Mental Health Commission

Knowledge Review

Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre

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Glossary

Act
Refers to the Mental Health Act 2001.

Admission
For the purposes of this code, admission refers to admission of an individual to an approved centre.

Advocate
Representative and supporter of resident's concerns and interests; may be formal or informal.

Best practice
Approaches that have been shown to produce superior results selected by a systematic process and judged as "exemplary", "good", or "successfully" demonstrated. They are then adapted to fit a particular organisation.

Child
A person under 18 years of age other than a person who is or has been married (S2, MHA 2001).

Community mental health team
A multi-disciplinary team offering specialist assessment, treatment and care to people in the community. The team should involve nursing, psychiatry, social work, clinical psychology and occupational therapy membership, with ready access to other therapies and expertise.

Confidentiality
Information to be kept private is safeguarded, with guaranteed limits on the use and distribution of information collected from individuals.

Consent
Consent is comprised of three key components: the provision of adequate information, decisional capacity, and voluntarism. The individual must be capable of understanding in simple language the nature, purpose and likely effects of treatment, be capable of retaining information for a sufficient period of time, be able to arrive at a decision and be able to communicate his/her decision. The individual's decision must be made freely, in the absence of coercion.

Continuity of care
Integration and linkage of components of individualised treatment and care across health service agencies, according to individual needs.

Co-ordinate
Work together effectively with collaboration among providers, organisations, services and people in and outside the organisation to avoid duplication, gaps or breaks.

Discharge
In the context of this code, discharge is when a resident leaves an approved centre.

Discharge against medical advice
Refers to a resident who takes his/her own discharge against medical advice (DAMA).

Discharge plan
An information exchange tool and management plan, including management of risk. A contract between stakeholders that defines expectations, roles and responsibilities.

Effective
A measure of the extent to which a specific intervention, procedure, regime or service, when deployed in the field in routine circumstances, does what it is intended to do for a specified population.

Efficient
Resources (inputs) are brought together to achieve optimal results with minimal waste, re-work and effort.

Follow up
Processes and actions taken after a resident has left the organisation's services.

Individual care and treatment plan
A documented set of goals collaboratively developed by the resident and the multi-disciplinary team. The care plan sets the direction for treatment and support, identifies necessary resources and specifies outcomes for the resident. The care plan is recorded in the one set of documentation.

Independent sector
Private mental health service providers.

Integrated care pathway
An integrated care pathway is a multi-disciplinary outline of anticipated care, placed in an appropriate timeframe, to help a resident with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes.

Key-worker
Person responsible for keeping close contact with the resident, and for advising other members of the multidisciplinary team of changes in the circumstances of the service user. The person who co-ordinates the delivery of the individual care and treatment plan.

Mental disorder
3.- (1) In this Act [Mental Health Act 2001] ''mental disorder'' means mental illness, severe dementia or

significant intellectual disability where-
(a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or
(*b*) (*i*) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and
(*ii*) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.

(2) In *subsection (1)*—
''mental illness'' means a state of mind of a person which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons;
''severe dementia'' means a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression;
''significant intellectual disability'' means a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person.

Mental health services
Services which provide care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist.

Multidisciplinary integrated care planning
System of delivering care ensuring that the primary tenet is collaboration among all disciplines. Multidisciplinary integrated care planning enhances communication among disciplines and co-ordinates resident care services.

Multidisciplinary team
A mental health team comprising a variety of professional staff. Core team members are: psychiatrists, psychiatric nurses, clinical psychologists, social workers and occupational therapists. Other specialist therapists may also be available

Needs
Includes physical, psychiatric, psychological, social, housing, informational, educational (if a child) requirement for well-being. Needs may or may not be perceived or expressed by the resident.

Patient
Person to whom an admission order or renewal order pursuant to the Mental Health Act 2001 relates.

Policy
Written statement that clearly indicates the position and values of the organisation on a given subject.

Primary care
Includes the range of services that are currently provided by general practitioners (GPs), public health nurses, general nurses, social workers, practice nurses, midwives, community mental health nurses, dieticians, dentists, community welfare officers, physiotherapists, occupational therapists, home helps, health care assistants, speech and language therapists, chiropodists, community pharmacists, psychologists and others.

Procedure
Written set of instructions that describe the approved and recommended steps for a particular act or sequence of acts.

Protocol
An accepted code of behaviour in a particular situation.

Public sector
All government and publicly- funded organisations.

Referral
A request from one provider or organisation to another to provide care and treatment/service; or direction, to the service user or on behalf of the service user, to obtain additional care/services from another organisation or provider.

Resident
A person receiving care and treatment in an approved centre.

Service user
A person who uses the mental health services.

Staff
Staff refers to all employees including permanent staff, temporary staff, agency staff, and locums.

Timely
Activities which are carried out within an appropriate/beneficial timeframe.

Transfer
Transfer refers to a resident's move within an approved centre, between approved centres (which includes from an independent sector facility to a public sector facility and vice versa), from an approved centre to the Central Mental Hospital and vice versa, from an approved centre to a health facility abroad, and at times, from an approved centre to a general hospital.

Voluntary sector
Voluntary or charitable organisations.

Whole system
A whole system is not simply a collection of organisations that work together but a mixture of different people, professions, services and buildings which have individuals as their unifying concern and deliver a range of services in a variety of settings to provide the right care in the right place at the right time.

1. Introduction

The Mental Health Commission, established under the Mental Health Act 2001, is an independent statutory body. One of its statutory duties is to promote, encourage and foster high standards in the delivery of mental health care.

Section 33(3)(e) of the Mental Health Act 2001 obliges the Mental Health Commission to *"prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services"*. In accordance with Section 33, the Commission is bringing out a code of practice for approved centres on admission, transfer and discharge of service users to and from an approved centre.

A draft code of practice has been prepared based on a synthesis of the best available information internationally and nationally in these areas. The aim of this document is to inform all stakeholders in the mental health arena, including service providers, staff working in approved centres and community mental health services, service users and advocates, of current international and national thinking on the admission process, the process of transfer and the discharge process to and from inpatient mental health facilities. Recent research in the area and the legal and human rights context to these issues are also addressed.

1.1 Methodology

The formulation of the draft code of practice on admission, transfer and discharge has been influenced by a number of sources including:

a) Stakeholders views as expressed in *"Quality in Mental Health – Your Views"* (2005)

b) International best practice, protocols and policies

c) Relevant research studies

d) Conventions, standards & legislation

e) Local admission, transfer and discharge policies in Ireland

f) The Professional Codes of Conduct for the medical profession, nurses and midwives, psychologists, social workers and occupational therapists in Ireland

g) Health Boards Executive: Admissions and Discharge Guidelines (2003)

h) ICGP/HSE pro-forma letters for referral and follow up

i) A Vision for Change and associated consultation documents of the Expert Group on Mental Health: *"Speaking Your Mind", "What They Said"*

A literature search was conducted of peer reviewed journals which included, inter alia, the British Journal of Psychiatry, Evidence-Based Mental Health, and Psychiatric Services. The electronic databases PsycINFO and the Psychology and Behavioural Science Collection, and the Cochrane Library were also searched. Key search terms used to identify possible relevant articles for admission included "admission" (title) AND "polic*" (all text) and "psychiatric admission" (title); "transfer" (title) and polic*(abstract) and "psychiatric" OR "mental health" (keywords) for transfer policies; and "discharge" (title) AND "polic*" (abstract) for discharge. A general internet search was also undertaken for relevant studies and international publications, which included a search on "referral". Searches were extended to include all types of studies since the nature of this code does not lend itself easily to clinical trials.

Overall, a paucity of relevant articles was retrieved for admission and transfer. There was a stronger evidence base for the discharge process, although most of the studies were not specific to mental health. Many of the recommendations for admission and transfer are based primarily on standards and good practice outlined in international mental health policy documents not specific to admission and transfer. These policy documents originate mainly in the UK and Australia. McDaid (2005) notes that the development of national mental health policies across Europe has been limited in the past because the main focus has often been on treating the clinical aspects of mental health problems. Relatively little attention has been paid in health research to evaluating methods of service delivery, or to the most appropriate methods of evaluating the effectiveness of organisational change (Houghton et al, 1996). Further research is essential to establish a strong evidence base for good practice. The paucity of similar codes of practice and policy documents available

from other countries presented a major limitation in establishing what constituted international best practice in the field. Every effort has however been taken to ensure that the draft code of practice developed is based on the best available evidence.

The Mental Health Commission additionally made contact with every inpatient mental health facility in Ireland to obtain copies of local policies relevant to admission, transfer and discharge. A significant number of facilities replied, and furnished the Commission with related policies, where in existence. A disparity existed in the comprehensiveness and quality of these policies, with a considerable lack of uniformity. Keogh et al (1999) cited the lack of detailed well-presented admission policies in the Eastern Health Board (EHB)[1] as perhaps the greatest weakness in the admission process in most services there.

Lastly, the Commission held several in-house workshops with relevant members of staff, to further the process of devising the draft code.

[1] The Health Service Executive (HSE) assumed responsibility for the health service in the Republic of Ireland on 1 January 2005. The former Eastern Health Board is now under the auspices of the HSE.

2. The Legal & Human rights Context

2.1 International Conventions & Standards

2.1.1 General

The Mental Health Commission considers it paramount that the provision of mental health care and treatment respects, protects and fulfils the fundamental rights of persons with mental illness as outlined in national legislation such as the Mental Health Act 2001 and in binding and non- binding international human rights documents, such as the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles, 1991). Underpinning the Mental Health Act 2001 is the requirement to take the best interests of the person into account at all times, and the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.

The code of practice on admission, transfer and discharge is aimed at bringing Irish mental health practice in line with international human rights standards and international human rights law. It is intended that implementation of the code will promote, as recommended by the World Health Organisation (2001), the following rights: individual autonomy, equality and non-discrimination; the right to information and participation; the right to privacy; physical integrity; and freedom of religion, assembly and movement.

One of the most important human rights conventions (WHO, 2003), the *"International Bill of Rights"*, which comprises of the Universal Declaration of Human Rights (1948), the International Covenant on Civil and Political Rights (ICCPR, 1966), and the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966) has as its core the fundamental human rights obligation to protect people against discrimination. Ireland has ratified the ICCPR and ICESCR treaties and thus is legally obliged to guarantee every person on its territory without discrimination, all of the rights enshrined in both treaties. Although not specifically designed for the protection of persons with mental illness, these treaties provide legally enforceable protection of human rights. The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. Article 12 of the International Covenant on Economic, Social, and Cultural Rights recognises:
"The right of everyone, [including people with mental illness] to the enjoyment of the highest standard of physical and mental health".
According to General Comment 14[2] of the Committee on Economic, Social and Cultural Rights, the right to health includes: availability, accessibility, acceptability and quality, all of which are interrelated.

[2] General comments are non- binding but represent the official view as to the proper interpretation of the convention by a human rights oversight body

The most important international consensus document regarding the protection of the rights of people with mental illness is the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles), which were adopted by the United Nations General Assembly in 1991. The 25 principles bring together a set of basic human rights standards in mental health provision relating to areas such as protection of confidentiality, standards of care and treatment, and the rights of people in mental health facilities. Principle 1.1 states that *"all persons have the right to the best available mental health care, which shall be part of the health and social care system"* and principle 1.2 states that *"all persons with mental illness, who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person"*.

Considered of particular relevance to admission, transfer and discharge are principles 6, 7, 8, and 9. Principle 6 states that *"the right of confidentiality of information concerning all persons to whom these Principles apply shall be respected";* Principle 7.1 asserts that "*Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives* and 7.2 states that "*Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible";* Principle 8.1 states that *"every patient shall have the right to receive such health and social care as is appropriate to his or her needs, and is entitled to care and treatment in accordance with the same standards as other ill persons";* Principle 9.3 states that *"mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics adopted by the United Nations General Assembly"* and 9.4 states that *"the treatment of every person shall be directed towards preserving and enhancing personal autonomy"*. Although these principles are not legally binding, they are considered the minimum human rights standards of practice which should be present in the mental health field.

The European Convention for Protection of Human Rights and Fundamental Freedoms (1950) provides further protection of the human rights of people with mental illness. Recommendation 1235 on Psychiatry and Human Rights (1994) adopted by the Parliamentary Assembly of the Council of Europe additionally specifies standards for care and treatment of persons with mental illness. The United Nations Declaration on the Rights of Disabled Persons (1975) and the United Nations Resolution 48/96 on Standard Rules for the Equalisation of Opportunities for Persons with Disabilities (1993) both aim to ensure equal opportunities and protection of the rights of people with disabilities, which includes people with mental illness. The Declaration of Madrid adopted in 1996 by the General Assembly of the World Psychiatric Association sets out standards for professional behaviour and practice, which includes the standard, that treatment must be based on partnership with persons with mental illness. In 2005, the Mental Health Declaration for Europe made several recommendations for action. The Ministers of Health of the Member States in the WHO European Region have committed themselves in this declaration to implementing several measures, including offering people with mental health problems choice and involvement in their own care, enhancing the central role of primary health care and general practitioners in mental health care and enhancing partnerships between

agencies responsible for care and support such as health, benefits, housing, education and employment. Recently in December 2006, the United Nations General Assembly adopted the Convention on the Rights of Persons with Disabilities. This Convention covers the rights of people with disabilities in such areas as liberty, security of the person, freedom from violence, abuse and exploitation, and protecting the integrity of the person.

2.1.2 Admission

Principles 12, 15 and 16 of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles) relate specifically to admission. Principle 12 states that *"A patient in a mental health facility shall be informed as soon as possible after admission, in a form and language which the patient understands, of all his or her rights in accordance with these Principles and under domestic law, which shall include an explanation of those rights and how to exercise them"*. Principle 12.2 also provides that if a patient is unable to understand the information, the rights of the patient must be communicated to a personal representative if one exists or to the person best able to represent the patient's interests and who is willing to do so. Recommendation 1235 (1994) of the Parliamentary Assembly of the Council of Europe on psychiatry and human rights also recommends that a code of rights be brought to the attention of patients on their arrival at a psychiatric institution.

Principle 15 states that "*every effort shall be made to avoid involuntary admission"*, and that "*access to a mental health facility shall be administered in the same way as access to any other facility for any other illness"*. It also states that *"every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or retention as an involuntary patient, as set forth in Principle 16, apply, and he or she shall be informed of that right"*. Principle 16 relates specifically to involuntary admission. It states that a person may only be admitted involuntarily if *"a qualified mental health practitioner authorized by law for that purpose determines, in accordance with Principle 4, that person has a mental illness"* and considers there to be a *"serious likelihood of immediate or imminent harm to that person or other persons"* or that in the case of a person whose illness is severe and whose judgement is impaired, failure to admit them is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility. In the case of the latter, it is advised that a second mental health practitioner, independent of the first, be consulted where possible, and that involuntary admission does not take place unless the second mental health practitioner concurs. If a patient is involuntarily admitted, Principle 16(2) states that:

"The grounds of the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient's personal representative, if any, and, unless the patients objects, to the patient's family."

2.1.3 Transfer

There is a paucity of international legislation relating directly to the transfer of residents, however, there are some international recommendations applicable to the transfer process. These include the right of the individual to have treatment near his/her home where feasible, the importance of taking the best interests of the individual into account, the importance of providing care appropriate to the individual's needs, and the importance of taking the individual wishes into account in the transfer process.

Principle 7 of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care provides that:

> *"Where treatment takes place in a mental health facility a patient shall have the right whenever possible to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible."*

Principle 8 provides that:

> *"Every patient shall have the right to receive such health and social care as is appropriate to his or her needs"*

While Principle 9 states that:

> *"Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others"*.

Article 7 of the Council of Europe Recommendation 83(2) of the Committee of Ministers to Member States concerning the Legal Protection of Persons suffering from Mental Disorders Placed as Patients provides that:

> *"A patient should not be transferred from one establishment to another unless his therapeutic interest and as far as possible his wishes are taken into account"*.

2.1.4 Discharge

Internationally, there appears to be little reference to discharge other than the recommendation that discharge should take place as soon as possible. Principle 7.2 of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care states that:
"Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible".

Principle 15.3 further provides that:
"Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her detention as an involuntary patient as set forth in Principle 16 (See Section 2.1.2 Admission), apply, and he or she shall be informed of that right."

2.1.5 Children

Children are protected under all human rights instruments. Principle 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR, 1950) specifically sets out that:
"Special care should be given within the purposes of these Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member".

In addition, the *United Nations Convention on the Rights of a Child* (1989) addresses issues relevant to the provision of mental health services for children, including the right to a judicial review when separated from one's parents, access to parents when separated from them, the right to seek and receive information, and the right of the child to express his or her views in all matters affecting him or her and for those views to be given due weight in accordance with the child's age and maturity. The definition of a child under the Convention is a person under 18 years of age.

2.1.6 People with Intellectual Disability

People with intellectual disability have the same rights as everyone else however often in the past these rights have been neglected or denied. During the last decade, there has been a growing emphasis and importance accorded to the human rights of people with intellectual disability. The challenge for mental health services therefore is to ensure that services are at all times respectful of and promote the rights enunciated in all conventions.

In addition to that set out in the general legislation section, the United Nations Declaration on the Rights of Mentally Retarded Persons (1971) aims to protect the rights of persons with intellectual disability.

2.2 National Legislation

2.2.1 General

The Mental Health Commission intends to implement the code of practice on admission, transfer and discharge under Section 33 of the **Mental Health Act 2001.**

Section 33 states:

(1) *The Principal functions of the Commission shall be to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under this Act*

(2) The Commission shall undertake or arrange to have undertaken such activities as it deems appropriate to foster and promote the standards and practices referred to in subsection (1).

(3)(e) *Without prejudice to the generality of the foregoing, the Commission shall prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services.*

Part 1 Section 4(1) and 4(3) of the Mental Health Act 2001 are also applicable to the processes of admission, transfer and discharge, and should guide all decisions made in relation to the care and treatment of persons with mental illness or mental disorder.

Section 4 states that:

(1) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made.

(3) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.

The code of practice also overlaps with several provisions under the Mental Health Act 2001 (Approved Centres) Regulations 2006. Specifically, it overlaps with Reg. 7- Clothing, Reg. 8- Residents' Personal Property and Possessions, Reg. 15 – Individual Care Plan, Reg. 18- Transfer of Residents, Reg. 20- Provision of Information to Residents, Reg. 23 – Ordering, Prescribing, Storing and Administration of Medicines, Reg. 27 - Maintenance of Records, and Reg. 32- Risk Management Procedures.

The **Disability Act 2005** was passed into law in June 2005. Disability as defined in the Act includes people with "*enduring physical, sensory, mental health or intellectual impairment*". The Act has been designed to advance and underpin the participation of people with disabilities in everyday life. It establishes a statutory basis for, inter alia, an independent assessment of individual health needs (including personal social services) for persons with disabilities over age 18 years and access to complaints, appeals and enforcement mechanisms, where entitlements are not delivered. The NDA is currently working on codes of practice for the legislation.

The **Citizens Information Act 2007** was passed into law on 21st February 2007. The Citizen's Information Act introduces, under Section 5, personal advocacy services specifically for people with disabilities ("disability" as defined in the Disability Act). The new personal advocacy service will be administered by the Citizens Information Board and envisages the provision of a personal advocate to persons with a disability who have difficulty in obtaining, without assistance or support, a social service.

2.2.2 Admission

The Mental Health Act 2001 makes legislative provision primarily for individuals' involuntarily admitted.

Section 4 of the Mental Health Act 2001 provides that individuals are involved and consulted in their treatment and care.

> *(2) Where it is proposed to make a recommendation or an admission order in respect of a person, or to administer treatment to a person under this Act, the person shall, so far as is reasonably practicable, be notified of the proposal and be entitled to make representations in relation to it and before deciding the matter due consideration shall be given to any representations duly made under this subsection.*

Section 29 of the Act states:

> *Nothing in this Act shall be construed as preventing a person from being admitted voluntarily to the approved centre for treatment without any application, recommendation or admission order rendering him or her liable to be detained under this Act, or from remaining in an approved centre after he or she has ceased to be so liable to be detained.*

In respect of involuntary admission, Section 3(1) provides the legal definition of "mental disorder" [3] under which a person can be detained. Section 8 addresses the criteria for involuntary admission, which essentially provides that a person must only be involuntarily admitted to an approved centre on the grounds that he or she is suffering from a mental disorder.

Section 8(1) states that:

[3] See glossary

A person may be involuntarily admitted to an approved centre pursuant to an application under section 9 or 12 and detained there on the grounds that he or she is suffering from a mental disorder.

Section 8(3), which addresses involuntary admission to an approved centre, provides that:

The Commission shall, from time to time, issue guidelines for staff in approved centres in relation to the provisions of this section.

Section 10 provides the basis for making a recommendation for involuntary admission. It states that:

(1) Where a registered medical practitioner is satisfied following an examination of the person the subject of the application that the person is suffering from a mental disorder, he or she shall make a recommendation (in this Act referred to as "a recommendation") in a form specified by the Commission that the person be involuntarily admitted to an approved centre (other than the Central Mental Hospital) specified by him or her in the recommendation.

(2) An examination of the person the subject of an application shall be carried out within 24 hours of the receipt of the application and the registered medical practitioner concerned shall inform the person of the purpose of the examination unless in his or her view the provision of such information might be prejudicial to the person's mental health, well-being or emotional condition.

(4) A recommendation under subsection (1) shall be sent by the registered medical practitioner concerned to the clinical director of the approved centre concerned and a copy of the recommendation be given to the applicant concerned.

Section 14 and 15 of the Act refer to the admission order.

Section 14 provides that:

(1) Where a recommendation in relation to a person the subject of an application is received by the clinical director of an approved centre, a consultant psychiatrist on the staff of the approved centre shall, as soon as may be, carry out an examination of the person and shall thereupon either- (a) if he or she is satisfied that the person is suffering from a mental disorder, make an order to be known as an involuntary admission order and referred to in this Act as "an admission order" in a form specified by the Commission for the reception, detention and treatment of the person and a person to whom an admission order relates is referred to in this Act as "a patient", or (b) if he or she is not satisfied, refuse to make such an order.

(2) A consultant psychiatrist, a medical practitioner or a registered nurse on the staff of the approved centre shall be entitled to take charge of the person concerned and detain him or her for a period not exceeding 24 hours (or such shorter period as may be prescribed after consultation with the Commission) for the purpose of carrying out an examination under subsection (1) or, if an admission order is made or refused in relation to the person during that period, until it is granted or refused.

Section 15(1) states that:

An admission order shall authorise the reception, detention and treatment of the patient concerned and shall remain in force for a period of 21 days from the date of the making of the order and, subject to subsection (2) and section 18(4), shall then expire.

Section 16 relates to the provision of information to the patient and the Mental Health Commission following involuntary admission to inpatient care.

Section 16 states that:

(1) *Where a consultant psychiatrist makes an admission order or renewal order, he or she shall, not later than 24 hours thereafter-*
(a) send a copy to the Commission, and
(b) give notice in writing of the making of the order to the patient.

(2) *A notice under this section shall include a statement in writing to the effect that the patient-*
(a) is being detained pursuant to section 14 or 15, as the case may be,
(b) is entitled to legal representation,
(c) will be given a general description of the proposed treatment to be administered to him or her during this period of his or her detention,
(d) is entitled to communicate with the Inspector,
(e) will have his or her detention reviewed by a tribunal in accordance with the provisions of section 18,
(f) is entitled to appeal to the Circuit Court against a decision of a tribunal under section 18 if he or she is the subject of a renewal order, and
(g) may be admitted to the approved centre concerned as a voluntary patient if he or she indicates a wish to be so admitted.

2.2.3 Transfer

There is little legal provision specifically relating to the transfer of residents either between or within mental health facilities in Ireland. There is no provision in the Mental Health Act 2001 for the transfer of a voluntary patient from one facility to another, for internal transfer from one unit to another within an approved centre, or for the transfer of a patient abroad. Sections 20, 21 and 22, address the external transfer of a patient[4] from an approved centre for treatment to an approved centre, a hospital or other place.

Section 20 of the Act refers to application for transfer of a patient and provides that:

(1) Where a patient or the person who applied for a recommendation under which a patient is detained in an approved centre applies to the clinical director of the centre for a transfer of the patient to another approved centre, the clinical director may, if he or she so thinks fit, arrange the transfer of the patient to the centre with the consent of the clinical director of the second-mentioned approved centre.

[4] See glossary

(2) Where a patient is transferred to an approved centre under subsection (1), the clinical director of the centre from which he or she has been transferred shall, as soon as may be, give notice in writing of the transfer to the Commission.

Section 21 provides for the transfer of a patient to another approved centre and states that:

(1) Where the clinical director of an approved centre is of the opinion that it would be for the benefit of a patient detained in that centre, or that it is necessary for the purpose of obtaining special treatment for such patient, that he or she should be transferred to another approved centre (other than the Central Mental Hospital), the clinical director may arrange for the transfer of the patient to the other centre with the consent of the clinical director of that centre.

(2) (a) "Where the clinical director of an approved centre-

(i) is of the opinion that it would be for the benefit of a patient detained in that centre, or that it is necessary for the purpose of obtaining special treatment for such a patient, to transfer him or her to the Central Mental Hospital, and

(ii) proposes to do so,

he shall notify the Commission in writing of the proposal and the Commission shall refer the proposal to a tribunal.

(b) Where a proposal is referred to a tribunal under this section, the tribunal shall review the proposal as soon as may be but not later than 14 days thereafter and shall either-

(i) if satisfied that it is in the best interest of the health of the patient concerned, authorise the transfer of the patient concerned, or

(ii) if not so satisfied, refuse to authorise it.

(3) Where a patient is transferred to an approved centre under this section, the clinical director of the centre from which he or she has been transferred shall, as soon as may be, give notice in writing of the transfer to the Commission.

(4) The detention of a patient in another approved centre under this section shall be deemed for the purposes of this Act to be detention in the centre from which he or she was transferred.

Section 22 refers to the transfer of a patient to hospital. It states that:

22(1) A clinical director of an approved centre may arrange for the transfer of a patient detained in that centre for treatment to a hospital or other place and for his or her detention there for that purpose.

(2) A patient removed under this section to a hospital or other place may be kept there so long as is necessary for the purpose of his or her treatment and shall then be taken back to the approved centre from which he or she was transferred.

(3) The detention of a patient in a hospital or other place under this section shall be deemed for the purposes of this Act to be detained in the centre from which he or she was transferred.

2.2.4 Discharge

The Mental Health Act 2001 focuses exclusively on procedures that should take place for the discharge of patients[5]. Unlike the Mental Treatment Act 1945, there is no provision in the Act for a relative to apply for the discharge of a patient. Section 23 and 24 refer to the powers of an approved centre to detain a voluntary patient who wishes to leave an approved centre. In addition, unlike the Mental Treatment Act 1945 (*S194*) where a voluntary patient had to give 3 days notice of his or her wish to leave the approved centre, there is no requirement for the giving of notice under the Mental Health Act 2001. Section 28 of the Act refers to the procedures that must take place in the discharge of a patient. It includes giving the patient notice of discharge and providing the Mental Health Commission with documentation regarding the discharge process.

Section 28 states:

(1) Where the consultant responsible for the care and treatment of a patient becomes of opinion that the patient is no longer suffering from a mental disorder, he or she shall by order in a form specified by the Commission revoke the relevant admission order or renewal order, as the case may be, and discharge the patient.

(2) In deciding whether and when to discharge a patient detained under this section, the consultant psychiatrist responsible for his or her care and treatment shall have regard to the need to ensure:
(a) *that the patient is not inappropriately discharged, and*
(b) that the patient is detained pursuant to an admission order or a renewal order only for so long as is reasonably necessary for his or her proper care and treatment.

(3) Where a consultant psychiatrist discharges a patient under this section, he or she shall give the patient concerned and his or her legal representative a notice in a form specified by the Commission to the effect that he or she-
(a) is being discharged pursuant to this section,
(b) is entitled to have his or her detention reviewed by a tribunal in accordance with the provisions of section 18 or, where such review has commenced, completed in accordance with that section if he or she so indicates by notice in writing addressed to the Commission within 14 days of the date of his or her discharge.

(4) Where a consultant psychiatrist discharges a patient under this section, he or she shall cause copies of the order made under subsection (1) and the notice referred to in subsection (3) to be given to the Commission and, where appropriate, the relevant health board or housing authority.

[5] See glossary

(5) Where a patient is discharged under this section-

(a) if a review under section 18 has then commenced, it shall be discontinued unless the patient requests by notice in writing addressed to the Commission within 14 days of his or her discharge that it be completed, or

(c) if such a review has not then commenced, it shall not be held unless the patient indicates by notice in writing addressed to the Commission within 14 days of his or her discharge that he or she wishes such a review to be held,

and if he or she requests that a review under Section 18 be completed or held, as the case may be, the provisions of Section 17 to 19 shall apply in relation to the review with any necessary modifications.

2.2.5 Children

Under the Mental Health Act 2001 a child is defined as a person under 18 other than a person who is married or has been married. Therefore, a child's parent, guardian or legally responsible adult may request for the voluntary admission of his/her child to an approved centre for treatment. A child admitted voluntarily at the request of his/her parents does not have the automatic right to have his/her inpatient stay reviewed.

Under section 23(2) of the Mental Health Act 2001, a child being treated as a voluntary patient may be detained and placed in the custody of the Health Service Executive, despite the wishes of the child's parents to remove him or her from the approved centre, if a consultant psychiatrist, registered medical practitioner or registered nurse in the centre believe the child is suffering from a mental disorder[6]. Should this occur, section 25 of the Act should be followed.

Section 25 of the Mental Health Act 2001 provides for the involuntary admission of a child to an approved centre. A child may be admitted to an approved centre following a District Court Order authorising the detention of the child. The order allows treatment of the child for 21 days, and the court can extend this period to a maximum of 3 months. A further order can then be made by the court for a maximum of 6 months. The Mental Health Commission issued a code of practice in November 2006 on the admission of children under the Act, which provides further guidance on the admission of a child to an approved centre.

The Child Care Act 1991 contains a number of provisions relating to the care, protection, and welfare of children under the age of eighteen in Ireland. This Act focuses on the child and the promotion of the child's welfare. It also places a specific duty on Health Boards (now the Health Service Executive) to identify children who are not receiving adequate

[6] See glossary

care and protection and in promoting their welfare to provide child care and family support services. This Act underpins the basic tenet that the welfare of the child is of paramount importance.

2.2.6 People with Intellectual Disability

People with intellectual disability are governed by the same legislation as everyone else. The Health Bill 2006 places the Social Services Inspectorate on a statutory basis and provides for its expansion to inspect and register residential services for people with disabilities. There will be clearer procedures to close a centre if its continued operation poses a risk to the health or welfare of residents, including an explicit procedure for an immediate or urgent closure of a centre.

The Law Reform Commission in its consultation paper on *Vulnerable Adults and the Law: Capacity* (2005) and its 2006 report – *Vulnerable Adults and the Law*, recommends the enactment of capacity legislation in order to create clear rules on legal capacity, which would apply to a wide-range of decisions. The 2006 report contains a draft scheme of a Mental Capacity & Guardianship Bill to give effect to the recommendations which require legislative interpretation.

2.3 Policy Context

The provision of mental health services is delivered in a national policy context of Report of the National Task Force on Suicide (1998), Guidelines on Good Practice and Quality Assurance in Mental Health Services (1998), Quality and Fairness: A Health System for you (2001), the National Strategy for Action on Suicide Prevention (2005), A Vision for Change (2006), the Quality Framework for Mental Health Services in Ireland (2007), the Code of Practice for the Admission of Children under the Mental Health Act 2001 (2006) and the Code of Practice for the Use of Physical Restraint in Approved Centres (2006).

3. Best Practice in Admission

Admission needs to work well if the whole system is to function optimally (Inglis & Baggeley, 2005). Admission to approved centres should be managed effectively and appropriate care should be delivered in a timely manner. It may be the individual's first contact with an approved centre and can be a very traumatic ordeal for both the individual and his/her family. Consequently, it is imperative that every measure is taken to enable the individual to be as fully involved as possible in his or her admission, thus alleviating some of the anxiety which he or she may be experiencing about what lies ahead while in inpatient care.

One of the primary objectives of having a code of practice for admission is to guarantee the resident a consistently high standard of care regardless of which approved centre he or she attends. The standard of care experienced on admission should reflect the standard of care that the resident can expect throughout his or her stay in inpatient care.

Having a code of practice for admission is also important to ensure that referral is made through the appropriate channel and that unnecessary or inappropriate admission is avoided. The appropriate channel of referral is referral from community mental health services. It is important that admission is planned as much as possible to ensure that only those who require inpatient care are admitted. The safety of the individual must be a prime consideration when deciding whether to admit.

The evidence base for mental health admission policies is underdeveloped. There is a consistent lack of evidence on what constitutes best practice on admission to inpatient mental health care. There are however several recommendations and standards for admission outlined in international mental health policy documents and policy documents on admission to general hospital. Although there is a dearth of research studies in this area, a number of recurring principles have been highlighted as being pertinent to admission. These include comprehensive assessment, provision of information on rights and general information, resident and family involvement, multi-disciplinary team approach, and effective communication between inpatient services and both primary care and community mental health services.

3.1 Appropriate Admission

It is important that mental health services work towards the appropriate admission of individuals to approved centres. Appropriate admission is where it is in the individual's best interests to receive inpatient care. Inappropriate admission may be viewed as the admission of an individual to an approved centre because the service he or she requires is not available elsewhere or the admission of an individual to an inappropriate unit of an approved centre. For example, the admission of a child to an adult service due to a lack of child & adolescent mental health services or the admission of a person with intellectual

disability to a long stay general psychiatric ward. Appropriate admission is essential so that the individual receives suitable care to meet his or her current needs.

The question of appropriateness of admission is particularly relevant in the case of homeless people with and without mental illness, children and adolescents with mental illness, people with intellectual disability and mental illness, people with alcohol and drug problems and people with a forensic history and mental illness.

3.1.1 Homeless People

A higher risk of mental illness has been found in homeless people (Amnesty International, 2003). The Dublin Simon Community (2003) found that 22% of people in contact with Dublin's Simon Outreach Services in 2002 had a mental health problem. In some cases, this has lead to the problem of homeless people inappropriately occupying inpatient beds, as well as problems in discharging homeless people. A recent US study, for example, found that homeless persons treated for mental illness in a large public mental health system were more likely to use inpatient services compared to their non homeless counterparts and were more than twice as likely to be admitted (Folsom et al, 2005). Such findings may be in part due to a lack of community-based services, in particular community-based residential care accommodation and supported housing in which to discharge homeless people. According to the submission of the Simon Community of Ireland to the Department of Health (Health Strategy, 2001 cited in Amnesty International, 2003) less than 200 units of supported accommodation are provided for people with mental illness who are homeless in Ireland. The findings of the US study may also be the result of homeless people experiencing difficulties in accessing appropriate community mental health care, which might avoid inpatient admission in the first place.

There is also the additional problem of homeless people without a mental illness being inappropriately admitted to approved centres because of a lack of appropriate accommodation. This is a social issue, which needs to be tackled by the appropriate statutory authorities and voluntary agencies that provide accommodation and services for homeless people.

Homeless people with mental illness also face a problem with access to inpatient services. Given that everyone should have the right to the best available mental health care according to international mental health standards (MI Principle 1) homeless people must also be entitled to this right. Consequently, homeless people with mental illness necessitating inpatient care should not be denied access to approved centres because they are not resident in the catchment area. The first priority of any health professional must be a duty to the needs of those presenting for care. In 2004, the Department of Health and Children, issued correspondence to mental health services based on the recommendations of the former Inspector of Mental Hospitals, Dr. Dermot Walshe, which stated that irrespective of whether a person resides within a catchment area, or whether he or she is homeless, a individual presenting at an inpatient unit should be examined and assessed by medical staff and the case discussed with the relevant consultant psychiatrist. If it is

determined that a person has a serious mental illness and is in need of immediate inpatient care, the former Inspector recommended that the person should be admitted to the service (Appendix 1). The HSE South East Region recommend keeping a record all homeless persons admitted to approved centres (HSE South East, 2003).

3.1.2 Children and Adolescents

Problems also exist for children and adolescents with mental illness for whom there is a lack of adequate services in Ireland. In England and Wales, for example, it is estimated that 600 young people are inappropriately placed each year on adult or paediatric wards (O' Herlihy, 2001 cited in Royal College of Psychiatrists, 2002). Children and adolescents have the right to age-appropriate services, separate from adult services (World Health Organisation, 2005; Institute for Health & Clinical Excellence, 2005). Children under 16, for example, should not be admitted to adult mental health services but should be referred to a suitable Child & Adolescent mental health service (Mental Health Commission, 2005a; The Royal College of Psychiatrists UK, 2002). The Royal College of Psychiatrists (2002) in the UK recommend that those aged 16 or 17 should only be admitted to adult services when no suitable specialist adolescent inpatient bed is available; when the person is likely to have a serious mental illness; and when acceptable standards of care are met in the adult unit, and child and adolescent psychiatric consultation and advice is available throughout the admission. The Department of Health UK and Welsh Office (1999) recommend that if a child is placed in an adult unit, facilities, security and staffing appropriate to the child's needs should be provided. It is vital that both child and adolescent, and adult mental health services, work collaboratively in the care of this group (Royal College of Psychiatrists UK, 2002).

3.1.3 Intellectual Disability

People with intellectual disability and mental illness are often admitted to general adult approved centres, due to a lack of speciality services. This is a particular problem in Ireland with only two specialist approved units nationally for this target group (Mental Health Commission, 2005a). For this reason, close liaison between adult approved centres and mental health services for intellectual disability is essential (Irish College of Psychiatrists, 2003; Chaplin & Flynn, 2000).

3.1.4 Substance Abuse

In the Mental Health Commission's Annual Report for 2004 (2005a), the Inspector of Mental Health Services recommended that individuals should not be admitted to approved centres for simple intoxication or for uncomplicated detoxification from alcohol. An individual's primary complaint must be one of mental illness. This precludes however centres with a unit specifically designed for alcohol misuse and detoxification.

Furthermore, pursuant to section 8(2) of the Mental Health Act 2001, individuals should not be admitted involuntarily solely on the basis of addiction to drugs or intoxicants. Individuals should only be admitted involuntary when they are believed to be suffering from a mental disorder[7]. Individuals presenting with dual diagnosis of mental illness and substance abuse should be treated in the environment which offers the most appropriate care and treatment to meet their current needs. In the absence of appropriate services, it is imperative that centres have in place relevant policies e.g. "substance misuse" policy, to manage possible inappropriate admissions. Such policies should include an assessment of risk and an evaluation of the immediate needs of the person.

3.2 Pre-Admission Process

The Health Boards Executive (2003) asserts that there should be a clearly defined pre-admission process to hospital, which applies to both emergency and elective admission. Although, it is referring to general health, the same may be said of admission to an approved centre. The pre-admission process essentially refers to the assessment of the individual by primary care services, referral to community mental health service if necessary, thorough assessment by the community mental health team (CMHT) and then appropriate referral. The latter includes referral to an approved centre, where necessary. Having a structured pre-admission process fulfils several functions. Firstly, by accessing approved centres through the appropriate channels, it ensures that the individual requires inpatient care and that a more appropriate less invasive form of care would be insufficient. It also enhances service delivery by streaming individuals into the appropriate centres or units within mental health services. In the Irish study *"We have no beds"*, Keogh et al (1999), stress the importance of each admission being evaluated on its own merit and not on the past admission record of the individual. It is in the individual's best interest if care is accessed through the appropriate channels, so that he or she can receive care most appropriate to his or her current needs and care is provided in an appropriate location.

3.3 Assessment

Best practice indicates that a comprehensive assessment should be conducted upon admission to inpatient care (e.g. The Royal College of Psychiatrists, 2004; The Mental Health Commission, 2005a; Office of the Chief Psychiatrist, 2002; NHS, 1999; Sainsbury Centre for Mental Health, 1998; American Academy of Child & Adolescent Psychiatry, 1996; Commonwealth of Australia, 1996; American Psychiatric Association, 1992). A comprehensive assessment should include an assessment of physical, psychiatric, psychological, social, risk, housing and personal circumstances such as details of family/carers or chosen advocate.

[7] See glossary

Assessment for children and adolescents should also include an educational assessment (National Institute for Health & Clinical Excellence, 2005; Royal College of Nursing of the UK, 2005; American Academy of Child & Adolescent Psychiatry & American Psychiatric Association, 1996). Consent should be obtained for assessment of a child or adolescent from their parent, guardian or legally responsible adult (National Institute for Clinical Excellence, 2004). Several recommendations call for the provision of educational services to a child or adolescent while in inpatient care (Royal College of Nursing of the UK, 2005; Department of Health & Welsh Office, 1999; American Academy of Child & Adolescent Psychiatry & American Psychiatric Association, 1996).

Detailed multi-disciplinary assessment is also advised for people with an intellectual disability and mental illness (Bouras et al, 2000). A full psychological assessment is particularly important in order to establish the level of intellectual functioning of the person. The Department of Health UK and Welsh Office (1999) recommend carrying out the assessment of a person with intellectual disability in consultation with a family member, friend or supporter of the person to facilitate communication. Bouras et al (2000) also recommend consulting other relevant agencies to maximise the gathering of information on the person.

Comprehensive initial assessment can draw attention early to factors other than health, for example housing, which may influence the length of a person's inpatient stay (Scottish Executive, 2002; Ryan, 1994) and will therefore need to be considered in discharge planning. Very little attention has been paid in the past to the reasons for admission, particularly social factors, in assessment and care planning according to Moore (1998), however, since such factors can militate against discharge, it is crucial that they are identified from the outset.

3.4 Rights and Information

International human rights legislation (MI Principles), international mental health standards (e.g. Commonwealth of Australia, 2000) and several professional codes of conduct (e.g. Medical Council, 2004; Irish Nursing Board, 2000) emphasise the importance of providing individuals with information at the time of admission, including information on their rights. Information on rights is important in the case of involuntary admission from a human rights perspective. It is also important that voluntary patients are made aware of their rights on admission and are cognisant of the holding power of approved centres under section 23 and section 24 of the Mental Health Act 2001 (O'Neill, 2005). Section 23 and 24 state that a voluntary patient may be detained in an approved centre if it is believed that he or she is suffering from a mental disorder. In the case of adults, detention is subject to examination by a consultant psychiatrist. Children may be detained and placed in the custody of the Health Service Executive (HSE) and an application to the District Court is then made by the HSE.

Best practice indicates that individuals admitted to inpatient care should be provided with a range of information, including information on their mental illness, on the service they can expect while in inpatient care, and on treatment options available to them (The Royal College of Psychiatrists, 2004; Office of the Chief Psychiatrist Australia, 2002; Commonwealth of Australia, 1996). The importance of individuals being informed of how to access advocacy and voluntary organisations has been highlighted in the Australian National Standards for Mental Health Services (Commonwealth of Australia, 1996). Studies of individuals' experiences of inpatient care have highlighted the lack of information often given to individuals on, for example, medication and possible side effects while in hospital (Irish Society for Quality and Safety in Healthcare, 2005; Goodwin et al, 1999; Ballard et al, 1990).

Information should always be provided to the individual and his or her chosen advocate in clear understandable language. The importance of adapting the extent and content of information based on the needs of the individual has been highlighted (Thienhaus, 1995). For example, children should be provided with age appropriate information (National Institute for Health & Clinical Excellence, 2005; Royal College of Nursing of the UK, 2005; Mental Health Act Commission, 2001). Parents of children should also be provided with information regarding their child's intended treatment and care (National Institute for Health & Clinical Excellence, 2005; American Academy of Child & Adolescent Psychiatry, 1989). Adapting information is equally important for people with intellectual disability where intellectual functioning, capacity to consent and decision making ability may be limited.

The need for service user information booklets was highlighted in one UK study (Dale, 2002). Several approved centres in Ireland have in existence service user information booklets, although these vary in quality and content. Information provided includes general information on the approved centre to which a person is being admitted and details of a person's multi-disciplinary team. Thus, it may be beneficial to roll this practice out nationwide, and have all approved centres to develop their own service user information booklets.

3.5 Integrated Care Pathway & Care Planning

The Health Boards Executive (2003) recommends the use of an integrated care pathway approach to acute hospital care. An integrated care pathway is a multi-disciplinary outline of anticipated care, placed in an appropriate timeframe, to help an individual with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes (Middleton et al, 2003). Several recommendations call for the use of individualised care plans formulated by multi-disciplinary teams in consultation with residents (The Health Boards Executive, 2003; Department of Health UK, 2002; The American Academy of Child & Adolescent Psychiatry & American Psychiatric Association, 1996).

The Mental Health Act 2001 (Approved Centres) Regulations 2006, S.I. no 551 of 2006, place a statutory obligation on approved centres to have an individual care plan for every resident in the approved centre. The regulations define an individual care plan as *"a documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include educational requirements. The individual care plan shall be recorded in the one composite set of documentation."* Shared documentation by the multi-disciplinary team has been recommended (Department of Health UK, 2002) to foster greater communication and sharing of information. A written copy of the care plan should be given to the resident (Welsh Assembly Government, 2002; NHS, 1999).

In terms of planning the length of a resident's stay, stays in approved centres should ultimately be kept as short as possible, so that the resident can return to the community as soon as he or she is well enough to be supported in a community environment. Several studies and reports recommend anticipating the resident's length of stay upon admission (Jones & Bowles, 2005; Moore, 1998) and documenting it in the care plan. It is argued that having a projected discharge date allows staff in both the approved centre and the community mental health facility to tentatively plan for discharge. The date can be changed if required and thus there is still flexibility in the provision of care. Some studies examining length of hospital stay and rates of re-admission have found no relationship between shorter lengths of stay and re-hospitalisation rates (e.g. California Department of Mental Health, 2002) indicating that shorter stays for residents do not necessarily lead to an increased risk of re-admission. Resident outcomes following inpatient care may be more contingent on the quality of care the resident receives while in an approved centre and on the degree of support and follow up care the individual receives following discharge, rather than on the actual length of stay in inpatient care.

3.6 Multi-disciplinary Team Involvement

There is consistent evidence for adopting a multi-disciplinary team approach to all aspects of care (e.g. Mental Health Commission, 2005a; Health Boards Executive, 2003; Department of Health UK, 2002; NHS, 1999; The American Academy of Child & Adolescent Psychiatry & American Psychiatric Association, 1996). Evidence suggests that the quality of initial assessments is enhanced by multi-disciplinary involvement (Strathdee & Thornicroft, 1996 cited in NHS, 1999). A multi-disciplinary approach allows for the multiple needs of the resident to be addressed. One of the key themes emerging from the Mental Health Commission's (2005b) stakeholder consultation was the importance of multi-disciplinary teams. The first theme of the quality framework is the provision of a holistic, seamless service and full continuum of care delivered by a multi-disciplinary team.

3.7 Key-Worker

The appointment of a key-worker upon admission has been recommended (Centre for Addiction and Mental Health, 2004; Commonwealth of Australia, 1996). The key-worker is the person responsible for keeping close contact with the resident, and for advising other members of the multi-disciplinary team of changes in the resident's circumstances. The key-worker should facilitate the care pathway (Health Boards Executive, 2003) and has the overall responsibility of co-ordinating the delivery of the integrated care plan. He or she should ensure that an individual care plan is completed and regularly updated, that it is carried out in consultation with the resident and family or chosen advocate, where appropriate (i.e. with the consent of the resident), and, that the resident and his/her family or chosen advocate are aware of the appropriate health and social care professionals to contact. The key-worker should liaise with appropriate agencies to co-ordinate the resident's care and should ensure that discharge planning occurs in collaboration with the community clinician (Commonwealth of Australia, 1996). The key-worker may be any member of the multi-disciplinary team, for example, a psychiatric nurse, social worker, psychiatrist, occupational therapist, or clinical psychologist. The role of key-worker should be assumed by the person who is best placed to oversee the resident's care planning.

3.8 Resident & Family Involvement

The Health Boards Executive (2003) state that the decision to access a hospital service should be a joint decision made by both the individual and his or her general practitioner. Thus, resident involvement in inpatient care should essentially begin before the individual is admitted to an approved centre. In the Mental Health Commissions Annual Report 2004 (2005a), the Inspector of Mental Health Services recommends that the resident is involved in care delivery at every stage of his or her stay in an approved centre. The involvement of a resident in his or her care as well as the family or chosen advocate, where appropriate (i.e. with the consent of the resident), has been widely recommended across the literature (Medical Council, 2004; The Royal College of Psychiatrists, 2004; Sainsbury Centre for Mental Health, 2002; Wallace et al, 1999; Australian Health Ministers Advisory Council's National Mental Health Working Group, 1996).

It has been recommended that documentary evidence of resident and family involvement in the treatment process is made (American Academy of Child & Adolescent Psychiatry & American Psychiatric Association, 1996). This should begin with the documentary evidence of involvement of the resident and his or her family or chosen advocate in the admission process.

With regards to children and adolescents, parents should be involved (World Health Organisation, 2005; Royal College of Nursing of the UK, 2005; National Institute for Health & Clinical Excellence, 2005; Ministry of Health New Zealand, 2001; American Academy of Child & Adolescent Psychiatry, 1989) in the admission process where appropriate. The Mental Health Commission's Code of Practice relating to Admission of

Children under the Mental Health Act 2001 should be referred to for guidance in relation to consent for children and adolescents.

In respect of people with intellectual disabilities, this client group may require additional support to express their views due to communication barriers (Scottish Executive Health Department, 2000b). For this reason, the involvement of family, carers or advocates for people with intellectual disability has been advised to facilitate communication (Scottish Executive Health Department, 2000b; Department of Health & Welsh Office, 1999). The Mental Health Commission has established a working group for mental health services for people with intellectual disability, which will be devising a code of practice to address issues confronted by staff working in mental health services for people with intellectual disability and this code will be issued for consultation in the near future.

3.9 Collaboration with Primary Health Care, Community Mental Health Services, Relevant Outside Agencies & Information Transfer

Primary health care services, community mental health services and approved centres need to work closely together to foster a two-way system of communication and promote and enhance continuity and quality of care. The Canadian Psychiatric Association (2005) highlights several communication problems between general practitioners (GPs) and mental health services. These include lack of sufficient information transmitted by the general practitioner on referral, lack of information communicated back to the general practitioner about the progress of a resident in inpatient care, and general practitioners being unclear about inclusion and exclusion criteria for admission to inpatient care.

In the recent report *"Mental Health in Primary Care"*, (Irish College General Practitioners, 2004) both general practitioners and consultant psychiatrists agreed that there was a compelling need to improve communication channels between general practice and mental health services. General practitioners proposed the standardisation of correspondence between the two services in relation to referral letters, follow up letters and discharge plans. The Irish College of general practitioners recently recommended a pro-forma referral letter (Appendix 3) which included: GP contact information, resident contact information, reason for referral, whether referral is urgent or non-urgent, presenting complaint(s), history, including psychiatric and medical, other relevant information such as drug/alcohol abuse, family/social history, medication, allergies and clinical examinations. Referral letters and direct communication between GP's and staff in approved centres, where possible, are necessary so that the multi-disciplinary team is provided with adequate information regarding the resident upon referral. This is particularly important from a safety perspective, where the resident may pose a risk to himself/herself or others. The Welsh General Assembly (2002) also recommends developing referral protocols between primary and secondary care as part of its national service framework.

It is crucial that communication is two-way, with staff in approved centres reporting back to general practitioners/primary care teams and community mental health staff at the time of admission. A member of the multi-disciplinary team should make contact with community mental health staff upon admission of an individual and advise them of the intended care to be provided to the person so that there is mutual expectation and understanding (Office of the Chief Psychiatrist, 2002). The Department of Health Western Australia in a document *"Adult Mental Health Services Care Pathway Standards for Admission through to Discharge Planning"* (n.d., circa 2005) recommends notifying the appropriate community mental health service within 3 working days of admission. Doing so, allows community mental health staff to remain involved in the care of the individual until the individual is ready to return to life in the community. The Canadian Psychiatric Association (2005) makes numerous recommendations for improved communication between mental health services and general practice. Some of the most relevant recommendations for admission include, greater face-to-face contact between the two services, improved telephone contact, inpatient services contacting a general practitioner when an individual is referred or significant treatment changes take place, and agreement between psychiatrists and general practitioners on the information required at the time of referral and discharge. The Department of Health in Western Australia (n.d., circa 2005) recommends that a member of the community team attend weekly discharge team meetings, where possible.

Close collaboration between approved centres and outside agencies is important, for example, in the case of people with intellectual disability admitted to approved centres. Several recommendations call for close liaison between mental health services and intellectual disability services during inpatient care (Estia Centre, 2003; Irish College of Psychiatrists, 2003; Chaplin & Flynn, 2000; National Assembly for Wales, 2000 cited in Royal College of Psychiatrists, 2003; Royal College of Psychiatrists, 1999). This becomes particularly important when it comes to discharge planning (Chaplin & Flynn, 2000; Watts et al, 2000).

3.10 Record-keeping & Documentation

Documenting every aspect of the admission process is essential for several reasons. It provides a reliable record of care, ensuring that various procedures are carried out and it allows for auditing of the admission process. Documentation also acts as a communication tool (Department of Health UK, 2002). According to the Mental Health Commission's document *"Excellence in Mental Healthcare Records"* (Mental Health Commission, 2005c), clinical records serve two functions: communication and protection. Records communicate information on assessment, care plans, progress and discharge plans, and they provide an evidential role which may be important in cases of litigation.

The guidelines on clinical records proposed in "*Excellence in Mental Healthcare Records"* (Appendix 2) should be adhered to when completing clinical records and care plans. Record-keeping should also be in accordance with the guidelines relating to individual

professional practice. The cardinal rule of record-keeping is that records are kept simple and accurate (Mental Health Commission, 2005c).

Several recommendations call for an integrated system of record-keeping (e.g. Department of Health UK, 2002). An integrated system of record-keeping is one in which all records on the resident are kept in the one file and this file is used in all treatment settings. Such a system allows for the easy access of comprehensive resident information, and means that all members of the multi-disciplinary team can access the resident's file and be fully informed as to the resident's care and treatment. Such a system can facilitate team functioning (Onynett et al, 1994 cited in Mental Health Commission, 2005c).

3.11 Specific Groups

3.11.1 Patients

Patients should be treated in the same manner as voluntary patients when it comes to admission, however, there are certain statutory obligations under the Mental Health Act 2001 that must also be complied with.

4. Best Practice in Transfer

4.1 Introduction

The internal or external transfer of a resident from an approved centre may occur at some point in the resident's inpatient stay. Transfer may occur because the resident requires care or treatment that is not available in the current approved centre or facility, and he or she would benefit from being transferred to a more appropriate centre or facility which could meet his or her current needs. Transfer may also occur from an independent sector facility to a public sector facility due to issues surrounding health insurance cover or because the resident wishes to be moved to an independent sector facility or facility that is closer to his or her home.

The transfer process must be considered as part of the continuum of inpatient care and it is therefore imperative that the smooth transition of care from one facility to another occurs so that the resident does not experience any major disruption to the care process. Timely and effective transfer of care is an important component of the care pathway, which demands the availability of an alternative more appropriate service to ensure the continuing needs of the resident are met. The full and complete transfer of information is crucial to the transfer process so that staff in the receiving facility are fully aware of the individual needs of the resident being transferred and can provide the appropriate care to address those needs. When a resident is being considered for transfer to another facility by the multi-disciplinary team, the best interest of the resident should serve as the primary influencing factor in deciding whether transfer should take place.

4.2 Literature Review

There is a dearth of information available on best practice in the transfer process in mental health. Evidence-based material on the transfer process in mental health is hugely lacking making it difficult to develop an evidence-based code of practice on the subject. There is a clear need for more research to establish an evidence base for good practice.

As a result, the code as it relates to transfer is largely informed by expert recommendations such as that made by the previous Inspector of Mental Hospitals, directives in general medicine from other countries and from existing transfer policies operating at a local level in Ireland. Some of the recommendations have also been extrapolated from international mental health policy documents, which allude to the transfer process.

A salient theme that has emerged on the transfer of residents is the full, complete and timely transfer of information from the current inpatient facility to the receiving facility.

Good communication between facilities is particularly important from a safety perspective. It is imperative that the receiving facility is fully cognisant of any risk which the resident may pose to either himself/herself or others. Being aware of such factors allows for the provision of the appropriate level of care to the resident upon arrival in the new facility.

The transfer of a resident can potentially create disruption to the care process for the resident and therefore should only be considered when the needs of the resident cannot be met in the approved centre where he or she is currently receiving care and can be better met in another facility. In relation to involuntary admission, international mental health legislation provides that patients should only be transferred when it is in their therapeutic interest. Residents and their families/carers, where appropriate (i.e. with the consent of the resident), should be involved in the transfer process and their wishes taken into account in so far as is possible. Consent from the resident, family/carer (in the case of a child) or advocate should be sought for transfer to another facility.

5. Best Practice in Discharge

5.1 Introduction

Planning for discharge is important to ensure the smooth transition of care from an approved centre to the community. It is important that following discharge appropriate services are available which meet the individual needs of the resident, so that he or she can function at an optimal level in the community with better outcomes and greater resident satisfaction. Discharge planning must operate within a whole systems approach and address all of the post-discharge needs of the resident including psychiatric, psychological, medical, social, cultural, and informational needs.

Discharge planning and the development of an aftercare plan are paramount to the provision of care to residents. They are particularly important in light of the high re-admission rates for mental health service users who have previously been in inpatient care, which has lead to what is known as the "revolving door" phenomenon. The ultimate aim of effective discharge is to maintain care of the individual in the community but a flexible system must also be in place to allow for re-entry of individuals into inpatient care should they require it.

The development of a national code of practice for discharge provides the framework for the implementation of a comprehensive and structured approach to discharge from an approved centre based on international best practice. A key finding of a recent comprehensive study of discharge from inpatient care conducted in Scotland was that the effectiveness of discharge policies is influenced by a number of factors. These factors include the admission process, discharge planning, interagency and multi-disciplinary relationships, the discharge event itself and the support available post-discharge (Scottish Executive, 2002).

Health professionals must not be mistaken in thinking that discharge is an isolated event which refers only to the discharge event itself. Rather the discharge process is ongoing throughout a person's stay in an approved centre, which commences upon admission to the centre and continues on even after the individual has been discharged (Fisher, 1994 cited in Durgahee, 1996). Planning for discharge is an active process and timely discharge decisions are central to this process (Office of Chief Psychiatrist Australia, 2002).

Unlike admission and transfer, there is a growing evidence base for the effective discharge of residents from hospital. The research relates primarily to general health, but some research is specific to discharge from inpatient mental health care. Many of the issues highlighted in the general literature are mirrored in mental health studies on the discharge process. Discharge planning has been researched widely over the past 30 years however it has often been vaguely defined in the literature (Lundh & Williams, 1997; Ryan, 1994). Several generic conceptual frameworks for the discharge process have been proposed (eg. Mamon et al, 1992; Victoria Government Department of Human Services, 2005; Jupp &

Sims, 1986 cited in Lundh & Williams, 1997). Several elements have been highlighted as being important for effective discharge. Most of these can be found in the framework developed by the American Medical Association Council on Scientific Affairs (1996). They recommend 6 essential components to a structured discharge process, which are as follows:

1. Discharge criteria should be based on a multi-faceted assessment of needs
2. Interdisciplinary input is essential
3. Early assessment and planning to prepare for discharge
4. Post-discharge care
5. Patient and care-giver education
6. Co-ordinated, timely and effective communication between all parties involved

There is remarkable consistency in what elements constitutes good practice in the discharge of care from hospital based on the findings from studies spanning general health, the health of older people and mental health. The components highlighted above, although often addressed separately in different studies have frequently been cited in the literature as being vital for effective discharge (e.g. Lundh & Williams, 1997; Sheppard et al, 2004; Ryan, 1994; Houghton et al, 1996). There is still, however, a lack of empirical evidence for any specific model of discharge planning (Victorian Government Department of Health Services, 2005). Relatively few studies have evaluated the impact of different approaches to discharge planning on post-discharge care and individual outcomes (Mamon et al, 1992). Standardised and easily quantifiable measures of the key attributes of discharge planning do not exist (Mamon et al, 1992).

Despite the fact that the above elements are frequently reported as being essential for effective discharge, research shows that the preparation of residents for discharge and discharge planning often falls far short of this (e.g. Durgahee, 1996). Inadequate assessment, poor organisation and poor communication which were identified as far back as 20 years ago as causing problems in discharge from hospital (Barker, 1985 cited in Shepperd et al, 2005) still present as problems today.

5.2 Discharge Planning

Discharge planning should commence as soon as possible after admission (Scottish Executive, 2002; Moore, 1998; Ministry of Health, 1993; Department of Health, 1989). Support for early discharge planning comes from general medical research, where randomized clinical trials report improved outcomes of care for those in which discharge planning commenced early (Potthoff et al, 1995; Anderson & Helm, 1994; Health Care Financing Administration, 1992). In a recent Irish study "*Mental Health in Primary Care"*, general practitioners emphasised the importance of commencing discharge planning from the onset of referral from general practice (ICGP, 2004).

There is a good deal of support for specifying specific time periods within which certain actions should be completed within discharge policies (Scottish Executive, 2002; Department of Health, 2003; Account Commission, 1999 cited in Scottish Executive, 2002; American Academy of Child & Adolescent Psychiatry & American Psychiatric Association, 1996). The purpose of this is to ensure that timely discharge decisions are made. The Accounts Commission (1999) in Scotland, for example, recommend that NHS Trusts review their discharge policies to ensure that agreed set timescales for action have been stated, and in particular stress the importance of district and practice nurses receiving information within an appropriate timescale. The American Academy of Child & Adolescent Psychiatry & the American Psychiatric Association (1996) recommend that a *"comprehensive discharge plan is formulated…implemented in a timely manner and includes specific target dates for implementation of each procedure involved in the discharge process"*. The Scottish Executive (2002) refer to a practice in East and Midlothian NHS Trust in Scotland where a discharge integrated care pathway is used, in which again time periods are specified within which specific actions are to be completed. An initial integrated discharge plan should be developed early in the resident's inpatient stay. This plan should then be reviewed and revised throughout the residents stay in light of the residents needs. Discharge planning must be individualised for each resident (Ministry of Health, 1993).

5.3 Pre- Discharge Assessment

Discharge planning should address the therapeutic social, cultural, and informational needs of the resident (Ministry of Health, 1993). A comprehensive assessment of the resident's needs is as integral to the discharge planning process as it is to the admission process. Irish general practitioners recently highlighted the importance of a needs-led assessment of residents for discharge (Irish College of General Practitioners, 2004). In a Scottish survey of residents and carers experiences of discharge from inpatient mental health care, residents called for a fuller assessment of needs, while carers called for more time to discuss the service user's needs (NSF Scotland, 1998). In the Mental Health Commission's stakeholder consultation, attention was drawn to the fact that carers are often not provided with enough information on the individual needs of the resident and as a result,
"Many families are frightened by their family member returning from hospital. They feel alone, isolated from the rest of the community and anxious for their own safety and that of the patient" (Mental Health Commission, 2005b).

Needs assessment should serve as the bedrock for the development of a discharge plan. Examining the factors that contributed to admission is important in helping to prevent relapse or crisis following discharge. For example, social needs are often ignored in hospital discharge (Nixon et al, 1998). One of the reasons discharge is often delayed is due to a lack of suitable accommodation for the resident to return to following discharge (Keogh et al, 1999; Moore, 1998).

Pre-discharge assessment for children and adolescents must additionally address educational needs, with a plan made for the re-entry of the child or adolescent back into the school system (Royal College of Nursing of the UK, 2005; American Academy of Child & Adolescent Psychiatry and American Psychiatric Association, 1996).

A comprehensive assessment prior to discharge should include risk assessment. Risk assessment is a prime consideration in discharge decisions, and should consider whether with adequate medication, care, and supervision in the community, the individual could still present any serious risk to him/herself or others (Durgahee, 1996). Inadequate training and education of health professionals in risk assessment has been found in the past (Durgahee, 1996).

5.4 Multi-disciplinary Team Involvement

There is consistent evidence to suggest that best practice in hospital discharge involves the multi-disciplinary team to actively manage all aspects of the discharge process (Scottish Executive, 2002; Health Boards Executive, 2003; Department of Health UK, 2003; Department of Health, UK 1989). Discharge planning can be incorporated into the existing multi-disciplinary case review processes (Victorian Government Department of Human Services, 2005). A multi-disciplinary team approach to care can lead to a broader perspective in care provision, consistency of approach, continuity of care, and improved communication between disciplines (Pollack, 1986 cited in Cowan, 1991). Randomized clinical trials have found that comprehensive multi-disciplinary team discharge planning results in improved outcomes of care such as fewer readmissions and fewer total days re-hospitalised (Council on Ethical & Judicial Affairs, 1998). Having all staff involved in the discharge process enables the various needs of the resident, including medical, psychiatric, social, and psychological issues to be addressed following discharge. The social worker for example, is particularly useful in discharge planning (Inglis & Baggaley, 2005) to identify and address any social needs that the resident may have. Having multidisciplinary team input into planning can lead to appropriate referrals and services can be co-ordinated and executed in a timely manner (Mamon et al, 1992).

Barriers that have been cited to multidisciplinary team working include professional rivalry and mistrust, and the lack of knowledge of what other mental health professionals do and what skills they possess. In the Mental Health Commission's Annual Report 2004 (2005a, p. 119) the Inspector of Mental Health Services highlighted the "*disturbing lack of awareness and acceptance of the concept of true team working*" in many approved centres visited in Ireland.

A multi-disciplinary team approach to care is clearly the way forward and is by no means a new phenomenon however one of the major barriers to cultivating such an approach may be the low staffing levels of certain disciplines in parts of Ireland. The lack of the necessary range of staff in many services was reported by the Inspector in her recent report. A UK study similarly found that only 43% of consultants reported a full team assigned, which

may be due to both a lack of acceptance of the benefits of multi-disciplinary team working and to low staffing levels (Cowan, 1991). It is therefore essential that sufficient staff numbers are present for a multi-disciplinary team approach to occur.

5.5 Key-Worker

The importance of having a designated key-worker to co-ordinate all aspects of the discharge process has been highlighted in many documents (Health Boards Executive, 2003; Department of Health UK, 2003; Taraborrelli et al, 1998 cited in Scottish Executive, 2002; Nixon et al, 1998; Hartigan & Brown, 1985; Ministry of Health, 1993). Key-workers should be identified in the discharge plan and all partners should be aware of who the key-worker is. The key-worker has responsibility for co-ordinating the implementation of the integrated discharge plan and involving persons with extensive knowledge of community services (Ministry of Health, 1993). The key-worker should ideally contact relevant outside agencies which can help address needs other than health that the resident may have, for example, social services and drug and alcohol services (Victorian Government Department of Health Services, 2005).

5.6 Collaboration with Primary Health Care, Community Mental Health Services, Relevant Outside Agencies & Information Transfer

Ample research exists that poor communication exists between hospital and community staff with ineffective dialogue, and insufficient or inaccurate information being exchanged (Nixon et al, 1998). Timely and ongoing communication between hospital and community staff, including general practitioners has repeatedly been cited in the literature as being paramount for effective discharge (e.g. Victorian Government Department of Human Services, 2005; Simons et al, 2002; Taraborelli et al, 1998 cited in Scottish Executive, 2002). With the increasing emphasis on a community care model for mental health, greater contact and communication with general practitioners/primary care teams and community mental health services staff is vital. Clear communication allows discharges from the approved centre to be co-ordinated and planned, and allows for the smooth transition to community care and prompt follow-up (Inglis & Baggaley, 2005; Office of the Chief Psychiatrist, 2002).

A number of issues come to the fore when examining communication between inpatient facilities and the community. These include mode of communication (e.g. telephone, letter, fax), timing of communication (e.g. how soon discharge summaries are sent out) and content of communication. Best practice would indicate that both written and verbal information should be given to general practitioners/primary care teams and other service providers (Victorian Government Department of Human Services, 2005).

A strong link between general practitioners and the mental health services has been identified as being important to the delivery of a quality service (Mental Health Commission, 2005b). In the report *"Mental Health in Primary Care"* (Irish College of General Practitioners, 2004) both general practitioners and consultant psychiatrists agreed there was a compelling need to improve communication channels between general practice and mental health services. The recently published National Strategy for Action on Suicide Prevention (Health Service Executive & Department of Health, 2005) emphasised the need for an information system to be developed for general practitioners to facilitate the accurate and timely feedback of information to general practitioners on the status of their patients with an indication of how health and social needs are being met.

Naji et al (1999) carried out a randomized control trial of 343 service users in inpatient care, in which general practitioners were contacted by telephone prior to the discharge of a service user and a GP appointment arranged for post-discharge. This approach found some benefits. Service users who received this 'novel discharge protocol' had more general practitioner consultations related to mental health and less hospital out-patient appointments in the 6 months after discharge. General practitioners furthermore deemed the advantages of receiving timely communication about discharge outweighed the costs. The desire for pre-discharge telephone contact with inpatient staff is echoed in a survey of general practitioners in England, in which the majority of general practitioners were dissatisfied with the lack of communication with inpatient staff, and 96% suggested pre-discharge discussion preferably with a medical member of the multi-disciplinary team would be useful (Wylie, 1994). Thus, direct contact between relevant inpatient staff and general practitioners prior to discharge may facilitate the smooth transfer of care back to a primary care setting.

Moore (1998) found that community mental health staff had very little involvement in the discharge process until the last minute, leading to problems in supporting resident discharge back into the community. They recommended that community mental health staff should be involved from the onset of each resident's inpatient stay. The Department of Health in Western Australia (n.d., circa 2005), recommend that a member of the community team attend weekly discharge team meetings, or if not feasible telephone contact may suffice.

When a child or adolescent is admitted for inpatient care, it is important that the key-worker liaises with the relevant outside agencies, such as social care, education and child care services, throughout the child's stay. In the case of people with intellectual disability, inpatient staff should foster communication channels between approved centres and intellectual disability services. The National Disability Authority (2003) recommend that where a individual with intellectual disability has been referred from intellectual disability services to an approved centre, protocols should be put in place to secure a post-discharge residential place for this person, and the relevant agency should normally accept the person back into its service following inpatient care. It is imperative that this occurs in order to have timely discharge.

5.6.1 Transfer of care

In Victoria, Australia, discharge from specialist mental health services is viewed as a 'staged' process. Care is transferred to the general practitioner and the involvement from specialist mental health services gradually diminishes over time (Victorian Government Department of Health Services, 2005). There is some evidence to suggest that resident communication with outpatient clinicians prior to discharge, either face to face or over the telephone, may aid the smooth transition to outpatient care. A study of service users with schizophrenia, found that compared to controls those who had communication with the outpatient clinician which consisted primarily of face to face contact at an outpatient facility, were significantly more likely to complete the outpatient referral, and had a lower total Brief Psychiatric Rating Score at a three month follow up and less self-assessed difficulty controlling symptoms (Olfson et al, 1998).

Another study found that some residents benefited from having the opportunity to 'phase' their discharge by spending only a few nights away from the hospital to begin with (NSF Scotland, 1998). The Scottish Executive (2002) report that in some services in Scotland residents go home on 'extended pass', which turns into discharge if all goes well. Some residents have found that this helps them prepare for discharge. Going home on 'weekend pass' is also common practice in Ireland. However, little work has been done on the effectiveness of 'passes' and furthermore little attention has been paid to what happens on pass and the setting of goals for this process (Scottish Executive, 2002).

Thus, communication or contact with community mental health services prior to discharge may facilitate the transition between an approved centre and the community and may lead to more favourable outcomes and greater service user satisfaction. Where possible, it might also be useful to bring former residents into the discharge planning process as advocates to exchange information on living successfully in the community following discharge from inpatient care (Ombudsman of British Columbia, 1994).

In Victoria, Australia, best practice indicates that planned contact should occur between the Area Mental Health Services (AMHS), the resident and the general practitioner when care is being discharged from AMHS back to general practitioner care (Victorian Government Department of Health Services, 2005). Area Mental Health Services are specialist mental health services, including community and residential care, in addition to inpatient care. There is a transition phase of up to 12 months, with the first planned contact within a month post-discharge, and a review at the end of the transition period. The level of contact recommended between services in Victoria however may be more readily obtained between inpatient services and community services than between inpatient services and general practitioners. The same report also recommends that general practitioners put in place a strategy to periodically check former AMHS residents to prevent avoidable relapses.

Thus, the evidence base suggests that prior contact between the resident and community mental health staff or primary care, improves the transfer of care and has beneficial results for all. A staged transfer of care between inpatient and community facilities may be the

best way to ensure a smooth transition between services because the individual experiences continued support.

5.6.2 Information Transfer: Discharge Summaries

Several studies have looked at the information needs of general practitioner's on discharge, most of which have focused on the form and content of discharge summaries (Wylie, 1994). Discharge summaries often fail to meet the needs of either general practitioners or psychiatrists (Craddock & Craddock, 1990). Problems with discharge summaries include lack of adequate information and transmission delays (Nixon et al, 1998).

In some countries, such as Scotland and England, two discharge documents are sent to general practitioners following discharge from hospital after treatment for general health or mental health care: an immediate discharge summary or letter followed later by a more detailed discharge summary. This approach is adopted primarily to allow for the rapid transfer of initial information followed by more detailed information at a later date.

The Royal College of Physicians (2005) question the necessity of sending two documents, citing a study of older people in which GPs believed that one structured document was sufficient (Howard, 1986 cited by Royal College of Physicians, 2005). Given however the importance of the timely transfer of information in mental health, two documents may be necessary to ensure the initial transfer of crucial information. The Royal College of Physicians (2005) do however suggest that regardless of whether one or two documents are sent, the same standards should apply to both. The Royal College of Physicians specify nine standards, which include the resident being informed of what information is being communicated and certain information, such as current diagnoses, information given to the resident and intended outcomes being contained in the discharge summary. Craddock and Craddock (1989 cited in Scottish Executive, 2002) found psychiatrists prefer a longer standardised format, while general practitioners prefer a shorter focussed summary. Closs (1997) recommends a brief but comprehensive discharge summary sent before or on the day of discharge to community staff. Several studies have shown that the majority of general practitioners prefer a structured discharge document (SIGN, 2003). In a recent Irish study, general practitioners called for the standardisation of follow up letters and discharge plans in Ireland (Irish College of General Practitioners, 2004).

In terms of the content of discharge summaries, Craddock and Craddock (1990) recommend that information on prognosis, personality, mental state at discharge, management advice and the information given to residents and their relatives should be included in discharge summaries. A survey of general practitioners found that their top information priorities were diagnosis, discharge treatment, inpatient treatment, prognosis, and information given to the resident (Walker & Eagles, 1994 cited in Scottish Executive, 2002). The Irish College of General Practitioners recently recommended a Pro Forma follow up letter which includes the consultants contact information, the resident's contact information, the presenting complaint, course of treatment, diagnosis, care plan, medications, key-worker details, and any other information such as information on social

needs, voluntary agency and additional support needed. The Scottish Intercollegiate Guidelines Network (SIGN, 1996) developed a generic immediate discharge document, in which they recommend a minimum dataset for the hospital/community interface comprising of 21 main fields. These include: discharge diagnosis, discharge medications, active problems at discharge, therapeutic procedures, complications, medical or social issues outstanding at discharge, follow up arrangements, community services arranged, and prognosis.

How soon should discharge documents be sent? The SIGN (2003) recommend that the immediate discharge document should be available at the time of discharge. The Royal College of Physicians (2005) recommend that discharge information should be dispatched before the service user is next seen by his/her general practitioner. General practitioners rate the timeliness of receipt of discharge summaries highly and some have recommended that summaries should be available on the day of discharge (Adams et al, 1993 cited on the Royal College of Physicians, 2005). In terms of mental health, some of the most comprehensive discharge policies in Scotland recommended that the brief discharge summary be sent within 72 hours and the more comprehensive discharge summary within 7-14 days. The use of fax as a mode of data transfer can speed up communication, however certain additional factors must be taken into account when fax is used, such as confidentiality and completeness of information.

Providing community mental health staff and general practitioners with advice on the service to be provided and actions to be taken following discharge, and the varying roles and levels of responsibility such staff should assume following discharge have all featured as important issues in the literature (Victorian Government Department of Human Services, 2005; Ministry of Health, 1993; Durgahee, 1996). In a small scale study of community psychiatric nurses in the UK (Durgahee, 1996), community psychiatric nurses recommended a better flow of communication from the ward to the community, early notice of referrals and in particular a follow-up policy, which specifies the nature and amount of nurse-client contact upon discharge. Thus, community nurses need clear guidelines about their roles and responsibilities in the community care of discharged service users. In a review of a psychiatric hospital in British Columbia, community mental health service providers highlighted the importance of receiving information on the service user's coping skills and behaviours over and above information relating to medication and psychiatric history (Ombudsman of British Columbia, 1994).

There is a need for timely comprehensive discharge summaries to be sent to all the relevant community staff who will be working with the service user following discharge, given the consent of the service user. The Royal College of Physicians (2005) advise that service users' permission should be sought before transferring information to other professionals and agencies.

5.7 Resident/Family Involvement & Information Provision

Residents and their families/carers are often not involved enough in the discharge process and not provided with sufficient verbal or written information (NSF Scotland, 1998). Best practice indicates that residents and their families should be actively involved in the discharge process (Government Department of Human Services Victoria, 2005; NHS, 2004; Health Boards Executive, 2003; Department of Health UK, 2003; Office of Chief Psychiatrist, 2002; Centre for Addiction and Mental Health, 2004; Ministry of Health, 1993; Ombudsman of British Columbia, 1994; Department of Health, 1989). Parents should be made aware of the expectation for their involvement in discharge and aftercare planning in respect of children and adolescents (American Academy of Child & Adolescent Psychiatry, 1989), where appropriate. Although not specific to mental health, several studies have found that the greater the level of resident and family involvement in discharge planning, the more positively patients perceived themselves to be ready for discharge (Jackson, 1994 cited in Lundh & Williams, 1997; Coulton et al, 1982; Jacobs et al, 1985; Simmons, 1986 cited in Nixon et al, 1998).

The provision of care needs to be carried out in partnership with residents. There is much support for the involvement of families/carers in decisions about discharge given appropriate consent by the resident (Moore, 1998; Centre for Addiction & Mental Health, 2004; Ombudsman of British Columbia, 1994). The pivotal role families/carers often play in the discharge process needs to be recognised through consultation and the provision of information (Scottish Executive, 2002). A discharge planning meeting would provide the opportunity for residents, families/carers and community mental health staff, where possible, to be involved in the discharge process (Scottish Executive, 2002; Moore, 1998).

5.7.1 Information & Education

Providing residents with adequate information prior to discharge is crucial (Ryan, 1994). A lack of information can compromise the provision of care and impede continuity of care following discharge into the community. It has been recommended that both written (Accounts Commission cited in Scottish Executive, 2002) and verbal information be provided to residents before discharge (Victorian Government Department of Human Services (2005). The provision of a discharge information pack containing both generic and individualised information for service users and carers may be a worthwhile method for achieving the provision of information. Providing discharge information packs in plain language has been suggested as a means of providing information to residents (Ombudsman of British Columbia, 1994). A study of older people being provided with an information package on discharge however, found poor results notably due to the lack of multi-disciplinary team co-operation (Lundh & Williams, 1997). Thus, it seems that the provision of information must occur in conjunction with a change in the way services operate and the way staff work together.

Service users require information on a range of practical issues including information on medication, diagnoses, contact details for community mental health and other support services such as local advocacy services and voluntary agencies, crisis contact numbers and how to re-access the service (Irish College of General Practitioners, 2004; Scottish Executive, 2002; NSF Scotland, 1998). Service users need information on how to access counselling, support to "*get back on [their] feet"* and back to work (Mental Health Commission, 2005b).

Families and carers also need to be provided with timely information to ensure adequate planning and preparation for discharge (Mental Health Commission, 2005b). The provision of information and time spent involving residents and their families/carers in discharge planning are all areas of work that suffer when hospital staff are stressed or under pressure, or where there is not a culture of open communication with service users and families (NSF, Scotland, 1998). These broader issues must also be addressed if services are to change in the way they are delivered.

5.7.2 Notice of Discharge

Lack of sufficient notice of discharge to residents and carers has been cited as a major shortcoming in the discharge process in both generic and mental health studies (e.g. Lundh & Williams, 1997; Scottish Executive, 2002; Moore, 1998; Nixon et al, 1998; Durgahee, 1996; NSF Scotland, 1998) with residents often being informed of discharge at the last minute. This is often due to the fact that discharge is rushed (Durgahee, 1996; Ministry of Health, 1993) and planning only takes place a day or two before discharge. However, discharge planning should ultimately be completed by the day of actual discharge and further planning should not be necessary (Department of Health UK, 1994) unless a change occurs in the resident's circumstances.

The Scottish Executive (2002) recommend best practice as being 2-5 days notice. Providing residents and their families/carers with adequate notice is important for both groups so that they are truly involved in the discharge process and are given sufficient time to prepare for discharge.

5.8 Follow up and Aftercare

Aftercare is a critical component of a quality mental health service. However, discontinuity between inpatient care and community care has often been highlighted. A service user in a Scottish study asserted that:
"There is a gap between leaving hospital and being seen by the community services…I feel that everyone should have a CPN in the first week after discharge". (Scottish Executive, 2002, pg 91).
Without the provision of support for people leaving approved centres, there can be an increased risk of re-admission. As many as a quarter of residents have been found to be re-

admitted during the 3 months following discharge (Boydell et al, 1991 cited in Crawford, 2004; Olfson, 1999, cited in California Department of Mental Health, 2002).

Studies have also found that the risk of suicide is higher during the period immediately following discharge from inpatient care than at any other time in the resident's life (Crawford, 2004; Appleby et al, 1999a, cited in Crawford, 2004). There are several possible explanations for this, including reduced continuity of care, reduced social support following discharge, and easier access to means of suicide. A recent Danish study, found that risk of suicide peaked in the first week after admission and the first week after discharge and the authors recommended the systematic evaluation of suicide risk among inpatients before discharge, and the immediate initiation of outpatient treatment and family support following discharge (Qin & Nordentoft, 2005). Data from the National Confidential Inquiry into Suicide and Homicide in the UK reported that over a quarter of all deaths occur within the first 3 months of discharge from a psychiatric hospital (Appleby et al, 1999b) and 35-66% of post-discharge suicides occurred before the first follow up appointment (Department of Health, 2001). The report made the recommendation that all service users with severe mental illness or a history of deliberate self-harm within the previous 3 months should be followed up within a week of their discharge (Department of Health, 2001). The Department of Health in Western Australia (n.d., circa 2005) also recommend that all service users with a current history of mental illness and/or self harm be followed up within 5 days of discharge from inpatient care. The Scottish Executive (2002) found in a review of acute psychiatric discharge across Scotland, that all service users had an outpatient appointment 4-6 weeks following discharge. The National Strategy for Action on Suicide Prevention (Health Service Executive & Department of Health, 2005) recommend standardising pre-discharge planning, planning and delivering basic suicide awareness training to mental health services staff, and further resourcing and appointing multi-disciplinary community-based mental health teams and developing and evaluating pilot service initiatives which aim to improve the early detection and improved treatment of psychological distress and mental health problems through community services.

The provision of early follow up services appears to be a crucial part of aftercare following discharge. Although certain characteristics have been identified which place people more at risk of suicide, such as social isolation, being male, suicidal ideation on admission, and history of self-harm, it remains unclear who exactly should be targeted (Crawford, 2004). Most mental health service users who commit suicide are not regarded as being immediate high risk at their final contact with mental health services according to Appleby (1999b). Consequently, the best way to militate against suicide and re-admissions would appear to be enhanced support and follow-up for all residents. Discharge preparation groups, meeting out-patient staff before discharge and the endeavours of discharge co-ordinators have been found to increase resident attendance at follow up appointments (Crawford, 2004). Helping residents prepare for discharge by providing them with clear information on follow-up plans and crisis services and helping them re-adjust to community life would appear worthwhile (Crawford, 2004). The Scottish Executive (2002) refer to a pilot study in Scotland in which a discharge group bridged the gap between hospital and the community.

Residents attended the first session of a six week group as an inpatient and the remainder of meetings after discharge.

In the Mental Health Commission's stakeholder consultation, "*Quality in Mental Health- Your Views"* families and carers advocated for a high level of follow up in the first year following discharge (Mental Health Commission, 2005b). Families/carers and service providers highlighted the need for follow up reminders about appointments and checks on missed appointments. This form of care is particularly important in ensuring continuity of support and preventing service users from falling through the cracks and losing contact with services. Failure to follow up with outpatient care greatly increases the risk of relapse and re-hospitalisation (Green, 1988, Stickney et al, 1980 cited in Olfson et al, 1998). Non compliance with treatment and loss of contact with services are also common before suicide (Appleby, 1999b). Thus, mechanisms must be put in place to follow up missed appointments. Support for families and carers, is also vital following discharge.

"Support for families is often a neglected area. Having a family member who is diagnosed with a mental health difficulty can be very distressing for all concerned, not just the individual with the diagnosis" (Mental Health Commission, 2005b, p. 82)

In relation to children and adolescents, the National Institute for Health and Clinical Excellence (2005) recently recommended in the case of children and adolescents with depression, that a child or adolescent discharged after a first episode should be regularly reviewed for 12 months post discharge and a child or adolescent with recurrent depression who is discharged should be followed up for 24 months post discharge. It recommended that the exact frequency of contact should be agreed between the mental health professional and the child or adolescent and/or the parent or carer and documented in the service user's file. If at the end of this period remission is maintained, the child or adolescent can then be discharged back into primary care.

Aftercare is largely contingent on the availability of community resources, such as community psychiatric nurses, counselling and psychological services, day services, outreach programmes and help returning to employment. The Inspector of Mental Health Services in the Mental Health Commissions Annual Report 2004 (2005a) recently highlighted low staffing levels at community level. This may therefore pose problems in the provision of adequate aftercare services.

5.9 Record-keeping & Documentation

Each step of the discharge process should be documented fully and precisely (NHS, 2004; Office of Chief Psychiatrists, 2002; Victorian Department of Health Services, 2005). Clinical files should be maintained in accordance with the guidelines made in *"Excellence in Mental Healthcare Records"* (Mental Health Commission, 2005c). Fully documenting the discharge process ensures that information is recorded and transmitted to other professionals and allows for accountability and later auditing to ensure compliance with discharge policy. According to the guidelines for discharge planning of the Chief Psychiatrist in Victoria, Australia, documentation of the discharge process should

demonstrate that: discharge planning commenced on admission, that comprehensive clinical review in consultation with the service user and carer was undertaken prior to discharge, that the treating team reviewed the decision to discharge, that necessary referrals and follow up were undertaken within a reasonable timeframe, discharge was formalised in writing and service users and carers were provided with the necessary information (Office of the Chief Psychiatrist, 2002). It has also been recommended that a crisis action plan be documented (Victorian Government Department of Health Services, 2005). All documentation should be stored in the one place.

The use of an integrated care plan approach, which includes a discharge plan, has been recommended in some studies (Durgahee, 1996; Scottish Executive, 2002). An integrated discharge plan would bring all discharge documentation together as a package of care for the service user. It should be stored in the one place and accessible to all members of the multi-disciplinary team. It has been recommended that all members of the multi-disciplinary team work to one set of documentation (Department of Health UK, 2003).

Lastly, the use of a discharge checklist has been highlighted as a good way of ensuring that all necessary actions are taken in making arrangements for the residents discharge (Scottish Executive, 2002; Nixon et al, 1998; Ministry of Health, 1993; Ombudsman of British Columbia, 1994). Discharge lists are often in a 'tick the box' format. The Ombudsman of British Columbia (1994) recommends that when an item on the discharge checklist has not been dealt with when a resident is discharged, an explanatory note should be written.

5.10 Day of Discharge – Some Practical Considerations

5.10.1 Transport

As part of a holistic approach to care, residents should be facilitated in their transport home following discharge (Ombudsman of British Columbia, 1994).

5.10.2 Medication

Several studies recommend that residents should be provided with adequate information regarding their medication in accessible language prior to discharge. In addition, the Scottish Executive (2002) based on best practice in Scotland recommend that residents be given a 7 day supply of medication on discharge. It is probable that the provision of medication in inpatient services in Ireland however will need to be contingent on the individual needs of a resident and on the services he/she accesses following discharge. Some residents may be referred back to day services where they can receive medication on a daily basis. Other residents will however return to their general practitioner and may

therefore require several days supply of medication until their follow up appointment with the general practitioner.

5.11 Information Systems

There is a need to develop mental health information systems to monitor the whereabouts of service users following discharge and ensure continuing access to the necessary services (Ministry of Health, 1993). Such a system should be capable of following up residents who miss appointments as too often residents lose contact with services.

5.12 Specific Groups

5.12.1 Patients[8]

Patients should be treated in the same manner as voluntary patients in that discharge planning should commence upon their admission. Approved centres will, however, need to put in place protocols on discharge planning to address the revocation of admission orders by mental health tribunals. Additionally, in terms of record-keeping, documentation and correspondence, other specified forms and procedures will need to be carried out pursuant to the relevant sections of the Mental Health Act 2001.

5.12.2 Homeless people

It is vital that approved centres have in place as part of their discharge policy, guidance for the discharge of people who are homeless. Residents should not be discharged back into unsuitable accommodation or homelessness (Department of Health 2005; Cross Departmental Team on Homelessness, 2001). Here, interagency communication and collaboration is particularly important. Homelessness services should ideally be notified when a resident admitted to an approved centre is judged to have accommodation problems following post-admission assessment. Good practice can be achieved if there is clear agreement between the mental health services and social, housing or homelessness agencies on how best to deal with the discharge of homeless residents. The Cross Department Team on Homelessness (2001) recommends the need for greater development of appropriate community residential facilities and day care services to cater for the homeless, as there is presently a short supply of such facilities. The HSE South Eastern Region (2003) makes several recommendations in relation to the discharge of homeless people from inpatient mental health facilities. It recommends that, inter alia, a multi-

[8] See glossary of terms

disciplinary team should be in place in each county with responsibility for homeless persons and the team should develop a post-discharge plan in consultation with a discharge officer. It advises that staff in hostels should be trained and supported in order to create greater awareness of the needs of homeless persons with mental health problems and that homeless hostels should notify the multidisciplinary homeless persons' team about all new admissions. It also recommends that every approved centre should, where possible, maintain a record of the location to where a homeless resident has been discharged.

6. Common Issues

6.1 Confidentiality

All health professionals working with people with mental illness are required to maintain confidentiality with resident's personal information at all times under the various professional codes of conduct and to obtain written consent, where possible, before transferring information (Medical Council, 2004; Irish Psychological Society, 2003; Association of Occupational Therapists of Ireland, 2002; Irish Nursing Board, 2000; Irish Association of Social Workers, 1995). Confidential and personal information must be handled with the highest level of professionalism with due care not to release or disclose information outside the course of that necessary to fulfil legal and professional requirements.

6.2 Information Transfer

Faxing information between primary care, community mental health services and approved centres may facilitate the timely transfer of information when information is promptly required. The US the Department of Health and Human Services Office for Civil Rights has endorsed the use of fax as an acceptable way to transmit protected health information (Hatton, 2004). However, reasonable safeguards must be employed to protect information from inappropriate use or disclosure. For example, best practice in Scotland dictates that, fax machines should be located in a reasonably secured area in order to protect confidentiality of information being sent or received, and the sender should phone in advance to verify the receiver's identity, fax number and to see that he/she is available to receive the information (NHS Scotland, 1997). A standardised fax cover sheet should be used with all faxes. The fax confirmation sheet should be attached to the original document. It is also imperative that information sent by fax is checked by both the sender and receiver for clarity, legibility, and completeness.

6.3 Staff Roles & Responsibilities

The World Health Organisation (2004) recommend that all stakeholders responsible for carrying out the actions identified in mental health policy including general health workers and mental health workers, have a clear understanding of their roles and responsibilities.

Several reports have highlighted the importance of clarifying staff roles and responsibilities in multi-disciplinary team working and the care process (Expert Group on Mental Health Policy, 2004; Department of Health UK, 2002). In the Expert Group on Mental Health

Policy's report (2004) *"Speaking your Mind"* the importance of clarity of roles for members of the multi-disciplinary team for good team work was highlighted. The Department of Health UK (2002, p. 9) recommend having *"a clear written philosophy providing a shared vision with clarity of multi-disciplinary roles and responsibilities locally derived, documented and clearly understood"*.

Specifying the roles and responsibilities of staff in the admission process may enhance service delivery because staff know and understand what is expected of them when an admission occurs and can therefore work more efficiently and effectively in providing timely care. The success of any discharge policy is also hugely contingent on staff being aware of their roles and responsibilities in the discharge process and furthermore accepting and being happy with the roles they play in the process. It also means that the various skills of staff are appropriately used. Best practice in Scotland with regard to discharge policies and protocols is one in which duties are specified for the named nurse/key-worker and other professionals involved in the discharge process (Scottish Executive, 2002). Although a multi-disciplinary approach to discharge planning is widely recommended, most of the literature is discipline specific (Nixon et la, 1998) making it more difficult to identify the roles and responsibilities members of staff should have. Thus, ultimately multi-disciplinary teams will need to decide at a local level the role each member of the team should play in discharge planning.

6.4 Staff Information & Training

One of the standards of the NHS national service framework (1999) and the national service framework for Wales (Welsh General Assembly, 2002) is to have a motivated, well trained, well led and well supported workforce. It is important that staff are supported and well trained to create a motivated and friendly working environment with high morale (Welsh General Assembly, 2002). It is also necessary to ensure quality and safety in the provision of care and to ensure the delivery of an effective service.

It is imperative that staff working with children and adolescents are appropriately trained in this area. Staff should receive specific training on issues of consent and capacity, the use of current mental health legislation and the application of childcare laws (National Institute for Health & Clinical Excellence, 2005; National Institute for Clinical Excellence, 2004). The Mental Health Act Commission (2003) in the UK also recommend that all staff involved in the care of minors detained in adults facilities should be police vetted or if not, two members of staff should be allocated to work with the minor at all times.

In the case of people with intellectual disability, Lennox & Chaplin (1995, cited in Chaplin & Flynn, 2000) assert that many of the problems with management of this group are due to a lack of specialist training for psychiatrists in assessment and treatment of mental illness in people with intellectual disability. Thus, increased training in assessment and treatment in this area is imperative.

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Appendices

Appendix 1 Correspondence from Department of Health & Children to Mental Health Services

27th February 2004

Re: Report of the Inspector of Mental Hospitals on the circumstances surrounding the contact of a named individual with the mental health services.

Dear

I enclose for your information and attention the recommendations of the Inspector of Mental Hospitals arising from his investigation of the above case.

While some of the detailed recommendations made by the Inspector may be of particular relevance to the mental health services in the Eastern Regional Health Authority, the general issues involved are of relevance to all mental health in-patient facilities.

It is the Minister's wish that these recommendations be noted and put into operation in all mental health services with immediate effect.

Yours sincerely

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Mr. Donal Devitt
Assistant Secretary

REPORT TO THE MINISTER FOR HEALTH AND CHILDREN ON THE CIRCUMSTANCES SUROUNDING THE CONTACT OF A NAMED INDIVIDUAL WITH THE MENTAL HEALTH SERVICES.

Recommendations:

1. On the arrival of any patient at a psychiatric service requesting assessment or being referred by any agency or person, irrespective of where that patient resides, whether within the catchment area that service or not, or being homeless, that patient should be fully examined and assessed by a junior doctor and discussed by this doctor with a consultant who on the basis of the details of the case presented should decide himself or herself whether personally to see and evaluate the case. Should, as a result of this examination, it be determined that the patient is seriously ill and in need of immediate inpatient care than that patient should be admitted to that service; in the first place, irrespective of residency qualifications.

2. When, following assessment it is determined that the patient is not acutely ill and not in need of immediate inpatient care, and it is decided to refer him/her to the service of his/her catchment area that patient should never proceed unescorted but always accompanied by a relative or friend, or where none is available, a staff member.

3. Where a patient is referred from one catchement area to another for urgent assessment that patient should seen immediately.

4. Detailed documentary records of persons presenting for assessment, including results of clinical examination, should be kept and detailed letters of referral should accompany all patients being referred from one service to another. Copies letters of referral should be kept in clinical notes.

5. Each service in the ERHA should have a clearly delineated map and street index of the addresses within each catchment area. There should be central responsibility for this within each health board and because of the continuous growth of housing in the ERHA area this information should be constantly updated and disseminated.

Appendix 2 Excellence in Mental Health Records

Guidelines on Clinical Records

- Quality of record should ensure that continuity of care is always guaranteed
- Complete records contemporaneously (note time of event and time of recording (24 hour clock))
- Frequency of recording – must be sufficient to show accurate picture of patient at all times
- Avoid late entries, if required do not squeeze in
- Do not predate entries
- All healthcare professionals encouraged to read each other's entries
- Avoid subjective comments or if necessary explain, record the facts
- Do not alter, delete or destroy any original record
- Record must provide evidence of planning and provision of care
- Record must be up to date, accurate and unambiguous
- Write notes clearly and legibly
- Request others to rewrite record if unclear
- Ensure record is permanent and capable of photocopying
- Avoid initials
- All entries must be signed off and recorder clearly identifiable by name and status
- Students and assistants entries must be counter-signed
- Maintain register of sample signatures and keep it up to date
- Record must be made in chronological order, explain any variance
- Identify names and status of other healthcare professionals involved
- Identify when other professionals contacted and any advice given
- Avoid abbreviations, make acceptable list for organisation
- Use only acceptable official grading systems
- Record all advice give to patient
- Record any decisions made

- Be systematic by maintaining all patients records together and having patient's name and record number on every page of the record
- Use care plans to assist
- Supervise standards of recording by those in positions of responsibility
- Regularly audit standards of recording

Additional Pointers

Prescription Writing

Must be

- Accurate
- Appropriate
- Unambiguous

Any advice given including details of foreseeable and unforeseeable risks must be documented.

Abbreviations

- Abbreviations should be kept to a minimum in clinical records and must only be used in the context of care
- References must be approved locally
- To be avoided in transfer or discharge situations

Retrospective Notes

- Record the date and time the entry is made date and time the entry refers to

Narrative Case Notes – Guidelines

- Keep sentences short
- Use big words sparingly
- Be simple and direct
- Notes must be legible
- Avoid broad generalities
- Minimise confusion
- Be specific
- Identify purpose of the notes
- Avoid jargon
- Watch abbreviations
- Distinguish facts from opinion
- Is the note clear and objective?
- Is it relevant?
- Support your professional opinions?
- Are you following best practice?
- Does the record convey a high respect for the client?
- Is the design, structure and content one that can show the patient's legal status?
- Evidence of a treatment plan?
- Evidence of classifiable diagnosis?
- Evidence of periodic review?
- Think before you write!
- Put line under the end of each entry

Appendix 3 Sample Referral Letter for Primary Care to Mental Health Services