The long wait

A thematic review of delays in the transfer of mentally unwell prisoners

by HM Chief Inspector of Prisons

February 2024

Contents

Introduction 3

Background 5

Key concerns 8

Section 1 The transfer process 9

Section 2 Arriving in custody 14

Section 3 Initial referrals 17

Section 4 Access assessments 20

Section 5 Urgent referrals 23

Section 6 Patient experience and advocacy 26

Section 7 Keeping people safe and arrangements for transfer 32

Section 8 Detaining patients on release 38

Appendix I Methodology 40

Appendix II Glossary 43

Appendix III References 45

Introduction

When we think of prisons, we assume they are full of those who have committed crimes for which they are being held accountable or those awaiting a court judgement. Yet they remain a legal 'place of safety' which can be used when there is no suitable provision in the community. Our prisons continue to hold a number of very seriously mentally unwell men and women.

All too often, I meet prison officers and health professionals struggling to care for these patients. To be clear, we are not talking about those who have the will and capacity to accept support during a mental health crisis or when they are at risk of self-harm. These include people whose psychosis or paranoid delusions can make them so violent they are held in isolation in the segregation unit, requiring multiple officers to unlock them just to deliver their meals. Or those so driven to harming themselves they have repeatedly blocked their own airways with bedding, removed teeth or maimed themselves to the point of exposing their own intestines, frequently causing life-changing injuries.

Treatment, assessment and care for patients under the Mental Health Act (MHA) cannot legally be provided in prisons. Early treatment for mental health disorders is vital and delays in accessing care that cannot be provided in prison can cause irreversible harm. Given this, the current strain on prison places, and the psychological and physical challenge for prison officers and nurses attempting to care for such unwell people, their prompt removal from prison to secure hospitals should be a priority. But it is not. Instead, people linger in prison for weeks, often months and even, in the worst cases, for more than a year waiting for their transfer to be completed.

In 2022–23, over three-quarters of our inspection reports commented on the delays in transferring these seriously unwell men and women from prison to secure mental health beds where they can receive the care they so desperately need and to which they are entitled.

In this review, we focus on the actual wait for these patients rather than just the process: we reveal the extent of these delays, where they occur, and the effect that this is having on those living and working in places of detention. We found many examples where staff assessed, cared, and advocated for their patients. Yet it was evident that, no matter how hard they tried, the ultimate barrier to improving outcomes was the limited access to mental health beds. Of the cases we looked at, fewer than 15% of patients were transferred within 28 days.

We found that access assessments, a key part of the transfer process, were frequently delayed without any recourse and that there was a lack of transparency on how admissions were authorised or rejected and how priority for beds was determined, despite clear commissioning specifications being in place. This was a process-driven pathway constructed to gatekeep beds rather than to optimise patient outcomes.

Prisoners, other prisoners, nurses and prison staff are suffering real harm because of the delays in transferring people to hospital. The level of distress for

some of the most unwell people hidden behind the bleak walls of prisons across England and Wales is appalling.

I will always remember the deep shock of walking into a unit in Eastwood Park, where acutely mentally unwell women were being held in appalling conditions with bloodstains on the floor and scratch marks on the walls; evidence of the levels of distress of the women being held there. I was also hugely concerned by the effect trying to care for these highly distressed women was likely to be having on staff – prison officers with little or no training in mental health.

At Low Newton women's prison in Durham the screams from the inpatient unit where the most mentally unwell women were held were so distressing that other prisoners told us they were put off going for their medical appointments. An experienced and dedicated prison officer told me, with palpable frustration, about his attempts to look after these desperate women without either the training or the resources to support them.

Both of these examples are from women's prisons, but this is not a problem confined to women. In almost every men's prison I have set foot in since becoming Chief Inspector I have seen desperately unwell men awaiting transfer to hospital while being held in the bleakest of conditions.

The draft Mental Health Bill 2022 sought to remove the use of prison as a place of safety and to reform the Bail Act to prevent courts from remanding defendants for own protection solely for mental health reasons. The Bill also proposed a statutory time limit of within 28 days to complete transfers under the Mental Health Act from prisons to hospital. However, the Bill was not included in the King's speech in November 2023, meaning that there will be no legislative reform of the Mental Health Act 1983 in the forthcoming parliamentary session. It is therefore more important than ever to shine a light on this issue.

This report raises a number of concerns which should be addressed to enable a process that ultimately improves outcomes and reduces harm, both for very unwell patients and the staff who care for them.

Fundamental change requires a commitment to placing the patient at the centre, creating an independent and accountable admissions process so that they can access early care and get the help they desperately need.

Charlie Taylor
HM Chief Inspector of Prisons

February 2024

Background

Acutely mentally unwell men and women, who do not consent or lack the capacity to consent, cannot legally receive the assessments, stabilisation and therapeutic interventions needed to treat them while they are held in prison. This level of care can only be provided in an appropriate hospital ward. Patients requiring such care must therefore be transferred to hospital in order to access it. The legal framework underpinning this process is the Mental Health Act 1983 (Mental Health Act 1983 (legislation.gov.uk)).

The transfer and remission of adult prisoners under the Mental Health Act 1983: good practice guidance 2021 (NPGP, see Figure 2) stipulates two timelines of 14 days by which a patient requiring care under the Mental Health Act should be transferred. The first commences at the point of referral, which is initiated as soon as it is identified that a person's mental health needs cannot be appropriately treated within a prison and the first psychiatric assessment (access assessment). The second is the time between this assessment point and the transfer to hospital. Taken together, these should not exceed 28 days. For those with an urgent need, transfer should take place more quickly. However, it is often delayed.

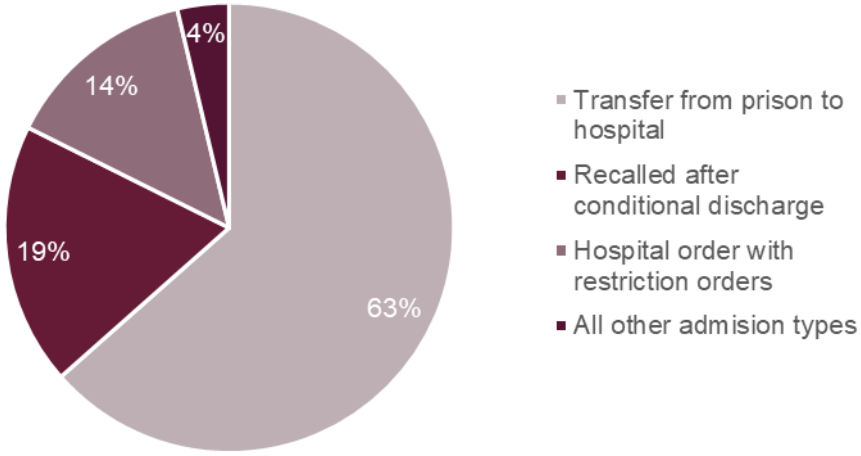
In 2022–23, we noted delays in mental health transfers in over three-quarters of our prison inspection reports. We consistently found during inspections that patient wait calculations were inaccurate. Staff interpreted the wait based on the process rather than from the patient perspective. Even though the need for referral was articulated in clinical records, the patient wait was often only calculated once a referral had been completed, despite delays occurring before this point.

HM Inspectorate of Prisons has been concerned about access to mental health care in prisons for many years. In our 2007 thematic review, *The mental health of prisoners*, we said:

> '… the need will always remain greater than the capacity, unless mental health and community services outside prison are improved and people are appropriately directed to them.'

While there is no comprehensive national data on the number of people awaiting a transfer from prison to hospital, data on all past admissions to secure hospitals shows that the single largest source was transfer from prison. On 31 December 2022, there were 7,796 restricted status patients in England and Wales (mentally disordered offenders who are detained in hospital for treatment and who are subject to special controls by the Secretary of State for Justice), of whom 4,580 were detained in hospital and 3,216 were conditionally discharged into the community. Of the 1,665 restricted status hospital admissions in 2022, the largest source was transfer from prison (63%).

Figure 1: The majority of restricted status patients in 2022 were transferred from prison to hospital.
Based on 1,665 restricted status hospital admissions in England and Wales, 2022 (see Restricted_Patients_Statistical_Bulletin_2022.pdf (publishing.service.gov.uk).



We have been told previously that a lack of secure beds is in part caused by how difficult it is to return patients to prison from hospital once treatment there is no longer required. Yet, although 63% of all restricted status hospital admissions come from prison, on 31 December 2022 only 29% of the patients held in hospital were from prison, suggesting that returning patients to prison is no more difficult than returning them to the community. Remissions (i.e. the return of a patient to prison) also occurred earlier for prisoners in comparison with patients returning to the community. This requires further research to understand the causes and to ensure there is an equivalence of care.

In 2021, HMI Prisons took part in *A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders*. That report recommended that the Department of Health and Social Care, NHS England and Improvement and the Welsh Government should:

> 'Ensure an adequate supply of medium and high secure beds to reduce the unacceptable waiting times for transfer from custody.'

Despite this recommendation being accepted in March 2022 by NHSE Specialised Commissioning, the action plan indicated that additional beds were not required:

> 'There is an adequate supply of adult secure beds. The focus is on improving efficiency across the whole pathway, i.e., ensuring appropriate lengths of stay, reducing transitions, and thereby improving throughput. This will make better use of existing capacity across the whole system, including the pathway to and from prison.'

We have seen little indication that this recommendation has been achieved, or progress made towards this. Our 2022–23 annual report outlined our repeated concerns from inspections of prisons:

> ‘We continued to be very concerned by the plight of mentally unwell prisoners waiting protracted times for transfer to specialist mental health inpatient facilities for treatment under the Mental Health Act. All too often, those in mental health crisis were held in conditions that were clearly detrimental to their health and well-being, usually in segregation or inpatient units.’

The government published a draft Mental Health Bill in June 2022. This proposed removing prison as a place of safety and to end remand for own protection solely for mental health reasons under the Bail Act (courts use the provisions in the Bail Act 1976 to remand people to prison for their own protection or welfare when proper alternatives in the community are not available). The Bill also proposed a statutory 28-day time limit within which people in prison with a severe mental health need must be transferred to hospital for treatment under the Mental Health Act. The Bill was not included in the King’s speech in November 2023, meaning that there will be no legislative reform to the Mental Health Act in the next parliamentary session.

Against a backdrop of rising prison populations and frailties in staffing, HM Inspectorate of Prisons, in partnership with the Care Quality Commission (CQC), undertook this thematic to scrutinise the delays in people accessing care, so that the reasons can be understood and addressed. The review involved fieldwork at 21 prisons to examine the conditions in which those awaiting transfer to a secure hospital are held. We also reviewed the case notes of patients to understand when delays occurred and why.

We hope that our findings will encourage immediate action so that acutely unwell people do not continue to suffer further harm awaiting the care that they need and to which they are entitled.

Key concerns

During this review we identified eight key concerns.

1. **Only 15% of patients in our sample were transferred within 28 days and waiting times for a bed were too long.** The average wait was 85 days from the point it was identified that their mental health needs could not be treated in prison, with a range of three to 462 days.

2. **Despite a service within local courts to divert patients with acute mental health issues to community services, we continued to find people being placed in prison for their own protection, who were arriving in prison very unwell.** Prison was being used as an alternative to a hospital bed even when the need for an admission was evident before imprisonment.

3. **There were delays for two-thirds of the patients waiting for a referral once it was identified that their mental health needs could not be treated in prison.** In some prisons there were considerable delays for patients waiting for an initial referral.

4. **There was little oversight or accountability for the long waiting times for assessment and transfers, of the responsible commissioned health providers.** Data describing access and waiting times for beds were not publicly available. There were no comprehensive national data on the number of patients awaiting transfer under the Mental Health Act and their waiting times.

5. **An urgent referral as a result of a patient's rapid deterioration in mental or physical health did not guarantee prompt transfer, despite guidelines requiring a more rapid response.**

6. **The outcomes for and experience of patients were not central to the transfer process.** Patients did not receive an independent assessment which was accepted by all commissioned services, meaning that the process often included multiple unnecessary assessments. There was a lack of safeguarding and independent advocacy for patients awaiting transfer (see Glossary).

7. **Patients, other prisoners and staff were coming to harm during the time it took to transfer patients.** Patients' conditions deteriorated, staff suffered assaults and the effect of supporting patients with a level of need for which they had not been trained. There was no national reporting on incidents involving this vulnerable group and staff did not always have the appropriate training in recognising specific safeguarding issues associated with patients awaiting assessment or transfer under the Mental Health Act.

8. **Very unwell patients were still being released back into the community while waiting for an access assessment for admission under the Mental Health Act.** This meant that they were being detained by the community mental health team at the gate on release.

Section 1 The transfer process

Key concern 1: Only 15% of patients in our sample were transferred within 28 days and waiting times for a bed were too long. The average wait was 85 days from the point it was identified that their mental health needs could not be treated in prison, with a range of three to 462 days.

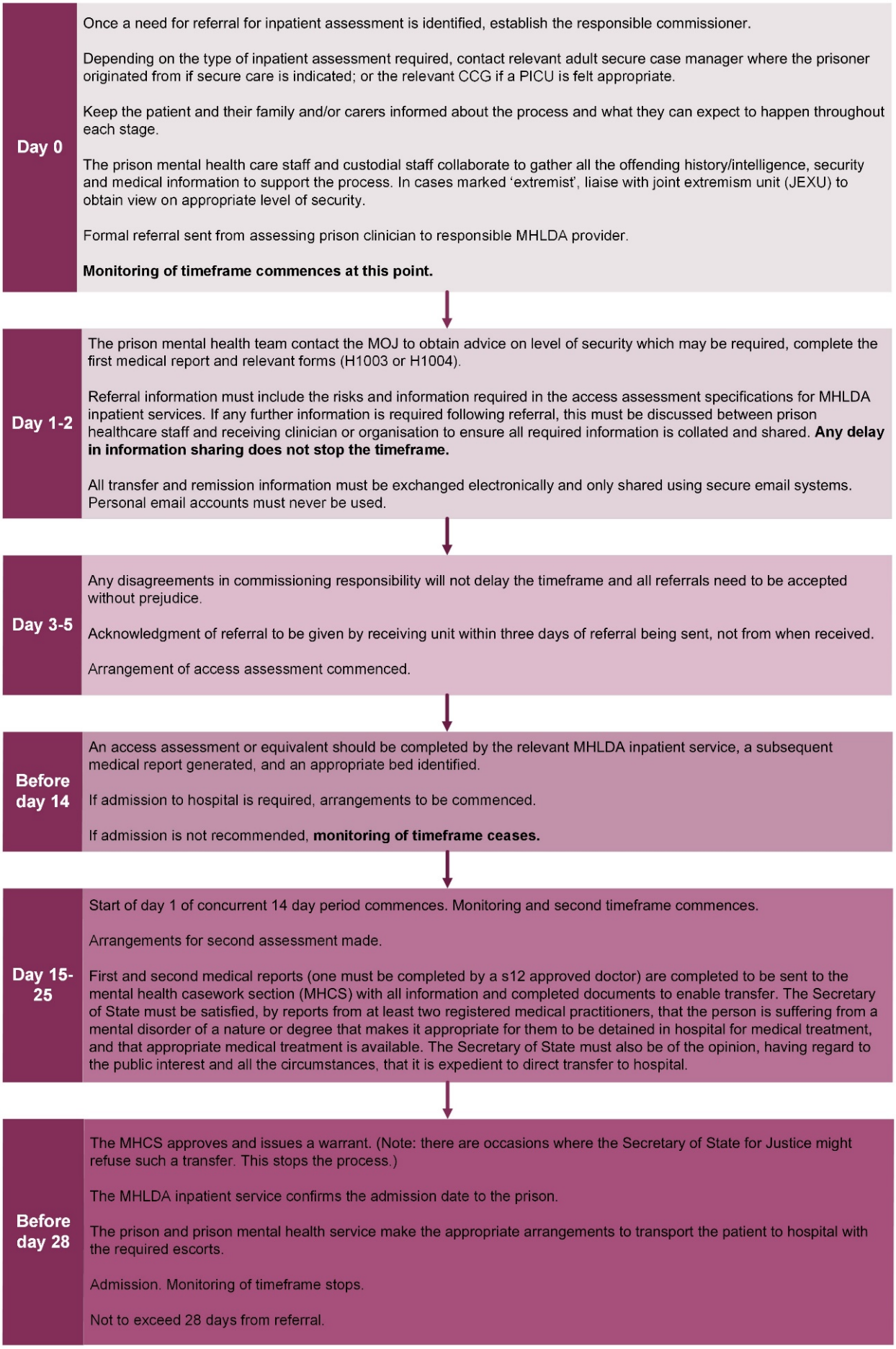
What should happen

1.1 People with specialist mental health, learning disability and autism needs in England should receive care as close to home as possible. The responsibility for this care sits with NHS-led provider collaboratives for medium and low secure beds, NHS specialised commissioning which is responsible for high security beds, and regional integrated care boards which are responsible for psychiatric intensive care units (PICU).

1.2 Provider collaboratives control the budget and commissioning of services for their local population. The collaboratives are led by an NHS provider accountable to NHS England. Prison health staff refer directly into a provider collaborative or to a commissioner based within the patient's catchment area.

1.3 The National Good Practice Guidelines (NGPG) sets out the expected time limits for the transfer from prison to hospital of those over the age of 18 who are sentenced, unsentenced or remanded. These are set out in Figure 2.

Figure 2: The National Good Practice Guidelines.



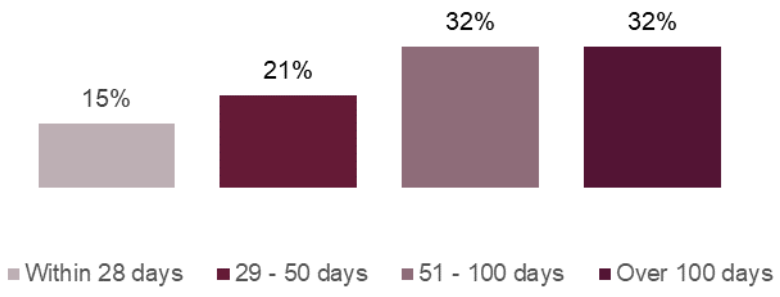
1.4 Other guidance, which exists in parallel to the NGPG, is the national service specifications for the providers of low, medium and high security beds. This breaks the process down into urgent and non-urgent referrals. For urgent referrals, the national service specifications for low and medium secure beds sets out a specified target of two days for an access assessment to take place. But non-urgent referrals for low, medium and high secure beds all set a target of 21 days for an access assessment instead of the 14 days required by the NGPG.

What we found

1.5 Only 15% of patients were transferred to hospital within 28 days from the point it was identified that their mental health needs could not be treated in prison, with an average wait of 85 days. One patient waited an astonishing 462 days.

1.6 We excluded from the calculation above, one patient who had died while waiting for transfer and 13 patients who were still waiting for a bed at the point of collecting our data. If we had included these, the average wait would have been higher as at the point we finished our case file review, these 13 cases had already accrued an average waiting time of 145 days, with the longest having waited 308 days.

Figure 3: Most patients we sampled were not transferred within the recommended 28 days.
Based on 171 patients in 21 prisons across England and Wales 2022–23.



1.7 Of the 171 cases who transferred, six were transferred from prison to hospital under court order. This meant that the route into hospital was different and some of the assessments were undertaken as part of the court processes. These patients had an average wait of 81 days from the point it was identified that their mental health needs could not be treated in prison, with only two (33%) being transferred within the 28-day national guidelines and the longest wait being 256 days. The court processes could both expedite an admission and create long delays.

Admissions from court are directed under different legislation pathways.

1.8 Three patients were detained under the Mental Health Act at the gate as they left prison. Their average wait from referral while in prison to admission on release was 38 days, with the longest wait being 106 days.

1.9 We found serious flaws with the data held on patients waiting for transfer (see key concern 6).

- Data describing access and waiting times for beds were not publicly available. The responsible commissioning team for low and medium secure beds was unable to provide us with any live data.
- We were given access to regional data sets from the NHS England data hub (for English prisons) on the numbers of patients/prisoners awaiting transfer each month. When we reviewed this data, we found significant gaps because of a lack of consistent and accurate reporting from providers.
- Data we requested directly from providers as part of the thematic review were not reliable. For example, one of the sites gave us data with a large number of errors, whereas data from London were almost all correct.
- The 15 provider collaboratives held their own unpublished waiting list that included community patients as well as patients in prison. However, the time it took to assess or admit patients was not linked to any contractual performance monitoring or financial penalties.

The impact on patients

1.10 The extent of the delays for patients is set out in Figure 4. The impact of the delay at each stage is set out in the sections of the report that follow.

Figure 4: Expectations at each stage and what we found.

Section 2 Arriving in custody

Key concern 2: Despite a service within local courts to divert patients with acute mental health issues to community services, we continued to find people being placed in prison for their own protection, who were arriving in prison very unwell. Prison was being used as an alternative to a hospital bed even when the need for an admission was evident before imprisonment.

Diversion from custody

What should happen

2.1 Wherever possible, those needing immediate assessment and treatment under the Mental Health Act should be diverted away from the criminal justice system into a mental health hospital. This does not mean that people are not held to account for their offence, but that any necessary treatment is undertaken as soon as possible. It is well established that the longer it takes to begin treatment the poorer the outcome. Detention in a secure hospital setting is not time-bound and can be longer than an expected prison sentence, as release is determined by a mental health tribunal rather than the end of a sentence. Court proceedings can also occur after a hospital admission.

2.2 To help achieve an early diversion, court and police custody suites have access to liaison and diversion services. These NHS-commissioned services support the decisions on how to manage acutely mentally unwell people in contact with the criminal justice services in the community rather than in custody. This is done by using relevant information from health providers to make recommendations to the judiciary.

What we found

2.3 We found several concerning cases where individuals who almost certainly should have been diverted into health care services from police custody or court – remanded to hospital under section 35/36 of the Mental Health Act – ended up in custody on remand or serving short sentences. Once in prison, there were significant delays in transferring patients to hospital.

2.4 There were also a small number of cases where restricted status patients, who were already being managed under the Mental Health Act, were removed from hospital or the community following a criminal offence to prison rather than to a higher security hospital bed. These already unwell patients were often required to undergo additional access assessments for a mental health bed despite a clear, known underlying mental health disorder.

The impact on patients

Case study 1

John had received several short sentences for a breach of a restraining order. These had been minor public order offences, but the most recent breach had involved a serious physical assault.

It was evident from the notes and what was set out in earlier psychiatry assessments, that the breaches of the restraining order had been wholly consistent with abnormal thinking associated with underlying serious mental illness. These factors were known at the point of John's arrest. John was well-known to community mental health services and had been receiving intermittent support in the community.

Clinical records were available to liaison and diversion; however, John was not diverted at this point due to his presentation, in which he was calm and able to mask his illness. On arrival in prison, he was placed on a wing with little observation due to a significant lack of time out of cell and his level of illness was only noticed because of concerns raised by officers. His legal defence team and prison in-reach services eventually triggered the appropriate referral, but due to the delay he still received a custodial sentence.

No bed was available in John's catchment area, so the case was reassigned to an out-of-area independent sector provider under Section 47 of the Mental Health Act.

From the point of referral, the delay in transfer was recorded at 134 days. However, this did not include the two months that John spent on the wing undetected. John's presentation did not cause difficulties for others within the prison, so his treatment needs were not identified promptly enough.

Case study 2

Robert was known to community services and had previous admissions to hospital with a diagnosis of schizophrenia as well as several previous convictions. Despite this, following discharge from hospital, he had had only sporadic further contact with specialist mental health services.

He had a documented history of delusional beliefs due to his illness and reported hearing voices telling him to harm himself and others at the time of the alleged offence. On arriving at prison on remand, Robert was immediately placed on assessment, care in custody and teamwork (ACCT) case management and moved to the segregation unit due to his risks to others. Robert was reported to have been actively experiencing auditory hallucinations, claiming he was being controlled and interfered with in several ways, commensurate with experiencing a clear episode of psychosis at that time.

It is very likely that his mental health had been unstable for some time. There were reports that he was acutely psychotic at the time of the alleged offence, and his symptoms were an accepted contributing factor. This view was endorsed by the independent psychiatric report for court which stated that '… psychiatric illness is a major factor in the offending behaviour'.

We were told that Robert had waited 41 days for transfer under Section 48 of the Mental Health Act to a medium secure hospital. However, this could be classed as a 79-day wait based on the date of the independent psychiatric court report and nearer 123 days if it is accepted that his acute ill-health was evident at the point of arrest.

Section 3 Initial referrals

Key concern 3: There were delays for two-thirds of the patients waiting for a referral once it was identified that their mental health needs could not be treated in prison. In some prisons there were considerable delays for patients waiting for an initial referral.

What should happen

3.1 Once a health professional has identified that a patient's mental health needs cannot be treated in prison and they require referral to hospital under the Mental Health Act, a referral should be made to the responsible mental health, learning disability and autism provider. In prison this is almost always undertaken by a psychiatrist or Section 12-approved doctor. Additional information gathering, for example liaising with the Ministry of Justice to obtain advice on the level of security required by the receiving hospital and providing the required documents for the mental health caseworker, can happen in the following days, but any delay in information being provided should not change the timeline within which a patient should be referred.

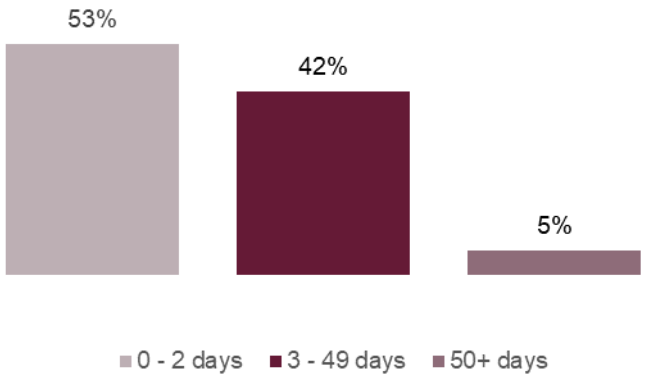
3.2 We recognise that, where diagnosis is not clear, or, in order to implement medication with consent, a period often referred to as 'watch and wait' may be required. Where relevant, we have not included periods of 'watch and wait' in our calculations.

What we found

3.3 Almost all (18) of the 21 health providers were calculating the waiting time from the date of referral, even when the referral was delayed, rather than from the moment when the need for referral was identified. Three providers calculated the wait from the access assessment, even later in the process.

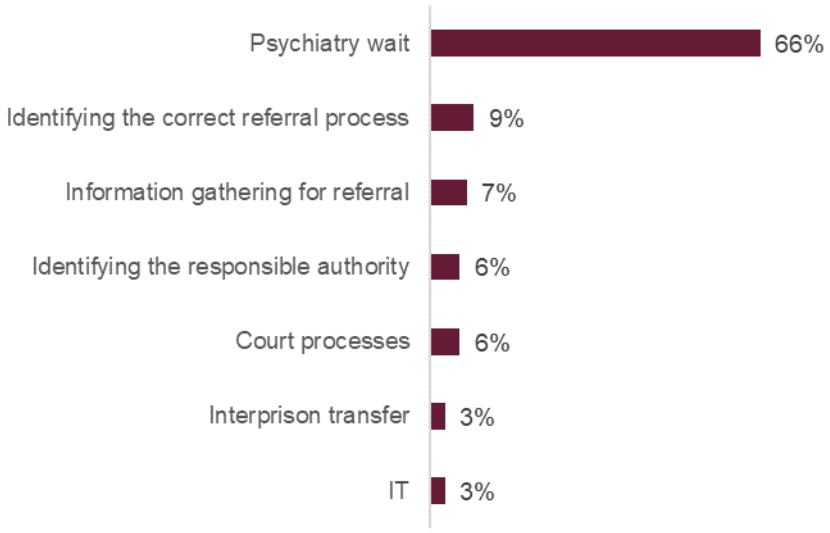
3.4 Only 34% of patients were referred on time (on day 0) and 66% were delayed. Fifty-three per cent were referred within two days. For 5% of patients the wait for a referral was over 50 days, and the longest wait for a patient in our sample was 118 days.

Figure 5: Most patients did not get referred on the day the clinical notes identified that their mental health needs could not be treated in prison.
Based on 184 patients in 21 prisons across England and Wales, 2022–23. Note: this information was not available for one patient.



3.5 Referrals were made by a psychiatrist; most sites believed this was a requirement and some referred to referrals being rejected because there was no covering psychiatrist letter. Sixty-six per cent of the recorded delays were due to the wait to see a psychiatrist. The most common reasons given for the delays included: a lack of psychiatry appointments (one site which had experienced inconsistent psychiatrist cover over a long period had an average wait of over a month); limited administrative time for the psychiatrist; and, at a small number of sites, a lack of prioritisation of referral paperwork.

Figure 6: Most referral delays were as a result of prisoners waiting to see a psychiatrist.
Based on 68 patients in 21 prisons across England and Wales, 2022–23. Note: The cause of delay was not clearly documented in 55 of the cases we reviewed.



3.6 The second most common reason for delay at this stage was a lack of clear referral pathways. Some referrals were sent to the wrong responsible commissioner, and when health providers were referring a patient out-of-area they risked making errors due to unfamiliarity with other region's processes.

3.7 In describing their experiences of the referral processes, prison mental health professionals from all disciplines outlined systems that were not always patient centred. This included needing to respond to the varying information requirements of different providers; having to use different templates to capture information; and finding the correct person to escalate concerns with long waiting times. Though this was usually standardised within the collaborative close to the prison, clinicians had to adapt and modify the referral process, particularly when referring patients outside of their own catchment area. Two prisons specifically identified an electronic referral process as a barrier to referral due to the extensive amount of information required.

The impact on patients and staff

3.8 Many prison clinical staff were concerned that it took so long to work out the right referral pathway for patients and that the time spent on these administrative tasks reduced the time they could spend delivering face-to-face therapeutic work with patients. This was exacerbated when mental health teams were short-staffed.

'It would be really helpful to have a generic referral process or resource that was the same nationally and didn't involve extensive googling hospitals and cold calling them to establish if they are the correct service.'

Consultant psychiatrist, HMP Ashfield, HMP Bristol, HMP Erlestoke, HMP Leyhill.

Section 4 Access assessments

Key concern 4: There was little oversight or accountability for the long waiting times for assessment and transfers, of the responsible commissioned health providers. Data describing access and waiting times for beds were not publicly available. There were no comprehensive national data on the number of patients awaiting transfer under the Mental Health Act and their waiting times.

What should happen

4.1 An access assessment is the clinical assessment of the mental health and risk management needs of an individual. It is used to inform decisions about the most appropriate inpatient placement for the person given their care and treatment needs, and the level of security required.

4.2 The NGPG states that an access assessment or equivalent should take place within 14 days of a patient's referral being made (the referral should happen at the point it is identified that the patient's mental health needs cannot be treated in prison.) The access assessment is the responsibility of the relevant mental health, learning disability and autism (MHLDA) provider. The access assessment should take place sooner for urgent referrals.

4.3 We reviewed the wait between the referral and the access assessment, as well as the resulting cumulative delay for the patient.

What we found

4.4 The average time between the point it was identified that a patient's mental health needs could not be treated in prison and carrying out the access assessment was 29 days. Sixty-three patients (34%) had waited more than 28 days at this point.

4.5 Fifty-seven per cent (106) of patients received an access assessment within the required 14 days of the initial referral. However, the 14-day timeline had already been breached for 35 of them due to earlier delays between identification of the need for referral and when it took place. Access assessments were delayed in the remaining 43% (79) of cases.

4.6 Most access assessments were facilitated by prisons and prison health providers as a priority. They were undertaken face to face, by remote paper reviews and by remote video link assessment. It was not always clear which method was the most effective to optimise timeliness, but the range of options was helpful to expedite the assessment.

4.7 We saw multiple unnecessary assessments of some patients which were driven by the bureaucratic process rather than their need. Fewer

assessments occurred where there was an existing professional relationship between the referring psychiatrist and the access assessor and an increased number of assessments when an out-of-area bed was required.

4.8 Unexpectedly we also saw a small number of access assessments abandoned or delayed because patients either refused to engage or lacked the capacity to do so. This delayed the admission process considerably. This mostly affected patients in segregation units who were a risk to others. The challenging nature of these patients made the impact of these delays greater on the officers caring for them.

4.9 Despite the performance targets in the published national specifications, we found no evidence of performance management or consequences for protracted waiting times for access assessments which allowed these poor practices to proliferate.

4.10 Mental health teams and other stakeholders expressed disquiet about the absence of any national coordination or standardisation of approach. We were told that there was no overarching national framework to assist with these processes or to monitor activity in relation to admissions. However, in London each prison had access to a transfer coordinator and pathway lead, which allowed the clinical teams to focus on delivery of care while the coordinators tracked and chased the referrals. The impact of this additional resource had not yet been evaluated against waiting times as there was limited comparative data. We did however see a more consistent approach to admission based on risk. Despite this, the limiting factor for admission remained bed availability.

Figure 7: Most of the recorded delays for access assessments were due to waiting for an assessment to be booked by an assessor.
Based on 80 patients in 21 prisons across England and Wales, 2022–23.

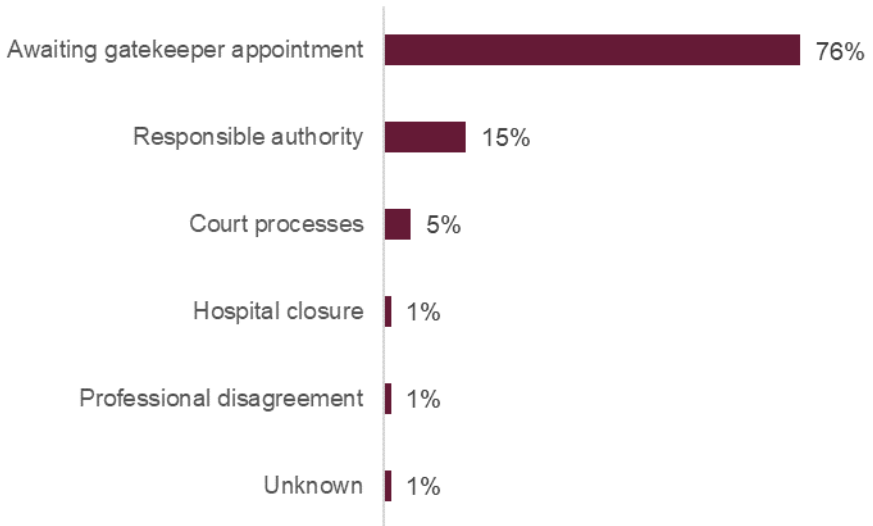
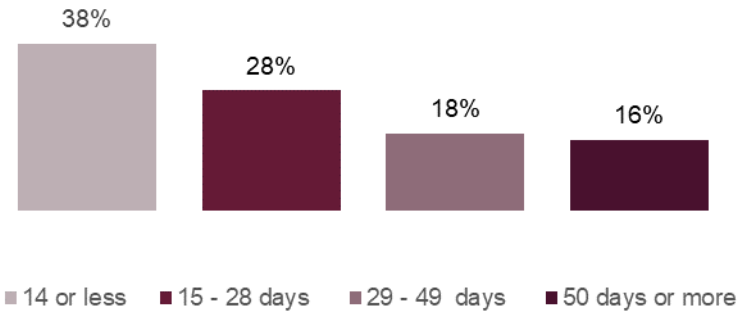


Figure 8: Most patients wait too long for an access assessment – delay from day 0.
Based on 185 patients in 21 prisons across England and Wales, 2022–23.



The impact on patients

Case study 3

James was declined an access assessment following a review of the paper referral. The access assessor offered an assessment two weeks later.

The assessment was then delayed by a further two weeks. At this point, four weeks after the review of his paper referral, James had his access assessment and was accepted for admission. The rejection of the initial referral stopped the clock, meaning that the intervening four weeks were not included in the recording of the total time that James waited for transfer.

There was no obvious rationale in the clinical records for declining the initial referral or delaying James's assessment by four weeks.

One interpretation of this could therefore be that assessment processes are being used unofficially to manage admissions timelines or stagger admission as the rejection of the initial request meant that the four-week delay was not included in the official record of James's transfer waiting time.

Section 5 Urgent referrals

Key concern 5: An urgent referral as a result of a patient's rapid deterioration in mental or physical health did not guarantee prompt transfer, despite guidelines requiring a more rapid response.

What should happen

5.1 The NGPG sets out that the presenting clinical indication and the clinical risk will determine the priority and pace for a patient's transfer to be completed. Urgent cases should therefore be expedited and transferred sooner than the maximum 28 days. It also lists three areas of risk to consider.

- Is there evidence of a rapid deterioration in mental health presenting a risk to self, other prisoners, and staff?
- Is there evidence of a rapid deterioration in physical health due to mental health problems?
- Is there a need for restrictive practices in prison to maintain safety due to mental health presentation?

5.2 Most clinical staff did not reference these risks but told us that the assessment was a dynamic process based on the patient's presentation.

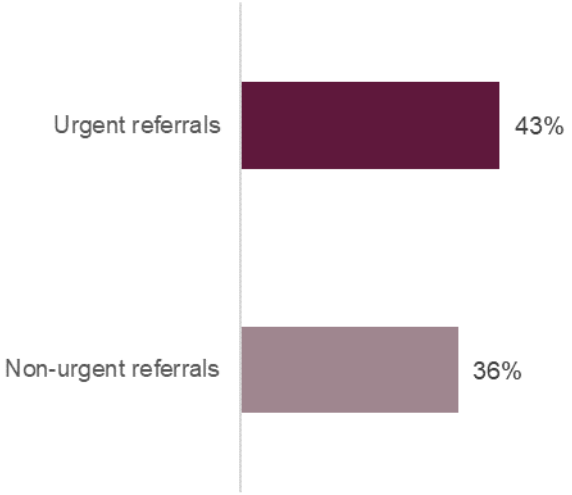
What we found

5.3 In some cases, referrals were not categorised as urgent despite the patients arriving at the prison in an extremely disturbed state. One patient, who was not categorised as an urgent referral, was presenting with psychosis and howling like a dog on arrival; his notes indicated that they had a serious mental health condition. A second patient, who arrived having been charged with a serious offence, was agitated and combative with staff, appeared to be experiencing auditory and visual hallucinations, and had no obvious awareness of their ill health. This patient also arrived without their prescribed medication and there was no indication of when they last took it.

5.4 Fifty-three patients (30%) within our sample were categorised as urgent referrals. Of these only 43% received an access assessment within the good practice timeline of 14 days.

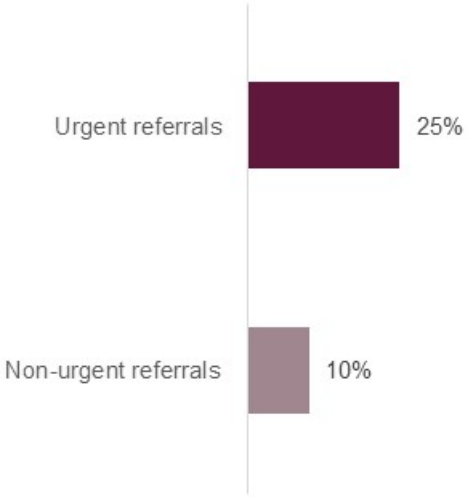
5.5 This was a higher proportion than those with a non-urgent referral, of which 36% of a total of 132 had an access assessment within 14 days.

Figure 9: A slightly higher proportion of urgent referrals received an access assessment within 14 days from the point it was identified that their mental health needs could not be treated in prison.
Based on 53 urgent and 132 non-urgent referral patients in 21 prisons across England and Wales, 2022–23.



5.6 Only 25% of patients who were urgently referred were transferred to secure mental health provision within the national guidelines of 28 days, compared with 10% of the non-urgent patients. Of the 13 patients who were still waiting for a bed at the time of our visit 12 were non-urgent; the one urgent patient had been waiting for 203 days at the time of our fieldwork visit.

Figure 10: A higher proportion of urgent referrals were transferred within 28 days from the point it was identified that their mental health needs could not be treated in prison.
Based on 52 urgent and 119 non-urgent referral patients in 21 prisons across England and Wales, 2022–23.



The impact on patients

Case study 4

Andrew was detained in a high security prison and was known to community mental health services. He was identified on arrival through the court processes as unfit to plea.

An urgent referral was sent but was rejected by the responsible commissioner as they believed he was no longer their responsibility. The referral was then sent on to the local provider collaborative. It took 35 days for an access assessment from referral and a further 30 days for feedback that he had been accepted for admission.

After an additional month of waiting due to discussions between the medium secure and high secure hospitals, Andrew was finally admitted to a medium secure bed on day 149. The urgency of his need had had no impact on the speed of the admission.

Section 6 Patient experience and advocacy

Key concern 6: The outcomes for and experience of patients were not central to the transfer process. Patients did not receive an independent assessment which was accepted by all commissioned services, meaning that the process often included multiple unnecessary assessments. There was a lack of safeguarding and independent advocacy for patients awaiting transfer (see Glossary).

Delays in decisions following access assessments

What we found

6.1 We saw many access assessors giving a clear and concise response to the prison health providers following an assessment, and some of these were given on the day of the assessment.

6.2 However, at times there were delays agreeing to a bed because professionals disagreed about the level of security needed or whether a specialist bed was needed. The national guidance states that these issues should not cause a delay to the transfer time of patients deemed to require admission.

6.3 In some cases, it took an excessive amount of time to hear the outcome of an assessment. Sixteen patients included in our sample (9%) waited nine days or more for feedback following an access assessment; the longest wait was 70 days for an assessment report for a specialist bed.

6.4 Health and justice commissioners had funded transfer coordinator roles to chase up transfers and apply pressure to the bed managers and escalate to the commissioners of the required beds. Where this resource was not available, nurses and psychiatrists had to undertake these administrative tasks which reduced their availability for providing clinical care for patients.

6.5 The impact of the transfer coordinator role was positive. In most cases the data collection accuracy was better, but not all coordinators calculated the patient wait, instead focusing on the process. For example, we found one transfer coordinator only starting the clock once the patient was accepted for a bed. However, the speed of transfer entirely depended on the availability of beds.

‘We ask the commissioners to escalate the bed and they don’t get back to you, we are just so powerless.’

Transfer coordinator

The impact on patients

Case study 5

Liam arrived in the prison and was admitted directly into the segregation unit as he was a risk to others, particularly to women.

After 18 weeks in the segregation unit, he was moved into the inpatient unit as there were concerns about his mental health. During this period, he could only be unlocked by three officers due to his risk of violence. Following a period of observation whereby health professional attempted to encouraged Liam to take some medication, he was referred for an access assessment for transfer to a secure hospital where antipsychotic medication could be administered.

There was discussion about his level of risk to others, which took so long to resolve that Liam's access assessment was not undertaken until three months later. The outcome of this assessment took one month, and it then took a further 33 days for Liam to be moved to hospital under section 47. The total wait time was 163 days.

The receiving hospital advised that he was acutely psychotic on arrival and that he required an immediate antipsychotic injection as he continued to refuse treatment. The extra month waiting for a reply after a three month wait for an assessment created needless suffering for both Liam and the prison and health staff responsible for him.

6.6 Once patients had been accepted as requiring admission to hospital many were still not transferred in a timely manner, and we found evidence of further practices that were inexplicable. The ways in which these delays impacted some of the patients in our study are set out below.

Multiple assessments

What we found

6.7 Some patients were subjected to additional and often unnecessary assessments prior to admission, which lengthened waiting times. Of the 185 cases reviewed, 28% (52) underwent assessments in addition to the required second assessment prior to transfer.

6.8 The reasons for multiple assessments included: additional nursing assessments being required by the receiving hospital; changes to the decision on the level of security of the hospital needed and additional out-of-area bed access assessments.

The impact on patients

6.9 Records showed that patients were confused and distressed by the repeat assessments, sometimes undertaken as many as five or six times.

6.10 The prioritisation of additional assessments over a timely admission was clearly not patient-centred, and several patients' mental health deteriorated during this time. Additional assessments were consistently required for the high secure pathways as the psychiatrist and nursing assessment were not always undertaken at the same time. For all admissions there was frequent evidence of a reluctance to trust other professional assessments and attempts to gatekeep who was admitted.

Case study 6

It took 10 days to identify the responsible commissioner for Darren, who required an out-of-area transfer. The referral took 55 days to be acknowledged by the responsible authority with no reason given for the delay. It took a further 24 days for an assessment to be undertaken and another 31 for the outcome to be shared. The admission was rejected at day 120.

Darren was being held in the prison segregation unit, having mutilated himself and assaulted staff and another prisoner. His case notes indicated that the prison health care team was using sedation to reduce his distress. The decision to reject the referral was appealed, but the responsible commissioner requested a second referral. A second assessment was undertaken, and it was agreed on day 170 that a medium secure bed was required. However, no bed was available with the responsible MHLDA provider.

A third assessment was undertaken by a private sector provider 13 days later. Five days after the assessment the provider declined admission as they were unable to manage Darren because he required an elevated level of observation.

A fourth assessment was undertaken by another private provider 26 days after this rejection. Over the next two days, two further hospitals declined to admit Darren as they were not able to manage his needs.

A week later the original responsible access assessor returned to undertake Darren's fifth assessment overall and their third. They admitted Darren 11 days later. This highly distressed patient had waited 234 days for transfer, mostly in isolation in a segregation unit.

Rejection for admission

What we found

6.11 Of the 171 patients who had been transferred to hospital at the time we collected our data, 15 were initially refused admission following the access assessment. Despite this, they were all eventually admitted, but after waiting between 41 and 462 days.

6.12 It is unclear whether the access assessment itself was ineffective or the patients were required to deteriorate in order to reach the threshold for

admission. However, it is evident that such delays reduce the benefits of early intervention and increase the damage caused by delayed care.

The impact on patients

Case study 7

Halina's referral was rejected after 25 days as being inappropriate. In this time, Halina was admitted to the local hospital three times for 10 episodes of serious self-harm.

The decision was appealed, and during the 27 days it took to wait for an appeal and for the access assessment to be undertaken, Halina inflicted a further 16 injuries on herself, seven of which required hospital admission, including 13 nights for surgical treatment. A further 19 days were required in hospital due to self-harm while she waited for a bed to be available. The mental health admission was further delayed while waiting for Halina to recover from her physical injuries.

Self-harm is not in itself a reason for admission, but serious self-injurious acts are a criterion for urgent admission for someone with an underlying mental health condition. The lack of a face-to-face assessment in this case may have impacted the decision to accept the referral. It is possible that some of the serious self-harming may have been avoided if Halina had been able to access earlier treatment.

Mental health advocacy and adult safeguarding

What should happen

6.13 There is no specific regional or national platform to report violence, restraint, or self-harm for the patients waiting for assessment or transfer under the Mental Health Act.

6.14 As patients in prison are hidden from public view and may struggle to receive a visit from their families – particularly those in the segregation unit and inpatient units who are very unwell – it is important that they are represented by an independent advocate. The National Institute for Health and Care Excellence (NICE) describes advocacy as a structure to help ensure that people's voices, wishes and preferences are heard, their rights are upheld, and their needs are met. This is particularly important when they have difficulty in speaking up for themselves or are concerned that they are not being heard.

6.15 Health care professionals understand that they are responsible for advocating for patients and reviewing capacity and best interests while caring for an individual. However, where a health professional is making decisions and prison managers are part of the management of unwell patients, an independent advocate who can represent the interests of the patient should be involved. Having someone to represent patients when they are enduring long waits for a bed, being held in isolation and, in a few instances, being restrained and

handcuffed for the most basic of daily activities is important to prevent the risk of abuse and to ensure someone is independently representing their best interests while keeping all those involved safe.

What we found

6.16 Only one of the 21 sites had mental health advocacy. During our July 2022 inspection of HMP Liverpool, we noted:

> 'The mental health team had good resources including mental health and learning disability nurses, occupational therapy, psychiatry, speech and language therapy, social work, psychology, counselling and IAPT practitioners (Improving Access to Psychological Therapies). Independent mental health advocates worked alongside the team… The care programme approach was used consistently for patients with complex or severe and enduring mental health conditions and involved a range of professionals, including independent advocates.'
>
> **Report on an unannounced inspection of HMP Liverpool**

6.17 At least one prison in this review used local clinical incident reporting mechanisms to report when a patient exceeded the 28-day national target. Safeguarding reports had occasionally been submitted for these patients in recognition of the risk to their welfare, but in most prisons, we found a lack of understanding of what type of incident should result in a safeguarding report being submitted.

The impact on patients and staff

6.18 While held in prison, patients were not accessing the further assessment or treatment they needed. Clinicians said it was common to see patients deteriorate and levels of disturbance increase while they waited to be transferred to hospital. They also had concerns about patients who were more 'quietly ill' or with hidden symptoms.

6.19 Cases we reviewed revealed harrowing stories of self-mutilation, violence towards staff and other prisoners, resulting in some severe and life-changing injuries. These are the extreme cases, but it was not exceptional during our review to see patients arrive in prison and be placed directly into the segregation unit due to the extreme risk they posed to others, or on constant watch due to the risk they presented to themselves.

6.20 In our 2022–23 annual report, we noted concerns about the very limited mental health training that most prison officers receive, given the high level of need among prisoners. Health staff and officers told us about the stress they experienced in managing these acutely unwell patients. Many officers felt ill-equipped to care for patients and described their distress in watching people physically and mentally suffer while waiting for treatment. They described patients committing acts of violence and injuring themselves. They told us that they experienced anxiety when

opening cell doors to offer patients food or activities due to the unpredictability of some of the patients.

Case study 8

Jas was so unwell at time of arrest that the police psychiatrist made an urgent referral while in police custody to the high secure hospital estate.

On the day of Jas's arrest, the community health team were in the process of undertaking a recall from the community to hospital under section 37/41 due to a deterioration in mental health. Jas was arrested during this process due to significant resistance during which he committed a criminal offence.

On arrival at prison the patient was placed directly into the segregation unit due to his assessed risk to others.

Four weeks later Jas refused to attend an access assessment within a secure room. As a result, the assessment did not take place. Thirty-nine days later an assessment was undertaken by a social worker and a further doctor assessment took place over the phone the following week. It took a further two weeks for a response to be received that Jas had been accepted for a bed.

During the wait for an assessment and later a bed, Jas remained combative and assaulted staff by stabbing and biting them. Due to the ongoing risks to staff, activities in the unit were undertaken with a higher safety protocol which required multiple officers to unlock. There were required planned interventions which resulted in injury to both Jas and some staff during restraint.

The safety protocol escalated to the use of handcuffs and shields to enable the patient to access food and showers, which created a highly restricted regime. Clinical notes indicated that Jas was not provided with a meal on one occasion as the safety protocol was not adhered to. There was no evidence of safeguarding or advocacy for the patient within the health records.

It took a further 36 days for Jas to be transferred: a total of 18 weeks.

Section 7 Keeping people safe and arrangements for transfer

Key concern 7: Patients, other prisoners and staff were coming to harm during the time it took to transfer patients. Patients' conditions deteriorated, staff suffered assaults and the effect of supporting patients with a level of need for which they had not been trained. There was no national reporting on incidents involving this vulnerable group and staff did not always have the appropriate training in recognising specific safeguarding issues associated with patients awaiting assessment or transfer under the Mental Health Act.

Where patients are held in prison

What should happen

7.1 Patients identified as requiring transfer under the Mental Health Act should be held in the safest place. Their time in prison should be minimal, and while they are waiting to transfer the environment should be therapeutic and calm.

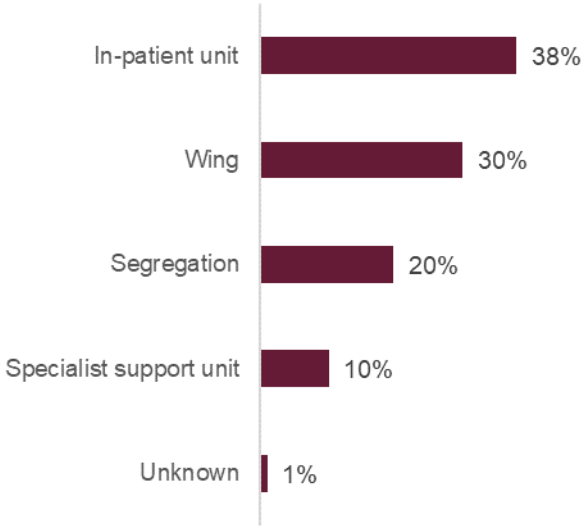
7.2 We know that not all patients transfer under the Mental Health Act. Inpatient and specialist units with suitably qualified staff offer an opportunity to prevent further deterioration if patients consent to treatment. There is the potential of an improvement in mental health if the conditions are good and the episode is managed early. We see good outcomes for patients where there is early intervention and regular monitoring by clinical staff and psychiatry support. However, staffing is often depleted by vacancies and patients can arrive in prisons acutely unwell. The prison environment is rarely calm and therapeutic and offers little in the way of safe space and purposeful activity.

What we found

7.3 While waiting for admission most patients were held either in prison inpatient units (38%) or on prison wings (30%). Twenty per cent were held in segregation units, and 10% were located on a specialist support unit.

7.4 Where people were held depended on the facilities available in the prison, and the risk that the patient posed to themselves or to others. Wherever patients were held, they had very little opportunity to participate in a regime or to leave their cells, as many were too unwell. None of the environments were appropriate for acutely unwell people.

Figure 11: Most patients in our sample were located on wings or inpatient units while awaiting transfer.
Based on 185 patients in 21 prisons across England and Wales, 2022–23. Note: percentages in this chart do not total 100% due to rounding.



Examples of cells in inpatient units

Unfurnished segregation cell (left) and furnished segregation cell (right)

Constant supervision cell in inpatient unit (left) and inpatient cell with constant CCTV (right)

7.5 Inpatient units are not the equivalent of hospital facilities and being located there does not mean that patients are receiving treatment, particularly if they are refusing medication. Inpatient units are usually a group of cells which are separate from the main prison wings. They are staffed by health care and prison staff, but health care staff may only visit during the day, rather than being based there. The units allow consistent supervision for patients who pose a risk to their own safety.

7.6 Most of the category B prisons in our fieldwork had inpatient units, but none of the category C establishments did. Category C patients were therefore often transferred to a category B inpatient unit to provide increased supervision in a smaller unit. The remaining patients were managed on the wings or in segregation.

7.7 Patients who pose the greatest risk to others are managed in segregation units. Segregation in prisons is managed differently to high security hospitals and conditions are generally bleak. Because they pose a high level of risk to themselves and others, patients held in segregation are only unlocked with multiple officers. Staff told inspectors how difficult it was to care for patients in distress in these circumstances.

7.8 Patients were frequently moved between different units in a prison, for example if the risk that they posed to others increased. Sometimes, they were transferred to other prisons where they could be more consistently observed while awaiting transfer.

7.9 Most of these were planned transfers to other prisons for better oversight, but in some of the cases we reviewed patients who had been transferred unnecessarily between prisons for administrative reasons. One example of this was court appearances which, combined with prison population pressures, triggered a move to a different prison, requiring a further transfer back to the original prison days later. We did not see safeguarding reports being undertaken for patients transferred between prisons where it was clearly not in their best interest, and there was no evidence of a handover of care.

7.10 Surprisingly, staff told us that patients managed on the wings who presented with less complex needs and were more compliant were likely to be transferred faster than those with more complex or challenging needs.

The impact on patients

7.11 The review identified one patient where an access assessment was missed because they were not in the location noted in the original referral. This was due to the patient attending a court appearance, after which they had not been returned to the same prison. Clinical staff were obligated to locate the patient and arrange suitable transport for the transfer between prisons.

Second medical assessment

What should happen

7.12 The decision to move a patient to a secure hospital requires specific evidence to enable a prompt decision by the Mental Health Casework Section (MHCS) within the Ministry of Justice. This includes two medical assessments with a recommendation to admit, the first of which takes place at the outset of the referral process. The second

medical assessment must be undertaken by a Section 12- approved doctor or psychiatrist.

7.13 The NGPG states that a second assessment should then take place between days 14 and 25 of the patient's need for hospitalisation being identified.

What we found

7.14 We had complete case information for 145 patients at this stage. The following 40 cases have been excluded from our analysis:

- 10 of the 13 patients who were still waiting for a bed at the time of our visit and had not yet had a second assessment
- four patients who had moved under court direction
- 25 patients who had no date recorded for the second assessment or there was no copy of the document in their case notes
- one patient who had died while waiting for transfer.

7.15 Of the 145 patients who had a date for their second medical assessment recorded, only 29 received this within 25 days from the point it was identified that their mental health needs could not be treated in prison.

7.16 The average wait between the first and second assessment was 48 days, with most of the delays incurred waiting for a bed to be available. In most cases (77%) where the second assessment was undertaken over 25 days from the point it was identified that their mental health needs could not be treated in prison, it was only completed once an appropriate secure bed was available. Completing a second assessment early meant that the assessment often expired prior to transfer and then needed to be repeated to make sure there was a current recommendation for the MHCS.

7.17 Many specialist providers only admitted patients from prison into a seclusion room, rather than other parts of the hospital, which at times felt unnecessary.

7.18 All clinicians and other local stakeholders categorised the main reason for delays in transferring patients under the Mental Health Act as a shortage of beds. In most cases patients needed at least a psychiatric intensive care unit (PICU), or other facility with a particular level of security, though it was commendable that, in London, they utilised low secure and psychiatric intensive care units when appropriate and not just on the point of release. This was rare in most other areas.

Issuing a warrant for transfer

What should happen

7.19 When the MHCS receives the expected legal documentation, it is required to make an approval decision. If the move is approved, it issues a warrant. MHCS works to a set of key performance targets to

prevent delays. The target for restricted patients moving to hospital is five days from receipt of all required paperwork, but there is an internal target of 24 hours.

7.20 The MHCS also requires a specific bed to be identified as part of the application process to ensure security levels are adequate to maintain public protection.

What we found

7.21 The MHCS was rarely a cause for delay, and there was good practice and comprehensive data on transfers and remissions.

7.22 Of the 129 cases where there was full information, warrants had been issued within five days for most (92%) of patients, and for 87 prisoners (67%) this was within 24 hours. In only 10 cases did this take over five days. The MHCS provided us with unpublished management data which indicated that in 2022–23 fewer than five transfers exceeded the five-day KPI and the average wait was one day.

Section 8 Detaining patients on release

Key concern 8: Very unwell patients were still being released back into the community while waiting for an access assessment for admission under the Mental Health Act. This meant that they were being detained by the community mental health team at the gate on release.

What should happen

8.1 Unwell patients should be assessed urgently and admitted prior to release.

What we found

8.2 Staff told us that patients previously known to both community and forensic mental health services were frequently in prison for very short sentences or remand. These patients arrived requiring treatment under the Mental Health Act and would have benefited from an earlier court or community treatment plan. The time in custody could range from a few days to a few weeks and despite a referral during the prison stay, would end in a mental health assessment on release. This Mental Health Act assessment took place at the point of release, as an emergency by the community mental health team to ensure the patient was admitted to hospital at that point.

8.3 These cases created additional pressure for health providers as it often required two parallel processes to be started, in anticipation of a failed urgent referral for admission from prison. Staff worked extremely hard to make sure that acutely unwell patients were not released back into the community without a hospital admission, particularly if they were a risk to themselves or others.

8.4 Three patients in our sample were detained under the Mental Health Act by the community mental health team at the gate.

The impact on patients and the community

8.5 There are risks to patients themselves and to others if they are released without treatment. We saw at least one patient in this group who was detained under the Mental Health Act who had previously been unexpectedly released on bail while waiting for an assessment and was remanded a few months later following serious violent and sexual offence charges. This is not always the case, but the serious risk remains.

8.6 Despite community services being informed of such releases, the opportunity to engage with these patients is limited. They regularly have transient accommodation and community services are often not

resourced to undertake assertive outreach for patients who are not engaging.

Appendix I Methodology

Project group members

A small project group was invited to oversee the work, which included inspection partners in England and Wales. Health Inspection Wales (HIW) were unable to join the thematic review, but we were supported by the Local Health Board in Wales. We wrote to our prison and health partners to advise them of the project with an overwhelmingly positive response.

Fieldwork

HM Chief Inspector of Prisons also undertook a fact-finding visit to a medium secure unit at Northgate Park in Morpeth, part of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, where he met with the associate director for secure care and a nurse consultant.

Selection of prisons

The fieldwork was undertaken between March and May 2023. It followed our standard inspection methodology and included an inspector from the Care Quality Commission (CQC) specialist team and three registered clinicians from HM Inspectorate of Prisons. CQC's mental health policy lead supported this review. Health inspectors visited 21 adult prisons. The prisons were chosen to ensure a wide geographical spread, and at least one in each region was included, including one in Wales. Our sample included 12 category B prisons, three prisons in the long-term and high secure estate and four category C prisons. We also visited two women's prisons. Due to the small number of cases in the two women's prisons we visited, all cases were included in the review, and we have not conducted a separate analysis for these prisons. Category D (open) prisons were excluded from our selection of prisons, in part due to transfer numbers being extremely low. Patients who were acutely unwell in category D prisons were often transferred back into the category B estate for an inpatient bed.

A pilot was conducted in one prison to test the methodology. The findings of the pilot are not included in the subsequent analysis.

Case selection and data collection

Before our thematic visits each prison provided the data on the transfer and waiting times for those who had transferred to a secure mental health bed between 1 April 2022 and 31 March 2023. Details for those still waiting for transfer were also included to make sure there was a full picture. The data provided by the establishments was triangulated with information from individual records to check for accuracy.

The individual patient case files selected for in-depth review covered varying durations of wait. This ensured that those who had waited the longest and shortest times were included to enable us to identify good practice.

A total of 185 patient cases were sampled across the 21 prisons. While most cases were eligible for the full analysis, some cases were incomplete; for example, 13 patients had still not been transferred at the time of our fieldwork visit, and one patient sadly passed away while awaiting their transfer. These 14 cases have been excluded from any total transfer time calculations. In total 15 cases were excluded once we verified data accuracy, as they fell outside of the transfer times or lacked adequate information for the analysis.

Some of the case studies included in this report were not eligible for analysis but have been included to describe the impact of extended waiting times for patients.

What we measured against

This review measured the time it took for patients to be transferred to a hospital bed once it was identified that their needs could not be met in prison.

We used the NGPG to structure the report, but outcomes for patients were our priority.

We referenced the national specifications for low, medium and high secure inpatient beds for NHSE adult secure services publications.

We reviewed the data sets that were provided by health providers directly and then triangulated the information for accuracy through paperwork and electronic records.

- Patient arriving unwell and as a place of safety.
- Pre-identification watch and wait or treat: We acknowledged a period time may be required, where diagnosis was not clear, for a period of observation or treatment.
- Day 0: The date the clinical staff identified in the clinical records that a patient's mental health needs could not be treated in prison, and a referral should be sent to the responsible MHLDA provider requesting a gatekeeping assessment.
- Days 1–14: The time it should take for an access assessment to be undertaken, a response received, and a specific bed agreed for those accepted for admission.
- Days 15–25: The time to get a second assessment and approval for the transfer from the MHCS and the Secretary of State.
- Day 25 – before day 28: The arrangements for transfer to be made.
- Those released prior to admission.

Other sources of information

Clinical leads and psychiatrists

We met with the clinical leads within the prison mental health teams to understand their experience of managing transfers and with a wide range of professional staff to better understand the pathways, and what work was currently being undertaken to improve access and waiting times.

Prison staff

We met with some governors who facilitated our visits and prison staff who were frequently in contact with mentally unwell prisoners. We spoke with segregation staff at most sites and officers who supported inpatient and specialist units to understand their experiences.

National health leads

We spoke with the lead commissioner for adult secure services, mental health policy leads within NHS England, HMPPS and the Ministry of Justice. We met with senior staff within the Mental Health Casework Section and senior clinical psychiatry and psychology within the high secure estate at Broadmoor hospital. We also met with senior Health and Justice commissioners in England. Discussions were also undertaken with one of the larger provider collaboratives.

Other data

As well as the information we collected on individual patient journeys we have also used some additional information to inform this review.

- Published data from Mental Health Casework Section (MHCS) information (Restricted_Patients_Statistical_Bulletin_2022.pdf (publishing.service.gov.uk).
- HMI Prisons reports were referenced for comparators and information report from inspections undertaken between 1 April 2022 and 31 March 2023, as well as the HMI Prisons 2022–23 Annual Report.

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find.

ACCT
Assessment, care in custody and teamwork (ACCT) is the case management system for prisoners identified as being at risk of suicide or self-harm. ACCT requires that certain actions are taken to ensure that the risk of suicide and self-harm is reduced.

Autism
Autism spectrum disorder (ASD) describes differences in the brain. People with ASD often have problems with social communication and interaction, and restricted or repetitive behaviours or interests. People with ASD may also have different ways of learning, moving, or paying attention.

Care Quality Commission (CQC)
CQC is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. For information on CQC's standards of care and the action it takes to improve services, please visit: http://www.cqc.org.uk.

Independent advocacy
Advocacy is a structure to help ensure that people's voices, wishes and preferences are heard, their rights are upheld, and their needs are met.

Integrated care boards (ICB)
NHS organisations responsible for planning health services for their local population. There is one ICB in each integrated care systems (ICS) area. They manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices, to agree a joint five-year plan which says how the NHS will contribute to the ICP's integrated care strategy.

Liaison and diversion
Liaison and diversion services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects or defendants.

Mental Health Act
The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.

Paranoid delusions
Paranoid delusions, also called delusions of persecution, reflect profound fear and anxiety along with the loss of the ability to tell what is real and what is not real.

Psychiatrist
A psychiatrist is a medical doctor who's an expert in the field of psychiatry – the branch of medicine focused on the diagnosis, treatment and prevention of mental, emotional and behavioural disorders.

Psychosis
Psychosis refers to a collection of symptoms that affect the mind, where there has been some loss of contact with reality. During an episode of psychosis, a person's thoughts and perceptions are disrupted and they may have difficulty recognising what is real and what is not.

Referrals for access assessment
A psychiatrist can refer patients for an access assessment after the psychiatrist has done their own assessment and decided that the patient's mental health needs cannot be treated in prison.

Remissions
The return of a patient from hospital to prison.

Responsible commissioner
Commissioning is the process of assessing needs, planning and prioritising, purchasing and monitoring health services. The responsible commissioner is from the patient's catchment area and is responsible for their care.

Responsible provider
The mental health, learning disability and autism health provider in the patient's catchment area or designated by the commissioner to be responsible.

Restricted status patients
In England and Wales are mentally disordered offenders who are detained in hospital for treatment and who are subject to special controls by the Secretary of State for Justice.

Safeguarding
The protection of adults at risk. Safeguarding duties apply to an adult who: has needs for care and support (whether or not the local authority is meeting any of those needs); and is experiencing, or is at risk of, abuse or neglect; and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect (Care Act 2014).

The Bail Act
Under the Bail Act 1976, the courts can remand an adult to prison for their 'own protection', or in a child's case for their own 'welfare', without that person being convicted or sentenced – even in cases where the charge they face could not result in a prison sentence.

Time out of cell
Time out of cell, in addition to formal 'purposeful activity', includes any time women are out of their cells to associate or use communal facilities to take showers or make telephone calls.

Appendix III References

Department of Health (2002), *Mental Health Policy Implementation Guide. National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments.* Available at: 2002-NMS.pdf (napicu.org.uk)

Department of Health and Social Care (2022), *Policy paper: Draft Mental Health Bill 2022.* Available at: Draft Mental Health Bill 2022 - GOV.UK (www.gov.uk)

Her Majesty's Inspectorate of Probation (2021), *A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders*. Available at: A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders (justiceinspectorates.gov.uk)

Her Majesty's Prison and Probation Service, Ministry of Justice (2023), *An updated response to: A Joint Thematic Inspection of the Criminal Justice Journey for Individuals with Mental Health Needs and Disorders*. Available at: Updated_response_to_the_Joint_Thematic_Mental_Health_Needs_and_Disorders_action_plan.pdf (publishing.service.gov.uk)

National Association of Psychiatric Intensive Care Units (2023), *The Referral and Admission of Prisoners to General Adult Psychiatric Intensive Care Units (PICU)*. Available at: Prison Guidance | NAPICU

National Health Service (2018), *Service specification: medium secure mental health services (Adult), Schedule 2 - The Services.* Available at: Adult-Medium-Secure-Service-Specification-SCFT-WSBS-addendum-version.pdf (england.nhs.uk)

NHS England (2017), *Access Assessment Service: Adult Low and Medium Secure Mental Health Services, Appendix 1, easy read.* Available at: accessassessmentappendix1easyread.pdf (england.nhs.uk)

NHS England and NHS Improvement (2021), *The transfer and remission of adult prisoners under the Mental Health Act 1983 Good practice guidance* (2021). Available at: Report template - NHSI website (england.nhs.uk)

Royal College of Psychiatrists (2019), *Standards for Forensic Mental Health Services: Low and Medium Secure Care – Third Edition. Quality Network for Forensic Mental Health Services.* Available at: standards-for-forensic-mental-health-services-fourth-edition.pdf (rcpsych.ac.uk)

UK Parliament (1976), Bail Act 1976. Available at: Bail Act 1976 (legislation.gov.uk)

UK Parliament (1983), Mental Health Act 1983. Available at: Mental Health Act 1983 (legislation.gov.uk).