

Managing the interface with the NHS and other agencies

This section is intended to be used in conjunction with the guidelines on the diagnosis and management of particular disorders.

Developing effective liaison with the NHS and other agencies

Effective liaison with the NHS and other agencies is crucial to good-quality care and may be necessary at various points during a stay in custody.

- When prisoners first come into custody.
- On first suspecting that a prisoner is suffering from a mental disorder.
- During the course of a sentenced prisoner's career — 'throughcare' or 'resettlement' and sentence planning.
- When a prisoner is about to be released.
- In the week following release.

Certain structures and systems may make liaison with other agencies more effective. For example:

- Service agreements with local mental-health services.
- Designated liaison worker within the prison.
- Use of the Care Programme Approach (CPA).
- Agreements for sharing information while respecting patient confidentiality.

Service agreements

It will be important for some establishments to have a service agreement with local mental-health services that include the following.

- Provision of psychiatric assessments.
- Standards for the speed of response to emergency, urgent and routine requests for assessments. Scottish Prison Service specifications for mental-health services include the following standards: response to emergencies (within 24 hours), to urgent referrals (within 7 days) and routine referrals (within 4 weeks).
- Advice on the management of patients in prison who are refused transfer to hospital. This advice should include:
 - immediate and long-term management of the patient within prison
 - arrangements for liaison before release and
 - risk management and guidelines on when to re-refer, if the situation changes
- Advice on management, including medication.
- Where appropriate, the local service will also provide some services within the prison, eg daycare or clinics on the wings.

Liaison worker

Effective liaison with health services in the community takes time and effort. A designated member of staff can speed liaison and referrals when an individual first comes into prison or is first diagnosed with a serious mental disorder, during their prison career and before release. The liaison worker could ensure that each individual with a serious mental illness has a care plan and a designated care coordinator in the community before release, as stipulated in the NHS plan. Establishments with experience of such mental health liaison staff include the following.

- HMP Liverpool. Contact: Merseyside Criminal Justice Mental Health Liaison Service. Tel: 0151 255 0040; Fax: 0151 236 4799.
- HMP Belmarsh. Contact: Juliet Telfer (Forensic Mental Health Liaison Nurse) or Jo Fox (Psychiatrists PA), HMP Belmarsh, Western Way, Thameswade, London SE28 0EP. Tel: 020 8317 2436 ext. 338.

Participating in the joint Prison Service–NHS partnership work

Very useful personal links may be developed and maintained by participation in joint projects, eg needs assessments, continuing professional development opportunities, and local or regional Joint Planning Groups.

Agreements for sharing information while respecting patient confidentiality

There are several ways to maximise the sharing of information that is required for multidisciplinary care while maintaining the requirements of confidentiality and the trust of the patient. These are outlined in **Ethical issues** (page 300).

Where there is a grave risk of serious harm to the individual or to others, but the individual refuses consent to disclose information to avert such harm, the duty of confidentiality can be overridden by the duty to prevent the serious harm. In this case, information relevant to managing that risk should be shared on a 'need to know' basis. Unless doing so risks serious harm, the individual should be informed about who has been told what and why. For more details, see **Ethical issues** (page 300).

Assessment

Before making a referral, it is important to carry out an assessment with the following steps.

- Take a history and do a Mental State Examination (MSE) of the patient, including:
 - previous mental-health problems and treatment
 - recent drug or alcohol abuse
 - current symptoms and
 - observation and documentation of the sleep pattern, eating, speech, behaviour and interaction with others. (This will require information from residential staff or observation within the health centre). A brief overview of the MSE is provided on the disk .
- Obtain the previous inmate medical records (if any).
- Carry out a physical examination and investigations as required.
- Perform a urine drug screen.
- **With the patient's consent**, and where possible obtain more information from the following:
 - past psychiatric records (if any)
 - CPA key-worker (if appropriate)
 - general practice notes
 - sentence planning assessments and reviews (available from the sentence planning officer or probation officer)
 - relative or close friend and
 - solicitor.

It is always good practice to seek the patient's consent. However, if in the judgement of the responsible medical officer (RMO) previous records are needed to make proper and informed treatment decisions, then the patient's consent is not required to obtain information from previous health professionals, or to obtain a list of previous convictions or pre-sentence reports. Wherever appropriate, the patient should be informed if records are obtained without their consent. If records are obtained without consent, the reasons for doing so must be documented. It would be highly undesirable to contact a relative or close friend without the person's consent.

Care Programme Approach (CPA) and Section 117

All people who have previously been patients of secondary mental-health services and who have complex and continuing needs should have a care programme (an on-going care plan based on an assessment of their health- and socialcare needs) and a key-worker. The key-worker, most usually a community psychiatric nurse (CPN) or social worker, coordinates the care and should maintain some contact or knowledge of the patient even during his/her prison sentence. Patients who were on CPA when they entered prison should continue to be treated in accordance with their care plan — suitably amended to reflect their change in circumstances.

In addition, where an individual has previously been treated under Section(s) 3, 37, 47 or 48 of the Mental Health Act 1983, they are entitled to on-going aftercare under Section 117, whether or not they are in prison. Their previous care coordinator should stay in contact with the individual while they are in prison and be involved in planning their care.

- Assess the risk to self or others (for information on assessing risk to self, see **Assessing and managing the risk of suicide**, page 204).

Psychiatric assessment of risk to others

History:

- Previous violence and/or suicidal behaviour.

- Evidence of rootlessness or social restlessness, eg few relationships, frequent changes of address or employment.
- Evidence of poor compliance with treatment or disengagement from psychiatric aftercare.
- Presence of substance misuse or other potential disinhibiting factors, eg a social background promoting violence.
- Identification of any precipitants and any changes in mental state or behaviour that have occurred before violence and/or relapse.

Are these risk factors stable or have any changed recently?

- Evidence of recent severe stress, particularly of loss events or the threat of loss.
- Evidence of recent discontinuation of medication.

Environment:

- Does the patient have access to potential victims, particularly individuals identified in mental state abnormalities, eg those who figure in the patient's delusional system?

Mental state:

- Evidence of any threat/control override symptoms: firmly held beliefs of persecution by others (persecutory delusions) or of the mind or body being controlled or interfered with by external forces (delusions of passivity).
- Emotions related to violence, eg irritability, anger, hostility, suspiciousness.
- Specific threats made by the patient.

Conclusion:

A formulation should be made based on these and all other items of history and mental state. The formulation should, so far as possible, specify factors likely to increase the risk of dangerous behaviour and those likely to decrease it. The formulation should aim to answer the following questions.

- How serious is the risk?
- Is the risk specific or general?
- How immediate is the risk?
- How volatile is the risk?
- What specific treatment, and which management plan, can best reduce the risk?

Source: with permission of Royal College of Psychiatrists Special Working Party on Clinical Assessment and Management of Risk. *Assessment and Clinical Management of Risk of Harm to Other People*. Council Report CR, April. London: Royal College of Psychiatrists, 1996

A brief risk indicator checklist is provided on the disk . These are examples of risk assessment tools that may be useful.

Liaison with wing staff will often be a useful source of information.

Where the patient is admitted to a healthcare centre, observations by the nurse or health care officer in charge of their care form a valuable part of the in-patient assessment. An initial assessment form to be completed by a nurse or other staff member is provided on the disk .

Consider referral to the psychiatric services

After the assessment, decide whether a referral is needed and, if so, how urgently. See also the criteria for referral in the guidelines for specific disorders.

Criteria for non-urgent referral

Non-urgent referral will be required for a number of reasons including the following.

- Danger of harm to self or others and the patient is or may be mentally disordered.
- Treatment in hospital is likely to be required. If mental illness is suspected, the patient should be referred for assessment, and the solicitor notified, with patient permission. Do not rely on the patient coming to psychiatric notice by other means (eg through the court).
- Patient is so disabled by their mental disorder that they cannot be managed on an ordinary location or fulfil activities of daily living.
- An individual on hunger strike should be referred for assessment at an early stage, before the individual's physical health has deteriorated, even where mental illness is not thought to be present (see **Food refusal and mental illness**, page 292).

- General practitioner requires the expertise of secondary care to confirm a diagnosis or to implement specialist treatment.
- There is a need for care and/or treatment beyond the capacity of primary-care services in prison, eg particular psychotropic medication such as clozapine or lithium.

Criteria for urgent referral and possible transfer

Urgent referral will be required for a number of reasons including any one of the following:

- Serious psychotic symptoms causing severe distress, dangerous behaviour or major disruption to functioning.
- Patient cannot be looked after safely in the prison because of his/her mental illness.
- Patient is not accepting treatment and may, if left, deteriorate to the point of requiring emergency treatment under common law or has needed this already.
- Severe physical deterioration of the patient (eg ceasing to eat and drink because of mental illness).
- Patient is at high risk of suicide (eg requires 'within eyesight' or 'within arms length' observation).
- Stupor.

Vigorous steps should be taken to remove such patients urgently (within days not weeks) to a more appropriate setting.

Making a referral

Making an urgent referral for possible transfer to the secondary mental-health services. A number of steps are required when making a referral to such services.

Consider where to refer

Refer to dedicated or sessional mental-health services within the prison, if they exist. If not, refer to the mental-health service covering the patient's original catchment area.

To locate the catchment area service, do the following:

- If the last address and a pre-custody general practitioner are available, the catchment area can usually be traced.
- If the prisoner is of no fixed abode and/or not registered with a general practitioner, then the place of offence or magistrate's court is used as a proxy for the last address. In some areas, there may be a 'no fixed abode rota' between all the main psychiatric hospitals within a defined area.
- If the person is an immigration detainee with no place of residence, contact the Director of Public Health (or equivalent) at your Primary Care Trust for advice on the most up-to-date procedure.

Consider to whom to refer

Obtain the names, telephone numbers, fax numbers, emergency availability (eg bleep or mobile) of the following key personnel:

- Senior consultant psychiatrist in the catchment area.
- Manager of the community mental-health team.
- CPA key-worker (if the person is previously known to the psychiatric services).
- Manager of the mental-health service of which the community mental-health team is a part (eg Director of Mental Health in the NHS Mental Health Trust). Ask if they are currently available or on leave. Ask who to contact if they are not available. This senior manager may help resolve differences or problems that arise with the clinical staff.

Should you refer to general or forensic psychiatric services?

Psychiatrists visiting prisons may be general psychiatrists (adult or adolescent) or forensic psychiatrists (adult or adolescent) according to local arrangements.

In addition to local arrangements, considering the following factors may be helpful in deciding between referral to a general or forensic psychiatrist.

- Offence.
- Clinical picture.
- Assessment of risk.

A forensic psychiatrist is more likely to be required if the following apply.

Offence:

- Offence involves homicide, a serious sexual assault or serious violence.
- Prisoner has offended while within a treatment setting and that environment is no longer considered suitable or safe.

Clinical picture:

- Prisoner is sentenced and likely to need a Section 47 transfer to hospital for treatment or remanded for a serious offence and is likely to need transfer to hospital under Section 48.
- Assessment is required for treatment of a major personality disorder.
- Prisoner or court is asking for an opinion about treatment for sexual offending.
- There is a past history of treatment in a medium secure unit or special hospital.
- There is a history of serious violence whether or not convictions have ensued.
- The presentation of their illness is such that, after assessment by local generic services, they could not be managed by these services.

Risk assessment: there is a risk of serious violence or this risk needs to be assessed.

A local directory of services can be useful. Further advice may be obtained from administrators, medical records' departments, clinical team leaders in local hospitals or from community mental-health teams.

Exchange all relevant information

With due regard to patient consent and confidentiality, obtain the names and addresses of the individual's general practitioner, solicitor and any friends or relatives that the individual nominates to act on their behalf.

Contact the senior consultant psychiatrist or CPA key-worker in the first instance. Give as much information as possible about the current problem including severity, provisional diagnosis, current management, problems in managing the person, pending court appearances and the urgency of transfer required, eg 1 day, 1 week, 2 weeks, 1 month, etc. with reasons. Be able to give the index offence and any relevant previous convictions. This will help to assess the risk and to decide which service may be appropriate (eg forensic, high dependency, open ward).

Check that the person you are talking to has the same understanding as you do of terms such as 'severe', 'urgent' or 'very ill'. If there is any doubt, describe the behaviours; be explicit.

If you are familiar with the services, indicate where you think the person is likely to need to be placed, if transferred out of prison (eg open in-patient ward, locked ward, medium secure unit, maximum security). If not, say that you are not familiar with how the services are organised and ask the mental-health service to re-refer to a more appropriate person or service, if necessary. It is their responsibility to do so.

Negotiate the timetable for assessment

Ask how soon the service can assess the individual. Indicate to them if you feel the delay is unacceptable. If the service cannot offer an earlier date, ask the contact person if they can advise an alternative service and agree who will refer to this service. Ensure both general and forensic services are considered. If the catchment area service has no beds available anywhere, ask the contact person to seek alternative beds in other hospitals or services. It is their responsibility to do so, not yours.

Document all actions and conversations

Use both telephone and fax and follow up any verbal discussions with a record of what is discussed. Send this record to the person involved so that they can identify discrepancies or misunderstandings. Diligently copy into the inmate medical record (IMR) at all times.

Consider involving the Home Office Mental Health Unit

It is often helpful to involve the Home Office Mental Health Unit at an early stage. It has a database of hospitals. Contact:

- Mental Health Unit, Home Office, 50 Queen Anne's Gate, London SW1H 9AT.
- Tel: 020 7273 3394 in office hours for prison transfers to hospital for remand and sentenced prisoners. In case of difficulty, ask switchboard on 020 7273 4000 for an officer of the Mental Health Unit, quoting the patient's surname.
- Fax nos: 020 7273 3411/2937/2172.
- On-call, out-of-hours service for emergencies. **Tel: 020 7273 2069.**

If transfer under Sections 47 or 48 of the Mental Health Act 1983 is planned, write a letter to the Home Office Mental Health Unit indicating what action is planned and has been taken, soon after referral to the catchment area service (see **Use of the Mental Health Act 1983**, page 163).

Take further action if no progress is made

If there is still no acceptable resolution, contact the senior manager of the NHS Trust. Most senior managers try to resolve disputes before recourse is made to outside agencies. If the problem is not resolved at this stage, do the following.

- Inform the patient's solicitor, general practitioner, relatives or nominated representatives and, in the case of a patient on remand, write to the local court clerk that the patient is scheduled to attend, indicating what is happening.
- Telephone and write to the Mental Health Lead in the Strategic Health Authority that serves the catchment area. This is the person with lead responsibility to identify suitable placements for those who need secure mental health services, including prisoners and to intervene if necessary in cases that are difficult to resolve. Copy the letter/fax to the Prison Lead in the catchment area Primary Care Trust. Ensure you have up-to-date contact details of the relevant person(s) for your establishments.
- At this stage, where the prisoner is on remand, write a full letter/report detailing the difficulties encountered in transferring the person to hospital, to the local clerk of court so that information is available to magistrates, judges and the patient's legal representatives.
- Advise patients of other parties that they could contact (eg Community Health Council or its equivalent, European Court of Human Rights).

An up-to-date list of the contact details of Primary Care Trusts, Strategic Health Authorities and other NHS agencies can be obtained from: Prison Service Health Task Force, Wellington House, 133-155 Waterloo Road, London SE1 8UG.

Tel: 020 7972 2000.

Making an urgent referral for acute medical treatment

Where a patient requires medical treatment as an emergency (eg for an overdose or acute confusional state that may be delirium), but, because of mental disorder or otherwise (eg unconscious after a fall), does not have capacity to give or refuse consent, such a patient may be taken to a general hospital for treatment under common law. In such a case, a medical doctor may make this decision without the involvement of a psychiatrist. The Mental Health Act does not come into play for treatment for a physical disorder, including an overdose. Transfer the individual under escort, by ambulance if necessary, to the nearest A&E and inform the relevant consultant that the patient is on his/her way (for more information, see **Consent and capacity**, page 300).

Where the patient's physical condition has deteriorated as a direct consequence of mental illness (eg patients with anorexia nervosa and reduced insight who require special forms of feeding, and patients with severe depressive illness who stop eating or drinking), treatment for these direct consequences of mental illness may be provided under the Mental Health Act. In this situation, obtain an urgent (on-call) assessment in the prison, stating that transfer to an NHS psychiatric hospital under Sections 47 or 48, or to an NHS general hospital under common law, will be needed, depending on the urgency of the need for treatment. If the urgent need is for a psychiatric bed and there are difficulties obtaining one, telephone the Home Office Mental Health Unit: 020 7273 3394 (office hours) or 2069 (out of hours emergencies).

Arranging the assessment visit

When the date of the assessment visit is agreed, give the visiting team as much information as possible about how to arrange a visit, how to find the prison, when it is possible to see inmates, security arrangements, etc. (a leaflet may be useful here) and smooth their entry at the gate.

Try to arrange for a healthcare worker who knows the inmate to be available to discuss the problem and to deal with feedback after assessment.

Consider treatment

See the relevant disorder-specific guidelines. In addition:

- Discuss with the catchment area team whether to start treatment before assessment.
- Find out what has been effective before.
- Initiate the CPA if specialist care is involved. Request that the mental-health specialist documents the assessment and the care plan, agrees who the key-worker is and sets a date for the review of the care

plan. Ensure that you have a copy of the care plan in the medical notes. Write the name and contact details of the key-worker clearly on the front of the notes. Copies of CPA documentation should be provided by the local NHS Trust.

Other issues

Other issues may need to be considered, for example:

- **Consider opening a 2052SH form** (in Scotland, an Act to Care form).
- **Consider the most appropriate location for the patient.** Discuss between the healthcare team and other relevant staff whether the prisoner needs to be located in the healthcare centre and the levels of observation (see **Observing a patient at risk of suicide**, page 220). Consider a single/shared cell/care suite. If the prisoner is to be on ordinary location, give the wing manager as much advice about the appropriate management of the patient as is consistent with patient confidentiality. One of the information leaflets for prison officers on the disk may help.
- **Consider who needs to be informed:**
 - **Court:** it may be necessary to make the prisoner 'unfit for court'. Write/fax the court, explaining the reasons for this.
 - **Next of kin:** consider informing the next of kin and/or the solicitor if the patient gives permission.
 - **Health services:** where the prisoner has had previous contact with the health services, support the maintenance of contact wherever possible. For example, ask if the patient had hospital appointments booked and, if so, what for.
 - **Sentence planning:** where the patient is a sentenced prisoner, consider informing the sentence-planning officer and a probation officer if the patient gives permission. It is in the patient's best interests for healthcare input to be made to the process for planning multidisciplinary care to the individual while in prison and following release (for more details, see **Throughcare** below).
- **Consider the need for 'medical hold'.** To ensure continuity of treatment, consider placing the prisoner on 'Medical Hold' to complete assessment or a course of treatment.

Participation in prison multidisciplinary care planning

Where prisoners have mental-health needs, it is in their interests for these to be considered alongside their social, psychological and offending behaviour needs, within existing prison multidisciplinary assessment and care-planning procedures. Such multidisciplinary health- and socialcare is a requirement of community mental healthcare outside prison and of mental healthcare in all Scottish prisons. For some prisoners, it is appropriate for their key-worker to continue to oversee their care plan and to provide follow-up care under Section 117 while they are in prison. This is easier to arrange when the prison is near the catchment area.

Sentence planning

Sentenced prisoners already receive a multidisciplinary assessment of their needs and a plan is developed to meet these needs, as far as possible. Interventions that may form part of the sentence plan include educational courses, substance misuse courses, offending behaviour courses, including anger management, sex-offender treatment and enhanced-thinking courses. The aim is to reduce future offending, provide support to the individual and his/her family, help towards better social functioning and prepare for release. The sentence-planning process may be coordinated by a probation officer/prison social worker or by a prison officer.

Further multidisciplinary assessments are also made in order to plan the release of the prisoner, either permanently or under **supervision on temporary licence**, on **life licence** or on **discretionary conditional release (also known as parole)**. Psychiatric reports for these purposes should ideally be written by a psychiatrist with catchment area responsibility for the locality to which the prisoner is likely to be released.

Providing healthcare input to throughcare processes

In Scotland, arrangements to ensure healthcare input are made to throughcare processes and they are mandatory. In England and Wales, if it is not yet routine for healthcare input to be made to throughcare processes in a prison, consider a regular meeting between the healthcare manager, senior medical officer, mental-health staff, probation staff, chaplain, psychologist, education manager and sentence-planning manager to discuss how best to achieve this. The discussion should include the issue of confidentiality.

An appropriate member of the healthcare team should attend multidisciplinary care-planning meetings.

Benefits of healthcare input

Information about mental-health needs, prognosis and the likely pattern of relapse (if known) is relevant to the following.

- Assessments of risk.
- Planning an appropriate location, eg moves between wings, especially healthcare centre to wings and 'respite' stays in the healthcare centre; management, eg need for quiet, lack of confrontation; and activities, eg varying activities to match varying patterns of symptoms arising from depot medication. Jointly consider a mixed location (eg education centre or sheltered work during the day; healthcare centre at night, or daycare centre during the day, normal wing location at night).
- Identifying and responding appropriately to signs of relapse.
- Planning a response to a crisis. This can be particularly helpful in cases of chronic self-injury in the presence of a personality disorder, where several disciplines may be involved.
- Appropriate goals for substance misuse interventions.
- Integrating treatment of mental-health needs with offending behaviour needs; eg an individual might make better use of offending behaviour groups if he/she first attended an anxiety management group.
- Planning aftercare following either temporary release on licence or permanent release.

What information to provide

Provide information, with the patient's permission, to the sentence-planning team on the patient's:

- mental health history
- previous contact with the mental-health services
- current presentation and treatment
- prognosis
- early warning signs of relapse
- guidelines for further management within the system and
- recommendations, as appropriate, for further assessments.

Ensure that staff in areas where the individual spends time (eg wing manager, workshop supervisor, teacher) have a copy of the appropriate information .

If attendance at meetings is not possible

- Ask to be kept informed in good time of discussions about possible release dates, including temporary licence or home detention curfew.
- Ask for a summary of planned throughcare, including care after release.
- Send a letter outlining the patient's mental-health needs and giving clear guidelines for further management within the system. This may include a recommendation that a further opinion be sought, eg from a clinical psychologist or drug/alcohol services.

Liaison with residential and other staff about all patients

Whether or not the individual is in prison for long enough to have a sentence plan, residential and other staff will need information to provide appropriate management and support to the patient on ordinary location. With patient permission, consider providing advice, where appropriate, on the following:

- Location (eg single or shared cell).
- Risk of suicide, self-harm or harm to others.
- Suitable work placements.
- Signs of relapse (eg becoming very withdrawn or verbal content becoming strange or out of context), when the health centre should be contacted again.
- Reducing noise and stress.
- Promoting increased family contact, extra visits, telephone calls.
- Facilitating a safe environment, eg concerns about bullying or debt.
- Provision of activities in a cell, eg art materials, reading materials.
- How to respond to difficult behaviours.

Prerelease planning and liaison

Arrangements for appropriate on-going care in the community need to be put in place, wherever possible, before a prisoner is released. This should be done before release of any kind (eg on temporary licence, for home detention curfews and before permanent release) and should be done, wherever possible, as part of a multidisciplinary plan (see the disk for a description of different types of temporary release).

Unplanned release

When prisoners are released unexpectedly (eg criminal proceedings discontinued, bail) and the individual is in need of admission to hospital, consider contacting the following:

- General practitioner.
- Mental Health Crisis Service.
- General mental-health services.
- Probation Service.
- Court Liaison Service.
- Police mental health liaison officer.

Alternatively, consider contacting the Police so that they can alert the relevant Local Authority. They may then consider the use of Part II of the Mental Health Act.

Planned release 1

Notify the individual's general practitioner that release is planned, with patient permission. Give the release date if known. If the individual gives permission, give the general practitioner sufficient information to enable him/her to coordinate quickly the services required should problems arise. Include as many of the following as possible.

- Patient's name, date of birth, address and telephone number.
- Brief personal and social history.
- Past psychiatric history.
- Current mental state.
- Current medication and details of any medication tried in the past.
- Drugs and alcohol history.
- Details of carers and significant others.
- Recommended involvement of other services, eg socialcare, housing.

If the individual does not have a general practitioner, support him/her in registering with one. If possible, obtain from the local Primary Care Trust/Local Health Group a list of practices whose lists are open (still taking new patients). Give the individual information about how to register with a general practitioner. If there is a primary-care service in the area that provides walk-in treatment for homeless or unregistered people, give its details. Inform the individual that if an acute injury or illness occurs before they register, they may ask for short-term treatment at any practice. All general practitioners must provide such treatment that is 'necessary and immediate' and may claim payment for doing so from the Primary Care Trust, without the patient being registered.

Planned release 2

Where the release date is known, refer as soon as possible and at least 4–6 weeks before release to the mental-health services in the appropriate area. Prisoners with serious mental illness should have a designated care coordinator and care plan agreed before release. The referral letter (or fax) is best written by a mental-health worker or psychiatrist and sent to the mental-health services, with a copy to the individual's general practitioner. Include the following information.

- Background circumstances of referral.
- Index offence.
- Forensic history.
- Personal history.
- Social circumstances (eg housing).
- Psychiatric history.
- Substance misuse.
- Current mental state.
- Current treatment and progress.

- Details of other services that have been put in place to tackle other areas of the individual's needs (eg probation, substance misuse). Where healthcare staff have not already had input into the plans of both probation and sentence-planning staff, liaise now to ensure you are fully aware of plans.
- Where the individual has both psychiatric and substance misuse needs, ensure that services (if separate) are aware that the individual needs both services concurrently. Where you are certain that symptoms of mental illness are not substance-induced (eg where successive drug screens have shown an individual to have psychotic symptoms while drug free), state this clearly.
- If the individual has previously been treated in hospital under Sections 3, 37, 47 or 48, include the information and send a copy of the letter to the Local Authority concerned. Health Authorities and Local Authorities have a duty to provide aftercare for these individuals under Section 117.
- Where the individual does not have a general practitioner, make sure that the care coordinator is aware of this fact and include help for the individual in registering with a general practitioner as part of the care plan.

Planned release 3

Where the individual has a range of complex needs and is likely to find it difficult to access or maintain contact with the appropriate statutory services in the community (eg someone with some mental illness plus personality disorder who also abuses substances and is of no fixed abode), request an assessment visit before release by the catchment area psychiatrist or other team members. Establishing personal contacts increases the chance of successful follow-up.

In some areas, voluntary agencies may operate services that specialise in supporting this group of patients in making and maintaining contact with statutory services, eg Revolving Doors, which operates a service in HMPs Pentonville, Holloway, Woodhill and Wormwood Scrubs, and the Mental After Care Association (MACA), which operates in the Inner London area. Access to MACA's schemes is via the London Probation Service. The relevant specialist commissioning group (now based in Strategic Health Authorities) will have details.

Consider the need for practical help to ensure that the individual can get from the prison, when released, to the first of his/her appointments.

Follow-up

Where possible, the care coordination plan should include an appointment with both the general practitioner and the mental-health service within 5 days after release. There is a need for partnership work between the health, prison, probation and social services to ensure continuity of care.

Liaison when a patient is transferred back to prison from hospital

Someone who has been transferred to a secure hospital under Sections 37, 47 or 48 may be returned to prison. Such patients **are entitled to on-going care under Section 117 of the Mental Health Act**. This section obliges Primary Care Trusts and Local Authorities to provide aftercare for those treated under the Mental Health Act in hospital and then discharged. Prison healthcare staff should expect, before transfer of the patient from hospital to prison:

- to be invited to a case conference along with in-house or sessional mental-health services if available, or the appropriate Health Trust and local social services to agree Section 117 needs and arrange suitable CPA and aftercare services
- to receive a copy of a discharge plan that includes risk factors for relapse, a crisis plan and what to do if the patient relapses after transfer to prison and
- to receive the results of the assessments and advice on how the person's behaviour should be managed, if the patient is to be returned as 'untreatable'.

For more information about the use of the Mental Health Act 1983, see page 163.