Mental Welfare Commission for Scotland

Report on announced visit to:

Dungavel House Immigration Removal Centre, Muirkirk Road, Strathaven, South Lanarkshire, ML10 6RF

Date of visit: 8 June 2023

Where we visited

Dungavel House opened as an immigration removal centre in 2001. It is the only immigration removal centre (IRC) in Scotland, and it has maintained close links with similar centres in England. It holds people being detained under immigration powers, pending their deportation from the UK. The centre had capacity for 249 residents; however, this was limited to 125 (113 males and 12 females). There were 45 residents in the centre at the time of our visit. Of these 45 residents, 11 individuals were receiving support from the mental health team under a vulnerable adult care plan.

The centre is inspected by His Majesty's Inspectorate of Prisons (HMIP) and Healthcare Improvement Scotland (HIS). Dungavel operates on behalf of the Home Office and is managed by the Mitie Group PLC. Nursing with general medical provision and counselling was provided by Med-Co Secure Healthcare Services Ltd, with visiting psychiatry input contracted from NHS Lanarkshire. The health centre had close links to NHS Scotland and was supported by NHS England.

We last visited this service on 25 January 2018 and made recommendations in relation to nursing care plans and advocacy provision.

The response we received from the service was that the care plans had been reviewed and improved, and that advocacy services had been re-contacted with information on this service refreshed for residents.

On the day of this visit, we wanted to follow up on the previous recommendations and look at how the care and separation unit had been developed, as we heard this was a work-in-progress when we last visited the centre.

Who we met with

We met with and reviewed the care and treatment of 10 residents. We also attended a community meeting that 14 residents attended and a gardening group that three residents attended.

We spoke with the health centre manager, service manager, nurses and a student nurse on duty, the centre counsellor, and the visiting psychiatrist.

Commission visitors

Margo Fyfe, senior manager

Dr Arun Chopra, executive director (medical)

Justin McNichol, social work officer

What people told us and what we found

Care, treatment, support, and participation

The primary focus of our visit was the specialist care and treatment provided for the small number of individuals who were particularly vulnerable and who experienced significant mental health difficulties.

We were pleased to hear that, as at the time of our last visit, residents were seen by a member of the health care team within two hours of arrival, and that referrals to the mental health team from any source, were seen within 48 hours. Telephone interpreters were available, but when full mental health assessments were undertaken, interpreters were there in person. Care plans were put in place around those with identified vulnerabilities, and individuals who required this were closely monitored to ensure their wider needs were being met.

Individuals we met with highly praised the centre staff. We were told that everyone on the staff team helped out, and took time to listen to the residents' concerns and requests for support. Individuals said, "this place is good", "staff are nice and treat you well", "health staff are amazing". Everyone we spoke with said that being at the centre was much better than being in prison.

Care and treatment

The visiting psychiatrist was formally contracted for two sessions per month, but we heard that as previously provided by previous psychiatrists, they were very accessible and supportive. The psychiatrist was in the centre most weeks and was available by telephone out with their visits. The mental health nurses worked closely with the psychiatrist to deliver appropriate care and treatment to the benefit of the detainees they cared for.

There continued to be daily access to GP services, with a drop-in service available to residents. Centre staff continued to encourage residents to talk about issues and concerns and to consider wider talking therapies, alongside or instead of, medication as treatment. There was a counsellor on site who provided a range of counselling options to the residents, which incorporated individual and group sessions. In addition to this, nursing staff also provided group work and individual support to the detainees. There was also an art therapist who provided sessions in the art centre and health centre, and a gardening group had been developed that took place in the centre's polytunnel.

There were nine nurses on the health care team, along with the health centre manager, who had a nursing background. New to Dungavel, there were two student nurses from the University of the West of Scotland, who had commenced a placement at the centre.

We were told that there were weekly meetings regarding the adults at risk, with a register that was in place, which helped track vulnerable residents. This was added to the daily briefing for all staff.

Care plans

The care files we examined, both on Vision, the electronic record system, and in paper files, contained clear risk and needs assessments. There was a record of when individuals were seen on arrival, and subsequent referrals for further physical and mental health interventions. The care plans for mental health care needs were clear and person-centred. We did not see full reviews in the care plans, but found these elsewhere in the care record. We suggested that a note on the care plan, indicating where reviews were located, would be helpful.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/node/1203

Access to interpreters

Due to the multicultural background of the residents, the need for regular access to interpreting services was essential. We heard that there were two telephone services as well as attendance by interpreters, when requested. Residents and staff also regularly used tablets and telephones to access translation. We heard that the telephone service has at times been problematic and we experienced this on the day of the visit, when at least two conversations were unexpectedly cut short by the interpreters, without explanation. We discussed this with managers and suggested discussions with the services should take place to ensure issues are promptly addressed.

Rights and restrictions

When we last visited, we heard that access to advocacy had been difficult due to the waiting time from referral to allocation. On this occasion, we heard that although information on the advocacy service had been updated for residents, the response from the service had not improved. When we last visited, we had discussed the issue of independent advocacy and highlighted that it can be extremely helpful in supporting vulnerable people; we advised that access to advocacy has had a positive impact in establishments where it is well used. Once again, we suggested that there should be further discussion with the advocacy service to consider how a service that was timely and effective, could be introduced in this setting. We look forward to hearing how this has progressed when we next visit.

We took the opportunity to discuss with managers the rights and restrictions of residents, in particular those with mental health concerns. We were pleased to hear that the use of seclusion was a last resort. When we last visited, we heard that if there was a requirement to support someone closely to ensure their safety and protect their dignity, that staff would adapt areas of the centre for this purpose.

We were informed that on the rare occasions that seclusion had to be used, it would be for the minimum amount of time possible, and the visiting psychiatrist would be fully involved, as well as the mental health nurses, and this continued to still be the approach used. During this visit, we discussed the ongoing focus of getting the environment right for individuals who require enhanced support. We were shown the dedicated care suite that had been developed, to provide care to people who require intensive support for a period of time. We heard that there was ongoing improvement work to ensure that any risks are addressed appropriately.

Any individuals in this suite continued to have accompanied access to the wider centre facilities, if assessed as appropriate.

We were told that a room that was currently designated as a group activity room was to be developed as a sensory room, which will also be available to these residents at times of distress. We look forward to seeing this when we next visit.

There was clear recognition that a person who was seriously mentally ill should not be admitted to an IRC or, if they became unwell while at an IRC, they should have been promptly moved to an appropriate healthcare setting. If removal to hospital was required, this was carried out under the procedure set out in section 136 of the Mental Health (Care and Treatment) (Scotland) Act 2003. The transfer usually took place in five days. Transferred detainees had the status of restricted patients and had to go to a locked environment. The wards accessed to date have been in NHS Lanarkshire, NHS Greater Glasgow and Clyde and NHS Lothian.

When we last visited, we asked about the techniques used to ensure someone who may be very distressed was safe during transfer. We were informed that staff at Dungavel could not administer medication, either orally or as intramuscular medication, without consent to calm individuals prior to the transfer journey. There is no current legislation that would allow them to do so. This has been an issue in the past, and has meant that more intensive restraint has had to be used, which can cause a great deal of distress to the individual and those caring for them. However, we heard that where at all possible, the nursing staff accompanied the individual being transferred to hospital and, in the majority of cases, the use of restraint was not required. Should someone have required restraint for transportation, this was provided by another company who have supervised the transport and were trained in the use of a specialist restraint belt that restricts movement but does not incapacitate the individual.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

We were pleased to see an emphasis on activity and that the range of options available to the residents had not diminished. We saw good attention to the multicultural needs of the residents with a range of books and DVDs available in several languages. There was access to an art room, a faith centre, a gym, an outdoor games space, a garden space that included gardening activity in a polytunnel, language lessons, access to computers, and kitchen areas where residents could cook their own meals if they wished. There is a shop on-site where residents could purchase essentials; we were informed that it was well-stocked and at the regular community meetings, residents could ask for additions to the stock that was available.

The gardening group provided a therapeutic environment where residents could work on set targets, either together or on their own. These sessions took place once a week, from March to October. The feedback from residents was that the sessions were “very good” and “help you forget about everything”.

Residents were encouraged to attend the weekly community meetings. At these meetings they put forward ideas for activities, stock for the shop, and could air any concerns that affected the group. Staff attended and tried to answer queries, as well as address any concerns promptly.

We saw photographs of events and heard about the attention to faith and seasonal celebrations. We also witnessed individuals accessing activities and heard about the variety of jobs available to residents around the centre, for which they are paid. A few residents felt that they would benefit from more availability of structured activity, as at times they can often feel stressed about their situation and would welcome the distraction.

It was clear from our visit that the staff were culturally aware and tried to meet the cultural needs of the detainees as far as possible.

We discussed with the health centre manager the development of therapeutic activity, specifically for the patients with mental health issues, to sit alongside the work of the counsellor and the art therapist. She informed us that this was currently under consideration by nursing staff.

Recommendation 1:
The health centre manager and nursing staff should develop therapeutic activities, which will benefit individuals with mental health support needs.

The physical environment

The main part of the centre is the original country house. There have been extensions made to accommodate the population. Rooms are large and residents are encouraged to personalise their bed areas. Some of the bedrooms can accommodate up-to three residents, although most bedrooms accommodate two. On speaking with staff, we heard there was the option for residents to have their own bedrooms or the choice to share bedrooms. Residents specifically highlighted the benefit of being able to choose, with one stating, “I like having my own space” whilst another resident reported “being on my own can be very stressful”. There was a bright, well-furnished family area for visitors. Visitors could have a meal with the residents. Private rooms were available for meetings with legal representatives. There was a library with computer access area and a large art room for residents use. We saw a multi-faith area and the on-site shop.

The health centre has several rooms that were used for individual and group work. There is a separate gym, with a variety of equipment, as well as a large games hall and outside football area. During the visit, we observed a table tennis session taking place in the games hall between residents and staff. There were pleasant gardens that the detainees could access, where the polytunnel was located and where residents grew vegetables for use in the centre.

Any other comments

We were disappointed to hear of the ongoing difficulties in obtaining the health records from prisons when individuals were transferred to the centre. As advised in our previous visit, we were told that records were delayed or had to be chased up by health centre staff and this caused delays in people receiving required medications. Health records provide important information that informs the initial assessment and ongoing health care and treatment of individuals. The health centre manager informed us that there was a service level agreement in place with Scottish Prison Services (SPS) around sharing information when individuals transferred into the unit, and they shared our disappointment that the transfer of health records does not appear to be working.

Recommendation 2:

Managers should discuss the service level agreement with SPS and ensure that health records information is fully included and that improvements are made in the sharing of this information.

Good practice

The health centre manager provided mental health training to the custodial staff, and there was an emphasis on a whole community approach to care and support, which was evident in interactions we witnessed between residents and staff during the visit.

Summary of recommendations

Recommendation 1:
The health centre manager and nursing staff should develop therapeutic activities, which will benefit individuals with mental health support needs.

Recommendation 2:
Managers should discuss the service level agreement with SPS and ensure that health records information is fully included and that improvements are made in the sharing of this information.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland and HM Inspectorate of Prisons.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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