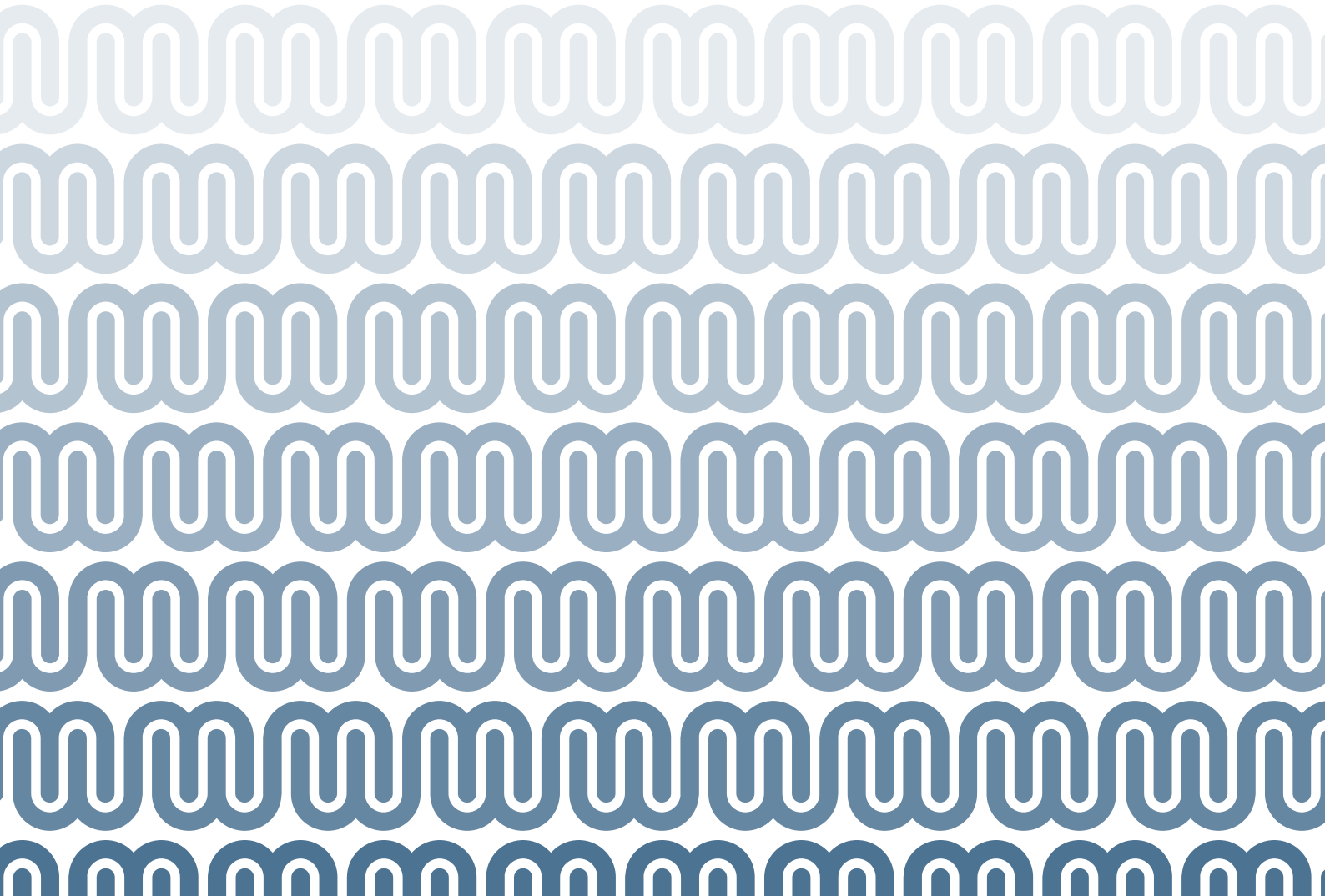
mental welfare commission for scotland

Mental health support in Scotland's prisons 2021: under-served and under-resourced

Themed visit report

April 2022



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Contents

Foreword – Julie Paterson, chief executive

Scotland has one of the highest rates of imprisonment in Western Europe, and the majority of people arriving at prison reception have a history of mental ill health.

Suicides in prison remain a serious concern in Scotland.

While we visit and report on individual prison mental health services on a regular basis, we last undertook a national, themed visit to all of Scotland's 15 prisons a decade ago, in 2011.

At that time, we highlighted many areas that needed improvement. Also at that time, responsibility for the care and treatment of prisoners with mental ill health was transferring from the Scottish Prison Service to the NHS.

In this themed visit, we wanted to see whether the changes we'd called for then had been implemented, and whether the change in service responsibility had made a difference.

Little has changed

Today's report disappointingly shows that while structures and processes are different, little has changed in relation to the outcome for prisoners' mental health.

We found that access to, and the delivery of, mental health support across Scotland's prisons is inconsistent and lacks cohesion.

Prisoners who are seriously and acutely mentally ill are still not being transferred to hospital care without delay.

A significant majority – 77% – of the prison staff group who engaged with us reported that they had concerns about the provision of mental health support within the prison.

Of the 107 prisoners who spoke to us, 81 reported addiction issues, to alcohol or drugs.

Our report acknowledges the fact that Scotland's prisoners disproportionately originate from disadvantaged backgrounds. We know that many prisoners have a combination of mental health and social problems that impact their lives whilst in prison and on their release.

Impact of the pandemic

Our report takes account of the unprecedented backdrop of the pandemic. All 15 prison governors and over 70 prison officers commented on the impact of Covid-19 for them and the prisoners they looked after. Although not asked a specific question around the impact of Covid-19, nearly 30 prisoners referred to it during their interviews with us.

Committed workforce

Pockets of good practice and a committed workforce were identified, both within the NHS and Scottish Prison Service, but the Commission found that the overall experience of mental health service provision in prisons continues to be in need of significant improvement.

This is despite a range of existing guidance, policy and local arrangements to support the mental health and wellbeing of prisoners.

Call for urgent action

So what now?

We make nine recommendations for improvement to the Scottish Prison Service or the NHS, or often to both.

And we make one overarching recommendation to Scottish Government, asking that they monitor the delivery of those nine recommendations, and work with the prison service and NHS to deliver better outcomes for people in prison with mental ill health.

We must get better, and I really hope that this report is deemed helpful and informative, and instigates positive change urgently.

Executive Summary

This report reflects on the key messages highlighted in our prison themed visit report of 2011. Ten years on, we wanted to learn about how practice had evolved, whether the intended improvements linked to the transfer of health care responsibility from the Scottish Prison Service (SPS) to NHS Scotland had had a meaningful impact and we aimed to highlight and respond to any other issues identified and raised with us. It was also necessary to understand the unprecedented impact of the Covid-19 global pandemic and its effect on prisoners and their care and treatment in custody.

In total, 380 people engaged with us as part of this work. This group included prisoners, their relatives/friends, prison officer staff, prison psychiatrists, prison governors and prison health care managers. We were keen to focus on the direct experience of those living and working across the 15 prisons in Scotland and have purposefully included their narrative in this report of how things are for them.

Whilst we found committed staff and some good areas of practice, it must be stated that our overwhelming impression was of a prison population (both prisoners and staff) which is under served and under resourced. Our key messages of 2011 have not been realised and the anticipated improvements of health care responsibilities being transferred to NHS Scotland have not materialised.

In chapter 2 we focus on the early days in prison when people are particularly vulnerable and in chapters 3 and 4, we consider what mental health support looks like for prisoners with mental health conditions and/or substance misuse related issues. The picture painted is one of inconsistency and reliance on small numbers of specialist staff. There was no overarching strategic approach referred to in relation to meeting the range of needs of those experiencing the continuum of mental health conditions, including learning disability. Neither did there seem to be any correlation between resources, size of the prison and the specific needs of the particular prison's population.

We would expect that prisons have mental health resources to support the mental health needs of their prisoners. However, those that know best, staff and prisoners, confirm that this is not the reality for them.

And whilst we did hear some positive feedback regarding some practice changes in relation to Covid-19, we also heard that the pandemic exposed the fragility of the mental health resources and there are significant concerns that no consideration has been given to proactive post pandemic planning and additional resource to support both prisoners and staff.

Where mental health supports were in place, there was a lack of care plans and dynamic review based on the prisoner's needs. This is a significant concern for the care of all prisoners who experience poor mental health and certainly for those placed in segregation. Care plans are critically important to coordinate care and support and to ensure consistency and continuity within prison and to plan for liberation. Indeed, prison officers said they would value care plans to direct them and assist them in providing agreed support to prisoners with mental health conditions. A holistic, joined-up approach is in the interests of every prisoner experiencing poor mental health.

In chapter 5 we restate that *"prison is not the place for seriously and acutely mentally ill prisoners."* This needs no explanation. Acutely mentally ill prisoners have the right to receive timely hospital based care. It is unacceptable that this is not their experience.

Chapter 7 reflects on the importance of training which is a theme raised throughout our report. Both prisoners and prison staff highlighted the need for additional front line staff training.

89% of frontline staff reported that they would like more training in mental health, not only basic awareness training on mental health, but also much more in depth training to fully equip them with the tools to utilise when working with an increasing number of prisoners with complex mental health needs and presenting behaviours. It could be argued that value based anti-discriminatory mandatory training in relation to mental health could educate staff to avoid the stigmatising behaviour reported and witnessed in chapter 10.

Family and friends of prisoners can be crucial sources of information with important knowledge about a prisoner's mental health state.

Despite the SPS *Family Strategy*, the six family and friends who responded to us neither felt included nor engaged. They experienced significant challenges communicating with both health and prisoner officer staff. Such reported failure to actively support family contact has the potential to negatively impact on outcomes for the prisoner but also the family member. We heard about family members' own mental health deteriorating because they were so anxious about prison staff not having full information, their relative in turn not receiving the care and support they needed and the fact they felt powerless to do anything.

In summary, whilst we identified some good areas of practice across the prison estate, the opportunity to address our key messages of 2011 has not been taken. To this end, we now make specific recommendations to the Scottish Prison Service, NHS Boards/Integration Joint Boards and the Scottish Government. The reason for doing so is that collaborative ownership and leadership at the highest level must now ensure urgent improvements.

The recommendations we make below are made in the context of the expectation that prison services and NHS mental health services proactively promote the mental health and well-being of all prisoners in their care.

Recommendations

Based on our 2021 findings, we make the following recommendations for delivery over the next 12–24 months:

Recommendation 1:
SPS and NHS should collaborate to implement a workforce planning tool; this should be undertaken across the prison estate to identify the required multidisciplinary mental health (including learning disability) staff establishment levels according to the needs of the prison population. This must include consideration of the consequences of the Covid-19 pandemic and capacity to deliver increased primary care/counselling and interventions for mild mental health issues.

Recommendation 2:
SPS and NHS should undertake a training needs analysis and a training implementation plan must be completed to support reception, residential and frontline staff to feel confident and competent in responding to, and having an appropriate knowledge of prisoner mental health issues, addictions, trauma and corresponding behaviours.

Recommendation 3:
SPS and NHS must review screening processes at each prison establishment to address gaps to ensure better identification of prisoners with specific mental health needs, such as learning disability, autism and personality disorder.

Recommendation 4:
SPS and NHS should consider the introduction of follow up assessments 7–14 days post admission and/or once the person is settled in prison to undertake a more detailed, informed consideration of mental health needs where indicated.

Recommendation 5:
SPS and NHS should audit and review the operation of multidisciplinary meetings and care planning processes. SPS and NHS must be satisfied that individual needs and outcomes are being identified, addressed and reviewed for all prisoners experiencing poor mental health and who are in need of support during their stay in prison including in segregation units.

Recommendation 6:
SPS and NHS must urgently audit their use of segregation for prisoners who are so mentally unwell that there is no alternative to safely managing their care in custody. The audit should consider qualitative and quantitative data including length of stay, opportunity for association, engagement in purposeful activity and feedback from prisoners.

Recommendation 7:
SPS and NHS should consider that where the CPA care planning model has not been adopted, there should be an alternative similarly effective, cohesive whole system pathway approach to the liberation planning of sentenced and remand prisoners. This must ensure individuals have opportunity of access to crucial community mental health and social supports to maximise their mental health and wellbeing upon release and reduce their risk of returning to prison, as far as possible.

Recommendation 8:
SPS is reviewing the *Talk To Me* strategy [1]. This must take account of all available feedback, particularly in relation to learning from its operation in practice over the past five years.

Recommendation 9:
SPS should review the *Family Strategy* [2]. It is recommended that an audit is undertaken to determine whether the intended outcomes of the SPS *Family Strategy* have been achieved in practice. As part of the review, consideration should be given to specific actions in relation to mental health and learning disability when reviewing the priority action to "support the wellbeing of those in our care and their families."

Recommendation 10:
The Scottish Government must monitor the delivery of the above recommendations and work with SPS and NHS to resource and deliver on better outcomes for people with mental health related conditions in prisons across Scotland.

Introduction

The Commission undertakes national themed visit programmes to enable the assessment and comparison of care and treatment for particular groups of people with mental health related conditions across Scotland.

In 2011, we undertook a themed visit to people in the 15 prisons across Scotland [3]. At the time of our visits mental health services in prisons were provided by the Scottish Prison Service (SPS) but there were plans for NHS Scotland to take over responsibility later that year. The decision to have the NHS in Scotland take responsibility for healthcare in prisons in 2011 was reportedly influenced by the Scottish Government's objective of reducing health inequalities by providing equitable care that is available to individuals in the community, in addition to improving sustainability and parity with the wider health service in Scotland [4].

Our 2011 report therefore highlighted the importance of establishing a baseline with regard to the services being provided so we could assess the impact of the changes to service delivery for prisoners with mental health conditions in the future; there were eight key messages arising from our report in 2011 as noted at appendix 1.

Since 2011, the Commission has continued to undertake individual visits to prisons, making recommendations and prioritising return visits where indicated.

Scotland's prison estate has evolved significantly, with new prisons opened, old prisons closed and others remodelled. There has been publication of the Auditor General [4 5] and HMIPS [5 6] 2019 reports which highlighted a number of concerns in relation to issues which impact on the mental health of prisoners across Scotland. The Commission's own report published in 2021 in response to findings [7] of the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (the CPT) visit to Scotland in October 2018, raised serious concerns in relation to women prisoners' mental health support, care and treatment within Her Majesty's Prison (HMP) Young Offender Institution (YOI) Cornton Vale (the only exclusively female prison in Scotland) [8]. All of the above informed the Commission's decision to visit all of Scotland's prisons once more and to report on our findings 10 years on.

As was the case in 2011, the focus for our themed visits to prisons in 2021 was not about whether the individuals should be in prison but about the mental health care and treatment they received.

We wanted to learn about how practice had evolved, how improvements had been made linked to the Commission's 2011 eight key messages, whether the intended improvements linked to the transfer of responsibility to NHS Scotland had had a meaningful impact and to respond to any other issues identified and raised with us. It was also critically important to take full account of the unprecedented impact of the Covid-19 pandemic and its effect on prisoners and their care and treatment in custody.

Scotland's prison landscape in context

There are 15 prisons in Scotland. Most are managed by SPS, with the exception of HMP Addiewell (Sodexo) and HMP Kilmarnock (Serco). There is a prison in all mainland, territorial health boards with the exception of NHS Borders and NHS Fife. Some establishments are mixed-gender. Some are for a specific population – these include HMP Castle Huntly (open prison), HMP Cornton Vale (women only), HMP Polmont (young offenders) and HMP Shotts (long-term prisoners). In addition, HMP Barlinnie and HMP Greenock have national 'top-end facilities' for prisoners who have progressed through to the end range of their sentence. As a result, 'top-end' prisoners are afforded a lower level of supervision than the general prison population.

Mental health

There is an over-representation of mental illness in the prison population compared with prevalence data in the general population. The strongest evidence is for psychotic illness, major depressive illness and substance use. This association is particularly strong for women in prison [9]. One in four episodes of psychosis in prison are related to intoxication or withdrawal from substances [10]. Despite methodological flaws in studies examining prevalence of personality disorder in prison settings, there is an acceptance that these rates are higher than for the general population [10] [11].

Suicide and self-harm are also more common in prisoners than the general population. Suicide in prison is associated with diagnosis of mental illness, particularly depressive illness, past history of self-harm/suicide attempt, current suicidal ideation, single cell occupancy and absence of social visits [10] [12]. Other risk factors include remand status, substance misuse and having been charged with a violent offence, particularly homicide [10].

Globally, prisoners with mental illness are disproportionately involved in prison rule breaking and violent incidents. They are also more likely to experience victimisation compared to prisoners without mental illness [10].

Foreign national prisoners are understood to have higher rates of psychiatric illness in the UK in comparison to the general prison population. Language barriers, difficulty maintaining family contact and immigration concerns are three major contributing factors, in addition to other culturally sensitive considerations [13].

Delivery of prison mental health services in Scotland

Scotland has one of the highest rates of imprisonment (136 per 100,000 population) in Western Europe [14].

Scotland's prisoners are disproportionately from the most deprived postcode areas and often the most disadvantaged backgrounds. The relationship between social exclusion and imprisonment is considered systemic [15]. We know that many prisoners have a combination of mental health and social problems that impact their lives whilst in prison and on their release.

There are many factors that provide a challenge when delivering care and treatment for individuals with mental illness in a prison setting. Firstly, prisons primarily function as a penal environment with a focus on security, rather than a therapeutic space [16]. They are often overcrowded, under-resourced and have difficulties with staff retention [17]. Diversion and misuse of prescribed medications and other substances remains a significant issue in the prison estate [18].

CHAPTER 1 – What we did

Methodology

Our themed visit to prisons in Scotland was impacted by Covid-19. We had to be pragmatic in our ways of collecting information and relied on electronic means and in person visits, online surveys, email questionnaires and telephone calls, in addition to visiting all 15 prisons. We were able to meet 101 prisoners face to face and 6 via virtual methods.

Online surveys were anonymous while face-to face surveys with prisoners included some information about the person filling it out. All identifiable information was securely stored electronically and no personal or identifiable information is included in this report.

In total, 380 people engaged with us as part of this work. This group included prisoners, their relatives/friends, prison officer staff, prison psychiatrists, prison governors and prison health care managers (see Table 1). All information was collected between July 2021 and October 2021.

Further respondent data can be found at appendix 2 and appendix 3.

Table 1. Overview of information collected

Group	Collection method	Distribution
Family/ friends/ partners	Online survey	An online survey was distributed via key organisations supporting families of people in prison custody in Scotland.[a] We received six responses.
Prisoners	Face-to-face/ telephone	A questionnaire was completed by a Commission practitioner in conversation with the prisoner. Due to Covid-19 and restrictions in some prisons at the time, telephone calls were made where face-to-face interaction was not possible. A total of 107 individuals participated, of which all but six were in-person.
Prison psychiatrists	Online survey	The survey was distributed to an email list of 28 forensic psychiatrists in Scotland working within the prison estate. A total of 14 psychiatrists responded.
Prison governors	Email	A questionnaire for self-completion was emailed to all 15 prison governors and returned over email. All 15 governors responded.
Health centre managers	Email	A questionnaire for self-completion was emailed to all 15 healthcare centres in the Scottish prison estate. All 15 managers responded.
Prison staff	Online survey	The survey was distributed by SPS and a link to the survey was placed on the intranet. A total of 223 prison staff responded (including prison managers and chaplaincy) to the survey.

[a] Families Outside and Circle Scotland

Focus of our surveys

The information we collected varied slightly depending on who we were speaking to but there were four key overarching areas that we wanted to include, as follows:

- Admission screening for mental health problems;
- Mental health support, care and onward planning supporting prisoners with particular mental health needs;
- Training for health and prison staff;
- Impact of Covid-19.

Analysis

All data was collated and analysed by the Commission's prison project team. There were overlapping questions across the questionnaires to allow us to gain as holistic a view as possible of how mental health services are experienced across Scotland's prison estate. All free text information was analysed and matched with the relevant chapter subjects, with verbatim statements inserted, as appropriate, to evidence the visit team's findings. All information presented throughout this report has been anonymised.

CHAPTER 2 – Arrival at prison: identifying prisoners with mental health needs

Our key message from 2011:

- *Prisoners are particularly vulnerable in the early days of their time in a prison. Skilled staff with knowledge of mental health issues need to be involved from the start.*

What we expected to find

There is an established legal and policy requirement in relation to the prison admission process. Therefore, we would expect that a person entering prison custody should receive an initial health screening assessment during the reception process. This should include questions about the person's medical history, medication, any current physical and mental health issues, alcohol use and substance misuse, self-harm and suicide risk [19].[b] There are existing standards detailing what this assessment should include [20]. This assessment should be carried out by prison nursing staff.

Within 24 hours of arriving in custody from the community, prisoners should receive a further health assessment. Medication normally prescribed in the community should be verified and continued, and clinical decisions regarding ongoing prescribing should be made on an individual basis, in line with best practice.

Individuals with significant past or present mental health issues or identified to pose a risk to themselves should be referred to the prison mental health team for further assessment.

Once in custody, there should be processes in place for prisoners to self-refer to the prison health service and for prison officers to refer to the mental health team if they have concerns about an individual.

What we found

Screening at reception

Most prison healthcare managers told us that registered general nurses (RGNs) from the prison primary care team carry out health screening assessments. Two prisons said that mental health nurses (RMNs) are involved in reception assessments: HMP Cornton Vale and HMP Polmont. In HMP Cornton Vale, the only establishment in the prison estate exclusively for women, we were told that mental health nurses usually carry out all health assessments at reception.

Risk assessments linked to the SPS suicide and prevention strategy *Talk To Me* (TTM) are included as part of the screening assessment. It was explained that people identified as being at potential risk are placed on regular checks by prison officers under *Talk To Me* protocols.

Some prisons (HMP Glenochil, HMP Castle Huntly and HMP Shotts) only receive prisoners transferred from other establishments, so do not admit directly from the community. They

[b] Good practice guidelines such as those developed by NICE and CCQI, whilst mainly adopted in NHS England, are helpful when equivalent guidance in Scotland is not available. We note that four prison mental health services in Scotland are currently members of the CCQI Quality Network for Prison Mental Health Services, and were among the 68 services accredited in the UK between 2019-2021.

told us that health information is already available from the previous prison and prescribing is already established, so their assessment process is different.

The day after arrival in custody a further review is carried out by a prison GP or, in some prisons, an advanced nurse practitioner (ANP). Prison healthcare managers told us that when concerns about a person's mental health or self-harm/suicide risk are identified, either at reception screening, by prison officers during the first night or at the GP/ANP review, they are referred to the mental health team for further assessment.

Some managers told us that if a person is prescribed antipsychotic medication in the community, they are automatically referred to the mental health team. This did not appear to happen consistently across the prison estate despite the NICE Guideline [19] which recommends that a person is referred for a mental health assessment in prison if the person is known to have previoulsy accessed mental health professional support.

Prescribing on admission

We asked prison healthcare managers about prescribing when someone first arrives in custody. Reception staff receive information about a person's prescribed medication from various places, most commonly from prisoners themselves. Other immediate sources include court and police custody records and family. This then needs to be verified before prescribing begins.

All except one of the prisons which admits directly from the community told us they were able to access electronic emergency care summaries (ECS). The ECS is a GP record that includes a person's medication, as prescribed by the GP.

In some prisons, the pharmacy team contact the prisoner's GP, pharmacy and community prescribers to verify prescribing the day after the person arrives in custody. The prison GP, or in some prisons an advanced nurse practitioner (ANP), completes medication reconciliation at initial review to ensure that community prescribing is safe and appropriate.

We asked healthcare managers to tell us about any difficulties with medication and prescribing. One highlighted difficulties out of hours:

> *"There is not a facility that allows for the healthcare staff to confirm any medications that are not available on ECS to allow for prescribing on admission into custody outwith GP hours."*

Others reported that there can be delays in prescribing due to difficulties confirming medication with community providers. A number said that information on the ECS is not always up to date. It may also not include medication prescribed by other services, such as opiate replacement prescribed by an addiction team, or depot antipsychotic medication and clozapine given by a community mental health team (CMHT). Occasionally, if a drug is not routinely prescribed and is not stocked in the prison pharmacy, there may be a delay in supplying it.

We asked the prisoners we met about medication and 67% (n=71) told us they were prescribed medication in the community before they entered custody. A third of this group reported problems receiving medication in prison. When asked if there had been a delay in getting

medication, about half had received it on the first day in prison, but 14% (n=15) had waited over two weeks.

A number of psychiatrists who completed our survey also highlighted issues related to medication in the prison where they work:

> *"There is a problem in accessing medications in prison it can take several days or weeks to get supplies of medication"*

One psychiatrist also raised concerns about decisions not to prescribe certain medications:

> *"There is an attempt to limit medications which may have a potential for abuse e.g. gabapentinoids, benzodiazepines and hypnotics. Whilst this is a reasonable principle it seems not always to involve detailed discussion with the prisoner nor account taken of reasons for prescribing or the provision of alternatives in all cases."*

The medication concerns highlighted suggest that current prescribing practices in prison are not consistent with person-centred care and treatment. In addition, medication challenges were also highlighted by some prisoners we interviewed, who said medication prescribed by their GP in the community, for example for anxiety or sleep, had been refused by the prison GP. The medications highlighted to us were primarily those described above. Alternative medication offered in prison was not always reported to be effective.

Guidance produced by the Royal College of General Practitioners *Safer Prescribing in Prisons* (2019) suggests:

> *"Clinical decisions to continue or suspend medicines on admission are a challenge and need to be considered on an individual case basis and not using generic stopping of specific medicines*" [p.17 [21]].

Accessing health information from community services

Mental health information gathered at reception is largely based on prisoner self-report. Sometimes additional information may be available from court records, from police custody assessment or from the person's family. For those who have previously been in prison custody, existing electronic prison health (Vision) records may provide additional information.

When we reviewed prison health records, 76% (n=75 of 99 records reviewed) had a history of mental ill health that was identified at reception screening.

We found that 60% of our prisoner respondents were receiving support for their mental health before coming into prison. Of these prisoners, 85% (n=52) had received this support from mental health services, with the majority (n=37, 61%)) having had contact with a community mental health team (CMHT). Other mental health services included addiction teams, homeless mental health services and inpatient support. Five young adults (aged 19-23 years) referred to contact with child and adolescent mental health (CAMHS).

We found that 23% (n=14) of individuals who had been receiving mental health support from primary care alone in the community, said their GP had been in the process of referring them to mental health services before they entered custody.

When we asked those prisoners who had received support pre-prison whether prison staff picked up on their mental health difficulties, 69% (n=42) said they did.

Accessing additional information from community services is critically important when someone has significant mental health problems or has been receiving mental health support.

We asked psychiatrists how often they had difficulties accessing patient information from different sources. Those surveyed told us it was rare to have difficulties getting information from locality mental health teams, but 10 out of 14 psychiatrists we spoke with reported experiencing difficulties accessing information from primary care. Similar numbers of psychiatrists experienced difficulties accessing information from social work, and more appeared to have difficulties when it involved requesting information from the Crown Office and Procurator Fiscal Service (COPFS).

A number of psychiatrists commented that information gathering processes could be improved.

Raising concerns about a prisoner's mental health

Health centre managers in 14 of the 15 prisons told us that there are processes in place to share concerns during a prisoner's first night. This was noted as not applicable in one prison as *"prisoners will have already spent time in another prison prior to their transfer."*

We asked prison healthcare managers how mental health concerns were raised about first night prisoners. A number commented on positive liaison between health and prison staff and described processes in place for this:

> *"There is an admission form that is available to all health care staff and we support a twilight report to the SPS and Out of Hours, the following morning we have a safety brief, around the previous night's admission".*
>
> *"There is effective communication via the SPS and NHS which takes place by phone/in person. NHS are verbally made aware every morning of any events overnight."*

We asked prison governors about arrangements to share concerns about the mental health of a prisoner; 14 out of 15 governors reported that such arrangements are in place for staff. Most governors (12 out of 15) were fairly or somewhat confident in SPS staff identifying and responding to mental health issues among prisoners. Three reported that they were not very confident in SPS staff identifying and responding to mental health issues in their prison.

Most prison staff (n=194, 87%) reported that there are arrangements for them to share concerns with the mental health team. Some did comment on liaison between prison and NHS staff and suggested this could be improved as we discuss later in this report.

Effectiveness of screening

In the surveys we asked prison governors, prison staff and psychiatrists about the health screening process on admission and how effective they thought it was in identifying a range of issues related to mental health.

Prison governors were positive about the effectiveness of screening in identifying self-harm or suicide risk in people arriving into prison custody. Most were similarly positive about the

effectiveness of screening for drug and alcohol issues. However, the effectiveness of screening to identify learning disability and mental health issues was reported as less effective.

While over half of all prison staff were very positive about the effectiveness of self-harm/suicide screening, 12% of the 107 prisoners rated it negatively. Similarly, opinions on alcohol and drug screening were split; 45% (n=100) rated it positively, while 45% (n=100) considered it less effective. Prison staff generally perceived screening for mental health issues and learning disability as less effective than prison governors. The majority of prison staff (n=163, 73%) felt that the screening process could be improved.

Overall, psychiatrists were positive about screening processes in the prison where they work. They rated effectiveness of screening for suicide/self-harm and for drug and alcohol issues highly, but were less positive about the effectiveness of screening for mental health issues and even less so in relation to learning disability and personality disorder. Ten out of the 14 responding psychiatrists (71%) felt that screening processes could be improved.

How screening could be improved

We asked all those surveyed to tell us how screening could be improved and many prison governors, prison staff and psychiatrists offered suggestions. Very similar concerns, and ideas for change, were raised across the three professional groups.

Common themes

Time

The timing of admissions and time constraints of the reception process was a shared concern particularly those working in larger, busier prisons. Prisoners often arrive from court in the evening:

> *"I feel that, due to the late arrival of admissions, staff are being pushed to the limit with demands of daily admissions from court."*
> (hall manager)

The impact this can have on prisoner assessment was highlighted:

> *"There have been occasions when nurses leave early, this results in admissions not properly being screened both medically and by TTM[c] process.*"
> (prison officer)

Others spoke of challenges and suggested improvements:

> *"More in depth interviewing at the admission stages, but this can be very time consuming and [prison name] takes in a high volume of admissions."*
> (prison officer)

> *"Ensuring all admissions arrive during normal working hours and not en masse at night."*
> (prison officer)

[c] *Talk To Me* is the is the Scottish Prison Service suicide strategy

Prison officers and other staff, including chaplains, also conveyed the importance of having time with prisoners, acknowledging how stressful the process can be, particularly for those arriving in custody for the first time, and the importance of "sensitivity" and "empathy".

Screening assessments could be:

> *"More interactive person centred and not tick box."*
> (prison officer)

As one respondent noted:

> *"Early intervention is critical, only by building relationships early and making them positive can this be done."*
> (prison officer)

Staffing

The need for more staffing, and in particular the addition of mental health nurses at reception was raised.

> *"Mental health screening could be improved if the reception had a mental health nurse on duty at all times in the reception."*
> (prison governor)

Access to medical support at reception was also suggested by some respondents.

Screening for mental health and learning disability

There was a suggestion that the focus at screening should be on mental illness as much as it was on self-harm and suicide prevention:

> *"Assessment for other issues should be as robust as the suicide strategy."*
> (head of residential)

> *"I do think there needs to be as much emphasis on mental health issues as there is on suicidal thoughts/tendencies."*
> (prison officer)

A greater ability to identify prisoners with a learning disability or those with autism spectrum disorder (ASD) was also frequently raised:

> *"There could be more done to help identify learning disabilities. This starts with providing staff with the opportunity to develop learning regarding learning disabilities and autism spectrum disorders (ASD). This would be the first step in upskilling staff to be able to identify individuals who may have a learning disability and take the appropriate actions to refer/seek support where required."*
> (prison officer)

> *"Should there be a robust/ thorough assessment done - front loaded. Currently can take up to 12 months to identify learning disability. Could the timeframe be shortened?"*
> (prison governor)

"I am concerned that we are not fully picking up those with spectrum disorders (ADHD, Aspergers, etc)."
(prison governor)

Training

Improved training for staff currently carrying out reception assessments was also raised, and it seemed there was a desire for this to involve SPS staff as well as health staff:

"*All reception staff would benefit from specific training on mental health awareness such as mental health first aid."*
(hall manager)

"Reception staff sent on mental health courses. We are the first point of contact for individuals within our care as they enter the establishment."
(prison officer)

"Training for assessing staff on presentation of mental disorder including PD [personality disorder] and mild LD."
(psychiatrist)

"Training provided to staff to identify vulnerable individuals."
(prison officer)

Another prison officer suggested *"Having a designated team to work on admissions"*.

Access to information

Challenges with lack of access to information about prisoners on arrival in custody was a significant issue raised by SPS staff as well as psychiatrists:

"We are very limited with the information on admission and staff and health care staff spend many hours on the phone trying to get information on individuals who are clearly unwell".
(prison hall manager)

"Current screening relies on honesty of information from the admitted person. There could be better/more immediate access to medical records to identify historic MH issues".
(deputy governor)

"Information is all self-reported. We need additional information from third party agencies to confirm such details"
(prison officer)

"I think that there should always be efforts to get background info before screening. Often people appear in clinic with self-reported diagnoses that are incorrect, and other people who should be seen get missed."
(prison psychiatrist)

And for prisoners transferred between establishments:

> *"There could be better handover of care between the prisons to identify the needs of these prisoners once they are transferred."*
> (prison psychiatrist)

Reception environment

A few people commented on the reception environment itself and how this could be improved to support prisoner experience:

> *"I think that building structure does not lend itself to having an interview area that offers a relaxed environment for discussing these complex issues."*
> (head of operations)

> *"Allowing more time for the process to be more effective and have a quiet area when it comes to personal issues."*
> (prison officer)

Further assessment

Following on from the reception process itself, a range of staff also discussed the potential benefit of prisoners receiving further mental health assessment after arriving in custody:

> *"At present, the immediate priority is to keep people safe. A person sees the nurse on admission, and the doctor the following day. It is felt that those with mental health issues are supported by the Talk To Me process when some of the options within this policy may have a more negative impact on the person. For each person, there needs to be a fuller mental health assessment 7–14 days after someone comes into prison, which gives time for immediate issues to be addressed and allow some kind of stability."*
> (prison governor)

> *"Having a follow up interview in regards to mental health, drug addiction and other such issues a week after admission once the prisoners have settled in and had time to reflect on the current circumstances."*
> (prison officer)

> *"More detailed screening should take place within the week following to consider presence of mental disorder (as defined under the act) and the presence of poor mental wellbeing. This would allow a tiered approach to identified need."*
> (psychiatrist)

One prison governor encapsulated a range of the challenges of screening assessments and how the reception process could be improved in this response:

> *"We would improve things if there were fewer admissions, more staff to do the assessments, more time to focus on new people and more training for staff. It would also be good if we had complete and immediate access to information held by different organisations on people arriving in prison, especially for the first time."*

Chapter 2 summary

It is a decade on from the Commission's last themed visit, and from the transfer of responsibility for the provision of health care in prisons from the prison service to NHS; and still we found continued challenges with the reception screening processes in relation to prisoners with mental health needs including learning disabilities. There are very few prisons which provide RMN support to the reception process and problems continue with prisoners being able to access mental health medication on arrival in custody without delay.

A series of concerns raised by professionals, such as the number of prisoners arriving in custody and the timing of arrivals from court, relate to wider ongoing issues in Scotland. These include the size of the prison population and processes in the court system, with high numbers of prisoners continuing to be placed on remand. These are concerns that have also been highlighted to Scottish Government by the CPT on their visits to Scotland over the last ten years [7].

Other Scotland-wide issues, such as improvements in information technology to enable the sharing of information between agencies (including prisons) to enhance continuity of individual care, are already reported to be under review by the Scottish Government (we addressed this issue in detail in our recent report on women in prison) [8].

Many of the suggested improvements to the screening process do however relate to aspects of prisoner care which are within the control of the Scottish Prison Service and NHS health boards to address.

Staffing, training and better management of admissions can be addressed by individual establishments, supported by SPS and bodies such as the Scottish Health in Custody Network to help drive national change.

CHAPTER 3 – Prison mental health support: what does it look like?

Two of our key messages from 2011 were:

- *Prisons should have staff and facilities in place that are able to support prisoners with a wide range of mental health difficulties.*
- *Where mental health difficulties are identified, a specific care plan detailing support should be in place.*

What we expected to find

Scotland's national *Mental Health Strategy 2017-2027* confirmed additional investment to train and grow the workforce "bringing investment to £35m over the next five years" [24 [22]]. Headlines at the time stated that action 15 of the strategy would deliver an additional 800 mental health professionals in post by 2022 in key settings: prisons are named as one of these key settings.

Despite this investment, the Commission regularly hears from stakeholders about staffing crises impacting inpatient, community and indeed prison mental health settings.

Our expectation remains that prisons must have the resources in place to support prisoners with a wide range of mental health difficulties throughout their prison stay. We therefore asked the prison health care managers for workforce data to inform our understanding of the extent of the reported challenges and the potential impact on a prisoner's experience of accessing mental health care and support as a result.

What we found

We found that whole time equivalent (WTE) registered mental health nurses (RMNs) working in each prison ranged from one to 11.6 WTE. We found no clear correlation between the size of the prison, its population and the provision of mental health nurses.

Five prisons also had learning disability (LD) nurses providing varying levels of support (between 1–2.8 WTE). There is no definitive data in relation to how many prisoners in the Scottish prison system are affected by learning disabilities, which is generally estimated to reflect 0.3% of the prison population and 0.6% of the general population [23].

However, international studies estimate a much higher prevalence at approximately 10–20% when compared to the general population [24]. Similarly research around specific neurodevelopmental disorders also estimate high prison prevalence compared with the general population [25] [26].

Given that many prisoners are suggested to have 'hidden or invisible disabilities', including learning disability and autism spectrum disorder (ASD) [23], the current prison establishment of learning disability nursing capacity in Scotland is likely to be under resourced for the needs of the prison population.

The input from psychiatrists was similarly as variable as the mental health nursing capacity and was not obviously linked to prisoner numbers or the needs of the population. We found that psychiatrists provided input via sessional work (one session being half a day). Input

varied between less than four hours to five sessions of psychiatry input per week between prisons.

Support from other multidisciplinary professionals was varied. Please refer to appendix 4.

- Clinical psychology was available in 14 prisons, with the number of psychologists ranging from 0.2 - 6.8 WTE.
- Occupational therapy (OT) support was available in nine prisons ranging from 0.1 to 3 WTE.
- Speech and language therapists were available in five prisons ranging from 1 to 2 WTE.
- Health care support workers were available in five prisons (1.8 - 8 WTE). Often this was for primary care, but support was also provided to the mental health team.

It was encouraging to note the addition of specialities such as speech and language therapy in five prisons, some of which we were told had been provided by funding linked to action 15 of Scotland's national mental health strategy mentioned earlier.

During our prison visits we heard consistently from prison mental health teams about the recruitment challenges, particularly in relation to filling vacant registered mental health nursing (RMN) posts.

> *"Staffing within the health centre has been challenging with sickness/isolation and staff shortages having an impact on all services. Attempts are being made to address these issues and improve care for our patients."*

In spite of these challenges, prison staff often commented positively about the support mental health nursing staff were still able to deliver.

> *"Staff have remained highly committed and flexible to meet the needs of their patients during the pandemic. Patients have demonstrated an increase in appreciation for the staff, demonstrated by verbal and written thank you cards and pictures for coming into work and caring for them in such difficult, strange times."*

Multidisciplinary mental health teams

We found that all of Scotland's 15 prisons have a multidisciplinary mental health team (MDT). Teams most frequently met on a weekly (n=5) or fortnightly (n=6) basis. In two prisons the team meets monthly and in two other prisons the team meets less than monthly.

MDTs require to coordinate, share information and provide responsive support based on individual needs; it is difficult to understand how this can be delivered when teams meet only monthly or even less frequently.

The range of MDT attendees varied between prisons, with all teams including mental health nursing input and in all but one including psychology.

Accessing mental health support

Referral

All 15 prisons reported having processes and protocols in place for prison officers to share concerns about prisoners' mental health with the mental health team. In 13 out of 15 prisons there are arrangements in place for other prisoners to share concerns and all 15 prison health care managers reported that there is a process for family members to also raise concerns. The relatives we spoke with however said that they found challenges in discussing concerns with prison and mental health service staff; this is further discussed in chapter 9.

Prisoners can self-refer to the mental health team in all prisons. When we looked at prisoner records, in just over half of the cases we reviewed, 53% of referrals were recorded as self-referrals. Prison staff represented 19% of referrals and 'other' was 20%, with most 'other' referred via reception screening. The remaining referrals were received from more than one source.

We learned that 14 prisons have a triage process in operation through which referrals are prioritised by health staff. In 10 out of 15 prisons, an RMN screens new referrals on a daily basis.

If there are urgent concerns about a prisoner, an RMN assessment then takes place within 24-48 hours; in HMP Cornton Vale and HMP Castle Huntly, urgent concerns lead to contact the same day. In the remaining prisons, new referrals are triaged at the MDT or allocation meeting, which is weekly.

Prison staff reported mixed views regarding the effectiveness of the referral process:

> *"The Mental Health Team have a referral system in place which gives open access to all prison staff to make referrals. On top of this the staff are very amenable to individual approaches regarding concerns for individuals."*

> *"The only way to identify concerns are the Talk To Me strategy for suicidal prisoners, however when there is a concern for a prisoner's mental health it is very difficult to speak to the mental health team and we are told that officers are not allowed to phone them…. if there is an urgent need for assessment it is very difficult to get someone to come down to the wing."*

The Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI) standards for prison mental health services includes the following as "essential" standards:

> "*5. A clinical member of staff is available to discuss emergency referrals during working hours"*

and

> *"6. Urgent assessments are undertaken by the team within 48 hours and routine assessments within five working days"* [p.8 [27]].

We heard from prison staff who reported their frustration specifically around waiting times for assessment once a referral to the mental health team had been made:

> *"We fill in MHT forms which take weeks to be seen, three months to be assessed, and most of the time NHS blame it on behaviour rather potential mental health issues."*

For the prisoners, we found that out of the 84 prisoners who responded to our question about how long they had waited to be seen by a mental health nurse following referral, 38% (n=32 told us that they were seen in less than a week.

We heard that 27% (n=23) waited more than a month, with the remaining 35% reporting waiting periods ranging from four months to "several months", with one prisoner highlighting his lengthy wait to a Commission visitor as follows:

> *"Initially when he put in a referral he just received a bundle of self-help leaflets – these were not even designed for a prison setting and suggested things like going for a walk or going to the cinema. He said this was not helpful and is a common response to a referral. He said that he is aware many prisoners give up asking for help at this stage as they feel let down and no one is interested in them."*

We found that every prison has a referral and/or triage process, which works well for some prisoners and staff; however we equally found that both prison staff and prisoners indicate lengthy waiting periods and indicate a shared sense of frustration with the current referral and triage systems. In addition, the prisoner's experience above of being given self-help leaflets which are aimed at a community setting is unacceptable for people whose punishment is loss of liberty and who have no means of undertaking the suggested self-help strategies.

Assessment

In all prisons a registered mental health nurse usually undertakes the initial mental health assessment following receipt of referral. In four prisons, a psychiatrist may carry out the initial review if this is indicated or urgent.

When assessment by a psychiatrist is indicated, timescales are highly variable. In one prison urgent psychiatry referrals could be seen within 48 hours, in five prisons this would take place within a week. In a few prisons, there was a wait of between 4–6 weeks for a psychiatry appointment.

Assessment is carried out using the mental health assessment tool through the electronic health record management system, Vision, or, in some prisons, a separate assessment tool in use by local NHS mental health services.

We asked about the use of additional screening tools. Standardised tools were in use in a few prisons, with the Hospital Anxiety & Depression (HAD) scale most commonly used (in three prisons). Specific assessment tools for attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) were also in use in two prisons, where one of the visiting psychiatrists carries out these assessments on a monthly basis.

It should also be noted that often these tools are self-rating and may be an issue for the lower levels of literacy in the prison population, which equally applies to the self-help materials referenced above.

Support and intervention

The variety of mental health interventions available within prisons are outlined in table 2 below.

Table 2: Mental health interventions available in prisons

Type of interventions	number of prisons
Psychological therapies	
Addiction	15
Guided self-help	15
Anger management	9
Anxiety management	15
Trauma interventions	14
Other	7
Peer support/listener services	11
Addiction education	15
Addiction counselling	12
Therapeutic activities	14
Other	6

Only six out of 15 prisons reported that they had adequate facilities to deliver mental health support to prisoners while the remaining nine reported that the facilities are not adequate, citing a lack of accommodation and/or competing organisational priorities for limited space.

Prisoners with specific needs

Prisoners are unique individuals and may experience a wide range of mental health difficulties including diagnosed mental health conditions.

In relation to general wellbeing, we asked if prisoners were routinely provided with information about looking after their mental wellbeing and found that information was provided in 10 out of 15 prisons.

The psychiatrists who responded to our online survey (n=14/28) commented about the need for increased support from GPs and primary care services in prison to help support prisoners with general mental health needs. We were told that this approach could release capacity within the mental health team to assess and support those with moderate to severe illness and complex mental health needs.

We found that none of the prisons reported having access to a specialist personality disorder service although two prisons had RMNs with a special interest and expertise in personality disorder.

In one prison we found that all mental health team members are trained in delivering *Safety and Stabilisation*, a module on the national trauma training programme available from NHS Education Scotland (NES) [28].[d]

When prisoners are identified as having a learning disability (LD), or had contact with LD services prior to coming into custody, assessment is carried out by LD nurses in the five Scottish prisons which have this expertise; the general mental health team will aim to assess in the other prison settings.

Some prison services refer to external specialist teams for support when needed, for example, Lothian prisons told us that they can refer to the local NHS Forensic Learning Disability Service for assessment and support.

There are no specialist services to support people with autism spectrum disorder and/or older adults with dementia, which we heard are emerging challenges within the prison. One prison told us they recently diagnosed five prisoners with dementia type illnesses and the team are now developing a dementia care pathway.

The picture painted is one of inconsistency and reliance on small numbers of specialist staff. There was no overarching strategic approach referred to in relation to meeting the range of needs of those experiencing the continuum of mental health conditions.

Care planning

Healthcare managers advised that prisoners receiving ongoing support from the mental health team generally have a mental health care plan (in 13 prisons).

In the prisoner records we viewed, only 42% (n=45) had evidence of a care plan and for 58% (n=62) there was no evidence of a care plan. Of the 45 individuals who had a care plan, 87% (n=39) had their needs and interventions reflected in it and 72% (n=32) of the care plans were regularly reviewed.

Prison mental health support: prisoner experience

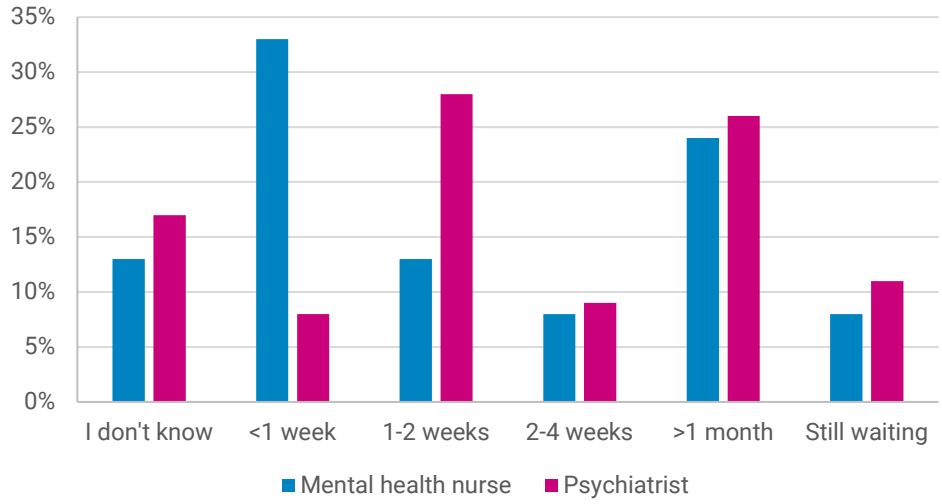
When we met with prisoners we asked about their experience of accessing support for their mental health in prison.

We asked about the time taken to see a nurse or psychiatrist. One third of those who had seen a mental health nurse were seen within one week, however around a quarter of respondents had waited more than a month.

[d] *Safety and Stabilisation* is a 2+ one-day training to develop the skills and competencies to deliver safety and stabilisation interventions as part of the phased based treatment of people affected by experiences of prolonged and repeated trauma.

The length of time people waited to see a psychiatrist was slightly longer overall, as evidenced in the chart below, we found that over a third were seen within two weeks.

Figure 2. Time to see mental health professionals in prison



The significant majority of prisoners we spoke with (81%; n=87) were receiving ongoing support from a mental health nurse, with ongoing psychiatry input being next most common at 39% (n=38).

Table 3: Interventions provided to prisoners

Intervention	Number (%)
Single contact with mental health nurse	13 (13)
Ongoing mental health nurse contact	79 (81)
Referred to psychiatrist	9 (9)
Single psychiatrist contact	10 (10)
Ongoing psychiatrist contact	38 (39)
Referred to psychologist	10 (10)
Single psychologist contact	2 (2)
Ongoing psychologist contact	20 (21)
Self-help materials provided	23 (24)
Referred to any other HCP	9 (9)
Other interventions	12 (12)

We asked prisoners to rate how helpful different supports had been to them. The results are shown below.

Figure 3. Helpfulness of different kinds of support

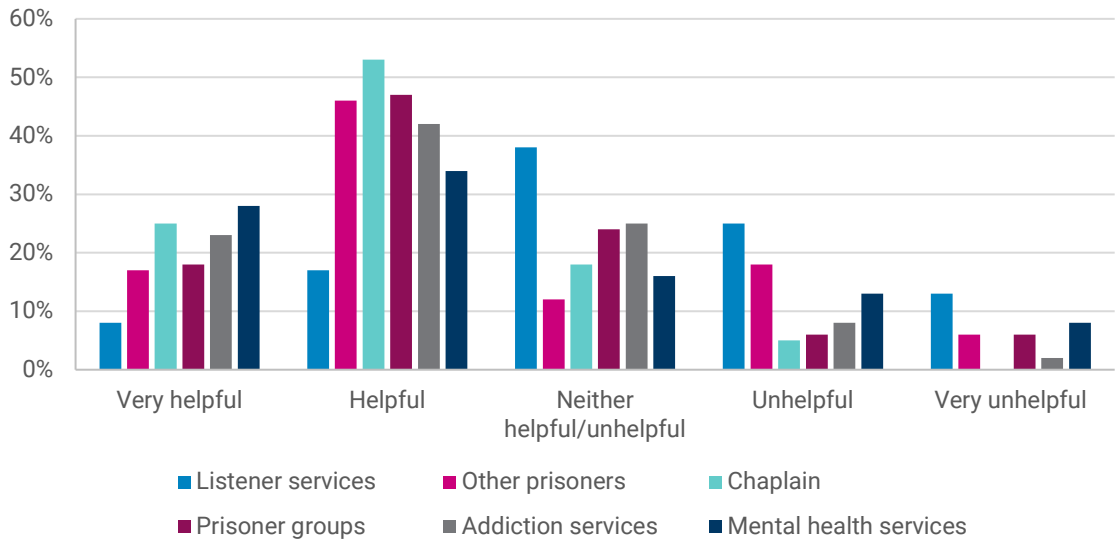


Table 4: Support type accessed by prisoners

Support type	Total No. prisoners using support*
Listener services	24
Other prisoners	65
Chaplain	57
Prisoner groups	34
Addiction services	48
Mental Health services	85

*prisoners access more than one type of support

We also asked prisoners about their overall experiences of mental health care in prison. We found that the experiences reported ranged from very positive:

> *"I have received very good help since I came into prison with my mental health. I am alive today because of the support I have received from staff."*
>
> *"I find mental health services helpful, available and supportive and have no concerns about accessing them."*
>
> *"Mental health support is better in prison than in the community."*

To highly negative:

> *"Worst jail – useless, they don't care about the impact on others of self-harm suicide. Mental health services are useless."*

One person talked about services being under resourced, with more help for prisoners needed:

> "*There is a feeling you have been forgotten about."*

Waiting times was a particular problem raised by several prisoners:

> "*My mental health gets worse in prison, feel prison staff are brilliant but mental health staff not always there. Can take months to be seen."*

A number of prisoners who had experience of transfer between prisons also spoke about differences in the mental health support they received in different establishments.

Comments about specific types of support were also varied. Many prisoners told us about their experience of support from mental health nurses, which was generally very positive:

> *"[Name of] the mental health nurse knows me well and so if I ask to see her, she usually responds quickly. I trust her to give me good advice and support and often I just need to speak with her rather than any other treatment. She knows me well and knows about my experiences as a child and in care – this is helpful as I don't need to speak about this every time I see her."*

Another person who had been seeing the mental health nurse weekly for one year told us she was the "*best mental health nurse I ever had."* This person also noted that the nurse was working alone and was busy as *"everyone wants to see her."*

Others described less positive experiences:

> *"I never know when I am going to see the mental health nurse - I can see her and she advises that she will see me again and then I don't hear anything for weeks so I re refer myself and then I am told that I don't need to refer because I am already open to them. It would be better if I knew when my next appointment was."*

Difficulty accessing psychiatry support was mentioned by a few prisoners:

> "*Felt I had to wait a long time to see a psychiatrist, took ages, was really slow, not sure if it was due to Covid."*

Others talked about the impact of support from psychology:

> *"…I have been attending the psychologist and this has been ok - I am learning new ways of managing stressors and sometimes these are effective."*

> *"I have felt that the psychology sessions have been really helpful and that I have probably needed this kind of help for some time. The reality is that I would probably not have sought this in the community as I didn't understand what it could offer. The other thing which is a positive in relation to promoting positive mental health is my access to education. I am using my time in prison to try to get as many qualifications as possible as preparation for the difficulties I am likely to have in getting back into employment on release."*

A number of prisoners commented on supports from prison staff. Again responses were varied. While one person spoke positively about prison officers being "approachable", identifying issues and arranging support if needed, others felt this support was less available:

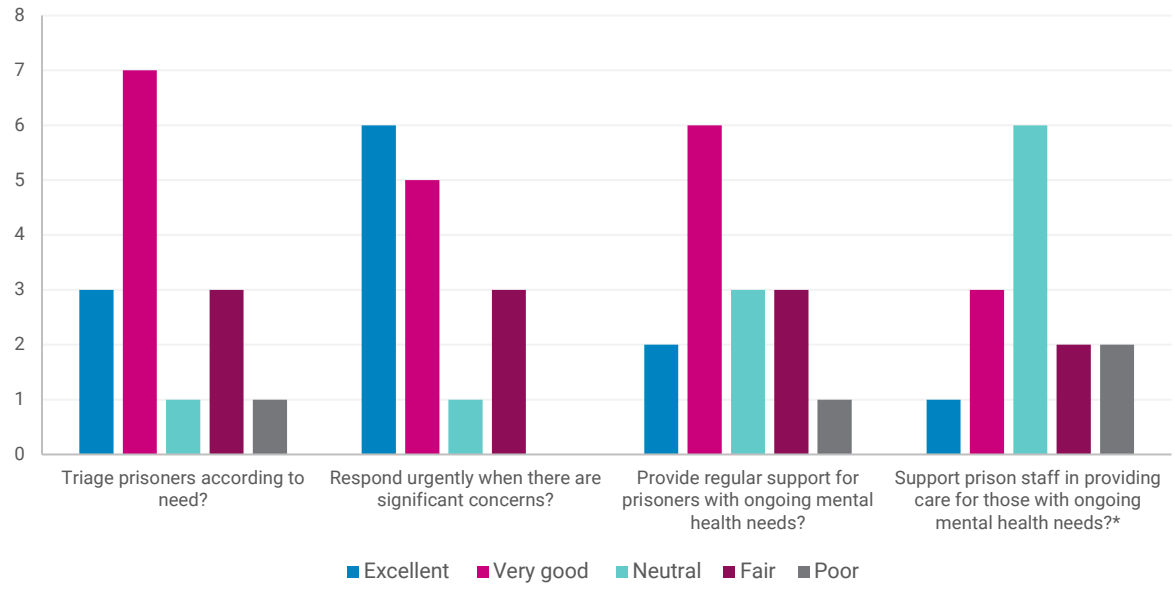
> *"There should be better understanding by prison officers of mental health issues. Officers should be supportive of the mental health staff."*

Views of prison governors and prison staff

In surveys, we asked prison governors and staff about their experience of mental health support in a number of aspects of prisoner mental health care. Tables of outcomes are provided below.

Most governors (10 out of 15) considered the mental health team either excellent or very good at triaging prisoners according to need. Similarly, 11 out of 15 considered the mental health team excellent or very good at responding to urgent significant needs. For providing regular support only eight out of 15 considered the mental health team excellent or very good. The area with less positive views was on supporting staff in providing care for those with ongoing needs, where only four out of 14 responding governors considered the mental health team either excellent or very good.

Figure 4. Prison Governor views on response/input from mental health team



We asked prison staff the same survey questions about the response and support they receive from the mental health team where they work. Generally, responses were less positive than those of prison governors. Perceptions of support or input from the mental health team varied, with many prison staff responding that this worked not so well or not well at all. The highest proportion of negative views was in relation to supporting prison officers to provide ongoing support to prisoners who need it; 51% (n=55) responded that it works not so well or not well at all.

Chapter 3 summary

77% (n=82) of the prison staff group who engaged with us reported that they had concerns about the provision of mental health support within the prison. The themes identified were consistent and related to resources, waiting times, collaborative working between NHS and SPS, the need for trauma informed and recovery based approaches and more therapeutic activity. We heard the following from prison governors from across the prison estate.

> *"There appears to be a lack of mental health resource within NHS services. There have been enduring vacancies within the mental health nurse team and the psychology team. Significant challenges have developed over the years with considerably more access to psychoactive substances and the impact these have on mental health – the mental health resource does not appear to have been adjusted to account for this".*
> (prison governor)

> *"The approach to mental health in prisons appears based on crisis management. The service needs to be properly funded with interventions and additional support services, such as counselling."*

> *"Additional resource in mental health and addictions and greater collaboration with the prison on developing trauma informed and recovery based approaches".*

> *"More training and awareness for staff, esp. trauma informed and MH awareness. More support for front line staff who work with those in our care e.g. supervision sessions."*

> *"More therapeutic activity could improve things. The approach should be to create conditions for positive mental health."*

These challenges, in turn, impacted upon the experiences of prisoners. We heard little from prisoners about individualised care appropriate to their needs; even in the minority of cases where care plans did exist, they were not consistently subject to dynamic review.

CHAPTER 4 – Management of suicide and self-harm

Background

One of the leading causes of death in the prison population is suicide. The rate of suicide is much higher in this group than in the general population, although it is important to recognise that those in prison have a higher number of risk factors for suicide than individuals in the community [29].

Scotland's suicide rate in prison was reported as nearly three times higher than in the general population, and slightly higher in males than females [30]. A higher risk of suicide was also found for those who served life sentences, had been convicted for violent offences, and were on remand [12].

The strongest evidence for those at increased risk of suicide were with prisoners who had displayed suicidal ideation during their current sentence, had a history of attempted suicide as well as history of self-harm, had a psychiatric diagnosis (depression in particular), were on medication for their mental health, had reported alcohol misuse, and had poor physical health [12]. Other important prison-related factors were living in single-cell occupancy and not receiving social visits.

In 2015, the Scottish Prison Service (SPS) implemented *Talk To Me: Prevention of Suicide in Prisons Strategy (2016-2021)* [31], an evidence-based strategy which supported the *National Prevention of Suicide Strategy* and the Scottish Government's priority to reduce suicide rates in Scotland.

The SPS worked in partnership with NHS Health Boards, NHS Health Scotland, Samaritans, Breathing Space, and Families Outside to develop the strategy; it also incorporated consultation from a wide range of people in prison, and took account of their experiences and feedback. The strategy recognised the complexity between the relationships of suicide and self-harm. Many people who die by suicide will have a history of self-harm but most people who self-harm will not go on to die by suicide. As such, self-harm is a clear risk factor for suicide, but it is also a phenomenon that SPS needed to understand and address in its own right. While the focus of the strategy is to reduce suicide, it also aims to benefit those who self-harm.

What we expected to find

We wanted to find out the views of prison governors, prison staff, prison health centre managers and prisoners on the use of the SPS suicide prevention strategy, *Talk To Me* (TTM).

We expected to find that TTM was well established in all prisons, and available to all prisoners from the point that they were received into the prison. We expected to hear that, for the staff working in prisons, training and using TTM had been of benefit when working with prisoners who were at risk of self-harm or suicide; we wanted to know of the impact of this strategy on prisoners and find out if individuals in custody had found they could access TTM when they needed to, and that it had been of benefit.

What we found

45.7% (n=49) of prisoners we spoke with told us that they had accessed *Talk To Me*.

We asked prison governors how effective they thought the current admission screening process was for identifying the risk of self-harm and/or suicide. All 15 governors indicated that they considered the current process to be effective, with more than half (n=8, 53%) indicating that they thought TTM was extremely effective. All 15 prisons in Scotland operate the TTM strategy, with most of the prison governors finding that there have been no difficulties in implementing TTM in their prison (n=11, 73%).

From the remaining 27% (n=4) we heard from governors who were experiencing challenges such as, having the "*right people available for [TTM] case conference meetings*" and the administrative aspects for the process were not to the required standard.

We heard from all 15 health centre managers that TTM was in operation in their prison as a suicide risk management strategy. Nearly half of the health centre managers (n=7, 47%) told us about the implementation of the strategy in their prison.

> *"The mental health team actively participate in the Talk To Me suicide prevention process. This strategy aims to care for those at risk of suicide, by providing a person-centred care pathway based on an individual's needs, and by promoting a supportive environment where people in custody can ask for help…This is the decision making process that supports those at risk and provides the care and interventions necessary to reduce the individual's risk of suicide.*"

The health centre managers also told us about some difficulties with TTM. We heard that the main challenge with TTM is that it can be restrictive and is not person centred. This was explained in terms of staff fears when a prisoner is provided with distraction items, which could subsequently be used by the prisoner as a means of self-harm. In addition, health centre managers considered there to be a stigma attached to TTM for prisoners as they are taken out of circulation and given safer clothing to wear.

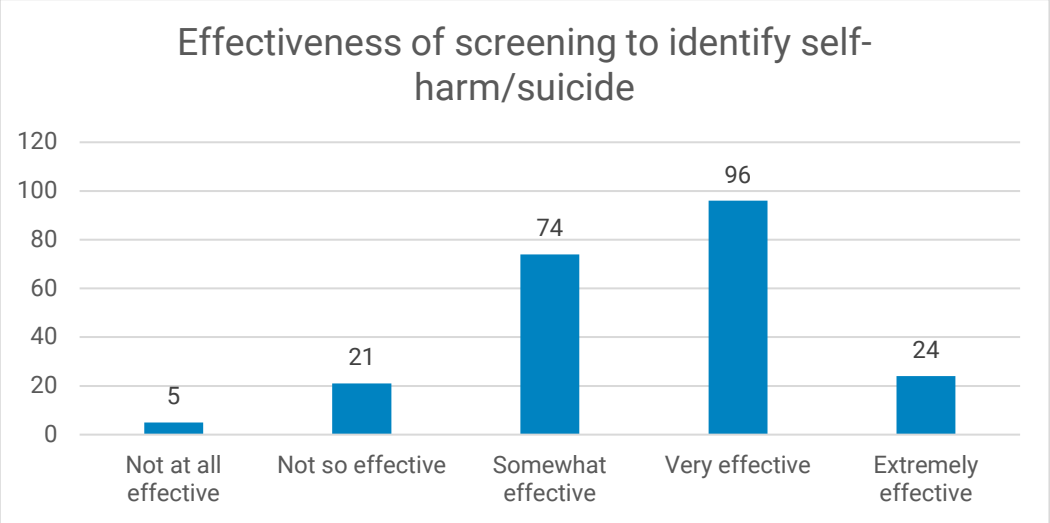
As part of the TTM strategy, there is a focus on using interventions such as safer cells and strong clothing/bedding to minimise risks to individuals. When a prisoner is considered to require this level of input, there should be a care plan drafted up immediately, and a health care assessment should be carried out promptly and an initial case conference held within a 24-hour time period.

We heard from health care managers that when there are high numbers of prisoners on TTM, attending multiple case conferences was said to be challenging for NHS nursing staff whilst balancing competing priorities.

Similar to the point raised by the prison governors, health care staff told us that having staff (both healthcare and SPS) available for case conferences can be a challenge.

We asked prison officers for their views about the effectiveness of screening in identifying self-harm and/or suicide, and this is shown in figure 5 below.

Figure 5. Effectiveness of screening to identify self-harm/suicide

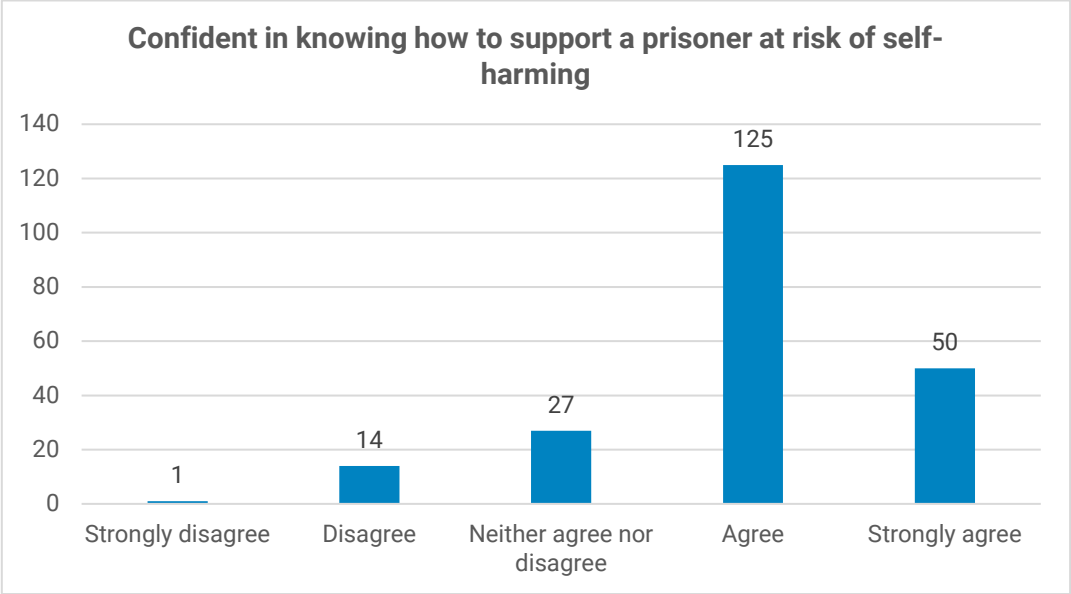


The responses reflected that 88% of the prison officers (n= 194) were positive about the screening process for prisoners who were self-harming and/or suicidal.

We also asked if prison officers had received training in TTM; nearly all of those that responded said they had (n=212, 96%), with very few either not responding, or indicating that they had not been trained (n=3 for missing answers, n=5 for no).

We also wanted to find out how prison officers felt when supporting a prisoner who was identified as at risk of harming themselves.

Figure 6: Prison staff confidence in supporting prisoners at risk of self-harm



There were very few respondents who did not answer this question (n=3, 1%), and for most who answered, they indicated that they felt confident in knowing how to support prisoners who were at risk. Some of the comments from prison officers specifically on TTM were positive:

> *"Talk To Me is a good system and we are trained well in this to support those who wish to harm themselves. But feel we could be better trained in how to deal with other mental health issues."*

> *"TTM is essential and a vital tool in managing people at risk."*

Although there were also some views that training could be improved:

> *"The Talk To Me training is very theory based, and does not train you in how to react with prisoners but I think you have to learn that yourself, it's something that can't be taught. Perhaps more scenario training and role playing to prepare for the real situations on the job."*

When we asked prisoners for their experience and views of TTM, some prisoners responded as follows:

> *"Talk To Me is just someone lifting a hatch to see you're okay - they didn't know me and didn't Talk To Me. I feel if I open up to prison staff they use it against me."*

> *"Talk To Me doesn't help, what would help would be a move to another wing where he could feel safe. He spoke to the governor but he was ignored. Prisoner is not eating, not getting out of his cell and currently in safe bedding. Not sure of what would help, other than being in a different wing/hall."*
> (as reported to Commission visitor)

For most of the prisoners we spoke with, TTM was not mentioned; those who did discuss this did not focus on the benefit of the strategy.

Chapter 4 summary

The SPS developed the TTM strategy in 2016 along with their commitment to never be complacent with regards actions to keep prisoners safe, stating that any death by suicide is a tragedy for all.

From our visits we learned that investment in training in relation to TTM has supported a work force who report feeling confident and competent and the approach is well embedded.

Feedback received confirmed that there is learning to be gleaned from TTM's operation in practice over the past five years. We heard that further work needs to be done to ensure a genuine person centred focus, a trauma informed approach with every effort made to eliminate associated stigma. The timing of the review is therefore welcomed.

CHAPTER 5 – Problem substance use and mental health

Background

We know that many prisoners have issues with both mental health and problem substance use. Figures from the Scottish Prison Service's drug testing on entry and liberation from prison showed that 71% of prison entrants tested positive for illegal drugs (including illicit use of prescription drugs), most commonly cannabis (44%), benzodiazepines (33%) and opiates (28%). Upon liberation, of those tested 26% were positive for illegal drugs, most commonly buprenorphine (12%), opiates (8%), and benzodiazepines (6%). Great variation between prisons was evident, as the proportion of positive tests for illegal drugs at entry ranged from 66% in Low Moss to 86% in Greenock, and at liberation from 4% in Polmont to 45% in Addiewell [32].

The misuse of illicit substances is prevalent in UK prisons [33]. There has been a shift in substance misuse patterns that reflect the significant increased use of novel psychoactive substances (NPS), with known impacts on mental health, treatment, levels of violence and staffing resources [34]. Some of these NPS have been associated with drug-related deaths, which in Scotland are now at an alarmingly high level. This includes unlicensed prescription benzodiazepines, such as Etizolam, in addition to the gabapentinoids such as Pregabalin and Gabapentin [35]. Indeed, gabapentinoids have recently been re-classified as a controlled drug [36]. These drugs can be more potent than more traditional illicit substances, having an additive/cumulative effect when used in combination with others and some of their effects can often be idiosyncratic and unpredictable [34].

SPS currently operate mandatory drug testing at specific intervals of a person's progression through prison. These tests are completed on a priority basis from a suspicion test, to a progression test, to a prisoner request test. These tests do not however detect NPS, which is increasingly undetectable as it is soaked in paper or clothing and enters the prison system in letters or parcels. With five reported prisoner deaths in 2021 from NPS and increasing risks to prisoners and staff, the Scottish Government, at the time of the Commission visits, were progressing secondary legislation to photocopy prisoner mail in a bid to identify and radically reduce NPS entering the prison system.[e]

What we expected to find

All prisoners should have the opportunity to access healthcare and treatment in prison of equal quality to community mental health and addictions services [37]. We would therefore expect all prisoners affected by mental ill health and addictions to be supported from initial reception and throughout their custodial sentence to access addiction supports within prison, or at least be offered addiction support where it is known the individual has a current or historical problem substance use.

We would expect that timely referrals are made by NHS and/or SPS staff, where applicable, to manage pharmacological and therapeutic needs to ensure the individual has every opportunity to access appropriate care and treatment.

[e] Prisons and Young Offenders Institutions (Scotland) Amendment Rules 2021 (SSI 2021/446)

The issue of the impact of NPS in Scottish prisons was previously highlighted as a significant challenge for the SPS by Audit Scotland [5], and Her Majesty's Prison Inspectorate for Scotland [6].

There have been legislative changes through the Psychoactive Substances Act 2016, with the aim of affording greater powers to prisons to manage the flow of illicit substances into Scotland's prisons. We therefore also expected to find evidence of action taken in response to this known challenge.

What we found

Problem substance use support (prisoners)

Of the 107 prisoners we met through our visiting programme, around 75% (n=81) of respondents reported that they have had, or currently experience problem substance use with alcohol (n=15, 14%) drugs (n=21, 20%) or both (n=44, 41%).

We heard that out of the 74 prisoners who reported that they have addiction issues, 35% (n=26) said they have not been offered addiction support in their current prison; for some they said they did not need support at the present time, while others continue to wait.

Table 5. Problem substance use and help seeking since arriving in prison

	Drugs	Alcohol	Both	No	Missing *	Total
Substance use difficulties past or present	21 (20)	15 (14)	44 (42)	24 (23)	3	107
Offered help for substance use difficulties	19 (26)	7 (9)	22 (30)	26 (35)	9	85

*not included in calculation of percentage

For one prisoner affected by poor mental health and addictions, they told us that they were:

> "*Not offered support in this prison [and] continue to take illicit substances as a way of managing anxiety and low mood."*

Whilst another reported:

> *"I don't want it [support] - I am able to access whatever substances I want in the prison so I don't need any support."*

It is important to note that all of Scotland's prisons have addiction services on site, with supplementary self-management educational programmes. Twelve out of the fifteen prisons also offer addiction counselling.

We heard mixed views from prisoners about addiction supports in prison.

We heard from prisoners who highlighted positive experience of addiction and mental health supports, with a peer led recovery café particularly highly regarded (although it had been closed due to Covid-19):

> *"Allocated drugs worker who I see in prison every few weeks has been really helpful. Most important thing for my mental health is family support. A phone call or visit really helps. They pick up quickly if there is something wrong; it's an early warning and they would let prison staff know. The mental health service is good if you ask. There is not enough information in the halls e.g. on notice boards".*

We also heard about delays.

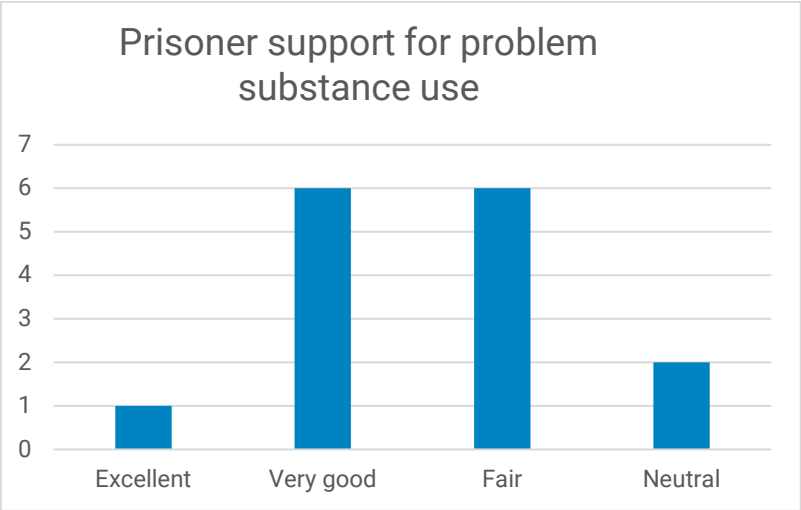
> *"Not picked up for ages. My whole life had been turned upside down and I was really not well so the drug stuff wasn't picked up. I used to go to NA [Narcotics Anonymous] on the outside and started that in here but it all stopped just now because of Covid".*

Around 18% of the prisoners who spoke to us told us that they have problem substance use but they do not wish to engage with addiction services or do not feel that they need the support at the present time.

Problem substance use support (prison governors)

Seven out of fifteen prison governors considered the support offered to prisoners with problematic substance use to be excellent or very good, six thought it was fair and two rated this neutral. (Figure 7).

Figure 7. Support for prisoners with problem substance use

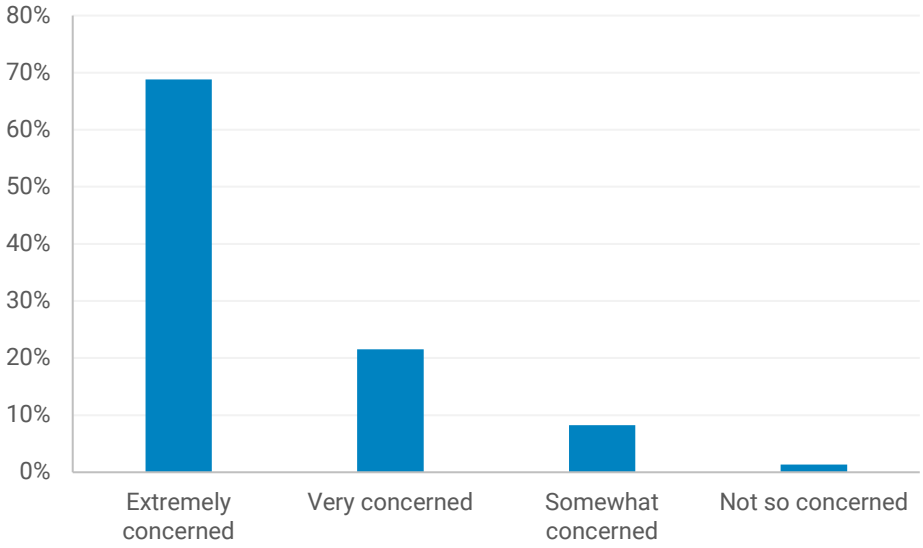


All governors expressed concern in relation to NPS, 10 of whom described these concerns as significant.

Problem substance use support (prisoner staff)

Prison staff were concerned about substance misuse and support; they shared governors' concerns relating to NPS. 69% (n=154) of staff reported being extremely concerned and 22% (n=49) were very concerned about NPS in their prison (Figure 8).

Figure 8. Level of concern about NPS



Concerns and genuine fears regarding the use of NPS in prisons was very evident in the feedback we received from staff.

> *"There seems to be no way of stopping it coming into the prison. The worry is of people overdosing especially where you have people who have never used drugs before being offered it."*
>
> *"…seems only a matter of time before there is a fatality."*
>
> *"High levels of use and high levels of resulting drug induced psychosis. Many prisoners reporting that after the main effects have faded they do not feel their mental health has ever returned to what is normal for them. The effects are long term."*
>
> *"I have been involved in an incident where the prisoners had to be restrained after taking NPS and then had to have a defibrillator used on him three times during the restraint. We tried everything to de-escalate the situation but he just wanted to fight with anyone and everyone. I genuinely thought he was going to die on each of the three occasions…… I know this is not the first time this has happened in here and it won't be the last".*

Chapter 5 summary

It is clear that there are a variety of interventions available to support prisoners with problem use of substances. We heard difficulties regarding access to support, knowing what the support available was and delays in receiving this support. Once engaged however, there was positive feedback from prisoners regarding the difference this made with the peer led café model rated particularly highly.

The most significant issue raised by prison staff and governors was the use of NPS which does not show up during regular screening processes but has caused significant harm to both prisoners and staff. In particular, the unpredictability of behaviours leading to increased episodes of violence, cardio resuscitation and second hand inhalation of fumes by staff; of significant concern for prison staff is their ability to keep prisoners safe from NPS effects.

During the analysis phase of our prison report in 2021, the Cabinet Secretary for Justice updated the Criminal Justice Committee to advise that, in the first four weeks of the secondary legislation being enacted, which gives SPS powers for non-official mail to be photocopied, there had been a significant reduction in NPS entering prisons.[f] However, the introduction of photocopied mail (except legal correspondence) is not without controversy in relation to prisoners' rights to access their mail, which is being monitored as the legislation is implemented. Despite the reported increase in perimeter fence illicit drug drops [38], the initial reported impact of the NPS measures on prisoner health is welcomed.

[f] *The Prisons and Young Offenders Institutions (Scotland) Amendment Rules 2021* (S.S.I. 2021/446) amends rule 55 of the *Prisons and Young Offenders Institutions (Scotland) Rules 2011*.

CHAPTER 6 – Segregation and delayed transfer

Background

In 2008, Her Majesty's Chief Inspector of Prisons for Scotland (HMICPS) expressed that prison is not the most appropriate place for people with severe and enduring mental health problems and alternative environments should be identified [39].

The Commission has been increasingly concerned during the last ten years about the use of segregation for prisoners with mental disorder and the continued reports of delayed hospital transfers for acutely unwell prisoners to specialist hospital care. The same concerns were highlighted by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (the CPT) in relation to their visits to Scottish Prisons in 2018, specifically HMP YOI Cornton Vale which was detailed in the 2019 CPT report [7].

During 2021, the Commission followed up on the CPT concerns about women who were mentally unwell in Cornton Vale prison. Our findings raised specific areas of concern, including the use of segregation for women who were mentally unwell and unacceptable delays in transferring individual women who were acutely mentally ill to hospital care. We were therefore keen to look at segregation and prison transfer delays through our 2021 prison themed visit programme across the prison estate in Scotland.

Segregation in prisons

Segregation is when a prisoner is separated from the general prison population and is either restricted to their own cell, or placed within the separation and reintegration unit (SRU). Segregation is generally applied under prison rule 95 or rule 41. Rule 95 is applied if prison staff assess that a prisoner needs to be separated to maintain good order or discipline in the prison, to protect the interests of any prisoner and to ensure the safety of other persons.[g]

During our visits we focussed on prisoners being held in prison SRUs under rule 41, which is applied to individuals who are accommodated in specified conditions within the prison following advice from a healthcare professional. The application of rule 41 includes the segregation of severely mentally unwell individuals to protect their (and/or other prisoners') health and welfare.[h]

Prison transfers

Prisoners who are acutely mentally ill and cannot be cared for within the prison should be transferred to an appropriate hospital setting without delay. Unlike a community setting where an individual is subject to compulsory treatment orders under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) and can be compelled to have mental health treatment, involuntary mental health treatment cannot be given in prison and if indicated, the prisoner must be transferred to a psychiatric inpatient bed under appropriate legislation [40].

[g] The Prisons and Young Offenders Institutions (Scotland) Rules 2011; https://www.legislation.gov.uk/ssi/2011/331/contents
[h] https://www.legislation.gov.uk/ssi/2011/331/pdfs/ssien_20110331_en.pdf

The Forensic Network[i] began monitoring transfers from prison to forensic mental health services in February 2018. By May 2020, they had recorded 70 referrals. This appears to be a significant underestimate based on recent studies [41] [42]. The average length of time for transfer following an urgent referral was found to be 11.4 days. The average length of time for transfer following a non-urgent referral was 27.4 days [43]. Commonly cited factors for delay in transferring individuals from prison to hospital include bed availability, disagreements over the required level of security, disputes over the responsible local authority/health board catchment area and disagreements over severity of illness [11].

While the Barron Review highlighted that transfers for men take place relatively quickly, with positive comparisons made to the time taken elsewhere in the UK, this is not necessarily the case for transfers of women. The average length of time for transfer following referral was 43.2 days. The lack of beds within forensic mental health services for women was felt to contribute to difficulties in transferring women from prison when they need secure hospital treatment. These concerns align with the findings from the 2019 CPT Report.

What we expected to find

A key message from our 2011 report was that:

- *Prison is not the place for seriously and acutely mentally ill prisoners. To address this, SPS and NHS Boards should:*
    - *Ensure that there are protocols and policies in place to make sure that seriously and acutely mentally unwell prisoners are moved quickly to be treated in a hospital setting.*
    - *Review the appropriateness of any facilities used to accommodate prisoners with mental health problems as to suitability and purpose.*

A prisoner with serious and acute mental illness should be offered the care and treatment equivalent to that which would be available from the NHS if they were not in custody. This was the basis of the Scottish Government's decision to have the NHS in Scotland take responsibility for healthcare in prisons from 1 November 2011.

Prisoners who are mentally unwell should only be placed in segregation as a last resort, when there is no alternative for safely managing their care in custody. Whilst in segregation, we expect these individuals to be supported by the mental health team, with multidisciplinary care plans in place to support their care. There should be good collaboration with prison staff and the need for segregation should be regularly reviewed in line with the Prison Rules. Opportunities for activity, social contact and exercise should be maintained wherever possible.

We would not expect mentally ill prisoners to be managed in segregation for extended periods of time. When a prisoner is seriously and acutely mentally ill, they should be transferred to hospital for treatment, in the same way as an acute physical illness would be treated.

[i] The Forensic Network is one of Scotland's managed clinical networks. Established in 2003, the Forensic Network seeks to bring a whole Scotland approach to the planning and development of pathways for forensic mental health services.

What we found

Segregation

Of the 107 prisoners we accessed, 10 (seven men and three women) were in an SRU at the time of our visit. The 10 individuals were in custody in seven different prisons and were all reported by staff to be located in segregation for reasons related to their mental health. Eight had a known history of severe mental illness, whilst two had difficulties relating to substance misuse.

Some of the prisoners we visited in SRUs were acutely mentally ill and unable to speak with us. We asked the mental health team and prison staff about their care. Three prisoners who were acutely mentally ill were awaiting transfer to hospital care.

Both health and prison staff shared concerns with us in relation to caring for mentally unwell prisoners in an SRU. In one case, the prison staff advised that they had been managing at maximum capacity for the last 7–8 months with individuals who were severely mental unwell, but who could not be transferred as there were no secure hospital beds available. We heard from SRU staff that they felt ill-equipped to manage severely mentally unwell prisoners, and the staff resource required impacted on the time they were able to spend with other prisoners. We heard suggestions from SRU prison staff that a specialist mental health nurse, located permanently in the SRU, would be of significant support for the prisoners and would contribute to SRU staff's understanding of how to effectively manage and support a person in acute mental distress.

The conditions of the SRU environment we found prisoners in varied. Sometimes the environment was reported or observed by the Commission's visit team not to be of concern:

> *"In segregation at the time of my visit - more like own cell with TV, bedding, personal items."*

Whereas other descriptions were less positive. The Commission practitioner noted:

> *"I saw his cell which was very dark (painted), access to a small toilet. The room was messy, he told me it is cleaned out daily..."*

In another prisoner's case:

> *"He was sitting on his bed frame, his mattress and soiled bedding were strewn on the floor. The floor was wet with what appeared to be pools of urine… We were advised his cell is bio-cleaned every 2–3 days. Prison officers told us they regularly try to encourage [prisoner's name] to shower, but on entering the showers in the SRU he usually refuses to wash. They cannot further intervene to support his personal care."*

We asked the prisoners we met in SRU about the prison routine. Among those able to speak with us, we found descriptions to be varied.

> *"He had access to a small screen and told me he could get books and DVDs from a small local library in the unit… He has access to exercise twice a day."*

Whilst another prisoner noted they were:

> *"Stuck in seg 24 hours a day - it's not that great."*

And again we heard other accounts of limited access to activities or exercise:

> "*Out for first time yesterday, got 30 minutes' fresh air. In seg 10 weeks, no idea why.*"

When we reviewed the health records of the ten prisoners, three did not have evidence of clear care plans relating to their mental health needs. Of the seven who did have care plans, in three cases it was noted that care plans were poor quality or lacked detail. Only one person was reported to have detailed care plans relating to their individual needs and risks. This prisoner had previously made a significant violent suicide attempt.

In the questionnaires and surveys we asked professionals about the use of segregation in the prison where they worked. When we asked prison healthcare managers whether SRUs were used to house prisoners who are distressed or behaviourally disturbed due to their mental health, the majority said this was the case sometimes (n=7) or often (n=4). Only one prison reported never using the SRU.

Healthcare managers commented that rule 41 would often be used to support the management of acutely mentally unwell prisoners. Several commented on the use of care planning, multidisciplinary working, and supportive collaboration with prison staff, particularly when managing patients in the SRU:

> *"The segregation unit officers at (name of prison) have a good relationship with the mental health team, are interested in supporting individuals and in understanding the difficulties they are managing."*
> (healthcare manager)

When we asked prison governors about the use of segregation, over half of governors (nine out of 15) reported that SRUs are rarely or never used for prisoners who are distressed or behaviourally disturbed due to their mental health, while four out of 15 reported that the SRU is often used and one out of 15 reported it is always used.

The response of prison staff suggested the use of the SRU for distressed prisoners appeared to happen relatively frequently in some prisons, with 30% (n=67) of staff responding that this usually or always happens.

We therefore found differing views of how frequently the SRU is used to relocate prisoners from the general prison population due to their mental health.

Transfer to psychiatric inpatient services

Among the prisoners we visited, three were awaiting transfer to hospital care at the time of our visit. One person was due to be transferred the following day, having waited several weeks for a bed. Another prisoner, who had been in the SRU for over three months, had been referred to medium secure care the previous week and was awaiting a bed.

The third person, who was severely and acutely mentally ill, had been recommended for transfer around 14 weeks previously and was still awaiting a bed when we visited. Despite multiple assessments, we heard that there had been disagreement between forensic mental health services about the level of security this person required and a lack of available beds in the units where referrals had been made. The individual was known to have a severe and enduring mental illness and had been subject to compulsory treatment under the Mental

Health Act in the community before being remanded in custody. They had already spent over 45 weeks in the SRU when we visited. Both prison and mental health staff were extremely concerned about the mental and physical health of this prisoner. We observed highly committed prison staff making every effort to support the person in exceptionally challenging circumstances. The Commission took further action in this case, escalating concerns to senior forensic clinicians and to the Scottish Government. The prisoner was eventually transferred to hospital one month later. Within six weeks of receiving appropriate care and treatment in a hospital environment, it was reported that the person's mental health had significantly improved.

When we consulted prison healthcare managers, visiting psychiatrists, prison governors and their staff about the care of acutely mentally ill prisoners, there was a clear and unanimous consensus of shared concern. Among the issues highlighted were concerns about the care of mentally ill patients by prison staff who felt ill equipped and inadequately trained to manage the care of those with serious mental illness. The added impact of delays in transferring prisoners to receive the appropriate hospital care they required was a concern widely shared.

Chapter 6 summary

Despite recommendations made by the Commission 10 years ago in 2011, and despite the transfer of responsibility for prison health care services to NHS in 2011, the same issues regarding the need for improved conditions within the segregation unit and for the timely and appropriate placement of prisoners with severe and enduring mental health conditions remain apparent in 2021.

We did find evidence of supportive SRU prison staff teams and healthcare staff, making every effort to support mentally unwell individuals in segregation and in very challenging conditions. For prisoners affected by severe and enduring mental illness however, some of their reported experience was akin to punishment for breaking rules e.g. being kept in a cell without right to open air or alternative setting, removal of privileges e.g. television.

For those who require the use of segregation under rule 41, individualised care plans must be in place and subject to dynamic review to allow for return to the prison community at the earliest opportunity.

Our visiting programme confirmed that there remains a difference in the ways in which prisoners who are mentally unwell are treated compared to individuals protected and supported by mental health legislation in the community.

CHAPTER 7 – Covid-19 impact on mental health in prison

Background

The 2021 Penal Reform Trust reported on global prison trends and on the crisis faced by prisons in light of Covid-19. It reported on the failures, on a global scale, to ensure that prisons were adequately protected from the disease with both staff and prisoners being at risk due to the often overcrowded living conditions of prison estates. Aside from the direct risks and consequences of Covid-19, the report also highlighted issues such as lack of access to harm reduction or treatment for people who use drugs. This was also the case for mental healthcare provision and in many places access has been limited or stopped [44].

Research from Scotland also highlighted that those in prison custody at the time of the pandemic felt that they were more at risk and disease control measures that were introduced were perceived as focusing on increased control. A particular issue, of relevance to mental health, was the increased time spent locked within cells. There were reports of confinement to cells for all but 30 minutes per day. Physical and social isolation resulted in deteriorating mental health for some people and difficulties in accessing support was reported, as there was reliance on external sources (such as Samaritans) rather than getting access within the prison [45].

What we expected to find

We are aware that Covid-19 has presented unprecedented challenges to everyone in society and no more so than in the enclosed environment of prisons. We wanted to know how the pandemic has impacted those involved in caring for the prison population and on the prisoners themselves.

Whilst acknowledging the sudden and all-consuming difficulties prisons have faced during the pandemic, we would expect SPS and NHS to have instituted the highest standard of care possible for prisoners in the circumstances.

Safety for their staff and for those in their care should be paramount and we would hope to see robust infection control and seamless access to general health care for those who become physically unwell.

We would also hope to see a fully resourced mental health team, responsive to the inevitable deterioration in the mental health and increase in self-harm of prisoners struggling with increased time locked in their cells. Crisis plans should also be in place.

Enabling communication with friends and family should be a priority to give an extra level of support to prisoners.

We also would expect to see an acknowledgement of the extra stress experienced by staff and some thought given and action taken in relation to their mental health and wellbeing.

What we found

All 15 prison governors and over 70 prison officers commented on the impact of Covid-19 for them and the prisoners they looked after. Although the prisoners were not asked a specific

question around the impact of Covid-19, nearly 30 prisoners referred to the impact of Covid-19 during their interview with Commission staff. Six relatives also shared their views.

We heard from prison governors who acknowledged how well their staff had coped with the extreme difficulties they have faced with one commenting that:

> *"Prison staff and health professionals have worked incredibly hard over the last 15 months to keep people safe and to support people in crisis."*

Another praised the joint working between the prison staff and NHS staff allowing infection control and immunisation protocols to be prioritised and also providing good liaison when transferring prisoners to NHS beds when needed.

All of the prisons however, struggled with the loss of clinical and prison staff, especially those that had had Covid-19 outbreaks and we heard, at the time of our visit, that prison staffing levels remain a concern with officers absent due to Covid-19 infections and isolating.

Almost all of the staff who responded had concerns about the deterioration in the mental health of prisoners in their care, which they recognised led to an increase in self-harm and drug use within prisons.

> *"Covid-19 has been the worst possible thing to have happened when it comes to mental health, this has made everyone get to breaking point and there has been next to no support available."*

A prisoner, asked whether he worried about his mental health replied that:

> *"When you are on lockdown due to Covid it is all I think about."*

Reduced staffing levels made the day to day running of the prison challenging and many activities usually enjoyed by the prisoners were no longer available. Those with adequate outdoor space used this effectively but for most, reduced time outdoors and no access to the gym added to frustrations.

Access to activities, including a recovery café, relaxation classes and addiction support like Narcotics Anonymous were no longer available to provide distractions and support, which increased the isolation and boredom experienced by the prisoners, who stated:

> *"Nothing to do, mind numbing if not working."*

> *"There is a feeling you have been forgotten about."*

Many statutory services also ceased and the lack of speech and language therapy (SALT) support and psychology in particular was reported to be difficult for many prisoners. One prisoner described the first lockdown as:

> *"Generally hellish - don't know if you're coming or going with NHS so backed up."*

> "*So hard to get hold of SALT during Covid, basically I'm left high and dry without support."*

Visiting restrictions and lack of contact with family and friends added to the loneliness and deterioration in the mental health of many prisoners. Five of the six relatives who engaged with us described the contact with their family members in prison as "much worse" over the

pandemic. They described seeing their relative's mental health deteriorate and felt little was being done to help them.

One said the lack of face to face support and having no time outside was contributing to their relative's increased drug use. With the additional stresses of lockdown, the lack of support for mental health within the prison was described as "extremely worrying" by one family member.

Several commented on the difficulty in speaking to anyone at the prison to highlight concerns they had about their relative.

> *"I called the prison to explain that his mental health was spiralling downwards, he also had Covid-19 and they were refusing paracetamol. My son thought he was going to die."*

Working with reduced numbers and under the threat of Covid-19 was very stressful for all the staff involved and many commented on the impact on their own mental health which in turn made supporting the prisoners more difficult. Officers were concerned at the time taken for the mental health team to assess prisoners and felt even after the assessment there was a lack of support. They reported that they felt that they were being left managing very sick prisoners without the specialised knowledge required to provide adequate support to individuals.

Despite the increased need for mental health support, staff shortages made this very difficult and even where the service was seen to be good there was "not enough of it."

> *"I haven't seen a mental health nurse in my unit in the past year, I can only assume this is due to the pandemic."*

Prison officer staff advised that they felt the level of need was further increased by some prisoners who could previously manage their own symptoms becoming unable to do so with the increased stress.

> *"MH care in custody is mainly provided by an increasingly busy and thinly stretched SPS staff in the first instance, it can take far too long for NHS intervention and even when there is, there is not much they can offer to support severe cases leaving SPS staff to manage through isolating the stricken individual, until their symptoms subside themselves or they are liberated."*

Crisis situations were more difficult with limited support and staff felt ill equipped to manage them and reported that transfer to secondary care was often delayed. Prison officer staff commented that some NHS mental health staff were too quick to dismiss some prisoners as being "at it". Assessments to confirm whether behaviour was illness or drug seeking was said to take too long and officers felt that they had no guidance on this.

In addition to the need for increased numbers of qualified mental health staff, some prison staff felt more training was necessary to adequately assess and treat this population:

> "*My main concern is that it takes too long for severely mentally unwell prisoners to get proper help, as in transferred to a mental hospital. The fact that these poor women are kept in prison longer than they should because of lack of beds etc, is an absolute disgrace."*

The officers also highlighted how upsetting it was for other prisoners to have to witness their peers in such distress.

The concerns about increased drug use among prisoners was felt to be directly related to their deteriorating mental health with more prisoners starting to use illicit substances for the first time. One officer stated he had seen a significant increase in the availability and use of new psychoactive substances (NPS).

Some officers were also concerned that staff shortages and changes in shift patterns meant prisoners often found themselves in situations where they did not know the officers on duty.

Many felt they had built up meaningful relationships with prisoners with a degree of trust such that they could "open up" to them. They said that this opportunity is lost with unfamiliar staff who will also not be able to pick up on subtle signs that a prisoner is becoming unwell. It was explained that a prison officer known and trusted by a prisoner is more likely to have a relationship, be able to observe early indicators and intervene as early as possible to offer support.

Officers also commented that some prisoners felt that things would be easier on their release when society was still in lockdown or undergoing restrictions. However, comments from two prisons noted they had a higher than normal "returns" rate from parole breaches. All of the prisoners affected said that loneliness, isolation and lack of support outside prison contributed to this. Some prisoners said they felt safer in prison and preferred the company.

However, there were some positive comments on some of the effects of living with the pandemic in prison. For example, we were told that relationships improved between officers and prisoners:

> "*Two mental health surveys undertaken during lockdown which indicated a camaraderie between residents and staff which helped to [promote] a general feeling of positive mental outlook."*

'Covid anxiety' meant staff and prisoners were united against a common enemy and improved compliance among the prisoners:

> *"During Covid-19 the strength of these relationships assisted us to collectively address the challenges we faced in a highly pressurised and unprecedented environmental situation. I believe collective responsibility and collective expectations of behaviours assisted all of us to manage our mental health relatively successfully (i.e. we're all in this together) as the main focus was on managing Covid-19."*

Reduced numbers of prisoners meant single cells were available and officers felt they could have more one to one contact with the more vulnerable individuals. Several prisoners commented that they preferred the lockdown habit of eating in their cells as this reduced the possibility of intimidation or bullying in the canteen. Smaller work groups or 'bubbles' were preferred for the same reasons and officers commented that it did make day to day supervision easier. One prisoner commented that he spent "less time looking over my shoulder". Some prisoners also preferred the earlier bed regime as it made their days seem shorter.

Support from governors who were proactive in the process was appreciated by many officers, in addition to funds agreed to provide in cell activities and distractions. One of the most successful Covid-19 related initiatives within prisons has been the provision of mobile phones for prisoners.

We were told that lack of contact and face to face meetings with friends and family have inevitably had a negative effect on the prisoners' mental health and contributed to the increase in distress and self-harm. Providing access to phones offered the chance of continued family contact which was greatly appreciated by prisoners and staff alike.

> *"Visits were difficult to arrange with the Covid restrictions but managed to have virtual visits and that was good."*

> *"Hard during Covid - mum can't do virtual visits & can't travel… Phone has helped a great deal."*

> *"During Covid, prisoners were given mobiles. This meant that I could have unlimited virtual visits from my family which has been brilliant."*

Some even managed to access online platforms which was greatly appreciated:

> *"I also have access to zoom and speak to her using this platform too. During Covid lockdown we were given mobile phones so I am able to chat to her twice daily. I also access my local LGBTI group via Zoom."*

Several comments were made by staff and governors warning about complacency now. While restrictions were easing slightly during our visit period it was acknowledged that the full force of the mental health distress caused by the pandemic may not, as yet, have come to light. We heard warnings of a potential 'backlash' as things return to 'normal' and suggestions to have support in place proactively for when this occurs:

> *"This has potentially created a store of 'trauma' that has yet to fully manifest itself and also will need to be addressed/managed and treated."*

Chapter 7 summary

Mental health support has been more difficult to access across all prisons due to the pandemic. Prisoners have struggled with the additional restrictions imposed on them by lockdowns and the loss of the majority of therapeutic and leisure activities has left many struggling with their mental health. Staff have also been affected with reduced numbers and increased stress which has impacted on their mental health and inevitably on the prisoners they care for. We found little evidence of focussed support to staff or any future plans to ensure this. Neither did we find planning to mitigate the impact of Covid-19 to ensure that the right mental health support is available to all at the right time in the future.

CHAPTER 8 – Mental health training in prisons

Our message in 2011 was that:

- *There needs to be more direct involvement from disciplines beyond the prison health centre in supporting prisoners' mental health issues – we saw little evidence of multidisciplinary working.*

Background

In chapter four we talk about the availability of other disciplines, for example speech and language therapists, specialists in learning disability and found little consistency or correlation with the needs of the particular prison population.

Throughout our visits we found that direct involvement is consistently provided by front line prison officer staff.

What we expected to find

We expected to find a clear training strategy in relation to mental health knowledge and awareness required for front line staff in the prison.

We expected prison officers to be able to tell us about the training they had received and how helpful it had been to enable them to manage the distress experienced by troubled and mentally unwell prisoners.

What we found

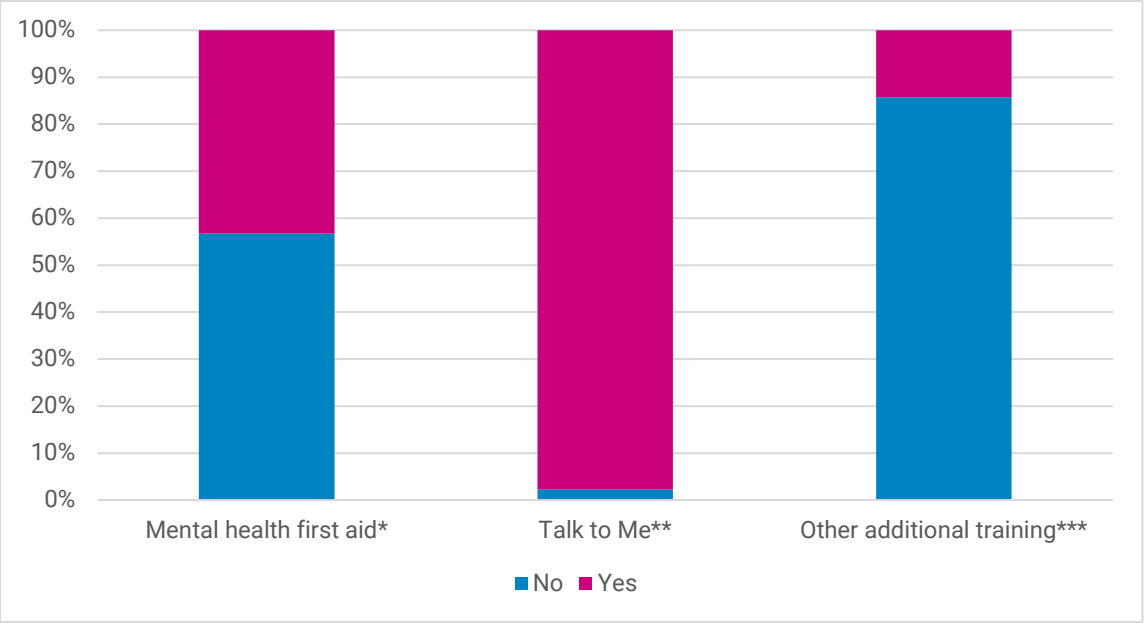
We asked prison governors about the specific mental health training that prison officers receive. Almost all respondents reported completion of *Talk To Me*, which is the prison service's core suicide prevention programme which we discuss in chapter five.

We were told that only a limited number of staff had completed two-day mental health first aid training and heard that prison staff do not have to complete any mandatory mental health training.

Some staff have received training as part of local mental health initiatives and also access online resources to support individuals; however, this is discretionary and dependent on the engagement levels of individual staff.

This correlates with what prison staff told us themselves. Almost all responding staff (n=219, 98%) had received training in *Talk To Me*. However fewer than half (n=96, 43%) told us they had received training in mental health first aid and only 14% (n=31) had received any other type of mental health training (See Figure 9).

Figure 9. Training received by staff



* 5 responses missing; ** 3 responses missing; *** 9 responses missing

Although the numbers were not significant, we heard that some members of prison officer staff have undertaken mental health specific training such as understanding personality disorder, distressed behaviours, autism, mental health first aid for young people, mentally healthy workplaces and workplace stress, as well as training in professional boundaries and domestic violence. Much of this training was delivered by community partners such as NHS, local authorities and Police Scotland.

We were also told that some prison officers are very experienced and have benefitted from the informal advice, support and guidance they have received over the years from the mental health team in the prison.

Although it was clear that a variety of training was available and had been undertaken by some, it was also evident that with the exception of the core suicide prevention programme (TTM), there was little consistency in respect to mental health training across the fifteen prison establishments.

The lack of consistency around mental health training for prison staff was also highlighted by the prisoners we spoke with; we heard a mix of views about support from prison officers, from recognition by prisoners of staff clearly trying to understand and support their mental health:

> *"Generally helpful but they are not trained and mental health support is not their job."*

> *"In general most are supportive – some good some not. Feels they could do with mental health training so they understand more. Outbursts can be seen as behavioural and can get sent to digger."*

"All prison officers should have better training; you trust some more than others. My Personal Officer didn't know about my mental health until I told them – I would have liked for them to have been aware."

Whilst other prisoners indicated that the lack of prison officers trained in mental health can act as a barrier to seeking support:

"They do not understand mental health issues and use this against you. I would never speak to any of the prison officers about my mental health."

"He feels they lack understanding of his situation and if he is upset [prison staff] just suggest things like get a good night's sleep."

We also heard that there is no consistency in the mental health support that is available from prison officers,

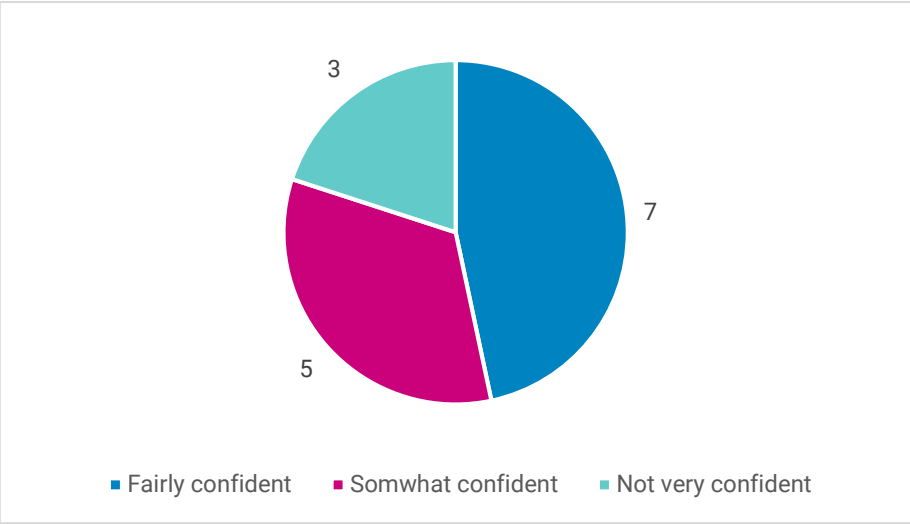
"This is unpredictable and depends on which officers are on duty. Prisoners pick and choose which officers they speak to. I think this is reasonable as they are not trained to deal with mental health issues."

"They don't have enough training in mental health to be supportive. High turnover/inexperienced."

Confidence in supporting prisoners

47% of governors (n=7) were fairly or somewhat (n=5, 33%) confident in prison officers identifying and responding to mental health issues among prisoners (Figure 10), however three reported that they were not very confident in their staff identifying and responding to mental health issues.

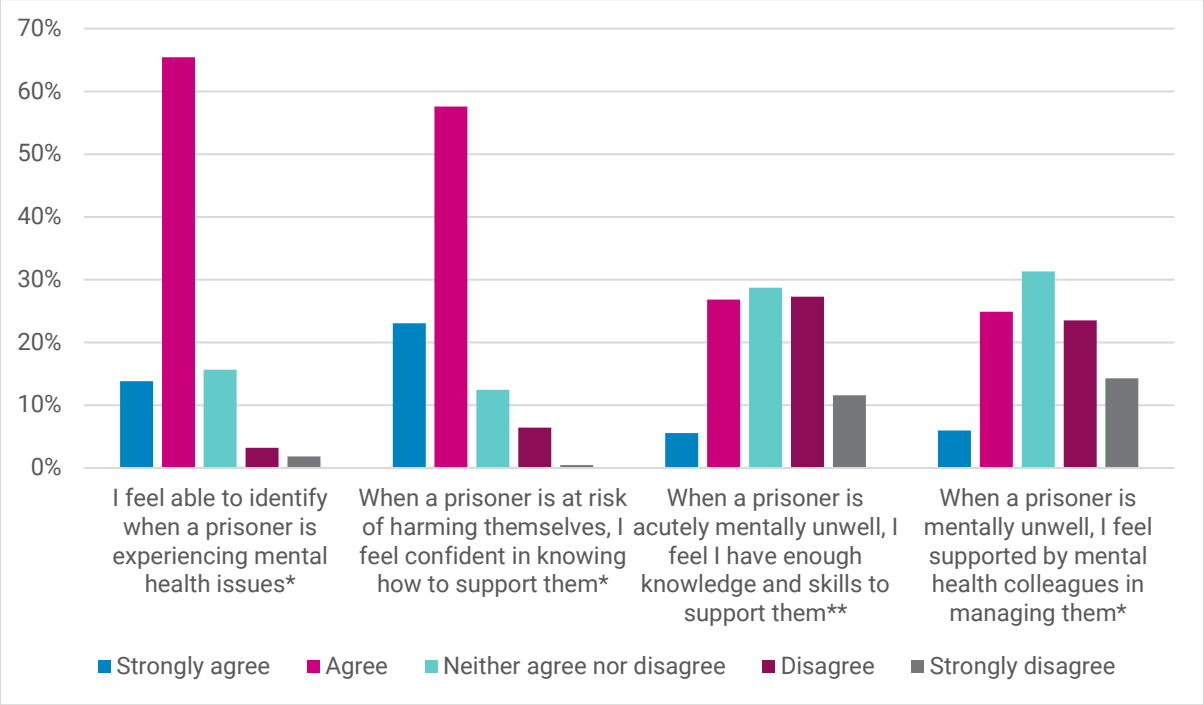
Figure 10. Governors' confidence in SPS staff identifying and responding to mental health issues



Overall, staff themselves reported that they felt able to identify when prisoners experience mental health issues (79% agree or strongly agree) and confident in supporting prisoners at risk of self-harm (81% agree or strongly agree). Less agreement was found for having the

knowledge and skills to support acutely mentally unwell prisoners and feeling they have support from the mental health team in managing acutely unwell prisoners. (Figure 11).

Figure 11. Staff confidence in identifying and supporting prisoners' mental health needs



We received many comments from prison officers regarding their views on mental health training and their ability to meet this need in the prisoners they care for. We found a common thread running through the responses that a sound working knowledge of mental health, mental illness and distressed behaviours is of paramount importance to frontline prison staff.

There was a whole spectrum of comments regarding competency in this area, which ranged from some staff feeling very ill equipped and quite anxious about their lack of skills to other staff who reported that although they have received no mental health training from SPS, they have drawn from existing skills and experience they developed through previous jobs, including as foster carers and support workers. A small number of staff reported that they had undertaken some mental health training whilst working with SPS and felt fairly confident in working with prisoners who are experiencing mental health difficulties.

We heard that more and more individuals are entering prison with mental health needs and also that more and more prisoners are developing mental health problems whilst in prison. We also heard that regardless of how many staff are trained, it will never seem enough due the high turnover of SPS staff.

What was significant was that almost all of the responding staff (n=198, 89%) reported that they would like more training in mental health. It was clear that there was not only an appetite for basic awareness training on mental health, but also much more in depth training to fully equip them with the tools to utilise when working with an increasing number of prisoners with complex mental health needs and presenting behaviours, with some prison officers reporting that mental health training should be mandatory in the prison service.

A few issues were highlighted including that some prison staff have highlighted their lack of mental health training to managers, but little has been forthcoming and that SPS staff barely have time to manage the 'prison regime', so are unable to spend meaningful time with prisoners with mental health issues. There was also a recognition that the prison environment is not best placed to meet complex mental healthcare needs, that only a clinical environment can do that and delays in transferring prisoners to hospital places additional pressures on prison officer staff. We also heard that some staff feel they are left to manage prisoners' mental health crises, especially at times when the mental health teams may be stretched or unable to respond. Some staff did say that it would be beneficial if the mental health team could create individual care plans and suggested interventions for prison staff to follow, as they are the ones who have the most contact with distressed prisoners.

Despite these issues, we also heard some positive comments about the way in which prison staff care for prisoners with one particular participant commenting that they have seen "*displays of compassion and caring that would take your breath away*."

Chapter 8 summary

We found that only 43% (n=96) of respondents had completed mental health first aid training and 89% (n=198) felt there should be more bespoke mental health training offered. Mental health training is not mandatory but some prison staff stated their view that it should be. It would appear that the initial drive to deliver mental health awareness training to all front line prison staff has been difficult to achieve and problematic to sustain. Given what prisoners have reported about a lack of understanding of mental health issues from some prison officers, this highlights the need to make sure front line officers receive adequate mental health awareness training as a minimum requirement. There is no doubt that having a staff group with a good knowledge and understanding of mental health needs equips them to promote an environment of positive wellbeing and offer increased support for prisoners with mental health problems. If staff feel more supported to be confident and competent in their abilities to manage complex mental health situations, their resultant stress levels and the negative impact on them should decrease. It is also likely that a culture informed by understanding of mental health will positively impact on behaviours which may be discriminatory or stigmatising.

CHAPTER 9 – The experience of families and friends

Background

In the Commission's 2011 prison themed visit report, we noted that "*prisons generally encourage family contact regarding any concerns relatives may have. Many involved family contact officers in this process*" [3]. In 2021, we were keen to further explore the extent to which family contact is prioritised within Scotland's prisons and the extent to which families are involved in informing their family member's mental health support.

Since 2013, the SPS have had a set of standards detailing the minimum support available in each prison, which includes access to family contact, good communication and maintaining respect and safety for the families visiting [46]. There is also a SPS protocol in place through which families can raise concerns. In addition, SPS are committed to implementing their SPS *Family Strategy* 2017-22, which provides that the SPS will "*actively encourage, facilitate and support family engagement throughout a relative's time in custody*" [p.8, 1].

Prior to the pandemic, we spoke with Families Outside [47], an organisation providing support to families affected by imprisonment across Scotland. Families Outside told us that family communication was problematic between prisons and families, with families often excluded and unable to voice their concerns about their relative's mental health. We heard of a family who had been trying unsuccessfully to raise concerns about a relative, and who had received no response from the prison until the police arrived to inform them their relative had taken their own life.

For these reasons, we considered that it was important to explore with families their experiences of communication and information sharing and their views around the availability of mental health support in prisons. We also sought relatives' views on what they would like to see improved, if anything, in terms of prison mental health support and family communication.

We are aware that the number of families and carers views referred to within this chapter is small (6); however the views of our family respondents in this report align closely with the experience and feedback received by Families Outside, particularly evidenced through the *Independent Review of the Response to Deaths in Prison Custody: Response from Families* Report published in November 2021 by HMIPS and coordinated by Families Outside [48].

What we expected to find

Having a friend or relative receive a prison sentence is very stressful but is even more of a concern when that person has a pre-existing mental health condition. We also know that many individuals develop problems with their mental health during their time in prison.

Therefore, we expected to find communication between families and prisons would be as supportive and as engaging as possible, particularly against the backdrop of the additional restrictions caused by the Covid-19 pandemic.

Families often have a unique knowledge of their relative's illness and can be sensitive to changes in mood, which can signify deterioration in their mental wellbeing. We would expect

that mental health staff would be available to listen and speak to families who are expressing concern for their relative's mental and/or physical health.

What we found

We issued an online questionnaire circulated by Families Outside and Circle Scotland.[j] We received only six responses, five were from family members and one respondent was a friend. The responses concerned prisoners from four prisons and five out of the six respondents were female.

One of the prisoners concerned was on remand and the remaining five had sentences ranging from six months to 18 years. Of the six prisoners, the relatives/friend reported that five had mental health problems before going into prison; four were described as having psychiatric problems, including anxiety and depression, and one as having a drug induced psychosis.

The relatives/friend told us that the five prisoners had requested support for their mental health following arrival in prison. We heard that only two individuals had received mental health support, two had not and the remaining two respondents did not know whether mental health support had been received.

Availability of support

We asked the relatives/friend for their views on the mental health services available within the prison. One of the main issues highlighted by all was the length of time it takes for the prisoner to receive mental health support. One respondent told us that their relative waited for months on remand, followed by over a year after sentencing before they were seen by mental health staff in the prison.

We were told that mental health support, when it started, was very effective. We heard that one prisoner eventually accessed support from mental health services, addiction services and attended a recovery group. However, this stopped with a change of prison and it was a further seven months before the support was reinstated.

> *"I think the length of time it takes for prisoners to get mental health help or drug addiction help is far too long*."

The relatives/friend told us that continuity of medication between prisons was not guaranteed and another prisoner was reported to have lost the benefits he had gained from an antidepressant when he had to move prison and the medication was not continued.

Communication with families

All respondents highlighted a lack of contact or communication with prisons. In addition, none had had any contact about the mental health of their relatives despite all having expressed concerns about them to the respective prisons. One respondent told us:

> *"I called the prison where I got no joy and told I couldn't speak to healthcare. The person I spoke to wouldn't even give me their name. I was told my concerns would be passed on and to maybe write a letter".*

[j] https://www.familiesoutside.org.uk/, and https://circle.scot/

Some did speak to prison staff and were assured that action would be taken. In all cases we were told that this did not happen. We heard that one relative/friend spoke with a prison governor who reassured them that the prisoner concerned would access a mental health assessment and the person remained waiting after seven months. Another respondent told us that they were a prisoner's named person under the Mental Health (Care and Treatment) (Scotland) Act 2003, and that they felt they did not matter and were "classed as a nobody."

Another respondent who was very concerned with the deterioration of their relative's health on video calls, contacted the prison visitor centre when all attempts to access information directly from the prison were unsuccessful. We were informed that their relative had been without medication for several weeks. The visitor centre staff emailed the prison twice which resulted in the prisoner's medication being restarted after a five-week delay. The relative was very impressed with the visitor centre saying that *"the help and support they gave me was invaluable."*

All of the six relatives/friend who engaged with us reported that they did not feel listened to and several described this as adding to their stress resulting in having a negative impact on their own mental health. One parent advised us, "*With all this going on I had so much worry, my mental health went down which did not help my son.*"

None of our family and friend respondents felt appropriate action had been taken after they raised concerns with prison staff, and they found the lack of opportunity to speak with mental health staff very frustrating. One person reported that there was "*nobody to talk to on the phone. Was told they will deal with it and he will get help but he never saw anybody*".

What would improve the care and support in prison?

We asked the six relatives and friend who engaged with us what changes would improve the experience of mental health care and treatment in prisons. They told us addressing the following issues would make a positive difference:

- Improve timely access for prisoners to access meaningful support for their mental health was highlighted repeatedly;
- Improve training for prison officers to recognise illness and distress;
- Increase mental health staff numbers to provide an efficient service;
- Promote an empathic response and compassionate approach to mentally unwell individuals;
- Improve the availability of meaningful and appropriate therapies for prisoners.

Additional Comments from family and friends

> *"More mental health professionals and training are needed in prisons."*
>
> *"I think the staff should actually listen to the sufferer of mental health, have training to spot the danger signs and have trained mental health teams available more often."*
>
> *"As said before people should be taken serious and not be belittled. Difficult enough being in prison."*

"My son has more or less been ignored. Coloured pencils and sheets of paper just does not help."

"Maybe family having access to speak to health care or mental health services directly as prisoners don't always disclose everything but might to a family member."

"Instead of pen pushing get up and get a plan to support people and families appropriately."

Chapter 9 summary

The SPS *Family Strategy* states its commitment to "*actively support and encourage family contact"* and to ensure that *"families feel included and engaged*".

We heard from five relatives and one friend that this was not the reality for them. They did not feel engaged and instead encountered significant challenges trying to communicate and discuss their relative's health conditions and concerns with prison and/or mental health NHS staff. Key information which could inform mental health support in prisons for these individuals appeared not to have been responded to in a timely manner leading to their experience of either no mental health support being provided for the prisoners they knew or there being lengthy delays. The inability to speak to any prison or NHS staff is seen as detrimental therefore to both prisoners and their family/friends.

CHAPTER 10 – Equalities and discrimination in prison

Our key message from 2011:

- *Support for people with mental health difficulties needs to be about more than just medication alone.*

Background

Our 2011 prison themed report highlighted the importance of SPS and NHS providing additional support to "*challenge stigma and discrimination in relation to prisoners with mental health problems at all levels*." We were therefore keen to follow this up and hear first-hand experience from prisoners themselves.

The SPS has a duty to comply with the Equality Act 2010, to ensure individuals with protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation) are not treated less favourably than people without protected characteristics.

The SPS *Equality Outcomes report for 2020–2022* outlines the service equality outcomes, underpinned by a human rights approach to deliver person centred care, which includes the promotion and support of the mental health and wellbeing of all who come into contact with SPS [46 [49]].

Who we spoke to

Of the 107 prisoners we met with 83% (n=89) identified as white Scottish and 7% (n=8) identified as white British other. This compares to Scottish Government prisoner data on ethnicity for 2019/20, which states that 96% (n=7859) of prisoners identified as white, which has remained generally constant since 2013/14 [[50]]. The data for prisoners not identifying as white Scottish or white British ethnicities during our visits is less than five in each category.

We asked the prisoner respondents about their gender identity, 79% (n=85) identified as male prisoners, 20% (n=21) identified as female, with 'other' gender identity as less than 1%.

The age of prisoners we met ranged from 20–74 years. 64% (n=66) were in the 25–44 age group and 25% (n=30) in the 45–64 age group. We found that 33.5% (n=38) told us that they were care experienced.

Table 6. Summary of demographic characteristics

Characteristic	Grouping	n (%)
Gender	Female	21 (20)
	Male	85 (79)
	Other	*
Age	18-24	9 (9)
	25-44	66 (64)
	45-64	30 (25)
	65-84	*
Ethnicity	White Scottish	89 (83)
	White Other British	8 (7)
	Pakistani	*
	Polish	*
	White Irish	*
	Ethnicity not provided	3

*<5

What we expected to find

We expected to find all individuals across the prison estate in Scotland to be treated with dignity and respect. We expected to find that every prisoner with a protected characteristic is treated fairly and no less favourably than a person without a protected characteristic. We did not expect individuals affected by poor mental health, learning disabilities, dementia and associated conditions to be subject to stigma or discrimination in the prison setting.

What we found

We asked prisoners if they had felt discriminated against during their prison sentence. We asked specifically in relation to prison staff, prisoners and mental health services. We heard that 66% (n=67) of prisoners had not experienced discrimination by prison officers, and 45% (n=46) told us they had never experienced discrimination in prison. We also found that 28% (n=28) of all prisoner respondents felt they had been discriminated against by prison staff; 29% (n=29) 28% by other prisoners and 17% (17) by mental health services.

Experience of discrimination is shown in Table 7.

Table 7. Discrimination experienced by prisoners

	Yes	No	I don't know	Missing*	Total
Discrimination by prison staff	28 (28)	67 (67)	6 (6)	6	107
Discrimination by other prisoners	29 (29)	66 (66)	5 (5)	7	107
Mental health services discrimination	17 (17)	73 (73)	10 (10)	7	107

*not included in calculation of percentage

From the prisoners who responded to the discrimination questions, 17% (n=17) identified discrimination by reason of disability, sexual orientation, religion, race and/or age. We noted that 4.9% (n=5) highlighted they had felt discriminated against on the ground of disability by prison staff, peers and mental health services.

Prisoners with a mental illness should have the same level of care they would receive in the community and a custodial sentence should not adversely impact on how prisoners are treated by staff, services and peers.

Some of the prisoners we met with however highlighted some of the problems they faced in seeking help. Some told us their mental health difficulties were not taken seriously:

> "*There is a view that if you need help from mental health services you have to 'do something to yourself' – that's why I slit my throat."*

> "*The mental health team only help those that they can see needs help like those that are cutting themselves."*

We also heard that prisoners can experience stigmatisation in relation to their mental health:

> *"Prison officers make sarcastic remarks e.g. saying in front of other prisoners 'that's your brain fixed now' when I came back from a mental health appointment. [Prison officers] also shout down in front of other prisoners, 'That's your psychiatrist appointment' rather than just say you have an appointment."*

This was also supported by a health care manager who expressed:

> *"SPS staff can often stigmatise the patients who have MH and addiction issues that is demonstrated in the language used and lack of compassion or care towards patients who are in mental health distress within the halls. There is also little respect or dignity shown towards patients when the MH team go to the halls to review a patient it is shouted out for all other staff and prisoners to hear."*

During our visit programme, the Commission visitors observed similar behaviour outlined above, with derogatory comments shouted loudly across the hall as the Commission staff waited to meet with a prisoner. The Commission finds this behaviour wholly unacceptable and followed up our direct observation with the prison governor. All prisoners should be treated with dignity, respect and their private, sensitive medical information should never be shared with others by prison staff, unless there is a health related reason to do so.

Support from other prisoners was valued by many but often they could not make best use of this due to the environment:

> *"This environment is triggering, panic attacks are frequent, don't feel safe due to the level of noise. It is a hostile environment, would speak to one peer but definitely not discuss issues with anyone else."*

> *"Prisoners help one another at times. They help out with supplying medication that you can't access from the mental health services."*

We also heard of positive support from prison staff and mental health staff:

> *"I have found being in Barlinnie very different [from previous English prison]. There is not such a big drugs issue. I am on a hall with less prisoners and prison staff help you more. I have got help here from the health centre and I feel I wouldn't be here without the help of the nursing staff."*

Chapter 10 summary

Discrimination and stigma in relation to mental health act as significant barriers to individuals seeking appropriate support, this applies both in prisons and in the community.

Whilst there is evidence of improvements in policy and legislation in respect of equalities in Scottish prisons in the last ten years, we heard views from some prisoners, supported by health staff and witnessed by our own Commission visitors, that stigma and discrimination continues to require robust challenge in the prison setting. There must be a culture of zero tolerance in relation to stigma and discrimination in prisons and vigorous challenge where this is not evidenced.

CHAPTER 11 – Liberation arrangements

Our key message from 2011:

- *Most prisoners return to their communities on release from prison. Proactive contact with community services can help maintain mental wellbeing and reduce the risk of reoffending*.

Background

Once a prisoner has been sentenced, they will be connected with Integrated Case Management (ICM). This is a multi-disciplinary and multi-agency process where the SPS works together with other agencies to provide support to prisoners throughout their sentence. This is largely focused on reducing re-offending by identifying risks and formulating a plan to reduce those risks in a sequenced and co-ordinated manner. The ICM meetings are held to plan for an individual's release and to decide what prison support or activities may help towards a successful return to their community. This may include participating in specific forensic psychology led programmes that aim to reduce risk of re-offending. There are four types of ICM, in accordance with the stage of the individual prisoner's sentence – initial, annual, pre-parole and pre-release meetings. Prisoners can either ask or be offered support in areas including addictions, education, housing, violence reduction, work skills, or support with their mental and/or physical health.

The Commission report on the concerns about women with mental ill health in prison in Scotland (2021) found that transition planning that took place well in advance of a liberation date was beneficial. Where support is offered in prison, for example, harm reduction sessions, liaison with local mental health and social care services, this can also ease the transition from prison to community. Other key areas which are likely to support a prisoner's liberation are when there is effective communication about their release from prison and where there is a well-defined after care plan.

What we expected to find

For prisoners who require ongoing support through mental health services in the community on liberation from prison, we expected to find evidence of proactive contact with local services, clear liberation support pathways and an aftercare plan, setting out the services and key contacts that would be in place at the point of liberation for ongoing community support.

What we found

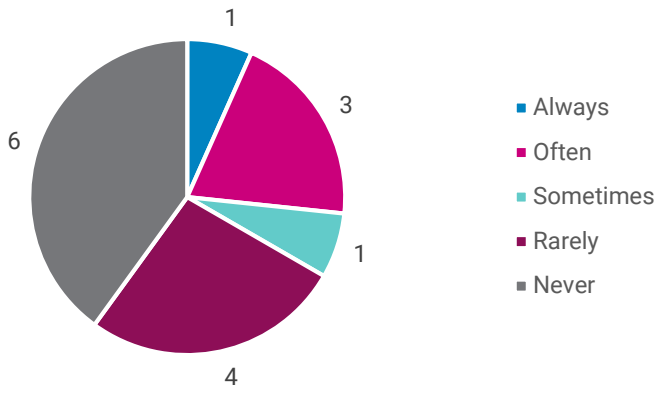
We heard from all 15 prisons that prisoners are made aware of support services available to them upon release from prison. We heard that there are various approaches to pre-liberation arrangements across prison health care services, which ranged from referrals to local community mental health teams (CMHT) and correspondence from prison to community on an as required basis, in addition to signposting where appropriate. We also heard that there are inherent challenges for liberation arrangements where the prisoner does not have an identified postcode area to return to following release. One prison told us that they are in the process of recruiting throughcare nurses to support aftercare in the community with addictions and mental health.

Thirteen out of 15 prisons health care managers reported that contact is made with the prisoner's community GP regarding future support, two reported this is not done. Fourteen out of 15 prison health care managers reported that links are made with community services to provide support for prisoners who are being released. Seven out of the 15 prisons' health care managers told us that the prisoner is provided with a GP letter or a discharge summary, where there are issues with knowing where a prisoner will live and be registered with a GP upon their release. With one prison not providing a response, the remaining seven prisons indicated that the health care staff contact the GP, CMHT and/or CPN as appropriate, to ensure medication and community support needs are identified on liberation. Most prisons highlighted that their liberation onward referral process is dependent on the individual and on whether the prisoner is registered with a GP/local mental health services.

We asked all health care managers about their use of the Care Programme Approach (CPA). The CPA is a coordinated multi-disciplinary care planning approach which includes all named relevant health, social care and third sector staff. The CPA care plan adopts a joined up holistic approach to an individual's mental health support and risk management. We found that few prisons reported using the CPA approach for prisoners with severe mental illness; only one prison reported always using CPA for this group of people and a further three prisons reported using CPA often.

For others who highlighted they do apply CPA, it was reported that it is generally used for prisoners who require secondary level mental health care and who meet the criteria for forensic CMHT support on liberation. We heard that this approach generally works well. A key issue highlighted related to inconsistency of the approach and uptake for individuals who require general adult CMHT support on liberation. The overall picture for the application of CPAs in prisons is one of inconsistency.

Figure 12. Frequency of using CPA approach for severe mental illness



Fourteen out of 15 prisons governors reported that letters are sent to the receiving mental health team on liberation, where an individual has been identified as requiring community support on liberation from prison. However, the responses from health care managers indicated that a follow up letter will generally be sent to community mental health services on an 'as required' basis, e.g. if the person is on a psychiatry caseload and/or where the individual is known to local mental health services. We further heard from health care managers that some will undertake a handover via telephone and when community connections are made,

the provision of information ranges from a discharge summary to referral letters, relevant reports and in one case all clinical contacts are shared with the local CMHT, where relevant. One prison health care manager explained that for individuals being liberated to an Ayrshire postcode, all information is made available through the Care Partner system.

It was reported that all 15 of Scotland's prisons provide a supply of medication to individuals on release. However, the number of days' medication provided to individuals varies from prison to prison. Eight out the 15 prisons reported that seven days or one week's medication supply is provided where there are no known risks to the prisoner on liberation. Three prisons provide a five-day medication supply, and one prison provides a two-week medication supply. One prison provides a seven-day supply and a prescription for 21 days in the community. For individuals treated through a harm reduction approach, they may require an opiate substitution therapy (OST), such as methadone, in which case the individual will be provided with a prescription to allow for daily dispensing; we heard from one prison health care manager that an appointment will be made with the individual's community prescriber.

Health care managers told us that the pandemic had limited access to community services, with some prisoners being provided with additional letters for their local [prescribing] community services. One prison told us that they found improved communication with criminal justice social work, CMHTs and addiction teams through the pandemic, whereas another told us about the challenges with pre liberation planning due to the availability of community services. More generally we heard that:

> *"Discharge can be complicated by the unscheduled liberation of a prisoner or a sudden transfer of establishments without the knowledge of the mental health team – this can happen quite frequently."*

And another highlighting, for unplanned liberations (i.e. those attending court):

> "*Short notice release for bail, parole hearings can be difficult to arrange without any notice period. Also non-returns from courts can give us problems with arranging through care."*

Out of the 107 prisoner respondents, 12 were identified as planning for liberation at the time of our visit. The remaining 95 were not at their expected date of liberation. We noted that a small number of this group were people on remand, with the potential for a community disposal and little evidence of care planning in their individual medical notes. We heard that one prisoner who has been on a prolonged TTM and possibly due to be released within the month of our visit, did not have a care plan in place, although there was evidence of possible third sector input. For another who was due liberation, there was no care plan in place, but there was evidence of planning through the mental health multi-disciplinary team.

We also heard from prison psychiatrists, with seven out of fourteen highlighting that the uncertainty of liberation from courts causes a challenge for prison health care to organise support on liberation.

In addition, one psychiatrist told us the following, which captures the wider psychiatrist respondent views:

> *"On the matter of liberation, this has always appeared to happen in a chaotic fashion, with prisoners leaving to no registered GP or address. This means that potentially prisoners are leaving with no means of getting their medication beyond about a weeks' supply, no GP to pass over any care needs to, and often no address to be able to refer to a community team, or even just to pass information over. It also does not promote stability of mental health if prisoners are leaving with no address or GP. If prisoners are leaving at their EDLs this is often known in advance, it seems like it should be possible to plan liberation better and give prisoners a better opportunity to succeed in the community."*

Chapter 11 summary

We know from our previous reports in 2011 and 2021 that transition planning for liberation can make a fundamental difference to prisoners' life chances on release from prison.

During our themed visits we heard that where the CPA approach is implemented it works very well and positively supports liberation arrangements. However, we generally found a variable picture of liberation arrangements fraught with a lack of joined up and accessible through and aftercare mental health support for prisoners on release. The inconsistencies around medication supply remains problematic beyond five days to a week for some individuals who may not be registered with a GP in their home area. In addition, unplanned liberation, for example directly from court for remand prisoners, is reported as a significant challenge to organise appropriate community supports.

Summary of findings

Throughout this report, we set out what we expected to find in terms of effective, person-centred and safe mental health services in prisons, applying our 2011 report as a baseline to chart improvements over the intervening ten-year period.

During July 2021 – October 2021 380 people engaged with us and told us their views and talked about their experience. We found evidence of some good practice, for example:

- We found a staff group committed to supporting those prisoners who are most vulnerable. They noted challenges in doing so to the best of their abilities and also provided solutions which are reflected in our recommendations.
- We heard from some people that once accessed, support provided in relation to mental health and/or substance misuse issues was good and of real benefit.
- The SPS *Talk To Me* strategy (TTM) 2015, underpinned by staff training, has been fully implemented across all prisons, and is mostly proving to be a well-established and useful strategy used by prison officers and health care staff.
- Despite the unprecedented challenges of Covid-19, we heard of some practice which impacted positively on some prisoners, e.g. access to mobile phones, being part of 'smaller bubbles'.
- Where the care programme approach was implemented this worked well as a cohesive whole system pathway approach to the liberation planning of sentenced and remand prisoners.

However, it must be stated that our overwhelming impression was of a prison population which is under served and under resourced; indeed we found that very little has improved since the NHS took over prison mental health services in 2011.

From chapters 2, 3, 4, 6, 9 and 11, we heard about the deficits in mental health care and support pathways from arrival screening, to follow up assessments and a lack of robust care planning to follow the individual throughout their sentence towards liberation. Family and friend respondents told us about the challenges they faced and the barriers to their involvement. The urgent need for an inclusive, joined up whole system approach to supporting prisoners' mental health from entry to prison through to liberation was apparent during our visits.

We heard from all respondent groups that prison staff are in urgent need of mental health training to meet the mental health needs of prisoners. The need for training is cross cutting in almost all areas we explored during our visits, including trauma informed training and anti-stigma and anti-discriminatory practice. We found NHS staff resources lacking across the prison estate. We know that mental health services across Scotland have been affected by the pandemic, however, we also found that there did not appear to be consistent application of a workforce tool to determine the needs of each prison population. Without targeted training and sufficient staff resources, the infrastructure supporting the mental health of prisoners will continue to act as a barrier for positive change.

We heard about the management of problem substance use in prisons, with a particular concern around NPS, which was being proactively addressed by the Scottish Government

through legislation in December 2021. We heard about positive addiction interventions which benefitted some prisoners. However, we also heard that there are missed opportunities to motivate change and recovery with 35% of prisoners reporting that they had not been offered support with their problem substance use.

A decade on, we found the ongoing use of segregation for prisoners with mental health conditions and heard continued reports of delayed hospital transfers for acutely unwell prisoners to specialist hospital care. This was unacceptable in 2011 and is unacceptable in 2021.

In summary, little has changed. There is undoubtedly a raft of policy drivers in train aimed at improving mental health care and support in prisons, however without a targeted whole system approach, with strong leadership and national commitment, it is likely that the same recommendations will continue to be highlighted in the future. None of us can sit back and allow this to happen again.

We have made ten recommendations below and commit to working with the Scottish Prison Service, NHS and the Scottish Government to actively monitor responses to these recommendations to the benefit of prisoners, their families and the staff charged with supporting them. These are the people who have told us what mental health services are like in prisons. They must be listened to and heard.

Recommendations

Based on our 2021 findings, we make the following recommendations for delivery over the next 12–24 months:

Recommendation 1: SPS and NHS should collaborate to implement a workforce planning tool; this should be undertaken across the prison estate to identify the required multidisciplinary mental health (including learning disability) staff establishment levels according to the needs of the prison population. This must include consideration of the consequences of the Covid-19 pandemic and capacity to deliver increased primary care/counselling and interventions for mild mental health issues.

Recommendation 2: SPS and NHS should undertake a training needs analysis and a training implementation plan must be completed to support reception and frontline staff to feel confident and competent in responding to, and having a good knowledge of prisoner mental health issues, addictions, trauma and corresponding behaviours.

Recommendation 3: SPS and NHS should review screening processes at each prison establishment to address gaps to ensure better identification of prisoners with specific mental health needs, such as learning disability, autism and personality disorder.

Recommendation 4: SPS and NHS should consider the introduction of follow up assessments 7–14 days post admission once the person has settled in prison to undertake a more detailed, informed consideration of mental health needs where indicated.

Recommendation 5: SPS and NHS should audit and review the operation of multidisciplinary meetings and care planning processes. SPS and NHS must be satisfied that individual needs and outcomes are being identified, addressed and reviewed for all prisoners experiencing poor

mental health and who are in need of support during their stay in prison including in segregation units.

Recommendation 6: SPS and NHS should urgently audit their use of segregation for prisoners who are so mentally unwell that there is no alternative to safely managing their care in custody. The audit should consider qualitative and quantitative data including length of stay, opportunity for association, engagement in purposeful activity and feedback from prisoners.

Recommendation 7: SPS and NHS should consider that where the CPA care planning model has not been adopted, there should be an alternative similarly effective, cohesive whole system pathway approach to the liberation planning of sentenced and remand prisoners. This must ensure individuals have opportunity of access to crucial community mental health and social supports to maximise their mental health and wellbeing upon release and reduce their risk of returning to prison, as far as possible.

Recommendation 8: SPS should review the *Talk To Me* strategy (was due 2021). This should take account of all available feedback, particularly in relation to learning from its operation in practice over the past five years.

Recommendation 9: SPS should review the *Family Strategy*. It is recommended that an audit is undertaken to determine whether the intended outcomes of the SPS *Family Strategy* have been achieved in practice. As part of the review, consideration should be given to specific actions in relation to mental health and learning disability when reviewing the priority action to "support the wellbeing of those in our care and their families."

Recommendation 10: The Scottish Government must monitor the delivery of the above recommendations and work with SPS and NHS to resource and deliver on better outcomes for people with mental health related conditions in prisons across Scotland.

Appendix 1 – 2011 key messages

Key message 1:
Prisons should have staff and facilities in place that are able to support prisoners with a wide range of mental health difficulties.

Key message 2:
Prisoners are particularly vulnerable in the early days of their time in a prison. Skilled staff with knowledge of mental health issues need to be involved from the start.

Key message 3:
Support for people with mental health difficulties needs to be about more than just medication alone. There needs to be a fuller range of supports available and facilities for them.

Key message 4:
There needs to be more direct involvement from disciplines beyond the prison health centre in supporting prisoners' mental health issues – we saw little evidence of multidisciplinary working.

Key message 5:
Prison is not the place for seriously and acutely mentally ill prisoners.

Key message 6:
People with learning disabilities are very vulnerable in prison. They are likely to have difficulty understanding and adjusting to the complex rules and regimes of prison and will require extra support. There needs to be systems in place to identify prisoners with a learning disability, help for prison staff in relation to communicating with prisoners with a learning disability and an understanding of the support needs of such prisoners.

Key message 7:
Where mental health difficulties are identified, a specific care plan detailing support should be in place.

Key message 8:
Most prisoners return to their communities on release from prison. Proactive contact with community services can help maintain mental wellbeing and reduce the risk of reoffending.

Appendix 2 – Respondent demographic characteristics

Of the 107 prisoner respondents, 79% were male, 90% were White Scottish or White Other British, average age was 39 years, and about one third served a sentence of four years or less (Table 1).

Tale 1. Summary of demographic characteristics

Characteristic	Grouping	n (%)
Gender	Female	21 (20)
	Male	85 (79)
	Other	*
Age	18-24	9 (9)
	25-44	66 (64)
	45-64	30 (25)
	65-84	*
Prison	Kilmar	13 (12)
	Low Moss	9 (8)
	Grampian	9 (8)
	Polmont	8 (7)
	Cornton Vale	8 (7)
	Edinburgh	8 (7)
	Greenock	8 (7)
	Addiewell	7 (7)
	Perth	8 (7)
	Barlinnie	6 (6)
	Dumfries	6 (6)
	Inverness	6 (6)
	Glenochil	5 (5)
	Shotts	*
	Castle Huntly	*
Ethnicity	White Scottish	89 (83)
	White Other British	8 (7)
	Pakistani	*
	Polish	*
	White Irish	*
	Ethnicity not provided	3
Care experienced	No	60 (56)
	Yes	38 (36)
	NULL	*9 (8)*
Recall from parole	No	75 (70)
	Yes	14 (13)
	NULL	*18 (17)*
Sentence length	On remand	26 (24)
	0-4 years	27 (25)
	5-9 years	16 (15)
	10+ years	12 (11)
	Life sentence	17 (16)
	NULL	*9 (8)*

*<5 or secondary suppression

Appendix 3 – Prison staff respondents

We received a response from every Governor in each of the 15 prison establishments in Scotland and a total of 223 prison staff from across Scotland responded to our survey. The highest number of respondents were from HMP Kilmarnock and HMP Barlinnie, as can be seen below in Table 1.

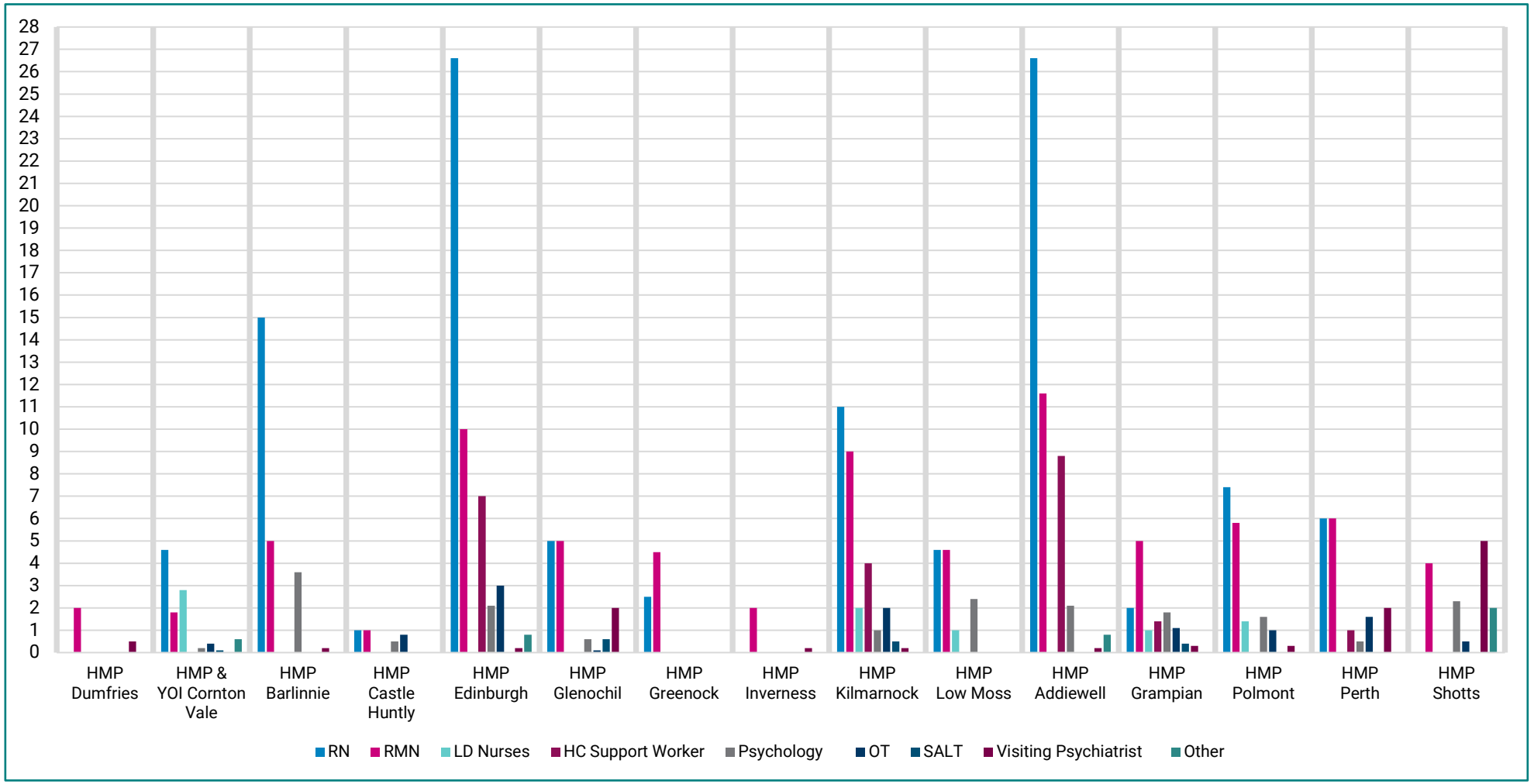
Table 1. Respondents to Prison Staff Survey

Prison	Number	Percentage of total respondents
HMP Kilmarnock	48	22%
HMP Barlinnie	28	13%
HMP Inverness	18	8%
HMP Shotts	16	7%
HMP & YOI Cornton Vale	15	7%
HMP & YOI Grampian	14	6%
HMP Low Moss	13	6%
HMP Edinburgh	13	6%
HMP Dumfries	11	5%
HMP Castle Huntly	10	5%
HMYOI Polmont	10	5%
HMP Greenock	9	4%
HMP Perth	7	3%
HMP Addiewell	7	3%
HMP Glenochil	1	0%

In order to elicit the views of SPS staff in regards to mental health training we disseminated a survey to prison governors and a further one to prison officers and other prison staff. We found that just over half of respondents worked as prison officers (n=122) and a third were 'other designations', (n=69), which included residential officers and a small group of other staff including chaplains and prison staff not in direct custody or roles.

Appendix 4 – Prison mental health supports per prison

Figure 1. Prison mental health supports per prison



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If you have any comments or feedback on this publication, please contact us:

Mental Welfare Commission for Scotland
Thistle House,
91 Haymarket Terrace,
Edinburgh,
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk