Mental Welfare Commission for Scotland

Report on an announced visit to: HMP Addiewell, 9 Station Road, West Calder, EH55 8QF

Date of visit: 4 March 2024

Where we visited

HMP Addiewell is one of Scotland's two privately run prisons (of a total of fifteen prisons). It opened in 2008 and is run by Sodexo Justice Services, contracted to the Scottish Prison Service (SPS).

HMP Addiewell is a "learning" prison, designed for individuals in custody to address their offending and improve future opportunity for employment. The prison serves the courts in Lanarkshire and West Lothian, holding prisoners remanded in custody as well as convicted adult male prisoners. The capacity of the prison is 700.

The Commission's last local visit to HMP Addiewell was in July 2019 and we made recommendations relating to auditing nursing care plans and recording missed health appointments due to prison officer shortages to monitor this issue.

We visited HMP Addiewell again in 2021, as part of our national themed visit on prisons. Our report *Mental health support in Scotland's prisons 2021: under-served and under-resourced* made a number of recommendations to the Scottish Government, NHS Scotland and the Scottish Prison Service (SPS) on changes that were needed to improve mental health services across the prison estate.

An HMIPS inspection in 2022 had been critical, making 126 recommendations for improvement, including of access to mental health support. Following this inspection, the NHS made some changes to the prison health service.

On this visit we wanted to find out about the current mental health services being offered to prisoners, as well as to speak with prisoners receiving mental health support to hear about their experiences of mental health care in the prison.

We were joined on this visit by a colleague from the Scottish Human Rights Commission. This was as part of a pilot looking in particular at the rights of prisoners in conditions of additional restriction.

Who we met with

We met with and reviewed the care of eight prisoners. We met with the lead nurse for prison health care, the senior charge nurse for the mental health team and nursing staff. We also spoke with some prison officers and met with the prison director and deputy director at the end of the visit.

Commission visitors

Dr Juliet Brock, medical officer

Dr Arun Chopra, executive director (medical)

Justin McNicholl, social work officer

Cathy Asante, legal officer, Scottish Human Rights Commission

What people told us and what we found

Care, treatment, support and participation

The prisoners and staff we met with spoke, in general, of a number of challenges in the prison. We heard that the prison could seem busy, noisy and with lots of activity at times, with the environment described by some as chaotic due to high levels of illicit drug use and violence. We heard that staffing levels meant that prison officers had a difficult job, with two prison staff being responsible for as many as sixty prisoners at some points.

Despite these challenges we heard generally positive feedback from healthcare staff and prisoners about the support provided by prison staff. Some individual prisoners acknowledged the challenges that prison staff were facing "the staff are under a lot of pressure" but told us that individual prison officers still took time to spend with them, particularly when they needed support for their mental well-being.

We heard from prisoners that there were long waiting times to be seen by the mental health team, both for nursing and psychiatry input. We were told "it takes too long to get to see anyone from the mental health team". Some individuals reported waits of two to three months to be seen. We heard that sometimes people felt they needed to make a complaint about delays. We also heard that people were sometimes self-medicating with illicit drugs while they were waiting for mental health support. When prisoners did receive mental health support, they were positive about this.

We heard from the mental health team that there were 54 people on the waiting list to be seen at the time of our visit and that the target was for individuals to be seen within 45 days of referral. It was explained to the Commission visitors that the waiting list was high due to the lack of mental health staff, who provide a daytime service from Monday to Friday, with primary care staff covering weekends and weekday evenings until 9pm. Previously, the mental health and addiction teams had worked jointly, however we heard that this had not been working and that the team had been very short-staffed, with the need for regular agency use.

With concerns about the waiting list for mental health review reaching 11 to12 weeks, changes were made, with mental health and addiction teams being separated and new staff recruited. This had happened in December 2023, so adjustments were still being made at the time of our visit. We heard that the improvements put in place were making an impact, with less use of agency staff and the waiting list for mental health assessment had reduced to under three weeks. We were told that there had been a positive impact on prisoner care as a result.

Concerns about the use of illicit drugs were repeatedly raised by prisoners who spoke with us. Individuals voiced fears about the levels of violence they were witnessing in the prison, and which they believed were directly linked with drug use. Both prisoners and staff spoke of the increase in particular of the street drug Etizolam, a benzodiazepine (which many referred to as 'tizzy'). Prisoners also shared

concerns about a number of recent prisoner deaths, which they believed were linked to illicit drug use. Concerns were also shared by health and prison staff, with the high levels of drug abuse appearing difficult to manage.

Prisoners we spoke with who had a history of addiction and were seeking help with this, reported good access to the addiction service in the prison. We heard from senior leaders of some positive plans in further developing this support, with the recent appointment of an Addictions and Recovery Manager, who was due to take up post. It was hoped that this would help improve integration between addiction services in the community and those in prison.

Pathways of mental health care in the prison

When prisoners first entered custody, reception health assessments were carried out by primary care staff. We were told that plans were about to be put in place for a mental health nurse to assist the reception team with these assessments three days a week.

Following reception assessments, all prisoners were reviewed the next day by a GP or advanced nurse practitioner (ANP); referrals for further input from the mental health or addictions teams could be made at this point.

Prisoners identified as being at risk of self-harm or suicide can be placed on 'Talk to Me', the SPS suicide prevention strategy. This would be instigated by prison officers or health staff when there are concerns about a person's safety. The individual would then be placed on 15-minute observations (carried out by prison officers) and seen by a mental health nurse within 24 hours. Care plans would then be agreed between NHS and SPS staff, with case conferences carried out to review the need and frequency of ongoing observations and to identify further interventions and any support that was required.

One person, who was a first offender, spoke about being placed on 'Talk to Me' when they first arrived in custody and recalled it being "helpful having checks in the night". In contrast, another person we met with spoke had the opposite view of their experience of being placed on 'Talk to Me'. They spoke of having suicidal thoughts at the time but alleged "nobody talked to me" and described their care as "nothing different except two meetings". This person had already raised complaints about their experience, including dissatisfaction about not receiving some medication they said they had been prescribed in the community; they were satisfied with the response received from NHS Lothian, reportedly upholding some of their complaints. We discussed the issues raised with us with the staff at HMP Addiewell on the day of visit.

Once prisoners were in custody, if concerns arose about their mental health, they could self-refer to the prison mental health team. Alternatively, prison officers could make a referral on their behalf. We were told that in-cell technology with electronic 'kiosks' meant that prisoners could make a self-referral directly for primary care,

addiction support or mental health support, providing better tracking and recording of referrals and wait times. Prison officer referrals could be made directly to the mental health team, and we were told this led to a review on the same day.

The kiosks enabled prisoners not only to self-refer for healthcare needs, but also to make calls, get information, apply for jobs and educational opportunities, make certain requests and also make complaints. The kiosks also offered translation ability where this is needed.

HMP Addiewell has been innovative in offering this in-cell technology, which is now planned for other prisons across the Scottish prison estate.

Feedback from prisoners about the electronic mental health referral process was generally positive. We heard that there was direct confirmation that their referral had been made and electronic updates were provided, such as confirmation that they had been added to the waiting list (the response time being reported as around 5-10 days). One person did not find the kiosk system helpful.

Some concerns were shared by staff that there was the potential for prison officers to become de-skilled in supporting individuals with their health needs and accessing support. The limitation of the kiosk system's accessibility to those with learning or communication difficulties was also recognised.

With regard to prescribing, we were told there were no significant issues providing medication to new prisoners and that prescriptions were usually issued swiftly, following cross-checking with the individual's Emergency Care Summary (ECS). The ECS is a document completed in the community by GPs; it summarises the medical history and current prescription for a patient. The electronic document, held in a patient's records, could be accessed by the prison health team.

However, staff advised that it was common for prisoners not to have GPs, particularly if they were homeless, so access to medication was not always straightforward. We heard that the pharmacist in the prison was working with addictions services in the community to try to provide more seamless access for those requiring ongoing treatment for addiction (for example ensuring continuity of prescription for opiate addiction in custody). There was also a focus on improving communication about prescribing on release, particularly for those spending a brief time in custody.

More broadly, we heard that there was a move towards electronic prescribing in prison. The plans for implementation of this would be around October 2025.

At the time of our visit eight individuals were prescribed regular depot injections of antipsychotic medication, which was being administered by prison nursing staff.

We had heard during a recent visit to another prison in Lothian that there were issues with the timing of medication being dispensing during the day, due to a shortage of

both primary care and prison staff. This had led to significant delays with medication being provided to prisoners. Although this was not an issue highlighted by prisoners we spoke with on this visit, senior staff told us that this was a problem in HMP Addiewell. We were advised of actions being taken to address this, including a review that was underway of medication being prescribed to all prisoners, to see how many could safely have this in their possession. It was acknowledged that this was a significant piece of work, but recent progress on this was welcomed. It was hoped by service managers that the result could be around a 70% reduction in daily dispensed medication across the prison when complete.

In common with other prisons we have recently visited, one medication issue raised with us, by both the mental health team and by a number of prisoners, was difficulty in accessing medication for ADHD (attention deficit hyperactivity disorder). This was due to the impact of national shortages of medication to treat ADHD. As with our visit to HMP Edinburgh, senior managers in NHS Lothian were monitoring the situation and advising staff to provide updated information to affected individuals.

Multidisciplinary team (MDT)

The prison mental health service was led by a senior charge nurse and healthcare manager, who provided line management to the rest of the team. The mental health team itself was small, comprising of two permanent mental health trained nurses, with additional support from healthcare support workers and a social worker. We were told that caseload numbers were low, with the main task of the team being carrying out mental health assessments.

There was weekly input from visiting psychiatrists, including a specialist in addictions, autism spectrum disorders (ASD) and attention deficit disorder (ADD) who ran monthly clinics.

Referrals could be made to clinical psychology and to speech and language therapy when required. The psychology team, comprising two psychologists and a trainee, held their own waiting list for referrals and were able to offer one to one work with individual prisoners.

There was a weekly multidisciplinary team meeting, where all new referrals were discussed.

A weekly person of concern meeting was also held jointly between NHS and senior prison staff, providing the opportunity to discuss concerns about mentally ill or vulnerable prisoners, particularly those subject to rule 41 restrictions[1] . We heard

[1] Rule 4: The Prisons and Young Offenders Institutions (Scotland) Rules 2011 enable restrictions to be put in place in certain situations. When 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 by 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 and placing them in segregation.

that around ten prisoners were discussed in each meeting and that this new forum was valued across the teams.

We were advised that prisoners subject to rule 41 for mental health reasons had a care plan that was updated by the mental health team and that any prisoners requiring transfer to hospital for mental health care were automatically placed on a rule 41. It was explained that this was a way of ensuring cohesive care, with regular feedback to prison officers and individualised care plans in place while the individual was awaiting hospital transfer. We asked about timescales for transfer to hospital for prisoners who were acutely mentally ill and required inpatient care, as delays in this process has been an ongoing concern, highlighted repeatedly by both the Commission and the National Preventive Mechanism (NPM) in Scotland in recent years. We were told that waiting times for hospital transfer were variable, with recent cases ranging from a few weeks to several months. A Standard Operating Procedure for prison transfers was being developed by a lead forensic psychiatrist for Lothian, with plans for this to be implemented to both prisons in the area: HMP Edinburgh and HMP Addiewell.

No-one was awaiting transfer to hospital for mental health care at the time of this visit.

Care records

Individual health records were stored on Vision, the electronic patient record system used across Scottish prisons. Unfortunately, on the day of our visit, some technical problems occurred, which meant that staff had no access to emails in the morning, and in the afternoon, there was no access to Vision records.

For those records that we were able to view, we found that entries by mental health nursing staff were generally brief, with little sense of continuity between contacts or of the individual's diagnosis or treatment plan. We also found it hard to find mental health risk assessments for those being seen. Recorded contact with the visiting psychiatrists was more detailed and showed clear plans for treatment and follow up, where appropriate. We found good evidence of regular psychology input.

There was very little in the way of nursing care plans for prisoners who were being seen.

The Commission has published a good practice guide on care plans[2]. 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.

[2] Person centred care plans good practice guide: https://www.mwcscot.org.uk/node/1203

Recommendation 1:
Managers should review the recording of contacts by the mental health team, to ensure that important information is captured, appropriate risk assessments are completed and individualised care plans are developed in line with identified needs.

The challenges identified in our previous visit, with prison staffing issues having an impact on prisoner attendance at health appointments was not raised as an ongoing concern on this visit. In the care records we reviewed, we saw good evidence of physical healthcare reviews, with appropriate referrals for specialist treatment when required.

However, we heard that GP provision in primary care was a significant concern in the prison, with no permanent input. A locum GP was soon to leave, with the plan for emergency cover to be provided by the GP who currently covered another prison in Lothian, with the advance nurse practitioner (ANP) providing additional support. With ongoing challenges in GP recruitment, the longer-term solution was unclear.

Rights and restrictions

We asked the prisoners we met with about access to independent advocacy support. There was limited awareness of advocacy among the prisoners and the prison staff that we spoke with.

We heard from the prison director that there was good engagement with the visiting independent prison monitors (IPMs), who were said to be quite visible, who ran small groups and who had good engagement with prisoners.

We found that there was limited information available about advocacy or IPMs. We discussed this with senior managers at the end of the day and recommended that access to advocacy support be prioritised, with information about this being made widely available (for example, via the new kiosk system).

Recommendation 2:
Senior managers should ensure there is access to independent advocacy within the prison, with information about this support made available and easily accessible to prisoners.

We heard from prisoners that they could raise complaints via the kiosk system or by using the traditional method of completing a written PCF1 form.

The Commission has developed *Rights in Mind*[3]. 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.

[3] Rights in Mind: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

We were aware that during the pandemic, restrictions were put in place that meant various activities and groups in the prison had to be put on hold; some prisoners struggled with the restrictions placed on their routine.

On this visit, we heard the opposite from prisoners that we spoke with. The new prison regime meant that cells were open for most of the day and there was access to a wide range of work and educational opportunities. Individuals we spoke with talked positively about their jobs and some of the opportunities included cleaning duties and working in the prison library. There was access to a range of classes, including art and design, and educational subjects including English and maths. There were also some therapeutic groups such as a recovery group.

We heard that some activities had not taken place due to staffing levels, but in general, the feedback was positive.

In the evening there was access to exercise for up to an hour.

Interestingly, feedback from some prisoners that we spoke with was that they felt the day was now too long as the daily routine had now re-opened and was more extensive. This was in stark contrast to a few of the other prisons we have visited post-pandemic, where a frequent complaint to us has been that there has been an ongoing, highly restrictive regime and prolonged time in-cell. We discussed this in feedback with senior prison staff at the end of the visit and wondered whether a consultation exercise might be helpful to gain more insight into prisoner experiences in regard to this.

Summary of recommendations

Recommendation 1:
Managers should review the recording of contacts by the mental health team, to ensure that important information is captured, appropriate risk assessments are completed and individualised care plans are developed in line with identified needs.

Recommendation 2:
Senior managers should ensure there is access to independent advocacy within the prison, with information about this support made available and easily accessible to prisoners.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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