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# Delays in transferring patients from prisons to secure psychiatric hospitals: an international systematic review

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## **Abstract**

**Background:** Transfer to a psychiatric hospital of prisoners who need inpatient treatment for a mental disorder is an important part of prison healthcare in the UK. It is an essential factor in ensuring the principle of equivalence in treatment for prisoners. In England and Wales, delays in transferring unwell prisoners to hospital were identified by the 2009 Bradley Report. There has been no subsequent systematic review of progress in so doing, nor a corresponding appraisal of transfer arrangements in other parts of the world.

**Aim:** To conduct a systematic review of international literature about transfers of mentally unwell individuals from prison to hospital for treatment for mental disorder since 2009.

**Method:** Eight databases were searched for data-based publications using terms for prison and transfer to hospital, from 1<sup>st</sup> January 2009 to 4th August 2022. Inclusion criteria limited transfer to arrangements for pre-trial and sentenced prisoners going to a health service hospital, excluding hospital orders made on conclusion of the criminal hearing.

**Results:** In England, four articles were identified, all showing transfer times remain considerably longer than the national targets of 14 days (range 14 days to >9 months); one study from Scotland found shorter mean transfer times, but more patients had been transferred to psychiatric intensive care units (PICU) than to secure forensic hospitals. There were only two studies that investigated prison to hospital transfers for mental disorder from outside the UK and only one reported time-to-transfer data.

**Conclusions:** Findings from this literature review highlight failures to resolve transfer delays in England and provide little evidence about the problem elsewhere. Given the lack of data, it is unclear whether other countries do not have this problem, or simply that there has been

no research interest in it. A possible confounding factor here is that, in some countries, all treatment for prisoners' mental disorders occurs in prison. However, the principle that prisons are not hospitals seems important when people need inpatient care. Prospective, longitudinal cohort studies are urgently needed to map transfer times and outcomes.

## Introduction

There is robust international evidence of high rates of psychosis, depression, neurodevelopmental conditions, personality disorders (PD), substance use disorders, self-harm, and suicide, amongst prisoners (Baranyi et al., 2019; Baggio et al., 2018; Fazel et al., 2017; Hawton et al., 2014; Fazel & Seewald., 2012). These large numbers contain a smaller number of people who require treatment in hospital and a smaller number still who require compulsory treatment.

Throughout the world, nations apply different rules for the psychiatric treatment of prisoners with acute mental disorders. Some countries such as USA seek to provide mental healthcare mostly or exclusively within the prison system, other countries such as UK, Australia, New Zealand accept that transfer to psychiatric hospital may be required and have mental health legislative frameworks to enable this (Vogel, Lanquillon and Graf, 2013; Woods et al, 2020; Carroll, Ellis, Aboud, Scott and Pillai, 2021). Alongside this, numerous international conventions and non-treaty instruments recommend that prisoners' basic rights should include healthcare provision. These include, but are not limited to, the United Nations International Covenant on Civil and Political Rights (1966), United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984), United Nations Convention on the Rights of Persons with Disabilities (2006) and United Nations Office on Drugs and Crime (2015). A key over-arching principle is that of equivalence – that people in prison should “enjoy the same standards or health care that are available in the community and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status” (United Nations, 2015). This has been

taken to mean that mental health services in prisons should be similar in access, scope and design to those in the community (Exworthy et al., 2012).

In meeting the principle of equivalence, an important consideration is that: “all prisons shall ensure prompt access to medical attention in urgent cases” (United Nations Office on Drugs and Crime, 2015). Nation states have not, however, applied a consistent approach to prisoners with acute mental disorders. Early intervention is important, as longer waiting times are associated with significantly poorer patient outcomes (Fazel, Hayes, Bartellas, Clerici & Trestman, 2016; Reichert & Jacobs, 2018). While some jurisdictions allow for the involuntary treatment of those with mental illness inside prison (Prendergast, Farabee, Cartier and Henkin, 2002), in many parts of the world, this may only be undertaken in designated hospitals where full medical personnel and facilities are available (Carroll et al, 2021). It is important to consider that, in the UK, if an individual in the community were to be sufficiently unwell not to recognise a need for treatment, then they would first have to be detained in hospital before such treatment could be enforced. As such, equivalence for people in prison would mean transfer to hospital in these circumstances; in addition, those ill enough to require inpatient treatment should have access to same. The special mental health legislative provisions should facilitate this, bearing in mind custodial obligations. Internationally, there appears to be no consensus about what constitutes a reasonable amount of time for transfer from prison to hospital. However, the UN Standard Minimum Rules for the Treatment of Prisoners state that people should receive “prompt access to medical attention in urgent cases” (United Nations Office on Drugs and Crime, 2015). In England and Wales, following a major independent review of people with mental disorders or learning disabilities in the criminal justice system, Bradley (2009) proposed a minimum target of 14 days “to transfer a prisoner with acute, severe mental illness to an appropriate healthcare setting”.

In England, only limited progress towards this target appears to have been made. A study of 149 transfers from two London prisons in 2009 found an average waiting time of 102 days, with 10% of the sample waiting longer than six months (Forrester et al., 2009). By 2011, transfer times were no better (Hopkin et al., 2016). Similarly, a 5-year follow-up study to the Bradley report found that while transfers had improved, there were “still some long waiting times, particularly for some specialist NHS secure services”, with additional concerns about regional variability (Durcan, Saunders, Gadsby & Hazard, 2014). In Scotland, there is some evidence of fewer transfer problems, with mean transfer times of 21.5 days (Okudo, 2020). We are aware of some research elsewhere in the world, also noting difficulties in ensuring timely transfers (Skipworth et al., 2019; Bone & Roberts, 2019). Despite increasing awareness of these problems, there has been no synthesis of international data on delays or reasons for these delays. Our aim, therefore, was to conduct a systematic review literature quantifying waiting times from prison to secure psychiatric hospitals and exploring reasons for delays.

## **Method**

We followed PRISMA guidelines for this review (Moher et al., 2015). We searched Medline, Embase, Emcare, PsycInfo, PsycArticles, Cinahl, Psychology and Behavioural Sciences Collection, and the National Police Library databases on 18 January 2021, using terms for prison, transfer and hospital. The full search algorithms are in online supplement 1. We updated our searches on 27 September 2021 and 4 August 2022.

In addition, the reference lists of all included articles were screened for additional papers not identified by the initial search, but this found no additional articles. A grey literature search found no relevant additions. To ensure we captured relevant papers, first line inclusion

criteria were as wide as possible: any prisoners who were convicted or on remand or the international equivalent *and* under consideration for transfer or transferred from prison to hospital. The authors then selected those that reported on transfer times from prison to hospital and included studies with discussions about delays or failure to transfer. Exclusion criteria were hospital orders made on conclusion of criminal hearings, samples being under 18 years, articles not in English and articles with entire sample recruited before 2009 (i.e., the date of publication of the Bradley Report and before improvements in the transfer process had been proposed and implemented within England and Wales). The dates were kept the same for the international searches to avoid confusion. Two authors (CS & JT) independently screened the first 100 titles and abstracts to check whether inclusion and exclusion criteria were consistently followed; there was 95% agreement on inclusion/exclusion. In the event of uncertainty or disagreement the third author (AF) was consulted.

Data were extracted using a framework designed specifically for this review (see table 1a and 1b). Information for England and Wales, where the same legislation applies and where we were confident of the legislation and guidance, was separated from Scotland, where legislation differs. Other countries' data, where legislation and systems are less familiar to us, were treated separately. Study quality was assessed using NIH quality assessment tool for observational, cohort and cross-sectional studies: <https://www.nhlbi.nih.gov/health-topics/study-quality-assessment-tools>. Each study was assessed against several criteria and the total number of criteria achieved impacts each study's result. Overall quality rating for all included studies were rated fair. As no effect size was being measured, meta-analysis was not deemed to be appropriate.



## Results

Figure 1 shows the search results. The overall searches identified 282 unique records. After review, seven full-text articles remained for our systematic analysis. Four were from England, one from Scotland, one from New Zealand, and one from Ghana. All studies relied on retrospective collection of routine data, rather than being purpose designed. There was heterogeneity in how data was accessed and recorded, and missing data. Studies included in this review failed to consider or register several potentially important variables, including assessing levels of self-harm and suicide whilst awaiting transfer, deterioration in mental health of patients whilst awaiting transfer, and duration of time required in segregation pre-transfer. Our review highlighted the relative lack of studies in non-UK countries.

INSERT FIGURE 1 HERE

### ***Studies in England & Wales***

Table 1a shows clinical characteristics of the four studies from England and Wales.

Diagnoses among those transferred did not appear to directly influence the level of security required. Woods et al (2020) demonstrated in high secure transfers about two-thirds of the sample had a PD diagnosis, whereas at other levels of security the majority had psychosis. Another study identified that the most common (62%) primary diagnosis was of psychosis (Sharpe et al, 2016), while another (Hopkin et al, 2016) did not record diagnosis. In the only study of transfers of female prisoners England and Wales, psychotic disorders were also the most common (55%) primary diagnosis (Bartlett et al, 2012).

### *Transfer times*

All four studies provided quantitative transfer time data. Transfer times ranged from 14 days to more than 9 months. Sharpe et al (2016) reported that only 11% of their transfers (East Midlands) were within 14 days and Bartlett et al (2012) reported a figure of 13% of transfers (Greater London) within 14 days. Hopkin et al (2016) reported that 34% of transfers (Greater London) occurred within 3 months.

Only two studies provided transfer data as it relates to speed of transfer and security level. One study (Woods et al (2020)) reported that High secure transfers had a mean 159 days, Medium secure 58 days, Low secure 55 days, PICU 16 days and other units 68 days. Another study in female prisoners (Bartlett et al (2012)) demonstrated WEMMS transfers took a mean of 108 days, medium transfers took a mean of 63 days, PICU taking mean 29 days and acute MH beds a mean of 69 days. Two studies also recorded when transfers were never completed: this was 12% in Hopkin et al (2016) and 2% in Bartlett et al (2012). Three of the articles reported on imprisonment phase at transfer, giving data on a total of 153 prisoners across studies. Slightly more remand (per-trial/pre-sentence section 48/49) prisoners (n= 84) were transferred than sentenced (section 47/49) prisoners (n= 69, Sharpe et al, 2016; Hopkin et al, 2016; Bartlett et al, 2012). Sharpe et al (2016) noted that transfers for remand prisoners and for prisoners who were self-harming occurred more quickly than other prisoners. Two studies reported transfer times according to destination of transfer. Sharpe et al (2016) reported that transfers to high secure hospitals took a mean duration of 110 days, medium secure 81 days, low secure 55 days, and psychiatric intensive care units (PICU) just under 69 days. Woods et al (2020) reported 159 days for high secure transfers, 58 days for medium security, 55 days for low security and 16 days for PICU.

### *Causes of delay*

In two studies reporting transfer times based on level of security (Sharpe et al, 2016, Woods et al, 2020) there was an overall pattern of longer delays as level of hospital security increased. This was likely to be related to both a shortage of secure beds and disagreements about the level of security required (Woods et al, 2020). In one of the larger studies, the authors expressed a view that responsibilities that lay with the hospitals - organising a clinical assessment, deciding upon acceptance or rejection, and identifying available beds – led to delays (Sharpe et al, 2016). One study estimated that bed availability was the biggest issue (Bartlett et al, 2012). Another identified disagreement between clinicians negating four transfers, i.e., stopping rather than delaying transfer, with an additional five prisoners being released before hospital transfers could be completed (Hopkin et al, 2016).

INSERT TABLE 1a HERE

### ***The Scottish study***

In Scotland, mental health legislation is fully devolved, while following similar principles to those elsewhere in the UK, as are criminal justice and health service provisions. There was one study, providing data on all 124 prisoners for whom transfers were completed (not including requests not implemented), for the year 2016. This covered all 15 prisons in the country, with a population of around 7,500 prisoners (Okudo, 2020). The most frequent diagnosis for prisoners transferred to high secure hospital services was personality disorder (67%), while in medium secure (69%), low secure (60%) and IPCUs (intensive psychiatric care units in Scotland) psychotic disorders were most common (65%).

### *Transfer times*

Okudo (2020) reported that 124 prisoners had been transferred to a psychiatric bed, with a mean time to transfer of 21.5 days (SD 29.7 days, range 0-198 days). Seventy (56.5%) of these prisoners were transferred to IPCU. Analysis demonstrated that transfer to IPCU occurred significantly quicker than transfers to high and low secure hospitals. Also like England and Wales, more (85) remand prisoners (section 52) were transferred than sentenced prisoners (39; section 136).

We were unable to find any data from Northern Ireland to enable a UK-wide comparison.

### ***Studies from outside the UK***

Table 1b shows the two studies of prison transfers from outside the UK. One study from New Zealand was a longitudinal review of individuals convicted of murder with and without severe or enduring mental illness. This stated that the pressure on forensic psychiatry beds was so severe that transfers from prison are all but impossible and concluded that due to bed pressure, a review of transfer times was “currently unlikely to be feasible” (Skipworth et al, 2019). Another study of the Patang hospital admissions in Ghana (Bone and Roberts, 2019) quantitatively reviewed 13 patients who met their inclusion criteria, exploring admission processes. Two prison transfers were reported, with one waiting on remand for four years before transfer.

INSERT TABLE 1b HERE

## **Discussion**

This is the first systematic review of the international literature on waiting times for the transfer of prisoners with mental disorder from prison to hospital. We found only five UK-based studies and only two from outside the UK. Studies in England confirmed that a 14-day transfer target is still not being met, more than a decade after it was introduced (Bradley, 2009). The other UK study - from Scotland – suggests that transfer time may be less of a problem, however this difference may be mainly accounted for by the fact that more than half the transfers in Scotland were to IPCUs. There was data only from one of two international studies which investigated transfer times.

In England, these findings highlight that the deficits identified by a commissioned report 14 years ago (Bradley, 2009) have yet to be resolved. This contributes to a national picture of failure in this area, with concerns that the needs of thousands of people with mental health conditions are missed at each stage of the criminal justice system, service shortages, and long delays to service access (Her Majesty's Inspectorate of Probation, 2021). Internationally, it should be noted that some countries seek to provide mental health treatment in prison as alternative to hospital transfers (Carroll et al., 2021). Our findings, however, highlight a concerning lack of quality empirical research into delays in transfer of mentally disordered prisoners to hospital, and into the reasons for these delays.

### ***Likely causes of delayed transfers from hospitals to prisons***

#### ***Bed availability***

While there was an increase in the numbers of forensic hospital beds between 1996-2006 in England and Wales (Vollm et al, 2018), there was also a reduction in numbers of general psychiatric beds, from 260.1 beds per 100,000 in 1984 to 37.6 per 100,000 in 2016. Further, there has been an increase in prisoner numbers from 89.3 per 100,000 to 151.1 per 100,000, an approximately 70% rise, with a likely concomitant rise in numbers with mental disorders. Prisoner transfer to hospital rates have increased, from 0.2 per 100,000 in 1984 to 1.6 per 100,000 in 2016, (Keown et al, 2019), but it seems likely that overall, hospital bed availability is not keeping pace with need.

### *Regional variation*

It should be noted that within the UK, regional factors may also play a role. For instance, in studies looking at transfer times to PICU / IPCU, mean time to transfer varied between 10.5 days in Scotland (Okudo, 2020), 16 days in London (Woods et al, 2020), and 69 days in the East Midlands (Sharpe et al, 2016). This is in keeping with concerns about geographic differences previously highlighted in a report 5 years after the Bradley Report (Durcan et al, 2014) and warrants closer examination in future work, which would ideally be conducted across multiple regions.

### *Possible suboptimal in-prison treatment*

While it is broadly accepted that prisons do not provide the optimal therapeutic environment for people with mental disorder, many practitioners believe that more could be done within the prison setting to optimise initial management. For instance, clozapine, which may have added benefit in managing aggression (Brown et al, 2014) and suicidality, is probably under-

used in prisons (Sheitman, Catlett & Zarzar, 2019; Patchan et al, 2018), even though its use there has been shown to be practicable and effective (Martin, O'Driscoll & Samuels, 2008; Foley, Goldenberg, Barley & Gayda, 1995; Zarzar et al, 2019). Prison mental health ('in-reach') teams have identified recruitment problems, growing caseloads of complex patients, and poor implementation of the in-reach model as impediments to delivery of quality care (Birmingham, Awonogun, & Ryland, 2017).

This is reflected in another emergent trend in the UK is 'gate sectioning'- detention under Section 2 or 3 of the MHA of prisoners immediately on leaving prison after completing their sentence. One prison had seven male prisoners compulsorily detained in this way in 2019/2020, accounting for approximately half of those transferred under Section 47, while another prison had eight prisoners gate-sectioned in 2020 (Prisoners Detained at Gates Under Mental Health Act (MHA), 2022). Critics say this demonstrates that beds can be found when necessary, and that making people wait until their release date before they are taken for specialist care demonstrates that mental health problems are taken less seriously than physical health problems (Prisoners Detained at Gates Under Mental Health Act, 2022). This is broadly supported by outcomes from deaths in prison inquiries.

### ***Consequences of delayed prison transfer***

#### ***Mental health sequelae***

Delays in transfer of mentally disordered prisoners may put their health or lives at risk. In most countries, suicide rates are high among prisoners compared to the general population (Woods et al., 2020; Fazel & Seewald, 2018; Baranyi et al., 2019; Zhong et al, 2021). Data are

lacking on rates of completed suicide specifically while awaiting hospital transfer, and this should be remedied, urgently.

Secondly, prolonged periods of untreated psychosis are associated with poorer long-term outcomes (Baranyi et al., 2019; Fazel et al., 2017). Early, effective treatment of psychotic episodes, particularly first onset, are critical to optimise the long-term prognosis of individuals who become psychotic (Penttilä et al., 2014; Howes et al, 2021) and this is unlikely to be optimally available in prisons. Furthermore, the psychological impact on an unwell prisoner of being in a noisy, unsettled, and sometimes volatile environment must also be considered (Armour, 2012).

Thirdly, mentally disordered prisoners who are denied prompt transfer to hospital when they need it are essentially being denied access to equivalent care, in likely breach of their human rights (Niveau, 2007). The principle of equal access to healthcare regardless of a person's legal status, is a key consideration in establishing adequate standards of healthcare for all. Despite this, prison healthcare in other western countries, such as the United States, often falls below what a civilised country may define as acceptable minimum standards (Prins, 2014). In the United Kingdom, the principle of equivalence has been the main driving force in improving prison mental health care, partly by trying to 'stem the flow' and diverting people to more appropriate services early in the criminal justice pathway and partly with the advent of prison mental health "in-reach" teams (Exworthy, Samele, Urquía, & Forrester, 2012; Birmingham, Awonogun, & Ryland, 2017; Durcan, Saunders, Gadsby & Hazard, 2014), so undue delays in transfer to hospital for treatment when considered clinically necessary is of particular concern.



### *Cruel and unjust treatment*

One consequence of undue delays of transfer to hospital of people who are very distressed and behaviourally disturbed may be excessive use of solitary confinement (or 'segregation'). In many jurisdictions, the only relatively safe option in prison for people with acute mental illness may be solitary confinement, but, in these circumstances, this is akin to 'cruel, inhuman, or degrading treatment or punishment' (Forrester et al., 2018).

Johner (2019) found that, in the UK, about 500 of the 85,000 prisoners at any one time were in solitary confinement. Further, in 2015, 24 of these prisoners had been held in solitary confinement "for more than six months" in category A / high-security prisons. It was not possible to determine the proportion of mentally unwell prisoners, but future research should include this an important variable alongside justification to confine. Having a mental disorder was linked with a 170% increased chance of extended solitary confinement. This was considered to be due to perceived lack of compliance to prison rule, although they commented this was only a partial explanation (Siennick, Picon, Brown, & Mears, 2022). In US prisons, there is evidence that prisoners with mental disorder can be in solitary confinement six time longer than those from the wider prison population (Knowles, 2015). Prisoners in solitary confinement report worsening of symptoms from pre-existing diagnoses, including paranoia and persecutory ideas (Luigi, Dellazizzo, Giguère, Goulet & Dumais, 2020). There is also evidence of additional (and new) psychiatric symptoms and disorders, especially stress-related disorders such as adjustment, affective, and post-traumatic stress disorders (Luigi, Dellazizzo, Giguère, Goulet & Dumais, 2020). These clinical consequences further perpetuate the poor outcomes for prisoners denied prompt transfer to hospital.

### ***Future directions***

Future research should be purpose designed, rather than relying on routinely collected data. Specific research questions should be asked, and data collection templates designed accordingly. These should include reason for transfer, clinical information including diagnoses and existing treatment approaches and past contact with psychiatric services (to identify factors which may reduce transfer times), well-defined reasons for delay beyond national or local guidelines, and steps taken to pre-emptively tackle potential delays. Pre-registration of data collection plans and analytical techniques will help bring this field in line with Open Science initiatives.

### **Conclusions**

In England and Wales, delays in transfer from prison to hospital of pre-trial or sentenced prisoners who have mental disorder and treatment needs that are not being met or cannot be met in prison were highlighted by a high-profile enquiry in 2009. There has, however, been little improvement and some evidence of worsening of the situation since then. The status of other countries in this respect is less clear. There are even fewer studies and analysis is complicated by differences in legislation and transfer arrangements. Further, studies since publication of the Bradley Report have added little to understanding reasons for the delays or their impact. There is a need for purpose-designed studies to clarify reasons for delays in transfer and a more detailed exploration of the specific needs of subgroups of prisoners with mental disorders, for example personality disorder and psychosis, in relation to transfer times. Clinical standards, healthcare equity, and human rights considerations all provide a basis for prioritising effective transfer arrangements for this vulnerable population.

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No potential conflict of interest was reported by the authors.

**Data Availability Statement**

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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