

NHS GG&C Mental Health Service Adult Mental Health & Forensic Services Shared Guidance and Specification for Interface Working.

Important Note:

The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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Revision/Amendment Information

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author(s)

1. SLWG Membership

This guidance was developed following a number of meetings between clinicians working within Forensic Mental Health & Learning Disabilities, Adult Mental Health and Rehabilitation. A full membership list can be found in Appendix 1.

2. Introduction and Background

This guidance has been developed to delineate the interface between forensic mental health services, managed by the Directorate of Forensic Mental Health and Learning Disabilities (DFMHL), and Adult Mental Health (AMH) services in NHS GG&C.

This protocol does not cover interface issues with Alcohol and Drug Recovery Services (ADRS), learning disability or Older People's Mental Health, although some of the principles outlined here may be useful when discussing individual cases.

The main interface for forensic mental health and core mental health services are as follows:

Table 1: Areas of interface

Forensic	AMH Services	Other
FCMHT	CMHT	Court Diversion
Leverdale low secure	Unscheduled care services (Formerly Crisis, HTT and OOH CPN Service)	MAPPA
Rowanbank medium secure	Adult acute admission wards	Prison health care (primary care)
	Psychiatric Intensive Care Units (IPCU)	
	Rehabilitation in-patients wards	
	Hospital Based complex care	

Structure of Forensic Mental Health Services

The Directorate of Forensic Mental Health and Learning Disabilities (DFMHLD) is a specialist mental health service. Although closely aligned with adult mental health services (predominantly hosted within Glasgow HSCP), the Directorate management and reporting structures are through Acute Regional services.

The DFMHLD provides services to adults aged 18 and over at a local, regional and national level. As well as providing specialist forensic services across NHS GGC, Rowanbank Clinic is the regional medium secure unit for the West of Scotland (WoS) and also hosts the National Medium Secure Learning Disability service (funded through National Services Directorate).

The forensic mental health service is spread across multiple sites as per Table 2:

Table 2: Forensic services in NHS GGC

Rowanbank Clinic	Medium Secure Unit (Regional unit for West of Scotland, WoS)	74 beds <ul style="list-style-type: none"> • Male Mental illness WoS <ul style="list-style-type: none"> ○ Acute admissions ○ Rehabilitation service • 6 Female mental illness (NHS GGC) • 4 female LD (National / NSD funded) • 8 male LD (National / NSD funded)
Leverndale Hospital	Low security NHSGGC	53 Beds <ul style="list-style-type: none"> • 30 Ward 5&6 (Male MI) • 9 Boulevard (Male pre-discharge) • 9 Campsie (Male Learning Disability) • 5 Bute (Female low security)
Douglas Inch Centre / Clutha House	Community Forensic Services NHSGGC	<ul style="list-style-type: none"> • Glasgow FCMHT • Clyde FCMHT • Forensic Community LD Team (FCLDT) • STAR (psychology led service)

Medium secure provision is regional and is partly funded by NHS Ayrshire & Arran, NHS Dumfries & Galloway, NHS Lanarkshire and NHS Highland (covering old Argyll & Clyde area). Therefore, the male mental illness service at Rowanbank accepts referrals for patients from all West of Scotland health boards and must ensure equity of access to all areas.

The medium secure Learning Disability service is funded by National Services Directorate (NSD) and is a national service, accepting referrals for patients from across Scotland. A clinical co-ordinating group ensures equal access for all areas.

The forensic service is a tertiary service and therefore does not routinely accept referrals directly from primary care, nor does the service routinely accept admissions out of hours.

The **low secure** service at Leverndale provides low secure forensic care to patients from NHS Greater Glasgow & Clyde. Out of area, referrals are only accepted in exceptional circumstances if there is spare capacity and / or for patients where it is agreed they cannot return to their local health board area.

There are two **Forensic Community Mental Health Teams (FCMHT)** to cover Clyde and Glasgow areas respectively, and a **Forensic Community Learning Disability Team** that covers

both. The Clyde Forensic CMHT also covers areas of NHS Highland that were part of the original Argyll and Clyde area (i.e. Argyll and Bute).

Forensic services mainly manage patients who are detained under mental health legislation, and a large number on the case-load are Restricted Patients. Due to the complexities of managing this population, case-loads tend to be smaller and teams offer more assertive input.

Referral Criteria

Information on referrals to NHS GGC forensic services can be found on the Staffnet Mental Health guidelines page: [MHS 11 Forensic Referral Guide](#):

- Patients accepted to forensic services will have a diagnosis of mental disorder and/or learning disability.
- Patients must be viewed as presenting a risk of serious harm to others due to the mental disorder.
- If a patient is being considered for inpatient care, he or she must be liable to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedure (Scotland) Act 1995.
- Patients with a sole diagnosis of personality disorder are generally not considered appropriate for inpatient admission or community team case management.

The Forensic Network publication [Guidance on Patient Referral to or between Scottish High and Medium Secure Services](#) offers further information to assist decisions regarding appropriate level of security:

Risk

Forensic mental health services in Glasgow have evolved and developed to provide ongoing support for individuals diagnosed with severe and enduring mental illness / learning disability and who have offended, whose behaviour may lead to offending and/or may put others at risk. When considering the need for risk management by forensic mental health services, there should be **a correlation between mental disorder and the behaviour to others that causes concern**.

This may be distinct from the risk of general offending / aggression that is not linked to mental disorder, and which is not the remit of health services. Offending behaviour *per se* is dealt with by the police and criminal justice services and should not, of itself, lead to a referral to forensic mental health services.

Court Diversion Scheme

The Forensic Directorate, primarily through the Forensic Community Psychiatric Nurses, supports a court liaison scheme covering four sheriff courts in NHS GGC (Glasgow, Paisley, Greenock and Dumbarton). There is a Higher Trainee rota (mainly General Adult and Forensic) who undertake medical assessments when diversion from custody, and detention under mental health legislation, may be indicated. The majority of individuals, charged with lower tariff offences, can be managed in AMH services. A small minority may require ongoing specialist forensic mental health advice or input.

Those charged with more serious offences, who may require transfer to medium or high security, are usually remanded to allow formal psychiatric assessments to be completed and referrals made to the appropriate level of security.

An outline of the SOP for the court service is included at [Appendix 2](#).

Prison Healthcare

Prison healthcare is managed by **Glasgow HSCP primary care services**. There are four prisons in the NHS GGC; HMP Barlinnie, HMP Low Moss, HMP Greenock and HMP Lillias.

Specialist mental health services are provided and each prison has access to a mental health team and addiction services. The mental health team usually comprises of mental health nurses based in the prison, alongside some psychology support. Prisoners can self-refer and will be assessed by a mental health nurse. Following an initial assessment by prison mental health nurses, prisoners can be listed to see a visiting psychiatrist. In NHS GGC, the visiting psychiatrist is provided by DFMHLD on a sessional basis. The visiting psychiatrist will assess and treat patients in prison. They will also make referrals for those who require in-patient care. Those attending the prison clinic have often been seen previously in adult mental health and addiction services. Few have had previous or ongoing contact with forensic mental health services.

MAPPA

The Multi-Agency Public Protection Arrangements (MAPPA), are a set of statutory partnership working arrangements introduced in 2007 by virtue of [Sections 10 and 11 of The Management of Offenders etc. \(Scotland\) Act 2005](#) (the 2005 Act). The 2005 Act places a statutory duty on the responsible authorities in a local authority area to jointly establish arrangements for assessing and managing the risk posed by certain categories of offenders. The responsible authorities are police, health, local authorities and Scottish Prison Service.

Health boards are a responsible authority in relation to the assessment and management of mentally disordered offenders and **restricted patients** who meet the criteria in section 10(1) of the 2005 Act. The Forensic Community service manager is Chair of MAPPA for Restricted patient health cases in NHS GG&C.

The Health Board also has a duty to co-operate with other responsible authorities who manage violent offenders and sex offenders. The MAPPA health single point of contact (Duty to Co-Operate) in NHS GG&C is managed through the Forensic Directorate. The DFMHLD also acts on behalf of the Board in fulfilling its role as a responsible authority. This involves senior managers representing the board on both operational and strategic MAPPA forums.

3. Scope

3.1 This policy applies to all staff working within the Directorate of Forensic Mental Health and Learning Disabilities (DFMHLD), Adult Mental Health Services and Rehabilitation Psychiatry in NHS GGC.

3.2 Patients referred to forensic psychiatric services should be 18 years and older. Those under the age of 18 should be referred to Forensic CAMHS services.

4. Roles and Responsibilities

4.1 Admission of FCMHT / FCLDT patient to General Adult services

The Forensic Directorate aim to admit patients who are case managed by the forensic community team to a forensic bed. However, due to the limited availability of low secure beds, and length of stay of patients in those beds, this is not always possible in a crisis and for that reason patients may be admitted to Adult Mental Health acute admission wards or IPCU, depending on the level and type of risk.

All FCMHT patients have a Risk Management Traffic light plan, outlining relapse indicators and actions that should be taken to manage risk. Risk Management Traffic Light plans are included in Enhanced CPA documents. Currently these can be accessed 24 hours a day by contacting the nurse page holder at Rowanbank Clinic (0141 232 6400). They should also be available on EMIS.

If the patient does not require a locked ward, or a secure forensic bed is not available, the FCMHT may request a locality open general adult bed / IPCU bed. The bed would be requested based on the individual's home address through liaison with the locality bed manager.

The Forensic CMHT would expect to be closely involved in any admission of a patient case-managed by forensic services. The Forensic Consultant will discuss at an early stage (and when possible before the admission) with the receiving General Adult Consultant to agree on the aims of the admission.

There will be ongoing liaison between the FCMHT and the general adult in-patient team as set out in Table 3.

Table 3: Responsibilities managing FCMHT patients in general adult settings

	Forensic service / Forensic Consultant (RMO or on-call)	General adult service / Consultant GA Psychiatrist
On admission	<ul style="list-style-type: none"> • Provide rationale for admission / involved in decision to admit. • Provide access to: <ul style="list-style-type: none"> ○ most recent enhanced CPA minutes & care plan. ○ Current structured clinical judgement (SCJ) risk assessment e.g. HCR-20. • Available to discuss and consult on management plan. 	<ul style="list-style-type: none"> ▪ Admit under care of General Adult Consultant who acts as RMO for duration of admission. ▪ Admission assessment by duty doctor / ward staff ▪ CRAFT risk assessment and risk management plan as per NHS GGC guidelines ▪ Agree observation level and free time (Forensic consultant available to discuss any aspects of management at all times)
1 st working day	<p>FCMHT RMO and CPN to make contact with in-patient team to share additional info & arrange to review patient on ward at earliest opportunity. Clarify who is link FCPN and forensic consultant.</p>	<p>As per Adult Acute Inpatient pathway. Liaise with Forensic RMO/ FCPN to arrange attendance at MDT</p> <p>Review CRAFT within 72 hours of admission.</p>
1 st MDT	<p>Forensic representative to attend</p> <ul style="list-style-type: none"> ▪ Aim of admission ▪ Exit strategy ▪ Discuss whether low secure bed may be required or is aim to discharge from adult MH? 	<p>Review risk management plan Clarify if any missing information Schedule enhanced CPA meeting, at latest 6 weeks post admission (for forensic patients, this should be through the forensic CPA co-ordinator)</p>
Weekly	<p>Weekly input from Forensic Team through telephone, VC or in person.</p> <p>Any change in frequency of contact to be agreed by both forensic link consultant and</p>	<p>Ongoing care needs reviewed and discussed / patient review.</p> <p>Any change in frequency of contact to be agreed by both forensic consultant and general adult</p>

	<p>general adult consultant, and documented on EMIS.</p> <p>Any forensic patient admitted to locality general adult inpatient bed will be added to the (1) Forensic bed management list*, overseen by Forensic Bed Manager, and (2) Forensic referral minutes*. (3) and progress updates to be discussed at weekly FCMHT Team Meeting</p> <p>*These two documents are reviewed on alternate weeks at the weekly referral meeting.</p>	<p>consultant, and documented on EMIS.</p> <p>Input from ward based AHP / patient activity co-ordinator</p>
CPA meetings	<p>Ensure forensic representation from either FCPN, Forensic consultant or Forensic bed co-ordinator. Forensic CPA co-ordinator to minute meeting</p>	<p>Forensic CPA co-ordinator to minute / co-ordinate meeting invite.</p>
As required	<p>Forensic consultant input and discussion with AMH RMO around decisions about discharge planning, significant changes in treatment, ongoing need for in-patient admission and level of security.</p> <p>Provide annual report / other reports required by Scottish Government (for restricted patients).</p> <p>2nd medical report for CTO application and support with MHTS.</p> <p><u>Up-date risk assessment in line with forensic processes.</u></p> <p>Refer to STAR if require specific offence related psychology work</p> <p>Consider if other specialist interventions will be required</p>	<p>Review of CO / CTO & attendance at MHTS.</p> <p>Involve link forensic consultant in decisions re free time / discharge planning / significant change in medication Ongoing review of need for in-patient admission Need to move from open ward → IPCU or vice versa.</p>

4.2 Admission from GAP or rehabilitation psychiatry to forensic services

In-patients in general adult services may be referred to forensic services for low or medium security.

The process to make a referral to forensic services is set out in [MHS 11 Forensic Referral Guide](#).

In summary, referrals should be made in writing to the forensic bed manager for discussion at the weekly forensic referral meeting (Wednesdays). Emergency referrals can be discussed with the relevant admission consultant (forensic bed manager can advise) or on-call forensic consultant.

If accepted for in-patient forensic admission, the aim is to move patients who require a higher level of security as soon as possible when a bed is identified. This will be co-ordinated by the forensic bed manager, although there will also be discussions between the receiving forensic consultant with the patient's current general adult RMO.

If there is a delay in transfer to a forensic in-patient bed, a link consultant will be identified but RMO responsibility will remain with the general adult or rehabilitation consultant psychiatrist.

The link psychiatrist can liaise with the general adult RMO to review the CRAFT risk assessment document and risk management plan.

If not already referred for CPA, a referral should be made for enhanced CPA (through locality CPA Co-ordinator) to help co-ordinate care planning. There will be forensic representation at CPA meetings. There should be explicit reference within the care plan, reviewed at every CPA meeting, about the need for a forensic bed and ongoing suitability for transfer.

The link consultant is also available to discuss management issues out with the CPA meetings.

Scenarios that would merit discussion and joint-decision making with the link forensic clinician would involve:

- Any change in presentation that may necessitate prioritising admission due to **increase in level of risk**.
- Change in SUS status / increasing unescorted free time / home visits
- Change in circumstances
- Decisions to make significant change to medication / treatment
- Request for specialist intervention e.g. specialist programmes through STAR / need for up-dated or specialist risk assessment

The patient's details will be added to the list of referrals accepted for admission and this list is kept under weekly review.

4.3 Admission from court diversion to IPCU

There is a standard operating protocol for the court diversion service [Appendix 2]. Although the service is co-ordinated and supported by DFMHLD, the majority of cases seen are admitted to AMH services in NHS GGC and do not require a forensic bed or ongoing forensic input.

If charges are dropped or bail granted (NB: bail should never be to a hospital address), and admission is not required, the assessing FCPN / on-call psychiatrist may request urgent community or crisis follow up through the CMHT if clinically indicated.

If charges are dropped and admission is required, this could be arranged as an informal admission. If the criteria for detention are met, the person may be detained on either an EDC or STDC. The decision on whether the person can be safely managed in an open or IPCU bed will be dependent on their presentation and assessed level of risk.

If charges are not dropped, and the individual would otherwise be remanded, then the assessing doctor may recommend an Assessment Order. To make an Assessment Order a suitable bed would need to be identified and available within 7 days of the Order being made. As the patient would otherwise be remanded, the bed should offer the appropriate level of security – usually in the IPCU (locked ward).

Forensic consultants are available on call to offer supervision and advice to Higher Trainees undertaking assessments at court but do not have admission rights to IPCU beds. Therefore, admission needs to be agreed following discussion with the locality bed manager and IPCU senior staff.

The process to identify a bed is set out in Appendix 3.

For all admissions, the FCPN and admitting doctor should try to obtain, if available from the Procurator Fiscal, a copy of the summary of evidence and summary of charges to be forwarded with legal paperwork to the admitting service. However, if this information is not available there should not be a delay organising an in-patient bed, if the criteria for admission are met.

If a bed is not available and the patient is remanded, the assessing doctor should make contact with the healthcare team at the prison where the prisoner / patient will be remanded and ensure a copy of their assessment is forwarded to highlight the mental health concerns. The prison mental health team can then do an assessment and put in place a management plan in custody. They may also ask the visiting psychiatrist to assess.

4.4 Referrals from in-patient forensic services to Adult Mental Health / rehabilitation

The majority of cases in forensic in-patient services will remain within forensic services until they are fully settled in the community, there has been suitable testing out of their care needs, and risk management plans. Due to the complexities around the management of long-term Restricted (CORO) patients, they will be managed by FCMHT until at least the point of Absolute Discharge from the Order.

However, there will be individual cases when, following a period of forensic in-patient assessment and treatment, the clinical view is that the patient no longer requires forensic services.

Examples of this may include:

- Patients admitted to forensic in-patient services who have become unwell in prison whilst serving a sentence, but where there is no clear link between mental disorder and risk / offending.
- Patients admitted for assessment when acutely unwell due to behavioural management problems but, once the mental health problem has stabilised, there are few forensic issues in the background that require ongoing input necessitating forensic management.
- Patients admitted on remand but who are not subsequently convicted of an offence and where the clinical risk is considered low.
- Patients who are older, or who have a progressive cognitive or neurological impairment, where the primary concern is supporting and managing those underlying problems, rather than being focused on specifically managing risk to others.

Transfer to other services (adult mental health, rehabilitation, continuing care), can be problematic, especially if the patient has been in medium secure care. There is often a stigma in relation to patients who have been managed in forensic services. However, all services in NHS GG&C must ensure that the patient is managed in the least restrictive environment to manage their needs, and that use of resources in adult mental health, forensic, rehabilitation and continuing care services are used as efficiently as possible.

Forensic to Rehabilitation Services / Adult Mental Health / Continuing Care

The forensic consultant will make a referral to the local sector consultant or rehabilitation service depending on what ongoing in-patient treatment they consider the patient requires and taking into account the least restrictive option for the patient.

If a patient is considered to require further psychiatric care, but does not require ongoing forensic input (including future forensic follow up in the community), the forensic consultant will refer to the relevant locality service. As part of the discussions, it would be helpful to invite a representative of the locality service to attend a CPA meeting.

Broadly, the information required when making a rehabilitation / adult mental health / CMHT referral will include:

- Reason for referral to Rehabilitation Service / adult mental health / CMHT
- Detailed information on the background and mental health issues;
- Up to date risk assessment;
- Up to date functional OT assessment;
- Risk management Traffic light information;
- Evidence patient has been tested with, and managed, unescorted time out (unless referral to IPCU);
- Patient willing and engaging in rehab approach (for rehabilitation service);
- An opinion from the referrer on whether FCMHT follow up is indicated post-discharge.

If accepted, both the forensic and adult mental health / rehabilitation team will work closely to agree a transfer plan, which may include visits and overnight passes.

In the event of a dispute between services, then the need to manage the patient is paramount and the referring service will retain primary responsibility to support discharge. However, this does not preclude a further referral if there is a change in circumstances. For some patients moving on from forensic services, a period of joint working may be considered appropriate.

Rehabilitation referrals:

If a patient is considered to require further rehabilitation, but does not require ongoing forensic input, the forensic consultant will refer to the relevant rehabilitation service based on where the patient is originally from. Before making a referral, the forensic consultant should contact the relevant rehabilitation service to clarify the rehabilitation referral process and, as above, invite a representative of the rehabilitation service to attend a CPA meeting.

If accepted for assessment by rehabilitation services, the rehabilitation consultant will work with the referrer to agree an assessment plan that may include visits and overnight passes to the rehabilitation ward. If, after a period of assessment, the rehabilitation service does not consider that the patient is suitable for rehab, they will advise Forensic services of the reasons why.

If the patient is accepted for transfer, then there can be a discussion on a case-by-case basis to retain the bed for a specified period to ensure the patient settles.

4.5 Referrals between CMHT and FCMHT

The Forensic Community Mental Health Team (FCMHT) provides a tertiary care service to mentally disordered offenders (MDO) residing in the NHS Greater Glasgow & Clyde area. The service was developed to provide ongoing support for individuals who have been diagnosed with severe and enduring mental illness and who have offended, whose behaviour due to mental disorder may lead to offending and/or may put others at risk of harm.

As with other specialist mental health services in NHS GGC, access from the CMHT is by referral, which may be accepted or declined following specialist forensic assessment (Service Specification for Mental Health Services in the Community, 2016).

Transfer of patients from FMCHTs to community AMH services would also be through a similar process of referral to CMHT's, which may be accepted or declined following assessment.

Whenever possible, agreement should be reached at a local level. Where an agreement between services cannot be reached, this should be escalated as appropriate to the relevant Clinical Directors and Heads of Service.

Referral guidelines for the Forensic Community Teams are within [MHS 11 Forensic Referral Guidance](#)

4.6 Interface FCMHT / FCLDT with Crisis Teams

The three Forensic community teams only operate between the hours of Monday to Friday 9-5pm. The usual process for out of hour (OOH) presentations is that NHS24 are contacted by the referrer, who would then contact the unit co-ordinator at Rowanbank to access the CPA and risk management plan and discuss with the on call forensic consultant. Depending on the information in the risk management plan, the patient may be either assessed by the Crisis Teams or asked to attend the Mental Health Assessment Unit (MHAU) for further assessment.

Although crisis presentations will be managed by the Forensic service within office hours, there may be occasions where referral to the crisis service may be made out with these hours. All out-patients who have a FCPN/FCLDN attached to their care will have Traffic Light Risk Management plans, which provide individualised guidance in the event of a patient presenting to the crisis service. All forensic will have a suitable alert placed on EMIS indicating whether they should be visited at home and by number of staff, or if they should only be seen in a hospital setting. This will enable crisis teams to respond appropriately and in confidence.

It is expected that in these circumstances, the role of the crisis service / MHAU will be to liaise with the Forensic services, through either the on-call Forensic Consultant (contacted via switchboard) and/or accessing the relevant electronic patient information and Traffic Light Risk management plan to inform and access the most appropriate service. It is anticipated that the crisis team's primary function will be to provide an appropriate signposting and referral on function for this group of individuals. It is not expected that the crisis team would provide support and direct intervention beyond a weekend and or public holiday and even during that time, the on-call forensic psychiatrist is available for advice.

4.7 Referrals by CMHT to STAR service

The STAR service is a specialist psychological service within DFMH&LD offering assessment, consultation and treatment across Greater Glasgow and Clyde. Individuals who are referred for the service must meet the criteria for a major mental disorder and have committed or are deemed at risk of committing a serious sexual or violent offence. Referrals are accepted from within DFMH&LD, MAPPA, Criminal Justice Social Work and other NHSGG&C mental health services.

Case management responsibility for the patient remains with the referring agency.

4.8 Referrals from NHS GGC prison mental health teams to CMHT

The prison mental health team is part of **primary care services** that deliver NHS care into prisons and custody settings. It is not a part of the forensic community mental health team.

All prisoners on remand or sentenced will have access, if required; to the prison mental health team (MHT) which offers the equivalent of out-patient CMHT psychiatric care. The prison MHT

refers a small number of prisoners seen by them to visiting prison psychiatrists who assess prisoners at scheduled weekly clinics.

Many of those accessing prison mental health care will be known to CMHTs and / or addiction services in the community. The prison mental health team will liaise with those teams to ensure continuity of treatment and to organise follow up as the individual nears liberation.

As there is a prison mental health team available, there is no expectation that prisoners will need to continue to attend CMHTs for review of their psychiatric treatment whilst in prison. For prisoners serving short sentences, if there is an established relationship with a CPN in the community, it may be helpful to maintain contact to aid transition at the point of liberation.

Prison health records are held on 'Vision' and cover primary care as well as other specialist services such as prison mental health. There is no interface between Vision and EMIS. Risk management in prison is done through Scottish Prison Service (SPS) procedures and the mental health team do not currently have the ability to use CRAFT.

Prison psychiatrists will often produce a clinic letter when they see someone in the prison clinic and this letter is uploaded to EMIS (if the patient is seen at a prison in NHS GG&C).

Prison to community mental health services e.g. CMHT / FCMHT

For those who require ongoing out-patient psychiatric care at the end of their sentence, the visiting psychiatrist will aim to arrange psychiatric follow up in the lead up to a prisoner's release. Practically, this can be difficult to do ahead of the liberation date, as prisoners are often not allocated housing until they present to local services on release.

The majority of individuals leaving custody and who require psychiatric follow up will not require forensic CMHT follow up. Therefore, a referral should be made to the local CMHT and/or addiction services. The visiting psychiatrist can only look after individuals whilst they are in custody; at the point of a prisoner's release, they can no longer access prison health care.

If there is a disagreement about appropriate follow up in the community, the CMHT should offer an initial gatekeeping assessment to ensure the patient is not lost to follow up. A request can then be made for a forensic opinion to address any concerns raised and this will inform a discussion between both the CMHT and FCMHT on a suitable management plan.

In some cases, there may be benefit, especially where there is dubiety about which service is the most appropriate, for a joint assessment appointment to be arranged.

It should be noted that follow up can be difficult to plan as prisoners may move between establishments with little notice. Prisoners may also be released unexpectedly at court if charges are dropped or downgraded; or if they successfully apply for bail or electronic tagging. Additionally, many prisoners do not have a confirmed address, even very close to the liberation date, and therefore planning who to refer to ahead of this can be very difficult, if not impossible, and is often done at short notice.

Prison to in-patient services

A small number of attendees at prison psychiatric clinics are so unwell that they cannot be safely managed in the prison setting and will need treatment as an in-patient in a secure hospital setting. If the prisoner is on remand this may be on an Assessment Order or Treatment Order. For convicted prisoners, the transfer if arranged via a Transfer for Treatment Direction (TTD). The appropriate bed may be in IPCU; low security; medium security or high security. Decisions on the appropriate level of security are made by the assessing psychiatrist and take into consideration the severity of the index offence and level of risk; presentation and management issues in

custody; risk of absconding.

If an IPCU bed is required, the referral should be made to the locality hospital who can advise on bed availability and the case should be discussed with the admitting service.

If a forensic bed (low or medium secure) is required, a referral should be made through the forensic bed manager.

Referrals for high security should be directed to The State Hospital.

The Forensic Network publication [Guidance on Patient Referral to or between Scottish High and Medium Secure Services](#) offers further information to assist decisions regarding appropriate level of security:

If available, it is helpful to send the receiving service a copy of current offences, past convictions or any other relevant information available to the prison psychiatrist.

However, this information is not always readily available in prison health care. If required, a request for information may need to be forwarded to the procurator fiscal or sheriff clerks' office.

Not all prisoners will require to remain in hospital in the longer-term and if they no longer meet criteria for detention, will be returned to prison. Prior to return to custody there should be consideration about whether they meet criteria for follow up from forensic services. This may involve an assessment that should be clearly documented on EMIS.

For other patients, it may be agreed that their rehabilitation needs and ongoing treatment are best managed by discharge through a hospital route, especially if they come to the end of their sentence and continue to meet criteria for civil detention.

Decisions on admission and detention under the Act must consider the least restrictive option. Patients in medium and high secure care are able to appeal against being managed in conditions of excessive security. If an appeal is upheld the Health Board have up to a maximum of 6 months to move to a more appropriate level of security or face potential judicial review.

5 Policy Principles

5.1 Patients should be managed in the least restrictive setting possible to manage the level of ongoing risk they are assessed as posing to the general public, staff and themselves.

5.2 In the case of a dispute then responsibility for delivering care lies with the service the patient is in. The caveat to this is that once a prisoner has left custody, their care cannot remain with the visiting psychiatrist in the prison.

5.3 Patients should be managed in services with the expertise and level of skills to deliver the appropriate level of care.

5.4 Where appropriate, the patient and named person / carer should be involved in any transfer of care between services.

5.5 Learning from SCIs repeatedly shows that transitions in care is a higher risk time for patient care and therefore any transition of care will require clear understandings of each team's roles and responsibilities, and to share relevant clinical information in a timely manner.

5.6 Transition arrangements should minimise the number of referrals and where possible should be managed directly within mental health services.

5.7 In the event of ongoing clinical disagreement between services, that have not been resolved informally, the relevant Clinical Director and Head of Service / Service Manager should be informed. Both parties who are in disagreement should set out the basis for the dispute, ideally with reference to available guidance on referral criteria or level of security. This should be shared between both services for each to consider. The relevant Clinical Directors, Service Managers and/or Head of Services will then be responsible for meeting to try and negotiate a resolution within 4 weeks, or sooner depending on the level of clinical acuity.

6 References

- 1) [MHS 11 Forensic Referral Guide](#)
- 2) [Guidance on Patient Referral to or between Scottish High and Medium Secure Services](#)
- 3) [Sections 10 and 11 of The Management of Offenders etc. \(Scotland\) Act 2005](#)

Appendix 1 – Membership of SLWG

Dr Rona Gow	Clinical Director, Directorate Forensic Mental Health & Learning Disability
Dr Pavan Srereddy	Consultant Psychiatrist -Adult Mental Health
Steven McCulloch	Mental Health Clinical Policy Manager
Dr Laurence Tuddenham	Consultant Forensic Psychiatrist
Dr Kalpana Sankey	Consultant Forensic Psychiatrist
Dr Susie Rooney	Consultant Psychiatrist – Adult Mental Health (IPCU)
Dr Mel Baker	Consultant Forensic Psychiatrist
Dr Judi Bolton	Consultant Forensic Clinical Psychologist
Shona Hendry	Service Manager – Forensic Services
Dr Doug Gray	Consultant Psychiatrist – Adult Mental Health (IPCU)
Dr Una Graham	Clinical Director – Glasgow South Adult Mental Health
Dr Alex Thom	Clinical Director – Glasgow North East Adult Mental Health
Dr Unoma Okudo	Consultant Forensic Psychiatrist, Leverndale low secure
Dr Katherine Sowerbutts	Consultant Psychiatrist, Adult Mental Health, IPCU
Dr Lucy Carrick	Acting Clinical Director - Glasgow NW Adult Mental Health / Consultant Psychiatrist (Rehabilitation)
Dr Russell Hosie	Consultant Psychiatrist (Rehabilitation)
Dr Sarah Weldon	Consultant Clinical Psychologist (STAR)
Dr Stephen Davidson	ST5 Forensic Psychiatry

Appendix 2



Forensic Community Mental Health Team Court Diversion Scheme

Standard Operating Procedure

Introduction

In line with the recommendations in the MEL (1999)5 NHS Greater Glasgow and Clyde provides a court diversion scheme to Glasgow, Paisley, Greenock and Dumbarton Sheriff Courts. The principal function of this service is to identify prisoners who may require to be transferred from custody to a mental health facility at the time of their present custody. This service is nurse led with an on-call medical provision. Forensic Community Psychiatric Nurses (FCPN) will attend in the first instance and complete a mental health assessment. This may be done in partnership with court social work services. Senior trainees with Forensic Psychiatrist support provide on-call cover to attend court to complete further assessment where deemed necessary.

Referral Criteria

1. Individuals who have been arrested in the preceding 24-72 hrs and are due to appear in custody court for the **first time** that day.
2. Individuals identified by the Procurator Fiscal, Police Officers or Court Social Work staff as displaying behaviour, mood or thought processes suggestive of a significant underlying mental illness or learning disability. ***This includes persons whose behaviour or expressed intent indicates a risk of serious offending involving danger or threat to others.***
3. Individuals who express self-harm/suicidal ideation, or intent.
4. Individuals identified as being known to local mental health services whose behaviour in custody is giving cause for concern.

Objectives of the Service

1. To provide a proactive service that carries out Mental Health Assessment on identified persons held prior to their **first appearance** in custody court in Glasgow, Greenock, Paisley and Dumbarton Sheriff Courts.
2. To inform the Procurator Fiscal office of the result of these assessments and to identify any person whose Mental Health state may have implications for their immediate disposal.
3. To liaise with local NHS bed managers.

4. To liaise with health and social care agencies for the immediate or future provision of care.
5. To work in a collaborative way to provide information, advice, and support as required, training to police, social and health care agencies and the office of the Procurator Fiscal and to seek the same from these agencies in return.

Service Provision

1. An FCPN will be available to take referrals, for Glasgow and Paisley courts Monday to Friday from 9.00am until 12 midday and 09:00 am till 11:00 am for Greenock and Dumbarton Courts, excluding public holidays (PH).
2. Referrals will arise from the Procurator Fiscal – National Initial Case Processing Unit. All other enquiries/requests will be referred to the Procurator Fiscal for consideration of referral to service.
3. The Procurator Fiscal will be given a written report of all Mental Health assessments carried out, as well as when the referral is declined.
4. A consent to interview form is always completed prior to assessment taking place
5. An identified Mental Health assessment is currently being utilised.
6. The FCPN will contact local services as appropriate to gain information about the person to assist with the assessment and to inform the court service of any services they are or have been known to previously.
7. If it is likely that the individual requires admission to hospital, then the on-call Psychiatrist is contacted to carry out further assessment and arrange admission. They are also available for advice on the management of an individual within the court if necessary.
8. NHS GGC will provide one on-call psychiatrist to support the service. In the event that there are, two medical assessments required in different courts the assessments will be prioritised and there may be the requirement for individuals to be carried forward until the following day.
9. The FCPN in conjunction with Social Work staff may indicate to the Procurator Fiscal those persons who may appear appropriate for consideration for other diversion schemes.
10. Any perceived risks pertaining to the individual are notified to the Procurator Fiscal and the receiving agency if they are remanded or the relevant hospital if they are to be admitted.
11. An audit sheet is completed for every person assessed.

Information Sharing

1. The Procurator Fiscal will provide a copy of the police and FP report (if seen by FP whilst in Police Custody) on the person to be assessed. This is shredded on completion of the assessment.
2. The FCPN will obtain the consent of the individual prior to contacting local services or any specific individuals for additional information.
3. A copy of the assessment is faxed to the Procurator Fiscal office.

4. Completed Mental Health assessments are filed in individual case records and copies are held at FCMHT base.
5. In the event that the person assessed is sent to custody, the FCPN ensures that a copy of the assessment accompanies them along with an alert to any risks they may present. This is delivered in a sealed envelope to the relevant Prison Health Centre.
6. The FCPN will share all relevant clinical written, and/or verbal information to the agencies where the person is referred.

The sharing of information is important to effective assessment, but is carried out within the terms of the Data Protection Act 1998 and associated guidance as well as within the policy framework of agencies involved.

Conclusion

This service will be subject to continual review at agreed intervals. All aspects of the service will be audited.

Appendix 3: Bed Management Procedure – Court Liaison Referrals

If a referral is received for IPCU bed from Medical staff at the Courts, the following process should take place:

- Medical Staff will contact appropriate locality hospital and request bed Manager (or page Holder where bed manager is not available)
- Bed Manager will clarify level of restriction required and if necessary direct enquiry to Forensic Service Bed Manager if higher level of security than can be provided by IPCU is required
- If confirmed IPCU is appropriate - Bed Manager receiving request will attempt to identify vacant IPCU bed within locality area
- Bed Manager will liaise with Consultant Psychiatrist in locality hospital for IPCU to determine if any patient currently suitable for transfer to open ward

If **no vacant** bed in locality area

- Bed Manager receiving request will contact IPCU's GGC wide to determine if any vacant beds
- Bed Manager will liaise with Inpatient Managers and Consultant Psychiatrist for IPCU's across GGC to determine if any patient currently in IPCU is suitable for transfer to open ward

If **no** patient suitable for transfer in GGC IPCU's

- Bed Manager who received request will contact other nearby board areas to determine if there is an IPCU available

If **no** bed available on that day Bed Manager will feed back to medical staff seeking bed and the following steps should be completed.

- Bed manager will note request was unable to be fulfilled and note follow up action for next day with the presumption that an IPCU bed will still be required.
- Medical staff will contact same locality bed manager dealing with the previous day's request for an update and will reassess the patient as required.
- The receiving bed manager should repeat the above process until a suitable bed is found or the bed is no longer required.
- Medical staff will complete the necessary paperwork depending on bed availability and the patient's whereabouts in subsequent days (court or prison).

*The court are likely to continue the case without plea and remand the patient until a bed is identified.

- The assessing doctor must contact the on-call forensic consultant for management advice.

- They should also – where possible - make contact with the healthcare team at the prison where the prisoner / patient will be remanded and ensure a copy of their assessment is forwarded to highlight the mental health concerns.
- The mental health team will ensure appropriate management in prison, and may ask the visiting psychiatrist to assess. The visiting psychiatrist may also liaise with the bed manager regarding identification of a bed.