



I. Introduction

I.1. Background

The purpose of this paper is to set out the role of the Mental Health Commission's Regulatory Team (the **Commission**) in supervising, monitoring and supporting services in their management and mitigation of the COVID-19 pandemic in Irish residential mental health services, and to provide preliminary observations on the Commission's role during the period of March-July 2020. The Commission has used this paper as an opportunity to review preliminary data and observations gathered from Irish mental health services during the COVID-19 pandemic, seeking to share learnings and developments in order to ensure that services are prepared to the utmost degree possible for the expected imminent outbreak of wintertime influenza, and any COVID-19 case surges.

COVID-19 is associated with acute respiratory illness, and clinical evidence indicates that a proportion of patients become seriously ill, requiring respiratory support and admission for intensive care treatment¹. While the disease is normally relatively mild for most, the severity rises with age primarily and some medical conditions, and is potentially severe for the over-70s age cohort. While the entire population is vulnerable during a pandemic, mental health service users resident in acute settings and long-term residential care units may be particularly susceptible to developing COVID-19 and adverse effects from COVID-19, because of pre-existing medical conditions, an inherent situational dependence on others for support in meeting their everyday needs, or because they live in a congregated setting².

The Commission is an independent statutory body that was established in April 2001, and is the regulator for mental health services in Ireland. The regulatory functions and process for independent review of involuntary admissions came into effect following full commencement of the Mental Health Act 2001³ (the **2001 Act**), in 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 2017, the Commission welcomed the establishment of the Decision Support Service (**DSS**) within the Commission under the Assisted Decision-Making (Capacity) Act 2015⁴. The DSS extends the remit of the Commission beyond mental health services to include all relevant persons in Ireland who may require support in decision-making.

I.2. Mental health services and regulation

Under the 2001 Act, the statutory scope of mental health regulation is limited to in-patient services (approved centres), which are estimated to make up <1% of mental health services in Ireland. 90% of mental health services are delivered in primary care settings. A further 10% are delivered within specialist mental health services, including 24-hour nurse staffed community residences, which are unregulated.

During the monitoring period of between 4 April and 10 July 2020 (the **Monitoring Period**), there were 67 approved centres nationally, comprising 2,649 beds. There were 114 24-hour nurse staffed community residences nationally, comprising approximately 1,250 beds. As these services are unregulated and are subject to regular reconfiguration, it is difficult to provide an exact figure in relation to community residence beds.

A wide range of services are provided within mental health residential facilities, including: acute adult mental health care, continuing mental health care, psychiatry of later life, mental health rehabilitation, forensic mental health care, mental health care for people with intellectual disability, child and adolescent mental health care (CAMHS), and specialist eating disorder services.

The Health Service Executive (HSE) provides the vast majority (92%) of residential mental health services. A small number (7%) operate as private and independent services, and 1% are funded by the HSE as Section 38 organisations, which amount to agencies contracted to provide work and services for the HSE.

1 Department of Health (2020). Ethical Considerations Relating to Critical Care in the context of COVID-19.

2 Department of Health (March 2020). Ethical Framework for Decision-Making in a Pandemic.

3 Mental Health Act 2001 (2001).

4 Assisted Decision Making (Capacity) Act 2015 (2015).

I.3. COVID-19 risk assessment, monitoring and response

On 13 March 2020, the Commission announced that it had suspended the inspection of approved centres. Under the 2001 Act, the Inspector of Mental Health Services is required to visit and inspect all approved centres on the Register of approved centres each year. The Inspector is required to assess compliance with the 2006 (Approved Centres) Regulations, Rules and Codes of Practice.

On 25 March 2020, the Commission also suspended compliance monitoring exercises relating to Corrective and Preventative Action Plans and condition monitoring reports in order to remove administrative burden from the services, and to ensure that the safety and wellbeing of people using mental health services remained a priority.

On 1 April 2020, the Department of Health (**DoH**) wrote to the Commission requesting a risk assessment of mental health services based on disease progression, environment and staffing levels. Mental health services were identified as being of potentially high risk, due to the prevalence of infection and adverse results for persons over 60 years of age, with underlying medical conditions and high contact physical environments.

The Commission undertook a rapid review of available national and international guidance in relation to long-term care provided in residential settings and developed a risk assessment framework⁵ (the **Risk Framework**), published on 6 April 2020, to objectively assess and record the level of risk in mental health services. The framework used the simple pillars of 'Space', 'Staff', 'Systems' and 'Stuff' to evaluate the ability of services to respond in an environment of catastrophic crisis where resources may become scarce and have to be targeted to areas of greatest need.



The Commission commenced weekly monitoring with 181 services, including all approved centres and 24-hour nurse staffed community residences on 7 April 2020. This monitoring included an assessment and reassessment against the risk framework, as well as weekly monitoring of disease progression, testing and access to personal protective equipment (**PPE**). The Commission's monitoring framework did not include low- or medium-support community residences.

5 Mental Health Commission (2020). COVID-19 Risk Assessment Framework.

From 18 May 2020, the Commission also commenced thematic monitoring of service continuity and COVID-19 preparedness in the context of the phased lifting of government restrictions. All services were required to answer weekly surveys, with questions including topics such as; admission protocols, residents' freedom of movement, visitation protocols, hygiene protocols, access to general health services and multi-disciplinary team involvement in resident care.

The Commission would like to highlight how responsive, communicative and proactive services were during the risk assessment and monitoring stages of the Commission's COVID-19 pandemic supervision and monitoring process.

In addition, the Commission collaborated with the Department of Health and the HSE to draft emergency legislation to provide an alternate format for mental health tribunals, which continued to ensure a person's right to due process and freedom from arbitrary detention.

All people who are involuntarily detained have the right to have their detention reviewed by a mental health tribunal within 21 days of the making of the admission or renewal order detaining the person. The tribunals are independent, and the reviews exist to protect patients' rights. Stringent requirements exist in the legislation, and the Commission carefully adheres to these statutory requirements.

The COVID-19 pandemic had created the potential for the failure of the current mental health tribunal procedures due to pressures and necessary restrictions on the health services and/or the unavoidable absence of tribunal panel members.*

**Please note that the Commission intends to publish a separate paper which will look specifically at the changes to the mental health tribunal process and the impact of same.*

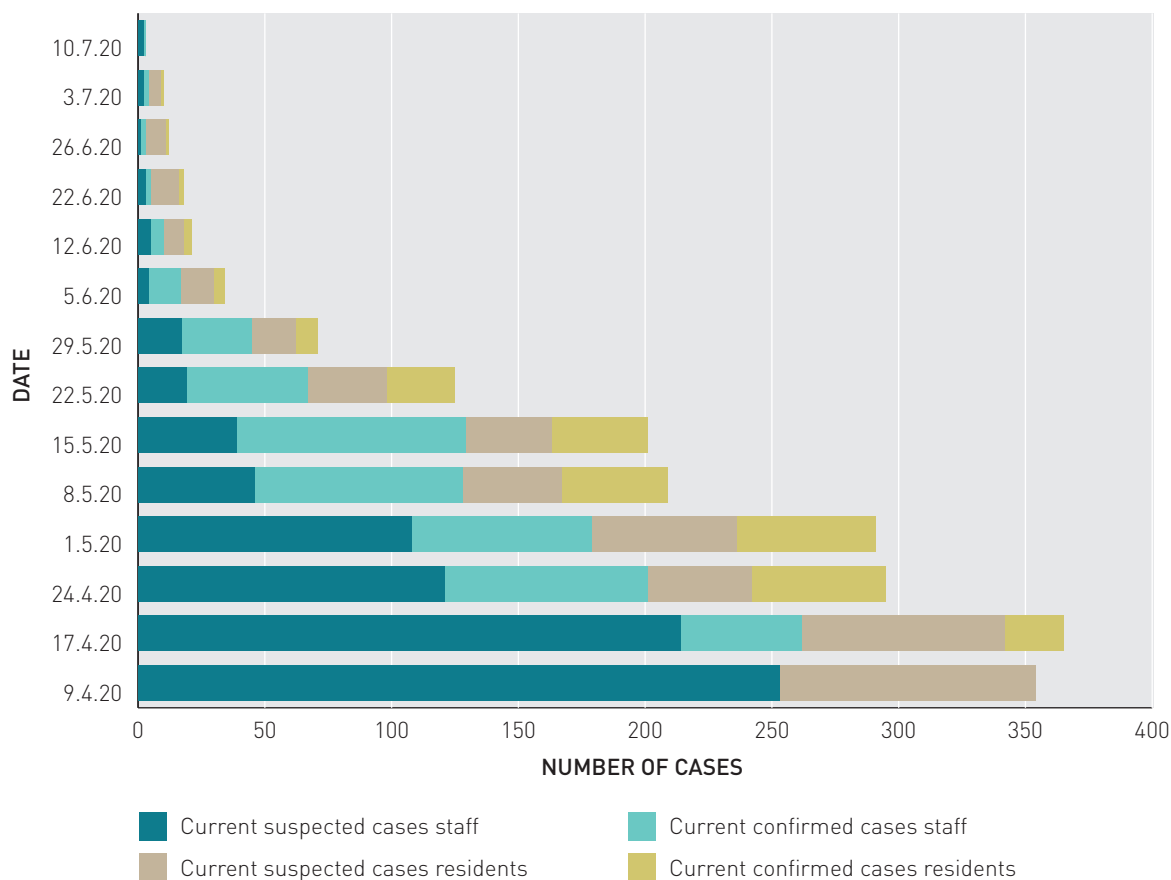
I.4. Prevalence of COVID-19 in residential mental health facilities

Based on data reported to the Commission by 181 services during the Monitoring Period, the prevalence of confirmed cases of COVID-19 was as follows:

- **28** services reported confirmed resident cases of COVID-19.
 - Of those 28 services, 19 were approved centres, and eight were community residences.
- 47 services reported confirmed **staff** cases of COVID-19.
 - Of those 47 services, 32 were approved centres, and 15 were community residences.
- In total, **31%** (56) of *all mental health services* monitored reported confirmed resident and/or staff cases.
- In total, **55%** (37) of *approved centres* reported confirmed resident and/or staff cases.
- There was a total of 17 COVID-19-related deaths across three approved centres.

Please note, these data were collated manually based on phone calls with individual services for the purpose of maintaining a live log of current suspected and confirmed cases. The Commission is in the process of contacting each of the services to obtain more comprehensive data on disease progression within mental health services. Services have been provided with a standard report template, which will allow for the validation and sign-off of the data within services, as appropriate. Services have been requested to provide a comprehensive list of staff and residents with a confirmed diagnosis of COVID-19, since the beginning of the pandemic, using non-identifiable information.

Figure 1: Confirmed and suspected resident COVID-19 cases; confirmed and suspected staff COVID-19 cases, in approved centres and 24-hour community residences, 9 April 2020 to 10 July 2020, as reported by services.



II. Methodology

II.1. Development of risk assessment framework

The Commission adopted a pro-active approach by risk assessing each service to assess preparedness, environment, and disease progression among the resident cohort and staff of all settings. Risk criteria were developed around a framework that emerged following the H1N1 pandemic, The Crisis Standards of Care (IOM, 2012),⁶ using the four simple pillars mentioned above; 'Space', 'Staff', 'Systems' and 'Stuff'. The model of the Commission's framework was a set of risk statements for each pillar and corresponding questions, comprising 51 criteria, that could be answered with a 'yes' or 'no'. Each criteria was phrased so that a 'yes' response indicated less risk, and a 'no' response indicated more risk. This allowed a large number of services to be reviewed, while removing the interviewer or interviewee's subjectivity in the risk assessment as much as possible.

Once each risk framework, and each follow-up monitoring call, had been completed, the risk score for each service was calculated and recorded on a central spreadsheet. The risk scores were calculated as shown in Figure 2 below, whereby the greater a risk score was, the lower the risk allocated to a service.

⁶ Committee on Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations; Institute of Medicine [2012]. *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*. Washington (DC): National Academies Press (US).

Figure 2: Risk score calculation

$$\frac{\text{Total 'Yes' responses}}{\text{Total \# Risk Assessment Framework Questions Asked}} \times 100$$

For the purposes of piloting, the risk framework was shared with the HSE national office on Friday April 3 2020. The framework was circulated to all mental health services on Monday 6 April 2020, with the framework being piloted with two services that same day. All services were contacted from Tuesday 7 April 2020.

Table 1: Risk assessment framework statements

Resident cohort
1. The resident cohort does not include at-risk populations
2. Residents are not accommodated in shared accommodation
Space
3. The physical environment is able to facilitate separation and cohorting of residents
4. The service maintains a schedule of cleaning
Systems
5. There are clear protocols for communications relating to COVID-19
6. Protocols have been established for visitors
7. The service is able to provide general health, emergency and palliative care services
8. Protocols have been established for the admission and transfer of residents
Staff
9. The service has access to staff with appropriate expertise
10. Staff have access to relevant training
11. Staff are not working across services
12. There is a plan for staff contingencies
Stuff
13. The services has a baseline stock of PPE
14. The service has contingency plans with suppliers

II.2. Development of ongoing monitoring framework

The Commission undertook a 'lessons learned' exercise, inviting feedback from the internal team undertaking the calls and carrying out the completion of surveys, on Thursday 9 April 2020. This feedback was incorporated into the development of a set of focused follow-up questions to form the basis of weekly ongoing monitoring calls with services. Those questions were added as an appendix to the Risk Framework, and related to: resident confirmed and suspected cases, the location of residents, and the number of residents recovered; staff confirmed and suspected cases and the numbers of staff recovered and those self-isolating; the current levels of access to PPE; any delays experienced in relation to testing; and any additional information, concerns or issues.

II.3. Application of risk assessment and monitoring frameworks

The initial average risk score calculated for the services was **79.87%**, with an updated average of **85.44%**, an improvement of **5.57%**. These figures indicated that services were, on the whole, operating at a very high level under the four key pillars of the Risk Framework, although there was room for improvement overall. Outcomes of risk assessments were compiled and compared across services and sectors by the Commission's Regulatory Management Team (**RMT**), which would provide weekly metrics to the Department of Health and HSE.

In the event of an immediate concern with one of the services surveyed, this was put in writing for escalation to the RMT, with particular concerns including: significant shortages of staff; an outbreak or cluster in service; and shortages of PPE to manage a suspected or confirmed case of COVID-19. Where necessary, particular concerns were identified and escalated to the HSE, where they would seek appropriate plans and mitigation, along with escalation to the Department of Health, as appropriate.

On an ongoing basis, services were contacted weekly in order to monitor disease progression and issues of concern arising, with metrics being updated into a central log and weekly updates provided to the Department of Health and HSE.

III. Preliminary Observations

The current paper was assembled not to consider the impacts of COVID-19 on mental health services, but rather to outline the preliminary observations of the Commission's role in supervising and supporting those services in managing and mitigating COVID-19 at a facility and service level. The Commission implemented a relationship-based approach to COVID-19 monitoring, establishing a supportive framework, which led to services contacting the Commission regularly and proactively as issues arose.

Defined escalation pathways and points of contact were established early between the Commission, HSE national office, the Department of Health, Mental Health Heads of Service, and with individual facilities. Regular communications and defined weekly reporting promoted collaboration and transparency. The HSE were highly responsive to escalated concerns; issues relating to services accessing PPE and delays in testing were responded to immediately and were either resolved or information was provided.

The Commission recognises the swift expansion of professional practice in undertaking new roles and responsibilities in mental health settings including undertaking COVID-19 test swabbing and in reviewing local and national policies to support practice on the ground. We also acknowledge the timely development of preparedness/outbreak plans in each centre. Finally, the Commission commends the implementation of HSE Webinars on Infection Prevention and Control which were delivered to mental health services in order to support staff.

III.1. Premises and accommodation

At the outset of the Monitoring Period, an early risk was identified in relation to facilities with shared accommodation and limited ability to isolate residents. Shared accommodation refers to a resident's primary bedroom accommodation being shared by more than one resident, for example, 2-bedded, 4-bedded, 6-bedded or larger dormitory-style accommodation. Rapid service reconfiguration was undertaken in many areas, including temporary closures and the use of alternative facilities. It has been observed that the use of dormitory-style accommodation was a factor in disease progression in a number of the services worst affected by COVID-19, however this will need to be examined further during the data validation process outlined in Section IV.2 below.

In April, the Commission expedited the registration of three modern IPC (infection and prevention control) compliant facilities with single room and en-suite bathrooms. The purpose of these expedited registrations was to move residents out of inappropriate and outdated accommodation and to facilitate the HSE in their COVID-19 contingency plans.

The Irish Government published its mental health policy, *Sharing the Vision (STV)*,⁷ in June 2020, as a much-awaited update of the 2006 policy *A Vision for Change*.⁸ STV noted that; “Approved centres or acute units are a particular part of the mental health infrastructure needing special attention. Many psychiatric units in acute hospitals were not purpose-built and were designed as standard hospital wards and simply designated as psychiatric units. This environment did not take into account the needs of people with mental health difficulties, particularly for access to outside space, and, indeed, more space generally”⁹.

It was found that not all residents in 57 of the 181 services (31%) had single rooms, while residents in 102 services (56%) used cohorted bathrooms, and were not provided with en-suite bathrooms. The Inspector of Mental Health Services, in the Commission’s annual reports, has consistently raised the inappropriate design of mental health facilities, including the ongoing use of cohorted bathrooms and sleeping quarters.

The COVID-19 pandemic has further highlighted these issues, and as a result, the Commission calls for more robust regulations on premises, including new regulations for community residences, in order to ensure that all residential and in-patient mental health services are in modern, fit-for-purpose buildings, which comply with IPC standards. A more robust regulatory framework may help to ensure that residents are not only provided with the surroundings and premises that have been proven to be best suited to their mental health care provision, but also to help protect against the risk of future infection of COVID-19, and in the case of other future pandemics.

III.2. Testing

The process for widespread testing measures was set out in the Interim *Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units*¹⁰, whereby Public Health determined that all staff of long-term residential care facilities should be tested for COVID-19. However, due to the lack of specificity, the Commission sought specific information on the roll out of widespread staff testing in services. Significant inconsistencies in the application of the guidance in relation to testing in residential care facilities were noted. The extent of planning, testing and the communication of test results varied significantly across geographic areas. End-to-end staff testing took more than a month, and many services reported significant delays in the communication of results.

No guidance was provided on criteria for retesting staff, or the expectations around how often staff would be tested. The Commission considers that staff testing should not be seen as a once-off process, and that a strategy for service wide or sampling of staff testing should have been embedded into health policy and repeated regularly.

The Commission observed the national testing strategy to be inconsistent and untimely. The Commission noted that there were significant geographic disparities in the ability to commence and complete the mass testing of staff and residents. At times, this process lacked coordination and oversight, and appeared to arbitrarily exclude certain services without explanation. The Commission expressed concern that certain mental health services such as private services and certain inpatient services were excluded from the testing plan for residential care facilities.

As outlined in Section III.2 above, the Commission’s risk and monitoring assessments evidenced that every acute inpatient mental health unit included either residents over the age of 60, or with underlying medical conditions, who are considered to be in high-contact physical environments and have higher numbers of admissions than other general health services.

7 Government of Ireland (2020). *Sharing the Vision: A Mental Health Policy for Everyone*.

8 Government of Ireland (2006). *A Vision for Change*.

9 Government of Ireland (2020). *Sharing the Vision: A Mental Health Policy for Everyone*, p75.

10 Health Surveillance Protection Centre (21 April 2020). *Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units*.

III.3. Access to therapeutic and community services

As experienced across the health sector, during the Monitoring Period, the Commission observed that access to community services and community teams was restricted. **27%** of services reported restricted multi-disciplinary team (**MDT**) numbers and input into the provision of residents' therapeutic programmes and services. Services indicated that occupational therapists in particular, as well as other general health and therapeutic service providers, either were not permitted access to services, or decided themselves not to attend due to the risk of infection. **37%** of services reported that all or some therapeutic programmes had continued, including socially distanced activities, with health and social care professionals sending in activities so that residents would be able to partake.

It also emerged that access to community mental health resources was restricted, with **6%** of services reporting that therapeutic day centres had been closed, and **12%** of services reporting that external services had been suspended. As reported by services, there may be a correlation between a lack of community mental health teams and a corresponding reliance on acute services, which remained open during the course of the pandemic, while specialist mental health care and therapies were suspended.

III.4. Guidance for residential mental health services

Throughout the Commission's monitoring, services were found to be increasingly aware of and responsive to the public health guidance issued by the HPSC. However, there were at times disconnects between the provision of guidance and the appropriate interpretation and implementation of guidance.

One set of guidance was provided for long-term residential care facilities, and another for acute hospitals. At the outset of the Monitoring Period, the guidance for these two types of services varied. Some approved centres fell between the guidance issued, as certain approved centres may be classified under either or both of these categories. The Commission consistently escalated concerns that there was confusion among services, particularly approved centres that took acute admissions, as to which guidance they should be following.

At the beginning of the Monitoring Period, all mental health services were advised to follow the various long-term residential care facilities guidance published by the HSPC. However, as time went on, significant inconsistencies were noted, in particular the divergent requirements for testing of residents and staff, admission, and community assessment and access to mental health services in acute mental health settings and long-term residential care facilities.

While services responded rapidly by suspending services, closing for admissions, and restricting visitors and contractors in line with public health advice, there was widespread uncertainty around the steps to recommence services and lessen restrictions.

IV. Next steps for the Commission

Mental health services, during the course of the Monitoring Period, have been made aware of the actions that are required of them to ensure the continuity of best possible care and treatment provision going forward, including the management and mitigation of risks associated with COVID-19 disease progression and secondary risks associated with the necessary suspension and restrictions on non-COVID-care.

The learnings uncovered during the Monitoring Period, and beyond, need to be entrenched in the supervisory and supporting role of the Commission for any future waves of COVID-19 infection, or other future pandemics. The Commission has sought meetings with the Department of Health and the HSE to discuss the detail of this paper and to commence planning for the management and monitoring of COVID-19 over the coming months. The Commission has identified the following four key actions to ensure that appropriate analysis is undertaken, and to ensure the greatest possible level of preparedness.

IV.1. Register of mental health service accommodation

There is currently no composite record describing the breakdown of accommodation within approved centres and 24-hour community residences. While this information is recorded for each facility, for example in the Inspector's Reports, it is not recorded centrally. As such, there is limited national oversight of the risk associated with shared or dormitory-style accommodation. Unregulated 24-hour nurse-staffed residences are not at present required to inform the Commission of a change in bed numbers, as there is no legal requirement for services to be able to isolate multiple residents if required.

The Commission intends to implement a live register of the format of accommodation in residential mental health services, with a view to being able to identify potential issues in the context of a second wave infection or future pandemic. As such, it will be used to firstly identify services with shared accommodation, and secondly, to assess whether, if a service has shared accommodation, it has the capacity to isolate multiple residents.

IV.2. Data validation

The Commission is in the process of conducting a data validation exercise in relation to the COVID-19 risk assessment and monitoring framework data collected during the monitoring period, as outlined in Sections II.1 and II.2 above. The exercise will provide important information on the number and profile of residents in mental health services who tested positive for COVID-19, as well as the number and means of identification of staff members who tested positive. The primary reason for this data validation process is to allow the Commission to be able to accurately access and report on disease progression (as requested by the DoH).

IV.2.1. Residents

All residents of an approved centre or 24-hour nurse-staffed community residence who tested positive for COVID-19 will be required to be recorded on the data validation form provided to each of the relevant governing bodies. These will include: (i) those who were resident in the facility when identified as being COVID-positive; (ii) those who were COVID-positive on admission to the facility; and (iii) those who were transferred to a medical facility for care or treatment following the identification of COVID-19 symptoms. Residents who were discharged or transferred to a hospital or other service and who subsequently became COVID-positive will not be recorded, nor will residents with a suspected case which was not confirmed with a test.

The information to be provided in the validation of resident data is as follows: (i) a unique anonymised identifier; (ii) date of birth; (iii) gender [female, male, other]; (iv) reason for testing [symptoms, close contact, mass testing, other]; (v) date suspected [if the resident was tested as a result of mass testing, this may be left blank]; (vi) date of testing; (vii) date results received; (viii) whether the resident was transferred to hospital for treatment; (ix) outcome [recovered, death, unknown, other]; (x) underlying medical conditions [cardiovascular disease, chronic respiratory disease; diabetes; cancer].

IV.2.2. Staff

All staff members who were working on the premises of a mental health service who tested positive for COVID-19 will be required to be recorded on the data validation form. This excludes administrative staff, or staff on leave who did not enter a mental health facility immediately before, during or after being confirmed as COVID-positive.

The information to be provided in order to validate staff case data is as follows: (i) a unique anonymised identifier [which is only requested to confirm that the staff recorded were not duplicated, and to observe whether they worked across services]; (ii) profession [RPN, CNM, healthcare assistant, consultant psychiatrist, multitask attendant etc.]; (iii) reason for testing [symptoms, close contact, mass testing, other]; (iv) date of testing; (v) date results received by staff member; (vi) working across facilities [a yes/no response is required].

IV.3. Inspection of services

The Commission has developed a plan to complete all remaining inspections to a process which is in line with public health advice, and aims to protect the safety of residents and staff of approved centres and Commission staff by limiting the risk of disease transmission. This plan will be kept under constant review to ensure that plans and protocols are in line with current official advice and guidelines.

At a high level, the plan aims to reduce the amount of time spent on site in approved centres by assistant inspectors, and to limit the number of inspectors required on site, while ensuring that compliance with all regulations, rules and codes of practice is inspected. Where onsite work is unavoidable, protocols to reduce the risk of COVID-19 disease transmission will be implemented in line with public health advice.

IV.4. Paper on the impact of COVID-19 on residential mental health services

The next follow-up step to the Commission's response to the COVID-19 pandemic will be to draft a paper using the data validation being undertaken with services. This data validation outlined in section IV.2 will seek to understand the impact of COVID-19 on residential mental health services, and to report on disease progression. This paper will be peer reviewed, and will use both quantitative and qualitative methods, using the data validation process outlined in Section IV.2 above, to establish the impacts of COVID-19 on residential mental health services.



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