Mental Health Commission publishes report on services in Carlow, Kilkenny and South Tipperary

"Targeted Intervention" follows apparent suicides and other incidents

Under embargo until Midnight Tuesday 21st July 2015: The Mental Health Commission has today published the report of a quality improvement initiative it carried out in relation to the mental health services in Carlow/Kilkenny and South Tipperary, arising from a number of deaths and other incidents between January 2012 and March 2014.

The initiative was prompted by concern within the Commission over the safety of mental health service users in the catchment area, and over the clinical governance and control of those services.

Between January 2012 and March 2014, 13 service users died by apparent suicide while under the care of the Carlow/Kilkenny/South Tipperary mental health services. There were also incidents including the death of the relative of a service user, and service users suffering burns, serious episodes of self-harm while resident in a crisis house, and a serious physical assault by a service user on a member of the public.

The Commission decided in March 2014 to instigate a process called a Targeted Intervention, rather than simply have a review of the facts with recommendations. A Targeted Intervention includes a review, an implementation plan for recommendations and a follow-up inspection to verify that required actions have been taken. The Commission chose this process to ensure that recommendations were actually implemented, and that their implementation was verified.

According to the Chief Executive of the Mental Health Commission Ms Patricia Gilheaney: "There were significant issues to be addressed in the Carlow/Kilkenny/South Tipperary catchment area. The Targeted Intervention approach has proven to be very effective in this case. Rather than the traditional approach of producing a report with recommendations, the Targeted Intervention has produced an implementation plan, and an inspection which has shown the recommendations have been implemented. I would like to express the Commission's appreciation of the work done by the review team, and also of the response from the services in the area in implementing the recommendations."

Commenting on the review John Saunders, Chairman of the Mental Health Commission said, "During this process we identified a number of significant issues and the Commission takes the view that a fundamental cultural change is required which can largely be implemented within the system that has been created by the new reforms within the region. This cultural change must foster a shared understanding of putting the patient first. Healthcare is dependent on people, not machines, and

openness, candour, compassion and transparency are key to ensuring a quality mental health service which does put the patient first."

The targeted intervention team made 19 recommendations, which are on page 29 of the report. A subsequent inspection and correspondence with the service established that 12 of these recommendations have been implemented, with implementation of the other seven underway.

The report concludes that:

- Adequate assessment of suicidality might have alerted clinical staff to the risk of suicide.
- Either training for risk assessment was insufficient, or else it wasn't being applied in all cases.
- However there was no basis for suggesting that the rate of apparent patient suicide in the Carlow/Kilkenny/South Tipperary catchment area was anomalous. The number of deaths by apparent suicide was comparable proportionally to the rate in the UK.
- The system for dissemination of information following incidents did not function well and did not support a safety culture.
- At the time of the review (Q1, 2014) newly presenting 16 and 17 year olds in South Tipperary were not receiving a safe, adequate service.
- There was a practice of transferring residents from the unit at the hospital to community residences to free up bed space.
- Lack of cohesion between senior management and the medical consultants had undermined clinical governance, and there was deep disharmony between them.
- There were inconsistencies in the level and quality of communication by the service with service users, families and carers.

The 19 recommendations of the Targeted Information team include:

- Assessment of suicidality should be carried out at each clinical evaluation of mental state.
- Service users should have a risk assessment which leads to a clearly articulated and implemented risk management plan.
- Training in assessment and management of risk is required.
- All unexpected deaths and serious untoward incidents should be followed by a review.
- Consultant psychiatrists should engage with all governance processes.
- The service should actively seek to appoint senior clinical personnel to permanent positions.
- A Child and Adolescent Mental Health Service must be provided to 16 and 17 year olds in the South Tipperary area in accordance with national policy.

The full report is available here: http://www.mhcirl.ie/File/TarInvRrptbyOIMHS.pdf

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About the Mental Health Commission

The Mental Health Commission is an independent statutory body. The primary functions of the Mental Health Commission are to foster and promote high standards of care and good practice in the delivery of mental health services and to ensure that the interests of those involuntarily admitted are protected, pursuant to the Mental Health Act 2001.