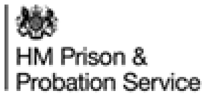

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Transfer guidance under Mental Health Act 1983 for children detained on youth justice grounds

Procedure for the referral for assessment, and transfer to and from hospital (under Part III of the Mental Health Act 1983) of a child held in custody in England

Version 2, 07 November 2022

Contents

1 Introduction 2

2 Glossary 3

3 Summary 4

4 The legal framework and the children to whom it applies 5

4.1 The legal framework 5

4.2 Children who are covered by this procedure 5

4.3 Children **not** covered by the procedure 6

4.4 Conditions for transfer 6

4.4.1 Conditions needed for transferring sentenced children (section 47 transfer) .. 6

4.4.2 Conditions needed for transferring remanded children (section 48 transfer) .. 7

4.4.3 A section 49 ‘restriction direction’ 7

5 Transfer to hospital 8

5.1 The importance of early action 8

5.2 The providers of hospital care and treatment 9

5.2.1 NHS England provision 9

5.2.2 Referral criteria for the ANMSU network 9

5.3 Stage 1 of the transfer process – the first medical assessment and referral....10

5.3.12 Key points about avoiding delay at Stage 1 13

5.4 Stage 2 of the transfer process – second medical report and gatekeeping 15

5.4.6 Key points about avoiding delay at Stage 2 17

5.5 Stage 3 of the transfer process – arranging the transfer 19

5.5.4 Avoiding the warrant lapsing 20

5.6 Informing the child, and their family and involving local services 20

5.6.1 Informing and involving parents and other relatives 22

6 Return from hospital, and arrangements for aftercare 23

6.1 Actions needed before return 24

7 Responsibilities of ICBs and NHS England specialised commissioning teams in relation to transfers 26

7.1 Establishing the responsible commissioner 26

7.1.1 Reducing delay and providing high-quality care 27

8 Responsibilities of the Mental Health Casework Section in relation to transfers..........28

9 Responsibilities of the Youth Custody Service Placement Team in relation to transfers 29

1 Introduction

This document – the *Procedure for the referral for assessment, and transfer to and from hospital (under Part III of the Mental Health Act 1983) of a child held in custody in England – Good practice guidance 2021* – is designed to support staff to work well with colleagues to ensure that the established transfer process works smoothly and that there are no unacceptable delays in providing a child with inpatient mental health care if that is what they need. Staff will also need to be familiar with the most recent version of the Code of Practice[1] to the Mental Health Act 1983 (MHA), particularly chapter 19 relating to children and chapter 22 relating to people in custodial settings.

Parents, families and carers with parental responsibility should be involved as much as possible in decisions about the hospitalisation of their children. The greater vulnerability of children that arises from their age and lack of maturity makes it unacceptable for them to remain in custody without immediate access to the right level of health oversight and expertise that their mental disorder requires. The document references a seven-day timeframe from referral for assessment to complete the transfer of a child,[2] should the assessment determine that that the child requires a transfer.

This document applies to children who are in custody, whether on remand or sentenced.

[1] Department of Health (2015) The MHA 1983: Code of Practice
[2] The Children Act 1989 and 2004 uses child/children as a term throughout, and therefore reference to child/children is used throughout this document. One of whom must be an approved clinician under section12 of the MHA 1983

2 Glossary

ANMSU	Adolescent national medium secure unit (network)
CYPMHS	Children and young people's mental health service
CPA plan	Care programme approach plan. The plan sets out arrangements for any continuing need for mental health services after a child's discharge from hospital.
Health and justice commissioning	NHS England health and justice commissioners have responsibility for the commissioning of health provision in all secure settings for young people. The Health and Justice services are commissioned via 10 Health and Justice teams across 4 regions (North, Midlands, London and South).
HMPPS	His Majesty's Prison and Probation Service
HMYOI	His Majesty's Young Offender Institution
ICB	Integrated Care Board
LASPOA	Legal Aid, Sentencing and Punishment of Offenders Act 2012
Looked after child	A child under a care order, or a child accommodated by the local authority under section 20 of the Children Act 1989
MHA	Mental Health Act 1983. Part III of the Act allows the Secretary of State for Justice to transfer young people in custody to detention in hospital.
Mental health team	A generic term for the range of different mental health services available in the young people's secure estate
MHCS	Mental Health Casework Section (of the Ministry of Justice)
PCC(S)A	Powers of Criminal Courts (Sentencing) Act 2000
SCH	Secure children's home
STC	Secure training centre
Specialised commissioning	NHS England specialised commissioners have responsibility for the commissioning of mental health inpatient services for children and young people. Specialised commissioning is delivered through regional specialised commissioning teams. The relevant team for the purposes of the transfer procedure is the one that covers the child's home area.
YOT	Youth Offending Team: a multi-agency team co-ordinated by a Local Authority and overseen by the Youth Justice Board.
YCSPT	Youth custody service placement team

3 Summary

This document outlines the procedure for transferring to and from hospital under the MHA 1983 any child who is sentenced to custody (in England) or who has been remanded to custody. The procedure covers the duties of secure estate settings in relation to the identification and transfer of children and the procedures that should be followed by the other agencies involved where detention subject to Part III of the MHA is considered appropriate.

The purpose of the guidance is to ensure a speedy and clinically appropriate response to children who might need admission to hospital under sections 47 or 48 of the MHA. It covers the way they are identified, referred for treatment, receive the required inpatient care, and subsequent discharge.

Referrals for admission to hospital under the MHA for this population are made to the Adolescent National Medium Secure Unit (ANMSU). The referral is considered at the weekly ANMSU referral meeting.

The direction of the Secretary of State for Justice that authorises transfer to hospital under the MHA is valid for fourteen days only, so any transfer must be completed by the end of that period. However, given the urgency required when responding to a child with mental disorder, good practice indicates that a transfer should be made within seven days from the start of the first medical recommendation.

The governors/managers/directors of secure settings have a vital role to play in ensuring that healthcare and front-line residential staff, are aware of and comply with the procedure for transfer.

The crucial role of parents and carers who have parental responsibilities is not to be underestimated. Their knowledge of the child will be extremely helpful to professionals; it is important, at each stage of the transfer procedure, that staff have clear processes for contacting those with parental responsibility and involving them in decisions.

4 The legal framework and the children to whom it applies

4.1 The legal framework

The Mental Health Act 1983 (the MHA) is the relevant legislation governing the transfer procedure described in this document.

The relevant sections covered in this guidance are in Part III of the Act:

- Section 47 of the MHA provides the Secretary of State with power to transfer to hospital people serving a sentence of imprisonment (known as a 'transfer direction') if the statutory criteria are satisfied.

- Section 48 of the MHA provides the Secretary of State with power to transfer to hospital people who are in custody on remand, civil prisoners or those detained under the Immigration Act 1971.

- Section 49 of the MHA provides the Secretary of State with the power to make a transferred person subject to the special restrictions set out in section 41 of the MHA whilst in hospital (known as a 'restriction direction').

4.2 Children who are covered by this procedure

In relation to sentenced children, **section 47** is used to transfer those who have been:

- sentenced to a Detention and Training Order (DTO) – under section 100 of the Powers of Criminal Courts (Sentencing) Act 2000 (PCC(S)A)

or

- sentenced for a serious offence – under section 90 or 91 of PCC(S)A or section 226, 226b or 228 of the Criminal Justice Act 2003 (CJA).

In relation to children on remand, **section 48** is used to transfer those who have been:

- remanded by the court to custody – under section 91(4) of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPOA).

Children on remand who are transferred under section 48(2)(a) or (b) must also be subject to a restriction direction under s.49 MHA. Other children subject to a transfer direction will be subject to a restriction direction if the Secretary of State thinks that is appropriate.

Custody includes:

- a secure children's home (SCH)
- a secure training centre (STC)
- a young offender institution (YOI)
- accommodation, or accommodation of a description, for the time being specified by order under section 107(1)(e) of the PCC(S)A 2000 (custody for purposes of detention and training order provisions).

4.3 Children **not** covered by the procedure

Not all children who come before the courts are covered by this procedure. The procedure does not apply to children in any of the following groups:

- Those who are remanded by the courts to **local authority accommodation** (under section 91(3) and 92, LASPOA 2012). This is because local authority accommodation does not count as custody.

- Those who have been remanded by the **Crown Court** to custody (under section 91(4), LASPOA 2012). Transfer to hospital for these children would need to be ordered by the Crown Court, under section 35 or 36 of the MHA. Children can also be remanded to hospital under section 35 by the Magistrates' Court, though can be transferred under s.48(2)(b) MHA.

4.4 Conditions for transfer

The conditions relating to the transfer of children under the procedure are very similar, irrespective of whether the child has been sentenced or remanded.

4.4.1 Conditions needed for transferring sentenced children (section 47 transfer)

A child or young person serving a custodial sentence may be transferred to hospital by warrant under a direction from the Secretary of State (through the Mental Health Casework Section (MHCS) under section 47(1) of the Mental Health Act 1983 if the

Secretary of State is of the opinion, having regard to the public interest and all the circumstances, that it is expedient so to do, and if he/she is satisfied by reports from at least two registered medical practitioners[3] that:

- the child is suffering from a mental disorder[4]

and

- the child's disorder is of a nature or degree that makes it appropriate for them to be detained in a hospital for medical treatment

and

- appropriate medical treatment is available for the child.[5]

4.4.2 Conditions needed for transferring remanded children (section 48 transfer)

Section 48 of the MHA 1983 provides that a child remanded to custody can be transferred to hospital under a warrant directing transfer (issued as in 4.4.1, above).

The Secretary of State for Justice must be satisfied of the three conditions required under section 47, (as listed above, in 4.4.1). There is an extra condition to be satisfied for a remanded child: the medical reports must also satisfy the Secretary of State that the child is in **urgent** need of treatment.

4.4.3 A section 49 'restriction direction'

When issuing a warrant for transfer, the Secretary of State for Justice will usually also issue a 'restriction direction'. This means that the Secretary of State, via the MHCS, remains involved in the management of the case. The child's responsible clinician cannot transfer them to a different hospital, grant them leave or discharge them without the Secretary of State's consent. The restriction direction also restricts the powers of the Mental Health Tribunal, so that it cannot direct discharge without agreement of the Secretary of State. Where a restriction direction is added, the Secretary of State may direct the return of the person to custody (known as 'remission') if notified that they no longer meet the criteria for detention in hospital under the MHA.[6]

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[3] One of whom must be an approved clinician under section12 of the MHA 1983

[4] Section 1 of the MHA 1983 defines mental disorder as 'any disorder or disability of the mind'. The MHA 1983: Code of Practice (DH, 2015), at para 2.4, comments: 'Relevant professionals should determine whether a patient has a disorder or disability of the mind in accordance with good clinical practice and accepted standards of what constitutes such a disorder or disability.'

[5] The Secretary of State will consider other matters, too, as described in Section 8 of this procedure.

[6] Section 49, MHA 1983

Further, if the tribunal notifies that the child would be entitled to be conditionally discharged, the recommendation may be that in the event of their not being discharged under this section they should continue to be detained in hospital.[7]

5 Transfer to hospital

5.1 The importance of early action

For any child thought to require inpatient specialist mental health treatment, it is essential that they are identified, assessed and, if clinically appropriate transferred to hospital as early as possible. Delay can make it more difficult to find a suitable hospital place at a later stage or hold up access to the specialist care needed and it may result in further deterioration in mental state. Avoiding this is as important for children in custody as for those living in the community.

Mental health assessments in the case of a child under the age of 18, should be undertaken by a professional with current clinical expertise, including specialist knowledge of children and young people's mental health services (CYPMHS). If this is not possible, professionals with the appropriate expertise and experience, including children under the age of 18 and where appropriate those with a learning disability should be consulted.

For children aged 17, early planning and assessment is particularly important because at 18 they will be too old to be admitted to the Adolescent National Medium Secure Unit.

For children nearing their release from custody, early action is particularly crucial to ensure that the MHA is used to best advantage. Case law[8] requires the Secretary of State for Justice to apply heightened scrutiny to late requests for transfer. This does not mean that consent will not be given, but there need to be clear reasons why the request has been made so close to release and why transfer is critical at this point. It may be possible for the transfer to be approved without

[7] Section 74 (1)(b), MHA 1983

[8] *R. (on the application of TF) v Secretary of State for Justice* [2008] EWCA Civ 1457; [2008] M.H.L.R. 370, where Waller L.J. said at para.31: "Where section 47 is proposed to be used at the very end of the sentence, and hopefully that will only be in very exceptional cases, the onus must be on the Secretary of State to show that the mind of the decision maker has focused on each of the criteria which it is necessary to satisfy if there is to be power to issue a warrant directing transfer to a hospital.

restrictions or it may be more appropriate for an application for admission to hospital to be made under Part II of the MHA as soon as the child has been released from custody. Early advice from the MHCS at the Ministry of Justice will help clarify what course of action to take.

5.2 The providers of hospital care and treatment

5.2.1 NHS England provision

NHS England has responsibility for commissioning inpatient children and young people's mental health inpatient services. This specialised commissioning is delivered through seven specialised commissioning NHS England regions.

Each specialised commissioning region has children and young people's mental health case managers (CYPMHCMs) and it is important to use them as an early point of contact when transfer to hospital is indicated. They hold up-to-date knowledge about the units and bed availability in their area. The relevant team is the one covering the child's home area.

Inpatient care and treatment for children in custody will be provided by the medium secure facilities of the ANMSU. The ANMSU network consists of five medium secure adolescent healthcare units. Relevant contacts are listed at Appendix 4. There are specific referral criteria for these units.[9]

While it is possible that the child may require care and treatment in conditions of adolescent low security, the ANMSU network is the assigned agency for triage and it is the arbiter as to whether the referral can be taken up by the low secure provision.

5.2.2 Referral criteria for the ANMSU network

Referral to the ANMSU network in the first instance should be made in the following circumstances:

- Where the child with a mental disorder including neurodevelopmental disorders such as learning disability and autism presents a grave danger to the general public (including those who are high risk without an offending

[9] https://www.england.nhs.uk/wp-content/uploads/2018/02/camhs-medium-secure-service-specification-v2.pdf

history, those charged with/convicted of specified violent or sexual offences under Schedule 15 of the Criminal Justice Act)

- Where a child is subject to a Restriction Order under the MHA (s49) including those in custody (remand/sentenced) and directed to secure inpatient care by the Ministry of Justice (MoJ) **or** has been sentenced by a Crown Court to a Restriction Order under the MHA (s41).

- On very rare occasions the ANMSU network will consider referrals for children with particularly severe presentations which may include prolonged self-harm and particularly challenging behaviour where there is evidence that they cannot be managed in any other setting including PICU or low secure services.

Responsibility for the care of the child remains with the referring service until the point at which they are formally received by the hospital.

Acceptance criteria:

- The child is under 18 at the point of referral

and

- liable to be detained under Part II or Part III of the MHA

and

- presents significant risk to others with one or more of the following:
  - direct serious violence liable to result in injury to others
  - sexually aggressive behaviour
  - destructive and potentially life-threatening use of fire

and

- there is clear evidence prior to referral that serious consideration of less secure provision has been made and/or tested and discounted as the child's needs/risk exceed the threshold for and ability of those services to manage.

5.3 Stage 1 of the transfer process – the first medical assessment and referral

5.3.1 If a child in the secure setting has a mental health disorder that exceeds the ability of available mental health services in the secure setting to meet their

need, the Head of Healthcare (or appropriate healthcare lead) responsible for the secure setting's healthcare services organises a local immediate medical assessment by the local Health and Justice NHS England provider clinician, with a view to making a referral to the ANMSU network. This is often completed by the Psychiatrist based in the secure setting, and should the assessment suggest a transfer would be suitable, this would form the first medical recommendation. Given the infrequency with which the referral procedure is used, they also ring the Adolescent Medium Secure unit nearest to the child's originating area to clarify the arrangements that might be needed. Form entitled 'Referral Form to Access Inpatient Services for Children and Young People (Form 1)' is completed.

5.3.2 Once a Referral Form has been completed by the local access assessor and discussed with the NHS England CYPMH case manager, referrals can be made to the closest unit to the patient's home even if it will not be the admitting unit. All referrals are discussed at a weekly national referrals meeting with input from all units (held via teleconference) and a NHS England CYPMH case manager when, if appropriate, the referral will be allocated to a specific unit for assessment. This allocation will be made based on available treatment, geography and current capacity to admit.

5.3.3 If the child is accepted by the unit there is a requirement for two medical recommendations, one of which must be made by a Section 12 MHA approved doctor. This should be co-ordinated by either the GP or the CYPMHS psychiatrist working in the secure setting.

5.3.4 Both doctors complete the required medical reports, which include confirmation that the child is suffering from mental disorder of a nature or degree that makes it appropriate for them to be detained in a hospital for medical treatment, and that appropriate treatment is available.

5.3.5 The Head of Healthcare alerts both the Youth Custody Service Placement Team (YCSPT) and the MHCS to the possible need for transfer, giving details of the child who has been assessed. The H1003 form is completed for the MHCS. They also ask the MHCS for advice about the appropriate level of security required in hospital, if the doctor is unsure about this. There

are three contacts at the MHCS for under 19-year olds. Relevant contacts are listed at Appendix 4.

5.3.6 The Head of Healthcare also contacts the mental health commissioner/ MHCM in the relevant NHS England specialised commissioning team (the one that covers that child's home area). This is to inform them that an inpatient placement might be required after the second assessment, and to inform them about the child's presentation (eg mental illness alone, or a combination of mental disorder and learning disability) and asks them for information held by local health or children's services that is relevant to the child's current situation, including their possible mental disorder. The second medical recommendation should also be given to assist the completion of the H1003 form submitted to the MHSC.

5.3.7 The Psychiatrist and Head of Healthcare work with health and other care staff (in conjunction with the ANMSU network) to gather the information that is needed by the ANMSU network to support the transfer process. This is about the child's medical condition and offending behaviour, risk profile and the likely level of security needed. The referral form[10] is used to record most of this information. The referral is then made to the closest unit to the child's home even if it will not be the admitting unit. All referrals are discussed at a weekly National Referrals Meeting with input from all units and a NHS England and CYPMH Case Manager when, if appropriate, the referral will be allocated to a specific unit for assessment. This allocation will be made based on available treatment, geography and current capacity to admit. By secure email, healthcare sends the following to the receiving unit:

- the doctor's medical report
- Form H1003/4
- the sentencing or remand warrant
- the latest available AssetPlus documentation
- the pre-sentence report, sentence plan and any progress reports
- information on any previous convictions

[10] The NHS England CYPMHS Specialised Mental Health Services Operating Handbook Protocol provides the guidance for Tier 4 services and the process for Secure CYPMHS Referrals. A copy of the protocol and/or referral form can be requested by contacting england.specmh@nhs.net.

- details of the index offence (usually the Police record of charge MG5 form).

5.3.8 Now, and at each subsequent stage of the process, the Head of Healthcare keeps the child informed about what is happening and what is likely to happen next. They also notify people close to the child, parents and others with parental responsibility (including the responsible local authority if the child is looked after under a care order), and the YOT supervising officer. Further guidance about informing children's parents and other relatives is included at the end of this Section (at 5.6.1).

5.3.9 Once the transfer procedure has been initiated – by the recommendation for transfer to hospital by the first doctor – the child continues to be cared for in their current secure setting unless, exceptionally, the YCSPT decides that an alternative arrangement is necessary in a situation where the current secure setting cannot safely continue to manage the child.

5.3.10 Children in YOIs can be subject to a 'medical hold' in order to prevent their removal to another secure setting. The Head of Healthcare will ask the YOI governor to apply the hold, if deemed necessary in a particular case.

5.3.11 The important point here is that the Head of Healthcare or appropriate healthcare lead needs to ensure that everyone involved with the child communicates closely, so that it is always clear where the child is being held, why and when they might be moved, and when and to where they have been moved following transfer.

5.3.12 Key points about avoiding delay at Stage 1

5.3.12.1 Have a robust system in place

The relatively infrequent need for transfer makes it important that the heads of secure settings have established a clear system for the procedures outlined above which they can reference easily. This is especially important for steps in the process that require staff in different departments to work together quickly to support the transfer, such as by collating information about previous convictions and current behaviour.

The Head of Healthcare responsible for the secure setting's healthcare services will have a lead role in the smooth operation of the agreed system. This will include

having a list of approved local medical practitioners with details of where to access this so it can be regularly updated, up-to-date information about specialised commissioning contacts, and details of the relevant ICB for a child, and overseeing transfer arrangements. It can be helpful to have a single point of contact in the healthcare centre for all liaison with the MHCS and the YCSPT.

5.3.12.2 Ensure staff confidence about data protection provisions

All clinical staff must understand the separation of the requirements for consent. Professional guidelines provide that any clinical intervention requires "consent to treat" – ie that the individual understands and consents to the care and treatment provided. Care should be taken with children, and whether they have "Gillick competence" to understand and consent to proposed care. The sharing of data, however, does not always require "consent". The need for "consent to share", rather than "consent to treat" is a different matter. These two issues should not be confused.

Where children are at risk of significant harm, information can be shared between teams within secure settings for the health, welfare and safeguarding purposes of the child. Under data protection legislation this does not require previous consent of the individual. Under (UK) GDPR (and associated data protection legislation) processing of personal data is undertaken legally to the extent that the following applies:

> "Article 6(1)e – processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller"

Additionally, the processing of special categories of data (of health data) is permissible under:

> "Article 9(2)h – processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of Union or Member State law or pursuant to contract with a health professional…"

See the relevant healthcare standards 3.1, 3.1.1, 3.1.2 here

5.3.12.3 Be clear about the requirements governing medical assessments

There are three main points here. First, at least one of the two assessing doctors must be approved under section 12(2) of the MHA (approval means that they have recognised special expertise in the diagnosis or treatment of mental disorder). Second, each doctor must provide a report that is up to date. Third, each must state that the child is suffering from mental disorder of a nature or degree that requires inpatient treatment. It is not sufficient for the second doctor to merely state that they endorse the opinion in the first report. In addition, for the Secretary of State to be satisfied that the statutory criteria under the MHA are met, he/she must be satisfied that appropriate treatment is available.

For transfers under section 48 MHA 1983, the reports must also confirm the child is in urgent need of treatment.

There should be no more than a seven day between the assessment of the child and the report being completed.

5.3.12.4 Resolving differences of opinion between staff and the assessing doctor

If the first doctor does not agree with the view of the secure setting's mental health team about the need for inpatient care, it will usually be possible to resolve this locally. If not, the commissioner of the secure setting children's mental health service will ask the provider or a different provider to identify someone to give a second opinion.

5.4 Stage 2 of the transfer process – second medical report and gatekeeping

5.4.1 The Head of Healthcare responsible for the secure setting's healthcare services updates the MHCM, explaining that the referral has been made to the ANMSU network.

5.4.2 The child is automatically assigned to the receiving unit closest to their home area, depending on the availability of beds and support for those with a learning disability. A senior clinician from the receiving unit, the unit which is closest to the child's home area, presents the referral to the referral meeting of the five national medium secure network units. If the referral is considered appropriate for assessment, the meeting allocates one Unit to lead on the second assessment and from this point this Unit is in charge of liaising with the referring doctor. (In the case of an emergency referral,

instead of waiting for the referral meeting, the receiving Unit will contact the chair of the referral meeting for immediate assessment of the referral.)

5.4.3 The allocated Unit arranges with the referring doctor and Head of Healthcare to visit the secure setting and assess the child. The assessing team will spend time with the child, review their files, and interview members of staff. Guidance notes for healthcare professionals visiting secure settings are at Appendix 2. The assessment is discussed at the next weekly referral meeting of the ANMSU network, where decisions will be made about suitability for admission and capacity to admit.

5.4.4 The second medical report is completed, using the same format as the first report if time allows. If not, the MHCS will accept a non-standard report or letter instead, provided that it includes information required by the MHA: that the child has a mental disorder that is of a nature or degree which makes it appropriate for the child to be detained in a hospital for medical treatment, and that appropriate medical treatment is available (and, in the case of remanded children, that the child is in need of urgent treatment). The report or letter must also state whether the report-writer is an approved clinician under section 12(2) MHA. The allocated Unit informs the first doctor of the decisions made.

5.4.5 The Head of Healthcare sends the following to the MHCS by secure email:

- i. both medical reports
- ii. Form H1003/4
- iii. the sentencing or remand warrant
- iv. the pre-sentence report, sentence plan and any progress reports
- v. the latest available AssetPlus documentation
- vi. information on any previous convictions and
- vii. details of the index offence (usually the Police record of charge MG5 form).
- viii. Details of the receiving unit identified.

and notifies the YCSPT that this has been done. If you have some, but not all of the background information available, you should send the two medical reports and whatever additional information you have, so that MHCS can decide whether it’s possible to make the necessary risk assessment with limited information, with a

view to obtaining full information once the transfer warrant is issued. This will avoid any unnecessary delay in MHCS being able to issue the transfer warrant.

5.4.6 Key points about avoiding delay at Stage 2

5.4.6.1 The timescale for responding to referrals

All referrals are considered on a weekly basis by the members of the ANMSU network which then allocates a specific unit to undertake an assessment of the child. The allocation is based on available treatment, patient gender, presence of learning disability, geography, patient mix on individual units and current capacity to admit.

The processing of referrals should not be delayed because of issues relating to establishing commissioning responsibility or ordinary residence status.

The provider will complete the assessment within seven days of allocation by ANMSU network referral meeting.

The ANMSU network cannot provide emergency cover but can provide a rapid response to contribute to the assessment and management of imminent harm to others in the context of the child's mental disorder. The network will provide advice to referring clinicians to ensure that any subsequent referral is appropriately directed to medium or low security.

5.4.6.2 Ensuring a comprehensive referral

The more comprehensive the referral to the local medium secure unit (local to the child's home, rather than local to the secure setting), the greater the chance of minimising delay. This is so generally, but it is particularly important if the situation is very serious. Healthcare and other staff can help by giving their view about the severity of the referral and why they consider it to be an emergency.

5.4.6.3 Resolving difference of opinion between the first and second doctor

If the second doctor concludes that transfer to hospital is not appropriate for the child, it is open to the secure setting holding the child to seek a second opinion from the ANMSU network. Staff at the secure setting will want to take account of the possible adverse impact on the child of going through an additional detailed assessment.

If they consider it appropriate to request a second opinion, the Head of Healthcare responsible for the secure setting's healthcare services will discuss the need for such a request with the NHS England relevant MHCM. If necessary, the MHCM will liaise with the responsible ICB commissioner, given that they will also fund a second opinion in addition to the second assessment.

The second opinion is conducted by a different unit in the ANMSU network. The request is discussed with the chair of the referral meeting, for a decision about which Unit will do the next assessment. Given the inevitable delay that will arise, the referral meeting will take on the role of co-ordinating with the referrer, the child, the secure setting where the child is and those with parental responsibility.

In the intervening period whilst a second opinion is being sought, there may need to be consideration of a discussion between the Health and Justice commissioner responsible for commissioning the CYPMHS within the secure setting and the multi-disciplinary team in the secure setting, about whether any additional resource/services are required to support the secure setting if they feel unable to meet the child's needs safely.

5.4.6.4 If the criteria for admission are met but there is no capacity in the Adolescent National Medium Secure Unit network

The lack of available placement in an ANMSU should not delay the transfer of a child in need of hospital treatment. The MSU determine the level of security level required for a child; the MSU may assess and suggest a placement in a LSU would be suitable.

The allocated Medium Secure Unit liaises directly with the referring clinician, giving an indication of when a bed might become available, and bed availability continues to be reviewed at the referral meeting of the ANMSU network. The network also discusses the case with the relevant NHS England mental health commissioner (because of their funding/gatekeeping role), to suggest alternative placements and other possible options. The mental health commissioner must do a risk assessment of the situation, based on the impact of any delay in transferring the child (see 5.4.1.1 and 5.4.1.2 acting in an emergency). The CYPMHS medium secure service specification references that the ANMSU network will provide a rapid response to contribute to the assessment and management of imminent harm to others by the child.

5.4.6.5 If the secure setting is unable to continue to meet the need

If there is no recommendation for admission to hospital, and after following the above advice, the secure setting does not feel able to continue to meet the needs of the child, the Health and Justice commissioner responsible for commissioning the CYPMHS within the setting will need to meet with the multi-disciplinary team in the secure setting, to discuss a care plan for the child and potentially offer to resource additional services in the interim, with a view to the child achieving recovery and therapeutic benefits from an enhanced package of care. The care plan can be discussed with the ANMSU network team that did not accept the referral and used as a basis for improved understanding of the threshold for admission and the care and treatment that medium secure units can provide.

A solution might also be found elsewhere in the secure estate, through discussion between healthcare teams in different secure settings about where the child's needs might be able to be met. The YCSPT will be informed of the outcome of this discussion.

5.4.6.6 Where the criteria for hospital admission are met but the need is lower than medium secure

A child's needs might not be so severe as to justify admission and treatment within the ANMSU network, especially where secure settings are following good practice and making referrals early, before needs become entrenched and difficult to treat. In those cases, an appropriate response after assessment would be for the ANMSU network to recommend placement in alternative provision, in accordance with the least restrictive principle set out in the MHA Code of Practice. The MSU determine the level of security level required for a child, the MSU may assess and suggest a placement in an LSU would be suitable.

5.5 Stage 3 of the transfer process – arranging the transfer

5.5.1 If a bed is available in the ANMSU network, the admitting unit liaises directly with the referring healthcare team, to agree the timescale and process for admission. This is done verbally, so that transfer can be made as quickly as possible, with the full written report sent later. The transfer should be completed within seven days from the date of referral for assessment by the secure setting.

5.5.2 The MHCS requires written confirmation of the admitting hospital and can issue a warrant prior to the date on which a bed is available. The Head of

Healthcare contacts the MHCS to inform it that a bed is available so that the warrant can be issued, and the warrant – which names the admitting hospital – is sent to the referring clinician, with a copy to the Head of Healthcare. A warrant will only be valid for 14 days, so if this time lapses before a bed is available, the warrant will have to be reissued.

5.5.3 It is important to confirm who is responsible for transporting the child. Generally, the secure setting is responsible for transport to the inpatient unit, and the inpatient unit is responsible for transport from hospital after treatment. YOIs, STCs and SCHs are all now covered by the Prisoner Escort and Custody Services (Generation 4) contract. The YCSPT will ensure all escorts are undertaken in a planned manner with consideration of their potential complexity (from custody to hospital). The MHA Code of Practice says that children "should be transferred under local escort and bed watch policies. They should be transported in 'usual transport' (eg a car) unless in an emergency or otherwise agreed, when an ambulance should be used."[11]

5.5.4 Avoiding the warrant lapsing

Time is of the essence and, in any event, a transfer direction will cease to have effect 14 days after the date it is made. MHCS has an internal target to produce a warrant for transfer within 24 hours of receipt of all of the required information. The average time from initial notification of the need for a warrant to the issue of a warrant is most recently noted to be 3 days.[12]

5.6 Informing the child, and their family and involving local services

Involve the child so far as possible; children should always be kept as fully informed as possible and should receive clear and detailed information concerning their care, explained in a way they can understand in a format that is appropriate to their age. The child's views, wishes, and feelings should always be sought, their views taken seriously, and professionals should work with them collaboratively in deciding how to support the child's needs.

[11] Department of Health (2015) MHA 1983: Code of Practice, para 22.33
[12] https://questions-statements.parliament.uk/written-questions/detail/2019-06-13/264365

The mental health case worker for the child at the secure setting should ensure that services with an interest in the child are aware of transfer decisions and arrangements. This is important so that the child can benefit from what everyone has to offer, and so that arrangements for the next stage of the child's care can be made in good time and include the right combination of services. The importance of ensuring care co-ordination in this way applies to all settings: to the secure setting where the child is held and to the inpatient unit to which the child is transferred.

The following list of services to liaise with regarding a transfer is not exhaustive, but should include:

- Give early notice of a transfer decision to the CYPMHS relevant **consultant psychiatrist** or equivalent from the child's home area. This is good practice because, on their release, the child might be discharged to that person under the Care Planning Approach (CPA) framework.

- Keep the **YOT supervising officer** informed about what is happening.

- If the child has alcohol and/or drug problems, the **substance misuse worker** at the secure setting can help ensure that the admitting unit has up-to-date information about the child's circumstances and any treatment programme and, on release, they can provide similar information to community services.

- **Advocates** have an important role to play, listening to children's concerns and at times liaising on their behalf with secure setting and inpatient staff, as well as parents.

- If the child is under a care order (section 31, Children Act 1989) the **local authority** responsible for them should be informed. It is preferable for contact to be made with the child's social worker or their manager, to ensure that they are involved in future planning[13] and that they are aware that the child has been, or is about to be, moved to another location. A decision will need to be made about who is best placed to keep the child's parent/families/carers with parental responsibility up to date with what is happening (see 5.6.1, below).

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[13] The Children Act 1989 Guidance and Regulations Volume 2: Care Planning, Placement and Case Review 2015; MHA Code of Practice 2015, chapter 19

The relevant local authority should also be informed if the child was looked after under section 20 of the Children Act 1989 before being sentenced or remanded to custody. Once the child has entered custody they will cease to be looked after under section 20 but local authorities retain some responsibilities towards them. It is important to remember that some children may have been in section 20 accommodation for some time. Local authorities are under a duty to visit children formerly looked after under section 20 (section 23ZA, Children Act 1989) and related guidance requires local authorities to identify any needs for support that the child will have on release. Many of these children will be entitled at that stage to support and assistance as former looked after children.

If a child was previously looked after under section 20, this will need to be considered again once they leave the secure setting or following the end of a period of time while they are held in a mental health setting under the MHA 1983.

5.6.1 Informing and involving parents and other relatives

It is good practice to involve parents and carers with parental responsibility in decisions made about children in custody unless it would be contrary to the welfare of the child to do so. This includes being involved as much as possible at all stages of their child's transfer – the referral decision, the assessments, the discussion about the inpatient placement, and the transfer arrangements to and from hospital. Parents might not agree with the transfer or with the proposed placement, but they need to know why particular decisions have been made and why their views might not prevail.

Where children are competent, and young people have the capacity to make decisions about the use and disclosure of information they have provided in confidence, their views should be respected. However as with adults, in certain circumstances confidential information may be disclosed without the competent child's consent, for example if there is reasonable cause to believe that the child or young person is suffering or is at risk of suffering, significant harm and the disclosure is necessary and proportionate.[14] Practitioners should encourage the child or young person to involve their parents or others with parental responsibility in decision making about their care and treatment.

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[14] *Information: To Share or not to Share Government Response to the Caldicott Review*. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/251750/9731-2901141-TSO-Caldicott-Government_Response_ACCESSIBLE.PDF

The level of contact between children in care and their parents and other family members will vary with individual circumstances. It will be important to check, with both the child and their social worker if the child has one, how parents and other relatives will be informed about and involved in the child's transfer. The Head of Healthcare for the secure setting will be aware of the level of contact the child has with their family and carers.

Where appropriate to share information, the information provided to parents will be like that required by parents of any child needing care and treatment in hospital. This will include knowing who their point of contact is at the hospital, how and when they can speak to their child's doctor, and how they will be involved in planning for their child's care and discharge. They will need to know the arrangements for visiting their child, and for telephone contact to and from their child in between visits. Parents eligible for travel warrants will need to know if they apply to hospital visits, including for pre-discharge and other planning meetings. Parents should also be informed of the arrangements for seeking feedback about their child's care and treatment and encouraged, both during the stay and on discharge, to pass on their views and wishes.

6 Return from hospital, and arrangements for aftercare

Once the clinical team providing inpatient treatment agrees that the criteria for detention under the MHA are no longer met, or that no more treatment can be given, **and** the child's sentence of detention has not expired or they are still remanded to custody, plans need to be made for the child's return to custody.

The MHA (section 117) places a duty on health and social care and other relevant agencies to co-operate to provide aftercare services for anyone who has been transferred to hospital under the MHA under a qualifying section. The 'restriction direction' that will in most cases have been issued with the transfer warrant by the Secretary of State for Justice will require that the MHCS continues to be involved in relation to remission to a youth detention setting.[15]

[15] Section 49, MHA1983, and see para 2.9 of this procedure

Remission to prison may be requested under s50, 51 of the MHA if the responsible clinician, any other approved clinician or a Mental Health Tribunal advises the Secretary of State for Justice that:

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

Another trigger for this may be a tribunal decision. If the First Tier Tribunal (Mental Health) concludes that a s47 MHA transferred patient would be entitled to a discharge if they were a restricted hospital order patient, then the hospital managers may return them to detention subject to any comments made by the First Tier Tribunal (s.74(1)(b)) and the decision of the Secretary of State for Justice.

6.1 Actions needed before return

In order to return a child to custody from hospital, the following actions should be taken:

- The responsible clinician writes to inform the MHCS and the YCSPT that the child no longer requires treatment in hospital. This should also include reference to any tribunal decisions related to this decision.

- The Inpatient Unit treating the child convenes a 'section 117 meeting', so called because of the section 117 MHA duty about the provision of aftercare for those who have been detained in hospital under the sections covered in this document. This meeting is required by MHCS prior to transferring a child back to custody.

- The purpose of this pre-discharge planning meeting is to draw up a CPA care plan (indicating whether the child needs ongoing mental health services), update the child's care and sentence planning and AssetPlus documentation and, if required, discuss which placement the child will return to in the secure estate. The placement will be authorised by the YCSPT before the MHCS can issue a remission warrant. Confirm at this point that the hospital will plan for transporting the child back to custody.

- The section 117 meeting should be attended by the inpatient staff providing the child's care, the YCSPT, the responsible commissioners for aftercare,

the child's YOT supervising officer (for continuity of support to the child) and – as appropriate – by parents, guardians and/or the local authority. Healthcare providers working in the secure estate setting receiving the child must be invited to attend the meeting and they should make every effort to attend. If the receiving secure setting cannot be represented this should not delay the child's return. Attendance by those listed above is important because the meeting will include planning and preparation for both the child's return to custody and their future release from custody.

- If the responsible clinician recommends the child's return to custody (and the child's restriction direction has not expired), the YCSPT will review the child's progress and requirements – as outlined in the CPA care plan – and will confirm and authorise the custodial placement to which the child will transfer. If this decision cannot be made during the meeting, the YCSPT must confirm the placement with those attending the meeting as soon as possible after the meeting. Children will generally be expected to return to the secure estate setting where they were placed by the YCSPT before their transfer to hospital.

- If a child reaches the age of 18 whilst in hospital, and is serving a DTO, the YCSPT will attend the section 117 meeting and will usually organise a placement back within the children and young people secure estate. The YCSPT are also able to transition to a young adult or adult setting. The YCSPT would look to take the latter route if the 18-year-old was felt to pose a risk to others in the children and young people secure estate, or where it was felt their needs could not be adequately met in the children and young people secure estate.

- If the individual has now turned 18 and is serving a non-DTO sentence, the YCSPT will liaise with the HMPPS Population Management Unit (PMU) to locate a bed within the Young Adult/Adult estate and will support with the transition planning arrangements. This will usually be allocated based on the home catchment area. The YCSPT may remain involved for young people aged 18, depending on the sentence.

- On confirmation that the section 117 meeting has been held and the placement agreed by YCSPT, the MHCS issues the remission transfer

warrant (section 50 or 51,[16] MHA 1983). The warrant will name the secure setting that the MHCS have been advised by the YCSPT is deemed the most appropriate for the child to move to.

- If a child's sentence or remand has expired before the responsible clinician or tribunal recommends that they leave hospital, the section under which they are detained there will change, (often referred to as a "notional section 37") by virtue of section 49(2) and s.41(5) of the MHA 1983. Once they leave hospital the process will be the same as for any patient returning to the community from a period of inpatient detention in hospital. It will be important for the YOT worker to be included in section 117 planning for aftercare.

Any inpatient unit will ensure that staff from the inpatient unit attend the first aftercare review of a child discharged from their care. The receiving secure setting should contact the treating unit to ensure attendance by the relevant representative.

7 Responsibilities of ICBs and NHS England specialised commissioning teams in relation to transfers

The first assessment of a child's possible need for hospital treatment for mental disorder is arranged by the secure setting and carried out by the Psychiatrist based in the secure setting. For decisions after that, the NHS England mental health commissioner from the Specialised Commissioning Team covering the child's home area will need to be involved because of their role in commissioning NHS or independent sector provision.

7.1 Establishing the responsible commissioner

Healthcare staff need to know which commissioners to contact and what information the commissioners will find helpful, in order to make timely decisions to secure the right response to a child's needs. The responsible **mental health**

[16] Criteria under s.50/51: Secretary of State is notified by the Responsible Clinician at the provider unit or the Tribunal that the child no longer requires treatment in hospital for mental disorder or that no effective treatment for their disorder can be given at the hospital to which the child has been removed.

commissioner for the inpatient provision is based in the NHS England Specialised Commissioning Team that covers the child's home area.

These are listed at Appendix 4. The responsible **ICB commissioner** for children in custody in England for section 117 purposes and other services not covered by the Board, in the case of transfers to hospital under sections 47 and 48 of the MHA 1983, is the one where the child was registered with a GP before being placed in custody. If the child was not previously registered with a GP, the appropriate ICB is the one where the child usually resided before entering custody. If a child is not registered with a GP, is not a 'looked after child', or is someone for whom a previous address cannot be determined, the responsibility normally lies with the ICB area in which the offence, or alleged offence, took place.

However, if the child is usually resident outside the UK, responsibility lies with the responsible commissioner area in which the secure estate setting is situated, regardless of where the offence or alleged offence took place.[17] In no case should disagreements or confusion about establishing the responsible commissioner delay or adversely affect treatment. An arrangement can be sought between commissioners for interim payment whilst commissioner responsibility is determined.

7.1.1 Reducing delay and providing high-quality care

To facilitate the smooth implementation of the transfer procedure, it can be helpful for commissioners to bear in mind the following aspects of good practice.

7.1.1.1 Providing high-quality care

- Promote and support timely assessments.
- Be pro-active about ensuring that everything is in place to support a child's care, including arrangements for their discharge and possible return to their home area.
  - Take part in the section 117 requirements for planning discharge and aftercare support.
  - Support the work around CPA care planning and the updating of the child's AssetPlus documentation and sentence plan.

[17] NHS England (2022) Who Pays? Determining which NHS commissioner is responsible for commissioning healthcare services and making payments to providers page 54-55

– Ensure that the local children's mental health service and other services have early notice of a child's release date.

8 Responsibilities of the Mental Health Casework Section in relation to transfers

The Secretary of State for Justice is not obliged to act on a recommendation made under section 47 or section 48 of the MHA 1983. He/she needs to consider whether it is appropriate to transfer the child to hospital considering all relevant circumstances, balancing any risk factors with the need for treatment. The Secretary of State must be satisfied that the statutory criteria for transfer under Part III of the MHA are met. This will involve consideration of several factors, including:

- whether the medical treatment required can be provided adequately in a setting within the secure estate for children and young people, and
- the length of remaining time to be served in custody.

The role of the Ministry of Justice and the Mental Health Casework Section is to ensure that the patient and the public are protected from harm. As a result, consideration will also be given to ensuring that the child is adequately and safely managed in an appropriate security setting.

Relevant factors include:

- the child's past and current presenting symptoms and risk profile (eg suicidal or self-harming behaviour).
- recommendations of medical practitioners
- the type and nature of the offence
- the length of the sentence
- notoriety (and how this may impact on the child's safety)
- victim issues
- previous convictions
- behaviour in custody
- any previous escapes or attempts to escape
- views expressed by the court.

MHCS will issue the warrant to direct transfer to hospital where the Secretary of State is satisfied that is required. The MHCS must be kept informed of progress relating to a child subject to a restriction direction and would need to authorise certain things during a child's detention such as section 17 leave, transfer to a different hospital etc.

MHCS is also responsible for directing the remission of the child once the relevant criteria for detention in hospital are no longer met (see Section 6 Return from hospital and arrangements for aftercare).

9 Responsibilities of the Youth Custody Service Placement Team in relation to transfers

The Youth Custody Service Placement Team is responsible for placement decisions of all children under 18 who are sentenced or remanded to custody.[18] This includes organising transport and liaising with the Mental Health Casework Section. The YCSPT acknowledges the vital importance of ensuring that children are placed in the most appropriate setting for responding to their risks and needs. The YCSPT also has the responsibility placing children under 18 back in custody if the restriction direction on them has not expired when they are ready to leave hospital. In the case of a child who is 18 and serving a Detention and Training Order, and where the risk is assessed as low, the service will consider placing them back into the children and young people secure estate. Placements and/or secure settings need to ensure an appropriate transition plan is in place should they be transferred to the adult estate.

[18] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/647093/Placement_Guidance_Sept_2017_YCS.pdf