, transfer and discharge to and from an approved centre. Again, these codes of practice do not apply to all approved centres. Only the code of practice related to the Admission of Children under the Mental Health Act 2001 had a compliance rate below 70% in both 2021 and 2020 and is discussed further below.

Areas of Concern

A number of regulations were identified as having poor compliance rates. In 2021, regulations with compliance rates between 70 and 80 percent included therapeutic services (76%) and privacy (71%). Regulations with compliance rates lower than 70% were risk management procedures (64%), individual care plans (64%), staffing (61%) and premises (33%). Compliance with Regulation 22 (Premises) in particular has been low over the past 5 years, with an average compliance rate of 35%.

The 2021 data show that there is a considerable variance in compliance levels across the HSE regional areas. Furthermore, it is evident that services which are operated by independent or voluntary service providers tend to have higher overall compliance rates than all but one of the HSE CHOs. A more in-depth analysis was completed on the 4 regulations (ICP, Premises, Staffing and Risk Management) with compliance rates below 70% across each CHO/sector, as illustrated in Table 6 below. On average, the independent grouping of services performed better than each of the CHOs, with the exception of CHO 5. Of note, CHO 3 and CHO 4 had the lowest compliance rates across the 4 regulations, with an average compliance rate of 31% and 25% respectively. In comparison, CHO 5 had a compliance rate of 82% across these 4 regulations, followed by the independent sector which had an average compliance rate of 80%.

In relation to codes of practice, the compliance rate with the Code of Practice on the Use of Physical Restraint was 73% in 2021, compared to 76% in 2020. The MHC is currently in the process of updating the Code of Practice on the use of Physical Restraint, to assist services in improving practice in this area and to reduce and eliminate coercive and restrictive practices.

Furthermore, 10 services were inspected on the admission of children to adult services in 2021, and all were found to be non-compliant with the code, which governs this area. Reasons for non-compliance included services not providing age-appropriate facilities and a programme of activities appropriate to age and ability. In 2020, all 10 adult services which admitted a child were also non-compliant with the code of practice. The MHC continues to closely monitor the admission of children and young people under the age of 18 to adult inpatient mental health services.

Critical Risks

In 2021, there were 19 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 premises (seven), risk (four), therapeutic services (three), staffing (three), individual care plans (one) and privacy (one).

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

Where the Inspector of Mental Health Services makes a finding of non-compliance, this non-compliance is categorised as low, moderate, high, or critical. Please refer to the Enforcement section on page 26 of this report for details of actions taken where critical non-compliances are identified.

Approved Centre Compliance with Regulations

Table 1: *Approved centre compliance with regulations in 2021*

Key		
80% Compliant and over	60 - 80% Compliant	Less than 60% Compliant

Approved Centre	CHO/Sector	% Compliance
Aidan's Residential Healthcare Unit	5	100%
Grangemore Ward, St Otteran's Hospital	5	100%
Linn Dara Child & Adolescent Mental Health In-patient Unit, Cherry Orchard	CAMHS	100%
Highfield Hospital	INDP	100%
Haywood Lodge	5	100%
Willow Grove Adolescent Unit, St Patrick's University Hospital	CAMHS	100%
Selskar House, Farnogue Residential Healthcare Unit	5	100%
St Edmundsbury Hospital	INDP	100%
Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital	CAMHS	100%
St Patrick's University Hospital	INDP	100%
St Ita's Ward, St Brigid's Hospital	8	100%
National Eating Disorders Recovery Centre	INDP	97%
Elm Mount Unit, St Vincent's University Hospital	6	97%
An Coillín	2	97%
Creagh Suite	2	97%
Teach Aisling	2	97%
St Gabriel's Ward, St Canice's Hospital	5	97%
Wood View	2	97%
Tearmann Ward, St Camillus' Hospital	3	97%
Acute Mental Health Unit, Cork University Hospital	4	97%
St Joseph's Intellectual Disability Service	ID	97%
Phoenix Care Centre	9	97%
Adult Mental Health Unit, Sligo University Hospital	1	97%
Avonmore & Glencree Units, Newcastle Hospital	6	94%
St Bridget's Ward, & St Marie Goretti's Ward, Cluain Lir Care Centre	8	94%
St Anne's Unit, Sacred Heart Hospital	2	94%

Approved Centre	CHO/Sector	% Compliance
Department of Psychiatry, St Luke's Hospital	5	94%
Acute Psychiatric Unit, Cavan General Hospital	1	94%
Jonathan Swift Clinic	7	94%
Cois Dalua	INDP	94%
Department of Psychiatry, Letterkenny University Hospital	1	94%
St John of God Hospital	INDP	94%
Adult Mental Health Unit, Mayo University Hospital	2	90%
Carraig Mor Centre	4	90%
Bloomfield Hospital	INDP	90%
O'Casey Rooms, Fairview Community Unit	9	90%
Adolescent In-patient Unit, St Vincent's Hospital	CAMHS	90%
St Aloysius Ward, Mater Misericordiae University Hospital	9	90%
Department of Psychiatry, Roscommon University Hospital	2	90%
Lois Bridges	INDP	90%
Department of Psychiatry, University Hospital Waterford	5	90%
Central Mental Hospital	NFMHS	90%
Ginesa Suite, St John of God Hospital	CAMHS	87%
Blackwater House	1	87%
Admission Unit & St Edna's Unit, St Loman's Hospital	8	87%
Acute Psychiatric Unit 5B, University Hospital Limerick	3	87%
Centre for Mental Health Care & Recovery, Bantry General Hospital	4	87%
Ashlin Centre	9	84%
Silver Lodge	8	84%
Owenacurra Centre	4	84%
Adult Acute Mental Health Unit, University Hospital Galway	2	84%
Acute Psychiatric Unit, Tallaght Hospital	7	84%
Drogheda Department of Psychiatry	8	84%
Lakeview Unit, Naas General Hospital	7	84%
Deer Lodge	4	84%
St Vincent's Hospital	9	81%
Le Brun House & Whitethorn House, Vergemount Mental Health Facility	6	81%
Eist Linn Child & Adolescent In-patient Unit	CAMHS	81%
Sliabh Mis Mental Health Admission Unit, University Hospital Kerry	4	81%
Department of Psychiatry, Midland Regional Hospital, Portlaoise	8	77%
Acute Psychiatric Unit, Ennis Hospital	3	77%
St Michael's Unit, Mercy University Hospital	4	74%
Units 2, 3, 4, and Unit 8 (Floor 2), St Stephen's Hospital	4	74%
Department of Psychiatry, Connolly Hospital	9	74%
St Catherine's Ward, St Finbarr's Hospital	4	68%
Cappahard Lodge	3	68%

Table 2: *CHO/sector compliance with regulations in 2021*

CHO/Sector	No. of Services	Average Compliance Rate	Lowest Compliance Rate	Highest Compliance Rate
CHO 1	4	92.7%	87.1%	96.8%
CHO 2	9	93.9%	83.9%	100.0%
CHO 3	4	82.3%	67.7%	96.8%
CHO 4	10	81.9%	67.7%	96.8%
CHO 5	7	97.2%	90.3%	100.0%
CHO 6	4	90.3%	80.6%	96.8%
CHO 7	4	90.3%	83.9%	100.0%
CHO 8	6	87.6%	77.4%	100.0%
CHO 9	8	87.9%	74.2%	96.8%
INDP	10	95.2%	87.1%	100.0%

Table 3: *Compliance with regulations in 2021*

Regulation	% Compliance
Reg 04: Identification	100%
Reg 05: Food and Nutrition	100%
Reg 06: Food Safety	98%
Reg 07: Clothing	98%
Reg 08: Residents' Property	97%
Reg 09: Recreation	100%
Reg 10: Religion	100%
Reg 11: Visits	98%
Reg 12: Communication	100%
Reg 13: Searches	97%
Reg 14: Care of the Dying	100%
Reg 15: Individual Care Plan	64%
Reg 16: Therapeutic Services	76%
Reg 17: Children's Education	100%
Reg 18: Transfers	94%
Reg 19: General Health	80%

Regulation	% Compliance
Reg 20: Information	100%
Reg 21: Privacy	71%
Reg 22: Premises	33%
Reg 23: Medication	88%
Reg 24: Health and Safety	98%
Reg 25: CCTV	97%
Reg 26: Staffing	61%
Reg 27: Records	91%
Reg 28: Register	94%
Reg 29: Policies	95%
Reg 30: Tribunals	100%
Reg 31: Complaints	98%
Reg 32: Risk	64%
Reg 33: Insurance	100%
Reg 34: Certificate	100%

Table 4: *Compliance with statutory rules and Part 4 of the Mental Health Act 2001 in 2021*

Rule	% Compliance
ECT	100%
Mechanical Restraint	100%
Leave	100%
Consent	97%
Seclusion	82%

Table 5: *Compliance with codes of practice in 2021*

Code of Practice	% Compliance
ECT	100%
Admission, Transfer, Discharge	77%
Physical Restraint	73%
Admission of Children	0%*

* Ten services were inspected in relation to adult services which admit children, and all were found to be non-compliant with the code of practice. Please refer to the Areas of Concern section page 21 for more information.

Table 6: *CHO/Sector compliance with ICP, Premises, Staffing and Risk Regulations*

CHO/ Sector	No. of Services	ICP	Premises	Staffing	Risk	Lowest	Highest	Average
CHO 1	4	50.0%	25.0%	75.0%	75.0%	25.0%	75.0%	56.3%
CHO 2	9	77.8%	33.3%	88.9%	77.8%	33.3%	88.9%	69.4%
CHO 3	4	50.0%	25.0%	25.0%	25.0%	25.0%	50.0%	31.3%
CHO 4	10	10.0%	20.0%	30.0%	40.0%	10.0%	40.0%	25.0%
CHO 5	7	85.7%	57.1%	85.7%	100.0%	57.1%	100.0%	82.1%
CHO 6	4	100.0%	0.0%	75.0%	75.0%	0.0%	100.0%	62.5%
CHO 7	4	25.0%	25.0%	50.0%	75.0%	25.0%	75.0%	43.8%
CHO 8	6	16.7%	33.3%	50.0%	66.7%	16.7%	66.7%	41.7%
CHO 9	8	75.0%	25.0%	37.5%	37.5%	25.0%	75.0%	43.8%
INDP	10	100.0%	70.0%	80.0%	70.0%	70.0%	100.0%	80.0%

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 Management Team. 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 42 enforcement actions in response to incidents, events, and serious concerns arising in 2021. These actions related to 20 approved centres, with an average of just over two enforcement actions per service. This compares with 17 enforcement actions in 2020, 40 enforcement actions in 2019, and 44 enforcement actions in 2018.

2021 saw a return to pre-COVID enforcement action levels. While it is not possible to definitively explain the reduction and increase from 2020 to 2021, it is likely the result of the COVID-19 pandemic and resultant changes to work practices in approved centres.

During 2021, enforcement actions included:

- 21 immediate action notices, relating to 34 serious concerns
- 18 regulatory compliance meetings
- Three proposals to attach a condition to the approved centre's registration

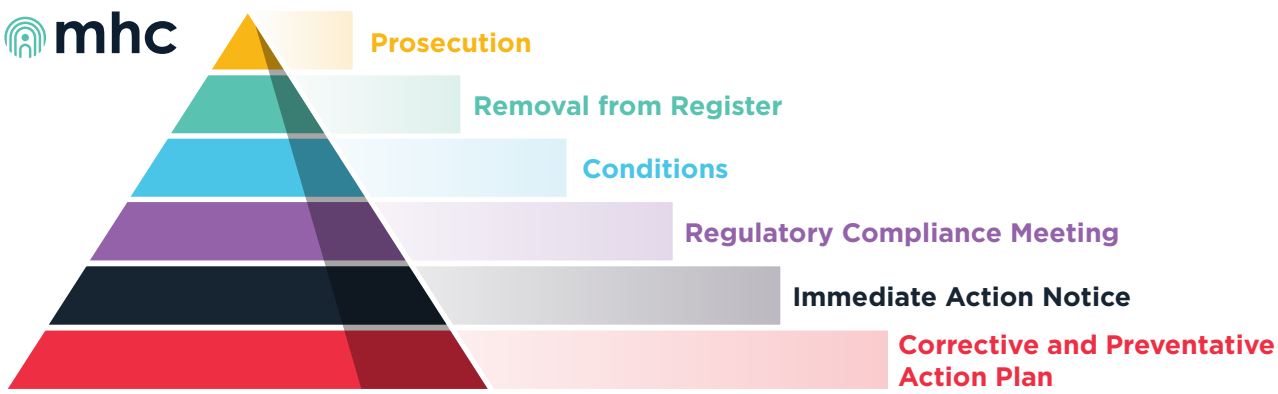
Most of the immediate action notices and regulatory compliance meetings arose from regulatory inspections conducted by the Inspectorate division.

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

They included:

- Maintenance of premises at the approved centre (42%)
- Appropriate staffing at the approved centre (16%)
- The provision of therapeutic services and programmes (15%)
- Risk management procedures at the approved centre (13%)
- Other service provision areas (14%)

Figure 2: *MHC enforcement model*



Registration Conditions

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

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 of registration.

Conditions Attached

In 2021, three **new** conditions were attached to the registration of three approved centres. These conditions related to additional governance reporting requirements and prohibiting the admission and transfer of residents to a centre. This compares to 109 new conditions attached to 36 approved centres in 2020, and 14 conditions attached to the registration of 9 approved centres in 2019.

At the end of 2021, there were 85 conditions attached to 39 approved centres in total, compared to 115 conditions attached to 42 approved centres in 2020. The most common conditions attached are presented in Table 6.

There was a notable difference in the number of registration conditions applied in 2021 compared in 2020. This may be explained by the following factors:

- 39 centres applied for re-registration in 2020, compared to only 10 in 2021.
- Many centres in 2020 had ongoing poor compliance in areas such as premises, care planning and training. This trend was addressed through the application of conditions in 2020.
- Conditions remain in place for the duration of the three-year registration cycle, where issues of poor compliance have not been fully addressed. The application of conditions to many services in 2020, at the time of their re-registration, meant fewer conditions were required in 2021.

Most conditions require that monthly or quarterly reports be submitted to the MHC, which allows for regular monitoring. There were 461 condition monitoring reports submitted by services in 2021, compared to 395 in 2020.

29 conditions were withdrawn during 2021 based on approved centres achieving compliance with the relevant regulations.

Table 7: *Conditions in force in 2021*

Condition Area	Number of Conditions Attached
Premises	34
Staff training	34
Care planning	5
Medication management	2
Closure	2
Other areas	8

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)
- Other 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 been incorporated into service practice.

In addition, we analyse notifications 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 2021, 471 deaths of people using mental health services were reported to the MHC. Of these, 174 deaths (37%) related to approved centres and 297 (63%) related to other community mental health services. This compares to 586 deaths in 2020, 207 of which were residents in approved centres and 379 of which were related to other community mental health services.

Fifty-eight percent of deaths reported in 2021 related to male residents. The average age of a resident was 61 years of age. The youngest resident was 18 years of age, and the oldest resident was 101 years old.

Death by suicide may only be determined by a Coroner's inquest, which may take place several months after the death. However, in 2021, 127 total deaths were reported to the MHC by services as a 'suspected suicide' and 30 of these related to residents of approved centres. This compares to 151 in 2020. It should be noted that approved centre deaths include those that are reported within four weeks of a resident's discharge. A breakdown of the deaths reported to the MHC is provided in Table 8 below.

Table 8: *Breakdown of deaths reported by type of death and service*

Type of Death*	Approved Centre	Other Mental Health Service	Total
Death was Sudden	59	182	241
Death was Not Sudden	113	111	224
Death was Suspected Suicide	30	97	127
Cause of Death Unknown	50	147	197

** A resident death may be reported under more than one Type of Death category*

Serious reportable events

All approved centres are required to notify the MHC of serious reportable events that occur in their service (SREs, HSE 2015). In 2021, 41 SREs were reported to the MHC in relation to 23 approved centres. In 2020, 36 SREs involving 19 approved centres were reported to the MHC.

Table 8 shows the number of reported SREs by category in 2021, broken down by SRE category. The highest reported SRE category was environmental events (5D) (37%), followed by care management events (4I) (24%) and criminal events (6C) (20%). In relation to the criminal events (6C) (sexual assault) category, there was an increase in the number of approved centre incidents in 2021 (8) compared to 2020 (6). The

MHC engaged with each service that reported a category 6C Criminal Event to ensure the safety of each resident. In addition to monitoring the actions taken by each of these services to safeguard and protect residents, the MHC has also highlighted these serious events at national level to the HSE. The MHC has requested assurances that additional procedures and resources will be put in place to strengthen safeguarding arrangements as provided for in the national policy "Sharing the Vision – a Mental Health Policy for Everyone", published in 2020.

Table 9 provides a breakdown of SRE by CHO. CHO 5 (27%) and CHO 3 (20%) reported almost half of all SREs in 2021. It should be noted that some services may be more likely to report a specific type of SRE based on the residents that they support, for example, falls and pressure ulcers are more associated with older adults in care.

Fifty percent of SREs related to female residents. The average age of a resident who was the subject of an SRE was 64 years of age. The youngest resident was 21 years old and the oldest was 97 years of age.

Table 9: *Serious reportable events in 2021 reported by category*

SRE Category	Description	Number Reported	%
Care Management Events (4I)	Stage 3 or 4 pressure ulcers	10	**24.4%**
Criminal Events (6C)	Sexual assault	8	**19.5%**
Criminal Events (6D)	Serious injury/disability resulting from a physical assault	3	**7.3%**
Environmental Events (5D)	Serious disability associated with a fall	15	**36.6%**
Patient Protection Events (3C)	Sudden or unexplained deaths or injuries which result in serious disability of a person who is an inpatient/resident	3	**7.3%**
Other	Other event	2	**4.9%**
	Total	**41**	

Table 10: *Serious reportable events reported by CHO*

SRE Category	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	INDEP
Care Management Events (4I)	0	2	5	2	1	0	0	0	0	0
Criminal Events (6C)	0	0	1	0	4	0	0	1	0	2
Criminal Events (6D)	0	0	0	0	0	1	0	1	1	0
Environmental Events (5D)	0	0	2	5	6	0	0	0	0	2
Patient Protection Events (3C)	2	0	0	0	0	0	0	0	0	1
Other	1	0	0	0	0	0	0	0	0	1
CHO Total	**7.3%**	**4.9%**	**19.5%**	**17.1%**	**26.8%**	**2.4%**	**0.0%**	**4.9%**	**2.4%**	**14.6%**

Regulated Practices

The MHC produces annual activity reports on the use of ECT and restrictive practices including seclusion, physical restraint, and mechanical restraint. Below is a high-level overview of the information which will be presented in greater detail when these reports are published later in 2022. The data presented is therefore provisional. The final figures for 2021 and additional information will be included in the activity reports.

Furthermore, and as outlined in more detail in the Quality Improvement section (page 36), the MHC has commenced its review of the rules governing the use of seclusion and mechanical means of bodily restraint and the code of practice on the use of physical restraint in approved centres, which came into effect in 2010. The update will bring the rules and code of practice in line with best practice in the use and reduction of restrictive interventions.

Electro-Convulsive Therapy (ECT)

Electro-Convulsive therapy (ECT) is a medical procedure in which an electric current is passed briefly through the brain via electrodes applied to the scalp to induce generalised seizure activity. The person receiving treatment is placed under general anaesthetic and muscle relaxants are given to prevent body spasms. Its purpose is to treat specific types of major mental illnesses.

The use of ECT in Ireland is regulated by the 2001 Act and approved centres must notify the MHC of all programmes of ECT.

In 2021 there were 333 programmes of ECT for 229 residents in 16 approved centres. This compares to 300 programmes of ECT for 239 residents in 2020. Eighty-two percent of residents who were administered ECT in 2021 were voluntary residents at an approved centre at the time of commencement of the ECT programme, compared to 78% of residents in 2020. In 2021, 69% of residents underwent a single programme of ECT, while 31% of residents received between two and six ECT programmes. In 2021, 60% of ECT residents were female, compared to 66% in 2020. The average age of a resident undergoing ECT in 2021 was 64 years, slightly older than in 2020 (62 years). The youngest ECT resident in 2021 was 22 years old and the oldest resident was 95 years of age.

A single ECT programme may involve up to 12 individual treatments. Only 55 programmes (16.5%) of ECT involved the full 12 treatments in 2021, with an average of seven treatments per resident. There were a total of 2,282 individual ECT treatments, compared to 2,329 in 2020. In 2021, 1,983 ECT treatments (86.9%) took place with the patient's consent, compared to 1,881 treatments (81%) in 2020. Forty-eight programmes of ECT (14%) in 2021 included at least one treatment without consent[1], lower than in 2020 (59 programmes (19%)).

Seclusion

Seclusion refers to placing or leaving a person alone in a room with the exit door locked or held in such a way as to prevent the person from leaving.

In 2021 there were 1,884 episodes of seclusion involving 654 residents in 27 approved centres. The shortest episode reported was three minutes, while the longest episode was 5,237 hours (218 days). Services are required to notify the Inspector of Mental Health Services if a resident is secluded for a period exceeding 72 hours. The MHC received 49 notifications from seven approved centres of episodes of seclusion that lasted longer than 72 hours in 2021.

In comparison, there were 1,840 seclusion episodes involving 669 residents in 27 approved centres in 2020. The shortest episode lasted less than 1 minute, and the longest episode was 2,424 hours. In addition, there were 74 episodes of seclusion that lasted longer than 72 hours.

[1] ECT cannot be administered to a voluntary patient without their consent. Section 59 of the Mental Health Act 2001 details the assessment criteria for administration of ECT treatment to an involuntary patient without their consent.

In 2021, 66% of residents who were secluded were male. The average age of secluded residents was 38 years. The youngest secluded resident was 15 years old and the oldest was 84 years of age. The majority of residents (55%) who were secluded were secluded only once. However, the average number of episodes per secluded resident was three.

In order to increase the protections provided to people who experience seclusion and other restrictive practices, the MHC intends to publish updated rules and codes of practice governing these practices in 2022.

Physical Restraint

Physical restraint refers to the use of physical force for the purpose of preventing the free movement of a resident's body.

In 2021 there was a decrease in the number of episodes of physical restraint. There were 3,460 episodes of physical restraint involving 1,169 residents in 47 approved centres. This compares to 3,990 episodes involving 1,211 residents in 48 approved centres in 2020. The average episode of physical restraint in 2021 lasted for five minutes. The shortest episode of physical restraint lasted for less than one minute, while the longest was two hours and 10 minutes.

Renewal orders are required for episodes of physical restraint that last longer than 30 minutes. In 2021, 13 episodes of physical restraint, less than 1%, required a renewal order.

CHO 9 accounted for 14% of physical restraint episodes in 2021, followed by CHO 2 (11%) and CHO 7 (10%). The highest number of physical restraint episodes reported by a single approved centre was the Central Mental Hospital (417), which accounted for approximately 12% of all episodes.

Fifty-four percent of residents who were physically restrained in 2021 were male. The average age of residents who were physically restrained was 41. The youngest resident who was physically restrained was 13 years old, and the oldest was 93 years of age. The average number of episodes per physically restrained resident was three. Approximately one in five residents (19%) who were physically restrained in 2021 were restrained on only one occasion.

Mechanical Restraint

Mechanical restraint refers to the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a person's body when they pose an immediate threat of serious harm to themselves or others.

In 2021, there were 25 episodes of mechanical restraint involving 10 male residents. All episodes of mechanical restraint were reported by the Central Mental Hospital. The total duration of mechanical restraint was 49 hours. The average episode of mechanical restraint lasted for approximately two hours. The shortest episode was 17 minutes, and the longest episode was four hours.

This compares to 153 episodes in 2020, involving three residents in two approved centres.

Areas that the MHC closely monitors

Overcapacity

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. In 2021, there were 64 instances of overcapacity reported by approved centres.

Overcapacity in 2021 related to the following five approved centres:

- Adult Mental Health Unit, Mayo University Hospital
- Acute Psychiatric Unit 5B, University Hospital Limerick
- Central Mental Hospital
- Drogheda Department of Psychiatry
- Department of Psychiatry, Roscommon University Hospital

The Department of Psychiatry, Roscommon University Hospital[2] reported 33 (52%) of the 64 instances of overcapacity in 2021. This was followed by Acute Psychiatric Unit 5B, University Hospital Limerick (19 instances (30%)) and the Adult Mental Health Unit, Mayo University Hospital (8 instances (12%)). The Central Mental Hospital and Drogheda Department of Psychiatry each reported two (3%) instances of overcapacity. The MHC engaged with services reporting overcapacity to ensure patient safety and dignity, to require evidence of surge management plans and to address the systemic causes of overcapacity.

In terms of how additional residents were accommodated, 49 overcapacity notifications (77%) refer to beds being available in the unit, i.e., residents were allocated a bedspace which was not part of the approved centre's registered bed count. A further 8 (12%) of the notifications received referenced the use of leave beds as a means of accommodating overcapacity. The Inspector of Mental Health Services considers the use of leave beds to constitute poor practice as patients may need to return from leave at any point and require their bed and further treatment. Seven overcapacity notifications (11%) were for 'other' reasons. The 64 instances of overcapacity in 2021 compares to 58 instances in 2020 and 208 in 2019. It is likely that the COVID-19 pandemic and resultant service reconfigurations have contributed to the significant reduction in reported instances of overcapacity in both 2021 and 2020, compared to 2019. 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 young people to approved centres in 2021 was 504. This compares with a total of 486 admissions in 2020 and 497 in 2019.

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 due to the lack of a bed in a specialist Child and Adolescent Mental Health Service (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 2021, there were 32 admissions involving 27 children to 11 adult units as presented in Table 10. This compares with 27 admissions to nine adult units in 2020 and 54 admissions to 15 adult units in 2019. Thirteen of those admissions in 2021

[2] Roscommon University Hospital successfully applied for a change in their registered bed numbers in 2021 in order to increase their capacity by two.

were for less than 48 hours, compared to eight admissions for less than 48 hours in 2020 and 23 admissions for less than 48 hours in 2019.

Seventy-eight percent of children admitted to an adult unit in 2021 were admitted due to an immediate risk to themselves, while 16% were admitted due to an immediate risk to themselves and others. Thirty-one percent of child admissions to adult approved centres in 2021 also occurred when there was no bed available in a CAMHS unit.

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. In 2021, 6.3% of child admissions were to adult units. This figure is slightly higher than in 2020 where 27 child admissions to adult units accounted for 5.6% of all child admissions, the lowest number since records began. Figure 3 presents child admissions to adult and CAMHS approved centres over the past five years.

Part of the decline in child admissions to adult units in 2021 and 2020 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.

Admissions to child and adolescent approved centres

There are six specialist CAMHS units nationally: four in Dublin, one in Cork and one in Galway. Two of the four CAMHS units in Dublin are private. In 2021, there were 472 admissions to CAMHS units nationally. The average duration of admission was 41 days, based on discharge information provided for 424 admissions. The shortest admission duration was less than one day, and the longest admission duration was 261 days.

Involuntary child admissions

The District Court is required to authorise the involuntary admission of a child. In 2021, there were 47 involuntary admissions orders of children to approved centres, pursuant to Section 25 of the Mental Health Act. This included:

- Two orders to adult units
- Forty-five orders to CAMHS units

In addition, there were:

- <5 Hight Court Orders for the admission of a child to an adult unit
- No High Court Orders for the admission of a child to a CAMHS unit
- No admissions of a Ward of Court to a CAMHS or adult unit

Table 11: *Child Admissions to Adult Units 2021*

Rank	Approved Centre	No. Admissions
1	Department of Psychiatry, University Hospital Waterford	10
2	Department of Psychiatry, Connolly Hospital	5
3	St Vincent's Hospital	4
4	St John of God Hospital	3
5	St Aloysius Ward, Mater Misericordiae University Hospital	2
5	Acute Psychiatric Unit, Cavan General Hospital	2
5	Sliabh Mis Mental Health Admission Unit, University Hospital Kerry	2
6	Department of Psychiatry, St Luke's Hospital	1
6	Department of Psychiatry, Letterkenny University Hospital	1
6	Acute Mental Health Unit, Cork University Hospital	1
6	Department of Psychiatry, Drogheda	1

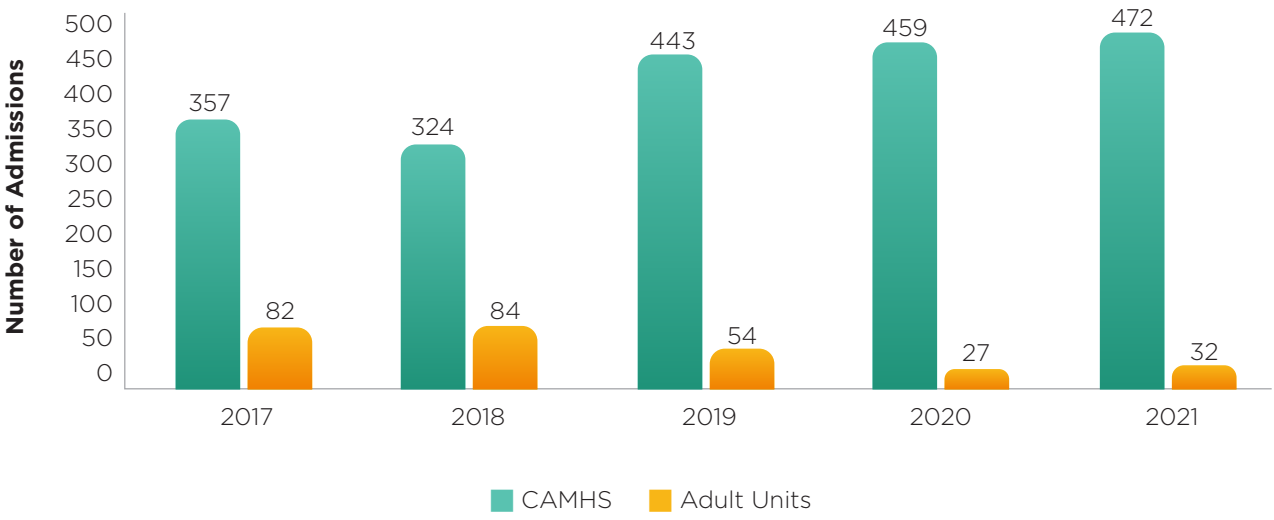
Age and gender of child admissions

In 2021, 73% of child admissions to CAMHS units were female. In comparison, 59% of child admissions to adult approved centres were female. In 2020, 72% of all child admissions related to female residents. The average age of a service user in 2021 was 16 years of age. The youngest resident was 10 years of age. A breakdown of admission by age is presented in Table 11. Eighty-eight percent of children admitted to CAMHS and adult units in 2021 were admitted only once, with 12% of residents admitted between two and five times in that period.

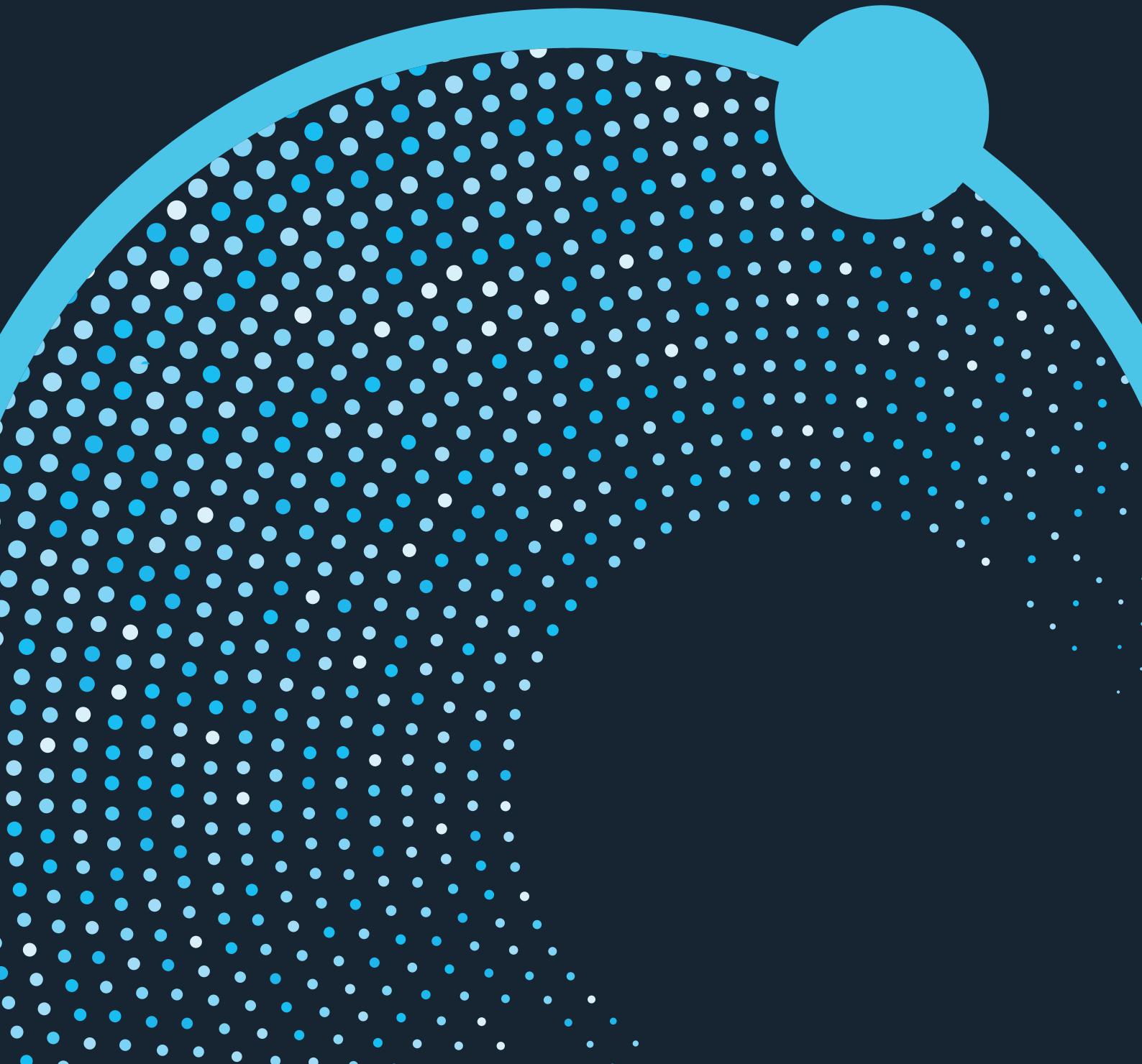
Table 12: *Child admissions to adult and CAMHS approved centres by age in 2021*

Age	Adult	CAMHS
17	25	138
16	<5	100
15	<5	85
14	0	59
13 and under	0	29

Figure 3: *Child admissions to adult and CAMHS approved centres for the past five years*



Quality Improvement



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

During 2021, our key activities under our quality improvement functions included the ongoing review of the rules governing the use of seclusion and mechanical means of bodily restraint and the code of practice on the use of physical restraint in approved centres. The MHC is also currently reviewing the Quality Framework for Mental Health Services in Ireland. It is intended that revised documents will be published in 2022.

In collaboration with the Health Information and Quality Authority (HIQA), the MHC is developing National Standards for the Care and Support of Children using Health and Social Care Services. These will be the first such standards developed in Ireland to apply to both health and social care settings and will be published in 2022, following Ministerial approval.

The MHC also published revised guidance for mental health services and staff on working with people from ethnic minority communities.

Publications

The MHC published several documents throughout 2021. These documents range from informative activity reports to quality standards:

- A Report on Physical Environments in Mental Health Inpatient Units – Overview report by the Inspector of Mental Health Services
- COVID-19 Paper 2: Examining the Impacts and Response in Residential Mental Health Services
- Access to Mental Health Services for People in the Criminal Justice System – Themed report by the Inspector of Mental Health Services
- Ethnic Minorities and Mental Health: Revised guidelines for mental health services and staff on working with people from ethnic minority communities
- The Use of Restrictive Practices in Approved Centres: Activity Report 2020
- The Administration of Electro-Convulsive Therapy in Approved Centres: Activity Report 2020

Collaborative Working

MHC Submissions

During 2021, the MHC provided submissions or comments on a number of draft standards, frameworks, strategies and position papers, including but not limited to:

- Stakeholder consultation for Psychologists Registration Board at CORU
- Stakeholder consultation on inspection of standards for Pharmacological Society of Ireland
- HIQA consultation on draft principles to underpin future national standards for health and social care services

Participation on Committees, Advisory Groups, and Interest Groups

During 2021, the MHC participated in several groups to contribute to the development of standards, share learnings and gain best practice

insights, including:

- National Clinical Effectiveness Committee
- Dialogue Forum on the role of voluntary organisations in publicly funded health and social care services
- Adult Safeguarding Policy Steering Group
- Sharing the Learning from Safety Incidents Steering Group (HSE)
- Oireachtas Sub-Committee on Mental Health
- Oireachtas Joint Committee on Justice

Review of the Rules and Code of Practice on Restrictive Practices

In early 2021, the MHC commenced our review of the 'Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint' and the 'Code of Practice on the use of Physical Restraint in Approved Centres'.

The Mental Health Act 2001 requires the MHC to develop rules on the use of seclusion and mechanical restraint and provides that the MHC can develop codes of practice on physical restraint. The rules and code of practice came into effect in 2010. Significant developments have taken place in the intervening decade with regards best practice in the use and reduction of restrictive interventions.

The MHC developed a comprehensive review project which is ongoing. An evidence review has been undertaken by an independent academic researcher and two advisory groups have been established: one comprising of experts by profession and one comprising of experts by experience.

A public consultation was undertaken from July to September 2021 and 97 responses were received. Focus groups were held with 36 participants. Interviews were conducted with additional stakeholders. The MHC is currently analysing the considerable evidence collected and the project team has begun drafting the revised documents. Following further stakeholder engagement on the draft revised rules and code of practice, the MHC intends to publish the documents in the latter half of 2022. The MHC anticipates that this will lead to greatly improved protections for people who use mental health services.

Review of the Quality Framework for Mental Health Services in Ireland

The current quality framework was published by the MHC in 2007 and applies to all mental health services in Ireland. It provides a mechanism for services to continuously improve the quality of care and treatment they are providing.

There has been significant best practice developments since the publication of the original framework and work is ongoing to review and revise the standards. The review will bring the framework up to contemporary international standards.

Researchers from the Royal College of Surgeons in Ireland (RCSI) were commissioned to undertake a detailed analysis of national and international peer reviewed evidence as well as evidence obtained from public consultation. A scoping consultation was open from May to June 2021 and focus groups and additional interviews were also undertaken. The MHC received 156 written responses to the consultation and 46 individuals attended focus groups. Interviews were undertaken with a further seven individuals.

The MHC is currently reviewing the draft documents provided by RCSI. An audit toolkit will be developed to support service implementation of the revised standards and this toolkit will be piloted in advance of publication. The MHC intends to publish the revised quality framework in the latter half of 2022.

Development of National Children's Standards

In 2021, the MHC continued collaborating with 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.

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 project team undertook extensive stakeholder engagement during 2021. The evidence review to inform the development of the draft standards was published in January 2021. From March to May 2021, focus groups were held with a wide range of stakeholders, involving over 150 participants. Meetings of the advisory group and children's reference group were held. A public consultation on the draft standards ran from September to October 2021 and 58 responses were received.

Final revisions are being made to the draft standards and it is anticipated that they will be approved and published by mid-2022.

Revised guidelines on Ethnic Minorities and Mental Health

In December 2021, the MHC and Mental Health Reform launched revised guidelines for mental health services and staff working with people from ethnic minority communities.

Titled 'Ethnic Minorities and Mental Health', the revised and updated guidelines are designed to inform mental health services and staff on how best to provide care to individuals from ethnic minorities.

The guidelines are the result of a public consultation process which gathered feedback from mental health service providers, service users and interested stakeholder groups. Feedback from the consultation led to the production of shorter and more user-friendly guidelines suitable for mental health professionals, including frontline workers and managers.

COVID-19

The MHC continued to observe evidence of the impact of COVID-19 on mental health services in 2021. The processes implemented by the MHC at the emergence of the pandemic enabled a more structured and focused monitoring system throughout 2021. The formation of the COVID-19 monitoring team in later 2020 allowed for a dedicated team to work in tandem with services to effectively track COVID-19 case numbers and impacts of the disease in 2021.

COVID-19 Monitoring Team and Methodology

The COVID-19 monitoring team was responsible for the tracking of COVID-19 cases across approved centres and 24-hour community residences. The monitoring of the progression of COVID-19 cases within services by the MHC commenced in March 2020 and a devoted monitoring team was established in October 2020. The team consisted of two monitoring support officers and a monitoring support manager.

The primary function of the team was to communicate and engage weekly with services to gather and record information pertaining to active COVID-19 cases and the arrangements in place to prevent further infections. Resulting from initial risk framework analysis, including several qualitative risk questions, a standardised set of monitoring questions were produced to elicit information in respect of disease progression and risk management of COVID-19 in services. The structure of the monitoring questions was subsequently adapted throughout 2021 to reflect relevant questions based on the evolution of the pandemic and the resultant effects on mental health services.

Data in respect of cases was then tracked in a live log which was updated daily as the MHC was notified of confirmed or suspected case numbers in both staff and residents. In addition to gathering epidemiological data, this system was used to identify individual services which were experiencing significant challenges in containing infections. Where required, MHC escalated services to the HSE which were identified as requiring additional supports.

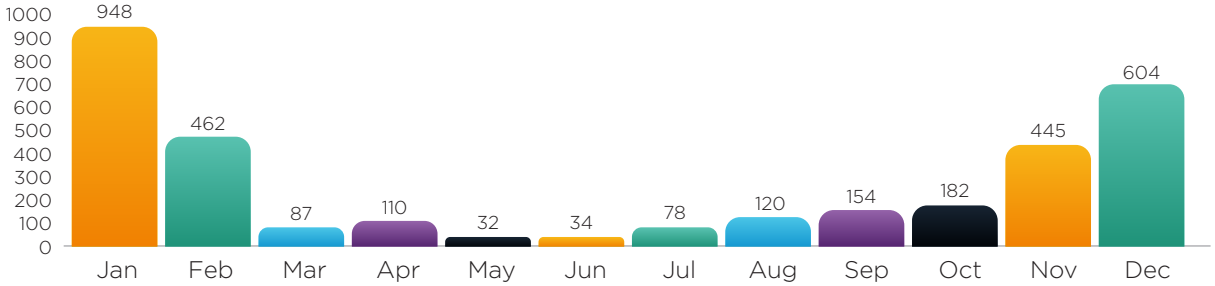
A 'point in time' report was produced each Friday detailing the current active cases of COVID-19 as notified to the MHC. This included the number of suspected and/or confirmed staff and resident cases and was circulated to relevant stakeholders in the HSE and the Department of Health (DOH).

COVID

Overview of Monitoring for 2021

Number of cases by month - the graph below (Figure 4), represents the number of total cases per month notified to the MHC. These figures included confirmed and suspected staff cases in addition to confirmed and suspected resident cases. The month with the highest cases was January with a total of 948 cases as opposed to the lowest month, May when only 32 cases were reported.

Figure 4: *Number of COVID-19 cases by month*



Number of Services with Cases – Figure 5 below displays the total number of services reporting cases per month in 2021. Parallels may be drawn between the total number of cases and the number of services reporting cases, with the peak in the number of services reporting cases occurring in January, whereas May and June saw the lowest number of services reporting COVID-19 cases.

Confirmed Staff vs. Resident Numbers - Figure 6 displays the total number of confirmed staff and confirmed resident cases per month. The graph demonstrates that, overall, the cases for staff and residents increased and decreased in unison throughout the year. However, there were significantly larger numbers of staff cases than resident cases, i.e., for every resident case there were 2.4 staff cases in 2021. The data have shown that staff in mental health services are more likely to acquire infection than residents.

Figure 5: *Number of services reporting COVID-19 cases 2021*

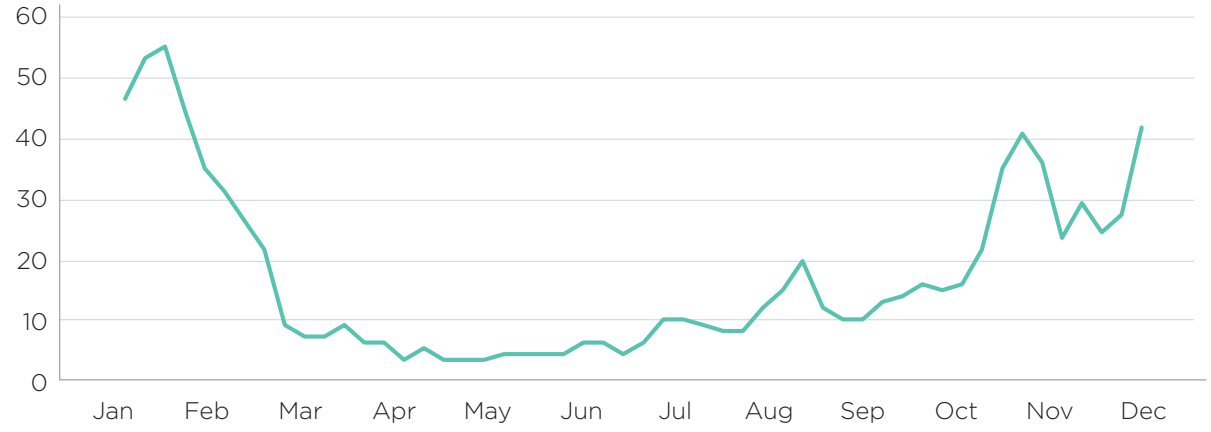
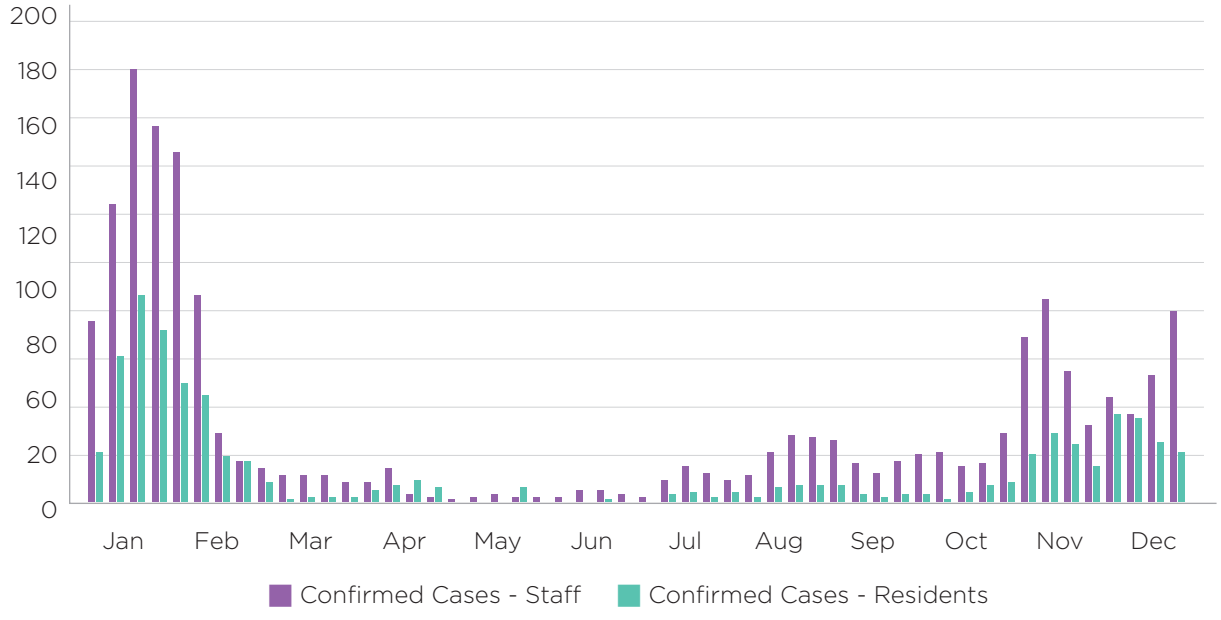


Figure: *6 Confirmed staff and resident COVID-19 cases 2021*



Escalations

A structure for escalating potential risks or services requiring additional supports during outbreaks, was established at the early stages of the pandemic. These risks were escalated to the HSE. In 2021, potential risks that were identified during the monitoring process continued to be escalated to ensure service users were at all times protected.

A total of 20 services were escalated in 2021 following the identification of potential risks. The 29 risks identified over each of these services are set out in Table 12 below.

Table 13: *Numbers and reasons for escalating potential risks*

Escalation Reason	Number
Vaccine Related	7
Staffing Issues	7
Outbreak	9
PPE	2
Other	4

Vaccination Programme

An important feature of the Covid monitoring function has been to gather assurances about the roll out of vaccines to service users.

In response to the initial vaccine roll-out programme in early January 2021, the MHC added an additional question to the monitoring calls relating to the vaccination schedule for services and the number of completed vaccinations for both residents and staff. The MHC continued throughout 2021 to monitor the vaccination roll-out and the progress of vaccinations in services against the Government's prioritisation plans.

An issue that arose out of the initial vaccine programme was the concern about the lack of a roll-out schedule for mental health services, particularly for those over 65 years old in long stay accommodation. These concerns were formally escalated by the MHC to the HSE in January 2021, stating that mental health services should be considered in parallel to physical health services in relation to all future vaccination plans. The MHC acknowledged the responsiveness of the HSE to the concerns raised and following the improved arrangements that were put in place to roll-out vaccinations to vulnerable individuals and staff in congregated care settings.

Later in 2021, the MHC focused on the monitoring of the vaccine booster roll-out in services. Over a nine-week period from early November 2021, this information was recorded from a selection of mental health services. This monitoring focused on the booster programme in services with residents over 65 and inquired as to individual roll-out schedules for each service as these were areas of concern in the initial vaccine phase.

The booster vaccine data indicated that residents in the eligible over 65s category were given priority when receiving the booster in early November 2021. By mid-December, the majority of services were reporting that their staff members had been offered a booster – either through on-site vaccinations, the HSE Portal or local community vaccination centres. By the last week of enquiries, all services contacted stated that all residents and staff had been offered a booster vaccine.

COVID Paper II

In June 2021, the 'COVID Paper II: Examining the Impacts and Response in Residential Mental Health Services' was published as a follow up paper to the MHC's previously published report, 'COVID-19 Paper 1: supervising, monitoring, and supporting Irish residential mental health services during COVID-19'

The purpose of COVID Paper II was to understand the impact of the COVID-19 pandemic on mental health services; to outline actions taken to mitigate risks and support resident wellbeing; and to report on disease impact within and between those services. The MHC also used this paper as an opportunity to analyse additional data collected in respect of disease progression between March 2020 and April 2021. The paper was then used to disseminate the learnings and developments in the current body of knowledge and to ensure services were as well prepared as

possible in the event of future surges of COVID-19, related variants or future pandemics.

In addition to data about disease progression, the MHC was keen to discover information about innovative practices and emerging best practice at a service level in response to COVID-19 and rapidly changing organisational and operational requirements. A questionnaire was devised and issued to services. The questionnaire helped identify the best practices used (individually or in collaboration with other services) with the purpose of sharing these innovations among mental health services, as well as enhancing conditions for both residents and staff. It was sent to the 183 services monitored by the MHC at the time of dissemination.

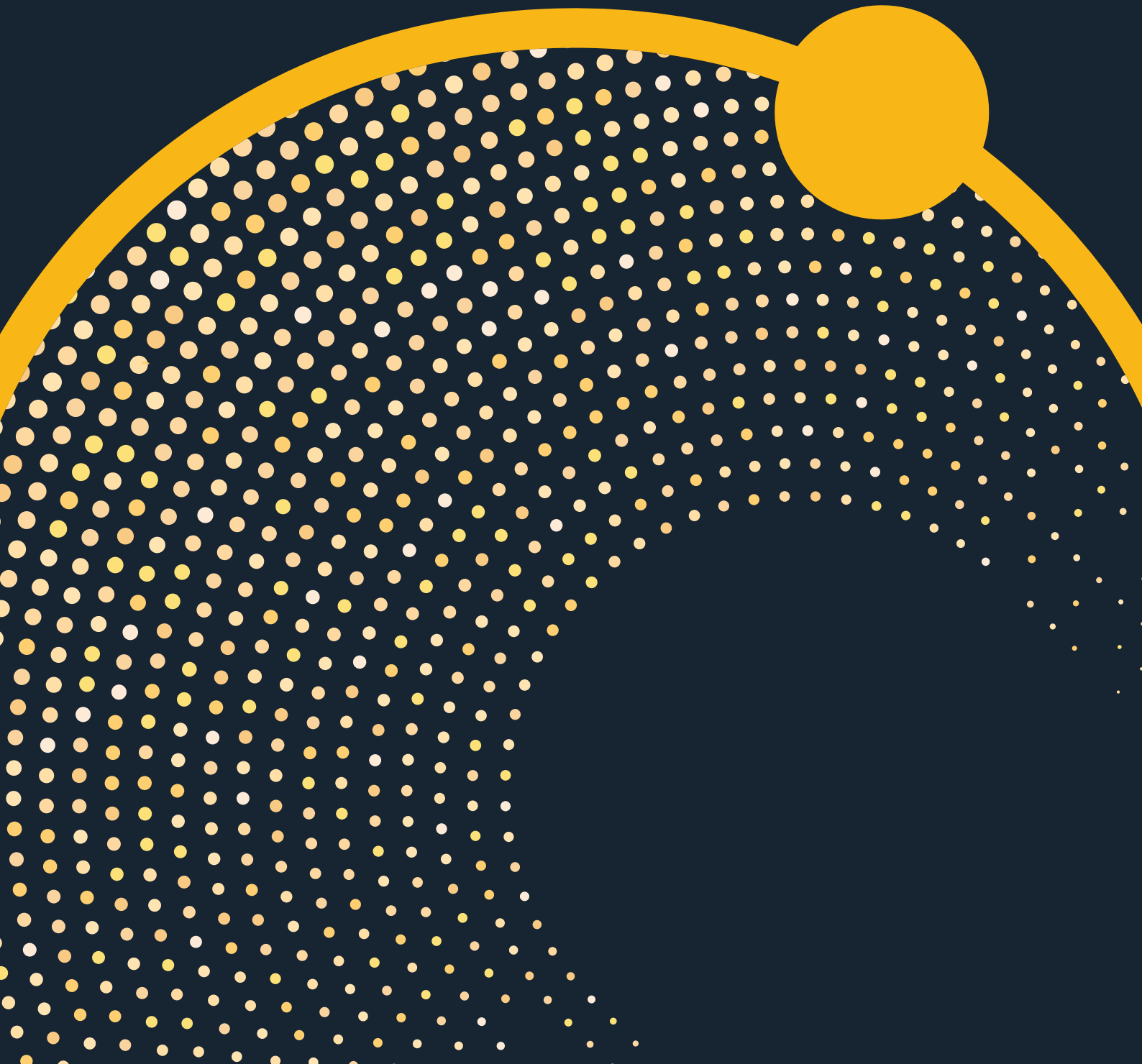
Four main areas of innovation were identified as being the most common to all participating services, and these had shown to improve service provision.

1) COVID-19 governance and management response
2) Resident wellbeing
3) Information sharing
4) Advancements in service use of technology

COVID Paper II also acknowledged the swift response from mental health services to the pandemic. The paper also praised the collaborative efforts of the services with the HSE and DOH and their considerable efforts and investments in the continuing welfare of residents, staff, and minimising disease progression throughout the pandemic.

Further information about COVID Paper II is available on the MHC's website www.mhcirl.ie.

Mental Health Tribunals



Mental Health Tribunals

Introduction

Over the past two years, during the COVID-19 pandemic, many people across Ireland have struggled with their mental health. This has been even more acute for those that were involuntarily detained.

The Mental Health Tribunal (MHT) team implemented processes and procedures during COVID-19 to ensure that it would continue to meet its obligation to vindicate the rights of those persons involuntarily detained, specifically the review of every order detaining a person and compliance with the strict statutory time limits in the legislation. These measures only went a small way to helping these people during this difficult time.

In 2020, the MHT team conducted a feasibility study on the use of videoconferencing for tribunal hearings and a subsequent pilot project commenced in the fourth quarter of 2020. This resulted in the rollout of videoconferencing to all approved centres by the end of the first quarter of 2021. The conversion of hearings from telephone to videoconferencing was a great success and the feedback from those detained and panel members was extremely positive.

Just when we thought we were on top of everything, the HSE cyber-attack occurred. This had the potential of having a significant adverse impact on the operation of tribunal hearings. Our first step was to dust off the fax machines, as there were many approved centres with whom we could only communicate with by way of fax. This resulted in hundreds, and often thousands, of pages being faxed to and from approved centres each day. This also required an urgent change by the MHT team to its standard operating procedures for all the affected approved centres, requiring increased diligence with regard to confidentiality, data protection and compliance with statutory time limits. It is very important to acknowledge the tremendous work by all involved during this period, with particular mention to the great work of the Mental Health Act Administrators in affected approved centres. This is a real positive example of state agencies rising to the challenge and ensuring that the rights of the less vulnerable take priority.

The MHC was still anxious to resume in-person hearings, which is considered the most favourable format for detained persons. Accordingly, a further project was commenced in the second quarter of 2021, regarding the return of in-person hearings. The MHC did return to in-person hearings in a number approved centres in September 2021, but this had to be suspended in November 2021 due to a further increase in the number of people with COVID-19[3].

The MHT team wanted to continue its stakeholder engagement. Firstly, it arranged a seminar on cultural diversity for the MHC staff and panel members, it then arranged individual seminars for four of its five panel member groups and jointly presented to the College of Psychiatrists.

The MHT team then considered how best it might communicate with the persons detained, their families, advocacy networks and others regarding the processes relating to involuntary detention. This was in the context of making information available in a more user-friendly manner against the backdrop of COVID-19, where we could

[3] In-person hearings were resumed again in 2022 but this has been impacted due to the continued high level of COVID cases in approved centres.

not physically go and meet people. A number of actions were taken – the MHT undertook a comprehensive review of its information booklets which were then redesigned and rewritten to make them more accessible and user friendly. These booklets are now available in written and audio versions in nine languages. With the assistance of the communications team this information was made more easily accessible on the MHC's new website. Finally, a comprehensive poster campaign, highlighting the updated information available on the mental health tribunal process, was undertaken. Mental health services and other related organisations across the country were asked to place the posters with information about the mental health tribunal process in their facilities, offices, and other relevant spaces.

Mental health tribunals (tribunals)

Under the Mental Health Acts 2001-2018 (2001 Act), every adult who is involuntarily detained in an approved centre shall have their detention order referred to a mental health tribunal to be reviewed. This is a core requirement in vindicating and upholding a detained person's 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.

The issues to be considered by the tribunal are –

1. Whether the person has a mental disorder as of the date of tribunal, and

2. If there has been compliance with certain specified sections of the 2001 Act, or not, and if not does that non-compliance effect the substance of the order or not.

Having considered the above issues, the tribunal must affirm or revoke the order. Currently, the decision of a tribunal is not published. However, it is proposed under the General Scheme to amend the 2001 Act, as published in July 2021, that these will all be published in an anonymised format. In preparation of this, all tribunal decisions are now delivered in a typed format and not handwritten format. This will result in greater transparency of the tribunal process.

As part of this process, the MHC assigns each detained person a legal representative (covered by legal aid) but, if they so wish, the person may seek to have another solicitor from the MHC's panel appointed to them and the person may appoint their own private solicitor.

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

Parties who may attend a tribunal in addition to the tribunal members are the detained person (who may not always attend), the person's legal representative (if the person wants them to attend) and the person's treating consultant psychiatrist.

A sample was taken of 45 hearings in 2021 (15 from April, June, and October) and 84% of patients attended their hearing. In 2019, 73% and in 2020, 82% of patients attended their hearing. Therefore, it would appear that COVID-19 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 2021, the following orders were made:

- 1,971 admissions orders from the community
- 578 admissions orders by way of re-grading
- 928 renewal orders for a period up to three months
- 281 renewal orders for a period up to six months

From 2020 to 2021, there was a 5% increase in admission orders and no change in renewal orders. The reason for the increase in admission orders is not clear.

Figures 7-9 and **Table 14** in the Appendices on pages 51 and 52 provide detailed information on admission and renewal orders.

Additional Reviews

Since October 2018, the maximum period for which an order can be made to involuntarily detain a person is six months. If a person is detained for longer than three months during that six-month order, the person is entitled to an additional review by a tribunal. This is an extra safeguard for patients. The additional review only considers the issue of mental disorder, it does not address any issues related to compliance, which are to be addressed at the initial hearing for the order.

In 2021, there were **190** detained persons who were eligible to seek an additional review, of which:

- Twenty-eight requests were received for hearing.
- Three orders were revoked before the hearing took place.
- Twenty-five hearings took place with all orders being affirmed.

The MHC expressed its concern about the low rate of uptake of additional reviews in the 2020 Annual Report. A number of measures were taken to seek to address this issue to include preparing and distributing a dedicated leaflet with regard to a patient's right to an additional review, addressing the issue in other information leaflets, placing an automatic reminder for legal representatives on our ICT (CIS) system to remind them to contact their client at the relevant time and addressing the issue with legal representatives at our seminar in 2021.

Unfortunately, the above did not yield the result that we had hoped. The MHC is proposing to revert to the Department of Health (DOH) asking them to consider limiting detention orders to 21 days and three months and removing six-month orders, and the need for additional reviews, or making the additional review after three months mandatory.

Tribunal Hearings

3,759 orders were made in 2021 and of those it is noted:

- 1,869 orders were revoked before hearing – 49.7%
- 1,910 orders went to hearing – 50.3%
- 203 orders were revoked at hearing

Both the % of orders revoked before hearing and at hearing remain the same as last year.

Orders revoked before tribunal:

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

In deciding whether to discharge a patient, the consultant psychiatrist must 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 reasonably necessary for their proper care and treatment.

Where the responsible consultant psychiatrist discharges a patient under the 2001 Act, they must give to the patient concerned, and his or her legal representative, written notice to this effect. When a patient's order is revoked, they may leave the approved centre, or they may agree to stay to receive treatment on a voluntary basis. 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 10** in the Appendices on page 53.

Orders revoked at tribunal:

A total of 1,910 orders were reviewed by a tribunal and of those 203 were revoked (i.e. 11% of the cases that went to hearing were revoked). This is the same % of revocations as in 2020. **Figure 11** in the Appendices on page 53 provides a further breakdown of these revocations. In relation to those revocations:

- 101 did not meet the criteria in section 3 of the 2001 Act.
- 87 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.
- 14 are a combination of the above i.e., they 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.
- 1 for another reason

The number of revocations for non-compliance has increased from 39% to almost 50% (101 cases) in 2021. This is a concern given the individual targeted seminars organised for the treating consultant psychiatrists and the individual panels.

In addition, in 2021, of the 43% (87 cases) of revocations that were solely due to issues of non-compliance approximately 50% of the cases related to errors on the patient notification form. The patient notification form was amended, and two forms produced – the first for admission orders and the second for renewals – together with a guidance document. It was hoped that this would see a reduction in the number of errors with this form but that did not happen.

The MHC shall consider further targeted training for the treating consultant psychiatrists and the panel members to see how these revocations for non-compliance may be addressed. Furthermore, it is proposed in 2022 to review the percentage of orders revoked per approved centre for non-compliance to ascertain if targeted training is required or not

Tribunals for transfers to the Central Mental Hospital (CMH)

There were no proposals received to seek the transfer of a patient to the CMH in 2021.

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 1,869 orders revoked before hearing, there were 37 requests for Section 28 tribunals of which 21 proceeded to an actual hearing. This is a very small percentage (1%) of the orders revoked before hearing.

The MHC in its submission to the DOH in March 2020 requested that section 28 be reviewed and its purpose clarified to assist persons involuntarily detained, those representing them and the tribunal members. The DOH has addressed this in the General Scheme to amend the 2001 Act published in July 2021.

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 2021, 92% 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.

In **Figure 12** in the Appendices on page 54, it can be seen on what day of that 21-day period tribunals were heard.

Admissions from the community

There were 1,971 admission orders from the community in 2021 and one of the issues which the MHC considers each year is who makes these applications.

The key changes in the 2021 figures compared to 2020 are that applications by family members are down by 4% and applications by authorised officers (AOs) remain the same. However, applications by An Garda Síochána are up again

and this time by 3% with applications by 'any other person' up by 1%[4].

Please refer to **Figure 13** and **Figure 14** in the Appendices on page 54 and 55.

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

- It welcomes the continued decrease in applications by family members.
- It is very disappointed that applications by AOs have remained the same as 2020 (see below), given the discussions on this issue.
- It continues to be 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.

However, since the publication of the Annual Report in 2020 the following has occurred:

1. The MHC met with An Garda Síochána on two occasions, and they share the MHC's concern with regard to the figures and the increase in same. The parties have agreed to work together where possible on this issue be it in relation to specific training for the Gardaí or otherwise.
2. The HSE re-established the Working Group to review the role of the AO and consider an increase in number of AOs. We await further information on this issue.
3. The DOH in its General Scheme to amend the 2001 Act took on board the recommendation made by the MHC in its Submission to the DOH in 2020(*), that no applications for involuntary detention should be made by the Gardaí (be it under section 9 or section 12 of the 2001 Act).
4. The MHC in 2021, as part of the pre-legislative scrutiny of the General Scheme to amend the 2001 Act, appeared before the Joint Sub-Committee on Mental Health and reiterated its argument on this issue.

* In its Submission to the DOH on the Heads of Bill to amend the 2001 Act in March 2020, the MHC noted several matters on this issue of authorised officers:

- There are several practical implications, which the DOH will have to address to ensure that the relevant amendments to the 2001 Act work which would include funding to the HSE to ensure that **24 / 7 service 365 days a year** is available throughout the country.
- The service will also have to be available for all approved inpatient facilities – public and private.
- The current Regulations relating to AOs will have to be amended, to redefine the professional requirements for someone to be appointed an AO (for example, relevant healthcare professional) and, of importance, specify the assessment tool / criteria to be applied by the AO when making an application.
- Consideration is to be given as to whether the MHC should be required to carry out some form of inspection and or an audit in relation to this part of the service to ensure that it is in fact vindicating the rights of persons.

The MHC has rejected the "resources" argument made by some parties for not proceeding with the change.

Voluntary to Involuntary

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

As noted above, there were 578 such admissions notified to the MHC in 2021.

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

Age and Gender

Analysis of age and gender for episodes of involuntary admission in 2021 show the following:

- People aged 35-44 had the highest number of involuntary admissions at 24% (up 1% from 2020).
- 57% of the total involuntary admissions were male.
- However, there were more female admissions in the age groups over 55.

See Tables 15,16 and 17 on page 55 for further detailed information.

Quality Improvement

The MHT undertakes audits across three main areas –

- The work of the MHT team.
- The decisions 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 360 tribunals 94% were scheduled within 12 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. Forty-five patients chose to be represented by another legal representative from the panel.
- Patients are also entitled to be represented by their own private solicitor or represent themselves under the Constitution. Five patients chose a private solicitor to represent them, and none 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 –

1. 120 decisions over a 12-month period were reviewed.

2. 26 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.

Ninety-eight (98) issues were logged. Of note:

- 67% of the issues were in relation to revocations of orders that were signed and received on the day of the patient's tribunal hearing, some at the time the tribunal was due to commence.
- Forms received later than the statutory 24-hour timeline accounted for 10% of issues, with consequences for the validity of the detention in some of those cases.

Sixty-six issues were recorded in 2020 and eighty-nine issues were recorded in 2019.

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 133 Circuit Court appeals in 2021. This is a reduction on previous years; in 2020, 156 appeals were received and in 2019, 153 appeals were received.

Of the 133 appeals received in 2021:

- 111 appeals did not proceed to full hearing.
- 13 appeals proceeded to full hearing.
- 11 were affirmed by the Court
- 2 were revoked by the Court.
- Some cases that were appealed in 2021 have still not gone to hearing, and some cases from 2020 only went to hearing in 2021.

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, which were incorporated into the General Scheme to include:

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 approved centre shall be the respondent to the proceedings as the detainer.

The above is separate to the MHC's submission 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

Figure 7: *Monthly involuntary admissions 2021*

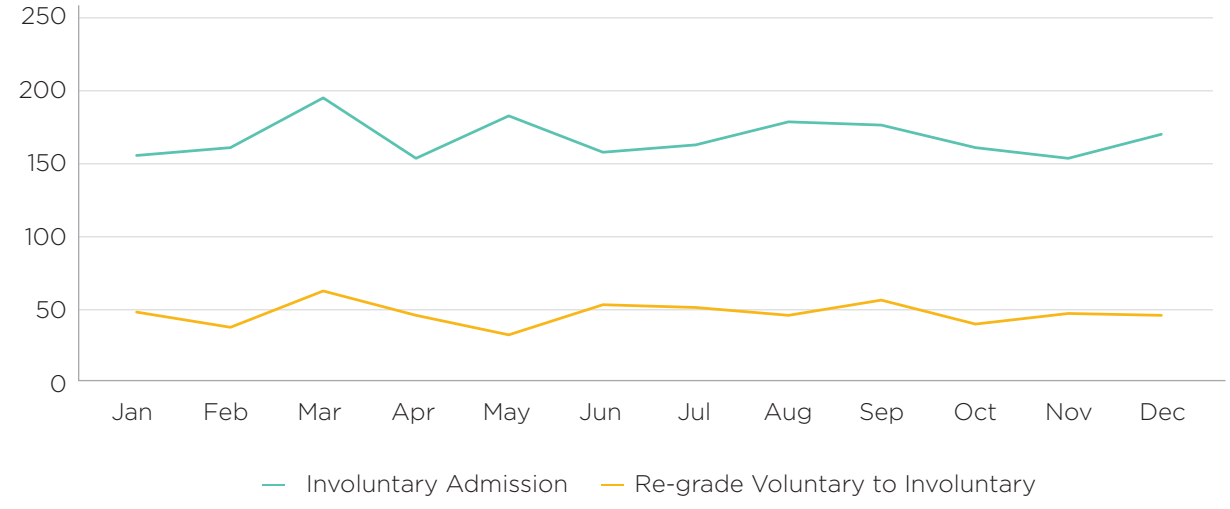


Figure 8: *Comparisons of total involuntary admissions 2017-2021*

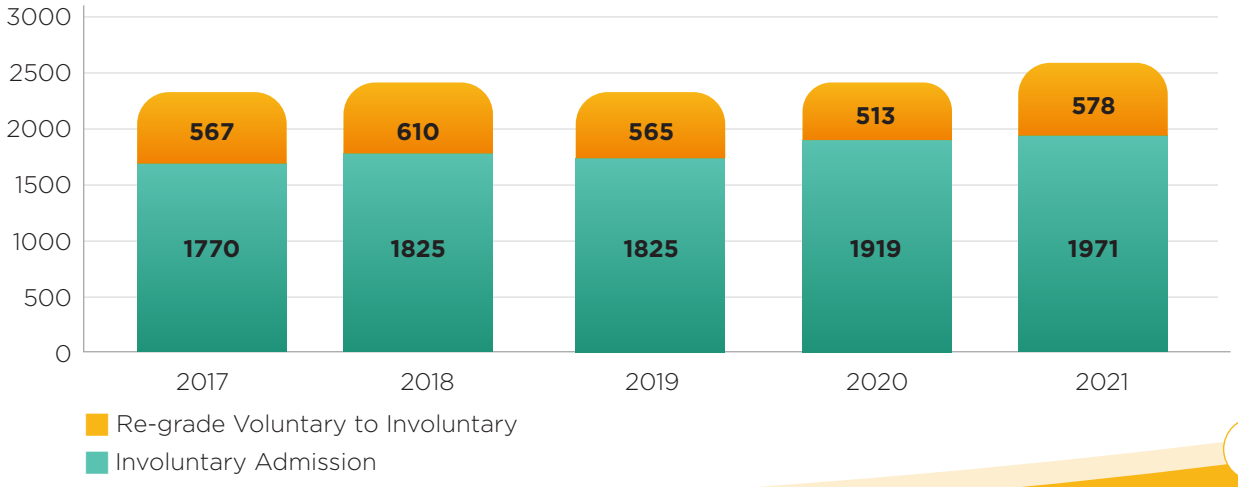


Figure 9: *Comparison of renewal orders 2017-2021*

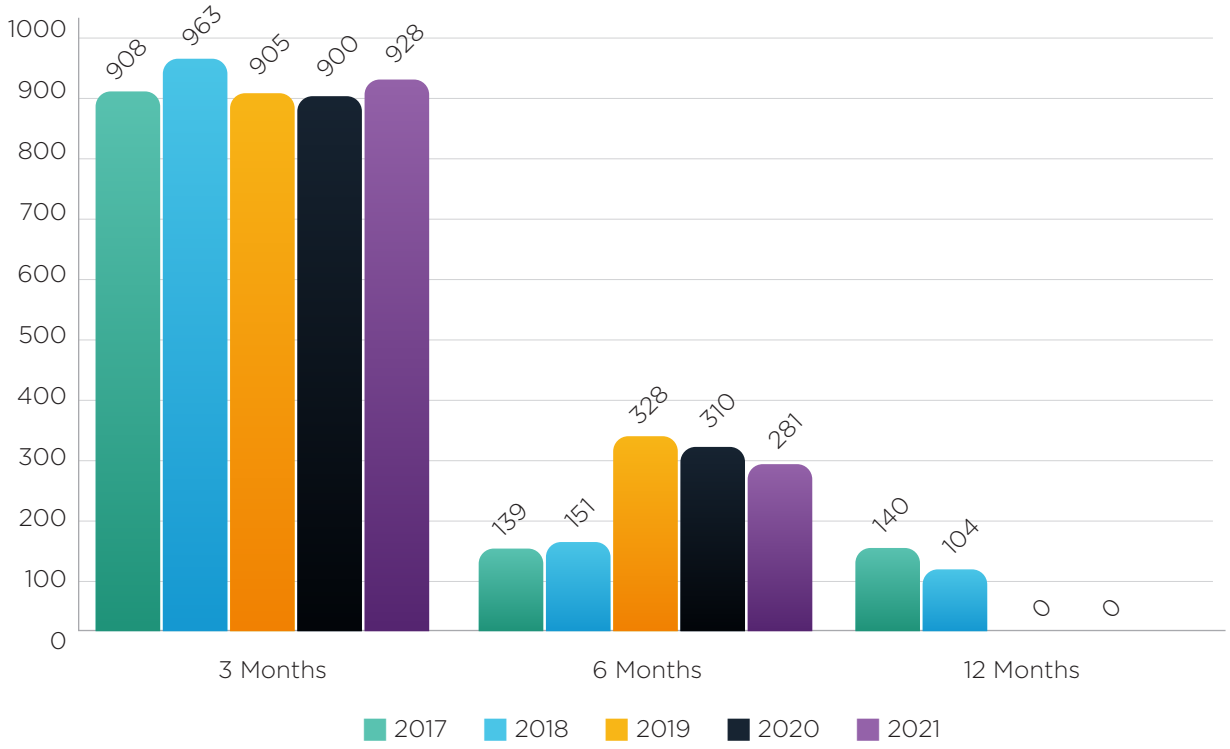


Table 14: *Involuntary admission rates for 2021 (adult) by CHO area and independent sector*[5]

	Involuntary Admissions	Re-grade Voluntary to Involuntary	Total Involuntary Admission Rate
CHO1	159	36	195
CHO2	205	43	248
CHO3	115	38	153
CHO4	297	101	398
CHO5	180	49	229
CHO6	142	15	157
CHO7	240	63	303
CHO8	213	47	260
CHO9	339	107	446
Independent Sector[5]	81	79	160
TOTAL (Exclusive of Independent sector)	1,890	499	2,389
TOTAL (Inclusive of Independent sector)	1,971	578	2,549

[5] There are eight independent approved centres

Figure 10: *Number of orders revoked before hearing by responsible consultant psychiatrists for years 2017 to 2021*

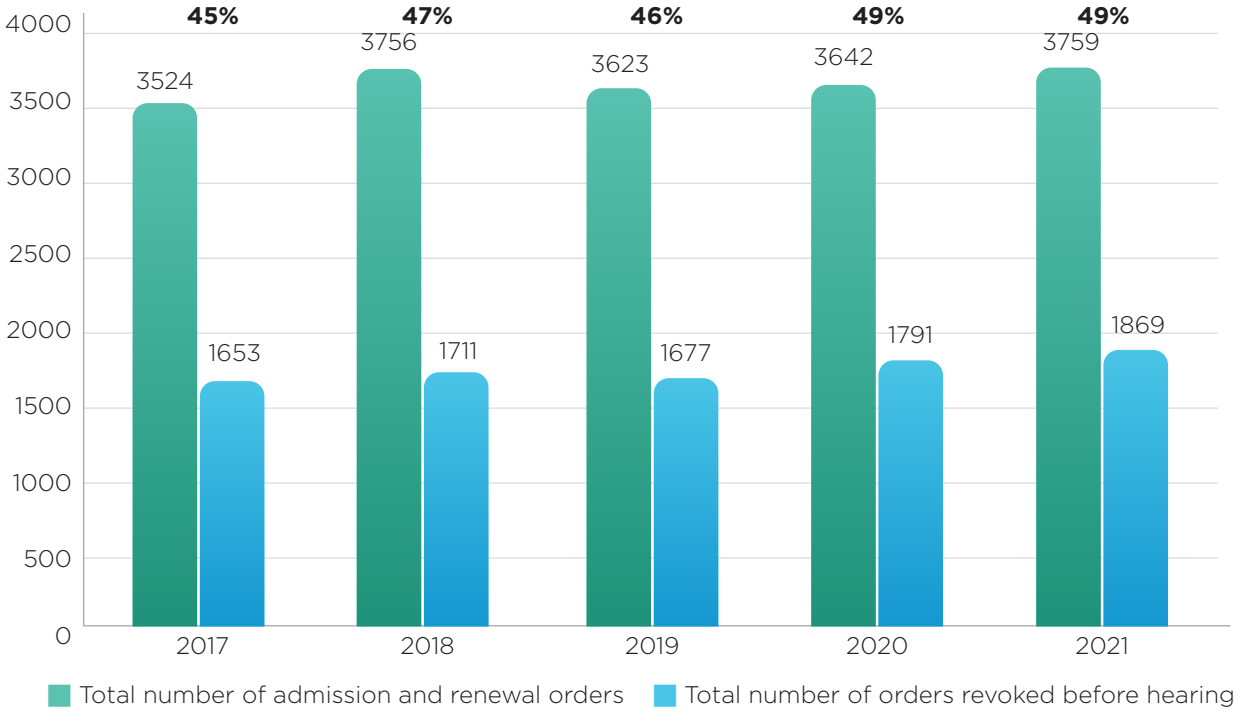


Figure 11: *Number of hearings and % of orders revoked at hearing 2021*

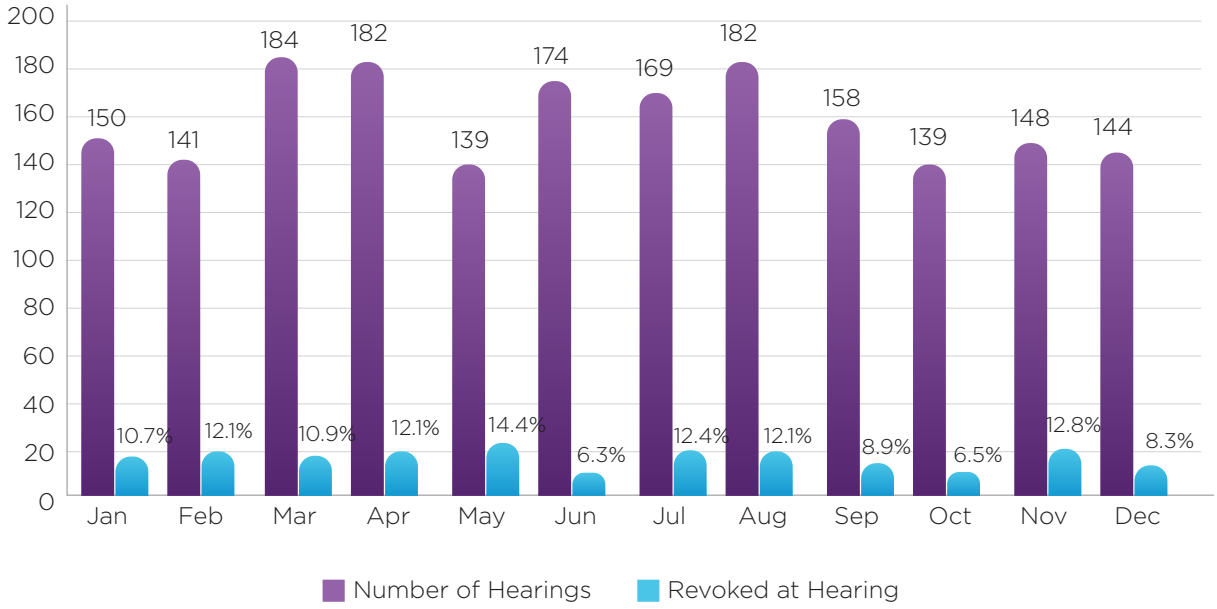


Figure 12: *Breakdown of Hearings in 2021 over 21-day period*[6]

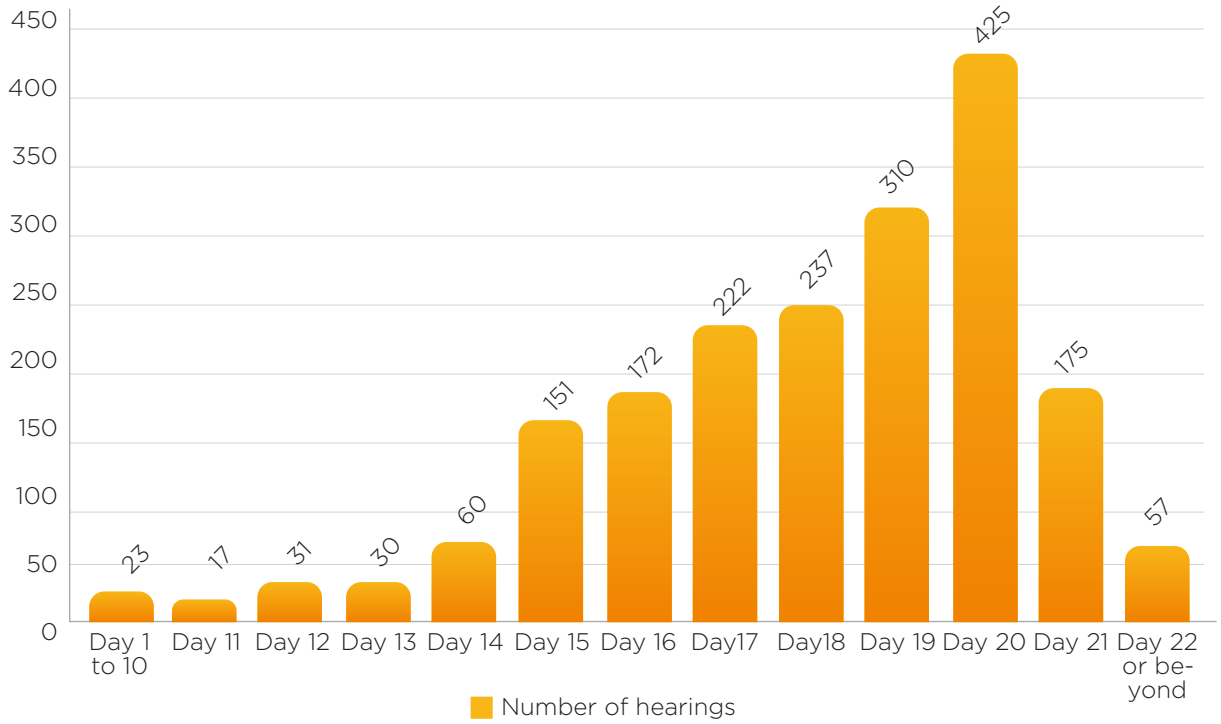
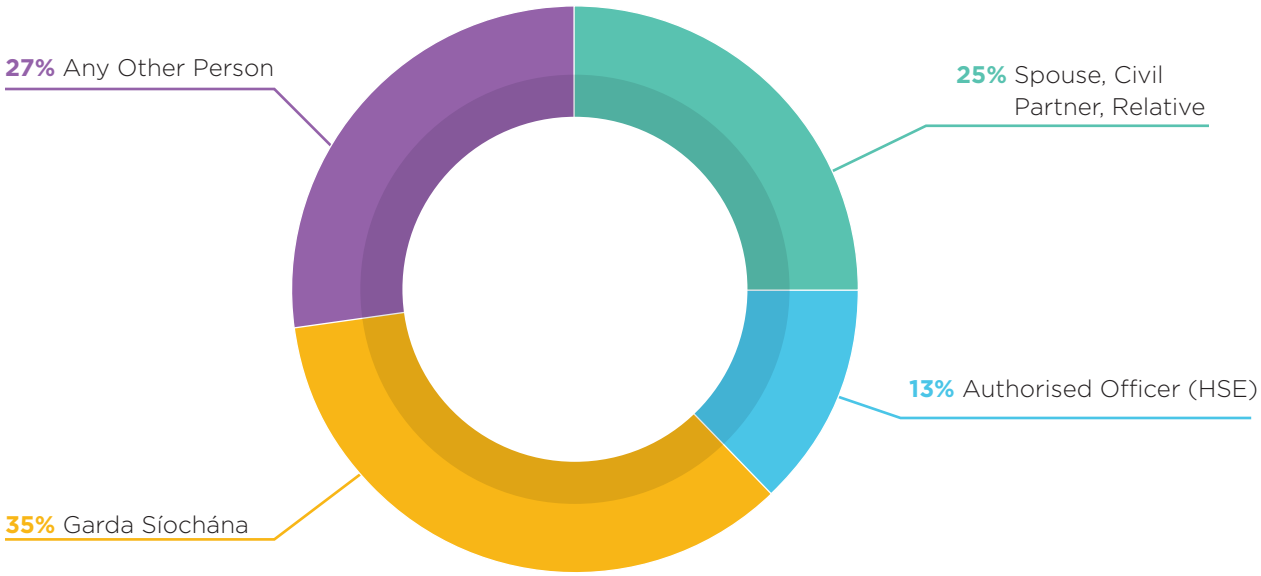


Figure 13: *Analysis of applicants for involuntary admissions from the community in 2021*



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

Figure 14: *Analysis of applicants of involuntary admissions from community from 2012 to 2021*

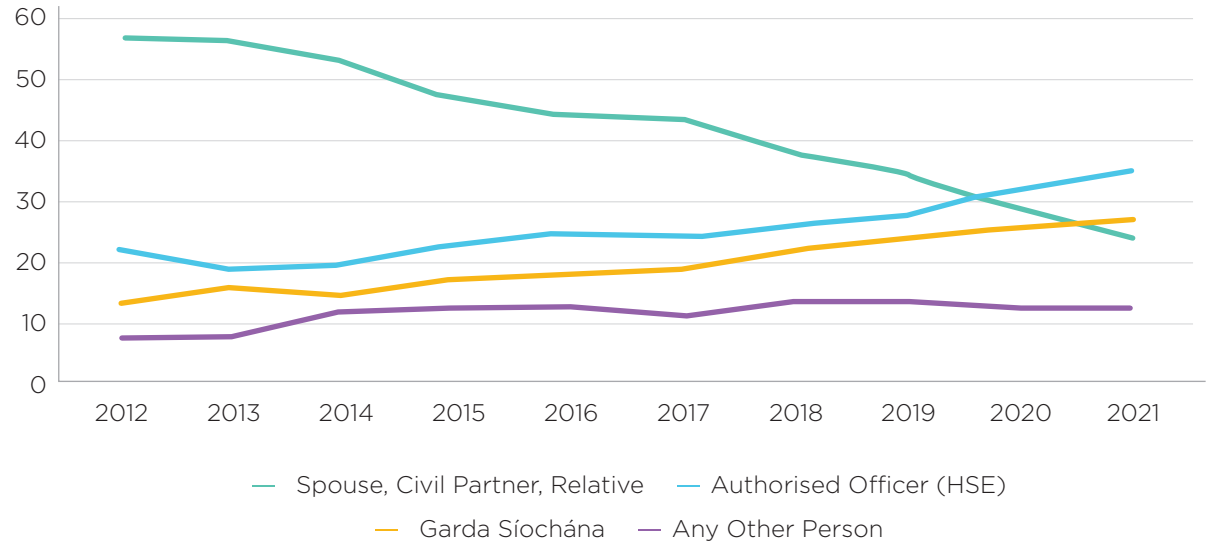


Table 15: *Analysis by gender and age of 2021 involuntary admissions*

Age	Male	Female	% Gender
18 – 24	220	102	68% male
25 – 34	384	177	68% male
35 – 44	344	260	57% male
45 – 54	220	199	53% male
55 – 64	136	154	53% female
65 +	158	195	55% female
Total	1462	1087	57% male

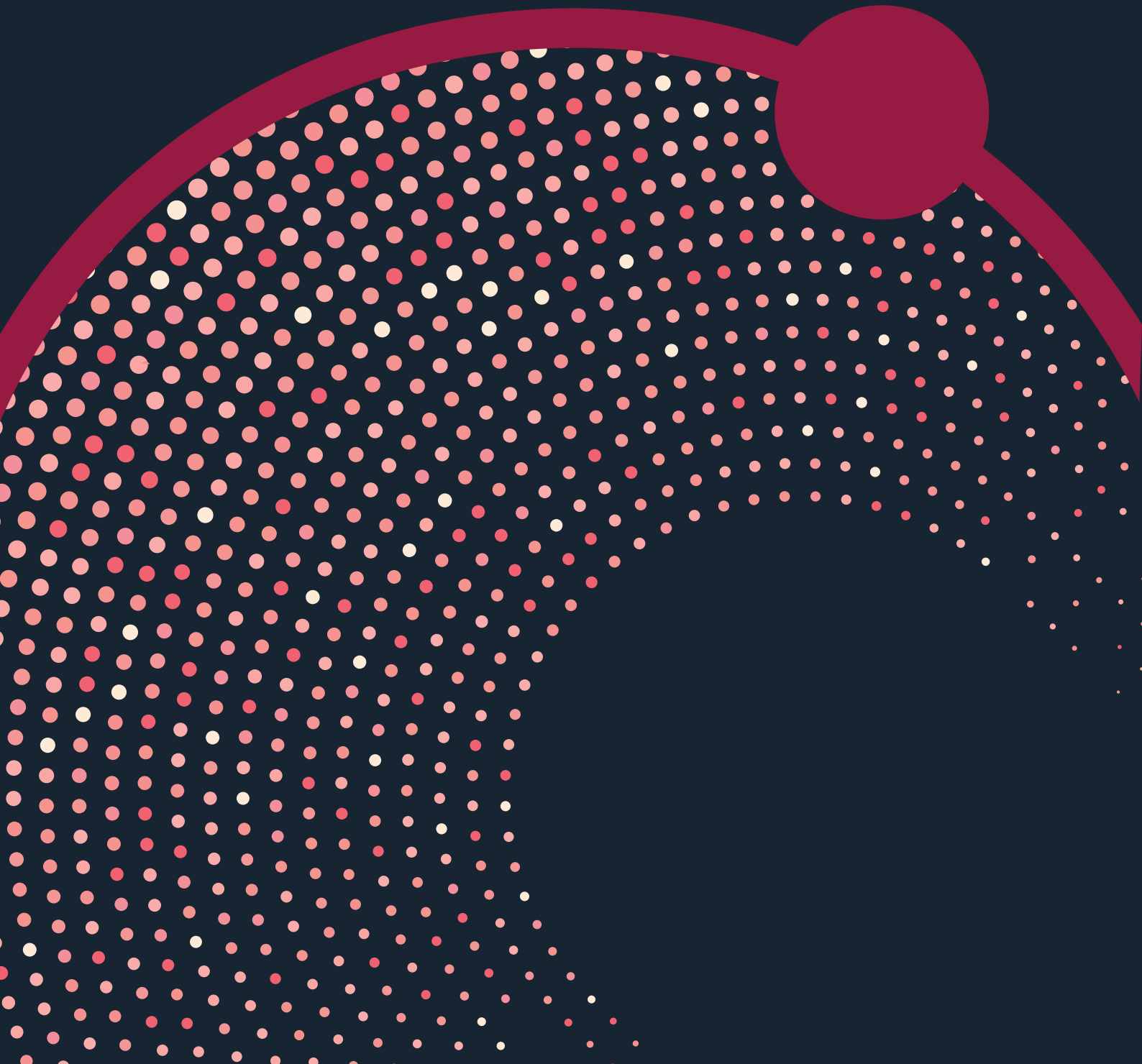
Table 16: *Analysis by gender and admission type of 2021 involuntary admissions*

Gender	Form 6	Form 13	Total	%
Female	803	284	1,087	43%
Male	1,168	294	1,463	57%
Total	**1,971**	**579**	**2,549**	**100%**

Table 17: *Analysis by gender, age and admission type of 2021 involuntary admissions*

Age	Form 6	Form 6 Female	Form 6 Male	Form 13	Form 13 Female	Form 13 Male	Total	%
18 – 24	227	66	161	95	36	59	322	13%
25 - 34	433	128	305	128	49	79	561	22%
35 - 44	488	190	298	116	70	46	604	24%
45 - 54	340	159	181	79	40	39	419	16%
55 - 64	217	113	104	73	41	32	290	11%
65 and over	266	147	119	87	48	39	353	14%
Total	**1,971**	**803**	**1168**	**578**	**284**	**294**	**2,549**	**100%**

Decision Support Service



Decision Support Service

General Update

Despite the disruption caused by the COVID-19 pandemic during 2021, the Decision Support Service (DSS) continued to prepare for the commencement of the Assisted Decision-Making (Capacity) Act 2015 (2015 Act) planned for June 2022.

Throughout the year, the DSS focused on progressing more than 20 sub-projects across six workstreams to ensure we met the critical milestones necessary and kept the roadmap to commencement on track.

The DSS continued to work closely with the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) in relation to various proposed amendments to the 2015 Act. The General Scheme and Heads of Bill were approved by the Government in November 2021 and the DSS commenced a detailed review of the practical implications of the proposed amendments for the delivery of the service.

On the working assumption that the amendments contained in the General Scheme will be enacted, the DSS has continued to progress key projects, including the ICT system development which is a cornerstone of our service. The DSS have also adjusted our plans for the delivery of the service to reflect the Department of Health's decision that it would not be introducing any regulations under Part 8 (advance healthcare directives) prior to the commencement of the 2015 Act. Based on this, the DSS adjusted planning and communication with stakeholders accordingly.

In May, the DSS completed our workforce plan. This detailed exercise was undertaken to establish the future workforce needs of the DSS and the wider MHC support functions. This was informed by a detailed analysis of expected demand levels for the DSS once operational and considered the necessary resources to achieve this objective. The projected resourcing needs to meet demand was developed through a detailed analysis of demand forecasts for services, and roles and responsibilities for the delivery of future business processes.

The Courts Service is a key stakeholder affected by the commencement of the 2015 Act, and the DSS continued to engage regularly with the Courts Service via a new inter-agency taskforce to ensure our processes will align effectively. The DSS conferred with the OWOC in relation to their plans for the review and discharge of current wards.

It has been projected that 40% of current adult wards will seek to exit within the first year following commencement of the DSS. This provided the DSS with an indication of the number of wards that could potentially enter the DSS decision support framework.

2021 ended with significant progress being achieved. It was confirmed that the DSS would receive a budget of €7.3m in 2022, an important uplift of €1.5m to facilitate commencement of the Act. The DSS published our Demand Forecasting Report in which we analysed existing data sets and applied methodology to estimate the numbers of decision support arrangements likely to be registered with the DSS in the first five years of operations. The first of two phases of our public consultation on the codes of practice commenced in November. Draft regulations dealing with several outstanding procedural and documentary matters were shared by DCEDIY for review.

2021 marked 150 years of the Lunacy Regulation (Ireland) Act 1871 under which the wardship system is administered. The 2015 Act and the reforms it delivers, based on a human rights approach will provide an enhanced level of rights for those who may need support with their decision making. The repeal of the Marriage of Lunatics Act 1811 was also commenced during the year, thus lifting the prohibition on persons in wardship being allowed to marry.

Engaging with Stakeholders

Due to the wide-ranging impact the 2015 Act has across multiple sectors, it is important that the DSS fulfils its statutory obligation to promote awareness and understanding of its provisions. Accordingly, despite the impact of restrictions due to the COVID-19 pandemic, the DSS successfully engaged with a large number of stakeholders by utilising online video conferencing. This enabled us to explain the complexities of the new decision support framework for organisations, professionals, and members of the public alike. This legislation is not targeted at, nor does it belong to a particular cohort of people. Anyone could experience difficulties with their decision-making capacity in the future due to illness or injury and the Act provides important tools for advance planning. Therefore, the Act has potential relevance for every adult in the state. In total the DSS met with 96 separate organisations throughout 2021. (See Table 18).

In addition to these engagements, the Director and management team attended a Joint Oireachtas Committee on Disability Matters in May, at which the Director provided a comprehensive statement detailing the implementation plan for the introduction of the new service. The Director also published articles in a number of publications in the health and financial sectors.

Project Update

Service Design

With significant groundwork completed, the DSS continued to develop the necessary policies, procedures and materials that will support the organisation and those that engage with the DSS. An important next step was to further assess and safeguard the personal data the DSS will collect in providing our services. This involved completion of a detailed data protection impact assessment which was drafted throughout the second half of 2021, ready for consultation with the Data Protection Commission in early 2022.

Demand Forecasting

2021 saw the completion and publication of the DSS service demand forecasting paper. This is an important document that will help shape the DSS service provision across our early years. The aim of the project was to identify and establish a baseline population of adults likely to benefit from supports and services provided by the DSS.

ICT Project

The DSS case management system and public facing portal are considered a cornerstone of the DSS service provision and 2021 saw the development of additional key functionality. The DSS is committed to creating a user-friendly system that meets international accessibility standards while ensuring end users are involved in its design. The objective of the DSS is to create a digital first service while providing accessible options to those unable to engage with us digitally.

Codes of Practice

Following submission of the draft codes of practice to the DSS by the National Disability Authority (NDA) and the HSE Advanced Healthcare Directives Multi-Disciplinary Working Group, the codes were aligned for consistency before being launched for public consultation in November 2021. The codes were split into two phases for public consultation with six of the 14 codes made available in phase one drawing a total of 163 responses. All codes will progress through a quality review process prior to ministerial approval.

Organisational Design

Following the completion of the workforce plan, sanction was received for eight posts for 2021 as well as the necessary funding to support these roles. In addition, sanction was received for 11 posts to be recruited in 2022. Work has developed on the development of the staffing and governance structures necessary to support the DSS in anticipation of commencement in 2022.

Training Strategy

Upon completion of the training strategy a detailed training plan for all DSS staff was developed. This provided a road map to ensure that all staff can be trained to the necessary standard. A separate training plan was also developed for all those who will be successfully placed on one of the DSS panels.

Panel Recruitment

There was significant preparatory work conducted throughout the year in anticipation of the recruitment campaigns to commence in Q1 2022 to establish the four panels of suitable persons under the Act. Following a tendering process in July 2021, Sigmar Recruitment was awarded the contract to provide recruitment services to establish these panels. Position papers were drafted on the scheme of fees for panel members, and approved by the DCEDIY in December 2021.

Table 18: *Stakeholders engaged with in 2021*

Neurological Alliance of Ireland	Laura Lynn Foundation	Social Care Ireland Conference	An Garda Siochana
National Advocacy Service and Patient Advocacy Service	IRD Duhallow	The Housing Agency	Irish Association of Chartered Physiotherapists
National Ambulance Service, Dublin Fire Brigade and Pre- Hospital Emergency Care Council	Focus Ireland	Irish Association of Occupational Therapists	HIQA (Disability and Residential Pillars)
The Irish Council for Social Housing	Dementia Research Network	Irish Prison Service	Family Carers Ireland
Downs Syndrome Ireland	KARE services	Citizens Information Service and MABS	Camphill Community
HSE Primary Care Manager's Group	The Legal Aid Board	Cheshire Ireland	National Coagulation Centre, St James Hospital
Irish Rural Links	Polish Community – Disabled Person's Association in Poland	Tallaght University Hospital	The Irish Hospice Foundation
Confidential Recipient	Galway University Hospital	Brokers Ireland	Nursing Homes Ireland
Our Lady of Lourdes Hospital	Chartered Accountants of Ireland	Dara Community Living	Insurance Institute
Cope Foundation	Irish Banking Culture Board	Trinity College Dublin	Insurance Ireland
Office of Public Guardian Scotland	The Irish League of Credit Unions & staff of Credit Unions	The Banking and Payments Federation of Ireland	Irish Wheelchair Association
St John of Gods Community Services	Ability West	Sunbeam House Services	Irish Adult Dysphagia Special Interest Group
St Michael's House	Financial Service and Pensions Ombudsman	Brothers of Charity Services	Western Care Association
James Connolly Memorial Hospital	Bons Secours Hospitals	Stewarts Care	Mater Hospital
St Vincent's Hospital	HSE National Safeguarding Office	Medical Defence Union UK	L'Arche Community
Sage Advocacy	NDA Conference	National Screening Service	Psychological Society of Ireland – Beaumont Hospital
Galway University Hospital	Education and Training Boards – Home Care Tutors	Department of Health	Joint Oireachteas Committee on Disability Matters
Joint Oireachteas Sub-Committee for Pre-Legislative Scrutiny on the Mental Health (Amendment) Bill	Joint Oireachteas Committee on Justice - on the topic of 'Minorities engaging with the justice system	Anne Rabbitte TD, Minister of State for Disability in the Dept of Health & Dept of Children, Equality, Disability, Integration and Youth	Department of Justice
Department of Children, Equality, Diversity, Integration and Youth	HSE	Courts Service	Wards of Court Office
Safeguarding Ireland	Central Bank of Ireland	IHREC	5 Nations
Scott Review of Mental Health and Incapacity Legislation in Scotland	Garda Victim Liaison Office GNPSB	STEP Mental Capacity SIG Spotlight UK	Maynooth University
PADMACS UCD School of Nursing	UCD Smurfit School of Business	Dementia Research Network Ireland	Inclusion Ireland
Irish Adult Dysphagia Special Interest Group	Legal Services Regulatory Authority	Law Society	Barnardos
National Federation's ADM Reference Groups			

2021 Stakeholder Engagement

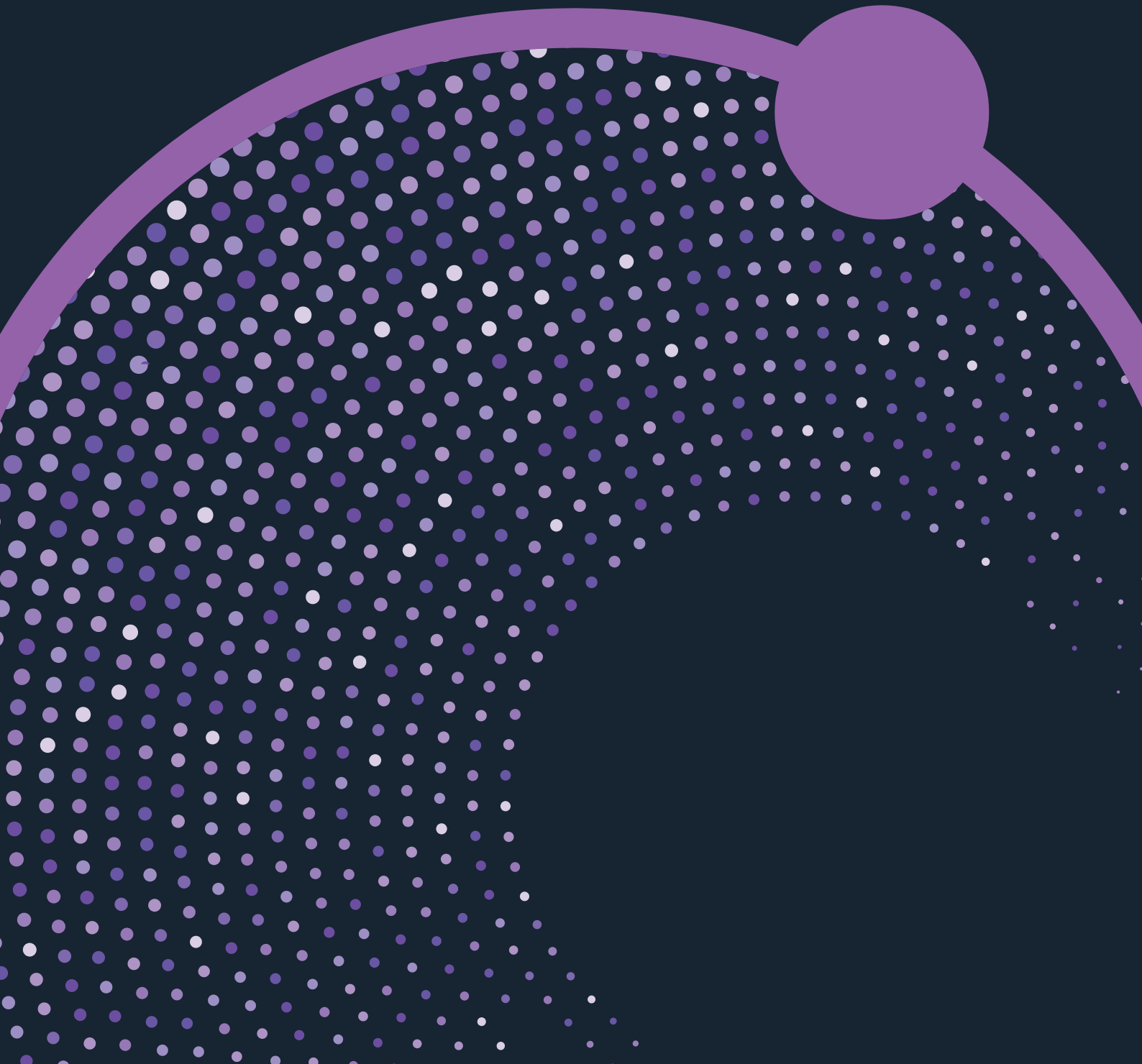
96 stakeholders

500 questions about the Assisted Decision-Making (Capacity)Act 2015 and the DSS

10 articles published

40 frequently asked questions on the website

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 2021 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 Commission (Board). These reserved functions include planning and performance functions, commission committees, financial transactions, internal controls, executive assurances, and risk management. The reserved functions are reviewed by the Commission every second year. In addition to this, the Commission also has a Scheme of Delegation in place to ensure that the organisation can carry out all 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. In the first quarter of 2021, the Commission undertook a full review of the Corporate Governance manual and related documents - the Reserved Functions of the Commission, Scheme of Delegation, Code of Conduct, Protected Disclosures Policies (internal and external) and Customer Charter.

Key Governance activities undertaken in line with the 2016 Code

Board effectiveness

In line with good governance, the Commission undertook a self-assessment survey for 2021. This was considered by the Commission Members at its meeting in January 2022. In addition to this, in November 2019, consistent with governance best practice and the requirements of the 2016 Code, the Commission engaged external providers to independently conduct a board effectiveness review, to report on its findings and to make recommendations. This report was presented at the Commission Meeting in April 2020. A set of actions arising from the report was agreed to be taken with a view to further improving the effectiveness of the Commission and its Committees. The Commission has taken ownership of these actions, which have been monitored and updated throughout 2021.

The Finance, Audit and Risk Committee (FARC) and the Legislation Committee also undertook self-assessments for 2021.

Gender balance in the Commission membership

As of 31 December 2021, the Commission had 5 (38%) female and 8 (62%) male members. The Commission almost meets the Government target of a minimum of 40% representation of each gender in the membership of State Boards, The Commission does meet the statutory requirements set out in the Mental Health Acts 2001-2018. In order to address and improve gender balance on the next Commission, the Chair of the Commission provided details of the current gender balance of the Commission to

the Minister of State for Mental Health and Older People who is responsible for appointing the Commission Members. As part of the appointment process for the next Commission, the Department of Health has requested that nominating bodies provide both a male and female nomination where relevant to ensure there is a gender balance on the next Commission.

Code of conduct, ethics in public office, additional disclosures of interest by board members and protected disclosures

For the year end 31 December 2021, the Commission confirms that a code of conduct was in place and adhered to. Furthermore, all Commission Members and relevant staff members complied in full with their statutory responsibilities under the Ethics in Public Office legislation.

Committees

The Legislation Committee met twice as required in 2021; 25 January 2021 and 27 August 2021. The focus of its work was the Commission's review of the Heads of Bill to amend the Mental Health Acts 2001-2018 and the General Scheme to amend the 2015 Act. The Committee also considered the timeline for the public consultation on Draft Codes of Practice given than the Bill in relation to the 2015 Act was not published by the end of 2021 as was expected.

The FARC (Finance, Audit and Risk Committee) held four meetings in 2021 and its annual report was provided to the Commission in March 2022. The report considered the following:

- Stakeholder Relationships
- External Audit (C&AG - Mazars)
- Annual Financial Statements for 2021
- Internal Audit

There were 5 internal audits completed with their reports approved by the FARC in 2021 as follows:

- Report on the Review and Effectiveness of Internal Financial Controls (refers to previous year, conducted in the last quarter of 2020 and reviewed in the first quarter of 2021)
- Review of Procurement Processes (conducted in the last quarter of 2020 and reviewed in the first quarter of 2021)
- Review of Health and Safety (conducted and reviewed and in first quarter of 2021)
- Review of DSS Commencement Project Governance and Management (conducted in the second quarter of 2021 and reviewed in the third quarter of 2021)
- Review of Operational Resilience (conducted in third quarter of 2021 and reviewed in the last quarter of 2021)

Two further audits were done in 2021 with those reports being considered by FARC at its first meeting in 2022:

- Review of Rules, Codes of Practice Processes (conducted in the fourth quarter of 2021)
- Review of Internal Financial Controls (conducted in fourth quarter of 2021)

The FARC annual report also considered:

- Management Accounts and Budget for 2021
- Risk Management – the operational requirements and the revised process to be implemented
- ICT – an ICT Strategy
- Governance and Internal Control / Internal Financial Control with additional assurances provisions having been put in place
- Protected Disclosures
- 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 2021, 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. Following a previous recommendation by FARC for a redesign of risk identification and risk descriptions, the Executive and Commission undertook a review of the risk management framework during 2021 with the assistance of the IPA. This involved a review of the MHC's risk appetite statement, corporate risk register (now known as the Strategic Risk and Opportunities Register) and divisional risk registers. The IPA held consultation meetings with the Commission, the FARC, the senior leadership team, and each division in relation to the review. Following the consultation process, the Commission approved the new risk appetite statement in September 2021 and new Strategic Risk and Opportunities Register ("SROR") and the revised risk management policy in December 2021.

The risk environment and the updating of the risk register was considered quarterly by the senior leadership team, which was in turn reviewed by the FARC, who then presented it to the Commission. Risk was a standing item on the agenda for each Commission meeting and the Chief Risk Officer reported on any significant events affecting the working environment of the Commission 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 March, July, September, and December 2021. Oversight and performance delivery agreements were signed for 2021.

The MHC met on a regular basis with the officials from the Department of Children, Equality, Disability, Integration and Youth (the government department with responsibility 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.

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. 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 2021, six 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 an FOI body. In compliance with this legislation, it provides its Freedom of Information Publication Scheme on the website and processes requests for information on a continuing basis.

Requests

In 2021, the MHC received 17 requests under the Freedom of Information Act 2014 with one request carried over from 2020. Of the 17 requests, three were granted, none were part-granted, three were withdrawn, none were transferred and seven were refused. At year-end, four cases remained open.

Most 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 also forms part of the MHC's delivery on, and commitment to, its strategic objective to uphold human rights.

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

For the year ended 31 December 2021, 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 2021.

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 2021. The MHC's policy for reporting of child protection and welfare concerns has been in place since January 2018 and has been updated regularly. No events were reported to the MHC during 2021.

Section 42 of the Irish Human Rights and Equality Act 2014

Section 42 of the Irish Human Rights and Equality Act 2014 places a legal obligation on all public bodies in Ireland to promote equality, prevent discrimination and protect the human rights of their employees, customers, service users, and everyone affected by their policies and plans. To fulfil this obligation the MHC set up a public duty working group. The working group drafted the Public Sector Equality and Human Rights Duty Plan which was approved in November 2020. The plan identifies current practices within the MHC which address human rights and equality issues as well as short- and medium-term goals that target these issues. The working group reviewed and updated this plan in December 2021.

Energy reporting

The MHC fulfils its reporting requirements under S.I.426 of 2014 by reporting to the SEAI through their monitoring and reporting system.

In December 2021, ESB Smart Energy Services carried out an energy audit for the MHC. The assessment focused on evaluating the energy usage associated with the MHC offices.

Business and financial reporting

The Department of Health's total allocation to the MHC for 2021 was €15.432m. The outturn for 2021 in the MHC was €15.070m. 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 €0.109m 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 Children, Equality, Disability, Integration and Youth allocation for the DSS establishment programme for 2021 was €5.7m million. In 2021, €5.353 million was drawn down by the DSS.

Key areas of expenditure related to the statutory functions as set out in the 2001 Act including the provision of mental health tribunals and the regulation of approved centres. The 2015 Act included expenditure for the establishment of the DSS in the MHC.

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 represent a true and fair view of the MHC's financial performance and position at the end of 2021.

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 2021. The COVID-19 pandemic and the resulting public health advice and safety measures, continued to affect the working practices in the MHC with remote and virtual working remaining the norm for most MHC staff during 2021. The MHC monitored the developments closely and mitigated the risks that affected the MHC's business operations, staff, and stakeholders. Actions taken by the MHC ensured that all statutory functions continued to be delivered throughout 2021.

The unaudited annual financial statements for 2021 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 2021 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 98.59% of valid invoices within 15 days of receipt. 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.

Maastricht returns

In 2021, the MHC complied with the requirement to submit a Maastricht Return to the Department of Health.

Procurement

In 2021, MHC undertook eight EU tendering process, two mini competitions under OGP Frameworks and 11 competitions by way of a 'Request for Quotation/ Request for Proposal' for goods and services valued at under EU thresholds, under €25k.

Twenty-five contract extension notices were agreed as permitted under the agreed terms of contract.

The MHC Corporate Procurement Plan for 2021 was approved by FARC on 26 June 2021.

The MHC Procurement and Contracts Manager continues to work with all MHC divisions to ensure forecasting and planning for the procurement of goods and services in line with best practice guidelines and the MHC procurement policy.

Information and Communications 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 2021, the MHC upgraded its ICT infrastructure including a storage area network and host servers.

Cyber security is one of the biggest threats facing the MHC. The MHC has taken a proactive approach to cyber security with both network intrusion prevention systems in place and third-party network monitoring. In addition to cyber security prevention and monitoring, the MHC is conducting on-going cyber security staff training.

ICT will continue to keep MHC systems under review to address cyber security risks.

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 (DSS).

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.

The communications team continued to generate a high volume of traditional media activity during the year. This activity was based upon some of key MHC publications, such as the annual report and themed reports by the Inspector of Mental Health Services, which the team promoted amongst key correspondents, editors and producers.

On the digital front, the team launched a new MHC website in April, which coincided with the introduction of a fresh MHC visual identity. This identity included a new logo that helps to reflect how individual human rights are at the very core of the work and functions of the MHC. The team worked closely with service users and service user groups over a 12-month period to help develop both the website and visual identity, as well as seeking the views of various other stakeholders, including MHC staff, services, and tribunal panel members.

The Communications team also continued to increase engagement levels on both the MHC and DSS websites, across all social media channels, and generated a significant rise in subscribers to both the MHC and DSS newsletters. This increase in engagement and followers can largely be attributed to a consistent focus on varied forms of

content, such as engaging video materials.

With ongoing restrictions on physical meetings and events due to COVID-19, the communications team developed and hosted two 'hybrid' events during the year. The first focused on an introduction to the DSS, while the second was based around a report by the Inspector on access to mental health services for people in the criminal justice system.

The communications team also continued to facilitate stakeholder engagement presentations at several Commission meetings with Board members hearing from people with direct and relevant experience of illness through the Alzheimer's Society of Ireland, Bodywhys, Inclusion Ireland, and the Cope Foundation.

In 2022, the communications team will continue to work with all stakeholders on issues that concern or relate to mental health and decision support services, with a special focus on the DSS as it readies for launch.

Human resources

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 vision and mission, business objectives and strategy.

Performance management

The Performance Management and Development System (PMDS) was successfully carried out in 2021 for all eligible employees with a focus on upskilling people managers to look for opportunities for development when giving performance evaluations.

Employee wellness

2021 saw the continued growth of the MHC's wellness programme (WorkWell) which continued to address results from the general staff survey 2019, tailoring the wellbeing facets to the feedback from the HR schedule of events 2019 survey.

As the 'WorkWell' programme develops, 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 to share and collaborate on wellbeing initiatives and recommendations.

Employee Assistance Service

The MHC's Employee Assistance Programme (EAP), provided by an external provider on a 24/7/365 basis offers a free, professional service for employees and their families to resolve personal or work-related concerns.

Remote working

The COVID-19 pandemic saw employees being transitioned to a remote working arrangement. The MHC continues to ensure that appropriate safety measures are in place.

Supports for Employees with Disabilities

The HR team provides an Access Officer to provide a progressive working environment and, in line with equality legislation, promotes equality of opportunity for all employees. The National Disability Authority (NDA) has a statutory duty to monitor the employment of people with disabilities in the public sector on an annual basis. In line with Government commitment 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 quantitively and narratively, to the NDA. In 2021, 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.

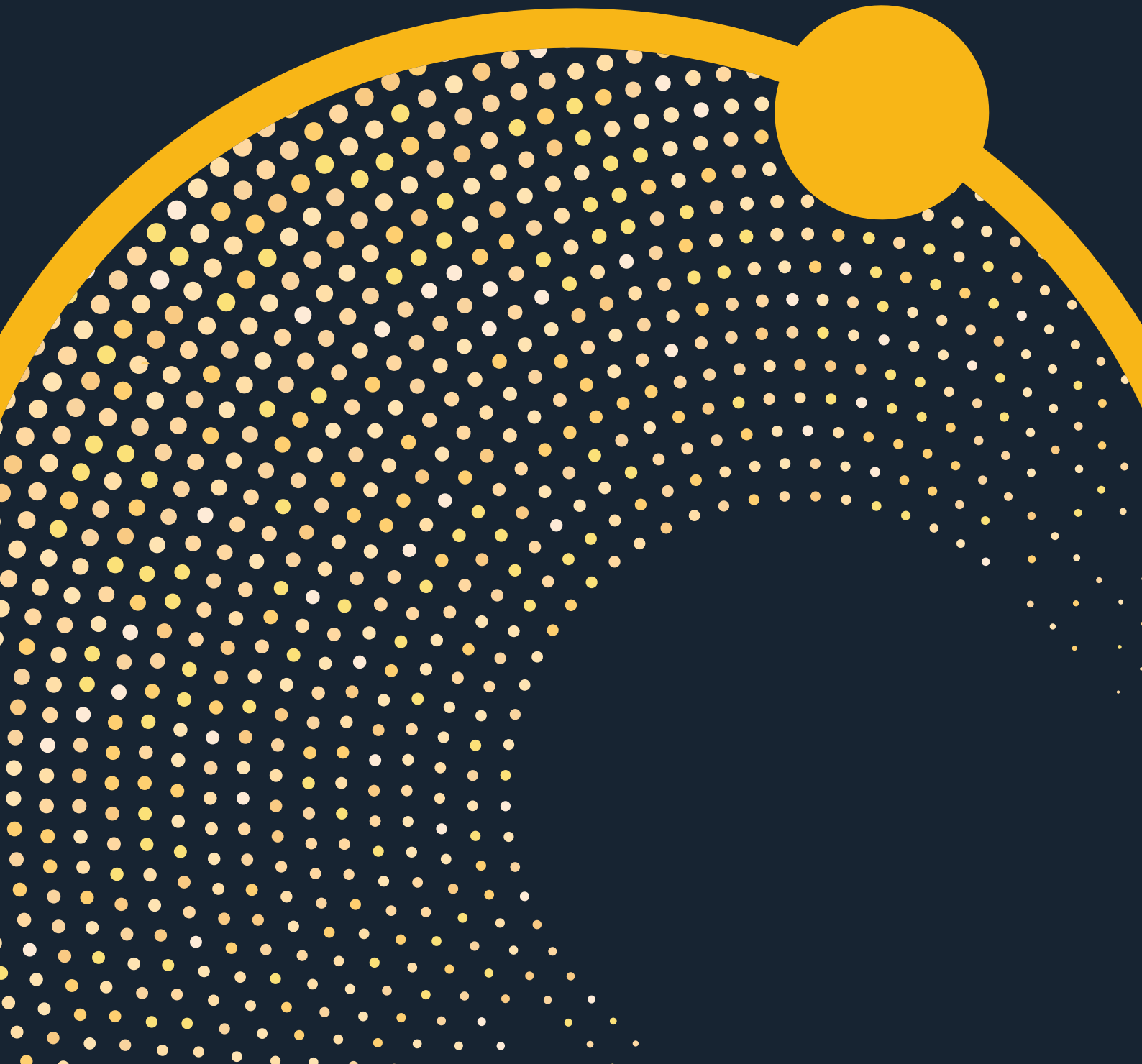
Training and development

2021 saw a high number of training activities delivered that provided upskilling, confidence and competence in job roles and work practices.

Recruitment

There has been a strong focus on recruitment, with the additional staffing requirements of the DSS, and this has given the MHC the opportunity to attract new talent while providing further career development opportunities to existing staff.

Appendices



Appendix 1 – Mental Health Commission Membership and Meeting Attendance 2021

No	Name	21/01	18/02	25/03	20/05	17/06	25/06[7]	15/07	16/09	21/10	18/11	16/12	Total
1	John Saunders	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11/11
2	Colette Nolan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗	9/11
3	Dr Margo Wrigley	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	10/11
4	Dr Michael Drumm	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	10/11
5	Ned Kelly	✗	✓	✓	✗	✓	✓	✓	✓	✓	✗	✓	8/11
6	Tómas Murphy	✗	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	9/11
7	Nicola Byrne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗[8]	10/11
8	Patrick Lynch	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/11
9	Rowena Mulcahy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11/11
10	Dr Jack Nagle	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11/11
11	Dr John Hillery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11/11
12	Fionn Fitzpatrick[9]	n/a	n/a	✓	✓	✓	✗	✓	✓	✗	✓	✓	7/9
13	Dr John Cox[10]	n/a	n/a	✓	✓	✓	✓	✓	✓	✓	✓	✗	8/9

[7] Additional Meeting held in 2021

[8] NB did not attend as she did not receive notice of the meeting or related papers due to ICT technical issues on the MHC side which have now been addressed.

[9] Appointed on 12 February 2021

[10] Appointed on 12 February 2021

Appendix 2 – Finance, Audit and Risk Committee Membership and Meeting Attendance 2021[11]

Name	19/03	25/06	24/09	26/11	Total
Patrick Lynch (Chair) (CM)	✓	✓	✓	✓	4/4
Nicola Byrne (CM)	✓	✓	✓	✓	4/4
Tomas Murphy (CM)	✗	✗	✓	✓	2/4
Ciara Lynch (EM)	✓	✗	✗	✓	2/4
Kevin Roantree (EM)	✓	✗	✓	✓	3/4
Richard O'Farrell (EM)	✓	✓	✗	✓	3/4
Mairead Dolan (EM)	✓	✓	✓	✓	4/4

Appendix 3 – Legislation Committee Membership and Meeting Attendance 2021

Name	25/01	27/08	Total
Rowena Mulcahy (Chair)[12] (CM)	✓	n/a	1/1
Ned Kelly (CM)	✗	✓	1/2
Michael Drumm (Chair)[13] (CM)	✓	✓	2/2
Dr John Hillery (CM) [14]	n/a	✗	0/1
Teresa Blake (EM)	✗	✓	1/2
Mary Donnelly (EM)	✓	✓	2/2

[11] CM = Commission Member and EM = External Member

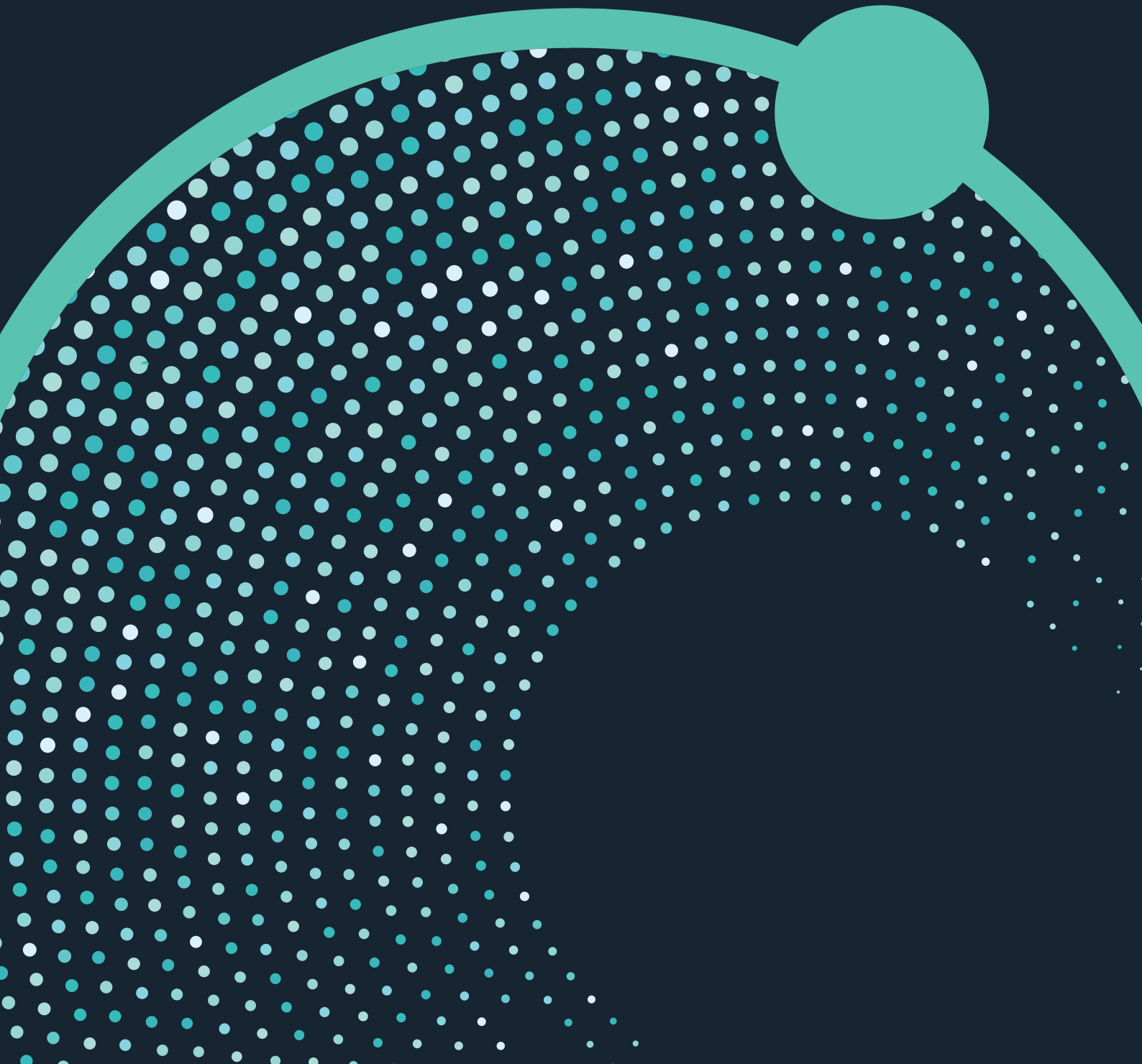
[12] RM resigned as Chair and as a Member of the Committee as of 18 February 2021

[13] MD was appointed as Chair of the Committee as of 15 July 2021

[14] JH was appointed as a Member of the Committee as of 15 July 2021

Report of the Inspector of the Mental Health Services

Dr Susan Finnerty



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This report may be cited as follows: 'Finnerty, Susan Dr, Report of the Inspector of Mental Health Services 2021 (2022), Mental Health Commission, Dublin, Ireland.'

Who we are

The Inspector of Mental Health Services has a statutory role under the Mental Health Act 2001 and is appointed by the Mental Health Commission to carry out inspections of mental health services nationally. The Inspector has a multi-disciplinary team of assistant inspectors, technical writers 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 accessed 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 regarding these facilities.

Our inspections of approved centres may be announced or unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection. In some circumstances we will decide to undertake an announced inspection, meaning that the service will be given up to one weeks' notice of the inspection by email.

In deciding if an inspection should be announced, we consider:

1. Whether an unannounced inspection may create an unacceptable level of disruption for patients.
2. Whether there is an outbreak of an infectious disease in the approved centre and certain measures must be taken to protect patients and staff.
3. Whether it is necessary to collect pre-inspection information from the provider.
4. Whether we need to ensure certain key staff are present on the day(s) of the inspection.

Due to the COVID-19 pandemic, all inspections in 2021 were announced in line with public health advice for the protection of patients and staff.

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 found out 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.

Each year the Inspector reviews - in detail - one sector of the mental health services. In 2020, under section 51(1)(b), we conducted a review of the Access to Mental Health Services for People in the Criminal Justice System. This review is published on our website: www.mhcirl.ie.

What we did in 2021

- We inspected 66 approved centres under the regulations, rules, and codes of practice.
- We inspected community residences that were staffed 24 hours a day.
- We carried out focused inspections 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 the Access to Mental Health Services for People in the Criminal Justice System.
- We met with service users and contacted peer advocacy representatives to get the views of mental health services from service users.
- We received and followed up submitted issues of concern from service users, carers, mental health staff, and the general public.

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

COVID-19

As with the population in general, approved centres had to contend with cases and outbreaks of COVID-19 among their staff and service users in 2021.

Once again, service users had very limited visits from families and friends, some had to be confined to their rooms for infection control purposes, and social events and outings from the approved centres were curtailed. This increased loneliness, boredom and stress in people who already had mental health difficulties. The availability of therapeutic programmes improved in 2021 as ways were found to increase face-to-face contact and improved online facilities were provided. We found that there were strains on nurse staffing levels due to infection with COVID-19, however, there was no situation where there was insufficient staff to provide a safe service. The inspectors found that all approved centres adhered to public health guidance about infection control.

What we found on inspection

Compliance with Regulations

We found that there was a very slight increase in the average compliance with regulations since 2020 and that over a 5-year period average compliance with regulations had increased by 14%. Despite COVID-19, high compliance levels were maintained in 2020 and 2021, although it should be pointed out that the majority of inspections in 2020 and all inspections in 2021 were announced.

Table 19: *Average compliance with regulations*

Year	2017	2018	2019	2020	2021
Average compliance with regulations	76%	79%	78%	89%	90%

The compliance levels with regulations are set out in Table 19 below.

Table 20: *Compliance levels with regulations*

Compliance levels with Regulations	Number of approved centres	Percentage of approved centres
100% compliance	11	17%
90-99% compliance	31	46%
80-89% compliance	17	26%
70-79% compliance	5	8%
Below 70% compliance	2	3%

A total of 11 approved centres achieved 100% compliance. In CHO 5, four approved centres achieved 100% compliance, as did four approved centres in the independent sector.

Table 21: *Approved centres that achieved 100% compliance in regulations*

Approved centres that achieved 100% compliance in regulations	CHO/Sector
Aidan's Residential Healthcare Unit.	CHO 5
Selskar House, Farnogue Residential Healthcare Unit	CHO 5
Grangemore Ward. St Otteran's Hospital	CHO 5
Haywood Lodge.	CHO 5
St Ita's Ward, St Brigid's Hospital	CHO 8
Linn Dara Child & Adolescent Mental Health In-patient Unit, Cherry Orchard	CHO 7 CAMHS
Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital	CHO 2 CAMHS
Willow Grove Adolescent Unit, St Patrick's University Hospital	Independent
Highfield Hospital.	Independent
St Edmundsbury Hospital	Independent
St Patrick's University Hospital.	Independent

Compliance with the Rules

Table 22: *Compliance with the rules*

Rule	% Compliance
ECT	100%
Mechanical Restraint	100%
Seclusion	82%

There was 100% compliance with the Rules Governing the Use of Electroconvulsive Therapy (ECT), reflecting the move a number of years ago to centres of excellence for ECT and accreditation for ECT by the Royal College of Psychiatrists (ECTAS programme).

In 2021, mechanical restraint was only used in the Central Mental Hospital for transportation purposes, and not within the confines of the hospital. Compliance with the Rules Governing the Use of Seclusion is discussed below.

Compliance with Codes of Practice

Table 23: *Compliance with codes of practice*

Code of Practice	% Compliance
ECT	100%
Admission, Transfer, Discharge	77%
Physical Restraint	73%
Admission of Children	0%

All adult approved centres were non-compliant with the Code of Practice relating to the Admission of Children. This reflects the unsuitability of adult mental health inpatient units to provide appropriate child centred care. This included lack of appropriate facilities and lack of appropriate therapeutic services and programmes.

Compliance with the Code of Practice on Physical Restraint is discussed below.

Critical Risks

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 2021, there were 19 non-compliances with regulations that received a critical risk rating, four less than in 2020.

Table 24: *Non-compliance with Regulations for 2020 and 2021 that received a critical risk rating*

	2020	2021
Therapeutic services and programmes	5	3
Premises	4	7
Privacy	3	1
Staffing	2	3
Maintenance of records	2	0
Seclusion	2	0
Consent to treatment	1	0
Residents' personal property	1	0
Individual care plan	1	1
Medication management	1	0
Risk management	1	4
Total	23	19

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 others[15]. These measures limit several fundamental human rights, such as liberty of choice or movement, autonomy, and physical integrity. There is no evidence of a therapeutic benefit associated with the use of restrictive practices and interventions that compromise a person's liberty should only ever be used as a last resort and for the shortest time possible.

The MHC commenced a review of the rules on restrictive practices in 2021 and this work continues in 2022.

Seclusion

The use of seclusion in Ireland is highly regulated by Rules Governing the Use of 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"[16]. A seclusion room is bare apart from a special mattress.

During seclusion, the service user has no social interaction apart from nursing and medical staff that periodically conduct checks. Heat, light and ventilation are controlled from outside the room. The decision to use seclusion should only be made where there is a balance between the potential risks of seclusion and any other intervention, such as prolonged physical restraint, indicates that it would be safer to use seclusion. There must be a robust assessment of risks which must consider all available information.

Over the past two years there has been a marked improvement in compliance with the rules governing the use of seclusion. Most approved centres that use seclusion now have a seclusion pack which includes a seclusion care plan, observation records and a check list for compliance with the rules.

Table 25: *Compliance with the rules on seclusion 2017-2021*

Compliance with the Rules on Seclusion	2017	2018	2019	2020	2021
	19%	33%	21%	61%	82%

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". Compliance with the Code of Practice on Physical Restraint had decreased in 2021, but there has been an overall increase in compliance over the past five years.

Table 26: *Compliance with the code of practice on the use of physical restraint 2017-2021*

Year	2017	2018	2019	2020	2021
Compliance with the Code of Practice on the Use of Physical Restraint	31%	19%	50%	76%	73%

The current Mental Health Act (2001) does not allow for the making of rules for physical restraint, with the result that there can be no enforcement should non-adherence to the Code of Practice on Physical Restraint occur. However, it is anticipated that the imminent revision of the Mental Health Act will include the provision to make rules for the use of physical restraint.

[15] Mental Health Act (UK) Code of Practice 2015

[16] Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint Mental Health Commission

Individual Care Plans

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

A documented set of goals developed, regularly, reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident.

The individual care plan:

- shall specify the treatment and care required which shall be in accordance with best practice,
- shall identify necessary resources
- shall specify appropriate goals for the resident.

For a resident who is a child, his or her individual care plan shall include education requirements.

The individual care plan shall be recorded in the one composite set of documentation

The intention of this regulation is to ensure that people in an approved centre have care or treatment that is personalised specifically for them. This regulation describes the action that the approved centre must take to make sure that each person receives appropriate person-centred care and treatment that is based on an assessment of their needs and preferences.

Each person's care and treatment needs and preferences should be assessed by staff on the multidisciplinary team with the required levels of skills and knowledge for the particular task. Assessments of people's care and treatment needs should include mental and physical health, personal care, emotional, social, cultural and spiritual needs and should be reviewed regularly and whenever needed throughout the person's care and treatment. Each person should have all the necessary information, in a way that the person understands, about their care and treatment and be involved in any treatment and care decisions in their care plan.

Compliance with the Regulation on Individual Care Plans has remained persistently low, with negligible change in 2021, where 36% of approved centres were non-compliant with this regulation.

Table 27: *Compliance with regulation 15 individual care plans 2017-2021*

	2017	2018	2019	2020	2021
Compliance with Regulation 15 Individual care plans	52%	58%	52%	59%	64%

The HSE states that **care planning and the individual care plan document are essential to person-centred recovery-based care within in-patient and community residential settings** and have provided a step-by step guidance in how to develop and review an individual care plan[17]. Despite this the HSE has failed to significantly improve care planning for service users over the past five years, with 36% of approved centres non-compliant with the regulation on individual care plans. This shows poor leadership and accountability.

Regulation 22 Premises

There have been several new approved centres built in the past 3-4 years which provide a modern environment, including communal and private spaces with rooms for leisure and therapeutic activities. However, there are a considerable number of outdated, unsuitable buildings which have suffered years of environmental neglect. Progress is slow on replacement of buildings or on renovations to bring them up to a modern standard. Of particular concern are risks in relation to fire safety and ligature anchor points. What inspectors find in relation to these risks should be recognised and remedied by the service to make an approved centre safe, not wait until the annual inspection identifies them and enforcement action takes place. Such knee-jerk response to adverse findings of an inspection does not indicate good

[17] Individual Care Plans - HSE.ie

governance. In CHO 4 (Cork) multiple serious risks and poor environments across five approved centres has required repeated focused inspections and escalating enforcement actions to compel the HSE to begin to remedy the non-compliances. These enforcement actions have had to continue into 2022.

Table 28: *Compliance with regulation 22 premises 2017-2021*

	2017	2018	2019	2020	2021
Compliance with Regulation 22 Premises	25%	30%	31%	55%	33%

We see how difficult it has been to isolate and restrict movement in mental health units that do not have single, en suite rooms or sufficient space during the COVID-19 pandemic.

Mental health units have had to reduce their bed numbers to obtain sufficient space to manage the pandemic in 2021 as well as in 2020. This has had knock-on effects in waiting lists for inpatient treatment. We can assume that the health service will face further COVID-19 waves as well as other viral outbreaks. The need, therefore, for effective infection control within hospitals should be a major priority in the future redevelopment or building of new inpatient units.

New builds by the HSE are providing mostly single en suite bedrooms but a number of older approved centres remain with multi-occupancy bedrooms.

Regulation 19 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 illness[18]. Monitoring for physical illnesses outlined above is relatively inexpensive, simple to do and provides a means to early intervention if illnesses are detected, thereby preventing and or reducing serious physical illness.

Regulation 19 General Health requires that approved centres monitor residents' physical health at least every six months.

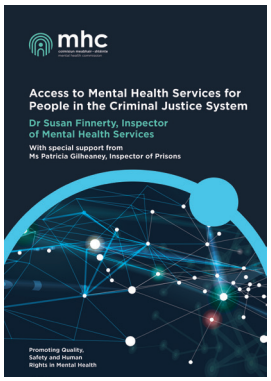
In 2018, due to the concern at the lack of adherence to international guidelines and best practice in monitoring physical health of those with severe mental illness, the MHC issued guidance to approved centres as to what was required. Since then, we have seen a steady improvement in the monitoring of physical health for people in approved centres.

Table 29 Compliance with Regulation 19 general health 2018-2021

	2018	2019	2020	2021
Compliance with Regulation 19: General Health	42%	42%	65%	80%

Themed Report

Access to Mental Health Services for People in the Criminal Justice System



In 2021, we published the report *Access to Mental Health Services for People in the Criminal Justice System*, which is available on www.mhcirl.ie

During our review of people with mental illness in the criminal justice system we noted that here are many gaps in Irish mental health services which lead to people with mental illness ending up in prison. There is an under-resourced mental health service where the only out-of-hours provision is through accident and emergency departments and there is no formal pre-arrest diversion. There

[18] Physical Health of People with Severe Mental illness. Dr Susan Finnerty. Mental Health Commission 2018 8457 Mental Health Commission - Severe mental illness report.indd (mhcirl.ie)

are people who are severely mentally ill locked in isolation units and other areas of prisons awaiting mental health care in appropriate settings, in particular in the Central Mental Hospital (CMH). This fundamentally breaches their human rights and we have been rightly criticised by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) for this. The in-reach teams are substantially under-resourced and struggle to provide a comprehensive service. The inpatient forensic mental health service in the CMH provides care and treatment based on international best practice, but the waiting list for a place in the CMH continues to be lengthy as more people with mental illness enter the prison, with insufficient intensive care rehabilitation beds to facilitate the onward recovery journey of residents who could be discharged. We found that catchment area restrictions mean that homeless people have insurmountable difficulties in accessing local mental health care following release and are often lost to follow-up and likely to reoffend. In addition, general adult services are often reluctant to take on patients with a "forensic history" due to inadequate resourcing and facilities.

We have a new state-of-the-art building for inpatient forensic mental health services in Portrane, which will ultimately increase in beds from 102 to 170, including a forensic unit for children and an Intensive Care Regional Unit. This brings our forensic beds from 2 per 100,000 to 3.5 per 100,000, which is still substantially lower than many other European countries. There are no intensive care regional units in the south and west, as set out in the government policy of a "hub-and-spoke" model of forensic mental health services. The High-Level Taskforce to Consider the Mental Health and Addiction Challenges of Persons Interacting with the Criminal Justice System, which was set up early in 2021, has yet to publish its report.

Submitted issues of concern

The MHC does not have the legal power to investigate complaints. However, if an issue of concern is received by the MHC about a mental health service, this is referred to the Submitted Issues of Concern Committee (SIC). The Committee consists of the Inspector of Mental Health Services, the Director of Regulation and an administration team. People may submit issues of concern through any communication medium and each concern is considered by the SIC. The SIC committee received 508 communications regarding individual concerns in 2021.

Responses may include request for information from the relevant mental health service, advice as to where and how the person raising the concern may make an official complaint, advice regarding support organisations or advice about contacting other regulatory bodies.

We welcome views, comments and concerns about mental health services and the process for contacting us is on our website www.mhcirl.ie.

Notes

mhc
coimisiun meabhair - shláinte
mental health commission

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