Mental Health Commission: too many residents still being treated like 'second-class citizens'

Concerns around restrictive practices, unclean premises and care planning highlighted in Commission's 2019 Annual Report

Thursday, July 2nd: The Chief Executive of the Mental Health Commission has said that too many mental health residents in Ireland are still being treated like second-class citizens whose fundamental human rights continue to be overlooked.

The Commission's 2019 Annual Report - which has been published today – shows that while overall average national compliance with regulations was recorded at 78%, many mental health residents are still being admitted to outdated and unclean premises without a meaningful care plan essential to their recovery. The report also found an increase in the number of approved centres that used physical restraint, while there was just 21% compliance with rules around seclusion.

"This year's report once again demonstrates that the needs and wants of mental health service users are not being prioritised," said John Farrelly. "The Commission has consistently and repeatedly underlined the failings in our mental health system year after year, yet these shortcomings are yet to be acted upon in any meaningful way.

"The report evidences that our mental health service users are still being treated like second-class citizens in this country. We may have made huge strides since we started to shut down the old mental hospitals, but it's abundantly clear to the Commission that we haven't come far enough. The basic human rights of many residents continue to be overlooked.

"While our enforcement proceedings are resulting in some progress, it is clear that there are a number of matters that are key to addressing these issues," added Mr. Farrelly. "There must be ring-fenced funding for mental health; the refreshed vision must, unlike the previous strategy, be fully implemented; the current Mental Health act must be reformed; and there needs to be a cultural change amongst those providing services."

Some of the starkest findings in the report are included in the annual review of services by the Inspector of Mental Health Services, Dr. Susan Finnerty. This review shows that 45 of the 65 (69%) in-patient centres were non-complaint with the regulation on premises, many because they were unclean or were suffering from poor structural or decorative conditions.

"It is clear in my annual review - as it has been in previous years - that a significant number of our premises are no longer suitable and need to be replaced," said Dr. Finnerty. "Of the 69% of in-patient units that were non-compliant with this regulation, 33% were dirty. Findings included a dirty seclusion room, unclean bathroom facilities, litter in outdoor areas and offensive odours. Ten approved centres were not adequately lit, heated, or ventilated. This is an ongoing problem, year on year. It is simply not good enough that people who are extremely unwell are forced to reside or recover in wards or rooms that are unclean, malodorous or poorly maintained."

The report also shows a pattern of poor practice in relation to seclusion and physical restraint. Almost 80% of centres that used seclusion were non-compliant, while just half of the 58 centres that used physical restraint were compliant with the relevant code of practice.

The review also demonstrated clear evidence that there remains an ongoing failure to provide all residents with a meaningful individual care plan - a document that is essential to person-centred, recovery-based care – with 31 centres non-compliant in this area.

“Continued poor compliance with the regulation on individual care plans needs to be tackled on a number of fronts,” said Dr. Finnerty. “Perhaps most importantly, there needs to be a change of culture. The patient’s care plan should be seen as the blueprint for their care pathway. And it should be viewed as the patient’s care plan, not the clinician’s.”

The report also showed that compliance in relation to the regulations on staffing was recorded at just 8%. “The non-compliance here relates predominately to staff training,” said Mr. Farrelly. “While compliance is very low, we have noted from our audits that most centres were making good progress in this area. However, this is something that we will be keeping a very close eye.”

The Commission has written formerly to the HSE seeking an action plan to address the significant issues raised in their report, and particularly around premises, seclusion and restraint, staffing and individual care plans.

Both Dr Finnerty and Mr. Farrelly complimented the quality of care offered by staff. “Once again, staff were observed to be kind, compassionate and caring towards residents, and this is something that we have all seen once again during the recent pandemic,” said Dr. Finnerty. “It was also notable that the best services improved their quality of care by working in partnership with the service users and empowering their staff.”

Enforcement

Enforcement action is taken where the Commission is concerned that an element of care and treatment provided in an approved centre may be a risk to the safety, health and wellbeing of residents, or where there has been a failure to address an ongoing area of non-compliance.

The report shows that the Commission took 40 enforcement actions against incidents, events and serious concerns that arose in 2019 and related to 31 centres. These included issues relating to premises, staffing and the privacy and dignity of residents, and the first ever prosecution under the current Mental Health Act on foot of findings that patients were deprived of basic dignity and human rights by being secluded in a dirty, malodorous, badly-lit and badly-ventilated room.

Forty-five per cent of enforcement actions arose from regulatory inspections conducted by the

Inspector of Mental Health Services. Forty-three per cent of enforcement actions arose from compliance monitoring and in particular pre-registration compliance monitoring.

Implementation and reform

The Chairperson of the Mental Health Commission, John Saunders, said that the report provides perhaps the clearest evidence yet that the new government must commit to ensuring the full implementation of the refreshed mental health policy, and that this implementation should commence without delay.

"If we want to see real change, the new government must implement the refreshed policy in full and this must be met with ring-fenced and prioritised funding," he said. "It is also critically important that we push forward and repeal and replace the current Mental Health Act to reflect a human rights approach. These reforms must include enhanced powers so the Commission can appropriately regulate all community, online and other forms of care and treatment.

Decision Support Service:

The annual report also detailed the work undertaken during 2019 to support the roll-out of a fully-operational Decision Support Service (DSS). Work during 2019 included engagement with a wide range of stakeholders to provide information and promote readiness for commencement of the Assisted Decision Making (Capacity) Act 2015; developing the operational structures necessary to deliver an accessible person-centred service; reviewing Code of Practice; and growing the DSS team.

"Significant progress was made collaboratively with the Department of Justice and Equality and the Department of Health towards the end of 2019 towards agreeing a costed, time-bound plan for commencement that all interested parties could work towards," said the Director of the Decision Support Service, Aine Flynn.

Ends

Notes to the Editor

Mental Health Commission 2019 Annual Report key statistics:

- 65 approved centres inspected
- 18 unregulated 24-hour supervised residences inspected
- 78% overall national compliance with regulations (compared to 79% in 2018)
- 33% of regulations rated as excellent (compared to 26 per cent in 2018)
- 22 risks labelled as critical (compared to 26 in 2018)
- 13 centres had 90 per cent compliance with regulations or higher (compared to 12 in 2018)
- 40 enforcement actions were taken across 31 approved centres
- There were 57 conditions attached to 35 approved centres.
- 69% of centres were non-compliant with the regulation on premises

- 48% of approved centres were non-compliant with the regulation on individual care plans
- 58% of centres were non-compliant with the regulation on general health
- 48% of centres were non-complaint with the regulation of maintenance of records
- 79% of the 28 approved centres that used seclusion were non-compliant
- 50% of the 58 centres that used physical restraint were non-compliant
- 563 deaths reported of people using mental health services
- 98 child and adolescent beds nationally (62 in Dublin, 20 in Galway and 16 in Cork)
- 54 admissions of children and young people admitted to 15 adult units
- 497 admissions of children and young people to approved centres
- 2,703 in-patient beds in approved centres at the end of 2019
- 208 instances recorded of overcapacity, relating to 13 approved centres

Premises: In total, 45 (69%) of approved centres were non-complaint with the regulation on premises. Of those 45, five (11%) were risk-rated as 'critical'. Fifteen (33%) of the 45 were non-compliant because they were unclean. Findings included a dirty seclusion room; unclean bathroom facilities, including discarded cigarette butts; litter in outdoor area; kitchen areas that appeared contaminated. Urine-soaked panels and floors were also observed, while offensive odours were observed in nine facilities.

Twenty-three (49%) of the 45 were non-compliant due to poor structural or decorative condition. Findings included peeling paint, chipped floor coverings and damaged ceilings; broken showers; cigarette burn marks; holes in walls. Ten centres were not adequately lit, heated or ventilated.

Eight approved centres did not have a programme of routine maintenance, which had implications for the upkeep of the buildings and was a factor in some cases of non-compliance. Twenty-five approved centres were not developed or maintained with due regard to the specific needs of residents and patients: 17 of these included the continued presence of ligature points.

Seclusion: Out of 65 approved centres, 28 (43%) used seclusion and had seclusion facilities. Three out of six Child and Adolescent Mental Health Services (CAMHS) units also used seclusion. In the centres using seclusion, there was only 21% compliance. The main reasons for non-compliance were as follows: the seclusion room was dirty and/or malodorous (23%); the seclusion room had hazards (27%); the patient was not reviewed in accordance with the rules (27%); and the patient was not given adequate information about their seclusion (27%).

Physical Restraint: Fifty-eight (89%) of approved centres used physical restraint in 2019, five more approved centres than in 2018. Of these, 50% were compliant with the relevant Code of Practice, a significant improvement since 2016 when the rate of compliance was 22%. However, the report stated that in 21% of non-compliant centres, there was no physical examination following an episode of restraint, which was the main reason for non-compliance.

Individual Care Plans: In 2019, 48% of centres were non-complaint with the regulation on individual care plans. Of those centres, 74% did not develop appropriate goals for residents. In some individual

care plans, there were no goals documented; in other care plans 'big picture' goals were stated. These included 'maintain physical health', 'improve mental health', and 'get accommodation'. In one case, the goal was documented as 'remains irritable'.

Child and Adolescent Mental Health Services (CAMHS): the annual report also highlighted ongoing concerns around child and adolescent mental health services. The total number of admissions of people under the age of 18 to approved CAMHS centres in 2019 was 443 (up from 324 in 2018), while there were 54 admissions of children and adolescents to 15 adult units during the year.

"Children and young people should not be admitted to adult units except in exceptional circumstances," said Dr. Finnerty. "There are just six CAMHS units in the country, located in just three counties nationally, and apart from two of these, they do not take out-of-hours admissions. Children and young people in crisis are left with the unacceptable choice between an emergency department, general hospital, children's hospital, or an adult in-patient unit."

Physical Health: in 2019, only 42% of centres were compliant with the regulation on general health. There was no improvement to the corresponding figure in 2018, despite the fact that all services had a further 12 months to take account of the best practice requirements introduced in early 2018.

Tribunals: In 2019, a total of 2,024 tribunals took place for people who were involuntarily detained in an approved centre. Of a total of 1,825 admission orders, 34% of applications came from family; 28% came from An Garda Síochána; 14% came from authorized officers (within the HSE), and 24% came from other person (including doctors in emergency departments).

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.

To operate an in-patient mental health service in Ireland, the service must be registered as an 'approved centre' with the Mental Health Commission. Upon registration, the service must comply with regulations and rules made under the Mental Health Act 2001. Failure to comply with regulations and rules may result in enforcement action including: corrective and preventative action plans, an immediate action notice, a regulatory compliance meeting, registration conditions, removal from the register (closure) and prosecution.

MHC inspection process:

There are 39 areas in the inspection process of approved mental health centres. Each approved centre is assessed against a suite of regulations, rules, and codes of practice.

Inspectors, over a three day period, use a combination of documentation review, observation and interview to assess compliance. The inspection team speak with residents to find out their experience of the service; talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre; observe practice and daily life to see if it reflects what people tell them; review documents to see if appropriate records are kept, that they reflect practice, in line with the standards.

Areas of inspection are deemed either compliant or non-compliant. Where areas are considered non-compliant, this is risk rated. Risk measurements are rated as low, moderate, high or critical.

Following the inspection, the Inspector prepares a report on the findings. A draft of the report is furnished to the registered proprietor of the approved centre, and includes provisional compliance ratings, risk ratings and quality assessments. The registered proprietor is provided with an opportunity to review the draft and comment on any of the content or findings. The Inspector takes into account the comments by the registered proprietor and amends the report as appropriate.

Following this, the registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance addressing the specific non-compliances identified.

The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

About the Decision Support Service (DSS):

Under the provisions of the Assisted Decision Making (Capacity) Act 2015, the Commission's remit has been extended to include the establishment of the Decision Support Service (DSS).

The DSS is an essential service for all adults who have difficulties with decision-making capacity.

This may include people with an intellectual disability, mental illness or acquired brain injury, as well as people with age-related conditions who may need supports to make decisions.

The supports provided for, and monitored by the DSS, will help to ensure that people are afforded the fundamental human right to make their own decisions as far as possible about their personal welfare and their property and finances.