THE STATE HOSPITALS BOARD FOR SCOTLAND

REFERRALS POLICY AND PROCEDURES (INCORPORATING REQUESTS FOR CHANGE OF RMO OR HUB)

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Contributing Author	Risk Management Facilitator
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Accountable Executive Director	Medical Director

The date for review detailed on the front of all State Hospital policies/ procedures/ guidance does not mean that the document becomes invalid from this date. The review date is advisory and the organisation reserves the right to review a policy/ procedure/ guidance at any time due to organisational/legal changes.

Staff are advised to always check that they are using the correct version of any policy, procedure or guidance rather than referring to locally held copies. The most up to date version of all State Hospital policies, procedures and guidance can be found on the Hospital's Intranet policies page.

REVIEW SUMMARY SHEET

Changes required to policy (evidence base checked) **Yes** ☐ **No** ☒

Summary of changes within policy: None required.

CONTENTS

1 INTRODUCTION

This policy describes the procedures for referral and assessment of individuals referred to the State Hospital. Referral can be for consideration for admission, advice as to management, or an opinion for certain legal requirements.

The policy is formulated in terms of the mental health legislation currently in force, namely the Mental Health (Care and Treatment) (Scotland) Act 2003 and Scottish Executive Mentally Disordered Offenders Policy (*see* Appendix 1).

The policy is influenced by guidance from and a clinical consensus within the "Guidance on patient referral to or within Scottish high and medium secure services" August 2019, NHS Scotland Forensic Network; it is acknowledged that this paper should be used to support, but not replace clinical judgement in individual cases.

It is also acknowledged that there are a small group of patients who will be exceptions to the clinical consensus and guidance which is framed in the terms of what is to happen "in normal or usual circumstances". There will be another group of patients who will be at the borderline between high and medium secure criteria. Full multi-disciplinary/agency consideration of individual cases by both referring and receiving teams will always be the cornerstone of resolving conflict. Very occasionally, the Forensic Network's "conflict resolution process" will have to be utilised (see Appendix 2).

2 PURPOSE OF POLICY

To ensure that individuals referred to the State Hospital, whether potentially for admission or for advice on management, are assessed comprehensively and timeously.

To ensure that patients referred for admission to the State Hospital (and for management advice) have a thorough assessment of their security needs.

To provide improved information for colleagues in local hospital services, the prison service and the Courts on the guidelines for admission to the State Hospital.

To establish auditable standards for the admission/referrals procedure—for both clinical governance and research purposes.

3 REFERRAL CRITERIA AND PROCESS

3.1 Sources of referral

Patients may be referred to the State Hospital from:

a) Other mental health services.
b) The Courts.
c) The prison service.

3.2 Referrers

Referrals may be made by:

a) Consultant psychiatrists (or their nominated deputies) working in other hospital settings.
b) Consultant psychiatrists (or their nominated deputies) working in a prison setting.
c) Procurators Fiscal.
d) Defence lawyers.

e) Judges and Sheriffs.

3.3 Involvement of local forensic and/or psychiatric service

The State Hospital is a national forensic mental health service and there is an expectation that referred patients will have had an initial multidisciplinary assessment by a local forensic psychiatry service, who should be in agreement or have recommended that the patient requires care in conditions of special/high security.

3.4 Legal status

All patients agreed for admission will be detained under The Mental Health (Care and Treatment) (Scotland) Act 2003, to include Sections of the Criminal Procedure (Scotland) Act (1995) as amended by the above legislation.

Section 328(2) of the 2003 Act, specifically states that a person is not mentally disordered by reason only of the following:

a) Sexual orientation.
b) Sexual deviancy.
c) Trans-sexualism.
d) Transvestism.
e) Dependence on, or use of, alcohol or drugs.
f) Behaviour that causes or is likely to cause harassment, alarm or distress.
g) By acting as no prudent person would act.

3.5 Age

In Scotland there is no distinct Secure Estate for patients aged over 65. Serious violence resulting in prosecution is rare in the elderly, albeit inpatient violence is frequently encountered in old age psychiatry units. Offenders over 65 can be admitted, considered on a case by case basis.

Section 2 of The Mental Health (Care and Treatment) (Scotland) Act 2003 supported the creation of age-specific services for those under 18.

In 2013, the Mental Welfare Commission published guidelines on the admission of young people to general adult wards “Mental Welfare Commission Guidance on the Admission of Young People to Adult Mental Health Wards (Mental Welfare Commission, 2013)

There should be no admission of someone aged 16 or under to The State Hospital. Admission of those aged between 16 and 18 should be exceptional and will require careful negotiation with a local specialist adolescent service to allow an appropriate assessment of the young person’s needs by adolescent services whilst in forensic care.

Any recommendation concerning the possible admission of a patient under 18 must first be considered and approved by the Child Referral Management Group whose role is to ensure that all reasonable alternatives have been considered. Referral to the State Hospital should be supported, inter alia, by a local CAMHS.

In the event of an admission of a patient under the age of 18 a report should be sent to the responsible commissioning Health Board, the Mental Welfare Commission for Scotland and the Inter-Regional Group to allow ongoing national oversight of the admission of the under 18s to forensic adult mental health services. All referrals for a patient under the age of 18 years must first be considered and approved by the hospital’s Child Referral Management Group (CRMG) – please refer to Appendix 3.

3.6 Reasons for and threshold for admissions/referrals

3.6.1 Kennedy (2002) detailed the components of security i.e. physical, relational, and procedural and specialist management arrangements. He produced a table (table 3 below) examining violence at presentation as a guide for security need at the time of admission. This should be considered with the factors listed in table 4 below. The referring letter should include an opinion as to the need for special/high security with reference to these criteria.

Table 1

Graveness of Violence	Behaviour
High (grade 1)	Homicide Stabbing penetrates body cavity Fractures skull Strangulation Serial penetrative sexual assaults Kidnap, torture, poisoning
Medium (grade 2)	Use of weapons to injure Arson Causes concussion or fractures long bones Sexual assaults Stalking with threats to kill
Low (grade 3)	Repetitive assaults causing bruising Self-harm or attempted suicide that cannot be prevented by two-to-one nursing in open conditions

Table 2

Admission Guidelines	Low Secure	Medium Secure	High Secure
Violence (grades refer to table 3)	Grade 3 Public order/nuisance offending	Grade 2	Grade 1
Immediacy	Acute illness or crisis likely to resolve in 3- 6 months	Relapses Abrupt Unpredictable	Unpredictable Inaccessible to staff
Specialist forensic need	Recall or crisis of former medium/ high-security patient. Current mental state associated with violence.	Arson. Jealousy. Resentful stalking. Exceeds low secure capacity.	Sadistic Paraphilia's associated with violence. Exceeds medium security
Absconding	Impulsive absconding	Pre-sentence serious charge. Other obvious motivation to abscond	Can coordinate outside help. Past absconding from medium or high security
Public confidence issues	Short-term family sensitivities	Predictable potential victims Local notoriety	National notoriety

Therefore, the degree of violence that patients admitted to High Security would have expected to display include:

a) Homicide.
b) Stabbing that penetrates a body cavity.
c) .Injuries resulting in a skull fracture.
d) Significant injuries resulting from strangulation.
e) Use of firearms, explosives or a history of concealing weapons in other secure environments would generally indicate the need for high security.
f) Repeated attempts at fire setting in other secure settings, where there is a significant likelihood of causing harm to others and particularly where there has been a degree of planning, the intention to cause harm and the motivation is due to mental illness.
g) Sexual offending, particularly rape, represents a wide range of offending requiring a carefully considered assessment of needs including management of risk. In general, where a patient is charged with rape an initial assessment by local Forensic Psychiatric Services should occur. In cases evidencing serious sadistic behaviours or serial penetrative sexual assaults an initial assessment by high secure services should be sought. Direct assessments by high security represent a relatively small group of patients and each individual's potential risk should be considered. While an initial assessment by high secure services may be undertaken this does not exclude admission to a lower level of security if deemed appropriate by both services. Section 3.7.4 provides further guidance for referrals for patients convicted of a sexual assault.
h) Offences involving kidnap, torture or poisoning.
i) In addition, patients with a high absconding risk or where there are significant public confidence issues can be considered for admission even if they have not committed a Grade 1 offence (as defined by Kennedy, 2002).

3.7 Women, People with a Learning Disability, Personality Disorder

3.7.1 Women

The National Forensic Network Report on women's secure care (2006) highlighted that the majority of women could be managed through relational and procedural security and that a High Secure Estate in Scotland was not justifiable. Consequently, the State Hospital has no facility for female patients. The process for referral of women in Scotland to high security in England is outlined in Appendix 4.

3.7.2 Intellectual Disability

Patients with a confirmed diagnosis of intellectual disability should be managed within the intellectual disability secure estate, including intellectual disability patients who have a comorbid mental illness. There are three criteria for a diagnosis of intellectual disability (as outlined by the British Psychological Society): significant cognitive impairment across a range of cognitive domains, significant impairment of adaptive functioning, and onset of disability during childhood. Services should guard against narrowly focussing in IQ scores, as the diagnosis is predicated on all three criteria being met and there are significant methodological issues with IQ scores. Specialist forensic ID service provision is consistent with the principles of Section 1 of the Mental Health (Care and Treatment) (Scotland) Act (2003). This should ensure that the specific specialist nursing, psychological rehabilitation and rehabilitation is available. It should be noted that some NHS Boards have forensic intellectual disability services. Any elective transfer between the intellectual disability and mental illness estate should involve negotiation between referring and receiving multi-disciplinary teams. Any dispute can be dealt with using the Forensic Network Conflict Resolution process (Forensic Network, 2005b; Scottish Executive Health Department, 2006) outlined in Appendix 4.

It should be noted that there is currently no high secure female provision in Scotland (including for females with ID). It is expected that females with ID who require high secure care will be managed as per the high secure pathway currently in place, and as part of female high secure provision as developed in Scotland in future (whether there is comorbid mental illness or not).

3.7.3 Personality Disorder

The Forensic Network paper on personality disorder (2005a) concluded that patients with a primary diagnosis of personality disorder are unlikely to have the significant impairment of decision making capacity to render them liable to civil detention. The Maclean committee (Scottish Executive, 2000) recommended that patients with a primary diagnosis of anti-social, dis-social, or psychopathic personality disorder are not admitted to the mental health system and that the Criminal Justice Services should be the primary agency responsible for the assessment and containment of risk. The report (Forensic Network, 2005a) advised that there should be no change in current Scottish practice (i.e. not to admit) at that time and this position still remains.

Personality disorder is a common co-morbid condition which should not result in exclusion for admission for assessment. There are circumstances in which the relative contributions of mental illness and personality order to offending is difficult to discern without recourse to an inpatient evaluation. There remain a small number of individuals who suffer from borderline, narcissistic or paranoid personality traits which cause diagnostic confusion. This group may benefit from admission to The State Hospital for assessment.

3.7.4 Patients charged or convicted of a Sexual Assault

Although sexual violence can be related to major mental illness, it is more likely to be associated with other co-morbid mental disorders such as Personality Disorder and Paraphilia, which are often found to be more relevant to reducing the risk of future offending. Given that for a number of these patient's personality characteristics can often be more relevant to understanding and managing risk of future offending, it will be important to consider:

- The seriousness of recent sexual violence e.g. chronicity or level of harm.
- Factors which indicate complexity in the assessment and treatment of an individual.

Patients who present with serious and continuing risk of sexual harm, where there is a co-morbid mental illness or intellectual disability, should be considered for referral to conditions of high security at The State Hospital. This is because these patients are likely to require a significant period of assessment and interventions, which will likely take place over a number of years. In these situations, there is no reasonable prospect of regular community access until the level of risk has been reduced and admission to a lower level of security may paradoxically be more restrictive and not be in the best interest of the patient. Issues of public confidence and medial interest may also be better addressed through admission to high security.

Indicators which suggest that referral to high security may be appropriate are:

- Single penetrative sexual assault with an ongoing risk of serious harm that cannot be managed in conditions of lesser security. Serious harm may include harm other than actual physical violence.
- Serial penetrative sexual assaults and/or diverse serious sexual offending.
- Specialist forensic need such as sexual sadism or other paraphilia associated with violence of a level that this would necessitate referral to a high secure setting.
- Current and/or previous serious sexual violence of a level as described above but that is not closely related to active symptoms of major mental illness.
- Co morbid established diagnosis of personality disorder of a severity such that this in association with sexual violence as described above may heighten the risk of future sexual violence to a degree that this needs to be managed in high security.

- Serious sexual assault (e.g. predatory or grooming behaviour, or penetrative assault) in a medium secure setting.

Assessment of these patients is likely to be complicated and there may be limited information at the point of referral. When a referral to high security is being considered, referrers should provide all relevant information (e.g. details of charge / index offence, reasons for concern, length of sentence, any existing risk assessment) to assist with the process of considering whether such a referral is appropriate.

Referrers may be asked to provide additional information to assist with making this initial decision, and discussion with Consultant Medical Staff prior to a referral to high security may be beneficial. In situations where the patient is admitted to medium security and further information comes to light which indicates that the criteria for referral to high security is now met, then a referral to the State Hospital may be appropriate.

In situations where the criteria for high security are not clearly met, it will be appropriate for local secure services to fully assess a patient who has committed sexual violence to decide on the appropriate level of security and if referral to high security is required. As a guide, a single serious assault (indictable) is likely to be appropriate for medium security, whilst a less serious sexual assaults (e.g. summary offences) may be considered for low secure services.

Referral to high security following a sexual assault in medium security should take into account not only the nature of the sexual assault that has taken place, but also other factors as otherwise described in this guidance that would lead to a consideration that assessment by high secure colleagues is required. However, any referral should be based in clinical judgement on a case-by-case basis and will be informed by a variety of factors, including the severity of the sexual assault. Inability to manage a patient assessed as requiring medium security due to the lack of single sex provision will not justify a referral to high security. In this situation, a bed may have to be sourced in a medium secure service providing single sex accommodation.

If a charge of sexual violence does not progress for legal reasons a decision will need to be made as to whether the risk presented by that individual requires them to remain in whatever level of security they are in. Allegation information can be used in structured professional judgment risk assessment, though they may carry a lower evidential weight, and decisions about transfer between levels of security are best made following such an assessment.

The above should be treated as guidance for referral to secure forensic facilities. It is likely that there will be exceptions to the above guidance and therefore having discussions prior to referral is often very helpful to clarify such issues.

3.7.5 Patients with identified additional care needs

The Scottish Secure Estate accepts that the additional needs of some individual patients may not be best met within our services. There are several principles within the Mental Health (Care & Treatment) (Scotland) Act 2003 which highlight the need for clinical teams to consider this including:

- Look at the full range of care options.
- Provide treatment of maximum benefit.
- Ensure that no one is treated less favourably.

Within the secure mental health estate, many individuals with specific needs receive the care they require. Clinical teams must consider however, whether any additional needs require care in a different environment which can provide additional care options ensuring equality of treatment and care for MDOs.

Examples of additional needs where consideration should be given to secure care outside Scotland include:

- Traumatic Brain Injury.
- Sensory Impairment e.g. hearing; sight.
- Progressive neurological disorders.
- Autism Spectrum Disorders.

3.8 Exceptional Circumstances

There may be circumstances where it may be necessary to consider the admission of patients to The State Hospital who do not satisfy the criteria for admission to high security. This will include occasions where there is no medium secure bed available in Scotland to which to admit to.

Prior to referral to the State Hospital the relevant medium secure service will have completed a full assessment of the patient and have accepted that they are suitable to be cared for in conditions of medium security. Thereafter there will be direct liaison between the Clinical Lead (or deputy) of the relevant medium secure service and the Associate Medical Director (or deputy) of The State Hospital before any referral is made to The State Hospital. This is in order to ensure that referrals are appropriately triaged.

Following admission, The State Hospital would require close liaison from the home NHS Board (and linked medium secure service) and an agreement facilitating a move to a placement which meets clinical need, as soon as possible, and in advance of any potential appeal against excessive security.

All such cases will be recorded through the Patient Pathway meeting at the State Hospital, they will also be subject to review by the Forensic Network Inter-Regional Group for monitoring and the Mental Welfare Commission for Scotland should be advised of the decision to admit under exceptional circumstances by the referring local service Forensic Consultant Psychiatrist. This should ensure that there is no doubt about the circumstances of the patient's admission to the State Hospital. The admission of such patients to the State Hospital will incur appropriate remuneration from the local NHS Board to The State Hospital.

3.9 Single referral point and standard for referral letter

All referrals should be typed and must provide the sufficient information in order for a decision to be reached as to whether or not the referral requires to be assessed by high security. **All referrals should utilise, where possible, the standard referral letter template - see Appendix 5.**

Routine referrals will be allocated at the weekly Patient Pathways Meeting. All routine referrals should be sent to the secure email distribution list TSH.Referrals@nhs.scot.

It is recognised that there may occasionally be situations of extreme clinical urgency that require an emergency referral to The State Hospital, but it is expected that such circumstances will be rare. For emergency referrals the referral should be discussed by the referrer with the On Call Consultant Psychiatrist.

All referrals to The State Hospital will be triaged by the Associate Medical Director (or deputy) and every referral will be discussed at the Patient Pathway Meeting held on a Monday morning, regardless of whether it is an emergency or routine referral. In the unusual event that a patient needs admitted before it is possible to discuss this at the Patient Pathway's Meeting, the assessing Consultant Psychiatrist should discuss the admission with the Associate Medical Director (or deputy) before the admission takes place.

The Associate Medical Director (or deputy) will allocate referrals to a multi-disciplinary team that has a vacant bed.

4 ASSESSMENT

4.1 Assessment process

The identified assessing clinical team will carry out a pre-admission assessment undertaken by up to 4 individuals from within the team: Psychiatrist, Nurse, Social Worker and Psychologist. Additional clinical team members can be involved in the assessment if required.

In certain circumstances (e.g. emergency referrals) it may only be possible for the referral to be assessed by a Psychiatrist. In this event the Psychiatrist should make every effort to discuss the referral with appropriate members of the clinical team prior to a decision being made to admit the patient.

If appropriate, the assessment may take place by all assessing disciplines meeting with the patient at the same time. However, there will often be circumstances where it is more appropriate for individual professionals to meet with the patient separately. Certain members of the team may choose to opt out of the pre-admission process depending on the specific needs of the patient.

4.2 Written reporting standards and the role of the Patient Pathway meeting:

For each referral all professionals involved in the assessment will complete a written report, using an agreed standard for their discipline. These reports will be stored in the patient's Health Record. Prior to presenting the case at the Patient Pathways Meeting the assessing clinical team will formulate a recommendation on whether the patient should be considered for admission.

Where there is difference of opinion within the assessing clinical team this should be reflected in the presentation at the Patient Pathway Meeting. The Patient Pathway Meeting will consider and discuss the recommendations made.

Where there is a difference of view between the recommendation of the assessing clinical team and the Patient Pathway Meeting the basis of this disagreement must be recorded in the minute of the meeting.

In the unlikely circumstance that a Consultant Psychiatrist felt compelled to admit a patient where either the assessing clinical team or the Patient Pathway Meeting was in disagreement, the circumstances and basis for such a decision should be clearly recorded in the minute of the meeting for governance purposes. Ultimately the decision as to whether to admit a patient will rest solely with the admitting Consultant Psychiatrist.

For each referral allocated the referring agency will receive an assessment report from the assessing Psychiatrist.

5 STRUCTURE AND RESPONSIBILITIES

5.1 Administration

An allocated Clinical Secretary will be responsible for recording the details of all those referred, the hub team allocated to, and the recording of the minutes of the discussions at the weekly Patient Pathway Meeting.

5.2 Medical Role

The psychiatric assessment will be carried out by a doctor recognised in terms of section 22 Mental Health (Care and Treatment) (Scotland) Act 2003. The role of the assessing psychiatrist is to lead the assessment and co- ordinate the various opinions from multidisciplinary colleagues from within his/her hub team. Each assessment will be ultimately the responsibility of the Consultant Psychiatrist allocated the referral.

The Consultant Psychiatrist will form an opinion and take full clinical responsibility as to the need for admission, (see criteria above), particularly in respect of diagnosis, detainability and risk.

5.3 Nursing Role

The role of the nurse assessor is to provide a nursing perspective, particularly on day to day risk management, to the assessing doctor; and whether any advice on nursing management issues would allow the person to stay in the current setting.

5.4 Psychologist role

The role of the psychologist is to carry out a psychological assessment of the patient's risks and needs and to consider how the psychology service at The State Hospital will be able to contribute to addressing these. They will provide a preliminary psychological and offence formulation, along with an opinion on the level of risk and how this could be managed in the future.

There will also be circumstances when the psychology assessment may be relevant to the decision on detainability, for example in the case of people thought to have a learning disability or where the patient has personality traits that are thought to be linked to a high risk of serious and violent offending.

5.5 Social Worker Role

The role of the social worker is to assess the social circumstances and background of the patient by means of collating information from the following sources:

- The offender / patient (where appropriate).
- The carer (home visit).
- The MHO.
- The current environment.
- The criminal justice system (where appropriate).
- Local social work services (where appropriate).
- Local mental health services.

The factors considered in pre-admission assessment are as follows:

- Impact of lifestyle / offending on current circumstances.
- Existing risk factors including in the community (i.e. drug/alcohol use).
- The social context of the individual.
- Relationships between peers and family (where possible).
- Previous offending behaviour.
- Mental health history.
- Child/ adult/ and public protection issues.
- Current living situation.
- Previous compliance with services and interventions.
- Family/social history.

Additional factors which will be considered include:

- A referral to Scotland from a service in another part of the UK or abroad.
- The age of the patient. (i.e. under 18 or over 65).

5.6 Informing the patient

Especially in emergency referrals, the decision to admit the patient will be conveyed to them by referring team in a manner that suitably manages the risk of self-harming behaviour or further aggressive or violent conduct, endangering others.

It is not considered appropriate for The State Hospital to inform the patient in writing, prior to admission, of the reasons for that decision. Although the rationale behind the decision to admit the patient will be conveyed to them following admission to The State Hospital.

In accordance with Mental Health (Care and Treatment) (Scotland) Act 2003 the managers of the referring service will be responsible for providing any required notice to the patient of any proposed transfer to The State Hospital.

The referring service will be fully responsible for the practical arrangements for the transfer of any patient accepted for admission to The State Hospital. The receiving clinical team should be advised of any admission date as soon as possible by the referring service to prepare for the patient's admission.

The referring service will be responsible for ensuring that the patient is appropriately detained, and completion of any required legal paperwork related to the patient's transfer, unless otherwise agreed with the receiving Consultant Psychiatrist.

5.7 Informing nearest relative/named person

Similar considerations occur in respect of informing nearest relatives. In many cases they will be consulted as part of the admission assessment process, and if the decision is made to admit their family member, they have a right to be informed as soon as practicable. This should be carried out by the referring service.

5.8 Exceptional use of remote assessment technologies

There may be exceptional occasions where a direct face to face assessment of a patient referred to The State Hospital is not possible. On such occasions the assessing clinical team can consider whether use of remote assessment technologies may be appropriate to perform the assessment. The decision as to whether or not to use a remote assessment will lie with the allocated Consultant Psychiatrist. The assessing Psychiatrist should be mindful of the potential effect performing a remote assessment will have on any legal requirements related to the assessment/admission. Where a patient is subsequently admitted having only had a remote assessment they should then be seen by a Consultant Psychiatrist in person within 2 hours of their admission.

6 REFERRALS FOR READMISSION

The criteria for readmission are essentially the same as those for a first admission, with the addition of information justifying the re-referral, particularly that the risk of serious harm posed by the patient in the lower security setting cannot be managed other than by readmission to the State Hospital.

Any patient readmitted within 12 months of discharge will be subject to a review of their case by a Consultant Psychiatrist who does not have a conflict of interest. The focus of the review will be to highlight any learning related to the patient's readmission.

7 REQUEST BY PATIENT FOR A CHANGE OF RESPONSIBLE MEDICAL OFFICER OR CHANGE OF HUB

The following process will be used where patients request either a change in their Responsible Medical Officer or a change in their Hub. A request of this nature can be made either by the patient or by the patient's Advocate. Such requests can be made directly through the patient's existing Responsible Medical Officer either verbally or in writing. Additionally, such requests can be made directly in writing to the Associate Medical Director. Where such requests are made directly to the existing RMO then these requests will be notified to the AMD. Where requests are made directly to the AMD then the RMO will be made aware of this. The Advocacy Service can support any patient in making a request.

Where a patient makes a request for a change to their Responsible Medical Officer or Hub this request will initially be considered by the patient's existing multi-disciplinary team through the Clinical Team Meeting. Details of the opinions of the Clinical Team members will be recorded. This opinion will then be shared with the Associate Medical Director.

7.1 Request for change of RMO within existing Hub

Where the Clinical Team agree with the patient's request for a change of Responsible Medical Officer which does not then require a move to another Hub, then this will be discussed within that Hub in the first instance to see whether one of the other RMOs within that Hub are willing to take on the role of RMO. In this instance such discussions and transfer to another RMO do not need further discussion outwith that Hub. Any change to the RMO should though be advised to the Health Records Department.

7.2 Request for change of RMO requiring a change of Hub

If the patient requests a change of RMO and following discussion within the clinical team it is felt appropriate that this be a RMO outwith the existing Hub, then this request will be advised to the AMD. The AMD will then request that a Consultant Forensic Psychiatrist based on another Hub review the patient, along with other clinical team members if felt appropriate, in order to reach a view as to whether the patient's request is clinically appropriate. It would be assumed that this Consultant Forensic Psychiatrist would be in a position to act as the patients' RMO if there is eventual agreement with the patient's request. This review will then be communicated to the AMD and the patient's existing RMO.

If there is agreement reached in relation to the patient's request, then this will be communicated in writing by the AMD to the patient and to the patient's existing RMO. Thereafter the patient will transfer to the care of the new RMO at a clinically appropriate time.

If the existing clinical team and the reviewing Consultant Forensic Psychiatrist are in agreement that a change of RMO is not clinically appropriate, then this decision will be communicated in writing to the patient and the patient's existing RMO by the AMD. The AMD will on request meet with the patient to communicate this decision in person.

If there is any disagreement in relation to the patient's request between the reviewing Consultant Forensic Psychiatrist and the existing clinical team, then the AMD will arrange a meeting between the relevant parties in order to attempt to seek a resolution to this disagreement. Following this the decision will be communicated in writing to the patient and the patients existing RMO by the AMD.

Where any conflict of interest lies in relation to the AMD's role in the process then the Medical Director will act in the place of the AMD.

Any patient moves will be managed through the Interhub and Ward transfer policy.

If there is any disagreement in relation to the decision reached by the AMD, then the Medical Director will be responsible for instigating a conflict resolution process.

In relation to the above process all such requests from the point from which they are received by the AMD will be responded to within four weeks.

8 STANDARDS

8.1 Timescales

The State Hospital aims to provide a rapid, responsive referral and admission assessment service to its NHS partners in Scotland, Northern Ireland and to the Scottish Prison Service and the Courts. The timescales below may be modified in certain circumstances, such as agreement that the assessment is less urgent or that a particular consultant/other multi-disciplinary professional should carry it out because of his/her specific expertise or previous knowledge of the patient. Referrals from services outwith Scotland or Northern Ireland may also take longer to complete.

The timescales referred to commence from when the case is discussed/allocated at the Patient Pathway meeting, not from receipt of the referral by the PA to the Associate Medical Director (excepting when a Monday is a public holiday). There are circumstances (e.g. clinical disputes, appeals against transfer etc.) when these timescales will not apply.

Table 3

Process	Timescale
From referral allocation at Patient Pathway meeting to multidisciplinary assessment.	2 weeks
From referral allocation to provision of to being presented at Patient Pathway meeting.	3 weeks
From date of acceptance for admission (date this was agreed at a Patient Pathway Meeting) to actual admission.	4 weeks

Please note that the above timescales apply to routine referrals, emergency referrals will always be dealt with rapidly and with the level of urgency demanded by the clinical situation. It will be at the discretion of the On Call Consultant Psychiatrist that receives an emergency referral as to when a patient is assessed. Consideration will need to be given in relation to the location of the referral, the potential need to attend to on call duties within the hospital and an assessment of any health and safety issues related to reviewing the referral on an emergency basis. If following this assessment, the On Call Consultant Psychiatrist deems that it is not appropriate to assess the patient on the day then they will have a range of options available to them.

These are:

a) To delay reviewing the patient until it is safe to do so. This would be no later than the next normal working day. If at this point it continues to be the view of the Consultant Psychiatrist that received the referral that it is not safe to review the patient, then this must be discussed with the Associate Medical Director (or in their absence the Medical Director). The On Call Consultant Psychiatrist that took the emergency referral will continue to hold responsibility for assessing the patient unless approval is sought from the Associate Medical Director (or in their absence the Medical Director) to hand this referral to another member of the Medical Staff.

b) To consider admitting the patient without directly reviewing them. It would be expected in this instance that other solutions to review the patient remotely would be considered i.e. telephone or video conferencing. Such solutions should also be used to obtain information from relevant sources to form as detailed a review as possible in the circumstances.

8.2 Waiting for Admission

Cases accepted for admission will be placed on the hospital waiting list, these will be reviewed on a weekly basis at the Patient Pathway Meeting. Regular contact will be maintained with referring agencies by the allocated Consultant Psychiatrist.

Patients should not have to wait longer than 4 weeks from the date of acceptance for admission at a Patient Pathway meeting (see 8.1 for possible exceptions).

8.3 Clinical Audit

To enable these standards to be audited, data sources need to be clearly identified, as well as the responsibility for collecting and collating this information. It is also essential to document any variation from the procedure because this will inform its future development.

The standards will demonstrate the following:

a) Good working practice.
b) Multidisciplinary working.
c) Involvement of outside / local services (sending standards to referring bodies in the first instance).
d) Involvement of patient / carer (where applicable).

9 GOVERNANCE

Key performance indicators will include:

a) Number of referrals, by Health Board of origin (usual residence of individual).
b) Sources of referrals – hospital, Court, prison.
c) Disciplines taking part in assessment.
d) Percentage of referrals admitted.
e) Percentage given advice only.
f) Variance analysis of adherence to standards.
g) Numbers and outcome of clinical disagreement.

Within the provisions of the Data Protection Act, data will be collected in such a way that it will be possible to track the outcome for patients refused admission to the State Hospital.

The Performance Indicators will be analysed on a quarterly basis and reviewed by the Referrals Meeting. Thereafter key KPIs and trends will be reported to the Hospital Management Team and the Clinical Governance Committee.

10 COMMUNICATION, IMPLEMENTATION, MONITORING AND REVIEW OF POLICY

This policy will be communicated to all stakeholders within the State Hospital via email, the hospital's intranet and through the staff bulletin.

The Patient Pathways Group will be responsible for the implementation and monitoring of this policy.

Any deviation from policy should be notified directly to the policy Lead Author. The Lead Author will be responsible for notifying the Advisory Group of the occurrence.

This policy will be reviewed every three years or earlier if required.

11 EQUALITY AND DIVERSITY

The State Hospitals Board (the Board) is committed to valuing and supporting equality and diversity, ensuring patients, carers, volunteers and staff are treated with dignity and respect. Policy development incorporates consideration of the needs of all Protected Characteristic groups in relation to inclusivity, accessibility, equity of impact and attention to practice which may unintentionally cause prejudice and / or discrimination.

The Board recognises the need to ensure all stakeholders are supported to understand information about how services are delivered. Based on what is proportionate and reasonable, we can provide information/documents in alternative formats and are happy to discuss individual needs in this respect. If information is required in an alternative format, please contact the Person-Centred Improvement Lead on 01555 842072.

Line Managers are responsible for ensuring that staff can undertake their role, adhering to policies and procedures. Specialist advice is available to managers to ensure that reasonable adjustments are in place to enable staff to understand and comply with policies and procedures. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Patient pre-admission assessment processes and ongoing review of individual care and treatment plans support a tailored approach to meeting the needs of patients who experience barriers to communication (e.g. Dementia, Autism, Intellectual Disability, sensory impairment). Rapid access to interpretation / translation services enables an inclusive approach to engage patients for whom English is not their first language. Admission processes include assessment of physical disability with access to local services to support implementation of reasonable adjustments. Patients are encouraged to disclose their faith / religion / beliefs, highlighting any adapted practice required to support individual need in this respect. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Carers / Named Persons are encouraged to highlight any barriers to communication, physical disability or anything else which would prevent them from being meaningfully involved in the patient's care (where the patient has consented) and / or other aspects of the work of the Hospital relevant to their role. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy".

12 STAKEHOLDER ENGAGEMENT

Consultation was undertaken at the time of policy development. Following review of the policy there have been no changes to current practice. Therefore engagement with the Key Stakeholders noted below has not been necessary for the 2024/25 review.

Key Stakeholders	**Consulted (Y/N)**
Patients	N/A
Staff	N/A
Carers	N/A
Volunteers	N/A

APPENDIX 1: LEGISLATIVE AND POLICY FRAMEWORK

Legislative and Policy Framework

1. Health, Social Work and Related Services for Mentally Disordered offenders in Scotland (NHS MEL (1999) (5)

Admitting people to the Secure Estate must be seen to be in accordance with the principles of this document, which states that mentally disordered offenders should be cared for:

With regard to quality of care and proper attention to the needs of the individual.

Under conditions of no greater security than is justified by the degree of danger they present to themselves or to others.

As near possible to their own homes or families if they have them.

Within services which maximise rehabilitation and their chances of sustaining an independent life.

2. The Mental Health (Care and Treatment) (Scotland) Act 2003

A guiding principle of the act (Section 1(4)) is that in discharging the functions of the Act, 'the minimum restriction on the freedom of the patient that is necessary in the circumstances should be used. In addition, there is a duty to consider:

a) The views of the patient, their carer or named person.
b) The range of options available.
c) The importance of providing maximum benefit.
d) Non-discrimination i.e. The patients should not be treated less favourably regardless of background and characteristics.

The Act has no generic description of the purpose of the State Hospital, but in several parts the "State Hospital" is mentioned, e.g.

Section 126(6) in respect of appeals to the Tribunal against transfer to the State Hospital, the Tribunal must be satisfied that:

a) The patient requires to be detained in hospital under conditions of special security; and
b) That those conditions of special security can be provided only in a state hospital.

Patients will continue to have a right of appeal against transfer to the State Hospital, to be exercised within 12 weeks of transfer. From 2006, patients have had a right of appeal against detention in excessive levels of security (section 264).

2. The Forensic Mental Health Services Managed Care Network Definition of Security Levels in Psychiatric Inpatient facilities in Scotland

The Forensic network commissioned the report which was endorsed by the Network Board in 2004, following wide consultation. The report defines the purpose of security as: "The purpose of security in psychiatric care is to provide a safe and secure environment for patients, staff and visitors which facilitates appropriate treatment for patients and appropriately protects the wider community".

The report identifies what characteristics which are designed to reduce risk are present in high security (The State Hospital) as compared to lower security. High security, as defined in the report, is taken as describing the special security of the State Hospital.

3. The Universal Declaration of Human Rights

“The protection of persons with mental Illness and the improvement of mental health care” comprises 25 principles adopted by the General Assembly of the United Nations in 1991. These include the statement that: “Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognised in the Universal Declaration of Human Rights.”

4. The Human Rights Act 1988

The State Hospital, along with other public authorities, is legally required to operate at all times and in all respects within the framework of the ECHR. In particular, admission can only be justified if patients are assessed by expert medical opinion as meeting the criteria for detention and this decision has been reviewed by due process of law.

The qualified rights to liberty, and to private and family life, apply to all patients in the State Hospital. The providers of Secure Services have to ensure that any limitation in these qualified rights can be justified on the basis of risk, by balancing the conflicting rights of other patients, staff and the general public.

The Human Rights Act requires the Act to be interpreted as placing an obligation on all Secure Hospitals to provide patients with both the factual and legal reasons for admission. Referring authorities must therefore ensure that the hospital has possession of all of the factual circumstances in order that the patient can be fully advised, including in writing, of the reasons for any subsequent admission. The patient is thus able effectively to exercise an appeal. Prompt patient access to advocacy services is an important element of the State Hospital’s admission pathway for patients.

APPENDIX 2: RESOLVING CLINICAL CONFLICTS BETWEEN FORENSIC MENTAL HEALTH SERVICES IN SCOTLAND

RESOLVING CLINICAL CONFLICTS BETWEEN FORENSIC MENTAL HEALTH SERVICES IN SCOTLAND

Introduction

This Annex sets out the arrangements for resolving clinical conflicts.

Caveats

This conflict resolution model takes into account that Responsible Medical Officers (RMO) cannot be obliged to accept a patient whom, in their professional judgement:

Y does not meet the criteria for compulsory detention under current mental health legislation; or Y would be inappropriately managed at their level of security – either that the level of security is excessive for the risks posed or insufficient to ensure safe care and treatment; or
Y would be inappropriate in terms of the treatment available in their facility.

In the case of an upheld tribunal as a result of the Mental Health (Care and Treatment) (Scotland) Act 2003 the responsibility to find a suitable location for a patient's treatment lies with the Health Board and not any particular RMO.

Conflict Resolution Group

A new Conflict Resolution Group will be established to manage the process. The group will be chaired by the Lead Clinician of the Forensic Network and will consist of experts such as Consultant Forensic Psychiatrist and other appropriate independent multi-disciplinary practitioners. The membership of the Group is set out at Appendix I.

Stage One – Initial Resolution

Where there is a dispute about the placement of a patient there should be first attempted an initial resolution which would involve a meeting between the two areas (referring Board and receiving Board); the referring Board should initiate the meeting. The meeting should involve the clinicians concerned and relevant managers. The meeting will either result in an agreement as to the appropriate clinical course of action (in which case there is no need for Conflict Resolution Group involvement) or an Agreed Joint Statement (AJS) of points of agreement and disagreement about the particular case.

Stage Two – Referral to Conflict Resolution Group

In the event of a failed initial resolution the case should be referred to the Conflict Resolution Group via the Forensic Network Lead Clinician. If there is a conflict of interest involving the Lead Clinician and any workings of the Group another member will take his/her role. Any member of the Group with a conflict of interest will not participate in any decisions relating to such a case.

The review of the case will be carried out by two or three experts, commissioned by the Conflict Resolution Group, independent to the case at hand. This expert group will carry out their review as they see fit and produce a report to be considered by the Conflict Resolution Group. It would be expected that the experts preparing the report would review case records, examine the patient and discuss clinical issues with relevant staff. At least one of those experts will be a Consultant Forensic Psychiatrist. The other one or two experts preparing a report on the case will be appropriate independent multi-disciplinary practitioners.

Within the experts' report there should be included a risk management plan.

It is expected that, except in exceptional circumstances, experts will provide a joint report.

Commissioners of the report should set out timescales at the time and will pay particular regard to Mental Health Tribunal timescales. Commissioners of the report should also consider geographical practicality when selecting experts as well as ensuring there is no conflict of interests. The timescale should not be inhibitive to the patient's care. Given the range of expertise now available in Scotland the use of experts from England or elsewhere would be exceptional and only in the circumstance of no available Scottish expert.

The experts will provide an independent report to the Conflict Resolution Group via the Forensic Network Lead Clinician.

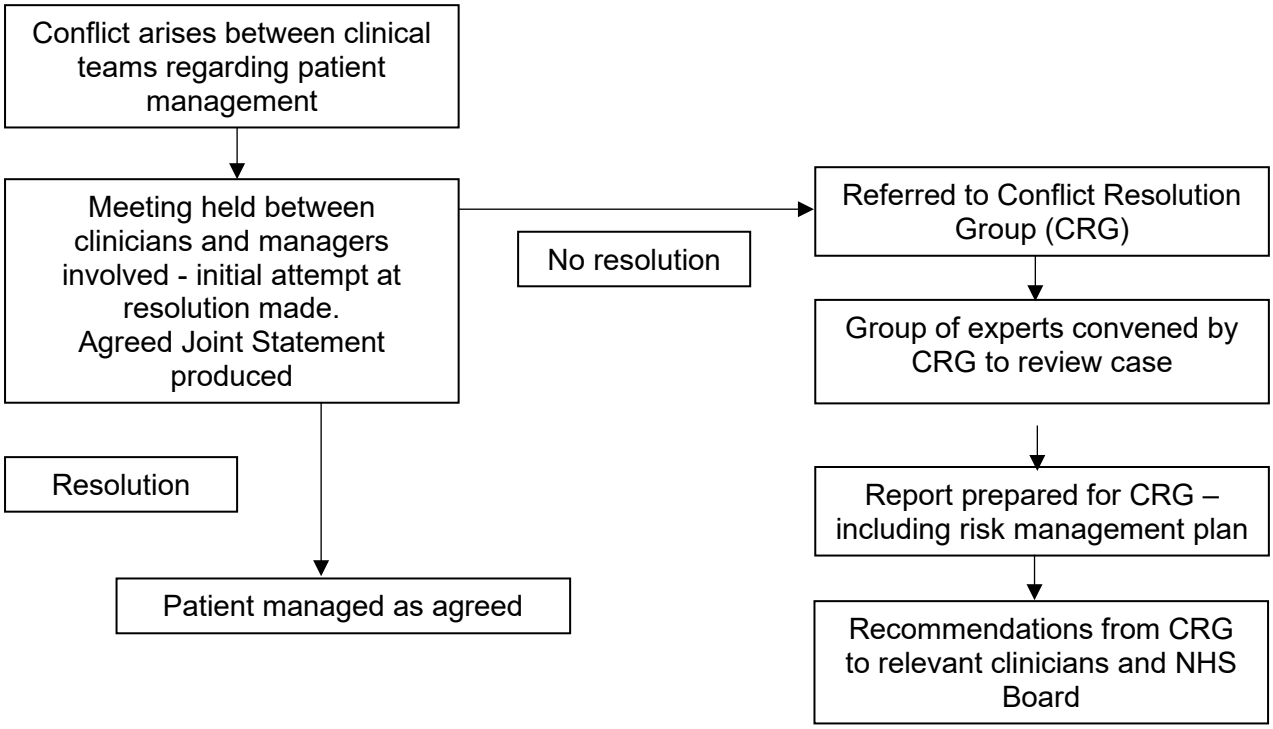
It must be agreed prior to referral to the Conflict Resolution Group who will pay for reports and consideration should be given to the costs involved for multi-disciplinary practitioners as well as consultant psychiatrists.

Stage Three – Judgement

The Conflict Resolution Group will consider the independent report. In most cases this could be done without the need for a meeting. The group will then make recommendations to the clinicians and Health Boards involved.

The conflict resolution model is illustrated in the flow diagram below:

Conflict Resolution Flow Diagram



Conflict Resolution Group

Membership

- Network Lead Clinician (Chair).
- Regional Clinical Leads.
- Senior Social Worker Psychologist.
- Nurse.
- Occupational Therapist.
- First Minister's Psychiatric Advisor (In attendance) Chair of Forensic Executive Group (In attendance) Forensic Network Project Manager (Secretariat).

Constitution

Meet quarterly, but in close contact between meetings – identify executive officers that meet more regularly and managed operationally by Clinical Lead and Project Manager. The group should decide its own ways of working at its first meeting.

Role in Conflict Resolution Process

- Allocate Experts to cases.
- Instruct experts.
- Decide who convenes experts.
- Receive report from experts.
- Question experts or agree report.

APPENDIX 3: CHILD REFERRAL PROTOCOL

Child Referral Protocol

Introduction

The State Hospitals Board for Scotland recognises that the Mental Health (Care and Treatment) (Scotland) Act 2003 places specific duties on Health Boards in relation to the provision of services for 'children'. For the purposes of the Act, a child is any person under the age of 18years. Under section 23(1)(b) of the Act Health Boards are required to provide "such services and accommodation as are sufficient for the particular needs of that child".

Therefore, any consideration of the possible admission of a 'child' to the State Hospital must first take account of the service implications as well as the assessed clinical need.

Child Referral Management Group (CRMG)

Any recommendation concerning the possible admission of a child to the State Hospital must first be considered and approved by the Child Referral Management Group (CRMG), before any proposed admission can take place.

Role of the CRMG

The role of the CRMG is to ensure that the specific duties of the Health Board are fulfilled. This includes being satisfied that:

- All reasonable alternatives have been considered in the circumstances of the case.
- The service implications are clearly identified and can be met.

Referral to the CRMG

Referral to the CRMG is the responsibility of the assessing State Hospital RMO.
The referral will include all background reports and information from local services and the full multi- disciplinary assessments of the State Hospital team. In addition, the assessing multi-disciplinary team must identify the specific services that will be required to manage the proposed admission of the child to adult care. This will include a risk assessment addressing the implications of the environment and other adult patients as required by the Code of Practice.

Membership of the CRMG

The membership of the CRMG will be:

Members	**In Attendance**
The Chief Executive	State Hospital Assessing RMO.
The Associate Medical Director	Relevant members of the State Hospital Multi-disciplinary Assessment Team.
The Social Work Team Manager	Appropriate Representation from the Local Referring Service.
Clinical Operations Manager	
Director of Security, Estates & Resilience	
Referring RMO	

Timing and Arrangement of CRMG Meetings

Depending upon the clinical circumstances of the case it may be necessary for the group to meet at short notice. Suitable deputising arrangements may be agreed in such circumstances.

Guidance

For the Assessment of a Child Referred for High Secure Care.

For the purposes of the Mental Health (Care and Treatment) Act 2003, a child is any person under the age of 18 years.

Section 2 requires that any functions under the Act in relation to a child with mental disorder should be discharged in the way that best secures the welfare of the child. In particular, it is necessary to take into account:

- The wishes and feelings of the child and the views of any carers.
- The carer's needs and circumstances which are relevant to the discharge of any function.
- The importance of providing any carer with information as might assist them to care for the patient.
- Where the child is or has been subject to compulsory powers, the importance of providing appropriate services to that child.
- The importance of the function being discharged in the manner that appears to involve the minimum restriction on the freedom of the child as is necessary in the circumstances.

Referral to the State Hospital

Referral should be supported by:

- A local CAMHS assessment.
- An undertaking from local CAMHS of ongoing involvement and provision of services to the State Hospital as required.
- Local MHO Assessment, where the child is already subject to compulsory measures.
- Local social work assessments, where such services are involved.
- Details of multi agency consideration of services and alternatives by health and local authority services.
- Evidence of referral to the UK forensic services commissioned by the Scottish Government and the response.
- Details of referral to and response from local and regional low and medium secure forensic services.
- Views and wishes of the child and immediate family.
- Copy of local notification to the MWC and any response.

Pre-admission assessment

Pre-admission assessment should include assessment by:

- Consultant Forensic Psychiatrist.
- Social Worker.
- Psychologist Nursing.

Required Practice in Consideration of an Admission

The Mental Health (Care and Treatment)(Scotland) Act 2003 Code of Practice, Volume 1 provides the following guidance in relation to children and young people: Wherever possible, it would be best practice to admit a child to a unit specialising in child and adolescent psychiatry.

Practitioners are reminded of the requirement which section 23(1)(b) of the Act places on Health Boards to provide "such services and accommodation as are sufficient for the particular needs of that child" who is either detained or voluntarily admitted to hospital for the purposes of receiving treatment for a mental disorder. The provision of services and accommodation must be sufficient for the particular needs of that child patient.

A child should only be admitted to an adult ward in exceptional circumstances, for example, where no bed in a child or adolescent ward is immediately or directly available. If the detained child cannot be admitted to a unit specialising in child and adolescent psychiatry, special consideration should always be given to the environment to which they are to be admitted, and what impact that may have on the child concerned. Any risks to them should be identified in advance and a plan put in place to minimise such risks. For example, the allocation of a single room with ensuite facilities may be prioritised, or special arrangements put in place to monitor the child's general well-being within the ward environment. Particular consideration should be given to the likely impact on the child of the behaviour of other patients on the ward and also the need to protect them from exposure to distressing experiences. Other ward policies, such as visiting, may also need modified to apply to children. Every effort should be made to provide for the child's needs as fully as possible.

Nursing staff with experience of working with children should also be available to provide direct input to care, support and guidance to ward staff. Best practice would be for the RMO to be a child specialist.

(In the context of the State Hospital consideration needs to be given to how such input may best be arranged -in particular joint working with local CAMHS teams.)

In the event of a child patient being admitted to an adult ward, it would be best practice for the hospital managers to notify the Mental Welfare Commission to enable them to monitor the general provision of age-appropriate services under the Act.

Parental Relationships

Section 278 requires health boards to take all reasonable steps to reduce any adverse effect on the relationship between a child and a person with parental responsibilities for that child.

Education

Education authorities have a duty to make arrangements for the education of pupils unable to attend school because they are subject to measures authorised by the Act or, in consequence of their mental disorder, by the Criminal Procedure (Scotland) Act 1995. (Section 277 of the Act amends the Education (Scotland) Act 1980 to that effect.)

NHS Arrangements for Secure Forensic Services for Young People

NHS National Services Scotland, National Services Division (NSD) commissions the secure forensic service for young people, resident in Scotland, from National Specialist Commissioning Advisory Group (NSCAG). This service is commissioned on a UK Wide basis by the Department of Health in England, under the auspices of NSCAG.

The process for referral and admission to the SFMHS for YP is clearly set out and applies to all young people being considered for referral regardless of their location.

At present when a young person, resident in Scotland, requires secure forensic accommodation a referral is made by their NHS Board to the National Secure Forensic Mental Health Service for Young People (SFMHS for YP). Where SFMHS for YP cannot provide the required specialist accommodation the young person's NHS Board can secure forensic accommodation from the private health sector. *

UK wide provision for young people with a learning disability was commissioned by NSCAG from 1 April 2007. *

* A person involved in criminal procedures in Scotland cannot be transferred cross border until such procedures are completed.

APPENDIX 4: REFERRAL TO HIGH SECURITY SERVICES – FEMALE PATIENTS PROTOCOL

Referral to High Security Services – Female Patients Protocol

Timescales for response should be built in to each step.

1. Female patient identified who may require high security Psychiatric services - Relevant Responsible Medical Officer and Multidisciplinary Team

2. Refer to Rampton Hospital admission criteria - Relevant Responsible Medical Officer and Multidisciplinary Team

3. Discuss referral by telephone with Lead Clinician for the female service at Rampton Hospital - Relevant Responsible Medical Officer and Multidisciplinary Team

4. Make written referral to lead clinician for the female service at Rampton Hospital - Relevant Responsible Medical Officer and Multidisciplinary Team

5. Inform the Scottish Government Mental Health Division that a referral is being made. They will liaise with Ministry of Justice and sort funding arrangements - Relevant Responsible Medical Officer and Multidisciplinary Team

6. Inform Scottish Government Mental Health Division of outcome of assessment - Relevant Responsible Medical Officer and Multidisciplinary Team

7. Invite the referring Scottish team to all case reviews – Rampton High Security Female Service. Carry out formal annual reviews for the need for high secure psychiatric care – Relevant Scottish RMO and MDT

Dr Lindsay Thomson
22 April 2009

APPENDIX 5: REFERRAL TO HIGH SECURITY SERVICES – STANDARD REFERRAL FORM

The following standard referral form should be used whenever possible when making a referral to the State Hospital.

The State Hospital Carstairs
Lanark, ML11 8RP
Telephone: 01555 840293

THE STATE HOSPITAL REFERRAL FORM

To be used when a patient is referred to the State Hospital for consideration for admission. Please complete as fully as possible and send to:

Email: TSH.referrals@nhs.scot

Any information that supports the referral process can also be sent to this email.

Referrals will be discussed at the Patient Pathways Meeting on Monday mornings. If the referral document is deemed to require further information from the local referrer prior to allocation, then this may delay assessment.

If the referral is clinically urgent, the on-call Consultant should be contacted through the State Hospital switchboard 01555 840293. Clinically urgent referrals require to be made by Medical Staff, with local Consultant Psychiatric staff being aware. ***The referral form still needs to be completed and submitted as soon as possible****.*

Referrer Details

Name:	
Organisation:	
Address:	
Email:	
Telephone:	

Patient Details

First Name(s):		Surname:	
Known as:		Gender:	
Date of birth:		CHI number:	
Home address:		Current location:	
Ethnicity:		Religion:	
Preferred Language:		Interpreter required:	Yes No
Health Board:		Local Authority:	

Legal Status

Detained under Mental Health section:	Yes	No	If yes, please give details:
Named Person:	Yes	No	If yes, please give details:
Advance Statement:	Yes	No	If yes, please give details:
Designated MHO contact details (if applicable)			

Specific Needs

Please note any needs the patient has which may impact on assessment (e.g. hearing-impaired)	
Please note any specific communication needs the patient has.	
Please note any specific accessibility issues the patient has.	

Reason for Referral

Urgency of referral (please tick)					
Emergency (requires assessment in 24 hrs)		Urgent (requires assessment 3 – 7 days)		Routine	

Service referred to (please tick)					
Male Mental Illness		Intellectual Disability		Exceptional Circumstances Patient	

Brief Reason for referral (including diagnosis with ICD11 code)

Index Offence and where relevant Charges/Conviction

Current mental state and management plan including medication

Summary of past psychiatric history

Summary of risk including details of risk assessments

Summary of relevant medical history (including current physical health, chronic conditions and weight)

Summary of substance use

Summary of forensic history

Relevant background information

Any other relevant information (e.g. carer details)

Signature of referrer:
(if emailed by referrer no signature required)

Date referral form completed:

To be completed by TSH admin staff:

Date received:		Received by:	
Date uploaded to RiO:		Uploaded to RiO by:	
Date of PPM:		Outcome of PPM:	