

WORKING TOGETHER
FOR QUALITY MENTAL
HEALTH SERVICES



**Mental Health Commission
Annual Report 2013**

**Including Report of the Inspector
of Mental Health Services**



OUR VISION

Working together for quality mental health services

We will continue to work collaboratively with our stakeholders to create this shared vision and deliver real change in our mental health services. We will continue the alignment of strategies and processes in the mental health domain with the aim of achieving quality mental health services

OUR MISSION

Our Mission is to safeguard the rights of service users, to encourage continuous quality improvement, and to report independently on the quality and safety of mental health services in Ireland



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Chairman's Foreword

I am pleased to present the 2013 Annual Report of the Mental Health Commission which includes the Report of the Inspector of Mental Health Services.

I noted in the Annual Report of last year that at the heart of Irish Government Policy as espoused in A Vision for Change are concepts such as recovery, person centredness, partnership, user and family involvement and the delivery of multidisciplinary community based services. These important principles are still relevant.

The implementation of policy to date is still reliant on innovative and imaginative clinical and administrative leadership at regional and local levels. There is considerable commitment to the policy. Despite these actions the policy is being implemented unevenly and inconsistently across the country and there is a requirement for innovative actions to be supported and reinforced by strong corporate governance at national level.

Such Governance was commenced in 2013 by the appointment of the Director of Mental Health Services and the creation of a National Mental Health Service Management Team. This was quickly followed by a detailed mental health Divisional Plan for 2014 which is in effect a mental health service Implementation Plan. The Commission is supportive of these developments.

I referred last year to the absence of any independent monitoring of a Vision for Change policy. This situation remains unchanged.

The Commission welcomed the €20 million budget allocation for revenue spending in 2014 on the development of community mental health teams, a core element of A Vision for Change. We note the Ministerial Commitment to ensure that the expected €15 million not forthcoming in 2014 would be reinstated in 2015. Notwithstanding the shortfall we are disappointed with the delay in the filling of the required posts and would urge the HSE to maximise the populating of Community mental health Teams as new resources permit.

Since 2007, staffing in mental health services has been reduced by the implementation of recruitment embargoes and employment moratoriums. The medium and long term effect of such policies is to endanger the delivery of confident and responsive community based services as envisaged in A Vision for Change. This situation needs to be reversed by the continued allocation of new revenue for the full development of community mental health teams and concomitant services.

The Commission is also pleased to see the continued progress towards ending the use of outdated and unsuitable buildings to provide inpatient services. This trend is to be welcomed, and the Commission stresses the need for the continued development of community mental health services to replace traditional models of inpatient care.

The concept of recovery – that mental health services are designed to assist in a person's recovery rather than simply to “manage” their illness – is now well understood,. Implementation of it is uneven, however. The information provided in this report points to a serious deficiency in the development and provision of recovery oriented mental health services. Service delivery is still largely delivered by medical psychiatric and mental health nursing staff. There is still a significant absence of psychology, social work, occupational, and other multidisciplinary team members.

In order for a fully developed recovery oriented service to be delivered there needs to be a cultural shift in how we deliver services away from a linear medical model towards a more holistic bio-psychosocial one.



There needs to be a change in attitudes and behaviours so that all staff delivering mental health services are trained in recovery competencies, work in a partnership style with service users and their families and work cohesively with other mental health professionals to provide an integrated, responsive and person centred service that responds to the needs of individuals and their families in a timely and appropriate manner. The development of a systematic recovery initiative 'Advancing Recovery in Ireland' by the HSE continued in 2013 and is an encouraging one.

The Commission is also concerned regarding a number of specific areas of service provision which impinge on human rights and where, in 2013, standards fell below what is acceptable.

In principle, for example, it is accepted that each service user should have their own individualised care plan, designed to assist in their recovery. Currently the Commission estimates that 60% of approved centres implement appropriate Individualised Care plans.

The extent of the continued usage of seclusion and physical restraint is unacceptable. It is worth noting that of the nine conditions attached to approved centres in 2013, four relate to non-compliance with care planning, two with use of seclusion and restraint, one regarding Transfer and one regarding staffing levels.

The Mental Health Commission has recently published a report on ECT activity for 2012. The year-on-year decline in the use of ECT and Seclusion, as well as the small decline in the use of restraint is very much welcomed and is a testament to the hard work undertaken by mental health practitioners and their commitment to building and delivering a truly modern mental health service for the Irish public. The Commission is still concerned that ECT can be administered to detained persons against their will.

In relation to younger service users, there is still a most unsatisfactory situation whereby children are being admitted to adult units – there were 91 (22.3% of all child admissions) such admissions in 2013.

A review of the Mental Health Act 2001, with a view to enhancing compliance with international human rights legislation is still underway. The Commission is very supportive of this process and looking forward to working within the jurisdiction of an amended Act. In particular the Commission is anxious that the Act be amended to allow the Commission to statutorily regulate mental health services beyond approved centres in line with the increasing trend for services to be provided in non-residential and localised Community settings.

There are other areas where progress remains slow and is a cause of frustration. Mental capacity legislation, called "assisted decision making (Capacity) legislation", published in July 2013 is still a Bill. Similarly Ireland's name remains absent from the list of signatories of the UN Convention on the Rights of People with Disabilities.

In relation to internal staffing it is worth noting that the effects of the public service moratorium are having serious effects on the Commission's ability to provide a comprehensive service as required under the Mental Health Act. Specifically there are vacancies at senior level and despite protracted discussions with the Department of Health including meeting with the Minister of State an effective resolution has not materialised. The effect of this delay in filling essential posts has been to slow down the work of the Commission and put in jeopardy the core activities of the Commission. I am now calling on the Departments of Public Expenditure and Reform and Health to resolve this matter speedily.

Finally, I would like to thank the members of the Commission for supporting me in my role as Chairman. I would like to thank the Chief Executive Patricia Gilheaney, the Senior Management Team, the Inspector of Mental Health Services Team and all of the Mental Health Commission staff for their support and commitment to the Commission.

John Saunders
Chairman



Chief Executive's Introduction

This, the twelfth Annual Report of the Mental Health Commission, sets out the work we undertook in 2013 and the progress made towards achieving our objectives as set out in our Strategic Plan 2013-2015, and our 2013 Business Plan.

In doing so we were guided as always by our statutory remit which, in broad terms, is to promote, encourage and foster high standards and good practices in the delivery of mental health services and to protect the interests of patients who are involuntarily admitted and detained.

Since the passage of the 2001 Mental Health Act and the subsequent establishment of the Commission, there have been significant improvements in many areas of patient care. Human rights principles have been incorporated more and more into the care and treatment of service users; older psychiatric hospitals have closed; some new build facilities have emerged; individual care planning has been adopted patchily but progress can be seen; and compliance with rules, regulations and codes of practice has grown. These trends were seen clearly, though somewhat unevenly, in 2013.

This report provides a wide range of data that give a picture of the progress that has been made towards achieving our statutory remit, and of the work that remains to be done. It provides the involuntary admission rates to approved centres in 2013, and allows comparison with involuntary admissions in each of the previous four years. Data is also provided in relation to the admission of children and the use of Electro Convulsive Therapy and Seclusion and Restraint.

It gives rates regarding compliance by approved centres with regulations, rules and codes of practice and shows that in most areas full compliance has not been achieved. It is very disappointing that seven years after the regulations and rules became a statutory requirement that mental health services are struggling to meet the minimum standards laid down in statute.

The Commission attached nine conditions to the operation of eight approved centres during the year. Four of these concerned compliance with the regulations related to individual care planning. The Commission has highlighted the importance of individual care planning, which empowers the individual in the planning of his or her care, in recent years and we will continue to do so.

Despite the continuing constraints on resources, we look forward to the year ahead as one in which we can continue to protect the interests of persons detained in approved centres, facilitate improvement in the quality of mental health service provision, and work to embed the concepts of individual care planning and of recovery within all our mental health services. We hope our actions will help ensure mental health services remain high on the public agenda.

I would like to thank all of my colleagues in the executive of the Commission, the Inspector of Mental Health Services and all of our staff for their support and their continued dedication which ensured the priority actions in the business plan 2013 were delivered upon within a context of reduced resources.

Finally I would like to thank the Chairman of the Commission Mr John Saunders and all the Commission members for their stewardship and support.



Patricia Gilheaney
Chief Executive



Mental Health
Commission
Who we are and
What we do



Mental Health Commission

Who we are and What we do

The Mental Health Commission is responsible for regulating and monitoring mental health services in Ireland as defined by the Mental Health Act 2001.

The Commission was established in April 2002. We are an independent statutory body and our functions are set out by the provisions of the Mental Health Act 2001.

Our main functions are to promote, encourage and foster high standards and good practices in the delivery of mental health services and to protect the interests of patients who are involuntarily admitted and detained (*Section 33(1), Mental Health Act 2001*).

The Commission's remit includes the broad spectrum of mental health services namely general adult mental health services, as well as mental health services for children and adolescents, older people, people with intellectual disabilities and forensic mental health services.

The Mental Health Act 2001 also outlines the additional responsibilities of the Commission. These include:

- › Appointing persons to mental health tribunals to review the detention of involuntary patients and appointing a legal representative for each patient.
- › Establishing and maintaining a Register of Approved Centres i.e. we register inpatient facilities providing care and treatment for people with a mental illness or mental disorder.
- › Making Rules regulating the use of specific treatments and interventions i.e. ECT (Electro-convulsive Therapy), seclusion and mechanical restraint; and
- › Developing Codes of Practice to guide people working in the mental health services.

WORKING TOGETHER
FOR QUALITY MENTAL
HEALTH SERVICES

Mental Health Commission Members

April 2012 – April 2017

(Position at time of Appointment)



Mr. John Saunders
Chairman
Director
Shine



Dr. Anne Jeffers
Consultant
Psychiatrist
Health Service
Executive West



Dr. Maeve Doyle
Consultant Child
& Adolescent
Psychiatrist
Health Service
Executive
Dublin North East



Dr. Mary Keys
Lecturer
NUI Galway



Dr. Michael Byrne
Principal
Psychology
Manager
Health Service
Executive West



Dr. Xavier Flanagan
General Practitioner
Clane, Co. Kildare



Mr. John Redican
National Executive
Officer
National
Service User
Executive (NSUE)



Mr. Martin Rogan
Assistant National
Director, Mental Health
Health Service
Executive



Mr. Ned Kelly
Director of
Nursing
Health Service
Executive South



Ms. Catherine O'Rorke
Director of Nursing
Health Service
Executive
Dublin North East



Ms. Colette Nolan
Chief Executive
Officer
Irish Advocacy
Network



**Ms. Patricia O'Sullivan
Lacy**
Barrister-at-Law



Ms. Pauline Gill
Principal Social
Worker
Health Service
Executive
National Forensic
Mental Health
Service



The Mental Health Commission has 13 Members, including the Chairman, who are appointed by the Minister for Health. The composition of the Commission is laid down in Section 35, Mental Health Act 2001. Members of the Commission hold office for a period not exceeding 5 years.

The current Commission was appointed in April 2012 and their term of appointment will run through to April 2017.

There were ten Meetings of the Mental Health Commission held in 2013, one of which was a two-day meeting (June). Commission Members attendance at meetings in 2013 was recorded as follows:

Mental Health Commission Committees

There are two Standing Committees of the Mental Health Commission, the Audit & Finance committee and the Legislation Committee. The Membership of the Audit and Finance Committee consists of Commission Members (CM) and External Members (EM), with Executive Members (E) in attendance. The Legislation Committee has both Commission (CM) and Executive (E) members. The Chairman is an ex-officio member of Commission Committees.

Audit & Finance Committee (2013)

Ms. Patricia O'Sullivan Lacy (Chair) (CM), Ms. Catherine O'Rorke (CM), Mr. Ned Kelly (CM), Mr. John Redican (CM), Ms. Noreen Fahy (EM), Mr. Declan Lyons (EM).

MEMBER	Jan 18	Feb 15	Mar 15	Apr 15	May 17	Jun 20/21	Jul 19	Sep 20	Oct 18	Dec 03	Total Meetings
Dr Michael Byrne	*	*	*	*	*	*	*	*	*	*	10/10
Dr Maeve Doyle	*		*	*		*	*		*		6/10
Dr Xavier Flanagan	*	*	*	*		*	*	*		*	8/10
Ms Pauline Gill	*	*	*	*	*	*	*	*	*	*	10/10
Dr Anne Jeffers	*		*	*	*	*	*	*	*	*	9/10
Mr Ned Kelly		*	*	*		*		*	*	*	7/10
Dr Mary Keys	*	*		*	*	*	*		*	*	8/10
Ms Colette Nolan	*		*		*	*	*	*			6/10
Ms Catherine O Rorke	*	*	*	*	*	*	*	*	*		9/10
Ms Patricia O Sullivan Lacy	*	*	*	*	*	*	*	*	*	*	10/10
Mr John Redican		*	*								2/10
Mr Martin Rogan	*	*		*	*	*	*				5/10
Mr John Saunders	*	*	*	*	*	*	*	*	*	*	10/10

Legislation Committee (2013)

Dr. Mary Keys (Chair) (CM), Ms. Pauline Gill (CM), Mr. John Redican (CM), Dr. Anne Jeffers (CM), Ms. Patricia O'Sullivan Lacy (CM), Ms. Patricia Gilheaney (E), Ms. Rosemary Smyth (E), Ms. Marina Duffy (E). Ms. Ulla Quayle (E) provided administrative support to the Committee.



Commission Executive

The Chief Executive, appointed by the Commission, has responsibility for the overall management and control of the administration and business of the Commission. The Chief Executive is the accountable officer for the organisation.

The Inspector of Mental Health Services, appointed by the Commission, is required to visit and inspect every approved centre at least annually and may visit and inspect any other premises where mental health services are being provided as he deems appropriate. The Inspector furnishes a report in writing to the Commission on an annual basis.

Management Team

- › Ms. Patricia Gilheaney - Chief Executive.
- › Ms. Patricia Gilheaney - Acting Director - Mental Health Tribunals (to May 2013).
- › Mr. David Hickey - Director - Mental Health Tribunals and Legal Affairs (from May 2013).
- › Dr. Patrick Devitt - Inspector of Mental Health Services.
- › Mr. Ray Mooney - Director - Corporate Services.
- › Ms. Rosemary Smyth - Director - Training and Development.
- › Ms. Rosemary Smyth - Interim Director - Standards & Quality Assurance.

Core Activities of the Mental Health Commission

The Mental Health Commission's work programme is focused on five core activities. These include:

- › Registration and Enforcement.
- › Inspection.
- › Quality Improvement.
- › Mental Health Tribunal Reviews.
- › Managing the Legal Aid Scheme.

All of our core activities reflect the Commission's statutory functions. We also engage in collaborative work with external stakeholders as a means of realising these statutory functions. A number of key enablers also allow the Commission to function as an effective organisation.

This year's annual report is structured by our core activities, our collaborative work and key enablers with links to the Commission's strategic priorities for 2013 - 2015.

The core activity of inspection is presented separately in the Report of the Inspector of Mental Health Services which forms the second part of this report.

	Our Core Activities	
Regulation	Registration and Enforcement	Registering approved centres. Enforcing associated statutory powers e.g. attaching conditions.
	Inspection	Inspecting approved centres and community mental health services. Reporting on regulatory compliance and the quality of care.
	Quality Improvement	Developing and reviewing rules under the Mental Health Act 2001. Developing standards, codes of practice and good practice guidance. Monitoring the quality of service provision in approved centres and community services through inspection and reporting. Using our enforcement powers to maintain high quality mental health services.
Independent Reviews	Mental Health Tribunal Reviews	Administering the independent review system of involuntary admissions. Safeguarding the rights of those detained under the Mental Health Act 2001.
	Legal Aid Scheme	Administering of the mental health legal aid scheme.



Strategic Plan 2013 - 2015



Strategic Plan 2013 - 2015

The Mental Health Commission published its fourth Strategic Plan in 2013. The Plan maps the strategic direction for the organisation for the period from 2013 to 2015 with an emphasis on the Commission's core activities.

The Strategic Plan has set our four Strategic Priorities for the three year period. These priorities are all outcome-focused, as we recognise that our mission must be to move mental health services forward in a positive direction, despite operating in a challenging environment.

Strategic Priorities 2013 - 2015

1. Safeguarding human rights and incorporating these principles in all our work

We will act at all times to safeguard the rights of service users and incorporate human rights into all our practices.

2. Supporting the development of high standards and good practices in mental health services and promoting good quality care

We will continue to set standards, promote good practice, review and inform on the quality of services, and facilitate the building of capacity within services through education and information.

3. Promoting service user - centred and recovery oriented services

We will continue to work with services and service users, family and carer groups to promote services which are person- centred and recovery-oriented.

4. Strengthening the profile of the Mental Health Commission and mental health services

We will increase understanding of our role and work collaboratively with others to maintain both the visibility of the Mental Health Commission and of mental health services in the public domain.



Guiding Principles and Core Values of the Mental Health Commission

The ethos and culture of an organisation is developed through its Guiding Principles and Core Values. The work of the Commission is especially guided by the principles articulated in the:

- › Mental Health Act 2001.
- › European Convention for the Protection of Human Rights and Fundamental Freedoms.
- › European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.
- › United Nations Universal Declaration of Human Rights.
- › United Nations Convention on the Rights of the Child.
- › United Nations Convention against Torture and other Cruel and Inhuman or Degrading Treatment or Punishment.
- › United Nations Convention on the Rights of Persons with Disabilities.
- › International Covenant on Civil and Political Rights.
- › International Covenant on Economic, Social and Cultural Rights.
- › United Nations Principles for the Protection of Persons with a Mental Illness and for the Improvement of Mental Health Care.
- › European Convention on Human Rights Act 2003.
- › Disability Act 2005.
- › Equal Status Acts 2000 - 2004.
- › Child Care Act 1991.
- › Childrens Act 2001.
- › Freedom of Information Acts 1997 & 2003.
- › Data Protection Acts 1988 & 2003.

Our Values

The Commission is committed to operating in a manner that demonstrates our core values.

- › **Accountability and Integrity:** We will operate at all times in a fair and transparent manner and take responsibility for our actions.
- › **Dignity and Respect:** We will show dignity and respect for those using services and those providing them.
- › **Confidentiality:** We will handle confidential and personal information with the highest level of professionalism and we will take due care not to disclose information outside of the course of that required by law.
- › **Empowerment:** Our goal is to empower stakeholders (service users, families, carers, service providers and general public) through our work.
- › **Quality:** We aim to provide a quality service to all our stakeholders through use of evidence informed practices and by adopting a responsive regulatory approach.
- › **Recovery:** Our work will be at all times oriented towards recovery, encouraging and focusing on strong, equal partnerships between service users, families and carers and service providers.



Progressing our
Strategic Plan and
Priorities through our
Core Activities in 2013



Regulation

Registration and Enforcement

The Mental Health Act 2001 provides the Commission with a range of powers to register approved centres and to ensure that such centres meet and maintain their statutory and regulatory obligations. Our registration and enforcement procedures are designed to protect the health and welfare of residents. Changes to the Register of Approved Centres and the actions taken by the Commission in response to evidence of non-compliance in 2013, are set out below.

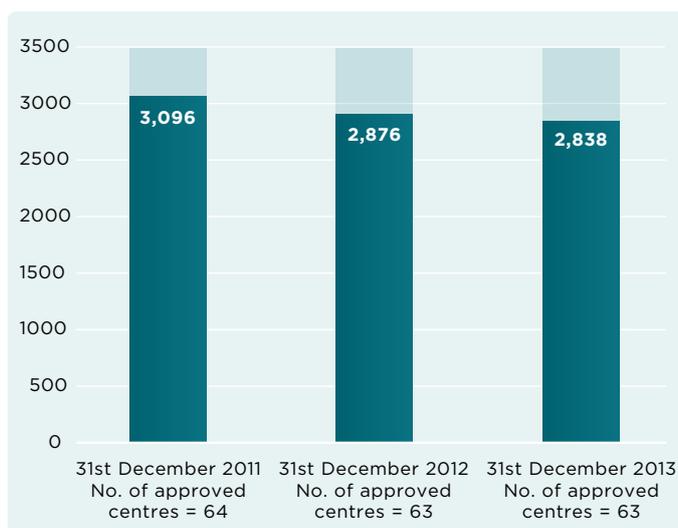
Register of Approved Centres

The Commission has maintained the Register of Approved Centres since 2006 and all in-patient facilities that operate as a centre must be registered by the Commission. Once a centre has been entered on the Register, it must comply with certain legal and regulatory requirements and will be inspected every year by the Inspector of Mental Health Services.

The number of approved centres on the Register of Approved Centres on 31st December 2013 was 63. Figure 1 shows the combined in-patient bed capacity of all approved centres on 31st December in each of the years 2011, 2012 and 2013.

The 63 approved centres registered at the end of 2013 had an in-patient bed capacity of 2,838 beds. This represents a net reduction of 1.3% (38) in bed capacity when compared to the numbers on 31st December 2012.

Figure 1: Combined Bed Capacity of All Approved Centres as at 31st December, 2011, 2012, & 2013





National mental health policy, as reflected in A Vision for Change, emphasises the need for a community based model of care. In-patient care will always be required but it should be provided in more appropriate modern facilities, which requires the closure of the remaining old psychiatric hospitals. During 2013, the number of in-patient beds in old psychiatric hospital buildings fell by 33.5% from 358 to 238. This reduction was achieved as follows:

- › The closure of the 14-bed St Monica's Ward in St Otteran's Hospital, Waterford in January 2013.
- › The closure of 46 beds when St Senan's Hospital, Co Wexford ceased operating as an approved centre in May 2013.
- › The closure of 23 beds when St Brendan's Hospital in Dublin 7 ceased operating as an approved centre in May 2013.
- › The closure of the 19-bed Ashlea Unit in St Joseph's Intellectual Disability Services, Portrane, Co Dublin in November 2013.
- › The closure of the 18-bed St Edna's Ward in St Loman's Hospital, Mullingar, Co Westmeath in December 2013.

Services that were provided in the two approved centres which ceased operating as centres were transferred to new build facilities after these were registered as approved centres for the first time. In-patient services had been provided in St Senan's Hospital in Enniscorthy, Co. Wexford since 1868. The closure of the hospital last year saw services transfer to Selskar House, Farnogue Residential Healthcare Unit in Wexford. This unit was registered as an approved centre on 2nd May 2013.

St Brendan's Hospital in Grangegorman in Dublin originally opened as the Richmond Lunatic Asylum in 1815. When in-patient facilities ceased being provided in the hospital last year following the closure of the approved centre, services were transferred to Phoenix Care Centre.

This facility was registered as an approved centre on 17th May 2013.

St Monica's Ward in St Otteran's Hospital in Waterford ceased offering an in-patient service and residents were transferred to community based mental health services in the area.

Following the closure of the Ashlea Unit in St Joseph's Intellectual Disability Services, Portrane, Co Dublin, residents moved to the newly refurbished Seafield Unit which is another unit on the grounds of the centre. The Seafield Unit was added to the approved centre's registration with effect from 15th November 2013.

When St Edna's Ward which was located in the original buildings of St Loman's Hospital, Mullingar closed, services were transferred to a refurbished stand-alone unit on the grounds of the hospital. This new unit is also called St Edna's Ward and was included as part of the registration of St Loman's Hospital with effect from 4th December 2013.

An up to date list of all approved centres, is available on the Commission's website at www.mhcirl.ie/registration/ACRegister

Expiration of Registration

The period of registration for approved centres is 3 years from the date of registration.

During 2013, the Commission registered 14 existing approved centres for a further three year period. Thirteen approved centres were required to make new applications to register as the three year period for which they were registered in 2010 expired in 2013. In addition, St Aloysius Ward, Mater Misericordiae University Hospital was required to make a new application to register as a centre because of a change in registered proprietor. Table 1 details these 14 centres and the dates on which they were registered.



Table 1: Approved Centres Registered during 2013

Approved Centre	Date of registration
Lois Bridges, Sutton, Dublin 13	19th January 2013
St Aloysious Ward, Mater Misericordiae University Hospital, Dublin 7	1st February 2013
Willow Grove Adolescent Unit, St Patrick's University Hospital, Dublin 8	30th April 2013
An Coillín, Castlebar, Co Mayo	17th May 2013
Bloomfield Hospital, Rathfarnham, Dublin 16	17th May 2013
St Catherine's Ward, St Finbarr's Hospital, Douglas, Cork	17th May 2013
St Fintan's Hospital - Ward 6, Portlaoise, Co Laois	17th May 2013
St John of God Hospital, Stillorgan, Co Dublin	17th May 2013
St Joseph's Intellectual Disability Services, Portrane, Donabate, Co Dublin	17th May 2013
St Edmundsbury Hospital, Lucan, Co Dublin	25th May 2013
Teach Aisling, Castlebar, Co Mayo	31st May 2013
Sycamore Unit, Connolly Hospital, Blanchardstown, Dublin 15	6th June 2013
Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital, Galway	9th December 2013
Eist Linn Child & Adolescent In-patient Unit, Blackrock, Cork	22nd December 2013

National Levels of Compliance with Regulations, Rules and Codes of Practice 2013

The compliance of approved centres with regulations, rules and codes of practice is assessed each year by the Inspector of Mental Health Services. By aggregating data from inspection reports, we are able to present data on national levels of compliance i.e. the proportion of all approved centres that fully comply with regulatory requirements and codes of practice. This year's annual report compares full compliance levels in 2012 and 2013. The graphs shown only identify the percentage of centres obtaining full compliance. Centres that did not achieve full compliance were either assessed by the Inspector of Mental Health Services as being substantially compliant, minimally compliant or non-compliant with the relevant regulation, rules or code of practice.

Compliance with Regulations

The Mental Health Act 2001 (Approved Centres) Regulations 2006 are legal requirements that all approved centres must adhere to. They set out minimum standards that approved centres must comply with in order to protect the health and welfare of residents. Figures 2 to 7 present data on national levels of compliance for the 31 relevant articles of the regulations in 2013 and compare these with those recorded in 2012.



National Levels of Approved Centres' Compliance with Regulations – 2012 and 2013

Figure 2

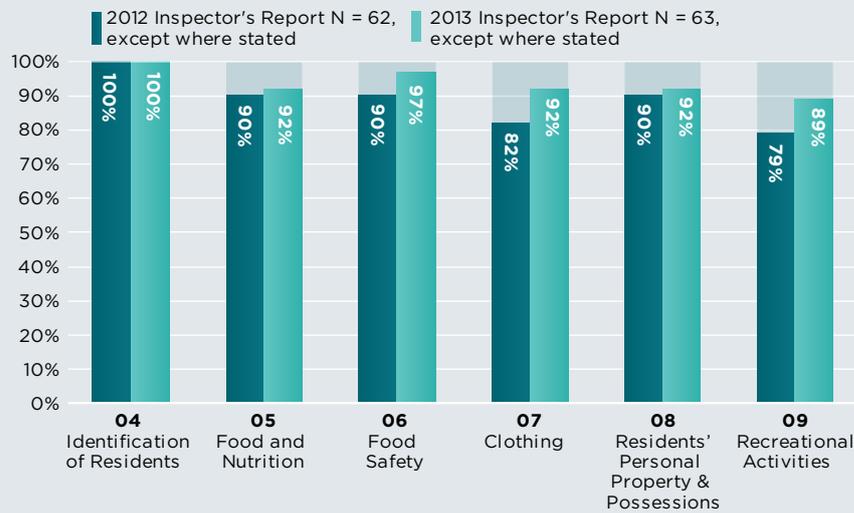


Figure 3

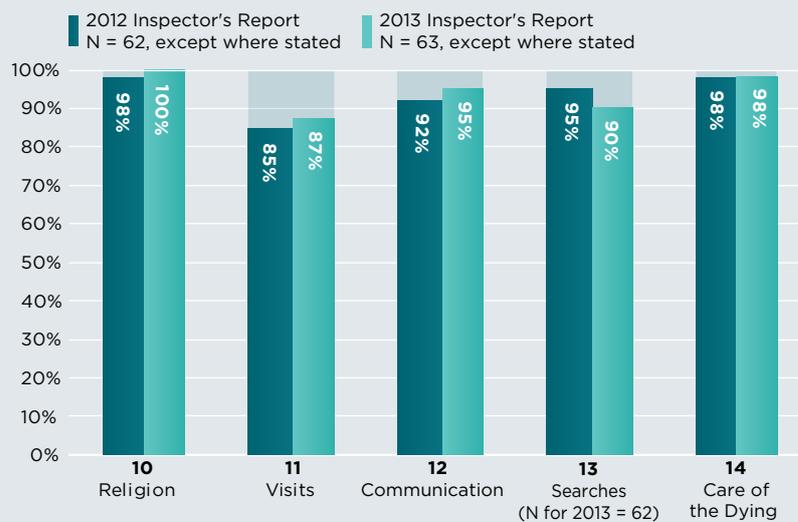
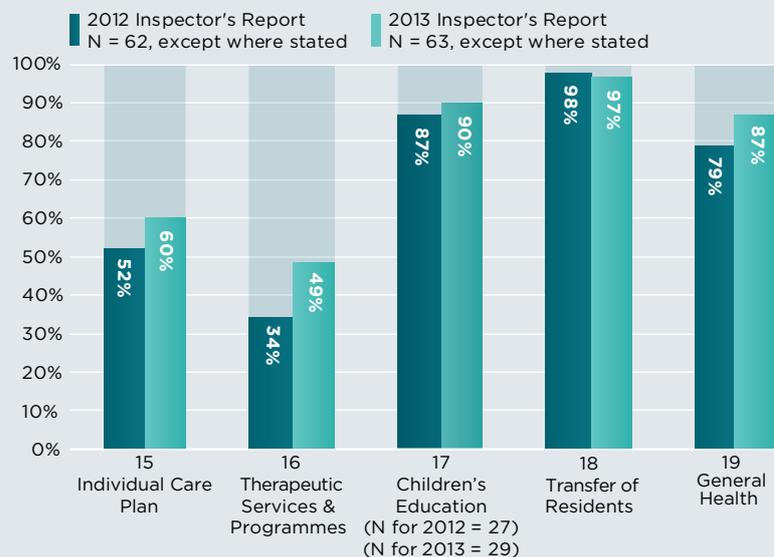


Figure 4



National Levels of Approved Centres' Compliance with Regulations – 2012 and 2013

Figure 5

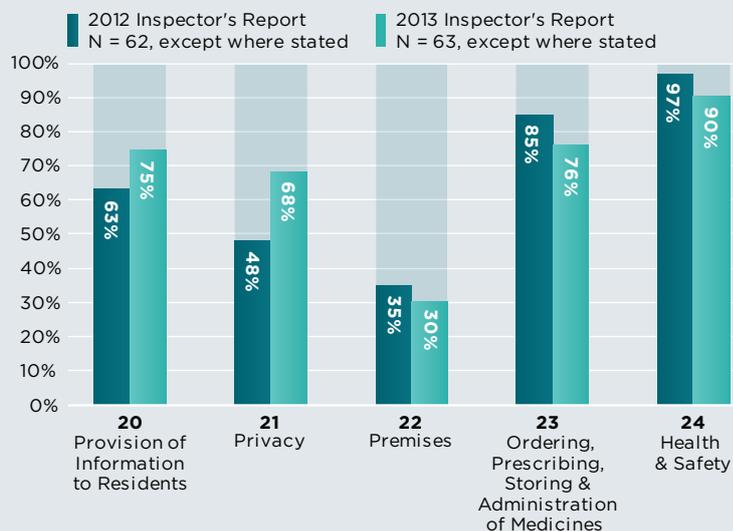


Figure 6

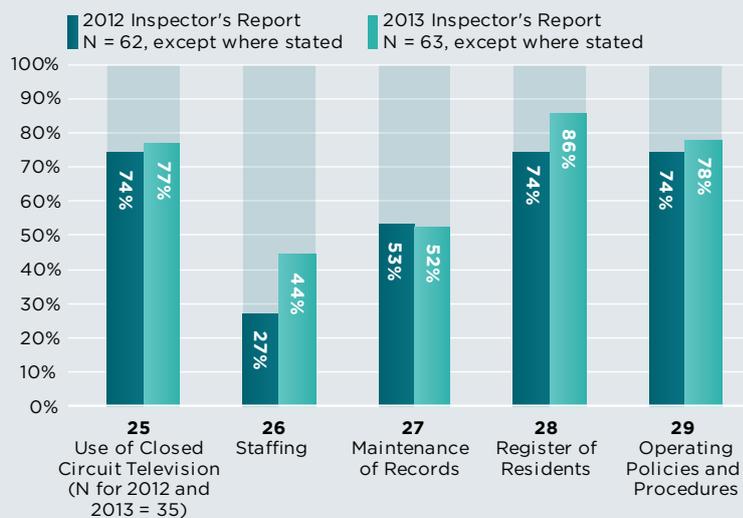
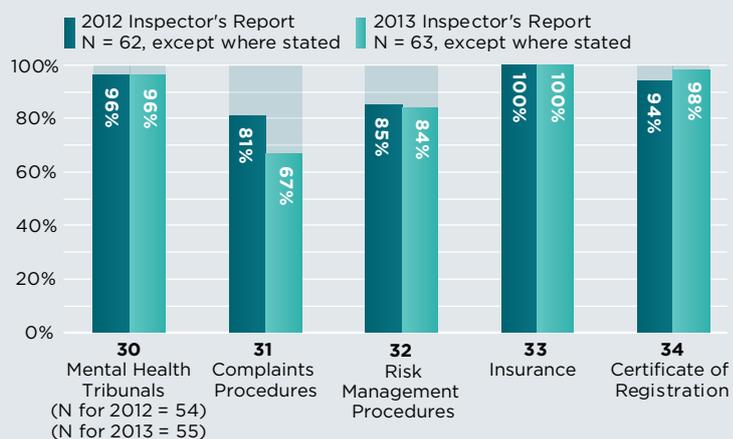


Figure 7





For 15 Articles of the Regulations between 90% and 100% of approved centres were fully compliant with requirements. We noted an overall improvement in full compliance levels for 19 of the 31 articles of the regulations. It is encouraging that between 2012 and 2013 increases in compliance were recorded for articles related to therapeutic services and programmes (34% to 49%); privacy (48% to 68%) and staffing (27% to 44%). Despite these improvements, this still means that less than half of approved centres fully meet the requirements that relate to therapeutic services and programmes and staffing.

An increase in compliance with the article concerning individual care and treatment planning was recorded in 2013, as 60% of approved centres were fully compliant with the requirement compared to 52% of approved centres in 2012.

For a number of articles of the regulations, compliance levels were broadly similar as in 2012 with little or no change in the percentage of approved centres meeting requirements. These included the three articles with which 100% of approved centres were fully compliant i.e. the requirements related to identification of residents, religion and insurance.

National levels of compliance fell for 8 articles of the regulations. The largest decrease related to complaints procedures with compliance falling from 81% of approved centres in 2012 to 67% in 2013. The decline in compliance levels with the article concerning premises from 35% to 30% is also a source of concern.

Compliance with Rules

The Commission has issued two sets of statutory rules since it was established. Table 2 below details these and the dates on which they came into effect.

Table 2: Statutory Rules Issued by the Commission

Rules	Date of Effect
Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint	Version 1 - 1st November 2006
	Version 2 - 1st January 2010
Rules Governing the Use of Electro - Convulsive Therapy (ECT)	Version 1 - 1st November 2006
	Version 2 - 1st January 2010

The Rules Governing the Use of ECT are rules that approved centres and staff working in these centres must comply with if an involuntary patient is receiving ECT. The Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint provide for the use of seclusion and mechanical restraint if it is in residents' best interests and prevents them from harming themselves or others.

Compliance with these Rules is assessed by the Inspector of Mental Health Services¹. As can be seen in Figure 8, 88% (15/17) of approved centres were fully compliant with the Rules on ECT in 2013 compared with 79% (11/14) of centres in 2012.

Levels of full compliance with the Rules on Seclusion remain very low. Only 33% (9/27) of approved centres met all the requirements of these rules in 2013 which was a slight improvement compared to 2012 when 29% (8/28) of centres met all requirements.

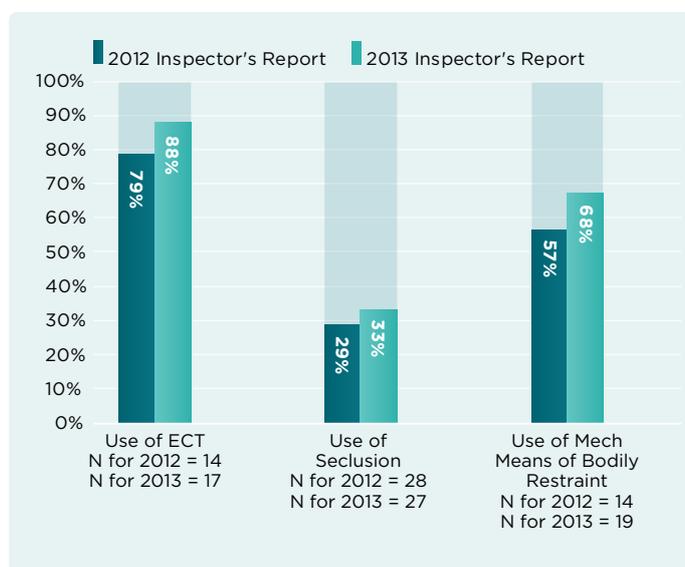
The proportion of approved centres achieving full compliance with the rules on mechanical restraint also increased year on year. Just over 68% (13/19) of centres were fully compliant with these rules in 2013 compared with 57% (8/14) in 2012².

1 Compliance levels are recorded separately for different sections of the Rules. Full compliance means that the Inspector of Mental Health recorded that an approved centre was fully compliant with all sections of the relevant Rules.

2 The Commission's recently published activity report for 2012 on the use of mechanical restraint illustrates that this form of restraint was only used under part 5 of the rules in 2012. This means that mechanical restraint was only used in approved centres in 2012 for the purposes of preventing an enduring risk of self-harm rather than for the purposes of preventing an immediate risk of harm to self or others.



Figure 8: National Level of Approved Centres' Compliance with Rules - 2012 and 2013



Compliance with Codes of Practice

Details of the six codes of practice that have been issued by the Commission and the dates on which their provisions took effect are provided in Table 3 below.

Table 3: Codes of Practice Issued by the Commission

Codes of Practice	Date of Effect
Code of Practice relating to Admission of Children under the Mental Health Act 2001	1st November 2006
Addendum to Code of Practice relating to Admission of Children under the Mental Health Act 2001	1st July 2009
Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting	1st February 2008
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	1st January 2010
Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities	1st January 2010
Code of Practice on the use of ECT for Voluntary Patients	Version 1 - 1st January 2008 Version 2 - 1st January 2010
Code of Practice on the use of Physical Restraint in Approved Centres	Version 1 - 1st November 2006 Version 2 - 1st January 2010

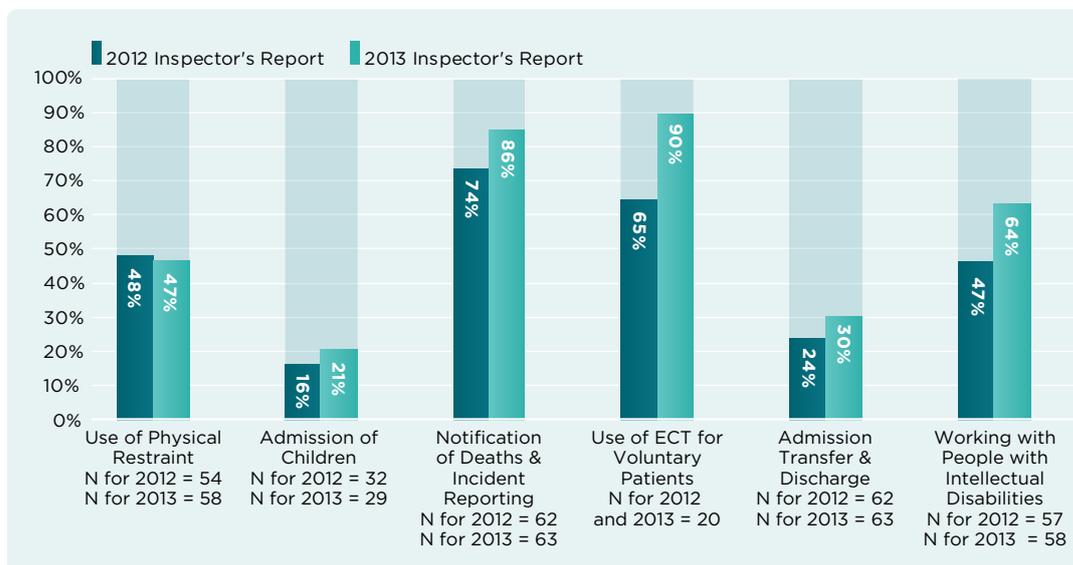


In 2013, full compliance with the code of practice on the use of ECT for voluntary patients was achieved by 90% of approved centres (Figure 9) which was the highest level of compliance for any code. Compliance improved from 2012 for this code when only 65% of approved centres were fully compliant with its provisions.

Full compliance with the code of practice for mental health services on the notification of deaths and incident reporting increased from 74% in 2012 to 86% in 2013. There was also an improvement in compliance with the code of practice that provides guidance to those working with people with intellectual disabilities. Whereas only 47% of approved centres achieved full compliance in 2012, this increased to 64% of all centres in 2013.

It is again disappointing that the proportion of approved centres achieving full compliance with the code of practice on admission, transfer and discharge (30%) and the code of practice on the admission of children to approved centres (21%) is very low in spite of small year-on-year improvements.

Figure 9: National Levels of Approved Centres' Compliance with Codes of Practice - 2012 and 2013



Regulatory Compliance and Enforcement

The Commission adopts a responsive approach to regulation. This means that where an approved centre is non-compliant with regulations, rules or codes of practice under the Mental Health Act 2001, we are responsive to the service's conduct and behaviour when deciding what regulatory actions to take. Consequently, if a service demonstrates a willingness to comply and can provide us with evidence to support these efforts, we will always consider these. We endeavour to support services to achieve full compliance once the welfare and safety of residents is not compromised.

Where a regulatory breach occurs, our default approach is to use 'persuasion' to assist services to meet requirements. We will escalate where deemed necessary such as where we are notified of a serious concern by the Inspector of Mental Health Services. Even with serious breaches in compliance, our first response will always be to engage in dialogue with the service in the first instance to establish the facts and identify steps to rectify the situation.

Full Compliance

Four approved centres achieved full compliance with all regulatory requirements in 2013. The four centres were:

- › St Stephen's Hospital, Cork.
- › Willow Grove Adolescent Unit, St Patrick's University Hospital, Dublin.
- › St Edmundsbury Hospital, Dublin and
- › St Patrick's University Hospital, Dublin.

Addressing Non - Compliance with Regulatory Requirements

We piloted new procedures for regulatory enforcement in 2013 in order to enhance our follow up procedures with those services who do not comply with requirements. These new procedures led to a significant reduction in the time that it took us to respond to regulatory breaches.

Table 4 summarises the actions we took in response to non - compliance by services with regulations and rules. There was no need to carry out any regulatory follow ups with the four services who fully complied with all regulations and rules.

Table 4: Summary of Actions to address Non-Compliance with Regulatory Requirements

Responses	N (%)
Regulatory Compliance Report Request	48 (81)
Regulatory Compliance Meeting Request	11 (19)
Total	59 (100)

For the majority of approved centres (81%), that were non-compliant with regulatory requirements a regulatory compliance report (RCR) was requested from the service's senior management team. An RCR was requested in situations where the overall risk posed to resident safety and welfare due to issues of non-compliance was deemed to be minor as provided for in our standard operating procedure. The reports required management to outline the actions planned or already implemented since the services's most recent inspection to achieve full compliance, the person(s) responsible for implementing the change, and the timeframes for completion of actions. Services were given one month to return their regulatory compliance reports.

For 11 centres (19%), a regulatory compliance meeting was requested in 2013. Details of these centres are provided in Table 5. Meetings were requested in situations where the overall risk posed to resident safety and welfare due to non- compliance was judged to be moderate as provided for in our standard operating procedure. Appropriate members of the service's senior management team were asked to attend, including the registered proprietor, or person with delegated responsibility for running the centre and the Clinical Director. The management team were asked to present a compliance report. These meetings provided an opportunity for the Commission to outline its greater concerns regarding these centres' compliance with legal requirements and offered a forum for services to provide in depth responses regarding how they planned to achieve compliance.



Table 5: Approved Centres Requested to Attend Regulatory Compliance Meetings as an outcome of the Findings of 2013 Inspections or Compliance Ratings

Area	Approved Centre
HSE Dublin Mid -Leinster	Department of Psychiatry, Midland Regional Hospital, Portlaoise
HSE Dublin North East	Acute Psychiatric Unit, Cavan General Hospital
	Joyce Rooms, Fairview
HSE South	Acute Mental Health Admission Unit, Kerry General Hospital
	Department of Psychiatry, St. Luke's Hospital, Kilkenny
HSE West	Acute Psychiatric Unit 5B, Mid-Western Regional Hospital, Limerick*
	Acute Psychiatric Unit, University Hospital Ennis
	Department of Psychiatry, Mid-Western Regional Hospital, Galway*
	Cappahard Lodge, Limerick*
Child/ Adolescent	Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital, Galway
Independent	Lois Bridges

* Also the subject of a serious concern

Conditions Attached to the Registration of Approved Centres

The 2001 Act provides for the Mental Health Commission to attach conditions to the registration of an approved centre at any time during its period of registration. This statutory power is exercised by the Commission where there is a pattern of repeated non-compliance with a given regulation, rule, or code of practice, or where the Commission deems there to be a significant risk to the safety or welfare of residents. It forms the next step in the Commission's responsive approach to regulatory compliance and enforcement.

In accordance with the 2001 Act, the Commission affords the proprietors of approved centres 21 days to consider and make representations on any proposal to attach conditions. These representations may take the form of comments on the Commission's proposal, action(s) the proprietor will take to address the issue(s) that prompted the proposal, or, in some cases, confirmation that the proprietor does not object to the proposed condition. The Commission considers any representations received and then informs the proprietor of its decision. If he/she so wishes, the proprietor may appeal the Commission's decision to the District Court.

The Commission attached nine conditions to the registration of eight approved centres in 2013, as set out in Table 6. Four of these nine conditions concerned compliance with Article 15 of the regulations related to individual care planning. The Commission has highlighted the importance of individual care planning in recent years. The involvement of the individual in his or her care and treatment is a significant cornerstone of the 2001 Act. Achieving full compliance with care planning requirements as specified in Article 15 also enables services to partly meet the requirements of other regulations. Those centres that had a condition attached to their registration requiring full compliance with this article of the regulations had not achieved full compliance with this requirement in each of the years 2009, 2010, 2011 and 2012.



Two conditions attached in 2013 related to compliance with the Rules Governing the Use of Seclusion. As was highlighted in Figure 8, only 33% of approved centres were fully compliant with the requirements of these rules in 2013. Those services that had conditions attached relating to the seclusion rules had demonstrated a pattern of not achieving full compliance over a number of years.

Table 6: Summary of Conditions Attached to the Registrations of Approved Centres During 2013

Approved Centre	Summary of conditions attached
Acute Psychiatric Unit 5B, Midwestern Regional Hospital, Limerick	<ul style="list-style-type: none"> Full compliance must be achieved with Article 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. <p>This condition was attached with effect from 26th March 2013.</p>
Acute Psychiatric Unit, Midwestern Regional Hospital, Ennis	<ul style="list-style-type: none"> The transfer of residents to another approved centre to alleviate bed shortages is prohibited. All residents must be accommodated in suitable sleeping accommodation that ensures the privacy and dignity of residents are respected. <p>These conditions were attached with effect from 26th March 2013.</p>
Adult Mental Health Unit, Mayo General Hospital	<ul style="list-style-type: none"> Full compliance must be achieved with the Rules Governing the Use of Seclusion & Mechanical Means of Bodily Restraint. <p>This condition was attached with effect from 26th March 2013.</p>
Cappahard Lodge, Limerick	<ul style="list-style-type: none"> Full compliance must be achieved with Article 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. <p>This condition was attached with effect from 26th March 2013.</p>
St Brigid's Hospital, Ardee	<ul style="list-style-type: none"> Full compliance must be achieved with Article 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. <p>This condition was attached with effect from 26th March 2013.</p>
St John of God Hospital	<ul style="list-style-type: none"> Full compliance must be achieved with the Rules Governing the Use of Seclusion & Mechanical Means of Bodily Restraint. <p>This condition was attached with effect from 26th March 2013.</p>
St Joseph's Hospital, Limerick	<ul style="list-style-type: none"> Full compliance must be achieved with Article 15 (Individual Care Plan) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. <p>This condition was attached with effect from 26th March 2013.</p>
Sycamore Unit, Connolly Hospital, Blanchardstown	<ul style="list-style-type: none"> Full compliance must be achieved with Article 26 (Staffing) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. <p>This condition was attached with effect from 6th June 2013.</p>



Compliance with Conditions

The Commission regularly reviews compliance with conditions and these reviews are informed by the Reports of the Inspector of Mental Health Services or by evidence provided by the registered proprietor where appropriate. During 2013, the Inspector assessed compliance with those conditions specified in Table 6, where the centre's 2013 inspection took place after the date on which the relevant condition was attached. The Inspector also assessed compliance with conditions attached to the registration of centres in 2011 and 2012 and which remained in place on the date of the centre's 2013 inspection.

Serious Concerns

The Chief Executive was notified by the Inspector of Mental Health Services of a number of serious concerns in 2013 that related to the contravention of conditions attached to the registrations of four approved centres:

- Department of Psychiatry, University Hospital, Galway.
- Jonathan Swift Clinic, St James' Hospital, Dublin 8.
- Acute Psychiatric Unit 5B, Midwestern Regional Hospital, Limerick, and
- Cappahard Lodge, Ennis, Co Clare.

Department of Psychiatry, University Hospital, Galway

Following an inspection on 26th February 2013, the Commission was notified by the Inspector of Mental Health Services of a contravention of the condition attached to the registration of this approved centre. The condition was attached on 6th November 2012 and required the centre to be fully compliant with Article 15 - Individual Care Plan of the 2006 Regulations.

After initial communication between the Commission and the registered proprietor, the Commission instructed the proprietor to request an appropriately qualified clinical person external to the approved centre to verify compliance. Monthly audit reports have been submitted to the Commission since April 2013 and have been made available to the Inspector of Mental Health Services.

A regulatory compliance meeting to address the breach of the condition was also convened.

The Inspector of Mental Health Services carried out a second inspection of the centre on 12th November 2013, and this inspection found that the centre had achieved full compliance with Article 15, as required by the condition. The Commission monitors compliance with this condition on an ongoing basis.

Jonathan Swift Clinic, St James' Hospital, Dublin 8

The Report of the Inspector of Mental Health Services for Jonathan Swift Clinic, found that the centre contravened a condition attached to the centre's registration, which required compliance with Article 26 - Staffing of the 2006 Regulations.

Following the convening of a meeting between the Commission and the registered proprietor to address the breach of the condition, it was noted that the centre had addressed the issues that initially led to the condition being attached. It was also noted that the Inspector's Report found that clinical and corporate governance in the centre had improved, and that training on the provisions of the 2001 Act was being delivered, as required by the second condition attached to the centre's registration. The Commission also received additional information relating to the staffing levels in the centre.

After consideration of all of these issues, the Commission notified the registered proprietor on 9th August 2013 of its proposal to remove the conditions attached to the registration of Jonathan Swift Clinic. The conditions were subsequently removed on 29th August 2013.

Acute Psychiatric Unit 5B, Midwestern Regional Hospital, Limerick, and Cappahard Lodge, Ennis, Co Clare

Following an inspection on 6th November 2013, the Commission was informed of a contravention of the condition attached to the registration of Acute Psychiatric Unit 5B, Midwestern Regional Hospital, Limerick. The condition, attached on 26th March 2013, required full compliance with Article 15 - Individual Care Plan of the 2006 Regulations.



On 3rd December 2013, the Commission was notified by the Inspector of Mental Health Services that, following an inspection on 27th November 2013, Cappahard Lodge, Ennis, Co Clare also was in breach of a condition that required full compliance with Article 15 – Individual Care Plan of the Regulations, which was attached on 26th March 2013.

Acute Psychiatric Unit 5B, Midwestern Regional Hospital, Limerick, and Cappahard Lodge, Ennis, Co Clare operated under the same registered proprietor and are part of one mental health service. The Commission therefore corresponded with the registered proprietor concerning both approved centres. This led to an instruction to the registered proprietor to engage the services of an appropriately qualified person to conduct ongoing audits of compliance with Article 15 for both approved centres, and to submit reports on these audits to the Commission on a monthly basis. The first report was received on 23rd December 2013, with further monthly reports due thereafter.

The Commission also notified the registered proprietor that it would convene a regulatory compliance meeting to address the breach of both conditions. It continues to monitor compliance with both conditions.

Conditions in place as of 31st December 2013

At the end of 2013, there were a total of 15 conditions attached to the registration of 11 approved centres. In comparison, there were 23 conditions attached to the registration of 12 approved centres at the end of 2012.

The conditions still in place as of 31st December 2013 include:

- ▶ A total of six conditions were attached during 2011 to the registrations of three approved centres: (i) St Finan’s Hospital, Killarney, Co Kerry, (ii) St Ita’s Hospital, Portrane, Co Dublin and (iii) St Loman’s Hospital, Mullingar, Co Westmeath.
- ▶ One condition attached in 2012 to the registration of Department of Psychiatry, University Hospital, Galway, and

- ▶ A total of eight conditions attached during 2013 to the following seven approved centres: (i) Acute Psychiatric Unit 5B, Midwestern Regional Hospital, Limerick, (ii) Acute Psychiatric Unit, Midwestern Regional Hospital, Ennis, Co Clare, (iii) Adult Mental Health Unit, Mayo General Hospital, Castlebar, Co Mayo, (iv) Cappahard Lodge, Ennis, Co Clare, (v) St John of God Hospital, Stillorgan, Co Dublin, (vi) St Joseph’s Hospital, Limerick and (vii) Sycamore Unit, Connolly Hospital, Dublin 15.

Details of the conditions attached in 2011 and 2012 are available in the 2011 and 2012 Annual Reports respectively. Details of the conditions attached in 2013 are set out in Table 6.



Regulation

Quality Improvement

One of the Commission's functions under the 2001 Act is to promote the development and maintenance of good practices and high standards in mental health services. It is also part of the Commission's mission to encourage continuous quality improvement in the delivery of mental health services.

A key component in developing good practices and in improving the delivery of services is the collection and analysis of information on activity within mental health services. Mental health services provide a range of information on activity to the Commission including on the admission of children, on the notification of deaths of service users, on the reporting of incidents within services, and on the use of electro-convulsive therapy, seclusion, and restraint. Summary data on the admission of children and on the notification of deaths are included in this annual report.

In 2013, the Commission also took further steps to encourage the use of the Quality Framework within community mental health services and continued to work in collaboration with other organisations to drive quality improvement.

Activity Data

Admission of Children under the Mental Health Act 2001

The Mental Health Commission has been collecting and reporting on data in relation to the admission of children³ to approved centres since 2007. In particular, we monitor admissions of children to adult units.

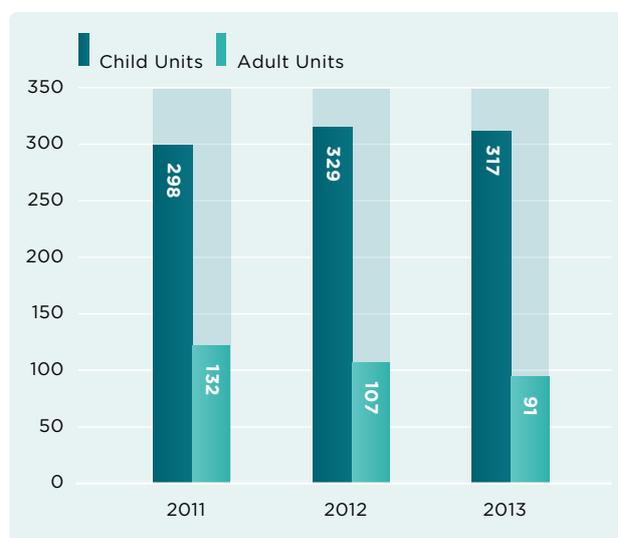
In December 2011, Section 2.4.1 c) of the Addendum to the Code of Practice Relating to Admission of Children under the Mental Health Act 2001 came into effect. This addendum placed tighter restrictions on the admission of children to adult facilities and stated that “no child under 18 years is to be admitted to an adult unit in an approved centre from 1st December 2011.”

It was emphasised that the above provisions should be followed except in ‘exceptional circumstances’.

Admission of Children in 2013

In 2013, the Commission was notified of 408 admissions of 332 children to approved centres⁴. This represents a 6.4% decrease on the total number of admissions reported in 2012⁵ (436). Of these 408 admissions, 91 (22.3%) were to 21 adult units and 317 (77.7%) admissions were to six child units (figure 10). A year-on-year decrease in the number and percentage of child admissions that were to adult units has therefore continued. There were 107 (24.5%) such admissions in 2012 and 132 (30.7%) in 2011.

Figure 10: Admissions of Children. Unit Type. 2011, 2012, 2013. Numbers



When a child is admitted to an adult unit, specific details must be submitted to the Commission outlining the circumstances of the admission. Services must outline ‘what efforts have been made to admit the child to an age appropriate approved centre’ and ‘what are the plans to place the child in an age appropriate approved centre’. In the case of 34.1% (31/91) of admissions to adult units, the child was subsequently discharged and admitted to a child unit when a bed became available. This represents an improvement on 2012, when 23.4% (25/107) of such admissions were followed by a discharge and subsequent admission to a child unit.

Involuntary Admissions

There are provisions under Section 25 of the Mental Health Act 2001 in relation to the involuntary admission of children that require the HSE to make an application to the District Court. In 2013, there were 14 Section 25 Orders for involuntary admission⁶ to approved centres. A total of 13 children were the subject of a Section 25 Order in 2013 as one child was admitted on two separate occasions under two separate Orders.

³ The Mental Health Act 2001 Section 2(1) defines a “child” as a person under the age of 18 years other than a person who is or has been married.

⁴ Includes approved centres for adults (adult units), approved centres for children and adolescents (child units) and a child and adolescent unit in an approved centre which also admits adults (child unit).

⁵ 2012 data was updated since publication of the 2012 Annual Report as a result of cross validation with the Health Research Board 2012 data, in line with the terms of our Memorandum of Understanding.

⁶ If a child was discharged from one approved centre and admitted to another approved centre under a single Section 25 Order this has only been reported as one involuntary admission. There were three such admissions in 2013.



One involuntary admission concerned a child who was initially admitted as a voluntary patient but had their legal status changed to involuntary during their admission.

Six of these admissions were to adult units and eight admissions were to child units. Five of the 13 children who were the subject of a Section 25 Order were aged 15 or younger, four were 16 years old and four were 17 years of age. Table 7 shows the number of involuntary admissions of children in each of the last three years. It shows that there has been a year-on-year decrease in Section 25 involuntary admissions from 21 in 2011 to 14 in 2013.

Table 7: Involuntary Admission of Children by Unit Type, 2011 – 2013. Numbers

Year	Adult Units	Child Units	Total
2011	9	12	21
2012	4	14	18
2013	6	8	14

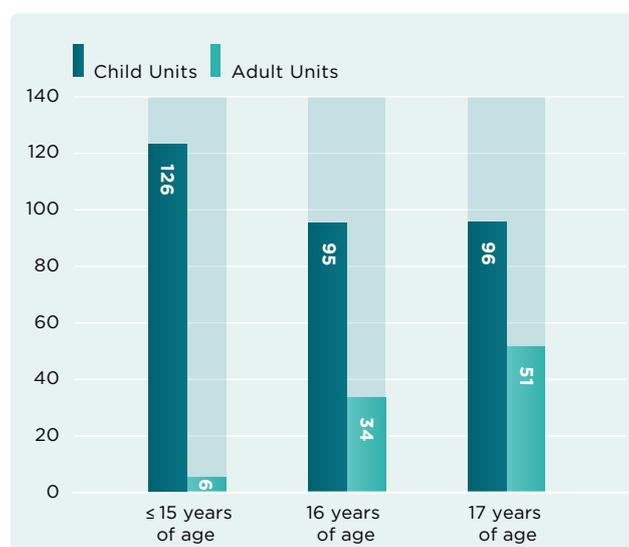
Age and Gender

In 2013, children admitted to adult units were more likely to be older than those admitted to child units. The mean age of children admitted to adult units was 16.5 years (median = 17) and the mean age of those admitted to child units was 15.6 (median = 16).

Figure 11 shows that 95% of admissions of children who were 15 years of age or younger were to child units (126/132). Almost three quarters (73.6%) of admissions of 16 year olds were to child units (95/133) and close to two thirds (65.3%) of admissions of children aged 17 were to child units.

The data show that there is then a particular difficulty for 16 and 17 year olds in accessing age appropriate mental health services.

Figure 11: Admissions of Children. Age and Unit Type. 2013. Numbers



Gender

Females accounted for the majority (63.7%) of child admissions in 2013. Of 408 total admissions, 260 concerned females. These 260 admissions related to 218 individuals. The 148 male admissions concerned 114 individuals.

Duration of admission

The mean duration of admission, for those children admitted in 2013 was 47.8 days (median = 36 days)⁷. The average length of stay was slightly longer in 2013 than in 2012 when the mean duration of admission was 40.8 days (median = 25 days).

Children admitted to child and adolescent units stayed on average much longer than children admitted to adult units. The mean length of stay of a child admitted to a child and adolescent unit was 59 days (median = 53 days) compared to an average of 10.5 days (median = 5 days) for children admitted to adult approved centres.

⁷ Length of stay figures for 2013 concern those children who were admitted in 2013 and discharged at the time of writing this report in May 2014.



Service Provider

There are five approved centres (4 HSE, 1 independent) registered with the Mental Health Commission catering specifically for children and adolescents with one child unit in each HSE area. There are six child and adolescent units in total as there are also 12 CAMHS beds in the Ginesa Unit in St. John of God Hospital Ltd, which is a registered approved centre. The total bed capacity on 31st December 2013 stood at 82 beds in six child and adolescent units.

Figure 12: Admissions of Children. Service Provider and Unit Type. 2013. Numbers



An up to date list of child and adolescent approved centres and the number of children who can be accommodated in each is available on the Commission's website at www.mhcirl.ie/registration/ACRegister

In 2013, 130 child admissions were to the two child units operated by Independent Service Providers, which accounted for 31.9% of all admissions (figure 12). No children were admitted to adult units in the independent sector.

In all HSE areas, most admissions of children in 2013 were to child and adolescent units. Of the four HSE areas, the highest number of admissions (90) was in the HSE West area, with 77.8% of admission to the Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital and 22.2% of admissions to four adult units in the region.



Children were admitted to six adult units in HSE South, four adult units in HSE Dublin North East and seven adult units in HSE Dublin Mid-Leinster.

Notes regarding child admission data

Under the terms of our Memorandum of Understanding with the Health Research Board, we cross reference our child admission data annually. If any discrepancies arise, approved centres are contacted for clarification and validation.

The number of admissions of children reported here may differ from those reported by the HRB for the following reasons:

- The HRB reports on the legal status of children on admission, whereas the Commission captures change in legal status from voluntary to involuntary throughout the period of admission and reports on such admissions once as an involuntary admission.
- The Commission's data on admissions of children only includes the admissions of children as defined in the Mental Health Act 2001. Section 2(1) states that "*child*" means a person under the age of 18 years other than a person who is or has been married. The HRB report on admissions of persons under 18 years of age irrespective of their current or previous marital status.

Notification of Deaths

Approved Centres are required to notify the Commission of the death of any resident of an approved centre in accordance with Article 14(4) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and Section 2.2 of the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting.

All sudden, unexplained deaths of persons attending a day hospital or a day centre, or living in 24 hour staffed community residences, should be notified to the Commission within 7 days of the death occurring.

In 2013, 47 approved centres notified the Commission of 156 deaths, including eight deaths where a person was recently discharged (within four weeks of the date of death) from an approved centre. Based on the information reported to us, 14.7% of notifications (23) related to sudden, unexplained deaths⁸. A breakdown of approved centre death notifications by service provider is provided in Table 8.

The Commission was notified of 105 deaths from community mental health services⁹ in 2013 (see table 8). Based on the information provided, it was not apparent in all cases that a sudden, unexplained death had occurred. For 44.8% (47/105) of these deaths, the circumstances surrounding death indicated that a physical illness was the cause of death.

All death notifications are forwarded to the Inspector of Mental Health Services in accordance with our standard operating procedures. The Inspector of Mental Health Services examines all death notifications. In cases suggestive of suicide or violent death he requests that a review is carried out by the service and a copy sent to him. These reviews are analysed to identify opportunities for improvement in patient safety, care and treatment and to form part of the ongoing dialogue between the Inspector and services.

8 A death is categorised as a 'sudden, unexplained death' by the Mental Health Commission on review of the circumstances surrounding the death, indicated by the service, on the death notification form. Where the circumstances suggest a likely suicide, missing patients, violence or any circumstance where negligence or malpractice may have been a factor the death is categorised as a sudden, unexplained death.

9 Community Mental Health Services include Day Hospitals, Day Centres, 24 Hour Staffed Community Residences and Other Mental Health Services (includes out-patient departments, resource centres, group homes, out-reach teams and other service types).



Table 8: Death Notifications. Service Provider and Service Type. 2013. Numbers

Service Provider	Approved Centres	24 Hour Staffed Community Residences	Day Centres	Day Hospitals	Other CMHS	Total
HSE Dublin Mid Leinster	25	1	3	1	1	31
HSE Dublin North East	28	8	4	3	2	45
HSE South	34	12	1	7	5	59
HSE West	22	17	9	25	6	79
St Joseph's Intellectual Disability Service	7	-	-	-	-	7
National Forensic Service	1	-	-	-	-	1
Independent Service Providers	39	-	-	-	-	39
Total	156	38	17	36	14	261

Incident Reporting

In accordance with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, approved centres also provide the Commission with six-monthly summary incident reports. These reports are made available to the Inspector to inform inspections.

Data on the Use of Electro-Convulsive Therapy (ECT), Seclusion, Mechanical Restraint and Physical Restraint

Approved Centres are required to return data on the use of ECT, seclusion, mechanical means of bodily restraint and physical restraint under the respective Rules and Codes of Practice issued in accordance with the 2001 Act. The Commission collects and reports on the above data, in annual activity reports. These reports provide a current picture of activity both within individual services and at national level and are intended to inform the quality improvement process with mental health services. The most recent reports, which relate to 2012, are available under the publication section of our website www.mhcirl.ie/Publications/.

Other Quality Improvement Initiatives

Quality Improvement in Other Mental Health Services

In 2013, the Commission introduced a new process to promote quality improvement in mental health services other than approved centres. Twenty three inspections took place of 24 hour staffed residences in 2013 where these services were assessed against the national mental health standards as set out in the Quality Framework for Mental Health Services in Ireland. Following receipt of the relevant inspection reports, the Commission requested 19 quality improvement plans to address standards in the quality framework that services were not currently meeting and also to address any recommendations that the Inspector of Mental Health Services had made. Services were requested to outline actions being taken or planned, timeframes for completion, and persons responsible for implementation of quality improvement plans.



Seclusion and Restraint Reduction Strategy

The Commission has been progressing work on the development of the Seclusion and Restraint Reduction Strategy. During 2013, a decision was taken to carry out an international review of the strategy. This review is being co-ordinated by Mr Kevin Mc Kenna, Programme Director at the School of Nursing in Dundalk Institute of Technology. A detailed work plan has been developed to progress the strategy.

Lesbian, Gay, Bisexual and Transgender (LGBT) Service Users

The Commission worked collaboratively with the Gay and Lesbian Equality Network (GLEN) in 2012 to develop a guidance document for staff working in mental health services on issues affecting LGBT service users. The need for this guidance arose from Irish research that identified increased mental health risk among LGBT people, and younger people in particular. It also arose out of the need to increase awareness amongst health professionals of mental health problems amongst LGBT persons. This document was launched in Trinity College Dublin in June 2013 as part of Gay Pride week and was widely circulated by the Commission across mental health services.



Independent Review System Mental Health Tribunals

Mental Health Tribunals and Legal Aid Scheme

Procedures for Involuntary Admission (Adults)

The 2001 Act introduced provisions for a system of free legal representation for adults and independent reviews during their episode of involuntary admission¹⁰. This independent review is performed by a mental health tribunal during each period of detention. This section of the report provides analysis of 2013 involuntary admissions and their review by mental health tribunals, and comparisons with previous years.

The 2001 Act has provisions for two methods of initiating detention; an Admission Order, (Form 6) and a Certificate & Admission Order to detain a Voluntary Patient (Adult), (Form 13). A person may be admitted to an approved centre and detained there solely on the grounds that he or she is suffering from a mental disorder as defined in the Act.

Involuntary Admission (Adults) 2013

Analysis was completed on the number of adults who were involuntarily admitted using the provisions of Sections 9, 10, and 14 of the Act in 2013. In such admissions the admission order is made by a consultant psychiatrist on statutory Form 6 Admission Order, which must be accompanied by an application (Form 1,2,3, or 4) and a recommendation by a registered medical practitioner (Form 5). There were 1591 Form 6 Admission Orders notified to the Commission in 2013.

Re-grading of a Voluntary Patient (2013)

Section 24 of the Mental Health Act 2001 outlines the procedures relating to a decision to re-grade a voluntary patient to involuntary status. In such situations an admission order is made on statutory Form 13 Certificate & Admission Order to Detain a Voluntary Patient (Adult), signed by two consultant psychiatrists. There were 541 such re-gradings from voluntary to involuntary status, notified to the Commission in 2013.

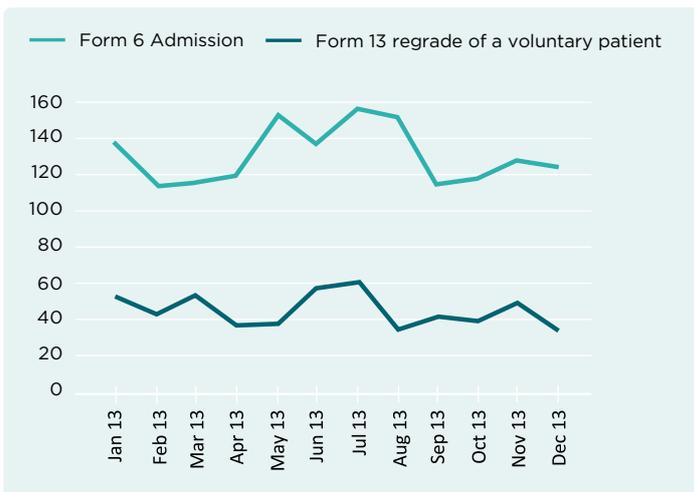
¹⁰ An episode is a patient's unbroken period of involuntary admission



Comparisons 2009 - 2013

Figure 13 summarises on a monthly basis the categories of involuntary admission for 2013, i.e. Form 6 Admission Orders, and Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult). The number of Form 6 orders fall within a range from 116 to 159 per month, and the number of Form 13 orders fall within a range from 34 to 60 per month.

Figure 13 Monthly Involuntary Admissions 2013



Comparison was made of 2013 involuntary admission activity with that for the four previous years. Figure 14 summarises these comparisons on an annual basis and shows a decrease of 4% from 2009 to 2010, an increase of 5% from 2010 to 2011, an increase of 4% from 2011 to 2012 and no change from 2012 to 2013.

A total of 46 patients had three or more involuntary admissions in 2013.

Figure 14 Comparisons of Total Involuntary Admissions 2009 - 2013

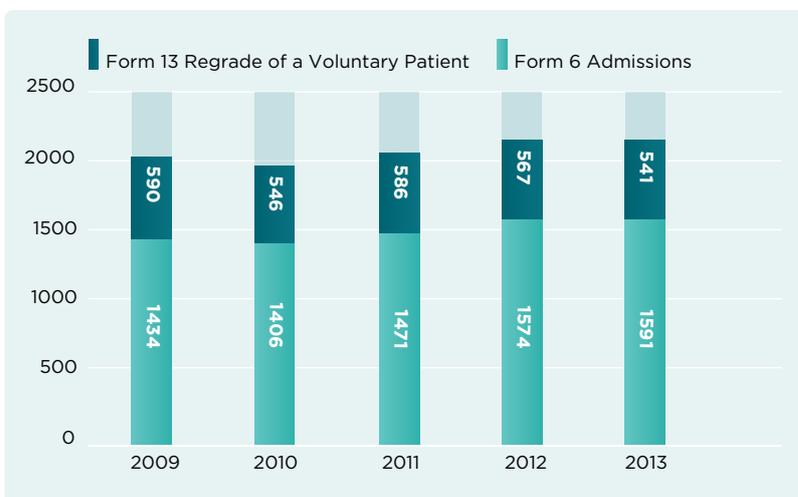




Table 9 provides further analysis of involuntary admission numbers for 2013 by HSE region and independent sector, with rates per 100,000 of total population.

Table 9 Involuntary Admission Numbers for 2013 (ADULT) by HSE Region and Independent Sector

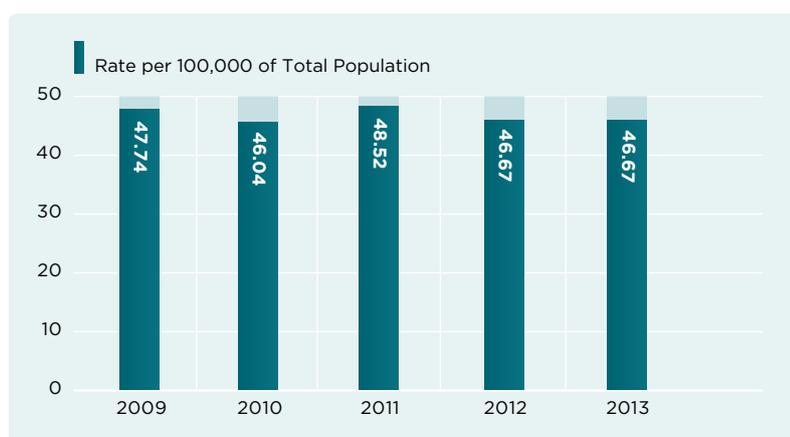
	Form 6	Form 13	Total Involuntary Admissions	Population ^A	Involuntary Admission Rate per 100,000 total population
HSE West	387	120	507	1,084,304	46.76
HSE South	364	99	463	1,133,858	40.83
HSE Dublin North East	374	141	515	1,018,535	50.56
Total HSE Dublin Mid Leinster	365	103	468	1,351,555	34.63
Independent Sector	101	78	179	N/A	N/A
Total (Exclusive of Independent Sector)	1490	463	1,953	4,588,252	42.57
Total (Inclusive of Independent Sector)	1,591	541	2,132	4,588,252	46.47

^A Population figures taken from CSO census 2011.

Detailed analysis of involuntary admission rates for 2013 by Approved Centre is provided on the Mental Health Commission web-site www.mhcirl.ie.

Analysis of Ireland's involuntary admission rates per 100,000 of total population, including involuntary admissions to independent sector approved centres, is shown in Figure 15 for the years 2009 to 2013.

Figure 15 Ireland's Involuntary Admission Rates per 100,000 of total population ^B for the years 2009 to 2013



^B Population figures taken from CSO census 2011.



Figure 16 further analyses involuntary admission rates per 100,000 of population for the years 2009 to 2013 by HSE Region.

Figure 16 Involuntary Admission Rates per 100,000 of population for the years 2009 to 2013 by HSE Region



Age and Gender

Analysis of age and gender was completed on the figures for episodes of involuntary admission in 2013. Tables 10 and 11 summarise these findings.

Table 10 Analysis By Age - Involuntary Admissions 2013 (Adults)

Age	Form 6	Form 13	Total	%
18 - 24	163	87	250	12%
25 - 34	321	119	440	21%
35 - 44	340	129	469	22%
45 - 54	263	83	346	16%
55 - 64	224	56	280	13%
65 and over	280	67	347	16%
Total	1,591	541	2,132	100%

Table 11 Analysis By Gender - Involuntary Admissions 2013 (Adults)

Gender	Form 6	Form 13	Total	%
Female	688	289	977	46%
Male	903	252	1155	54%
Total	1,591	541	2,132	100%

Type of Applicant

Analysis was undertaken of the categories of persons who applied for a person to be involuntarily admitted under Section 9 of the Act in 2013. Table 12 summarises this analysis.

Table 12 Analysis Of Applicant: Involuntary Admissions 2013 (Adults)

Form	Type	Total	%
1	Spouse, Civil Partner, Relative	900	57%
2	Authorised Officer	121	8%
3	Garda Síochána	311	19%
4	Any Other Person	259	16%
	Total	1,591	100%

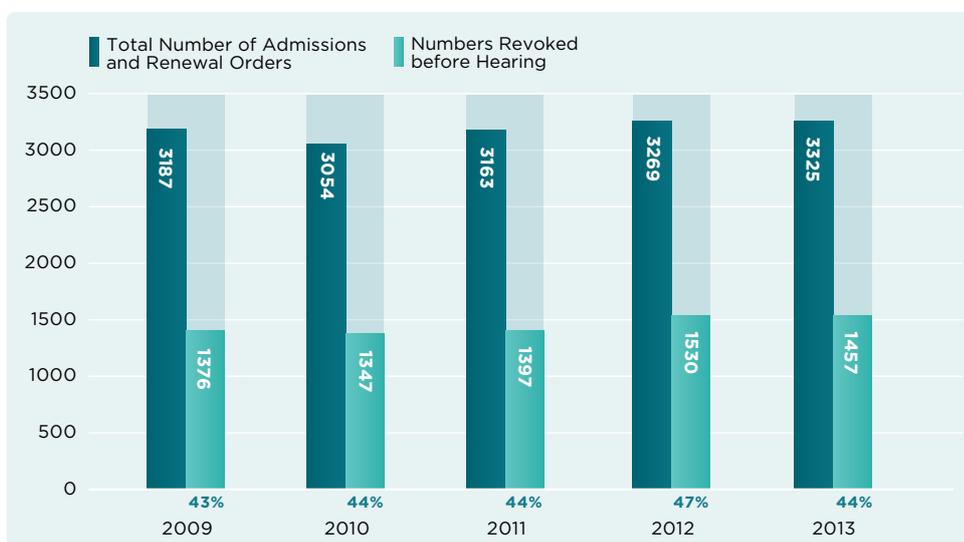
Comparison of the 2012 figures for type of applicant with the 2013 figures shows the number of applicants by spouse/relative and authorised officer has remained the same, Garda Síochána has decreased from 22% to 19% and any other person has risen from 13% to 16%.

An authorised officer is an officer of the HSE who is of a prescribed rank or grade and who is authorised to exercise the powers conferred on authorised officers by Section 9 of the Act.

Revocation by Responsible Consultant Psychiatrist

Section 28 provides that the consultant psychiatrist responsible for the patient shall revoke an order where he or she becomes of the opinion that the patient is no longer suffering from a mental disorder as defined in the Act. Where the responsible consultant psychiatrist discharges a patient under Section 28 he or she must give to the patient concerned, and his or her legal representative, notice to this effect (statutory Form 14, Revocation of an Involuntary Admission or Renewal Order). Analysis of orders revoked by the responsible consultant psychiatrist under the provisions of Section 28 shows that there were 1,457 such instances in 2013. The patient may leave the centre at this stage or stay to receive treatment on a voluntary basis. Figure 17 shows the number of orders revoked before hearing by responsible consultant psychiatrists under the provisions of Section 28 for the years 2009 to 2013.

Figure 17 Number of Orders Revoked before Hearing by Responsible Consultant Psychiatrists under the Provisions of Section 28 for the years 2009 to 2013

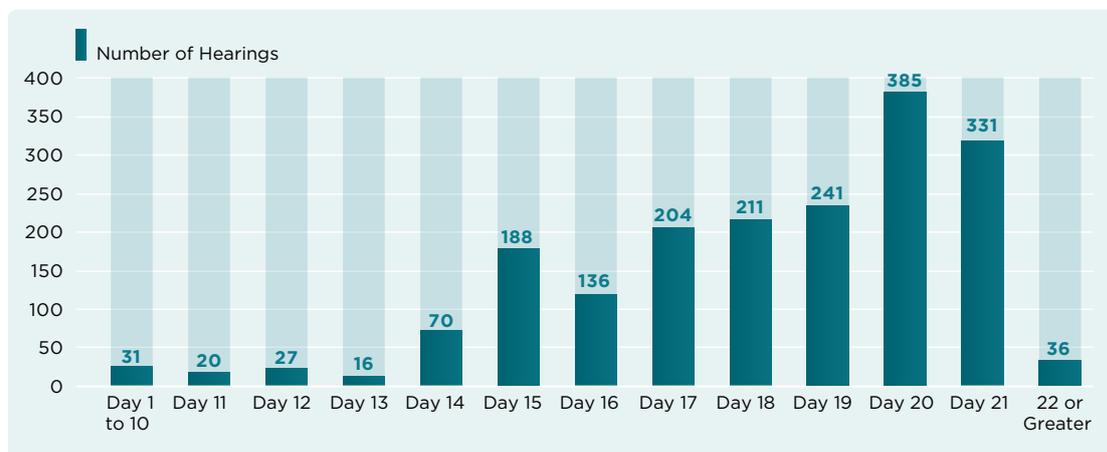




Independent Review by a Mental Health Tribunal

The Mental Health Act 2001 provides for the patients' right to an automatic independent review of an involuntary admission. Within 21 days of an admission (or renewal) order, a three person mental health tribunal consisting of a lawyer as chair, a consultant psychiatrist and another person review the admission (or renewal) order. Prior to the independent review, a legal representative is appointed by the Mental Health Commission for each person admitted involuntarily (unless s/he proposes to engage one privately). An independent medical examination by a consultant psychiatrist, also appointed by the Commission, will also have been completed. There were 1,896 hearings in 2013. Hearings were monitored by the Commission as to when in the 21 day period of the order the mental health tribunal occurred. Figure 18 shows the breakdown of hearings over the 21 day period of the relevant order. It is important to note that hearings that took place on Day 22 or greater were in relation to orders extended by tribunal or orders that were revoked and a hearing subsequently took place at the request of the patient (Section 28, Mental Health Act 2001).

Figure 18 Breakdown of Hearings over 21 day Period 2013

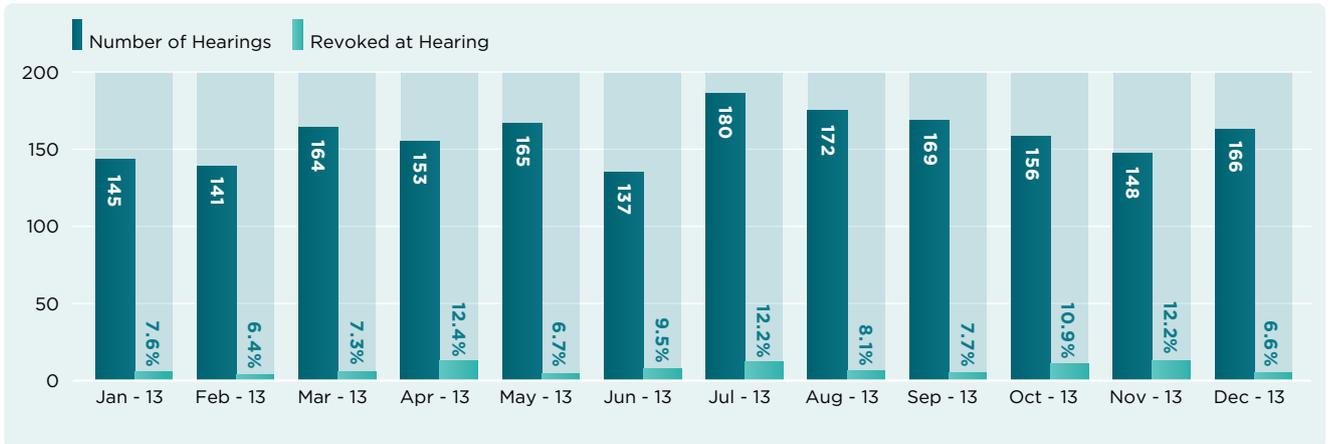


Orders Revoked at Hearing

Analysis was undertaken of the number of orders revoked at a mental health tribunal in 2013. Figure 19 shows the number of hearings on a month by month basis for 2013 and the percentage (%) of orders revoked in each month. In total, 9% of orders reviewed by mental health tribunals in 2013 were revoked. This shows a 1% increase in comparison with the percentage of orders revoked at hearing in 2012.



Figure 19 Number of Hearings and % of Orders Revoked at Hearing 2013



Cases Brought Before the Courts

Appeals Pursuant to Section 19 of the Mental Health Act, 2001

Section 19 (1) of the Mental Health Act, 2001 provides:

“A patient may appeal to the Circuit Court against a decision of a tribunal to affirm an order made in respect of him or her on the grounds that he or she is not suffering from a mental disorder.”

Section 19(16) of the Act provides:

“No appeal shall lie against an order of the Circuit Court under this section other than an appeal on a point of law to the High Court”.

The Commission was notified of 121 Circuit Court appeals in the period from 1 January to 31 December 2013. Of that number, 21 (17%) of appeals proceeded to full hearing. There was also one appeal brought from the Circuit Court to the High Court on a point of law which also proceeded to full hearing.

The Commission notes a steady increase in the number of Circuit Court appeals being brought on behalf of patients since Part II of the Act was commenced on the 1st of November 2006. 48 appeals were brought in 2008, 46 were brought in 2009, 67 were brought in 2010, 87 were brought in 2011 and 116 appeals were brought in 2012.

Prior to 2014, in every appeal which proceeded to full hearing, the Circuit Court upheld the order detaining the patient. In many cases, the patient does not have independent evidence that they are not suffering from a mental disorder. Thus, the expert evidence of the consultant psychiatrist responsible for the patient, while subject to cross-examination, is uncontested by an opposing expert.

In compliance with S.I. 11/2007, Circuit Court Rules (Mental Health) 2007 the Mental Health Tribunal is the respondent to these appeals notwithstanding that the ‘order’ which is under appeal is the order of the responsible consultant psychiatrist detaining the patient. The High Court has held on a number of occasions that the question to be determined by the Circuit Court is whether the patient “is” suffering from a mental disorder on the date of the hearing. *In DH v. The President of the Circuit Court and Others*¹¹ Mr. Justice Charlton stated at paragraph 19:

“The legislative purpose behind section 19 of the Mental Health Act, 2001, is to allow those patients who are still detained, following a hearing before a Mental Health Tribunal, to have the condition of their mental health reviewed before a Judge of the Circuit Court. It is not to engage in an historical analysis. Whether there would be a point, or would not be a point, to such an historical analysis is irrelevant given the express wording of the section.



I am obliged to give grammatical and ordinary sense to the use of the present tense in s. 19, and to the choice given to the Circuit Court of either affirming an admission or renewal order, or revoking it.”

This approach was recently confirmed by the High Court in *E.G. v. Mental Health Tribunal and Others*¹². As such, the reasoning and conclusions of the Mental Health Tribunal are irrelevant to determining the appeal. The patient and the responsible consultant psychiatrist together with the approved centre are the interested parties.

The Commission’s legal aid scheme is available to patients wishing to bring appeals under section 19, irrespective of whether those appeals are likely to be successful. The Commission is also liable for the costs of defending such appeals on behalf of the Mental Health Tribunals. Heretofore, the Commission has always granted legal aid to a patient wishing to bring an appeal under section 19. The Commission considers this approach to be in line with its function of protecting “*the interests of persons detained in approved centres under this Act*”¹³.

Training for Mental Health Tribunal Members

The delivery of training programmes for Tribunal Panel Members and Independent Medical Examiners commenced on 21 October 2013. Three programmes were developed, prepared and delivered:

- a. Induction programme for new Tribunal Panel Members.
- b. Refresher programme for Tribunal Panel Members who had a contract for services during the period 01/11/2010 – 31/10/2013.
- c. Induction programme for Independent Medical Examiners.

Aim of the Training Programme for Tribunal Panel Members:

- To provide Chairpersons, Consultant Psychiatrists and Lay Members with knowledge and skills to fulfil the role of a Mental Health Tribunal Panel Member as per the 2001 Act.
- To apply and operate the relevant sections of the Mental Health Acts in their role as Members sitting on a Mental Health Tribunal.
- To identify relevant case law and apply this to the operation of the Mental Health Acts.
- To interpret and apply relevant Data Protection and Freedom of Information legislation as applicable to Mental Health Tribunals.
- To develop an awareness of the Assisted Decision Making (Capacity) Bill 2013.

¹² Unreported High Court (O’Neill J.), 20 December 2013

¹³ Section 33(1) of the Mental Health Act, 2001

Aim of the training programme for Independent Medical Examiners:

- › To apply and operate the relevant sections of the Mental Health Acts in their role as Independent Medical Examiners.
- › To interpret and apply relevant Data Protection and Freedom of Information legislation as applicable to independent medical examinations.

Type of Training	Panel Members	No of Delegates
Induction Training (2 days duration) x 2	Chairpersons	27
	Consultant Psychiatrists	25
	Lay Members	37
	Total No of Attendees	89
Refresher Programme (2½ days duration) x 2	Chairpersons	59
	Consultant Psychiatrists	74
	Lay Members	43
	Total No of Attendees	176
Induction Programme Independent Medical Examiners (½ day duration) x 1	Consultant Psychiatrists	59
	Total Trained	324

Tribunal Panel Members and Independent Medical Examiners who were not in a position to attend the training programme delivered in October 2013 attended their training session on the 7th February 2014. The training for all members is now complete.

Course Evaluation

All programmes were evaluated at the end of each programme delivered by means of completing an evaluation form. Overall delegates were satisfied with the training programmes and agreed that the objectives were met from both a theoretical and practical perspective. The data produced from the evaluation also provides a basis for making decisions about further programme developments and revisions in the current programmes.

Training for Stakeholders

The Training and Development Division in conjunction with the College of Psychiatrists of Ireland jointly presented a Continuing Professional Development course on Mental Health Tribunal skills to Responsible Consultant Psychiatrists on 14th June 2013. The aim of this programme was to equip Consultant Psychiatrists who are responsible for detained persons with the skills required to perform competently at Mental Health Tribunals as per the Mental Health Acts 2001 & 2009.

The Training and Development Division worked in collaboration with key stakeholders in planning and delivering training programmes relevant to the Mental Health Commission throughout 2013.



External Environment & MHC Collaboration

External Environment and MHC Collaboration

Close collaboration with key stakeholders is key to the work of the Commission and important for the realisation of our statutory functions and engagement on issues in the wider health domain. In furtherance of this objective, we participate in working groups, make policy submissions and support key goals such as reducing the stigma and discrimination experienced by people with mental illness. Information on working groups and other collaborations during 2013 are detailed below.

Review of Mental Health Act 2001

In August 2012 the Chief Executive of the Commission was appointed as a member of the Expert Group by Ms. Kathleen Lynch TD, Minister for Disability, Older People, Equality & Mental Health. During 2013 the work of the Expert Group has progressed and it is planned that the Group's final Report will be presented to the Minister in mid 2014.

The Group's Terms of Reference are:

1. To examine each of the recommendations of the Interim Report on the review of the Mental Health Act 2001, and
 - propose which recommendations can be agreed without further assessment or modification,
 - establish which recommendations require further analysis before being finalised and reach conclusions in respect of the issues concerned,
 - make decisions on those areas where the Steering Group had offered choices rather than specific recommendations.
2. To consider Departmental proposals for amending the Mental Health Act which pre-dated the Steering Group report and recommend a course of action in respect of those matters.
3. To examine any further specific issues which may be referred to the Expert Group by the Minister.

4. To ensure that the recommendations of the Expert Group take account of any Capacity legislation published in the meantime and be consistent with such legislation and existing criminal law insanity legislation, which is also under review at this time.
5. To conclude its deliberations and submit final report to the Minister by end March 2013.

Assisted Decision Making (Capacity) Bill 2013

The Mental Health Commission welcomed the publication of the Assisted Decision Making (Capacity) Bill 2013 by the Minister for Justice and Equality in July 2013.

The provisions of the Bill, when enacted will change the existing law on capacity, shifting it from the current all or nothing status approach to a flexible functional one whereby capacity is assessed on an issue and time specific basis. During the latter part of 2013 the work programme of the Commission's legislation committee included the development of a submission to the Department of Justice and Equality for completion in quarter one 2014. A copy of the submission is available on the Commission's website at www.mhcirl.ie

A Vision for Change

Ireland's national mental health policy 'A Vision for Change' published in 2006 set out a ten year plan to shift the delivery of mental health services from an institutional model of care to a comprehensive community based service. The slow progress on the implementation of the policy has been highlighted by the Commission over the past number of years. Notwithstanding this, during 2013 the Commission took the opportunity to welcome a number of positive developments, namely:

- › The advertising and subsequent filling of the post of a National Director of Mental Health Services.
- › The retention of the mental health budget for 2012 in a difficult economic environment.
- › The Government commitment to the same level of spending in budget 2013 in addition to the €35 million which was not spent during 2012.

- › The continued roll-out of innovate youth friendly services and other mental health care services being developed through partnerships between the statutory, voluntary and philanthropic sector.

EPSO (European Partnership for Supervisory Organisations)

EPSO's aims are (i) to improve the quality of health care and social care in Europe, (ii) to connect between supervisory organisations and their individual members to improve the exchange of ideas, outcome of research, information and good practice and (iii) to promote co-operation on topics such as education and dissemination of knowledge. The Director Standards and Quality Assurance (Interim) was an invited speaker to address delegates and participate in a Working Group addressing the area of restrictive practices in health care.

The European Union Network for Patient Safety and Quality of Care (PaSQ)

The European Union Network for Patient Safety and Quality of Care (PaSQ) is co-funded and supported by the European Commission within the Public Health Programme. Its purpose is to promote the organisation of patient safety and quality of care platforms in all European Member States. The general objective of PaSQ is to contribute to patient safety and good quality of care by sharing knowledge, experience and good practices with each other, the Commission and relevant European and international bodies, as well as examining transferability of these practices.

Ireland's primary involvement in PaSQ is through Work Package 6: EU Collaboration for Healthcare Quality Management Systems. This package involves mapping and exchanging good organisational practice, focusing on the system level, including patient safety and patient involvement.

Ireland was invited to submit projects and the MHC submitted the National Mental Health Services Collaborative (NMHSC) as an example of good organisational practice for consideration to be included in the exchange mechanism.



The MHC submission was deemed eligible for inclusion as an option for selection by member countries in the exchange mechanism for 2014 under the Heading Professional Learning Programme on Quality and Safety.

See Change

See Change is an alliance of organisations working together through the National Stigma Reduction Partnership to bring about positive change in public attitudes and behavior towards people with mental health problems.

See Change was established to ensure a cohesive overarching approach to stigma reduction in relation to mental ill health and a partnership approach is central to the See Change ethos.

During 2013 the Mental Health Commission continued to be a 'partner organisation' with 'See Change'.

The See Change campaign is based on five pillars; community and grassroots; in the workplace; partner activity; and public engagement.

The aims and objectives of the See Change programme continue to be:

1. The creation of an environment where people can be more open and positive in their attitudes and behaviour towards mental health.
2. Promotion of greater understanding and acceptance of people with mental health problems.
3. The creation of a greater understanding and knowledge of mental health problems and of health services that provide support for mental health problems.
4. Reduction of stigma associated with mental health problems and challenge discrimination.

For further information on the See Change programme, visit www.seechange.ie

National Patient Safety Advisory Group

Established in 2011, the National Patient Safety Advisory Group (NPSAG) facilitates the process of continuing to drive the patient safety agenda forward at national level and to provide for continuity of high level engagement of the stakeholders that worked together on the implementation of the Patient Safety Commission's Report and the launch of the Patient Safety First Initiative.

The Commission's Chief Executive was appointed as a member of this group by Dr. James Reilly, T.D, Minister for Health and continued to contribute to the group's work programme during 2013.

The Terms of Reference of the NPSAG are as follows:

1. To support the Minister and the Department in providing national leadership on patient safety and quality.
2. To advise on the development of policy in the area of patient safety and quality as requested by the Minister.
3. To provide a forum for dialogue and discussion of important patient safety issues at national level as requested by the Minister from time to time.
4. To provide a national forum for the discussion and sharing of members' experiences, concerns and learning in relation to patient safety.
5. To advise the Minister and the Department and service providers of any new or emerging patient safety issues that come to its attention.
6. To advise on high level patient safety indicators for adoption at national level and comment on their implementation.
7. To act as trustees for the 'Patient Safety First' brand through ongoing advice and oversight in relation to website content and activities undertaken under this heading.
8. To oversee the implementation of the recommendations of the Commission on Patient Safety and Quality Assurance.

For further information you can refer to www.patientsafetyfirst.ie



National Clinical Effectiveness Committee

The Chief Executive of the Commission was appointed as a member of the National Clinical Effectiveness Committee by Dr. James Reilly, T.D. Minister for Health in 2010 and continued to contribute to the groups work programme during 2013. The Chief Executive attended 3 of the 4 scheduled Committee meetings in 2013.

The aim of the committee is to provide a framework for national endorsement of clinical guidelines and audit to optimise patient care, within the Irish health system, both public and private.

The Terms of Reference of the NCEC are as follows:

- › Apply criteria for the prioritisation of clinical guidelines and audit for the Irish health system.
- › Apply criteria for quality assurance of clinical guidelines and audit for the Irish health system.
- › Disseminate a template on how a clinical guideline and audit should be structured, how audit will be linked to the clinical guideline and how and with what methodology it should be pursued.
- › Recommend clinical guidelines and national audit, which have been quality assured against these criteria, for Ministerial endorsement within the Irish health system.
- › Facilitate with other agencies the dissemination of endorsed clinical guidelines and audit outcomes to front-line staff and to the public in an appropriate format.
- › Report periodically on the implementation of endorsed clinical guidelines.

For further information you can refer to www.patientsafetyfirst.ie

Health, Social Care and Regulatory Forum

The Chief Executive of the Mental Health Commission is a Member of the Health, Social Care and Regulatory Forum. Through the Chief Executive the Commission continued to contribute to the work of the Forum during 2013.

The Terms of Reference of the Forum are:

1. To enhance the overall practice by sharing knowledge and experience of Health, personal social services and regulation in Ireland.
2. Explore opportunities to harmonise certain business processes, share best practice and facilitate coordination where appropriate.
3. Act as a steering group for specific work projects agreed by the forum.
4. Provide advice on legislation to address anomalies or gaps as required.

Medication Safety Forum

The Mental Health Commission continues to be one of the stakeholders of the Medication Safety Forum which was established in 2008. The main aim of the Forum is to develop initiatives that will improve the safety of medication prescribing, dispensing and administration and improve the safe use of medicines in all hospital, community and home settings.



Our Key Enablers

Key Enablers

Good Governance: We continue to demonstrate good governance by reviewing and assessing internal systems, policies and processes to ensure they are effective and of high quality.

Expenditure

The non-capital allocation to the Mental Health Commission for 2013 was €14,406 million. The outturn for 2013 in the Mental Health Commission was €12.430 million.

Key areas of expenditure included Statutory Functions i.e. Mental Health Tribunals, Legal Aid Scheme, Inspections, staff salaries, legal fees, office rental, ICT technical support and development and research projects. Third party support contracts continue to be managed to ensure value for money and service delivery targets.

The accounts for 2013 have been submitted to the Comptroller and Auditor General as per Section 47 of the Mental Health Act 2001. The annual audited financial statements of the Mental Health Commission will be published on the Mental Health Commission's website at www.mhcirl.ie as soon as they are available.

Audit Committee

The Mental Health Commission Audit Committee met on four occasions in 2013 to conduct its business. Issues addressed by the Audit Committee included reviews of the Financial Statements for 2012, Budget 2013, Risk Register, Rolling Budget Reports 2013 and the Fraud Policy Overview. In addition the Committee also received and reviewed the Report of the Internal Financial Controls and the Audit Committee Quarterly Reports along with reports pertaining to Prompt Payment of Account Legislation. Other matters considered by the Committee included the Mental Health Commission ICT security review and terms of reference of the Mental Health Commission Audit Committee.

Prompt Payment of Account Legislation

The Commission complied with the requirement of the Prompt Payment of Account legislation and paid 97.3% of valid invoices within 15 days of receipt. In order to meet this target, strict internal timelines are in place for the approving of invoices. Details of the payment timelines are published on the Commission's website.

Freedom of Information

During 2013 the Mental Health Commission received thirty requests under the Freedom of Information Acts (1997 and 2003). Of these twenty were granted, seven were part-granted, two requests were refused and one was withdrawn.

Data Protection

One request for information was received in 2013 under the Data Protection Act and this request was granted.

Health and Safety

The Commission is committed to ensuring the well-being of its employees by maintaining a safe place of work and by complying with relevant employment legislation including Safety, Health and Welfare at work Act, 2005 and the Safety, Health and Welfare at Work (General Application) Regulations, 2007.

Energy Efficiency Plan 2009 - 2020

Under the National Energy Efficiency Plan 2009-2020 the Public Sector has been challenged to reach verifiable energy-efficiency savings of 33%. This target requires management commitment at the highest level and the involvement of all public sector employees. As part of this process the Mental Health Commission is required to complete an energy scorecard. The required data is due for submission to the Sustainable Energy Authority of Ireland (SEAI) in May 2014.

Information and ICT: We will publish and disseminate information online and in other formats that related to the work of the Commission. We will also maximize the use of information communications technology (ICT) to enhance our work and practices.

During 2013 the Commission had discussions with the Local Government Management Agency (LGMA) regarding the on-line payment system used by local authorities. This was with a view to using the system for Mental Health Tribunal Panel Member payments. The successful outcome of the discussions will lead to an enhanced MHC system in 2014 and also is supportive of the Commission's commitment to collaboration between Government agencies.

The Secure Messaging System's use was extended to 62 Approved Centres in 2013.

Developing our People: We will develop our people in the Commission so that they feel valued, motivated and are equipped with the necessary skills to deliver on our strategic priorities.

In line with our Strategic Plan the Commission continued to support staff and ensure maximum staff engagement; by maintaining a programme for staff training and development in order to encourage learning and professional development for all staff.

Working in Partnership: We will continue to collaborate and communicate effectively with our stakeholders (service users, families, carers, service providers and general public) and identify any new stakeholders to include in our work.

The Mental Health Commission collaborated with key stakeholders during 2013 while developing our Strategic Plan for 2013 - 2015. The feedback and input received was most welcome and the Commission was especially grateful for the time and effort our stakeholders made in contributing to the process.

Evidence-Informed Practice: We will use available international and national evidence and research to underpin all of our regulatory practices and oversight activities.



Research Projects

During 2013 the Commission provided funding for the following Research Programmes.

A project is funded under the Commission's former Research Programme Grant Scheme. Professor Colm McDonald is the Lead Applicant for this project with University College Galway being the Host Institution. Professor McDonald's project title is:

A prospective evaluation of the operation and effects of the Mental Health Act 2001 from the viewpoints of service users and health professionals

2013 represented the third year of this four year project.

Work also continued to progress in 2013 pertaining to a collaboration between the Mental Health Commission and the Royal College of Surgeons in Ireland in a joint PhD Research Programme.

Two Clinical Research Scientists Dr. Selena Pillay and Mr. Stephen Shannon undertook year two of this three year project in 2013. The project title is:

An analysis of the use of ECT and Seclusion in Clinical Mental Health Practice in Ireland

A clinical trial of supported employment (SE) and the Workplace Fundamentals Module (WFM) with people diagnosed with schizophrenia spectrum disorders was funded by the Commission from 2011 - 2013. The final report will be made available to the Commission in 2014.

The Academic Host Institution for the above project is University College, Dublin.



Additional Information

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Report of the Inspector of Mental Health Services 2013





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The following 2013 Reports of the Inspector of Mental Health Services are available on the Commission's website at www.mhcirl.ie. A CD of the Commission's Annual Report 2013 and the Report of the Inspector of Mental Health Services are also available from the Commission.

HSE Dublin Mid-Leinster

- › Acute Psychiatric Unit, AMNCH, Tallaght
- › Central Mental Hospital
- › Department of Psychiatry, Midland, Regional Hospital, Portlaoise
- › Elm Mount Unit, St. Vincent's University Hospital
- › Jonathan Swift Clinic, St. James's Hospital
- › Lakeview Unit, Naas General Hospital
- › Newcastle Hospital
- › St Bridget's Ward & St Marie Goretti's Ward, Cluain Lir Care Centre
- › St. Fintan's Hospital
- › St. Loman's Hospital, Mullingar

HSE Dublin North East

- › Acute Psychiatric Unit, Cavan General Hospital
- › Blackwater House and Ward 15, St. Davnet's Hospital, Monaghan
- › Department of Psychiatry, Connolly Hospital
- › Department of Psychiatry, Our Lady's Hospital, Navan
- › Hawthorn Unit, Connolly Hospital
- › Joyce Rooms, Fairview Community Unit, Griffith Court, Philipsburgh
- › O'Casey Wing, St. Vincent's Hospital, Fairview
- › Phoenix Care Centre

- › St. Aloysius Ward, Mater Misericordiae University Hospital
- › St. Brigid's Hospital, Ardee, (Unit One and St. Ita's Ward)
- › St. Ita's Hospital - Mental Health Services
- › St. Joseph's Intellectual Disability Services
- › St. Vincent's Hospital, Fairview
- › Sycamore Unit, Connolly Hospital

HSE South

- › Acute Mental Health Admission Unit, Kerry General Hospital
- › Carraig Mór Centre
- › Centre for Mental Health Care and Recovery, Bantry General Hospital
- › Department of Psychiatry, St. Luke's Hospital, Kilkenny
- › Department of Psychiatry, Waterford Regional Hospital
- › Heywood Lodge, Heywood Road, Clonmel
- › O'Connor Unit, St Finan's Hospital
- › South Lee Adult Mental Health Unit, Cork University Hospital
- › St. Finbarr's Hospital
- › St. Gabriel's Ward, St. Canice's Hospital
- › St. Michael's Unit, Mercy Hospital Cork
- › St. Otteran's Hospital
- › Selskar House
- › St. Stephen's Hospital

HSE West

- › Acute Psychiatric Unit 5B, University Hospital, Limerick
- › Acute Psychiatric Unit, University Hospital, Ennis
- › Adult Mental Health Unit, Mayo General Hospital
- › An Coillín
- › Cappahard Lodge
- › Department of Psychiatry, County Hospital Roscommon
- › Department of Psychiatry, Letterkenny General Hospital
- › Department of Psychiatry, University Hospital Galway
- › Sligo/Leitrim Mental Health In-patient Unit
- › St Anne's Unit, Sacred Heart Hospital, Castlebar
- › St. Brigid's Hospital, Ballinasloe
- › St. Joseph's Hospital, Limerick
- › Teach Aisling, Castlebar
- › Tearmann Ward, St. Camillus' Hospital

Independent Service

- › Bloomfield Care Centre - Donnybrook, Kylemore, Owendoher & Swanbrook Wings
- › Highfeld Hospital
- › Lois Bridges
- › St. Edmundsbury Hospital
- › St. John of God Hospital Limited
- › St. Patrick's University Hospital

Child and Adolescent Services

- › Adolescent In-patient Unit, St. Vincent's Hospital
- › Child and Adolescent Mental Health Unit, Merlin Park University Hospital
- › Eist Linn Child and Adolescent Mental Health Inpatient Services
- › Linn Dara Child & Adolescent In-patient Unit, St Loman's Hospital, Palmerstown
- › Willow Grove Adolescent Unit, St. Patrick's University Hospital

24 Hour Nurse Staffed Community Residences

- › Alacantha, Kilkenny
- › Carrigabrick Lodge, Cork
- › Cois Alla Kanturk, Cork
- › Cois Mara, Spanish Point
- › Courtview Hostel, Carlow
- › Cypress Lodge, Sligo
- › Elm Park, Carlow
- › Garryshane, South Tipperary
- › Glenmalure, Cork
- › Grove House, Gort
- › Hillcrest, Longford
- › Kelvin Court, Carlow
- › Kincora, Kilkenny
- › Linden House, Sligo
- › Lorica, South Tipperary
- › O'Connell House, Limerick

- › Park Lodge, Carlow
- › Rath na Riogh, Meath
- › Sacred Heart Hostel, Carlow
- › Sycamore, Clifden
- › Tithe na gCarad, Roscommon
- › Toghermore, East Galway
- › Writers Grove, Kerry

National Overview Meetings

- › HSE National Director Mental Health
- › Executive Clinical Directors
- › Service User, Family/Carer and Advocacy Group Involvement in mental health Services
- › Directors of Nursing

Catchment Area Meetings

- › Laois/Offaly
- › Waterford
- › Longford/Westmeath
- › Roscommon
- › South County Dublin
- › Limerick, Clare and North Tipperary
- › Sligo
- › North Cork
- › South Cork
- › North Dublin
- › Kilkenny

Themed Reports

- › 19th Century Public Psychiatric Hospitals due for closure - Table 2013
- › A Review of 24 Hour Supervised Community Residences 2009 - 2013
- › Complaints in Approved Centres 2013
- › Child and Adolescent Mental Health Services 2013 - Admissions of Children to Adult Units
- › Compliance with Article 15, Mental Health Act 2001 (Approved Centres) Regulations 2006 - in 2013 (see appendix 1)
- › Audit of Risk Assessment in Approved Centres 2013



National Review of Mental Health Services 2013

Mental Health Act, 2001, Section 51 (b):

The principal functions of the Inspector shall be:

In each year, after the year in which the commencement of this section falls, to carry out a review of mental health services in the state and to furnish a report in writing to the Commission (The Mental Health Commission) on:

- (i) the quality of care and treatment given to persons in receipt of mental health services,
- (ii) what he or she has ascertained pursuant to any inspections carried out by him or her of approved centres or other premises where mental health services are being provided,
- (iii) the degree and extent of compliance by approved centres with any code of practice prepared by the Commission under section 33(3)(e), and
- (iv) such other matters as he or she considers appropriate to report on arising from his or her review.

1. Introduction

Nowhere in the body of Irish mental health law are the basic underpinning principles and values of a modern mental health service more encapsulated than in the definition of an Individual Care Plan (ICP). The elements of an ICP are especially congruent with the principles of *A Vision for Change 2006*.

In the assessment of Ireland's mental health services in terms of principles, philosophy, attitude and approach, no measure is more appropriate than that of compliance with the requirement that each patient should have an ICP according to the definition in the Regulations of the Minister for Health (Mental Health Act 2001 (Approved Centres) Regulations 2006, S.I. No. 551 of 2006).

To the extent that an ICP defines what is a modern mental health service, the inspections of 2013¹⁴ reveal that, in general, Ireland's mental health services are making steady progress in a positive direction albeit with slower, more reluctant progress in some areas.

2. What is an Individual Care Plan?

As defined in the Regulations (Part 1, section 3), an "individual care plan means a documented set of goals developed, regularly reviewed and updated by the resident's multidisciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation".

3. Analysis of Elements of Definition

3.1. A documented set of goals

Referring to the old adage, "if it's not documented, it's not done", documenting an ICP is crucial from medico-legal and compliance perspectives and allows proper audit and governance.

Documentation is also important from the perspective of clarity of purpose and for communication between all team members and with the patient/service user and family.

Goals and targets should be set at an early stage and depend on assessment of need. Goals are important in order to measure progress and to avoid stasis that is sometimes seen in the treatment or care of some long-term patients/service users.

3.2. Regularly reviewed

Progress towards goals can only be measured by regular review of the clinical and psychosocial status of the patient/service user. Documented regular review is an example of best practice and avoids the situation seen on inspections where no record of patient/service user contact is evident over long periods.

3.3. The resident's multidisciplinary team

Multidisciplinary working is the cornerstone of a modern mental health service. The needs of individuals with mental health conditions tend to be complex and multifactorial involving constitutional, nurturing, psychological, social, vocational and spiritual (meaning) components. In order to capture this complexity, it is vital that the patient/service user can avail of a rich, integrated set of perspectives in addressing problems.

3.4. In consultation with each resident in so far as is practicable

This essential element indicates that the patient/service user or resident (if in an approved centre) is central to all deliberations around care and treatment. When a patient/service user is involved in formulation of a treatment plan, the likelihood of cooperation with that plan is enhanced especially as, in so doing, the individual is shown respect and treated as a person of value.

Acceptance of the patient/service user's sense of understanding or meaning attached to particular symptomatology is a powerful validation of the individual and indicates respect for autonomy. Moreover, it has been shown that, in those cases where the patient/service user incorporates particular symptoms into an overall life view in terms of meaning or philosophy, outcomes are improved. This relaxation of the medical reins can sometimes be difficult for professionals used to understanding conditions in mainly medical terms.

3.5. Specified treatment and care required in accordance with best practice

Having set goals, these are the means specified to achieve these goals. Various "best practice" guidelines are available and should be followed where practicable. Treatment and care should be audited against best practice on a regular basis.

3.6. Identifying necessary resources

Failing at an early stage to identify the resources required to implement care and treatment can result in unconscionable delay in the patient/service user receiving appropriate treatment. Inspections have too often revealed long, unnecessary hospital stays simply because necessary resources were not identified at an appropriate stage. Obtaining these resources is likely to be more successful if a coherent plan of care and rationale are documented in a high quality ICP.

3.7. Specify appropriate goals

The importance of goal-setting is reflected in this second mention of the term in a short definition.

3.8. Recorded in one composite set of documentation

This is an important point. Too often well-meaning services state that they have completed all the elements of an ICP and that "it is there somewhere in the file".

In order to accord the ICP its due importance and in order for best communication between staff and between staff and patient/service user and family, the ICP should be held separately, within the medical record, with preferably a copy for the patient/service user.

3.9. For a resident who is a child, include educational requirements

The importance of this point is self-evident.



4. Principles of a Vision for Change

Apart from a detailed analysis of the requirements of a modern mental health service in terms of specialisms, population, beds and staffing, perhaps the most important aspect of this document is that it clearly outlines the philosophical approach to such a service as follows:

- › A move away from a purely medical model of care and treatment.
- › Towards a multidisciplinary approach.
- › Which puts the patient/service user at the centre of all decisions regarding care and treatment.
- › And emphasises the primary aim of *Recovery* of individuals so that they can live fulfilled and satisfying lives.
- › In order to avoid institutionalisation and loss of life skills, hospitalisation be kept to a minimum.
- › And that treatment be provided primarily in a community setting close to families and social supports.

It can be seen that these philosophical principles are in full congruence with the elements of an individual care plan.

5. Factors Influencing Individual Care Planning

5.1. Culture/Philosophy

A culture of respect for the patient/service user, for the principles of autonomy, liberty and bodily integrity are essential for the concept of individual care planning to flourish.

5.2. Human Rights

Knowledge and appreciation of the human rights of individuals, but especially in a situation of power imbalance which pertains with involuntary detention, will have a strong influence on practice and will also help professionals to understand the importance and provenance of certain statutory provisions.

5.3. Leadership

Inspections have revealed that, where committed and enlightened leadership exists, individual care planning is more prevalent and of higher quality.

5.4. Teamwork

Good leaders also attract and manage good teams. Teamwork involves commitment by various disciplines to work for the good and dignity of the patient/service user and to respect the dignity of other professionals. It also involves working in a cohesive, cooperative manner. Where emphasis has been placed on the nurturing of team working, individual care planning has also improved.

5.5. Governance

Previous national reviews by the Inspectorate have criticised the weakness of governance in Ireland's mental health services. It now appears there is considerable cause for optimism with the appointment, in 2013, of the first National Director of the Mental Health Division of the Health Service Executive. Already, there are signs of improved organisation, accountability and an emphasis on reducing widespread variations.

Governance at local and national level should focus on holding clinicians accountable for individual care planning, auditing performance, comparing performance across sectors and catchment areas and implementing quality improvement projects to constantly improve the quality of ICPs.

In terms of assessing performance, quality and policy adherence, measurement of the existence and quality of ICPs should be regarded as the "Holy Grail" of indicators.

5.6. Professional Competence

Knowing how to engage with fellow disciplines to assess the complex needs of patient/service users, to consult with the patient/service user and family and to identify appropriate goals and resources are all matters of professional competence. These should be incorporated into professional competence schemes overseen by the professional regulatory authorities.

5.7. Resources

Implementing a national system which ensures that each resident has an ICP according to the regulations should not be a drain on resources. In fact, with more efficient working and more emphasis on the best practice of providing services in the community, it may even free up resources.

6. Likely Improvements which will Flow from Consistent, High-Quality Individual Care Planning

- › The development of better, more respectful relationships with patient/service users and their families due to their positioning at the centre of all decisions regarding their care and treatment.
- › Greater clarity on treatment goals between members of the multidisciplinary team will lead to enhanced efficiency and effectiveness resulting in reduction of length of in-patient stay.
- › Enhanced protection and safety of patients/service users.
- › Improved communication.
- › Improved perception of procedural justice.
- › Improved team working.
- › Sourcing and applying best practice guidelines.
- › Fulfilment of statutory duties.
- › Improved medico-legal protection.
- › Measurement of progress towards goals.
- › Ease of audit of individual services, catchment areas and of the national mental health services.

7. Arguments Against Care Planning

Two questions in particular have arisen in various discussions between the Inspectorate and services.

1. *“Has it been shown that individual care planning improves outcome?”*

Response:

- › No such randomised control trial has taken place.
- › In our jurisdiction, it would be both illegal and unethical.
- › In situations where a particular approach is so obviously correct in terms of ethics, human rights and best practice, the concept of comparison is redundant. Trials are not necessary to show obvious differences.
- › In any case, an ICP encapsulates what is the definition of a modern mental health service. Without ICPs, mental health services, as required by public policy and statute, are not being provided.

2. *“But will this not all result in just a box-ticking exercise and lead to less quality?”*

Response:

Of course, individuals and teams could “go through the motions...” of completing individual care plans in attempts to “game the system...”. It is a matter for conscientious inspection of these plans to identify and eliminate these strategems. It is reasonable, however, to maintain faith in the goodwill of Irish mental health clinicians who, when the rationale for care planning is fully understood, will in all likelihood invest this exercise with appropriate enthusiasm and propriety. It is a simple matter to establish criteria for measuring the quality of ICPs and then audit them on a regular basis.



8. Conclusions

- 1) Inspectorate figures from 2013 show gradual improvement in compliance with the statutory provision of individual care planning.
- 2) The work of the newly appointed National Director of the Mental Health Division of the Health Service Executive has given cause for optimism that improved governance measures with respect to ICPs will be effective.
- 3) The ICP encapsulates what is the definition of a modern mental health service as expounded in *A Vision for Change*.
- 4) In terms of measuring, on a local and national basis, progress of Ireland's mental health services towards *A Vision for Change*, no better indicator than the ICP could be found.
- 5) The ICP is the "Holy Grail" of performance, quality and policy-adherence indicators.
- 6) The requirement that each "resident" (of an Approved Centre) has an ICP underlines its bedrock importance.
- 7) Although not yet statutorily required, it is best practice that all outpatient patient/service users of Ireland's mental health services also have ICPs.
- 8) The definition of an ICP is the philosophy required to operate a safe and effective mental health service.
- 9) It is recommended that mental health managers ensure that all clinicians understand the philosophical underpinning of ICPs from a human rights perspective.
- 10) It is recommended that mental health managers and professional regulatory bodies ensure that all clinicians are fully familiar with the concept and importance of individual care planning.
- 11) It is recommended that regular local audits take place with respect to the existence and the quality of care planning.
- 12) It is recommended that national audits are conducted and that where deficiencies exist, these are addressed urgently.

APPENDIX 1

Compliance with Article 15 of the Mental Health Act 2001 (Approved Centres) Regulations S.I. No. 551 of 2006

As part of the inspection process and as a means of improving quality in the mental health services, the Inspectorate has tracked compliance with Article 15 over the past number of years. This Article relates to Individual Care Plans for residents of approved centres. The table below shows the compliance level for 2013:

Level of Compliance with Article 15 relating to Individual Care Plans in 2013

Level of Compliance	Number of Approved Centres	%
Full	38	60.3%
Substantial	14	22.2%
Minimal	4	6.4%
Not Compliant	7	11.1%
Total of Approved Centres Inspected	63	100%

Approved centres were deemed to be 'Not Compliant' with Article 15 of the Regulations where individual care plans did not meet the specifications for such care plans as described in the Regulations or where an approved centre had one or more residents without an individual care plan. In six of the seven cases noted here, the failure to be compliant was as a result of both criteria. Since 2012, twenty one (33%) approved centres have improved their compliance with Article 15 which is to be welcomed, while ten centres (16%) have reduced their compliance rating.

A comparison with previous figures compiled by the Inspectorate in relation to compliance with Article 15 shows an overall steady improvement from 2007, apart from 2011. However at no stage, has the compliance rate been higher than 62%, despite interventions by the Inspectorate and the Mental Health Commission.

2007	2008	2009	2010	2011	2012	2013
18%	33%	33%	42%	62%	53%	60.3%

Article 16, Therapeutic Services

With regard to compliance with Article 16 relating to Therapeutic Services, less than half of services were fully compliant.

Compliance with Article 16 relating to Therapeutic Services 2013

Level of Compliance	Number of Approved Centres	%
Full	31	49%
Substantial	18	29%
Minimal	7	11%
Not Compliant	7	11%
Total of Approved Centres Inspected	63	100



APPENDIX 2

Table 1 Approved Centres Inspections 2013

Approved Centre	Date of Inspection
1. Acute Psychiatric Unit 5B, Midwestern Regional Limerick	13 November 2013
2. Acute Psychiatric Unit, AMNCH, (Tallaght) Hospital	12 June 2013
3. Acute Psychiatric Unit, Cavan General Hospital	30 July 2013
4. Adult Mental Health Admission Unit, Kerry General Hospital	08 May 2013
5. Acute Psychiatric Unit, Midwestern Regional Hospital, Ennis	11 September 2013
6. Adolescent In-Patient Unit, St. Vincent's Hospital	15 May 2013
7. Adult Mental Health Unit, Mayo General Hospital	1 October 2013
8. An Coillín	1 October 2013
9. Bloomfield Care Centre- Donnybrook, Kylemore, Owendoher and Swanbrook Wings	19 February 2013
10. Cappahard Lodge	27 November 2013
11. Carraig Mór Centre	17 April 2013
12. Central Mental Hospital	8, 9 and 10 April 2013
13. Centre for Mental Health Care and Recovery, Bantry General Hospital	11 July 2013
14. Child and Adolescent Mental Health In-patient Unit, Merlin Park University Hospital Galway	26 February 2013
15. Department of Psychiatry, Connolly Hospital	12 February 2013
16. Department of Psychiatry, County Hospital, Roscommon	27 February 2013
17. Department of Psychiatry, Midland Regional Hospital, Portlaoise	18 June 2013
18. Department of Psychiatry, Our Lady's Hospital, Navan	22 May 2013
19. Department of Psychiatry, Letterkenny General Hospital	30 October 2013
20. Department of Psychiatry, St. Luke's Hospital, Kilkenny	12 March 2013
21. Department of Psychiatry, University College Hospital Galway	25 February 2013 Night inspection
22. Department of Psychiatry, University College Hospital Galway	26 February 2013
23. Department of Psychiatry, University College Hospital Galway	12 November 2013 Re-Inspection
24. Department of Psychiatry, Waterford Regional Hospital	5 June 2013
25. Eist Linn Child and Adolescent In-Patient Unit	18 September 2013
26. Elm Mount Unit, St. Vincent's University Hospital	21 February 2013
27. Hawthorn Unit, Connolly Hospital	20 March 2013
28. Heywood Lodge, Clonmel	12 March 2013
29. Highfield Hospital	11 June 2013
30. Jonathan Swift Clinic	23 April 2013
31. Joyce Rooms, Fairview Community Unit	14 May 2013



Approved Centre	Date of Inspection
32. Lakeview Unit, Naas General Hospital	20 June 2013
33. Lois Bridges	15 February 2013
34. Newcastle Hospital	16 July 2013
35. O'Casey Rooms, Fairview Community Unit	21 March 2013
36. Phoenix Care Centre	17 October 2013
37. Selskar House	31 October 2013
38. Sligo/Leitrim Mental Health In-Patient Unit	25 July 2013
39. South Lee Mental Health Unit, Cork University Hospital	16 April 2013
40. St. Aloysius Ward, Mater Misericordiae University Hospital	21 May 2013
41. St. Anne's Unit, Sacred Heart Hospital	2 October 2013
42. Unit One and St. Ita's Ward, St. Brigid's Hospital, Ardee	21 May 2013
43. St. Brigid's Hospital, Ballinasloe	13 June 2013
44. St Bridget's Ward & St Marie Goretti's Ward, Cluain Lir Care Centre	11 September 2013
45. St. Gabriels Ward, St. Canice's Hospital	13 March 2013
46. St. Davnet's Hospital, Blackwater House	31 July 2013
47. St. Davnet's Hospital, Blackwater House	28 August 2013 Re-Inspection
48. St. Edmundsbury Hospital	16 May 2013
49. St. Finan's Hospital- O'Connor Unit (East and West Wings)	10 July 2013
50. St. Finbarr's Hospital	19 September 2013
51. St. Fintan's Hospital, Portlaoise	19 June 2013
52. St. Ita's Hospital-Willowbrook and Woodview Units	12 February 2013
53. St. John of God Hospital Limited	15, 16 October 2013
54. St. Joseph's Hospital, Limerick	14 November 2013
55. St. Joseph's Intellectual Disability Services	19 March 2013
56. St. Loman's Hospital, Mullingar	10 September 2013
57. St. Michael's Unit, Mercy University Hospital	16 April 2013
58. St. Otteran's Hospital	07 November 2013
59. St. Patrick's University Hospital	9 October 2013
60. St. Stephen's Hospital	17 April 2013
61. St. Vincent's Hospital, Fairview	15 May 2013
62. Sycamore Unit, Connolly Hospital	13 February 2013
63. Teach Aisling	02 October 2013
64. Tearmann Ward, St. Camillus' Hospital	12 September 2013
65. Linn Dara	20 August 2013
66. Willow Grove Adolescent Unit, St. Patrick's University Hospital	09 May 2013



Table 2 Other Mental Health Services Inspections 2013

Other Mental Health Service	Name	Date of Inspection
1. 24 Hour Nurse Staffed Support Community Residence	Alacantha, Kilkenny	20 August 2013
2. 24 Hour Nurse Staffed Community Residence	Carrigabrick Lodge, Cork	21 August 2013
3. 24 Hour Nurse Staffed Community Residence	Cois Alla Kanturk, Cork	20 August 2013
4. 24 Hour Nurse Staffed Community Residence	Cois Mara, Spanish Point	27 November 2013
5. 24 Hour Nurse Staffed Community Residence	Courtview Hostel, Carlow	17 October 2013
6. 24 Hour Nurse Staffed Community Residence	Cypress Lodge, Sligo	4 October 2013
7. 24 Hour Nurse Staffed Community Residence	Elm Park, Carlow	22 August 2013
8. 24 Hour Nurse Staffed Community Residence	Garryshane, South Tipperary	14 March 2013
9. 24 Hour Nurse Staffed Community Residence	Glenmalure, Cork	22 January 2013
10. 24 Hour Nurse Staffed Community Residence	Grove House, Gort	12 June 2013
11. 24 Hour Nurse Staffed Community Residence	Hillcrest, Longford	20 March 2013
12. 24 Hour Nurse Staffed Community Residence	Kelvin Court, Carlow	8 August 2013
13. 24 Hour Nurse Staffed Community Residence	Kincora, Kilkenny	20 August 2013
14. 24 Hour Nurse Staffed Community Residence	Linden House, Sligo	3 October 2013
15. 24 Hour Nurse Staffed Community Residence	Lorica, South Tipperary	2 September 2013
16. 24 Hour Nurse Staffed Community Residence	O'Connell House, Limerick	25 April 2013
17. 24 Hour Nurse Staffed Community Residence	Park Lodge, Carlow	8 August 2013
18. 24 Hour Nurse Staffed Community Residence	Rath na Riogh, Meath	5 March 2013
19. 24 Hour Nurse Staffed Community Residence	Sacred Heart Hostel, Carlow	17 October 2013
20. 24 Hour Nurse Staffed Community Residence	Sycamore, Clifden	8 March 2013
21. 24 Hour Nurse Staffed Community Residence	Tithe na gCarad, Roscommon	5 September 2013
22. 24 Hour Nurse Staffed Community Residence	Toghermore, East Galway	7 January 2013
23. 24 Hour Nurse Staffed Community Residence	Writers Grove, Kerry	10 July 2013



Table 3 National Overview Meeting Reports 2013

National Overview Meetings	Date of Meeting
1. HSE National Director Mental Health	4 November 2013
2. Executive Clinical Directors	26 November 2013
3. Service User, Family/Carer and Advocacy Group Involvement in mental health Services	3 December 2013
4. Directors of Nursing	10 December 2013

Table 4 Catchment Area Meetings 2013

Catchment Area Meetings	Date of Meeting
1. Laois/Offaly	11 March 2013
2. Waterford	13 March 2013
3. Longford/Westmeath	20 March 2013
4. Roscommon	27 March 2013
5. South County Dublin	24 April 2013
6. Limerick, Clare and North Tipperary	9 May 2013
7. Sligo	24 May 2013
8. North Cork	4 June 2013
9. South Cork	5 June 2013
10. North Dublin	9 July 2013
11. Kilkenny	3 September 2013

Table 5 Themed Reports 2013

Themed Reports
1. 19 th Century Public Psychiatric Hospitals due for closure - Table 2013
2. A Review of 24 Hour Supervised Community Residences 2009 - 2013
3. Complaints in Approved Centres 2013
4. Child and Adolescent Mental Health Services 2013 - Admissions of Children to Adult Units
5. Compliance with Article 15, Mental Health Act 2001 (Approved Centres) Regulations 2006 - in 2013 (see appendix 1)
6. Audit of Risk Assessment in Approved Centres 2013



APPENDIX 3

Elements of an Individual Care Plan

“Individual care plan” means a documented set of goals developed, regularly reviewed and updated by the resident’s multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident.

For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation. (Part 1, Mental Health Act 2001 (Approved Centres) Regulations 2006.

Article 15, Individual Care Plan, Mental Health Act 2001 (Approved Centres) Regulations 2006, Statutory Instrument No. 551 of 2006

The registered proprietor shall ensure that each resident has an individual care plan.

- > Documented set of goals
- > Regularly reviewed and updated by the resident’s multidisciplinary team
- > In consultation with each resident in so far as is practicable
- > Specify treatment and care required in accordance with best practice
- > Identify necessary resources
- > Specify appropriate goals
- > Recorded in one composite set of documentation
- > For a resident who is a child include education requirements



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APPENDIX 4

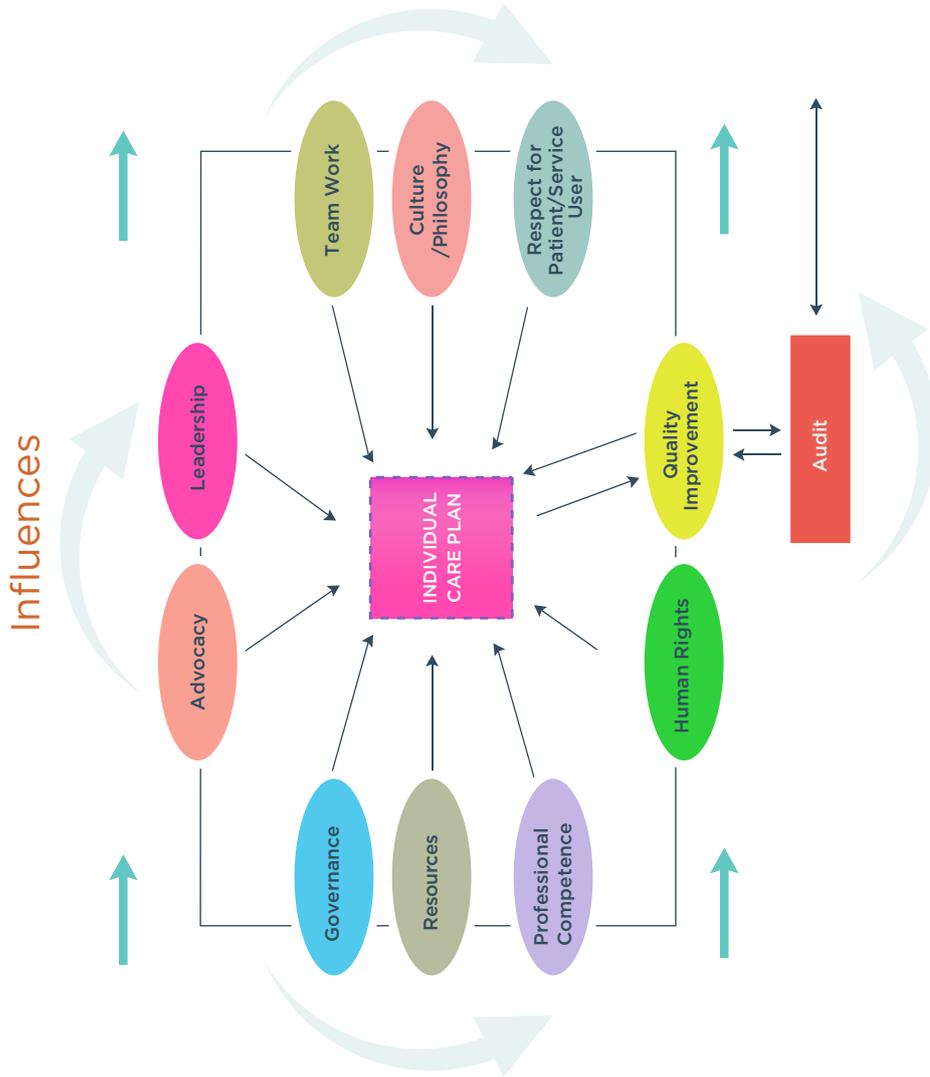
Principles

A Vision for Change

- > Less Medical Model.
- > Patient Centred.
- > Recovery.
- > Community based.

Individual Care Plan

- > Documented set of goals.
- > Regularly reviewed and updated by the resident's multidisciplinary team.
- > In consultation with each resident in so far as is practicable.
- > Specify treatment and care required in accordance with best practice.
- > Identify necessary resources.
- > Specify appropriate goals.
- > Recorded in one composite set of documentation.
- > For a resident who is a child include education requirements.



Improvements

- > Better relationships with patient/service user.
- > Patient/service user feels more respected.
- > Less confusion.
- > Shorter in-patient stays.
- > Better communication.
- > Best practice.
- > Better team working.
- > Better focus on problems.
- > Measurement of progress towards goals.
- > Statutory duty fulfilled.
- > Easier to audit.
- > Medico-legal protection.



ACKNOWLEDGEMENTS

The major task of completion of the 2013 inspection reports was only achieved by the dedication and commitment of all members of the Inspectorate team, inspecting and administrative, whose contribution is greatly appreciated. Thanks are also due to all staff members of mental health services both clinical and administrative without whose cooperation the inspection reports would not have been achieved and to all staff of the Mental Health Commission.

Particular thanks are due to Colette Ryan, Senior Administrator of the Inspectorate.



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