

Chain lines

**The transfer and remission of immigration removal centre detainees under the Mental Health Act 1983**

**Good practice guidance 2019**

NHS England and NHS Improvement

**The transfer and remission of immigration removal centre detainees under the Mental Health Act 1983**

**Good practice guidance 2019**

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# Contents

[Contents 2](#_Toc9364829)

[1. Executive summary 3](#_Toc9364830)

[2. Introduction 3](#_Toc9364831)

[2.1 Purpose and scope 4](#_Toc9364832)

[2.2 Implementation 5](#_Toc9364833)

[3. Commissioning 5](#_Toc9364834)

[3.1 Establishing the responsible commissioner 5](#_Toc9364835)

[3.2 Regional commissioning arrangements 6](#_Toc9364836)

[4. Implementing the guidance for referral, assessment and transfer 6](#_Toc9364837)

[4.1 Referral, assessment and transfers 7](#_Toc9364838)

[4.1.1 Timescales for referral, assessment and transfer 8](#_Toc9364839)

[4.1.2 The referral, assessment and transfer process in more detail 8](#_Toc9364840)

[4.1.3 Monitoring the timescales 9](#_Toc9364841)

[4.2 Problem solving (dispute resolution) 10](#_Toc9364842)

[5. Implementing remission from mental health inpatient services 10](#_Toc9364843)

[5.1 Remission process and timescales 10](#_Toc9364844)

[5.2 Receiving IRC 11](#_Toc9364845)

[6. Information sharing and confidentiality 12](#_Toc9364846)

[7. Patient, family and carer involvement 12](#_Toc9364847)

[8. Glossary 12](#_Toc9364848)

[9. Appendices 13](#_Toc9364849)

**1.** **Executive summary**

A proportion of the adult detainee population will experience mental health problems during their detention, either because of a relapse in a pre-existing condition or because they have become unwell for the first time.

Most individuals will be treated successfully by immigration removal centre (IRC) mental health services. Some will require inpatient care as their clinical needs cannot be met within an IRC setting and they have been assessed by a Section (s)12 doctor as meeting the criteria for detention under the Mental Health Act 1983 (MHA). Following a period of admission, assessment and treatment, some will be remitted back to an IRC.

Historically some patients have experienced delays in the referral, assessment, transfer and remission process. The aim of this good practice guidance is to facilitate timely access to appropriate treatment under the [Mental Health Act 1983](https://www.legislation.gov.uk/ukpga/1983/20/contents) (MHA) and reduce unnecessary delays.

The following guidance sets out the process for both the transfer and remission to secure inpatient treatment.

**2. Introduction**

Detainees with mental illness who require inpatient treatment can only be transferred to hospital under the MHA with the agreement of the Secretary of State for Justice.

Detainees are usually transferred under s48 of the MHA. The Secretary of State for Justice may add a restriction under s49 of the MHA.

Historically detainees have faced delays in accessing secure inpatient treatment. By providing appropriate and timely treatment, it is anticipated that the risk of harm to self and others, as well as suicide is reduced.

This guidance sets out the timeframe for completing assessment, transfer and remission to and from mental health secure services and IRCs. This applies to adult detainees aged 18 and over.

In some cases, and depending on the clinical and risk presentations, the transfer should be completed as a priority, providing equivalence to patients in the community with similar needs.

Providing appropriate intervention and treatment at the right time and in the right place is vital to improving outcomes to individuals with mental illness. For some detainees with severe mental illness, a transfer to inpatient treatment will be an important element in supporting better outcomes in the longer term.

This guidance supersedes and replaces the guidance on transfers [Good Practice Procedure Guide[[1]](#footnote-1)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215648/dh_125768.pdf) published by the Department of Health in 2011.

**2.1 Purpose and scope**

The purpose of this guidance is to promote good practice and support effective joint working between the agencies involved in transfer and remission processes, providing benefit to the patient and timely and effective treatment.

The guidance applies to adult detainees aged 18 years or over and remissions from high, medium, and low secure services and psychiatric intensive care units (PICU) in general adult mental health.

Although not a definitive guide to the MHA, this guidance sets out elements that are applicable to detainee transfers and remissions. Information about the wider application of the MHA is contained in the [Reference Guide to the Mental Health Act 1983](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/417412/Reference_Guide.pdf) [[2]](#footnote-2)and [Mental Health Act 1983:Code of Practice](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF)[[3]](#footnote-3).

The [Independent Review of the Mental Health Act 1983](https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act), December 2018[[4]](#footnote-4) has also recommended new timescales and principles for the transfer of patients, which have been incorporated into this guidance. The key elements of health care service improvements set out in the [NHS Long Term Plan[[5]](#footnote-5)](https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/) (LTP) have been also integrated throughout this guidance.

This guidance relates to the transfer and remission to and from IRCs and mental health secure services for patients in IRCs in England. It does not cover the procedure in Scotland, Wales or Northern Ireland and is for use by:

* IRC mental health services
* NHS England and NHS Improvement or parties who have been given devolved commissioning arrangements, such as New Care Model (NCM) provider collaboratives or equivalents. Throughout this document take NHS England and NHS Improvement specialised commissioning as the commissioner of adult high, medium and low secure services to be an inclusive term to include where other parties have taken on devolved commissioning arrangements
* Clinical commissioning groups (CCGs)
* Inpatient mental health providers
* Ministry of Justice (MOJ).
* Home Office.

**2.2 Implementation**

The effective implementation of IRC referral, assessment, transfer and remission is dependent on cooperation between several organisations and agencies. Early and timely information sharing will support the transfer and remission process and improve patient outcomes.

**3. Commissioning**

NHS England and NHS Improvement health and justice commissioning is responsible for commissioning all healthcare services delivered within IRCs, including mental health services.

NHS England and NHS Improvement specialised commissioning is responsible for commissioning adult, low, medium and high secure mental health services, in addition to a wider range of other specialised mental health services.

CCGs are responsible for commissioning health care services for their area, which includes adult mental health inpatient services together with adult PICUs.

The local clinical assessments in response to a referral and the access assessment process will recommend the service specification (high, medium, low secure or PICU) of inpatient care and treatment required ([Specialised Secure Mental Health Services Specifications](https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-c/c02/)[[6]](#footnote-6)). It is acknowledged that the clinical presentation can change and the decision for the least restrictive environment can be challenging.

**3.1 Establishing the responsible commissioner**

The process for transferring patients can be complex, particularly in terms of commissioning responsibility. Whilst this guidance aims to be comprehensive, other national guidance documents are relevant.

[Who Pays? Determining responsibility for payments to providers, August 2013](https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf)  [[7]](#footnote-7)

[Refocusing the care programme approach, policy and positive practice guidance, March 2008](https://webarchive.nationalarchives.gov.uk/20130124042407/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf)[[8]](#footnote-8)

The responsible commissioner guidance makes specific reference to:

* the transfer of individuals detained under the MHA
* individuals of no fixed abode
* individuals who have moved between areas / GP practices.

The general rules are as follows, but determination of the responsible commissioner can be a complex issue and so should always be carefully considered:

* Where an individual is registered as a patient at a NHS GP practice, the responsible commissioner will be the CCG of which the GP practice is a member. This also applies should the individual reside in a different CCG area to the GP practice.
* Where an individual is not registered with a GP practice, the responsible commissioner will be the CCG in whose geographical area the individual is ‘usually resident’.

The NHS England guidance, ‘Who pays? Determining responsibility for payments to providers, August 2013’, sets out an important principle that should be adhered to when disputes regarding funding arise:

**‘No treatment should be refused or delayed due to uncertainty or ambiguity as to which CCG is responsible for funding an individual’s healthcare provision.’**

This principle applies to cross-border issues within the UK. Whilst it is not possible to cover every eventuality within this guidance; the NHS is expected to act in the best interests of patients at all times and work together in the spirit of partnership.

**3.2 Regional commissioning arrangements**

It is important to understand the arrangements for commissioning secure mental health services as this dictates responsibility for agreeing to meet the costs of inpatient treatment.

Whilst a local commissioner is responsible for an individual, the mental health service they require may be commissioned under regional or national commissioning arrangements.

**4. Implementing the guidance for referral, assessment and transfer**

The effective implementation of IRC referral, assessment, transfer and remission is dependent on cooperation between a number of organisation and agencies. Early and timely information sharing will support the transfer and remission process and improve patient outcomes.

The process should continue to be followed during any disputes over funding responsibility. Access to inpatient treatment should not be delayed while this is resolved and should continue without prejudice. Unknown responsibility is not a reason to delay transfer.

In such circumstances, commissioners should agree interim arrangements for meeting costs of inpatient treatment whilst the dispute is resolved.

In some circumstances, the Secretary of State for Justice may decide to approve direct admission to a specific service regardless of who is responsible for meeting the costs of the admission.

**4.1 Referral, assessment and transfers**

The referral should be initiated as soon as it is identified that a person’s mental health needs cannot be appropriately treated within an IRC, they fit the criteria for detention under the MHA and they require a transfer to a mental health hospital.

All transfer and remission information is exchanged electronically and must only be done using secure email systems. Personal email accounts must never be used for this purpose.

Determining the level of clinical priority of a referral is key to ensuring that the assessment and any subsequent transfer takes place within appropriate timescales.  The assessment and transfer process does not stop whilst the level of priority is determined or if a decision is made to re-categorise this. Timescales will be monitored so that support can be provided in the event difficulties are experienced. This support can be accessed through regional NHS England and NHS Improvement health and justice commissioning teams or NHS England and NHS Improvement specialised commissioning teams.

Where it is believed or has been formally determined that the patient lacks capacity to make decisions about their care and treatment, provision within the [Mental Capacity Act 2005](http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf)[[9]](#footnote-9) should also be considered and applied where indicated.

The time frame will only stop when the detainee is transferred into hospital or a decision is made by the assessing service that the detainee does not require transfer.

The timescales that services will work to are described below.  It should be noted calculations are made in calendar days over a seven-day week.

The threshold for the priority of a transfer is determined through a clinically informed discussion between the referrer and assessing service, considering the following questions:

* Is there evidence of a rapid deterioration in mental health presenting a risk to self, other detainees and staff?
* Is there evidence of rapid deterioration in physical health due to mental health problems?
* Is there a need for restrictive practices in the IRC to maintain safety due to mental health presentation?

The monitoring of time to transfer ends:

* if the assessment of mental health inpatient services concludes inpatient treatment is not required as the criteria for detention are not met; or
* when the patient has been transferred to hospital.

The monitoring of time to transfer does not stop during processes to resolve differences of clinical opinion or disputes over commissioning responsibility. The clock will only stop when the difference of opinion has been resolved, and the patient is either accepted to hospital or the dispute over commissioning responsibility is resolved (whereby the clock continues until the patient is transferred), or the patient is deemed not suitable for detention under the MHA.

**4.1.1 Timescales for referral, assessment and transfer**

The time from referral for a first assessment to transfer should take no more than 28 days. In line with the Independent Review of the Mental Health Act 1983, December 2018, this guidance introduces two new, sequential, time limits of 14 days each from the:

1. point of initial referral to the first psychiatric assessment
2. first psychiatric assessment until the transfer takes place.

This incorporates the time between the first and second psychiatric assessments and the time to transfer.

* Monitoring of time to transfer begins on the day that the initial referral is made to the access assessor appropriate by the IRC mental health team.
* The appropriate clinical team at the assessing service (either a high, medium and low secure service or non-secure service, such as PICU) should then be completed.
* A proposed time frame in which the assessment will be conducted should be discussed and agreed, between the assessing service and the referrer, based on the patient’s clinical presentation and risk. The assessing service must confirm the time and date of the assessment to the referrer at this point.
* Where a transfer to hospital is indicated, the arrangements for identification of appropriate inpatient service and transfer should be started concurrently to the issuing of the written report.
* Monitoring of time to transfer stops when the patient is admitted to an appropriate mental health inpatient service.
* **The total time frame should be no longer than 28 days from beginning to end**.

**4.1.2 The referral, assessment and transfer process in more detail**

* Once the need for a referral for inpatient assessment is identified by an IRC mental health team, establish the responsible commissioner.
* Depending on the type of inpatient assessment required:

1. Contact the relevant NHS England and NHS Improvement adult secure case manager, or equivalent based on devolved commissioning arrangements, in the area where the detainee originated from if secure inpatient care is indicated.  Refer to the Who Pays? Determining responsibility for payments to providers, August 2013[[10]](#footnote-10) document.

OR

1. Contact the relevant CCG if PICU is felt appropriate. Refer to the ‘Who Pays? Determining responsibility for payments to providers, August 2013’ document.

* Make a formal referral to the responsible mental health provider in the patient’s originating area and arrange the relevant assessment.
* The IRC psychiatrist’s assessment generates one of the required medical reports.
* The IRC mental health team should work in conjunction with on-site Home Office staff to get advice on the level of secure mental health service likely to be required to satisfy the Secretary of State for Justice, sending in the H1003 form (Appendix 1) and first medical report to the mental health case section (MHCS) at the MOJ.
* Work with custodial staff to gather all offending, security and medical information to support the transfer process.
* Keep the patient informed about the process and what they can expect to happen throughout each stage.
* An access assessment or equivalent should be completed by the mental health inpatient service, and a subsequent medical report generated and an appropriate bed identified.
* First and second medical reports completed for transfer.
* Send MHCS and Home Office detention services all remaining information needed for the transfer with confirmation of bed availability in the appropriate service.
* MHCS approves and issues warrant. The Secretary of State for Justice has the right to refuse such a transfer, (albeit very infrequently).
* The mental health inpatient provider confirms admission date to the IRC.
* The IRC arranges appropriate escorts and transports the patient to hospital.

**4.1.3 Monitoring the timescales**

The monitoring of time to transfer ends:

i) if the assessment of mental health inpatient services concludes inpatient treatment is not required as the criteria for detention is not met

OR

ii) when the patient has been transferred to hospital.

The monitoring of time to transfer does not stop during processes to resolve:

* differences of clinical opinion
* disputes over commissioning responsibility.

**4.2 Problem solving (dispute resolution)**

In cases where there is a difference of clinical opinion on the need for transfer and a resolution cannot be agreed by the two doctors undertaking the assessments, an agreement should be made about seeking a third-party clinical assessment.

Where the issue relates to referrals to secure inpatient care, a third-party clinical assessment should be arranged with the agreement and involvement of NHS England and NHS Improvement case managers. The third-party view should be completed within three days to prevent undue delay in the transfer process.

The view of the third-party clinical assessment is to be accepted by all as the prevailing clinical recommendation

**5. Implementing remission from mental health inpatient services**

Remission to IRC may be requested under s50, 51 or 53 of the MHA if the responsible clinician, any other approved clinician or a mental health tribunal advises the Secretary of State for Justice that:

* treatment in hospital is no longer required or
* no effective treatment is available in the hospital where the patient is detained.

In these circumstances and where allowed under the legislative framework, remission to IRC should be achieved with the minimum delay and within 14 days.

It is essential that the patient understands and is involved in the remission process and knows what to expect at each stage.

**5.1 Remission process and timescales**

Continued liaison between the healthcare team at the IRC and the inpatient unit should be used to keep the Home Office and MHSC informed on progress and the likely return date to the IRC so appropriate care on return can be managed.

Responsibility for coordinating, overseeing and managing the remission process is shared between the inpatient service provider and the receiving IRC.

* The remission process should be completed within a **maximum of 14 days.**
* A decision to remit is made by the mental health team inpatient service and then communicated with the IRC operational staff and mental health team.
* The inpatient mental health service invites the IRC mental health team to a s117 planning meeting. The s117 meeting must provide detailed information regards management of risk and treatment whilst the patient has been in hospital and any information relevant to planning of care once returned to the IRC.
* The MHCS and HO must be informed of confirmation of acceptance by the relevant IRC operational manager.
* There are situations where remission needs to occur more urgently; for example, a serious subversion of security or very serious violence and the mental disorder is no longer of a nature or degree to warrant detention under the MHA. These are rare situations, but the level of risk should determine the need to ensure remission takes place appropriately and as soon as possible. The MHCS can be contacted for support and will consider these requests as expediently as possible.

It is important to note that not all transferred patients will return to an IRC. There are certain instances when changes in circumstance or legal status make the Home Office duty bound to release a patient from immigration detention. The inpatient treating unit should be informed of any decision not to continue immigration detention, in an immediate and clear way, and the Home Office should work with the treating inpatient service to facilitate the appropriate release from immigration detention and any onward management.

Release from detention can place an inappropriate burden on the inpatient treating unit, as accommodation and support measures need to be found in the community for the person.

In certain instances, it may be deemed appropriate by immigration enforcement officers to consider removal from the UK directly at point of release from the inpatient unit without a period of return to the IRC. In this instance it is for immigration enforcement to co-ordinate and manage this process. In such circumstances, they will ensure that this measure is lawful, and in the best interests of the individual, but it should not cause an imposition on the inpatient unit to hold the patient beyond the period of required treatment or criteria of detention under the MHA. This will occur when the individual is willing to voluntary or non-enforced return.

**5.2 Receiving IRC**

Male patients returning to IRC from mental health inpatient services will return to the reception IRC in the area where the inpatient treatment has been provided, unless there are exceptional circumstances that prevent this.

Female patients will return to the female estate.

When the transfer warrant is issued by the Secretary of State for Justice, IRCs are expected to make arrangements to accept the patient once informed by the clinical team that the criterion for detention in hospital is no longer met. Remission to IRC should be completed soon after the s117 meeting has been held and within the 14 day period stated above.

**6. Information sharing and confidentiality**

All staff involved in transfers and remission should understand the rules governing the appropriate sharing of confidential information between agencies, ie healthcare and IRCs.

There are no data protection issues preventing custody staff from passing information about a patient’s conviction and offending history to IRC healthcare staff for the purposes of a transfer to hospital under the MHA.

Necessary and proportionate personal information may be shared with other organisations to protect children and adults at risk, assess need, service delivery and treatment on a need to know basis.

The data protection officer, local Caldicott Guardian or information governance specialist should be contacted in any exceptional or difficult circumstances.

**7. Patient, family and carer involvement**

Patients, family members and carers, where appropriate, should be kept informed and be involved in decision making as far as possible at every stage within the process. Written information should be available for patients, to aide understanding.

**8. Glossary**

CCG clinical commissioning group

GP general practitioner

IRC immigration removal centre

LTP Long Term Plan

MHA Mental Health Act 1983

MHCS Mental Health Casework Section

MOJ Ministry of Justice

NCM New Care Model

NHS National Health Service

PICU psychiatric intensive care unit

UK United Kingdom

**9. Appendices**

**Appendix 1: \*where this states prisoner, please read detainee**

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**MEDICAL IN CONFIDENCE**

**H1003 FORM**

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

**PLEASE FILL OUT THIS FORM IN FULL**

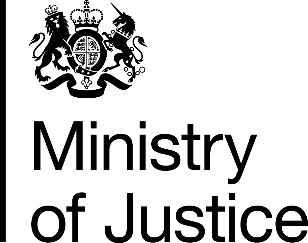
|  |
| --- |
| **SECTION 1 – DETAILS OF REQUESTING PRISON** |
| **NAME: HMP TELEPHONE NUMBER:** |
| **EMAIL: CONTACT NAME:** |
| **SECTION 2 – DETAILS OF PRISONER** |
| **SURNAME: FIRST NAMES:** |
| **ALIASES:** |
| **PRISON NUMBER: DATE OF BIRTH: / / GENDER M / F** |
| **SECURITY CATEGORY (please circle): A B C D OTHER (please specify for female detainees)**  **ON THE ESCAPE LIST? Y / N** |
| **SECTION 3 – SENTENCED PRISONERS** |
| **Name of Court:** |
| **Total sentence and order of court for each offence:** |
| **Date of (i) conviction: (ii) sentence (if different):** |
| **Is this prisoner close to their release date: Y / N**  **If Yes why is the transfer request being made: (e.g. short sentence, long wait for assessment etc.)** |
| **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)/**  **Sentence & Licence Expiry Date (SLED):** |
| **(viii) Lifers – Tariff Date/Indeterminate Sentence for Public Protection (ISPP) – specified period:** |
| **Details of responsible probation service NAME:**    **EMAIL:**  **PHONE:** |
| **Details of Prison Offender Manager: NAME:**    **EMAIL:**  **PHONE:** |
| **Has the prisoner lodged an appeal? Y / N**  **If yes, Criminal Appeal Officer Number:** |
| **SECTION 4 – DETAILS OF DISORDER** |
| **Type(s) of mental disorder from which the prisoner is suffering:** |
| **Is the prisoner suicidal, or has he/she a history of suicidal tendencies? Y / N**  **If yes, please give full details** |
| **Is the prisoner dangerous to others, or has he/she a history of violence? Y / N**    **If yes, please give full details** |
| **Has the prisoner a history of alcohol/drug abuse? Y / N**    **If yes, please give full details** |
| **Has the prisoner received psychiatric treatment previously? Y / N**    **If yes, please give details …………………………………………………………………………………………………………………………** |
| **SECTION 5 – PROGRESS WITH ARRANGEMENTS FOR ADMISSION TO HOSPITAL** |
| **Name of any hospital consultant (who may be the Responsible NAME:**  **Clinician) approached with a view to providing a place for the**  **inmate (including secretary or hospital admin EMAIL:**  **contact details as relevant)**  **PHONE:** |
| **Contact details of hospital to which prisoner will be transferred Email:**    **Phone:**  **Security Level (circle correct level) HIGH / MEDIUM / LOW / LOCKED / PICU / ACUTE (open)** |
| **Names and contact details of reporting medical practitioners:**  **Dr. Dr.**  **EMAIL: EMAIL:** |
| **Name of Medical Officer:**  **HMP:**  **Date:** |
| **SECTION 6 - NATIONALITY AND ETHNICITY** |
| **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) ………………………………………………………….** |

**ONCE FULLY COMPLETED, PLEASE EMAIL THIS FORM TO MENTAL HEALTH CASEWORK SECTION AT:** [**PRISON.TRANSFERS@HMPS.GSI.GOV.UK**](mailto:PRISON.TRANSFERS@HMPS.GSI.GOV.UK)

**PLEASE ALSO PROVIDE THE FOLLOWING DOCUMENTATION TO SUPPORT THE APPLICATION – TWO MEDICAL REPORTS, CASE SUMMARY (MG5), PNC PRINTOUT & ORDER OF IMPRISONMENT.**

**Appendix 2: \* where this reads prisoner please read detainee**

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| --- | --- |
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**Remission to prison of s.47 or s.48 patients**

**Mental Health Casework Section**

Please send the completed form to the Mental Health Casework Section: MHCSMailbox@hmps.gsi.gov.uk

**NB: If the situation is urgent (due to security or safeguarding issues for example), please telephone the Team Manager or Deputy Head of Casework for the relevant team to make them aware of the situation. Contact details: https://www.gov.uk/guidance/noms-mental-health-casework-section-contact-list**

Patient’s details

|  |  |
| --- | --- |
| Full name of patient |  |

|  |  |  |
| --- | --- | --- |
| MHCS reference |  |  |

**Section 47 Patients only**

1. Has the patient passed his or her release date?  Yes  No  
***If yes****, remission does not apply*.

**Section 48 Patients only**

2. Was the patient remanded in custody by a magistrates’ court and

transferred to hospital under s.48(2)(b)?  Yes  No  
***If yes****, please go to question 3 below.* ***If no****, please go to question 4.*

3. Has the patient now been committed to the Crown Court?  Yes  No  
***If no****,* ***remission by the Secretary of State is not appropriate. Please refer   
to the magistrates’ court for advice.***

**All Section 47 & 48 Patients**

4. Please confirm which of the following statements accurately reflect the current status of the patient:

(Tick one box only)[[11]](#footnote-11)

*The patient no longer requires treatment in hospital for mental disorder*?

**OR**

*No effective treatment for the patient’s disorder can be given in the hospital    
to which he/she has been removed*

Please provide information to support the response to question 4.

|  |
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5. Have you convened a section 117 meeting?  Yes  No  
*This should be arranged before remission unless exceptional circumstances   
apply (e.g. the patient poses a serious management problem or risk).*

6. Will a copy of the minutes of the section 117 meeting be sent to the prison  Yes  No  
on remission?

7. Has the prison agreed to this remission?  Yes  No

***(NB: MHCS can only accept the authority of the Prison Governor, or other appropriate Operational Manager (including OMU) – Healthcare staff do not have the authority to agree.)[[12]](#footnote-12)***

Please give the name, status, email address and telephone number of the person in the prison who agreed to accept the patient on remission.

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8. What is the security category of the prisoner? A / B / C / D / Restricted Status / not known

(delete as applicable)

9. Is the patient a **Category A** prisoner (or “Restricted Status” if under 18 or female) Yes  No

***If yes,*** *please ensure that the High Security Prisons Group has been contacted on 0300 047 6358.*

10. Is the patient **under the age of 18 years**?  Yes  No

***If yes,*** *please ensure that the Youth Justice Board is engaged at an early stage. Contact:*

YJB Placements: 08453636363 Email: [YJBPlacements-MentalHealthTransfers@yjb.gsi.gov.uk](mailto:YJBPlacements-MentalHealthTransfers@yjb.gsi.gov.uk)

Please give the name and secure email address of the person in the hospital requiring the remission warrant.

|  |
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|  |

|  |  |
| --- | --- |
| Name of Doctor  (please print) |  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Doctor’s signature |  | Date |  |
|  |

|  |
| --- |
| **For MHCS use only**   1. Ascertain whether prisoner is Cat A (or “restricted status” if under 18 or female). If so, refer to High Security Prisons Group before remission agreed. Copy warrant to HSPG. 2. If patient is under 18, Band 5 to contact Youth Justice Board *before* remission is agreed. 3. Confirm with prison that remission is agreed and obtain email contact. NB: Confirmation must be from the prison, not from Health Care or Psychology Department. 4. If mental disorder is continuing or if there are exceptions or difficulties with this case (including urgency), refer to a Senior Manager (Deputy Head or Head of Team) 5. If Lifer/IPP– copy warrant to PPCS. 6. In Foreign National cases, B3 to notify Home Office when remission occurs – milestone 05A on the case management system. |

**Appendix 3**

**Appendix 4**

**IRC remission process**

|  |
| --- |
| Day 1-14 |

|  |
| --- |
| Remission will be to the appropriate IRC local to the inpatient mental health service providing care. |

|  |
| --- |
| Inpatient mental health provider clinical team agree inpatient treatment no longer required / available. |

|  |
| --- |
| **Treating responsible clinician** informs MHSC, HO, receiving IRC operational and health staff and NHS England and NHS Improvement specialised commissioner.  IRC agrees to accept and attend S117 meeting. |

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| **Inpatient mental health provider:**   * convenes s117 meeting to plan discharge, remission and aftercare * informs MHCS and HO of s117 date * hosts s117 meeting and drafts agreed care plan * confirms plan in place with MHCS and proposed remission date * submits complete S50 to MHSC * provides returning detainee with care plan * sends care plan to receiving IRC. |

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| **Receiving IRC**  makes transfer arrangements ensuring escorted with appropriately qualified IRC health care staff and escorts. |

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| **MHSC**  agrees planned remission date and issues warrant |

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| Attendees at 117 meeting   * Patient and family. * Receiving IRC health and Home Office staff. * Inpatient mental health service provider. * Representative from NHS England and NHS Improvement specialised commissioning. * MHSC. |

**IRC transfer process**

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| **Day 1 – Day 28** |

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| **Key notes** |

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| **Inpatient service provider**   * Arrange visit for access assessment or  equivalent for patient service assessment and confirms with prison. equivalent for patient service assessment and * Complete written medical report and send to referrer. |

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| **IRC healthcare**   * Establish responsible commissioner. * Contact relevant commissioner / assessor. * Gather all offending, security and medical info to support referral in conjunction with Home Office staff. * Arrange first assessment with inpatient provider. * Follow up referral and make appointment for second assessment if appropriate. * Contact MHCS to obtain advice on level of security and send completed H1003 form and first medical report. |

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| Transfer **clock starts** on the day of referral for access assessment. |

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| First medical assessment. Patient meets MHA criteria? If **NO,** IRC health provide care. Transfer **clock stops.** |

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| **Transfer Clock does not stop**  -During disputes about  Commissioning  responsibility  -Differences of opinion |

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| **IRC healthcare**   * Send MHCS and HO all information required for the transfer with information of bed availability. * Arrange transport with prison to inpatient unit * with escorts. |

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| **Transfer Clock Stops**  -If medical assessment  concludes detention under  Mental Health Act not met  -When patient transferred  to inpatient unit |

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| **MHCS**   * Receives report with confirmation of appropriate bed and potential admission date. * Approves issues warrant. |

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| **Inpatient service provider**   * Complete second medical assessment and * written report. Send to referrer. * Confirm bed availability. * Confirm admission date with prison. |

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| ***Throughout process keep patient and family, carers informed what they can expect to happen through each stage.*** |

1. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215648/dh_125768.pdf> [↑](#footnote-ref-1)
2. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/417412/Reference_Guide.pdf> [↑](#footnote-ref-2)
3. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF> [↑](#footnote-ref-3)
4. <https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act> [↑](#footnote-ref-4)
5. <https://www.longtermplan.nhs.uk/> [↑](#footnote-ref-5)
6. <https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-c/c02/> [↑](#footnote-ref-6)
7. <https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf> [↑](#footnote-ref-7)
8. <https://webarchive.nationalarchives.gov.uk/20130124042407/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf> [↑](#footnote-ref-8)
9. <http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf> [↑](#footnote-ref-9)
10. <https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf> [↑](#footnote-ref-10)
11. If both criteria can be said to apply, contact the MHCS for advice. [↑](#footnote-ref-11)
12. If the patient is under the age of 18, (or 18 years old and subject to a DTO) the Responsible Clinician must contact the Youth Justice Board immediately. The Youth Justice Board must attend the s.117 meeting and is the placing authority for these detainees. See question 10. [↑](#footnote-ref-12)