Mental Health Commission submission

Part 1: Remit of the Mental Health Commission and our role in relation to COVID-19

1. Introduction

i. The Mental Health Commission (the Commission) is the regulator for mental health services in Ireland.

ii. We are an independent statutory body that was established in April 2001. The regulatory functions and process for independent review of involuntary admissions came into effect following full commencement of the 2001 Act, in November 2006.

iii. 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.

iv. In 2017, we welcomed the establishment of the Decision Support Service (DSS) within the Commission under the Assisted Decision-Making (Capacity) Act 2015. 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.

2. Mental health services and regulation

i. 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.

ii. There are 67 approved centres nationally, comprising 2,649 beds. There are 114 24-hour nurse staffed community residences nationally, comprising approximately 1,250 beds. As these services are unregulated and subject to regular reconfiguration, it is difficult to provide an exact figure in relation to community residences.

iii. 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.

iv. The vast majority (92%) of residential mental health facilities in Ireland are provided by the HSE. A small number (7%) operate as private and independent services (some of these provide services to the HSE as Section 38/39 organisations) and three (1%) are funded by the HSE as Section 38 organisations.

3. COVID-19 risk assessment, monitoring and response

i. On 1 April 2020, the Department on Health 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.

ii. 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 framework to objectively assess and record the level of risk in mental health services. This framework was published on 6 April 2020. The framework used the simple pillars of 'Space', 'Staff', 'Systems' and 'Stuff' to evaluate the ability of services to respond in an environment of contingency/crisis where resources may become scarce and have to be targeted to areas of greatest need.

iii. The Commission commenced weekly monitoring with all approved centres and 24-hour nurse staffed community residences from 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 PPE. The Commission's monitoring framework did not include low or medium support community residences.

iv. From 18 May, 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 surveyed with weekly 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.

v. 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.

vi. 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.

vii. 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.

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

i. Based on data reported to the Commission by 181 services between April-June 2020, the prevalence of confirmed cases of COVID-19 is as follows:

- **28** services reported confirmed **resident** cases of COVID-19
- Of those 28 services, 19 were approved centres and 8 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

ii. Please note, this data was collated manually based on phone calls with individual services and has not been subject to validation. The Commission is now preparing to contact all services to validate the data on disease progression within mental health services. Services will be provided with a standard report template which will allow for validation and sign-off of the data within services, as appropriate.

Part 2: Special Committee issues of interest

In response to the specific issues of interest identified by the Committee, the Commission has set out observations for which data has been gathered throughout the Commission's risk assessment, weekly monitoring and thematic monitoring of mental health residential facilities. Observations are made on the following issues:

1. Restarting non-COVID-19 care
2. Catch-up programme for missed care and services
3. Mental health and well-being
4. Additional capacity in the health service
5. Need for additional testing as non-Covid-19 care increases

1. Restarting non-COVID-19 care

i. Proper provision of care and treatment within mental health services takes a biopsychosocial model, which includes the provision of a holistic programme of therapeutic services tailored to the assessed needs of each person.

ii. This model of care is premised on a multi-disciplinary approach to care working in partnership with the person. Within specialist mental health services, such as mental health residential facilities, this model of care can also include activities which require social connection such as group therapies and integrated community services such as day centres and day hospitals.

iii. Community-based services and community mental health teams can follow a person on their care pathway and support them in their recovery. In the absence of a properly functioning community mental health team, there is a heightened risk of otherwise preventable admissions to acute mental health services.

iv. During COVID-19, across the monitoring period between April-June, the Commission observed a number of challenges for services to provide care and treatment to their residents in line with their assessed needs:

- **27%** of services reported restricted MDT numbers and input into the provision of a residents' therapeutic programmes and services
- **35%** of services reported that input from their MDT, in particular health and social care professionals such as occupational therapists, social workers and psychologists, was primarily by **phone**
- **6%** of services reported that all of their therapeutic programme was **suspended**, although **16%** of services indicated a recent or planned increase in therapeutic services
- **12%** services reported access to **external services** was suspended

v. During COVID-19, across the monitoring period between April-June, the Commission observed services employing creative and innovative methods in order to continue providing non-COVID-care:

- **37%** of services reported that all or some therapeutic programmes have continued, including socially distanced activities, with health and social care professionals sending in activities which residents will be able to partake in independently.

- **35%** of services reported that, by using various telehealth methods, nursing and care staff have been working with remote HSCPs to deliver therapeutic services and programmes to service users.
- **43%** of services reported that weekly MDT meetings were being conducted via teleconference.

Recommendation

vi. Therapeutic programmes and services should be resumed as a priority. Consideration should be given to how therapeutic programme and MDT involvement could be facilitated in a second wave infection or in a future pandemic. Services should 'share the learning' where innovations and opportunities were identified and implemented.

2. Catch-up programme for missed care and services

i. The Commission has had a strong focus on the physical health of residents of mental health facilities over the last number of years. 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.

ii. The Inspector of Mental Health Services has highlighted specific risks for people experiencing enduring mental illness and the need to ensure robust monitoring and provision of general health services.

> *"People with a serious mental illness will typically die between 15 and 20 years earlier than someone without a mental illness and their physical illnesses are largely preventable […] There was a widespread lack of access to essential healthcare such as physiotherapy, dietetics, speech and language therapy, and seating assessments […] These services are available to the rest of the population in the community and in general hospitals but are refused in many cases to residents in continuing care mental health units, because they are mental health patients".*[1]

iii. The Commission is aware that there is a significant cohort of residents in mental health residential facilities with underlying medical conditions unrelated to their mental health. In 2018, the Commission introduced mandatory requirements for general health assessments of residents in approved centres.

iv. As part of the Commission's COVID-19 monitoring, services were surveyed as to whether any of their residents had underlying medical conditions, including: cancer, cardiovascular disease or diabetes.

- **97%** of services reported having persons with underlying medical conditions
- **89%** of services reported having persons over the age of 60

v. The World Health Organisation (WHO) guidance has indicated that there is a prevalence of infection and adverse results for persons over 60 years of age, with underlying medical conditions and high contact physical environments. As such general health monitoring and provision of general health services is essential in mental health facilities both in the context of COVID and non-COVID healthcare.

[1] Finnerty S, (2019). *Physical Health of People with Severe Mental Illness*. Mental Health Commission.

vi. During COVID-19, across the monitoring period between April-June, the Commission observed significant service interruption in the monitoring, identification and provision of general health services to residents of residential mental health care facilities. As 97% of services reported having persons with underlying medical conditions, undertaking general health reviews is of the utmost importance.

vii. The Commission surveyed all services on whether general health reviews were being done (e.g. 6-monthly reviews) and how emerging medical needs were being identified, assessed and managed. The most notable finding from this question was the variety of responses received. These ranged from services operating as 'business as usual' to those who with delayed or suspended 6-monthly assessments and disruptions to accessing general health services.

- **55%** of services reported that 6-monthly physical health reviews, assessments and treatments were going ahead as usual
- **26%** reported that there had been delays in 6-monthly reviews, assessments and treatments
- **23%** of services reported that they have been making use of telemedicine where general practitioners were unable to review service users in person
- **34%** of services reported that they had maintained their usual access to general practitioners
- **9%** of services reported some constraints in accessing assessments, procedures and appointments

viii. In addition, as with all residential care facilities, screening services within residential mental health facilities have been suspended and it is essential that these are resumed. This is a regulatory requirement within approved centres.

Recommendation

ix. General health services should be resumed as a priority, and any missed or delayed general health assessments should be completed. The HSE should review procedures within services and protocols with external providers to examine discrepancies between services with maintained full service continuity and those where services were fully suspended.

x. In preparation for a second wave infection or future pandemic, services will need to begin contingency planning for the general health and wellbeing of service users. It has become evident that the standard methods and application of treatment and care may not always be available, and alternative measures should be incorporated into the operating procedures of mental health services as a priority to ensure continuity of care.

3. Mental health and well-being

i. Other stakeholders will be better placed to provide data and observations to the Special Committee on the wider societal mental health impacts of COVID-19, as well as the impacts on healthcare and frontline workers.

ii. Specific impacts on residents of mental health facilities include:

a) Limitations on the ability of services to provide the proper spectrum of services to meet residents' specific mental health needs. This is set out in detail under '1. Restarting non-COVID-19 care'.

b) Potential detrimental effects from not being able to visit with their family and wider support networks. All services were surveyed from 15 June 2020, following the introduction of new public health guidance on visitation. 27% of services reported allowing no visitors, although 26% and 22% of services respectively reported allowing visits in the gardens and in designated visiting rooms.

c) Isolation of residents from their wider communities and opportunities for social connection and integration. 12% of services reporting that outings and external services had been stopped, and 6% of services reporting a complete cessation in therapeutic services and programmes.

d) Many services reported increased limitations on residents' freedom of moment, over and above general public health restrictions:

- **25%** of services reported a suspension of visits by residents to the community
- **19%** of services reporting that residents were not permitted to leave the grounds for any reason
- **16%** of services reported discouraging residents from taking unnecessary journeys
- **13%** of services reported that no therapeutic leave was being permitted

iii. These points are not unique experiences and have likely been felt across all health and social care residential facilities. However, there are potentially heightened detrimental effects on people experiencing mental illness or distress.

Recommendation

iv. Services should examine alternative means for residents to remain connected to their communities. Any deprivations of liberty should be the least restrictive for the shortest possible period.

4. Additional capacity in the health service

i. The Commission has consistently highlighted the issue of residential mental health facilities operating at, or over, their registered capacity and the impacts this has on overall service provision. During 2019, there were 208 instances of overcapacity in approved centres, 115 of which related to emergency admissions.

ii. The Commission's discussion paper 'Access to Acute Mental Health Beds in Ireland' notes that services are found to be most effective at 85% capacity.[2] One of the goals of the new national mental health policy 'Sharing the Vision' is the establishment of an Expert Group to examine in-patient bed provision and to make recommendations on capacity reflective of emerging models of care, existing bed resources, and future demographic changes. This goal feeds into the urgent need to assess in-patient and community mental health service capacity in the context of a second wave of COVID-19 or other future pandemics.[3]

iii. Issues of overcapacity in mental health residential services have been further highlighted by the COVID-19 pandemic, in particular:

a. The ability to isolate residents on admission, or upon identification of symptoms, in line with public health guidance. A service at, or over, capacity may not be able to properly isolate

[2] Mental Health Commission (2020), *Access to Acute Mental Health Beds in Ireland*, p25.

[3] Government of Ireland (2020), *Sharing the Vision: A Mental Health Policy for Everyone*, p102.

residents without putting up additional beds or transferring residents. This is not appropriate and may risk the safety, health and wellbeing of residents.

b. Even after service reconfiguration and implementation of contingency plans, 84% of services indicated that they had the ability to isolate one resident, while just 71% of services indicated that they had the ability to isolate two or more residents.

c. The ability of staff to take on additional tasks, such as the donning and disposal of PPE, staff cohorting to care for suspected or confirmed cases, as well as more 1:1 programmes and services for residents in light of the need for social distancing. All of these tasks put considerable stress on a service which is under capacity and are of major concern for a service which is at, or over, capacity.

d. Services have utilised all available spaces in services, such as therapeutic spaces, day centres and day hospitals to allow for social distancing and isolating, where necessary. As services reopen, those operating at capacity, are forced into an unacceptable choice of either reopening important therapeutic spaces, or allowing residents to isolate and socially distance.

iv. The national in-patient census conducted by the Commission in November 2018 showed overall acute mental health bed occupancy levels to be 89.25%. Only nine of the 28 acute units were operating within the less than 85% safe level of occupancy, while a quarter of the 28 units had true bed occupancy levels equal to or over 100%.

v. In addition to the concern of services operating at or over capacity, is the appropriateness of existing accommodation within residential mental health services. This is discussed under Part 3 'measures necessary to prepare for further pandemics in the future'.

Recommendation

vi. Capacity planning for the wider mental health sector needs to take into account the ability of inpatient and residential services to respond to a pandemic or other crisis. The Expert Group recommended by Government Policy ‘Sharing the Vision’ should be established as a priority and should take into account the effects of COVID-19 and contingency planning for a future pandemic.

5. Need for additional testing as non-COVID-19 care increases

i. The Commission recognises the ongoing importance of a robust test strategy as service restrictions continue to lift and non-COVID-19 care increases.

ii. 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* on 21 April 2020. Public health determined that all staff of long term residential care facilities should be tested.

iii. The Commission sought specific information on the roll out of staff testing in services. The Commission expressed concern at significant inconsistencies in the application of the guidance in relation to testing in residential care facilities, including standardisation and oversight of the process. The extent of planning, testing and communication results, varied significantly across Community Healthcare Organisations (CHOs). End-to-end testing of staff took over a month and many services reported significant delays in the communication of test results. The Commission does not consider the timeframes for testing were acceptable.

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

v. The Commission also 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. The Commission's risk assessment evidenced that every acute inpatient unit included either residents over 60 or those with underlying medical conditions. In addition they are considered to be high physical contact environments and have higher numbers of admissions.

vi. There are inconsistencies in the requirements for testing residents on admission to residential mental health services. Mental health services classified as 'long term residential care facilities' are required to test on admission. However, services classified as 'acute mental health units' are required to screen residents on admission and only test on the basis of symptoms. Importantly, there is no clear guidance as to which services come under each classification, with many services admitting both acute and longer stay residents.

Recommendation

vii. Given the number of asymptomatic cases, consideration may need to be given to a process for testing on admission to all residential mental health services on an ongoing basis. We consider this is particularly important for admissions to acute mental health services, where residents may find social distancing challenging and there may be a high level of physical contact involved in providing care.

viii. Clear guidance should be given to each facility on how to access testing to allow services to proactively organise testing where necessary and not wait to be contacted by public health.

Part 3: Special Committee additional areas of interest

In response to the additional issues of interest identified by the Committee, the Commission has set out observations for which data has been gathered throughout the Commission's risk assessment, weekly monitoring and thematic monitoring of mental health residential facilities. Observations are made on the following issues:

1. Views on actions taken to date to deal with the Covid-19 emergency
2. Could anything have been done differently, and, if so, what?
3. What measures may be necessary to prepare for a potential second wave of infection?
4. What measures might be necessary to prepare for further pandemics in the future?

1. Views on actions taken to date to deal with the Covid-19 emergency

i. The Commission implemented a relationship-based approach to COVID-19 monitoring, establishing a supportive framework which lead to services contacting the Commission regularly and proactively as issues arose.

ii. 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 accessing PPE

and delays in testing were responded to immediately and were either resolved or information provided.

iii. An early risk was identified in relation to facilities with shared accommodation and limited ability to isolate residents. Rapid service reconfiguration was undertaken in many areas, including temporary closures and use of alternative facilities. However, tragically, the risk associated with dormitory-style shared accommodation appeared to be factor in the deaths of 9 residents in Maryborough Centre, St Fintan's Hospital.

iv. In April the Commission expedited the registrations of three modern IPC (infection prevention and control) compliant facilities with single rooms and ensuites. The purpose of these expedited registrations was to move residents out of inappropriate and outdated accommodations and to facilitate the HSE in their COVID-19 contingency plans.

v. The Commission found that there was reliance on Commission data about HSE services, including structural information, such as the number of facilities with shared accommodation. This reliance highlights potential data gaps at national level and the need for robust data and information systems.

vi. The Commission was required to take on a coordination and advocacy role as some services, in particular private services and section 39 services, did not have clear local escalation pathways. The Commission was required to escalate concerns on behalf of such services in relation to testing, staffing, PPE and applicability of public health guidance.

2. Could anything have been done differently, and, if so, what?

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

ii. The Commission consistently escalated concerns that there was confusion among services, particularly approved centres that take acute admissions, as to which guidance they should be following (i.e. guidance for acute hospitals or for long term residential care facilities). Many approved centres are in the somewhat unique position within the health service of being a community service under the governance of Community Operations, while being a ward or unit within an acute hospital. Some of these approved centres have one unit for acute admissions and another unit for long stay residents.

iii. There were conflicting messages on which services should be following which guidance. The Commission was advised that specific guidance would be developed for acute mental health units, however this was not provided.

iv. The Commission observed the testing strategy to be inconsistent and untimely. The Commission noted there to be significant geographic disparities in the ability to commence and complete mass testing of staff and residents. At times this process lacked coordination and oversight and appeared to arbitrarily exclude certain services without explanation.

v. Finally, while services were clear in the need to suspend services, close for admissions, restrict visitors and contractors, there was widespread uncertainty around the steps to recommence services and lessen restrictions. The Commission sought assurances on a number of occasions that guidance would be provided to services on measures to be taken during the phased lifting of government restrictions.

3. What measures may be necessary to prepare for a potential second wave of infection?

i. The Commission considers it is essential that guidance is provided to all mental health services providing clear triggers that would allow individual services to take action immediately in both the suspension and resumption of services. The issue of guidance for services that fall in between 'long term residential care facilities' and 'acute hospitals', must be addressed as a priority.

ii. A national review of risk factors within residential mental health facilities should be undertaken, with a specific focus on inherent risks associated with services' premises. Further investigation is required to determine the impact dormitory-style shared accommodation had on disease progression.

iii. A standardised approach should be taken in relation to contingency planning for services with shared accommodation. In addition, contingency plans needs to be reviewed, updated and shared with local, regional and national governance structures.

iv. Pathways need to be established aligning each residential mental health facility, including section 38/39 services and private facilities, to a testing centre, contact tracing service, public health contact and PPE contact. These pathways need to be disseminated to frontline staff and local management.

4. What measures might be necessary to prepare for further pandemics in the future?

i. The Commission considers there should be a national review of the appropriateness of accommodation in residential mental health facilities.

ii. On 13 August 2018, the Commission made a submission following a request from the *Joint Oireachtas Committee on the Future of Mental Health Care* on the physical infrastructure and clinical accommodation of mental health services and the extent to which it is fit for purpose across the HSE Community Healthcare Organisations. As evidenced in the Commission's submission, there are significant deficiencies in the physical premises of regulated services (in-patient mental health units) across all CHOs, in terms of their safety, maintenance and physical environment.

iii. In addition, there is currently no regulatory framework to assess or enforce the physical infrastructure of unregulated mental health services i.e. community residences, despite the number of units and vulnerability of service-users accommodated in such units

iv. The new Government policy for mental health *Sharing the Vision* notes:

> *"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."*[4]

v. The Commission calls for more robust regulations on premises, including regulations for community residences, to ensure all residential facilities are in modern, fit-for-purpose buildings, which comply with IPC standards.

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