Prison transfers

A survey from the Royal College of Psychiatrists

December 2011
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Executive summary

In his review of people with mental health problems and intellectual disabilities in the criminal justice system, Lord Bradley highlighted unacceptable delays in transferring acutely unwell prisoners to hospital. He recommended the government develop a new minimum target for the National Health Service (NHS) of 14 days to transfer a prisoner with acute, severe mental illness to an appropriate healthcare setting.

The Department of Health is currently working to identify some of the key barriers that have an impact on timely transfers. The Royal College of Psychiatrists consulted with its members who work within prisons and secure healthcare settings across England and Wales. The purpose of this consultation was to explore the issues around prison transfers (Section 47 and Section 48 of the Mental Health Act 1983) with the view to:

1. gauging whether a national 14-day transfer target was considered reasonable
2. identifying key barriers and possible solutions to timely prison transfers.

This consultation concentrated on a number of key areas within the prison transfer process including assessments, information-sharing, bed management, remittance and commissioning.

Although a clear majority of psychiatrists agree that 14 days is a reasonable target to transfer a prisoner with acute, severe mental illness to an appropriate healthcare setting to secure treatment as quickly as possible, there were some reservations about how this could practically be achieved. Many of the problems identified as contributing to the delays in the prison transfer process appear to be administrative, such as information-sharing, poor communication, etc. However, these administrative problems can lead to significant cumulative inefficiencies within the system, which can be costly and result in delays.

The consultation was designed to elicit problems and barriers associated with the prison transfer process and did not explore why psychiatrists thought the target was reasonable, or why they did not think provider assessments were always necessary. So although the majority considered the target reasonable, their reasons were not given. This is an area of great concern for many psychiatrists who participated in this consultation. Therefore, a follow-up questionnaire explored these issues with some participants and their responses are included here. The College would like to build on this work and explore further some of the issues raised as a result of this consultation.
MINIMUM TRANSFER TARGET

The majority of psychiatrists agreed that 14 days was a reasonable target to transfer a prisoner with acute, severe mental illness to an appropriate healthcare setting, and saw costly administrative procedures as the main cause of delays and problems.

They consented that there should be a maximum waiting time for those who are not deemed to be in urgent need of treatment, and that this should not exceed more than approximately 2 months.

ASSESSMENTS

The majority of psychiatrists identified difficulties in accessing the prison estate and clinical resources as well as the availability of resources as two of the most significant barriers to undertaking timely assessments. Just over a quarter of psychiatrists identified difficulties with establishing the responsible authority as a barrier to these assessments.

Improving knowledge and understanding of mental health among prison staff, better coordination of appointment bookings and greater flexibility by the prison estate were all suggested as ways of improving access to the prison to undertake timely assessments.

Most psychiatrists did not agree that a standardised assessment form would facilitate the prison transfer process, citing concerns with the quality of information captured by a form and the time it took to complete it. They also cited other issues, such as bed availability, as being of higher priority than forms.

On most occasions, psychiatrists indicated that they were likely to accept an assessment from a colleague. Knowledge of the assessing clinician and the quality of the assessment report were most likely to influence their decision to accept such an assessment.

Provider assessments were mostly considered always necessary, indicating that such assessments were needed to determine whether the service was able to meet the patient’s needs, to determine the level of risk, and finally, to determine whether the provider service had available resources to admit the patient.

INFORMATION-SHARING

Over a third of psychiatrists identified access to information (such as security records) and issues with the transfer and flow of information both between and within organisations as key barriers to effective information-sharing. A quarter of participants pointed to lack of clarity and understanding about security and confidentiality of data as a key barrier.

Psychiatrists called for greater integration of health and criminal justice information systems; improved awareness and understanding of data confidentiality; and clear protocols on information-sharing to facilitate prison transfer processes.
The majority were on most occasions provided with the appropriate clinical information in prison. However, approximately a third of psychiatrists experienced difficulties in determining a prisoner’s general practitioner (GP) and gaining access to details of a prisoner’s offence.

The majority of psychiatrists thought that the level of security for a prison transfer should be determined by clinical assessment.

**Bed Management**

Identifying and securing an appropriate bed for a prisoner was a problem for the majority of psychiatrists. The main reasons included availability of beds within services (particularly medium secure beds), difficulty establishing responsible authority, and securing funding for independent sector beds when beds cannot be found in the NHS.

Establishing the address and GP of a prisoner were highlighted most commonly as key problems in determining the responsible authority. This appears to be a particular problem for foreign nationals and for prisoners with no fixed address.

**Remittance**

Remitting a patient back to prison was not problematic for the majority of psychiatrists. Of those that did express concerns, psychiatrists highlighted unmet health needs, risk of relapse and lack of follow-up as reasons for being reluctant to remit.

The majority of psychiatrists did not apply the same criteria for remittance to prisoners as to patients being considered for community discharge. Most thought there should be a follow-up of prisoners remitted to prison, and that this should be undertaken by the prison in-reach team and local services.

**Commissioning**

Local commissioning structures were thought unsatisfactory by most psychiatrists, who cited lack of available services and beds, organisational commissioning and funding arrangements, and difficulties with resolving disputes concerning responsible authority.

The majority believed that commissioners would benefit from guidance on how best to achieve a 14-day transfer and thought this guidance should include information on the prison transfer care pathway, clarity on identification and determination of responsible authority, and a description of current problems and pressures with service provision and capacity.

Most psychiatrists thought that a single commissioner should be involved in the commissioning of mental health services in a region (prison and healthcare). This notion was supported by perceived advantages of having improved interface between prison and healthcare settings, enhanced communication and reduction in disagreements about funding arrangements and bed availability.
This occasional paper from the Royal College of Psychiatrists emerged following Lord Bradley’s independent review of people with mental health problems in the criminal justice system. It aims to gauge whether a national 14-day prison transfer minimum target recommended by Lord Bradley is reasonable. Historically, transferring prisoners to hospital for treatment of an acute mental illness has been problematic, with prisoners having to endure lengthy delays. As a result of Lord Bradley’s review the government is now exploring opportunities for improving this process – the Department of Health is considering the introduction of a new minimum target for the NHS of 14 days to transfer a prisoner with a severe mental illness to an appropriate healthcare setting.

The College was invited to contribute to a Department of Health review and in 2010 carried out an online consultation with members with experience of prison transfers. This consultation aimed to draw on the experiences and expertise of psychiatrists in identifying the barriers and possible solutions to timely prison transfers.

This occasional paper presents the findings of the consultation. It was written by Masood Khan, with initial research from Katie Gray, and advice and assistance from a number of College faculties (Faculty of Forensic Psychiatry, General and Community Psychiatry Faculty, Faculty of Addictions Psychiatry, Faculty of the Psychiatry of Learning Disability, Faculty of Child and Adolescent Psychiatry).
Method

The objective of this consultation was to explore the issues concerning prison transfers (Section 47 and Section 48 of the Mental Health Act 1983) with the view to:

1. gauging whether a national 14-day transfer target was considered reasonable
2. identifying key barriers and possible solutions to timely prison transfers.

A secondary objective was to provide the Department of Health with personal accounts from psychiatrists about their experiences in transferring prisoners to appropriate healthcare settings.

The consultation was available online for 1 month and was sent via email to psychiatrists in England and Wales who were members of a number of faculties and a special interest group within the College:

- Faculty of Forensic Psychiatry
- General and Community Psychiatry Faculty
- Faculty of Addictions Psychiatry
- Faculty of Psychiatry of Learning Disability
- Faculty of the Psychiatry of Old Age
- Adolescent Forensic Psychiatry Special Interest Group.

The consultation questions were developed in collaboration with a number of psychiatrists from each of the College faculties and the special interest group listed here. The consultation contained a total of 22 quantitative and 23 qualitative questions. A final question at the end of the consultation allowed participants to provide a ‘vignette’ about their experience with prison transfers.

Qualitative data were analysed and thematically grouped into categories. Where indicated, multiple themes have been identified within single participant responses.
Consultation

The following is a list of questions in the online version of the consultation.

MINIMUM TRANSFER TARGET

1 Have you ever been involved in transferring a prisoner between a prison and a healthcare setting?
2 Do you think that a new minimum target of 14 days to transfer a prisoner with acute, severe mental illness to an appropriate healthcare setting is reasonable?
   a If not, why?
   b* If yes, why?
3 Do you think that a new 14-day minimum transfer target should apply to all those with acute, severe mental illness who require treatment in hospital?
   a If not, who should it apply to?
   b* If yes, why?
4 Do you think there should be a maximum waiting time for those who are not deemed to be in urgent need of treatment?
   a If so, what should this be?
5 What would you like to see included within any new guidance around a 14-day minimum transfer standard (e.g. time for assessment, resolution of disagreements between providers)?

ASSESSMENTS

6 What are three key barriers to undertaking assessments of prisoners in a timely manner? What are some practical solutions for overcoming these barriers in a timely manner?
7 Do you think a standardised assessment form might assist in speeding up the process of transfer?
   a If yes, what information should be required?
   b* If not, why?
8 How often do you accept assessments made by a colleague?
9 What influences your decision whether to accept an assessment made by a colleague?

10 Do you think that provider assessments are always necessary?
   a If so, what information should be required?
   b* If not, why?

INFORMATION-SHARING

11 What are the three key barriers to effective information-sharing in the prison transfer process?
   a What are some practical solutions to improve information-sharing?

12 How often are you provided the appropriate clinical information from the prison health service/prison when visiting a prisoner?

13 How often have you experienced difficulties with:
   □ gaining access to a prisoner’s medical files?
   □ determining a prisoner’s GP?
   □ gaining access to details of the prisoner’s offence?

14 Do you share information with prison health services in the same way as with your local services?

15 How should the level of security of a prisoner be determined?

BED MANAGEMENT

16 Have you ever encountered any problems in identifying and securing an appropriate bed for a prisoner? If so, please describe the problems you have encountered.

17 How often do you experience difficulties in establishing the primary care trust (PCT) responsible for a prison transfer?

18 What are the three key problems you have encountered in establishing the responsible PCT?

19 What are the three key problems you have encountered in transferring a prisoner who is from a different geographical area?

REMITTANCE

20 Have you been reluctant to remit patients back to prison?
   a If yes, why?

21 Do you apply the same criteria for remittance to prisoners as to patients being considered for community discharge?

22 Do you think there should be follow-up of patients remitted to prison?
   a If yes, how?
COMMISSIONING

23 Do you think that current commissioning structures in your area are satisfactory in relation to prison transfers and the commissioning of appropriate secure beds?
   a If not, why?

24 Do you think commissioners would benefit from guidance about how best to achieve 14-day transfers?
   a If so, what should be in this guidance?

25 Do you think a single commissioner should be involved in the commissioning of all mental health services within a particular regional (prison and health) area? Please explain your answer.

*FOLLOW-UP QUESTIONNAIRE

Questions 2b, 3b, 7b, 10b were not included in the initial consultation but were considered necessary to give balance to this report. All relevant participants were approached again to answer the questions in the follow-up questionnaire. In the report participants who took part in the initial consultation are labelled by number and those who took part in the follow-up round are labelled by letter.
The prison population in England and Wales currently stands at 84,467 (Ministry of Justice, 2010), an increase of more than 60% over the past 15 years. By 2015, the Ministry of Justice expect that the demand for prison spaces could be projected to increase up to 93,900 (Ministry of Justice, 2009).

Prisoners have significantly higher rates of mental health problems than the general public. The oft-cited Office for National Statistics study on psychiatric morbidity among prisoners found that approximately 90% of prisoners had psychosis, neurosis, personality disorder or a substance misuse problem (Sainsbury Centre for Mental Health, 2006).

Government policy for prison healthcare is based on the principle of equivalence of care. In 2006, responsibility for prison healthcare transferred to the NHS and with it, the aim to give prisoners access to the same quality and range of health services as the general public receives in the community.

Prison in-reach teams aim to provide specialist mental health services to people in prison. They take referrals from a wide range of sources and generally support a high volume of prisoners with stable mental illness (Wilson et al., 2010). Those prisoners that have problems and needs that can only appropriately be met by in-patient treatment must be transferred from prison to hospital (Department of Health & Home Office, 1993).

Most sections of the Mental Health Act 1983 specify a waiting time limit for hospital admission. For hospital directions via the court (under Section 35 and Section 36), the time period is 7 days. For Section 37 and Section 38, the time limit is 28 days. For prison transfer directions under Sections 47 and 48, there is no waiting time limit (Wilson et al., 2010).

Historically, transferring prisoners to hospital for treatment of an acute mental illness has been problematic, and prisoners have had to endure lengthy delays (Bradley, 2009). Annually there are approximately 950 transfers to hospital from prison under Sections 47 and 48 of the Mental Health Act and in 2005–2008 an average of 42 prisoners per quarter waited more than 3 months for transfer from prison to hospital (Sainsbury Centre for Mental Health, 2007; Hope, 2009).

In 2005, the Department of Health funded the Prison Mental Health Transfer Programme, and as a result of this programme, developed guidance on transferring prisoners to and from hospital under Sections 47 and 48 of the Mental Health Act. The aim of this guidance was to promote collaborative working and to ‘secure and sustain significant improvements in unacceptable delays’ (Department of Health, 2007).

In 2009, the Bradley Review of people with mental health problems or intellectual disabilities in the criminal justice system highlighted unacceptable delays in prison transfers in England and Wales. Lord Bradley recommended
that the government review existing transfer process to ensure that prisoner transfers are undertaken in a timely manner, with the view to developing a new minimum target for the NHS of 14 days to transfer a prisoner with acute, severe mental illness to an appropriate healthcare setting.

The responsibility for overseeing and implementing these recommendations lies with the National Programme Board, made up of relevant healthcare, social care and criminal justice departments from England and Wales. In 2009, the Health and Criminal Justice Programme Board published Improving Health, Supporting Justice (Department of Health, 2009), a delivery plan which sets out an ambitious programme of work to improve the health and well-being of offenders across the criminal justice pathway. The plan commits to improving transfers between prison and appropriate NHS facilities.

There is further commitment on the national level to Lord Bradley’s recommendations in the government’s mental health strategy New Horizons (HM Government, 2009), which replaced the National Service Framework for Mental Health (New Horizons has since been superseded by No Health without Mental Health (HM Government, 2011)). The Care Quality Commission’s 5-year action plan for mental health (2010–2015) reaffirms this direction of travel, highlighting interfaces between services and timely transfers of prisoners to forensic mental health services as areas of concern (Care Quality Commission, 2010).

However, development and implementation of Lord Bradley’s recommendations are coming at a time of considerable financial challenges within the public sector. In the run up to the next election, uncertainty about the level of funding that public services might expect over the coming few years is likely to continue. The King’s Fund and the Institute for Fiscal Studies’ report, How Cold will It Be?, estimated that from 2011 to 2014 all government departmental budgets could experience a reduction in funding by an average of 2.3% per year (Appleby et al, 2009). For the NHS, the government has set out the challenge of finding £15–20 billion of efficiencies in the 3 years from 2011 (NHS Confederation, 2009) and the Ministry of Justice is expecting to face real-term budget cuts of around 24% over the next 5 years. This is in addition to the £900 million savings the Ministry has had to make by 2011 (as a result of the 2007 Comprehensive Spending Review; House of Commons Treasury Committee, 2007).

The government response to Lord Bradley’s review in mid-2009 acknowledged that there will be little, if any, scope for new resources in the foreseeable future (Sainsbury Centre for Mental Health, 2009). The Health and Criminal Justice Programme Board, responsible for delivering on Lord Bradley’s recommendations, further acknowledges that the public sector will be facing significant financial challenges and that opportunities for improvement must come through system reform, refocusing of existing services and more effective use of resources across agencies (Department of Health, 2009).

With the prison population rising rapidly, and financially austere conditions likely to have a significant impact on health, social care and criminal justice budgets, there are real concerns about how this might influence, both directly and indirectly, the treatment and care of offenders. In 2009, the Health Service Journal reported that ‘commissioners were already experiencing significant financial pressure from a surge in referrals to secure mental health services fuelled by the recession and crowded prisons’ (Santry, 2009).
Reforms to the health and criminal justice system will require careful consideration. The moral and ethical imperative to provide equivalence of care for those within prisons cannot be ignored and any delay is unacceptable.

THE ROYAL COLLEGE OF PSYCHIATRISTS CONSULTATION ON PRISON TRANSFERS

A total of 53 psychiatrists participated in this consultation. Three responses were submitted as written viewpoints. Where relevant, content has been included within this report, but these responses have not been counted within the quantitative or qualitative data-sets, except in the count of ‘ever involved in prison transfer process’. Responses were received from six psychiatric specialties (Table 1). The majority of participants \(n=34; 64\%\) identified forensic psychiatry as their main psychiatric specialty.

Responses were received from 12 different strategic health authorities (SHAs) and health boards across England and Wales (Table 2). The highest number of responses was received from London SHA (23%) and the North West SHA (15%).

<table>
<thead>
<tr>
<th>Specialty</th>
<th>(n) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation and social psychiatry</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Psychiatry of learning disability</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Psychiatry of old age</td>
<td>1 (2)</td>
</tr>
<tr>
<td>General and community psychiatry</td>
<td>6 (11)</td>
</tr>
<tr>
<td>Forensic psychiatry</td>
<td>34 (65)</td>
</tr>
<tr>
<td>Child and adolescent psychiatry</td>
<td>2 (4)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (4)</td>
</tr>
<tr>
<td>Unknown</td>
<td>6 (11)</td>
</tr>
</tbody>
</table>
### Table 2  Strategic health authorities and health boards

<table>
<thead>
<tr>
<th></th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic health authorities</strong></td>
<td></td>
</tr>
<tr>
<td>North East</td>
<td>5 (10)</td>
</tr>
<tr>
<td>North West</td>
<td>8 (15)</td>
</tr>
<tr>
<td>Yorkshire and Humber</td>
<td>1 (2)</td>
</tr>
<tr>
<td>East Midlands</td>
<td>2 (4)</td>
</tr>
<tr>
<td>West Midlands</td>
<td>3 (6)</td>
</tr>
<tr>
<td>East of England</td>
<td>5 (9)</td>
</tr>
<tr>
<td>London</td>
<td>12 (23)</td>
</tr>
<tr>
<td>South West</td>
<td>3 (6)</td>
</tr>
<tr>
<td>South East Coast</td>
<td>2 (4)</td>
</tr>
<tr>
<td>South Central</td>
<td>3 (6)</td>
</tr>
<tr>
<td>Unknown</td>
<td>6 (11)</td>
</tr>
<tr>
<td><strong>Health boards</strong></td>
<td></td>
</tr>
<tr>
<td>Abertawe Bro Morgannwg University</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Betsi Cadaladr University</td>
<td>1 (2)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>52 (100)</td>
</tr>
</tbody>
</table>
Prison transfer pathway (Section 47 and 48 of the Mental Health Act)

Identification of prisoner with mental health problems

Identification of responsible authority

Referral made to responsible authority

Provider assessment

Responsible authority accepts prisoner

Subject to transfer direction under the Mental Health Act 1983

One Section 12-approved doctor to interview the prisoner and agree transfer is appropriate

Section papers sent to Ministry of Justice (mental health unit)

Ministry of Justice approves level of hospital security and warrant for transfer is issued

Available bed identified at trust

Prisoner transferred from prison to hospital

Shaded boxes represent stages where barriers currently exist in the process.
Consultation – analysis of results

**MINIMUM TRANSFER TARGET**

1. **HAVE YOU EVER BEEN INVOLVED IN TRANSFERRING A PRISONER BETWEEN A PRISON AND A HEALTHCARE SETTING?**
   
   All 53 participants had been involved in transferring a prisoner between a prison and a healthcare setting.

2. **DO YOU THINK THAT A NEW MINIMUM TARGET OF 14 DAYS TO TRANSFER A PRISONER WITH ACUTE, SEVERE MENTAL ILLNESS TO AN APPROPRIATE HEALTHCARE SETTING IS REASONABLE?**

   The majority of participants agreed that a new minimum target of 14 days was reasonable (Table 3).

   **Table 3 Is the proposed minimum transfer target reasonable?**
   
<table>
<thead>
<tr>
<th>Response</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>17 (34)</td>
</tr>
<tr>
<td>Yes</td>
<td>33 (66)</td>
</tr>
<tr>
<td>Total</td>
<td>50 (100)</td>
</tr>
</tbody>
</table>

A. **IF NOT, WHY?**

   Just over a third of participants ($n=17$; 34%) did not think that a 14-day transfer target was reasonable, giving five main reasons why they thought so (Table 4; multiple themes could be identified in one response). These, however, were largely of an administrative nature and ones which unnecessarily compromised the health needs of mentally ill prisoners.

   **Table 4 Reasons why target is unreasonable**
   
<table>
<thead>
<tr>
<th>Thematic responses</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment/access</td>
<td>7 (41)</td>
</tr>
<tr>
<td>Inappropriate target</td>
<td>6 (35)</td>
</tr>
<tr>
<td>Bed availability</td>
<td>4 (23)</td>
</tr>
<tr>
<td>Intra-organisational working</td>
<td>4 (23)</td>
</tr>
<tr>
<td>Insufficient clarity</td>
<td>3 (18)</td>
</tr>
</tbody>
</table>
ASSessment/access

Participants (n=7) expressed concerns about their ability to assess a prisoner in a timely manner, and worried that the assessment itself may be delayed due to difficulties accessing the appropriate information and delays in the relevant information being communicated in a timely manner.

‘One needs to be able to assess adequately and have the opportunity to access appropriate information, including risk information, which may be important in determining the appropriate level of security such that the risk to the prisoner, public and the trust can be managed. Poorly considered assessments may lead to inappropriate referrals with risk and cost implications.’ (Participant 13)

‘Undue delays with communication and post, obtaining the appropriate medical and legal information to inform the most appropriate clinical decision as to whether transfer to hospital is appropriate.’ (Participant 46)

inappropriate target

Six participants thought that a minimum transfer target of 14 days was inappropriate. Of these, four argued that it may not be appropriate to carry out a transfer within this time frame:

‘There may also be a temptation due to bed shortages to bring prisoners in quickly and then send them back before they are properly treated in order to meet the 14 days, leading to “revolving-door” prisoner patients.’ (Participant 13)

‘I do not believe it can be undertaken practically within this timeframe. My concern is that the patient may be transferred to a less appropriate hospital setting [than their particular needs warrant] in order to meet this target.’ (Participant 21)

‘It is better to undertake a thorough assessment and identify the right healthcare facility rather than rushing people into inappropriate facilities. Might be better to wait longer to get to a facility with prior knowledge of the prisoner, or closer to family, etc.’ (Participant 31)

Two participants argued that the target time of 14 days was too long:

‘If an acutely unwell patient requires hospitalisation, then this should be immediate not two weeks later.’ (Participant 35)

Bed availability

Four participants argued that delays in identifying a suitable service and an available bed would make it difficult to achieve a 14-day target.

‘If they are then accepted, there is nearly always a delay for a bed to be available. On occasions there is further delay with arguments among services within an area over whether the patient should be transferred to medium or low [psychiatric intensive care unit] security.’ (Participant 20)

‘Waiting for an available bed, prolonged waits for funding of independent sector beds make 14 days unreasonable.’ (Participant 25)
**Intra-organisational working**

Four participants thought that achieving the target of 14 days was not practical as the processes involved in obtaining the relevant paperwork from other departments (such as the Ministry of Justice and the Crown Prosecution Service) were often lengthy.

'It is not practical as the issuing of the warrant itself can take a minimum of five working days.’ (Participant 20)

'There are often long delays from the Ministry of Justice who state that they are waiting on the case summary, etc., from the Crown Prosecution Service.’ (Participant 36)

**Insufficient clarity**

Three participants thought that greater clarity was required to distinguish between urgent and routine referrals and had queries about the parameters of the 14-day target (e.g. at what point the 14 days commences).

**B. If yes, why?**

Participants identified four main reasons why they thought the target was reasonable:

1. Treatment delay
2. Healthcare standardisation
3. Definition of acute
4. 14-day target start point.

**Treatment delay**

Concerns were expressed about prisoners urgently requiring treatment but being delayed in the transfer process.

'If someone is acutely unwell it is reasonable to expect that a bed is available within 14 days.’ (Participant D)

'Otherwise they will remain inadequately treated and might pose risk to self and others.’ (Participant G)

'Acutely ill people should not remain in prison, as they need urgent treatment’. (Participant H)

**Healthcare standardisation**

Participants stated that healthcare should be equally delivered irrespective of whether the treatment is required in prisons or the community.

'Being in prison is a punishment in itself – being denied access to healthcare services of an equivalent quality to those available to the ordinary community is not part of the status of being imprisoned – the same standards should apply as elsewhere: if someone needs admission to hospital that should be available on a basis of need; 14 days is generous in terms of arranging beds, etc.’ (Participant J)

'I would expect anyone who is acutely unwell to be transferred to hospital whether they were in prison or in the community.’ (Participant D)
DEFINITION OF ACUTE

Participants felt that the issue came down to the definition of ‘acute’. If it signalled a severely mentally ill prisoner, then an immediate transfer should be pursued:

‘I think the transfer time is reasonable, although the problem is the definition of what is acute and what is not. If someone is acutely unwell it is reasonable to expect that a bed is available within 14 days.’ (Participant D)

‘If the definition of acute, severe mental illness is correct and meaningful then the answer to this [question no. 2] has got to be yes.’ (Participant F)

‘I would expect anyone who is acutely unwell to be transferred to hospital whether they were in prison or in the community. The problem again is the definition of acute.’ (Participant D)

14-DAY TARGET START POINT

One person felt that the 14-day transfer should apply to all those with acute, severe mental health illness, but the transfer target time should start from a certain point.

‘The question remains as to 14 days from when. This needs to be appropriate to ensure that those most in need of treatment get the correct treatment and to ensure that resources are used appropriately. In my view this should be 14 days from when the provider is given the full and appropriate information to allow a decision to be made about assessment. Not 14 days from when seen by a doctor. This information provision is the responsibility of the prison and mental health teams in prison. The current system means that referrals are made to services that do not contain clear information about responsible [primary care trust], GP, home address, offence (including detail), security information from custody. This information is available in prison and must be provided at the point of referral. If a good-quality referral with appropriate seniority in referrer is made then services can almost always make a decision with a good degree of certainty from the information provided.’ (Participant F)

3. DO YOU THINK THAT A NEW 14-DAY MINIMUM TRANSFER TARGET SHOULD APPLY TO ALL THOSE WITH ACUTE, SEVERE MENTAL ILLNESS WHO REQUIRE TREATMENT IN HOSPITAL?

Over half of participants agreed that a new target should apply to this group of prisoners (Table 5).

<table>
<thead>
<tr>
<th>Table 5</th>
<th>Eligibility for transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>n (%)</td>
</tr>
<tr>
<td>No</td>
<td>21 (44)</td>
</tr>
<tr>
<td>Yes</td>
<td>27 (56)</td>
</tr>
<tr>
<td>Total</td>
<td>48 (100)</td>
</tr>
</tbody>
</table>

http://www.rcpsych.ac.uk
A. If not, who should it apply to?

Of those who disagreed (n=21), 12 participants elaborated on their position. Half of these indicated that only those with the most severe illness and those at high risk to themselves, who cannot be managed on the prison healthcare wing, should be transferred:

‘Only to the most severe. Based on the limited research, the needs of the prison population are just too high numerically to fit in with the existing secure services provision.’ (Participant 4)

‘Those at very high or imminent risk of suicide, self-neglect or harm from others; those who are acutely psychotic and pose an imminent risk of violence; and those who receive treatment under the Mental Capacity Act 2005.’ (Participant 24)

‘Those who cannot be managed in prison hospital wing.’ (Participant 30)

However, half of participants also suggested that eligibility for prison transfer should only be based on individual clinical need.

‘There are times when transfer to hospital needs to happen urgently as there are no appropriate treatment alternatives and others when a transfer is the result of a clinical process involving attempts at engagement and treatment within a prison, with the in-reach team acting as a home treatment team providing care for those with acute severe mental illness effectively and appropriately. The decision to access the right treatment in the right place at the right time is key. It is not appropriate to transfer all prisoners suffering from mental disorder to hospital in 14 days. Inflexible target setting will result in missed targets and aggravate conflicts between different agencies and health teams. Properly funded and integrated services able to identify, deliver specialist care and facilitate transfer when appropriate will be cost effective as they will prevent inappropriate transfer.’ (Participant 10)

‘It should be dealt with on an individual basis and depending on the clinical need.’ (Participant 41)

B. If yes, why?

It was felt that all acutely unwell prisoners should be transferred to hospital.

‘I would expect anyone who is acutely unwell to be transferred to hospital whether they were in prison or in the community. The problem again is the definition of acute.’ (Participant D)

4. Do you think there should be a maximum waiting time for those who are not deemed to be in urgent need of treatment?

The majority agreed that there should be a maximum waiting time (Table 6).

<table>
<thead>
<tr>
<th>Table 6 Maximum waiting time</th>
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</thead>
<tbody>
<tr>
<td>Response</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
A. If so, what do you think the maximum waiting time should be?

The 28 respondents who agreed there should be a maximum waiting time proposed an average of 58 days, or just over 2 months (Fig. 1).

![Bar chart showing the distribution of maximum waiting times proposed by respondents.](image)

**Fig. 1** Maximum waiting time.

5. What would you like to see included within any guidance about a new minimum transfer standard?

Participants (n=43) suggested that new guidance should include reference to six areas (Table 7; more than one theme could be identified in each response).

**Table 7 Guidance on minimum transfer targets**

<table>
<thead>
<tr>
<th>Thematic responses</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible authority</td>
<td>19 (44)</td>
</tr>
<tr>
<td>Time frames</td>
<td>18 (42)</td>
</tr>
<tr>
<td>Prison and healthcare cooperation</td>
<td>8 (19)</td>
</tr>
<tr>
<td>Minimum information standards</td>
<td>4 (9)</td>
</tr>
<tr>
<td>Access to prison estate</td>
<td>4 (9)</td>
</tr>
<tr>
<td>Standards for eligibility</td>
<td>2 (5)</td>
</tr>
</tbody>
</table>

**Responsible authority**

Just under half of participants (n=19; 44%) noted a need for clarity concerning establishing the responsible authority and adequate processes for dispute resolution.

‘Resolution between providers is crucial as is contingency planning for areas with contract positions that are already at capacity and PCTs that are unwilling to purchase beds above numbers.’ (Participant 13)

‘A process for disagreements around who a patient belongs to – there is Department of Health guidance around responsible authority but it
is often time consuming establishing whether unwell patient has a GP, getting info about where offence was committed, etc.’ (Participant 20)

‘Commissioners need to be willing to either provide equivalent of community beds for urgent transfers (which may remain empty or have fast-track arrangement if no NHS beds are available, psychiatric services need to be flexible to undertake assessments urgently. (In my experience it is not the assessment that delays things though.)’ (Participant 28)

‘Clearer rules for admission when PCT is in dispute; clearer instruction on who decides PCT responsibility (i.e. not getting in to a protracted to and fro battle between individual local commissioners).’ (Participant 38)

**Time frames**

Participants (n=18; 42%) also indicated that they would like explicit guidance about when the 14-day time frame commences, and more specific guidance about time frames required for each stage of the prison transfer process.

‘Explicit guidance on when the 14 days commences and ends.’ (Participant 3)

‘Critically, a clear definition of when the clock starts, will the 14 days be from the time of completion of assessment, the time the problem is identified by prison healthcare, or the point at which a unit accepts the patient as suitable for their level of security and care pathway. If not clearly defined, there will be a risk of incomplete assessments and premature decisions.’ (Participant 17)

‘Suggested time frames for the individual steps, i.e. for assessment within 7–14 days and time frame for a bed to be found after an assessment has been completed.’ (Participant 25)

‘Guidance on when the “clock” starts ticking and guidance on how long the initial assessment from the relevant hospital should take.’ (Participant 50)

However, there were also concerns about the inflexibility of introducing explicit time frames around prison transfer processes, and some participants called for in-built contingency planning for any time-sensitive transfer processes.

‘Time limits on assessment etc would add to inflexibility – some people need more time than others, sometimes the clinical picture changes rapidly – the process needs to be flexible and patient-centered.’ (Participant 10)

‘Guidance regarding quality of service provision, thus ensuring that the time limit does not lead to transfer to inappropriate services.’ (Participant 33)

‘The guidance should be realistic and keep in mind the financial and resource constraints all of us work under.’ (Participant 36)

‘Time for assessments bearing in mind, there are often multidisciplinary team members involved in the various assessments.’ (Participant 41)
PRISON AND HEALTHCARE COOPERATION

Participants (n=8; 19%) felt that any new guidance should include a clear commitment and ‘buy-in’ for responsibility of the prison transfer process from both prison and health services.

‘The prison and healthcare setting jointly taking responsibility for setting a guideline date of transfer.’ (Participant 5)

‘Clear local agreement on responsibility for the decision-making process and sign up by all consultant psychiatrists involved in the individual’s care pathway before transfer can be agreed.’ (Participant 10)

‘If this guidance is implemented, there will be delays in other parts of the system (as, for example triage, has done regarding waiting times in [accident and emergency]). Before setting any minimum standards, there need to be agreements both from psychiatric and prison services regarding the level of service provision and ease of access to prison.’ (Participant 28)

CASE STUDY 1

The most recent transfer arrived today 02/02/2010. Referred on 19/11/2009, could not be seen on day because too short notice for prison, could not be seen on Friday therefore had to wait until Monday 22/11/2009. Agreed he was unwell but could be managed in custody with observing medication and monitoring food intake. Despite regular visits almost every 2 days by advanced practitioner, prison could not get staff to observe him taking medication, monitor his food intake or spend time with him while he ate his food. Continued to lose weight and then needed admission. Agreed transfer, completed paperwork on 01/12/2009, huge delay because prison did not pass on relevant information to [the Ministry of Justice].

MINIMUM INFORMATION STANDARDS

Some participants (n=4; 9%) thought that clear minimum standards of information needed to be defined within any new guidance.

‘Requirements for referrers – this needs to include clear information to establish responsible commissioner; minimum information on risk – including current conviction/charge, PNC [Police National Computer] record, security information from prison, MAPPA [Multi-Agency Public Protection Arrangements] information.’ (Participant 16)

‘A minimum information set within any referral, with comprehensive referral information. Any referral should be screened by a forensic psychiatrist visiting the prison before it is sent.’ (Participant 31)

‘As a minimum, I would expect an initial full and comprehensive psychiatric (typed) assessment prepared by a senior colleague or at least an assessment which was supervised by a psychiatrist who had assessed the patient personally.’ (Participant 46)
Four participants (9%) also wanted agreement on how prisons can better facilitate timely access for psychiatrists to the prison estate.

Two participants (5%) wanted to include a standard for assessing whether the acuteness or severity of mental illness requires admission to hospital to ensure that the transfer is justified at the particular moment in time.

Participants identified a range of barriers, including those listed in Table 8.

<table>
<thead>
<tr>
<th>Table 8 Barriers to timely assessments</th>
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<tbody>
<tr>
<td>Thematic responses</td>
</tr>
<tr>
<td>Access to prisoner/prison estate</td>
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<tr>
<td>Clinical resources and availability</td>
</tr>
<tr>
<td>Responsible authority</td>
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<tr>
<td>Referral procedures</td>
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<tr>
<td>Level of security</td>
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</table>

Access to prisoners and/or to the prison estate was the most commonly identified barrier to undertaking timely assessments. This included:

- changeable prison procedures
- restricted visiting times
- difficulties with notice required prior to visits
- security clearance
- difficulties obtaining a room to interview/assess a prisoner
- movement of prisoners to other prisons without the assessing or referring doctor being notified
- difficulties accessing a prisoner’s records and information on security reports, medical notes and risk assessments.

‘Inadequate access to security reports at prison.’ (Participant 1)

‘Inconsistent and changing requirements of prison estate in facilitating access to assessment of prisoner.’ (Participant 16)

‘Prison inflexibility in arranging assessments and access to the prisons.’ (Participant 17)
'Poor cooperation by prison service, e.g. not having prisoner ready on arrival.' (Participant 25)

'Arranging the assessment with the prison and the patient has moved when the visit is arranged.' (Participant 49)

**Clinical Resources and Availability**

Over half of participants also identified clinical resources and availability as a significant barrier to undertaking timely assessments. The majority of responses (n=19; 68%) reflected difficulties with incorporating prison assessments within existing clinical workloads and time schedules.

'Geographical spread of inmates. They can be anywhere in the country, and freeing up time for staff to undertake assessments far away is tricky as they may have to make childcare arrangements, etc., to leave very early or return late.' (Participant 31)

'Having to travel large distance sometimes and hence needing a whole day free to do this. Existing workload, for example, I am dealing with three urgent cases who are currently already in hospital this week (they are not prisoners).’ (Participant 50)

**Responsible Authority**

For just over a quarter of participants establishing the responsible authority (PCT or primary care service) was a key barrier to undertaking timely assessments.

'Lack of clarity about a prisoner’s last community address/GP registration; and disagreements about responsible commissioners.’ (Participant 7)

'Not being able to identify a prisoner’s NHS commissioners and so clarify the care pathway for that prisoner.’ (Participant 10)

'Ascertaining which service is responsible (patients with no fixed address, no GP); and disagreements within service.’ (Participant 20)

**Referral Procedures**

Inefficiencies within the referral process were also mentioned. Respondents highlighted poor quality of referral information (n=3); referrals to inappropriate service/clinician (n=2) or delays in referral process (n=2) as particular issues.

'Cumbrous referral systems where referrals always seem to be sent to incorrect fax numbers or "lost" with a system of weekly meetings, meaning that if you refer at the wrong time of the week, they are not looked at or actioned until the next meeting.’ (Participant 20)

**Level of Security**

Disagreements about the appropriate level of security also resulted in delays.
A. WHAT ARE SOME PRACTICAL SOLUTIONS FOR OVERCOMING THESE BARRIERS TO TIMELY ASSESSMENTS?

A range of improvements were proposed to tackle barriers to timely assessments (Table 9; more than one option could be identified).

<table>
<thead>
<tr>
<th>Table 9 Delays in assessments – areas for improvement</th>
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<tbody>
<tr>
<td>Thematic responses</td>
</tr>
<tr>
<td>Access to prisoner/prison estate</td>
</tr>
<tr>
<td>Responsible authority</td>
</tr>
<tr>
<td>Referral process</td>
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<tr>
<td>Guidance/standards</td>
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<tr>
<td>Information technology</td>
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</table>

ACCESS TO PRISONER/PRISON ESTATE

Three areas were identified which might better facilitate access to prisoners/prisons and, as a result, facilitate the assessment process.

MENTAL HEALTH TRAINING AND AWARENESS FOR PRISON STAFF

Improving prison staff knowledge and awareness of mental health and the importance of psychiatric assessments may facilitate access and help undertake assessments in a timely manner.

‘Opening the resistant culture of prison security is a mammoth task. Education of prison security staff as to the role of mental health workers, and the need for information-sharing is a first step. Reciprocal arrangements with the involvement of prison security in secure service discharge might warm the relationship and aid understanding.’ (Participant 17)

‘Greater awareness by prison staff of importance of psychiatric assessments.’ (Participant 25)

IMPROVED ADMINISTRATIVE PROCESSES

Better coordination of appointment bookings by dedicated personnel was suggested as a way of overcoming delays to undertaking assessments.
‘Specific administration person who can deal with booking and also assist with medical records when in the prison.’ (Participant 13)

‘A central booking facility at each prison.’ (Participant 32)

**ACCESS TO PRISONS**

More flexibility by prisons in terms of visits by psychiatrists was also suggested.

‘Prisons being more flexible with inmates’ availability for psychiatric assessment.’ (Participant 21)

‘Remove inflexibility for approved number of assessors (e.g. forensic service consultants and advanced practitioners, interested general and community psychiatrists) who can visit at short notice and during extended hours than those available.’ (Participant 28)

**RESPONSIBLE AUTHORITY**

Psychiatrists had a number of ideas on how better to facilitate identification of the responsible authority:

- establishing central information mechanisms to identify NHS commissioners for homeless itinerant prisoners with no GP
- admitting patients to the medium secure unit local to the prison if no alternative is available
- raising awareness of the guidance on prison transfers
- developing an ‘admitting right’ where the receiving hospital places a prisoner on a waiting list while they complete the assessment
- enhancing prison reception procedures to identify SHA/PCT responsible as soon as all prisoners enter custody.

**REFERRAL PROCESS**

Improvements in the referral process were also thought to contribute to timelier assessments. This included the need for better quality of information to be provided in the referral (including GP and funding clarification) and more involvement by prison in-reach services in the referral process for follow-up purposes.

**GUIDANCE/STANDARDS**

Nine participants thought that new or enhanced guidance on assessments would assist with improving assessment times.

**INFORMATION TECHNOLOGY**

Assessments could be undertaken in a timelier manner with the use of:

- secure email
- teleconferencing facilities (in both prison and courts)
- the use of NHS numbers in prison.
7. **Do you think that a standardised assessment form would assist in speeding up the process of prison transfer?**

The majority of respondents did not agree that a standardised assessment form would assist in speeding up prison transfers (Table 10).

<table>
<thead>
<tr>
<th>Response</th>
<th>n (%)</th>
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<tbody>
<tr>
<td>No</td>
<td>29 (60)</td>
</tr>
<tr>
<td>Yes</td>
<td>19 (40)</td>
</tr>
<tr>
<td>Total</td>
<td>48 (100)</td>
</tr>
</tbody>
</table>

**A. If yes, what information should be required?**

Of those who agreed that a standardised assessment form might speed up the transfer process, 14 respondents indicated that the following information should be included:

- detailed assessment of risk issues
- psychiatric history
- prisoner’s past and current behaviour
- health demographic information, linking with criminal justice demographic information
- NHS number (for previous admissions)
- diagnosis (including full, detailed psychiatric history)
- PNC record
- case summary
- responsible commissioner
- GP
- offence history
- level of security (with rationale)
- goals and requirements for healthcare transfer
- foreign national/immigration information.

However, even among those who supported an assessment form, there were concerns about how well it would capture the appropriate information.

‘The difficulty is that a form would aim for a high standard of information, which is not always available. There is a trade-off between the quality of referral expected and the severity of the illness. For example, I am quite happy to accept a rudimentary telephone referral of a floridly psychotic man who is not eating and drinking and is liable to serious physical illness. But I would expect a great deal more about someone with a long-standing personality disorder who might warrant a long-term treatment placement.’ (Participant 27)

‘A form would help: but it is only as good as the person who devised it and the one charged with its completion.’ (Participant 46)
B. If not, why?

More issues emerged from the follow-up questionnaire, which specifically explored the reasons why participants thought that standardised assessment forms would not speed up prison transfers:

- too long and difficult to complete
- inadequately completed
- standardising forms results in further irrelevant information
- delays not always due to forms.

Forms too long and difficult to complete

‘In my experience, standardised forms are too long, delay things and are often poorly filled out. The Ministry of Justice new forms are brief and perhaps an example to follow.’ (Participant A)

‘They are usually clumsy and difficult to use and hamper rather than assist the assessment.’ (Participant S)

Inadequately completed

‘I think that forms can be useful where a person making a referral has not included the information that is necessary or adequate. I accept that this all too frequently occurs. Perhaps it could be useful but I am sceptical as to whether it would actually speed up the process of transfer.’ (Participant L)

‘A psychiatrist who conducts an assessment of a patient usually provides better overall assessment than a form which is likely to be unpopular, resented and not necessarily helpful. It is also much more rigid. Referral forms for hospital admission have been poorly completed and have lacked information.’ (Participant 13)

Standardising forms results in further irrelevant information

‘Assessments are often individualised and focused to the situation/risks/concerns based on clinical judgement. A standardised form may create additional work by requiring all transfers to have particular information even if that is not entirely relevant.’ (Participant I)

‘Standardised forms never capture all the relevant clinical and risk data, and in my view would tend to overestimate need in terms of risk and psychopathology.’ (Participant K)

‘Many clinicians prefer to use their own assessment process rather than an imposed one. I think there is nothing to gain from devising any more forms.’ (Participant E)

‘The assessment needs to be comprehensive enough so that the resulting report could be easily relied upon to choose the appropriate service/bed. A form-based approach is likely to cause delay as more relevant information may be asked for.’ (Participant 4)
DELYAS NOT ALWAYS DUE TO FORMS

Many participants stated that more forms are not required and instead expressed a need for alternatives such as essential checklists, focusing on increasing bed availability and more reliance on in-reach teams.

‘Perhaps a standard list of minimal information requirements to be included in any referral would be helpful.’ (Participant A)

‘A standardised form for assessment would not help but a standardised checklist for minimum information required for a referral under prison transfer would. The process should be about in-reach teams taking responsibility for supporting what is a decision with serious resource and patient care implication with a proper assessment. (This response is given as a clinical member of both an in-reach team and a medium secure service.) Too often teams see referral as passing on the responsibility to others. If the guidance has the point of assessment that identifies the need for transfer as the time the 14-day clock starts ticking, without any requirement for supporting information, then this will reinforce this passing the buck.’ (Participant F)

‘I don’t think that delays are about the assessment process – rather they are about the lack of bed availability. I think there is nothing to gain from devising any more forms – we need more secure beds and better planning for throughput in the ones we do have.’ (Participant E)

8. HOW OFTEN DO YOU ACCEPT ASSESSMENTS MADE BY COLLEAGUES?

Most psychiatrists were always, or on most occasions, likely to accept an assessment from a colleague, with only five stating they never accept such assessments (Table 11).

<table>
<thead>
<tr>
<th>Response</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Most of the time</td>
<td>30 (63)</td>
</tr>
<tr>
<td>Half the time</td>
<td>4 (8)</td>
</tr>
<tr>
<td>Occasionally</td>
<td>8 (17)</td>
</tr>
<tr>
<td>Never</td>
<td>5 (10)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>48 (100)</td>
</tr>
</tbody>
</table>

9. WHAT INFLUENCES YOUR DECISION TO ACCEPT AN ASSESSMENT MADE BY A COLLEAGUE?

A range of factors were named (participants could name more than one factor; n=40):

- knowledge of assessing clinician
- quality of assessment report
- pre-assessment/referral contact
- appropriateness of service
- knowledge of patient/prisoner.
KNOWLEDGE OF ASSESSING CLINICIAN
For the majority of respondents ($n=26; 65\%$) knowing the clinician who had completed the assessment would influence their decision to accept the assessment.

'I accept them as part of my own assessment, but would not admit someone on the basis of an assessment by a person who didn’t work in my unit.' (Participant 14)

'Knowledge and reputation of the colleague.' (Participant 26)

'Whether I know the colleague and I think that they are competent.' (Participant 37)

'If they are a fellow consultant in my hospital then I will accept their assessment.' (Participant 50)

QUALITY OF ASSESSMENT REPORT
Over a half ($n=21; 53\%$) stated that the quality of the assessment and the information contained within the report would influence their decision whether to accept an assessment. Particular reference was made to the quality of risk and security information; symptomatology and treatment plan; and urgency of the transfer.

'If I trust their judgement, and the assessment report is comprehensive and covers all relevant issues.' (Participant 31)

'Quality of the referral and information provided to me, particularly the level of detail.' (Participant 37)

PRE-ASSESSMENT/REFERRAL CONTACT
Five individuals (13\%) would accept an assessment by a colleague if there had been some prior contact or discussion about the prisoner/patient.

'Telephone contact made to allow clear explanation of urgency; competencies and qualifications of individual making the referral; clarity on treatment needs; security and risk information provided alongside clinical assessment.' (Participant 16)

'I would be more comfortable if I have been involved in discussions around the particular case at the multidisciplinary team meetings.' (Participant 41)

SERVICE APPROPRIATENESS
Five participants (13\%) would consider the patient needs and whether the service was appropriate to meet these.

'Whether my service can deal effectively with the patient referred, i.e. whether we can add something.' (Participant 37)
KNOWLEDGE OF PATIENT/PRISONER

For two individuals (5%) knowledge of the patient/prisoner would also influence their decision to accept an assessment.

10. DO YOU THINK THAT PROVIDER ASSESSMENTS ARE ALWAYS NECESSARY?

The majority (n=33; 69%) agreed that provider assessments were always necessary; 15 (31%) thought otherwise.

A. IF YES, WHAT INFORMATION SHOULD BE REQUIRED?

There emerged three main reasons why psychiatrists (n=30) thought that provider assessments were always necessary (some named more than one reason):

- ability to meet patient need
- risk management
- resources.

ABILITY TO MEET PATIENT NEED

The predominant view (n=21; 70%) was that provider assessments were always necessary to ensure the service was able to meet the needs of the patient.

‘Different organisations have different thresholds as to levels of difficulty that can be managed. Only the provider organisation knows the mix of patients in the accepting unit. Provider organisation will often have previous involvement and knowledge of the patient which may inform assessment.’ (Participant 30)

‘In medium and high secure services staff should not be expected to take individuals without the option of assessment and pre-admission planning.’ (Participant 31)

‘Because the assessment will indicate if that particular prisoner can be safely managed in the environment as it is at the time (need to consider patient mix, prior knowledge etc).’ (Participant 33)

‘It increases chances of appropriate referral, identifies relevant information before assessment by specialist services.’ (Participant 34)

‘To establish care plan prior to patient admission and clinical opinions vary greatly as to need for treatment.’ (Participant 45)

RISK MANAGEMENT

A third of participants (n=10; 33%) mentioned that provider assessments were required for risk assessment.

‘Taking on risk control and clinical responsibility for a high-risk patient is not an easy task. Accepting an unsuitable patient on the basis of somebody else’s judgement and then providing care is a risk.’ (Participant 4)

‘It is the provider who is taking the risk of managing the individual, and thus should always assess the individual. We are not prisons and
particularly in medium security cannot manage seriously disturbed behaviour in the way prisons can.’ (Participant 31)

‘There is a great risk in accepting for admission a referral who may be inappropriate for the service provided.’ (Participant 46)

**RESOURCES**

Six participants (20%) raised the issue of a lack of resources and available services as a reason necessitating provider assessments.

‘On one hand, clinically they are probably not necessary for acute and severely unwell patients as these patients need admission to hospital. But the fact is, prisoners are from all over the country and so prison psychiatrists are unaware what resources each medium secure unit (MSU) around the country has. Therefore, MSU clinicians need to perform an assessment to ensure that the clinical needs can be fully met by their unit and if not, gate-keep the referral to another service provider.’ (Participant 3)

‘In-patient care is a limited and scarce resource and there are other issues to do with their unit that only the provider is aware of.’ (Participant 29)

**B. IF NOT, WHY?**

Three main reasons why provider assessments are not always necessary emerged from participants’ responses (n=30):

- additional assessments delay transfer
- providers to trust referring clinician’s assessment
- comprehensive assessment provides enough information.

**ADDITIONAL ASSESSMENTS OFTEN DELAY TRANSFER**

‘In cases of very clear-cut psychosis, an assessment can often delay transfer. However, provider assessments are sensible, especially when there is significant personality disorder and dangerousness not linked to mental illness.’ (Participant A)

**PROVIDERS TO TRUST REFERRING CLINICIAN’S ASSESSMENT**

Psychiatrists feel more trust should be fostered between various clinicians and their respective work.

‘Because it should be possible for provider, in some cases, to trust the assessments of the clinicians making the referral.’ (Participant B)

‘I work in a prison and was previously a consultant at the local medium secure unit: they accept my referrals.’ (Participant C)

‘Provided the service is a trusted one where the clinicians have shown good judgement in the past, a provider assessment is not essential. However, not all services are of as high a standard as others.’ (Participant G)
'The prison referrer is often an experienced psychiatrist or forensic psychiatrist so their assessment is thorough enough/has enough information to not need duplicating by the provider.' (Participant I)

'I think that it is almost always useful for providers to have made some assessment (including by nurses) prior to a patient’s arrival in hospital, but I feel that if an experienced prison clinician is recommending a person’s urgent transfer into secure care, then this should really be sufficient for a decision to be made and the transfer instigated. If, in such circumstances, inappropriate transfers begin to occur, an audit of such things could be instigated such that any unmet clinical governance needs in the prison could be addressed.' (Participant L)

COMPREHENSIVE ASSESSMENT PROVIDES ENOUGH INFORMATION

Participants here felt that thoroughly completed assessments provide the required and appropriate amount of information.

'If full information is provided then there are times when provider assessments are not needed. This relies, however, on the prison mental health team to provide a full assessment to fulfil the need of:

- mental state assessment – i.e. mental illness requiring acute transfer to hospital; this would normally be from a specialty trainee, psychiatric assessment from in-reach consultant or senior specialty trainee;
- risk assessment – i.e. behaviour associated with risk – in prison, information about offence, victim issues;
- assessment will be needed when the referral is unclear and when there are issues about risks in hospital, patient mix in services; assessments for pre-admission care planning may be of benefit even if referral is accepted.' (Participant F)

CASE STUDY 3

In terms of the recommendation by the Bradley report, the problem will come in determining what is meant by ‘acute and severe mental illness’ and who will decide whether a patient meets the criteria.

Of the 47 referrals received at Ashworth in the past year, 29 were from prison and 20 of these (69%) were considered suitable for admission by the panel. In other words, 31% of referrals from prison were considered to be inappropriate by the Admissions Panel – this would support the argument that the hospital needs to continue to conduct rigorous assessments of referrals to avoid inappropriate admissions.
INFORMATION-SHARING

11. WHAT ARE THE KEY BARRIERS TO EFFECTIVE INFORMATION-SHARING PRACTICES IN THE TRANSFER PROCESS?

From among the answers provided by 36 participants, 5 key barriers were identified (there could be more than one theme in each participant’s response):

- access/data-sharing
- interface
- confidentiality protocols
- IT/administrative systems
- record management.

ACCESS/DATA-SHARING

Access to information was thought a key barrier by over a third of participants (n=14; 39%). This primarily centred on access to prison and criminal justice data, but also included access to health information.

'Delayed access to medical records by the prison, unavailable prison health records when conducting an assessment and difficulty accessing risk information, including information about the (alleged) offence and previous convictions, which delays transfer and also determining appropriate level of security.' (Participant 13)

'Lack of information from the prison and difficulties obtaining basic information about the most recent offence and history of convictions, which is vital to making a decision about security.' (Participant 29)

'Getting non-clinical information (e.g. security records) which may be important in deciding on security level for admission. It is difficult for non-prison staff and prison psychiatric teams are often too busy to routinely get this information; access to paper/electronic records.' (Participant 42)

CASE STUDY 4

On one occasion, the assessment was undertaken relatively quickly and bed was available but the administrative organisation led to delay. The Ministry of Justice required a copy of the case summary and the patient’s criminal record, none of which we had or had been given access to by the prison at the time of referral. If we had and been allowed to take copies we could have speeded up the process by at least 6–8 weeks.

INTERFACE

Various issues with the transfer and flow of information both within and between organisations were raised (n=13; 36%).

'Working across different NHS trusts, liaising with PCTs.' (Participant 4)
‘Inadequate liaison between primary and secondary care mental health systems in prisons.’ (Participant 9)

‘Difficulty in reaching staff (often work in different prisons/clinics) and time delays in obtaining collateral information from both the NHS and prison service.’ (Participant 25)

‘Lack of clarity about where responsibilities lie, sometimes it is unclear what is the responsibility of CMHT, criminal justice liaison, PICU assessment service, etc.’ (Participant 39)

**Security and Confidentiality**

There is lack of clarity and understanding about security and confidentiality of data, as pointed out by 9 respondents (25%).

‘Lack of mutual confidence in sharing security information and misunderstanding of confidentiality expectations.’ (Participant 1)

‘Lack of protocols and procedures to access this information or knowledge at team level about protocols if physical barriers are overcome, for example local health teams telling prison in-reach teams they are not allowed to have health information held at CMHTs or forensic service settings, despite being employed by the same mental health trust.’ (Participant 10)

‘Misunderstandings about data protection and confidentiality.’ (Participant 37)

**Information Systems**

A quarter of respondents (n=9; 25%) indicated that incompatible IT systems were a barrier to effective information-sharing.

‘Different electronic information systems in use across different sites, which are often incompatible.’ (Participant 37)

‘Problems with information from different prisons not being transferred between prisons because of different electronic note systems.’ (Participant 29)

**Record Management**

Five participants (14%) suggested that poor or incomplete records also hindered information-sharing.

‘Limited information goes in to prison (e.g. no clear way of ensuring previous psychiatrist’s contact information is included into prison notes), therefore often limited information available.’ (Participant 38)

‘Paper health records are poorly maintained and often difficult to locate.’ (Participant 48)

‘Prisons often do not have all the necessary information; the demographic details necessary to determine the responsible commissioner, the previous convictions and details of current offence to assess level of security.’ (Participant 51)
A. What are some practical solutions to improve information-sharing?

Three main solutions emerged (n=31 participants, multiple themes in some responses):

- Improved and integrated information/administrative systems
- Improved awareness and understanding of data confidentiality
- Guidance/data protocols.

Improved and integrated information/administrative systems

More than half of the participants (n=18; 58%) suggested that better integration of IT and administrative systems within and between health and criminal justice sectors could improve effective information-sharing.

'Better transfer of records between prisons when prisoners are moved between establishments, copies of prison records available for assessing doctors, and better liaison with prison security and the courts (although this information is often very difficult to trace).’ (Participant 13)

'Local NHS electronic patient records linked to healthcare units in prisons.' (Participant 10)

Case study 5

I am currently dealing with a remand prisoner who has two recommendations for a hospital order. The judge cannot pass sentence as, although a bed has been identified for him, we cannot identify his NHS number (he is homeless and has dementia) and therefore no PCT will fund an independent bed for him. He has now been in prison for 9 months because a bed could not be found for him earlier either, to facilitate a Section 48 transfer. He is confused and suffering due to not being in an appropriate facility with nursing care but there is nowhere to transfer him to.

Improved awareness and understanding of data confidentiality

An agreed process and commitment (at a high level) to sharing information is necessary and this needs to be supported by good working relationships between trusts and prison healthcare staff (n=18; 58%). A number of participants called for an identified staff member as a named point of contact in both prison and hospital.

'A clear available person identified in health organisations for practitioners to check that disclosure is appropriate.' (Participant 10)

'Develop good relationships between clinical staff in prison and mental health establishments, easier access to all prison information to receiving units at assessment.’ (Participant 28)

'Clear mutually agreed protocols and flow charts of process of referral including passage of information/paperwork. Clear named individuals at
both ends with a specific role of ensuring smooth transfers, with clear lines of communication and for challenges; clear hierarchies that are available to all sides.’ (Participant 47)

GUIDANCE/DATA PROTOCOLS

Six participants (19%) called for greater clarity and awareness on information-sharing protocols.

‘There should be clear and brief protocols for information-sharing understood at team level and a clear available person identified in health organisations for practitioners to check that disclosure is appropriate. Improved communication and training on confidentiality for health professionals regarding prisoners.’ (Participant 10)

‘Standards for what security information should be available to healthcare – and an agreed process in each prison for providing this.’ (Participant 16)

12. HOW OFTEN ARE YOU PROVIDED THE APPROPRIATE CLINICAL INFORMATION FROM THE PRISON HEALTH SERVICE/PRISON WHEN VISITING A PRISONER?

The majority of participants were provided with the appropriate clinical information on most occasions (Table 12).

<table>
<thead>
<tr>
<th>Table 12 Provision of appropriate clinical information in prison</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Response</strong></td>
</tr>
<tr>
<td>Always</td>
</tr>
<tr>
<td>Most of the time</td>
</tr>
<tr>
<td>Half the time</td>
</tr>
<tr>
<td>Occasionally</td>
</tr>
<tr>
<td>Never</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

13. HOW OFTEN HAVE YOU EXPERIENCED DIFFICULTIES WITH:

- gaining access to a prisoner’s medical files?
- determining a prisoner’s GP?
- gaining access to details of the prisoner’s offence?

In terms of accessing a prisoner’s medical files and records, the majority (n=25; 54%) of participants only experienced occasional difficulties. Over a third (n=16; 36%) had difficulties most of the time in determining a prisoner’s GP.

Similar issues were found for participants who experienced difficulties gaining access to details of a prisoner’s offence history – 32% encountered difficulties most of the time and 30% half the time (Table 13).
Table 13  Difficulties accessing prisoner information

<table>
<thead>
<tr>
<th>Response</th>
<th>Access to prisoner’s medical files</th>
<th>Determining prisoner’s GP</th>
<th>Access to details of prisoner’s offence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>4 (9)</td>
</tr>
<tr>
<td>Most of the time</td>
<td>2 (4)</td>
<td>16 (35)</td>
<td>14 (31)</td>
</tr>
<tr>
<td>Half the time</td>
<td>14 (31)</td>
<td>12 (27)</td>
<td>13 (30)</td>
</tr>
<tr>
<td>Occasionally</td>
<td>25 (54)</td>
<td>13 (29)</td>
<td>13 (30)</td>
</tr>
<tr>
<td>Never</td>
<td>5 (11)</td>
<td>4 (9)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Total</td>
<td>46 (100)</td>
<td>45 (100)</td>
<td>44 (100)</td>
</tr>
</tbody>
</table>

14. **DO YOU SHARE INFORMATION WITH PRISON HEALTH SERVICES IN THE SAME WAY AS WITH YOUR LOCAL SERVICES?**

The results were positive for the majority of participants (n=38; 84%), but 15% (n=7) did not share information with prison health services in the same way as with their local services.

15. **HOW SHOULD THE LEVEL OF SECURITY OF A PRISONER BE DETERMINED?**

The survey identified a range of factors that should be considered when determining the level of security for each prisoner (Table 14).

Table 14  Determining prisoner’s level of security

<table>
<thead>
<tr>
<th>Thematic responsesa</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical assessmentb</td>
<td>31 (74)</td>
</tr>
<tr>
<td>Risk assessmentc</td>
<td>19 (45)</td>
</tr>
<tr>
<td>Offence historyd</td>
<td>15 (36)</td>
</tr>
<tr>
<td>Prison authority recommendation</td>
<td>3 (7)</td>
</tr>
<tr>
<td>Service provider recommendation</td>
<td>2 (5)</td>
</tr>
</tbody>
</table>

a. Multiple themes were identified in individual participant (n=42) responses.
b. Includes assessment of risk posed to self.
c. Includes assessment of risk posed to others and violent/aggressive behaviour in prison.
d. Includes current and previous offence history.

**CLINICAL ASSESSMENT**

Participants mostly thought that the level of security of a prisoner should be determined by a clinical/psychiatric assessment.

‘Informed clinical judgement.’ (Participant 1)

‘Psychiatric assessment presentation.’ (Participant 25)

‘By mutual agreement of all the clinicians involved according to some objective standards/indications for different levels of security.’ (Participant 45)

**RISK ASSESSMENT**

Just under half of the respondents thought that the level of security should be determined by an assessment of risk. This included risk to others and risk of absconding.
‘The severity and frequency of past risk. Implications of absconding or escape to the public.’ (Participant 16)

‘On the basis of a risk history and its relationship to risk.’ (Participant 47)

**OFFENCE HISTORY**

Over a third of participants believed that seriousness of the offence and the offender history should contribute to a determination of the level of security of a prisoner.

‘Combination of factors relating to index offence, forensic history.’
(Participant 3)

‘Information in relation to the current offence, previous offences.’
(Participant 29)

**PRISON AUTHORITY RECOMMENDATION**

Three participants thought that the level of security of a prisoner should be determined by the prison authorities.

**SERVICE PROVIDER RECOMMENDATION**

Two participants thought that the service provider or accepting team should decide on the level of security.

**BED MANAGEMENT**

The consultation questions for this part of the report draw on the Department of Health’s guidance *Procedure for the Transfer of Prisoners to and from Hospital under Sections 47 and 48 of the Mental Health Act (1983)* (Department of Health, 2007). This guidance states that the responsible PCT is determined by where the prisoner was last registered with a GP before entering prison. If the prisoner is not registered with a GP, then the responsible PCT is determined by where the prisoner resided before entering prison. If neither a GP or a last known address can be determined, then responsibility is deferred to the PCT where the offence took place.

16. **HAVE YOU EVER ENCOUNTERED ANY PROBLEMS IN IDENTIFYING AND SECURING AN APPROPRIATE BED FOR A PRISONER?**

Identifying and securing an appropriate bed for a prisoner seems to be problematic for a large majority of psychiatrists (*n*=41; 89%), with only 11% (*n*=5) having had no problems in this area.

**A. IF YES, PLEASE DESCRIBE THE PROBLEMS YOU HAVE ENCOUNTERED.**

When asked to describe the problems they had encountered, participants named three main areas (some psychiatrists identified more than one):
- bed availability
- establishing responsible authority
- funding for independent sector bed.

**Bed Availability**

Problems finding an available bed were the most widespread \((n=26; 76\%)\). Medium secure beds were hardest to find \((n=7; 27\%)\), followed by low secure beds \((n=5; 19\%)\) and specialist beds \((n=5; 19\%)\).

‘Long waiting list for medium secure bed limited availability of low secure forensic beds separate from PICUs.’ (Participant 4)

‘Lack of meaningful low secure provisions with appropriate relational security; lack of medium secure provision expert in providing for individuals with autism-spectrum condition; lack of all-levels secure provision for individuals with autism-spectrum conditions.’ (Participant 17)

‘Full occupancy demanded in medium security making it impossible to arrange emergency admission.’ (Participant 53)

**Establishing Responsible Authority**

Just under half of participants \((n=15; 44\%)\) also had problems with establishing the responsible authority.

‘There was a protracted argument from different health authorities about who had responsibility for the prisoner.’ (Participant 29)

‘Excessive delays in specialised commissioners finding a bed, and different authorities arguing about who is responsible for funding a patient’s care, particularly if the patient is a foreign national.’ (Participant 37)

‘Establishing area responsible/identifying consultant team from that area/agreeing level of security/seeking agreement of commissioners if NHS bed not available.’ (Participant 45)

‘Difficulty in determining responsible commissioner (no fixed abode, no GP, more than one offence in more than one borough) and local service unwilling to help (e.g. they don’t take Section 48 patients, wrong diagnosis, wrong address).’ (Participant 51)

**Case Study 6**

There have been a lot of arguments over whose patient it is, but the one that sticks in my mind is a young person from an EU country who had an address written on their probation pre-sentence report. We referred according to this address; there were multiple phone calls from increasingly higher levels of management until we were informed that a community psychiatric nurse had been sent to the address and interviewed the landlady who said she did not recall this person so they would not accept the patient. (This patient was eventually transferred to this trust following the intervention of the Department of Health.)


**Funding for independent sector bed**

Four psychiatrists (12%) pointed out that lack of available beds in the NHS meant trying to secure a bed in the independent sector, and securing funding for independent sector beds resulted in delays.

‘Have to look to private sector. This delays funding.’ (Participant 34)

‘Lack of beds in the NHS means an independent sector bed has to be found which takes time and adds to the bureaucracy.’ (Participant 50)

**17. How often do you experience difficulties in establishing the responsible PCT for a prison transfer?**

Establishing the responsible PCT for a prison transfer was only occasionally an issue for the majority of participants (Table 15).

<table>
<thead>
<tr>
<th>Response</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Most of the time</td>
<td>4 (8)</td>
</tr>
<tr>
<td>Half the time</td>
<td>8 (18)</td>
</tr>
<tr>
<td>Occasionally</td>
<td>29 (64)</td>
</tr>
<tr>
<td>Never</td>
<td>4 (9)</td>
</tr>
<tr>
<td>Total</td>
<td>45 (100)</td>
</tr>
</tbody>
</table>

**18. What are three key problems you have encountered in establishing the responsible PCT?**

When asked to name specific problems in establishing the responsible authority, participants (n=35) identified five main areas (more than one area could be named by each participant):

- establishing address
- establishing GP
- incomplete records (other)
- establishing offence
- administration/personnel.

**Establishing address**

Establishing the address of a prisoner was cited most frequently (n=18; 51%) as a key problem in determining responsible PCT for a prison transfer. Prisoners with no fixed abode or foreign nationals presented particular difficulties.

‘There is a problem with unwell patients who can’t give an address and arguments by trust whether the address given is “really” their address, trying to establish details of offence when all else fails is time consuming. In this context I have had a trust refusing to
accept responsibility, despite sending them the Department of Health guidelines, needing to be resolved at director level. This is especially common with foreign nationals.’ (Participant 20)

'We had a homeless person arrested at a railway station – there are clear rules but it took a long time to find them. Unclear whose responsibility it was to establish this.’ (Participant 30)

'Those who don’t have permanent address but have tenuous links with various areas – often leads to situation where every PCT has a good reason why a different PCT is the responsible one. There are similar issues with foreign nationals who have had temporary addresses in different areas.’ (Participant 38)

'Homelessness, a mobile population who do not tend to consult medical practitioners/services and bureaucratic processes.’ (Participant 46)

**ESTABLISHING GP**

Finding out who a prisoner’s GP is was found problematic by over a third of respondents ($n=15; 43\%$).

'Often it is not clear whether a prisoner has ever been registered with a particular GP.’ (Participant 2)

'Not having a GP, not knowing who the GP is, lack of clarity about the rules that apply to how it is determined as to which secure service an individual should go to, etc.’ (Participant 26)

'Being bounced between different PCTs, lack of clarity about whether someone was registered with a GP.’ (Participant 29)

'Reception staff at prison need to be reminded of importance of recording prisoner’s GP. Some prison electronic systems (e.g. EMIS) automatically record prisoner’s GP as the prison GP, leading to confusion when it comes to establishing PCT responsibility. It would be useful if prison health administrator/manager had access to NHS tracking system to confirm prisoner’s GP.’ (Participant 38)

**INCOMPLETE RECORDS**

Incomplete records and information on the prisoner also created problems in identifying the responsible PCT ($n=7; 20\%$).

'Referrals are often made long after sentencing and information is lost over time.’ (Participant 2)

'Lack of information; differences of opinion regarding allocation of responsibility; and lack of speedy resolution processes.’ (Participant 23)

'Non-adherence to published guidance; attachments to more than one borough; and lack of information.’ (Participant 51)

**ESTABLISHING OFFENCE DETAILS**

Six participants (17\%) had encountered difficulties in establishing details of the offence.
‘The PCT covering where the offence occurred is often assumed to be responsible when this may not be the case.’ (Participant 2)

‘The issue is prisoners with no GP or address whose crime was committed in an area being dealt with by a court that has little connection with their previous social contacts. For example, substance misusing, mentally disordered itinerant offenders who commit sexual offences on a long-distance train. The problem is not so much establishing the responsible PCT but that the identified responsible PCT is clearly inappropriate for the prisoner’s previous social network and contacts.’ (Participant 10)

‘Committing offence away from home area.’ (Participant 40)

AdminISTRATION/PERSONNEL

Three individuals (8.5%) mentioned that identifying and contacting the appropriate personnel could also be an issue.

‘Frequent changes of personnel and telephone numbers.’ (Participant 1)

‘Lack of clearly identified person responsible. The problem is worse for London and low secure or PICU provision.’ (Participant 16)

19. WHAT THREE KEY PROBLEMS HAVE YOU ENCOUNTERED IN TRANSFERRING A PRISONER WHO IS FROM A DIFFERENT GEOGRAPHICAL AREA?

Multiple themes were mentioned, but two areas were found most problematic by respondents (n=29):

■ responsible authority

■ assessment.

RESPONSIBLE AUTHORITY

Establishing the responsible authority was cited most often (n=23; 79%). The biggest problem appears to be a lack of familiarity with local teams and lack of established relationships with the services in the area. Identifying funding and ascertaining commissioning arrangements also contributed to difficulties in transferring prisoners from different geographical areas.

‘Clashes between court jurisdiction for an area and PCT responsibility for home address.’ (Participant 1)

‘Lack of ownership by the accepting trust, disputes between the trust and the Ministry of Justice, it is more complicated if the prisoner is not from England or Wales.’ (Participant 13)

‘This is the biggest problem – lack of knowledge of who to refer to in a different area.’ (Participant 26)

‘Ascertain commissioning arrangements and to establish links with the family.’ (Participant 41)

‘I don’t know clinicians in another area so cannot make a “personal” request.’ (Participant 48)
ASSessment

Another issue often raised in participants’ responses (n=11; 38%) concerns delays with assessments, both delays from local services in providing assessments and practicalities of clinicians travelling to carry them out.

‘Practicality of travelling distance.’ (Participant 11)

‘Local services putting barriers in way, requiring multiple assessments.’ (Participant 32)

‘Delays in assessment from local service.’ (Participant 51)

REmITTANCE

20. HAVE YOU BEEN RELUCTANT TO REMIT PATIENTS BACK TO PRISON?

Most psychiatrists (n=28; 61%) had not been reluctant to remit patients back to prison, but 39% (n=18) said they had been.

A. IF YES, WHY?

Eighteen participants explained why they were cautious with patient remittance. The reasons given can be summed up as:

- unmet mental health needs
- relapse of prisoner
- lack of follow-up
- other.

Sometimes multiple reasons were given.

UNMET MENTAL HEALTH NEEDS

Concern that their patient’s mental health needs would not be adequately met in prison was cited most often (n=8; 47%).

‘Interventions (e.g. to support medication compliance) very variable, with rapid deterioration in mental state; lack of robust processes to support release and reintegration to local services.’ (Participant 28)

‘For fear that their mental health needs there would be unmet.’ (Participant 46)

RELAPSE OF PRISONER

The likelihood of relapse in prison was also brought up in participant responses (n=4; 24%).

‘I tend not to remit “revolving door” patients who have already had 1–2 relapses in prison as it seems inevitable they will relapse again and it does not seem fair for them to go through another lengthy transfer process.’ (Participant 38)
Lack of follow-up

Three participants (n=3; 18%) expressed concern with lack of continuity of care and level of psychiatric input after discharge.

Other

Three participants (n=3; 18%) cited other reasons such as lack of evidence of outcomes of remitted prisoners and pressure from patients and solicitors as contributing to their reluctance to remit patients to prison.

21. Do you apply the same criteria for remittance to prisoners as to patients being considered for community discharge?

We found that the majority of participants (n=31; 70%) did not apply the same criteria to prisoners as to other patients, but 30% did (n=13).

22. Do you think there should be follow-up of patients remitted back to prison?

An overwhelming majority (n=41; 97%) agreed patients remitted to prison should be followed up; only one person was against such a measure.

A. If yes, how should patients be followed up once remitted to prison?

Prison in-reach team and/or local services were thought most appropriate for facilitating follow-up of patients in prisons.

Prison in-reach team

The majority (n=28; 76%) thought that the follow-up of remitted patients should be undertaken by the prison in-reach team.

For a prisoner, being able to choose whether or not to engage in treatment, and being in different places to receive this treatment, can be very important. Therefore being remitted does not mean the prisoner is “cured” and it is not equivalent to a “community discharge”. This model is far too simplistic. This is also why prison in-reach teams are not equivalent to CMHTs and need specialist skills. Follow-up should be via specialist prison in-reach teams (set within the framework of criminal justice and mental health teams operating within and outside prison) implementing the care programme approach.

By in-reach teams within the prison with the same degree of staffing, competence and expertise as a community mental health and learning disability team with a similar demographic to the relevant prison population. Where the patients have ongoing high degrees of risk, liaison with a forensic psychiatry support within the prison would be appropriate.

(Participant 10)
CASE STUDY 7

A 40-year-old man was admitted under Section 47/49 for treatment of mental illness and a neurodevelopmental disorder. He progressed well in hospital, although continued to experience residual and breakthrough symptoms of mental illness, and had ongoing problems associated with his intellectual disability. A pre-remission Section 117 meeting was attended by the manager of the prison mental health in-reach service. Speaking with the authority of the prison, and liaising directly with the prison establishment, care planning thus followed, meeting the needs and anxieties of both the patient and the care teams concerned, and remission followed without incident.

LOCAL SERVICES

Twelve participants (32%) thought that follow-up of patients should be managed by local services, such as a visiting psychiatrist, and care programme approach (CPA) arrangements with local services.

‘Ideally by psychiatrists local to the prison. It should be no different from discharging an out-of-area patient to the community.’ (Participant 48)

‘Via CPA. Local services should identify the responsible local service for the aftercare and this service should be involved in [Section] 117 [aftercare] planning. They may wish to delegate some of their CPA functions to the relevant prison in-reach team.’ (Participant 51)

COMMISSIONING

23. Do you think that current commissioning structures in your area are satisfactory in relation to prison transfers and the commissioning of appropriate secure beds?

Most psychiatrists found commissioning structures in their area unsatisfactory (Table 16).

<table>
<thead>
<tr>
<th>Table 16  Appropriate commissioning structures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

A. If not, why?

Eighteen participants gave reasons why in their opinion commissioning services for prison transfer in their region were unsatisfactory (Table 17; more than one reason could be stated).
Table 17 Reasons for unsatisfactory commissioning structures

<table>
<thead>
<tr>
<th>Thematic responses</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of services/beds</td>
<td>9 (50)</td>
</tr>
<tr>
<td>Organisational commissioning arrangements</td>
<td>5 (28)</td>
</tr>
<tr>
<td>Dispute resolution</td>
<td>3 (17)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (5)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18 (100)</td>
</tr>
</tbody>
</table>

Lack of services/beds

Lack of services and availability of beds was the most frequently cited reason.

‘Commissioning structures are woefully inadequate – there is a lack of funds and appropriate services.’ (Participant 11)

‘Particularly in forensic settings where the turnover is inherently slow, the service is being asked to do two irreconcilable things. To run at 100% bed occupancy and be responsive enough to be able to admit all urgent prison referrals within 2 weeks. Both of these things cannot be done. The Department of Health cannot have both medium secure units being expected to run at 100% bed occupancy and be able to admit prisoners within 2 weeks. These two goals are mutually incompatible. It must decide which of these takes priority.’ (Participant 51)

Organisational commissioning arrangements

‘Most of the money located in medium secure services with long-term contacts about which the PCT commissioners have limited knowledge.’ (Participant 4)

‘Commissioners do not have the influence or expertise or confidence to challenge providers in their decisions.’ (Participant 4)

Dispute resolution

Disputes between services also contributed to unsatisfactory commissioning structures.

‘Lack of agreement as to who manages conflict between medium secure units and high secure hospitals.’ (Participant 1)

‘The system is cumbersome, prone to arguments about whose responsibility the patient is and loses sight of the need to transfer a patient urgently to hospital for clinical care.’ (Participant 21)

‘Too much delay due to disagreements between commissioners, even when this will have no impact on the actual bed the prisoner goes in to.’ (Participant 38)

Other

One person called for specific provision for immigration detainees within commissioning arrangements.
24. **Do you think commissioners would benefit from guidance about how best to achieve 14-day transfers?**

The majority of participants \( n=41; \, 95\% \) agreed that commissioners would benefit from such guidance, but two respondents thought that they would not.

A. **If yes, what should be in this guidance?**

Participants \( n=19 \) suggested that commissioners would benefit from guidance in three broad areas (they could list more than one):

- care pathway information
- responsible authority
- service provision and capacity.

**Care pathway information**

An explanation of the care pathway, and critically, useful information about contact points at each interface was thought to benefit commissioners \( n=11; \, 58\% \).

‘Explanation of the pathways into and through secure services, including appropriate receiving facilities, approximate lengths of stay, pathways out of secure care, etc.’ (Participant 2)

‘Standards for commissioner point of contact; standards for prison teams in information to provide at the time of referral; consistent application of protocol for no fixed abode/foreign nationals across PCTs/specialised commissioning groups; requirement on providers to have clear referral and point of contact for prison transfers at each level of security.’ (Participant 16)

**Responsible authority**

Over a third of participants \( n=7; \, 37\% \) indicated that commissioners would benefit from guidance on how to determine the responsible authority, with specific reference to dispute resolution.

‘The guidance should recommend establishing agreement between all providers involved in the care pathway of an individual before starting the 14-day transfer “clock”. Otherwise, the clock will continuously be stopped and started and delays will simply continue but not be counted as such.’ (Participant 10)

‘Clear guidelines on how to resolve disputes over which PCT [is responsible for the patient].’ (Participant 20)

‘Advice to allow clinical teams to get on with the clinical business of assessing/admitting patients and for there to be an easy structure to sort out the funding at a later date.’ (Participant 38)
SERVICE PROVISION AND CAPACITY

Psychiatrists (n=4; 21%) also wanted commissioners to be aware of the current problems and pressures with existing service provision and capacity.

‘Unless there is an increase in resources and beds, it will not be possible to transfer prisoners within 14 days unless prisoners are returned to prison much earlier which has an impact on mental health teams running within prisons. However, there needs to be less rigidity in capping the numbers of prisoners transferred from any area – though this has a cost implication. 14 days’ transfer including arranging and completing an adequate assessment is unrealistic.’ (Participant 13)

‘They cannot expect their MSU and high secure services to maintain 100% bed occupancy and be responsive. Or they will have to plan to keep some money aside for private sector bed purchases.’ (Participant 51)

CASE STUDY 8

Unfortunately, there is one very big barrier to full local trust involvement, and it is money. The bottom line is that money is presently organised such that it is not in the interests of local services to admit acutely unwell prisoners. This is because they only ever bring a net loss to the receiving unit, of the order of £160–200k per annum. This is, in my view, the central problem, and if it could be solved this problem would be fixed overnight. One potential solution would involve changing the commissioning structure for prisoners, with a central prisoner care trust for London, allowing money to follow the patient in individual cases. If we could get this right, trusts would be competing for prisoner business, a complete turnaround from the present position.

25. Do you think a single commissioner should be involved in the commissioning of all mental health services within a particular regional (prison and health) area?

More than half of respondents (n=25; 66%) agreed that there should be one central commissioning authority responsible for all regional mental health services; 13 individuals (34%) did not think this was a viable solution.

Support for a single commissioner arose from the perceived advantages of having improved interface between prison and healthcare settings, reduction in disagreements about funding arrangements and bed availability, and enhanced communication processes.

‘Centralisation and standardisation across the region.’ (Participant 5)

‘In London, I think the system of allocating patients to the various RSUs [regional secure units] and PICUs by borough is hugely problematic, and the fights and squabbles I have seen (that have largely revolved around the allocation of resources) have at times been hugely frustrating
to watch (powerlessly from prison) while a patient waits months for disputes to be resolved or beds to become available. A single commissioner would be an interesting idea to explore.’ (Participant 24)

‘In my view, by commissioning in silos, with different commissioners being responsible for secure services and prison health, there is a lot of vested interest which goes unchallenged in putting more and more funds in secure services rather than considering ways and resource injection to reduce input and improve output from secure services. Secure services are part of a system. Solely improving their resource without improving the other parts of the system is pointless.’ (Participant 26)

Ten participants who disagreed with the notion of a single commissioner thought that such a position would not be feasible given the expertise required to fulfil such a role, and the need for transparency in commissioning arrangements.

‘Perhaps, but this is a job that may come under different pressures from different organisations and may be unfair to expect one person to take sole responsibility for. One person may also lead to problems with individual personalities and relationship with key local stakeholders as I have experienced with substance misuse service commissioning at a regional level. Advisory panels or boards allow a more transparent decision-making process.’ (Participant 10)

‘The issue is more of joined-up thinking and of clear transition pathways; commissioning arrangements and expectations do need to complement each other but this does not necessarily require single commissioner to do so; single commissioner of all mental health services across an entire region would be too large and unwieldy to have appropriate local knowledge.’ (Participant 42)

‘These are complex problems beyond the gift of one, regardless of their abilities, competencies, skills and experience.’ (Participant 46)
Case studies

Case study 1
A young man, first presentation, clearly psychotic. Associated challenging behaviour and needed urgent admission to a PICU. Had no fixed abode before coming to prison and did not have a GP. He was on remand for four separate offences (of a less serious nature – criminal damage, driving offences) committed in four different London boroughs. None of the PICUs in these areas would agree to accept him for admission, although all agreed this was what was clinically indicated. In addition, he would move from prison to prison with each court appearance for each different offence as these were being dealt with by different courts, served by different local prisons. It took about 9 months to arrange his transfer to hospital.

Case study 2
The longest transfer was for an out-of-area patient with unusual mental health needs (intellectual disability and autism spectrum disorder) who had been in prison for over 6 months and whom the prison PCT were very reluctant to accept responsibility for. Once they did accept responsibility, the assessment took 6 weeks to plan. We waited several weeks for a response, then there was a delay while a specialist service and funding were arranged (the need for a specialist placement should have been evident at the point the referral was accepted), and when eventually the assessment by the specialist service went ahead, the prisoner was finally admitted to hospital about a year after the first referral was made.

Case study 3
The quickest transfer I am aware of occurred within hours of referral. The Ministry of Justice directed an admission of a prisoner who had self-harmed (by attempting to remove his left eye and some hours later his right eye): the admitting hospital did not assess prior to admission, the Ministry decreed the PCT and responsible service and the warrant was issued by return of fax.
CASE STUDY 4

I was involved in several prison transfers of foreign nationals which were significantly hindered by PCTs arguing about who was responsible for funding the patient’s care in a medium secure unit. This led to a significant deterioration in the mental health of the inmates, and strained relationships between health workers and the prison staff, who believed that we were being unhelpful.

CASE STUDY 5

My team were able to reduce local waiting times to 35 days in 2009. We did this by doing the following:

- senior involvement (consultant, team leader) in the transfer process
- involving local PCTs at an early stage and making them aware of financial responsibilities
- having a community psychiatric nurse to work across the transfer pathways and encourage timely assessment and transfer
- allowing the prison in-reach consultant to accept individuals for local PICU and medium secure units without the need for a second provider assessment
- driving the process through rolling audit, and regularly reporting the results to commissioners
- having a dedicated and high-quality admin team to keep the process together and assist in driving it (two admin posts, one secretarial, one mental health admin, although in reality there is some sharing of functions).

CASE STUDY 6

Prisoner A was charged with a serious violent offence. He had a history of schizophrenia, with underlying personality disorder and substance misuse. He was acutely unwell in prison and refused medication, so he was referred to his local medium secure unit. Following an acute deterioration, he required emergency treatment under common law, and after receiving this he improved. A psychiatrist from the unit came to interview him 3 weeks later, and declined admission given the extent of the improvement. However, A significantly relapsed in 2 days necessitating a further referral. The prison team signed section forms and forwarded them to the Ministry of Justice, but a further month went by before another psychiatrist from the unit came to see the patient. He was accepted for admission, but waited a further 2 months for a hospital bed. In the meantime, the prison in-reach team had escalated the case to local PCT commissioners and managers.
CASE STUDY 7

A prisoner was referred to the in-reach team after a landing officer became concerned about what he was saying. He believed he was King of the Earth and stated that he had declared sovereignty 4 years earlier. The in-reach team reviewed the prisoner and became aware that he was due for release the next day. He was of no fixed abode and had no GP. The in-reach team consultant spent the whole day telephoning local services trying to find a suitable place for him. This included escalating to commissioners and managers. No bed could be located and therefore a local approved mental health professional declined to attend to consider detention under the Mental Health Act. The prisoner was released into the community.

CASE STUDY 8

A prisoner became acutely behaviourally disturbed on the main prison wing. He was transferred to the healthcare wing, where first-onset psychosis was diagnosed. The prison in-reach psychiatrist was able to accept him for admission to the local PICU, in accordance with local agreements, and relevant section forms were completed in prison. The mental health administrator informed bed management the same day, and forms were sent to the Ministry of Justice. Following the remittal of a second prisoner, a bed became available 7 days later, and the prisoner was transferred to hospital on day 10.

CASE STUDY 9

An offender was referred to us for assessment in a category B prison. He had been transferred over from another part of the country. He was known to have a psychiatric history and before assessment we asked for the previous psychiatric records and treatment given. The process made us realise the delays in transfer of important information between prisons from one part of the country to another. It was a good few months that the prisoner had been in the new prison and yet the transfer of medical records was still in process. As far as the staff were aware, he was being treated in the previous prison and was on some antipsychotic, but more details were not known.

Owing to the delay in transfer of medical information, the prisoner had also failed to receive any form of psychiatric treatment in the new prison until his mental health started deteriorating, which led to a referral to us, the local prison outreach service. This was one instance where I observed the impact of delay in transfer of information causing a considerable disruption in a vulnerable patient's continuity of care, leading to deterioration in mental health and further consequences in terms of risk, behaviour, etc.
References


Sainsbury Centre for Mental Health (2006) London’s Prison Mental Health Services: A Review. SCMH.


Prison transfers

A survey from the Royal College of Psychiatrists

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