Report on the Consultation Process on the Draft Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre

Carried out by Joe Wolfe & Associates on Behalf of the Mental Health Commission

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Chapter 1 Introduction and Context

1.1 Introduction

In accordance with the Mental Health Act (2001), the Mental Health Commission has a dual mandate with regard to the provision of mental health services in Ireland, notably: -

- To promote, encourage and foster the establishment and maintenance of high standards and good practice in the delivery of mental health services and

- To take all reasonable steps to protect the interests of persons detained in approved centres

Under Section 33 (3)(e) of the Mental Health Act (2001), the Mental Health Commission is obliged to:

"prepare and review periodically, after consultation with such bodies as it considers appropriate, a code of codes of practice for the guidance of persons working in the mental health services".

Based on the above requirement, the Mental Health Commission commenced developing a draft Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre. The formulation of the draft code was proceeded by

- A literature search of peer reviewed articles

- Contact being made with every inpatient mental health facility in Ireland to obtain copies of local policies relevant to admission, transfer and discharge and a consideration of these policies and

- In-house workshops with relevant members of staff, to further the process of devising the draft code.

The subsequent formulation of the draft code was influenced by a number of sources including:

1. Stakeholders views as expressed in *"Quality in Mental Health – Your Views"* (2005)
2. International best practice, protocols and policies
3. Relevant research studies
4. Conventions, standards and regulations
5. Local admission, transfer and discharge policies in Ireland
6. The professional Codes of Conduct for the Medical profession, Nurses and Midwives, Psychologists, Social Workers and Occupational Therapists in Ireland
7. Health Boards Executive: Admissions and Discharge Guidelines (2003)
8. Irish College of General Practitioners/Health Service Executive pro-forma letters for referral and follow up
9. A vision for Change and associated consultation documents of the Expert Group on Mental Health: *"Speaking Your Mind", "What They Said"*

Following the above process, the draft consultation document 'Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre' was first circulated to services in November 2007.

In March 2008, Joe Wolfe & Associates undertook a specific consultation exercise in relation to this document, as an independent body, acting on behalf of the Mental Health Commission. A written submission feedback form was devised by Joe Wolfe & Associates, in consultation with the Commission, specifically for the purpose of this consultation. The Commission was eager that this consultation not only elicited stakeholders views on the content of the draft code, but also addressed potential implementation issues associated with the code. The consultation exercise therefore had two specific objectives.

(i) To obtain feedback on the content of the draft Code of Practice; and

(ii) To analyse the potential impact of implementing this code of practice

The draft Code of Practice and accompanying knowledge review and written submission template were distributed to a total of 164 relevant stakeholders.

Respondents were asked for specific comments on the draft itself and also specific comments on the impact of implementing the Code of Practice (in terms of potential benefits, challenges and costs). Respondents were further asked their views as to whether Part 6 of the draft Code of Practice (relating to special considerations for people with an Intellectual Disability) should remain in the Code of Practice. Lastly, respondents were given the opportunity to make any final comments which they may not have addressed previously in their submission.

This report presents the findings of this independent consultation process.

1.2 The structure of the report

This introductory Chapter outlines the context of the consultation, its methodology and gives an overview of who responded to the consultation.

Chapter 2 summarises the key themes emergent from the process.

Chapter 3 details all the specific comments made in the consultation that were linked to specific numbered sections within the draft Code of Practice. (These comments include criticisms, specific identified benefits, specific challenges related to particular sections and specific costs related to particular sections).

Views on the specific consultation question asked in relation to the inclusion (or not) of Part Six of the Draft Code, relating to special considerations for people with an intellectual disability, are summarised at the end of the summary of specific comments on Part Six (Page 95).

Chapter 4 summarises general comments made in relation to the draft Code of Practice, which were not linked to specific numbered sections.

Chapter 5 outlines the responses made with regard to the potential impact of implementing the Draft Code of Practice, including the potential benefits of implementation of this code, the potential challenges and the potential costs.

Chapter 6 offers some general conclusions and recommendations arising from this consultation process and in relation to the conduct of future such processes.

1.3 Consultation methodology

As previously mentioned, Joe Wolfe & Associates and the Mental Health Commission jointly developed a written submission feedback form for the consultation. Joe Wolfe & Associates then distributed this form to a total of 164 relevant stakeholders, with an explanatory letter[1]. The Stakeholders consulted included Service User Representative Groups, Professional Bodies, Clinical Directors of Approved Centres, Directors of Nursing of Approved Centres, Registered Proprietors of Approved Centres, Allied Health Professionals, the Department of Health & Children, the National Disability Authority and relevant others.

The written submission form was designed in a manner that enabled people to comment on each individual section and subsection of the draft Code of Practice, with additional space provided for any final comments. The form contained guidance notes to support people with completion and advised respondents that the Commission handles all confidential and personal information in a professional way and will not release or disclose this information unless it is necessary to fulfil our legal and professional requirements. Where respondents were commenting on specific aspects of the draft Code of Practice, they were asked to provide suggested wording or evidence to support their view. Furthermore, where respondents considered that specific content was too simplistic, too complex or too detailed they were asked to recommend alternative wording.

Stakeholders were given the choice as to whether to submit their views electronically or by post.

[1] 136 of these were distributed by email, while the remainder (28) were distributed by post.

1.4 Overview of responses to consultation

A total of 29 responses were received from 27 respondents (two respondents made two submissions). Two respondents were members of different groups who sent in submissions and therefore their views were represented on a number of occasions.

Respondents were asked to specify whether the response was on their own behalf or whether it represented a number of respondents. Not all respondents completed this section, therefore in some cases, it was hard to discern if responses were being made by individuals whose role was to represent a specific group (but who were speaking without wider consultation) or if wider consultation had in fact taken place within those groups. A number of submissions were received representing multiple respondents. Table 1 below details the submissions received.

Table 1 Details of Submissions Received

Area that respondents were from	Number of responses	Representing number of respondents
Advocate	1	1
Service User Representative Group	1	Not Specified
Professor of Forensic Psychiatry	1	1
Statutory Bodies	1	2
Professional Representative Bodies	5 responses from 4 bodies[2]	Not Specified
HSE PPG Groups	2	Not Specified
Nurse management groups / committees	8	Minimum of 18 people (potentially more as 2 respondents did not state how many were represented in response)
Consultant	4	Minimum of 5 people

[2] 1 Body sent in two submissions

Psychiatrists		(potentially more as 1 respondent did not state how many were represented in response and 1 other was unclear)
Mental Health Service Teams	2	Minimum of 26 people (potentially more as 1 respondent did not state how many were represented in response)
Social Work Departments	2	6
Practice Development Co-ordinator	2[3]	1
Totals	29	59 (minimum)

Responses represented services for children and adolescents, adult services, forensic services, later life services and intellectual disability services. Views have also been elicited from staff of inpatient and community services.

[3] from same person, 1 pre-formal consultation process and 1 during formal consultation process

Chapter 2 Key Themes Emergent from the Consultation

This chapter presents a number of key summary points emergent from the consultation process. These are important to consider as they present an overview of the key thematic issues from the consultation process. These thematic issues are detailed as follows: -

1. There was a low response rate to this consultation process despite the extensive timeframe provided for feedback. In particular the response from service users, service user groups and statutory/representative bodies was disappointing.

2. A considerable number of submissions (11) welcomed the Draft code of Practice and many of these highlighted particular aspects of the Draft Code as being very positive.

3. Approximately one quarter of respondents (7) identified benefits to implementation of the Draft Code of Practice and these centred on:

    - Benefits to service users
    - Guidance and clarity to professional staff and
    - Opportunities to standardise practice

4. Over one third of respondents (11) identified challenges associated with implementation of the Draft Code of Practice and these centred on: -

    - Difficulties in implementing the Draft Code of Practice, due to absence of or incomplete multi-disciplinary teams and due to other resource deficits including clinical time
    - Training requirements to implement the Draft Code of Practice
    - Poorly developed facilities (including Information Technology Systems) or facilities that are not fit for purpose

- The need for standardised policies, procedures and protocols

- The need for the document to be enforced and the need for accountability of staff in implementing the Draft Code

5. Approximately one quarter of respondents (8) responded to the question dealing with the cost of implementing the Draft Code of Practice and these comments centred on: -

    - The need for costing and providing for full multi-disciplinary teams in each area

    - The need for training costs, particularly around multi-disciplinary working

    - The need for “one-off” costs in relation to Information Technology

    - The need for funding for ward clerks

    - The need for funding for audit and research

    - Resource implications around following up people who are discharged within one week

    - The cost of not implementing good practice initiatives (such as Draft Codes) on individuals and on society

6. A considerable number of respondents (10) expressed views with regard to section 2.3.4 (page 21) of the document in relation to eligibility for admission.

7. A considerable number of respondents (10) expressed views with regard to section 3.3 (page 21) of the document in relation to self referrals.

8. A considerable number of respondents (9) expressed views with regard to section 4 (page 22) of the document in relation to the decision to admit. The central focus of these comments centre on the need for the document to explicitly

state that the decision to admit is a medical decision, made in consultation with the Multi-Disciplinary Team (M.D.T.) where possible.

9. Many respondents (7) also spoke of the difficulties centering on the absence of full M.D.T's in many services, and the non-availability of some M.D.T. members out of hours.

10. A considerable number of respondents (14) expressed views with regard to section 6 (page 23) of the document in relation to assessment. Point 6.3 in particular, relating to securing residents accommodation drew comments from 10 respondents.

11. The issue of consent needs to be re-considered bearing in mind a number of points made with regard to this, as addressed in Part 2: Section 7 (Rights and Information), section 8.3 (Individual Care and Treatment Plan) and section 13.2 (Record keeping and documentation) and Part 3: Section 8.4 (Record keeping and documentation)

12. The issue of key worker and their role drew considerable comment. The central theme here revolved around a general agreement with the concept of a key worker, but practical difficulties with regard to resourcing key workers.

13. The issue of full M.D.T. involvement in the transfer (5.1. Page 31) process was highlighted as impractical and unnecessary.

14. A considerable number of respondents (8) expressed views with regard to Part 4: Section 2.1 (page 34) of the document in relation to the decision to discharge. The central focus of these comments centre on the need for the document to explicitly state that the decision to admit is a medical decision, made in consultation with the M.D.T.

15. The issue of who co-ordinates the discharge process and the responsibility of different people in this regard received considerable comment (from 9 respondents). There are significant differences in views expressed with regard to the discharge process.

16. In general, only six respondents answered the question as to whether part 6 of the code (relating to people with Intellectual Disabilities) should remain. Four of these six stated that this part of the code should remain, whereas the other two respondents stated that it should be removed.

17. Two respondents also highlighted questions of enforcement, essentially asking how the Code of Practice will be implemented and what happens if it is not followed.

18. A number of respondents (5) stated that there would be merit in having standardised admission, transfer and discharge policies that could be applied nationally. This recommendation would appear to have merit from a resource utilisation and a best practice perspective and we would recommend that the Commission refer this point on to the Health Service Executive.

Chapter 3 Summary of the Responses

The following tables provide a comprehensive analysis of the submissions received with regard to the draft Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre. A separate table has been provided for each Part of the Consultation document.

A faithful representation of the core relevant points as presented by the relevant respondent is detailed in relation to each section. Comments are attributed to the relevant respondent for ease of reading and clarity purposes; however the authors have not identified any individuals in the body of the report, for reasons of anonymity.

The Preamble (Page 2)

Subject	Summary of Comment	Source
Contact with inpatient mental health facilities in Ireland (P4)	It would be useful to know how exactly how many services actually replied as this would give understanding of the significance of the Irish influences in the development of the Code.	Department of Health & Children
"Relevant members of staff" (P4)	Please expand as could be read to mean relevant members of staff from Mental Health Commission, or relevant members of staff from Mental Health Services.	Department of Health & Children
Use of "etc" (P4 – "codes of practice etc")	Good practices in record keeping note importance of being explicit and noting clearly what is actually meant – suggest avoidance of the use of "etc".	Department of Health & Children
Two way approach to consultation process (P4)	The use of a two-way approach is Commendable. The provision of a template in which to scope responses in relation to possible impact of implementation would be helpful, whilst recognizing that feedback would be based on a guesstimate of impact as the code itself has not been applied in practice.	Department of Health & Children
The phrase "there are undoubtedly resource implications" (P4)	The inclusion of this phrase could be considered to be leading respondents to include such considerations – suggest either removing this or change to 'may be resource implications…" as there may not be in some areas.	Department of Health & Children
Vision (P5)	This requires more explanation. "When did the Commission actually "work together" with service users?" "a little "twee" and trite"	Irish Advocacy Network

The Glossary (Page 10)

Subject	Summary of Comment	Source
General	Whole of this section is very poorly thought out, and little thought has been given to explaining things in a clear and simple manner so that all stakeholders will find the document equally accessible	Irish Advocacy Network
Advocate (P10)	definition ... is not representative of our role – refer to our literature	Irish Advocacy Network
Approved Centres	Suggest should be included	Department of Health & Children and CP 1
Best Interests	Not defined – favour definition in line with (UK) Richardson Report	Irish Advocacy Network
Community Mental Health Team (P10)	Suggest expanded definition "An expanded multidisciplinary team of clinicians who work together to serve the needs of service users across the lifespan. CMHT's should serve defined populations and age groups and operate from community based mental health centres in specific sectors offering specialist assessment, treatment and care to people who are in the community. Teams should include input from psychiatry, nursing, social work, clinical psychology, occupational therapy, and clinicians with specific expertise, with ready access to other professional / therapies and expertise"	Department of Health & Children
Competency	See "consent" below	Department of Health & Children
Comprehension of information	See "consent" below	Department of Health & Children
Confidentiality (P10)	wrongly defined, suggest "confidentiality means the obligation of staff to protect someone else's personal information in their care, to maintain the integrity and secrecy of personal information and not misuse of wrongfully disclose it" – in line with definition from Canadian Federal Privacy Commissioner	Irish Advocacy Network

	A complex, challenging and confusing principle, when applied in practice, as personal information can be known by many, whilst only divulged to one. It would be useful to define confidentiality in the context that information to be kept private is safeguarded and only shared as necessary within the context of the care encounter, as defining 'guaranteed limits on the use and distribution of information' is not always possible as a range of person data is shared across an organization and beyond, for example : - sharing of registration information - sharing of status under MHA 2001 information - sharing of clinical data - sharing of billing information" (ref : Jenkins S. (1991) Keeping it in the family, The Health Service Journal, 25th July, pp 35-36)	Department of Health & Children
Consent (P10)	Seems to only be defined in the context of treatment. Applies to other tasks besides medication decisions. A complicated and challenging process – whilst primary function and rationale for obtaining informed consent is to facilitate and safeguard the individuals' autonomous choice... it might be useful to note that these may be further complicated when people are\deemed to be mentally ill and / or have an intellectual disability Deeper analysis of the elements of consent (and debate continues in relation to them) shows ; - Competency means that the residents have the ability to make sound and reasonable decisions, but is a variable concept relative to what one is being considered competent as to. Competence in decision-making is connected to autonomous decision making, as well as the validity of the consent. - Comprehension of information means that the health care providers must	Irish Advocacy Network Department of Health & Children

	provide each resident with adequate information about their care and treatment and all that it entails, including possible consequences. Further, information must be given in a language, style and pace familiar with and accessible to them. Such information comprises that which the healthcare professional believes to be material, including the purpose of consent as an act of authorization. Moreover it requires health care providers to establish that residents have understood what was discussed. - Voluntariness means that the residents, in giving consent, are in a state of mind from which they have the ability to make decisions of their own free-will and are acting without coercion in the decision-making process - Consent also requires an affirmative decision and authorisation	
Co-ordinate (P10)	Tortuously defined, plain simple language is required.	Irish Advocacy Network
Data Protection	The Data Protection Acts 1988 & 2003 is a safeguarding of the privacy rights of individuals in relation to the processing of their personal data.	Irish Advocacy Network
Designated Centres	Should be clearly defined	CP1
Discharge (P11)	Definition too broad – suggest "following a decision-making process between MDT, resident, family / carer and chosen advocate where it is deemed that resident no longer requires in-patient care & treatment in an approved centre" Does this also include someone who leaves without the consent of the service provider i.e. absconds or only relates to someone who leaves following a planned discharge? Also refer to P17, section 4.3 of draft code for further definition.	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services Department of Health & Children
Facility	Should be clearly defined	CP1
Freedom of Information	The Freedom of Information Acts 1997 & 2003 confer on all persons the right of access to information held by public bodies to the greatest extent possible, consistent with public interest and the right to privacy	Irish Advocacy Network

Individual Care and Treatment Plan (P11)	Is this not a documentary record of the actual or planned care and treatment prescribed for an individual including the documented set of goals collaboratively developed by the resident and the multidisciplinary team? Suggest place the 'goals' in the context of the overall acre and treatment plan rather than as the first line of the descriptor	Department of Health & Children
Key-worker (P11)	Suggest including examples of whom / professional group could be a key worker	Department of Health & Children
Mental Health Services (P12)	"not necessarily under the direction of a consultant psychiatrist"	Irish Advocacy Network
Multidisciplinary integrated care planning (P12)	Is this not a system of care planning in which all members involved with the care and treatment of a person develop a comprehensive and integrated plan ? The descriptors used in the glossary relate to aspects of ensuring the process occurs as opposed to what the term means.	Department of Health & Children
Needs (P12)	Education is a big part of care, not just for children – suggest educational (including formal education, if a child).	Nurse Education & policy Development Committee, Louth/Meath Mental Health Services
Patient (P12)	Should distinguish between patient, resident, service user and individual and state explicitly if these are being used interchangeably.	CP1
Privacy	Should be defined as "the right of a person to control information about themselves, including the collection, use and disclosure of that information". - in line with definition from Canadian Federal Privacy Commissioner.	Irish Advocacy Network
Protocol (P13)	An Bord Altranais (2000) "Guidance to Nurses and Midwives on the Development of Policies, Guidelines and Protocols" notes protocols in the context of: A protocol is defined as "a written plan that specifies procedures to be followed in	Department of Health & Children

	defined situations, a protocol represents a standard of care that describes an intervention or set of interventions" (Ohio Nurses Association 1992). Protocols are more specific and explicit in their detail than guidelines; they specify who does what, when and how." (Section 2.3) The definition in the document seems more open than this. Why is this word used in this document when it hasn't been in other MHC documents? We believe it is introducing unnecessary confusion.	Senior Nursing Management, St. Brendan's Hospital
Transfer (P13)	Terminology should be similar to that used in the context of MHA 2001 i.e. specialised treatment.	Nurse Education & policy Development Committee, Louth/Meath Mental Health Services
Voluntariness	See "Consent" above.	Department of Health & Children

Part 1: Introduction (Page 15)

Reference	Subject	Summary of Comments	Source
Section 1	Purpose of the code	General acceptance with contents of this section.	Mental Health Nurse Management Group, North Cork and Policy & Procedure Group, HSE South
1.1		No comment	
1.2		Suggest amend to include 'during the course of legal and / or disciplinary proceedings'.	Department of Health & Children
1.3		Should be "aims".	Department of Health & Children
1.4, 1.5		No comment.	
1.6(g)		"Where feasible" should be deleted and replaced by "if at all possible".	Irish Advocacy Network
1.7		Move 1.7 up to above 1.6 and add in under primary objectives, to emphasise the importance of adequate provision of information between healthcare providers to ensure continuum of care from admission to aftercare. "Best interests" is not defined (see Glossary), term is open to wide interpretation / misinterpretation in the interests of expediency.	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services Irish Advocacy Network
1.8		No comment	
2.1, 2.2	Scope of the Code	No comment	
2.3		Include administration – they play a large part in the admission process	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services

2.4		No comment.	
3.1	Monitoring and Review	No comment.	
3.2		Audit will ensure that the policy is effective and used. Suggest addition of words “in clinical practice” at end of sentence. Recommend increased detail on the purpose, content and reason for regular audit. Also outline who is ultimately responsible to oversee/ensure compliance e.g. Clinical Director, Hospital Policy Committee, Multidisciplinary management team, local health office manager etc. Requires designated person for implementation. There will be human resource implications. Suggest standardised audit format as part of integrated IT system.	Irish College of Psychiatrists Senior Nursing Management, St. Brendan’s Hospital Association of Occupational Therapists Dublin South West Mental Health Services / Mental Health Services, St. Ita’s Hospital
3.3		The word ‘centre’ is missing. Specified period for review is important to take account of local and national changes.	Department of Health & Children Irish College of Psychiatrists
3.4		No comment.	
4.1, 4.2	Key definitions	No comment.	
4.3		Definition for discharge provides more detail than that in Glossary.	Department of Health & Children

Proposed Approved Centre Admission to Discharge Pathway (Page 18)

Subject	Summary of comment	Source
General	Pathways are unworkable on the ground and are really only practical or relevant in the case of complex severe mental illness.	Wexford Mental Health Services, Management Team
General	Correctly implies that admission, once initiated, is also about discharge and forward planning. Might be useful to explicitly note this in Preamble or elsewhere before P18.	Department of Health & Children
Omission	No mention of assisted admissions – should be included for completeness.	West Galway Mental Health Services
Omission	No mention of discharge to alternative settings and the MHC document relating to this.	West Galway Mental Health Services
Risk screening	Should be included as part of the pre-admission process. This is of particular importance in relation to Assisted Admissions and the Assisted Admission process.	West Galway Mental Health Services
Referral sources	Only includes Primary Care Team – some old age psychiatry services will accept referrals from another consultant (medical or psychiatric), a social worker, public health nurse and, as recommended within this draft, self referrals. Referrals can often come from within CMHT.	CP1 Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services
Pre-admission assessment	Should include consultation with staff of approved centre / determination of admission needs – should there be a pathway for inappropriate referrals?	Nurse Education & Policy Development Committee , Louth/Meath Mental Health Services
Formulate individual	Suggest inclusion of words “and risk management plan”	Department of Health & Children

Care & Treatment Plan		
Comprehensive Pre-Discharge Assessment	Suggest note “including risk assessment” in line with best practice, including practices to reduce incidence of suicide post discharge	Department of Health & Children
Discharge	No mention of re-direction of key worker.	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services

Proposed Transfer Pathway (Page 19)

Subject	Summary of comment	Source
Physical Transfer	Would be useful to note that in exceptional circumstances this happens at night.	Department of Health & Children.

Part Two: Admission Process (Page 20)

Reference	Subject	Summary of Comments	Source
General	The term ‘resident’	We suggest ‘patient /resident’.	HSE PPG Group / Policy & Procedure Group, HSE South / Mental Health Nurse Management Group, North Cork
	Duty of care	What is the duty of care to a person who presents to an AC for assessment but decides to leave before the assessment can take place? Can the holding power be applied if staff feel he needs assessment or possible admission?	HSE PPG Group / Policy & Procedure Group, HSE South
	When 24 hours begins	There is no guidance in relation to the admission of an involuntary patient as to when the 24 hours begins, which is given under the act before a patient is seen and examined by a consultant psychiatrist.	NPDC 1
1.1	Admission criteria	Suggest include footnote here to effect ‘please see glossary’. Respite and crisis admissions?	Department of Health & Children Mental Health Nurse Management Group, North Cork
1.2		Are all centres under mental health service, though not designated, considered approved? The guidance should acknowledge that some patients, though meeting the criteria for detention (e.g. dementia with challenging	CP 1

		behaviour) may be safely cared for, with support of community mental health team, in specialist nursing home.	
1.3		Unless risk and safety of others overrides the patients best interests. "in the best interests of the individual AND OF THOSE AROUND THEM" should be added Suggest should be broken into two points with the second being: "The best interests of the individual must be the primary consideration when deciding whether or not to admit" as this underpins all aspects of the admission process.	CP 2 Department of Health & Children Department of Health & Children
1.4		No Comments	
2.1	Pre-admission process	Risk screening should be completed as part of the pre-admission process A pre-admission process is often impractical as there are no community staff available out of hours and a high proportion of admissions occur then What if service user is already within existing services?	NPDC 1 HSE South Clinical Directors Group Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services

		What control do staff at approved centres have over what happens prior to admissions?	Mental Health Nurse Management Group, North Cork
2.2 general	Primary Care	Out of hours GP services and GP services requested to use HSE referral letters to Mental Health Service from 'primary care box'. GP Co-ops increasingly send high proportion of referrals to Mental Health Services through triage, without being familiar with patients. In any event, assessment by primary care may not be indicated if the patient is known to services. GP referral letter should also include a mental state examination with the relevant risk factors and should rule out medical aetiology.	Policy & Procedure Group, HSE South / HSE PPG Group HSE South Clinical Directors Group HSE South Clinical Directors Group HSE South Clinical Directors Group
2.2.1		A primary care assessment should be undertaken however with the advent of Primary Care teams, it needs to be considered if this could be done by health professionals, other than the GP. Currently lack of standardized GP referral system means quality of information is dependent on individual GP. Recommend MHC devise a template in	Dublin South West Mental Health Services Dublin South West Mental Health Services Dublin South West Mental Health

		conjunction with ICGP and representatives of specialist mental health services. Currently there is a closed system of referral from Doctor to Doctor. Any change in this referral process has to be agreed.	Services Mental Health Services, St. Ita's Hospital
2.2.2		Out of hours GP services and GP services requested to use HSE referral letters to Mental Health Service from 'primary care box'. Should refer to a clinical file not a resident file, as you only become a resident once admitted – term could be confusing for individuals who do not go on to become residents. Recommend standardized referral letter. Suggest highlighting importance of using the standardized mental health service letter for children. Most community teams work 9 to 5, Monday to Friday – 60% of admissions are out of hours and therefore this item is impossible in majority of cases. Individuals' right to privacy and the obligation of confidentiality should be inserted here, along with relevant sections of FOI and Data	Mental Health Nurse Management Group, North Cork Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services / Department of Health & Children Mental Health Services, St. Ita's Hospital Nurse Management Group, St. Stephen's Hospital Wexford Mental Health Services, Management Team Irish Advocacy Network

		Protection legislation. Where it is necessary to disclose information to other persons the consent of the service user must be sought. Information should only be recorded with the individual's consent.	
2.3	Community Mental Health Services	The existing resources in terms of staffing and security arrangements is such that a pre-admission assessment by Community Mental Health Services is often impractical and unsafe. Some day services may have only one or two members of staff on duty at times which would not allow the safe assessment of patients who present serious risks to others. Risk screening should be completed as part of the pre-admission process.	HSE South Clinical Directors Group West Galway Mental Health Services
2.3.1		No comments.	
2.3.2		A thorough pre-admissions assessment by community mental health services should be carried out prior to referral to an approved centre. A written assessment / input by different disciplines should be encouraged. However a nationwide reconfiguration of nursing posts would be required to ensure all CMHT's have full teams. Many MDT's lack full range of core disciplines. Needs to specify by whom assessment should	SW 1 Nurse Education and Policy Development Committee,

		be carried out. We welcome this section. A welcome concept that may not be practical. Not possible with 60% of our admissions. Delete – where admission is likely, thorough assessment by the community service is usually not feasible; especially where two thorough assessments would involve additional distress for the patient. 2.3.3 is adequate and encompasses the normal requirements.	Louth/Meath Mental Health Services Policy & Procedure Group, HSE South / HSE PPG Group Dublin South West Mental Health Services Wexford Mental Health Services, Management Team NPDC 1
2.3.3		If a phone call is made, a referral letter should always follow; details of the call should be documented. This would be a welcome new practice. Services with homecare teams will have the same treating consultant in the community as in the acute unit, so referral letters may not be	Mental Health Nurse Management Group, North Cork/ Nurse Management Group, St. Stephen's Hospital Dublin South West Mental Health Services

		required. Instead of sending a referral letter, we suggest a copy of the assessment is sent to the admission unit with a verbal referral by phone. We also suggest that a log for telephone referrals is maintained.	 Policy & Procedure Group, HSE South / HSE PPG Group
2.3.4		Last line of paragraph is too simplistic. It is quite broad – suggests everyone should be admitted. Needs to be more specific re type of arrangements to be put in place when required. "Duty of care" should be explained. It should be established in this section of the code that patients not from a catchment are admitted and when possible transferred to their local catchment area or service. In the knowledge review it is recognized that patients should access their local mental health service. We welcome this section and would add a provision that "no-one is turned away from an Approved Centre irrespective of their catchment	Mental Health Services, St. Ita's Hospital Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services Irish Advocacy Network NPDC 1 / West Galway Mental Health Services Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South / HSE

		area” No child should be turned away because he is from another catchment area. Would good practice not suggest that eligibility for admission be established prior to admission in all approved centres? Is there a need to highlight independent sector approved centres here? Last sentence could be taken to suggest all persons who present will be admitted. Suggest rewording e.g. “arrangements should be put in place to ensure that all individuals referred for admission will be assessed and if admission clinically indicated, will be admitted to an approved centre.”	PPG Group Nurse Management Group, St. Stephen’s Hospital Department of Health & Children
3 general	Unplanned referral to an approved centre	It should be stated clearly that the vast majority of admissions are unplanned and are of an emergency nature. This code of practice gives the impression otherwise.	HSE South Clinical Directors Group
3.1		It won’t be some circumstances, it will be most. Can people self refer to the Central Mental Hospital, as it is both an approved centre and a designated centre?	Wexford Mental Health Services, Management Team Association of Occupational Therapists
3.2.1	Urgent referrals	Protocol will need to be developed to deal with urgent referral. In the case of urgent referrals, all cases should	Nurse Management Group, St. Stephen’s Hospital NPDC 1 / West Galway Mental

		have a risk screening done prior to admission. This would be considered best practice. Many centres do not audit policies. Key are buy-in from all, LHO involvement and funding for training.	Health Services Association of Occupational Therapists
3.2.2		No comments	
3.3.1	Self - referrals	Not relevant for the admission of a child to an approved centre Difficulties may ensue when someone presents as a self-referral in the early hours of the night and there is no a/e attached to psychiatric unit and nearest a/e is 20 miles away. What are alternative options? Suggest addition of following sentence "Individuals who self-present should be assessed initially in the Accident & Emergency department, where this exists, in the approved centre". (In some centres, self-referring individuals are currently seen in the admitting ward and excluded from A&E, which can be distressing for those who may not need admission or equally can be a factor in making it difficult to avoid an unnecessary admission. A&E staff and management should have an	Nurse Management Group, St. Stephen's Hospital Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services Irish College of Psychiatrists CP1

		input / be consulted regarding this CoP. Suggest a standardized template for a protocol for dealing with urgent referrals. Specify the elements required in the protocol, for what purpose and provide a sample of same. Protocol should also include issues such as: out of hour's presentation, when a person presents intoxicated by alcohol or substance, persons presenting from outside the catchment area, and referral from other agencies. Every approved centre should have in place a policy / procedure for dealing with individuals who self-present. The self-referral into the A&E with those suffering from mental disorder needs clarity, as A&E is not an approved centre.	Dublin South West Mental Health Services Mental Health Services, St. Ita's Hospital Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South / HSE PPG Group Senior Nursing Management, St. Brendan's Hospital
3.3.2		After 'admission' insert "or other appropriate pathway".	Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South / HSE PPG Group
3.4		Change 'every effort' to 'effort' or 'reasonable effort'. A protocol will be needed for contacting the	Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South / HSE PPG Group

		primary care / GP services. Add 'and follow up with a fax of written referral, if possible' to the end of this point.	
3.5		We suggest term mental disorder should be used throughout the document instead of mental illness as defined in the Act. It should be acknowledged that all approved centres are not suitable for all individuals who are detainable under the Act – e.g. specialized centres for older people are unlikely to have the facilities to safely admit a younger adult. Amend to "if it is *clinically* determined" and add at end of paragraph "Transfer can be effected when deemed clinically appropriate" – to emphasise that decisions should be clinically based. Would put even greater strain on already overstretched approved centres in City Centres with large A&E's where there are much higher numbers of self-referrals and patients brought in by ambulance. In cities of Dublin and Cork, it would seem more sensible that patients are admitted to the appropriate catchment area approved centre following assessment in the	Senior Nursing Management, St. Brendan's Hospital CP1 Irish College of Psychiatrists HSE South Clinical Directors Group

		approved centre in which they present. There is no mechanism to ensure that this occurs. Relies on goodwill of other catchment areas to take their clients back. Some centres are put under excessive pressure. Other catchment areas should be obliged to take service users from their catchment back.	Mental Health Services, St. Ita's Hospital
3.6		"This service has an existing mechanism to ensure this occurs, however, we are reliant on the goodwill / capacity of the other catchment area to admit their patient when they have vacancies. Suggest change 'should' to 'must' – an assessment must occur. Also it would be better to note that if a person is from another catchment area, there is an onus on that area to accept transfer as soon as possible. Begs the question as to what is to be done when there is no bed available.	Dublin South West Mental Health Services Department of Health & Children HSE South Clinical Directors Group
4.1	Decision to admit	Not relevant to children (issues that arise include admitting with and without parental consent). Not possible because we don't have enough MDT members and those we have are	Nurse Management Group, St. Stephen's Hospital Wexford Mental Health Services,

		deployed in community. Vast majority of admissions take place out of hours when there are no members of MDT in the community and such consultation as described is impossible. How practical will this be without full MDT service in each area? The decision to admit should be made by the Responsible Psychiatrist, (this can then be followed with where possible other members of the MDT should be consulted). Consultation with MDT would be a major cultural shift that the medical profession is not ready for. Professional bodies need to educate and promote merits of multi-disciplinary assessments One should not ignore offered information if the patient objects. Consent is necessary to give information not receive it. Change to "the decision to admit should be made by a medical practitioner in consultation … … and after exploring alternative treatment	Management Team HSE South Clinical Directors Group HSE PPG Group CP 3 SW 1 CP 2 Irish College of Psychiatrists

		options”. To clarify responsibility for admission and possible sources of aid, change to “the decision to admit a patient is a medical decision made, where possible or appropriate, in consultation with the individual, members of the multi-disciplinary team and the individual’s family / carer or chosen advocate”.	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services
4.2		Not relevant to children (issues that arise include admitting with and without parental consent). It might be useful to include a footnote to note that if a person is admitted as an involuntary patient, he or she must be informed of and given the option to become a voluntary patient if he or she indicates a wish to be so admitted (MHC Reference Guide).	Nurse Management Group, St. Stephen’s Hospital Department of Heath & Children
5.1	Decision not to admit	This will ensure that those who are not admitted will be smoothly integrated back to primary care or to the community mental health services. The importance of maintaining accurate and contemporaneous records cannot be overstated. It might be helpful to note where such records or in what format they should be maintained, if consistency of approach is the	Irish College of Psychiatrists Department of Health & Children

		underlying principle. Matters of confidential nature need to be respected regarding any communication process other than to the specific referring health professional e.g. family member or other relevant person (referred to in 12.1). Add in outlining reason. Add service user should be informed of reasons not to admit. This would be better reading 'following a request for admission a decision not to admit an individual should be documented'. Where a decision is taken not to admit a person, the person has responsibility to make their own arrangements for getting home.	Dublin South West Mental Health Services Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services Mental Health Social Workers, Kildare and West Wicklow HSE South Clinical Directors Group West Galway Mental Health Services / NPDC 1
5.2		The importance of maintaining accurate and contemporaneous records cannot be overstated. It might be helpful to note where such records or in what format they should be maintained, if consistency of approach is the underlying principle. Written protocols for acceptance to specialist	Department of Health & Children

		services should be available e.g. forensic, eating disorder units. Add service user should be informed of reasons not to admit.	CP 2 Mental Health Social Workers, Kildare and West Wicklow
6.1	Assessment	There may be a need to distinguish between initial assessment and comprehensive assessments. General comment re assessment – may be helpful to state the obvious i.e. assessment is an ongoing process and following the initial completion of an initial and / or comprehensive assessment on admission, ongoing assessment should occur throughout the resident's admission, treatment and care. Comprehensive assessment may not be just confined to a once off assessment limited to a single discipline at the first contact, but include assessment by a number of members of the multidisciplinary team over a number of days to determine the variables. The term "resident" is confusing, as it is used usually to denote a person who is **not** admitted to a ward. "Admitted patient" or "detained patient" are terms which are unambiguous.	Dublin South West Mental Health Services Department of Health & Children Dublin South West Mental Health Services Irish College of Psychiatrists

		Residents should receive a comprehensive, multi-disciplinary assessment on admission in so far as is practicable. Core disciplines need to have designated roles in assessments and MHC to take a stronger stance on need for CMHT to have a full complement of core disciplines. Residents should receive a comprehensive assessment on admission, and it should as far as practicable have an MDT input. On admission, residents should receive a joint nursing and medical assessment. This assessment should be discussed with the Responsible Consultant Psychiatrist. (extra) All residents should have a full Multidisciplinary Assessment within one week of Admission. The clinical responsibility for the patient rests with the Responsible Consultant Psychiatrist. Might be helpful to include after 'practicable' words to the effect 'and a record is made to indicate why a comprehensive assessment is not completed if this is the case'.	SW 1 Mental Health Social Workers, Kildare and West Wicklow CP 3 CP 3 Department of Health & Children
6.2		Different team member should compile the assessment e.g. Doctors would not assess	CP 2

		dietary requirements. More clarity around risk assessment tools Specify who should carry out assessment and risk assessment. Suggest paragraph should include “and any other relevant information e.g. work situation.” Or “work and school situation” Change to “assessment should include, but is not limited to, the current mental state, evaluation of risk, the presenting problem ….” (Comparative importance of these first two points on the list needs to be conveyed). Put full stop after ‘current medication’ and then change next part to “Family history, social and housing circumstances should be assessed by a social worker, as soon as is possible. Delete sentence “It should also include a current mental health assessment and a comprehensive risk assessment and risk management plan” (implies a formalized, time-consuming and inappropriate instrument for individuals who in most cases will not need admission at that time.	 Policy & Procedure Group, HSE South / HSE PPG Group Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services Nurse Management Group, St. Stephen’s Hospital Irish College of Psychiatrists SW 1 Irish College of Psychiatrists

6.3		Define what securing premises means (locking up or making sure they don't lose their tenancy?) and whose responsibility (staff of approved centre may not be in a position to do this – may be complicated in relation to pets etc). Clarify what is meant by accommodation. Add in "address social needs where required". Add "protocols need to be put in place in each approved centre to ensure this occurs". This section seems to be sitting on its own, not related to previous or following points re assessment. Suggest it should be under general guidance, unless being amended to say that assessment should include ascertaining if the person's home is safe and secure (this would then suggest a range of areas to be considered in the context of the admissions process).	Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South / HSE PPG Group / Mental Health Services, St. Ita's Hospital / Dublin South West Mental Health Services / Irish College of Psychiatrists Association of Occupational Therapists Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services SW 1 Department of Health & Children
6.4		This may not always be possible e.g., liaison psychiatry in A&E, particularly if there is a perceived risk for the health professional seeing	Dublin South West Mental Health Services

		the person alone. Add “and ensure the safety of patient and staff” to the end of this point.	 Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South / HSE PPG Group
6.5		No comments	
6.6		The most appropriate unit for patients to be admitted to are often not available. Agree with statement but difficulty meeting this due to lack of appropriate beds and high occupancy. Suggest omitting the sentence in brackets “admission units should be capable of meeting the needs of the individual”. Suggest adding a subsection “relatives and informal carers needs should be assessed and attended to at the time of Admission of the Individual.	HSE South Clinical Directors Group Mental Health Services, St. Ita’s Hospital CP 3 CP 3
7.1	Rights & Information	Suggest adding a line to effect that staff check resident’s understanding of their rights following the delivery of the information and record this (a process that would be good practice relative to the full continuum of care and treatment). People experiencing anxiety during the admission and assessment process may not	Department of Health & Children

		retain information (ref Feely and McBennett). Add between 7.1 and 7.2 “Written and aural information on Patient Rights under Mental Health Act 2001 should be available in all admission units”.	CP 3
7.2		No comments.	
7.3		Challenging. A computer portal should be available in each Approved Mental Health Centre with information / translations that can be modified and updated centrally, rather than each service developing booklets which soon become outdated. A possible MHC / HSE conjoint initiative?	Dublin South West Mental Health Services
7.4		Suggest move this to 7.2.	Department of Health & Children
7.5		a) could read ‘upon admission, residents / children and their family should be orientated …’ b) Booklets need to be available in several languages, including information on illnesses. c) Section specifically welcomed. c) Could read ‘residents/ child/ parents/	Nurse Management Group, St. Stephen’s Hospital Mental Health Social Workers, Kildare and West Wicklow Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South / HSE PPG Group Nurse Management Group, St. Stephen’s Hospital

		guardian. c) Very idealistic – how many languages?	 Senior Nursing Management, St. Brendan's Hospital.
7.6		'Care and treatment plan' should be called 'care, treatment and recovery plan'.	Irish Advocacy Network
7.7		In the absence of consent, if the patient is too unwell to consent to the family / carer or advocate involvement in their care plan, this should be respected until the patient is able to give their consent. Add "or possible" after "where appropriate (i.e. with the consent of the resident)" – since it is not always possible to find someone outside the MDT who can advocate or who can understand the information. Might be useful to add line to the effect that providing such information to family members /advocate /or person best able or willing to represent the resident's interest does not abrogate the need for staff to continue to provide the information to the resident until such time as the resident articulates personal understanding.	Policy & Procedure Group, HSE South / HSE PPG Group Irish College of Psychiatrists Department of Health & Children
7 and 8 general		Involvement of MDT and service users in individual treatment plans needs to be enshrined in accordance with best practice in all	Association of Occupational Therapists

		approved centres. Plans should be documented and signed off by all approved stakeholders.	
8.1	Individual care and treatment plan	Many “residents” have brief crisis admissions because of a lack of community alternatives to admission. They need only be in hospital a few days and would be inappropriately delayed if they had to wait for a number of planning meetings to plan their discharge. Also we have no in-patient MDT members (apart from doctors and nurses), so we can’t have MDT input into discharge planning. Resources and beds are so thin on the ground that only those patients with severe mental illness remain in hospital long enough for such planning to occur. Will require common care plan format and education / training to get staff to participate in MDT care plans.	Wexford Mental Health Services, Management Team Mental Health Social Workers, Kildare and West Wicklow
8.2		Add “The multi-disciplinary team should consist of social worker, psychologist and occupational therapist. Catchment area management teams and the LHO should continue to strive to ensure that this complement is available”. MHC needs to take responsibility for ensuring that care and treatment plans are truly multi-disciplinary, given lack of staff and pre-dominant (nursing and medical) culture.	SW 1 SW 1

8.3		Specify who initiates the care plan.	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services
		The role of the family / carer seems easy to relegate with this wording. What about the situation where the illness renders the patient hostile to their family who are trying to help? Surely the family should be involved in this instance?	Department of Health & Children
		Review of care plan within 72 hours is not practical (n.b. bank holidays etc) – recommend it should take place at the first weekly multidisciplinary team review meeting (and that a revised plan should be drawn up there). The plan should also be reviewed on an ongoing basis	Mental Health Services, St. Ita's Hospital / Dublin South West Mental Health Services / HSE South Clinical Directors Group
		The capacity to consent is not commented on here. As patients are unwell on admission they may not have the capacity to consent to others being involved in their care. The code does not address this.	West Galway Mental Health Services
		In the absence of consent, if the patient is too unwell to consent to the family / carer involvement in their care plan, this should be respected until the patient is able to give	Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South / HSE

		consent. The plan should be developed in consultation with the resident and his / her family and the appropriate members of the multidisciplinary team with whom the resident will be involved. The following would be more practical and effective: given that most admissions will be because of a breakdown in community supports. Emphasis must be on quality of care plan, rather than rushing: "An initial risk management and care plan should be developed for the resident. Following multidisciplinary assessment a Recovery Care Plan can be completed. This plan should be developed by the key worker and the patient, with family / informal carer involvement where the patient permits. This Care Plan will be developed within one week of admission." Will require education / training. Also – see submission from Anonymous Advocate, at the end of this section.	PPG Group / NPDC 1 Association of Occupational Therapists CP 3 CP 3 Mental Health Social Workers, Kildare and West Wicklow
8.4		No comments	
8.5		The plan should include names and contact details of the appropriate members of the	Association of Occupational

		multidisciplinary team with whom the resident will be involved. This is excessively prescriptive and in any case individual care and treatment plans have been described elsewhere. Documenting a date of discharge may raise false expectations and in fact be counter therapeutic for some patients.	Therapists Irish College of Psychiatrists HSE South Clinical Directors Group
8.6		The plan should be signed by the resident and appropriate team members.	Association of Occupational Therapists
8.7		Replace “where appropriate” with “on request” Suggest noting that a resident should be offered opportunity to sign care and treatment plan and where this does not occur that a record is made to this effect. Some services currently do this. A copy of the Care and Treatment Plan should be given to the Patient	Irish Advocacy Network Department of Health & Children CP 3
9.1	Multi-disciplinary Team Involvement	Multidisciplinary team involvement is essential within one week of admission. (With community commitments, it is not practical to suggest anything shorter. If person is discharged within one week, MDT involvement can take place in the Community Health Centre.)	CP 3 Association of Occupational

		Lack of staffing a challenge. Numerous MDT's not at full compliment. Needs ring-fenced funding commitment and systems to improve recruitment and retention. Add, "this requires that priority be given to ensuring that the full complement of the multi-disciplinary team is available". Roles of specific disciplines need to be clarified, especially social work in relation to family assessments, child welfare issues, carer assessment and provision of information and support. MHC need to be more proactive to "agitate for appointment of other disciplines"	Therapists / HSE South Clinical Directors Group Association of Occupational Therapists SW 1
9.2		Numerous MDT's not at full compliment. Needs ring-fenced funding commitment and systems to improve recruitment and retention. Could read "the resident / child should be introduced to the relevant members of the multi-disciplinary team". Change to "resident to be introduced to relevant members of the MDT".	Association of Occupational Therapists Nurse Management Group, St. Stephen's Hospital Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South / HSE

		Roles of specific disciplines need to be clarified, especially social work in relation to family assessments, child welfare issues, carer assessment and provision of information and support. MHC need to be more proactive to "agitate for appointment of other disciplines"	PPG Group SW 1
10 general	Key-worker	There may be a danger of imposing a key worker system on all services. A degree of flexibility is required here and it should be the local MHS that decide what approach is to be taken. The key worker system may also be resource dependent. Suggest a line be included to note name of key worker, as this ensures that all staff accessing the record are aware of who the key worker is.	NPDC 1 / West Galway Mental Health Services Department of Health & Children
10.1		The key worker is usually a nurse. Some units may use social workers or OT's as key workers. The key worker should liaise closely with the service users Community based Care Coordinator. The key worker is vital to ensure complete and integrated treatment for the individual. Agree with proposal, but cannot be	CP 3 Irish College of Psychiatrists Mental Health Services, St. Ita's

		implemented within current resources. Staffing issues. Staff shortages, roster requirements and use of overtime and agency staff make it difficult to ensure that the same key worker is available to the resident for the duration of their admission. The resident should have an identified staff member who will work with residents in addressing the elements of the care plan as the patient may have more than one key worker.	Hospital Association of Occupational Therapists Dublin South West Mental Health Services
10.2		Agree with proposal, but cannot be implemented within current resources. Some staff may be unfamiliar with the requirements of keyworking. Should not be confined to any one discipline. There needs to be a standardized job description for key workers.	Mental Health Services, St. Ita's Hospital Association of Occupational Therapists
10.3		Agree with proposal, but can not be implemented within current resources. The key worker should liaise with the multidisciplinary team members involved in the resident's care during all stages of the process. Concerns of role blurring. There need to be ring-fenced hours for working with key clients.	Mental Health Services, St. Ita's Hospital Association of Occupational Therapists Association of Occupational

		Support and supervision for keyworkers is needed. The role of key worker needs not to usurp roles of liaising with other agencies. Need clarity of role definition. Consideration should be given to a social worker per approved centre, in addition to sector team social workers.	Therapists SW 1
10.4		Agree with proposal, but cannot be implemented within current resources. Add in sub-point re arrangements when key worker absent and also alternative arrangements where there is difficulty in relationship between key worker and resident.	Mental Health Services, St. Ita's Hospital Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services
10.5		What criteria on decision of who key worker is and who makes this decision re who is the most appropriate person?	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services
11 general	Resident and Family Involvement	Greater emphasis on involvement needs to be promoted and supported. Written consent policies must be drawn up. Fear remains around provision of information to families and residents. It will need commitment from approved centres to do this.	Association of Occupational Therapists

11.1		Implication in relation to additional resources Approved Centre should have a policy regarding informed consent. Written consent should be obtained where practicable, and all approved centres should have a protocol regarding informed consent. A standard written consent form should be in place, and signed copy placed in file. Suggest moving this to earlier point in the document to highlight the importance of this in relation to all aspects of the treatment and care, as this does not appear to 'sit' in this section.	Mental Health Services, St. Ita's Hospital Senior Nursing Management, St. Brendan's Hospital Association of Occupational Therapists Department of Health & Children
11.2		Delete – it is commonly not possible, appropriate or beneficial to include relatives in the admission process. The autonomy and independence of the individual must not be overlooked.	Irish College of Psychiatrists
11.3		Residents should be encouraged to involve family / carers in their care and inform family / carers of their admission. Add in 'where appropriate'.	Senior Nursing Management, St. Brendan's Hospital Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services

		I suggest replacing carers with 'informal carers'. Also family and informal carers needs must be assessed and addressed while the service user is an in-patient.	CP 3 CP 3
12.1	Collaboration with Primary Health Care, Community Mental Health Services, relevant outside agencies & information transfer	Greater emphasis on involvement needs to be promoted and supported. The distinction between a right to privacy and a duty of confidentiality needs to be clearly made. "it is considered good practice" should be replaced by "it is essential". Too broad – needs to be tightened up to correspond with statement in part five, Section 2. There needs to be standardized template (see 2.2.1 above) Suggest omitting Community Mental Health services from sections 12.1, 12.2 and 12.3. All CMHTs should work with users, whether inpatients or outpatients to ensure continuity of care. Role is different to that of GPs and PCTs. 10.1 deals with importance of liaising with the Community based care coordinator.	Association of Occupational Therapists Irish Advocacy Network Mental Health Services, St. Ita's Hospital Dublin South West Mental Health Services CP 3

			Irish College of Psychiatrists
		Add “to outside agencies” as clarification after “transfer of information” – at end of paragraph. Amend to “staff should accord with best practice around the transfer of information and that patient confidentiality should be respected at all times. Each professional body will have guidance on this” The point “good practice to seek informed consent from the resident regarding the transfer of information” could be taken to mean that without such consent, such information transfer can not occur, which could have a negative impact on the continuity of care for the resident. For example, someone with an element of paranoia may want no information shared with their GP, PCT or CMHT.	HSE South Clinical Directors Group Department of Health & Children
12.2		Will the ‘timely’ verbal communication with GPs be ‘direct communication’ or via ‘reception’, as GPs may not always be in a position to take calls? The concept of ongoing communication with CMHT and GP seems highly unlikely and excessive.	Department of Health & Children Department of Health & Children

		Delete – implies communication even when no need, adequately covered in 12.3. Should indicate that there should be timely and ongoing communication as deemed clinically appropriate with GPs / PCTs / Community Mental Health services from the time of referral.	Irish College of Psychiatrists HSE South Clinical Directors Group
12.3		This does not happen routinely. Advise clear guidance and a named member of the MDT who would be responsible for this type of communication, ideally doctor to doctor. At the moment this information is given by telephone. Should this be documented? Who should do it? Can one estimate projected length of stay? Add, "in the case of physical illness, the patients own GP should always be contacted by staff in rehab centres rather than using other doctors. Internal doctors should only be used in case of emergency" – thus helping keep contact with GPs, encouraging responsibility of GPs and a higher standard of physical care generally.	Nurse Management Group, St. Stephen's Hospital Mental Health Nurse Management Group, North Cork Anonymous Advocate
13.1	Record keeping and documentation	Work to one set of documentation? MDT care plan only. 24hr access to records (not at present, notes being taken the night before a clinic). Need for adequate record storage.	Mental Health Nurse Management Group, North Cork

		The level of record keeping and documentation suggested in this section is totally impractical in the absence of ward clerks in most approved centres. Much of this is an extra needless bureaucratic exercise. There are poor standards regarding documentation and record keeping in many centres. One central file needs to be promoted and activated. (Nursing often still maintain nursing files). Greater flexibility regarding accessing files outside of hours needs to be encouraged. (Due to geographic spread of many catchment areas and the non existence of electronic patient records) Services must begin to think creatively about services provided at times which meet needs and encourage new and enhanced models of working. National policy / guidelines around this should be developed. Moves towards electronic records are needed. Situation regarding physical location of files will be impossible to address in many areas.	HSE South Clinical Directors Group Association of Occupational Therapists
13.2		Feel this is good idea. We agree with this and feel it is a good idea to introduce a general consent form for admission	Mental Health Nurse Management Group, North Cork Nurse Management Group, St.

		and treatment to be signed by the parents or person acting in loco-parentis. "Good … practice to use an admission form for voluntary patients" What evidence is this based on? What is the function of such a form? Does it have any legal standing? Whole section should be erased. Re-introduces old voluntary blue form and causes confusion in staff and patients mind regarding the right to refuse treatment. General consent should only apply to admission. Where there may be capacity issues, the notion of "implied consent" is not satisfactory. Replace term voluntary patients with voluntary residents. Suggest change word 'obviate' to 'negate' or 'preclude'. Recommend that a standardized form on voluntary admission should be devised by the MHC. (Needs to be cognisant that a person may not have the capacity to consent).	Stephen's Hospital CP 1 CP 2 Irish Advocacy Network Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services Department of Health & Children Dublin South West Mental Health Services / Mental health Services, St. Ita's Hospital
13.3		The second sentence seems superfluous. This	CP 3

		is covered under the Mental Health Act.	
13.4, 13.5, 13,6		No comments.	
13.7		Appendix one is very detailed. Reference may also be needed to professional bodies guidance documents in relation to good practices in record keeping. Signature bank? Currently not signed by students and medical staff. This would require updating every six months? Whose role would this be? The responsibility of maintaining the signature bank and updating it should be part of the team leader's role. Bank book to be maintained in ADON's office and reviewed 6 monthly to annexe medical changeovers.	Department of Health & Children Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South / HSE PPG Group Policy & Procedure Group, HSE South / HSE PPG Group/ Nurse Management Group, St. Stephen's Hospital
14.1	Environment	We do not know what is meant by this sub-section. This section is so limited; it should either be excluded or expanded to describe an appropriate environment in more detail. Not all Approved Centres have designated admission beds, as some are old institutions, which are due to be closed.	Irish College of Psychiatrists Department of Health & Children Policy & Procedure group, HSE South / HSE PPG Group
15.1.1 and		No comments	

15.1.2			
15.1.3	Personal property and clothing	Suggest amend to include at current sentence end “and in instances where they are removed, the rationale for this decision is clearly documented in the residents’ records”.	Department of Health & Children
15.2.1	Medication	Local policy reflects this. Erase this – staff cannot be responsible for medication which may be out of date, doctored, unrecognisable.	Dublin South West Mental Health Services CP2
16.1.1	Children	It might be useful to include explicitly a reference to the issues around consent for treatment in the case of children and young people (under 18 years old). This might be confined to this particular section. This is not to ignore the Code of Practice on the Admission of Children to Approved Centres. Addition “Children should only be admitted to approved Child & Adolescent units”. The code should recognize that it is not desirable to admit children to adult settings. It is made very clear in the knowledge review and in the preamble for the code of practice for the admission of children. This should be reflected in the code on admission, transfer and discharge. If not, it is condoning the practice and will relieve the HSE of its responsibility of	DN1 Irish College of Psychiatrists NPDC 1 / West Galway Mental Health Services

		providing suitable services for this group.	
16.2 general	Homeless people	Many catchment areas have agreed inter catchment protocols around the admission of homeless people. This cohort (homeless children) should have equal access to care and treatment in an Approved Centre in appropriate designated beds.	HSE South Clinical Directors group Nurse Management Group, St. Stephen's Hospital
16.2.1		No comments	
16.2.2		If admitted from a hostel, is it to the approved centre for the catchment area for that hostel? All felt that the criteria used should be equal and fair as for those patients who have an address. This would help continuity of care. Difficult to access beds – improved national policy and increased rights to health and social care are needed, along with training and support.	Mental Health Nurse Management Group, North Cork Association of Occupational Therapists
16.2.3		We have concerns in relation to breach of patient confidentiality if protocol is too broad. Would the same point, as relates to the sharing of information and collaboration with GPs, primary Health and Community Mental Health services regarding resident consent not be needed in this section, or else reference made to examples of additional agencies noted in the	Mental Health Services, St. Ita's Hospital Department of Health & Children

		points covered in Section 12, page 26. After 'approved centres' add "with the patients consent".	 CP 3
16.2.4		No comments.	
16.2.5		Suggest this should be the first sentence of this section.	Dublin South West Mental Health Services

The following comments were made by 'an anonymous advocate' in relation to 8.3 above, but have been outlined here, due to their size and broader nature:

"As advocates, we struggled with a psychiatrist and the MDT to have a quality 'rehabilitation' care plan written (after five years of total inaction). It was eventually supplied but never implemented in any shape or form. The people supposed to be carrying out the tasks often didn't know they had been assigned these tasks and if they did they chose to ignore them. The key worker only existed on paper. So the fundamental problem is implementation. In our experience, this is not a resource issue as the person we advocate for is in a centre with a full MDT and a nursing ration of about 1/5 patients + numerous care attendants. The problem with a written care plan and treatment plan is that people have to explain why care policies are not carried out. There is a culture of non-transparency and non-accountability in the mental Health Services and staff resent being questioned by family and advocates.

(Recommendations)

- Designate someone, other than the key worker, to act as 'case manager'. This should be someone such as a GP or an advocate, who is not a member of the MDT;
- All people listed as implementers should sign to this effect, to prove that they have been informed of their specific role;

- Rehabilitation duties should become a specific role in job descriptions of nurses in rehabilitation centres;
- Accreditation should be removed from centres if specific rehabilitation tasks are not performed;
- The name ‘rehabilitation centre’ should be reserved for places where rehabilitation takes place and not used to describe hostels that are only nursing homes for the mentally ill.
- Only nurses trained in psychiatric rehabilitation should be employed in rehabilitation centres;
- Existing staff should be re-trained so that an old fashioned nursing culture be transformed into a rehabilitation recovery culture
- Rehabilitation roles should as often as possible be assigned to people outside the mental health services to avoid stigmatization and lowered expectation of mentally ill people. This means that all services in the community should be accessed and not just organisations specifically for the mentally ill, such as...(Organisation named but anonymised)
- Social workers should have a specific information and referral role written into their job descriptions;
- A detailed booklet on rehabilitation services in the community should be given to patients and their advocates to inform them of everything available (social, vocational and recreational);
- Patients and their families should be able to self-refer rather than being vetted for rehab activities by occupational therapists and social workers;
- This interface role of professionals gives them too much power. The balance of power between professionals and patients and their families needs to be redressed;
- The management duties of consultants and nurse managers need to be more strictly defined and monitored to ensure that care plans are implemented;
- Disciplinary procedures for non-implementation of care plans need to be instituted;
- Complaints procedures to the Mental Health Inspectorate should be more direct. The present system of having to exhaust traditional complaints procedures is time consuming and ineffective given the lack of accountability in the HSE. Patients dissatisfied with their care should be able to go directly to a mental health ombudsman or mediator. At the moment patients, families and advocates have no-one to turn to;
- Official Advocacy organizations should not be funded by the HSE so that they are not afraid to openly confront management of the Mental Health Services in defence of residents.

Part 3: Transfer Process (Page 30)

Reference	Subject	Summary of Comments	Source
1.1	Transfer criteria	The patient's home may be nearer the hospital, but outside the sector. Add in requests / consents, appears consent not considered in considering the transfer of a resident. Also an option to consider transfer may be due to needs of the service or bed management. No mention of key worker in whole transfer process.	CP 2 Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services
1.2	Patients	In relation to involuntary patient's transfer, guidance needs to be added in relation to the renewal of admission orders while the patient on transfer from the original admitting approved centre.	NPDC 1 / West Galway Mental health Services
1.3	Transfer abroad	Legal provision need to be provided and a code developed by the MHC / HSE for the transfer abroad. Suggest add an additional point to the effect that where a service has to transfer a patient abroad, the service's transfer policy will include provisions for international or cross jurisdictional transfer.	Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South / HSE PPG Group / Nurse Management Group, St. Stephen's Hospital Department of Health & Children

2.1	Decision to transfer	Mental Health Tribunals have a role in the decision to transfer. To clarify responsibilities and indicate sources of information which may aid decision making, change to “the decision to transfer a patient is a medical decision made, where possible or appropriate, in consultation with the individual, members of the MDT and the individual’s family / carer or chosen advocate.” Change to “the decision to transfer should be made by the Responsible Consultant Psychiatrist, in consultation with the rest of the multidisciplinary team.”	Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South / HSE PPG Group Irish College of Psychiatrists CP 3
2.2		No comments.	
3 general	Emergency transfers	In the HSE South we do not have the facility of a dedicated Children’s Psychiatric Intensive Care Unit.	Nurse Management Group, St. Stephen’s Hospital
3.1 and 3.2		No comments.	
4.1	Assessment	Agree with this section, but feel there is a need to have more clarity around risk assessment, risk management and the appropriate tools to be used.	Nurse Management Group, St. Stephen’s Hospital

		Change to “Clinical risk assessment should be an integral part of the assessment of the patient prior to transfer” (current draft could be taken to mean completion of a formalized instrument every time a patient is transferred, which could happen often and be time-consuming and impractical, given often urgent nature of transfer.)	Irish College of Psychiatrists
5.1	Multidisciplinary team involvement	Agree with this section. Erase: impractical for more than a few members of a team to liaise with several members of another team. Change “staff” for “the multidisciplinary team”, as the latter is normally community based. No need for whole MDT to be involved in transfer and quite impractical. Change to “prior to transfer, a decision should be made as to which members of the multidisciplinary team should liaise with their colleagues on the receiving team”	Nurse Management Group, St. Stephen’s Hospital CP 2 Irish College of Psychiatrists CP 3
6.1		Change “involved in” to “informed of” – involvement may not be useful for practical and safety reasons.	Irish College of Psychiatrists
6.2	Resident & family involvement	No comments.	
7.1	Communication between the approved centre and the receiving facility &	No comments.	

	information transfer		
7.2		"new" facility should be replaced by "receiving facility".	Irish Advocacy Network
7.3		We would suggest the development of a transfer form as suggested for adults. Suggest including that this information should be sent / given to a named individual within the receiving mental health facility and a record to this effect be maintained. Insert "Statutory form 10 needs to be completed"	Nurse Management Group, St. Stephen's Hospital Department of Health & Children Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South / HSE PPG Group
7.4		No comments.	
8.1	Record keeping and documentation	Agree with this section and would highlight the importance of informing the District Court and the Mental Health Commission.	Nurse Management Group, St. Stephen's Group
8.2		No comments.	
8.3		Delete for same reasons as above.	Irish College of Psychiatrists
8.4		Patients may not have capacity to or may not be willing to consent – guidance should be given for these situations. Delete. Adding documented consent for transfer confuses rather than protects individual rights. The main issue is consent to admission, which may be	CP1 Irish College of Psychiatrists

		withdrawn at any time for a variety of reasons, including impending transfer. If an individual is transferred to another facility, the fundamental consideration should be consent, or otherwise, to admission.	
9.1	Day of transfer – some practical considerations	Safety and wellbeing of both resident and staff involved, if appropriate, in the transfer should be key considerations in this policy.	Association of Occupational Therapists
9.2		This unnecessary statement is too self-evident. It is difficult to envisage transfer without transport, unless it is not needed.	CP 2
9.3		No comments.	
9.4		Delete “well being” – too vague and meaningless.	CP 2
9.5		No comments.	
9.6		“new” facility should be replaced by “receiving facility”. Beyond scope of code of practice to ensure admission policy is implemented when area is not a mental health facility.	Irish Advocacy Network Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services.

Part 4: Discharge process (Page 34)

Reference	Subject	Summary of Comments	Source
All		"Discharge plan" should include "recovery".	Irish Advocacy Network
1.1	**Patients**	Agree with this section, but fully appreciate that the decision to discharge will come from the District Court, except in the case of a voluntary patient. In busy acute psychiatric units with high bed occupancy, it must be recognized that a resident may need to be discharged in order to facilitate the admission of patients who are at serious and immediate risk of harm to self and others. This should be stated clearly in the Code of Practice.	Nurse Management Group, St. Stephen's Hospital HSE South Clinical Directors Group
2.1	**Decision to discharge**	Should read, "the decision to discharge a patient is the responsibility of the Consultant Psychiatrist. This decision should be made in consultation with the MDT …" Change to "the decision to discharge a patient is a medical decision made, where possible or appropriate, in consultation with the individual, members of the multidisciplinary team and the individual's family / carer or chosen advocate" (thus clarifying the responsibility for discharge and the sources which may aid in the decision to discharge.) The code should state whether it is <u>all</u> or <u>part of</u> the Multidisciplinary team that makes the decision to	CP 3 Irish College of Psychiatrists Policy & Procedure Group, HSE South / HSE

		discharge or alternatively the code should specifically state that the final decision to discharge is medical following consultation with the MDT, Patient and Family. If the MHC thinks otherwise, it should be stated, as this is a break from traditional practice.	PPG Group
		Many discharges are of necessity outside normal working hours, when it is not possible to be in full consultation with the MDT.	HSE South Clinical Directors Group
		Where disagreement exists between MDT and family / resident / family on whether discharge is advisable medically or otherwise, the patient should have the right to a second opinion. (Medical staff tend to cover themselves against risk by being over cautious about discharge, therefore patient can be left in acre when there is no necessity for it. There should be an outside mediator in the form of an official hearing of both parties by someone from the Mental Health Inspectorate).	Anonymous Advocate
		Decisions of the MDT as to whether to discharge or not should be transparent. Where there is disagreement among the MDT about discharge, each member should state their opinion and give reasons, in a written document to patient and advocates.	Anonymous Advocate
		The MHC should give consideration to approved centres with policies involving patients and illicit	NPDC 1 / West Galway Mental Health Services

		substances and the possibility of discharge as a result of possession of such substances. - There is little notice given to discharge to alternative settings and the MHC document relating to this (Discharge from approved settings to alternative settings). - This document puts considerable responsibility on local MHS who are discharging patients to alternative settings and this should be expanded on in the discharge section to older people. - There should also be a section relating to learning disabilities and their discharge.	
New 2.2 and 2.3		Add "Discharge of a detained patient should only happen following a Discharge Meeting. This meeting should be attended by the patient, key worker in hospital, members of the MDT who will have input post discharge and the patient's family / informal carer and advocate where possible. There should be one weeks notice given of this discharge meeting." (This is similar to the Section 117 meeting in the UK).	CP 3
3 general	**Discharge planning**	The inclusion of a date of discharge in an individual's discharge plan may be counter therapeutic in some instances. A patient may be given the impression that they will be discharged on a certain date and tensions may develop where this does not occur, potentially leading to an increase in involuntary detentions. It	HSE South Clinical Directors group

		would be better reworded as “a target date for discharge is desirable, but its implementation may not always be possible due to clinical constraints”. Concerns re a projected date of discharge.	 Dublin South West Mental Health Services
3.1		It is difficult to plan discharge when there are a lack of community services e.g. supported hostels – also when people are admitted to the Central Mental Hospital where permission is required by the Department of Justice. There is a possible need for a specific discharge pathway for persons admitted to specialised units e.g. forensic, dual diagnosis.	Association of Occupational Therapists
3.2		All members of the multidisciplinary team where appropriate should be involved in the discharge planning process. Greater focus on discharge planning must begin immediately on admission. All team members must be involved and be aware of the plan. Plans must be developed in consultation with all involved, and not confined to nursing and medical decisions. In the case of residents who are not considered ready to move into the community, the care plan should give the ‘yardsticks’ by which this ‘readiness’ will be measured (e.g. ability to self-medicate, ability to cook meals etc) – psychiatrists seem reluctant to provide this. It is practically impossible to evaluate readiness	Association of Occupational Therapists Association of Occupational Therapists Anonymous Advocate

		in an institutional environment where the resident has become totally dependent on being 'serviced' by staff. OT reports should be based on real life observation, rather than standardized OT tests (observing the resident at home at weekends, out shopping etc). A weekly log should be completed by resident and staff to measure / evaluate what is being achieved and what still needs to be worked on. This duty should be included in the job description of psychiatric nurses in residential step down hostels. Vague statements such as 'staff will work with you to improve your independent living skills' should be avoided, as they are meaningless unless accompanied by yardsticks.	
3.3		Delete – this is extremely time-consuming and of no clinical value to the patient. The important aspects are already covered in other sub-sections and in the Individual care and treatment plan. Who is responsible for carrying out discharge planning? The service considers discharge planning as part of the integrated care plan and not as separate document / entity. We must also be cognizant that patients have anticipated recovery goals reflecting patient perspective /social supports etc. Patients and advocates have requested that the integrated care	Irish College of Psychiatrists Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services Dublin South West Mental Health Services / mental Health Services, St. Ita's Hospital

		plan be called a ‘care and recovery plan’. If a patient remains in a centre for longer than a specified time (a year?) the MDT should have to justify and give reasons for this on medical / other grounds to a (designated) outside body (mental health ombudsman???) – the old culture of long stay patients is alive and well in Irish psychiatric institutions; outside bodies have to be involved to ensure stays are not prolonged.	Anonymous Advocate
3.4		All members of the MDT need to be aware of the demands imposed by these time frames.	Policy & Procedure Group, HSE South / HSE PPG Group
4.1	**Pre-discharge assessment**	Keep consistent with admission to include housing needs. Change to “comprehensive MDT assessment” Change to “patients should be assessed prior to their discharge to ensure appropriate discharge plan is in place” – wouldn’t normally be possible to do such a comprehensive assessment due to time constraints, especially as these aspects will have already been addressed.	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services HSE PPG Group Irish College of Psychiatrists

		There should be discussion at this point with the patient about possible future involvement of relative / carer / advocate in care planning, if the individual does not have the ability to consent at that stage. This has significant staff resource implications e.g. the availability of admin support. Is it a comprehensive assessment by one or all of the MDT members; if so how practical are the resource implications of this?	Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South Dublin South West Mental Health Services Policy, Procedure and Guideline Group, HSE South
4.2		Why at this stage? Should this not have been addressed at point of referral / admission? For all patients admitted who have children, a preliminary social work assessment should occur.	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services Policy & Procedure Group, HSE South / HSE PPG Group
4.3		No comments	
5	**Multi-disciplinary team involvement**	The code should specifically state that the final decision should be medical in consultation with the MDT or is it all or part of the MDT that makes the decision to discharge?	Policy & Procedure Group, HSE South / HSE PPG Group
6.1	**Key-worker**	Re-allocation of key-worker where key worker was staff member of approved centre.	Nurse Education & Policy Development Committee, Louth/Meath Mental

			Health Services
		There is an assumption that the key worker isn't part of the MDT – it should read "MDT key worker"	HSE PPG Group
		Key workers need training on discharge planning, including education on what patients are entitled to on discharge. Multidisciplinary discharge groups should be available in all centres.	Association of Occupational Therapists
		The importance of confidentiality needs to be mentioned in this section.	Dublin South West Mental Health Services
6.2		Change to "relevant MDT members".	HSE PPG Group
		This section seems to be a departure from normal protocol where medical staff would usually liaise with the GP.	Nurse Management Group, St. Stephen's Hospital / Mental Health Nurse Management Group, North Cork
		There is an assumption that the key worker isn't part of the MDT. It should be the responsibility of the NCHD to notify the GP in writing.	Policy & Procedure Group, HSE South
6.3		There is an assumption that the key worker isn't part of the MDT. The MDT key worker should ensure that all relevant documentation is completed. It should be the responsibility of the NCHD to notify the GP in writing.	Policy & Procedure Group, HSE South / HSE PPG Group

7.1	**Collaboration with Primary Health Care, community mental health services, relevant outside agencies & information transfer**	Case conferences involving all stakeholders prior to discharge must become the norm and be actively encouraged. Suggest a standardized template. In this service, patients are discharged to follow up care c/o CMHT.	Association of Occupational Therapists Dublin South West Mental Health Services
7.2		We agree with the statement that the CMHN should be involved in the discharge process as outlined in a) and b) of this section. Currently this is not always the practice because of their developing role within their functional area within the community services. A very important part of the discharge process would be the communication of pre and post discharge plan to Social Services b) This is a new requirement and will have implications for MDT members or could this just mean that the Consultant and a member of the ward staff could satisfy the criteria. b) it is impossible and inefficient to have a member of the CMHT at discharge meetings for all patients b) it is not practicable (due to time and travel) to have community based staff coming to separate discharge meetings outside of weekly MDT meetings in which inpatients are discussed.	Nurse Management Group, St. Stephen's Hospital Policy & Procedure Group, HSE South Department of Health & Children Irish College of Psychiatrists
7.3		Clinical judgment and the professional opinion of the	Dublin South West Mental

		MDT should determine this.	Health Services
7.4		The emphasis on provision of information and documentation of the patient's understanding will help ensure his / her rights are protected. Suggest break point a) into two specific points; One relating to a preliminary discharge summary (& prescription information and follow up) sent within three days. Thereafter a comprehensive discharge summary is sent to the general practitioner / primary care team / community mental health services responsible within 14 days. This way the system will be uniform. a) A preliminary discharge letter should be sent to the GP on the day of discharge. This will, however, have implications for the NCHD's and medical staff. Again need for a standardized template for discharge summary. There are resource implications in arranging a written discharge summary to be sent and received within 3 days. Significant staff resource implication. Additional admin staff needed to fulfill obligations. Some units will not have the resources.	Irish College of Psychiatrists Department of Health & Children Policy & Procedure Group, HSE South Dublin South West Mental Health Services Mental Health Services, St. Ita's Hospital CP1
7.5		Names and contact details of key people for follow up	Association of

		should be clearly written in the discharge summary. The development of a relapse prevention strategy and crisis management plan may be addressed by the CMHT following discharge who are more familiar with the individual patient rather than with the inpatient team.	Occupational Therapists HSE South Clinical Directors Group
8.1	**Resident / Family involvement & information provision**	Quite broad, final sentence, should be re-worded to include every effort should be made to identify the support needs of the individual within the family / care setting. Might include a line to note in what format this information will be given and that a record will be made of the provision of the information in the residents' records? Might be helpful for information to be written. An assessment of the carer's needs should occur, where appropriate by a social worker or OT prior to the discharge of the patient. The family should be aware of the key members of the multidisciplinary team for follow up. Guidelines are required as to how far services can assist family members. Access to family therapists and out of hour support services would be required.	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services Department of Health & Children Policy & Procedure Group, HSE South / HSE PPG Group Association of Occupational Therapists Association of Occupational Therapists

8.2		Part a) should become 8.2 then set down b and c as 8.21 and 8.22 – makes it clearer. a) and b) key worker may not be the best person to provide details of generic services, members of CMHT may be better b) Relevant community groups should be included in list. b) A discharge booklet may need to be devised and given to the patient with all the relevant information prior to discharge.	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services SW 1 Association of Occupational Therapists Policy & Procedure Group, HSE South /HSE PPG Group
8.3 and 8.4		No comment	
9.1	**Notice of discharge**	We agree with this statement and would suggest that it should include notification of discharge to the Mental Health Commission, the District Court (if involuntary) and other allied professionals. If involuntary, the District Court will make the decision to discharge. Should a record be made of providing residents and their families / carers of the notice of discharge and the impact of this information on the resident and their families / carers. Delete – unrealistic, amelioration of mental state is an imprecise process. Other patients may require urgent	Nurse Management Group St. Stephen's Hospital Department of Health & Children Irish College of

		admission. It is not practical to give a minimum of two days notice of discharge in many cases because of the busy nature of acute psychiatric units. Usually the decision to discharge is taken at the ward round and may often be a decision to discharge that same day. This can often suit the clients if it means avoiding staying in hospital over the weekend unnecessarily. We suggest that notice of discharge should be individualised.	Psychiatrists HSE South Clinical Directors group / Association of Occupational Therapists Mental Health Nurse Management Group, North Cork Mental Health Services, St. Ita's Hospital
10.1	**Follow up & aftercare**	If one member of the team is not given primary responsibility for follow up then there is a danger of lapsed contact. Key worker from CMHT needs to be appointed. Missed appointments can be avoided if all documents go to advocates as well as the patient, with the patients consent on an official document (currently hospital staff often refuse to give information, even when there is a letter of consent). There is a need for a secure IT system with unique patient identifiers so information can be promptly dispatched between specialist and community services. Different health professionals could have	SW 1 Anonymous Advocate Dublin South West Mental Health Services

		different levels of access, appointments could be made and audits of activity undertaken. Draft code needs to be cognisant of current capacity and capability in the absence of such an IT system.	
10.2		Check ref – resident should be notified of appointment in writing. b) This may not always be possible if a patient is discharged at a weekend c) There appears to be a conflict in respect to a broad range of health professionals having access to patient / client information as outlined in the previous section. c) Change to “clinician” in place of “multi-disciplinary team” – judgment of when to follow up is best made at time of discharge and exact time of discharge is often unpredictable. An appointment can be made at this time c) And d) 3 months / one week should not be prescribed. Clinical judgment and the professional opinion of the MDT should determine this. d) Some patients with a history of deliberate self harm may not need a follow up appointment within one week of discharge and this stipulation is too	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services Dublin South West Mental Health Services Dublin South West Mental Health Services Irish College of Psychiatrists Mental Health Services, St. Ita’s Hospital HSE South Clinical

		prescriptive in nature and should be left to a clinician's individual judgment as stated in 10.2 c). d) Dates of previous self-harm events should be recorded as part of the patient's risk assessment on admission.	Directors Group Policy & Procedure Group, HSE South / HSE PPG group
11.1	**Record keeping & documentation**	This section is not relevant for a child. When dealing with a child the parents / family guardian will be involved through the entire process. Standardised discharge template. c) Delete – this is a medical decision. Admission can be brief and sometimes engagement with MDT will only take place after discharge???	Nurse Management Group, St. Stephen's Hospital Dublin South West Mental Health Services Irish College of Psychiatrists
12.1	**Day of discharge – some practical considerations**	Might be helpful to make a note re old medication brought in that is not required on discharge not being returned (unless this is already covered in local policy). Also suggest a note in relation to provision of medication on discharge (if appropriate) – ensuring timely provision and documenting same.	Department of Health & Children Department of Health & Children
12.2 and 12.3		No comments	
New 12.4		Suggest inclusion of supply of medications / prescription, medical cert etc.	Dublin South West Mental Health Services

13.1	**Discharge against medical advice**	This section is not relevant for a child. What are the guidelines for discharge when a person is discharged by Tribunal against the advice of the MDT? A form should be in place for all those patients who wish to discharge themselves against medical advice to sign.	Nurse Management Group, St. Stephen's Hospital Association of Occupational Therapists Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South / HSE PPG Group
14	**Specific groups**	No mention of children & young people. Need to consider assessment of home environment, including the parent / carer capacity, education etc needs in discharge planning and aftercare arrangements. Other agencies may need to be involved e.g. education.	DN1
14.1 general	**Homeless people**	There appears to be a conflict between a broad range of health professionals having access to patient / client information and the need to uphold client confidentiality. If a homeless child is admitted involuntary / voluntary the social services are invariably involved from a very early stage and the Gardai will also be notified whenever appropriate. In the case of a resident discharging against medical	Mental Health Services, St. Ita's Hospital Nurse Management Group, St. Stephen's Hospital

		advice it is impossible to get housing. This is because public housing authorities consult the MDT (particularly the social worker) and are reluctant to go against assessments. People in psychiatric units are not considered homeless. The consequence is that a voluntary patient is effectively not able to self-discharge without becoming homeless. Psychiatric patients should be allowed to self-refer to public and voluntary housing agencies. Social workers in housing agencies should have to consult families and advocates and give them equal credibility in their assessment. The link between public and voluntary housing lists should be broken to diminish the inordinate power and control that social workers have over patients and their families.	Anonymous Advocate
14.1.1 and 14.1.2		No comments.	
14.1.3		In the case of a psychiatric patient with a physical disability, a personal care assistant should be approved in advance of their discharge.	Anonymous Advocate
14.1.4		No control over whether person turns up at that accommodation. Delete “It is recommended that staff in the approved centre follow up to see if the person turns up at the accommodation” – This is not practical. If assertive follow up is necessary it should be done by the	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services Irish College of Psychiatrists

		homeless agencies. Suggest a note to say what staff should do if a person does not attend at their accommodation, time frame for follow up and need for a record of this activity.	Department of Health & Children
14.2	**Older people**	No comments.	
New 14.3		Re psychiatric patients with physical disabilities The assessment process for a personal care assistant should start before discharge and approval from the HSE for funding be accepted before the person is discharged so that the person will be able to function normally on discharge. A physical disability should not be used as a discrimination to prevent discharge and keep psychiatric patients in residential units against their will.	Anonymous Advocate

Part 5: Common issues Page 40

Reference	Subject	Summary of Comments	Source
General		Staff training and information should be mandatory to ensure that it is prioritized and resources are allocated to it.	West Galway Mental Health Services
1	Patients	No comments.	
2.1	Confidentiality	Insertion of the word relevant "prior to the transfer of relevant information".	Mental Health Nurse Management Group, North Cork
2.2		Delete first sentence, as it is unclear and has been addressed earlier in the document. Consent should be obtained in writing, wherever possible prior to the transfer of personal information. Insertion of the word relevant "prior to the transfer of relevant information". If resident refuses to give consent prior to the transfer of personal information – any guidance in relation to this relative to best interest of resident, clinical need, continuity of care and so forth? It may not be possible to obtain consent for a resident to transfer personal information in an emergency transfer situation. Therefore include comment re documentation of reasons if consent not obtained.	Irish College of Psychiatrists Association of Occupational Therapists Policy & Procedure Group, HSE South / HSE PPG Group Department of Health & Children Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services
3	Risk Management	Guidelines needed for content of training and funding for courses and guidance as to how training should be updated	Association of Occupational Therapists
4.1	Information	Might be good practice to include line that receiving facility should	Department of Health &

	Transfer	confirm receipt of documents via fax.	Children
4.2		It is limiting to outrule electronic transfer of patient information – this is the way forward and there are many examples of secure electronic transfer that should be adopted. E-mail needs to be secure – security can be increased by using password protection and encrypted information. Need secure systems, training and one national system. Germany are currently piloting electronic record system with view to increasing their electronic communication in healthcare. This would be especially beneficial for CMHT increasing economic use of time. Money set aside for enhancing systems *"embedding the e in health"* (2004) needs to be followed up. If e-mail is used for transfer of personal and confidential data, a test e-mail is sent (and confirmed received) to ensure the receiving facility receives it (files sent in this manner should be password protected) Information is sent via reply to e-mail from receiving facility. A note is made as to the rationale for use of e-mail as opposed to any other means of information transfer. Receiving facility should send response to note safe receipt of data. Data should be stored in secure area (password protected) in computer. All data should then be deleted from e-mail system and trash bin (as indicated) both in recipient facility and sender facility to reduce risk of inappropriate access. Except for the patient secure information IT information system.	Department of Health & Children Association of Occupational Therapists Department of Health & Children Mental Health Services, St. Ita's Hospital
5.1and 5.2	Staff Roles &	No comments.	

	Responsibilities		
6.1	Staff Information & Training	Delete sentence beginning “Documentary evidence …” – very difficult to manage in practice, especially with constant turnover of staff.	Irish College of Psychiatrists
6.2		No comments.	
6.3		Need to be more specific re what is meant by appropriate training and relevant staff.	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services / Senior Nursing Management, St. Brendan’s Hospital
6.4		a) There are many forms of risk assessment including health and safety. This document should specify the context of this term in relation to risk assessment i.e. clinical risk assessment of an individual. b) Needs to be clarified in order to source a suitable / appropriate risk management training course.	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services

Part 6: Special Considerations Page 42

Reference	Subject	Summary of Comments	Source
General	**People with Intellectual Disability**	Clear treatment pathways required. The accommodation in the service the person came from should be kept to prevent inappropriate placement of the individual in the Mental Health Service. Capacity issues in relation to admission consent, understanding information and advice. Development of on site mental health facility within the ID services. It is positive to note that special consideration is being given in relation to people with an intellectual disability. Activity has occurred in relation to ascertaining the views of service users in the development of an integrated psychiatric service for people with an intellectual disability, which provide additional points to consider in the context of good practice (ref Parkes and Hassiotis (2007) British Journal of Learning Disabilities Vol 35, pp23-39). In addition the Royal College of Nursing (2006) developed a guidance document entitled "*Meeting the health needs of people with learning disabilities: Guidance for nursing staff*" which provides a range of useful data to support nurses who are trained in disciplines other than intellectual disability to provide health care to people with an intellectual disability. There are particular additional issues re consent e.g.	Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South Department of Health & Children Department of Health & Children

		deficits in verbal and memory ability, difficulties with problems solving, tendency towards acquiescence and suggestibility, problems with concreteness and abstracting from examples, and difficulties processing complex sequences of information, (ref Arscott, Dagnan and Kroese (1999) Psychological Medicine, Vol 29 (6), pp 1367-1375) Emphasis on participation from National Disability Strategy (2004) and Disability Act (2005) should be noted in the context of treatment and care. Would be helpful to explicitly note re information provision, resident decision-making and participation in this Part (based on part 2).	Department of Health & Children Department of Health & Children Department of Health & Children
1.1	Admission Criteria	No comments	
2.1	Assessment	Assessment should be carried out by appropriate trained staff to meet the specific needs of people with ID – who are appropriate staff? Is it the key worker? Reference to training required needs to be clarified, as there are resource implications, particularly in services with staff shortages.	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services Dublin South West Mental Health Services
2.2		"With resident consent" should be included at end of sentence and in subsequent sentences, where appropriate i.e. affording people with an intellectual disability with the same rights as others receiving mental health care.	Department of Health & Children
3.1	Resident and Family	Welcome the involvement of the family / carer and advocate in the assessment of the patient /resident.	Mental Health Nurse Management Group, North Cork / Policy &

	involvement		Procedure Group, HSE South / HSE PPG Group
4.1	Interagency Collaboration	b) Does part two of 6.3 not equally apply in relation to person with an intellectual disability whereby their place of residence is secured for them?	Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services
5.1	Staff Training	Welcome specialist staff training for management of specific issues for people with ID, resources will be required to provide this	Mental Health Nurse Management Group, North Cork / Policy & Procedure Group, HSE South / HSE PPG Group / Association of Occupational Therapists
Extra		People with physical disabilities (also require special consideration) The specific mobility needs of this group should be taken into consideration particularly in regard to wheelchair access of residential centres. Being wheelchair-bound should not be used as an excuse to limit mobility and use of public transport. Kitchen and other facilities should be adapted for this group. The specific needs of this group should be taken into consideration in the care and treatment plan. Staff should be trained for the specific needs of this group, especially OT's.	Anonymous Advocate

Specific consultation question enquiring as to whether Part 6 should remain in the Draft Code of Practice.

A specific consultation question was asked as to whether Part Six should remain in the code of practice or not.

Only six respondents answered this question.

Four agreed that Part Six should stay in the Code; one person mentioning that extra protection was needed.

Two disagreed and suggested that equal protection should be automatic and thus that the separate part was unnecessary.

References and Bibliography: Page 44

The Department of Health & Children was the only respondents to this section of the document. They commented that the “Breadth and scope of source documents is commendable”.

Reference to associated consultation documents of the Expert Group on Mental Health: *“Speaking Your Mind” and “What They Said”* referred to in bibliography. Examination of *A Vision for Change* notes reference to:

- Expert Group on Mental Health Policy (2004a) *Speaking Your Mind. A Report on the Public Consultation Process.* Department of Health and Children
- Expert Group on Mental Health Policy (2004b) *What We Heard. A Report on the Service User Consultation Process.* Department of Health and Children

The Bibliography Section includes a range of nursing source documents, and whilst mentioning a number of professional codes of practice for different disciplines, there appears to be no reference to the An Bord Altranais *Code of Professional Conduct* whose purpose is “to provide a framework to assist the nurse to make professional decisions, to carry out his / her responsibilities and to promote high standards of professional conduct.” (An Bord Altranais 2000)

Appendix 1: Excellence in Mental Health Records Page 56

The Department of Health & Children was the only respondents to this section of the document. They stated that the document presents….

Very useful guidance in relation to promoting high quality record keeping practices. Might be useful to note that professional guidance from relevant professional bodies should also be taken note of, as would augment this process.

An Bord Altranais' (2002) *Recording Clinical Practice Guidance to Nurses and Midwives,* for example would be another useful resource to consider (Department of Health & Children)

Appendix 2: Sample Transfer Form Page 61

Four respondents commented on this form. The following was suggested with regard to this form: -

- Anywhere phone number is requested we should also include mobile. (to act as prompt) (HSE PPG Group, Mental Health Nurse Management Group, Cork, Policy and Procedure Group, HSE South)
- Where PPSN number is, medical card number should also be included. (HSE PPG Group, Mental Health Nurse Management Group, Cork, Policy and Procedure Group, HSE South)
- Present medication – suggested that 'known allergic reaction' should be included here. (HSE PPG Group, Mental Health Nurse Management Group, Cork, Policy and Procedure Group, HSE South)
- Name of approved centre – phone number should also be included. (HSE PPG Group, Mental Health Nurse Management Group, Cork, Policy and Procedure Group, HSE South)
- Name of hospital transfer to – phone number should also be included. (HSE PPG Group, Mental Health Nurse Management Group, Cork, Policy and Procedure Group, HSE South)
- Suggest "signature of resident" be placed after field (has the resident consented to have their file transferred" (Department of Health & Children)
- Typographic error on page 63 "Jon Title" (Department of Health & Children)

Appendix 3: Sample Discharge Summary Page 64

Three respondents commented on this form. The following was suggested with regard to this form: -

- It was felt that this form should be more reflective of the section (Part 4) in the code of practice. (HSE PPG Group, Mental Health Nurse Management Group, Cork, Policy and Procedure Group, HSE South)
- Anywhere phone number is requested we should also include mobile. (to act as prompt) (HSE PPG Group, Mental Health Nurse Management Group, Cork, Policy and Procedure Group, HSE South)
- Where PPSN number is, medical card number should also be included. (HSE PPG Group, Mental Health Nurse Management Group, Cork, Policy and Procedure Group, HSE South)
- Present medication – suggested that 'known allergic reaction' should be included here. (HSE PPG Group, Mental Health Nurse Management Group, Cork, Policy and Procedure Group, HSE South)
- Page 2 – limited space for some fields. (HSE PPG Group, Mental Health Nurse Management Group, Cork, Policy and Procedure Group, HSE South)
- Individual Care and Treatment plan / discharge plan: suggest tick boxes – Yes, No, Attached. (Mental Health Nurse Management Group, Cork, Policy and Procedure Group, HSE South)
- Prognosis – query what should go in here. (Mental Health Nurse Management Group, Cork, Policy and Procedure Group, HSE South)
- Information given to resident & relative – something should go in to the form to show that consent was given by resident. (Mental Health Nurse Management Group, Cork, Policy and Procedure Group, HSE South)
- We would suggest that tick boxes should be added to show where the form has been sent to by key worker. (Mental Health Nurse Management Group, Cork, Policy and Procedure Group, HSE South)

Chapter 4 General Comments Made by Respondents

This chapter summarises the comments made that weren't linked to a specific numbered section of the draft Code. Some of these comments were made in the final comments section of the feedback form and some were made by respondents who did not use the specific feedback form provided to them. This Chapter cannot be interpreted as a full summary of comments in the consultation as a whole, as many respondents chose to relate all their comments to specific sections. Therefore, to give a full overview, this Chapter needs to be read in conjunction with the previous one.

Summary of Comments

1. A total of 8 respondents gave a broad welcome to the draft Code (Policy and Procedure Group, HSE South; West Galway Mental Health Services; NPDC 1; Department of Health & Children; Mental Health Social Workers, Kildare and West Wicklow; Association of Occupational Therapists; Dublin South West Mental Health Services; Senior Nursing Management, St. Brendan's Hospital).

2. A useful document that sets out clearly the issues that need to be considered in each situation. It will also be useful in guiding the development and review of policies and procedures developed locally in relation to each of these areas. (DN1)

3. A particular welcome to inclusion of sections on homeless and ID. (Department of Health & Children)

4. Welcome premise underpinning the document of Quality and Best Practice. (CP 1)

5. In general, it is a helpful guide for students and patients. One would hope other professionals would be aware of the content already. (CP 2)

6. It provides a mechanism to ensure that patient receive appropriate interventions and dedicated clinical time. (Dublin South West Mental Health Services)

7. Overall, the CoP may give guidance on best practice, but some of the document is so far removed from realities of service that it lacks credibility. (HSE South Clinical Directors Group)

8. Document is well written and comprehensive. However, the lack of availability of social workers, occupational therapists and psychologists to many sector teams, means that the multi-disciplinary thrust of the policy will remain largely aspirational (SW 1)

9. Hope document doesn't lead to a reticence to admit people when they need admission. Need to make sure pendulum doesn't swing too far the other way. Who determines if an admission is 'inappropriate'? (Department of Health & Children)

10. Draft does not refer to issues specific to approved centres which are also designated centres – currently only Central Mental Hospital, but likely to be extended to others in the near future. Likely issues include use of S21 (2), admissions under S4 of the Criminal Law (Insanity) Act 2006, especially S4 (6), other admissions from the criminal justice system, discharges involving the criminal justice system (courts, prisons, probation etc) and use of S13 and S14 of the Criminal Law (Insanity) Act 2006 as part of aftercare (CD1)

11. Is the conveyance of patients (assisted admissions) going to be tied into this code? (Dublin South West Mental Health Services)

12. Is there any recommendation that the Section 23 power to prevent voluntary patient who wishes to leave be amended to say that it is preferable that this is a role for a registered psychiatric nurse? (Dublin South West Mental Health Services)

13. Code needs to be checked with front line mental health and primary care staff (Department of Health & Children) (Dublin South West Mental Health Services)

14. Too much emphasis on care plans. In general treatment plans at end of Doctors' entries and perhaps a contact sheet are more practical and have statutory backing. (CP 2)

15. CoP does not address some of the major difficulties that are faced by clinicians around the admission and discharge of patients.

These realities put patients at serious risk and need to be addressed: e.g.

- A patient presents needing acute admission, but no beds are available in the approved centre
- A patient is brought to an approved centre for admission under the Mental Health Act, but no beds are available in the approved centre
- The use of leave of absence beds where patients are asked to remain on leave for extra nights because their leave of absence bed has been taken for an acute admission
- Patients who present for admission at busy city centre A&E's from different catchments areas

Some approved centres are under huge strain, working at bed occupancy rates approaching 100% with very poorly developed MDTs in many areas and the availability of out of hour's community treatment being a rarity. The fact that this Code of Practice may be referred to during the course of legal proceedings further exposes consultant psychiatrists to the threat of litigation.

The level of documentation and record keeping suggested in the Code of Practice is totally impractical in the context of current staffing levels within the Irish Mental Health Services. Such levels of documentation will inevitably lead to less time being spent by clinicians in direct patient contact." (HSE South Clinical Directors Group)

16. The absence of the word "recovery" throughout the document is regrettable. (Irish Advocacy Network)

17. The right to privacy and duty of confidentiality are inadequately addressed throughout. Data Protection and Freedom of Information Acts are not even mentioned. (Irish Advocacy Network)

18. The document does little to reassure service users that they are regarded as central to the planning, design, delivery and evaluation of services or that they are genuinely viewed by the Mental Health Commission as equal partners in a collaborative process. (Irish Advocacy Network)

19. We agree that standards of care in nursing homes are extremely important and must be addressed. There are three

particular issues which we have concerns about…..On-going monitoring of discharged patients. There are concerns that those discharged from psychiatric services might, only as a result of this code, be followed up automatically and indefinitely. The psychiatric follow up surely should be based on need….Who should monitor standards in nursing homes? The code does not specify who will monitor the nursing homes AND it is an extensive piece of work. This is not a role for consultant psychiatrists/clinical staff who have no training in this area. This is a role for an independent body – a nursing home inspectorate/HIQA (IACPOA).

20. Welcome concept of implementation impact analysis to ensure that the code is practicable. (Department of Health & Children)

21. All clinical staff groups, patient representative groups, DOH and HSE Management need to be involved in consultation; the latter in particular as COPs on other aspects of the act have been accepted WITHOUT appropriate funding being made available. (CP 1)

22. Important to note paucity of evidence for procedures, particularly in mental health and to acknowledge that more research is required and as such guidelines can only be based on current common practice informed by experience. Could funding be made available for specific research and audit? (CP 1; HSE South Clinical Directors Group)

23. Care arrangements should be based on diagnosis and clinical need – one size does not fit all. For instance a person with uncomplicated dementia needs GP follow up, but those with dementia plus behavioral problems will require support from a Psychiatry of Old Age service. (CP 1)

Chapter 5 Stakeholders' Views on the Impact of Implementing the Draft Code of Practice

This chapter summarises the responses given with regard to the Impact Analysis of implementing the Draft Code of Practice. Stakeholders were asked to consider the impact of implementing the Draft Code, particularly with regard to:

a) Potential Benefits
b) Potential Challenges and potential solutions to these challenges and
c) Potential Costs (once off and ongoing costs)

The majority of respondents did not respond to this aspect of the consultation process. Of those that did respond many made general rather than specific comments about the benefits, challenges and costs. A small minority of respondents were very specific about benefits and challenges of particular aspects of the Draft Code of Practice.

The responses given are presented below.

5.1 Benefits of Implementing the Draft Code of Practice

A total of 7 respondents commented on the benefits of implementing cost implications of implementing the Code of Practice. The comments made/issues raised were: -

- Audit will ensure that the policy is effective and used (Referring to Section 1, Subsection 3.2) (Irish College of Psychiatrists)

- The Specified period for review is important to take account of local and national changes. (Referring to Section 1, Subsection 3.3) (Irish College of Psychiatrists)

- This will ensure those who are admitted will be smoothly integrated back to primary care or to the community mental health services. (Referring to

Section 2, Subsection 5.1) (Irish College of Psychiatrists)

- The emphasis on provision of information and documentation of the patient's understanding will help ensure his/her rights are protected. (Referring to Section 2, Subsection 7.4) (Irish College of Psychiatrists)

- The key worker is vital to ensure complete and integrated treatment for the individual. (Referring to Section 2, Subsection 10.1) (Irish College of Psychiatrists)

- Setting time scales in which discharge summaries should be dispatched is helpful in encouraging good communication. (Referring to Section 4, Subsection 7.4.a) (Irish College of Psychiatrists)

- This highlights the importance of follow-up and aftercare. (Referring to Section 4, Subsection 10.1) (Irish College of Psychiatrists)

- High quality service with safeguards for service users. (Mental Health Social workers, Kildare and West Wicklow)

- Lays out clearly what service users should expect. (Mental Health Social workers, Kildare and West Wicklow)

- All members of the MDT will have to provide care as per this code and in the best interests of the residents. (Senior Nursing Management, St. Brendan's Hospital)

- Ensures that the service users understand their clinical journey in the approved centre. (Mental Health Services, St. Ita's Hospital)

- Provides a mechanism to ensure that service users receive appropriate interventions and dedicated

clinical time. (Mental Health Services, St. Ita's Hospital)

- Enhanced care from service users perspective. (Mental Health Services, St. Ita's Hospital)

- Co-ordinates ongoing care for individuals and their families when acute needs are experienced. (Mental Health Services, St. Ita's Hospital)

- Provides guidance to healthcare professionals on how service users are admitted in everyday situations. (Mental Health Services, St. Ita's Hospital)

- Opportunity to standardize processes and enable implementation of quality framework. (West Galway Mental Health Services; NPDC 1)

- Possibility of developing a national standard for MHS on Admission, Discharge and Transfer of patients. (West Galway Mental Health Services; NPDC 1)

- Standardised referral and discharge forms. (West Galway Mental Health Services; NPDC 1)

- Possibility of implementing an instant method of communication between GP and MHS re admission, discharge and transfer e.g. use of text or e-mail. System could also be used to remind patients regarding out patient appointments. (West Galway Mental Health Services; NPDC 1)

- Benefits of implementation of codes of practice, generally are unmeasurable. A commitment by all staff to providing a modern, progressive, enlightened and attractive mental health service would have far more beneficial outcomes for the individual. This is probably a matter for the HSE. (Irish Advocacy Network)

5.2 Challenges associated with implementing the Draft Code of Practice

A total of 11 respondents commented on the challenges associated with implementing the Draft Code of Practice. The comments made/issues raised were: -

- It is pointless discussing potential benefits without addressing enforcement. The Inspector of mental health services reports have annually demonstrated an inability and unwillingness on the part of some approved centres to even adhere to rules which are technically legally enforceable. (Irish Advocacy Network)

- Staff attitudes are the biggest barrier to a progressive mental health service, and this is not explicitly addressed in the Code of Practice…Make all staff accountable with yearly evaluations and assessments of competence as part of contracts (including role for service users)….salary increments should be linked to performance not length of service. (Irish Advocacy Network).

- Significant additional clinical time required to meet requirements, especially around written information and communication (Mental Health Services, St. Ita's Hospital; DN1; Dublin South West Mental Health Services). Generally more time spent on documentation and less time with the patient. (HSE South Clinical Directors Group)

- Auditing can be time consuming, a specific skill and costly. (Senior Nursing Management, St. Brendan's Hospital)

- Resources for strengthening MDT's (HSE PPG Group), links also to achievement of integrated care planning. (Nurse Education & Policy Development Group, Louth/Meath Mental Health Services)

- Is currently aspirational as resources are not uniform. (CP 1)

- Teams should be able to communicate through leaders, rather than hit and miss general liaising. (CP 2)

- Community facilities underdeveloped in most areas making it difficult to prevent admissions and also to provide adequate follow up care. (West Galway Mental Health Services; NPDC 1)

- If nurse is key worker, there may be conflict in co-ordinating care with other team members who feel they have higher authoritative powers in the team working / decision making process. (Nurse Education and Policy Development Committee, Louth/Meath Mental Health Services)

- Key workers are too moveable; responsibility should be assigned to specific officers. (CP 2)

- Difficult to get buy-in particularly from primary care when MDT's not fully in place. Buy-in needed to develop effective protocols and information sharing practices with a wider range of agencies. (Nurse Education & Policy Development Group, Louth/Meath Mental Health Services, DN1)

- Current admission units not fit for purpose therefore limited space. (Mental Health Services, St. Ita's Hospital)

- Our present IT infrastructure will inhibit our communication process. (Senior Nursing Management, St. Brendan's Hospital)

- An integrated IT system is required (Mental Health Services, St. Ita's Hospital) with a unique patient identifier. A strategic framework should be agreed between the HSE, MHC & HRB with a lead in time to develop the system. Implementation should be incremental. (Dublin South West Mental Health Services)

- Administration already has difficulties in keeping up with discharge summaries, this code of practice may add to these difficulties. (Nurse Education & Policy Development Group, Louth/Meath Mental Health Services)

- Need to balance information sharing and rights of confidentiality. (Mental Health Services, St. Ita's Hospital; Dublin South West Mental Health Services)

- Safety is ignored compared to consent and input in planning by relatives etc. (CP 2)

- Admissions after 5pm (Mental Health Services, St. Ita's Hospital), self-referrals at nighttime when nearest A&E is 20 miles away. (Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services)

- Discharges not always planned - leads for need for some flexibility with notification to District Court. (West Galway Mental Health Services; NPDC 1)

- Difficulties in housing patients causes delays in discharge and blocking of beds – can be countered by developing step down facilities and increasing continuing care places. (West Galway Mental Health Services; NPDC 1)

- Accessing appropriate risk management training programme. (Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services)

- Development of additional policies and protocols. (Should be done by a national group) (West Galway Mental Health Services; NPDC 1)

- Developing a protocol of admission of people with ID to an acute unit not specific to their needs. (Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services)

- Some staff may have previous training / expertise reworking with people with an ID, however not always on duty. Dilemma when to admit would breach code and not to admit would also breach code. (Part 2 3.5) (Nurse Education & Policy Development Committee, Louth/Meath Mental Health Services)

- No statutory powers to implement all recommendations. (CP 2)

- DoH and HSE must be made aware of the HR implications required to roll this out and fulfill the practice guidelines. (CP 1)

5.3 The Costs associated with implementing the Draft Code of Practice

A total of 8 respondents commented on the cost implications of implementing the Code of Practice. The comments made/issues raised were: -

- Perhaps we should be asked to define the cost to individuals and society of not implementing good practice initiatives in all areas of health services. (Irish Advocacy Network)

- A need for appointment of full complement of multi-disciplinary team for each sector and catchment area. (SW 1; HSE South Clinical Directors Group)

- A need for one off cost in relation to IT systems and training. (Mental Health Services, St. Ita's Hospital; Dublin South West Mental Health Services)

- A need for Continuing costs re: clinical and clerical staff (Mental Health Services, St. Ita's Hospital) and audit person. (Dublin South West Mental Health Services)

- Ward clerks are not in place in most areas. (HSE South Clinical Directors Group)

- A Quality Assurance framework needs to be enhanced and developed in order to monitor and evaluate on an ongoing basis. (Mental Health Services, St. Ita's Hospital; Dublin South West Mental Health Services)

- Thirteen policies must be developed. Audits of admission, discharge and transfers must be completed. Information booklets must be available in different languages. Following discharge of people with deliberate self harm / suicide attempts, there must be follow up within one week. Because of these resource implications, think introduction should be phased over a couple of years. (Mayo Mental health Services)

- Modules of training and education re multidisciplinary working need to be developed". (Mental Health Services, St. Ita's Hospital; Dublin South West Mental Health Services)

- Funding needs to be made available for research into good practice given the acknowledged evidence gap upon which to base this code of practice. (CP 1)

- Cost of implementation of the Code. Resource implications must be acknowledged. Implementation of other aspects of the Act have proven difficult as local resources have not been forthcoming (IACPOA)

Chapter 6 Conclusion

As is evident from earlier in this report, the response has not been extensive with regard to this consultation process, despite considerable time been given to stakeholders in which to submit their views. In relation to the limited number of responses received, a number are from groups of singular professionals, a number are from multi-professional groups and a number are from representative bodies. In addition to these, responses have been received with regard to child and adolescent services, general adult services, services for older people and forensic services. Views have been elicited from staff of inpatient and community services.

It is important to acknowledge that the response from service users, service user groups and statutory/representative bodies has not been as substantial as one would have expected.

This exercise has been beneficial in that it has raised the challenges present in consulting with service users and with other possible stakeholders. The other key learning points that emerged with regard to the process of consultation were: -

1. A number of individuals did not utilise the consultation forms distributed and wrote general commentary letters.

2. Despite been given considerable time to give their views, a number of respondents requested (and were given) an extension of time to make their submission.

3. In conducting the consultation exercise, we endeavoured to engage all stakeholders. In a number of incidences, we went to considerable difficulty to source a contact person as the identified contact person was no longer with the organisation/body. Despite identifying a new contact within these organisations/bodies and speaking with them to explain the process, and despite been given the impression that they would engage in the process, we did not subsequently receive submissions from them.

The Irish Advocacy Network, one of only two respondents from a service user representative perspective, put a strong case forward

with regard to the low response rate from service users in stating that…..

"The consultation process itself was not conducive to service user input. The paper version was not fit for purpose, the language is tortuous and inaccessible. Not too many service users have access to a computer. It appears from the form at the beginning and can be inferred from the types of questions asked (e.g. potential costs of implementation) that the Mental Health Commission is more concerned with getting a response from professionals than from service users. This is an issue of growing concern, as service users feel increasingly that the Commission has very little relevance to the reality of their experiences. This type of consultation is completely inappropriate if the Commission wishes to elicit a meaningful response from those who use mental health services".

The above comment and the limited response from service users and their representatives pose two pertinent questions, notably: -

1. What type of consultation would elicit a meaningful response from service users (and indeed carers, family members and advocates)?
2. What can be done to involve service users, carers, family member and advocates as much as possible in the development and implementation of this code?

Issues for the Mental Health Commission to consider with regard to the current consultation process

The following are suggestions as to how the Commission could address the aforementioned challenges.

1. Consider a series of discussion workshops with service users, families and advocates/advocacy groups. These workshops could **either**

    A) Involve direct consultation on the Draft Code as it is currently constituted and/or

    B) Involve scoping out the key requisites from a service user perspective with regard to admissions, transfers

and discharges to and from approved centres. The key issues that emerge from this scoping exercise could then be proofed against and incorporated into the draft Code of Practice.

2. Invite comments from service users/service user representative groups as to how best to consult with service users on this document, including addressing issues of accessibility (such as how the code can be communicated as accessibly as possible).

Issues for the Commission to consider with regard to future consultation

In reflecting on the above, we recommend that the Commission: -

A. Consider involving multi-stakeholder groups in scoping out the core components of future codes of practices as part of the drafting process.

B. Consider how best to engage service users and their representative groups in consultation processes, in line with the recommendations on the previous page and with any other learning that emerges during the completion of this process. Consideration could be given (as part of this) to consulting with a service user or a panel of service users when designing consultation processes.

C. Reconsider the timeframe allowed to respondents in future processes, in light of the fact that the lengthened timeframe did not increase the response rate.

D. Use the learning from this consultation process specific to the design and layout of consultation questionnaires/forms, perhaps with a view to shortening the length of the form. This exercise also indicated that respondents gave less attention to the latter parts of the form.

E. Consider the possibility of conducting research into effective processes for engaging service users, families, carers and service user representative groups.