Mental Welfare Commission for Scotland

Report on announced visit to: Kilmarnock Prison, Mauchline Road, Kilmarnock, KA1 5AA

Date of visit: 20 November 2023

Where we visited

HMP Kilmarnock was first opened in 1999 and is located on the edge of Kilmarnock. The prison has capacity for 692 prisoners; there were 596 prisoners on the day of our visit. This has meant many prisoners have to share cells as a result of an increase in the prison population.

HMP Kilmarnock has adult male remand, short and long-term prisoners; it mainly serves Ayr and Kilmarnock Sheriff Courts. The prison is operated by Serco on behalf of Kilmarnock Prison Services Ltd, who provide the services to the Scottish Prison Service (SPS) under a contract with the Scottish Ministers. It was the first private prison in Scotland and the contract is due to end on 17 March 2024 when the prison will transfer its operation to the SPS.

Our last local visit to HMP Kilmarnock was in 2019, although we did visit the prison in 2021 as part of our themed visit report, *Mental health support in Scotland's prisons 2021: under-served and under-resourced*. This report made a number of recommendations to the Scottish Government, NHS Scotland and the SPS on changes that were needed to improve mental health services across the prison estate. Our local visit in 2019 made three recommendations about reasons for failed attendance and discharge being reviewed and documented clearly, to review the process of care planning for individuals with complex health needs, and increase the clarity and accessibility of referrals.

We wanted to hear how the service has adapted over the last four years, including how the Covid-19 pandemic had impacted on the service, and to hear from those who had received care from the healthcare team.

Who we met with

We met with and reviewed the care of eight prisoners and reviewed the care notes of a further three.

We spoke with the service manager, the nursing team leader, members of the mental health and addictions nursing team, the advocacy worker, the head of compliance, the custodial operation manager of the segregation and reintegration unit and other members of Serco prison staff.

Commission visitors

Justin McNicholl, social work officer

Mary Leroy, nursing officer

Gemma Maguire, social work officer

Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

For this visit, we wanted to find out about the specialist care and treatment provided for those prisoners who were experiencing mental health difficulties in the prison. We heard that there was a health team which consists of a clinical team leader in mental health, a mental health charge nurse and just under nine full time mental health nurses alongside two occupational therapists and a half-time speech and language therapist. The mental health team had a charge nurse and five and a half nursing staff vacancies; we were told of the difficulties recruiting registered nurses and the negative impact these vacancies have on the ability to provide care and treatment in the prison. There were two learning disability nurses in the nursing team and we heard about the benefits their skills bring to those they care for.

There was a separate addictions team which is staffed by a charge nurse and four case workers who have experience working with addictions, but are not nurses. Prisoners had access to daily GP appointments on an as-required basis.

We were informed that anyone who required an urgent psychiatric assessment was seen upon admission to the prison. Nurses were involved in the admission process with any individuals who were felt to need additional mental health support or had been open to mental health services in the community, or were referred into the mental health service. All prisoners were given a self-referral form on admission and these forms can be posted into locked boxes located on each wing or handed into to any member of staff. Referral can also be made by prison officers, other health care teams in the prison or families can phone with notes of concern. The nurses are involved in a daily triage of referrals that have been received. These were then rated according to acuity and urgency under a red, amber, green (RAG) rating system; an emergency case (red) will generally be seen immediately, urgent (amber) in 72 hours and routine (green) within four weeks. All referrals are discussed at the weekly multidisciplinary team (MDT) meeting. If referrals are not assessed as requiring further intervention, then a signposting letter is sent back to the referrer.

We were advised that the team were supporting 41 individuals at the time of our visit.

We heard at our last visit that a psychologist had been employed for the team, to work in the assessment and treatment of prisoners with complex care needs and to assist with staff training and supervision for low intensity psychological therapies. It was disappointing to hear that this post was, again, unfilled and had been for 18 months. The previous post holder had highlighted the difficulties of being the only psychologist in the service, and also had found the environment in the prison health centre unsuitable for conducting psychological interventions. Currently no low-level psychological interventions are carried out by the nursing team.

Improving access to therapeutic interventions was a recommendation in our reports in 2016 and 2018, and was recognised as a gap in 2019. It is concerning there has been little progress in the provision of this service for prisoners in this time frame. We heard that there are plans to expand access to mental health and wellbeing supports. NHS Ayrshire & Arran have undertaken a mental health needs analysis in the service, and reviewed the psychology

provision. It is intended that employing a clinical associate psychologist (CAP) as an interim measure may help to provide some access to psychological therapies. It is hoped that this will help support the development of a psychological therapies team and the recruitment of a clinical psychologist. CAPs are psychology graduates who undertake further study at Master's level. Once qualified, they undertake high quality psychological assessments and interventions under the supervision of a clinical psychologist. It is recognised that the absence of a clinical psychologist is a continued gap in service provision. We heard from prisoners that we met with that they feel the lack of psychology services negatively impacts on their care and treatment. One individual commented that in other prison establishments he had been in, he had access to psychology and found this very beneficial.

We also heard from advocacy services that around half the referrals to their service was to enquire about the availability of mental health services and talking therapies.

Recommendation 1:
NHS Ayrshire & Arran managers should progress the provision of psychology and psychological therapies for the prison population at HMP Kilmarnock to ensure it is adequate to meet the needs of the population and update the Mental Welfare Commission on progress made.

We heard that the psychiatrists are providing some psychological therapies. One individual that we spoke with reported this was very helpful. We were told there was minimal waits for an appointment with a psychiatrist however, this was at odds to the experience of one individual we met, who reported he had to wait five months for an appointment. Most of the individuals we met with told us that they would like more regular contact with the psychiatrist. The occupational therapist, and speech & language therapist have recently started running a 'Deciders Skills' group which focuses on teaching emotional regulation skills using cognitive behavioural therapy and dialectical behaviour therapy skills. We were told the group has had good uptake and attendance.

Those that we spoke with were generally positive about the mental health care they had received; they reported that staff were "friendly", "approachable", and "you can talk to them openly". We also observed this through the interactions that took place between individuals and the mental health team on the day of our visit. The mental health nurses were regular visitors to the prison halls, and they had day-to-day contact with the prison officers, allowing discussions and concerns to be raised about prisoners' mental health, so that this could be addressed at an early stage. We saw variation in the interactions between health and prison staff. In some cases, we saw unprofessional language and interactions that showed a lack of respect and courtesy – this was discussed on the day, and we were told these issues would be followed up.

Recommendation 2:
Managers should ensure the culture in the prison maintains open, respectful communication.

We also saw close working relationships between the services with good communication and an effort to develop services jointly to ensure the best possible outcomes for individuals accessing the service. Prison staff in the segregation and reintegration block told us of improved processes between themselves and the mental health team since the recruitment

of the new team leader in May. This had led to faster response times from the mental health team and improved pathways for those prisoners requiring mental health services.

Care plans

We reviewed the notes of 11 individuals, including the notes of those we met with. The mental health team used two different electronic systems to gather and record information on prisoner healthcare. These were Vision, and Care Partner; some information was also held on the online team folder. These electronic systems did not directly communicate with each other, which caused challenges when trying to swiftly access information.

We found information held on Care Partner easy to locate and navigate. We were told how having notes on this system allowed access to previous mental health records for those individuals from Ayrshire & Arran health board area; this improved transitions between services. It was reported there were, at times, issues accessing past medical histories for those individuals from other health board areas although staff informed us generally this was not an issue. We were disappointed to find prisoners who received health care had no formal care plans in place. These are important documents, with a purpose to ensure a consistent approach and a clear understanding of their needs and care goals. This is particularly important where individuals are being seen by several services such as nursing, addictions, psychiatry, and other agencies.

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

Recommendation 3:
Health service managers should urgently review and address the system of care planning for all prisoners open to the mental health team.

We found care plans for those prisoners subject to rule 41 measures of the Prisons and Young Offenders Institutions (Scotland) Rules, 2011; these were located in the online team folder. These were detailed and person-centred and regularly reviewed. There were also paper copies of the plan with officers in the segregation and reintegration unit, which ensured a consistent approach to the prisoner's care.

We saw that physical health care needs were being addressed and followed up appropriately. This provision was supported by the primary health care team. Some individuals we met with discussed difficulty accessing appointments with GP services, they described frustration at not having their medication reviewed by the GP. When the notes of these individuals were reviewed, we found that there had been regular reviews documented by the addictions team who liaised with the GP.

In relation to risk assessments and management plans, we noted that the Ayrshire Risk Assessment Framework was used in the prison. We found some risk assessments had not been updated on admission to the prison and the risks were out-of-date. There were no clear management plans accompanying the risk assessments. We did however find detailed reviews of risk and associated management plans in Care Partner notes, which were updated

at each review. This information was difficult to find and would be more easily accessible if a record was maintained in the risk assessment.

Recommendation 4:
Managers should review and ensure improvement in the current mental health risk assessments and management plans for all individuals who require these to be in place.

Multidisciplinary team (MDT)

In the prison, we heard that there is a health team which consists of a clinical team leader in mental health, mental health nurses, one senior occupational therapist, an occupational therapist and a half-time speech and language therapist. The team is also supported by two consultant psychiatrists who each provide three sessions a week. We were informed how the recruitment of a speech and language therapist and two occupational therapists have enabled additional therapeutic activities.

It was clear from detailed MDT meeting notes that everyone involved in an individual's care and treatment is invited to attend the meetings and provide an update on their views. We were pleased to see the involvement of families in the assessment and treatment planning of individuals where appropriate. Families' needs were also considered in the treatment plans. The case notes evidenced progression of care and treatment, regular assessment, and reviews of mental state.

Use of mental health and incapacity legislation

On the day of our visit one of the individuals we met with was subject to a guardianship under the Adults with Incapacity (Scotland) Act 200 (the AWI Act). We found details of the local authority authorised officer in the notes, but there were no copies of the order. We also found it was not flagged on the electronic system that the individual had a welfare guardianship in place.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We did not find a s47 certificate in place for this individual.

Recommendation 5:
Managers should ensure that copies of welfare guardianship powers are available for relevant staff and these powers are clearly documented within notes.

Recommendation 6:
Managers should ensure that s47 treatment plans are completed, available and correctly filed in accordance with the AWI Code of Practice (third edition).

We were told when prisoners require transfer to hospital wards for treatment of significant mental illness under the Criminal Procedures (Scotland) Act 1995, this is usually facilitated without prolonged waits. There is good communication between Woodland View and the prison which helps this process.

We were concerned to hear the difficulties experienced with transfer services provided by GEOAmey. Transfers were often cancelled by the company at very short notice or were unable to be provided. Transfers were then required to be facilitated by Serco staff in unsuitable vehicles, potentially increasing the risk for both prisoners and staff. These transfers by Serco staff were not factored into the current staffing model and were often reliant on good will of staff. If these transfers were not completed in a timely way, it could lead to a delay in the individual receiving appropriate care and might increase distress and agitation. We heard this had an impact on other activities, such as attendance at hospital appointments and funerals, thereby increasing the stress and distress on the individual involved. We were told this is a national issue that is occurring across all prisons in Scotland and has been escalated by managers to the National Prison Care Network and raised nationally with the SPS.

Rights and restrictions

We were pleased to hear that advocacy services have returned to in-person visiting in the prison, and saw evidence that this had been offered to some prisoners we met with. However, not all were aware of their right to discuss their circumstances with advocacy services. We felt that advocacy could be better promoted in the prison, though recognise there has recently been a new worker appointed, following a gap in service, and this may have had an impact as to how this service has been promoted. Advocacy staff explained most referrals came from health care staff and felt it would be beneficial if prison officers could also promote this service to those who are not open to health services.

The Commission is aware that advocacy will not have a role for everyone, however the service could assist prisoners who are potentially being transferred to a hospital from prison under the Mental Health (Care Treatment) (Scotland) Act 2003 or the Criminal Procedures (Scotland) Act 1995. We discussed this with the service on the day of the visit.

We took the opportunity to look at the Separation and Reintegration Unit (SRU) in Kilmarnock. We met with two prisoners who were in the SRU at the time of our visit. One spoke of feeling ''fed up'' and told us that he didn't find any of the interventions he received helpful. The other person we met with was, unfortunately due to his mental state, not able to engage with us in a meaningful way. We did see a comprehensive care plan for this individual's care in the SRU, and daily reviews from the mental health team. There was good communication between prison staff with the SRU and the mental health team, which showed a beneficial effect on the care and treatment for individuals who were in the unit.

The Prisons and Young Offenders Institutions (Scotland) Rules 2011, sets out that individuals can be restricted in certain situations. If there are concerns from prison staff and/or health professionals about a person's behaviour due to their health, restrictions can be placed on their movements and social contacts through the use of rule 41. A health professional must make a request to the prison governor to apply a rule 41. Use of this rule can include confining a prisoner to their own cell or placing them in segregation. One person we met with who was subject to rule 41 found this to be overly restrictive and meant they had no interaction with their peers. On reviewing their notes, we found detailed plans and reviews of these restrictions and clear reasoning for them being in place. There were plans in place to consider when restrictions could be lifted.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that individuals 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

Kilmarnock prison is a working prison which means all prisoners, except those who are unable to, or who are on restrictions, are expected to work. There are various vocational and educational opportunities that individuals can take part in. We heard there are around 75 prisoners who are unable to work due to health conditions and are on a disability schedule.

The senior occupational therapist is undertaking a project to provide these individuals with occupational opportunities, including an activity group and a 'Deciders Skills group. This has been well received and it is hoped to be expanded in the future. There was also ongoing work to address the occupational needs of neurodiverse individuals. It is hoped to start developing sensory profiles, and to consider the impact on individuals in the different environments of the prison. We look forward to hearing how these developments progress in our future visits.

There is recognition of changes in the prison population, with an older, increasingly frail population who have complex health needs. The occupational therapy service is developing a falls pathway in line with NHS Ayrshire & Arran, given physical frailty of some individuals and were providing advice and guidance to wider prison staff on how to support these individuals.

We were told the safer custody officer holds regular family events, to support encouraging and maintaining relationships and contact for individuals with children. These sessions are held in the gym area and staff have games, activities, and a bouncy castle available.

We were also pleased to hear prisoners had access to the Link Centre where they are able to access housing, welfare rights and third sector advice. We were told how this can positively affect the transition back to the community on release.

The physical environment

The health centre rooms were adequately furnished but there was a lack of space; it was recognised that if the team was at full complement, there would be difficulty accommodating the team. The clinic rooms were very open, and we heard of the team's concerns about confidentiality related to this, and also from some of the individuals we met with.

The rooms, outdoor spaces, and activity areas that we visited were of a good size and were well maintained, appropriately furnished, clean, and hygienic. Each person we met with when in their cell had a bed, bedding and suitable clothing, access to toilets and washing facilities, and were provided with necessary toiletries and cleaning materials. There was limited access to accommodation that was suited to individuals with mobility issues, with only two assisted rooms in the prison.

Staff from the mental health and addictions team told us before Covid-19 restrictions were introduced, a recovery group ran supporting 12 to 14 individuals in each group. This has not been able to be re-started as staff were advised by Serco managers there was no

accommodation in the prison for the group. Health services reported this was ‘greatly missed’ and that all addiction support is now provided on a one-to-one basis.

Summary of recommendations

Recommendation 1:
NHS Ayrshire & Arran managers should progress the provision of psychology and psychological therapies for the prison population at HMP Kilmarnock to ensure it is adequate to meet the needs of the population and update the Mental Welfare Commission on progress made.

Recommendation 2:
Managers should ensure the culture within the prison maintains open, respectful communication.

Recommendation 3:
Health service managers should urgently review and address the system of care planning for all prisoners open to the mental health team.

Recommendation 4:
Managers should review and ensure improvement in the current mental health risk assessments and management plans for all individuals who require these to be in place.

Recommendation 5:
Managers should ensure that copies of welfare guardianship powers are available for relevant staff and these powers are clearly documented within notes.

Recommendation 6:
Managers should ensure that s47 treatment plans are completed, available and correctly filed in accordance with the AWI Code of Practice (third edition).

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 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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