

Submission to the Joint Committee on Health from the Inspector of Mental Health Services



Executive Summary

- There are some positive developments in mental health services delivered in the State; overall compliance levels with regulations and rules in approved centres are slowly improving, a person-centred approach to care and treatment can be seen in some services, and the majority of old unfit-for-purpose psychiatric institutions have closed.
- We remain concerned that some of the basic and fundamental aspects of care and treatment in regulated mental health services continue to be lacking; some services have been observed to be dirty and in disrepair and service users are not afforded proper privacy during their admission.
- There remains a lingering complacency around restrictive practices such as physical restraint and seclusion. In many services these practices are accepted and common-place. Such practices directly affect a person's human rights to liberty, autonomy and bodily integrity. We have seen little real engagement in the proper scrutiny and reduction of these practices.
- A large number of specialist community based mental health services, in particular 24-hour nurse staffed community residences, remain without regulatory oversight or safeguards, despite the number of units and vulnerability of service-users accommodated in such units.
- Rehabilitation services for people with enduring mental illness are inadequate, resulting in people living in unsuitable, expensive-to-run accommodation without an opportunity to reach their full potential.
- There is inadequate and inconsistent monitoring of physical health needs of people with enduring mental illness and inadequate and inequitable access to essential healthcare services.
- There are concerns about the provision of Child and Adolescent Mental Health Services (CAMHS) in the community. Concerns include poorly staffed community teams, the number of young people admitted to adult units, the variation in funding across the CHOs.

Introduction and Background

About the Mental Health Commission

The Mental Health Commission is the regulator for mental health services in Ireland. We are an independent statutory body that was established in April 2001 under the Mental Health Act. The regulatory functions of the Commission came into effect following full commencement of the 2001 Act, in 2006.

The Commission's mandate is to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to protect the interests of persons admitted and detained under the 2001 Act.

90% of mental health services are delivered in primary care settings. A further 10% are delivered within specialist mental health services, including community residences. Under the 2001 Act, the statutory scope of mental health regulation is limited to in-patient services only, which are estimated to make up less than 1% of mental health services in Ireland.

About the Inspector of Mental Health Services

The role of the Inspector of Mental Health Services is set out under Section 50 of the 2001 Act. The principal functions of my role are to:

- Visit and inspect regulated services (approved centres) annually, to assess compliance with Regulations, Statutory Rules, Codes of Practice and Part 4 of the 2001 Act;
- Visit and inspect any premises where mental health services are provided; and
- Review the quality and safety of mental health services in the State.

Following every inspection, I produce a detailed report of my findings. The report sets out: whether or not a service is compliant with legal requirements, makes an assessment as to the quality of the service, identifies areas of good practice and areas for improvement, and highlights any concerns in relation to the safety, wellbeing or human rights of service users.

I also report annually on themed inspections that I have carried out each year. For example in the last two years I have reported on CAMHS services, 24-hour supervised community residences, physical health in people with severe mental illness and mental health rehabilitation services.

Findings on developments in mental health services

The Joint Committee has sought information on developments in mental health services in the State. The basis of this report is taken from recent inspection findings, as well as information compiled by the Commission as part of our ongoing monitoring of compliance and receipt of quality and safety notifications from services.

While the scope of the Commission's regulation is limited, we nevertheless closely monitor developments across the broad range of mental health services in Ireland, including: acute adult, rehabilitation, continuing care, child and adolescent, forensic and community mental health services. As a general comment, it is evident that the provision of mental health services is inconsistent across the country and lacks proper integration.

A young person in need of mental health services in Galway will be able to access a vastly different range and level of services than a young person in Waterford. Similarly a person in Cavan/Monaghan or Sligo/Leitrim will have access to mental health rehabilitation services, while a person in Donegal will not; this is despite them being in the same CHO area.

The Commission welcomes the implementation of Sláintecare, which envisages a system of integrated care, provided based on need, not location, age, or diagnosis. We hope that this will finally realise the goals included in *A Vision for Change*, which was set out a Government policy thirteen years ago, in 2006. We understand *A Vision for Change* is currently undergoing a review and refresh and look forward to seeing the revised policy.

Regulated services

Positive developments

We have seen an **overall increase in the national average compliance** with regulatory requirements from 74% in 2016, to 76% in 2017 and 79% in 2018. Progress is slow, but is consistently trending in the right direction. For the most part, we have seen good engagement from services in working towards compliance and implementing the *Judgement Support Framework*, the Mental Health Commission's Quality Framework.

There have been some notable improvements, such as the Department of Psychiatry, Roscommon University Hospital, who went from 52% compliant with regulatory requirements in 2017, to 83% in 2018. Other marked improvement included St Brigid's Hospital, Ardee who went from 64% in 2017, to 93% in 2018.

We have also seen some **improvement in fundamental aspects of care provision** such as medication management, individual care planning and consent procedures for involuntary patients. These are positive developments, but are not consistent across the country. There is work yet to be done to ensure people receive the same consistent high quality care and treatment, no matter where they are located.

There has been ongoing progress towards decommissioning outdated and unsuitable buildings for the provision of inpatient services. In 2006, 17 approved centres were operating in inappropriate institutional settings. By 2019, only three remain, with two due to close by 2020.

It is important to recognise positive developments, as constant focus on negative attention, particularly from the media, can be demoralizing for those staff on the ground who are working hard towards service improvement, and who are committed to providing safe, high-quality care and treatment.

Ongoing concerns

1. Premises

The Commission continues to highlight concerns in relation to the physical infrastructure of mental health facilities and premises. Inspection reports have consistently identified concerns relating to the overall suitability of premises to meet patient needs, concerns relating to the physical safety of premises, and concerns relating to the maintenance of the premises, including basic repair works and cleanliness.

In 2018, 70% of regulated services were found to be non-compliant with the regulatory requirements relating to their premises.

I find it unacceptable that in 2019, we still find service users in long stay units living in 'dormitory style' accommodation, units where one shower is shared between 20 people, and to find units which are dirty and in disrepair. This does not respect the basic privacy and dignity of service users.

2. Restrictive practices

It is the position of the Commission that there is no therapeutic benefit to the use of restrictive practices such as seclusion or physical restraint. Seclusion is where a person is involuntarily confined in a room or area, usually by a locked door. Physical restraint is the use of force for the purpose of preventing the free movement of a person's body. These practices should only ever be used as a last resort, where there is a serious and urgent safety concern.

Despite this, physical restraint was used in 81% of all approved centres in 2018 and 97% of acute adult services. Seclusion was used in 42% of all approved centres in 2018 and 65% of acute adult services.

We are concerned that there is a lingering complacency in the use of these practices. In many services, these practices are accepted and common place. Such practices directly affect a person's human rights to

liberty, autonomy and bodily integrity. We have seen little real engagement in the proper scrutiny and reduction of these practices by the mental health services

3. Persons with severe and enduring mental illness

As well as acute mental health facilities, the Commission regulates facilities that provide continuing care to persons with severe and enduring mental illness.

In a recent report, I highlighted serious concerns in relation to the provision of general health services to persons with severe mental illness in continuing care approved centres. People with a severe mental illness will die on average 15-20 years earlier than the general population for largely preventable reasons, unrelated to their mental illness. Following a review of 10 services across the country, I highlighted inadequate and inconsistent monitoring of patients' physical health needs, and inadequate and inequitable access to essential healthcare services.

The Commission has sought a national response from the HSE to address these serious concerns.

I also have concerns about the provision of specialist rehabilitation and recovery services for people with enduring mental illness. This can be summarised as lack of appropriate housing for people to move to more independent living; too few rehabilitation teams (48% of the number recommended by *A Vision for Change*); existing teams which are very poorly staffed, and a lack of localised community and inpatient specialist rehabilitation units. We have a large number of people who are still residing in institutional care who, with rehabilitation and recovery services, could live more autonomous, satisfying lives as part of their own community.

Unregulated services

While the statutory scope of mental health regulation is limited to in-patient services, as the Inspector, I have the statutory power to visit and inspect any premises where a mental health service may be provided.

1. Community residences

Over the past three years, I have been undertaking a systematic review of all 24-hour nurse staffed community residences in the State. There are 118 such community residences across the nine HSE Community Healthcare Organisation areas (CHOs), accommodating over 1200 service users.

The residents of these services are often in long-term accommodation and the community residence is their only home. They represent a large number of potentially vulnerable adults with enduring mental illness whose voice is rarely heard. The community residences are often poorly maintained, too big, institutionalised, restrictive and at times not respectful of service users' privacy, dignity and autonomy. Many residences were in poor physical condition, with 19% of those inspected in 2018 requiring urgent maintenance and refurbishment. A significant number of people living in these residences should, with appropriate support, move to smaller less institutionalised accommodation. These units remain without regulatory oversight or safeguards, despite the number of units and vulnerability of service-users accommodated in such units.

Over a number of years, the Mental Health Commission has called for these residences to be regulated. Regulation would allow the Mental Health Commission to enforce changes where deficits and risks are found, protect the human rights of people living in these residences and help mental health services to provide care and treatment in accordance with best practice standards.

2. Child and Adolescent Mental Health Services (CAMHS)

At the end of 2017, I reviewed the provision of Adolescent Mental Health Services (CAMHS). This review highlighted a number of concerns about the provision of CAMHS nationally. These include:

- Poorly staffed community teams; overall the staffing in 2017 was 60% of that recommended by *A Vision for Change*.
- The number of young people admitted to adult units, which the Commission had continued to raise as a concern across a number of years.
- The variation in funding for CAMHS across the CHOs; which varies between €40 per capita in CHO 5 to €92 per capita in CHO 2.
- The lack of out of hours emergency CAMHS both for assessment and for inpatient beds.
- Waiting times (up to 15 months) for non-urgent outpatient appointments with CAMHS teams.

Recommendations

1. The Commission recommends national oversight and governance to address the ongoing concerns within regulated mental health services, noting that the ongoing and widespread nature of the concerns points to systemic issues that will not be addressed with a solely local or regional focus.
2. The Commission recommends the revised national mental health policy *A Vision for Change* should reflect the aims set out in *Sláintecare*, in particular a focus on the provision of integrated care based on need, not on location, age or diagnosis.
3. The Commission recommends putting proper regulatory safeguards in place to uphold the human rights and ensure the safety and wellbeing of persons in specialist community-based residential mental health services, i.e. 24-hour nurse staffed community residences.
4. The Commission recommends the establishment of an out of hours mental health service for young people in crisis, including a clear pathway for their families and loved ones.
5. The Commission recommends the proper provision of funding to ensure there are adequate services for persons with severe and enduring mental illness, including appropriate accommodation, general health and rehabilitation services.
6. The Commission recommends the prioritisation of funding to ensure all accommodation in residential mental health services (approved centres and community residences) are safe and fit for purpose.