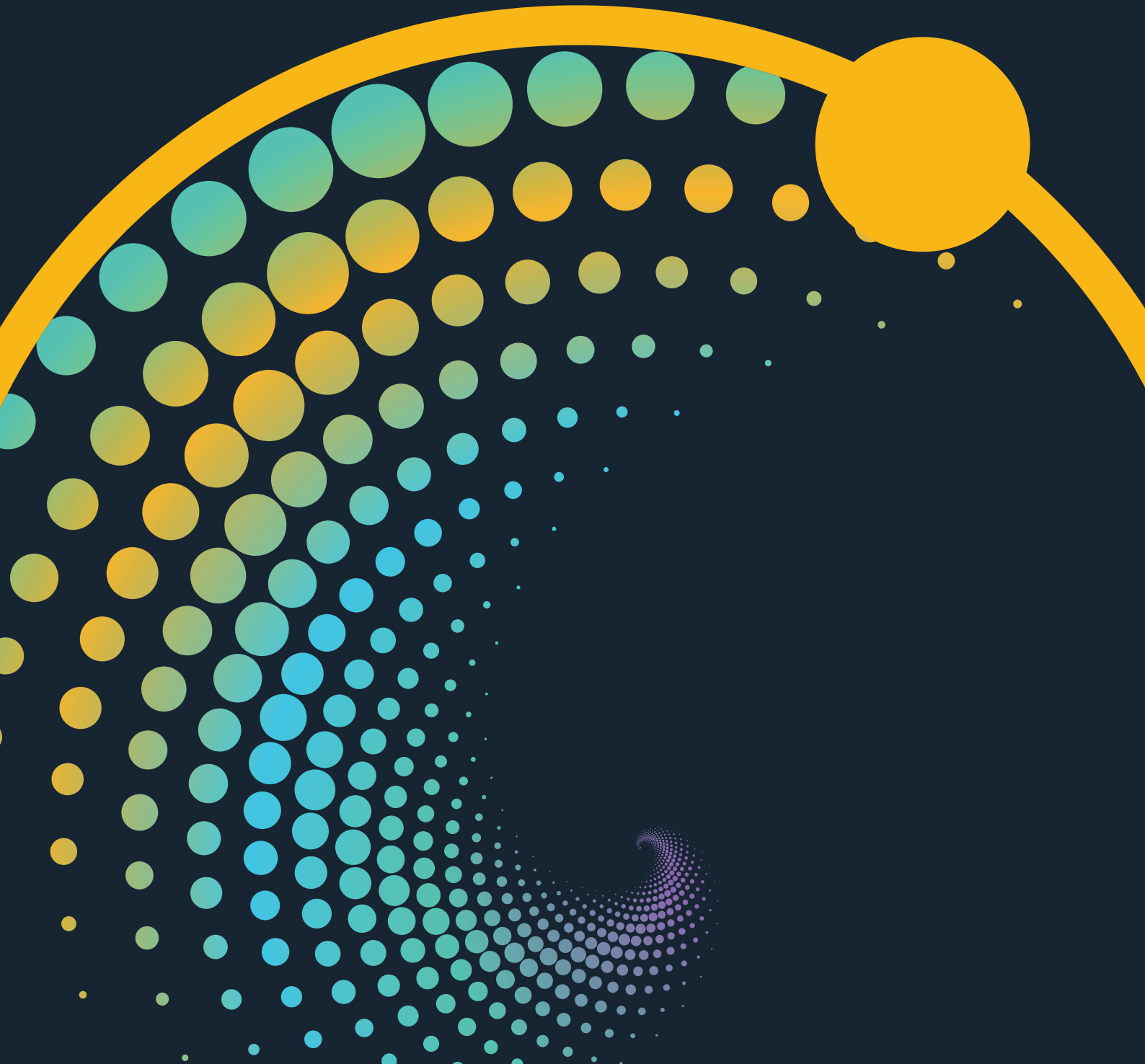




**mhc**  
coimisiún meabhair - shláinte  
mental health commission

# Mental Health Commission Annual Report 2022

Including the report of the Inspector  
of Mental Health Services



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## CHAIRPERSON'S STATEMENT

**2022 marked the final 12 months of the 2019-2022 Strategy of the Mental Health Commission (MHC), which was entitled 'Protecting People's Rights'. Once again, the Board of the Commission (the Board) and the Executive focused on upholding and protecting human rights across all aspects of our work. This report delineates the processes undertaken in 2022, and the outcomes that these processes have produced across that calendar year.**

The same 12-month period also saw a decrease in the impact of Covid-19 on all of our lives. Despite this, it continued to have an effect on health service provision, and I want to congratulate all involved who strove to provide high-quality supports for those in need during this period. The regulatory and tribunal processes of the MHC continued and while I want to thank the teams, I also wish to thank those on the frontline of mental health service provision for maintaining a focus on the rights of service users through this unprecedented time.

This annual report includes statistics that result from much work that is unheralded but is the core of regulation in the public interest. There are concerns raised by the Inspector's Report and, though the MHC tries to pursue a co-operative formative approach to regulation, we must continue to prompt and, where needed, escalate matters to ensure service providers sustain service development so that Ireland has a uniformly high-quality, modern, human-rights based mental health service in every area of the country.

The duty of the MHC is to constantly insist on high standard mental health services for those in need of them. It is disappointing that some of the public discussion of MHC reports can be of a 'shoot the messenger' nature. If services are suitable for purpose and have a culture that meets the needs of people with mental illness, we will acknowledge this but, if not, we have been, and we will continue to be, robust in our approach to facilitating change. If a regulator simply observes deficits but does not act then it would, by omission, be supporting the unsupportable and would be pointless. The needs of vulnerable people for appropriate supportive environments and therapeutic services must be our guiding star in our activities. The recognition of the human rights of service users and the provision of evidence-based support for frontline staff so that they work in appropriate settings with appropriately-trained colleagues guides all our activities. The MHC will continue to identify deficiencies in the hope that service providers shall seek to address these and the State will allocate the resources to address them.

A new Board was appointed in April 2022. Some of the members of the previous Board were reappointed, which is important in fostering continuity in the way the Board carries out our duties. Most to those appointed will stay in place until 2027 unless the forthcoming amendments to the Mental Health Act dictates an earlier change. Members come from a broad variety of backgrounds including mental health clinicians, administrators, and service users. I particularly want to thank all members of the Board for their proactive interest, reflectiveness and contributions over the last year, which was a very busy year that included commencement of the process for the new Strategic Plan for the period 2023 to 2027. The MHC continuously reviews and develops its strategic objectives. We do this to ensure that the MHC remains responsive, transparent and inclusive\*.

The commencement of the Assisted Decision-Making (Capacity) Act 2015 did not occur as hoped in 2022. Despite this, the Executive worked constantly to ensure that the Decision Support Service (DSS) was ready as soon as the Act was commenced. This required a major expansion in staff numbers with the associated requirement for training. Panels of decision-making representatives, special visitors and general visitors have been convened after an exhaustive recruitment process. A new fit-for-purpose IT system was readied to meet the needs of the service.

At the time of writing, the 2015 Act (as amended) has been commenced and we look forward to helping this become a part of people's everyday life and future planning. The commencement of the Act will bring challenges, but I am assured that the MHC is ready to meet them. The continued liaison of the MHC with officials from the Department of Children, Equality, Disability, Integration and Youth has been a major part of ensuring such readiness.

I want to thank all the MHC staff involved for their commitment, and Minister Roderic



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O'Gorman and Minister of State Anne Rabbitte and their staff for their availability and support.

I wish to thank and acknowledge the support of the Minister of State for Mental Health and Older People, Mary Butler TD, and her team for their responsiveness and support for all the MHC's statutory activities during 2022.

In conclusion, I am privileged to be the Chairperson of the Mental Health Commission and to work with a Board who are demonstrably committed to promoting the highest standards in human rights-based mental health care and decision support services. The MHC has a skilled and committed executive body with a highly motivated and hard-working Chief Executive and Senior Leadership Team. They are complemented by the individual members of staff who work within their teams. I want to thank all the staff of the MHC for their dedication during 2022 and to remind all who read this report that the MHC welcomes constructive feedback.

  
John Hillery  
Chairperson

\* At the time of writing, the Board has launched the new Strategic Plan.



## CHIEF EXECUTIVE'S REVIEW

**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 and decision support services. With the service user at the centre of our work, we delivered a programme of work in 2022 which vindicated human rights, targeted risk and promoted quality and safety in services.**

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.

We welcome the high levels of compliance with regulations found during our inspections. We commend all the clinical staff and management who delivered these improvements. While there was a marginal overall decrease in compliance levels in 2022, there has been a steady and increasing trend in compliance over the last four years. In 2022, overall compliance across 31 Regulations was 88.37% compared with 80.04% in 2019, thus indicating an overall improvement of 8.33%. We also welcome that seclusion, physical restraint, instances of overcapacity and child admissions to adult units all continue to decline as a human rights-based approach continues to be rolled out and embedded in services across the State.

However, our work in 2022 showed the need for improvement by some providers in risk management, individual care planning, staffing and premises. Compliance with Regulation 22 (Premises) has been low over the past five years, most particularly in a number of HSE premises. This emphasises the need for a targeted, funded strategic capital investment programme in our public system.

Unfortunately, our inspection team continues to find inadequate meaningful engagement by some services and clinicians with care planning. The level of compliance with the associated regulation has been consistently low for many years, particularly in a number of HSE services. It is a basic requirement to ensure that all residents in an approved centre have a care plan to which they have made some contribution. In some centres, staff have worked with the resident to develop meaningful achievable goals and have included therapeutic services and programmes to achieve these goals. There is clear clinical leadership

evident, and the individual care plan is the blueprint for the resident's care, treatment and eventual recovery. In other approved centres, the basic concept of care planning does not seem to have been understood or appreciated. Goals are vague and meaningless and obviously not developed with residents. In these centres, it is clear that clinical leadership in care-planning is absent and staff have not been trained adequately in recovery-focused care planning. It is a matter that we have raised to the highest levels within the HSE.

Of great concern is the admission of younger people with enduring mental illness to long stay approved centres. Through our history we have learned that long term congregated settings are not good for people and, while contrary to national policy, are not against the law. As a society, we need to reject the re-establishment of congregated settings for people and instead invest in specialised rehabilitation services and houses in the community. We should pay heed to the warning by the Inspector of Mental Health Services that there is a growing interest in providing more of these continuing care congregated settings, particularly by some private/independent providers. To quote the Inspector: "Where there are gaps in the public provision of adequate community and rehabilitation mental health services, there is a risk that we will allow large continuing care centres to contain the "problem".

The MHC is also the custodian of the process for vindicating the rights of patients who are involuntarily detained. We want service users to know that we are independent, and a robust system exists to vindicate their rights when an involuntary detention is required. It was very disappointing to see again in 2022 that the majority of applications to involuntary detain from the community was by An Garda Síochána as opposed to a health care authorised officer. When people are unwell, they need to be met by a health care practitioner and not a law enforcement officer. The fact that this is happening so



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often indicates a systemic issue that needs to be addressed at the highest levels. We hope this shall be addressed in the forthcoming amendments to the Mental Health Acts.

In 2022, the Inspector of Mental Health Services commenced an independent review of the provision of Child and Adolescent Mental Health Services (CAMHS) in Ireland. Following review of the provision of CAMHS in five out of nine Community Healthcare Organisations she issued an interim report because of the serious concerns and consequent risks for some patients that she found. The Interim Report was published on 23 January 2023. The Final Report will be published in mid-2023.

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

## 2022 in Brief



**45** enforcement actions related to **28** approved centres


**86%** of approved centres achieved an 80% rate of compliance or higher with the regulations in 2022






No individual service had a compliance rate lower than **71%**,


**20** child admissions to 11 adult units. This compares with **32** admissions to 11 adult units in 2021.




**1,874** Mental Health Tribunal Hearings




**18%** decrease in the number of episodes of physical restraint in 2022



**48%** of Individual services achieved over **90%** compliance with Regulations





**14** new conditions attached to registration of **12** approved centres


**84** conditions attached to **37** approved centres

**2,040** involuntary admissions, **581** regrade voluntary to involuntary







**36%** of applications for involuntary admission were from An Garda Síochána



**2,686** registered inpatient beds in 67 approved centres

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





**33** Instances of overcapacity reported in 2022

**14%** of applications for involuntary admission were from an Authorised Officer of the HSE



**95** presentations, consultations and meetings with DSS stakeholders



A **36%** decrease in the number of episodes of seclusion compared to 2021





# 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.

As part of the development of the strategy for the coming years, various stakeholders were consulted. This included staff, panel members and the public. As part of this consultation, performance against the current strategy was evaluated. The most notable achievements relating to the 'Strategy 2019 to 2022' included preparation for the successful launch of the Decision Support Service and the rapid and agile change to working to ensure the fulfilment of statutory requirements to hold mental health tribunals and conduct annual inspections of approved centres during the COVID-19 pandemic and the subsequent cyber-attack on the HSE.

## Vision, Mission and Values

### Our Vision

Equity of access to person-centred mental health services and decision support services that deliver high-quality care and support.

### Our Mission

Promotion and vindication of human rights in relation to mental health services and decision support services.

The MHC is guided by the following core values, centred around the value of person-centred support and care.



# Strategic Priorities

This Strategy has five key Strategic Priorities. Each Priority sets out key Actions through which the Strategic Priority will be delivered by 2027.



### Strategic Priority 1:

Continue to be a leading voice in relation to mental health services and assisted decision-making.



### Strategic Priority 2:

Effective and accessible communication and engagement, emphasising and promoting the voice of the person.



### Strategic Priority 3:

Continue to drive standards, improve quality and safeguard persons in relation to mental health services that are regulated by the MHC.



### Strategic Priority 4:

Promote and support assisted decision-making in society by embedding the Decision Support Service as a respected public service.



### Strategic Priority 5:

Be an effective, cohesive, transparently governed and agile organisation acting in the public interest.

# Mental Health Commission and its Members (April 2017 – April 2022 and April 2022 – April 2027)

**The Board of the Mental Health Commission (MHC) is known as the Board and it is the governing body of the organisation. The Board 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 Board. 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 Board’s membership and meeting attendance for 2022 can be found in Appendix 1, 2 and 3 on pages 74-75.

During 2022, the Board 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 75-76



### John Hillery (Dr)

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

Reappointed 05/04/2022 End of Term 04/04/2027

**Position Type:** Member  
Reappointed as Chairperson

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



### Rowena Mulcahy

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

Reappointed 05/04/2022 End of Term 04/04/2025

**Position Type:** Member

**Basis of Appointment:**  
Nominated and appointed by the Minister for Health following PAS Process



### Michael Drumm (Dr)

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

Reappointed 05/04/2022 End of Term 04/04/2025

**Position Type:** Member

**Basis of Appointment:**  
Nominated by the Psychological Society of Ireland. Appointed by the Minister of State for Mental Health and Older People



### Margo Wrigley (Dr)

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

Reappointed 05/04/2022 End of Term 04/04/2025

**Position Type:** Member

**Basis of Appointment:**  
Nominated by the Irish Hospital Consultants Association. Appointed by the Minister for Health



### Fionn Fitzpatrick

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

Reappointed 05/04/2022 End of Term 04/04/2027

**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

Reappointed 05/04/2022 End of Term 04/04/2027

**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.



### Ray Burke

First appointed: 05/04/2022  
End of Term: 04/04/2027

**Position Type:** Member

**Basis of Appointment:** nominated by PAS; appointed by the Minister of State for Mental Health and Older People.



### Joseph Duffy

First appointed: 05/04/2022  
End of Term: 04/04/2027

**Position Type:** Member

**Basis of Appointment:** nominated by Jigsaw; appointed by the Minister of State for Mental Health and Older People.



### Tammy Donaghy

First appointed: 05/04/2022  
End of Term: 04/04/2027

**Position Type:** Member

**Basis of Appointment:** nominated by Spunout; appointed by the Minister of State for Mental Health and Older People.



### 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



### 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



### Orla Healy (Dr)

First appointed: 05/04/2022  
End of Term: 04/04/2027

**Position Type:** Member

**Basis of Appointment:** nominated by the HSE; appointed by the Minister of State for Mental Health and Older People.



### Martina McGuinness

First appointed: 05/04/2022  
End of Term: 04/04/2027

**Position Type:** Member

**Basis of Appointment:** nominated by PNA; appointed by the Minister of State for Mental Health and Older People.



### Linda Curran

First appointed: 05/04/2022  
End of Term: 04/04/2027

**Position Type:** Member

**Basis of Appointment:** nominated by IASW; appointed by the Minister of State for Mental Health and Older People.



### 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



### 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



### 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



### Catherine Cocoman

First appointed: 05/04/2022  
End of Term: 04/04/2027

**Position Type:** Member

**Basis of Appointment:** nominated by Nursing & Midwifery Board of Ireland; appointed by the Minister of State for Mental Health and Older People.



### Tómas Murphy

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

**Position Type:** Member

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

### Additional Roles

**Secretary to the Board:** 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:** Brian Gillespie



## Senior Management Team at the MHC



Chief Executive  
**John Farrelly**



General Counsel for the MHC (DSS)  
**Orla Keane**



Inspector of Mental Health Services  
**Dr Susan Finnerty**



Director, Decision Support Service  
**Áine Flynn**



Director of Regulation  
**Gary Kiernan**



Chief Operations Officer  
**Brian Gillespie**

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# What do we do?

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**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.**

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## Regulatory Process

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# 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 following a stepped approach to escalation.



Figure 1: MHC model of regulation

# Registration

All inpatient facilities that provide care and treatment, as defined in Section 62 of the Mental Health Act, 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 the 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 (NFMHS)
- Mental health care for people with intellectual disability (ID)
- Child and adolescent mental health care (CAMHS)

At the end of 2022, there were 67 approved centres registered with the MHC. During the year there were two new registrations, two approved centre closures, and 20 applications for re-registration were approved.

At the end of 2022, there were 2,686 registered inpatient beds in 67 approved centres across the country. During 2022, 17 approved centres notified MHC of temporary reductions to their operational beds. Approved centres reported that this was necessary due to staff shortages or refurbishment works. Highfield Hospital permanently reduced its operational beds by 10 due to a redevelopment of its Farnham ward.

- There were 98 CAMHS beds nationally, 62 in Dublin, 20 in Galway, and 16 in Cork.
- There were 773 adult beds in the independent sector, of which 757 were in Dublin.
- There were also 130 registered forensic beds (NFMHS) and 91 mental health intellectual disability (MHID) beds. These beds were located in Dublin, with a national catchment area.

Table 1: Beds per Sector 2022

	Dublin	Cork	Galway	Other Areas	Total
Inpatient Beds	348	268	79	899	1594
CAMHS Beds	62	16	20	0	98
Independent Beds	757	16	0	0	773
NFMHS Beds	130	0	0	0	130
ID Beds	91	0	0	0	91
	Total Beds All Areas				2686

Details of all approved centres and their location is available on the MHC's website.

## New Registrations

### Two applications to operate new approved centre were approved in 2022:

Both of these newly registered units provided residents with single room and, ensuite accommodation in modern, purpose-built facilities.

### Closures

Silver Lodge, Tullamore, Co. Offaly was removed from the register following a request from the registered proprietor. Silver Lodge was registered to accommodate residents from Maryborough Centre, St Fintan's Hospital during planned refurbishment works in 2022. The Sycamore Unit, Connolly Hospital was also removed from the register in 2022 following a decision by the HSE not to apply to renew registration.

### Inspection

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

On inspection, the Inspector rates the compliance against:

- 31 Regulations
- Part 4 of the Mental Health Acts 2001-2018
- Three Statutory Rules
- Four Codes of Practice

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 may make a Quality Assessment of 'Excellent', 'Satisfactory', 'Needs Improvement' or 'Inadequate'.

Due to the impact of the COVID-19 pandemic, the quality rating was not used for 2022 inspections.

The Compliance Monitoring section discusses compliance findings for 2022 in more detail.

## Compliance Monitoring

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

MHC uses a judgement support framework as a key document to guide how compliance is assessed on inspection. In 2022, a revised *Judgement Support Framework Special Edition, For Use During the COVID-19 Pandemic* ('the revised JSF') provided a consistent inspection framework for assessing compliance with regulatory requirements.

Sixty-six of the 67 registered approved centres were inspected in 2022 using the revised JSF as published in February 2022. One approved centre, Sycamore Unit, Connolly Hospital, was not inspected as it was not operational and did not provide a mental health service during 2022.

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 2022 inspection cycle. In addition, the revised JSF provided that a service would not be found 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 or the management of a COVID-19 outbreak. During 2021, staff education and training under Regulation 26(4) was not assessed. However, this was included in the 2022 assessment.

It should be noted that prior to 13 March 2020, 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 since March 2020, which also impacted all inspections carried out in 2022, 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.

To access copies of individual service inspection reports, the revised 2022 JSF and JSF Version 5.1, please visit the MHC website.

### Key Compliance Findings

**71%** regulations with over 90% compliance nationally

**48%** individual services that achieved over 90% compliance with Regulations

**71%** no service had less than 71% compliance with Regulations

Overall, the compliance rate with the 31 regulations at 88.37% was marginally lower in 2022 in comparison to 2021 (when it was 90.13%). Approximately 86% of approved centres achieved an 80% rate of compliance or higher with the regulations in 2022, compared to 89% of services in 2021, and 82% of services in 2020. Only nine services had a compliance rate lower than 80% in 2022, and no individual service had a compliance rate lower than 71%, an overall increment of 3% when compared with the previous year. In comparison, seven approved centres had a compliance rate lower than 80% in 2021, and the lowest compliance rate in 2021 was 68%. Twelve approved centres had a compliance rate lower than 80% in 2020.

There was a marked difference in levels of compliance achieved across the HSE's Community Healthcare Organisations (CHOs). In 2022, 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 (81%). The average compliance rate across services operated by independent providers was 95%.

### Four-year overview across all regulations

While there was a marginal overall decrease in compliance levels in 2022, there has been a steady and increasing trend in compliance over the last four years. Table 2 illustrates compliance levels since 2019. The comparison with 2019 is noteworthy as it allows comparison with data prior to the impact of Covid-19.

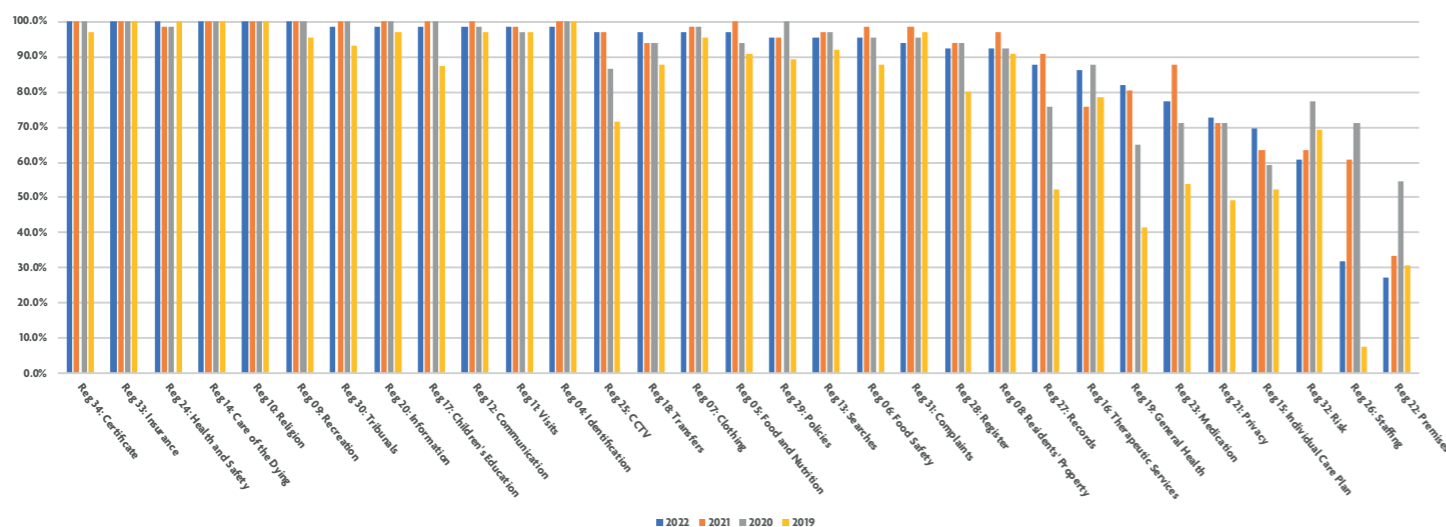
#### The biggest reduction in compliance 2022 versus 2019

- Risk 8.6%
- Premises 3.5%
- Complaints 3.0%

#### The biggest improvement in compliance 2022 versus 2019

- General Health 40.3%
- Records 35.6%
- Staffing 24.1%
- Medication 23.4%

Table 2: Regulatory Compliance chart 2022 -2019



2022 overall compliance across 31 Regulations was 88.37% versus 80.04% in 2019 indicating an overall improvement of 8.33%

#### The biggest reduction in compliance in 2022 versus 2021

- Staffing 28.8%
- Medication 10.6%
- Premises 6.1%
- Residents' property 4.5%
- Food & Nutrition 3.0%

#### The biggest improvement in compliance 2022 versus 2021

- Therapeutic services 10.6%
- Individual care plan 6.1%
- Transfers 3.0%

### Areas of Good Practice

In addition, 25 (81%) of the regulations had an approved centre compliance rate of 81% or higher in 2022. Six (6) regulations (19%) were fully complied with by all 66 approved centres, including Health & Safety, Recreation, Care of the Dying and Religion. In 2021, 25 (81%) of the regulations had a compliance rate of 80% or higher; full compliance by services was achieved with 11 regulations; 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 83% across all applicable services in 2022. In 2021, compliance with the five Statutory Rules and Part 4 of the Mental Health Act 2001, did not fall below 80%. 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 all of the four codes of practice did not fall below 82% across applicable services in 2022. 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. The code of practice related to the Admission of Children under the Mental Health Act 2001 had a compliance rate of 88% in 2022, a significant improvement from 70% in both 2021 and 2020.

### Areas of Concern

A number of regulations were identified as having poor compliance rates. In 2022, regulations with compliance rates below 80% included Medication (77.3%) and Privacy (72.7%).

Four regulations had compliance rates lower than 70%. These were Risk Management procedures (60.6%), Individual Care Plans (69.7%), Staffing (31.8%) and Premises (27.3%). Compliance with Regulation 22 (Premises) has been low over the past five years, with an average compliance rate of 35.12%.

The 2021 Annual Report also identified low levels of compliance with these same four regulations. The data for both 2021 and 2022 shows that there is considerable variance in compliance levels across the HSE regional areas with regard to these four regulations. Furthermore, it is evident in both years that services which are operated by independent or private service providers tend to have higher overall compliance rates than all but one of the HSE CHO areas. In 2022, the MHC found that the average compliance rate for these four regulations was below 70% across all CHO areas, with the exception of CHO5, as illustrated in the Table 3 below. Of note, in 2022 CHO 3, CHO 4 and CHO 7 had the lowest average compliance rates across the four regulations, with an average compliance rate of 18.8%, 22.2% and 16.7% respectively. In comparison, CHO 5 had a compliance rate of 78.6% across these four regulations, followed by the independent sector which had an average compliance rate of 78.1%.

In relation to codes of practice, the compliance rate with the Code of Practice on the Use of Physical Restraint was 82% in 2022, compared to 73% in 2021, and 76% in 2020. Furthermore, nine services were inspected on the Admission of Children to adult services in 2022, and eight were found to be non-compliant with the code. Reasons for non-compliance included services not providing age-appropriate facilities and a programme of activities appropriate to age and ability. In 2021 and 2020, all 10 adult services which admitted a child were 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.

**Table 3:** 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	75.0%	25.0%	0.0%	25.0%	0.0%	75.0%	31.3%
CHO 2	8	87.5%	12.5%	62.5%	62.5%	12.5%	87.5%	56.3%
CHO 3	4	50.0%	0.0%	0.0%	25.0%	0.0%	50.0%	18.8%
CHO 4	9	44.4%	11.1%	0.0%	33.3%	0.0%	44.4%	22.2%
CHO 5	7	100.0%	42.9%	85.7%	85.7%	42.9%	100.0%	78.6%
CHO 6	3	100.0%	33.3%	33.3%	100.0%	33.3%	100.0%	66.7%
CHO 7	3	0.0%	0.0%	0.0%	66.7%	0.0%	66.7%	16.7%
CHO 8	6	33.3%	33.3%	0.0%	50.0%	0.0%	50.0%	29.2%
CHO 9	7	57.1%	28.6%	28.6%	42.9%	28.6%	57.1%	39.3%
INDP	8	87.5%	62.5%	62.5%	100.0%	62.5%	100.0%	78.1%
Forensic	1	100.0%	0.0%	0.0%	100.0%	0.0%	100.0%	50.0%
CAMHS	6	100.0%	33.3%	33.3%	66.7%	33.3%	100.0%	58.3%

## Critical Risks

In 2022, there were 28 approved centres with 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, risk, therapeutic services, and staffing.

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 28 of this report for details of actions taken where critical non-compliances are identified.

**Table 4**

Key		
80% Compliant and over	60 - 80% Compliant	Less than 60% Compliant
Approved Centre	CHO/Sector	% Compliance
Aidan's Residential Healthcare Unit	5	100%
Avonmore & Glenree Units, Newcastle Hospital	6	100%
Cois Dalua	INDP	100%
Creagh Suite	2	100%
Grangemore Ward St Otteran's Hospital	5	100%
Haywood Lodge	5	100%
St Patrick's Hospital, Lucan	INDP	100%
Willow Grove Adolescent Unit, St Patrick's University Hospital	CAMHS	100%
An Coillín	2	97%
Ashlin Centre	9	97%
Department of Psychiatry University Hospital Waterford	5	97%
Highfield Hospital	INDP	97%
Linn Dara Child & Adolescent Mental Health In-patient Unit, Cherry Orchard	CAMHS	97%

Approved Centre	CHO/Sector	% Compliance
Lois Bridges	INDP	97%
Selskar House, Farnogue Residential Healthcare Unit	5	97%
St Patrick's University Hospital	INDP	97%
Teach Aisling	2	97%
Adult Mental Health Unit Sligo University Hospital	1	94%
Carraig Mor Centre	4	94%
Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital	CAMHS	94%
Ginesa Suite, St John of God Hospital	CAMHS	94%
Maryborough Centre, St Fintan's Hospital	8	94%
St Gabriel's Ward, St Canice's Hospital	5	94%
St Ita's Ward, St Brigid's Hospital	8	94%
St John of God Hospital	INDP	94%
Department of Psychiatry, St Luke's Hospital	5	90%
Elm Mount Unit, St Vincent's University Hospital	6	90%
Lakeview Unit, Naas General Hospital	7	90%
Le Brun House & Whitethorn House, Vergemount Mental Health Facility	6	90%
O'Casey Rooms, Fairview Community Unit	9	90%
Owenacurra Centre	4	90%
Phoenix Care Centre	9	90%
Adolescent In-patient Unit, St Vincent's Hospital	CAMHS	87%
Adult Acute Mental Health Unit, University Hospital Galway	2	87%
Adult Mental Health Unit, Mayo University Hospital	2	87%
Blackwater House	1	87%
Bloomfield Hospital	INDP	87%
Cappahard Lodge	3	87%
Deer Lodge	4	87%
Department of Psychiatry Midland Regional Hospital, Portlaoise	8	87%
Department of Psychiatry Roscommon University Hospital	2	87%
Jonathan Swift Clinic	7	87%
National Eating Disorders Recovery Centre	INDP	87%
Acute Psychiatric Unit, Cavan General Hospital	1	84%
Acute Psychiatric Unit, Ennis Hospital	3	84%
Central Mental Hospital, Portrane	Forensic	84%
Department of Psychiatry Connolly Hospital	9	84%
St Anne's Unit, Sacred Heart Hospital	2	84%
Acute Psychiatric Unit, Tallaght Hospital	7	81%
Admission Unit & St Edna's Unit, St Loman's Hospital	8	81%
Centre for Mental Health Care & Recovery, Bantry General Hospital	4	81%
Department of Psychiatry, Letterkenny University Hospital	1	81%
Sliabh Mis Mental Health Admission Unit, University Hospital Kerry	4	81%
St Aloysius Ward, Mater Misericordiae University Hospital	9	81%
St Joseph's Intellectual Disability Service	ID	81%

Approved Centre	CHO/Sector	% Compliance
St Vincent's Hospital	9	81%
Tearmann Ward, St Camillus' Hospital	3	81%
Acute Mental Health Unit, Cork University Hospital	4	77%
Acute Psychiatric Unit 5B, University Hospital Limerick	3	77%
Eist Linn Child & Adolescent In-patient Unit	CAMHS	77%
Units 2 3, 4, and Unit 8 (Floor 2), St Stephen's Hospital, Woodview	4	77%
Drogheda Department of Psychiatry	2	77%
St Bridget's Ward, & St Marie Goretti's Ward, Cluain Lir Care Centre	8	74%
St Catherine's Ward, St Finbarr's Hospital	8	74%
St Michael's Unit, Mercy University Hospital	4	74%
	4	71%

**Table 5:** CHO/Sector Compliance with Regulations in 2022

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 6:** Compliance with Regulations in 2022

Regulation	% Compliance
Reg 09: Recreation	100.0%
Reg 10: Religion	100.0%
Reg 14: Care of the Dying	100.0%
Reg 24: Health and Safety	100.0%
Reg 33: Insurance	100.0%
Reg 34: Certificate	100.0%
Reg 17: Children's Education	98.5%
Reg 04: Identification	98.5%
Reg 11: Visits	98.5%
Reg 12: Communication	98.5%
Reg 20: Information	98.5%
Reg 30: Tribunals	98.5%
Reg 05: Food and Nutrition	97.0%
Reg 07: Clothing	97.0%
Reg 18: Transfers	97.0%
Reg 25: CCTV	97.0%
Reg 06: Food Safety	95.5%
Reg 13: Searches	95.5%
Reg 29: Policies	95.5%
Reg 31: Complaints	93.9%
Reg 08: Residents' Property	92.4%
Reg 28: Register	92.4%
Reg 27: Records	87.9%
Reg 16: Therapeutic Services	86.4%
Reg 19: General Health	81.8%
Reg 23: Medication	77.3%
Reg 21: Privacy	72.7%
Reg 15: Individual Care Plan	69.7%
Reg 32: Risk	60.6%
Reg 26: Staffing	31.8%
Reg 22: Premises	27.3%

**Table 7:** CHO/Sector Compliance with Regulations in 2022

Rule	% Compliance
Rules: ECT	88%
Rules: Mechanical Restraint	91%
Section 26 Leave	50%
Part 4: Consent	74%
Rules: Seclusion	61%

**Table 8:** Compliance with Codes of Practice in 2022

Code of Practice	% Compliance
COP: ECT	100%
COP: Admission, Transfer, Discharge	88%
COP: Physical Restraint	76%
COP: Children	11%

\* 9 services were inspected in relation to adult services which admit children, and eight found to be non-compliant with the code of practice. Please refer to the Areas of Concern section above for more information.

# Enforcement

**Enforcement action is taken when the Mental Health Commission (MHC) is 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 commonly arise from 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 45 enforcement actions in response to incidents, events, and serious concerns arising in 2022. These actions related to 28 approved centres, and the maximum enforcement action initiated against any one approved centre was 8.

This compares with:

- 42 enforcement actions in 2021,
- 17 enforcement actions in 2020,
- 40 enforcement actions in 2019,
- 44 enforcement actions in 2018.

During 2022, enforcement actions included:

- 26 Immediate Action Notices, relating to 39 serious concerns
- 18 Regulatory Compliance Meetings
- 1 proposal to attach a condition to the approved centre's registration

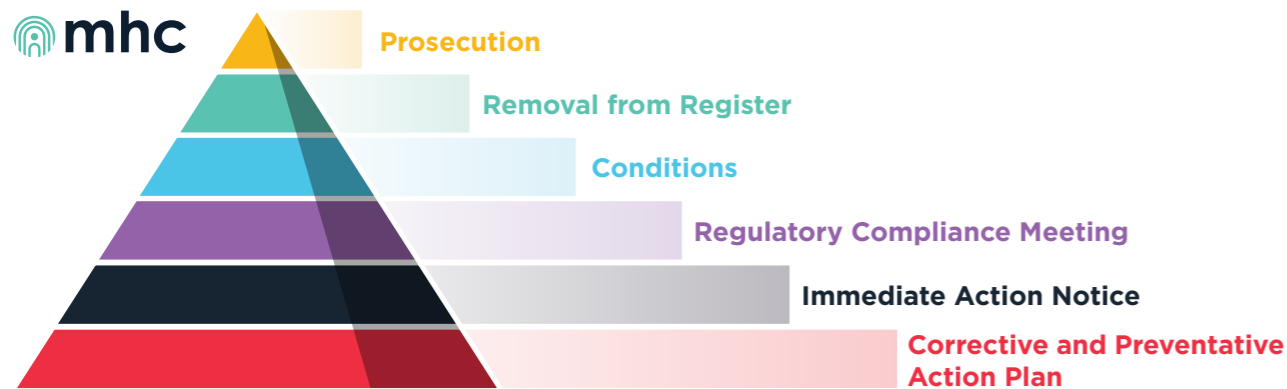
The majority of Immediate Action Notices and Regulatory Compliance Meetings arose from regulatory inspections conducted by the Inspectorate division.

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

They included:

- Maintenance of premises at the approved centre, 33%
- Risk management procedures at the approved centre, 19%
- Appropriate staffing at the approved centre, 8%
- The provision of therapeutic services and programmes, 8%
- Other service provision areas, 32%

**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 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 2022, 14 **new** conditions were attached to the registration of 12 approved centres, relating to additional governance reporting requirements, staffing, premises and prohibiting the admission and transfer of residents to a centre. This compares to three new conditions attached to three approved centres in 2021, 109 new conditions attached to 36 approved centres in 2020, and 14 conditions attached to the registration of nine approved centres in 2019.

At the end of 2022, there were 84 conditions attached to 37 approved centres in total, compared to 85 conditions attached to 39 approved centres in 2021, and 115 conditions attached to 42 approved centres in 2020. The most common conditions attached are presented in Table 9.

- 20 centres applied for re-registration in 2022, compared to only 10 in 2021 and 39 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.

Most conditions require that monthly or quarterly reports be submitted to the MHC, which allows for regular monitoring. In 2022, 428 condition-monitoring reports were submitted, compared to 461 condition-monitoring reports submitted in 2021 and 395 in 2020.

Twelve conditions were withdrawn during 2022 where approved centres implemented improvements and achieved compliance with the relevant regulations.

**Table 9: Conditions in force in 2022**

Condition Area	Number of Conditions Attached
Premises	35
Staff training	27
Care planning	3
Risk management	1
Closure	2
Other areas	16



# Quality and Safety Notifications

**Approved centres and other community mental health services are required to record and submit Quality and Safety Notifications to the MHC via the CIS system. There are 18 Quality and Safety Notifications which relate to incidents and adverse events and regulated practices, including:**

- Child Admissions
- Deaths
- Incident Reporting
- Serious Reportable Events
- Overcapacity
- Operational Bed Capacity
- Electro-Convulsive Therapy
- Restrictive Practices

All notifications received are reviewed by the Standards and Quality Assurance (S&QA) division of the MHC, to ensure quality, safety of care, dignity and human rights practices are adhered to in the provision of mental health services in approved centres, and in other community mental health services as defined by the MHC pursuant to the Mental Health Act (2001)

The S&QA division closely monitors and reviews these notifications and may request further information from a service in relation to a notification, 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, the MHC analyses notifications for trends and uses these data to inform its regulatory practices. The MHC also produces annual activity reports on regulated practices, which can be found on the MHC website.

## Adverse Events

### Deaths

In 2022, 498 deaths of people using mental health services were reported to the MHC. Of these, 147 deaths (29.5%) related to approved centres and 346 (69.5%) related to other community mental health services.

This compares to:

- 471 deaths in 2021, in which 174 were residents in approved centres and 297 were related to other community mental health centres.
- 586 deaths in 2020, 207 of which were residents in approved centres and 379 of which were related to other community mental health services.

63.7% (317) of deaths reported in 2022 related to male residents. The average age of a resident was 59 years of age. The youngest resident was 18 years of age, and the oldest resident was 96 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 2022, 144 total deaths were reported to the MHC by services as a 'suspected suicide' and 26 of these related to residents of approved centres. This compares to 127 in 2021, where 30 related to residents of approved centres.

**It should be noted that deaths notified to the MHC 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 below.

**Table 10:** Breakdown of deaths notified to the MHC

Type of Death*	Approved Centres	Other Mental Health Services	Total
Death was Sudden	26	118	144
Death was Not Sudden	118	222	340
Death was Suspected Suicide	26	118	144
Cause of Death Unknown	122	213	335

\* 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 2022, 51 SREs were reported to the MHC in relation to 23 approved centres. In 2021 42 SRE's involving 23 approved centres were reported.

In 2020, 36 SREs involving 19 approved centres were reported.

Table 11 shows the number of reported SRE's by category in 2022, broken down by SRE category. The highest reported SRE category was

**Table 11:** Serious Reportable Events in 2022 reported by category

SRE Category	Description	Number Reported	%
Care Management Events (4I)	Stage 3 or 4 pressure ulcers	10	19.6%
Criminal Events (6C)	Sexual assault	12	23.5%
Criminal Events (6D)	Serious injury/disability resulting from a physical assault	6	11.8%
Environmental Events (5D)	Serious disability associated with a fall	17	33.3%
Patient Protection Events (3C)	Sudden or unexplained deaths or injuries which result in serious disability of a person who is an inpatient/resident	2	3.9%
Other	Other event	4	7.8%
Total		51	

Environmental Events 5D (33.3%), followed by Criminal Events 6C (23.5%) and Care Management Events 4I (19.6%). In relation to the Criminal Events 6C (Sexual Assault) category, there was an increase in the number of approved centre incidents in 2022 (12) compared to 2021 (8). The MHC engaged with each service that reported a category 6C Criminal Event to ensure the safety of each resident and to require assurances regarding the wider safeguarding arrangements in place. 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 the national level to the HSE. The MHC has requested assurances that additional procedures, oversight, and resources will be put in place to strengthen existing safeguarding arrangements as provided for in the national policy "Sharing the Vision - a Mental Health Policy for Everyone," published in 2020.

Table 12 provides a breakdown of SRE by CHO. CHO 4 (37.2%) and CHO 5 (15.7%) reported almost half of all SRE's in 2022. It should be noted that some services may be more likely to report a specific type of SRE based on the profile of residents that they support. For example, falls and pressure ulcers are associated with older adults in care.

Fifty four percent of SRE's related to female residents. The average age of a resident who was the subject of an SRE was 60 years of age. The youngest resident was 21 years old and the oldest was 95 years of age.

**Table 12:** 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	0	0	1	2	0	2	0	0	5
Criminal Events (6C)	0	0	3	5	1	0	1	0	0	2
Criminal Events (6D)	0	0	0	2	1	2	0	0	1	0
Environmental Events (5D)	3	0	0	6	3	0	0	1	0	4
Patient Protection Events (3C)	0	0	0	1	1	0	0	0	0	0
Other	0	0	0	4	0	0	0	0	0	0
<b>CHO Totals</b>	<b>5.9%</b>	<b>0.0%</b>	<b>5.9%</b>	<b>37.3%</b>	<b>15.7%</b>	<b>3.9%</b>	<b>5.9%</b>	<b>2.0%</b>	<b>2.0%</b>	<b>21.6%</b>

## Regulated Practices

The MHC produces detailed annual activity reports on the use of ECT and also on restrictive practices including seclusion, physical restraint, and mechanical restraint. All annual activity reports for ECT and restrictive practices can be found at [mhcirl.ie/publications](https://mhcirl.ie/publications). Below is a high-level overview of the information which will be presented in greater detail when these reports are published later in 2023. The data presented is therefore provisional. The final figures for 2022 and additional information will be included in the activity reports.

### 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.

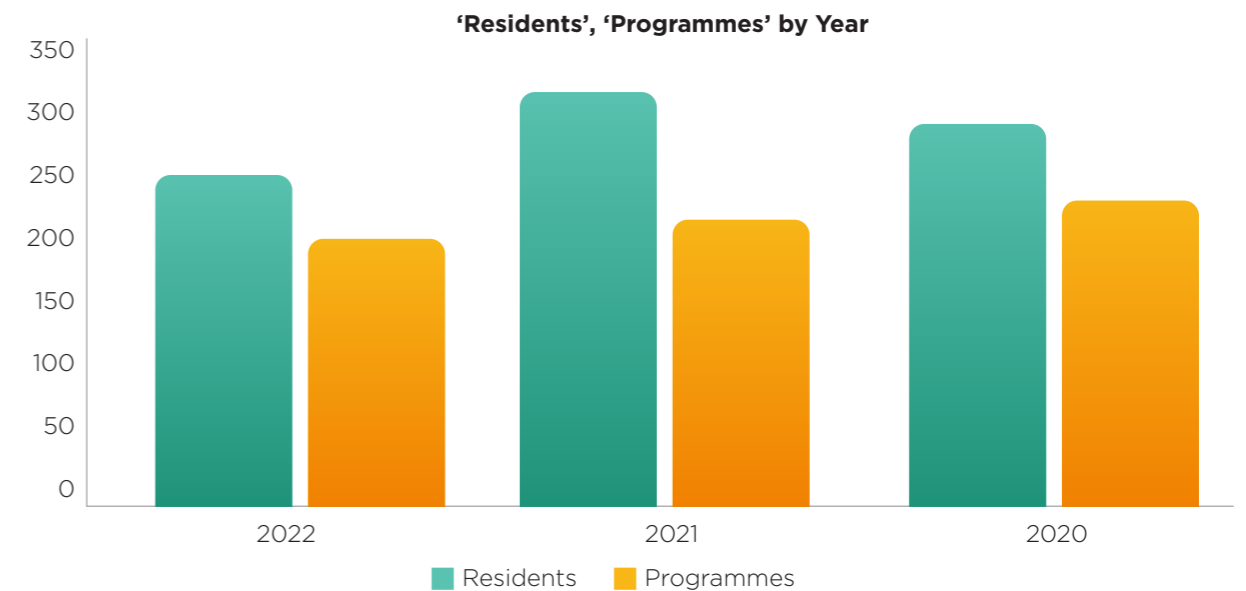
In 2022 there were 263 programmes of ECT for 206 residents in 15 approved centres. In 2021 there were 333 programmes of ECT for 229 residents, and in 2020 there were 300 programmes of ECT for 239 residents. (As indicated below in Figure 3).

One independently operated approved centre, St Patrick's University Hospital, delivered 47.5 % of all programmes (125 programmes) in 2022.

80.9% percent of residents who were administered ECT in 2022 were voluntary residents at an approved centre at the time of commencement of the ECT programme, compared to 82% in 2021, and 78% of residents in 2020.

In 2022, 78.2% of residents underwent a single programme of ECT, while 22% of residents received between two and six ECT programmes. In 2022, 63.6% of ECT residents were female, compared to 60% in 2021 and 66% in 2020. The average age of a resident undergoing ECT in 2022 was 64 years and in the 2021 average age was also 64 and in 2020 it was 62 years. The youngest ECT resident in 2022 was 22 years old and the oldest resident was 95 years of age.

**Figure 3:** ECT Programs per year 2022 - 2020



A single ECT programme may involve up to 12 individual treatments. Only 74 programmes (28.1%) of ECT involved the full 12 treatments in 2022, with an average of eight treatments per resident. There was a total of 2,109 individual ECT treatments in 2022, compared to 2,282 in 2021, and 2,329 in 2020.

In 2022, 1,767 ECT treatments (83.8%) took place with the patient's consent, compared to 1,983 (86.9%) in 2021 and 1,881 treatments (81%) in 2020. Forty-four programmes of ECT (16.7%) in 2022 included at least one treatment without consent<sup>1</sup>, a lower actual count than in 2021 (48 programmes and 14%) but a higher percentage due to the fact that there were fewer programmes in 2022.

## 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.

There was a 36% decrease in the number of episodes of seclusion compared to the previous year.

In 2022, there were 1,202 episodes of seclusion involving 579 residents in 26 approved centres. The shortest episode reported was one minute, while the longest episode was 13,272 hours 39 minutes (553 days). This seclusion started in August 2020 and ended in February 2022. 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 98 notifications from 18 approved centres of episodes of seclusion that lasted longer than 72 hours in 2022.

In comparison, in 2021 there were 1,884 episodes of seclusion involving 654 residents in 27 approved centres with 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.

CHO 9 accounted for 23.8% of seclusion episodes in 2022, followed by CHO 5 which accounted for 17.9% and CHO 8 which accounted for 12.6%.

In 2022, 67% of residents who were secluded were male. The average age of secluded residents was 35 years. The youngest secluded resident was 15 years old and the oldest was 85 years of age. The majority of residents (68%) who were secluded were secluded only once. However, the average number of episodes per secluded resident was two.

In order to increase the protections provided to people who experience seclusion and other restrictive practices, the MHC published updated rules and codes of practice governing these practices in 2022. The new rules and codes of practice came into effect on 1 January 2023.

## 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 2022, there was an approximate decrease of 18% in the number of episodes of physical restraint. There were 2830 episodes of physical restraint involving 1,027 residents in 47 approved centres. This compares to 3,460 episodes of physical restraint involving 1,169 residents in 47 approved centres in 2021 and 3,990 episodes involving 1,211 residents in 48 approved centres in 2020. The average episode of physical restraint in 2022 lasted for five minutes. The shortest episode of physical restraint lasted for less than one minute, while the longest was six hours and two minutes.

Renewal orders are required for episodes of physical restraint that last longer than 30 minutes. In 2022, 14 episodes of physical restraint, (0.5%), required a renewal order.

CHO 7 accounted for 15.1% of physical restraint episodes in 2022, followed by CHO 9 (13.3%) and CHO 4 (11.1%).

Fifty-three percent of residents who were

physically restrained in 2022 were male. The average age of residents who were physically restrained was 41. The youngest resident who was physically restrained was 11 years old, and the oldest was 99 years of age. The average number of episodes per physically restrained resident was two. Approximately 58% of residents who were physically restrained in 2022 were restrained on only one occasion.

In order to increase the protections provided to people who experience seclusion and other restrictive practices, the MHC published updated rules and codes of practice governing these practices in late 2022. This followed a comprehensive 18-month review, stakeholder engagement process and consideration of the national and international evidence and best practice. The outcome of the review saw the introduction by the MHC of new rules for seclusion and mechanical restraint, and a new code of practice for physical restraint, all of which came into force on 1 January 2023. The new rules included an outright ban on mechanical means of bodily restraint for children, including the use of hand and leg cuffs. They also require all public and private services to adopt a rights-based approach and publish information about their efforts to reduce and, where possible, eliminate the use of restrictive practices on an annual basis.

The MHC considers that the revised rules and code will encourage continual efforts to avoid, reduce and, where possible, eliminate restrictive practices. All publications are available on the MHC website and include:

- Rules Governing the Use of Mechanical Means of Bodily Restraint
- Rules Governing the Use of Seclusion
- Code of Practice on the Use of Physical Restraint
- Consultation and Evidence Review
- Consultation Report- Revision of the Rules and Code of Practice relating to the use of seclusion, mechanical means of bodily restraint, and physical restraint in approved centres
- Evidence Review Restrictive Practice

# 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 2022, there were 33 instances of overcapacity reported by approved centres. (Compared with 64 instances of overcapacity in 2021).**

Overcapacity in 2022 related to the following seven approved centres:

- Adult Mental Health Unit, Mayo University Hospital
- Acute Psychiatric Unit 5B, University Hospital Limerick
- Drogheda Department of Psychiatry
- Department of Psychiatry, Roscommon University Hospital\*
- Adult Acute Mental Health Unit, University Hospital Galway
- Lakeview Unit, Naas General Hospital
- Department of Psychiatry, St Luke's Hospital

The Adult Acute Mental Health Unit, University Hospital Galway reported nine (27.27%) of the 33 instances of overcapacity in 2022. This is followed by Acute Psychiatric Unit 5B, University Hospital Limerick and Drogheda Department of Psychiatry with seven (21.21%) instances of overcapacity in each. The Adult Mental Health Unit, Mayo University Hospital, the Department of Psychiatry, Roscommon University Hospital; and the Department of Psychiatry, St Luke's Hospital each reported three (9.09%) instances of overcapacity, while the Lakeview Unit, Naas General Hospital reported one (3.03%) instance of overcapacity.

Only five CHO areas reported overcapacity in their approved centres. CHO 2 accounted for 15 (45.5%) of the overall overcapacity notifications; CHO 3 and CHO 8 submitted seven (21.2%) notifications each; CHO 5 submitted three (9.1%) notifications; and CHO 7 submitted one (3.03%) notification. During 2022 there were no overcapacity notifications reported by Independent Centres.

The MHC requires additional information and assurances from all services reporting overcapacity to ensure patient safety and dignity, to require evidence of surge management plans and to require that they address the systemic causes of overcapacity.

In terms of how additional residents were accommodated, 19 overcapacity notifications (57.6 %) 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. One (3%) notification 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.

The remaining 13 (39.4%) residents were accommodated in 'other' areas of the approved centres. 'Other' normally describes the use of rooms not designated as accommodation rooms, such as interview rooms, high observation rooms, sitting rooms and day rooms. Most of these instances occurred due to emergency involuntary admissions. Based on the information provided, the approved centres focused on ensuring that the comfort, dignity, and privacy of service users were maintained in accordance with the guidelines until a bed could be allocated to them.

The number of instances of overcapacity has decreased by 48% when compared to the previous year and by 43% when compared to the year before. In 2022 there were 33 instances of overcapacity across all approved centres when compared to 64 notifications in 2021 and 58

notifications in 2020. The continued downward trend could be a result of post-COVID-19 operations as bed capacity was reduced in many services during the pandemic to enable the implementation of COVID-19 infection prevention and control guidance.

Figure 4: Overcapacity 2019-2022

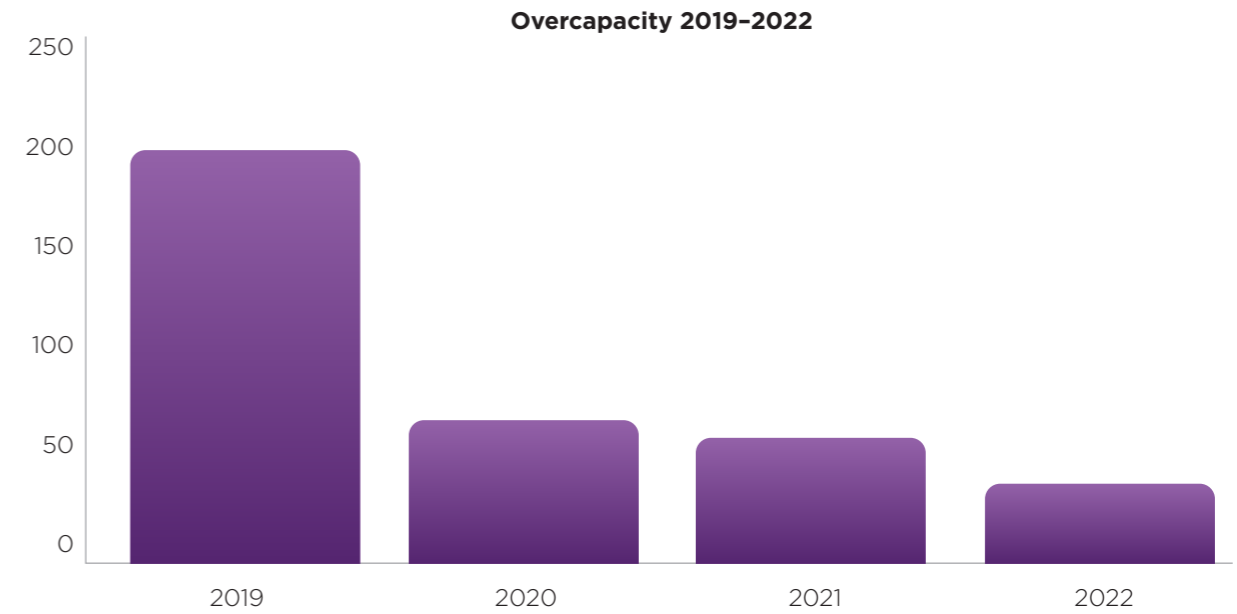
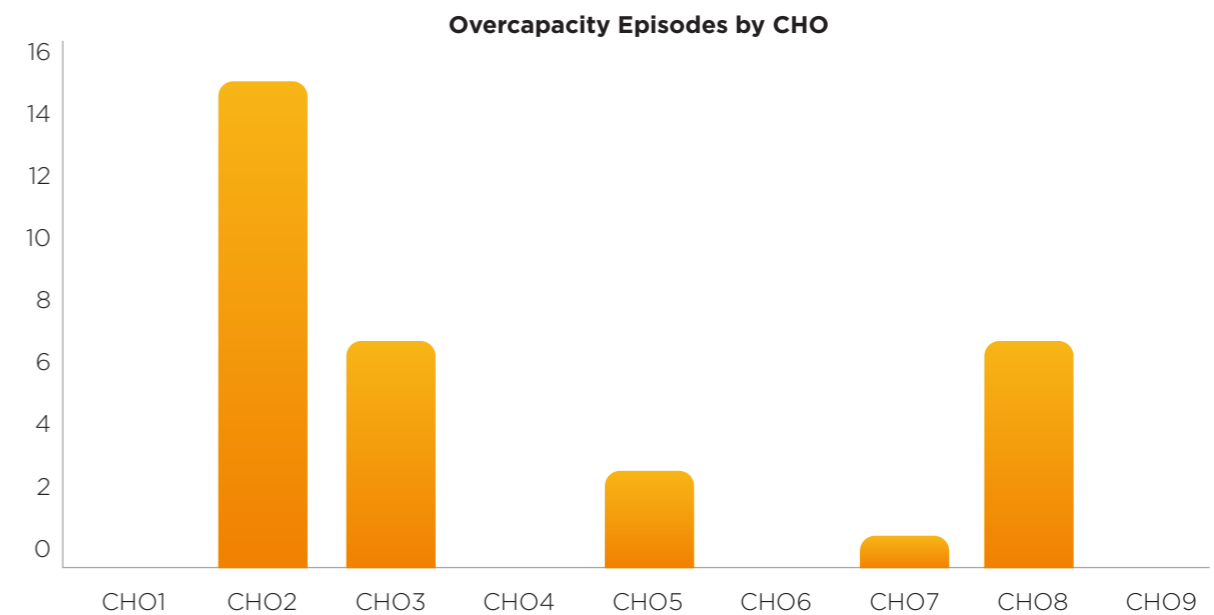


Figure 5: Overcapacity Episodes by CHO



\* Department of Psychiatry, Roscommon University Hospital's bed capacity increased by two on 11 February 2022



## 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 all admissions of young people to approved centres in 2022 was 366. This compares with a total of 459 admissions in 2021, 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 most common reasons for admissions to adult units are:

- Immediate risk to the young person or others.
- Lack of a bed in a specialist Child and Adolescent Mental Health Service (CAMHS) unit.

Residential CAMHS units are only located in three counties nationally. Due to the availability of CAMHS beds children and young people in crisis may be left with the unacceptable 'choice' between an emergency department, general hospital, children's hospital, or an adult inpatient unit.

In 2022, there was a significant decrease in the number of children admitted to adult units, when compared with the previous year. There were 20 admissions to 11 adult units in 2022. This compares with 32 admissions to 11 adult units in 2021, 27 admissions to nine adult units in 2020 and 54 admissions to 15 adult units in 2019. Thirteen of those admissions in 2021 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.

Eighteen percent (18%) of children admitted to an adult unit in 2022 were admitted due to an immediate risk to themselves, while 10% were admitted due to an immediate risk to themselves and others. Fifty two percent (10 admissions) of child admissions to adult approved centres in 2022 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 2022, 5.2% of child admissions were to adult units. This figure is lower than in 2021 where 32 children were admitted to adult units, accounting for 6.3% of child admissions. The 2022's admissions of children to adult units in 2022 is the lowest number since records began. Figure 6 presents child admissions to adult and CAMHS approved centres over the past six years.

Part of the decline in child admissions to adult units in 2022 may relate to the fact that there was an overall decline in child admission which resulted in available beds at CAMHS units. The reason for the lower overall admission cannot be determined with the current available data. Without tracking the actual patient journey, there cannot be a factual conclusion.

**Table 13:** Child Admissions to Adult Units 2022

CHO/Sector	No. Admissions
CHO 1	<5
CHO 3	<5
CHO 4	<5
CHO 5	6
CHO 9	6

## 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 2022, there were 346 admissions to CAMHS units nationally. The average duration of admission was 70 days, based on discharge information provided for 345 admissions. The shortest admission duration was less than one day, and the longest admission duration was 328 days. This data excludes the 20 admissions that were not discharged before 1 January 2023

## Involuntary child admissions

The District Court is required to authorise the involuntary admission of a child. In 2022, there were 20 involuntary admissions orders of children to approved centres, pursuant to Section 25 of the Mental Health Act. This included:

- 3 (Three) orders to adult units
- 17 (Seventeen) orders to CAMHS units

In addition, there was:

- No Admissions of a Ward of Court to an adult Unit

## Age and gender of child admissions

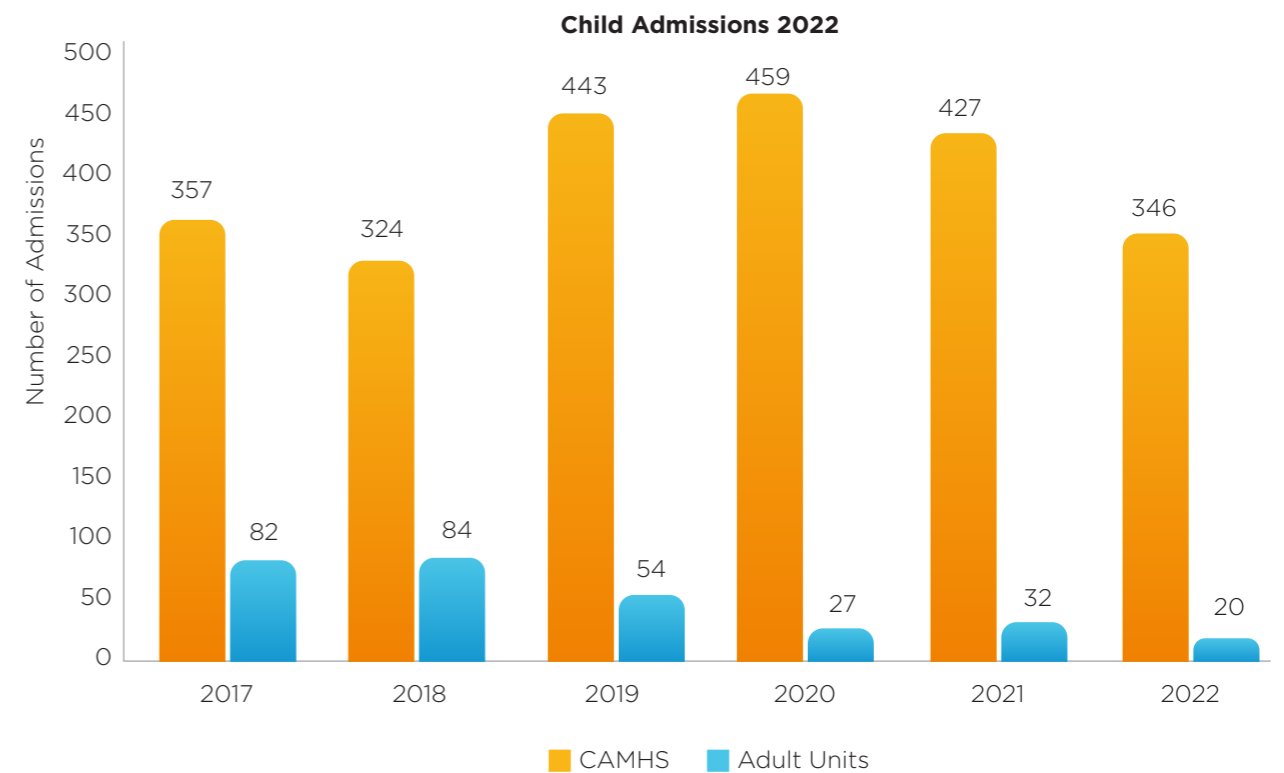
In 2022, 75.4% of child admissions to CAMHS units were female. In comparison, 36.8% of child admissions to adult approved centres were female. In 2022, 73.4% of all child admissions

related to female residents. The average age of a service user in 2022 was 15 years of age. The youngest residents were 11 years of age. A breakdown of admission by age is presented in Table 14. Eighty-one percent of children admitted to CAMHS and adult units in 2022 were admitted only once, with 12% of residents admitted twice and 6 % 3-4 times in that period.

**Table 14:** Admissions to Adult and CAMHS approved centres by age in 2022

Age	Adult	CAMHS
17	18	120
16	2	88
15	0	58
14	0	57
13	0	14
12	0	7
11	0	2
10	0	0

**Figure 6:** Child Admissions to Adult and CAMHS approved centres for the past 6 years



# Mental Health Tribunals

## Mental Health Tribunals



### Introduction

**Mental health tribunals (tribunals) are a key part of vindicating the rights of those involuntarily detained and while they only relate to a tiny percentage of people, those people are some of the most vulnerable in our society who require our support and assistance.**

### Post COVID-19

The plan at the beginning of 2022 was to return fully to in person hearings for all those involuntarily detained. The data from an interim survey conducted during the pandemic found that patients preferred to have their hearings in person as it involved direct engagement with the parties involved. During the year, the number of approved centres with COVID-19 fluctuated between three to nineteen. However, by the year end the impact of COVID-19 had finally waned. With the return to in person hearings the Tribunals team sought to introduce a protocol for tribunal rooms to ensure that they were appropriate given the serious nature of the issues to be decided. The plan for 2023 is to introduce a formal standard operating procedure for tribunal rooms which will be considered by the regulatory team as part of the registration process for approved centres and will also be considered as part of the inspection process\*.

### Guidance from the Courts for tribunals

#### A) Belief by An Garda Síochána when making an application for detention under Section 12 of the 2001 Act:

Section 12(1) states that “Where a member of the Garda Síochána has reasonable grounds for **believing** that a person is suffering from a mental disorder and that because of the mental disorder there is a serious likelihood of the person causing immediate and serious harm to himself or herself or to other persons, the member may either alone or with any other members of the Garda Síochána— (a) take the person into custody, and

(b) enter if need be by force any dwelling or other premises or any place if he or she has reasonable grounds for believing that the person is to be found there.”

The Court of Appeal in March 2022 stated that “... compliance with the relevant provision [section 12] **involves a tribunal in addressing whether or not the necessary opinion was actually so held by the officer concerned on objective grounds.**”

In the particular case, the Court found that the tribunal could not have held on objective grounds that such an opinion had been formed. As a result of this decision, the Tribunals team amended the relevant statutory form to be completed by a member of An Garda Síochána. This ensures that a member of the An Garda Síochána can clearly set out their belief that the person is suffering from a mental disorder and that because of the mental disorder there is a serious likelihood of the person causing immediate and serious harm to himself or herself or to other persons.

The Court, very helpfully in support of the Gardaí, added that it was not being suggested “... that the opinion which an arresting Garda must hold for the purposes of section 12(1) be one which would withstand forensic analysis. Of its very nature, the opinion which the Garda must form is one based on **a non-medical behavioural observation** of a person, and the threshold for the formation of the reasonable opinion necessary for the purposes of section 12(1) is low.”

The Tribunals team and An Garda Síochána liaised closely in relation to the immediate implications of this Court decision and monitored its impact during 2022.

\* At the time of writing this protocol has been introduced.

## B) Key requirements for a decision of a tribunal:

The Court of Appeal, in December 2022, stated "... that adequate reasons were not given [**in the decision**] in the present case albeit that only a little more by way of explanation would have been sufficient to satisfy the "adequate reasons" requirement. Nonetheless, **in a matter of such significance for the liberty of a vulnerable individual** such as the appellant, **an explanation should be explicit and unambiguous even if it is simple and short**, in order to demonstrate that all the evidence was properly considered and ruled upon, **and that the respondent was clearly satisfied from its conclusions on that evidence that the relevant legal criteria were fulfilled.**

Where persons suffering from mental illness participate in proceedings of the respondent by giving evidence, respect for not only their liberty but also their dignity, self-determination and autonomy requires that the decision-maker engage with their evidence and to explain, if it be the case, why it has not been accepted. Leaving inferences to be drawn is not sufficient."

The MHC welcomed this guidance from the Court and communicated same to all the MHC panel members.

## 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 as follows:

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 affect 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 all tribunal decisions will all be published in an anonymised format. In preparation for this, all tribunal decisions are now delivered in typed not handwritten format.

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 also 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 and 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.

## 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 2022, the following orders were made:

- 2,040 admission orders from the community
- 581 admission orders by way of re-grading
- 884 renewal orders for a period up to three months
- 264 renewal orders for a period up to six months

**From 2021 to 2022, there was a 3% increase in admission orders and a 5% decrease in renewal orders.**

**Figures 1-3** and **Table 1** in the Appendices 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 2022, there were 227 detained persons who were eligible to seek an additional review, of which:

- Twenty-four (24) requests were received for a tribunal hearing.
- Two (2) orders were revoked before the hearing took place.
- Twenty-two (22) hearings took place with nineteen (19) orders being affirmed and three (3) orders being revoked.

The positive message from the above is that 24 patients had an opportunity to have their detention reviewed before the end of the six-month order and five of those had their orders revoked either before or at the hearing as they did not have a mental disorder.

However, the MHC expressed its concern in the 2020 and 2021 Annual Reports that despite taking additional measures to address this low uptake - including 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 system (CIS) to contact their client if three months of the six month order has elapsed and addressing the issue with legal representatives at our seminar with them in 2020 - the low update continues.

At the time of publication of this report the Department of Health (DOH) is working on the Bill to amend the Mental Health Acts. The MHC will now formally write and ask them to consider limiting detention orders to 21 days and three months with no six-month orders thereby allowing all patients to be automatically reviewed on a more regular basis.

## Tribunal Hearings

3,769 orders were made in 2022 and of those it is noted that:

- 1,943 orders were revoked before hearing (50.9%)
- 1,874 orders went to hearing (49.1%)
- 255 orders were revoked at hearing

## 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 has to balance the need to ensure that the person is not inappropriately discharged with the need to ensure that the person is only involuntarily detained for so long as is 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 4** in the Appendices.

No	Issues	Number of Revocations	% of Revocations
1	No mental disorder (section 3 not met)	127	50
2	Errors with sections 9 to 12 (applications and recommendations for involuntary admission) and the related Forms	38	15
3	Errors with sections 14 and 15 (admission and renewal orders for involuntary admission) and the related Forms	26	10
4	Patient Notification Form issues (information to be provided to the patient from the admission and renewal orders)	24	9
5	Errors with sections 23 and 24 (admission form where someone is regraded) and the related Form	12	5
6	Other non-compliance issues	5	2
7	No mental disorder (section 3 not met) <u>and</u> non-compliance issues	23	9
	Total	255	

Approximately 50% of cases were revoked because of mental disorder (did not meet the criteria in section 3 of the 2001 Act) and 41% solely for reasons of non-compliance with statutory provisions (No. 2-6 above) with 9% being revoked for a combination of both. The rate of cases revoked for reasons of non-compliance with statutory provisions is disappointing given the updating of the statutory Forms; to make them more user friendly; guidance issued to specific practitioners on how to complete the statutory Forms; and training for a number of the relevant stakeholders.

However, it is important to note that:

- A number of cases were revoked due to errors by An Garda Síochána in completing the application forms for detention. This arose from the legal case referred to in the Introduction. As stated, An Garda Síochána have worked closely with the MHC to ensure these non-compliance issues have been addressed and do not reoccur in 2023; and
- There has been a decrease in the errors relating to the completion of patient notification forms, admission orders and renewal orders, which is positive.

### Orders revoked at tribunal

A total of 1,874 orders were reviewed by a tribunal and of those 255 orders were revoked at hearing. The number of revocations for 2022 increased to 13.5% from 11% in 2020 and 2021 (the figure for 2019 was 12%). **Figures 7 and 8** in the Appendices provide a further breakdown of these revocations. In relation to these revocations please note:

The following individual instances and issues with regard to revocations in 2022 are also noteworthy:

- Mental disorder could not be assessed as the patient's responsible consultant psychiatrist had not reviewed the patient the day of the tribunal or the previous day
- The person who made the recommendation was disqualified from doing so, which is not an issue that has featured for a number of years
- A slight increase in the number of errors in completing the admission order for those who are being regraded from voluntary to involuntary (sections 23 and 24)

The MHC shall continue its targeted training in 2023 to ensure that the rate of non-compliance reduces and continues to reduce.

### Tribunals for transfers to the Central Mental Hospital (CMH)

There was one proposal received to seek the transfer of a patient to the CMH in 2022. However, the person was not transferred as of 31 December 2022. It is expected that now the new National Forensic Mental Health Service has opened that regional approved centres will again seek to have

patients transferred for specialist treatment and those patients will in fact be transferred. This is an issue that the Tribunals team with the Inspectorate team shall be reviewing and reporting on.

### Section 28 tribunals

If an order is revoked before a tribunal, the patient can still proceed to have a tribunal. This is commonly referred to as a section 28 tribunal. Of the 1,943 orders revoked before hearing, there were 31 requests for section 28 tribunals of which 20 proceeded to an actual hearing. This is a very small percentage (1%) of the orders revoked before hearing.

The MHC has repeatedly stated that, in its opinion, it is not clear what a tribunal is to decide at a section 28 tribunal. The MHC, in its submission to the Department of Health in March 2020, sought for section 28 to be reviewed and its purposes clarified to assist persons involuntarily detained, those representing them, and the tribunal members. The Department has addressed this in part in the General Scheme to amend the 2001 Act published in July 2021, but further clarity is required.

### Admissions from the community

There were 2,040 admission orders from the community in 2022 and one of the issues which the MHC considers each year is who makes these applications.

The key changes in the 2022 figures compared to 2021 are that applications by family members are down by 2% and applications by authorised officers of the HSE (AOs) are up by 1%, but applications by An Garda Síochána are up again by 1% with applications by 'any other person' remaining the same<sup>1</sup>.

Please refer to **Figure 5** and **Figure 6** in the Appendices.

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

- the continued decrease in applications by family members is welcomed.
- It is disappointed that applications by AOs have only increased by 1% from 2021 (see below), given the extensive discussions on this issue over the last two years.
- 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.

The MHC will continue to liaise with the following:

1. The Department of Health to ensure that the legislation is amended, as per the General Scheme, to ensure that detentions should not be made by An Garda Síochána.
2. The HSE to chart the progress of its Authorised Officers Working Group with regard to the proposal in the General Scheme that all applications for detention be made by authorised officers.
3. An Garda Síochána in relation to any practical matters to ensure up to date knowledge of the law and the relevant statutory forms and how they should be completed.
4. Meet with all other related stakeholder groups on this matter.

### Voluntary to Involuntary

If a voluntary patient indicates a wish to leave an approved centre they can be involuntarily detained, if a specific member of staff is 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 581 such admissions notified to the MHC in 2022.

### Age and Gender

Analysis of age and gender for episodes of involuntary admission in 2022 can be found at **Tables 2,3 and 4** in the Appendices and three of the key findings are as follows:

- People aged 35 - 44 had the highest number of involuntary admission at 24% (the same as 2021).
- 55% of the admissions were male.
- There were more female admissions than male in the age groups over 45.

<sup>1</sup> Other person is very wide and can include a doctor in an A&E department.



## 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 tribunals. Some items of interest from these audits are:

- From a sample of 270 tribunals, 92% 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. Nine (9) 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. None chose a private solicitor to represent them, and one (1) chose to represent themselves (save for those who sought to do so directly at a tribunal and without notice to the MHC).

### Audit of the tribunal decisions:

This 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. 31 of the 120 patients did not attend the hearing. This does not take account of those who attended all or part of hearing and did not attend for the decision.
3. In 113 of the 120 decisions the tribunal separately addressed the issues of compliance and mental disorder as required in section 18(1) of the 2001 Act.



31 of the 120 patients did not attend the hearing. This does not take account of those who attended all or part of hearing and did 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.

One hundred and ninety-two (192) issues were logged. Of note:

- 62% 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 that the tribunal was due to commence.
- 5% related to Forms received later than the statutory 24-hour timeline, with consequences for the validity of the detention in some of those cases.

While less issues were recorded in 2020 and 2021, the threshold for recording issues has increased and the more serious issues which arose in 2021 have not arisen in 2022.

## 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 only 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 if it is not specifically the subject of the appeal to the court.

The MHC was notified of 146 Circuit Court appeals in 2022. This is an increase from 2021, (135 appeals) but 2021 had seen a reduction from 2020, where 156 appeals were received.

Of the 146 appeals received in 2022 –

- 120 appeals did not proceed to full hearing.
- 16 appeals proceeded to full hearing.
- 15 were affirmed by the Court
- 1 was revoked by the Court.
- Some cases that were appealed in 2022 had not gone to hearing by 31 December 2022.

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 most notably that the approved centre shall be the respondent to the proceedings as the detainer. This is in addition to the fact that the burden of proof should rest with the detainer and the patient. Both these proposals were incorporated into the General Scheme published in 2021 and it is hoped will be retained in the Amendment Bill to be published in 2023.



The MHC was notified of 146 Circuit Court appeals in 2022. This is an increase from 2021, (135 appeals) but 2021 had seen a reduction from 2020, where 156 appeals were received.

# Decision Support Service

## Decision Support Service



### Ready to open doors

**2022 was a significant year for the Decision Support Service (DSS) as it got ready to open its doors as a new State service for all adults who may need support making decisions.**

The Assisted Decision-Making (Capacity) (Amendment) Bill 2022, was finally enacted on 17 December 2022, clearing the last major milestone for the DSS to become a fully operational service.

The enactment of the Assisted Decision-Making (Capacity)(Amendment) Act 2022 was welcomed by the DSS. It contains many important provisions that will help to ensure that the DSS is an effective, accessible, and person-centred service. These include:

- A new two-step process for the registration and notification of enduring powers of attorney, which will allow the donor to address any potential issues with the DSS at the earliest stages while they still have capacity to do so.
- Allowing applications and associated forms to be specified by the DSS instead of provided for by way of regulation, which will make the forms more easily adaptable.
- The reduction and simplification of supporting statements required to register a co-decision-making agreement and enduring power of attorney
- Amended provision for the reimbursement and remuneration of decision-making representatives.
- Amendments to clarify the DSS complaints procedure and the role of special and general visitors.

The DSS worked closely with the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) throughout the development of the General Scheme of the amending legislation, to ensure any operational impacts for the service could be quickly analysed and

implemented, where necessary. The DSS also had the opportunity to engage with DCEDIY on the development of regulations to address procedural and documentary matters.

The DSS used the time gained from commencement delays to good effect by progressing our workforce plan and training new staff, continuing to build and test our new ICT case management system and customer portal, and developing forms and guidance for people who will use the DSS.

### Engaging with Stakeholders

The DSS has a statutory obligation to promote awareness and understanding of the provisions of the 2015 Act, which has potential relevance for every adult in the state. The task of reaching the diverse range of potential users of our service has, at times, been challenging. During the COVID-19 pandemic, we engaged with stakeholders by utilising online video conferencing. However, with the lifting of the restrictions at the end of February, we were able to adopt a blended approach to reaching our potential stakeholders, making presentations and hosting meetings both in-person and online. The return to in-person engagement early in the year enhanced our ability to build on the important relationships already established with our key stakeholders.

In total, the DSS met with or presented to more than 95 separate organisations throughout 2022. (See 2022 Stakeholder Engagement). In addition to these engagements, we had regular meetings throughout the year with the following:

- Department of Children Equality, Disability, Integration and Youth
- Department of Health
- Courts Service
- HSE National Office for Human Rights and Equality Policy
- Legal Aid Board

- Banking & Payments Federation of Ireland
- HSE National Safeguarding Office
- National Federation of Voluntary Service Providers.
- Safeguarding Ireland Advisory Committee

The Director addressed international gatherings at the World Congress on Adult Capacity, the Society of Trusts and Estate Practitioners Global Congress and the European Disability Forum.

In June, our staff held a workshop with potential users of our digital system from Inclusion Ireland to test and receive feedback on our DSS Portal.

Also in June, our DSS Stakeholder Forum was established and comprised experts by experience from a range of relevant organisations. The organisations represented included Inclusion Ireland, the Independent Living Movement Ireland, the Neurological Alliance of Ireland/Acquired Brain Injury Ireland, Cairde, Mental Health Reform and the Irish Deaf Foundation. The main purpose of the Forum was to obtain valuable feedback in relation to some of the resources we were preparing in advance of the commencement of our service.

The Director and other members of the management team attended a Joint Oireachtas Committee on Disability Matters in November, during which the Director provided an update on the amending legislation and the progress being made to establish our new service.

The Director wrote articles in several publications across the health, social care, legal and financial sectors.

During the year, our dedicated Information and Support Services Team answered 802 calls and queries from members of the public (consisting of 450 calls and 352 emails).

To keep our diverse range of stakeholders updated throughout the year, the Director published information material and videos on our website. These resources were designed to impart information in a clear and comprehensive way. The demand for our leaflets and posters continued to increase throughout the year, reflecting the ever-increasing levels of interest and engagement across our stakeholder groups.

## Codes of practice and guidance materials

The DSS has prepared 13 statutory codes of practice. These codes will be an important tool to provide guidance to all those engaging with the 2015 Act, including decision supporters, financial services, legal and healthcare professionals and other interveners such as general and special visitors. The codes provide overall guidance on the interpretation and practical implementation of the guiding principles in relation to supporting decision-making and assessing capacity.

The development of the codes of practice has been through a number of stages and in 2022 we concluded our public consultation, commissioned an independent legal review and submitted the codes of practice for review by DCEDIY and the Department of Health.

We undertook a robust public consultation process between November 2021 and February 2022 and received over 300 responses. All submissions received were given due consideration and have led to meaningful changes in the quality and accessibility of the codes.

During 2022, we continued to develop a range of accessible guidance documents, step-by-step guides and videos that will support people who want to make a decision support arrangement and use our services.

## DSS Panels Recruitment

In 2022, the DSS commenced the recruitment of the special visitor, general visitor, and decision-making representative panels. Based on overall demand forecasting, the DSS will recruit approximately 125 people to the DMR Panel, 50 to the general visitor panel and 35 to the special visitor panel.

Applicants went through a rigorous recruitment process including application, Garda vetting, interview, proof of credentials and professional reference check.

At interview stage candidates were required to satisfy eligibility criteria based on a competency framework. The purpose of the competency framework is to ensure consistency and to guide the panel members in their role. The competency framework for the decision-making representative panel can be seen (See page 54).

We also delivered a two-day comprehensive

training program to applicants on their role as panel members.

The final stages of the recruitment of the panel members will take place in 2023.

## DSS Service Design and Delivery

Our teams continued to work on developing the necessary policies and procedures that will support those that engage with the organisation. We allocated significant time to monitoring and reporting on our operational readiness to ensure we were ready to serve the public at commencement.

## ICT Project

Development of the DSS case management system and public facing portal continued throughout 2022 to ensure the latter would be ready for the public to use come commencement, with additional functionality and improvements being released throughout 2023. The objective of the DSS is to create a digital-first service while providing accessible options to those unable to engage with us digitally.

## Data Protection and Privacy

Following consultation with potential users, we finalised our data protection impact assessment (DPIA) and began consulting with the Data Protection Commission (DPC). The purpose of our DPIA and our consultation was to ensure that all data collected by the DSS in providing our services is captured, stored and processed in a fair, balanced and secure manner. Following enactment of the Assisted Decision-Making (Capacity) (Amendment) Act 2022, the DPIA is being updated and consultation with the DPC will continue as necessary in 2023.

## DSS Registers

Once operational, the DSS will initially maintain three searchable registers for the following types of arrangements:

- Co-decision-making agreements
- Decision-making-representation orders
- Enduring powers of attorney

One key reason for providing searchable registers is to allow certain eligible professionals and organisations the ability to access the register. This will allow them to confirm an arrangement exists, see details of the arrangement and, if needed, get a copy of the arrangement. In order to prepare for the digital launch of the register in 2023 a project was established in 2022 to engage with key stakeholders (such as the HSE) in order to ensure all parties are ready. It is expected that this project will broaden its engagement with other organisations in 2023.

## 2022 Stakeholder Engagement

### January:

- Meeting with HIQA – Development of E-learning module for health & social care staff on Advocacy
- Presentation to CHIME (Former National Association for the Deaf)
- Presentation to the Law Society of Ireland Medico/Legal Society of Ireland
- Presentation to Social workers in HSE Mental Health Services – Sligo/Leitrim

### February:

- Presentation to staff in the Irish Hospice Foundation
- Presentation to Dementia Advisers – Alzheimer's Society of Ireland
- Presentation to Irish Association of Social Workers
- Meeting with Independent Living Movement Ireland
- Meeting with the National Federation of Voluntary Service Providers- (issues dealing with banks)
- Presentation to HSE Safeguarding Teams – CHO areas
- Presentation to HSE Occupational Therapists – National Memory Technology Library (South Tipperary)
- Presentation to Older People's Council – South-East
- HSE Webinar 1 – "Decision-Making Support arrangements under the 2015 Act - How do I support someone to make a decision"?
- Presentation to Solicitors for the Elderly
- Presentation to Disability Federation of Ireland
- Presentation to Housing Agency
- Presentation to Irish Advocacy Network



**March:**

Presentation to Primary Care Social Workers in North Dublin

Presentation to Down Syndrome Ireland

Presentation to staff in Avista Services

Presentation to Social Work Department, Western Care Association

Presentation to Social Work Department, UCHG

Presentation to Commission of Regulation of Utilities

Presentation to St Patrick's Hospital - Clinical Staff

Presentation to staff in Beaumont Hospital

Presentation to Donegal Mental Health Services for Older People

Presentation to Cheeverstown House

HSE Webinar 2 - "How and when to engage with the DSS"

**April:**

Presentation - Information Conference - La Touche Training for legal professionals

Presentation at Social Care Ireland Annual Conference

Presentation to staff in St Vincent's Hospital, Fairview - trainee psychiatrists and staff

Presentation to Irish Association of Social Workers

Presentation to Psychiatry of Later Life team, Portlaoise

Presentation to Donegal Mental Health Services for older people

Presentation to Rehab Group

HSE Webinar 3: "Positive risk taking and "unwise" decisions"

**May:**

Meeting and presentation to representatives of Pavee Point

Presentation at Ground Rounds, Galway University Hospital

Presentation to Dementia Carers Campaign Network

Meeting with Family Carers Ireland

Meeting with Mental Health Reform and Mental Health Recovery Unit

Presentation to Inclusion Ireland Community Networks

Presentation to St. Christopher's Services CLG, Co. Longford

Presentation to Avista Services

Presentation to Talbot Group

Presentation to NHI National Nursing Committee

Presentation to Old Age Psychiatry Trainees

Meeting with Banking and Payments Federation of Ireland

**June:**

Presentation to Credit Union Managers and Directors

Workshop with Focus Group re DSS Portal -Inclusion Ireland

Presentation to staff in St James' Hospital

Presentation to Civil Service Data Protection Network

Attendance at the World Congress on Adult Capacity, Edinburgh

Presentation to Nurse Managers in Mental Health DSS Stakeholder Forum Inaugural meeting

**July:**

Presentation to families of persons supported by Avista Services

Presentation to families of persons supported by Sunbeam House

Presentation to therapists in the Rape Crisis Centre

Presentation to ASIAM

Presentation to staff in Connolly Hospital

**August:**

Break

**September:**

Presentation at the Learning & Development Webinar for St Vincent de Paul staff

Presentation to the Family Forum, Mulhuddart Day Services

Presentation to the Irish Institute of Pharmacists

Presentation to staff in Sunbeam House

Presentation to staff in the Money Advice and Budgeting Service (MABS)

Presentation to Western Care Association, Castlebar

Meeting with the National Federation of Voluntary Service Providers

**October:**

Presentation to staff in Beechpark Respite Services, Kilnamanagh/Tymon Primary Care Centre

Launch of Discussion Paper on the Review of the Central Bank's Consumer Protection Code

Panellist at the Launch of Irish Hospice Foundation's revised Think Ahead Form

Presentation to National Helpline - Alzheimer Society Volunteers

Presentation to WALK - Disability Services in Walkinstown

Presentation to Avista Families

Presentation to families of service users in Praxis Care

Presentation to staff in the Department of Social Protection

**November:**

Presentation to families and carers, St Columba's Hospital, Kilkenny

Presentation to staff in University Hospital, Waterford

Presentation to Adult Safeguarding Programme - Trinity College Dublin

Presentation to RCSI Masterclass

Presentation to Conference - Office of Social Services in Dept of Health, Northern Ireland

Presentation to SAGE Advocacy - Erasmus Event

Presentation to Peer Support Group, Mental Health Services - DCU

Presentation to multidisciplinary team working with older persons - community-based services (St Mary's Hospital)

Presentation to Kerry Law Society

Presentation to Aftercare Workers in Tusla

Presentation at Inclusion Ireland's - International Day of Persons with Disabilities - My Life, My Choice

**December:**

Webinar Courts Service - Transition from Wardship to the Assisted Decision-Making (Capacity) Act 2015: Guidance for Staff

Presentation to staff in the Revenue Commissioners Presentation to CORU Council Meeting

Presentation at Grand Rounds, University Hospital Limerick

Presentation to College of Psychiatrists -senior trainee consultant psychiatrists

Presentation to Legal Practitioners - La Touche Training Annual Event

Presentation to Insurance Ireland Conduct Committee

Presentation to Certified Public Accountants Ireland

Presentation to National Working Group of acute hospital occupational therapists



**The competency framework for the decision-making representative panel**

<b>Integrity</b>	<ul style="list-style-type: none"> <li>• Adopt a rights-based, inclusive approach at all times underpinned by the guiding principles of the Act</li> <li>• Act sincere and respectful when carrying out role requirements</li> </ul>
<b>Expert Knowledge</b>	<ul style="list-style-type: none"> <li>• Ability to interpret and apply the legislation correctly</li> <li>• Maintain up to date knowledge of the Assisted Decision-Making (Capacity) Act 2015 including: <ul style="list-style-type: none"> <li>• grounds for complaint and the committing of offences</li> <li>• guiding principles</li> <li>• codes of practice</li> <li>• Relevant case law</li> </ul> </li> </ul>
<b>Effective Person-Centred Communication Skills</b>	<ul style="list-style-type: none"> <li>• Excellent written and oral communication skills</li> <li>• Interpret and present information in an easy-to-understand way</li> <li>• Ability to communicate clearly using accessible language</li> <li>• Good active listening skills</li> <li>• Confident speaker - comfortable giving oral evidence if necessary</li> </ul>
<b>Case Management Skills</b>	<ul style="list-style-type: none"> <li>• Possess good organising, planning and administration skills</li> <li>• Strong analytical skills</li> <li>• Skilled in information gathering, conducting interviews and evidence-based report writing</li> <li>• Coordinate required meetings, court dates effectively</li> <li>• Excellent time keeping</li> <li>• follow all procedures specified by the DSS</li> <li>• open to personal development and willing to accept feedback</li> <li>• Adhere to required deadlines and respond to DSS requests in a timely manner</li> </ul>
<b>ICT Skills</b>	<ul style="list-style-type: none"> <li>• Proficient using information and communications technology (ICT)</li> <li>• Submit case papers and reports electronically using the DSS Case Management System</li> </ul>
<b>Interpersonal Skills</b>	<ul style="list-style-type: none"> <li>• Must act in a polite, professional, empathetic and respectful manner at all times.</li> <li>• Maintain professional composure in challenging circumstances</li> <li>• Possess strong resilience and assertiveness skills</li> <li>• Develop good working relationships with relevant person and key stakeholders</li> <li>• Open to learning and continuous professional development</li> </ul>
<b>Resource Management</b>	<ul style="list-style-type: none"> <li>• Ability to utilise all available resources</li> <li>• strive to ensure value in the expenditure of resources</li> </ul>

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# Governance

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# Governance

**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, in September 2020 with an Annex on Gender Balance, Diversity, and Inclusion; and in June 2021 in relation to specific superannuation and remuneration proposals.

The MHC has procedures in place to ensure compliance with the provisions of the Code. All reporting requirements for 2022 have been met.

As required under the 2016 Code, the MHC has a formal schedule of matters specifically reserved for decision by the Commission (the MHC Board) to ensure the direction and control of the Commission. 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 or as otherwise required. 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.

Following the appointment of the new Commission in April 2022, the following relevant matters were addressed at subsequent meetings.

## May 2022 Meeting

Review and approval of:

- Secretary to the Commission
- Secretary to the FARC

- Members of the FARC
- Members of the Legislation Committee
- Members of the Working Group for the review of the Strategic Plan
- The Agenda for the Commission meetings
- Reserved functions of the Commission

## June 2022 meeting

Review and approval of:

- The Corporate Governance Manual
- Schemes of Delegation
- 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 2022. This was considered by the Commission Members at its meeting in January 2023. A set of actions arising from the review was agreed to be taken with a view to further improving the effectiveness of the Commission. This set of actions is being monitored by the Board Secretary with the Commission.

The Finance, Audit and Risk Committee (FARC) also undertook self-assessments for 2022. The Legislation Committee did not undertake a self-assessment having only met once during the year as that was all that required during 2022.

### Gender balance in the Commission membership

As of 31 December 2022, the Commission had five (38%) male and eight (62%) female members. The Commission was in compliance with the statutory requirements of the Mental Health Acts, which

is no less than four women or no less than four men. The Commission also meets the Government target of a minimum of 40% representation of women but is just below the 40% requirement for men. This latter point will be referred to the Department of Health in relation to future appointments<sup>3</sup>.

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

For the year end 31 December 2022, the Commission confirms that a code of conduct was in place and adhered to. Furthermore, all Commission Members and relevant staff members declared that they were in full compliance with the relevant statutory responsibilities under the Ethics in Public Office legislation.

### Committees

In 2022, the Legislation Committee met on one occasion, in January.

It was intended that work plan of the committee would focus on the Mental Health Acts and the General Scheme to amend the 2015 Act. However, the report of the Pre-Legislative Scrutiny Committee in relation to the General Scheme did not issue until October 2022 and the Department of Health did not give priority to the drafting of the Amendment Bill. As a result, the work planned for 2022 will now be prioritised for 2023.<sup>4</sup>

The FARC (Finance, Audit and Risk Committee) held five meetings in 2022 and its annual report was provided to the Commission in March 2023.

The report considered the following:

Membership and Meetings 2022,

- Stakeholder Relationships
- External Audit (C&AG - Mazars)
- Annual Financial Statements for 2022, Internal Audit
- Management Accounts and Budget for 2022

- Risk Management System and Strategic Risk and Opportunities Register
- ICT
- Governance and Internal Control / Internal Financial Control
- Protected Disclosures
- FARC Performance Management

There were three internal audit reports approved by the FARC in 2022 as follows:

- Report on the Review and Effectiveness of Internal Financial Controls (March 2022) (Refers to previous year)
- Report on the Regulatory Teams' Rules and Codes of Practice Processes (March 2022): [Completed December 2021]
- Review of Payroll (June 2022)

Three further audits were commenced in 2022 but those reports were not considered by FARC in 2022:

- ICT Audit (conducted in the fourth quarter of 2022)
- Contract Management - Outsourcing: Third party risk in relation to external vendors (conducted in fourth quarter of 2022)
- DSS - Procurement and Contract Management (conducted in fourth quarter of 2022)

## 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 2022, the MHC adhered to three main principles of governance:

1. Openness
2. Integrity
3. Accountability

<sup>3</sup> The tenure of three members ends in April 2025. These members will be replaced in accordance with the Mental Health Acts, including any amendments in the interim.

<sup>4</sup> Priority drafting was given to the Scheme in January 2023.

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 tender process, Decision Time was selected as the provider of the Risk Management system. The new system was used for the first time in Q3 2022 and will continue to be used to monitor risk management within the organisation.

The Strategic Risk and Opportunities Register (“SROR”) 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 between officials at the Department of Health and the Executive took place in March, June, September, and December 2022. An oversight and performance delivery agreement was signed for 2022.

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 policy and funding of the Decision Support Service) in relation to the governance mechanisms required to be put in place once the Decision Support Service commences operations.

It was agreed with the Department of Health and the Department of Children, Equality, Disability, Integration and Youth that the Department of Health would remain the parent department of the MHC.

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



Governance meetings between officials at the Department of Health and the Executive took place in March, June, September, and December 2022.

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 2022, six data subject access requests were made under data protection legislation. Of the six requests received, five were processed and one was in process at year end. Two were part-granted, one was not granted and two were withdrawn.

The MHC received one data subject erasure request and this request was granted.

## 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.

In total, the MHC received thirty freedom of information requests, of which twenty-one had been processed by year end. Of that twenty-one, one was granted, five were part-granted, thirteen were not granted, two were withdrawn. Nine decisions were outstanding.

Of the thirty requests received, fourteen related to personal requests, thirteen to non-personal and three were a mix of personal and non-personal.

## Health Act 2007 (Part 14) and Protected Disclosures Act 2014<sup>5</sup>

Under Section 22 of the Protected Disclosures Act 2014, a public body is required to publish an

annual report outlining the number of protected disclosures received in the preceding year and any actions taken in response to such disclosures.

For the year ended 31 December 2022, the MHC had procedures in place for the making of protected disclosures in accordance with the relevant legislative requirements.

There was one protected disclosure reported to the MHC during 2022.

## 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 2022. 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 2022.

## 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, which was subsequently updated. 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.

## 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.

We are working towards the 2030 Targets:



We participated in the Reduce Your Use Campaign and established a Green Team in September 2022 to become drivers of sustainability in the MHC.

- 51% Reduction in greenhouse gas (GHG) emissions by 2030
- 50% improvement in energy efficiency by 2030

**2022 Energy-related CO2 Emissions = 28,565 kgCO2**

24.3% better than 2021

**2022 Energy Consumption = 164,053 kWh**

20.5% better than 2021

60.5% better than energy efficiency baseline (2009)

43.8 % better than 2030 target

We participated in the Reduce Your Use Campaign and established a Green Team in September 2022 to become drivers of sustainability in the MHC.

We received a Zero Project Earth Day Award in April 2022, from City Bin for participating in an awareness campaign of how to divert waste from landfill, recycle more and create awareness of how to manage waste more effectively.

## Business and financial reporting

The Department of Health’s allocation to the MHC for 2022 was €15.932m. The amount drawn down was €15.55m. The underspend in the year reflected COVID-19 cost savings in travel and subsistence claims for mental health tribunals as tribunal hearings were held remotely.

The MHC received an additional €0.105m as an ICT Capital Grant from the Department of Health.

<sup>5</sup> The Protected Disclosures Amendment Act 2022 came into effect on 1 January 2023. The MHC has updated its Protected Disclosures Policies to comply with the amending legislation and will comply with all requirements under the amended Act



Key areas of expenditure related to the statutory functions as set out in the 2001 Act, primarily the provision of mental health tribunals and the regulation of approved centres plus the independent review of Child and Adolescent Mental Health Services by the Inspector of Mental Health Services.

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 Department of Children, Equality, Disability, Integration and Youth allocation for the Decision Support Service establishment programme for 2022 was €7.3million later cut to €6.52m. The amount drawdown was €6.52m.

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 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 2022.

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 2022.

The unaudited annual financial statements for 2022 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 2022 annual audited financial statements of the MHC will be published on the website as soon as they are available.

## Prompt payment of account legislation

The MHC complied with the requirements of the Prompt Payment of Accounts legislation and paid 99.29% 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 2022, the MHC complied with the requirement to submit a Maastricht Return to the Department of Health.

## Procurement

In 2022, MHC undertook two EU tendering processes, five mini competitions under OGP Frameworks and eleven competitions by way of a 'Request for Quotation/ Request for Proposal' for goods and services valued at under EU thresholds, under €25k. Sixteen contract extension notices were agreed as permitted under the agreed terms of contract.

The MHC Corporate Procurement Plan for 2022 was approved by FARC on 9 June 2022. 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 & Contracts 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 activities. This includes the implementation and configuration of corporate IT systems, as well as supporting the underlying technology.

During 2022, the MHC upgraded its ICT systems by implementing new network firewalls and cortex end point security. Cybersecurity is one of the biggest threats facing the MHC and in the light of this MHC has recruited an ICT Systems and Security Officer. The MHC has taken a proactive approach to cybersecurity with both network intrusion prevention systems in place and third-party network monitoring. MHC is conducting on-going cyber security staff training and will continue to keep MHC systems under review and up to date.

## Human Resources

The Human Resources function plays a significant role in developing positive culture and improving employee engagement and productivity. Treating

our employees fairly and providing them with opportunities to grow assists the MHC to realise its strategic objectives.

## Performance management

The Performance Management and Development System (PMDS) was successfully carried out in 2022 for all eligible employees with a focus on upskilling people managers to look for opportunities for staff development when giving performance evaluations.

## 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.

## Blended Working

The MHC introduced a Blended Working Policy as part of its commitment to embracing opportunities for remote and blended working and to build a more dynamic, agile and responsive organisation, while sustaining strong standards of performance and high levels of productivity. The policy provided a procedure for staff employed by the MHC to apply for blended working arrangements.

## 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 quantitatively and narratively, to the NDA. In 2022, through the response of the NDA staff census returns, the MHC reported a rate of 3.22% of their employee base as having a disability.

## Training and development

In 2022 training activities were delivered to build competence in job functions and work practices and to encourage professional development.

## 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 also providing further career development opportunities to existing staff.

## Communications and Stakeholder Engagement

The objective of the communications team is to proactively contribute towards the realisation of the organisation's strategic objectives by helping to drive awareness of the Mental Health Commission (MHC), and by effectively communicating about the Assisted Decision Making (Capacity) Act 2015 and 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 key publications, such as the annual report; the launch of revised restrictive practices code and rules; and key activity and reports by the regulatory team, all of which the communications team published and publicised across the political, media and public arena.

A large part of the team's time in 2022 was taken up by working with creative and media buying agencies to develop a significant public awareness campaign for the DSS. This work involved recruiting nine campaign 'champions' who would feature across all advertising, and much of the campaign's media and PR activity. The team also held a hybrid event in March - and a joint event with the Courts Service in May - to highlight the work realised by the DSS team to date and update stakeholders on what still needed to be achieved



by all stakeholders before the service could open its doors.

On the digital front, the team continued to increase engagement across both the MHC and DSS websites, on all social media channels, and generated a significant rise in subscribers to both the MHC and DSS newsletters. A social media strategy - which included the addition of an organisational-wide YouTube channel, a new DSS Facebook page and a new DSS Instagram account - was developed and the implementation process of said strategy commenced in full. Content for all channels was supported by an increased focus on the production of 'explainer' videos with the organisation's Chief Executive, and the Director of the DSS and her staff on various aspects and themes relating to our work.

The communications team also continued to facilitate stakeholder engagement presentations at several Board meetings with members hearing from people with direct and relevant experience of illness, including representatives from Pavee Point, An Saol foundation, See Change and the Galway Community Café. The team also organised consultative stakeholder forums in both mental health and decision support services with the objective of engaging with experts by experience to inform our ongoing work.

The team did not forego internal comms and ensured that all staff were regularly updated and informed about the work of the organisation through regular email updates and videos from senior management, monthly staff 'town hall' events, and by various other means.

In 2023, the communications team will continue to proactively engage with all stakeholders on issues that concern or relate to mental health and decision support services to help ensure that the strategic objectives of the MHC are achieved.

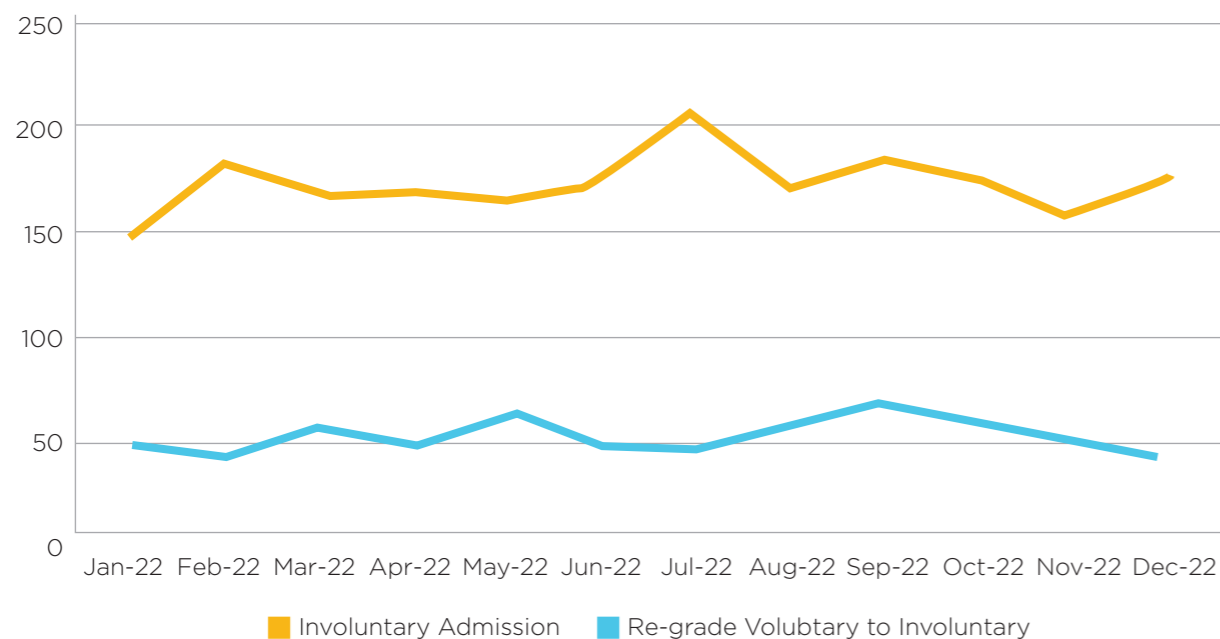
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# Appendices

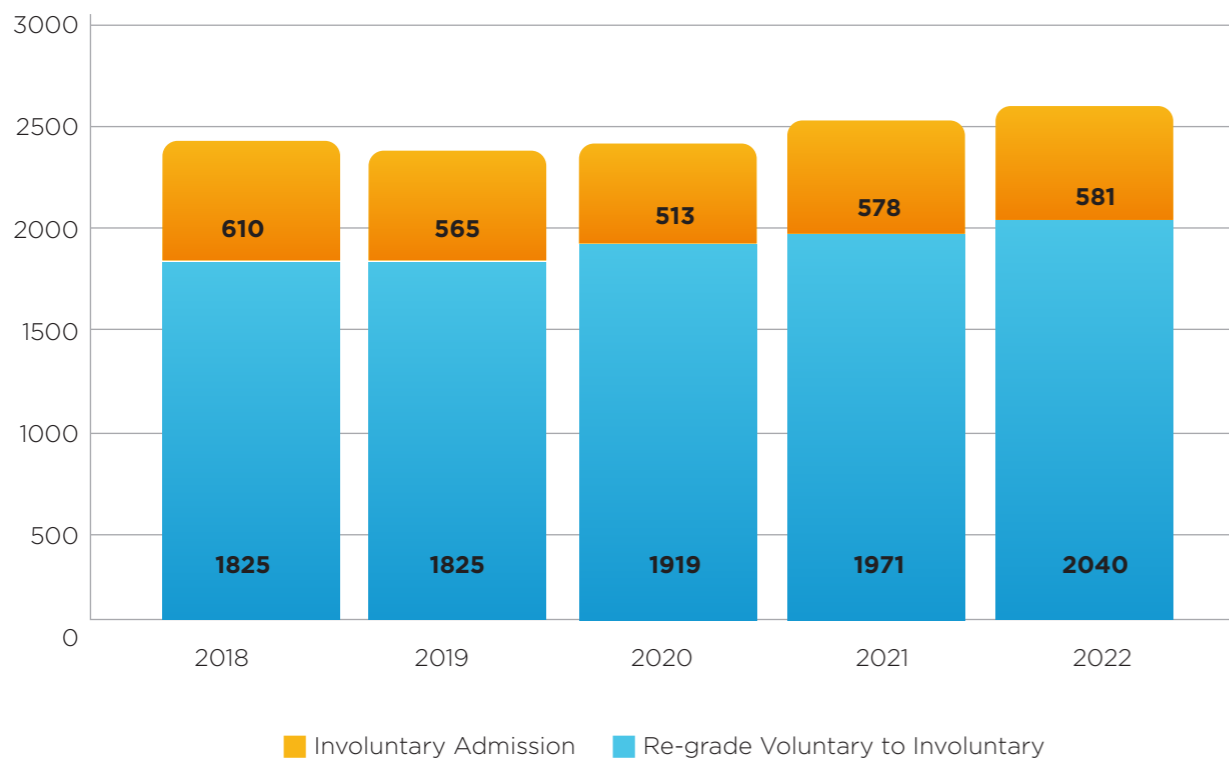
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# Mental Health Tribunal Information

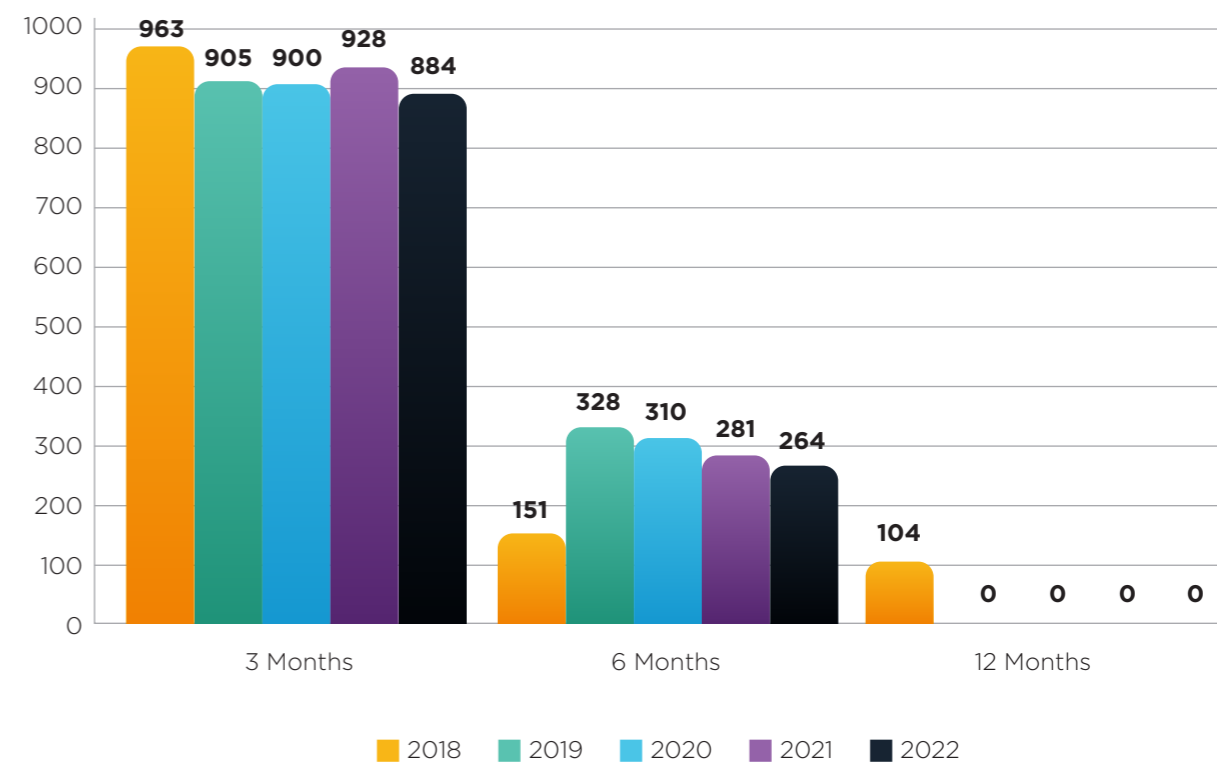
**Figure 1:** Monthly Involuntary Admissions 2022



**Figure 2:** Comparisons of total involuntary admissions 2018-2022



**Figure 3:** Comparison of renewal orders 2018 -2022

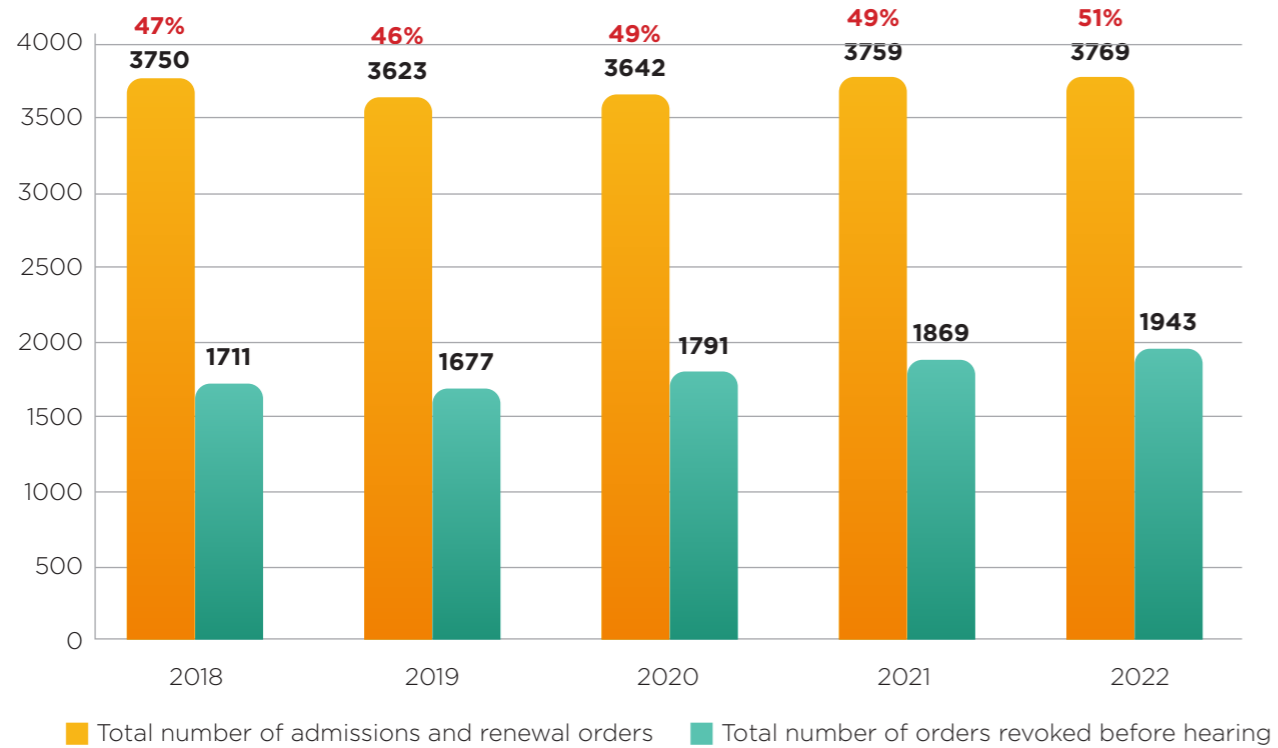


	3 Months	6 Months	12 Months
2018	963	151	104
2019	905	328	0
2020	900	310	0
2021	928	281	0
2022	884	264	0

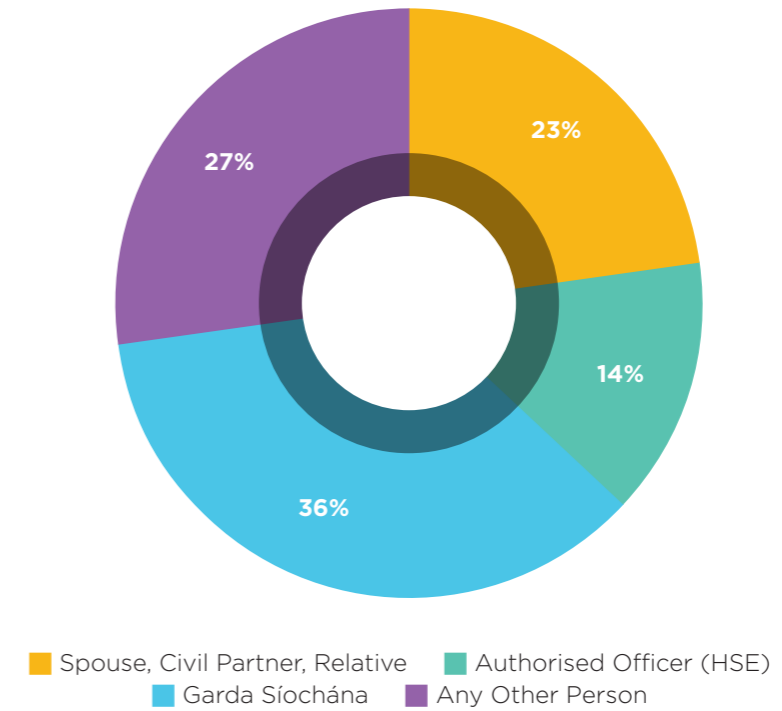
**TABLE 1: Involuntary Admission Rates for 2022 (Adult) by CHO Area and the Independent Sector\***

	Involuntary Admissions	Re-grade Voluntary to Involuntary	Total Involuntary Admission Rate
CHO1	163	28	191
CHO2	203	49	252
CHO3	152	35	187
CHO4	346	95	441
CHO5	158	56	214
CHO6	132	30	162
CHO7	278	67	345
CHO8	235	55	290
CHO9	307	99	407
Independent Sector*	66	67	133
TOTAL (Exclusive of Independent sector)	1,974	514	2,488
TOTAL (Inclusive of Independent sector)	2,040	581	2,621

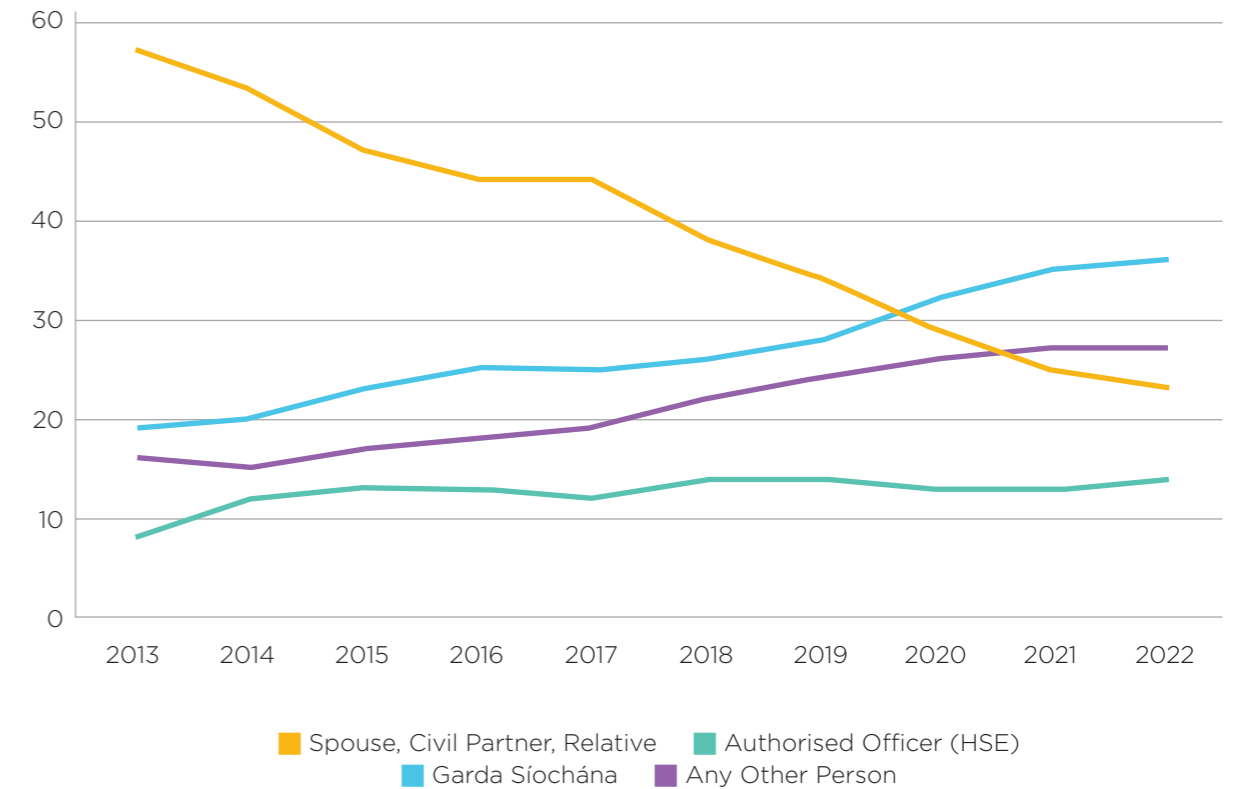
**Figure 4: Number of Orders Revoked before Hearing by Responsible Consultant Psychiatrists for Years 2018 to 2022**



**Figure 5: Analysis of Applicants for Involuntary Admissions from the Community in 2022**

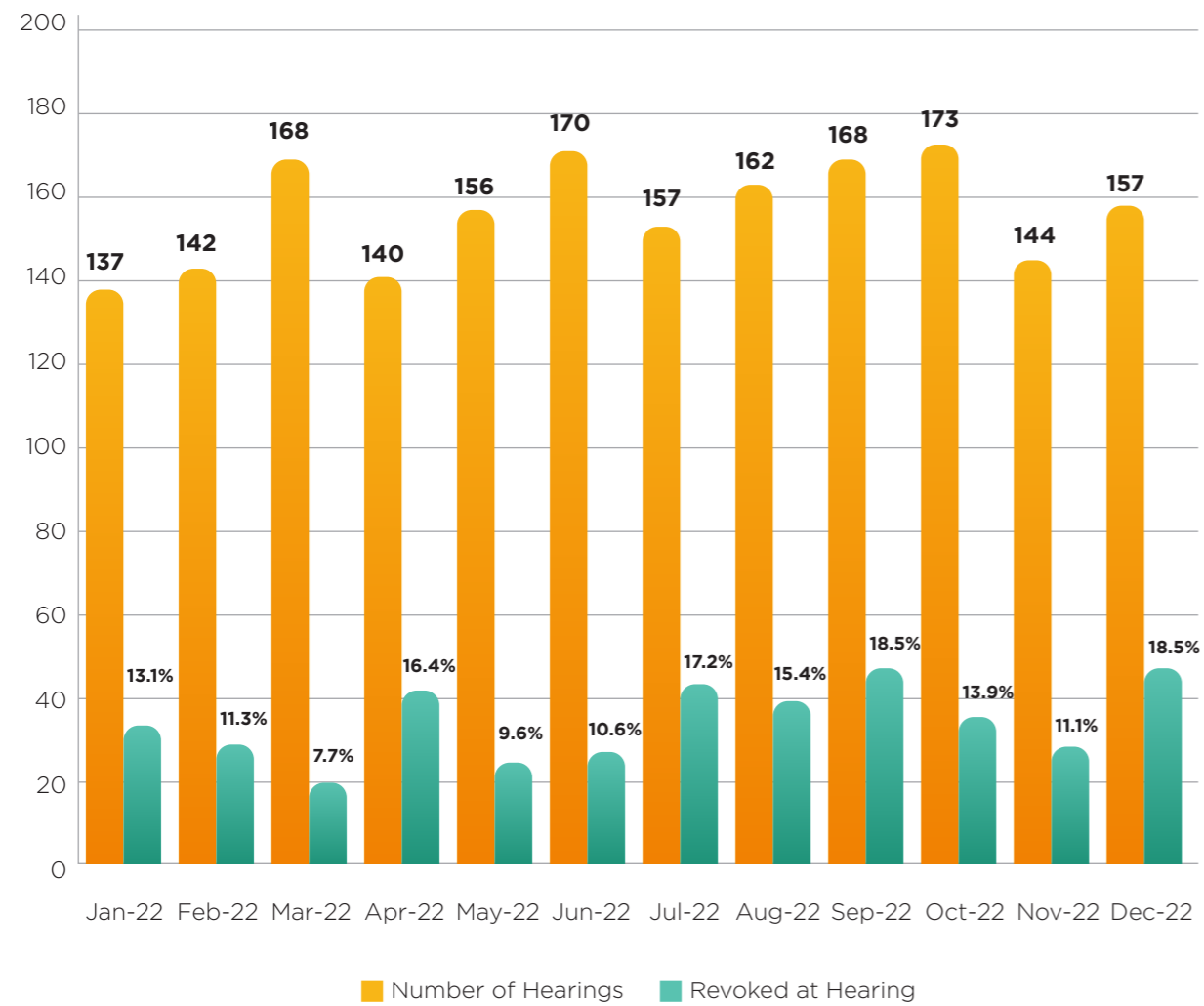


**Figure 6: Analysis of Applicants of Involuntary Admissions from Community from 2013 to 2022**



\* There are eight independent approved centres

**Figure 7:** Number of hearings and % of orders revoked at hearing 2022



**Figure 8:** Summary of Revoked Decisions

No	Issues	Number of Revocations	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1	No mental disorder (section 3 not met)	127	9	7	7	10	8	9	10	12	18	14	7	16
2	Errors with sections 9 to 12 (applications and recommendations for involuntary admission) and the related Forms	38	1	2	1	8	2	3	5	8	2	3	2	1
3	Errors with sections 14 and 15 (admission and renewal orders for involuntary admission) and the related Forms	26	4	1	0	2	1	3	5	1	3	0	2	4
4	Patient Notification Form issues (information to be provided to the patient from the admission and renewal orders)	24	2	2	2	0	1	1	2	1	4	2	2	5
5	Errors with sections 23 and 24 (admission form where someone is regraded) and the related Form	12	0	2	1	0	1	1	0	1	0	4	0	2
6	Other non-compliance issues	5	1	2	0	0	0	0	0	1	0	1	0	0
7	No mental disorder (section 3 not met) and non-compliance issues	23	1	0	2	3	2	1	4	2	3	1	3	1
	<b>Total</b>	<b>255</b>	<b>18</b>	<b>16</b>	<b>13</b>	<b>23</b>	<b>15</b>	<b>18</b>	<b>26</b>	<b>26</b>	<b>30</b>	<b>25</b>	<b>16</b>	<b>29</b>



Examples of issues under the headings

No	Reason for Revocation	Examples of issues and errors
1	No mental disorder (section 3 not met)	<ul style="list-style-type: none"> <li>Of the ten revocations in April in this category, patients had absconded in two instances so the Responsible Consultant Psychiatrist (RCP) could not give evidence of mental disorder as of the date of the hearing.</li> <li>In two of the revocations in September the RCP had not seen the patient on the day of the hearing</li> </ul>
2	Errors with sections 9 to 12 (applications and recommendations for involuntary admission) and the related Forms	<ul style="list-style-type: none"> <li>Spouse was disqualified from making the application</li> <li>Person not a formal civil partner</li> <li>Person was separated from husband and alleged issues of violence</li> <li>Of the eight revocations in April in this category, five related to the Form 3 (An Garda Síochána) as a direct result of the High Court decision in GB. In one instance a GP did not tell the patient the purpose of the exam, there was one Form 2 error and one error on the Form</li> <li>Form 3 had been completed incorrectly with the Garda completing both section 9 and section 12</li> <li>GP did not complete the Form 5</li> <li>In one instance the family, not the Gardaí, made the application but given the circumstances it should have been made by the Gardaí</li> <li>In August issues were predominantly relating to Form 3</li> <li>Order of times on application, recommendation and admission forms not consistent.</li> <li>Of the two revocations in November, one error was made by the GP on the Form 5 and in the other an error was made by a Garda on Form 3</li> </ul>
3	Errors with sections 14 and 15 (admission and renewal orders for involuntary admission) and the related Forms	<ul style="list-style-type: none"> <li>Examination not done within 24 hours</li> <li>Of the four revocations in January there was one error on Form 6 (plus error on PNF), a delay in making an admission order under section 14, an error on Form 7 (plus error on PNF) and an error on Form 7</li> <li>Of the two revocations in April, one related to a Form 6 which was not complete and the other to a Form 7 which was not completed by the RCP</li> <li>Section 15(2) ticked instead of section 15(3)</li> <li>Order extended for a day longer than possible</li> </ul>
4	Patient Notification Form issues (information to be provided to the patient from the admission and renewal orders)	<ul style="list-style-type: none"> <li>Of the two revocations in February one PNF was not given to the patient within 24 hours and in the second there was an error in relation to the dates</li> <li>No indication of a wish to leave</li> <li>Of the two revocations in March both PNFs were not completed</li> </ul>

No	Reason for Revocation	Examples of issues and errors
5	Errors with sections 23 and 24 (admission form where someone is regraded) and the related Form	<ul style="list-style-type: none"> <li>Form 13 completed by 3 different RCPs</li> <li>Form 6 was completed instead of a Form 13</li> <li>The nurse who detained under section 23 was not the one who signed the Form</li> <li>Of the revocations in October one included errors on the PNF as well as the Form 13 and the others had errors on the Form 13 that varied from incomplete form, errors in times and errors in facts by second consultant</li> </ul>
6	Other non-compliance issues	<ul style="list-style-type: none"> <li>Duplicate orders</li> <li>Section 10 of Form 4 - GP had not examined the person</li> <li>Person had been made a ward of court, but MHC not notified</li> <li>GP completed Form 5 before the application was made</li> <li>Revoked on the basis of a matter outside the remit of the MHT</li> </ul>
7	No mental disorder (section 3 not met) and non-compliance issues	<ul style="list-style-type: none"> <li>In January both compliance issues related to the PNF</li> <li>In April two of the compliance issues related to the PNF and one related to sections 9/10</li> <li>In both revocations in May the Form 3 had been completed incorrectly with the Garda completing both section 9 and section 12</li> <li>The non-compliance issue in the one revocation in June related to Form 3 and the completion of both parts</li> <li>Patient was AWOL so the section 3 text could not be met and in addition there was an issue with the PNF</li> <li>In November two of the compliance issues involved errors on the PNF and one where the order was extended for a day longer than possible</li> </ul>

**Table 2:** Analysis by Gender and Age of 2022 Involuntary Admissions

Age	Male	Female	% gender
18 - 24	232	97	71% male
25 - 34	366	220	62% male
35 - 44	336	282	54% male
45 - 54	209	237	53% female
55 - 64	130	184	59% female
65 +	163	165	51% female
Total	1,436	1,185	55% male

**Table 3:** Analysis by Gender and Admission type of 2022 Involuntary Admissions

Gender	Form 6	Form 13	Total	%
Female	889	296	1,185	45%
Male	1,151	285	1,436	55%
<b>Total</b>	<b>2,040</b>	<b>581</b>	<b>2,621</b>	<b>100%</b>

**Table 4:** Analysis by Gender, Age and Admission type of 2022 Involuntary Admissions

Age	Form 6	Form 6 Female	Form 6 Male	Form 13	Form 13 Female	Form 13 Male	Total	%
<b>18 - 24</b>	235	59	176	94	38	56	329	13%
<b>25 - 34</b>	465	165	300	121	55	66	586	22%
<b>35 - 44</b>	476	212	264	142	70	72	618	24%
<b>45 - 54</b>	349	181	168	97	56	41	446	17%
<b>55 - 64</b>	264	149	115	50	35	15	314	12%
<b>65 and over</b>	251	123	128	77	42	35	328	12%
<b>Total</b>	<b>1,970</b>	<b>889</b>	<b>1151</b>	<b>581</b>	<b>296</b>	<b>285</b>	<b>2,621</b>	<b>100%</b>

# Board Appendices

## Appendix 1 – Mental Health Commission Membership and Meeting Attendance 2022

Name	20/01	31/01*	17/02	04/03*	24/03	19/05	16/06	27/06*	21/07	15/09	20/10	17/11	15/12	Total
John Saunders	✓	✓	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	5/5
Ned Kelly	✓	✓	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	5/5
Rowena Mulcahy	✓	✓	✓	✓	✓	✓	✗	✓	✓	✗	✓	✓	✓	11/13
Dr Michael Drumm	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓	✓	✓	✓	11/13
Nicola Byrne	✓	✗	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	4/5
Dr Margo Wrigley	✗	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	11/13
Patrick Lynch	✓	✗	✓	✗	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	3/5
Colette Nolan	✓	✓	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	5/5
Tómas Murphy	✓	✓	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	5/5
Dr Jack Nagle	✓	✓	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	5/5
Dr John Hillery	✓	✗	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	11/13
Fionn Fitzpatrick*	✓	✓	✓	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗	6/13
Dr John Cox	✓	✗	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	11/13
Ray Burke	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✗	✓	✓	✓	✓	7/8
Dr Joseph Duffy	n/a	n/a	n/a	n/a	n/a	✓	✗	✓	✓	✓	✓	✓	✓	7/8
Tammy Donaghy	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✓	✓	✗	✓	✗	6/8
Dr Orla Healy	n/a	n/a	n/a	n/a	n/a	✓	✓	✗	✓	✓	✓	✓	✓	7/8
Martina McGuinness	n/a	n/a	n/a	n/a	n/a	✓	✓	✗	✓	✓	✓	✓	✓	7/8
Linda Curran	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✓	✓	✓	✓	✓	8/8
Catherine Cocoman	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✓	✗	✓	✓	✓	7/8

\* This member was on long term sick leave.

\* These three meetings were exceptional meetings outside of the regular scheduled Commission meetings.

## Appendix 2 – Finance, Audit and Risk Committee Membership and Meeting Attendance 2022\*

Name	11/03	09/06	24/06	22/09	24/11	Total
Nicola Byrne (CM)	✓	n/a	n/a	n/a	n/a	1/1
Patrick Lynch (CM)	✓	n/a	n/a	n/a	n/a	1/1
Tómas Murphy (CM)	✓	n/a	n/a	n/a	n/a	1/1
Dr John Cox (CM)	n/a	✓	✓	✗	✓	3/4
Dr Orla Healy (CM)	n/a	✓	✓	✓	✓	4/4
Martina McGuinness (CM)	n/a	✓	✓	✓	✓	4/4
Mairead Dolan (EM)	✓	n/a	n/a	n/a	n/a	1/1
Richard O'Farrell (EM)	✓	n/a	n/a	n/a	n/a	1/1
Ciara Lynch (EM)	✓	✓	✓	✓	✓	5/5
Kevin Roantree (EM)	✓	✓	✓	✓	✓	5/5
Audrey Houlihan (EM)	n/a	✓	✗	✓	✓	3/4
Cliff O'Keefe(EM)	n/a	✓	✓	✗	✓	3/4

## Appendix 3 – Legislation Committee Membership and Meeting Attendance 2022

Name	12/01	Total
Michael Drumm (CM)	✓	1/1
Ned Kelly (CM)	✓	1/1
John Hillery (CM)	✓	1/1
Teresa Blake (EM)	✓	1/1
Mary Donnelly (EM)	✓	1/1
Ray Burke (CM)	N/A	N/A
Linda Curran (CM)	N/A	N/A

\*CM = Commission Member EM = External Member

# Report of the Inspector of Mental Health Services

**Dr Susan Finnerty**



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## Introduction

**The functions and duties of the Inspector of Mental Health Services are set out in sections 51 and 52 of the Mental Health Act 2001 (“the Act”). Inspections are carried out in approved centres to see if they are compliant with the Mental Health Act 2001 (Approved Centres) Regulations 2006<sup>1</sup> (“the Regulations”), Rules<sup>2</sup> and Codes of Practice<sup>3</sup> and any other issues relating to the care and treatment of residents in the approved centres (these documents can be found on the MHC website: [www.mhcirl.ie](http://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 which is under the direction of a consultant psychiatrist. The Inspector must also carry out a review of the mental health services in the State and give a report to the MHC. This national review must include: (a) a report on the care and treatment given to people receiving mental health services; (b) anything that the inspector has found out about approved centres or other mental health services; (c) the degree to which approved centres are complying with codes of practice; (d) any other matter that the Inspector considers appropriate that have arisen from the review.

## Who are we?

The Inspector has a multi-disciplinary team of assistant inspectors and administrative staff to assist in the inspections. In 2022, this team had 11 assistant inspectors (10 whole time equivalents), two technical writers, a business manager and two administration staff. The Inspectorate is part of a wider Regulatory Team whose functions include Registration, Inspection, Enforcement, and Monitoring.

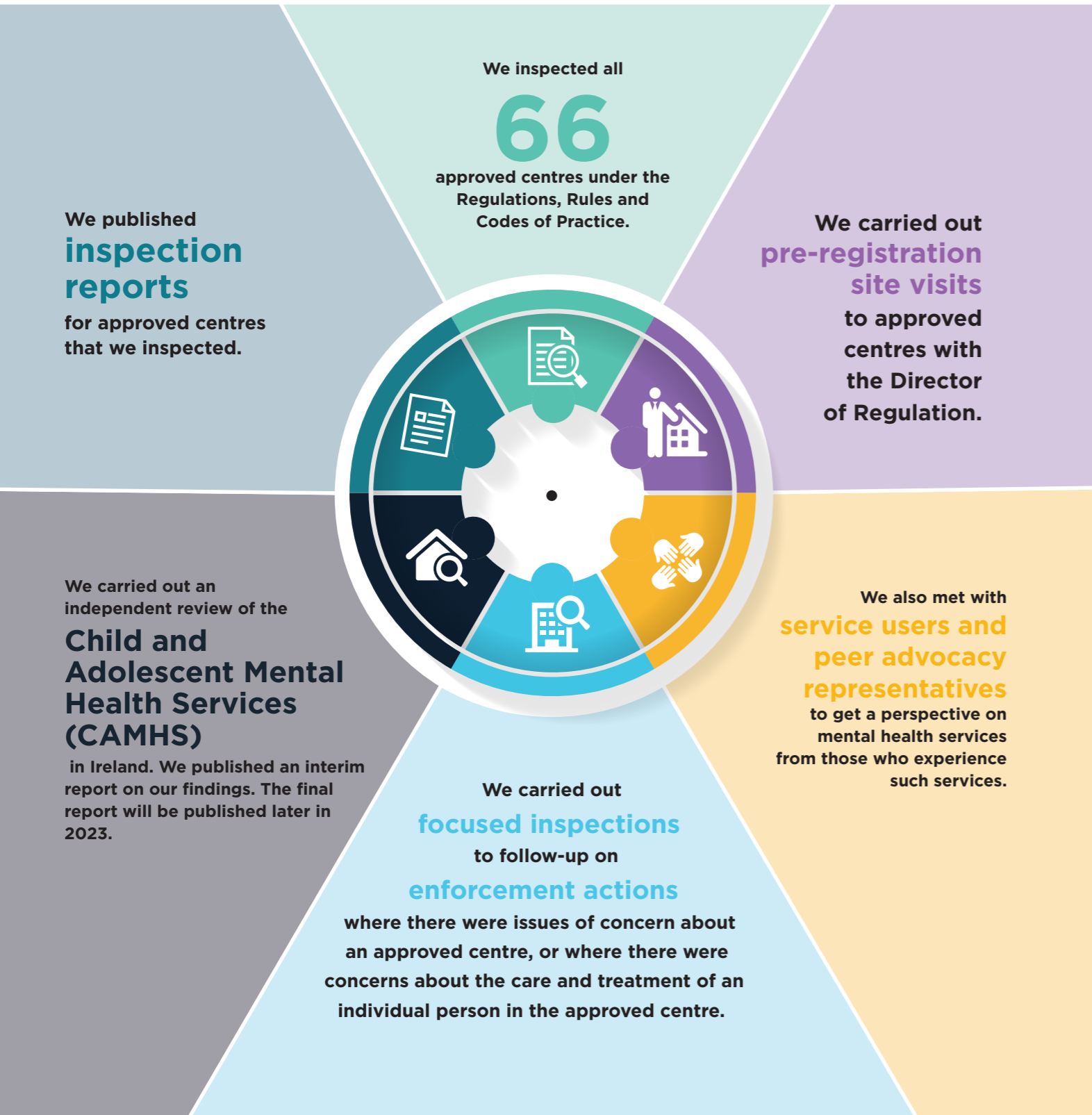
<sup>1</sup> Mental Health Act 2001 (Approved Centres) Regulations 2006 (S.I. No. 551 of 2006)

<sup>2</sup> Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint. Mental Health Commission Rules Governing the Use of Electro-Convulsive Therapy (ECT). Mental Health Commission

<sup>3</sup> Code of Practice relating to Admission of Children under the Mental Health Act 2001. Mental Health Commission Code of Practice on the Use of Physical Restraint in Approved Centres. Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an approved centre.. Mental Health Commission Code of Practice on the Use of ECT for Voluntary Patients.

# What did we inspect in 2022?

Figure 7:



All our reports are published on our website: [www.mhcirl.ie](http://www.mhcirl.ie).

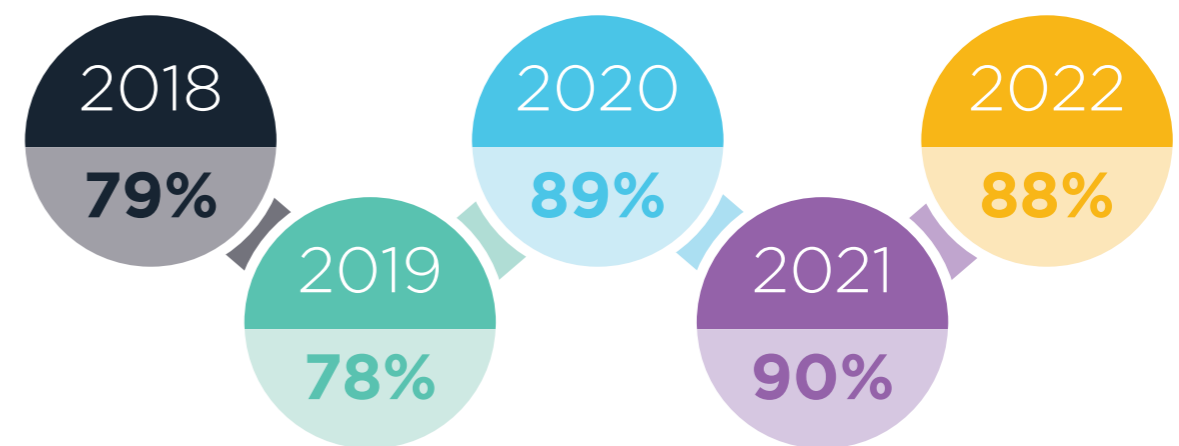
# What Did We Find?

Figure 8:

Compliance with regulations	2020	2021	2022
100%	21 %	17%	12%
90-99%	42%	46%	36%
80-89%	18%	26%	38%
70-79%	14%	8%	14%
Less than 70%	5%	3%	0%

Figure 9:

# Average compliance with regulations



All approved centres had a compliance rating of above 70% in 2022. The number achieving above 90% compliance had decreased since 2020 but the number achieving above 80 % compliance had increased (Figure 8). Sustaining high levels of compliance can be difficult and requires ongoing quality monitoring and improvements, including continuous auditing and learning. Funding for quality improvements should be maintained and improved where necessary.

The average compliance with Regulations has not significantly increased since 2020. (Figure 9)

## Long-term residential mental health care

### Continuing Care and Psychiatry of Later Life (POLL) Approved Centres

Some approved centres are continuing care units and provide long-term care for residents. These provide inpatient care for people who would find it hard to live in the community without intensive support. Many were transferred to these approved centres when the large asylums closed in the 1990s and early 2000s and are now elderly. Initially, use was made of existing older units within the asylum campus. Over the last few years, we have seen some improvements in the accommodation, with more single en suite bedrooms, larger and more pleasant spaces to move around in, and the addition of therapeutic spaces. Examples of such approved centres include Blackwater House, Aidan's Unit, Selskar House, and Cluain Lir. But this is by no means universal across the current continuing care settings. Many older, unsuitable units remain, with examples including St Catherine's Ward in St Finbarr's Hospital, Le Brun House and Whitethorn House in Vergemount campus, and St Stephen's Hospital.

Of great concern is the admission of younger people with enduring mental illness to these long stay approved centres, often with little prospect of moving on due to lack of more independent accommodation and rehabilitation. Years can be spent in the approved centre waiting for more independent accommodation and all the while becoming more institutionalised. It is for people like this that the importance of having a well-staffed rehabilitation team is paramount to maintaining and improving life skills.

There are usually large numbers of residents, often 15 or more people living in these approved centres, sometimes in shared dormitories. There have been efforts by the HSE to provide single en suite room accommodation in all continuing care and POLL approved centres with good success in many areas. This has been accelerated by infection control concerns during COVID-19.

The poor resourcing of rehabilitation teams has meant that some residents who could be living in more independent accommodation are left in a continuing care approved centre. This is magnified by the lack of specialised rehabilitation units (SRUs), medium and low supported accommodation, and independent housing for people to progress to more independent living.

We have seen very little reduction in the number of these approved centres and it appears that there is an interest in providing more of these continuing care congregated settings, especially with some private/independent providers. Where there are gaps in the public provision of adequate community and rehabilitation mental health services, there is a risk that we will allow large continuing care centres to contain the "problem".

### 24-hour supervised residential units

As well as continuing care approved centres, there are 125 residences that are staffed 24 hours a day accommodating approximately 1,000 people. These residences are their home and many have been living there for many years and are now elderly. It is again concerning that younger people, some in their 20s and 30s, are being admitted to these residences for either long term care or rehabilitation. Many of these younger people reside there due to the lack of more independent accommodation. All of the approximately 1,000 people in these residences have enduring mental illness or intellectual disability. They often have complex mental health problems, with associated cognitive difficulties that impair their organisational skills, motivation, and ability to manage activities of daily living. The support they need to live successfully in the community is mainly of a practical nature, including assistance to manage their medication, personal care, laundry, shopping, cooking, and cleaning. Most residents are unemployed, socially isolated, and many do not participate in civil and political processes. Regulation of community residences (as well as other community mental health

services) under the revised Mental Health Act will allow the MHC to enforce changes where deficits and risks are found, protect the human rights of people living in these residences, and help mental health services to provide care and treatment in accordance with best practice standards.

### Rehabilitation

The purpose of specialist rehabilitation services is to deliver effective rehabilitation and recovery to people whose needs cannot be met by less intensive mainstream adult mental health services. The focus is on the treatment and care of people with severe and complex mental health problems who are, or would otherwise be, high users of inpatient and community services. Despite developments in mental health interventions and services that provide early intervention to people presenting with psychosis, around 20% of people entering mental health services will have particularly complex needs that require rehabilitation and intensive support from mental health services over many years and they absorb around 25-50% of the total health and social care budget for people with mental health problems<sup>4</sup>. The aim is to promote personal recovery even if there are continuing mental health difficulties and to gain control over their own lives.

There are two SRU's provided by the private sector (in Highfield Hospital and Bloomfield Hospital) which provide a service to the HSE nationally. This has resulted in service users receiving treatment for up to two years at great distance from their locality. It means that they do not remain under the care of their local

rehabilitation team; they are far away from family, friends and local support in their own community; and there is the potential of disjointed care. There is one SRU in development in Castlebar, Co. Mayo, which is provided by the HSE.

There are over 1,500 people living in highly supported residential units and in-patient continuing care. Many of these people have grown old in the mental health services and have social and behavioural features of institutionalisation. Most have not received rehabilitation services at any stage of their illness. Others are younger with differing needs and require focused rehabilitation services to promote a more independent life, with an occupation and social outlets. For yet another group of people, the lack of access to a local rehabilitation service means remaining at home with their families and being reliant on the care and support of increasingly elderly relatives in circumstances of unacknowledged distress. There is a long way to go to provide an acceptably comprehensive service for those who are often vulnerable, distressed and struggling with enduring mental illness, but there are signs that we are moving in the right direction. There has been a small increase in the number of rehabilitation teams in the past two to three years with some improvement in staffing. The development of the SRU in Teach Aisling in Mayo is progress. However, we need to provide more early intervention in psychosis as well as rehabilitation services across the country to prevent people becoming stuck in long-term residential care and not reaching their recovery potential.

Table 15:

	Dublin	Cork	Galway	Other Areas	Total
Inpatient Beds	348	268	79	899	1594
CAMHS Beds	62	16	20	0	98
Independent Beds	757	16	0	0	773
NFMHS Beds	130	0	0	0	130
ID Beds	91	0	0	0	91
Total Beds All Areas					2686

<sup>4</sup> Killaspy, H., Marston, L., Green, N. et al. (2016) Clinical outcomes and costs for people with complex psychosis; a naturalistic prospective cohort study of mental health rehabilitation service users in England. BMC Psych, 16:95.

### The Right to the highest attainable standard of mental health

The right to the highest attainable standard of physical and mental health is particularly important, including dimensions such as:

1. Access to appropriate services;
2. The right to individualised treatment;
3. The right to rehabilitation and treatment promoting autonomy;
4. The right to community-based services;
5. The right to the least restrictive services;
6. Protection of human dignity.

The right to community-based services, expressly recognised in Article 19 of the United Nations Convention on the Rights of People with Disabilities (CRPD), has significant implications for the organisation of mental health services, since it implies that:

- 1) All persons with disabilities have the right to live in the community, choose their place of residence and have access to residential and domiciliary services as well as other community services;
- 2) States should facilitate the inclusion and full participation in the community of persons with disabilities;
- 3) Community services and facilities for the general population should also be available for people with disabilities<sup>5</sup>.

*The experience in most countries is that the development of community services is a complex process that faces several important barriers. Some of these barriers exist at the policy level, and may occur when there is a lack of adequate mental health policies and legislation, budgets are insufficient or where there is procedural discrimination against persons with mental disorders, in terms of limited or lack of health insurance. Other barriers are found at the level of the health system and include: difficulties in releasing resources from the large institutions (which absorb the greater part of the available funding), resulting in under investment in community-based services; lack of integration of mental health services with the general health system; lack of integration between mental health and social care systems, including poor co-ordination with housing, welfare and employment services; lack of co-ordinated partnership working between statutory and non-statutory mental health services, including the voluntary and independent sectors; and inadequate training of staff across systems (WHO, 2001)<sup>6</sup>.*

The Irish Government has addressed a number of these barriers: there is a new Mental Health Bill, soon to be enacted, with extended reach of regulation to community services, including residential units; a new mental health policy (Sharing the Vision); the implementation of Slaintecare; and the closure of the large institutions, although the funding that was powering the large asylums did not always transfer to the community services. There is some considerable work yet to do with regard to integration of mental health, general medical health, primary care, and social care. Lack of training is being addressed but approved centres are still not adequately training their staff in mandatory training. While nursing staff and medical staff have ring-fenced training budgets, this is not always the case with health and social care professionals.

<sup>5</sup> Long-Term Mental Health Care For People With Severe Mental Disorders .Jose Miguel Caldas de Almeida and Helen Killaspy 2011. healthcare\_mental\_disorders\_en\_0.pdf (europa.eu) Accessed 15 April 2023

<sup>6</sup> WHO. World Health Report 2001. Mental Health: New Understanding, New Hope. Geneva, World Health Organization, 2001.

## Premises where Mental Health Services are delivered

Environments providing mental health services are regarded as having an effect on a patient's sense of well-being. Patients' experience of such spaces can have a highly emotional dimension, which suggests that environment design of mental health facilities should be investigated as a potential means to influence therapeutic efficacy. Mental health facilities are often criticised as being poorly designed which may contribute to violent incidents and patients' complaints of feeling bored and lacking meaningful interactions with peers and staff. Early studies showed that when furniture is rearranged to promote social interaction (e.g., chairs facing one another at a comfortable distance, chairs arranged around a table), social interaction among hospitalized patients increases, and isolated, passive behaviours decrease<sup>7</sup>.

The maintenance of the premises of acute inpatient approved centres varies greatly. Some units such as Adult Mental Health Unit Galway, Department of Psychiatry Drogheda, Adult Mental Health Unit Cork University Hospital, and Adult Mental Health Unit Sligo were built in recent years and have plenty of space, single en suite bedrooms, therapeutic and recreational spaces and designed garden or courtyards. Other older acute units are not fit for purpose: St Michael's Unit at the The Mercy University Hospital Cork, Roscommon University Hospital, Bantry General Hospital, Jonathan Swift Clinic, and the admission unit in St Stephen's Hospital. Other approved centres need extensive refurbishment. The HSE has provided capital funding to address some issues such as the presence of ligature anchor points, fire safety, refurbishment and renovation, and structural changes, which will go some way to addressing their non-compliance in Regulation 21: Privacy; Regulation 22: Premises; and Regulation 32: Risk Management Procedures.

The state of maintenance of long-stay units varies. There are some state-of-the-art new premises

such as Aidan's Unit, Blackwater House, and Deer Lodge. Others are clearly unfit to provide a modern mental health service after decades of neglect and reactive responses to maintenance crises. This is even after a considerable amount of minor capital has been spent to increase compliance with the regulatory framework. These include St Catherine's Ward, Vergemount, An Coillin, Grangemore, O'Casey Rooms, and St Stephen's Hospital. For most people residing in these premises, this is their home.

This is not a criticism of the staff who work hard on the ground to provide age-appropriate care and therapeutic interventions and who try and make the approved centre as homely and welcoming as possible.

Addressing maintenance, refurbishment, and inadequate structures do not necessarily lead to compliance with regulations. We also inspect processes and their implementation. The identification and management of risks is as important as changing part of the structure of the building. The respect for privacy and dignity is more about attitude, internal stigmatisation, rights of residents, and culture. Upkeep of premises is also about cleanliness, noise levels, furnishings, and ventilation.

### Compliance with Regulation 21: Privacy and Regulation 22 Premises

Total Compliance rate for Regulation 21: Privacy in 2022 was 72.7% and has remained static since 2020.

The total compliance rate for Regulation 22: Premises was 27%. Table 16 shows that total compliance with Regulation 22: Premises has continued to drop since 2020. Reasons for non-compliance with Regulation 23: Premises include lack of maintenance and the presence of ligature anchor points.

**Table 16:** Compliance table for Regulation 21 Privacy and Regulation 22 premises

	2018	2019	2020	2021	2022
Compliance Regulation 21: Privacy	53%	49%	71%	71%	72.7%
Compliance with Regulation 22: Premises	30%	31%	55%	33%	27.3%

<sup>7</sup> From: A Report On Physical Environments In Mental Health Inpatient Units 2021dr Susan Finnerty, Inspector of Mental Health Services. Mental Health Commission Premises Report 2020\_FINAL.pdf (mhcir.ie) Accessed 15 April 2023



Table 17:

CHO/Sector	No. of Services	Average compliance with Regulation 22: Premises
CHO 1	4	25.0%
CHO 2	8	12.5%
CHO 3	4	0.0%
CHO 4	9	11.1%
CHO 5	7	42.9%
CHO 6	3	33.3%
CHO 7	3	0.0%
CHO 8	6	33.3%
CHO 9	7	28.6%
INDP	8	62.5%
Forensic	1	0.0%
CAMHS	6	33.3%

## Physical Health in people with a severe mental illness

In 2018, I found that there was a disregard for international best practice guidelines for monitoring the physical health of inpatients who are resident in mental health units and those who are on antipsychotic medication. There is a large amount of evidence-based research over many years on the importance of such monitoring in people with severe mental illness to identify metabolic syndrome, a cluster of the most dangerous heart attack risk factors. People with severe mental illness and on antipsychotic medication have a higher-than-normal risk of developing metabolic syndrome. The excess mortality rates in persons with serious mental illnesses are largely due to modifiable health risk factors. Therefore, the monitoring and treatment of these factors should be a part of clinical routine care of the psychiatrist and general practitioner (GP). People with a severe mental illness will typically die between 15 and 20 years earlier than someone without a mental illness and their physical illnesses are largely preventable. The excess mortality rates in persons with severe mental illness are largely due to modifiable health risk factors. Therefore, the monitoring and treatment of these factors should be a part of clinical routine care by the mental health services and GPs.

It was obvious that monitoring of the physical health of people with severe mental illness – who were in hospital for more than six months – was not in line with best practice and did not meet international guidelines. In view of this, in early 2018, we added the specific monitoring required

to the guidance for approved centres in achieving compliance with regulations, i.e., the Judgement Support Framework<sup>8</sup>.

Table 18:

Year	2019	2022
Compliance with Regulation 19: General Health	42% (97% was due to insufficient monitoring)	81.8%

From Table 18 we can see the improvement in compliance in Regulation 19 General Health. Non-compliance is mainly due to omission of one part of the physical examination rather than the absence of an entire physical examination.

## Restrictive practices

Restrictive practices such as seclusion, mechanical restraint and physical restraint are used to control movement of residents who display aggressive or violent behaviour as a part of their mental illness. In 2022, there were Rules Governing the Use of Seclusion and Mechanical Restraint and a Code of Practice on Physical Restraint. The number of centres using seclusion and physical restraint were:

Table 19:

Restrictive practice	Number
Seclusion	26
Mechanical Restraint	2
Physical Restraint	47

Compliance with the Rules on Seclusion and Mechanical Restraint and the Code of Practice on Physical Restraint were inspected during the annual inspection.

<sup>8</sup> [https://www.mhcirl.ie/Inspectorate\\_of\\_Mental\\_Health\\_Services/Themed\\_Reports/Rehabilitation\\_and\\_Recovery\\_Services](https://www.mhcirl.ie/Inspectorate_of_Mental_Health_Services/Themed_Reports/Rehabilitation_and_Recovery_Services)

Table 20: Compliance with the Rules on Seclusion and Mechanical Restraint and the Code of Practice on Physical Restraint were inspected during the annual inspection.

Year	2018	2019	2020	2021	2022
Compliance with Rules for seclusion	33%	21%	61%	82%	83%
Compliance with Code of Practice on physical restraint	19%	50%	76%	73%	82%

Compliance with the Rules and Code of Practice has increased substantially since 2018, although there was only a slight improvement in compliance between 2021 and 2022. The inspectors have seen improvements in seclusion facilities, observation of people in seclusion, and in documentation.

In January 2023, new Rules Governing the Use of both Seclusion and Mechanical Restraint were commenced, as well as a new Code of Practice on the Use of Physical Restraint.

## 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.

While the definition does not emphasize person-centeredness and recovery, it is a basic requirement to ensure that all residents in an approved centre have a care plan to which they have made some contribution. We have inspected some centres where staff have worked with the resident to develop meaningful achievable goals and have put in therapeutic services and programmes to achieve these goals. There is clear clinical leadership evident and the individual care plan is the blueprint for the resident's care, treatment and eventual recovery. In other approved centres, the basic concept of care planning does not seem to have been learnt. Goals are vague and meaningless and obviously not developed with residents and interventions

Table 21

Year	2018	2019	2020	2021	2022
Compliance with Regulation 15: Individual Care Plan	58%	52%	59%	64%	70%

<sup>9</sup> Maskey S. Report On The Look-Back Review Into Child & Adolescent Mental Health Services County MHS Area A.14 January 2022

are not adequately specified. It is clear that clinical leadership in care-planning is absent and staff have not been trained adequately in recovery-focused care planning.

## Review of the provision of Child and Adolescent Mental Health Services (CAMHS) in the State

Each year as part of my statutory duty under the Mental Health Act 2001, I carry out a review of mental health services in the State. In 2022, I commenced a review of the provision of Child and Adolescent Mental Health Services (CAMHS) in Ireland. During this review, we were cognisant of the findings of the Look-Back Review Into Child & Adolescent Mental Health Services in South Kerry by Dr Sean Maskey<sup>9</sup> and the public concerns about the provision of CAMHS.

The review included meeting with all 73 CAMHS teams and specialist CAMHS teams, reviewing 10% of each team's caseload; and meeting with young people, their parents, and other stakeholders.

Following a review of the provision of CAMHS in five out of nine Community Healthcare Organisations (CHOs 3, 4, 5, 6 and 7), I decided to issue an interim report because of the serious concerns and consequent risks for some patients that we had found across areas of four out of five Community Healthcare CAMHS. The concerns included the risk to safety and wellbeing of children receiving mental health services, the management of that risk, and the lack of clinical governance. We had made five escalations of risk

to the HSE due to risks that we had found to the wellbeing and safety of children.

In light of our findings across five CHOs and the concerns that they have raised for the safety and wellbeing of children, we made the following recommendations:

1. There should be an immediate clinical review of all open cases in all CAMHS Teams, using the National Institute for Health and Care Excellence (NICE) Guidelines and the CAMHS Operational Guideline. Particular focus should be given to identifying and assessing open cases of children who have been lost to follow up, and physical health monitoring of those on medication.
2. Immediate regulation of CAMHS under the Mental Health Act should also be a priority.

The Interim report was published on 23 January 2023<sup>10</sup>. The Final Report of the Review will be published in 2023.

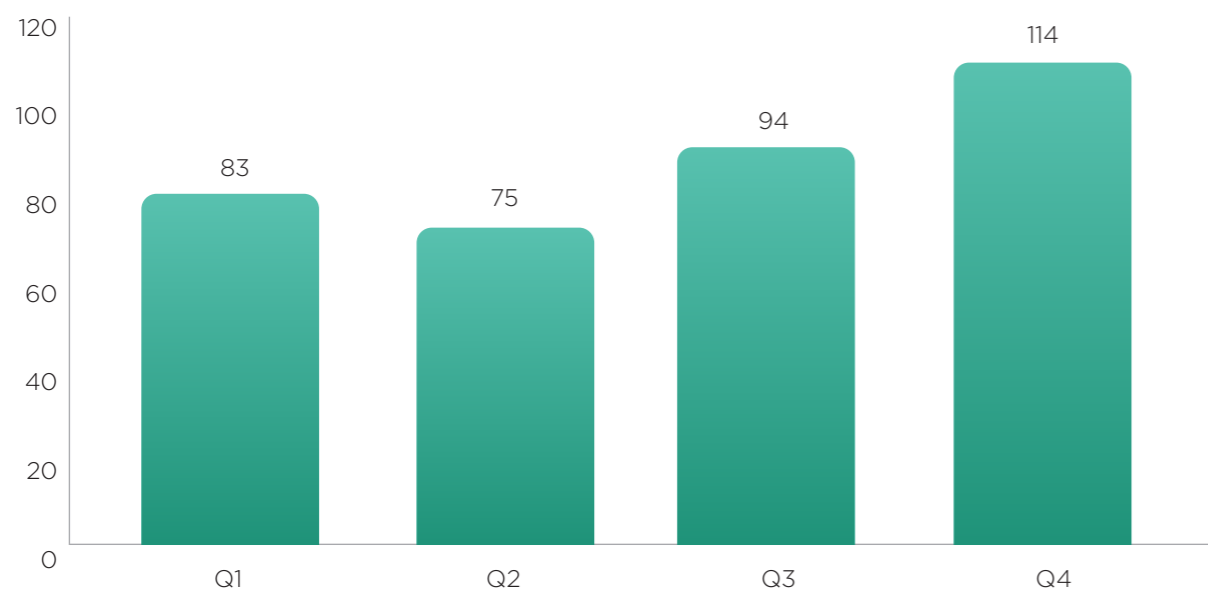
### Submitted issues of concern

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 (SIC) committee. 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 committee.

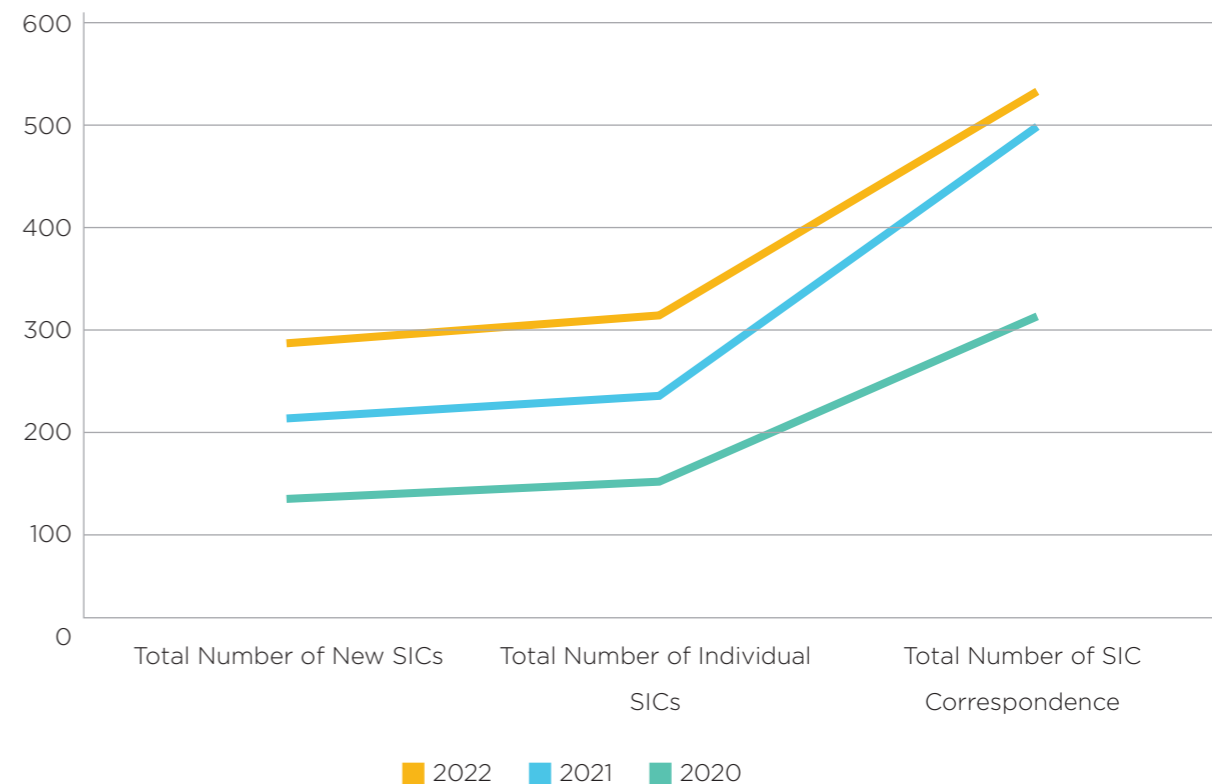
An issue of concern is a report from a member of the public and must relate to the health, wellbeing, or safety of a person in receipt of mental health services. Each issue is considered and acted upon immediately and/or taken under consideration during the next annual inspection of that service.

The Submitted Issues of Concern committee received 366 individual concerns and 542 communications regarding these concerns in 2022. Responses may include a 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.

**Figure 10:** Total Number of Individual Concerns Received in 2022



**Figure 11:** Number of Concerns Received 2020-2022



We welcome views, comments and concerns about mental health services and the process for contacting us is on our website [www.mhcirl.ie](http://www.mhcirl.ie).

<sup>10</sup> [Independent Review of the provision of Child and Adolescent Mental Health Services \(mhcirl.ie\)](http://www.mhcirl.ie)

## Conclusion

Ireland has come a long way in the provision of mental health services in the past 15-20 years, primarily due to in the closure of psychiatric asylums, rigorous regulation of the structures and processes of mental healthcare delivery, independent review of the detention of people in approved centres, and the provision of evidence-based and better person-centred care. Management and staff should be proud of the progress made. We have seen evidence of compassionate, enthusiastic, and skilled staff in most approved centres and the community CAMHS services that we visited.

There are, however, many improvements yet to be made. The provision of safe buildings that have well-maintained private spaces, garden areas, spaces to socialise, therapeutic areas, and décor that is therapeutic and relaxing, needs to continue. Too many premises remain that require replacement or major refurbishment, in both acute mental health units and those providing long-term care.

Inpatient care should be seen as one part of the treatment options available. In most cases other options should be considered before hospitalisation is necessary. But the community services are not adequately in place to provide these options. Although funding for staffing has improved over the past few years, community teams are chronically short-staffed through lack of funding and difficulty in recruiting staff. Retention of staff in under-resourced teams is also a problem. CAMHS, which is essential for treatment of moderate to severe mental illness in children and young people (which can lead to ongoing mental health problems in adult life), is under resourced in staffing, specialist teams and day treatment facilities. Early intervention teams are still not provided in most Community Healthcare Organisations (CHOs) and there are too few rehabilitation teams, which are under resourced. Acute hospital beds operate at well above the recommended capacity of 85%, sometimes exceeding their number of registered beds. Operational CAMHS bed numbers have decreased rapidly from 98 beds that should be operational, due to shortage of nursing staff through retention and inability to recruit.



There are, however, many improvements yet to be made. The provision of safe buildings that have well-maintained private spaces, garden areas, spaces to socialise, therapeutic areas, and décor that is therapeutic and relaxing, needs to continue. Too many premises remain that require replacement or major refurbishment, in both acute mental health units and those providing long-term care.

This lack of ability to staff teams and inpatient services is likely to continue unless we make it attractive for staff to take up posts and stay in them. The HSE has recruited from abroad and made use of remote telepsychiatry to try to alleviate difficulty in staffing teams but it is not enough. It is not sufficient to say that “we can’t get staff ” without looking at different ways of making posts attractive and competitive with other jurisdictions. This involves opportunities for training and upskilling, adequate supervision, manageable caseloads, competitive salaries and career pathways. It may involve reviewing the model of how we provide mental health services: more cross sector teams, amalgamating teams to make use of economies of scale, having approved centres of excellence, better integrated care with other agencies in both public and voluntary services, and querying whether the current team structure is the best way of providing access to mental health services.

The Irish mental health services have a number of strengths. These include: a highly skilled and dedicated workforce and an engagement with

quality improvement and increased provision of person-centred care. There are also opportunities to push the improvement agenda, namely the: Sharing the Vision mental health policy, the new Mental Health Act due in 2023, the change to Regional Health Areas (RHAs) and Population-Based Resource Allocation (PBRA) funding model due under Slaintecare, the new National Quality Framework, and the new Rules and Code of Practice for restrictive practices.

However, we have a chronically underfunded mental health service for many years and an inclination for drifting towards providing institutional care for vulnerable groups of people. It is more cost effective to build larger buildings for residential care rather than smaller staffed residential homes with five to six service users in each. It is easier and cheaper to admit a service-user who requires some level of support to a large residence/approved centre with 20 beds than it is to source a more appropriately-sized supported residence. This maintains a steady level of people who are living in but not of the community. There is a real risk that we are beginning, as we did in the past, to once again re-institutionalise people who are mentally ill and/or elderly or who do not “fit in”. As a country, we urgently need to provide all our citizens with rights-based personalised care in their own communities when they need it, or risk once again becoming a society that locks away its vulnerable citizens.

Funding allocated to mental health has been between 5-6% of Ireland’s total health budget in recent years. This is a very low national spend on mental health services when compared internationally. Data in the UK shows that 14.8% of their local health spend was allocated to mental health in 2021/2022. Slaintecare proposed allocating “...at least 10% of the health budget to mental health.” Budget 2023 sees an additional €72.8 million of funding for mental health services, including €14 million of new developments and €43.8 million for existing level of services. There will be €10 million in mental health capital funding. This is, of course, welcome, but we are still a long way off from reaching the 10% of health funding proposed by Slaintecare.









**Mental Health Commission  
Coimisiún Meabhair-Shláinte  
Waterloo Exchange  
Waterloo Road  
Dublin 4**

**Telephone: 01 636 2400**

**Fax: 01 636 2440**

**Email: [info@mhcirl.ie](mailto:info@mhcirl.ie)**

**Web: [www.mhcirl.ie](http://www.mhcirl.ie)**

**Facebook: Decision Support Service**

**Twitter: @DSS\_Ireland**

**Twitter: @MHCireland**

**Instagram: [decisionsupportserviceire](https://www.instagram.com/decisionsupportserviceire)**

**LinkedIn: Mental Health Commission**

**YouTube Channel: Mental Health Commission - YouTube**