

An Evaluation of the Department of  
Health's 'Procedure for the Transfer of  
Prisoners to and from Hospital under  
sections 47 and 48 of the Mental  
Health Act 1983' Initiative  
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## Executive summary

This report presents the findings of a study funded by the NHS National R&D Programme on Forensic Mental Health and conducted by a team of researchers from the University of Manchester, HM Prison Service, Cardiff University, the University of the West of England, Bristol and Bromsgrove NHS Trust. The study was an evaluation of the Department of Health's *Procedure for the Transfer of Prisoners to Hospital under the Mental Health Act 1983* which aimed to help colleagues work together more effectively to reduce delays in transfer of prisoners from prison to hospital.

The evaluation had a number of aims: to assess the extent to which the guidance was meeting its objective of creating and sustaining significant improvements in transfer procedures; to assess the impact of delays on prisoners with mental health needs; to assess how actively involved prisoners are with transfer procedures; and to identify factors which promote or inhibit effective transfers. The research was guided by the three-pronged method of evaluation (Ellis and Hogard, 2006) which measures outcomes, describes processes and explores the perspectives of stakeholders in order to evaluate effectiveness.

There were four parts to the study.

1. Clinical assessment of the mental state of prisoners identified as possibly requiring transfer.

This part of the research evaluated the mental health needs of prisoners awaiting transfer. Psychiatric symptoms were identified with the Brief Psychiatric Rating Scale (BPRS), a validated, structured assessment tool. The mean BPRS score of prisoners awaiting transfer was higher than scores previously found in studies of psychiatric inpatients. We concluded that prisoners awaiting transfer were severely ill with respect to the intensity of psychiatric symptoms.

## 2. Audit of transfer times

This aspect of the research involved an audit of transfer times achieved under the new DH guidance and compared these with previous transfer times. The study found that transfers are currently taking between 0 and 175 days with a mean of 42 days (median value 31.5 days). These figures mark an improvement in transfer times compared with previous studies (Hargreaves, 1997; Isherwood and Parrott, 2002) and with more recent studies (McKenzie and Sales, 2008). On the whole, transfers were significantly quicker for women (mean 15 days) than men (mean 50 days). Foreign national prisoners faced the longest waits, due in large part to the consistently reported difficulties in establishing responsible PCT commissioners for such prisoners.

## 3. Tracking of the pathways to care

The aim of this part was twofold; to document the care received by prisoners both before the formal commencement of the transfer process and during the process; and to audit the completion of documentation required throughout the process to thereby identify administrative/bureaucratic delays and barriers to transfer.

Before formal commencement of the transfer process, there was, in general, little formal healthcare contact with 61% of prisoners not being seen by medical staff and 73% of prisoners not being seen by nursing staff. However, the audit highlighted the relatively high number of adjudications, behavioural problems and incidences of self-harm resulting in heightened observation levels for this group. It was concluded that prisoners awaiting transfer were likely to cause concern for prison management and discipline staff in terms of the need to respond to disturbed behaviours.

During the time awaiting transfer, individual care pathways and contact with prison based mental health services varied greatly. Some people were monitored closely and seen by healthcare staff daily while others had no apparent contact with

healthcare staff for prolonged periods. It was concluded that many prisoners were effectively assessed and transferred in a timely manner. However for some, transfers continued to take prolonged periods, with some prisoners having infrequent healthcare contact and/or interventions whilst waiting. This is worrying considering the identified high levels of mental health pathology which was identified in this group.

#### 4. Semi-structured interviews

This part of the research constituted a process evaluation exploring the process of transferring prisoners to psychiatric units from different stakeholders' perspectives to gain a deeper understanding of practical and systemic barriers and facilitators to transfers. This was highly illuminating and highlighted common reasons behind the delays, many of which were complex and seemingly inextricably linked. Stated barriers to effective transfers included: breakdown in communication; administrative problems; availability of beds at appropriate levels of secure care; delays in establishing the responsible commissioner; security, diagnostic and financial disputes; lack of awareness of procedures around transfers; differing organisational cultures; and negative attitudes and perceptions of mentally disordered offenders.

Interviews with prisoners highlighted that disputes between prisons, mental health services and the Ministry of Justice Mental Health Unit can negatively affect their wellbeing. People were already experiencing heightened distress by virtue of being mentally ill and they reported additional feelings of distress, isolation, disorientation and fear of the transfer process.

Interviewees identified good practice, evidenced by effective communication and collaborative links both within and between prisons and hospital units. Interviewees agreed that, where this was the case, the transfer process operated more quickly and smoothly. It was also commonly believed that the process was better facilitated when agencies were in close geographical proximity. It was stated that, once pathways and professional relationships between partner agencies were established, those relationships could then be effectively fostered.

It is clear from the findings of this research that significant improvements have been made in the transfer process since the new procedural document. The research identified the lowest ever published waiting times for prison to hospital transfers under the Mental Health Act 1983 due, in part, to better collaboration within and between agencies in some areas. The establishment of such links between agencies improves communication within and between multi-disciplinary teams and there is evidence to suggest that such relationships are continuing to grow, including cross governmental partnerships. There have been reports that the related 14-day pilot initiative has been successful in facilitating speedier transfers by raising awareness of the complex reasons for delay, thus generating a degree of 'competition' as services work together to avoid failure. Consequently, there was agreement among interviewees that the 14-day initiative should be implemented more widely.

Finally, recommendations to further improve the transfer process are presented:

#### Minor changes to the process

- Further emphasis on developing and sustaining effective working relationships and communication systems within and between all agencies, with a specific focus on facilitating communication between agencies that are not in close geographical proximity.
- The piloting of a secure and safeguarded multi-agency electronic information sharing system that links the NHS and CJS agencies.
- Dual care-custody training for staff working within prisons and CJ agencies and NHS settings.
- Transfer co-ordinators within both prison and NHS establishments acting as single points of contact.
- Small booklet and poster/wall chart versions of the transfers' procedure guidance should be made available, including versions containing information for prisoners, as well as staff.
- More contact between healthcare, discipline and other support staff and prisoners whilst awaiting transfer due to the negative affect on wellbeing, high levels of mental distress and risk of suicide.

## Radical changes to the process

- Designated time of 14 days for transfers should be implemented nationally.
- A single assessment following which, in the absence of a clear need for high security, the prisoner-patient is transferred to medium security and further decisions regarding future placement are made whilst the person is in hospital care, rather than remaining in the prison system.
- Development of an effective security and clinical needs tool that is universally agreed and accepted by all agencies, thus removing the need for, and delays caused by repeated assessments by different clinical teams.

## The bigger picture

- A national review of occupancy levels and barriers/facilitators to timely progression through the secure mental health system, from high security through to community placements.
- Increased use of early diversion at police custody or court stages for people with mental illness.
- Further research into the clinical, security and placement challenges for foreign national prisoners.

## **Introduction**

### ***The prevalence of mental disorder in prison populations***

The prevalence of psychiatric morbidity among prisoners is high; over 90% of the current prison population has some type of diagnosable mental illness, personality disorder and/or substance misuse problem (Singleton *et al.*, 1998). In their large scale point prevalence study of psychiatric morbidity in prisoners conducted on behalf of the Department of Health, Singleton and colleagues interviewed 3,142 prisoners, men and women, both sentenced and on remand. The survey reported rates of “probable psychosis” for women: 21% of the remand population and 10% of the sentenced population. For men, the rates were 9% of the remand population and 4% of the sentenced population. Seventy eight percent of men on remand and 50% of women on remand were diagnosed as having a personality disorder. The most prevalent was antisocial personality disorder, identified in 63% of remanded men and 31% of remanded women. With regard to neuroses, all types of prisoners returned high rates of symptoms such as sleep problems and worry. Seventeen percent of men remanded and 21% of women remanded were diagnosed as experiencing a current depressive episode. Eleven percent of both men and women remand prisoners were experiencing Generalised Anxiety Disorder. Rates of self harm, both potential and actual, were also assessed, with 12% of men remanded and 23% of women remanded prisoners reporting having experienced suicidal thoughts in the previous week.

### ***The Mental Health Act 1959***

Prior to the Mental Health Act 1983, Section 72 of the Mental Health Act 1959 enabled sentenced prisoners to be transferred to hospital for treatment if two doctors certified that they suffered from a mental illness, psychopathic disorder, sub normality, or severe sub normality, of a nature or degree which warranted detention

of the patient in hospital for medical treatment. Similarly, Section 73 enabled mentally disordered remand prisoners to be transferred. Transfers were usually accompanied by a restriction order under Section 74 of the Act (Grounds, 1990). If such restrictions were included only the Home Secretary could authorise discharge. Patients on restriction orders could not apply directly to the Mental Health Review Tribunal, but had to make a request to the Secretary of State, who then referred the case to the tribunal.

Limited research exists surrounding the transfer procedure under the 1959 Act. Coid (1988) conducted a retrospective study of 362 'mentally abnormal' men remanded to HMP Winchester for psychiatric reports between 1979 and 1983. One in five of the prisoners were rejected for treatment by the NHS consultant psychiatrist responsible for their care. The most common reasons for rejection were that treatment was not deemed appropriate; no secure beds were available; diagnosis was disputed; admission was refused by staff; and/or that the consultant had failed/refused to visit the person in prison. The author stated that the fact some mentally ill people were starting to receive adequate care and treatment upon reception into prison raised serious questions about the adequacy of management policies and range of facilities provided by regional health authorities.

Grounds (1991) studied the transfer of all 380 sentenced prisoners sent to Broadmoor high secure hospital under Section 72 (MHA 1959) from 1960 to 1983. Seventy two percent had received a determinate sentence (mean length 4.5 years); most were detained in hospital beyond their latest date of release. Of the 31% that were discharged to the community, the length of hospital stay related to gravity of offence; sex offenders remained in hospital significantly longer than patients sentenced for other types of offences. Prisoners transferred earlier in the study were compared to those transferred later; later prisoners were transferred closer to their earliest release date, tended to stay longer, and the admission process took longer, which appeared to be caused by a waiting list for admissions. Although the results were restricted to one high secure hospital during a particular period, the research highlighted an apparent practice of transferring mentally disordered sentenced prisoners into secure hospital care at a late stage of sentence. The authors emphasised the importance of detecting mental disorder and effecting transfer from

prison at the earliest possible stage. It was felt that the use of Section 74 of the Act was, in certain cases, being used to effectively prolong the sentences of prisoners. Additionally, prison populations were rising but proportionally fewer prisoners were being transferred to hospital (Parker and Tennent, 1979). This may have reflected a change in attitude and circumstances among local psychiatrists who no longer had such free access to long-stay beds as may have previously been the case (Cheadle and Ditchfield, 1982), which in turn caused delays in transfer due to “bed-blocking” in high secure hospitals through difficulties in obtaining acceptance of prisoner-patients by local NHS hospitals (DHSS, 1975).

The Butler Committee was set up to examine the law relating to mentally disordered offenders and recommended that transferred prisoners should have a right of application to a Mental Health Review Tribunal, and that the Home Office should consider lifting restrictions on discharge at the earliest date of release (DHSS, 1975). These recommendations were incorporated into the Mental Health Act 1983. Restrictions on discharge ceased at the earliest date of release, at which point the patient could apply for a Mental Health Review Tribunal. Additionally, criteria for recommending a return to prison were broadened (Grounds, 1990).

### ***The Mental Health Act 1983***

Sections 47 and 48 of the 1983 Act state that a prisoner may be transferred to hospital under a direction from the Home Secretary, following reports from two doctors, one of whom must be recognised as having special experience in the diagnosis and treatment of mental disorder, as recognised by Section 12 of the Act. Both reports must state that the prisoner is suffering from the same form of mental disorder and that the prisoner is in need of in-patient treatment.

Under Section 47, the prisoner must be sentenced and suffering from a mental illness, psychopathic disorder, mental impairment, or severe mental impairment. The prisoner’s mental disorder must be of a nature or degree which warrants detention in hospital, and that treatment is likely to alleviate or prevent a deterioration of the

condition. Under Section 48, the prisoner must be awaiting trial, suffering from a mental illness or severe mental impairment, and in urgent need of treatment.

Section 49 of the Act allows for the transfer of prisoners who may be subject to additional restrictions as long as the Home Secretary, through the Home Office Mental Health Unit, remains involved in the management of the case.

Throughout the late 1980s and early 1990s, the number of transfers from prisons to mental health hospitals under Section 47 and 48 with restriction orders underwent a dramatic rise, from 180 in 1987 to 745 in 1997 (Kershaw and Renshaw, 1998). For sentenced prisoners, the number being transferred increased nearly two and a half fold from 103 in 1987 to 251 in 1997; for prisoners on remand the increase was even greater, nearly 6 and a half fold from 77 in 1987 to 494 in 1997 (*ibid*). Since then, the numbers transferred have remained fairly constant; in 2003 there were a total of 721 restricted patients admitted to hospital from prison, comprising 296 convicted prisoners and 425 remand prisoners (Ly and Howard, 2004).

Despite the rise in the number of people being transferred, studies have shown that there are many problems with the process. Dell *et al.*, (1993) examined the transfer processes of 95 psychotic women in HMP Holloway between April and October 1989. Eighty one of the 95 (85%) were referred to outside psychiatrists but only 54 (57%) were assessed. After consultants' visits, hospital admission was offered to 38 of the 54 women (70%); the main reasons for refusal were due to doubts over diagnosis or need for detention. Other reasons included a lack of available beds, or that women had previously been 'blacklisted' due to difficult behaviour. They concluded that, for psychotic women on remand, transfers rather than court orders should initially be used to effect admission.

Robertson *et al.*, (1994) examined 336 referrals to medical officers of psychotic remanded men in HMP Brixton over a five-month period in 1989. Of the 336, 19% (n=63) were referred to outside doctors for assessment but subsequently never visited. Reasons for this included courts disposing of the case before a visit could be arranged; transfers to other prisons; and, in one case, a hospital refused to consider any admission from prison. Of the 57% (n=192) men who were referred and visited,

half were rejected as unsuitable. In 81% of cases this was due to differences in clinical diagnosis, while other reasons included: lack of suitable secure beds and administrative issues; for example, disputes regarding catchment areas. The researchers examined the cases of those accepted and found that the average delay between someone being accepted for a bed by an NHS doctor, and that person's admission to hospital was between five and six weeks. They concluded that there should be greater use of Section 48 to transfer prisoners more effectively.

Hargreaves (1997) examined the transfer of severely mentally ill prisoners from HMP Wakefield by reviewing Inmate Medical Records. A total of 688 records were reviewed and 21 prisoners with serious mental illness were identified. Seventeen (81%) had a diagnosis of schizophrenia. Eight prisoners were identified at initial reception; of the remaining 13, 1 appeared to have self-presented, while all the others had aroused the concern of the prison staff. All had been reviewed by local visiting psychiatrists. The 8 identified at reception waited between 1 and 14 days for assessment (median 4 days). For the 13 presenting later, time to assessment ranged from 6 to 390 days (median 42.5 days). In many cases there appeared to be no specific reason for the delay, but in some cases there was a failure to attend for the assessment, the prisoner was inaccessible due to being in segregation and/or there were differences in clinical diagnosis. Seventeen were referred to hospital. The time from assessment to referral for transfer ranged from 2 to 2,453 days (median 85 days). Indications for referral were most frequently florid positive symptoms and significant management problems. Time between transfer request and assessment ranged from 1 to 140 days (median 23 days). Eleven of the 17 (65%) referred were accepted for transfer, with reasons for rejection including: diagnostic grounds (possible personality disorder, rather than mental illness); security considerations and because people required long-term care. The time between acceptance and actual transfer ranged from 4 to 192 days (median 43 days). The researchers concluded that the results of the study, although limited to one prison, showed that the transfer process was slow and characterised by unacceptable delays at each stage of the process. They recommended reducing the time to perform assessments; more clarification on the reasons for delays; expansion of secure facilities, especially those able to provide long-term care; and introduction into the legislative provision to allow transfer for a period of assessment.

Isherwood and Parrott (2002) conducted an audit of transfers of prisoners to psychiatric services for the period 1<sup>st</sup> December 1998 to 1<sup>st</sup> December 1999, following the establishment of the partnership between Oxleas NHS Trust and HMP Belmarsh. These data were then compared with data collected before the partnership from 1996 to 1997. In comparison to 1996/7, the study period showed an increase in the annual overall number of prisoners transferred; numbers of transfers under Section 48 increased however numbers transferred under Section 47 decreased. In terms of delays in transfer, times across all placement types did not differ significantly. The transfer time was studied by placement type and the results indicated a trend of increasing delay with higher levels of security, with the longest delays associated with those requiring high security, mean 209 days (range = 16 – 482) in the first period and 163 days (29 – 447) in the second period. The most common reason for delay in the process was a lack of bed availability. Other reasons were differences in opinions regarding the level of security required; legal reasons; diagnostic disagreements resulting in repeated referrals and assessments; long delays to initial assessment; and catchment area disputes. They concluded that, despite government policies to facilitate transfer of mentally disordered offenders, there were increased delays compared to previous audits.

The research above highlights that delays in the transfer of mentally ill prisoners are common. These delays included problems with facilitating assessments, a lack of psychiatric beds, and being rejected by psychiatric units (e.g. Robertson *et al.*, 1994; Birmingham, 1999; Isherwood and Parrott, 2002). Reasons for rejection include longer duration of illness; multiple handicaps; the need for longer term care; disputes between prison and hospital; the 'blacklisting' by hospitals of specific prisoners; and refusal by psychiatrists to visit prisoners (Hargreaves, 1997 ; Robertson *et al.*, 1994 ; Dell *et al.*, 1993). Delays in transfer result in a reliance on prisons to care for and manage those with severe mental disorders, a situation which may result in adverse events including suicide and self-harm amongst waiting prisoners and location in 'strip cell conditions' (Brooke *et al.*, 1996; Rutherford and Taylor, 2004; Skegg and Cox, 1991; Coid *et al.*, 2003). In prison, whilst acutely unwell prisoners can be moved to 24 hour care in prison in-patient units and receive care from qualified nursing staff

and specialist mental health in-reach teams, they cannot be treated without consent under mental health legislation (McKenzie and Sales, 2008).

### ***Current developments***

In 1999, the NHS entered into a formal partnership with HM Prison Service (HMPS/NHS Executive, 1999) and, in April 2006, full financial responsibility for prison based healthcare services was devolved to the NHS, with services being commissioned by local Primary Care Trusts (PCTs). The aim of this partnership was to improve clinical health services available to prisoners. Central to the reform was the simple but radical concept that healthcare in prisons should be equivalent to that available to the wider community (*ibid*). Despite this partnership, challenges to effecting timely transfer continue, including issues around establishing the responsible PCT commissioner; the provision of timely psychiatric assessments; the management of out of area transfers; and a lack of knowledge amongst some stakeholders about the processes required. In view of these gaps in knowledge the Department of Health undertook a work programme aimed at speeding up mental health transfers from prison to hospital (Fowler, personal correspondence).

In November 2005, the DH guidance document *Procedure for the Transfers of Prisoners to and from Hospital under Sections 47 and 48 of the Mental Health Act 1983* was issued. It aimed to encourage multi-agency working to secure and sustain significant improvements in reducing unacceptable delays (DH, 2005). The rationale for this initiative included the research highlighted above, media coverage surrounding a few high profile cases whereby significant delays in transfer of acutely mentally ill people had occurred (Fowler, personal correspondence) and also pressure from The Royal College of Psychiatrists (*ibid*), The Royal College of Nursing (*ibid*) and Her Majesty's Prison Service (*ibid*).

To launch the work programme, regional events with key stakeholders in each Care Services Improvement Partnership (CSIP) region were held to identify the challenges and barriers preventing effective, timely, transfer. Additionally, a national audit

across the prison estate was conducted to provide contemporary data to inform the development of a pilot programme (Fowler, personal correspondence).

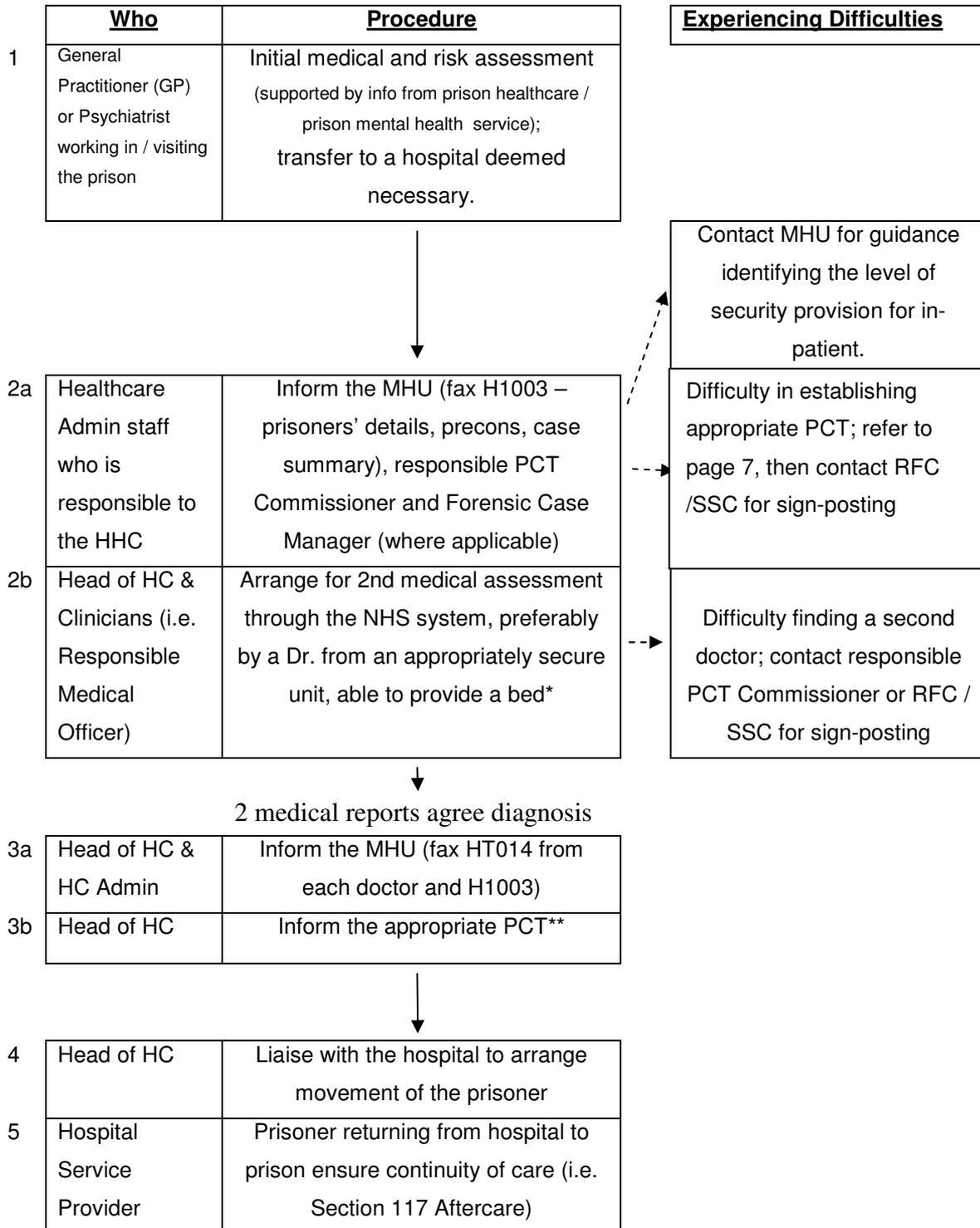
To date there has been one published study examining the effects of the new guidance. McKenzie and Sales (2008) aimed to determine whether the application of the guidance led to any impact on delays to transfer to hospital from prison. The authors examined transfers to a psychiatric unit from HMP Pentonville during two 6-month periods, before and after the implementation of the guidance. A total of 75 patients were transferred to hospital, 33 in the first period and 42 in the second period. The two groups were similar in age, ethnicity and offending behaviour. Upon identification of suitability for transfer, 81% were found to have psychosis and 71% had a past psychiatric history. Many individuals awaiting transfer refused to agree to treatment whilst in prison. The delay from identification to eventual hospital transfer ranged from 15 days to 301 days for the first period and 8 to 148 days in the second period. The longest delays in each group were for those awaiting admission to medium secure units (MSU). Overall, there was a reduction in mean waiting time from 77 days in the first period to 53 days in the second. Factors which contributed to the reduction in delays included ensuring that the referral to the admitting unit was made as soon as possible after the identification of the need for transfer, and that the medical recommendation by the psychiatrist and documentation required by the Home Office were sent within the specified times. The research highlighted that enlisting the assistance of the mental health commissioner within the responsible PCT after 28 days was important, especially in relation to transfers to MSUs. Transfer times to MSUs remained high; the reasons for this included shortage of beds and a lack of step-down facilities. They found that approximately half of the men identified for hospital transfer refused medication in prison. These people with a treatable mental illness were kept in prison without treatment for about 2 months. The authors concluded that unacceptable delays in transfer are likely to remain, even with the new procedures. They recommended that time limits should be specified for hospital transfers from prison comparable to norms under civil sections.

Since its initial publication, the guidance document has been reviewed and revised and is now in its fourth version, published October 2007 (DH, 2007). The procedure for transfers of prisoners is depicted in a flow chart showing best practice to complete

transfers within 14 days (see figure 1 below). A second flow chart within the document describes the process to identify the responsible Primary Care Trust Commissioner (see figure 2 below). The document provides specific details on the procedure for transferring sentenced and unsentenced prisoners to and from prison under Sections 47 and 48 of the Mental Health Act 1983 to psychiatric intensive care units (PICUs) low, medium or high secure healthcare facilities.

In addition to the transfers guidance, there is also currently underway a joint Department of Health (DH) and National Offender Management Service (NOMS) 14 day pilot initiative. Pilot sites are in operation, using locally agreed protocols to reduce transfer delays to enable completion of transfers in 14 days or less.

**Figure 1: Prison Mental Health Transfers Best Practice Flow Chart**



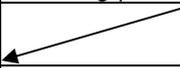
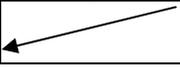
**The MHU issue the Transfer Warrant which is only valid for 14 days from day of issue.**

\*One of the two Doctors must be approved under Section 12(2) of the MHA 1983 \*\*LHB (Local Health Board) in Wales

**Key**

Mental Health Unit, Ministry of Justice (MHU)  
Regional Forensic Commissioner (RFC) /Secure Services Commissioner (SSC)  
Head of Healthcare (HHC / Head of HC)  
Healthcare Administration staff (HC Admin)  
Primary Care Trust (PCT), Responsible Medical Officer (RMO)

**Figure 2: Flow Chart of Actions to Help Identify the Responsible Commissioner (PCT)**

Stage	Procedure	Possible Difficulties
1	<b>Responsible PCT is where the prisoner was last registered with a GP before entering prison<sup>1</sup></b>	
	If Responsible PCT is not known, this information can be found by logging onto the NHS Choices website. Instructions are listed below:- 1. Type in <a href="http://www.nhs.uk">www.nhs.uk</a> 2. Under Choose Services (to the right hand side) click "Find NHS Services" 3. Under Find Health Services, in the box "Enter Your Postcode or Location" type in the postcode of the Doctor's surgery if known and select under "For" Doctors 4. Click "Search". A map will appear with a list of Doctor's down left hand side 5. If you select a relevant Doctor, at the top a sentence will appear stating "This practice provides services for .....PCT" 6. If you click on the relevant PCT, it will bring up a page, with their contact details	
		<i>If not registered with a GP before entering prison</i>
2	<b>Responsible PCT will be where the prisoner resided before entering prison</b>	
	If this information is not known follow stages 1 – 2 as above, but under stage 3 instead of typing in postcode of Doctor's surgery, enter in postcode of residential address. Under "For" still select Doctors. Continue to then follow stages 4 - 6	
		<i>Not registered with a GP and for whom a previous address cannot be determined (i.e. No fixed Abode)</i>
3	<b>The responsibility is then deferred to the PCT where the offence took place</b>	

<sup>1</sup> In Wales the responsible commissioner is determined by usual residence not GP registration in the first instance.

## **Study aims and objectives**

The aim of this study is to evaluate the Department of Health's *Procedure for the Transfers of Prisoners to and from Hospital under Sections 47 and 48 of the Mental Health Act 1983* initiative. The key objectives of the study are as follows:

- To assess the extent to which the *Procedure for the Transfer of Prisoners* protocol has met its objectives of creating and sustaining significant improvements in reducing delays in transfers;
- To assess the impact of delays to transfer on prisoners with mental health needs;
- To identify factors which promote or inhibit effective transfers;
- To identify ways in which prisoners are actively involved in transfer procedures; and
- To report on the appropriateness and effectiveness of the collaborative methodology in providing safe and appropriate care for prisoners with mental health needs.

## **Method**

### ***Setting***

The research took place in five prisons in England. These sites were selected after close liaison with Offender Health at the Department of Health in order to ensure, as far as practically possible, that the research sites were representative of the prison estate and related PCTs. Collection of data began in July/August 2006 for all prisons apart from prison A which began in December 2006 due to delays in gaining research governance approval. Data collection terminated at all prisons in October 2007. A description of each prison is provided below:

#### *Prison A*

Prison A is a closed prison housing young female offenders from 18 years of age and adults whether on remand, awaiting sentencing or convicted. It has certified normal accommodation (CNA) <sup>2</sup> for 513 prisoners. Healthcare provision consists of 24 hour care in a 21 bed unit, with 4 “safer cells”, which have fixed furniture and are free of ligature points. Additionally, there is a 60 bed detoxification unit. Healthcare is provided by a multi-disciplinary team, including, for mental health, psychiatrists, forensic psychiatrists, psychologists, registered mental health nurses (RMNs) and community mental health nurses providing inpatient and outpatient care.

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<sup>2</sup> Certified Normal Accommodation (CNA) is the uncrowded capacity of a prison (HM Prison Service order 1900, 2001, [www.hmprisonservice.gov.uk](http://www.hmprisonservice.gov.uk))

### *Prison B*

Prison B holds men from 15 years that are received from courts in the London area, the majority of whom are unconvicted and awaiting trial. It has CNA for 675 prisoners. Prison B provides 24-hour healthcare with a 24-bed inpatient unit, 2 of which are “safer cells” for young people requiring enhanced levels of observation. Its multi-disciplinary mental health team consists of RMNs, psychiatrists, forensic psychiatrists, psychologists and various therapy staff including occupational therapists (OTs) who provide input on a sessional basis. It also has an in-reach team of 4 community mental health nurses.

### *Prison C*

Prison C is a category B local prison housing adult men on remand or sentenced. It has CNA for 980 prisoners. The healthcare department provides in-patient services on a 16 bedded unit with 24 hour nursing care, as well as outpatient facilities. There is also a Safer Custody Unit offering a dedicated 4 week programme for clients with drug and mental health issues, which links closely with the substance misuse team and the Counselling, Assessment, Referral, Advice and Through-care Services (CARATs)<sup>3</sup>. Primary mental health services are provided via a newly developed day hospital facility and a dedicated team of mental health nurses provide out-reach services to the main prison wings. There is also a mental health in-reach team for clients with severe and enduring mental health issues.

### *Prison D*

Prison D is an adult prison for men. It houses both remand and sentenced prisoners and has CNA for 1300. The 24-hour healthcare unit provides both outpatient facilities and an inpatient unit of 28 beds. The unit has a multi-disciplinary mental health care team including psychiatrists, RMNs, and most recently a Primary Care

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<sup>3</sup> CARATs is a low-level intervention that provides a gateway assessment, referral and support service to prisoners for drug misuse problems in custody and immediately upon release. They are provided by multi-disciplinary teams working in partnership. (Prison Service Order 3630, 2004a, [www.hmprisonservice.gov.uk](http://www.hmprisonservice.gov.uk))

Mental Health Team, with input from clinical psychology. Prison D also has an in-reach team which provides long term support to prisoners, along with crisis intervention support. There are also two dual diagnosis nurses who provide support services to prisoners who experience both mental health problems and drug/alcohol problems.

### *Prison E*

Prison E is an adult prison for men with a CNA for 1193 prisoners. It houses remand and sentenced prisoners including detainees from immigration centres. Prison E has a 17 bed healthcare unit. It has a multi-disciplinary mental health team consisting of psychiatrists and RMNs.

## ***Research overview***

The research was guided by the structure of the ‘trident model’ (Ellis and Hogard, 2006) which suggests that evaluations should incorporate three prongs of data collection: the measurement of outcomes, a description of process and the sampling of multiple stakeholder perspectives. In order to evaluate whether the Department of Health’s guidance has achieved its objectives of creating and sustaining significant improvements in transfer waits we used across-method triangulation (Begley, 1996, cited in Curtin and Fossey, 2007) with both quantitative and qualitative methods in order to capture as complete a picture of the procedure for transfers as possible.

There were four parts to the research centred around outcomes, processes and stakeholder perspectives:

1. Clinical assessment of the mental state of prisoners identified as possibly requiring transfer
2. Audit of transfer times
3. Tracking of care pathways and interventions received by prisoners awaiting transfer; audit of relevant paperwork and
4. A series of qualitative semi-structured interviews with key informants regarding the transfer process as whole.

## ***Clinical assessment of mental illness***

### *Aim*

The aim of part one was to ascertain the presence and severity of a wide range of psychiatric symptoms in prisoners awaiting transfer to hospital under the Mental Health Act 1983, as measured by the Brief Psychiatric Rating Scale (BPRS; Overall and Gorman, 1962).

### *Procedure*

During the study period all prisoners identified by the prison medical officer as possibly requiring transfer to a psychiatric hospital were approached for possible inclusion in the study by the designated member of healthcare staff within the participating prisons. If participants were able to provide informed consent, information sheets were read through with all potential participants to ensure they fully understood the implications of taking part in the research. Once the member of staff was confident that the prisoners understood the study, and they agreed to take part, consent forms were signed. For prisoners who were unable to give informed consent, permission from the NHS ethics committee had been granted to still allow the completion of the BPRS, either through direct administration of the tool, or by using information from general observations, supplemented by collateral information from clinical records. The BPRS was conducted within 24 hours of consent to the study being sought.

### *Measures*

#### *Brief Psychiatric Rating Scale (BPRS)*

The Brief Psychiatric Rating Scale (BPRS; Overall and Gorman, 1962) is a 24-item scale designed to assess the presence and severity of a wide range of psychiatric symptoms. Items 1-14 are based on the patient's answers to the interviewer's question; the time frame being the last 2 weeks. Items 15-24 are based on the interviewer's observations of the patient's behaviour during the interview. Each item is scored on an 8-point Likert-scale from 1 (absent) to 7

(extremely severe). A score of 4 or above indicates the presence of a symptom at a clinically-significant level.

The current research team has successfully employed the BPRS in previous studies with prison populations (Senior *et al.*, 2007; Shaw *et al.*, 2006). Figure 3 below shows items included in the BPRS.

**Figure 3: Items on the BPRS**

*1-14 Rated on interview*

- |                           |                      |
|---------------------------|----------------------|
| 1 Somatic concern         | 8 Grandiosity        |
| 2 Anxiety                 | 9 Hallucinations     |
| 3 Depression              | 10 Disorientation    |
| 4 Guilt                   | 11 Suicidality       |
| 5 Hostility               | 12 Self neglect      |
| 6 Suspiciousness          | 13 Bizarre behaviour |
| 7 Unusual thought content | 14 Elevated mood     |

*15-24 Rated on Behavioural Observation*

- |                               |                             |
|-------------------------------|-----------------------------|
| 15 Conceptual disorganisation | 20 Mannerisms and posturing |
| 16 Excitement                 | 21 Uncooperativeness        |
| 17 Motor retardation          | 22 Emotional withdrawal     |
| 18 Blunted affect             | 23 Motor hyperactivity      |
| 19 Tension                    | 24 Distractability          |

*Analysis*

Analysis was conducted using SPSS for windows version 14

## ***Audit of transfer times***

### *Aim*

The aim of part two was to conduct an audit of the transfer times for the study sample and compare this with previous transfer times, to evaluate the effectiveness of the application of the procedure guidance document to the transfer process.

### *Procedure*

Clinical records were examined at each respective prison for all prisoners identified as possibly requiring transfer to hospital under the Mental Health Act 1983 within the study period. The proforma collated the length of time each person waited from initial assessment to actual transfer and all demographic information to highlight any variations in waits within and between different prison establishments and prisoner types.

### *Analysis*

Analysis was conducted using SPSS for windows version 14

## ***Tracking of the pathways to care***

### *Aim*

The aim of part three was twofold: to document the care received by prisoners awaiting transfer and to track the paperwork completed during the transfer process.

### *Procedure*

To identify care pathways, clinical records were examined at each respective prison for all prisoners who were identified as possibly requiring transfer to hospital under the Mental Health Act 1983 within the study period. The proforma recorded two sets of information. Firstly, we collated any input the prisoner had received for up to four weeks prior to the start of the transfer process. Secondly, the same information was recorded from the formal start of the transfer process, and for each day thereafter until the day the prisoners were transferred to hospital (or when/if prisoner was identified as no longer requiring transfer). Information recorded on the proforma included which staff the prisoners had seen, and the type of healthcare intervention they received. The types of events recorded included episodes of self-harm/suicide attempts, episodes of threatened or actual violence, disciplinary adjudications, location changes, psychological interventions and medication details/changes.

For the tracking of paperwork, we collated all administrative procedures related to the transfer process. This included information such as who the first and second medical assessments were conducted by, the timing of those assessments and other significant milestones, the source of the referrals, bed availability, type of unit prisoners were transferred to and under which section.

### *Analysis*

For the pathways to care, we conducted a descriptive narrative review. For the tracking of paperwork we used descriptive statistics using SPSS for windows version 14.

## ***Qualitative interviews with key informants***

### *Aim*

The aim of part four was to conduct a process evaluation to explore the process of transferring prisoners to psychiatric units under the Mental Health Act 1983 in order to gain a deeper understanding into 'what works' in the context of the new DH guidance, and what problems are commonly encountered that affect the completion of timely transfers.

### *Procedure*

Part four consisted of forty-six interviews with key stakeholders involved with the transfer of prisoners under the Mental Health Act 1983 at the participating prisons, their associated PCTs and mental health service providers (NHS and non-NHS). Other key informants consisted of the DH transfer project commissioner, Mental Health Unit staff at the Ministry of Justice, regional forensic commissioners, healthcare managers, healthcare staff, discipline staff, governors, administrators and prisoner-patients (see appendix 1 below for breakdown of key informant roles).

Key informants were interviewed regarding their experiences of the process of transferring a prisoner to a psychiatric unit under sections 47 and 48 of the Mental Health Act 1983. Questions in the semi-structured interview focussed on which aspects promoted or inhibited transfer arrangements, with a view to understanding how collaborative working between agencies could be further improved to affect timely transfers.

### *Analysis*

Process evaluation was used as an overarching framework in order to analyse changes over time within the transfer process. This enabled us to identify contemporaneous factors in the transfer process that promoted or inhibited delays, at what stage and in what context.

It is becoming increasingly acknowledged by patients, professionals and managers within healthcare settings that aspects of process are just as important as final outcomes (Calnan and Ferlie, 2003). Actual process is seen as important as it has the ability to capture the *quality* of the process at the intermediate stages as heard by way of those people currently experiencing the process itself. Process evaluation 'tends to evaluate or understand how an intervention operates, examines the factors that come together to make this intervention what it is and examines how an outcome is produced, rather than look at the outcome itself' (*ibid*; p186).

The forty-six interviews with the key informants were transcribed verbatim and imported into Nvivo7 qualitative analysis software (QSR International Pty Ltd, 2007). Thematic analysis of the interviews was conducted for each subgroup of participants (prison-based staff, hospital staff (NHS and non-NHS), Mental Health Unit staff and prisoner-patients). Each group of interviews was analysed for commonly recurring themes relating to the transfer process. Themes were prioritised where they emerged across three or more respondents within the same group the aim being to find concordance or homogeneity across the accounts. To reflect the process of transfer the findings from the interview data are discussed in a chronological sequence that follows the transfer pathway beginning with: prison-based staff, then Mental Health Unit staff, then mental health service providers and finally, prisoner-patients.

- I: Analysis of prison staff interviews;
- II: Analysis of Mental Health Unit staff interviews;
- III: Analysis of mental health service staff interviews;
- IV: Analysis of prisoner-patient interviews

### ***Ethics and Research Governance***

Ethical approval was received from Thames Valley Multi-centre Research Ethics Committee in February 2006. As part of the application for approval, the Ethics Committee was consulted regarding the possibility of including prisoners who were unable to provide informed consent to take part in the research. Our proposal was that if eligible prisoners had the capacity to provide informed consent they should be asked to take part in the study and included if they consented, but excluded if they declined. However, if an eligible prisoner did not have the capacity to provide informed consent, they should still be included. The committee agreed that it was vital to include such prisoners as they would, by definition, be those with the most severe mental health problems and therefore should be represented in the data.

In addition, approval was given by the National Prison Research Ethics Committee under the terms of Prison Service Order 7035 relating to the conduct of research in prison establishments. Governance approval was sought from each PCT and Mental Health NHS Trust in which a participating prison was based. The researchers in this study also obtained honorary contracts from the relevant PCTs before data collection began. Approval was given from the University of Manchester Ethics Committee, which provided indemnity for research staff. Finally, the governors of all participating sites gave permission for the research to be undertaken at their establishments.

### ***Research team***

It was decided that the work to identify prisoners who may require transfer to hospital should be conducted by staff already working in prison health care departments. The team felt that the existing clinical team was best placed to identify new cases speedily, to review their notes regularly and to interview them immediately prior to transfer. External researchers would miss potential participants in the time lag between being notified of possible cases, gaining entry to the prison, and organising a suitable location and time to see the prisoners. This was also in line with the Offender Health Research Network's

(formerly the Prison Health Research Network) commitment to involve front-line prison and healthcare staff in all stages of research to promote a 'research-friendly' environment within prisons and add to the research capabilities of individual practitioners. Healthcare managers selected suitable and interested members of staff, and the research team trained these staff members in study procedures including obtaining consent, and the administration of the BPRS. Regular supervision sessions were convened to ensure the prison staff seconded to the research adhered to the protocol and were able to discuss any difficulties in the practicalities of the research. Prison healthcare departments were compensated for the time staff would take to complete the research. External (i.e. university-employed) researchers were appointed to conduct the qualitative interviews, given that they would be conducting fieldwork across the different sites and be able to reflect critically on their observations.

## Results

### *Demographics*

Forty-five prisoners were identified as in need of transfer to hospital during the study period across the 5 prison sites. Numbers of transfers for each prison are shown in table 1 below:

**Table 1: Number of people identified as in need of transfer during the study period by prison**

Prison	N	Percentage <sup>4</sup>
A	11	24%
B	8	18%
C	11	24%
D	4	10%
E	11	24%
<b>Totals</b>	<b>45</b>	<b>100%</b>

Thirty-five of the 45 transfers were completed (78%) and 10 (22%) failed. Seven (70%) prisoners' condition stabilised enough not to warrant a transfer to hospital and 3 (30%) prisoners were transferred out to another prison outside of the research area.

Of the original sample, 54% were white, 26% black, 7% Asian and for 13% their ethnicity was unrecorded. The vast majority were men (74%), within the age group 31-40 (51%), with just over half of the sample (52%) awaiting sentencing (37% convicted, 11% unknown).

### ***Clinical assessment of mental illness***

An assessment of the mental state of a sample of 24 prisoners awaiting transfer across the five prison sites was conducted using the Brief Psychiatric Rating Scale (BPRS). The mean BPRS score was 65 with a range 25-120.

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<sup>4</sup> Percentages rounded to equal 100.

This is higher than the mean score of 45 previously reported for a sample of prisoners being monitored under the self-harm/suicide risk management systems (F2052SH/ACCT: Senior *et al.*, 2007).

Numerous studies reporting BPRS scores for samples of psychiatric inpatients with psychotic illness report mean BPRS scores of 53 (Wetzel *et al.*, 1998), 60 (Beasley *et al.*, 1996), 61 (Puech *et al.*, 1998) and 65 (Carriere *et al.*, 2000). Gray *et al.* (2003) assessed 34 people in two UK medium secure units (MSUs) using the BPRS and found a mean score of 42. Therefore, higher rates of symptom intensity were reported in the prisoners awaiting transfer in this research than in the previous studies.

Using the BPRS, symptoms can be scored as absent, present but of sub-clinical intensity or present and of clinical intensity. Using this approach, for the whole sample of prisoners, mean scores in the domains of hostility, suspiciousness and unusual thought content were considered to be pathological in intensity.

Although the reliability and validity of the BPRS is well examined, Leucht *et al.* (2005) reported that the clinical implications of overall scores on the BPRS are not clear. Using statistical comparison with the Clinical Global Impression Scale (CGI; Guy, 1976) Leucht *et al.* (2005) suggested that 'mild illness' corresponded with a BPRS score of 31, 'moderate illness' with a score of 41 and 'marked illness' with a score of 53 or greater. Therefore, according to this approach, the mean score of the sample of prisoners awaiting transfer signifies the presence of marked illness.

### ***Audit of transfer times***

Table 2 shows the overall mean transfer time was just less than 42 days for the 35 completed transfers. The quickest was affected on the same day as the prisoner was assessed (0 days) and the slowest transfer took 175 days. Just over a quarter (n=9, 26%) were affected within 14 days. Due to the large range of transfer times possibly skewing the mean, the median is also reported at 31.5.

Mean transfer time for women was 15 days (n=8) with a median of 8 days (range 4-41). Mean waits for transfer of men was 50 days with a range of 0-175 days, the median was 41.5 (n=27). A Mann Whitney U test found transfer waits were significantly shorter for women (Z value -2.8, p=.006) than men.<sup>5</sup>

Table 2 below gives a comparison of transfer delays overall and for each prison establishment. It clearly shows that prison E had the highest transfer waits. A possible reason for this was that 5 of the 9 prisoners from this establishment were foreign nationals (Although numbers of foreign national prisoners for each prison establishment were unobtainable for the research period). Ministry of Justice statistics for the following year state that prison E generally receives more foreign national prisoners than the other 4 prisons in the study<sup>6</sup>

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<sup>5</sup> Kolmogorov-smirnov test indicated scores for men violated the assumptions of normality with a probability value of .002, this is far less than the probability level of above .05 for a normal distribution of scores. Further analysis of box plots found two outlying scores for men extending more than 1.5 box-lengths and one extreme outlying score extending more than 3 box-lengths. Scores for women showed normal distribution, kurtosis and skewness.

<sup>6</sup> September 2007: Foreign national prisoners comprised 39% of the total establishment population for prison E compared to 34%, 28%, 8% and 7% for the other prison sites. December 2007: Foreign national prisoners comprised 41% of the total establishment population for prison E compared with 34%, 30%, 8% and 7% for the other prison sites.

**Table 2: Transfer times in days for whole sample and for each prison**

Prison	N	Mean	Median	SD	Fastest	Slowest	No. transfers <14 days <sup>7</sup>	No. transfers >14 days <sup>8</sup>
A	8	15.3	8	12.7	4	41	5 (63%)	3 (37%)
B	5	51.4	21.5	60.2	8	155	1 (20%)	4 (80%)
C	9	39.8	36	25.8	0	80	1 (11%)	8 (89%)
D	4	23	24	19.0	1	43	2 (50%)	2 (50%)
E	9	71	50	50.2	18	175	0 (0%)	9 (100%)
<b>Totals</b>	<b>35</b>	<b>41.9</b>	<b>31.5</b>	<b>41.1</b>	<b>0</b>	<b>175</b>	<b>9 (26%)</b>	<b>26 (74%)</b>

***Tracking of the pathways to care***

The pathways of care received by prisoners awaiting transfer were collated on a pro forma adapted from a previous, similar study (Senior *et al.*, 2006). The pro forma collated details of how many times prisoners were formally seen by either medical or nursing staff during two time periods. The first time period was during the 4 weeks prior to the prisoner being formally identified by staff as having a mental health problem possibly requiring transfer and the second time period was whilst awaiting transfer.

***Four weeks prior to formal identification***

Tables 3 and 4 below show how often prisoners were visited by medical (table 3) and nursing (table 4) staff for the 4 weeks prior to formally being identified as having a mental health problem possibly requiring transfer.

**Table 3: Frequency of contact prisoners received from medical staff during the 4 weeks prior to formal identification**

Weeks prior to identification	Number of times prisoners seen by medical staff					
	0	1	2	3	4	5
4 weeks prior	9	7	1	0	0	0
3 weeks prior	14	2	1	0	0	0
2 weeks prior	9	6	1	0	0	1
1 week prior	9	3	5	0	0	0

Sixty one percent of prisoners were not seen by medical staff in the 4 weeks prior to identification, 27% were seen once and 12% were seen twice.

<sup>7</sup> Percentages rounded to equal 100.

<sup>8</sup> Percentages rounded to equal 100.

**Table 4: Frequency of contact prisoners received from nursing staff during the 4 weeks prior to formal identification**

Weeks prior to identification	Number of times prisoners seen by nursing staff					
	0	1	2	3	4	5
4 weeks prior	15	2	0	0	0	0
3 weeks prior	14	3	0	0	0	0
2 weeks prior	12	4	1	0	0	0
1 week prior	8	5	2	1	1	0

Table 4 shows that 73% of prisoners were not seen by nursing staff in the 4 weeks prior to identification, 21% were seen once and 4% were seen twice. One prisoner was seen 3 times and one 4 times.

*Whilst awaiting transfer*

Tables 5 and 6 below show the amount of contact a sample of 24 prisoners received from medical (table 5) and nursing staff (table 6) during the first 7 days after identification and in the 7 days before actual completion of the transfer.

**Table 5: Frequency of contact prisoners received from medical staff 7 days after identification and 7 days before transfer**

Time period N=24	Number of times prisoners seen by medical staff						
	0	1	2	3	4	5	6
7 days after identification	1	7	7	5	3	0	1
7 days prior to transfer	5	8	7	3	1	0	0

Collectively, the sample of 24 prisoners was seen by medical staff a total of 54 times during the 7 days after identification (mean 2.3 times). This decreased to 35 times (mean 1.5 times) in the 7 days before transfer was completed, a decrease of 35%.

**Table 6: Frequency of contact prisoners received from nursing staff 7 days after identification and 7 days before transfer**

Time period N=24	Number of times prisoners seen by nursing staff						
	0	1	2	3	4	5	6
7 days after identification	9	4	6	1	3	0	1
7 days prior to transfer	14	5	4	1	0	0	0

Collectively the sample of 24 prisoners was seen by nursing staff in total 37 times during the 7 days after identification (mean 1.5 times). This decreased to 16 times (mean 0.7 times) in the 7 days before transfer was completed, a decrease of 57%. Nine individuals were not seen at all by nursing staff in either of the 2 time periods.

This increased contact with medical and nursing staff upon commencement of transfer procedures is probably due to the many assessments being conducted to assess the prisoners' mental condition. However, this contact then generally tails off, with many prisoners being seen infrequently during the wait for transfer. To illuminate this, several practice examples have been provided below which describe some of the quality of the pathways to care for some of prisoners.

### Prisoner/Patient Example 1

*Prior to identification* - Two weeks prior to day 0, the prisoner was seen by discipline staff, CARATs and the mental health in-reach team. During this time the prisoner was moved to a different cell, was noted to have had behavioural problems, self harmed twice resulting in an ACCT<sup>9</sup> being opened. Anti-psychotic medication was prescribed and the prisoner had an adjudication hearing (proven) for being in possession of an unauthorised article. Following this, another adjudication for violence toward others was proven and an IEP<sup>10</sup> warning was given. One week prior to day 0, the prisoner was seen by Primary Care Mental Health Services and referred to both a psychiatrist and a psychologist, but was not seen during this week. The prisoner had another incident of self harm, further changes to medication and a third adjudication hearing for damage to property (proven). The prisoner was moved to segregation, then to a safer cell before being admitted to the in-patient unit.

*Post identification* – the prisoner waited 14 days for transfer and contact with healthcare staff is recorded on 8 of those days. The interventions on those days are as follows: on day 0 the prisoner was located in a safer cell, prescribed medication and placed on an increased level of observation after being seen by a psychiatrist and a psychologist. The prisoner was seen on day 1 by the Safer Custody Assessor<sup>11</sup> and by the education department and commenced an educational programme. They were also assessed by the community mental health team, a psychiatrist and a psychologist on days 5 and 12, seen by a resettlement team on day 7, had their level of observation reviewed on day 9 after seeing Safer Custody/ACCT officer. Transfer was completed on day 14.

<sup>9</sup> Assessment, Care in Custody and Teamwork (ACCT) is the care planning system in place for prisoners at risk of suicide or self harm ( [www.hmprisonservice.gov.uk](http://www.hmprisonservice.gov.uk)).

<sup>10</sup> The Incentives and Earned Privileges Scheme (IEPS) was designed to encourage responsible behaviour and hard work by prisoners to make a more controlled safe environment. Prisoners are placed on one of three levels; basic, standard and enhanced which determines the number of privileges he/she has access to ([www.prisonersadvice.org.uk](http://www.prisonersadvice.org.uk)).

<sup>11</sup> Safer custody assessors are active in providing supportive arrangements for those at risk of suicide ranging from safer cells, to developing listener schemes (Jewkes, 2007)

## **Prisoner/Patient Example 2**

*Prior to identification* - Three weeks prior to day 0, the prisoner was assessed by a psychiatrist. Two weeks pre day 0 the person was seen by a reception nurse, a doctor and discipline staff, and moved to a specific substance misuse unit following an IEP warning. They were referred to the in-reach team and seen a few days later. In the week preceding day 0, the prisoner was seen by the in-reach team, a forensic psychiatrist and placed on a higher level of observation before being admitted to healthcare.

*Post identification* – this prisoner was transferred out on day 27 and contact with healthcare staff is recorded on 14 of those days. Between days 1 and 4 the prisoner was assessed by a psychiatrist and in-reach. Observation levels were reviewed on day 4, and an adjudication hearing was scheduled for day 5, for which the prisoner was assessed as unfit to attend. Further risk assessment was undertaken and a decision made to increase the number of staff required to unlock them to two. Prior to a court appearance on day 12 a letter was faxed to the court diversion team but it was recorded that the letter was considered insufficient evidence to allow for diversion from court and the person was returned to prison. The prisoner was assessed on day 18 by in-reach staff, a psychiatrist and a psychologist. On day 25 observation levels were reviewed and antipsychotic medication prescribed. Transfer was completed on day 27.

### **Prisoner/Patient Example 3**

*Prior to identification* - nothing noted.

*Post identification* – this prisoner waited 39 days for transfer and was seen by healthcare staff on 5 of those days. On day 0, they were seen by a psychiatrist and observation levels heightened. On day 4, they were referred to an external nursing team, and an ACCT form was initiated. There is no further recorded contact with healthcare staff until day 19 when they were seen by an external nursing team. This prisoner experienced a 15 day wait between being referred to the external team and being seen at which point the decision of the external team was that the prisoner would only be transferred if their condition deteriorated further. Further incidents of self harm were reported on days 23 and 24 and the external nursing team conducted a further assessment on day 34. The patient was transferred on day 39.

### **Prisoner/Patient Example 4**

*Prior to identification* - Four weeks prior to day 0, the prisoner was seen by a forensic psychiatrist and placed on 15 minute observations, which were later increased to greater frequency. The prisoner was also placed on antipsychotic medication. Three weeks prior to day 0, the prisoner was referred to an external nursing team and was seen by mental health staff. Two weeks prior to day 0, the prisoner was seen by a forensic psychiatrist and admitted to the prison healthcare unit. One week prior to day 0, the prisoner's observation levels were reviewed and they were seen by in-reach staff.

*Post identification* – the prisoner was seen every day during their 30 day wait for transfer. During this time, observation levels were reviewed, they commenced antipsychotic medication, had contact with an art therapist, were reviewed by a forensic psychiatrist and saw a psychologist for anger management.

### **Prisoner/Patient Example 5**

*Prior to identification* – nothing noted

*Post day 0* – The prisoner waited 50 days for transfer and contact with healthcare staff is documented on 11 of those days. The prisoner was seen on day 0 and prescribed medication; on day 1 a mental health assessment and review of medication were conducted by a psychiatrist. From day 5 the process of trying to establish the responsible PCT commissioner commenced. The prisoner was seen by a psychiatrist on days 7, 9 and 12 for further assessment and checked on by psychiatrist on days 19, 22, 26, 36 and 42. No other interventions were documented during this time.

These findings highlight that, after identification of a need for transfer, the frequency and type of contact with prison-based mental health services varies widely. The practice examples illustrate that some people were monitored closely and seen by healthcare staff daily; however others received very little intervention, with prolonged periods between each contact. Additionally, some waited considerable lengths of time from referral to external services to those teams actually attending the prison to see them. Delays appeared greatest and interventions most infrequent for foreign nationals.

Thus, whilst many prisoners were effectively assessed and transferred in a timely manner, there were a number for whom transfer (or discontinuation of transfer procedures) took prolonged periods, and this could be accompanied by them having infrequent healthcare contact or interventions whilst waiting.

## ***Tracking of transfer paperwork***

### *Roles and responsibilities of staff*

The *Procedure for the Transfer of Prisoners to and from Hospital under sections 47 and 48 of the MHA 1983* document outlines the actions and responsibilities of prison healthcare staff (section 6), PCTs and mental health service staff (section 5) and the Mental Health Unit (section 7), described below.

#### *Prison staff*

The guidelines expect prison healthcare staff to identify prisoners in need of transfer to hospital for treatment under sections 47 or 48 of the MHA 1983 at the earliest possible opportunity. They must then arrange for a GP or psychiatrist within the prison to assess the person. Following this, they must identify the responsible PCT commissioner and arrange for a second medical assessment to be conducted, usually by staff from the intended mental health unit. They are required to ensure that at least one of the assessments are conducted by a section 12 (2) approved medical practitioner. Concurrently, the MHU must be informed that a transfer is needed (by faxing a HI003 document) and provided with information about the prisoner. Prison governors and heads of healthcare are responsible for ensuring an established structure is in place within their prisons to facilitate the transfers. And finally, beds must be secured at the required level of security.

#### *Mental Health Unit staff*

Mental Health Unit (MHU) staff at the Ministry of Justice are required to issue the warrant for the transfer of prisoners to psychiatric units. They are not obliged to act on recommendations made under section 47 or 48. Their prime concern is to manage any risk to the public, so they routinely consider the security aspects of each case (Department of Health, 2007). In order to risk assess the prisoners and identify the appropriate level of security, they liaise with prisons to obtain information regarding a prisoner's current

charge/conviction, previous convictions, relevant behaviours, medical practitioners' recommendations and consider other matters such as any victim issues and the person's notoriety. The MHU will reach a decision on the degree of security required once all relevant information has been considered, assessed on a case by case basis before issuing the transfer warrants.

#### *Mental health service staff*

The *Procedure for the Transfer of Prisoners to and from Hospital under sections 47 and 48 of the MHA 1983* states that, if identified as the Responsible Commissioner, the appropriate PCT/lead commissioner is to support the head of healthcare, prison mental health team and related staff throughout the transfer process. The guidance states that in no cases should disputes about establishing the responsible commissioner delay or adversely affect a prisoner's treatment. They are required to facilitate safe and effective commissioning by: encouraging timely assessments; promptly funding placements in either the NHS or independent sector if NHS provision is not available; and by agreeing to pay for in-patient services first and resolving disputes later if situations of urgency arise.

#### *Tracking of paperwork findings*

Based on the total sample of 35 prisoners successfully transferred, the majority of referrals for initial assessment were made by the in-reach team (40%, n=14) and just over a quarter made by prison healthcare units (26%, n=9). First medical assessments tended to be conducted by either a general psychiatrist from the in-reach team (31%, n=11), a forensic psychiatrist from the in-reach team (20%, n=7) or by a visiting forensic psychiatrist (17%, n=6). Just under three quarters of doctors conducting first assessments were section 12 approved (74%, n=26). For 51% (n=18) of prisoners the Mental Health Unit at the Ministry of Justice was informed of their need for transfer at the time of the first medical assessment. PCT commissioners were mostly identified via GP registration (31%, n=11) or by virtue of the prisoners' previous addresses (29%, n=10).

For 34% (n=12) of the sample a bed was available at time of referral; however no bed was available for 20% (n=7). For the remainder of the sample this information was unknown. Again, a high percentage of doctors undertaking second assessments were section 12 approved (83%, n=29). The vast majority of referrals at the time of second assessment were made to medium secure units (43%, n=15) or psychiatric intensive care units (40%, n=14). Actual numbers of transfers to medium secure units were slightly less than the referral rate (37%, n=13), with one prisoner initially referred to an MSU being admitted directly to high secure conditions and a second prisoner being transferred to a low secure unit in the independent sector.

### ***Qualitative interviews with key informants***

This section is arranged into three sub-sections, discussing the themes arising from interviews with prison-based staff, Mental Health Unit staff, and mental health service providers, respectively.

During the interviews, participants discussed their experiences, perceptions and understandings of the transfer process. The findings reveal a range of barriers to developing an efficient and effective transfer process for prisoners with mental health problems. Participants also discussed how the transfer process might be improved.

#### ***I: Interviews with prison-based staff***

The interviews with prison-based staff highlighted nine main themes that reflected the key issues currently affecting timely transfers. These are illustrated schematically in figure 4.

Figure 4: Schematic representation of perceived reasons for delays in the transfer process (perspectives of prison-based staff).



Respondents agreed that the transfer process worked well when there was effective collaboration links and good communication between prisons, the Mental Health Unit, PCTs and mental health service providers. The interviews also provided insight into how the transfer process had improved, since the introduction and dissemination of the transfers procedure document, and suggestions of how to improve the process.

### ***Factors perceived to impact on the efficiency of the transfer process***

#### Breakdown in Communications

Prison-based staff perceived a lack of effective communication within and between departments in prisons as well as between prisons and external agencies:

*'Communication is probably the most important thing that keeps things ticking over ... and yet it is the most ignored thing.'* (RMN)

*'... people are not communicating within their own group.'* (Social Worker).

*'.. the process within the prison is logical ... the teams off site - sometimes we have communication problems with them.'* (Prison RMN)

Some prisons also had communication problems with the Ministry of Justice:

*'The Home Office is an example where there is a high turnover of staff. You have three or four different caseworkers on one case and, from week to week, you don't know who you're supposed to be talking to and, in that, communication is lost sometimes and paperwork is misplaced. So that again causes problems'* (Transfer Co-ordinator)

It was suggested that the large number of agencies involved in the transfer process, all working to different shift patterns in pursuit of different

aims/policies, did not lend itself to effective communication and consequently affected transfer times. Trying to find the right person or department with whom to communicate was also identified as an issue:

*'There are delays because problems with communication occur. It seems to us that when the ward managers become overwhelmed, they don't leave messages. So we can never catch them on the phone, they don't return our calls for one reason or another, and a week may pass by just trying to get hold of them. (RMN)*

*'My understanding is that there is no one person you can go to for an answer to a question. So the consultant spends much of her time ringing round, trying to find the right person to talk to who can answer a question that would facilitate the transfer process. There needs to be a streamlining or clarification about who the consultant should speak to. I think the multiplicity of agencies involved just adds to the delays. Each PCT has its own way of working, with a different set up. By talking to one person in one organisation you would think that if you spoke to their equivalent in another organisation, you would then get the contact...but you don't.'* (Clinical Team Leader)

The reasons given for lack of effective communication stem, in part, from the differing organisational cultures within the Prison Service and the NHS:

*'There are a lot of different disciplines that work (together) and, let's face it, the nursing discipline, it just doesn't go with prison really; they are two totally different disciplines. We have this argument on many occasions - nurses don't lock people up, yet we do. We have a hard enough job as it is without adding communication breakdowns. That can halt any movement of any prisoner.'* (RMN)

*'We don't have shared goals ... The prison system is there for a reason. It's there for the incarceration of offenders. Their priority is not always treatment of the ill, which is understandable; they're not a hospital.'*

(Visiting Psychiatrist)

*'It gets very complicated because there are so many different agencies involved. So, when it goes wrong (communication), it goes wrong big style.'* (Senior Clinician)

### Administrative Problems

When a prisoner is identified as requiring transfer to hospital, the prison has to provide the Mental Health Unit with details of the prisoner's previous convictions, current charge/offence, court indictment, court results sheet, pre-sentence reports and sentencing warrant. This informs the decision as to the appropriate level of security. Staff reported that transfers had been significantly delayed because of difficulties gathering this information. This is, in part, due to prisons having to request it from the Crown Prosecution Service (CPS):

*'Sometimes the Home Office doesn't always get all the paperwork regarding the case. Recently, we've been waiting several weeks for the paperwork to get across to the Home Office before they'll issue a warrant.'*

(Secretary, Health Care Unit)

*'It can take time getting all the information together to fax to the Home Office.'* (Senior Health Care Officer)

*'Different pockets of people have the different bits of information that you need. Sometimes it can be quite difficult to get, physically, hard copies of the information you need. They do need that information on offending, so it is quite hard.'* (RMN)

*'We have a lot of paperwork to collate to send through to the Home Office and, sometimes, getting hold of that can be difficult because different departments have different access to different paperwork. So we have to liaise with these different departments.'* (Healthcare Officer/RMN)

Some staff seemed unclear about the actual requirements of the Ministry of Justice with regard to information:

*'The big delay can be the Mental Health Unit - it's not very clear what (information) they want.'* (Healthcare Manager)

Delays could also occur between Prison Service administration departments, the Mental Health Unit and the CPS:

*'The Mental Health Unit requires the pre-conviction histories which are dealt with by prison service administration. Sometimes when we send a request to them, or the MHU requests them to be sent, they don't understand that it is urgent ... They just put it down as another request for 'pre-cons' as is requested by the courts, the police, the probation service every day.'* (Deputy In-Patient Manager)

Evidently, the organisational inertia within the prison estate, with the particular problems obtaining and constantly chasing up paperwork held within different departments, both within and outside the prisons, adversely impacted on the transfer process. The following extracts illustrate some of the administrative problems faced by prison staff:

*'Sometimes with the Home Office, faxes go missing. There are breakdowns in communication. On occasion, when a fax is sent, phone calls are also required to make sure the fax is received ... and that it has gone to the right person.'* (Senior Health Care Officer)

*'There's too much to-ing and fro-ing of paperwork, and there's a lot of faxing that we're having to do at the moment.'* (Deputy In-Patient Manager)

*'We always fax and send a hard copy through, but it is remarkable how many times people say they haven't received either. So what we tend to do is fax it and then the nurses will ring 48 hours later to check receipt - they're having to double check all the way through.'* (Consultant Forensic Adolescent Psychiatrist)

*'There seems to be a lot of paper chasing of simple things that could be faxed or discussed over the phone ... and if it goes missing, as can happen in big corporations or big establishments, then the whole process can just grind to a halt.'* (RMN)

Likewise,

*'Letters of confirmation can go missing - a bed had been agreed and, although we had it confirmed in principle over the phone, we were waiting for a letter of confirmation (from the receiving hospital)... But then it went missing, so they had to send out another letter.'* (RMN)

Some prisons reported inadequate resourcing:

*'We don't have adequate admin support in the prison. Our admin support is provided by one secretary who appears to be really overworked. We're not allowed to bring in dictation machines and so we have to hand write letters and then get the secretary to type them up, and then they [the prisons] don't even have a fax machine or a telephone ... very basic things like that should be sorted.'* (Visiting Psychiatrist)

*'One of the problems is that we don't have internet access, so we struggle.'* (Secretary, Prison Healthcare Unit)

## Bed Availability

Lack of available beds was perceived to be a major contributing factor to delays in transfers. The following extracts highlight this:

*'When there isn't a bed, and there is a need for a patient to go, then we are stuck ... We need more beds so people are not hanging about.'*

(Social Worker)

*'There's a huge demand for secure beds, and generally there are waiting lists.'* (Clinical Head Psychiatrist)

*'The hitch comes when a hospital accepts someone but there's no bed available. So that can be really problematic.'* (Transfer Co-ordinator)

*'Availability of beds ... I mean, that's the other thing, obviously ... that is a big, big problem ...'* (Clinical Team Leader)

*'in certain Trusts there is clearly a shortage of beds.'* (Associate Specialist Psychiatrist)

*'... you've got to fight to get a bed.'* (Lead RMN)

*'I think it's purely the pressure on beds. I don't think the system's at fault but I do think the facility isn't big enough to house the number of people who really need help ... We need to build more psychiatric hospitals.'*

(Deputy In-Patient Manager)

*'Hunting a bed down can be unbelievably problematic.'* (RMN)

*'Even if you fix the administration issues and open up the channels of communication, a prisoner is not going anywhere if you don't have beds.'*

(Transfer Co-ordinator)

Shortage of NHS beds appeared to cause both direct and indirect delays in the transfer process. Directly, this was perceived to be due to national shortages, and, indirectly, due to the need then to find appropriate independent sector beds, together with the required funding.

*'When the beds are just not available, you've then got to either look for a private bed or look outside the area, and then the process gets even more delayed.'* (RMN)

*'There are private beds available, but I think there's reluctance within the PCT to pay for a private bed if there's a possibility of getting an NHS bed. Obviously, the costs are more and that can delay things as well while people make the decision.'* (Transfer Co-ordinator)

Interviewees highlighted difficulties with co-ordinating the securing beds and with the issue of warrants:

*'We have to look for a bed for the hospital that's going to be admitting them, because the Home Office needs that information before they can approve a transfer. So we have to find the bed, which means we have to phone the consultant who is able to provide the bed. If they haven't got a bed, then the Home Office will say, 'We can't give you a transfer direction because you haven't got a bed.' So that's really the stumbling block.'*  
(Social Worker)

*'The Home Office doesn't like to provide warrants unless there's an identified bed. ... In one case, a bed was available, but because it took a while to get the warrant, the bed was lost, which meant we were having to apply for a new warrant when a bed became available again.'* (Transfer Co-ordinator)

*'It can be frustrating because the hospital will often say that they have a bed for a couple of days and then the window period has gone because*

*the Ministry of Justice takes too long to send us the warrant.'* (Associate Specialist Psychiatrist)

*'It's a question of getting the transfer warrant from the MHU. That used to be fairly simple, but it's become an enormous problem in the last four to six months. Now we're getting many more delays with the warrants.'*

(Consultant Forensic Psychiatrist)

On some occasions, staff had used the fact that a warrant had been issued but was nearing expiry to apply pressure on hospitals to produce a bed:

*'They won't come up with a bed until you tell them that the warrant is expiring today. What else can we do? The patient needs medication. They would then start to involve the Bed Manager and the Ward Manager, and they will do whatever they have to do because the warrant is going to expire that day. But before the Ministry of Justice gives us a warrant, they insist that first you must get a bed, because they know that the warrant might expire without us getting one.'* (Clinical Team Leader)

Healthcare staff at one of the participating prisons suggested a need for a designated time period for prison transfers in order to try to produce more timely transfers, as illustrated here:

*'Normally, we are ringing wards to see if they have a bed available. And they will say; 'Oh, we have another two weeks in front of us yet'. It seems they have this tendency to use all the time available to them, which at least gives us hope that at the end of that time they will come up with a bed. But if there is no set time, prisoners will end up waiting much longer.'* (RMN)

The need for a specified time limit for prison transfers will be returned to later.

There was general consensus among healthcare staff that, due to a lack of community aftercare provision, the throughput of patients from psychiatric units, post-treatment, was not quick enough to release beds for new

admissions. Staff highlighted the need for an overview of the whole step down process throughout the secure mental healthcare system.

### Establishing the responsible commissioner

Section 5 of the transfer policy document (version 3) clearly describes the correct procedure for establishing who the responsible commissioner is. The guidance states that the appropriate commissioner should be the commissioning NHS organisation where the prisoner was registered with a GP before entering prison. For prisoners who were not previously registered with a GP, this decision rests upon where the prisoner resided before prison. If a previous address cannot be determined, the responsibility is then deferred to the PCT responsible for the area where the offence took place.

Respondents identified that there were still problems getting some commissioning organisations to accept responsibility for the treatment of mentally ill prisoners from their catchment areas. The following extracts illustrate some of the difficulties encountered by prison staff when attempting to establish responsibility for the mental healthcare of prisoners:

*'The biggest difficulty I think we face is trying to find the responsible PCT and then getting them to agree.'* (Secretary, Healthcare Unit)

*'Getting a PCT to accept responsibility can be difficult. Having a list of contacts, such as the relevant commissioner, helps.'* (Locum Psychiatrist)

*'With the CMHT, not all of them know the process very well. If a patient from their borough is in prison, they still don't consider it their responsibility to come and do an assessment and then offer a bed if necessary. They have a strong belief that if a person is in prison, not in the community, then it is not their responsibility. They have suggested we refer patients to them only after they have left prison.'* (RMN)

*'There is quite a protracted dispute about catchment areas and PCT responsibility.'* (Consultant Forensic Psychiatrist)

*'People won't accept responsibility. They argue that it's not their responsibility, that's it's this team or it's that person, when it should be them. It is the most frustrating thing ever.'* (Lead Mental Health Nurse)

There was also a problem persuading already financially stretched Trusts to accept and acknowledge responsibility for the provision of in-patient mental healthcare to prisoners. The updated policy document (version 4, October 2007) has already taken steps to help alleviate these issues and clearly states that, *'In no case should disagreements or confusion about establishing the 'responsible commissioner' delay or adversely affect a prisoner's treatment'*.

### Security disputes

Decisions about security created an additional perceived barrier to smooth and efficient transfers.

*'It's frustrating because once we have made the referral, we're waiting for other people to act. There are delays because the hospital we've referred to is debating with itself which unit is the most appropriate in terms of security.'* (Associate Specialist Psychiatrist)

*'Sometimes there is quite a protracted dispute about level of security.'*  
(Consultant Forensic Psychiatrist)

There were agreed pathways of referral within some Trusts, though these differed between Trusts, with notable contradictions.

*'A referral would first be made to medium secure and then to low secure. But we go through low secure, then medium secure, and then from*

*medium secure to high secure. We have to go through that process.'*  
(Clinical Team Manager)

*'We agreed a pathway - low to medium to high. We should be able to go straight to a high secure hospital. But they prefer the buffer of medium security, who also prefer the buffer of low security. And the high secure are very reluctant to take direct referrals from us ... They want the prisoner to pass through low to medium to high, and I just don't think that's appropriate.'* (RMN)

Progressing through these pathways to find an appropriate bed could take a considerable amount of time.

*'It's when you get the 'ping pong' effect between the different tiers of security. If only there was just an agreement between different clinical teams as to the appropriate level of security needed for that patient.'*  
(Senior Nurse Clinician)

Seemingly, a variety of agencies are involved in this process, each with differing roles and priorities. There can be several stakeholders involved, all making individual security risk assessments. Staff thus acknowledged the benefit of employing a universally agreed risk assessment tool, which could incorporate individual clinical and security needs assessment with wider considerations, such as notoriety or victim protection issues. It was felt that such a tool could aid the identification of appropriate levels of security for individual patients.

### Assessment Delays and Clinical Disputes

In general terms, staff felt that too many assessments were being conducted:

*'Assessments ... there are too many assessments. The idea was that you would have one assessment and then you would look at the possibility of*

*transfer. But we're still getting two or three assessments ... It just seems to be so long-winded.'* (Healthcare Manager)

*'There's always a delay with the second assessment, and that's partly to do with the funding. Then if the Consultant is really busy ...'* (Secretary, HealthCare Unit)

Where there was debate over the appropriate security level, each unit seemed to require its' own assessment and was reluctant to accept others' assessment decisions.

*'How many assessments do people need? Can we not make an assessment (of mental state) from one, rather than three or four assessments? Acceptance of one assessment, rather than all the others ... Everyone wants their own assessment.'* (Healthcare Manager)

Difficulties also arose in trying to get a second assessment conducted, when the responsible commissioner's area was a considerable distance from the prison:

*'We've had prisoners from Brighton and even one from Devon ,, we actually have people from all over the UK, and that causes a whole lot of problems because people are not exactly keen to travel to London to make their assessments.'* (Lead RMN)

Disagreements over diagnosis also affected the progress of transfers; the following four extracts illustrate this:

*'We had one consultant from the in-reach team who thought a prisoner had a major psychotic illness and required transfer. A doctor came from a medium secure unit and said, 'No, I think it's a detox issue.' That prisoner was then transferred to another prison and he's now on the waiting list for a special hospital. Because there was a disagreement on diagnosis and it*

*took that much longer to resolve. We know it's not always clear with Mental Health diagnoses, but ...'* (Senior Clinician)

*'It only takes two RMNs to disagree on someone's diagnosis and you're already on the slow track ... It can slow things down a hell of a lot if you've got two doctors disagreeing.'* (RMN)

*'Doctors do disagree on diagnosis in general and that does slow things down.'* (RMN)

*'There was a case where a clinical opinion differed quite considerably across the three or four consultants that touched the case - differences in both diagnosis and prognosis in terms of suitability for transfer.'* (Head of Healthcare)

The need to have multiple assessments was therefore felt to cause significant transfer delays and was inherently linked to disputes over who the responsible commissioner was, finding beds and determining security levels.

### Financial Disputes

Disputes over funding also affected the efficiency of the transfer process:

*'The biggest problem we have, I think, is with the PCT agreed funding.'*  
(Secretary, Healthcare Unit)

*'Delays occur because of the funding, who's responsible for it ...'*  
(Healthcare Manager)

*'The healthcare teams don't know if they've got the go-ahead to offer a bed because of the finances.'* (Clinical Team Leader)

Delays with second assessments were sometimes perceived to be due to reluctance to accept responsibility for a prisoner's healthcare costs. The policy

states that, *'with regards to financing a transfer [to NHS sites], the necessity of immediate action may require moving the prisoner before the finances have been fully resolved'*. Staff reported that this was not being adhered to. Funding disputes were slowing progression of the transfer process by delaying second assessments:

*'The RMO agreed to come out the next day. But then they sent me a fax, saying, 'By the way, he charges £700 per visit ... Who is going to pay?' I had to go back and say that as a prison we don't pay for this. The lady ended up staying in prison for nearly two more months until we could find someone else to agree to come out to do the assessment.'* (RMN)

*'Sometimes there's a delay in the second assessment, which is partly to do with disputes over funding.'* (Secretary Healthcare Unit)

*'Once we've made the referral, we are waiting for other people to act and I think that sometimes the argument is about funding.'* (Associate Specialist Psychiatrist)

There was also the view that transfers were being delayed because PCTs were debating whether or not to pay for independent sector beds, or whether to await an NHS bed becoming available:

*'PCTs are reluctant to pay for private beds if there is the possibility of getting NHS funded beds. Obviously, the costs are more, so that can delay things ...'* (Transfer Co-ordinator)

### Attitudes and Perceptions

Negative attitudes towards mentally disordered offenders among prison and hospital-based staff were also perceived to impede transfers. The following two extracts suggest lack of insight on the part of some prison officers into issues surrounding mental illness:

*'There isn't the understanding from the prison side about why someone needs to be transferred. It goes to that kind of moral judgement, that someone's here for punishment and therefore they should be punished ... "Going to hospital, they get an easy ride".'* (Clinical Team Leader)

*'Some prison officers are derogatory in the way they talk about patients with mental health problems, and don't seem to understand. It's quite difficult when people have been in-patients and they're mentally stable and we need to discharge them back to the prison. And I feel quite uncomfortable taking patients back to prison because of the way the prison officers are towards them.'* (RMN)

On the other hand, the following extracts suggest reluctance among some hospital-based staff to accept referrals from prison of mental health patients:

*'Some consultants don't believe that if someone has a psychotic illness they need to be transferred to a PICU. Not all consultants agree that their PICU should be taken up with such patients.'* (Associate Specialist Psychiatrist)

*'There is one consultant who runs a PICU who is extremely reluctant to admit anyone from prison ...'* (Consultant Forensic Psychiatrist)

This, it seems, is due in part to some professionals' perceptions of mentally disordered offenders:

*'There's always been a bit of mystique around the Prison Service. Plus, I think sometimes, when you talk to other hospitals or units, they think that because you're ringing from a prison, the man you're holding is a very bad man, and very often that's not the case. They've just ended up in here for affray or shoplifting ...'* (Deputy In-patient Manager)

The following extract suggests how such negative perceptions can impinge on the efficiency of the transfer process:

*'When you're working with forensic services, transfers tend to work much more smoothly than when you're working with local mental health teams. They seem to be much keener to do prison visits – and they're much more interested in the client group. I guess it's about perception ... their perceptions are different because they do understand forensic systems.'*

(Lead RMN)

#### Lack of awareness of policy/procedures

It became apparent, during the interviews, that some prison staff were unaware of the existence of the DH transfers policy document.

*'I haven't seen the recommendations.'* (RMN)

*'I'm not going to lie and say I have read all of that because I haven't. So, I don't know, I can't say.'* (Lead RMN)

In the case of some respondents who had claimed to have read the guidance, it became clear that they had not, since they espoused the need for changes that the policy document already addressed. For example, a Clinical Team Lead suggested the need for

*'... a list of names, a list of PCTs ... some kind of co-ordinated and signed up national strategy.'* (Clinical Team Leader)

## **Summary**

The prison-based staff interviews brought to light nine factors perceived to reduce the efficiency and effectiveness of the transfer process.

1. Communication difficulties, between prisons and other agencies and between different departments within the prisons themselves, were felt to be major issues. The key reasons identified for this related to the differing organisational cultures of the NHS and the Prison Service, compounded by the lack of a single unified vision regarding the purpose of transfers within the context of offender management.

2. Administration problems were perceived to cause delays, particularly due to the number of agencies involved and the amount of information required from various partner agencies. Prison-based staff felt that they had insufficient resources or staff to co-ordinate and manage the transfer process effectively in terms of constantly chasing up paperwork and permissions from different agencies.

3. Respondents reported that a major problem arose in establishing the appropriate responsible PCT commissioner and then getting PCTs to *accept* responsibility for the healthcare of the prisoner.

4. Perceived shortages of NHS beds, differences of opinion over required security levels and different pathways of referral for each PCT, combined with funding disputes, hampered the process further. This then created delays with second assessments.

5. There was also the perception that *too many* assessments were conducted by different units, which, together with disputes over diagnoses, inevitably delayed the production of the transfer warrant.

6. Delays in transfers were also perceived to arise due to the clash of organisational cultures. The NHS and criminal justice system have differing

and competing philosophies and cultures. Differences in attitudes and perceptions prevailed among Prison Service and NHS professionals regarding mental illness. Likewise, there were differences in perceptions of, and attitudes towards, offenders. This illustrates the need to develop appropriate training for professionals dealing with offenders, that address values, attitudes and beliefs about mental health issues and offending; this may help to establish better multidisciplinary and multi-agency relationships.

## **Conditions perceived to facilitate effective transfers**

### Positive Communication and Collaboration

Participants reported overwhelmingly that the transfer process worked best when good levels of communication and collaboration between agencies had been established.

*'Here, I would say that, 95% of the time, communication is excellent, because we're an established team. Across our team, communication is excellent.'* (Senior Nurse Manager)

*'The relationship is three hundred times better now, between the healthcare department and the in-reach team. We're working much closer together, and we communicate a lot better.'* (Senior Clinician)

*'Our relationship with the PCT is so much better ... We work a lot more closely with them now ... that's been a big improvement.'* (Healthcare Manager)

*We have a really good relationship with the in-reach team ... we work very well together. We never used to ... That has improved over the last three or four years.'* (RMN)

Some teams had managed to establish common goals with their partner agencies.

*'We all attempt to work as one team. We're all obviously focusing on giving the best care and treatment for prisoners, whether they're suffering from a mental illness or not'* (Deputy In-Patient Manager)

*'The team works best when we're all singing from the same hymn sheet, wanting to work together as a team.'* (Healthcare Senior Officer)

*'We now have more psychiatrists, more psychiatric nurses, and prison officers with experience in mental health ... The fact that the multidisciplinary team is quite robust, I think, has helped.'* (Associate Specialist Psychiatrist)

Some respondents felt that the transfers' policy document had helped them and their colleagues to bring improvements to the transfer process:

*'I think it [the policy] has made things clearer, so that people at various points in the system understand exactly what needs to be done ... this has facilitated the transfer process ... made it more speedy.'* (Psychiatrist)

Having a list of key contacts, especially commissioners, was felt to be essential. Furthermore, the 14-day pilot initiative was felt to be helpful.

*'A big change for me has been having this pilot. People are a bit more conscious and focused on the 14-day pilot scheme ... for once, it's given people a bit of focus.'* (Healthcare Manager)

The following extract illustrates how the pilot scheme was effective in raising awareness of the transfer process and in improving communication within teams:

*'As a provider, we are not meeting our 14-day target. So it's made us more aware of this and we don't want to be the ones failing in the pilot ... We've sat down together and decided that even if we can't meet the 14-day target, if we're gathering that data and logging it, and identifying where we've got to improve ... It's given us some evidence to work with.'* (Senior Clinician)

## **What could further improve the transfer process?**

### **1. Training and Education**

There was general consensus that more training was needed about the transfer process.

*'Training should be put in place, just so that people understand the system, the processes.'* (Social Worker)

It was also felt that professional training (across the range of specialisms) should include some induction or input on offender health.

*'I think it's important that general psychiatrists have some exposure to the criminal system.'* (Clinical Head Psychiatrist)

*'People who come into prison healthcare would benefit from some kind of further induction or on the job training.'* (Clinical Team Leader)

It was also felt that by raising awareness of different professionals' roles, through training and education, could improve collaborative working and thereby have a positive impact on the transfer process:

*'I think we need a more consistent approach, so that people in PCTs, at the Department of Health and within the prisons are synchronised, you know, speaking the same language ... You've got lots of different agencies*

*doing their own thing, and they need to be better co-ordinated, overall ... and to hopefully sing from the same hymn sheet.'* (Clinical Team Leader)

Education about mental health and illness was also thought to be important:

*'We need to educate staff about mental illness, so that when you say it's urgent, then they will see the need.'* (Clinical Team Leader)

*'Unless we can raise awareness, they [prison officers] will continue to feel that the prisoners on the unit are not a priority.'* (Health Care Senior Officer)

## 2. A single national information database

Respondents felt that the transfer process could be greatly improved if they had access to a single national database of information on offenders that covered the NHS and the CJS, which would speed up the time it was taking to collate information required by the Ministry of Justice.

*'If there was a link between the NHS system and the prison system, where we could just transfer information across, that would be hugely helpful.'* (Clinical Team Leader)

*'Some sort of centralised database with all the relevant information on ... different groups of people need access to different bits of information ... and everyone is vying for each others' time and help ... And then sometimes it gets difficult to actually get physically access to hard copies of the information you really need.'* (RMN)

## 3. Policy changes

Some respondents felt that particular policy changes were needed to improve the transfer process. Some felt that the Mental Health Act 1983 should change so that it could apply to mentally disordered offenders held in prisons:

*'There needs to be a part of the Mental Health Act that applies to prisoners with mental health problems who are waiting for a bed.'* (Clinical Team Leader)

It was also felt that people with mental health problems should be diverted to hospitals from the courts, rather than being sent initially to prison only to be transferred out again:

*'If people didn't come into prison in the first place ... We get warnings, on a daily basis, about people coming in with mental health problems ... They don't have to come here. We get people regularly, who are seen in the courts and we then have to get the warden to say the person is suffering from schizophrenia. He'll probably be going to a mental health unit, but they'll still send him to prison knowing that he'll be sectioned three or four weeks down the line.'* (Deputy In-Patient Manager)

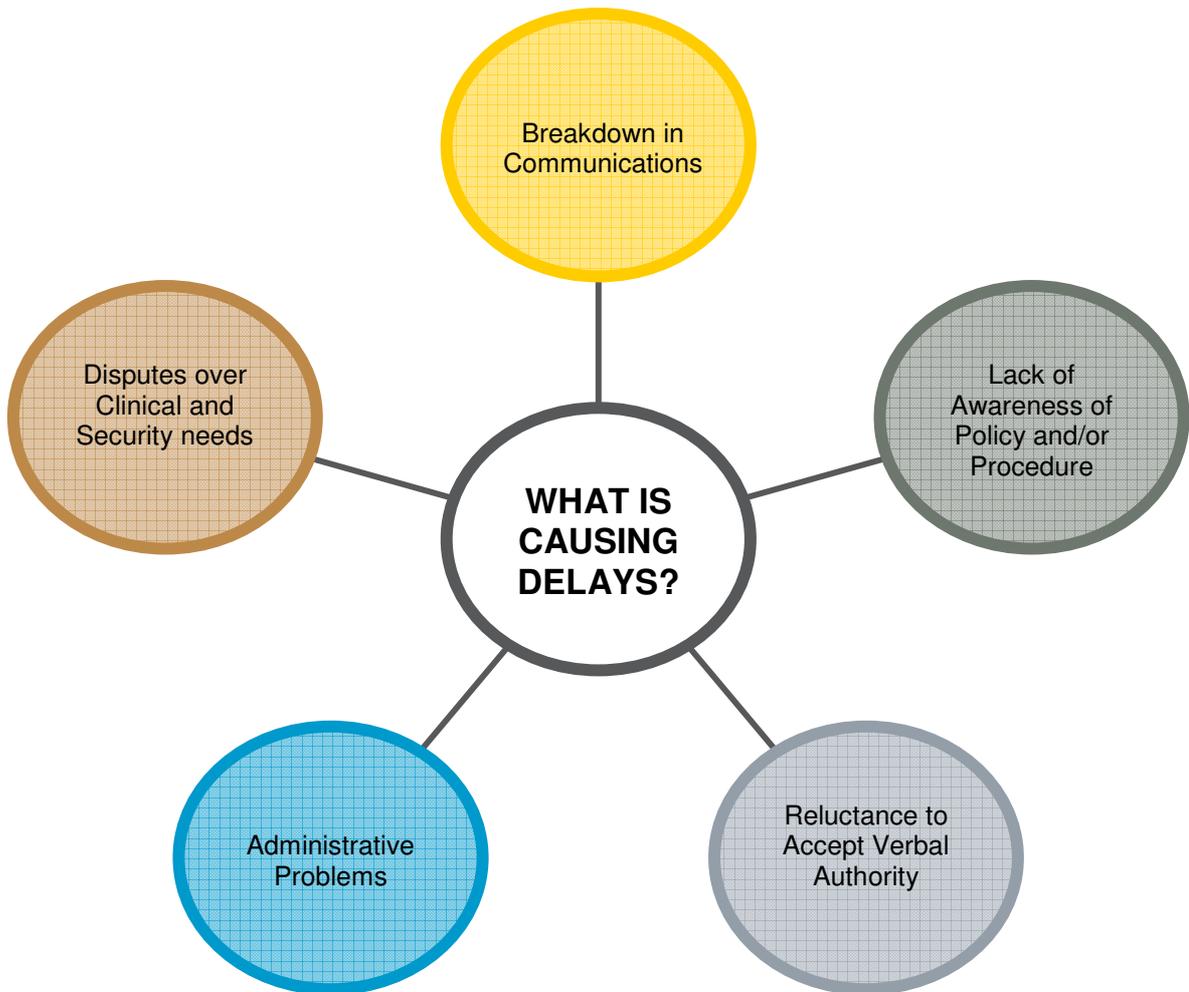
*'Why come back to prison to wait a couple of days for us to arrange a transfer to take them to hospital? They should go straight from court to hospital ...'* (Senior Clinician)

Finally, many respondents said that a time limit within which transfers should take place would be beneficial, enabling quicker responses to referrals and assessments to be made.

## ***II: Interviews with Mental Health Unit staff***

Five themes relating to the efficiency of the transfer process emerged from the interviews with Mental Health Unit staff, which are illustrated schematically in figure 5.

**Figure 5: Schematic representation of perceived reasons for delays in the transfer process (perspectives of Mental Health Unit staff)**



## Breakdown in Communications

As with the prison-based respondents, these participants perceived general communication problems between the MHU and the prisons. However, communications between the MHU and receiving mental health units was generally viewed to be better, although relatively less frequent.

*'Between us and the hospitals, I think [communication is] quite good. The downfall is with the prisons.'* (Caseworker)

MHU staff had experienced ineffective communication within prison departments, especially between discipline and healthcare staff:

*'The discipline staff don't really understand the healthcare side ... The two don't talk to each other ...'* (Casework Manager)

MHU staff often spent time liaising with both discipline and healthcare departments, trying to establish who was managing the transfer in order to collate the necessary paperwork. They described this as time-consuming and perceived lack of communication between departments to be the main reason for delays.

## Administrative Problems

The production of warrants could be delayed because of insufficient information being forwarded to the MHU, resulting in them having to follow up this information.

*'Sometimes they'll just send through the medical reports, which is no help whatsoever because you can't do anything until you've got the H1004 ... because you need the name of the court and offence ... It's just hit and miss, depending on which prison you are dealing with.'* (Casework Team Leader)

Information was often held up by prisons as they had to apply to external agencies, such as the courts or receiving hospitals:

*'We hope to have details of the index offence and previous convictions ... [but] ... we always have to ask for it. This is our difficulty - actually obtaining the information that we need. 95% of the cases sent to us lack any information of the index offence or original police report, which means we have to go back to the prison, usually several times, to ask for the information.'* (Caseworker)

When asked whether this could delay the transfer process, it was suggested that

*'it could do, but we shouldn't stop transferring simply because we don't have the right information to hand ... This is where we are in danger of losing somebody's life, depending on the nature and degree of the illness. Also, we are looking at whether he or she poses a risk of harm ... Was it a violent offence?'* (Caseworker)

Some prisons would require the MHU to fax their information requests and sometimes to confirm the information that was needed, rather than allow the request to be made verbally over the telephone:

*'Sometimes we need to confirm that the dates are correct, and then they want us to fax a request to ask them for this information, and then there is a delay.'* (Caseworker)

*'We have to check the information with the discipline office. Some are happy to do this over the phone, but sometimes they will insist on the admin officer faxing it over to them and then they'll fax us back which is absolutely ridiculous.'* (Casework Team Leader)

## Reluctance to Accept Verbal Authority

Linked to the previous issue, the Mental Health Unit had experienced delays in transfers arising from prisons' reluctance to exchange information with them verbally, which could effectively undermine their authority:

*'Verbal authority can be given, but governors don't have to act on it and, in certain cases, have refused to act on it ... I think it's because the prisons work on paperwork and that's the sticking point.'* (Casework Manager)

Respondents commented on difficulties they encountered facilitating transfers out of hours, despite there being a member of the MHU team on call at weekends for this purpose.

*'I spent the whole of a Friday night and a Sunday talking to the prison, who were quite happy to act. But the assistant governor wasn't. As a result, the patient, who, I was told, could die if they stayed in over the weekend, couldn't be moved, because the assistant governor wouldn't authorise it.'* (Casework Team Leader)

Respondents suggested that not all prisons were aware of the transfers document (Version 3), which states that the MHU can: *'give verbal authority should a transfer be deemed necessary out-of-hours'* which should be *'sufficient to permit the movement of the prisoner'*. There was evidently a lack of awareness of the policy and procedures within some prisons.

## Limited Awareness of Transfer Policy or Procedures

Some respondents said that they commonly liaised with prison-based staff who had poor awareness of their roles and responsibilities in the transfer process. In their experience, some were not aware that the procedural document existed or, if they were aware of it, had not read it.

*'Unfortunately, some [prison staff] don't even know what their role is. We don't usually have a problem with hospitals. the problem is with the Prison Service. They don't seem to understand or appreciate their role in providing us with information. Several times I have had to point them in the right direction – to their Prison Service Instructions.'* (Caseworker)

Again, respondents identified the problem of having many people from different departments or agencies involved in the transfer process, increasing the complexity of decision-making.

*'Whereas before we were dealing with prison staff in the healthcare centres, transfers are now being affected by outreach and in-reach teams as well.'* (Caseworker)

One respondent suggested that the process would be more efficient if the MHU liaised with just one person within each prison.

### Security Disputes

It is the responsibility of the MHU to evaluate the individual prisoner-patient's level of perceived risk and to then identify the appropriate level of security. The MHU liaises with prisons to obtain all the information necessary to conduct their evaluation. A clinical assessment of need is also undertaken to establish the appropriate destination for the individual. Evidently, the MHU had experienced delays in transfers due to disputes over clinical and security needs, as suggested in the following extract:

*'A prisoner/patient clinically needed conditions of low security, but, on the grounds of national security [he was allegedly a terrorist], he probably needed high secure. The high secure hospital therefore refused him.'*  
(Casework Manager)

Respondents highlighted the need for better assessment tools to evaluate both clinical and security needs, jointly agreed by the Ministry of Justice, the Prison Service and NHS psychiatric units.

### ***Conditions perceived to facilitate effective transfer***

There was general consensus among MHU staff that there was little wrong with the actual transfer procedure; one respondent felt that the sheer numbers of people involved and the turnover of staff made the process difficult:

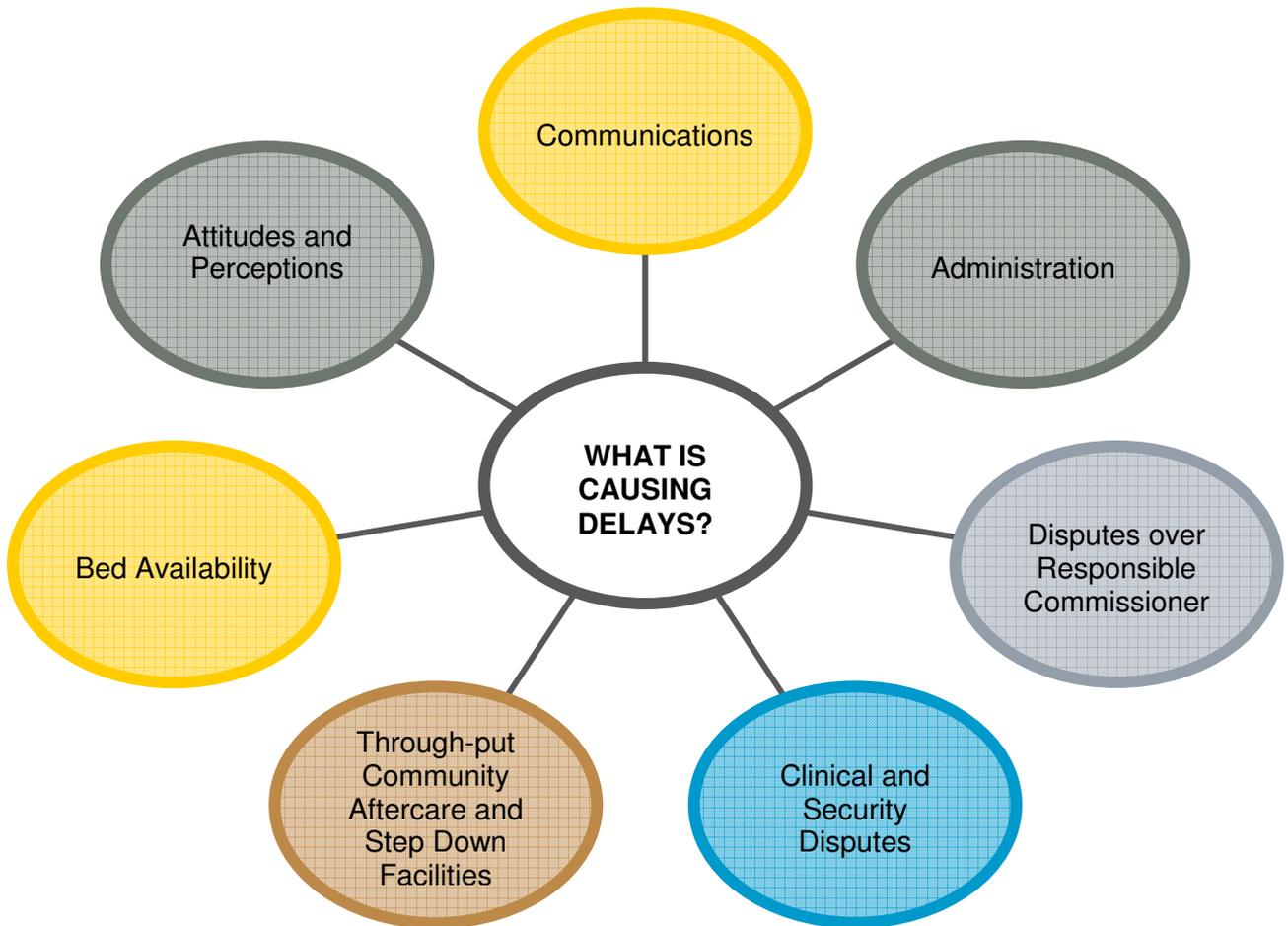
*‘... If anything, it’s the fact that so many people are involved.’* (Casework Manager)

It was suggested that the procedure guidance needed to be more widely disseminated, with refresher training provided as the policy was updated. It was also suggested that prisons would welcome an abridged version. Under-resourced teams could not commit to reading lengthy documentation, whereas more visually-appealing and concise flow charts or posters could bring the process to the forefront of people’s minds, whilst providing signposting to the more in-depth documentation.

### ***III. Interviews with mental health service providers***

Interviews with mental health service providers brought to light very similar issues to those already raised. Respondents provided examples of both causes of delay in the transfer process and of where the transfer process worked well. They expressed their views about the pilot 14-day initiative and its effectiveness, and of the impact of the transfer procedural document. Additionally, they offered suggestions concerning how to improve the transfer process. Seven key themes emerged relating to the efficiency of the transfer process, which are summarised in figure 6.

**Figure 6: Schematic representation of the perceived reasons for delays in the transfer process (mental health service providers).**



## Communication

Several mental health service providers mentioned the negative impact of poor communications on the transfer process.

*'Sometimes the problem is that people don't speak to each other. For example, in one prison, the discipline staff were doing things, healthcare knew about the problems and were dealing with things, in-reach knew about the problems and were dealing with things, and a psychologist was involved ... but no one was speaking to each other ... They didn't manage the process together.'* (Health and Social Care Criminal Justice Lead)

The interviews evidenced good communication with the Mental Health Unit:

*'I think we have a good relationship with the Ministry of Justice. We've had lots of debates with them in the past, where they've said that Mr X can't go to such a unit because it's within 20 miles of the offence being committed, but then we've been able to work with them.'* (Consultant Forensic Psychiatrist)

This was not the case with all regions, though:

*'Some regions do have more difficulty than others, in their links with the Ministry of Justice, which we don't have.'* (Forensic Psychiatrist)

Good communications and positive relationships between agencies were seen as an important and integral part of multi-disciplinary working:

*'We work hard on relationships because we see them as links to people – as a very vital part ... it's like oiling the system ... So we work hard at building and maintaining good relationships by talking to people and working things through with them.'* (Director of Secure Commissioning)

The consequence of negative working relationships was highlighted in terms of their detrimental effect upon the transfers' process:

*'If you have a referral from a prison that you don't have a good relationship with, and traditionally you have problems getting in, you might say, 'I'll leave that one till next week'. But if a referral comes in from a prison where you have a good working relationship, where you can get in and out very quickly, you may think, 'Yes, I'll go there tomorrow'. If this aspect of the relationship was improved, I think it would help improve assessment times and transfer times.'* (Forensic Psychiatrist)

It was felt to be easier to build up relationships with prisons in the local area than with those further afield:

*'We have very good links with the various remand prisons, whereas this is more difficult over greater geographical distances; the assessments become more difficult to organise ... If you have a good working relationship with colleagues in the prisons, it then helps at all levels of the transfer process and, obviously, you get to know and trust people ... That level of personal contact is extremely important.'* (Consultant Forensic Psychiatrist)

*'We deal mainly with Prison X and Prison Y, which are the two main prisons we get people in from ... and we have a good relationship with them. Sometimes we'll get people in from other prisons and, obviously, it can then be a little bit more restricted because we don't have the constant communication like we do with the two local prisons. The communication helps in getting people here quicker.'* (Mental Health Co-ordinator)

*'We generally have good links with local prisons, but when we are dealing with prisons out of the area, we don't have as good a communication network, which can delay the process.'* (Consultant Forensic Psychiatrist)

These statements suggest that proximity can affect timely transfers. Liaison with prisons outside the local area could make it more difficult to establish and maintain good working relationships between agencies. Contacts had to first be made, and then new relationships established. This was stated as time-consuming and would inevitably slow down the transfer process. However, distance was not an issue for everyone:

*'If we have someone who's serving a prison sentence, quite often they will be from out of the area. We've never found it to be that much of a problem, as long as we have the point of contact with the consultant who's in charge of them, and the bed manager.'* (Forensic Psychiatrist)

In one locality, having a central point of contact seemed to help facilitate the transfer process and aid communication:

*'Having one point of contact with the bed manager and the referral manager is really useful, as the transfer is only dealt with by one person. I think that works really well.'* (Clinical Director of Forensic Services)

### Administration

Some respondents felt that general administrative problems could cause minor disruptions to the transfer process, with delays in paperwork and in the communication of basic information. There was general consensus that most administrative delays occurred between the MHU and the prisons:

*'With the MHU, yes, that has been our main area of an administrative difficulty ... I can think of one example when the section papers and other relevant paperwork were faxed and left in an in-tray of someone on leave.'*  
(Prison Health Customiser)

*'Occasionally there are problems that come up with the Ministry of Justice, usually because the consultant has not filled in a form for the transfer.'*

(Clinical Director of Forensic Services)

Many of the administration problems were perceived to be down to human error:

*'I've always felt we have good system. Occasionally, someone falls through the net and things take a bit longer, but that's usually something administrative. It might be that the referral's got lost, or the assessing doctor's not doing a report; sometimes it might not be signed or something like that, and then it might cause a little bit of a delay ...'* (Mental Health Co-ordinator)

Again, there had been difficulties for some in obtaining all the information required from the prisons, which then held up the production of transfer warrants. However, it was acknowledged by some respondents that prison-based staff did have to deal with a vast quantity of paperwork on a daily basis. There were also minor questions over the timing of paperwork completion:

*'One of the problems is with the PCTs' Section 47/48 recommendation, whether this should be done as soon as you have seen the patient or whether you should wait for the bed before completing the recommendations.'* (Forensic Psychiatrist)

Likewise, it was also unclear to some who should complete the Section papers.

### Establishing the Responsible Commissioner

As highlighted previously, the transfer procedure document states: *'in no case should disagreements or confusion about establishing the 'responsible commissioner' delay or adversely affect a prisoner's treatment'*. Despite this,

the process of establishing who the responsible commissioner was for a prisoner's healthcare was perceived to be as a key barrier to efficient transfers.

*'If you say, well, "Here's their address ... That's where they're from," then it would be fine. The argument is usually about what period they lived there - Was it truly their address? Does it really count? It's all a question of timescales ... I can think of people who've come out of prison and gone into a bail hostel in area A, then moved to area B, then moved on to a bail hostel in area C. And, actually, they used to live, years ago, in area D. Who's responsible for them? ... This is the kind of mess we can get into, but it shouldn't affect their access to healthcare.'* (Director of Secure Commissioning)

This interviewee acknowledged that disputes *should* be resolved later:

*'There's this battling to and fro ... either us or them would say, "Right, without prejudice, we will place that person while we resolve the dispute." That's what should happen. We can't make someone suffer because we're having a bureaucratic argument about who the responsible commissioner is.'* (Director of Secure Commissioning)

The interviewee also highlighted the need for further changes to the rules of residency:

*'They need to be consistent. They're not consistent across health and social care, so, I would say, it is a major issue for us.'* (Director of Secure Commissioning)

Establishing the responsible commissioner was reportedly a difficult and lengthy process if the person was homeless prior to prison, or if they had lived at several addresses. This could result in the prisoner being wrongly referred to services that were not really responsible for the funding of the prisoner's care:

*'Something that happens frequently is that we'll receive some details, but it is far from clear what the catchment area hospital is, due to the prisoner having no fixed abode, not being registered with a GP, especially with more and more foreign nationals. Often, you are left having to look at the actual offence area. This is a process that could be started in the prisons and, if that could be clarified before referral, than you wouldn't have the problem of the person being seen by the wrong doctor and having to be re-referred.'* (Forensic Psychiatrist)

These interviews were conducted prior to the dissemination of the revised version 4 of the transfer document (October 2007), which provided a more comprehensive guide to establishing the responsible PCT; it is hoped this will further alleviate some of these problems.

#### Bed Availability / Throughput

As mentioned previously, lack of available hospital beds was perceived by prison-based staff to be a major factor affecting the transfer process, and the need for more psychiatric beds was highlighted in many of the interviews. However, mental health service providers suggested it was necessary to look at the bigger picture:

*'The trouble is, you can have as much capacity as you like and I suspect you would still fill it, and more besides. For me, it's working on the care pathways and making sure we have the right people in beds. It may be the case that we've got people stuck in beds who need to move out, either back to the prison system to lower levels of security, or out, with no security at all. I can't justify more capacity, because, actually, we have got the capacity; it's just that it's blocked. It's about the process, through the system ... We have got to see PCTs investing in local services, and there needs to be that through-care pathway for people to step down to ... and it*

*needn't necessarily be provided by the NHS.'* (Director of Secure Commissioning)

*'I think a whole system approach has to be taken ... You would think that the immediate response would be [...] to extend our capacity. But I don't think that's the answer. What we have to do is think of developing more the community services and community facilities to facilitate quicker transfers.'* (Clinical Director of Forensic Services)

These views emphasise the need for better pathways to care, to speed up the through-put of patients. Some respondents felt that there should be better step-down facilities, so that patients could be transferred to lower levels of security, while having access to more community after-care provision when in-patient care is no longer necessary.

*'I have about ten people who are ready for discharge, awaiting funding or community placements, due to the lack of community placements for MDOs. If I could get these out, I could get the ones out of the prisons quicker.'* (Clinical Director of Forensic Services)

A consequence of there not being sufficient aftercare provision was the perceived increased in length of stay within psychiatric facilities, which, in turn, exacerbated the problems of bed availability and thus transfer:

*'Lengths of stay are increasing ... We've got a lot of people out of high secure that didn't need to be in high secure; they just needed long term secure care. And medium secure have had quite a lot of cases over the last couple of years that are over-5-year stayers. So we have to think about how we provide for those ... And if the rehab services were much better, and you had places for them to go to in the community, you could reduce length of stay so that the beds then become available much quicker.'* (Clinical Director of Forensic Services)

Additionally, occupancy levels were directly affecting bed availability in some regions.

*'Units, such as ours, run at 100% bed occupancy. So we don't have empty beds and there are financial penalties if we have an empty bed for any length of time. When we are confronted with someone who needs to be transferred to hospital, someone else needs to be discharged first from that hospital. And you can't guarantee that the discharge will coincide with a prison referral. (Consultant Forensic Psychiatrist)*

On the other hand, one interviewee says that beds were being successfully managed in their unit, ensuring the efficient movement of patients in and out:

*'We are a unit that manages beds well ... The fact that we don't have a waiting list is down to that. We don't bed-block, and the consultant here insists we start planning for discharge as soon as we know they're coming in ... Having that philosophy has helped ... So we can keep moving them through, and have beds available for those who are ill.'* (Mental Health Co-ordinator)

### Security Level Assessments

As previously highlighted, Mental Health Unit staff perceived that disputes could arise when different agencies' disagreed on the appropriate security level for a prisoner-patient. Disagreements arose across the board and were therefore not specific to low, medium or high secure settings.

*'Fairly often, we have disagreements with colleagues over whether a person should be managed in a low secure or a medium secure environment.'* (Consultant Forensic Psychiatrist)

*'Disagreements tend to be with the high to medium interface.'* (Forensic Psychiatrist)

*'Trying to move them into high secure hospitals is where the problems have occurred for us.'* (Prison Health Customiser)

In response to the question, 'Does the transfer process, on the whole, work for you?' the latter respondent replied,

*'... For medium secure, yes, for high secure, no.'* (Prison Health Customiser)

As with the interviews with prison-based staff, disagreements were perceived to arise when prison security decisions clashed with clinical opinions. Prisons, receiving psychiatric units and the Ministry of Justice appeared to all have different reasons for directing a prisoner to a specific unit; sometimes they were judged to need a low level of security on clinical grounds, but were considered a greater security risk from an offending point of view.

*'One of the difficulties we have with prison transfers is when the level of the prisoner's need dictates that they shouldn't go to a secure setting, but then the Ministry of Justice requires that they go to a medium secure unit, because of the nature of the offence.'* (Director of Secure Commissioning)

The general consensus was that low secure units were not always equipped to deal with prisoners or prison transfers, and therefore what was needed was the development of specialist intensive care units for prison transfers.

*'Low secure units are really intensive care units, whose main remit is to admit people from open wards who are acutely disturbed. They weren't set up to deal with prison transfers. I think there is a definite need for dedicated intensive care units to deal with prison transfers.'* (Consultant Forensic Psychiatrist)

A common perception was that it was generally more difficult to find appropriate places for young people, women and those with personality disorders.

*'For young people and women, it is hard to get a prompt transfer, simply because, for the rest of the population, it is difficult to get an appropriate place. With young people, it's about getting them a place near their home, and with women it stems from the location of the female prisons. Women are generally a more complex group where they can have a bit of mental illness and a bit of personality disorder.'* (Health and Social Care Criminal Justice Lead)

### Attitudes and Perceptions

As previously highlighted, the different organisational cultures – primarily of the NHS and the Prison Service – were perceived to foster normative values, attitudes and what were sometimes viewed as prejudices among certain professional groups, regarding mentally disordered offenders. Two quite different examples illustrate this:

*'There's a general degree of reluctance [to visit prisons and assess prisoners with mental health problems] ... I've come across one psychiatrist who said he would retire the day he had to go into a prison to do an assessment.'* (Consultant Forensic Psychiatrist)

*'Low secure units are often staffed by doctors without a huge amount of forensic experience. Because of that, others are quite wary of taking prisoner referrals ... and quite fearful of what that may entail.'* (Consultant Forensic Psychiatrist)

Another example illustrates the care-custody conflict:

*'One could argue that if you need treatment, you shouldn't be kept in a prison setting. But this is a difficult philosophical debate of ... after all,*

*you're being punished for something, but should you carry on in that secure environment? And, actually, it would be a lot cheaper to bring healthcare into the prison setting.'* (Director of Secure Commissioning)

### Working Towards the 14-Day Pilot Scheme Target

Mental health service providers were, on the whole, positive about the 14-day pilot. Some felt that being involved in the pilot had helped them become focused on and galvanised around the transfer agenda. On the other hand, there were others who felt that they would never be able to achieve the 14-day target:

*'Routine transfers are not happening within 14 days ... If we manage a transfer within 6-8 weeks, I think we're doing quite well.'* (Clinical Director of Forensic Services)

*'It takes us four to five weeks, so we wouldn't have made the 14-day period if we had been signed up for the pilot model.'* (Consultant Forensic Psychiatrist)

Moreover, it was also thought that adherence to the 14-day rule could lead to increased use of independent sector beds:

*'Since we've had the 14-day pilot, we're using the independent sector more.'* (Prison Health Customiser)

This, it was felt, would inevitably result in increased costs:

*'There are cost pressures then ... and we already have a budget for private sector placements that we are currently over-spent on.'* (Consultant Forensic Psychiatrist)

*'... We would end up with such a deficit in the independent sector panel ... The cost would be astronomical. We'd then have to pay the penalty if we couldn't manage.'* (Clinical Director of Forensic Services)

Some respondents suggested that the 14-day target could be achieved without utilising independent sector beds, through increasing capacity:

*'I think, initially, the only way we could manage the 14-day initiative, if we had to do it tomorrow, is to massively increase capacity and massively increase the number of beds. They're already cutting back on beds and talking about capping.'* (Clinical Director of Forensic Services)

Once again, the argument reverted back to timely transfers not being achieved, seemingly due to the lack of available beds, and exacerbated by 100% (or near) capacity, which was resulting in increased utilisation of independent sector beds. A more systematic and sustainable approach could be to improve step-down facilities and community after-care provision, thereby improving through-put.

*'It worries me a little, because it is too simplistic to state that the only way we can do 14-day transfers is to increase capacity. Maybe we need to increase capacity initially, but I think what we need in the long term is not capacity ... actually, we have to think of through-put ... then I think we can probably manage 14 days.'* (Clinical Director of Forensic Services)

### Awareness of Transfer Policy and Guidance

All the mental health service providers interviewed said that they were aware of and, in some cases, had read and had a good understanding of transfer policy and guidance.

One interview was conducted with a Director of Nursing within an Independent Sector Unit. This interviewee had experience of good relations with prisons from across a wide geographic area and had only very infrequently

experienced administrative delays. Prisons they had liaised with had been accommodating in terms of arranging assessments. There had sometimes been delays of three to four weeks, due to inability to contact the Mental Health Unit out-of-hours or during public holidays. At the other end of the treatment journey, however, they had experienced significant delays when prisons had been reluctant to re-admit prisoners on completion of their treatment.

This respondent had not been involved with any security level or clinical disputes, but was familiar with PCTs appearing reluctant to accept commissioning responsibility for prisoners' healthcare. Prejudice on the part of PCTs was thought to stem from the view that healthcare services for the general (non-offender) population should be prioritised above those of prisoners, who were already arguably in a 'place of safety'.

During the interviews, mental health service providers suggested a range of measures that might further improve the transfer process:

1. Improve working relationships and communication systems with prisons and the MHU, particularly focusing on links with agencies outside the geographic areas of receiving units;
2. Employ transfer co-ordinators as single points of contacts within each region;
3. Create a single, unified national information database that covers the NHS and the CJS;
4. Improve and develop community after-care provision and step-down facilities, to increase the through-put of patients and free up beds / in-patient places;
5. Creation a universally accepted and fully validated assessment tool that is sensitive to clinical and security needs and priorities; and
6. Work towards reconciling cultural and value differences of healthcare and offender management professionals, through developing joint training and awareness raising opportunities.

## Summary

Table 7 summarises the most commonly perceived reasons cited for delays in the transfer of prisoners to and from mental health facilities, and illustrates general concordance between the different professional groups.

**Table 7: Sector comparison of most common causes of delays to transfers**

Reason for delay	Sector		
	MHU	Prison	Mental Health Services (MHS)
Breakdown in communication	•	•	•
Administration problems	•	•	•
Bed availability	•	•	•
Delays in establishing the responsible commissioner		•	•
Security disputes	•	•	•
Assessment delays/clinical disputes		•	
Financial disputes		•	
Pressure on staff		•	•
Lack of awareness of policy/procedure	•	•	•
Verbal authority	•		•
Geographical Area			•
Attitudes/Perceptions		•	•

The data reveal consensus across several themes, including the areas of administration, communication, training/awareness, and security disputes.

#### ***IV: Interviews with Prisoner-Patients***

Prisoner-patients were either interviewed in prison, pre-transfer, or in psychiatric units, post-transfer, in order to capture their experiences of the process, and to establish the impact of transfer on their wellbeing. The following short vignettes from participants' interviews illustrate some of their key experiences of the transfer process.

##### **Participant 1**

*'I waited about three weeks in healthcare ... When I was down in healthcare, they sent someone to come and see me once a week. The nurses were always on the phone trying to get me a bed.'*

The prisoner said he had been kept informed and updated whilst awaiting transfer, but was never given a reason for the delay.

The assessments were *'... quite uncomfortable ... There were three of them: one doctor, one nurse ... They spoke to me at healthcare.'*

Anticipating transfer: *'I was quite relieved that I wouldn't have to be ill in my cell anymore.'*

Hospital experience: *'It's quite good ... You can't do anything to hurt yourself.'*

What would improve the process? *'Just quicker, really.'*

## Participant 2

This prisoner had experienced two transfers from prison to hospital. He described his first transfer: *'I waited three months for a second assessment. I was badly treated by the prison staff ... The prison officers would wind me up, telling me there were cameras in the lights. I was not kept informed ... It was stressful, scary and frightening ... It was frightening, as I didn't know what to expect.'*

*Hospital experience: 'The staff at X were brilliant.'*

The second transfer: *'... more swift than the last ... I was notified in writing and kept updated.'*

Benefits of the transfer: *'I was off drugs, I had better family relations and I wasn't as paranoid, scared or frightened.'*

### Participant 3

This participant was severely distressed by the transfer process:

*'When I was transferred, I was unwell ... I was ill in prison, and I didn't know what was going on and what was happening with me.'*

The assessment procedure: *'The doctor came from this (hospital) unit, and the psychiatric doctor from the prison. I didn't understand what was happening with me ... They asked me all kinds of questions, it was terrible. I was thinking that the television was talking to me and I thought if I told them this they wouldn't believe me.'*

*'Nobody told me [what was happening]. They just said they would be sending me to hospital. They didn't tell me when or where ... I didn't know nothing.'*

News of Transfer: *'I thought they were joking about the hospital ... I thought I was going to a Polish prison where they kill people ... those were my thoughts.'*

Hospital experience: *'Because I am not well, I think this is a good place, as they help me very much. I am not thinking about the Polish prison anymore. Everything is positive.'*

Reflections of Transfer: *'I know everything now [...] They were nice to me.'*

#### Participant 4

This participant reported positive experience of the transfer process, both within the prison and at the receiving psychiatric unit, although the waiting time was about 6-8 weeks: *'I was waiting about two months, a month and a half ... It went quite quickly ... I was told there was a long waiting list, I was told I had to wait my turn ... It wasn't too long.'*

[The doctors] *'... saw me two or three times [and] they kept me informed of what was going on ....I didn't know what to expect.'*

*'It went quite smoothly ... I was here [hospital] within an hour, and was treated quite nicely when I got here.'*

## Participant 5

This participant had a negative transfer experience:

*'Originally, I had no help. I was in my cell on the wing, stayed in my cell ... I couldn't explain what was happening ... I was ignored by the prison officers. The healthcare staff were ok – they tried to help ...*

*I was looking for an explanation of what was happening ... but there was no one to talk to.'*

Transfer: *'I was refused at first as they thought I was too dangerous ..... that was four years ago. At the end of my sentence, I was able to be transferred. It was difficult to face things ... I felt like I was on fire, and I wanted to hang myself.'*

*'I would have liked to have seen a counsellor at the time.'*

Hospital Experience: *'It's better than prison ... you get more help and you're treated more like a human being.'*

## Summary

These respondents reported delays before transfer of between three and twelve weeks. Some described being badly treated by prison staff on prison wings and having to endure multiple uncomfortable assessments. Some reported feelings of severe distress, disorientation, fear of the process, or lack of information or support. Some described experiencing suicidal thoughts which stemmed from lack of understanding of what was happening to them. Others, however, reported positive experiences of being kept up-to-date on progress, receiving frequent visits or contact with professionals whilst in healthcare in-patient units, and of relatively smooth transfers. There was a

general sense of relief at no longer having to remain in prison while ill, which was perceived as the most positive outcome of transfer. The need for a counsellor during the transfer process was suggested, and the need to communicate better with foreign nationals who may have had heightened negative experiences.

## **Discussion**

This evaluation was commissioned to assess the extent to which the Department of Health's *Procedure for the transfer of Prisoners to and from Hospital under Sections 47 and 48 of the Mental Health Act 1983* initiative was meeting its objectives of creating and sustaining significant improvements in reducing transfer delays. The four strands of research, guided by the 'trident' model of; outcomes, processes and stakeholder perspectives were as follows:

1. Clinical assessment of the mental state of prisoners identified as possibly requiring transfer;
2. Audit of transfer times;
3. Tracking of the types of care pathways and interventions received whilst in prison awaiting transfer; and
4. Qualitative semi-structured interviews with key informants regarding the transfer process as whole.

### ***Clinical assessment of mental illness***

Part one of the research involved assessing the severity of the psychiatric symptoms of those prisoners awaiting transfer. From the results of the Brief Psychiatric Rating Scale (BPRS) we found that, at the time prisoners were identified as in need of transfer to hospital, mean BPRS scores were 65. This is higher than the mean score of 45 reported for a recent sample of prisoners being monitored under the self-harm/suicide risk management systems (F2052SH/ACCT: Senior et al, 2007).

The mean BPRS score from this study is also higher than numerous other samples of in-patients with schizophrenia, (e.g. Wetzel *et al.*, 1998; Beasley *et al.*, 1996; Puech *et al.*, 1998) and equally as high as one study (Carriere *et al.*, 2000). It is also higher than that reported for a sample of mentally disordered offenders in two UK medium secure units (Gray *et al.*, 2003). Additionally, the sample of prisoners awaiting transfer had scores over a threshold of 53, recently classified as denoting 'marked illness' (Leucht *et al.*, 2005).

Therefore, we can conclude that the sample of prisoners awaiting transfer to hospital under the Mental Health Act 1983 were severely ill, with respect to the intensity of their psychiatric symptoms.

### ***Audit of transfer times***

Part two of the research identified forty-five prisoners in need of transfer to hospital during the study period across the 5 prison sites; 35 transfers were subsequently completed. Of the sample of 35, just over half (54%) were white; over three quarters were men (74%) and just over half the sample (52%) were awaiting sentencing.

Transfers took between 0 and 175 days from first medical assessment to transfer, with an average wait of just under 42 days (median 31.5 days). These figures mark an improvement in transfer waits compared with those previously reported by Hargreaves (1997). Here, delays of up to 390 days were reported for an assessment; 2,453 days from assessment to referral; and up to a further 192 days from acceptance for a bed to actual transfer.

Our waiting time figures are also an improvement in the times reported by McKenzie and Sales (2008). They reported waits of 15-301 days before the formal transfer guidance and 8-148 days after the guidance. Our results also showed that four of the six study prisons had managed to achieve transfers in less than 8 days. On the whole, transfers were significantly quicker for women than men with a mean wait for women at 15 days compared with mean waits

for men of 50 days (median 41.5 days). In one of the prison sites transfer waits were longer than in the other 4 sites; it was identified that 56% (n=5) of the sample of prisoners awaiting transfers from that prison were foreign nationals. Reportedly, it is more difficult to progress transfers for foreign nationals due to particular difficulties in establishing a responsible PCT commissioner and getting them to accept responsibility for the provision of the person's healthcare. The delays in the transfer process can be further exacerbated by a lack of information about the prisoner and by both language and cultural barriers.

### **Recommendation**

*Considering approximately 13% of the prison population in the UK are foreign nationals (Her Majesty's Inspector of Prisons, 2006) we recommend that the mental health and possible transfer needs of foreign nationals be specifically examined by a joint NHS and HMPS working group.*

### ***Tracking of the pathways to care***

Part three of the research tracked pathways of care before and after formal identification for possible transfer. For the month before the formal commencement of the transfer process, there was, in general, little contact with medical and nursing staff; sixty one percent of prisoners were not seen by medical staff and 73% were not seen by nursing staff. However, there were relatively high numbers of adjudications, documented behavioural problems and incidences of self harm, often resulting in increased levels of observation. It appeared that the prisoners who were subsequently identified for transfer were time-consuming in terms of the demands their presentations placed on management and discipline staff as well as healthcare workers.

## **Recommendation**

*We highlight the need for increased contact with medical and nursing staff before the commencement of formal transfer procedures. As medical and nursing staff rely on referrals from discipline officers we recommend that mental health awareness training for discipline officers should be mandatory, with opportunities for refresher training, to allow prisoners' behaviours to be routinely considered in the context of possible mental health problems.*

The tracking of prisoners after the need for possible transfer was identified showed that input from healthcare staff varied greatly. Practice examples showed that some individuals were monitored closely and seen by healthcare staff daily; however, others had no documented contact or intervention for days. This lack of contact is worrying considering the high levels of psychiatric distress and the elevated risk of suicide in people with mental illness (Shaw, Appleby and Baker, 2003). Some prisoners waited considerable lengths of time from referral to assessment by external clinical teams. In this part of the research, once again it seemed that delays were longest and interventions most infrequent for the foreign nationals.

The results of the tracking exercise indicated that many prisoners are effectively assessed and transferred in a timely manner. However, there were a number for whom transfer (or discontinuation of transfer procedures) continued to take prolonged periods, some also having infrequent healthcare contact or interventions whilst waiting.

## **Recommendation**

*We recommend that, as a consequence of the initiation of the transfer assessment process, an individual care plan based on the Care Programme Approach, is agreed with the prisoner and is implemented. The care plan should state the required frequency of contact which should be proportional to risk and need and specifically consider the possible negative affect of prolonged waits on individuals' wellbeing, mental distress and risk of suicide.*

## **Recommendation**

*We recommend that, where an individual remains on normal location whilst awaiting transfer, a care plan is shared between the prisoner, healthcare staff and discipline staff. It should state any risks present and prescribe required actions in the case of a mental health crisis.*

### ***Qualitative interviews with key informants***

In part four of the research, we interviewed forty-six key informants with direct experience of the transfer process to gather their views on the reasons for delay and ways to improve the process. This process evaluation was highly illuminating and highlighted common reasons behind the delays, many of which were complex and inextricably linked. It was acknowledged that the whole transfer process hinged on communication; yet breakdown in communication was common and occurred between prisons and mental health service providers, and prisons and the Ministry of Justice Mental Health Unit as well as within prison departments themselves. This apparent lack of effective communication was inherent in the differing organisational cultures of the Prison Service and the National Health Service.

The transfer process, in order to be effective, needs effective collaborative working within and among a multitude of different agencies. Functional issues were highlighted with the transfer process but fundamentally it seemed there was a clash of cultures manifested in the underlying professional belief systems of employees. Attitudes and perceptions of mental illness differed between discipline and healthcare workers as did the understanding of offender populations. The main role of prisons is to provide security and the provision of healthcare is a secondary function. It is likely therefore, that healthcare professionals working within a prison setting experience first hand care-custody conflict.

Historically, there have been negative attitudes/perceptions towards prisoners. Studies have reported reluctance of local NHS hospitals to accept prisoner/patients (DHSS, 1975; Robertson *et al.*, 1994). Some negative attitudes were still evident throughout the interviews. What appeared to be lacking was a unified perspective with regard to the needs of mentally ill prisoners and where they would be best placed. This was highlighted during the interviews with numerous people referring to a need to be '*singing from the same song sheet*' suggesting that this is currently not always the case.

However, there was also evidence of effective communication and collaborative links, with functioning multi-disciplinary teams both within and between prisons and receiving hospital units. Interviewees agreed that, where this was the case, the transfer process operated more quickly and smoothly. It was also commonly believed that the process was better facilitated with agencies in close geographical proximity to each other. It was stated that once pathways and professional relationships between agencies were established, those relationships could be effectively fostered.

### **Recommendation**

*We recommend that joint training opportunities for both prison-based healthcare and discipline staff, along with NHS colleagues, be developed around the issues and challenges inherent in dealing with severely mentally ill people in prison. Joint training will encourage the breaking down of role-related cultural norms and engender a sense of shared purpose. The 14-day pilot initiative is an ideal vehicle through which to trial such training.*

All sectors reported administration problems. The main delay arises early on in the process when prison staff are required to obtain all the prisoner's offence details, previous convictions, behavioural records, court indictments and medical practitioners' recommendations. They do not always have this information and have to request this from different CJS departments. This almost inevitably delayed the production of the warrant at the MHU. It was suggested that one national information database would alleviate these delays. This would consist of an electronic system that is both secure and safeguarded. Stepped access could be used to ensure that only professionals who need to know information about a person can readily access it. The research team (JS, JJS) is currently piloting research in this area. Until then it may be useful to incorporate into the transfer guidance, assistance for prison healthcare staff as to where they can obtain documents needed for the H1003/MHU.

## **Recommendation**

*We recommend that ways of streamlining this information gathering process be trialled. This is likely to involve the following: an examination of the roles of all agencies across the CJS to determine data each agency is best placed to provide, and how that can best be achieved; and whether this be electronically, or by having named responsible individuals.*

## **Recommendation**

*We recommend that in the age of electronic transfer of information verbal instruction should only be used if all other means of electronic transfer are not possible. Verbal authority should only be used in an extreme emergency and should be followed up with written authorisation at the earliest opportunity. This would need to be agreed by all parties and incorporated into the DH guidance if adopted.*

## **Recommendation**

*We recommend that a small booklet and poster/wall chart versions of the transfers' procedure guidance should be made available, including a version for prisoners.*

Isherwood and Parrott (2002) found that delays in transfers were often due to a lack of available psychiatric beds. This was also a common perception among prison-based staff and some mental health service staff. However, a number of staff working in psychiatric units suggested that merely increasing bed capacity was not a long term solution. Rather, what was needed was a whole system approach in terms of better provision of community aftercare and increased access to step down facilities; this has also been suggested by McKenzie and Sales (2008). A current perceived deficit in community aftercare provision was thought to contribute to increased length of stays and the 'silting up' of the system from high security downwards. Additionally, and

exacerbating the problem further was the fact that most units run at 100% capacity with penalties for having vacant beds for any length of time.

### **Recommendation**

*We recommend that further national research is undertaken into the issue of the perceived lack of timely process through the secure mental health system. This needs to concentrate on identifying best practice, in terms of facilitating progress and movement and ensuring that people are always located in the lowest level of security which safely and proactively meets their clinical needs. There is a need to review levels of bed occupancy in secure units, and examine step down facilities to the community.*

### **Recommendation**

*We recommend that there should be an increase in the use of appropriate court diversion schemes for people with mental illness at earlier stages of the criminal justice system, for example from police custody or courts.*

Isherwood and Parrott (2002) reported that delays in transfer increased with increasing security levels. This was confirmed by the current research. Additionally, it was suggested that better aftercare provision for re-entry into the community post psychiatric admission would free up beds in low secure units which would enable patients to be stepped down through security levels. This in turn would free up beds at the higher security levels for those assessed as requiring this, whether from the community or via prison transfers.

### **Recommendation**

*We recommend that best practice models in community mental healthcare provision for ex-offenders who have spent time in secure mental health services be identified and disseminated.*

The interviews highlighted that some delays were still occurring in trying to establish responsible commissioners; as discussed this was particularly the case for foreign national prisoners. However, staff were aware of the newly updated policy document which had already taken steps to alleviate these issues by stating *'in no case should disagreements or confusion about establishing the 'responsible commissioner' delay of adversely affect a prisoner's treatment'*. Inextricably linked into establishing the responsible commissioner, were issues of finding a bed appropriate for both the patient's clinical and security needs.

### **Recommendation**

*We recommend that a set time limit be imposed on the initial attempt to establish the responsible commissioner, after which the PCT responsible for the health services in the prison in which the "disputed" prisoner is located should accept responsibility for funding placement, at least temporarily, so as to allow the person to be transferred without further administrative delay.*

It has become apparent that prisons, receiving psychiatric units and the Ministry of Justice routinely make their own assessments of clinical and security needs. Competing perspectives, both within and between agencies arise when the identified clinical needs impinge or conflict with identified security needs. It was also stated that some people may need a certain level of security, but not necessarily within a forensic directorate. Or, indeed, that security needs can be dictated more by general public/media conceptions of mentally disordered offenders, or by an individual's particular media or political profile, than strict clinical or risk necessity. It was evident from the interviews that staff from all professional groups perceived a need for a universally agreed security need/risk assessment tool. This would need to incorporate clinical and security needs of the patient and incorporate government considerations such as notoriety and victim issues with the aim of better identifying the appropriate level of security for the individual patient and thus improving more timely transfers.

Previous research has consistently shown security/clinical disputes as an issue affecting timely transfers (Robertson *et al.*, 1994; Isherwood and Parrott, 2002). The current research highlighted a need for better integration of the working practices of all agencies involved in the transfer process. It is understandable that different assessments currently being conducted by each agency are undertaken in response to their organisational goals. The MHU has a duty to consider factors such as victim issues and notoriety. Similarly, mental health services have a duty to consider clinical and risk aspects and a prisoner's/patient's likelihood of benefitting from the facilities provided by their units. That said, a unification of procedures across agencies would both reduce paperwork and ultimately reduce the prisoners' suffering endured by virtue of remaining potentially inadequately or untreated for a mental illness within a prison.

### **Recommendation**

*We recommend that work is undertaken to develop a new tool, or adapt existing tools, to provide an effective single risk and clinical assessment instrument which fulfils the requirements of all stakeholders and that agreement for all to accept the implementation of this one stage assessment process is sought. This could be based upon the principles of the Security Needs Assessment Profile (S.N.A.P, Collins and Davies, 2005). S.N.A.P measures security needs across open, low, medium and high secure services and provides a security needs profile that is able to match a patient to a service. This could be adapted for prison to hospital transfers.*

### **Recommendation**

*We recommend that, following evaluation of early implementer sites, the 14 day initiative for transfers should be implemented nationally.*

The prisoner interviews highlighted that disputes between prisons, mental health services and the Mental Health Unit can negatively affect their

wellbeing. People are already experiencing heightened distress by virtue of being mentally ill and they reported feelings of distress, isolation, disorientation, fear of the whole process, with thoughts of suicide. This suffering is exacerbated with prolonged waits for a transfer to hospital. As one interviewee stated '*we can't make someone suffer because we are having bureaucratic arguments*'.

## **Recommendation**

*We recommend that prisoners be regarded as an active partner in the process of transfer. This can be formalised through care planning under the Care Programme Approach, with required actions for staff to keep people apprised of progress.*

## **Conclusion**

It is clear from this research that significant improvements have been made in the transfer process since the publication of the new procedural document.

The findings of this research report the lowest ever waiting times for a prison to hospital transfer under the Mental Health Act 1983. Those involved in the process attributed this, in part, to better collaboration within and between agencies in some areas. The establishment of such links between agencies has improved communication within and between multi-disciplinary teams and there is evidence to suggest that these relationships are continuing to grow with cross governmental partnerships.

There have been reports that the 14-day pilots have been successful in facilitating speedier transfers by raising awareness of the complex reasons for delay. The pilot schemes also appear to have generated a degree of healthy competition as services work together to avoid failure. Consequently, there

was agreement among interviewees that it should be implemented more widely.

This research reports at an interesting and potentially exciting time for those involved in the care of people with mental health problems who are in contact with the criminal justice system.

The Department of Health has just completed a period of public consultation on a wide-ranging, cross agency strategy designed to better serve the health needs of people in contact with police, courts, prisons and probation services. Alongside the proposed strategy, an independent review of diversion away from the criminal justice system for people with mental health problems is underway, under the chairmanship of Lord Bradley. The results of both pieces of work are due for publication in the first few months of 2009. Both the DH strategy and the independent review acknowledge that offenders suffer health inequalities and wider social disadvantage and exclusion which can perpetuate their offending behaviours and that, through tackling the former, a positive impact on the latter may result.

For those people in prison who are so severely mentally ill as to require transfer to hospital under mental health legislation, emphasis on both the *macro* societal issues addressed by the strategy and independent review, and attention to the *micro* issues addressed by the transfer procedures document evaluated in this research, positive change cannot come too soon.

### ***Limitations***

The greatest limitation of the research is the small sample size, although, considering that transfer to hospital is a relatively rare event, the sample does represent a large proportion of the transfers taking place within the study period at the respective sites. However, generalisation from this research needs to be treated with caution for the following reasons:

Although every attempt was made to select prisons across geographical areas, transfer times and procedures may vary greatly between establishments across the UK.

The abnormal distribution of transfer waits for men, together with there only being one female establishment in the research means that any comparison between transfer delays for men and women should be treated with caution.

Although transfer waits for prisoners of a foreign national origin were reported to be lengthy, this was only noted in one prison establishment whilst attempting to understand the overall increased delays at that site in comparison to the others.

It was reported that collating information for research purposes whilst being responsible for the daily clinical care of patients with serious mental illnesses was very challenging. The tracking exercise suffered most as a result. Therefore, it was only possible to present the information that was recorded. Subsequently, contact with medical and nursing staff may have been more frequent but unrecorded.

The research study methods were well triangulated with findings being repeatedly supported across methods. In hindsight, it may have been useful to assess changes in implementation of the transfer procedure both pre and post the Department of Health guidance. Similarly, it may have been useful to conduct a post guidance comparison between sites that did and did not participate in the 14 day pilot initiative.

## References

### *Introduction*

Birmingham, L. (1999) Between prison and the community: the revolving door psychiatry patients of the nineties. *British Journal of Psychiatry* 174, 378-379.

Birmingham, L. (2001) Screening prisoners for psychiatric illness: who benefits? *Psychiatric Bulletin* 25, 462-464.

Birmingham, L. (2004) Mental disorder and prisons. *Psychiatric Bulletin* 28, 393-397.

Brooke, D., Taylor, C., Gunn, J and Maden, A (1996) Point prevalence of mental disorder in unconvicted male prisoners in England and Wales. *British Medical Journal* 313, 1524-1527.

Cheadle, J., and Ditchfield, J. (1982) Sentenced mentally ill offenders. London: *Home Office Research and Planning Unit*.

Coid, J.W (1988) Mentally abnormal prisoners on remand: I- Rejected or accepted by the NHS? *British Medical Journal*. 296, 1779-1782

Coid, J., Petruckvitch, A., Bebbington, P., Jenkins, R., Brugha, T., Lewis, G., Farnell, M and Singleton, N (2003) Psychiatric morbidity in prisoners and solitary cellular confinement, II: special ('strip') cells. *Journal of Forensic Psychiatry and Psychology* 14, 320-340.

Dell, S., Robertson, G., James, K and Grounds, A. (1993) Remands and psychiatric assessments in Holloway prison I: The psychotic population. *British Journal of Psychiatry* 163, 634-640.

Department of Health (2005) Procedure for the transfer of prisoners to and from hospital under sections 47 and 48 of the 'Mental Health Act 1983'. London: Department of Health.

Department of Health and Ministry of Justice (2007) Procedure for the transfer of prisoners to and from hospital under sections 47 and 48 of the 'Mental Health Act 1983'. London. Department of Health.

DHSS (1975) Report on the committee on mentally abnormal offenders CAA 6244. London, HMSO.

Earthrowl, M., O'Grady, J., and Birmingham, L. (2003) Providing treatment to prisoners with mental disorders: development of a policy. Selective literature review and expert consultation exercise. British Journal of Psychiatry, 182, 299-302.

Farrar, M. (1996) Government policy on mentally disordered offenders and its implementation. Journal of Mental Health 5, 465-474.

Grounds, A. (1990) Transfer of sentenced prisoners to hospital. Criminal Law Review, 37, 554-551.

Grounds, A. (1991) The transfer of sentenced prisoners to hospital 1960-1983: Study in One Special Hospital. British Journal of Criminology, 31 (1), 54-71.

Gunn, J., Maden, A. and Swinton, M. (1991) Treatment needs of prisoners with psychiatric disorder. British Medical Journal 303, 338-41.

Hargreaves, D (1997) The transfer of severely mentally ill prisoners from HMP Wakefield: A descriptive study. Journal of Forensic Psychiatry 8, 62-73.

Information Centre (2006) Inpatients formally detained in hospital under the Mental Health Act 1983 and other legislation, England: 1994-5 to 2004-5. Information Centre.

Isherwood, S. and Parrott, J (2002) Audit of transfers under the Mental Health Act from prison – the impact of organisational change. Psychiatric Bulletin 26, 388-370.

McKenzie N and Sales B (2008) New procedures to cut delays in transfer for mentally ill prisoners to hospital, Psychiatric Bulletin 32, 20-22

Office for National Statistics (1998) Psychiatric Morbidity among Prisoners in England and Wales. London. The Stationery Office.

Parker and Tennent, (1979) The 1959 Mental Health Act and mentally abnormal offenders: a comparative study. Medicine, Science and Law 19, 29-38.

Penal Affairs Consortium. (1998) An unsuitable place for treatment: Diverting mentally disordered offenders from custody. London. Penal Affairs Consortium.

Robertson, G., Dell, S., James, K. and Grounds, A (1994) Psychotic men remanded in custody to Brixton prison. British Journal of Psychiatry, 164, 55-61.

Rutherford, H and Taylor, P.J (2004) The transfer of women offenders with mental disorder from prison to hospital. Journal of Forensic Psychiatry and Psychology 15, 108-123.

Singleton, N., Meltzer, H., Gatward, R., Coid, J., and Deasy, D., (1998) Survey of psychiatric morbidity among prisoners in England and Wales. London: Department of Health.

Skegg, K and Cox, B (1991) Impact of psychiatric services on prison suicide. *The Lancet* 338, 1436-1438.

Walker, N. and McCabe, S. (1973). Crime and insanity in England, vol 2. New solutions and new problems. *Edinburgh University Press*.

### **Method**

Calnan, M and Ferlie, E (2003) Analysing process in healthcare: the methodological and theoretical challenges. *Policy and Politics* 31(2), 185-193.

Curtin, M and Fossey, E (2007) Appraising the trustworthiness of qualitative studies: guidelines for Occupational Therapists, *Australian Occupational Therapy Journal*, 54, 88-94.

Nvivo7, QSR International Pty Limited (2007) [www.qsrinternational.com](http://www.qsrinternational.com)

Overall, J.E. and Gorman, D.R. (1962) The Brief Psychiatric Rating Scale. *Psychological Reports* 10, 799-812.

Senior, J., Hayes, A.J., Pratt, D., Thomas, S.D., Fahy, T., Leese, M., Bowen, A., Taylor, G., Lever-Green, G., Graham, T., Pearson, A., Ahmed, M., Shaw, J. (2007) The identification and management of suicide risk in local prisons. *The Journal of Forensic Psychiatry and Psychology* 18 (3), 368-380

Shaw, J., Senior, J., Hayes, A. et al (2006) Evaluation of the care of at risk prisoners project, Report to Safer Custody Group, *HMPS*

### **Results**

Beasley, C. M., Tollefson, G. D., Tran, P et al (1996) Olanzapine versus haloperidol and placebo: acute phase results of the American double-blind olanzapine trial, *Neuropsychopharmacology*, 14, 111-123.

Carriere, P., Bonhomme, D and Lemperiere, T (2000) Amisulpride has superior benefit/risk profile to haloperidol in schizophrenia: results of a multicentre, double-blind study (The Amisulpride Study Group), *European Psychiatry*, 15, 321-329.

Gray, N. S., McGleish, A., MacCulloch, M. J., Hill, C., Timmons, D and Snowden, R. J. (2003) Prediction of violence and self-harm in mentally disordered offenders: A prospective study of the efficacy of HCR-20, PCL-R, and psychiatric symptomology, *Journal of Consulting and Clinical Psychology*, 71 (3), 443-451.

Guy, W (1976) Clinical global impressions: in ECDEU, Assessment manual for psychopharmacology pp 218-222, Revised DHEW pub (ADM) Rockville MD: National Institute for Mental Health.

Leucht, S., Kane, J. M., Kissling, W., Hamann, J., Etschel, E and Engel, R (2005) Clinical implications of the Brief Psychiatric Rating Scale scores, *British Journal of Psychiatry*, 187, 366-371

Peuch, A., Fleurot, O and Rein, W (1998) amisulpride, an atypical antipsychotic , in the treatment of acute episodes of schizophrenia; a dose ranging study v haloperidol. *Acta Psychiatrica Scandinavica*, 98, 65-72.

Walsh, E., (2007) The emotional labour of nurses working in HM Prison Service. Personal Correspondence, *University of Leeds*.

Wetzel, H., Grunder, G., Hillert, A et al (1998), Amisulpride versus flupentixol in schizophrenia with predominantly positive symptomology – a double-blind controlled study comparing a selective D-2 like antagonist to a mixed D-1/D-2 like antagonist, *Psychopharmacology*, 137, 223-232

Ministry of Justice population in custody for England and Wales, monthly tables. [www.justice.gov.uk/publications/populationincustody.htm](http://www.justice.gov.uk/publications/populationincustody.htm)

## **Discussion**

Her Majesty's Inspector of Prisons, Foreign national prisoners: a thematic review, July 2006

Shaw, J., Appleby, L. and Baker, D (2003) Safer prisons: A national study of prison suicides 1999-2000 by the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness, Department of Health, [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4130857](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4130857) (retrieved on 29th October, 2008)

## **Recommendations**

Collins, M., and Davies, D (2005) The security needs assessment profile: A multidimensional approach to measuring security needs, International Journal of Forensic Mental Health, Vol 4 (1), 39-52

## Appendices

### *Appendix 1: Breakdown of stakeholder interviews by job title*

<b>Job titles</b>	<b>Sector</b>	<b>Number interviewed</b>
Registered mental nurses	Prison	6
Social workers	Prison	1
Clinical team leader	Prison	2
Senior nurse manager	Prison	2
Community psychiatric nurse	Prison	1
Transfer co-ordinator	Prison	1
Healthcare officer	Prison	1
Head of psychology	Prison	1
Administrator	Prison	1
Consultant forensic psychologist	Prison	1
Healthcare manager	Prison	1
Head of healthcare	Prison	1
Prison health customiser	Mental health services	1
Deputy in-patient manager	Prison	1
Secretary in healthcare unit	Prison	1
MHU caseworkers	MHU	3
MHU casework manager	MHU	1
Clinical head psychiatrist	Prison	1
Locum staff grade psychiatrist	Prison	1
Associate specialist psychiatrist	Prison	1
Senior clinician/nurse prescriber	Prison	1
Visiting psychiatrist	Prison	1
Clinical lead/consultant adolescent psychiatrist	Prison	1
Consultant forensic psychiatrists	Mental Health Services	2
Health and social care criminal justice lead	Mental Health Services	1
Head of secure commissioning	Mental Health Services	1
Director of secure commissioning	Mental Health Services	1
Clinical director of healthcare	Mental Health Services	1
Clinical director of forensic services	Mental Health Services	1
MH co-ordinator	Mental Health Services	1
Prisoner/patients		5
Director of nursing	MHS Independent Sector	1
<b>Total interviews</b>		<b>46</b>

**Appendix 2: Demographic characteristics of prisoners awaiting transfer**

<b>Prison</b>	<b>N<sup>12</sup></b>	<b>Percentages<sup>13</sup></b>
A	12	26%
B	8	17%
C	11	24%
D	4	9%
E	11	24%
<b>Totals</b>	<b>46</b>	<b>100%</b>
<b>Gender</b>		
Men	34	74%
Women	12	26%
<b>Totals</b>	<b>46</b>	<b>100%</b>
<b>Marital Status</b>		
Married/Partner	4	9%
Single	31	67%
Divorced/Separated	3	7%
Other	1	2%
Missing Data	7	15%
<b>Totals</b>	<b>46</b>	<b>100%</b>
<b>Ethnicity</b>		
Asian	3	7%
Black	12	25%
White	25	54%
Other	3	7%
Missing Data	3	7%
<b>Totals</b>	<b>46</b>	<b>100%</b>
<b>Security Category</b>		
B	23	50%
Women	12	26%
Young Offenders	8	18%
Other	2	4%
Missing Data	1	2%
<b>Totals</b>	<b>46</b>	<b>100%</b>
<b>Age (minus Y.Os)</b>		
Under 21	2	5%
21-30	11	30%
31-40	19	51%
41-50	4	11%
50+	1	3%
<b>Totals</b>	<b>37</b>	<b>100%</b>
<b>MAPPA Level</b>		
1	18	39%
2	1	2%
3	0	0
4	2	4%
N/A or Not Assessed	14	31%

<sup>12</sup> N=46 here due to two transfers for one prisoner completed during the study period.

<sup>13</sup> Percentages rounded to equal 100.

Missing Data	11	24%
<b>Totals</b>	<b>46</b>	<b>100%</b>
<b>Status</b>		
Remand	24	52%
Convicted	17	37%
Missing Data	5	11%
<b>Totals</b>	<b>46</b>	<b>100%</b>
<b>Index Offence</b>		
Violence	13	28%
Sexual	1	2%
Acquisitive	3	7%
Robbery	6	13%
Other	13	28%
Missing Data	10	22%
<b>Totals</b>	<b>46</b>	<b>100%</b>
<b>Time in Custody (Current)</b>		
Less than 3 days	3	7%
Less than 1 week	2	4%
Less than 2 weeks	7	15%
Less than 3 weeks	1	2%
Less than 1 month	4	9%
Less than 2 months	4	9%
Less than 3 months	1	2%
Less than 6 months	2	4%
Over 6 months	12	26%
Missing Data	10	22%
<b>Totals</b>	<b>46</b>	<b>100%</b>
<b>Length of Sentence</b>		
Not applicable	22	48%
Less than 6 months	3	7%
Less than 1 year	2	4%
Less than 5 years	4	9%
Less than 10 years	2	4%
Life	2	4%
Other	2	4%
Missing Data	9	20%
<b>Totals</b>	<b>46</b>	<b>100%</b>
<b>Regime</b>		
Basic	9	20%
Standard	22	48%
Enhanced	0	0
N/A	3	6%
Missing Data	12	26%
<b>Totals</b>	<b>46</b>	<b>100%</b>

### Appendix 3: Inferential statistics for BPRS

Domains on the BPRS	Mean score per domain
Somatic concern	2.32
Anxiety	3.57
Depression	2.62
Guilt	1.62
Hostility	4.22*
Suspiciousness	5.26*
Unusual thought content	4.79*
Grandiosity	2.57
Hallucinations	3.67
Disorientation	1.65
Suicidality	1.67
Self-neglect	2.79
Bizarre behaviour	3.18
Elevated mood	2.38
Conceptual disorganisation	2.36
Excitement	3.33
Motor retardation	0.1
Blunted affect	1.54
Tension	3.26
Mannerisms/posturing	2.59
Un-cooperativeness	3.74
Emotional withdrawal	2.91
Motor hyperactivity	2.91
Distractibility	3.23
<b>Pathological domains *(Scores &gt; 4)</b>	<b>3</b>
<b>Non-pathological domains (Scores &lt; 4)</b>	<b>21</b>