Workforce Planning in the Irish Mental Health Sector

Opening Statement to the Joint Committee on Health

Mental Health Commission and the Inspector of Mental Health Services

Introduction

Chairperson, members. On behalf of the Mental Health Commission, I would like to thank you for the opportunity to address the Joint Committee on Health. I am joined today by my colleagues Dr Susan Finnerty, Inspector of Mental Health Services, and Ms Rosemary Smyth, Director of Standards and Quality Assurance. We are pleased to be here today to discuss workforce planning as it applies to in-patient mental health services. As an organisation with 13 years' experience in the regulation and monitoring of Ireland's mental health services, and due to our knowledge of systems and models of international best practice, the Commission is well placed to provide advice and provide observations in relation to this matter.

About the Mental Health Commission

The Commission is the regulator for mental health services in Ireland. We are an independent statutory body 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, on the 1 November 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. In addition, under the provisions of the Assisted Decision Making (Capacity) Act 2015, the Commission is responsible for establishing the Decision Support Service to support decision-making by and for adults with capacity difficulties.

At this juncture, I feel it is important to point out that 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. Though the Inspector of Mental Health Services can inspect all Mental Health Services, there is effectively no regulatory oversight of the majority of services that are delivered outside of in-patient facilities. We welcome the work of Minister for Mental Health and Older Persons Jim Daly TD to drive change in this area by commencing a process to amend the current Mental Health Act.

Inspector of Mental Health Services

Set out under Section 50 of the 2001 Act. The principal functions of the 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, a detailed report is produced and published by the Commission. The report details whether or not a service has been compliant with legal requirements and makes an assessment as to the quality of the service, identifying areas of good practice and areas for improvement, and highlighting any concerns in relation to the safety, wellbeing, or the human rights of service users.

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

While the Commission's formal regulatory scope is limited, we nevertheless closely monitor developments across the broad range of mental health services in Ireland, including acute adult care, 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 are inconsistent across the country, and lacks proper planning, resourcing and integration to ensure each geographical area receives the same level of quality.

Mental Health Policy

In a well-organised health-system, policy is set by the Government on foot of a political mandate. Policy is then implemented by the relevant stakeholders or service providers. Implementation is monitored against agreed metrics using a data/evidenced-based approach and reviewed and evaluated on a regular basis.

The Irish national mental health policy, *A Vision for Change* ("AVFC"), has been in place since 2006. Its core concepts are recovery, person-centeredness, partnership, user and family involvement, and the delivery of multi-disciplinary, community-based services.

The Commission notes the continued endeavours of the Government, the statutory and independent service providers, and the voluntary sector in implementing the policy. The Commission has repeatedly indicated that much needs to occur to ensure the delivery of consistent, timely, and high-quality services in all geographic regions, and across the full range of clinical programmes and age groups.

The Commission has referred on numerous occasions to the absence of any independent monitoring of *AVFC*; a situation that has remained unchanged since 2013. The Commission is aware of a review group established to consider progress in the implementation of *AVFC,* and while we have been informally notified of its review, we have not been included in the policy's consultation and development. The Commission strongly advocates that any reviewed or refreshed document should include and consider modern evidenced-based approaches to service transformation, leadership, workforce planning and development.

As the highest level of our mental health services workforce, it is both noteworthy and disappointing that the HSE removed the post of National Director for Mental Health. The removal of this core leadership position sent out a clear and unambiguous, although perhaps unintended, message that mental health is not a priority. It is also evident to the Commission that this has negatively impacted on the delivery of services nationally. The fact that this was permitted to occur in addition to the slow, ad hoc, and unmonitored implementation of AVFC is disappointing.

Resources

Irish mental health services have significant resourcing challenges, not least in staffing. In order to make progress in these areas, adequate funding is required. The Commission welcomed the additional funding allocated by the Government to mental health services in 2019. However, we are conscious that the current level of expenditure on mental health is still less than the 8.24% target (based on 2005 figures) envisaged in *AVFC.*

As will be discussed in more detail, the Commission is also cognisant of the continued difficulties in maintaining and increasing levels of adequately trained staff in mental health services. The HSE's Workforce Planning document, published in October 2018, outlined that the mental health workforce is at 76% of the levels recommended in *AVFC* and identified that the "Main data findings indicate that community staff only accounts for 27% of the overall workforce within Mental Health."

Based on our inspections, we are aware of the serious effect that a lack of adequately trained staff has on the quality and quantity of services that can be provided. Given the labour-intensive nature of mental health care services, it is imperative that the matter of increasing the mental health service budget to at least the percentage outlined in *AVFC* be addressed if full and effective staffing of mental health teams across the country is to be achieved.

Research clearly shows the economic returns and benefits of investing in mental health supports and the effective training of mental healthcare staff, as well as indicating the enormous cost of limiting investment, both on the health and the economy of our country. If we are to put in place modern community services and move out of the shadow of institutional care, workforce planning and change management are key.

Workforce Practices and Development

Additional funding is of course fundamental to transforming our Mental Health Services. However, there is also a need to change how the State uses existing funding in order to redevelop services. For example, creative and innovative approaches, improved team working, building up community services and changing work practices are having an impact in certain CHO areas, while others appear to be stagnant, trapped in a closed loop of unhealthy logistical and clinical practices from the traditional institutional system.

The highest quality mental health services in the country have adapted, changing their approaches and practices. For example, some services have recruited and trained mental health support workers to undertake non-nursing duties, which has allowed for the further development of specialist nursing roles. Nursing staff in some services facilitate additional specialist outpatient services, for example in early intervention and homeless services. These services contribute to decreased admissions to inpatient facilities, shorter lengths of stay, early discharges and, as a result, reduce pressure on the staff in approved centres. Lack of these community services have the knock-on effect of longer lengths of stay of residents in-patient mental health services, which has in some facilities resulted in overcrowding. Another key development is the use of the voluntary sector in providing services to people with psychiatric illnesses in non-residential community care.

In countries with highly developed mental health services, clinical workforce planning is rooted in and supported by prudent and decisive strategies and programmes. While these may exist in Ireland, it is not evident to the Commission that governance, leadership development and transformation strategies link to or drive workforce development in Irish mental health services. It is disappointing, for example, to observe the continued lack of development of mental health rehabilitation services in Ireland. While national mental health policy, A Vision for Change (2006) recommended a total of 48 rehabilitation teams (based on current population), we currently have only 23 very poorly staffed teams. Our only specialist rehabilitation in-patient units are privately provided, with the HSE funding beds providing an out-of-area service, a practice which has been strongly criticised internationally. We have over 1,000 people in highly supervised residences with little or no prospect of moving to more

independent living due to lack of both adequately resourced rehabilitation teams and suitable accommodation.

Performance Management, Development and Support (PMDS)

Following on from recent Public Service Agreements, PMDS is now common practice across the Irish civil and public services. It is a process for establishing a shared understanding about what is to be achieved and how it is to be achieved, and an approach towards managing people that increases the probability of achieving success. If we are to transform our health services, it is an essential aspect of governance and management to facilitate individuals and teams to link performance to policy and operational plans.

The Commission is aware that in 2012, the HSE introduced a formal Performance Management System in fulfilment of the terms of the Public Service Agreement. The system was intended to cover all grades and professional disciplines and was introduced on a phased basis; commencing with National Directors to Grade VIII and equivalent, including comparable clinical grades in 2012. The Commission has found very little evidence of this approach in practice. The Commission would have reservations about the success of any national policy, workforce initiatives, or plans which are not underpinned by an appropriate performance management framework.

Regulation 26: Staffing

KEY FINDINGS

- An average of **91%** of approved centres were non-compliant with Regulation 26: Staffing between 2016 and 2018.
- Non-compliance with Regulation 26: Staffing comprised **16.5%** of all non-compliance in 2016, **13.9%** in 2017, and **13.8%** in 2018.
- The most common reason for non-compliance with Regulation 26 was **subsection 4,** relating to **staff training.**
- **CHO Area 4: Kerry, North Cork, North Lee, South Lee, West Cork** had the highest instance of non-compliance with Regulation 26 each year between 2016 and 2018.
- Only **three** approved centres were consistently compliant with Regulation 26 over the three-year period.

The most common reason for non-compliance within Regulation 26: Staffing over the three-year period was consistently Subsection 4, relating to staff training, which reads: "*the registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice*". Essentially, many approved centres were non-compliant with this regulation because not all health care professionals were up to date with mandatory training in Basic Life Support, Professional Management of Aggression and Violence, Fire Safety and the Mental Health Act 2001.

In 2016, for instance, 35% of breaches of Regulation 26 were risk rated High or Critical, indicating that a significant proportion of non-compliance with this regulation occurred as a result of little to no training of clinical staff in the aforementioned areas. In 2017, this number rose to 47.5% being risk rated as either High or Critical, rising again in 2018 to 56.9%. This indicates that while the number of breaches of Regulation 26 remained static (between 58 and 60 breaches, with 86 individual reasons in 2016, 129 individual reasons in 2017, and 117 in 2018) over the three-year period, the severity of those breaches has increased significantly over that same period.

Conclusion

The last number of years have been a difficult period to provide and maintain high quality and safe mental health service for our citizens. However, we have ample opportunity, for the future lives of those people suffering with mental ill health, to transform our mental health service, if we put the right policy in place now, fund it, and implement it.

The end goal for each and every one of us must be to move out of the shadow of institutional care by creating modern, well-staffed community services in the areas where people live and can be close to their families.

The Commission recommends that any workforce planning should be aligned with national policy in order to ensure that the system as a whole develops, innovates, and transforms. The Department of Health and the HSE should reinstate the National Director role to ensure dedicated, senior level, executive oversight and accountability. The transformation of our mental health service must be evidenced-based, connected to and underpinned by a performance development and support system.

I thank the Committee for listening. We are happy to take any questions you may have.

Appendix I: Figures

Figure 1: Regulations least complied with, 2016

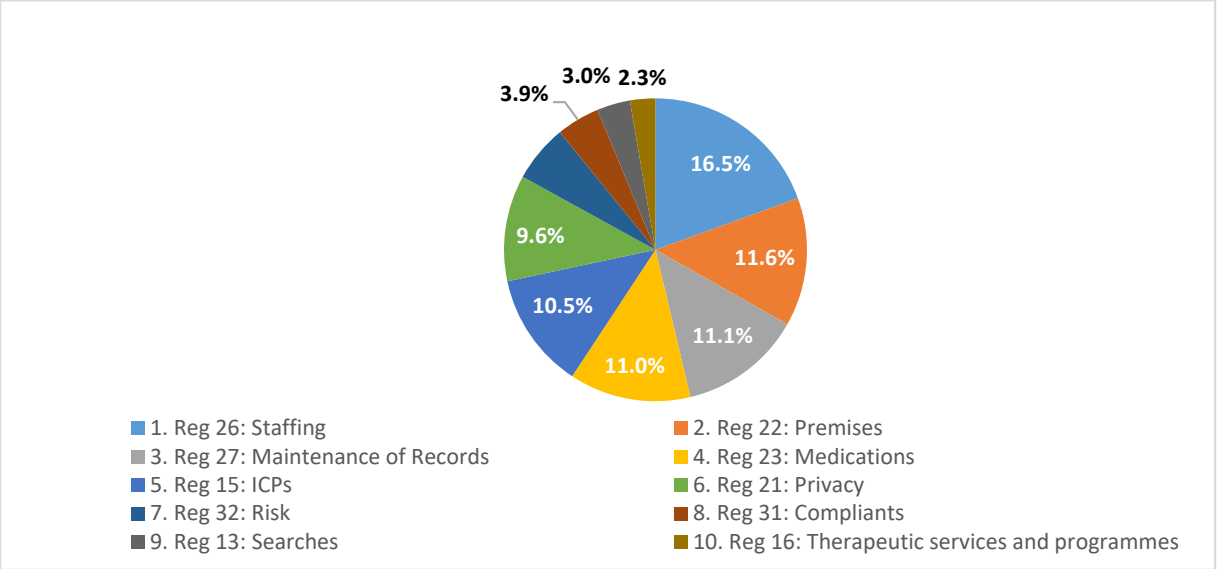


Figure 1 shows that in 2016, the regulation least complied with was Regulation 26: Staffing, comprising a total of 16.5% of reasons for non-compliance (with a total of 178 reasons) for non-compliance.

Figure 2: Regulations least complied with, 2017

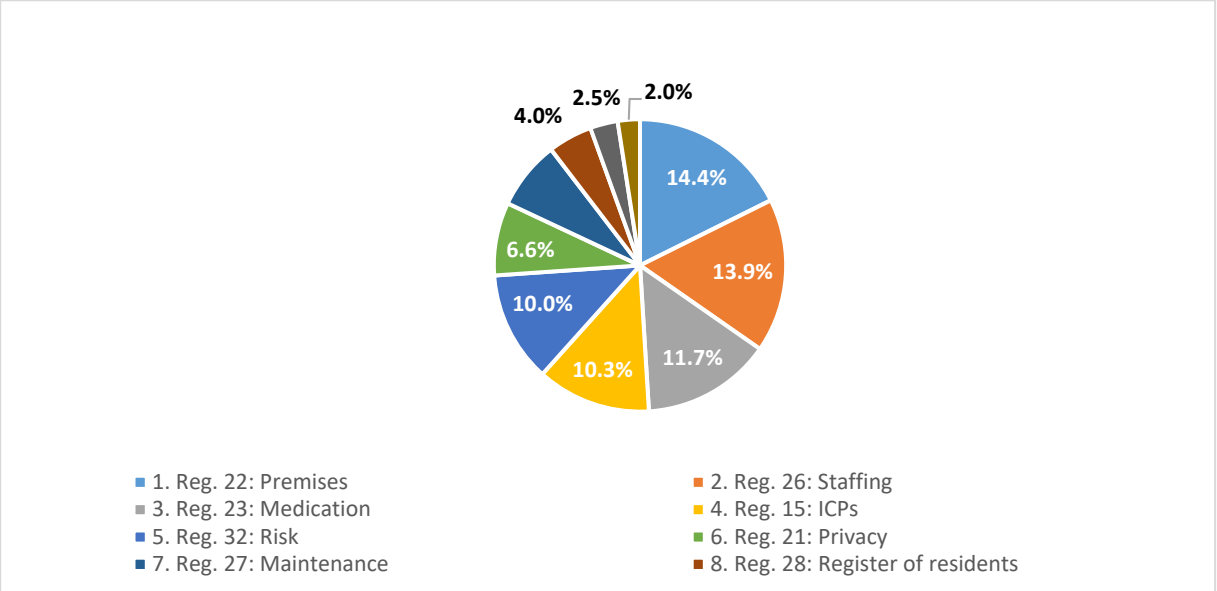


Figure 2 reflects the fact that problems with approved centres' premises have been longstanding issues, arising since the beginning of Mental Health Commission inspections. 2017 and 2018 saw Regulation 22 as the Regulation least complied with. In 2017, there were a total of 137 reasons for non-compliance with Regulation 22 among 49 approved centres.

Figure 3: Regulations least complied with, 2018

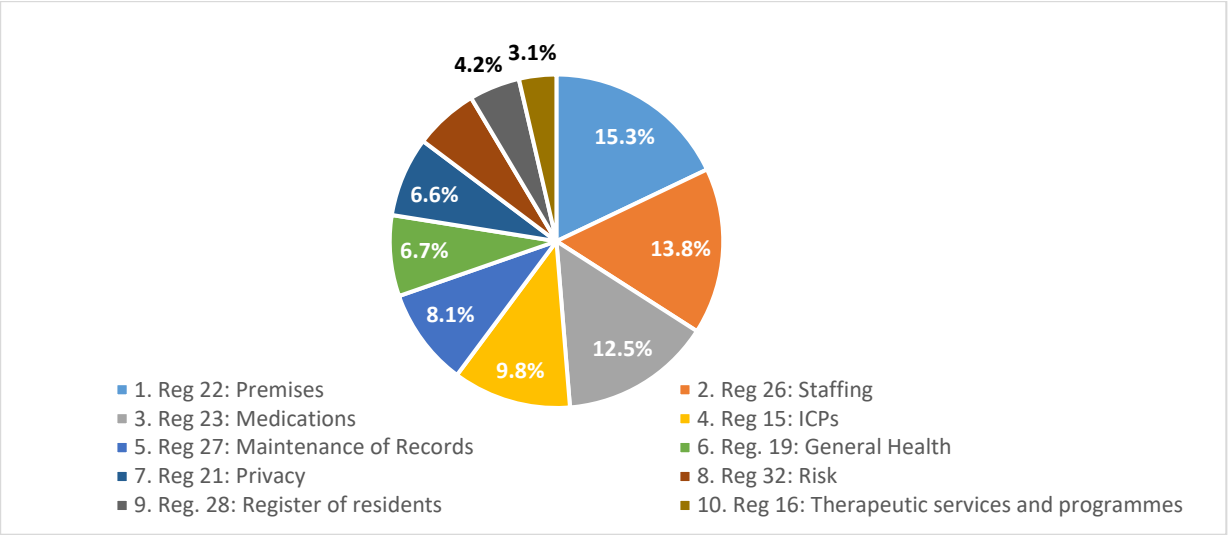


Figure 3 shows that in 2018, Regulation 22 comprised 15.3% of all regulations not complied with, made up of a total of 130 reasons for non-compliance, while Regulation 26 comprised 13.8%, made up of a total of 117 reasons for non-compliance.

In 2018, there were a total of 130 reasons for non-compliance with Regulation 22 among 45 approved centres. Further to the Regulation, the more specific reasons given for non-compliance were more detailed than those provided for Regulation 26. Under Regulation 26, there were 115 reasons for non-compliance among 58 approved centres.

Figure 4: Regulation 26: Staffing breakdown of reasons for non-compliance, 2016-18

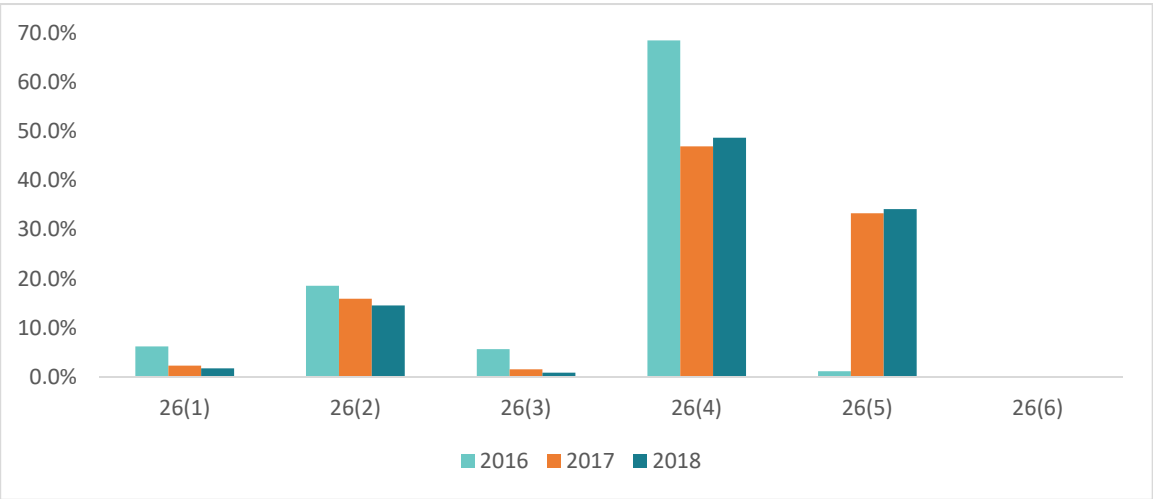
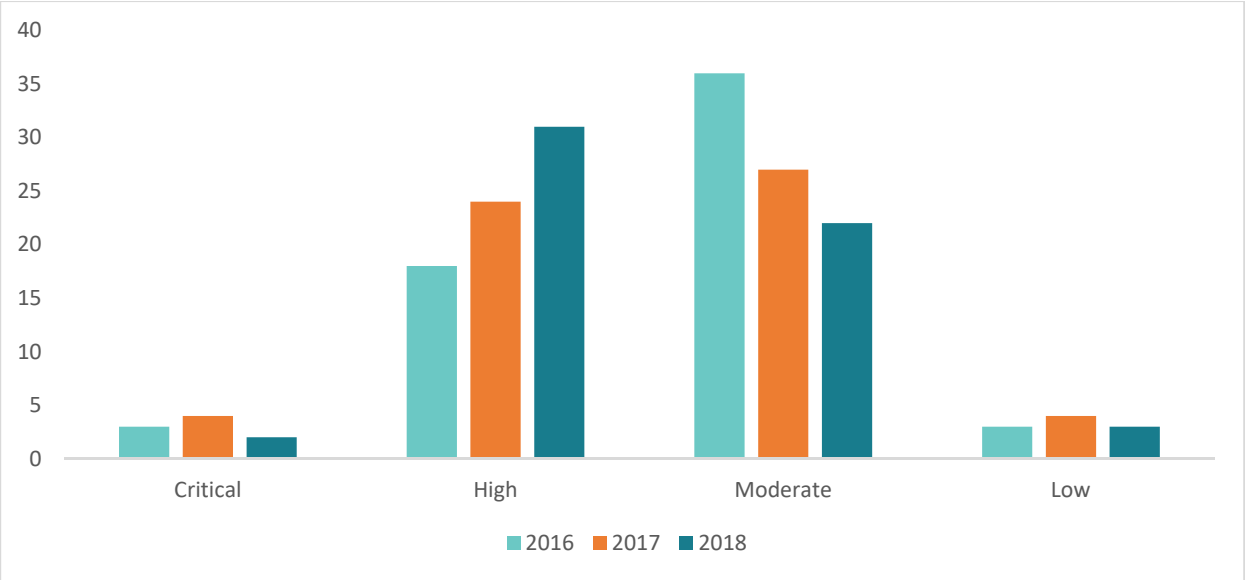


Figure 4 shows the breakdown for reasons for non-compliance within Regulation 26, finding that the most common reason was subsection 4, which reads: "***The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in***

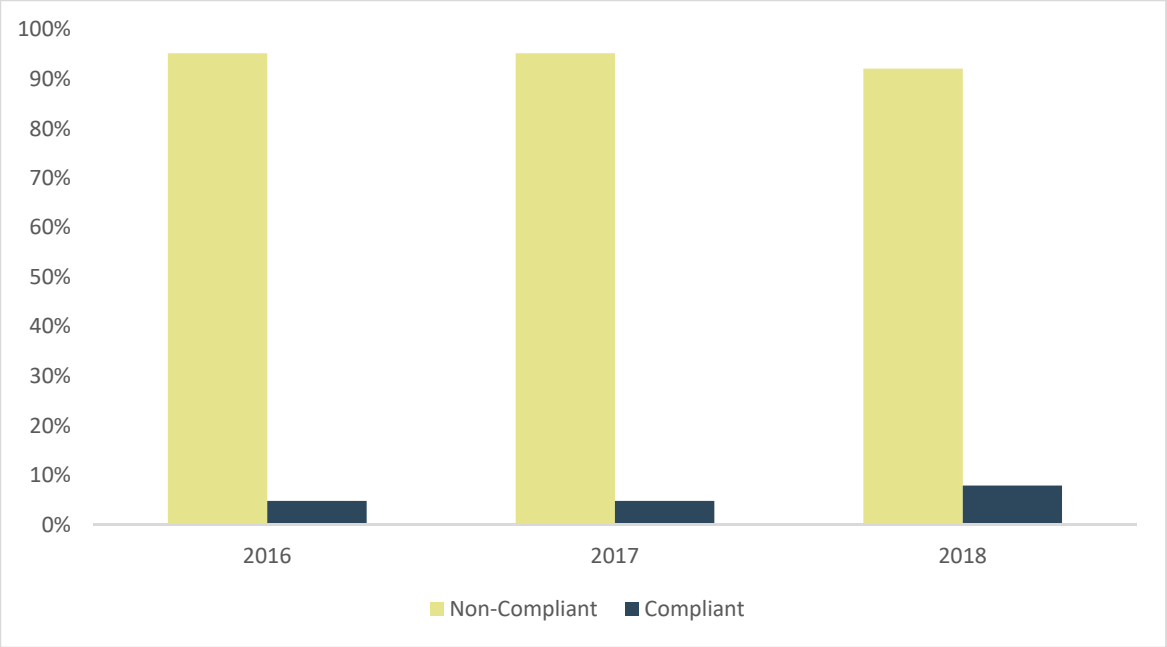
accordance with best contemporary practice". Each approved centre's inspection report, and indeed the compliance monitoring tables compiled by the Standards and Quality Assurance division of the Commission, go into much greater detail on the percentage of staff who have received training in each of the compulsory areas, namely, Basic Life Support, Professional Management of Aggression and Violence, Children First, and the Mental Health Act 2001. The fact that a centre may be non-compliant with Regulation 26 as a result of a single member of clinical staff not having received training in one of the compulsory modules makes the analysis of the dataset to hand not immensely useful, as the severity of the breach is divided up into only four categories: Critical, High, Moderate, and Low.

Figure 5: Risk rating of breaches of Regulation 26: Staffing, 2016-2018



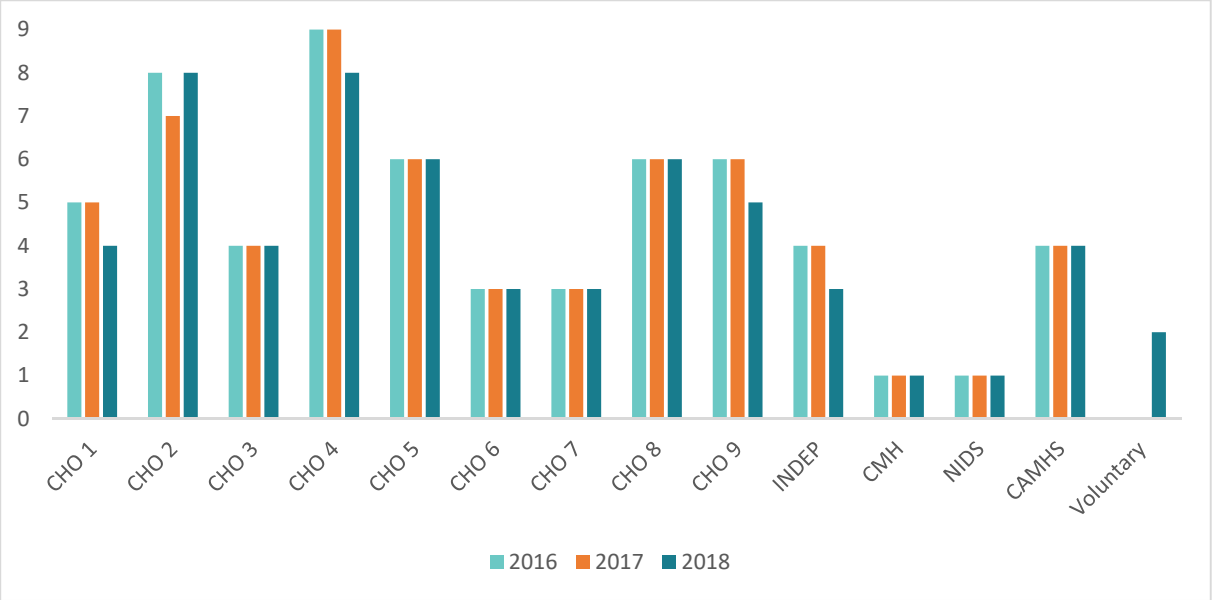
In 2016, for instance, 35% of breaches of Regulation 26 were risk rated High or Critical, indicating that a significant proportion of non-compliance with this regulation had happened where little to no training of clinical staff was occurring. In 2017, this number rose to 47.5% being risk rated as either High or Critical, rising again in 2018 to 56.9%. This indicates that while the number of breaches of Regulation 26 remained static (between 58 and 60 breaches, with 86 individual reasons in 2016, 129 individual reasons in 2017, and 117 in 2018) over the three-year period, the severity of those breaches has increased significantly over that same period. For closer consideration of the cause and effect of the consistent non-compliance of centres with Regulation 26, it would be useful to do a more in-depth thematic analysis of the text of the individual inspection reports of each of the non-compliant approved centres from 2016-18.

Figure 6: Ratio of non-compliance to compliance with Regulation 26 by approved centre, 2016-18



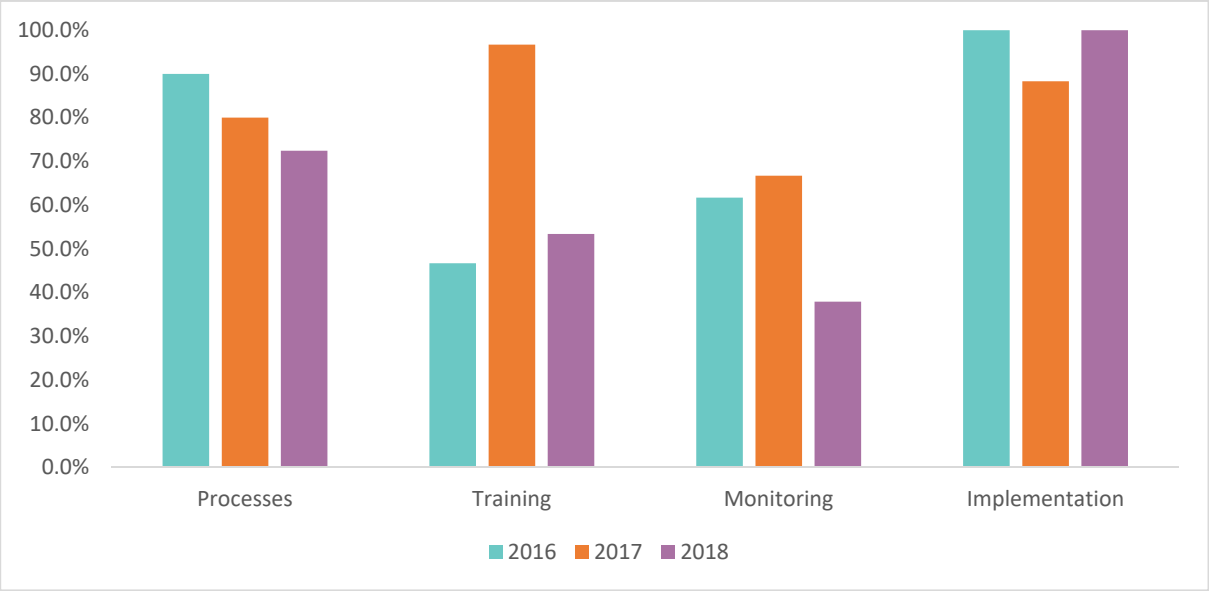
Across all three years, less than 10% of approved centres were compliant with Regulation 26 (see additional details in *Table 2*). Based on *Figure 6* above, only three of the total number (ranging from 64 to 66 centres over the three-year period) of approved centres, namely St Patrick's University Hospital, Willow Grove Adolescent Unit, St Patrick's University Hospital, and St Edmundsbury Hospital, were consistently compliant with Regulation 26 between 2016 and 2018. Of the remaining 63 centres, only three (Deer Lodge, Drogheda Department of Psychiatry, and Rehab and Recovery Unit, St John's Hospital Campus) managed to be compliant for more than one of the years, showing that consistent improvement or consistency in achieving compliance with Regulation 26 was very difficult to achieve. This speaks to a deep-rooted systemic issue with how training is being delivered and implemented in approved centres, and would also be cause to consider how the regulation is being inspected against, and whether this is having an impact on approved centres' ability to satisfy the criteria of Regulation 26.

Figure 7: Number of approved centres not compliant with Regulation 26 by CHO, 2016-18



Improvement was seen in a number of CHO areas (CHO 1, CHO 2, CHO 4, CHO 9), but never for more than a single year. The voluntary sector deteriorated in 2018 (increasing from zero to two non-compliant approved centres), having been totally compliant in the years 2016 and 2017.

Figure 8: Quality pillars not complied with under Regulation 26 by non-compliant approved centres, 2016-18



Over the three-year period spanning 2016 to 2018, the most common of the *Judgement Support Framework*'s four quality pillars under which approved centres were found to be non-compliant in

relation to Regulation 26 were Processes and Implementation. In practice, and as it relates to subsection 4 of the regulation, this amounts to the fact that non-compliant approved centres either did not have the processes in place to allow training to be organised and conducted effectively, or that, if there were processes in place, they were being carried out improperly.

Appendix II: Tables

Table 1: % of approved centres compliant with Regulation 26(1)-(6), 2016-18

	2016	2017	2018
26(1)	90.9%	95.3%	96.9%
26(2)	77.3%	70.3%	73.8%
26(3)	93.9%	96.9%	100.0%
26(4)	12.1%	9.4%	12.3%
26(5)	97.0%	31.3%	38.5%
26(6)	100.0%	100.0%	100.0%

The data contained in *Table 1* indicate that approved centres were for the most part compliant, in terms of the staffing required for acute inpatient beds, but that the services were not providing each of those members of staff with the mandatory training required by the 2001 Act.

Table 2: Overall percentage of approved centres not compliant with Regulation 26: Staffing, 2016-18

	2016	2017	2018
No. Registered Approved Centres	66	64	65
No. Non-Compliant with Regulation 26	60	60	58
% Non-Compliant	**90.9%**	**93.8%**	**89.2%**

Table 2 indicates that an incredibly high percentage of centres were not compliant with Regulation 26 between the years 2016 and 2018, ranging from 89% to 94%.

Appendix III: Compliance by Approved Centre, 2016-18

Approved Centre	2016	2017	2018
Adult Mental Health Unit, Mayo University Hospital	N	N	N
Acute Psychiatric Unit 5B, University Hospital Limerick	N	N	N
Avonmore & Glencree Units, Newcastle Hospital	N	N	N
Admission Unit & St Edna's Unit, St Loman's Hospital	N	N	N
Maryborough Centre, St Fintan's Hospital	N	N	N
Jonathan Swift Clinic	N	N	N
Department of Psychiatry, Roscommon University Hospital	N	N	N
Acute Psychiatric Unit, Tallaght Hospital	N	N	N
Sligo/Leitrim Mental Health In-patient Unit	N	N	N
Centre for Mental Health Care & Recovery, Bantry General Hospital	N	N	N
St Ita's Ward, St Brigid's Hospital	N	N	N
St Gabriel's Ward, St Canice's Hospital	N	N	N
Carraig Mór Centre	N	N	N
Acute Psychiatric Unit, Cavan General Hospital	N	N	N
Department of Psychiatry, Connolly Hospital	N	N	N
St Davnet's Hospital - Blackwater House	N	N	N
Acute Psychiatric Unit, Ennis Hospital	N	N	N
DOP Galway	N	N	N
Lakeview Unit, Naas General Hospital	N	N	N
St Aloysius Ward, Mater Misericordiae University Hospital	N	N	N
St Michael's Unit, Mercy University Hospital	N	N	N
Department of Psychiatry, Midland Regional Hospital, Portlaoise	N	N	N
Grangemore Ward & St Aidan's Ward, St Otteran's Hospital	N	N	N
Sycamore Unit, Connolly Hospital	N	N	N
Department of Psychiatry, University Hospital Waterford	N	N	N

Units 2, 3, 4, and Unit 8 (Floor 2), St Stephen's Hospital	N	N	N
Department of Psychiatry, St Luke's Hospital	N	N	N
St Catherine's Ward, St Finbarr's Hospital	N	N	N
St John of God Hospital	N	N	N
Central Mental Hospital	N	N	N
St Joseph's Intellectual Disability Service	N	N	N
Elm Mount Unit, St Vincent's University Hospital	N	N	N
O'Connor Unit	N	N	N
St Vincent's Hospital	N	N	N
Sliabh Mis Mental Health Admission Unit, University Hospital Kerry	N	N	N
An Coillín	N	N	N
Bloomfield Hospital	N	N	N
Teach Aisling	N	N	N
Cappahard Lodge	N	N	N
St Anne's Unit, Sacred Heart Hospital	N	N	N
Tearmann Ward, St Camillus' Hospital	N	N	N
Adolescent In-patient Unit, St Vincent's Hospital	N	N	N
Lois Bridges	N	N	N
Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital	N	N	N
Eist Linn Child & Adolescent In-patient Unit	N	N	N
O'Casey Rooms, Fairview Community Unit	N	N	N
Drogheda Department of Psychiatry	N	N	N
Haywood Lodge	N	N	N
Highfield Hospital	N	N	N
St Bridget's Ward & St Marie Goretti's Ward, Cluain Lir Care Centre	N	N	N
Selskar House, Farnogue Residential Healthcare Unit	N	N	N
Phoenix Care Centre	N	N	N
Ashlin Centre	N	N	N
Le Brun House & Whitethorn House, Vergemount Mental Health Facility	N	N	N
Acute Mental Health Unit, Cork University Hospital	N	N	N

Creagh Suite, St Brigid's Healthcare Campus	Y	N	N
Drogheda Department of Psychiatry	Y	Y	N
Rehab and Recovery Mental Health Unit, St John's Hospital Campus	Y	Y	N
Linn Dara Child & Adolescent Mental Health In-patient Unit, Cherry Orchard	N	N	Y
Wood View	N	N	Y
Owenacurra Centre	N	N	Y
Adult Acute Mental Health Unit, University Hospital Galway	N	N	Y
Deer Lodge	N	Y	Y
St Patrick's University Hospital	Y	Y	Y
St Edmundsbury Hospital	Y	Y	Y
Willow Grove Adolescent Unit	Y	Y	Y
Cois Dalua			Y
No (Non-Compliant)	***90.9%***	***90.9%***	***86.6%***
Yes (Compliant)	***9.1%***	***9.1%***	***13.4%***