IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Response to Mental Health Commission's Stakeholder Questionnaire

On the Mental Health Commission's Strategic Plan for 2016 to 2018

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Irish Medical Organisation

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1. **What are the strengths and achievements of the Mental Health Commission?**

A considerable achievement of the Mental Health Commission (MHC) has been the implementation of the involuntary admission procedure of the *Mental Health Act, 2001*. This is working well and the MHC deserves to be applauded for its success in this area. The operation of the procedure is clear and well-documented. Also, inspections are generally done in a timely and transparent manner.

2. **What do you see as areas where the Mental Health Commission needs to improve?**

The MHC must aim to ensure that consistency is applied to all inspections. Inspectors may opt to focus on a diverse range of issues while conducting inspections, but this should not lead to a failure on the part of the Commission to apply the same judgement and standards to all inspected facilities and the quality of care provided therein. The training and the auditing of the practises of inspectors should aim to ensure a high level of consistency is applied generally.

Regrettably, compliance with the *Mental Health Act, 2001 (Approved Centres) Regulations, 2006*, is low in many areas, and down on last year's figures in a number of articles. In only fourteen of the thirty one articles of the regulations was compliance considered to be high, and notably level of compliance fell for nine articles of the regulations nationally, with Health and Safety falling from 90% to 75%; Ordering, Prescribing, Storing and Administration of Medicines falling from 76% to 52%; and Privacy falling from 68% to 43%. Many articles score poorly, including the compliance of Premises at 22%; Risk Management Procedures at 62%; and Staffing at 51%. There were also reductions in compliance with statutory rules for Use of Seclusion and Electro-Convulsion Therapy, as well as for all Codes of Practice, with the exception of that for those Working with People with Intellectual Disabilities. Of concern is the fact that compliance with the Code of Practice on the Admission of Children stands at just 16% nationally.

Given that compliance remains persistently low in many areas, with it slipping in the case of some articles, the MHC must make greater use of its enforcement powers and leverage to ensure more complete compliance with established regulations and standards, for the benefit of enhanced patient and staff safety.

3. **Over the next 2 to 3 years and being mindful of the current constraints what do you think should be the strategic priorities for the Mental Health Commission?**

In addition to the areas highlighted as requiring improvement in the response to Question Two, the IMO believes the following should be regarded as strategic short and medium-term priorities.

The MHC has developed a *Quality Framework for Mental Health Services* in Ireland, national standards for use in mental health settings. Patients in need of mental health treatment frequently present to medical facilities other than those dedicated for use specifically for mental health, such as hospital emergency departments, for example. The use of appropriate clinical guidelines for the treatment of patients who present to such units is just as crucial as in dedicated mental health settings, and the MHC must develop standards to guide the interaction with and treatment of those suffering from a suspected mental health problem upon their presentation. Inspections too must be carried out to ensure clinically appropriate practice is observed in such units, and that a high standard of care is afforded to all mental health patients in the country, regardless of the facility at which they initially attend.

The Health Service Executive's (HSE's) *National Tobacco Free Campus Policy* aims to ensure that smoking is prohibited on all HSE campuses by no later than then end of 2015. It is particularly important that this policy is adhered to in mental health facilities, given that tobacco use is higher among groups suffering from mental health problems than it is in the general population. In many Western populations it is estimated that over 40% of all tobacco is used by those with a mental illness and it has been demonstrated that tobacco control policies for the general population are not as effective in mental health populations (Le Cook *et al.*, 2014). It is therefore imperative to ensure that the HSE *National Tobacco Free Campus Policy* is adhered to in mental health campuses, and that all appropriate assistance is provided to mental health patients who wish to cease tobacco use. The MHC inspectorate should include compliance with this policy amongst its inspection reports and establish compliance as a mandatory aspect of inspections.

While the number of children admitted to adult mental health units has been steadily decreasing in recent years, inappropriate admissions of this nature remain unacceptably high. It is unwise, and potentially unsafe, to admit children to adult mental health units and it is in the best interests of all that children are treated and cared for in a suitable and appropriately designed environment. A significant portion of the shortfall in beds in child units stems from inadequate staffing and, as already highlighted, national compliance with regulatory requirements in staffing sits at just 51%. Steps must be taken too to ensure that elderly patients too are cared for in appropriate facilities with adequate geropsychiatric resources. The MHC must use its resources to work towards the rectification of these long-standing problems.

The physical health of mental health patients should also not be neglected. People with mental illness have, on average, a higher morbidity of chronic illness than the general population (Robson and Gray, 2007). The reasons for this are various but can include side effects of medication, substance abuse, mental illness as a secondary condition to a physical ailment, and poor mental health acting as a barrier to access of other health services. The IMO has stated that all patients in acute and long-term mental health facilities should have access to full physical health services, including radiology, laboratory facilities, and ECG equipment, as well as allied health professionals, and the MHC must make this a mandatory component of inspections in all such facilities.

The IMO also calls on the MHC to audit the adequacy of facilities available for the physical monitoring of outpatients prescribed long term psychotropic medications.

4. **What do you see as the most significant challenges and developments (political, economic, social, technical) that the Commission needs to address in its 2016-2018 strategy?**

A Vision for Change recommended a systematic change in the way mental health services are delivered in Ireland, advocating for a far greater reliance on community based care. Regrettably change has been slow and incomplete. Of the 119 general adult community mental health teams across the country, none have the complement of staff recommended in *A Vision for Change* (Mental Health Reform, 2015). There are approximately 14% fewer staff working in mental health services today than there was in 2008. Many parts of the country have no community rehabilitation and recovery teams, and addiction services remain severely under-resourced and underdeveloped.

Last year the Office of the Inspector of Mental Health Services published reports on the service provision within the various catchments nationwide, while also contrasting staffing levels from 2008 to 2013. These reports reveal the seemingly haphazard approach to mental health service provision and staffing in the years since *A Vision for Change* was published. Of the ten catchment areas

reviewed, five had fewer psychiatrists than in 2008, six had fewer psychologists than in 2008, and three had no addiction counsellors, in adult services. The grossly inadequate staffing levels represent a threat to the welfare of patients and staff, and perpetuates the poor outcomes and high readmission rates that are characteristic of mental healthcare in Ireland.

With mental health services allocated just 6% of the public health budget, far less than the 10% to 11% spent by comparator states such as the France, Germany, and the United Kingdom, the ability of Irish services to operate in an effective manner is heavily constrained. While the MHC has limited power to alter the HSE's allocation of resources to mental health, less tolerance of breaches of regulatory or statutory requirements would draw greater political attention to deficits in standards of care within mental health services and create greater pressure to solve outstanding resource issues (Murray, 2011). Therefore greater use of these statutory powers should be adopted. The MHC must use all actions at its disposal to advocate for improved staffing and adequate resource allocation to mental health services. Furthermore, the IMO calls on the MHC to conduct an inquiry into the service and patient safety implications of the current crisis of retaining and recruiting doctors in the Irish health service. Since the onset of austerity, IMO members have been increasingly concerned about the effects of successive budget cuts and reduced staffing levels on patient safety and quality of care and have called for legislation to create a coalition of frontline staff who can commission HIQA and the MHC to conduct an inquiry into issues of patient safety.

5. **In line with the Commission's statutory remit what do you see as the main issues within the Mental Health Services that the Commission needs to address in the 2016-2018 strategy?**

The Commission should address all issues detailed in the responses to Questions Two, Three, and Four, in addition to the issues listed below.

Those suffering from mental illness are at far greater risk than the general population to develop, or suffer from, addictions or dependency. Similarly, approximately one-third or more those being treated for substance abuse suffer from a comorbid psychiatric disorder. There is an acknowledged use of illicit substances by some patients within HSE facilities and this problem must be appropriately dealt with. This should involve the development of a set of standards that units could use to minimise this issue, in addition to placing a focus on dual-diagnosis. Bar a dual diagnosis clinic at the National Drug Treatment Centre, few developments have been made in the establishment of services for patients with comorbid substance abuse and mental illness, or in the development of agreed protocols in the management of patients with co-existing disorders. Research has indicated that addiction services in Ireland are reluctant to admit and treat patients with comorbid disorders due to a lack of mental health training of staff in those facilities (Byrne, 2006).

Additionally, given that personality disorders, addictions and anti-social behaviours are excluded from involuntary admissions under the *Mental Health Act, 2001*, the MHC must devise a policy on how those presenting with problems should be dealt with, and what the responsibility of mental health services in relation to behavioural difficulties of those with personality disorders is. This would provide greater guidance for those working within the health services and aim to guarantee that a consistent and high standard of care is delivered.

While patient safety is, rightfully, a key priority for the MHC, staff safety in mental healthcare environments should also become a greater focus. Staff operating in mental healthcare

environments deserve to be a supported in a manner that best assures their safety at work, and the MHC must investigate means of improving and better safeguarding such safety.

Currently there are a range of private mental health services providers whose facilities are not inspected by the MHC. All those in receipt of mental health services within the state, regardless of whether those services delivered privately or publicly deserve high quality and safe care. The IMO believes that all independent agencies and services providing mental health services should be obliged to achieve accreditation to international standards, and that the MHC's remit must be expanded to allow for the inspection of all agencies providing psychotherapy and counselling services. The MHC, therefore must advocate for an expanded role in this regard.

Admissions under the *Mental Health Act, 2001*, occur as emergencies in the schedule of general practitioners (GPs). Such admissions are sporadic, time consuming, resource intensive, and difficult to plan for as a result of the small team system that exists in general practice. Equally, such admissions may delay timely access to care for patients. GPs are contractors who are not resourced for this care, which is compounded by the absence of GPs from the performance of their ordinary ongoing duties, and thus manifests as a delay in the care of those patients discommoded by their GPs' absence. The complete lack of planning for this resource provision acts as a barrier to the optimum treatment of this vulnerable patient group and will continue to do so until suitable resourcing is in place. The IMO is disappointed at the on-going failure to address this problem and seeks a suitable resolution to the issue. Further to this, IMO calls on the MHC to review the role of the GP in terms of medico-legal implications as they pertain to the *Mental Health Act, 2001*, and additionally review the cost implications for GPs in respect of the *Act*.

6. **When you reflect on the performance of the Mental Health Commission in delivering on the commitments of the 2013-2015 strategy what do you see as the initiatives and programmes that should be:**
    a. **Sustained during 2016-2018 period?**
    b. **Strengthened during 2016-2018 period?**

Greater use must be made of the MHC's enforcement powers to ensure that high quality mental health services are provided to patients nationally. Currently, compliance with many regulatory requirements and Codes of Practice are low, and improved focus and diversion of resources to these areas will be required to boost appropriate metrics. Initiatives and programmes aimed at tackling these issues that stem from the MHC's 2013-2015 strategy should therefore be strengthened, and focus should also be placed on measures address to issues raised in the IMO's responses to Questions Two, Three, Four, and Five.

    c. **Accelerated during 2016-2018 period?**
    d. **Ceased during 2016-2018 period?**

7. **Any additional comments?**

Given that *A Vision for Change* recommends the co-location of psychiatric admission units with general hospitals, the IMO requests that the MHC work with other agents of the health service to define the age of a child. The new children's hospital will only admit and review patients under the age of 16 meaning that 16 and 17 year olds must attend adult emergency departments.

As admission via emergency departments is a common route of entry into the mental health services, 16 and 17 year olds must be initially assessed by adult liaison services. As noted previously mental and physical health problems often coexist and, as such, patients with co-morbid illnesses would be required to be admitted to adult units in order to access appropriate physical health care in the co-located hospital.

This variance in definition of child between mental and physical health services also reinforces the stigma surrounding mental health as being separate from physical health problems.