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# The Referral and Admission of Prisoners to General Adult Psychiatric Intensive Care Units (PICU)

## Quality and Good Practice Guidance

## 2023

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Image designed by an inmate from Leicestershire prison in the 'Prisoner Art in Mental Health Project' by Soft Touch Arts

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# Foreword

The interface between general adult psychiatry and forensic mental health services continues to receive considerable interest. With a landscape of admission processes, commissioning responsibilities and inpatient provision, the transfer of prisoners to inpatient mental health services is a particularly complex and interesting one.

There are currently over 87 000 people in prison across the UK. We know that rates of mental illness are high and that those requiring transfer to inpatient units need a timely but effective pathway.

NAPICU are pleased to be able to publish this good practice guidance for the transfer of prisoners to general adult PICUs.

NAPICU was founded in 1996 and is a multidisciplinary organisation committed to supporting patients, clinicians, service providers, carers and commissioners with evidence-based guidance and innovative practice.

Developed in consultation with relevant stakeholders, clinicians and offender health professionals, this NAPICU guidance aims to support the appropriate transfer from prison for those who are in need of mental health care in hospital.

By maintaining focus on the mental health needs of people in prison, we hope that those who need to facilitate transfer will find this NAPICU good practice guidance helpful for accessing the right setting, at the right time, and in the least restrictive way.

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# The referral and admission of prisoners to General Adult Psychiatric Intensive Care Units (PICU)

**Quality and Good Practice Guidance**

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## 1. Introduction

1.1 This guidance aims to support timely access to appropriate inpatient mental health care for people accommodated in the prison estate. Where required, the guidance refers to the Mental Health Act applicable in England and Wales. The guidance may have some more general value for practitioners in other jurisdictions.

1.2 Specifically, it is intended to be of benefit to patients, practitioners and services in identifying when the transfer of a prisoner to a general adult psychiatric intensive care unit (GAPICU) is appropriate. Also, it describes some of the considerations applicable to transferred prisoners during treatment in a GAPICU.

1.3 The guidance outlines the procedures and considerations helpful in promoting timely and safe access for prisoners to appropriate services. It relates to GAPICU only and excludes 'forensic PICUs' located within designated High or Medium secure estate.

### Why is this guidance needed?

1.4 Many GAPICU practitioners do not have specific detailed training and expertise in 'forensic' mental health or criminal justice matters. In addition, procedures and considerations for accessing the adult secure estate may not be well understood within general adult services.

1.5 Similarly, practitioners within the mental health adult secure estate are not always familiar with clinical practice, procedures and considerations associated with mental health general adult inpatient services including GAPICU.

1.6 With finite resources and high levels of demand, it is important that the needs and risks of the general adult population are balanced with those of the prison population.

1.7 It is expected that needs appropriate services are accessible at the point at which they are required.

1.8 It is centrally important that high quality services are available to prisoners in a timely manner with the required levels of appropriate treatment and risk management (see 3.5).

# 2. Background

## General adult PICU: service outline

2.1 The UK PICU national estate was widely developed during the mid-1990s in response to the recommendations of the Reed Committee [1][1]. The need was identified to improve the quality of care offered to acutely unwell patients in local hospitals and reduce dependence upon the adult secure estate for this group.

2.2 Most GAPICU patients will not be subject to criminal justice procedures or related MHA sections at the point of PICU admission or discharge [2][2].

2.3 The primary purpose of the GAPICU is to provide inpatient, short-term intensive care to local populations. The need for PICUs, with associated levels of security, arise specifically from acute symptoms which when reduced, results in prompt transfer back to a general adult ward. Admission to PICU is not expected to exceed eight weeks and will often be much shorter.

2.4 Admissions to and discharges from the GAPICU are principally from and to acute general adult wards and the local general community.

2.5 Many PICUs experience high levels of demand serving their primary purpose, often requiring additional beds to be sourced out of county [3][3]. This can also disadvantage local GAPICU patients having to be accommodated in the private sector long distances away from home with additional cost pressures for local Integrated Care Boards (ICBs) [4][4].

2.6 This guidance defines ‘general community’ as those who are not in a registered mental hospital or in the prison estate [5, 6][5].

[1] Chiswick, D (1992) https://doi.org/10.1136/bmj.305.6867.1448
[2] Pereira et al. (2021) https://doi.org/10.7748/MHP.2021.E1467
[3] https://digital.nhs.uk/data-and-information/publications/statistical/out-of-area-placements-in-mental-health-services/september-2021
[4] Haw et al. (2016) https://doi.org/10.20299/JPI.2016.020
[5] Woods et al. (2020) https://doi.org/10.1108/JCP-03-2020-0013; Brugha et al. (2005) https://doi.org/10.1176/appi.ajp.162.4.774

2.7 GAPICUs, in the main, are commissioned by local ICBs as part of mainstream local services [7][6].

2.8 Within the prison population, it is recognised that there are high rates of mental illness compared to adult general community [5, 8, 9][7]. At times, prisoners who experience acute psychiatric symptoms require transfer to hospital for treatment. People in prison should not be disadvantaged in their right to access healthcare including where appropriate referral to GAPICU services. Prison transfers to GAPICU are expected to represent a small minority of the overall PICU service delivery.

## Mental health adult secure estate: service outline

2.9 Adult secure services are centrally commissioned by NHS England. A purpose and priority for the adult secure estate is to provide specific expertise and appropriate security to accommodate prisoners (and others with criminal justice engagement) in need of transfer to hospital for inpatient treatment [10, 11, 12][8].

2.10 Levels of security within the adult secure estate include High Secure (for immediate and grave risk), Medium Secure (for serious risk) and Low Secure units (for significant risk) [10, 11, 12].

2.11 Only Medium and High Secure hospitals have perimeter security designed to prevent rather than impede absconding.

2.12 The three levels of security offer the appropriate environmental, procedural and relational processes to manage the assessed risks, including escape, from hospital appropriate for transferred prisoners [10, 11].

2.13 These services are also supported by specific ‘forensic’ training and expertise in engaging with the interface between mental health, offending and the criminal justice system.

2.14 Prisoners are transferred to one of the three levels of security based on risk and treatment needs.

2.15 Prison transfers are a priority within the adult secure estate and expected to represent a large proportion of admissions [10, 11].

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[6] NAPICU (2016) https://doi.org10.20299/napicu.2016.001

[7] Woods et al. (2020) https://doi.org/10.1108/JCP-03-2020-0013; Fazel et al. (2012) https://doi.org/10.1192/bjp.bp.111.096370; Singleton et al. (1998) https://tinyurl.com/yckkzdbc

[8] NHS England (2021) https://tinyurl.com/57x92uvh; https://tinyurl.com/2p9xx463; https://tinyurl.com/2p9hhv9s

## Purpose and role of a GAPICU

2.16 The primary function of a PICU is defined within PICU National Minimum Standards [13][9]. PICUs provide rapid assessment and intensive management of acute mental disorder and behavioural disturbance within an integrated care pathway, involving the local general community mental health teams and general adult acute wards.

2.17 Psychiatric intensive care is for patients who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self-control, with a corresponding increase in risk, which does not allow their safe, therapeutic management and treatment in a general acute mental health ward. Care and treatment must be patient-centred, multidisciplinary, intensive and have an immediacy of response to clinical and risk situations.

2.18 Patients should be detained under the appropriate Mental Health Act (MHA) section, predominantly represented by Part II of the MHA (civil sections).

2.19 The clinical profile of the patient and acute symptoms will directly result in increased risk that is considered beyond the capacity of a standard general adult ward.

2.20 As soon as the clinical condition of the patient has improved to the extent that they can be accommodated in a less restrictive environment, then transfer from the PICU should occur.

2.21 Perimeter security within a GAPICU is expected to impede rather than prevent absconding [13].

2.22 Care is delivered by qualified and suitably trained multidisciplinary clinicians according to an agreed philosophy of unit operational policy, underpinned by the principles of therapeutic intervention and dynamic clinically focused risk management [13].

2.23 Length of stay should be appropriate to clinical need and assessment of risk but should aim to not exceed eight weeks in duration [13].

2.24 Psychiatric intensive care services have a clear and defined care pathway describing exactly how a person enters and leaves a PICU [13].

2.25 All patients, including prisoners, referred to the unit should have an assessment of their needs and risks undertaken by members of the PICU team who decide if admission is appropriate, prior to the patient arriving in the unit [13].

2.26 Appendix 1 details PICU admission and exclusion criteria.

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[9] NAPICU (2014) https://doi.org/10.20299/napicu.2017.001

### GAPICU admission pathways

2.27 The primary function of a general adult PICU is to serve the local population; the large majority of admissions will originate from and return to acute adult mental health wards [2][10].

2.28 The majority of PICU patients will be admitted for reasons of acute psychiatric symptoms directly resulting in disturbed behaviour without criminal justice involvement.

2.29 Ideally, there should be no legal restrictions for transferring a patient from the PICU as soon as their clinical condition has improved to the extent that a PICU is no longer required [13][11]. For transferred prisoners who remain subject to section 49 restrictions and no longer require a PICU, this will require prompt communication with relevant clinical teams to implement the next step in the care pathway.

## 3. Specific assessment considerations for a prisoner referred to a GAPICU

3.1 PICUs will have a range of clinical interventions appropriate for the treatment of acute mental health conditions. A transferred prisoner can expect to receive the same standard of treatment as any other PICU patient.

3.2 While treatment approaches and expectations are largely the same, there are some considerations that apply specifically to the assessment and transfer of prisoners.

3.3 In addition to the standard PICU admission assessment, there are prisoner specific issues which also require assessment.

### PICU assessment arrangements

3.4 Each PICU should define and agree a process for how a referral of a prisoner will be received, considered and progressed.

3.5 For prisoners referred for mental health care, there are expected time scales for processes to be completed. Time frames and other helpful information can be found in NHS England *Guidance for the transfer and remission of adult prisoners and immigration removal centre detainees under the Mental Health Act 1983* [14][12].

3.6 The decision to admit to PICU should be based on clinical need and an assessment that the acute symptomology with any associated behavioural disturbance will benefit from the PICU treatment model.

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[10] Pereira et al. (2021) https://doi.org/10.7748/MHP.2021.E1467
[11] NAPICU (2014) https://doi.org/10.20299/napicu.2017.001
[12] NHS England (2021) https://tinyurl.com/bde4yjxf

3.7 This PICU assessment is required to determine if appropriate treatment is available and can be safely delivered within the receiving PICU.

3.8 The availability of appropriate treatment is dependent on specific consideration of the security requirements as well as psychiatric pathology and associated clinical treatment.

3.9 The PICU assessment should also consider if specific specialist interventions such as index offence work and specialist risk assessment (e.g. HCR 20) are required and, if so, are available.

3.10 Other expertise in criminal justice processes (e.g. court reports) may also be required and will need to be available where the PICU assessment indicates this.

3.11 Once a prisoner has been referred for admission to the PICU, a prompt full assessment should be carried out by PICU staff to decide on the appropriateness of PICU admission.

3.12 At times, it will be possible to complete an initial PICU screening assessment and recommendations on the basis of the referral information.

3.13 Caution should be exercised to ensure appropriate criminal justice, risk and offending information is considered before arriving at a decision regarding PICU admission. There should be a standard agreed schedule for the minimum referral information required on which to base a PICU admission decision.

3.14 At the point of assessment, discussion could take place with the referring service, liaison and diversion service (remand prisoners) and Ministry of Justice (MoJ) to identify potential routes for transfer once PICU is no longer clinically warranted.

3.15 In the case that PICU admission is recommended and the PICU assessors are not section 12 approved, staff within prison mental health service and primary care providers in the prison, may be able to further support the transfer process.

## Joint assessments

3.16 It is important that, so far as possible, unnecessary delays are avoided in securing appropriate treatment for prisoners.

3.17 Arrangements should be made for joint assessments between the adult secure estate and PICU where this is considered appropriate and likely to improve the prospects of a prompt agreed outcome.

## Prisoners previously referred to the adult secure estate

3.18 Some prisoners referred to PICU may have been subject to adult secure estate access assessment prior to PICU referral. Where this is available, it should be requested and reviewed as part of the PICU assessment process.

3.19 To assist with decision making, standard assessment formats are often used within the adult secure estate. These include the 'DUNDRUM' triage, decision-making and follow-up tool kit of patients referred to the adult secure estate [15][13].

3.20 This tool kit is validated for use in forensic secure mental health services and not local adult services including GAPICU and therefore cannot represent the sole method of determining the need for admission to PICU.

3.21 Where a DUNDRUM assessment has been completed by the adult secure estate, it should be considered as part of the PICU assessment although does not, in itself, define the outcome.

3.22 In the case that a prisoner has already been considered not to require the adult secure estate, this does not result in automatic eligibility for PICU services. The outcome of the PICU assessment will determine the appropriateness of admission. In some circumstances, this may require further collaboration with the adult secure estate to achieve an outcome for the referral.

## Prisoner specific issues to be included in PICU assessment

### *Offending profile*

3.23 For the purposes of PICU assessment, the 'index offence' refers to the offence that resulted in the period of imprisonment. Alleged or convicted upper-level index offences (e.g. GBH, arson reckless or with intent, rape, serious sexual assault, homicide (or attempted) or equivalent) should not be considered appropriate for a GAPICU admission. A short summary of example offences and their category are detailed in Appendix 2.

3.24 The adult Medium Secure estate specification [11][14] specifies that prisoners serving long sentences including for non-violent or non-sexual offences should not be transferred to a low or non-secure (PICU) hospital environment.

[13] Freestone et al. (2015) https://doi.org/10.1186/S12888-015-0620-9
[14] NHS England (2021) https://tinyurl.com/2p9xx463

3.25 Prisoners who have committed, or are considered an ongoing active risk of serious offending, should not be admitted to a general adult PICU.

3.26 Active risk of an offence refers to assessment considerations that are relevant to clinical risk assessment although may not have centrally featured in the criminal justice processes.

3.27 Criminal justice processes are required to meet a high standard of evidence within specific legally defined criteria. In contrast, clinical risk assessment can consider a wider range of assessment information.

3.28 By the time of PICU assessment, there may have been developments in risk profile while subject to custody that require further assessment beyond the original index offence.

3.29 For example, a person may have been convicted or remanded for a relatively minor offence, although assessment evidence may identify new issues occurring since imprisonment. This may change the overall risk.

3.30 In addition, detailed clinical risk assessment may conclude that there is risk of more serious acts than was originally charged within the criminal justice processes. Considerations include the current mental/behavioural state of the prisoner, and/or other clinically relevant evidence that the risk may be higher than indicated purely by the index offence description.

3.31 A person's offence is not a reason, in itself, to admit to a PICU. The nature of an individual's offending behaviour should be viewed concurrently with the clinical presentation. Criminal behaviour can include a pattern or range of offences that should be considered when assessing an individual's appropriateness for admission to PICU.

3.32 Longer term patterns of offending or propensities toward criminal behaviour can represent particular challenges to a GAPICU which may be more appropriately engaged within a specialist forensic service.

3.33 Experienced prisoners may be familiar with methods of subverting security which require further consideration as to the appropriate level of security required in a receiving mental health unit (see PICU security risk assessment, below).

3.34 The PICU assessment should consider the relationship between mental health and offending. Lower-level offences which are considered to have been a direct result of acute symptoms which are likely to be susceptible to short term treatment may be most appropriate for a GAPICU admission.

3.35 When a prisoner is referred to PICU, the PICU team need to consider the patient's overall offending history. A trajectory of offending across a life-span can be an indicator that the adult secure estate is best placed to provide inpatient care.

3.36 The PICU team needs to consider the presence of expertise within the service for relational security and understand how patient 'mix' can affect the overall risk profile of the ward [16][15].

3.37 A checklist of offending categories is included in Appendix 2.

### *Criminal justice and psychiatric history*

3.38 There should be agreed procedures for the sharing of information pertaining to past criminal justice history. Wherever possible, this should be included in the initial referral information.

3.39 An understanding of how offending behaviour is/is not related to mental health condition.

3.40 Processes should be agreed for requesting offending and risk history from appropriate agencies (e.g. prison mental health team, probation, Police National Computer services (PNC)).

3.41 There are no data protection issues preventing custody staff from sharing information about a patient's conviction and offending history with prison mental health team staff to support this process [14][16].

3.42 Consideration needs to be given to any ongoing criminal justice process and the extent to which this may affect PICU admission. Examples include access to or opportunity to contact victims, court appearances, ongoing criminal investigations etc.

3.43 Any prison risk assessments that may have been completed (e.g. Offender Assessment System (OASys) or National Offender Management Information System NOMIS ) should be requested [17][17].

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[15] Department of Health (2010) *See, Think, Act* https://tinyurl.com/4a7mt9pu
[16] NHS England (2021) https://tinyurl.com/bde4yjxf
[17] Moore (2015) https://tinyurl.com/mpv3jap2

3.44 A detailed account should be sought of the prisoner's presentation while in custody. This should include:

- Daily engagement with the prison regime
- Observations of prison staff as well as the prison mental health team
- Location of the prisoner within the establishment
- For prisoners located in 'segregation' or in a 'close supervision unit' (CSU) a detailed account should be taken of their behaviour preceding and during this placement. This type of location may be more indicative of the need for the adult secure estate.
- Any special prison procedures in place (e.g. self-harm 'unlock' procedures, self-harm management).

3.45 Appendix 3 includes a short description of common prison locations and procedures.

## Psychiatric history

3.46 Psychiatric history should be recorded including previous admissions particularly to the adult secure estate, with risk history. In the case of previous adult secure estate placements, requests should be made for previous risk assessment (e.g. MAPPA notes, HCR 20, SAPROF, RSVP) [18, 19][18].

3.47 Account should be taken of any established mental health condition with associated treatment. Consideration should be given to the extent to which a previous mental health condition is related to behaviour within the prison.

3.48 In the case of an established mental health condition, an assessment should be made as to the extent to which the referral may be related to an acute exacerbation of an existing mental disorder, which is expected to respond to the treatment approaches available to the PICU within a relatively short period of time [13][19].

[18] RCPsych (2017) https://tinyurl.com/2p8rhbp5; Taylor & Yakeley (2013) https://tinyurl.com/mrvw95rk
[19] NAPICU (2014) https://doi.org/10.20299/napicu.2017.001

## Personality disorder

3.49 Prison populations present with high rates of Personality Disorder and PICU assessment should consider the presence of a comorbid personality disorder when assessing the appropriateness of PICU admission [20][20].

3.50 When considering offending behaviour and whether the acute symptomology is appropriate for PICU, it is important that the presence of a comorbid personality disorder is formulated and assessed.

3.51 The acute presentation may respond to the PICU model of treatment; however, the underlying or comorbid personality disorder may be related to the offending history. The receiving treatment centre may be required to have programmes available for positively engaging with personality disorder.

3.52 In the case of Personality Disorder or prolific offending profiles (underlying or primary in the presentation) there may not be appropriate treatment available within adult acute or PICU services.

3.53 These interventions (e.g. offence related work, anger management, victim empathy, and relapse programmes) are available within the adult secure and prison estates. For example, psychologically informed prison environments (PIPE) therapeutic community. In contrast, these interventions are unlikely to be available within a GAPICU, which does not usually have access to a clinical psychologist with forensic experience.

## Mental health and offending

3.54 Mental health and offending are complex areas of practice the expertise for which is predominantly within the adult secure estate sector and/or supported by specialist training.

3.55 Mental illness and violence have long been associated, although the relationship between violence and mental disorders is complex, requiring consideration of the interaction between relational, individual, cultural and environmental factors.

3.56 For the prison population, this is further complicated by high rates of comorbidity and known risk factors such as substance misuse.

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[20] Constantinou et al. (2015) https://doi.org/10.1016/j.eswa.2015.05.025

3.57 There is evidence of the link between mental illness and violence found in the literature relating to personality disorders, both comorbid to other disorders and as a primary diagnosis [21, 22][21].

3.58 In psychotic patients, the presence of a comorbid personality disorder has been significantly associated with an increased risk of violence, with strongest associations found with the sub-categories of antisocial and paranoid personality disorders. It is also acknowledged the violence can result from psychotic illness alone in the absence of personality disorder.

# 4. PICU security risk assessment

4.1 There should be particular attention paid to individuals referred to PICUs who are serving longer sentences, have committed violent and/or sexual offences or arson. Individuals who have a history or active risk of weapon use, manufacture or concealment should also be considered a particular concern.

4.2 These individuals require an assessment of the relationship between offence and mental health condition to establish if the PICU model will be sufficient to manage current risks. This profile would generally not be considered appropriate for PICU.

4.3 NHS England published guidance on the admissions of prisoners to the adult secure estate [16][22] within which the criteria for admission to Low Secure conditions include:

- History of non-violent offending behaviour
- Low risk of abscond or escape
- Offending behaviour connected to mental disorder
- Risk of self-neglect, challenging behaviour and/or self-harm
- Risk of lower level violent offending (e.g. common assault, actual bodily harm).

4.4 While the above pertains to Low Secure forensic units (LSU) in terms of risk, it may also be helpful reference for consideration during PICU assessment. PICU should not be used in place of Low Secure estate where these services are most appropriate to meet the needs of the referral.

[21] Fazel et al. (2009) https://doi.org/10.1371/journal.pmed.1000120; Moran et al. (2018) https://doi.org/10.1192/bjp.182.2.129
[22] NHS England (2016d) https://tinyurl.com/bde4yjxf

4.5 GAPICU should not be used as a 'stop gap' where the assessment concludes that the patient's needs are consistent with LSU rather than PICU. It may be unhelpful to the patient's recovery process to be placed in an environment with a treatment model inconsistent with their needs.

4.6 Patients admitted to the PICU are expected to respond to treatment in a relatively short period of time and should not be admitted to provide security for its own sake on the basis of legal restriction. In other words, the patient is not presenting the need for acute treatment although does have a legal rather than clinical requirement for security.

## PICU security assessment key themes

4.7 There are four key areas for consideration for appropriate security representing the availability of 'appropriate treatment' in a GAPICU they are:

- Risk to perimeter security and escape (risk to the general community)
- Risk to fellow patients
- Risk to staff
- Care plan for identified risk mitigation.

### *Risk to perimeter security and absconding*

4.8 Transferred prisoners, for the period of time they remain subject to MHA sections 47/49 and 48/49, remain subject to MoJ restrictions. In the case of absconding, their status should be considered that of an 'escaped prisoner' in addition to an absconded patient.

4.9 In the case of escape, the MoJ should be contacted and informed immediately. Transferred prisoners who have escaped should be reassessed as to the suitability of continued treatment in non-secure services. Consideration should be given towards return to custody or transfer to the adult secure estate if further treatment in hospital is required.

4.10 In this assessment domain the following issues should be considered:

- What is the assessed risk of absconding/escape or potential for challenging the PICU impediment to absconding security measures?
- If the person were to successfully abscond, what would the risk assessment be to the general community, person specific or otherwise?
- Does the person have associations with people in the general community who are likely to represent a perimeter security challenge (e.g. bringing restricted items or items of concern to the unit, represent difficulties during visits or other negative collusion)?
- Are there any known factors within the general community including specific relationships/issues that may make the likelihood or consequences of absconding more serious?
- Does the person have a history of challenging perimeter security (e.g. absconding, bringing in, or organising to be brought in, restricted items or items of concern)?

*Risk to fellow patients*

4.11 In this assessment domain the following issues should be considered:

- Has the person been involved with altercations, aggression or violence towards fellow prisoners? If yes, then what is the active level of risk?
- Has the person formed friendships or relationships positively or negatively within the current environment at the point of assessment?
- Has the person been involved in collusion to challenge security or in other ways negatively affected other in-mates within the setting?
- History of weapon use, manufacture or concealment?
- Are they judged to be particularly susceptible to suggestion/manipulation or represent these risks to others?
- At the point of assessment, are any previous relationships or difficulties known with existing patients within the PICU?
- Are issues expected with the mix of patients within the PICU?

*Risk to staff*

4.12 Consideration of the assessed risk that the potential patient may represent to staff is required. The following issues need to be considered:

- History of violence towards staff in previous residential as well as current settings
- History of weapon use, manufacture or concealment?
- Active risk at the time of assessment including information from prison, previous mental health units and general community staff
- If there has been a history of violence towards staff, what is the active (current) risk at the time of assessment
- Within the prison setting, is the person subject to special measures for violence towards staff? These may include:
  - Segregation
  - Close supervision unit within segregation
  - Being subject to 'unlock' procedures for violence towards staff.
- How is the person likely to respond to the freedoms and restrictions within the PICU regime? Specific questions can be asked with regard to potential escalation points (e.g. smoking policy, access to communications and general PICU living arrangements that may represent areas of increased freedom or conflict).
- Is the person compliant with medication and, if not, what would the likely challenges/risks be for implementing a medication regime?

4.13 Appendix 3 provides further details of prison accommodation locations and procedures.

*Care plan for identified risk mitigation*

4.14 In this assessment domain, the following issues should be considered:

- Is the person's risk profile appropriately management within the PICU security measures?
- Are there any additional measures required beyond the standard care plan/risk mitigation measures provided within the core infrastructure of the PICU?
- If additional measures are required, what preparation would be necessary before the admission?
- The security of the PICU including relational and procedural domains and how this may be affected by the admission.

*Mixed-gender considerations*

4.15 Some GAPICUs offer mixed-gender accommodation. Mixed-gender inpatient facilities can experience specific challenges in maintaining sexual safety. The Care Quality Commission report on sexual safety sets out the main issues [23][23]. The following points should be covered in mixed gender PICUs processing prison referrals:

- Very careful documented consideration is required for prisoners with sexually problematic or offending histories.
- In particular, the risk to other vulnerable GAPICU patients should be carefully considered and documented.
- Female prisoners may also be at risk in mixed gender accommodation.
- Depending upon the nature of the risk, admission to a single gender GAPICU will often be required

# 5. PICU Pathways for prisoners

5.1 PICU assessments should take clear account of the specific criminal justice procedures to which the referral is subject at the time of assessment. Consideration should be given to any ongoing procedures that will require intervention from the PICU clinical team.

## Transfer from PICU

5.2 At the point of referral assessment, there should be a clear expected pathway defined for transfer from the PICU when appropriate.

## Prison mental health teams

5.3 Each prison will have a mental health team who are in a position to provide information and engagement with assessing PICU staff. The relevant prison mental health worker should be identified early on the referral pathway and thereafter represents a consistent point of contact with the prison service.

[23] CQC (2018) https://www.cqc.org.uk/publications/major-report/sexual-safety-mental-health-wards

## Prison arrangements for the transfer of prisoners

5.4 Each prison will have departments which have a role in organising the required authorities for prisoner movement within, and transfers out of the prison estate.

5.5 The prison integrated mental health team make the referral, complete the necessary paperwork and process this with the medical recommendations. The transfer warrant is sent to the Mental Health Team who will liaise with prison security and detailing office to arrange appropriate transport with escorting custodial staff.

5.6 In dealing with a referral, there should be close communication between the PICU, prison mental health and any other identified relevant teams.

## Status of prisoner

5.7 At the point of PICU assessment, it is important to determine the basis on which the person has been imprisoned. Prisons also have a 'category' security rating which can be helpful in assisting with determining security level if transferred to hospital. There are different processes applicable to specific imprisonment status.

5.8 All prisoners will either have the status of:

- **Sentenced**: A prisoner who has been convicted and is serving a specific defined sentence **or**
- **Remanded**: A prisoner who remains subject to criminal justice procedures and is not serving a defined sentence.

## Gate assessments

5.9 'Gate assessments' refer to a civil MHA assessment taking place at the point a prisoner is being released from prison. This usually results from concerns regarding mental health not being identified until very close to release and/or insufficient time to make arrangements for assessment during the course of imprisonment.

5.10 They are often completed by local duty teams. Arrangements made very quickly may not provide the best opportunity for appropriate background information to be requested and processed prior to assessment.

5.11 Short recalls to prison and short duration custodial sentences can mean it is difficult to avoid gate assessments in some cases.

5.12 Gate assessments are generally not considered good practice and should be avoided wherever possible.

## Sentenced prisoners

5.13 PICU assessment should establish details about the length of the sentence and the estimated date of release often referred to as 'custody release date'.

5.14 Prisoners serving longer sentences are not recommended for transfer to Low Secure or PICU environments [11][24].

5.15 The legal basis for the transfer of sentenced prisoners (excluding for civil matters) to hospital are sections 47/49 of the MHA (see Appendix 4).

## Patients whose release date passes during admission

5.16 During the PICU assessment, it is important to consider the earliest estimated date of release of a sentenced prisoner. If admission to PICU is considered appropriate and the release date passes during admission, then the section 47/49 will be considered to have been automatically regraded to 'notional section 37' at the release date. This process can be considered a suitable pathway for transfer to PICU and can be planned for at the point of referral.

5.17 Any restrictions under section 49 will expire on the release date.

5.18 At the point that the patient is considered subject to the provisions of notional section 37, the Responsible Clinician has the authority to grant section 17 leave or discharge from hospital without reference to the MoJ.

## Remand prisoners

5.19 All remand prisoners remain subject to court proceedings.

5.20 The legal basis for the transfer of remand prisoners to hospital are sections 48/49 of the MHA (see Appendix 4).

## PICU engagement with liaison and diversion services

5.21 Liaison and diversion services are available in most areas and may be able to provide helpful advice about court and other issues prior to prison engagement.

5.22 This service has specific expertise in court processes and is often able to assist the patient, PICU and the court in navigating ongoing criminal justice process and mental health interface. This can extend to offering written and verbal reports to the court.

[24] NHS England (2021) https://tinyurl.com/2p9xx463

5.23 Where appropriate, the PICU assessing team could engage the local liaison and diversion service, which may be able to advise about court processes.

## Court processes relevant to remand prisoners

5.24 In England and Wales, all cases are initially heard by a magistrates' court. Within that hearing, the severity of the allegation determines whether the case will remain at a magistrates' court or will be committed to the Crown Court. For their own reasons, a defendant may elect to have their case heard at the Crown Court in front of a jury of their peers.

5.25 All remand prisoners' cases will need to return to court for the conclusion and final outcome of the criminal justice process to which they are subject. See Appendix 5.

5.26 PICU assessment should take account of the reasons for remand to custody and the initial refusal of bail.

5.27 A remand in custody may have been sought by the Crown Prosecution Service (CPS) if there is:

- An ongoing risk to self or others **or**
- Risk of further offending **or**
- Previous failures to attend court at allocated times.

### *PICU provision for ongoing court processes*

5.28 The PICU assessment will need to determine the specific basis of remand. This includes those on remand awaiting:

- Trial
- Sentence.

### *Court hearings*

5.29 For admitted patients subject to sections 48/49, the PICU will need to make arrangements for court attendance either in person or by video link. Also, the PICU should have suitable arrangements for the patient to engage with their legal representation.

5.30 Following any court hearing, a prisoner's remand status can change and the PICU team will need to remain aware of any changes which may affect on going treatment or legal basis for continuing detention in hospital. For example, during any court hearing the following outcomes are possible:

- The case is discontinued (e.g. due to lack of evidence) at which point the person is no longer eligible to be detained in hospital under the provisions of sections 48/49.
- The case can be adjourned for reports.
- The case can be adjourned to allow time for the processing of further evidence.
- The case can result in a conviction and a defined sentence, which can include 'time served' meaning that the person is immediately released and is no longer eligible to be detained in hospital under sections 48/49.
- The case can result in a conviction and be adjourned for sentencing which can include the request for pre-sentence reports.
- The court may grant bail at which point section 48/49 ceases and the person is no longer eligible for detention in hospital.

### *Reports and evidence requested by a court*

5.31 There is no requirement that the PICU treating Responsible Clinician or other members of the PICU team provide the criminal court with reports or other evidence in respect of transferred remand prisoners. The primary responsibility of the PICU is the treatment of the patient during the course of hospital admission. However, it should be acknowledged that the treating team will often be best placed to provide reports and should expect to do so. This is in the patient's best interests.

5.32 Some organisations may have local arrangements for processing requests for court reports.

5.33 Where required, courts and counsel have procedures for requesting reports from independent clinicians.

### *Guilty plea*

5.34 When a defendant enters a guilty plea or is found guilty following a trial, they are classed as being convicted but not sentenced. The court has the option to adjourn for pre-sentence reports or expert reports to assist in the determination of sentence. This can include a request for psychiatric reports which could be requested from the PICU

Responsible Clinician. There is no statuary obligation to provide a court report although the Responsible Clinician can expect to do so if requested.

### *Not guilty plea*

5.35 If a not guilty plea is entered, this results in a trial which can be heard in a magistrates' court or the Crown Court. This may result in a conviction or an acquittal. The Crown Prosecution Service may choose not to offer any evidence and the case is withdrawn. If this occurs during PICU admission, then the patient may choose to remain as an informal patient or may require further assessment under the MHA.

### *Fitness to plead*

5.36 If a defendant is deemed unfit to plead or stand trial, then the case is usually dealt with in the Crown Court and medical reports are sought to determine their fitness. Fitness to plead guidance is outlined in Appendix 6.

5.37 The judge will determine the defendant's fitness to plead. A jury trial can be held based on the facts only. The defendant cannot participate in these proceedings. This process is considered a 'trial of fact'.

5.38 There are no fitness to plead provisions within a magistrates' court, however a trial of facts may be held to determine outcome. If convicted, medical reports will be commissioned to determine fitness. This could be requested from the PICU Responsible Clinician.

### *Section 37 Recommendations*

5.39 If the reports identify the individual lacks the ability to plead or stand trial, then options for the patient and PICU team include recommendation for section 37(3) hospital order or an absolute discharge.

5.40 If the reports deem that the defendant has the ability to plead, the case can progress to trial or entry of a guilty plea.

5.41 Under the provisions of Part III of the MHA, consideration can be given to those requiring assessment and treatment to be remanded by the court to hospital.

## Returning to prison from mental health care

5.42 Once the PICU team assess that a person no longer meets the criteria for detention under the MHA, or that admission to PICU is no longer appropriate, remission to prison can occur.

5.43 There is specific guidance regarding the transfer and remission to prison of patients pertaining to the adult secure estate [24][25]. For a patient to return to prison, effective working relationships can be helpful between the PICU, Responsible Clinician, the MoJ Mental Health Casework Section (MHCS) and the offender management unit of the prison.

5.44 It is recommended that PICU staff have a named individual identified within the local prison with whom to liaise when instigating the remission process. This will usually be an identified governor who manages the offender pathway department and Mental Health Lead / Head of Healthcare.

5.45 Reasons for a patient's remission to prison can include:

- The patient's condition has improved and/or clinical assessment indicates that they no longer meet the criteria for detention in hospital
- The patient security needs have been assessed to be beyond the PICU level (e.g. the patient has absconded or has committed further offences rendering the unit unable to offer appropriate treatment).

5.46 To promote best practice in relation to patient care, the receiving prison's mental health team should always be informed of the remission request.

5.47 A section 117 aftercare meeting should occur prior to the patient returning to prison. This should always include representatives from the prison mental health team and probation where appropriate.

5.48 Ideally the patient should be involved throughout the remission process and kept informed regarding the different stages.

5.49 There may be circumstances (e.g. potential for increase in risk or hostility) which may require a more careful approach to this process.

*Process for remission of remand prisoners*

5.50 For transferred prisoners remanded by a magistrates' court and where the case has not been referred to Crown Court, it is required for the case to return to the court for remission to prison. It is required for the court's 'listings department' to be contacted to arrange a hearing. In some areas, the liaison and diversion team may be helpful in advising about this process.

[25] NHS England (2021) https://tinyurl.com/bde4yjxf

5.51 Prisoners who were remanded by, or the case is before a Crown Court can be remitted by application to the MoJ in the same way as sentenced prisoners.

5.52 The patient's identified Responsible Clinician is required to contact the MoJ Mental Health Casework Section and the receiving prison at the same time to request remission.

# 6. Leave of absence

6.1 The use of section 17 for patients subject to civil sections of the MHA is a fundamental aspect of the care delivered within the GAPICU.

6.2 A transferred prisoner must be considered a restricted patient, leave from the hospital or unit named on the detention authority cannot be granted without the consent of the Secretary of State (SoS). In practice, decisions are taken by officials from the Mental Health Casework Section within the Prison and Probation Service (HMPPS).

6.3 Applications for leave are required to be submitted to the Mental Health Casework Section by the Responsible Clinician in all cases where leave has not been included within the transfer direction correspondence.

6.4 Prisoners transferred to hospital remain subject to MoJ restrictions under section 49 and leave of absence during admission to hospital will generally be a rare event only authorised in exceptional circumstances.

6.5 It is unlikely that therapeutic leave (escorted/unescorted general community leave for rehabilitation reasons) will be granted by the MoJ for patients subject to section 49.

## Leave for urgent or routine medical treatment

6.6 Detailed guidance is provided by the MoJ Mental Health Casework Section [25][26].

6.7 On entry into hospital either from court, immigration centre or prison (unless the patient is designated as high profile), authority for leave outside the hospital will automatically be granted to allow patients access to either emergency treatment or to attend routine medical appointments [25].

6.8 In emergency situations, prior Secretary of State permission does not need to be sought for any patient but the Responsible Clinician should inform the Mental Health

[26] HMPPS (2020) https://www.gov.uk/government/publications/leave-guidance

Casework Section as soon as possible via email giving brief details and expected or actual date of return to their detaining unit.

## Arrangements for leave

6.9 For other types of leave, the Mental Health Casework Section sets out the conditions applying to the authority in the letter sent to the Responsible Clinician following the prison transfer direction [26][27]. Many GAPICUs may have limited experience of the specific arrangement required to support leave from the unit of transferred prisoners.

6.10 Escorts are defined as employees of the hospital trust or those engaged on a formal contract basis or individuals authorised for this purpose by the hospital under section 17(3) of the MHA.

6.11 Generally, the number and ratio of escorts to patients will be left to the Responsible Clinician to determine but the Sectary of State may, on occasion, specify a number and type of escort. Patients should be within a reasonable distance of escorts at all times so as to enable them to intervene quickly, if so required, to ensure public safety and security (and that of the patient).

6.12 The provision of handcuffs (and escorts trained in their application) and that of a 'secure vehicle' (a vehicle that impedes escape) are particular measures which are recommended by the MoJ but may not be available within most GAPICUs.

6.13 Due consideration should be paid to this during the assessment process with contingency measures in place prior to any agreed transfer.

## Leave to attend court

6.14 Where a court directs the attendance of a patient, the Secretary of State will rarely refuse consent to leave and for transferred prisoners remanded to prison (section 48), escorted leave to attend court in relation to the offence(s) under trial will be granted at the time of their transfer.

[27] HMPPS (2017) https://www.gov.uk/guidance/noms-mental-health-casework-section-contact-list

## Good practice guidance key points summary

- PICUs will have a range of clinical interventions appropriate for the treatment of acute mental health conditions. A transferred prisoner can expect to receive the same standard of treatment as any other PICU patient.
- The decision to transfer a prisoner to a general adult PICU should be based on clinical need and will be determined by an assessment carried out by PICU staff.
- The admission of a prisoner to a general adult PICU may be appropriate when the presenting clinical pathology meets the admission criteria outlined in the National Minimum Standards [13][28] and the security assessment set out in this guidance.
- A prisoner should not be transferred to PICU because of the need for security for its own sake where the clinical presentation does not otherwise indicate need for PICU.
- Effective working relationships should be formed between PICU staff, adult secure estate and the local prison estate. Where indicated, joint assessments between the PICU and secure estate may be helpful in achieving a prompt outcome to the referral.
- Arrangements should be discussed and agreed between all the involved agencies.
- At the point of referral, joint assessments by PICU and adult secure estate colleagues can support a timely admission to the appropriate setting.
- PICU teams should develop local protocols to support the transfer and remission of prisoners at each stage on the pathway.
- Admission to PICU should not be used as an interim measure whilst an adult secure estate bed is identified.
- Prior to admission to PICU, a clear pathway of care which includes transfer to a more appropriate setting as warranted by the clinical or risk profile should be planned with the referring service and the MoJ Mental Health Casework Section.
- The primary purpose of the general adult PICU is to service the residing within the local population with admissions and discharges to and from acute general adult wards and the general community. Prison transfers are expected to form a small minority of the PICU service delivery.

[28] NAPICU (2014) https://doi.org/10.20299/napicu.2017.001

# 7. Managing disagreements

7.1 Prisoners who have been assessed by the adult secure estate as not requiring admission do not automatically become eligible for PICU admission.

7.2 The prisoner's best interests and management of risk must represent priority considerations.

7.3 PICU assessments should always take place to determine the appropriate outcomes for treatment and placement.

7.4 Services should establish clear lines of communication between local PICU, adult secure estate, commissioning case managers and prison mental health teams within which disagreements can be resolved.

7.5 Reference to the NHS England document *Who pays?* may be helpful in determining which PICU should receive a referral [27][29].

[29] NHS England (2020) https://tinyurl.com/4zjpf32n

## Case Example 1

Patient A is a 53-year-old man with an established diagnosis of schizophrenia. He has been stable in the general community for 7 years and managed via his GP.

He was arrested and taken into custody following an assault on a female member of the public in the local supermarket and was subsequently charged with actual bodily harm and remanded into prison.

The local PICU received a referral from the prison mental health team as he was presenting with overt signs of acute psychosis and refusing medication.

On assessment, Patient A presented as acutely unwell and behaviourally disturbed. History indicated no previous contact with the criminal justice system and no previous admissions to PICU.

Patient A was admitted to the PICU under section 48/49 of the MHA and treated with medication. He responded well to treatment and there were no on-going risks against others.

The patient returned to court with a recommendation for section 37.

### Rationale for PICU

Patient A was presenting with an acute exacerbation of a serious mental disorder and met the admission criteria for PICU under the National minimum standards.

His offending behaviour was at the lower level in the context of his mental condition and risks could be appropriately managed within the PICU environment.

There was no presence of comorbid personality disorder.

## Case Example 2

Patient B is a 23-year-old male referred to PICU for a section 47/49 transfer. He is serving a 12-week sentence for affray and the prison mental health team are concerned he is experiencing psychosis.

On assessment he presents with overt signs of psychosis, including a fixed belief that prison staff are trying to kill him. He refuses to accept any medication within the prison estate.

The assessing PICU team review his history. Patient B has an extensive prison history from the age of 15. He has convictions for a range of offences including theft, GBH, offences related to the courts, breach of a non-contact order and drug offences.

There is evidence of substance misuse and he has been subject to discipline measures in the prison estate as a result of institutional violence. At the time of assessment, he was located within segregation.

PICU assessment recommended transfer to Medium Secure estate.

### Rationale for transfer to Medium Secure estate

Patient B clinical profile is in line with some of the PICU National Minimum Standards however there is evidence that he is a significant active risk to others. He is considered an escape risk and would also be a serious risk to the general community if he absconded.

History of a range of offences including violent offences within institutions requires security beyond PICU. There is indication of personality disorder which may require longer term psychological work outside of the PICU remit.

# List of consultees

Joint National Mental Health Medical and Nursing Directors Council
Royal College of Psychiatrists Quality Network for Psychiatric Intensive Care Units
Mr Seamus Watson, National Improvement Director, NHS England and NHS Improvement
Mr Dan Impey, Expert by Experience
Mr Bernard Fox, NAPICU Director of Service User Experience, NAPICU Executive
Mr Andy Webb, Team Manager, Criminal Justice Liaison Service
Ms Jo Rance, Senior Implementation and clinical Support Manager
Mr Glyn Thomas, Head of Non-Custodial Services
Dr Phil Moore, GP, Chair of the Mental Health Commissioners' Network, Learning Disabilities & Autism System Group
Dr Ruairi Page, Consultant Forensic Psychiatrist
Dr Daniel Hume, Lead Psychiatrist Forensic Healthcare
Dr Warren Stewart, Principal Lecturer Mental Health Nursing
Prof. Andrew Forrester, Forensic Psychiatry, Cardiff University
Dr Tim Dickerson, Consultant Psychiatrist
Mr Cliff Hoyle, Strategic Lead for Mental Health and Wellbeing, NHS England Health and Justice
Ms Fiona Banes, Mental Health Pathway Lead (Offender Health)
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Dr Jane Padmore, Interim CEO
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# Glossary of Terms

| | |
|---|---|
| ACCT | Assessment, care in custody teamwork. A care plan document opened for anyone at risk of self-harm or suicide. All prisoners on ACCT are subject to increased observations. |
| Active risk | The assessed level of risk at the time of assessment which may be different to the risk level at the time of referral. |
| Adult secure estate | Secure inpatient provision commissioned by NHS England. Includes Low, Medium and High Secure. |
| ICB | Integrated Care Board |
| Convicted | Person has been found guilty of an offence. |
| CPS | Crown Prosecution Service |
| CSU | Close Supervision Unit |
| DUNDRUM | Structured tool for professional judgement in respect of required levels of therapeutic security. |
| Expected release date | The date a person is due to be released from prison. |
| GAPICU | General Adult Psychiatric Intensive Care Unit. Commissioned by the local ICB. |
| HCR-20 | A structured professional judgment risk assessment tool used within adult secure estate for risk of violence. |
| Index offence | The offence preceding imprisonment. |
| MHA | Mental Health Act 1983 https://www.legislation.gov.uk/ukpga/1983/20/contents |
| MHCS | Ministry of Justice Mental Health Casework Section |
| MoJ | Ministry of Justice. Government department responsible for prisons and courts. |
| OASys | Core risk assessment tool used by national probation service for offenders. |
| OMU | Offender Management Unit |
| Part III | Refers to part of the MHA which deals with criminal justice proceedings. |
| Remand | A prisoner is on remand if in a prison setting prior to being found guilty of an offence or pre-sentencing. |
| RSVP | Risk of Sexual Violence Protocol |
| SAPROF | Structured Assessment of Protective Factors |
| Sentenced | A sentenced prisoner has been found guilty of an offence and is serving their sentence. |
| SoS | Secretary of State |

# Appendix 1: PICU admission and exclusion criteria

The **inclusion criteria** for PICU admission is outlined in the *National Minimum Standards*[30] and include the following:

- Externally directed aggression **or**
- Internally directed aggression including significant risk of suicide and suicidal behaviour **or**
- Unpredictability in the context of other risks including increased potential for absconding with assessed concern for other associated risks **and**
- There is a requirement for a goal-orientated period of more intensive treatment that could not be achieved in a less intensive environment within the context of other associated risks **and**
- Patients should be cared for in an age-appropriate PICU service, and hence there will be PICU service-specific age criteria.

The **exclusion criteria** within the same document state that admission should not occur in the following circumstances:

- The patient is assessed as presenting too high an internal or perimeter security risk for the PICU type, requiring Medium or High Secure PICU
- The patient has a primary diagnosis of substance misuse and the primary purpose of admission is solely to prevent access to substances
- The patient's behaviour is as a direct result of substance misuse and they are not suffering from an exacerbation of their mental disorder at the time of referral
- The patient has a primary diagnosis of dementia
- The patient has a primary diagnosis of Learning Disability (LD) and requires a specialist LD facility
- The patient's physical condition is too frail to allow their safe management in a PICU
- The patient has a chronic condition which would not benefit from admission to PICU
- The patient is restricted (subject to restrictions under the MHA, via the courts, prisons or MoJ) and has no clear pathway or provision for transfer from the PICU once clinically warranted
- Admission would mix the gender of the patient population unless there are separate sleeping and day areas.

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[30] NAPICU (2014) https://doi.org/10.20299/napicu.2017.001

# Appendix 2: Example offence categories

| Violent offences | |
|---|---|
| Murder | A person unlawfully kills another with malice aforethought. |
| Manslaughter (voluntary) | A person kills another, intending to kill or cause grievous bodily harm, but their culpability is reduced by one of three mitigating circumstances:<br>• Loss of control<br>• Diminished responsibility<br>• Pursuance of a suicide pact. |
| Manslaughter (involuntary) | A person unlawfully kills another without malice aforethought, either by an unlawful or dangerous act likely to cause bodily harm ('constructive manslaughter) or by gross negligence ('gross negligence manslaughter'). |
| Grievous bodily harm (GBH) with intent | Unlawfully and maliciously wounding or causing really serious harm with the intention to do some really serious harm. A higher offence level than wounding or inflicting GBH without intent. |
| Grievous bodily harm (GBH) | Unlawfully and maliciously wounding or inflicting really serious harm. |
| Actual bodily harm (ABH) | An injury calculated to interfere with the health or comfort of a person. |
| Common assault | Conduct which causes a person to apprehend the imminent application of unlawful force upon him or her, e.g. threatening words, acts, gestures, 'silent' telephone calls. |
| **Sexual offences** | |
| Rape | Penetration by the penis of the vagina, anus or mouth without consent (where vagina is to be taken as including the vulva). |
| Sexual assault | Intentional sexual touching without consent. |
| Child sexual offences (can be contact or non-contact offence) | Sexual offences committed against a person aged less than 18 years. |

| Drug offences | |
|---|---|
| Possession | Carrying controlled drugs without intent to supply. |
| Supply | The act of selling or sharing drugs. |
| Importation | Importing or exporting drugs. |
| Drug production | Involvement in the production of controlled drugs. |
| **Verbal abuse and harassment** | |
| Public order offence | Threatening, abusive or insulting words or behaviour which are likely to cause fear or provoke immediate violence. |
| Harassment | A person engaging in a course of conduct which amounts to the harassment of another person, and they know it amounts to harassment or they ought to know. |
| Stalking | An offence of stalking is committed when harassment amounts to stalking by following a person, contacting or attempt contact, monitoring, loitering or watching/spying on a person. |
| **Theft Act offences** | |
| Robbery | Stealing with the use of force or putting or seeking to put a person in fear of being then and there subjected to force. |
| Burglary | Entering a building or part of a building as a trespasser with intent to commit theft. |
| Aggravated burglary | Committing burglary whilst in possession of a firearm or imitation firearm, weapon of offence or explosive. |
| Taking without consent (TWOC) | Taking any conveyance (car etc.) without the consent of the owner. |
| Handling stolen goods | To receive, or arrange to receive, stolen goods. |
| Going equipped | When a person is found not at their place of residence with an article to be used in or connected to any burglary or theft. |

# Appendix 3: Common prison locations, procedures and definitions

| Term | Definition |
|---|---|
| Healthcare wing | A wing or 'unit' in the prison which provides healthcare to prisoners. Can be mental health and physical health. |
| In-reach team | A mental health team working inside the prison estate. |
| Vulnerable prison wing (VP Wing) | A wing housing prisoners who are at risk from other prisoners. Can include those charged or committed of sexual offences. |
| Segregation | A unit where prisoners are segregated from other prisoners due to risk or behaviour. |
| Good order or discipline (GOOD) | A prisoner can be held in segregation on 'GOOD' due to behaviour. |
| Safer custody team (SCT) | All prisons have a SCT, who lead on safer custody measures including self-harm and violence reduction. |
| Assessment care in custody and teamwork (ACCT) | A care plan document opened for anyone at risk of self-harm or suicide. All prisoners on ACCT are subject to increased observations. |
| Constant watch | An enhanced observation level due to risk to self. |
| Prison regime | Refers to the day to day running of the prison including jobs, association time, education. |
| 'Basic' regime | A prisoner can be placed on 'basic' regime as a consequence to behaviour. Access to items such as TV's, Kettles, the gym, association are restricted. |
| Association | Time out of cell to spend with others on the wing. |
| Unlock procedures | Refers to the number of prison officers required to be present as a result of risk on each occasion that the cell door is unlocked. May also specify what Personal Protective equipment is required. |

# Appendix 4: Legal framework

## Scope

The following is intended to provide practice guidance to general adult PICUs for the appropriate transfer and remission of patients detained under sections 48/49 and 47/49 of the MHA[31].

It should be read in conjunction with the *National Minimum Standards*[32] and *Guidance for the transfer and remission of adult prisoners and immigration removal centre detainees under the Mental Health Act 1983*[33]

- The most appropriate means to transfer a prisoner to a PICU is via a MoJ warrant or 'transfer direction', issued by the Mental Health Casework Section, following reports by two registered medical practitioners.
- Section 47 of the MHA is for sentenced prisoners with grounds for detention and states:

  **Removal to hospital of persons serving sentences of imprisonment, etc.**

  (1) If in the case of a person serving a sentence of imprisonment the Secretary of State is satisfied, by reports from at least two registered medical practitioners—

  (a) that the said person is suffering from mental disorder; and

  (b) that the mental disorder from which that person is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and

  (c) that appropriate medical treatment is available for him;

- Section 48 of the MHA is for unsentenced prisoners:

  If in the case of a person to whom this section applies the Secretary of State is satisfied by the same reports as are required for the purposes of section 47 above that

  (a) that person is suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and

  (b) he is in urgent need of such treatment; and

  (c) appropriate medical treatment is available for him;

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[31] https://www.legislation.gov.uk/ukpga/1983/20/contents
[32] NAPICU (2014) https://doi.org/10.20299/napicu.2017.001
[33] NHS England (2021) https://tinyurl.com/bde4yjxf

- No formal definition of 'urgent' is found within the MHA or CoP[34] in relation to section 48. However, when considering the application of section 48, it is advisable to consider the conditions contained within section 62 which authorises urgent treatment as that:

  (a) which is immediately necessary to save the patient's life;

  (b) which is immediately necessary to prevent a serious deterioration of his condition;

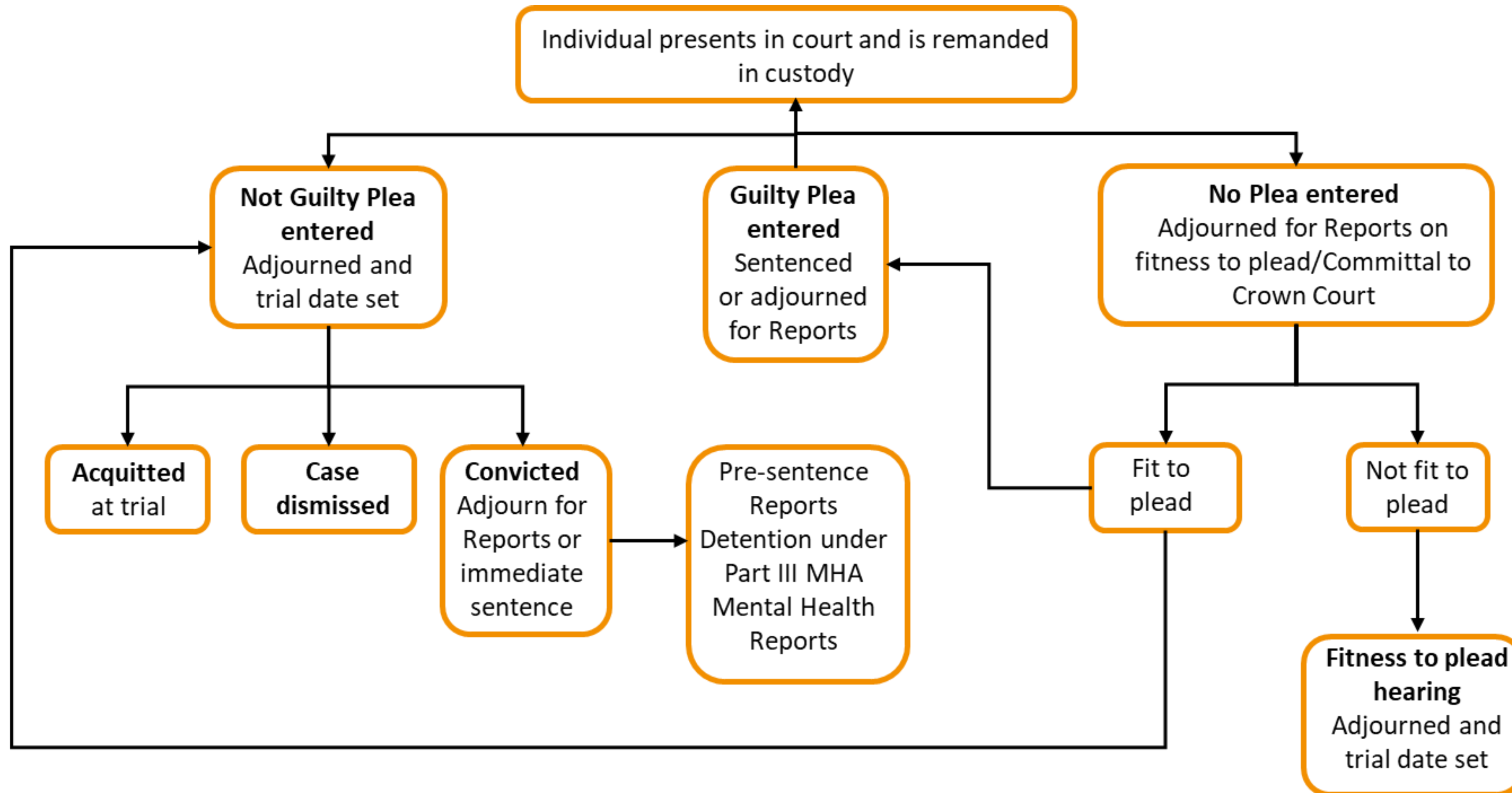
  (c) which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or

  (d) which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.

- Section 49 of the MHA allows for the transfer of a prisoner who may be subject to additional restrictions if the MoJ Mental Health Casework Section remains involved in the management of care and is now routinely attached to all prison transfers.

[34] https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

# Appendix 5: Flowchart for remand prisoners



# Appendix 6: Fitness to plead in the Crown Court

## Fitness to plead assessment

As a legal procedure, the overall intention of fulfilling the obligations of a fitness to plead assessment is to create parity and transparency between the need to protect a defendant who has, potentially, committed no crime yet is perceived to be unfit to plead at their impending trial, and the need to safeguard the general public from a defendant who has potentially committed an injurious act which would constitute a crime if done with the requisite mens rea.

This is divided into two stages:

- Whether the offender is under a disability (i.e. whether they are 'unfit' to plead (section 4 Criminal Procedure (Insanity) Act 1964); **and if so**
- Whether they committed the act/made the omission charged against the individual (section 4A Criminal Procedure (Insanity) Act 1964).

If the accused is unable to undertake any one of the following then they are unfit to plead and stand trial:

- Understand the charge(s)
- Decide whether to plead guilty or not
- Exercise his or her right to challenge jurors
- Instruct solicitors and counsel, which includes understanding details of the evidence
- Follow the course of the proceedings
- Give evidence in his or her own defence.

Under the current law on unfitness to plead, section 4(6) of the Criminal Procedure (Insanity) 1964 Act provides that a court cannot make a determination as to the accused’s unfitness to plead ‘except on the oral or written evidence of two or more registered medical practitioners at least one of whom is duly approved’.

## Further reading

Rix, K., Nathan, R. (2021) Reports for criminal proceedings and in prison cases. *In* Rix, K., Mynors-Wallis, L., Craven. C. (eds) ( 2021) *Rix’s Expert Psychiatric Evidence*, 2nd edn. Cambridge University Press. https://doi.org/10.1017/9781911623670.011

What are the Pritchard Criteria? Psychology Direct (https://www.psychologydirect.co.uk/resources/) posted 24 January 2019.

Unfitness to Plead. Volume 1: Report (2016) The Law Commission (LAW COM No 364).

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