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Deputy Cian O'Callaghan.
Dail Eireann,
Leinster House,
Kildare Street,
Dublin 2.

10th August 2023

PQ Number: 31376/23
PQ Question: To ask the Minister for Health what supports are in place regarding housing and aftercare for a person who has been admitted involuntarily into care under the Mental Health Act 2001 and who can no longer return to the family home upon their discharge; and if he will make a statement on the matter. -Cian O'Callaghan

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Dear Deputy O' Callaghan,

The Health Service Executive has been requested to reply directly to you in the context of the above Parliamentary Question, which you submitted to the Minister for Health for response. I have examined the matter and the following outlines the position.

As per Section 28 of the Mental Health Act 2001: Discharge of patients.

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

(2) In deciding whether and when to discharge a patient under this section, the consultant psychiatrist responsible for his or her care and treatment shall have regard to the need to ensure:

(*a*) that the patient is not inappropriately discharged, and

(*b*) that the patient is detained pursuant to an admission order or a renewal order only for so long as is reasonably necessary for his or her proper care and treatment.

(3) Where a consultant psychiatrist discharges a patient under this section, he or she shall give to the patient concerned and his or her legal representative a notice in a form specified by the Commission to the effect that he or she—

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(a) is being discharged pursuant to this section,

(b) is entitled to have his or her detention reviewed by a tribunal in accordance with the provisions of section 18 or, where such review has commenced, completed in accordance with that section if he or she so indicates by notice in writing addressed to the Commission within 14 days of the date of his or her discharge.

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

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

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

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

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

MHC: Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre
In addition to the requirements above, the Mental Health Commission have set out a Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre. Part 5: Discharge Process sets out in detail the discharge planning process, collaboration with Primary Health Care, Community Mental Health Services, Relevant Outside Agencies, including housing authorities, follow up and aftercare.

Discharge Planning
A comprehensive and structured discharge plan should be developed as a component of the individual care and treatment plan. Discharge planning should commence as soon as possible after admission. This plan should be developed, reviewed and updated as per the care plan. The discharge plan should focus on the resident's recovery and should include an estimated date of discharge, documentary evidence of communication with the relevant GP/primary care team or community mental health team, a follow-up plan and early warning signs of relapse and risks.

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A discharge meeting should take place before discharge. This meeting should be attended by the resident, his/her key worker, relevant members of the multidisciplinary team and the resident's family, carer or chosen advocate where appropriate (with the consent of the resident).

Pre-Discharge Assessment
A resident should have a comprehensive assessment prior to discharge, which is multidisciplinary in so far as is practicable. It should include an assessment of mental health and psychological needs, a current mental state examination, comprehensive risk assessment and risk management plan, any social and housing needs that the resident may have and any other relevant information. Where necessary, suitable accommodation should be secured before a resident is discharged.

Multi-disciplinary Team Involvement
A multi-disciplinary team approach to discharge planning should be adopted and relevant members of the MDT should actively manage the discharge process. A key-worker should co-ordinate the discharge process. He/she should liaise with the resident, family, carer and/or chosen advocate, where appropriate (with the consent of the resident) and work with other members of the MDT to ensure that liaison with the GP/primary care team and/or community mental health services and relevant outside agencies takes place.

Collaboration with Primary Health Care, Community Mental Health Services, Relevant Outside Agencies
Community mental health staff should be involved in the discharge process from an early stage. Where feasible, planned contact between a resident and the relevant community mental health services/general practitioner/primary care team should be established prior to discharge. GP's /primary care teams and/or community mental health services should always be informed of the discharge of a resident. Every reasonable effort should be made to inform them within 24 hours.

Upon discharge, a discharge summary should be sent to the patients' GP/primary care team/community mental health services responsible for follow up care within 3 days of discharge. Discharge summaries should include information regarding diagnosis, prognosis, medication, mental state at discharge, any outstanding health or social issues at discharge, follow up arrangements, the names and contact details of key people for follow-up and risk issues such as signs of relapse.

Notice of Discharge
Approved centres should provide the resident, his/her family/carer and/or chosen advocate where appropriate (with the consent of the resident), with a minimum of 2 days' notice of discharge. A timely post-discharge follow-up appointment with the relevant services should be made prior to discharge. It is considered good practice that individuals with severe mental illness and a history of deliberate self-harm within the previous 3 months or who are assessed as being at risk of suicide should have a follow up appointment within one week of discharge. In the case of the discharge of an involuntary patient, statutory forms must be completed in accordance with the Mental Health Act 2001 Act.

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If the person cannot return to the family home or is homeless, the team Social Worker will look at placing the person on the homeless list with the local authority. The person may also be considered for a community placement in a HSE High Support residence if they need this level of care and supervision and part of their initial transition out of an in-patient setting into a community placement. After that, the HSE engages with approved housing bodies (AHB's) who can provide supported community placements along with tenancy supports being put in place to maintain a tenancy in the community.

In addition, a Mental Health Community Living Transition Protocol is in currently in development. This protocol, which is a joint piece of work being led by the Department of Housing, Local Government and Heritage and the Department of Health, sets out arrangements for cooperation and coordination of internal processes between local authorities and the HSE in guiding the effective transition of individuals from HSE supported accommodation to community living.

Further information can be found by consulting with the following links:

https://www.irishstatutebook.ie/eli/2001/act/25/section/28/enacted/en/html#:~:text=%E2%80%94(1)%20Where%20the%20consultant,the%20case%20may%20be%2C%20and

The MHC Code of Practice also makes reference to Specific Groups. Section 44.1 provides detail on Homeless People.

https://www.mhcirl.ie/sites/default/files/2021-01/COP_ATD.pdf

I trust this information is of assistance to you.

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Paul Braham
Senior Operations Manager (Area DON)
National Mental Health Services