

**Thames Valley Forensic Mental Health Service**

**Procedure**

**Title: Referral Criteria and Process**

# Introduction

The Thames Valley Forensic Mental Health Service provides medium secure facilities at the Oxford Clinic, Littlemore Mental Health Centre and Marlborough House, Milton Keynes, the former being the Head Quarters of the service. In addition there are low secure services for men and women at Woodlands House, Aylesbury, low secure and pre-discharge services for men and women at Littlemore Mental Health Centre site. A forensic community mental health team supports patients across Oxfordshire, Buckinghamshire, Berkshire and Milton Keynes. A community treatment service called Pathfinder provides a service for adults of working age with a diagnosis of Personality Disorder where violence or high risk of violence to others is a significant feature.

The service is currently commissioned by NHS England.

## Gate-keeping

The service delivers a gate-keeping service for secure forensic mental health services on behalf of NHS England. This aims to ensure that admissions to high, medium and low secure inpatient facilities are assessed by specialists in forensic mental health in order to ensure that individuals who require secure inpatient care receive the optimum level of care and treatment, appropriate to their forensic and mental health needs, in the least restrictive environment.

Forensic mental health services provide assessment of patients who may be on the borders of adult and forensic services, high and medium secure psychiatric provision, Independent and NHS facilities, and prison and health service. Referrals in this Gate-keeping category will be considered for admission as in-patients, or advice on management and the most suitable placement will be provided to our commissioners.

Admission will usually be to medium or low secure care. It is unlikely that patients would transfer into the forensic service directly at a pre-discharge unit level. The exceptions are likely to be cases that are transferring to the service from a location outside the Thames Valley area. Although referrers are welcome to give their opinion on the security level required it is not necessary to do so. This decision will ultimately be made by the clinical team conducting the assessment.

## Community Support and Capacity Building

There is very limited capacity to take patients directly into community forensic care. Those that are most likely to fall into this category are cases with a recorded conviction for serious offences. Patients may be assessed as requiring a period of psychological intervention. Such cases will be considered in the same way as all other referrals. There is no separate pathway for referrals to psychology and no open-access treatment programmes accessible outside of this process.

The service will provide assessments and advice for cases where the referrer is of the opinion that a forensic mental health opinion would provide *additional* benefit to the management of the patient. This may encompass issues such as diagnostic uncertainty but there must also be prominent risk issues which would benefit from a forensic opinion. Referrers should bear in mind that the service may be able to bring additional expertise in areas such as the assessment of risk and the use of security and legal measures to manage risk. If the requirement is essentially for a second opinion or a specific treatment dilemma such as in treatment resistant schizophrenia or managing those with personality disorder, referrers should consider whether services other than TVFMHS are able or better placed to meet this requirement.

The service will not see cases simply to provide an initial risk assessment and would expect this to have been conducted by the referring team.

## Pathway Management

Forensic services should support local CMHT’s in managing discharged forensic patients.  Neither adult nor forensic services can do this practically or safely by doing it alone, although there will be occasions when particular patients are managed in the community, exclusively by either forensic or adult services. The expectation is that Forensic and Local services work collaboratively to establish a safe pathway between secure and open conditions, such that the service is sensitive to changes in patient risk and need, and is capable of responding in a timely and proportionate way to ensure the welfare of the patient and the safety of the community. Clinical teams will decide on which of their resources will be allocated to facilitating the progression of these Community patients, in collaborations with local services. If clinically appropriate there may be a period of joint working as patients’ transition between forensic and adult services. During these periods it must be clear that the patient has one Responsible Consultant Psychiatrist and the transition period should not normally exceed three months unless there are exceptional clinical reasons to extend the joint working period. This is to ensure that the responsibility for the patient’s care is clearly defined.

# Criteria for Referral

Although in many cases there will be a link between the mental disorder and offending behaviour, this is not a pre-requisite for referral to the service. For example, when someone in prison develops a mental health problem and requires hospital treatment. However, all patients referred to the service will demonstrate both a degree of psychiatric complexity and forensic need, necessary to require a tertiary service such as TVFMHS. It is helpful if referrers could indicate the purpose of the referral made to TVFMHS with reference to these dimensions, which are elaborated below. In addition, referrers should indicate whether they are seeking admission to TVFMHS for their patient or specialist forensic assistance to assess or support them in the community as described in the previous section. This may not always be clear. It is appreciated that in some cases there may be some overlap across these categories.

## Psychiatric Complexity

Psychiatric complexity involves those aspects of a mental health problem that compound the risks and management of the patient. This would include the patients’ insight into mental health problems, their experience of delusions that might increase the probability of harm to others, in combination with, for example, the vulnerability to and speed of relapse in the mental health of the patient, medication/ treatment/ supervision compliance, use of substances or other aspects of life style that may disinhibit behaviour, and the degree of specialist monitoring and intervention required to keep others safe.

The service will not accept referrals of individuals who do not suffer from mental disorder regardless of the level of risk posed by the individual. The service does not assess cases involving learning disability and referrers should determine if learning disability is present and direct their referral to specialist learning disability services. The service also excludes those whose ONLY disorder is dependence on drugs or alcohol.

Although the service does not exclude those with a diagnosis solely of paraphilia or personality disorder, such cases are only likely to be accepted into the service where mental health input is likely to confer significant additional benefit to the patient and/or risk management compared to, for example, the Criminal Justice System.

## Forensic Need

Forensic need refers to both the probability of harm occurring to others and the seriousness of that harm should it occur. In some circumstance the ‘harm’ may refer to the damage done to an individual or public organisation such as in the circumstances of there being political sensitivity associated with an individual patient.

In the majority of cases the primary consideration will be the risks posed by the individual to others. There may be some cases where the risk that individuals pose to themselves is relevant, but this is not normally a ‘forensic’ matter. Significantly more weight will be given to a history of risk behaviours illustrated by convictions and current charges.

Referrers should keep in mind that the service has no investigative powers or resources and where concerns are largely focussed on the prevention of criminal acts by individuals in the community who are not subject to any legal framework, the most appropriate method of dealing with such concerns, including for individuals with mental disorder, will be the Criminal Justice System. This may be by direct contact with the police or through the MAPPA framework. This process does not necessitate TVFMHS involvement.

The majority of cases involving acquisitive offending or offences such as criminal damage will not be appropriate for the service as, regardless of the probability of the offence occurring, the seriousness of harm done is low. The exception will be remand or sentenced prisoners who require hospital treatment and present with mental disorder and a risk profile (including risk of absconding) by virtue of being prisoners, which makes treatment in a general psychiatric ward or psychiatric intensive care unit inappropriate.

The forensic service does not work to a rigid list of offences which meet the criteria for care by the service. However to aide those who may make referrals the following broad indication is given.

1. Offences highly likely to be managed in forensic services - homicide, attempted murder, grievous bodily harm with or without intent, rape, arson reckless and arson with intent to endanger life.
2. Offences which may be appropriate for forensic care – robbery, indecent assault, simple arson.
3. Offences unlikely to meet the criteria – assault occasioning actual bodily harm, common assault, acquisitive offences, indecent exposure.

The above is intended to be only a broad guide and each case will be considered on its own merits including the exact nature of any offences regardless of the final charge or conviction. If a referrer is uncertain they should feel free to make a referral and are encouraged to do so. In borderline cases it is particularly important that the referral contains the full amount of information as outlined in this document.

# Sources of Referral

The service would normally expect referrals to be from other consultant psychiatrists or consultant clinical psychologists. It is appreciated that other members of mental health teams may be involved in the referral process but there would be an expectation that there is oversight of such referrals at consultant level, and certainly that consultants are aware of and agree to such referrals.

The patient’s General Practitioner should normally be within the catchment area of Oxfordshire, Buckinghamshire, Berkshire and Milton Keynes. In exceptional circumstances, patients residing outside these catchment areas may be accepted by prior arrangement, with the agreement with our commissioners.

Within the Thames Valley referrals will be accepted from Community Mental Health Teams and psychiatric intensive care units. Referrals will also be received from outside of the Thames Valley area where a prison mental health in-reach team in another region encounters a prisoner from the Thames Valley with mental health needs. Referrals would usually only be seen if referred by secondary level mental health services. The service does not accept referrals from primary care. Such cases should, in the first instance, be referred to the local secondary care mental health service. Exceptions to this are likely only if an individual has previously been known to the TVFMHS, and in particular, if it has been indicated at the time of discharge from the TVFMHS, that if future problems arise the case should be referred directly to us.

We do take referrals from the Prison In-reach, and from Consultant Psychiatrists from High Secure Hospitals and Private Secure Hospitals. Exceptionally, by arrangement, the service may receive referrals from the National Offender Management Service, The Courts & Crown Prosecution Service, the Police or Probation Services and the Local Authority, but in the absence of contractual agreements there is no obligation to do so and is entirely at the discretion of the service.

# Referral Content and Process

## Content

Referrals should be made directly to the relevant Forensic Clinical Team. In the interests of flexibility this service does not currently operate a system of referral forms. However, it is imperative that adequate and clearly ordered information is provided before a referral can be accepted.

A referral should include the following:-

* An indication of reason for referral, current circumstances and problems. For those within the Criminal Justice System this should include a clear indication of their current status within the Criminal Justice System and any key dates, for example, earliest dates of release, licence expiry dates and sentence expiry dates.
* A detailed background history in the standard format covering family history, childhood, employment, relationships, substance abuse, social history, previous offending and past medical history.
* A **detailed chronological** summary of the individual’s mental health history.
* Current mental state of the individual.
* The team/referrers current opinions regarding diagnostic formulation, risk assessment and management plans.
* Current CPA and Risk Assessment documentation.
* The referral should clearly indicate the reason why the assessment is required and include confirmation that the patient has been informed of the referral and where necessary is willing to attend an appointment for a forensic assessment. If it is thought clinically inappropriate to inform the patient this should be clearly indicated with reasons.

The service appreciates that in many cases much of the above information would have been prepared in previous reports such as Admission/Discharge Summaries or Mental Health Review Tribunal reports. In such circumstances it would be perfectly acceptable for these to be attached with a detailed covering letter. However, we ask that where the information is contained in multiple documents, the information is decanted into a single document prior to referral. Referrals which simply state that the information is contained in electronic records will be rejected and returned to the referrer. The service accepts no responsibility for the consequences of any delay as a result of such referrals.

**Thames Valley Pathfinder Service** (TVPS), the inclusion and exclusion referral criteria are as follows:

## Adults of working age with a diagnosis of Personality Disorder where violence or high risk of violence to others is a significant feature. This will include women whose violence is likely to be less severe, but who are deemed to be at high risk of harm to others. Undiagnosed service users can also be referred when psychological problems are considered to be part of their violent behaviour, including sexual offending, and where diagnosis needs to be clarified. Generally there will be a history of serious and/or prolific offending and the range of offences will include a high level of those considered to be ‘grave’ offences, as defined by the Ministry of Justice.

**Inclusion Criteria for Pathfinder**

* A diagnosis of personality disorder associated with longstanding emotional and interpersonal difficulties.
* A history of antisocial or offending behaviour, including physical and/or sexual harm to others.
* Persons 18 or over irrespective of gender, culture, ethnicity, and sexual orientation.
* Service users with a primary or secondary diagnosis of personality disorder or presentation consistent with personality disorder.
* Service users with complex needs including emotional, relationship, psychological issues.
* Service users at immediate risk of entering secure provision
* Service users who are expected to return to the community within 12 months, subject to satisfactory care pathway and risk management planning
* Service users who are still inpatients, in the lowest level of security accommodation who have an identified discharge pathway and some realistic expectation of community access during the period they attend the Programme.

**Exclusion criteria for Pathfinder**

* A co-morbid psychotic illness that has not been well controlled for at least six months.
* Significant current substance misuse and absence of motivation to address this, or lack of progress in doing so.
* Service users with moderate to severe learning disability
* Service users with organic brain dysfunction
* Although we will not actively engage with individuals who demonstrate the above, we will offer consultancy to those services that treat them

## Process

On receiving the completed referral, it will be discussed at the relevant referrals meeting associated with the relevant geographical region. The Multidisciplinary Team (MDT) will determine if an assessment is appropriate and the referrer should be notified within 14 days. If an assessment is agreed this will take place within one month of all the referral information being received as outlined above.

A decision about the outcome of an assessment should be made within two weeks of that assessment. This response should include clear and concise recommendations for the future care of the patients and be shared with the referrer. Following the decision being made a bed should be offered within 6 weeks. If there is a problem with the timescale for admission the service should contact the relevant commissioner within 24 hours of a decision that the person is suitable for admission.

All patients who are referred are entered onto the minutes of referral meetings. If the patient is accepted for community, psychology or in-patient admission they will be entered onto the forensic database and regularly reviewed by the Performance & Business Manager & the Forensic Case Manager. Information will be shared with the key stakeholders (commissioners, referrers, potential recipients of patients) as agreed.

If a patient is accepted by the TVFMHS, the Forensic Case Manager will monitor and track progress of the patient, jointly working with the admitting ward to facilitate a quick transfer. High Secure patients will only be placed on the waiting list once Ministry of Justice permission has been received.

## Disputes/Appeals

In the event of the referrer or gatekeeper disagreeing with the outcome of the assessment, the TVFMHS must have a system in place to review the decision and resolve any conflicts that may arise as a result. The care of the patient must not be compromised because of a dispute. Resolution of disputes will be the responsibility of the parties involved in the assessment and must be undertaken in a timeframe commensurate with the patients needs. The dispute will be resolved by a group consisting of the Clinical Lead for Forensic Services, Head of Forensic Nursing, Head of Forensic Psychology and the Forensic Case Manager.

##  Emergency Referrals

For urgent referrals, an initial verbal response regarding the appropriateness of a referral should be made within 24 hours of receipt of the referral and an initial multi-disciplinary assessment conducted within seven days. The outcome should be notified verbally within 24 hours of the assessment and a formal written assessment should follow within seven days. It should be noted that determining the urgency of a referral is a matter for the TVFMHS in collaboration with its commissioners.