Department of Health

Care Services Improvement Partnership CSIP

Ministry of JUSTICE

Health and Social Care in Criminal Justice

NOMS National Offender Management Service

Working together to reduce re-offending

PROCEDURE FOR THE TRANSFER OF PRISONERS TO AND FROM HOSPITAL UNDER SECTIONS 47 AND 48 OF THE 'MENTAL HEALTH ACT (1983)'

Version 4
Revised October 2007

This document details the procedure for transferring sentenced and unsentenced prisoners to and from prison under Sections 47 and 48 of the Mental Health Act (1983). The transfers are from prisons to either PICU's, low, medium or high secure healthcare facilities.

Overleaf is a best-practice flow chart describing the ideal process for a prison to hospital transfer and a second flow chart describes the process for identifying the Responsible Primary Care Trust Commissioner. Further details of these processes can be found in the main body of this document. This document offers guidance and support should any difficulties arise whilst also acknowledging differences between local commissioning structures[1].

N.B. Contacting the relevant PCT Mental Health Commissioner is one of the most essential first steps in the transfer process.

[1] Reference throughout the document is to NHS organisations in England, e.g. PCTs, SHAs, RFCs – the Welsh equivalents are LHBs, RO's and HCW. The procedures for transfer are generally the same as those in England, but where there is divergence further explanatory footnotes will appear.

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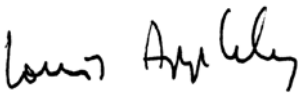
Foreword

There are currently some unacceptable delays in the transfer of acutely mentally ill prisoners to and from hospital under Sections 47 and 48 of the Mental Health Act 1983.

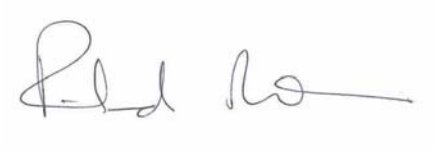
The 'Procedure for the Transfer of Prisoners to and from Hospital under Sections 47 and 48 of the Mental Health Act 1983' aims to help colleagues to work together more effectively to secure and sustain significant improvements in unacceptable delays over the coming months.

The procedure is a result of wide national consultation and explains each stage of the transfer process, providing clear guidance for key stakeholders to enable timely transfer. In particular, the procedure highlights the vital role of safe and effective commissioning by responsible commissioners. A list of useful contacts and their details is also provided for further support.

We encourage those involved in the process of transferring prisoners to and from hospital under Sections 47 and 48 of the Mental Health Act 1983 to use this document to support them in their work to enable prisoners to access timely care and treatment as afforded by service users accessing mental health services in the community.



Louis Appleby
National Director for Mental Health



Richard Bradshaw
Director, of Prison Health, HM Prison Service
Head Of Offender Health, DH

Prison Mental Health Transfers Best Practice Flow Chart

Key
Mental Health Unit, Ministry of Justice (MHU) Primary Care Trust (PCT)
Regional Forensic Commissioner (RFC) /Secure Services Commissioner (SSC)
Head of Healthcare (HHC / Head of HC) Responsible Medical Officer (RMO) Healthcare Administration Staff (HC Admin)

	Who	Procedure	Experiencing Difficulties
1	General Practitioner (GP) or Psychiatrist working in / visiting the prison	Initial medical and risk assessment (supported by info from prison healthcare / prison mental health service); transfer to a hospital deemed necessary.	
			Contact MHU for guidance identifying the level of security provision for in-patient.
2a	Healthcare Admin staff who is responsible to the HHC	Inform the MHU (fax H1003 – prisoners' details, precons, case summary), responsible PCT Commissioner and Forensic Case Manager (where applicable)	Difficulty in establishing appropriate PCT; refer to page 7, then contact RFC /SSC for sign-posting
2b	Head of HC & Clinicians (i.e. Responsible Medical Officer)	Arrange for 2nd medical assessment through the NHS system, preferably by a Dr. from an appropriately secure unit, able to provide a bed*	Difficulty finding a second doctor; contact responsible PCT Commissioner or RFC / SSC for sign-posting
		2 medical reports agree diagnosis	
3a	Head of HC & HC Admin	Inform the MHU (fax HT014 from each doctor and H1003)	
3b	Head of HC	Inform the appropriate PCT**	
4	Head of HC	Liaise with the hospital to arrange movement of the prisoner	
5	Hospital Service Provider	Prisoner returning from hospital to prison ensure continuity of care (i.e. Section 117 Aftercare)	

The MHU issue the Transfer Warrant;
The warrant is only valid for 14 days from date of issue.

**One of the two Doctors must be approved under Section 12(2) of the Mental Health Act 1983*
***LHB (Local Health Board) in Wales ****HCW (Health Commission Wales) in Wales*

Flow Chart of Actions to Help Identify the Responsible Commissioner (PCT)

Stage	Procedure	Possible Difficulties
1	**Responsible PCT is where the prisoner was last registered with a GP before entering prison**[2] If Responsible PCT is not known, this information can be found by logging onto the NHS Choices website. Instructions are listed below:- 1. Type in **www.nhs.uk** 2. Under Choose Services (to the right hand side) click "Find NHS Services" 3. Under Find Health Services, in the box "Enter Your Postcode or Location" type in the postcode of the Doctor's surgery if known and select under "For" Doctors 4. Click "Search". A map will appear with a list of Doctor's down left hand side 5. If you select a relevant Doctor, at the top a sentence will appear stating "This practice provides services for …..PCT" 6. If you click on the relevant PCT, it will bring up a page, with their contact details	
2	**Responsible PCT will be where the prisoner resided before entering prison** If this information is not known follow stages 1 – 2 as above, but under stage 3 instead of typing in postcode of Doctor's surgery, enter in postcode of residential address. Under "For" still select Doctors. Continue to then follow stages 4 - 6	*If not registered with a GP before entering prison* →
3	**The responsibility is then deferred to the PCT where the offence took place**	*Not registered with a GP and for whom a previous address cannot be determined (i.e. No fixed Abode)* →

For further details please see Section 10 'Establishing the Responsible Commissioner' in the main body of the text

[2] In Wales the responsible commissioner is determined by usual residence not GP registration in the first instance.

'TRANSFER OF PRISONERS TO AND FROM HOSPITAL UNDER SECTIONS 47 AND 48 OF THE 'MENTAL HEALTH ACT (1983)'

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1.Transferring sentenced prisoners under Section 47 of the Mental Health Act 1983

Definition of sentenced prisoner

For the purposes of Section 47(1), prisoners serving a sentence of imprisonment are defined by Section 47(5) to include those who are:

a. sentenced to life imprisonment, and extended term of imprisonment, youth custody or detention during Her Majesty's Pleasure under Section 53 of the Children and Young Persons Act 1933. Excluded are persons ordered to be detained under Section 5 of the Criminal Procedure (Insanity) Act 1964;
b. committed to custody under Section 115(3) of the Magistrates' Courts Act 1980, for failing to enter into recognisances to keep the peace or be of good behaviour (in all other respects these persons will be treated as civil prisoners);
c. detained in custody in default of payment of any sum adjudged to be paid on conviction.

Conditions for transfer under Section 47

A prisoner serving a sentence of imprisonment may be transferred to hospital by warrant under a direction from the Secretary of State (Through the Mental Health Unit) under Section 47(1) if he is of the opinion, having regard to the public interest and all the circumstances, that it is expedient so to do, and if he is satisfied by reports from at least 2 medical practitioners that:

a. the prisoner is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment; **and**
b. the prisoner's mental disorder is of a nature or degree which warrants his detention in a hospital for medical treatment and, in the case of psychopathic disorder or mental impairment, that such treatment is likely to alleviate or prevent a deterioration of his condition.

At least one of the medical practitioners must be approved under Section 12(2) of the Mental Health Act (1983), and no direction will be given by the Secretary of State unless both practitioners report that the prisoner is suffering from the same form or forms of mental disorder, whether or not the prisoner is described by either of them as suffering from an additional form of mental disorder. Once Section 47 action is pending, the prisoner must not be transferred to another prison establishment unless absolutely necessary (i.e. in the interim the prisoner may need 24 hour care in a Type 3 Healthcare Centre to reduce risk to the self and others). If this does occur, the Mental Health Unit (MHU) must be informed immediately of the new location. Movement of the prisoner during this process can result in significant delays in the transfer, as the assessment procedure must be repeated.

2.Transfer of prisoners not yet serving a sentence to hospital under Section 48 of the Mental Health Act 1983

Definition of an unsentenced prisoner

For the purposes of Section 48 prisoners not yet sentenced are defined as follows:

a. persons detained in prison not serving a sentence of imprisonment or persons in any of the three categories below (Section 48(2)(a));
b. persons remanded in custody by a magistrates' court (Section 48(2)(b));
c. civil prisoners (but not persons committed for failing to enter into recognisances to keep the peace or be of good behaviour) (Section 48(2)(c));
d. persons detained under the Immigration Act 1971 (Section 48(2)(d)).

Conditions for transfer under Section 48

A prisoner other than one serving a sentence of imprisonment may be transferred to hospital by warrant under a direction from the Secretary of State under Section 48 if he is satisfied by reports similar to those required under Section 47 (see page 6) that:

a. the prisoner is suffering from mental illness or severe mental impairment of a nature or degree which warrants his detention in a hospital for medical treatment (note: not for psychopathic or mental impairment); **and**
b. the prisoner is in urgent need of such treatment ('urgent' is defined as 'if the doctor would have recommended in-patient care for that person were they seen at an out-patient clinic in the community).

At least one of the medical practitioners must be approved under Section 12(2) of the Mental Health Act (1983), and no direction will be given by the Secretary of State unless both practitioners report that the prisoner is suffering from the same form of mental disorder, whether or not the prisoner is described by either of them as suffering from an additional form of mental disorder. Once Section 48 action is pending, the prisoner must not be transferred to another prison service establishment unless absolutely necessary (i.e. in the interim the prisoner may need 24 hour care in a Type 3 Healthcare Centre to reduce risk to the self and others). If this does occur, the MHU must be informed immediately of the new location. Movement of the prisoner during this process can result in significant delays in the transfer, as the assessment procedure must be repeated.

3.General Overview of Transfer Procedure

The procedures within this document apply equally to those people with a learning disability as to those without a learning disability.

Transfer upon receipt of 2 medical reports

Under the terms of the Mental Health Act (1983), the Secretary of State may direct the transfer of a prisoner to hospital for psychiatric treatment on receipt of two separate medical reports stating that the prisoner is suffering from mental disorder and is in need of in-patient treatment. One of the two doctors/medical officers must be approved under Section 12(2) of the Mental Health Act (1983) (i.e. have recognised special experience in the diagnosis or treatment of mental disorder).

It is important that the NHS Responsible Medical Officer (RMO) / Clinical Director from the prisoners home Medium Secure Unit (MSU) / low secure unit (LSU) is informed at the earliest stage possible, especially when the catchment area service has not been involved in the initial decision to transfer the patient (e.g. when a transfer is initiated by a GP working in the prison and a private sector Section 12 approved doctor). Recommendations for transfer must be from a Section 12(2) approved doctor acceptable to the responsible PCT.

The completion of the H1003 document (see attached) is imperative for the processing of the transfer by the Mental Health Unit at the Ministry of Justice.

Where a prison's in-house / sessional Section 12 approved doctor does not concur, with the view of the clinical team supporting the prisoner, that transfer under the Mental Health Act 1983 is required, local resolution and agreement must be sought in the first instance. Where agreement has still not been reached, the clinical team can request a second opinion from a different Section 12 approved Doctor.

Sentenced and Unsentenced prisoners

Under Section 47 of the Act, sentenced prisoners may be transferred if they are suffering from one or more of the four classifications of mental disorder outlined in the Mental Health Act i.e. mental illness, psychopathic disorder, mental impairment, severe mental impairment. Remand, unsentenced, civil prisoners and immigration detainees can be transferred under Section 48 of the Act, *only* if they are suffering from mental illness or severe mental impairment and are assessed as being in urgent need of such treatment.

4. Returning the prisoner to prison from hospital and Section 117

Under Section 49 of the Mental Health Act 1983, the Secretary of State may impose upon the transferred prisoner restrictions set out in Section 41 of the Mental Health Act. The order imposing the restrictions is known as a "Restriction Direction". This ensures that the Secretary of State, through the MHU, remains involved in the management of the case. A restriction direction makes it possible to return the patient to prison if they recover before their prison release date. This ensures that they are not set at liberty earlier than would have been the case had they remained in prison. Where imposed, the restrictions, unless terminated by the Secretary of State, last until the earliest date on which the prisoner would have been discharged from detention had they not been transferred to hospital, or in the words of the Mental Health Act, "the release date".

Patients can be returned to prison by order of the Secretary of State under Section 50 or 51 of the Mental Health Act 1983, if the responsible Psychiatrist (RMO) decides that the individual is no longer in need of medical treatment or that no effective treatment for the disorder can be given at the hospital to which he has been transferred.

In order to return the prisoner to prison from hospital the following actions should be undertaken:

- The Responsible Medical Officer writes to inform the MHU that the patient no longer requires treatment in hospital
- A Section 117 meeting is held between the hospital and the receiving prison
- Upon confirmation of the Section 117 meeting being held (except in emergencies) the MHU will issue the remission to prison transfer warrant

Prisoners are generally returned to the prison from which they were originally transferred to hospital from. In some circumstances the receiving prison may advise that the establishment is unable to receive the returning prisoner. When this occurs, the following steps should be undertaken:

- For Section 47 and 48 returning prisoners the Prison Service Area Office (see contact list page) which hosts the original sending prison should be contacted
- For Section 45A returning prisoners the Prison Service Area Office which hosts the sentencing court should be contacted
- For returning prisoners intended to return to a Contracted Prison contact the Regional Offender Manager for the relevant area

Section 117 Aftercare Plan

It is expected, in keeping with best practice protocols and the Mental Health Act 1983, that prisoners returning to prison from hospital will be accompanied by a CPA Care Plan that incorporates the requirements of Section 117 of the Mental Health Act 1983 (i.e. indicating whether or not the individual requires on-going mental health services at the time of transfer). Section 117's are a statutory after-care arrangement. Mental health service providers working in the prison receiving the transferred patient must be invited to attend the pre-discharge planning meeting and make best efforts to attend. Where representation from the receiving prison is not possible in a timely manner this should not delay the prisoner returning to prison. This meeting needs to include thought and planning for both return to custody and future release from prison including transportation requirements.

Only in exceptional, emergency circumstances (i.e. where the patient poses a severe, non-containable risk) can a patient be returned to prison before a Section 117 plan has been agreed In such a case a Section 117 meeting should be organised as soon as possible after his/her return to prison. This will be reinforced by the Mental Health Unit which will not issue a remission warrant unless such a meeting has been arranged, except in exceptional circumstances. The MHU must be advised to which prison the patient is to be returned before the remission warrant can be issued.

Expiration of Restriction Direction

When the restrictions expire (e.g. at the end of a person's sentence) the Secretary of State has no further responsibility for the case. However, if the responsible Psychiatrist (RMO) considers that the patient continues to need treatment, the patient may still be liable to detention in hospital under Section 47 of the Mental Health Act. This is equivalent to being detained under Section 37 of the Act (i.e. a hospital order without restrictions) and is known as a 'notional 37 hospital order'.

For those prisoners remanded in custody by a **Magistrates Court** and made subject to a transfer direction under Section 48(2)(b) MHA, the transfer direction will cease to have effect at the expiration of the period of remand unless the accused is then committed in custody to the Crown Court. However if the Magistrates Court further remands the accused under Section 52(3) MHA, the direction will not expire. Alternatively, if the court is satisfied that the accused no longer requires treatment in hospital, it may direct that the transfer direction cease to have effect.

Where a court subsequently makes an order under Sections 35, 36 or 38 or grants the accused bail, these will take precedence over an administrative direction from the Secretary of State and the transfer direction ceases to have effect.

In the case of a prisoner committed to trial in a Crown Court, the transfer direction remains in force unless it is terminated by the direction of the Secretary of State or the Crown Court, following the receipt of evidence that the person no longer requires treatment in hospital.

Restriction directions made under Section 48 in the case of civil prisoners or immigration detainees cease to have effect, along with the transfer direction, on the expiration of the period during which the patient would, but for his/her removal to hospital, be liable to be detained in the place from which he/she was removed.

Need for urgency in identifying and transferring mentally ill prisoners

The Head of Healthcare (HHC) at the prison, in conjunction with the Prison Mental Health Team*, must ensure that prisoners, who may need treatment in hospital, are identified as soon as possible. It is Government policy that people who are suffering from mental disorder who require specialist medical treatment need to receive it from Health and Social Services. The fact that the person is a prisoner must not prevent or delay access to appropriate care and treatment, in hospital if necessary. Once a prisoner is identified as possibly needing a transfer under the Mental Health Act (e.g. after their first medical examination by the GP or Psychiatrist working in / visiting the prison), the MHU must be informed of the prisoners details immediately, by fax, using form HI003 or HI004 (formerly F218) completed as fully as possible, together with a copy of previous convictions, details of the Index Offence, court summary etc.

** The term 'Prison Mental Health Team' has been used as a generic term to describe mental health services available to prisoners as different titles for prison mental health services are used across the prison estate.*

5.The Role of Primary Care Trusts (PCTs)

As the Responsible Commissioner, the appropriate PCT / Lead Commissioner can support the Head of Healthcare, Prison Mental Health Team and related staff with the transfer process.

It is important to note that each geographical area may have their own, local commissioning structures (e.g. gate keeping processes, Trust placement panels, forensic hub services, the Mental Health Trust may be the commissioner in some areas) that would be too detailed and specific to include in this document. If challenges establishing the responsible commissioner do occur please contact the relevant local leads identified in Appendix 5 of this document which lists those who can advise and inform you about local commissioning structures. If difficulties are experienced, contacting the local prison PCT Commissioner for guidance may be helpful.

Establishing the Appropriate PCT

The appropriate PCT, for English prisoners, in the case of transfers to hospital under Sections 47 and 48 of the Mental Heath Act (1983), is the PCT where the prisoner was registered with a GP before entering prison. If the prisoner was not registered with a GP before entering prison the responsible PCT is where the prisoner resided before entering prison (this is in contrast to the majority of other healthcare, for which the prison PCT becomes responsible)[3].

Prisoners whose last known residence was in **Wales** and are deemed to require transfer to hospital under the Mental Health Act should contact Health Commission Wales in the first instance. This process would also include offenders under 18 years of age.
Contact details: Susan Thompson: 02920 807573/807571 Fax: 02920 807579
The Mental Health Act does not make a distinction between levels of security, so these guidelines apply regardless of the type of healthcare facilities to which the prisoner is transferred. The local Regional Forensic Commissioner / Secure Services Commissioner can aid in helping you source and determine the prisoners' usual place of residence (see Appendix 5, for a contacts list of all RFCs / SSCs).

Contacting the Relevant PCT Mental Health Commissioner

When contacting commissioners, providing the following information is helpful:

- Indicate whether the referral is for mental illness, Personality Disorder or Learning Disability services
- Indicate which level of security is thought to be appropriate (i.e. PICU / LSU, MSU, HSH) bearing in mind the client's offence history
- Indicate whether the individual is known to local services or has a history of mental illness

If a prisoner who is usually resident within the UK is not registered with a GP, and for whom a previous address cannot be determined, the responsibility is then deferred to the PCT from where the offence took place (see page 20, 'Establishing Responsible Commissioner', para. 82, 2007). In the case of immigration detainees, who are detained because of their immigration status, 'then the responsible commissioner should be determined by the address of the unit providing treatment. In this context, the PCT in which the facility is located becomes the responsible commissioner' (ref para 95. 'Establishing Responsible Commissioner', 2007).

Where an illegal immigrant is detained for a criminal offence not related to their immigration status 'responsibility will remain with **the PCT in which he is present**, which will usually be the PCT in which the prison is located' (ref para 82 'Establishing Responsible Commissioner', 2007).

If the person is sent to a mental health in-patient facility *without being transferred to a prison first* then the responsible PCT is where the mental health in-patient facility is as this is the first place he is properly '**present'**.

[3] In Wales, responsible commissioner is determined by usual residence rather than GP registration prior to entering prison.

Immigration Act Detainees

For those detained under the Immigration Act, Border Immigration Agency (BIA) case-workers will need to be approached by the Healthcare Manager initially for a decision on whether Temporary Admission is appropriate. Admission may be by Sections 2 / 3 if the case-worker decides on Temporary Admission. Where continued detention is required transfer will be by Section 48. If Section 48 is used it is imperative that the Borders Immigration Agency case-worker is informed by the Healthcare Manager and that there is good subsequent communication between the case-worker and the patients' RMO. If the BIA case-worker decides that a person admitted under Section 48 is no longer to be detained, it is important that the psychiatrist involved is given notice, so that he/she can consider whether Section 2 / 3 is required. Once ready for discharge from hospital the individual will be liable to be re-detained in the removal centre. It will be important for the receiving team to request an invitation to attend the Section 117 aftercare plan meeting or if unable to attend at the minimum request copies of the aftercare plan in accordance with the Care Programme Approach.

It is imperative that the Healthcare Manager informs the receiving hospital and MHU of the immigration status of the prisoner.

'Who Pays? Establishing Responsible Commissioner' Guidance (2007).

Paragraph 82.

'The responsible commissioner for the commissioning of psychiatric hospital care for people transferred from prison to hospital under Sections 47 or 48 of the Mental Health Act will be determined in the usual way as set out in the Functions Regulations. This arrangement also applies for the funding of any assessment of an individual to access the NCG-commissioned secure forensic mental health service for young people. For prisoners not registered with a GP practice, and for whom a previous address cannot be determined, usual residence should be interpreted as being in the area in which the offence for which he/she is detained was committed. Alternatively, if detained pending trial, the area where the offence with which he/she is charged was committed. For persons usually resident outside the United Kingdom, responsibility will remain with the PCT in which he is present, which will usually be the PCT in which the prison is located (see Annex A)'.

Paragraph 83

'PCTs and prisons have been given further guidance. However, prior to April 2003, the responsible PCT for prisoners was determined by the usual means'.

If, for some reason, none of this information is accessible or applicable, the responsibility lies with the prison PCT. When this occurs the responsible PCT is often confirmed through the appeal and arbitration process which is led by the relevant Strategic Health Authorities.

In no case should disagreements or confusion about establishing the 'responsible commissioner' delay or adversely affect a prisoner's treatment. An arrangement can be sought for payment in the interim of responsibility being determined. If any difficulties arise it is vital that contact is made with the appropriate Strategic Health Authorities, Regional Forensic Commissioner (RFC) / Secure Services Commissioner (SSC) and PCT. If following this contact, there are continued difficulties, please contact the Mental Health Unit for advice.

See page 26 and Appendix 5 for helpful contacts and web links.

Safe and Effective Commissioning by responsible PCTs incorporates:

- Encouraging timely assessments
- Willingness to promptly fund placements in either the NHS or independent sector in the interim of local NHS provision being available
- Promote the necessity of CPA Care Plans and Section 117 requirements on the patients return to prison
- In situations of urgency, where responsible commissioner is in dispute, PCTs should agree to pay for in-patient services in order to identify immediate risk then proceed to arbitration for resolution

Tertiary Care Transfers

For prisoners referred to specialist (tertiary) services provided by the NHS that do not involve transferring the prisoner under the Mental Health Act 1983 the 'responsible commissioner' guidelines apply as for secondary care i.e. it is the responsibility of the prison PCT. If transfer to these services is deemed to be necessary, the prisoners' home PCT acts as the responsible commissioner.

Young People under 18

For young people under age 18, the commissioning responsibility for medium/high secure forensic services lies with the National Commissioning Group (NCG). The current healthcare units for young offenders are Roycroft (Newcastle), Gardener (Manchester), Ardenleigh (Birmingham), Bill Yule (Beckenham, South London), Wells Unit (Middlesex), Malcolm Arnold Unit (for young people with learning disabilities at St.Andrews, Northampton) and Bluebird House (Southampton, due to open April 2008). Funding has been top-sliced from PCTs to pay for this service. These services

must receive a psychiatrist's referral - and where known the young person's home psychiatrist notified of the arrangement, after which they will arrange visits and further assessment of the possible future patient. The cost of this assessment is funded by the responsible PCT. For further information on young people please refer to Appendix 1.[4]

Payment of transfer

The role of 'responsible commissioner' encompasses local commissioning procedures (i.e. gate-keeping), providing assistance to healthcare staff in locating a bed as well as paying the healthcare costs of the transferred prisoner. Once the responsible commissioner is established all payment procedures should be taken care of by the commissioner. With regards to financing a transfer, the necessity of immediate action may require moving the prisoner before the finances have been fully resolved.

Transfers to Independent Sector Providers (non NHS providers)

The only possible exception may be transfer to independent sector healthcare providers whereby the receiving healthcare unit may have a policy of upfront payment. All private transfers must go through local commissioning procedures and RFC / SSC. It is important that delays in transfer are not caused by the lack of available NHS in-patient facilities when, in the interim, a private facility has assessed and accepted the patient for transfer. Independent sector placements should not cause a delay in the transfer of prisoners under the Mental Health Act 1983.

When local NHS facilities are not able to provide a bed and the need of the prisoner is urgent (i.e. the prisoner is acutely mentally ill) the PCT is obliged to find an appropriate placement whether the placement offered is in the independent sector or the NHS. When funding issues in isolation (i.e. reticence of the PCT to fund a private, interim placement) are inhibiting placement, the MHU may direct a patient in order to prevent delay.

6. Actions/Responsibilities for staff involved in a Section 47 or Section 48 transfer.

The Role of Prison Healthcare Staff

It is Government policy that all those prisoners deemed in need of hospital treatment must be transferred as quickly as possible. It is therefore important that healthcare and mental health staff seek assessment at the earliest moment that they think transfer is appropriate. Delays at this stage can mean that it becomes more difficult to effect transfer at a later stage. It can be particularly difficult for the receiving hospital if an assessment is completed close to the prisoner's release date, when it was clear from earlier behaviour that an assessment would have been appropriate.

After the prisoner's initial medical assessment, if the GP or Psychiatrist working in / visiting the prison considers that the prisoner is suffering from a form of mental disorder (as described on pages 6 and 7) that necessitates their transfer to a hospital for medical treatment, they must arrange for the prisoner to be examined by an appropriate medical practitioner. It is essential that the Psychiatrist working in / visiting the prison liaises with their medical and HCC colleagues. They must also inform the MHU at this point (via the Head of Healthcare for the prison), pending further notification that the second doctor is in agreement with the first doctor. If the first doctor is not approved under Section 12(2) of the Mental Health Act (1983), the second doctor must be approved. Where possible, the second doctor should be from a hospital able to make a bed available to the prisoner (see page 8 regarding obtaining the second doctor). If the referring medical practitioner is unsure about the appropriate level of security required for the prisoner, he can discuss the matter with the MHU (see contacts list, Appendix 4).

It is important that those co-ordinating the prisoners case keep relevant stakeholders informed as early on in the process as possible (e.g. the prisoner, Probation Officer, the Forensic Case Manager, MHU, and, if the prisoner is a drug user, the relevant single point of contact under the Drug Intervention Programme)

Emergency Second Doctor

If the prisoner appears to be mentally disordered and there is any prospect that they might require transfer to hospital as a matter of extreme urgency for treatment for a physical condition, for example, because they are refusing food or drink, a second medical practitioner (must be Section 12(2) approved) may be called in. The prison healthcare / mental health team must inform MHU Division immediately by telephone to discuss the case (see Appendix 4 for contact details).

Where assessment indicates lack of capacity to consent, an application to a Magistrates' Court for a Court Order to enforce food and fluid intake can be sought. The patient will then be treated by the local Acute Hospital Trust. Where this approach has been successful a local individual (e.g. prison PCT Clinical Governance Lead) has led the case and co-ordinated a multi-disciplinary team of PCT, prison service, Acute Trust representatives to manage the case. At no time can mental health in-patient units be expected to treat urgent food and fluid refusals, except in the situation where the food and fluid refusal is a direct result of mental illness e.g. severe depressive disorder.

Medical Reports

Each doctor must prepare a separate report, as it is not considered adequate for the opinion of one doctor to be endorsed upon the report of the other doctor. If the second doctor is of the same diagnostic opinion, both doctors will then submit their reports (usually by fax), on form HT014 (formerly the F.1305) to the MHU. If the second medical practitioner has time available they should

complete a HT014 Form. If time is not available, a non-standard report (e.g. a letter) may be accepted provided it includes information that meets the requirements of the Mental Health Act.

A completed Form HI003 (formerly the F.218), giving the prisoner's particulars, must be attached, see Appendix 2). Failure to provide prisoners' details may cause a serious delay in the transfer procedure. Reports must not be more than 2 months old and there should be no more than 2 weeks between the date of examination and the date of the report. All transfer correspondence must note whether a bed is available, if known, when the medical reports are submitted to the MHU. See pages 11-14 for details on finding a bed.

Healthcare administration staff to inform the Mental Health Unit

In order to eliminate delays, the MHU must be informed whenever a prisoner has been assessed as needing a transfer (by the first doctor) by means of a faxed copy of form HI003. Healthcare Administration staff must arrange with the Discipline Office to fax details of the previous convictions and, if available, a summary of details of the offence, court indictment, court results sheet, any pre-sentence reports and the sentencing warrant. Governors must ensure that systems are in place to ensure this is done without delay.

These details are important for the MHU as failure to forward them accompanied by any other transfer documents can cause serious delays in the transfer process. There are no Freedom of Information or Data Protection issues in giving the Mental Health Unit this information (para 4.1.4 of PSO 9020 refers to this). The administration staff must ensure that both medical practitioners complete all appropriate paperwork (see page 17) and must assist them in faxing the necessary forms to the MHU if a transfer is deemed necessary.

The Role of Head of Healthcare, Prison Mental Health Team and Regional Forensic Commissioners / Secure Services Commissioners

In the first instance the Head of Healthcare (HHC) will lead, in conjunction with the Mental Health In-reach Team, to oversee the transfer of prisoners and ensure an established structure is in place within their prison health centre to facilitate transfer. This includes providing readily available contacts who are able to advise on how to identify the responsible Primary Care Trust (see pages 11-14) and a list of approved local medical practitioners. To enable timely transfer it is advisable that the HHC or Prison Mental Health Team contact the RFCs / SSCs and their teams as soon as possible about any possible high or medium secure unit transfers.

The role of Regional Forensic and Secure Services Commissioners may slightly vary geographically depending on the role of other local colleagues (e.g. forensic case managers, PCT Mental Health Commissioners) but in general the RFCs and SSCs will advise how to identify and

establish the appropriate PCT/Responsible Commissioner. They will also know how to source and access the GP Registration system. The RFCs / SSCs / Lead Commissioner for Forensic Services (see Appendix 5) can lend support to facilitate a timely assessment by a psychiatrist if the healthcare team working in the prison encounter difficulty in doing so. They will also be able to direct cases through appropriate, local commissioning structures.

Thus, the general order of contacts that can help resolve problems with transfers is; the appropriate PCT, followed by the RFC / SSC for support and direction and, if still unresolved, the MHU.

Possible High Secure Transfer

When it is believed by the Section 12 (2) approved doctor that a prisoner is in need of treatment in a high secure hospital, the HHC or Prison Mental Health Service can arrange for a consultant psychiatrist from the appropriate high secure hospital to examine the prisoner. In some areas the NHS Mental Secure Unit (MSU) for the responsible PCT catchment area will manage referrals to High Secure Hospitals

It is important to note that commissioning arrangements for the three High Secure Hospitals (Ashworth, Broadmoor and Rampton) operate referral gate-keeping processes which, in some areas, may require initial assessment by Medium Secure Services prior to High Secure Hospital referral. It is important to clarify local commissioning arrangements for High Secure Hospitals with the Regional Lead Commissioner for the area that has responsibility for the referral.

The high secure hospitals have catchment areas. Contact your RFC / SSC if there is doubt as to the HSH appropriate to your establishment. The resulting psychiatric report must be faxed to the MHU, which will assess the security recommendation and decide whether to authorize the transfer accordingly. See page 23 for more information in high secure transfers.

Process for resolving disputes between High Secure and Medium Secure Service Providers

Occasionally there may be a difference of opinion between Medium Secure and High Secure Service providers as to the suitability of a prisoner / patient for either service. If this should occur it is important that resolution is sought quickly by following the appropriate processes in accordance with each high secure hospitals local procedure and policy. The following steps should be taken:

- Ashworth Hospital – there is one Admission Panel which is scheduled to meet on a weekly basis. The referrer must inform the High Secure Commissioner for Ashworth Hospital and the Referrals Manager / Admissions Panel Co-ordinator and request that the Appeals

Procedure be triggered; whereby the Heads of Profession sit and consider the case. Where disagreement occurs a second opinion is often sought.

- Broadmoor Hospital – All referrals must be based on an assessment by the catchment area medium secure service making a case why high security is needed. Following an assessment by Broadmoor staff the Admission Panel will take a decision whether to offer a bed or to offer other advice. If the decision of the panel not to offer a bed is disputed, the case may be referred for review by the Appeals Panel. The Appeals Panel will come to a final decision in not more than 6 weeks. Broadmoor Hospital expects medium secure units to abide by the decision of the Appeals Panel.
- Rampton Hospital – Except in exceptional circumstances all referrals must be based on an assessment by the catchment area medium secure service making a case why high security is needed. Following an assessment by Rampton staff the Admission Panel will take a decision whether to offer a bed or to offer other advice. If the decision of the panel not to offer a bed is disputed, the case may be referred for review by the Appeals Panel. The Appeals Panel will come to a final decision in not more than 6 weeks. Rampton Hospital expects medium secure units to abide by the decision of the Appeals Panel.

Problems in finding an appropriate second medical opinion

If it is not possible to arrange for the prisoner to be examined by a medical practitioner who is able to offer a hospital place it will be necessary to ask the Strategic Health Authority (in Wales, the Health Commission Wales) for the prisoner's home area to nominate a doctor. Form 1302 is provided for this purpose. It may be used as formal confirmation of a request previously made by telephone. The RFCs / SSCs may be able to help find a second medical practitioner if the HHC or Prison Mental Health Service experience difficulties finding one, or if difficulties are experienced in determining the prisoner's home SHA. Where utilizing the services of the prisoner's home SHA would cause significant time delays, i.e. due to availability/distance of the home SHA psychiatrist, it is advisable to approach the local SHA for contact details of a Section 12 approved practitioner/psychiatrist, or alternatively your RFC / SSC can advise and assist in sourcing local psychiatrists. Where issues of bed capacity and identification of specialist services is difficult RFCs / SSCs will be able to advise.

Transfer warrant valid for 14 days

On receipt of the Secretary of State's warrant directing transfer, arrangements must be made directly with the hospital named in order for the transfer to be carried out as soon as possible. The transfer direction ceases to have effect 14 days after the date it is made. If, for some reason, transfer within this time period is not possible please contact the MHU (see contacts, Appendix 4).

Order of Contacts able to assist in Transfers

Any difficulties in arranging a transfer in the first instance must be taken up with the relevant PCT (see pages 11-14). The Regional Forensic Commissioners / Secure Services Commissioner can be contacted in the case of medium and high secure unit placements, if the appropriate PCT are unable to help. Guidance and information regarding local, specific commissioning arrangements (i.e. gate-keeping, panels, hub models) can be obtained from the contact list in Appendix 5. In the case of *continued* difficulty in finding a placement, the MHU must be contacted immediately (after consulting the PCT and RFC / SSC).

Out-of-Hours Transfers

If a transfer is deemed necessary out of office hours, it is possible for the MHU to give verbal authority. This is sufficient to permit movement of the prisoner. The appropriate paperwork will be issued on the next working day. Please see contacts (Appendix 5) for the out-of-hours phone number to reach the MHU 24-hour duty officer.

7.Responsibility of the Mental Health Unit

Government considerations regarding transfers

The Secretary of State is *not obliged* to act on a recommendation made under Section 47 or 48. He/she needs to consider whether it is right and expedient in the public interest to transfer the prisoner to hospital. The factors that need to be considered in this context include:

- whether the prisoner presents such a risk that s/he should remain in prison for the protection of the public;
- whether the prisoner is so notorious that transfer could undermine public confidence;
- any expressed intentions of the court in sentencing the person to imprisonment;
- the possible effect of a pending appeal;
- whether the medical treatment required can be adequately provided in a prison;
- the length of time the prisoner still has to serve.

The MHU's prime concern is to guard against danger to the public that may ensue should a patient escape from, or be improperly allowed out of, hospital. The factors taken into account by the MHU include:

- the type and nature of the offence
- length of sentence
- notoriety
- victim issues
- previous convictions
- behaviour in prison
- any previous absconds

- prisoner's security category
- views expressed by the court
- the medical practitioners' recommendations
- the prisoner's past and current presenting symptoms (e.g. actively suicidal or assaultative)

Appropriate level of security required

In the first instance, the MHU will be advised by the Section 47 or 48 recommended transfer to ascertain the level of security required but will ultimately reach a decision on the degree of security once it has looked at all relevant information available**. This information consists of: the patient's previous convictions, details of offence, court indictment, court results sheet, pre-sentence reports, and the sentencing warrant.**

This information must be supplied to the MHU by the prison as early as possible. The MHU will reach a view on the type of hospital to which the patient can go: i.e. high secure, medium secure, low secure or a general acute ward in a local mental health hospital. This may occasionally involve brokering disputes between hospitals about the level of security required. The medical practitioners' recommendations will be assessed, but ultimately the MHUI decides the transfer security level**.** It must be stressed that the following criteria are not definitive and each case will be considered on an individual basis.

High Secure Hospitals

High secure provision for forensic mental health patients provides a treatment environment for those patients who would pose a grave and immediate danger to others if at large. Security arrangements at these hospitals are generally capable of preventing determined escape attempts and are generally equivalent to Category B prisons.

Prisoners can be considered for high security if they meet any of the following criteria;

- Charged or convicted of a grave offence, including those with sadistic or sexual motives;
- Assessed as being of an immediate danger to others if at large in the community;
- Significant capacity for co-ordination of outside help to perpetrate an escape attempt or absconding;
- Abscond from hospital; would seriously undermine confidence in the criminal justice system;
- Significant risk of subversion of staff;
- Risk predominantly to others;
- Offenders with a history of violent behaviour who cannot be managed in medium secure provision.

It should be noted that if there is a strong possibility of an escape attempt, high secure hospitals are not as equipped as the highest category prisons to prevent such an escape.

Medium Secure Units

Medium secure provision for forensic mental health service users provides a treatment environment for patients who present a serious but less immediate danger to others. Physical security with security protocols and procedures, supported by high levels of staff are sufficient to deter all but the most determined to escape or abscond.

Prisoners can be considered for medium security if they meet any of the following criteria:

- Risk predominantly to others;
- Significant capacity or risk to attempt escape or to abscond– significant previous history of non-compliance with bail/failure to attend;
- Serious but less immediate danger to the public if at large;
- Offenders with a history of violent behaviour who cannot be managed by local services;
- Past failed placements in lower levels of security;
- Repeated violent behaviour within custody or care.

Low Secure Units/Locked Wards/PICU (Psychiatric Intensive Care Unit)

Low secure provision for mental health service users provides a treatment environment for patients who present a less serious physical danger to others. Security arrangements are provided to impede rather than completely prevent those who wish to either escape or abscond. Low Secure provision will have a greater reliance on staff observation and support rather than physical security arrangements.

Prisoners are considered for placement in low security/locked wards if they meet any of the following criteria:

- Acute illness
- Mix of offending and non-offending behaviours such as challenging behaviour, self neglect, and deliberate self-harm
- History of non-violent offending behaviour
- Risk predominantly to others
- Low risk of abscond

Open wards

MHU would not normally agree to the transfer of a prisoner to an open ward. They are not usually secure and staff are often not trained in the management of patients who require forensic services. An exception to this might occur when a serving prisoner is within days of his release into the community and if the transfer was unrestricted. In addition, MHU always take into account that the person has been remanded in custody or sentenced to a term of imprisonment by the Courts and that they thought it necessary to do so for public safety.

However an open ward may be considered for prisoners with the following characteristics:

- Low or negligible risk to the public
- Low or negligible risk of abscond
- No previous offending history
- Offending very much connected with mental illness
- Co-operative behaviour in prison

It is always worth speaking to a caseworker at MHU before considering an open ward.

Re-cap on instances where staff must contact/inform the MHU

- Whenever a prisoner is identified, for transfer by the GP or Psychiatrist working in / visiting the prison (i.e. after first assessment), (fax HI003 (formally F.218) with prisoners particulars).
- After the two medical practitioners have examined the prisoner and their separate reports reach the same medical diagnosis (fax form HT014 (formally F.1305) to the MHU), with an attached HI003 noting the prisoner's particulars. If the second medical practitioner does not have access to the form HT014 then a letter containing the required information is also acceptable.
- If there is uncertainty about the appropriate hospital with regards to security levels.
- If it is a medical emergency and both medical opinions have been from medical practitioners employed by the same organisation (e.g. Prison Service, NHS Trust) one of them must be Section 12 approved.
- If the prisoner is awaiting transfer and they are moved to a different prison.
- In the case of continued difficulty in finding a bed in an appropriate health unit (i.e. after consulting with the appropriate PCT and/or RFC / SSC to no avail).

Emergency (Immediate) Transfer from prison to hospital under the *'Prison Act 1952'*

Under Section 22(2)(b) of the Prison Act 1952, the Secretary of State may direct the removal from prison to hospital of a prisoner who requires medical or surgical treatment of any description. This power is generally used for people suffering from physical ailments but it can be used for persons suffering from mental disorder. Where a prisoner is transferred to hospital under this power, it is always necessary for a prison officer escort to remain with him. It is normally only used on a short-term basis. It is for the Governor of the prison to authorise any move under the Prison Act. Under the Prison Act, the prisoner is still the responsibility of the prison when in the hospital.

The power is most commonly used in cases of mental disorder where the prisoner is very ill (e.g. fluid refusal) and a request for a transfer direction under Section 47 (or Section 48) of the Mental Health Act is under consideration but no suitable bed is available in a psychiatric unit, or a final decision has not been reached or the formalities have not yet been completed.

General Ministry of Justice; Mental Health Unit (MHU)

- For contact details please visit, http://www.homeoffice.gov.uk/about-us/organisation/directorate-search/noms/hopd/mhu
- General MHU Number: 020 7035 4848
- Only contact the MHU for those instances listed in page 25, and/or after having contacted your local RFC and PCT.

Out-of-hours contact for Transfers

- MHU Switchboard - Contact Number: 020 7035 4848 and ask for MHU Duty Officer

Welsh Contacts

- **LHBs** for all Welsh Regions, http://www.wales.nhs.uk/directory.cfm
- **HCW** – general Contact Number: 029 2080 7575

Links and Publications relating to the Mental Health Act 1983

An official, full version of the Mental Health Act (1983) is not available in electronic format. To order a copy please contact: -

The Stationery Office – http://www.the-stationary-office.co.uk/

Summary of the Mental Health Act (1983)
http://www.dh.gov.uk/PublicationsAndStatistics/Legislation/ActsAndBills/ActsAndBillsArticle/fs/en?CONTENT_ID=4015546&chk=dJbw10

Mental Health Act (1983): Code of Practice
http://www.dh.gov.uk/assetRoot/04/07/49/61/04074961.pdf

Useful webpage detailing most of the Mental Health Act (1983)
http://www.markwalton.net/guidemha/index.asp

Guidance for General Practitioners: Medical Examinations and Medical Recommendations under the Act (June 2001)
www.dh.gov.uk/assetRoot/04/05/67/58/04056758.pdf

NHS 'Responsible Commissioner' for prisoners
For clarification on the appropriate PCT
www.dh.gov.uk/assetRoot/04/03/43/43/04034343.pdf

HOWIS Welsh Health Directory

http://www.wales.nhs.uk/

Department of Health Exposition Book

Provides a full list of resource adjustments for all PCTs under the heading 'NHS funding for prisoners.'

http://www.dh.gov.uk/allocations/exposition

National Commissioning Group (NCG)

General Enquiry Number 020 7972 4772
Fax number: 020 7972 4324

Email: ncg@dh.gsi.gov.uk

DH and Welsh Assembly Government Procedure for cross-border Healthcare Commissioning between England and Wales

http://www.wales.nhs.uk/documents/WHC(2007)036.pdf

APPENDIX 1

THE TRANSFER OF YOUNG PEOPLE AGED UNDER 18 TO AND FROM HOSPITAL UNDER SECTIONS 47 AND 48 OF THE MENTAL HEALTH ACT 1983

1. This flowchart and guidance should be read in conjunction with Procedure for the Transfer of Prisoners to and from Hospital under Sections 47 and 48 of the Mental Health Act (1983) version 4.

2 **Prison Mental Health Transfers Best Practice Flow Chart for Young People**

The following flow chart is adapted from page 3 of the adult procedure and ties in with existing NCG Admission Criteria and Process Following Referral to National Secure Forensic Mental Health Services for Young People.

	Who	**Procedure**	**Experiencing Difficulties**
1	Child and Adolescent Psychiatrist working in / visiting the prison	Initial medical and risk assessment (supported by information from healthcare / prison mental health service); transfer to a hospital deemed necessary.	

	Who	**Procedure**	**Experiencing Difficulties**
2a	Healthcare admin staff responsible to HHC	Informs • responsible PCT Commissioner • MHU (faxH1003 – prisoner's details) • YJB placements section, • NSCAG • PH • YOT Supervising Officer. (details should be in clinical record)	Contact MHU for guidance to give indicative view (without access to full information such as previous convictions) of the level of security provision for in-patient.
2b	Head of Health care	Secures clearance from PCT to pay for NCG assessment or placement in independent sector Refers to NCG via local NCG unit * Second medical assessment to be provided by suitably secure unit ideally able to offer bed Where admission to a NCG centre is not appropriate or no bed is available, the PCT Commissioner should be informed and refer to appropriate independent sector provision If the Responsible Commissioner is the Health Commissioner for Wales, an additional assessment is required from the Health Commissioner for Wales's designated Child Psychiatrist before a transfer can proceed.	**Difficulty in establishing responsible PCT – see para 4.4 below.** **Difficulty in finding appropriate bed after all other options have been** exhausted – contact Responsible PCT Commissioner .
	NCG local unit	If application not accepted by NCG, advice and management plan is offered to referring prison	

Two medical reports agree diagnosis

	Who	**Procedure**	**Experiencing Difficulties**
3a	Head of HC & HC Admin	Informs • MHU (fax HT014 from each doctor and H1003) • YJB placements section • YOT Supervising Officer	
3b	Head of HC	Informs the appropriate PCT Where the young person's home psychiatrist is known they should be notified of the transfer.	
	Who	Procedure	Experiencing Difficulties

4	Head of HC	Liaises with the hospital to arrange movement of the prisoner	

	Who	**Procedure**	**Experiencing Difficulties**
5	Hospital Service Provider	*Young person returning from hospital to prison* Informs YJB Placement Section that S 117 meeting with a view to transfer back to custody is planned, provides summary of mental state, risks and aftercare needs to inform placement decision in custodial estate, invites YOT Supervising Officer to S117 meeting and provides them with summary of meeting decisions.	
	YJB Placement Section	Informs S117 meeting of the custodial unit the young people will be placed in following discharge.	
	Hospital service provider	Confirms transport arrangements back to custody after S117 meeting. Ensures discharge summary goes with young person when transferred to custody for the attention of the Head of Healthcare, Informs YJB Placement Section, YOT Supervising Officer and GP same day	

Key

Mental Health Unit, Home Office (MHU)
Primary Care Trust (PCT)
Head of Healthcare (HHC / Head of HC)
Responsible Medical Officer (RMO)
Healthcare Administration Staff (HC Admin)
National Commissioning Group (NCG)
Secure Forensic Mental Health Service for Young People (SFMHS for YP)
Youth Justice Board (YJB)

Timescales

The transfer process should usually take **no longer than 7 days**.
Keeping seriously mentally ill young people in prison is likely to have a harmful effect on their well-being as well as the well-being of fellow prisoners and prison staff.

Contact details

	Name	Phone	Fax	e-mail
MHU – Ministry of Justice	Chris Kemp	020 7035 1475	020 7035 8975	Chris.Kemp3@homeoffice.gsi.gov.uk
YJB Placements Section	Peter Minchin	020 7271 3104		Peter.Minchin@yjb.gov.uk YJBPlacements-mentalhealthtransfers@yjb.gov.uk.cjsm.net
NCG -Senior Commissioner	Sean Farran	020 7932 3954	020 7932 3800	sean.farran@ncg.nhs.uk

4. Additional notes in relation to young people

4.1 **Additional vulnerability of young people.**

The incidence of mental health disorders amongst young offenders is high, over 40 per cent according to the Children's NSF. Harrington and Bailey's study (2005) found that mental health problems go largely unidentified in secure establishments for children, are inadequately treated, and result in unnecessary and untimely crisis responses with a poor chance of effectiveness.
Offenders under the age of 18 are children by law; they are covered by child protection requirements and their parents retain some degree of responsibility for their care and upbringing. The Government's policy to transfer as quickly as possible prisoners in need of hospital treatment is particularly important for young people due to the added vulnerability associated with their youth

4.2 **Current policy on CAMHs**

"All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality, multidisciplinary mental health services to ensure effective assessment, treatment and support, for them and their families."

(Children's NSF Standard Nine, The Mental Health and Psychological Well-being of Children and Young People, DH, Sept 2004)

This standard recognises that at least 40% of young offenders have a diagnosable mental health disorder and expects that the needs of young offenders are recognised in local needs assessments and commissioning arrangements. The NSF expects that there should be a network of local services at tiers 3 and 4 for young people

with severe and challenging problems and that secure units should be part of this network. (chapter, para 9.12)

The Department of Health is committed to improving CAMHS in line with the vision set out in the Children's National Service Framework published in 2004. DH has invested heavily in improving CAMHS through targeted funding to both the NHS and Local Authorities.

4.3 Responsible Commissioner

The area in which the young person is registered with the GP determines the responsible commissioning PCT. If the young person has no GP it is the area in which the young person has his home address. If the young person has neither a GP nor home address, the commissioning PCT is the PCT for the area in which the arrest was made. Usually the local YOT will be able to identify the responsible PCT. If the young person is subject to a care order the local authority responsible for the order may be able to help identify the responsible commissioner.

4.4 Parental responsibility, looked after children, young people's views

It is good practice to involve people with parental responsibility for children and young people in all decisions about their assessment, treatment and placement.

Where a young person is looked after under a care order by the local authority that authority has parental responsibility and therefore should be involved in decision making.

The views of young people about the involvement of their parents and others with parental responsibility in their care and treatment should be taken into account.

4.6 Return of Young Person to Prison (Section 117 Meetings)

The Section 117 aftercare meeting is key to ensuring continuity of care for young people returning from hospital to prison.

Caroline Twitchett
Programme Lead Children & Young People
Prison Health, Department of Health
August 2007

APPENDIX 2 - H1003 FORM

INFORMATION ON MENTALLY DISORDERED PRISONER
RECOMMENDED FOR GUARDIANSHIP OR ADMISSION/TRANSFER TO HOSPITAL UNDER SECTIONS 47/49 OF THE MENTAL HEALTH ACT 1983

SECTION 1 – DETAILS OF PRISON

NAME: HM	**TELEPHONE NUMBER:**
FAX NO:	**CONTACT NAME:**

SECTION 2 – DETAILS OF PRISONER (please tick appropriate boxes)

SURNAME:		**FIRST NAMES:**	
ALIASES:			
PRISON NUMBER:	**DATE OF BIRTH:**	**SEX**	**M** ☐ **F** ☐
SECURITY CATEGORY: A ☐	**OTHER (please specify)** ☐	**ON THE ESCAPE LIST?**	**YES** ☐ **NO** ☐

NATIONALITY OR PLACE OF BIRTH (IF KNOWN):

ETHNIC ORIGIN:

A White

☐ **British** ☐ **Irish** ☐ **Any Other White Background (Please Specify) ……..**

B Mixed

☐ **White & Black Caribbean** ☐ **White & Black African** ☐ **White & Asian**

☐ **Any Other Mixed Background (Please Specify) ……..**

C Asian or Asian British

☐ **Indian** ☐ **Pakistani** ☐ **Bangladeshi**

☐ **Any Other Asian Background (Please Specify) …….**

D Black or Black British

☐ **Caribbean** ☐ **African** ☐ **Any Other Black Background (Please Specify) ……..**

E Chinese or Other Ethnic Group

☐ **Chinese** **Any Other (Please Specify) ……**

SECTION 3 – SENTENCED PRISONER

(a) Name of Court:
(b) Offence(s):

(c) Total sentence and order of court for each offence:
(d) Date of (i) conviction: (ii) sentence (if different):
(e) Release Dates (please complete as appropriate):
(i) Automatic Release Date (ARD):
(ii) Conditional Release Date (CRD):
(iii) Release on Temporary Licence Eligibility Date (ROTL):
(iv) Parole Eligibility Date (PED):
(v) Non-Parole Release Date (NPD):
(vi) Licence Expiry Date (LED):
(vii) Sentence Expiry Date (SED):
(viii) Lifers – Tariff Date:
(f) Details of responsible home probation service:
(g) Name of supervising probation officer:
(h) Has the prisoner lodged an appeal? YES ☐ NO ☐ **If yes, Criminal Appeal Officer Number:**

SECTION 4 – DETAILS OF DISORDER

(a) Type(s) of mental disorder from which the prisoner is suffering:
(b) Is the prisoner suicidal, or has he/she a history of suicidal tendencies? YES ☐ NO ☐ **If yes, please give details ……..**
(c) Is the prisoner dangerous to others, or has he/she a history of violence? YES ☐ NO ☐ **If yes, please give details ……..**
(d) Has the prisoner a history of alcohol/drug abuse? YES ☐ NO ☐ **If yes, please give details ……**
(e) Has the prisoner received psychiatric treatment previously? YES ☐ NO ☐ **If yes, please give details ……**

SECTION 5 – PROGRESS WITH ARRANGEMENTS FOR ADMISSION TO HOSPITAL

(a)	**Name the official address of any hospital consultant who has been approached with a view to providing a place for the prisoner** **Outcome, if known ……..**	**NAME ……..** **ADDRESS ……..** **……** **TEL NO. ……**
(b)	**Address at which prisoner was living at the time of arrest or, if unknown, the name of the police station which dealt with the case**	**ADDRESS ……** **……..** **……**
(c)	**Name and address of next of kin:**	**NAME ……** **ADDRESS ……** **……** **……**
(d)	**Place where offence was committed or, if unknown, the name of the magistrates court or police station which dealt with the case**	
(e)	**Health authority catchment area**	
(f)	**Details of hospital to which prisoner is to be transferred**	
Names and official addresses of reporting medical practitioners:		
DR……..		**DR……**
ADDRESS……		**ADDRESS……**
		Medical Officer …… **HM …… Date …….**

APPENDIX 3

Guidance Document for Healthcare Professionals entering HMPS Establishments

This guidance document is designed for members of professional bodies who are required to visit patients who are held in Her Majesty's Prisons at the request of the Prisons Health Service with a) a view to assessing prisoners who are deemed to require transfer under the Mental Health Act 1983 from prison to a mental health facility or b) to prepare medico-legal reports on behalf of the defence, CPS, or court. These may include professions such as Psychiatrists, GP's, Registered Mental Health Nurses, Approved Social Workers etc.

Issue

The Royal College of Psychiatrists (RCP) have identified issues where staff requiring to see a patient held within a prison have been refused entry until they have produced a number of pieces of identification. This has resulted in patients who require immediate attention being disadvantaged.

Solution

Below is a guidance flow chart that should be followed to allow reasonable time for Healthcare professionals to gain access to patients.

1. Contact establishment and speak to the head of the department (Healthcare) you need to visit

2. Explain the reason you need to visit

3. Give the name and number (if you have it) of the Prisoner you wish to visit

4. Describe the nature and reason for any facilities, access to clinical information and access to those supporting the individual in the prison that you require to aid your visit and assessment, together with an estimate of the time you expect to need for the consultation. If you need to bring a laptop computer or other electronic equiptment into the prison for the consultation you should discuss this with the prison at the time of booking the visit.

5. Arrange a mutually agreeable date and time. It should be noted that in most prisons staffing levels do not permit consultations to take place over the lunchtime period. However, some local prisons will, at the discretion of the Governor, allow official visits to take place during the evenings in urgent cases.

6. Arrange to be met at the gate at the allocated date and time

7. Check with the head of department that you have the correct acceptable photo I.D.

On arrival at the prison you will you will normally be required to produce a recognized photographic identity document in the form of a photo driving licence, valid passport or photographic identity card issued by your employer. The latter will need to bear the name of the issuing authority.

8. Even when you are expected security procedures may take a little time to complete, especially at busy periods. Please arrive allowing plenty of time for these procedures to be completed. Mobile phones are not allowed in prisons, nor are laptop computers except by prior arrangement (see above). As a general rule, the less you carry with you, the quicker the security procedures will be completed.

9. You should be afforded the same facilities as legal representatives, namely that the interview or consultation will take place within sight but out of hearing of a member of staff.

10. The Governor is responsible for the safety of staff, prisoners and visitors to the establishment. In exceptional circumstances he/she may refuse or terminate the interview or consultation if he / she feels this is necessary for your safety. His / her decision in this respect is final.

In order to complete comprehensive assessments of need these procedures will support Third Party staff to gain robust access to patients and clinical information.

APPENDIX 4 – MHU Contact List

MINISTRY OF JUSTICE MENTAL HEALTH UNIT - CONTACT LIST

The telephone list is updated monthly; the latest version is on the MHU website

Address: Ministry of Justice, 2nd Floor, Fry Building, 2 Marsham Street, London SW1P 4DF

Tel: 020 7035 plus extension number below or Switchboard 020 7035 4848

Fax: A = 020 7035 8974 B = 020 7035 8978 C = 020 7035 8975 D = 020 7035 8979

Email: public enquiry.mhu@homeoffice.gsi.gov.uk

- Patients are allocated to our staff according to the first letter of the patient's surname.
- If you have difficulty, please ring the Ministry of Justice switchboard and ask for the Mental Health Unit, quoting the patient's surname. The Switchboard should also be contacted in cases of emergency outside normal office hours.

Caseworkers (EO) – for s47 transfer of sentenced prisoners and general casework enquiries

Patient surname	Allocated to	Tel 020 7035 ….	Fax	Line Manager
A - Au	Vidia Narayan-Beddoes	1489	C	Jacqui Woodward-Smith
Av - Bev	Debbie Clarkson	1491	C	"
Bew – Buch	John Griffin	1481	C	"
Buci - Clare	Christina Clark	1513	C	"
Clarf - Cun	Lissa McDonald	1456	B	Mike Turner
Cuo - Dunk	Burty Valydon	1454	B	"
Dunl - Fk	Mel Flint	1453	B	"
Fl - Gooda	Mary Robinson	1488	B	"
Goodb - Han	Claire Ratcliff	1507	B	Jane Stearman
Hao - Hog	Sylvia Williams	1511	B	"
Hoh - Ja	Philip Drummond	1499	B	"
Jb - Khai	Katherine Hutchins	1487	B	"
Khaj - Lib	Sara Nall T/P	1490	D	Lyndel Grover
Lic - Mar	Fiona Mcghie	1502	D	"
Mas – Miller C	Sophia Mir	1464	D	"
Miller D - Ne	Christian Secondis	1467	D	"
Nf - Patte	Martine Green	1510	A	Geraldine Marsh
Pattf - Rat	Sarah Conroy	1509	A	"
Rau – Ryan K	Matt Picot	1457	A	"
Ryan L - Sl	Patrick O'Dwyer	1473	A	"
Sm - Swa	Kerry Dougan T/P	1468	A	Ros Arnold
Swb - Varl	Nicola Jeffrey	1472	A	"
Varm - Wild	Pat Dunwell	1506	A	"
Wile - Z	Stephen Lott	1485	A	"

Casework team leader (HEO) – for s48 transfer of remand prisoners

Patient surname	Allocated to	Tel 020 7035 ….	Fax	Line Manager
A – Clare	Jacqui Woodward-Smith	1504	C	Alison Gallagher
Clarf – Gooda	Mike Turner T/P	1458	B	"
Goodb – Khai	Jane Stearman T/P	1498	C	Greg Nanda
Khaj – Ne	Lyndel Grover	1463	C	"
Nf – Sl	Geraldine Marsh	1514	A	Matt Bullard
Sm – Z	Ros Arnold	1471	A	"

Senior Caseworker (SEO) – responsible overall for detained patients

Patient surname	Allocated to	Tel 020 7035 ….	Fax	Line Manager
A - Gooda	Alison Gallagher	1493	B	vacant (A – Clare) Bernard Bennet-Diver (Clarf–Gooda)
Goodb - Ne	Greg Nanda	1486	C	Sarah Denvir (Goodb – Khai) Chris Kemp (Khaj – Ne)
Nf - Z	Matt Bullard	1450	A	Lindsay McKean (Nf – Sl) Richard Westlake (Sm – Z)

Casework Manager (Grade 7) – responsible overall for conditionally discharged patients, including recalls

Patient surname	Allocated to	Tel 020 7035 ….	Fax	Line Manager
A - Clare	vacant	1505	C	Heads of Unit
Clarf - Gooda	Bernard Bennet-Diver	1494	B	"
Goodb - Khai	Sarah Denvir	1496	C	"
Khaj - Ne	Chris Kemp	1475	C	"
Nf - Sl	Lindsay McKean	1462	A	"
Sm - Z	Richard Westlake	1474	A	"

Casework support (AO)

Patient surname	Allocated to	Tel 020 7035 ….	Fax	Line Manager
A - Bev	Toby Hamilton	1512	B	Vidia Narayan-Beddoes
Bew - Clare	Christopher Eseigbe	1466	B	Christina Clark
Clarf - Dunk	Graham Copeland	1451	B	Lissa McDonald
Dunl - Gooda	Elizabeth Bamigboye	1452	B	Mel Flint
Goodb - Hog	Ravi Sond	1461	B	Claire Ratcliff
Hoh - Khai	Stuart Foreman*	1503	B	Philip Drummond
Khaj - Mar	Verna Beckford	1492	D	Mike Turner
Mas - Ne	Bunmi Oyewunmi*	1465	D	Sophia Mir
Nf - Rat	Matt Noise	1508	A	Matt Picot
Rau - Sl	Sarah Lemon	1459	A	Geraldine Marsh
Sm - Varl	Godfrey Oswald*	1469	A	Jane Stearman
Varm - Z	Bernadette Child	1497	A	Stephen Lott

Casework administration (AA)

Patient surname	Allocated to	Tel 020 7035 ….	Fax	Line Manager
A - Cres	Joanna Wong	1501	C	Debbie Mortimore
Cret - Henr	Rebecca Doran (Mon – Wed) / Faisal Rafique (Thurs – Fri)	1715/1460	B	Burty Valydon
Hens - McGo	Stephen Curtis	1495	C	Sylvia Williams
McGp - Sand	Graham Shuter	1455	A	Matt Picot
Sane - Z	Richard Elcome	1470	A	Nicola Jeffrey

Management Team

Title / Grade	Name	Tel 020 7035 ….	Fax	Line Manager
Grade 6	James Toon	1481	D	Heads of Unit
SEO	Nigel Battson	1482	D	James Toon
EO	Linda Doran (Mon – Wed)	1484	D	Nigel Battson
AO	Richard Webb	1484	D	Linda Doran

Mental Health Bill Team & Head of Casework

Title / Grade	Name	Tel 020 7035 ….	Fax	Line Manager
Grade 6 Bill lead & Head of Casework	Nigel Shackleford	1479	D	Heads of Unit
Grade 7	Julian Gibbs	1476	D	Nigel Shackleford
EO	Naomi Hawdon	1477	D	Julian Gibbs

Heads of Unit

Title / Grade	Name	Tel 020 7035 ….	Fax
Head of Unit (SCS)	Elizabeth Moody (Mon–Wed)/ Penny Snow (Wed – Fri)	1478 4974	D
PA	Karol Groom	1483	D

Policy Responsibilities (contact details above)

Allocated to	Policy responsibilities
vacant	Liaison with Mental Health Review Tribunal; Treasury Solicitors; Risk assessment/Risk management; Conditional Discharge and supervision in the community; Recall. Liaison with hospitals and prisons in the South Western and West Midlands Forensic Commissioning Areas, and Wales
Bernard Bennet-Diver	Liaison with Voluntary sector; Independent sector hospitals; CP(I) and insanity; Lifers, including technical lifers; BME; Patients' rights and privileges. Liaison with hospitals and prisons within the Northern & Eastern Forensic Commissioning Areas
Sarah Denvir	Liaison with Social Workers and Institute of Psychiatry Forensic Teaching Unit. Women's services; Research; Leave; Training and Development. Liaison with hospitals and prisons within the South Eastern Forensic Commissioning Area
Chris Kemp	Liaison with Probation, MAPPA; Prisons (including prison transfers); Victims; Dangerous Offenders;

	Children and Adolescents; On-Call rota; time-limited s37/41s. Liaison with hospitals and prisons within the London Forensic Commissioning Area (SW / SE / NW)
Lindsay McKean	Liaison with Police, Security Services, CPS, Courts. Sentencing; Commissioning; Terrorism; Comms. Liaison with hospitals and prisons within the North West Forensic Commissioning Area
Richard Westlake	Liaison with Immigration Nationality Directorate; Immigration Service (including foreign nationals). High secure hospitals; Capacity planning; Freedom of Information; Data Protection. Liaison with hospitals and prisons within the Yorkshire & East Midlands Forensic Commissioning Area
James Toon	Management Team; Performance Management; Strategy and Business Planning, Casework organisation, Finance, E-caseworking. Liaison with hospitals and prisons within the London Forensic Commissioning Area (NE and N Central)

* Agency staff

APPENDIX 5

REGIONAL FORENSIC COMMISSIONERS LIST

Regional Forensic Commissioners (RFCs) / Secure Services Commissioners (SSCs)

Can advise appropriate PCT and associated services, finding doctors etc for high and medium secure units.

(Names of those in post as of June 2007 are provided below, these are subject to change)

Region	*Lead Commissioner*	*Contact Number/E.mail*	*Regional Case Manager/Worker*	*Contact Number*
Eastern	Carole Theobald	Carole.theobald@erscg.nhs.uk 01371 877242 07977 437368	Owen Fry	01371 877243 07770 644894
North West Regional Development Team: 01257 248625			Tony Barrett	01925 406052
Head of High Secure Commissioning for North West Region:	Carole Jobbins	Carole.jobbins@nwsct.nhs.uk 01925 406013	Alison Cannon	01925 406013
		Cumbria and Lancashire Specialized Services Commissioning Team	Mick Booth	01925 406141
West Midlands	MaryAnn Doyle	Mary ann.doyle@wmssa.nhs.uk 0121 6952527	Mike Young: Covers Wolverhampton, Walsall, Sandwell, Dudley, Solihull, Shropshire, North Staffs	0121 6952276
			Graham Butler: Covers Warwickshire, Worchester, South Staffs, Hertfordshire, Coventry	0121 6952276
			Becky Hipkins: Covers Shropshire, Staffordshire Phil Walsh	0121 6952276 0121 6952276
South West	Wendy Searle West of England LSSCG	wsearle@nhs.net 0117 3302594 07867 807609	Patrick Neville: Forensic Clinical Case Manager West of England LSSCG Fromeside Covers: Avon, Gloucestershire, Somerset and Wiltshire PCTs There is no case management for medium secure patients for Dorset currently. Wendy Searle to be contacted for specific issues. High Secure Dorset currently Phil Holder South Central see below	0117 3784114
South West	Sandra Miles covering Devon and Cornwall	Sandra.miles@CIOSPCT.cornwall.nhs.uk 01726 627879 07966 678621	Andy Jones Covers: Devon and Cornwall PCT's	01626 884508
East Midlands & S Yorkshire	Lee Brammer	lee.brammer@lcrpct.nhs.uk 0116 2957461 07876 740344	Kieran Preston	0116 2957641
South Central	Mark Satchell South Central SCG	Mark.satchell@southcentral.nhs.uk 02380 725551 07900 214107	Phil Holder Covers: Hants and Isle of Wight and Dorset	02380 725549 0788 4490324
			Vanessa Odlin Covers: Berks, Oxford and Bucks	01865 223464

South East Coast	Jo Scott South East Coast SCG	Jo.scott@aaw.nhs.uk 01903 707467 07876 390456	Denise Cuddy	01622 723151 07919 113852
Yorkshire	Ged McCann	ged.mccann@sypct.nhs.uk 01904 724004	Louise Davies	01924 327454
			Andrea Pounder	01482 336197
Northern	Jim Ennis	jim.ennis@tney.northy.nhs.uk 01642 853571 07771 866995	Shaun Brannegan: St Nicholas Hospital	0191 2232868 07798 925880
			Gary Womack: St Lukes Hospital	01642 283370 07775 764374
			Graham English: Northgate Hospital	01670 394000
Wales	Susan Thompson	02920 807573		
London	Alison Armstrong	Alison.armstrong@nwlondon.nhs.uk or Alison.armstrong@londonscg.nhs.uk 0207 7167025	Janet Alldred North London Forensic Service	0208 375 2700 janet.alldred@beh-mht.nhs.uk
			Andy Weir West London Forensic Service	020 8354 8150 andy.weir@wlmht.nhs.uk
			Leanne McGee East London & the City Forensic Service	Leanne.mcgee@elcmht.nhs.uk 0208 919 8562
			John Enser Service Director South East London Forensic Services	01322 294 300
			Alison Hooper Service Director South West London Forensic Services	0208 682 6067

Appendix 6

Prison Service Area Offices

AREA	AREA MANAGER	ESTABLISHMENTS
HIGH SECURITY ESTATE Room 512 Cleland House, Page St, London, SW1P 4LN Tel: 020 7217 2888	Director Steve Wagstaffe	High Security Estate
NORTH EAST AREA OFFICE 2 Artemis Court St Johns Road Meadowfield Durham DH7 8XQ Tel: 0191 378 6000 Fax: 0191 378 6001	Phil Copple	Acklington, Castington Deerbolt, Durham Holme House, Kirklevington Low Newton (F)
NORTH WEST AREA OFFICE Stirling House Ackhurst Business Park Foxhole Road Chorley PR7 1NY Tel: 01257 248600 Fax: 01257 248604	D I Lockwood CBE (Ian)	Buckley Hall (F), Garth Haverigg, Hindley Kirkham, Lancaster Castle Lancaster Farms, Liverpool Preston, Risley Styal (F), Thorn Cross Wymott
YORKSHIRE AND HUMBERSIDE AREA OFFICE Marston House Audby Lane Wetherby West Yorkshire LS22 7FD Tel: 01937 544500 Fax: 01937 544501	Tony Hassall	Askham Grange (F), Everthorpe Hull, Leeds Lindholme, Moorland Closed Moorland Open, New Hall (F) Northallerton, Wealstun Wetherby (J)
WALES OPERATIONAL OFFICE 102 Maryport Street Usk, Monmouthshire Gwent NP15 1AH Telephone: 01291 674850 Fax: 01291 674865	Geoff Hughes	Cardiff Swansea Usk/Prescoed

WEST MIDLANDS AREA OFFICE PO Box 458 HMP Shrewsbury The Dana Shrewsbury Shropshire SY1 2WB Telephone: 01743 284542 Fax: 01743 284551/3	Sue McAllister	Birmingham, Blakenhurst Brinsford, Brockhill (F) Drake Hall (F), Featherstone Hewell Grange, Shrewsbury Stafford, Stoke Heath Swinfen Hall, Werrington (J)
EAST MIDLANDS AREA OFFICE Empriss House Unit C Harcourt Way Meridian Business Park Leicester. LE19 1WP Tel: 0116 281 4000 Fax: 0116 281 4060 (1st Floor)	Danny McAllister	Ashwell, Foston Hall (F) Gartree, Glen Parva Leicester, Lincoln Morton Hall (F), North Sea Camp Nottingham, Onley Ranby, Stocken Sudbury, Wellingborough Whatton
EASTERN AREA OFFICE Drayton Old Lodge 146 Drayton High Road Drayton NORWICH NR8 6AN Tel: 01603 264100 Fax: 01603 264111	Adrian Smith	Bedford, Blundeston Bullwood Hall (F), Chelmsford Edmunds Hill (F), Highpoint Hollesley Bay, Littlehey The Mount, Norwich Warren Hill (J), Wayland
SOUTH WEST AREA OFFICE 1 Tortworth Road Leyhill Wotton Under Edge Gloucestershire GL12 8BQ Tel: 01454 264053 Fax: 01454 264065	Alan Scott	Bristol, Channings Wood Dartmoor, Dorchester Eastwood Park (F), Erlestoke Exeter, Gloucester Guys Marsh, Leyhill Portland, Shepton Mallet The Verne

SOUTH CENTRAL AREA OFFICE Second Floor White Rose Court Oriental Road Woking Surrey, GU22 7PJ Tel: 01483 716600 Fax: 01483 716612 The Old Warden's House 21 Bierton Road AYLESBURY, HP20 1EN **NB**: Please note that correspondence for the Area Manager should be sent to the Woking office	Colin McConnell	Albany, Aylesbury Bullingdon, Camp Hill Coldingley, Downview (F) Grendon/Springhill, Haslar High Down, Huntercombe (J) Kingston, Parkhurst Reading, Send (F) Winchester
LONDON AREA OFFICE Room 726 Cleland House Tel: 020 7217 6180 Fax 020 7217 2893	Nick Pascoe	Brixton, Feltham Holloway (F), Latchmere House Pentonville, Wandsworth Wormwood Scrubs
KENT & SUSSEX AREA OFFICE 80 Sir Evelyn Road Rochester Kent ME1 3NF Tel: 01634 673000 Fax: 01634 673048	Paul Carroll	Blantyre House, Canterbury Cookham Wood (F), Dover East Sutton Park (F), Elmley Ford, Lewes Maidstone, Rochester Standford Hill, Swaleside

Appendix 7

HM PRISON SERVICE

Public Sector Prisons

Prison Service Instruction

Number

50/2007

TITLE	**TRANSFER OF PRISONERS TO AND FROM HOSPITAL UNDER SECTIONS 47 AND 48 OF THE MENTAL HEALTH ACT 1983**
PROCESS	Mental Health Act 1983
IMPLEMENTATION DATE	7 December 2007
EXPIRY DATE	6 December 2008

CONTAINS MANDATORY INSTRUCTIONS

For Action

Governing Governors
Directors of Contracted Prisons
Heads of Health Care

Monitored by

Area Managers
Directorate of Offender Health
Strategic Health Authorities

Issued 3/12/07

For Information

Prison Mental Health In-Reach Teams
Reception staff, custody office staff and all prison staff having contact with prisoners

On authority of

Prison Service Management Board
Office of Contracted Prisons

Contact Point

PCT Mental Health Commissioners
Regional Forensic Commissioners
Home Office Mental Health Unit

Contact Details at Appendices 4, 5 and 6 of the Procedure Document

Other Processes Affected

None

NOTES

This PSI replaces PSI 03/2006 which is now revoked

TRANSFER OF PRISONERS TO AND FROM HOSPITAL UNDER SECTIONS 47 AND 48 OF THE MENTAL HEALTH ACT 1983

Policy and Output

Purpose

This PSI introduces a revised joint Home Office/Department of Health Procedure for the transfer of prisoners to and from hospital under Sections 47 and 48 of the Mental Health Act. It sets out mandatory requirements for establishments regarding the identification and transfer of prisoners and explains the procedures to be followed by the other agencies involved in the process.

Output

2. Prisoners who may need treatment in hospital under Sections 47 or 48 of the Mental Health Act are identified and the appropriate referrals made.

3. Where the Secretary of State directs a transfer to or from hospital, the transfer is implemented in accordance with the direction (which is valid for 14 days).

Impact and Resource Assessment

4. There should not be any additional work or resource implications as appropriate procedures should already be in place.

Mandatory Action

5. Support from Governors to ensure that healthcare, reception and custody office staff are aware of, and comply with, the attached procedure. In particular :-

- *The Head of Healthcare (HHC) at the prison, in conjunction with the Prison Mental Health Team, must ensure that prisoners who may need treatment in hospital are identified as soon as possible (section 9 of the Procedure)*

- *If the prisoner appears to be mentally disordered and there is any prospect that they might require transfer to hospital as a matter of extreme urgency for treatment for a physical condition, for example, because they are refusing food or drink, a second medical practitioner must be called in. (see section 16 of the Procedure). One of the medical practitioners must be Section 12 (2) approved.*

- *The prison healthcare / mental health team must inform MHU Division immediately by telephone to discuss the case (see Paragraph 7 of the Procedure for further details). If a second doctor is not available quickly, for example during the night, the prison should call MHU for advice without waiting for the second doctor. (Out of Hours Contact Number: 0207 035 4848 and ask for MHU Duty Officer)*

- *Each doctor must prepare a separate report, as it is not considered adequate for the opinion of one doctor to be endorsed upon the report of the other doctor (section 17 of the Procedure).*

- *A completed Form HI003 (formerly the F.218), giving the prisoner's particulars, must be attached (this information is available from the Healthcare administration staff). Failure to provide prisoners' details will cause a serious delay in the transfer procedure. Reports must be not more than 2 months old. Doctors are expected to*

complete the report no more than 2 weeks after the date of examination. (section 17 of the Procedure).

- *In order to eliminate delays, the MHU must be informed whenever a prisoner has been assessed as needing a transfer (by the first doctor) by means of a faxed copy of form HI003. Healthcare Administration staff must arrange with the Discipline Office to fax details of the previous convictions and, if available, a summary of details of the offence, court indictment, court results sheet, any pre-sentence reports and the sentencing warrant (section 18 of the Procedure). Governors must ensure that systems are in place to ensure this is done without delay.The prisoners Responsible PCT Commissioner will also need to be informed at this time.*

- *In the first instance the Head of Healthcare (HHC) will lead, in conjunction with the Mental Health In-reach Team, to oversee the transfer of prisoners and ensure an established structure is in place within their prison health - centre to facilitate transfer; this includes providing readily available contacts able to advise how to identify the responsible Primary Care Trust (see paragraph 6 of the Procedure) and a list of approved local medical practitioners (section 19 of the Procedure).*

- *On receipt of the Secretary of State's warrant directing transfer, the prison must make arrangements directly with the hospital named in order for the transfer to be carried out as soon as possible. <u>The transfer direction ceases to have effect 14 days after the date it is made</u>.*

6. *The prison Healthcare Centre / Head of Healthcare must contact the MHU in all the following instances :-*

   - *Whenever a prisoner is identified, by a G.P. or Psychiatrist working in / visiting the prison (i.e. after first assessment), for transfer (fax HI003 (formally F.218) with prisoners particulars).*
   - *After the two medical practitioners have examined the prisoner and their separate reports reach the same medical diagnosis fax form HT014 (formally F.1305) to the MHU, with an attached HI003 (formally F.218) noting the prisoner's particulars. If the second medical practitioner does not have access to the form HT014 then a letter containing the required information is also acceptable.*
   - *If there is uncertainty about the appropriate hospital with regards to security levels.*
   - *If it is a medical emergency and both medical opinions have been from medical practitioners employed by the same organisation (e.g. Prison Service, NHS Trust) one of them must be section 12 approved.*
   - *If the prisoner is awaiting transfer and they are moved to a different prison. Any such transfers should only be undertaken in consultation with both the Establishments healthcare and mental health in-reach staff.*
   - *In the case of continued difficulty in finding a bed in an appropriate health unit (i.e. after consulting with the appropriate PCT and/or RFC / SSC to no avail).*

<u>Custody Office procedures</u>

7. The Mental Health Unit will require information from the prisoner's custodial records on form H1003, details of previous convictions, the index offence or alleged offence, court indictment, court results sheet, pre-sentence reports, and sentencing warrants, as applicable. It is best practice to designate a single point of contact in the healthcare centre for the establishment's dealings with MHU. There are no data protection issues which prevent custody office staff from passing this information to healthcare staff for these purposes.

Monitoring

8. The Prison Traffic Light system records the numbers of prisoners waiting transfer to hospital under the MHA. This data is monitored by Area Managers, Directorate of Offender Health, and Strategic Health Authorities.

Advice, Information and Contact Points

9. See Appendices 4, 5 and 6 of the Procedure.

Richard Bradshaw
Director of Prison Health

Phil Wheatley
Director General