Mental Welfare Commission for Scotland

Report on announced visit to: HMP Edinburgh, 33 Stenhouse Rd, Edinburgh, EH11 3LN

Date of visit: 19 October 2023

Where we visited

HMP Edinburgh is a large prison, receiving prisoners mostly from courts in Edinburgh, the Lothians and Borders. The prison accommodates adult males, including those on remand, prisoners with short-term sentences (serving less than four years), long-term sentences (serving four years or more), life sentences and prisoners on extended sentences (order of lifelong restrictions). The design capacity of the prison is 870.

The Commission's last local visit to HMP Edinburgh was in 2016 and we made no recommendations at that time. We visited HMP Edinburgh 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*[1] 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.

On the day of this visit, we wanted to find out about the current care and treatment provided for individuals who were experiencing mental health difficulties in the prison. We also wanted to look specifically at care of prisoners with mental health difficulties who were being held in conditions of segregation. This followed concerns raised in both the Commission's prison themed visit, and in a recent thematic report[2] by HM Inspectorate of Prisons for Scotland (HMIPS) about prisoners held in segregation. Concerns particularly related to the care of prisoners with mental ill health in separation and reintegration units (SRUs) in Scottish prisons. We were joined on this visit by a representative from the Scottish Human Rights Commission, to provide expertise, particularly on aspects of the rights of individuals being held in conditions of segregation. This formed part of a pilot of joint work with the SHRC on prisons.

At the time of this visit we were advised that 21 prisoners were receiving follow up from the mental health team, with two of these prisoners held in the SRU. One prisoner was subject to Rule 41 restrictions[3].

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[1] Mental health support in Scotland's prisons 2021: under-served and under-resourced: https://www.mwcscot.org.uk/node/1755

[2] A Thematic Review Of Segregation In Scottish Prisons: https://prisonsinspectoratescotland.gov.uk/publications/thematic-review-segregation-scottish-prisons

[3] Rule 41: 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.

Who we met with

We met with and reviewed the care of nine prisoners and spoke with one relative.

We met with the lead nurse for prison health care, the prison health service manager, acting senior charge nurse for mental health and addictions, as well as mental health nurses and the lead occupational therapist (OT). In addition, we met with prison staff in the SRU, spoke with senior prison staff and with the prison Governor at the end of the visit.

Commission visitors

Dr Juliet Brock, medical officer

Claire Lamza, executive director (nursing)

Dr Margaret White, senior psychiatry trainee

Cathy Asante, legal officer, Scottish Human Rights Commission

What people told us and what we found

From the prisoners that we spoke with, we heard that there was generally good support for mental health and wellbeing in the prison; feedback about contact with the prison mental health team was positive. In particular, prisoners spoke about receiving good support from mental health nurses and from occupational therapists (OTs).

When we asked about waiting times, some prisoners expressed concerns about delays. The waiting time for medical review after referral to psychiatry, and for OT assessment, were both reported as lengthy.

Several prisoners also raised concerns about the dispensing of medication in the prison. We heard that nurses carried out medication rounds twice a day, the first round often being late morning, sometimes not until 11:30am, with the second taking place mid-afternoon. This had presented a number of difficulties for some prisoners. For example, those taking twice daily medication (with doses prescribed 12 hours apart), were sometimes receiving treatment with only a four-hour window between doses. This has the potential to both reduce the effectiveness of medications and to cause negative effects (due to unstable levels circulating in the body). We also heard from prisoners who had received sleeping tablets at 3:30pm, with the result that they slept through the afternoon/evening and were then awake through the night. This was due to there being no option of late dispensing.

Senior health staff confirmed this was happening and that it was a concern. This concern was also shared by SPS management, who advised that there was time built into the regime from early morning to support NHS staff with dispensing rounds and from 6pm for evening medication. The dispensing of evening medications in the afternoon was not a practice supported by the prison.

We were told that Ingliston Hall, which housed convicted prisoners over four floors, experienced more problems, as due to short staffing only one of the two dispensaries on Ingliston could be opened for use. Staffing shortages were experienced by both SPS and the primary care team. Medication was dispensed to prisoners by primary care nurses, not mental health nurses. We heard that sometimes prisoners did not receive any medication until midday; this could include pain medication, methadone and medication for attention deficit hyperactive disorder (ADHD). For those prescribed three times daily medication, dispensing more than twice daily was not possible. We were told that weekends were particularly challenging.

To address this issue, individual prisoners were in possession of a limited supply of their own medication and could self-administer treatment at the appropriate times, where this was assessed to be safe. Importantly, it was confirmed that this was the

case for most people taking diabetic medication, and that those on insulin were prioritised.

When we discussed these concerns at the end of the visit, the prison governor and senior NHS staff gave assurance that urgent action was being taken to address this issue. We were told that the new lead pharmacist for prisons and police custody was also reviewing the situation. There were plans to review prescribing for all affected prisoners and to provide 'in possession' medication for as many individuals as possible, where it was safe to do so. We were also advised that the health team were hoping to have a full complement of primary care staff by the end of 2023 and that, in addition to improved SPS staffing levels, this would improve daily dispensing practice and timely access to medications.

Recommendation 1:
Senior health centre managers should review the practice in place for prescribing and dispensing medications, to ensure that the treatment prisoners receive is comparable to that which they would receive if they were not in custody.

Another medication issue raised with us, by both the mental health team and by several prisoners, was difficulty in accessing medication for ADHD. We heard about the impact that national shortages of medication to treat ADHD were having. Dexamphetamine and Atomoxetine were out of stock in the UK at the time of the visit and we heard from prisoners and staff that people were not finding alternative medication as effective. The mental health service was keeping prisoners affected by this updated by letter.

The prison mental health service offered specialist support for individuals with specific needs, and a visiting consultant psychiatrist offered clinics for people referred with a known or suspected diagnosis of ADHD or autism spectrum disorder (ASD). These regular clinics offered assessment and diagnosis. We were told that due to the national medication shortage, local NHS leaders had considered it unethical to diagnose new cases of ADHD without treatment being available, and new assessments had therefore been put on hold. There was a waiting list for ADHD assessments in the prison and at the time of our visit eight people were on this waiting list. The waiting time for the clinic was eight months, having previously been one year. Individuals who had already been assessed, but were waiting to start ADHD treatment, were being kept updated.

In addition to concerns about medical treatment, we also heard from both prisoners and staff about problems with access to prison transport (which was contracted privately to GeoAmey). This issue, which had been an ongoing concern impacting prisons across Scotland, was having significant impacts on prisoners. We were told NHS appointments for prisoners were frequently being missed, due to transport not being available to take them to attend hospital. We were also told that prisoners

were not always able to attend court appearances and that moves between prisons were often cancelled or delayed. Since this visit took place, the issue had been raised by the Auditor General for Scotland and highlighted as a "considerable risk".

Pathways of mental health care in the prison

An initial health assessment is carried out for every prisoner arriving in custody. These reception assessments were undertaken by advanced nurse practitioners (ANPs) from the primary care team, with the addition of a further ANP specialist in addictions. The mental health nurses were not involved in the reception assessments. Any prisoners presenting with mental health concerns were then referred to the mental health team for review.

We heard about improvements in the pathways for prisoners with substance misuse, with ANPs in the addiction team running a fast-track programme that supported swift access to prescriptions such as methadone, rather than detoxification for those with opioid dependency.

Prisoners also had access to primary care support, in addition to support from the mental health team on a referral basis. Prisoner officers, or prisoners themselves, could make a referral to the mental health team. We were told that all new referrals were dealt with immediately by a mental health nurse, on a duty rota basis, enabling prisoners to be seen the same day for initial review and then allocated for further assessment/ follow up.

We heard from senior staff about particular challenges for the prison mental health team. These included an increase in the number of prisoners aged over 65 who were experiencing cognitive difficulties, which had led to an increase in referrals for cognitive testing. There was no direct input from older adult mental health specialists into the prison, or access to memory clinics for dementia care. Visiting forensic psychiatrists would therefore carry out initial assessments and then seek expertise and advice from consultant psychiatry colleagues in local older adult mental health services, when needed. This was an issue we were aware had been identified across the prison estate for a number of years. We were advised that SPS was working jointly with the University for the West of Scotland to develop national dementia pathways for people in prison.

The Commission had raised concerns in recent years about delays in transferring acutely mentally ill prisoners to inpatient units when they required urgent hospital treatment. This had been happening in prisons across Scotland. We had been involved in reviewing a number of cases where this had happened at HMP Edinburgh since the Commission's themed visit to prisons in 2021. On this visit we were pleased to note that there were no prisoners awaiting transfer to inpatient mental health care.

Prisoners identified as being at risk of self-harm or suicide were placed on the 'Talk to Me' SPS suicide prevention strategy, which can be instigated by prison officers or health staff when there are concerns about a person's safety. The individual should then be placed on 15-minute observations (carried out by prison officers) and seen by a mental health nurse within 24 hours. Care plans are then 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 support required. We were advised that family representatives could join these meetings. The reviews and case conferences were recorded on the individuals' PR2 (SPS prison record), which was separate to Vision and not accessible to NHS staff. One prisoner we spoke with raised concerns about the lack of observation and support when he was placed on 'Talk to Me' when in distress and feeling at risk to himself. This person said he had made complaints but did not feel he was being listened to. We escalated these concerns to senior health managers.

At a national level, we were aware that in addition to SPS developing a new trauma-informed mental health strategy, they were also reviewing the Talk to Me strategy.

We asked about mental health training for SPS staff in the prison. Psychologists told us they offered direct support to prison staff when required and were also delivering training in how to support prisoners with ADHD, learning disability and autism spectrum disorder in custody. It was acknowledged by prison managers however that mental health training for staff had not been a recent focus and given staffing shortages, it had even been a struggle to support core statutory training for prison officers during recent times.

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. We were pleased to hear that (with the exception of long-term sickness absence) the mental health team had a full complement of nursing staff, with a team of six nurses.

Two specialist learning disability nurses, working jointly with the primary care team, had also joined in June 2023. We heard positive feedback about this additional role within the service, both in directly supporting prisoners with a learning disability and in helping to provide 'easy read' materials for the wider prison population.

Mental health nurses were available in the prison on weekdays until 6pm. Emergency mental health input out of hours (evenings and weekends) was provided by the primary care team.

In addition to nursing staff, two mental health OTs also provided support to the mental health team. These posts had been funded by money linked to 'Action 15' of the Scottish Government's Mental Health Strategy 2017-2027. We were told that the

OTs were providing vital support, helping prisoners with mental health difficulties to structure their day and engage in activities. This included supporting prisoners held in the SRU.

The OT lead acknowledged that the OT service had a waiting list of between four to six weeks, confirming that prisoners experienced delays waiting for initial assessment. Once they had been assessed, the OT team offered a range of interventions to meet everyone's needs. These included offering one-to-one support, goal-based work, help with individual routine and structure, support with anxiety management and developing coping strategies and engagement in mindful activities. Positive formulation and working with prisoners around self-identity were also described within the OT role.

There were two full time clinical psychologists providing input to the team. We were informed that they provided psychological therapies, regular groups and supported the mental health team with formulations. Psychologists also undertook joint work with OT colleagues.

Psychiatry input was offered on a sessional basis by two visiting consultant forensic psychiatrists. In addition, a psychiatrist with expertise in addictions and a specialist interest in ADHD and ASD ran a fortnightly clinic in the prison.

We asked about MDT meetings, as well as forums where SPS staff and NHS staff could discuss complex cases. MDT meetings to discuss clinical cases and new referrals were held weekly and attended by members of the clinical team, including nursing, psychiatry, OT and psychology.

We were also told about the risk management process, with risk management team meetings, where an ANP worked with social work and police to look at the risks and needs of people moving on from custody.

We heard positive feedback about a weekly 'persons of concern' meeting that had been implemented to improve communication and collaboration between SPS and NHS staff in relation to prisoners posing particular mental health concerns in custody. This meeting, held jointly by SPS and NHS staff in the prison, with representatives from SPS headquarters joining remotely, reviewed and discussed prisoners who were subject to rule 41. We were told this forum had input from primary care, mental health, addictions, OT and psychology, as well as from chaplaincy, unit managers and senior prison representatives in attendance. These meetings were highly valued by the professionals we spoke with. We were told that referrals to the mental health team were sometimes generated from these discussions.

Care records

Day to day health records were stored on Vision, the electronic patient record system used across Scottish prisons. For prisoners who had individual mental health care plans, these were stored separately.

We were told that health staff also had limited access to TRAK, the electronic patient management system used in NHS Lothian. No equivalent health records for prisoners from other jurisdictions were accessible. Health staff also had access to summary information about individuals from their GP records, available in the form of an emergency care summary (ECS).

In the Vision records we viewed, we found the day-to-day entries from staff carrying out mental health reviews to be quite basic, with limited detail of the person's presentation, working diagnosis or treatment plan. In some cases, we found it difficult to see long-term illness progression, improvement or recovery from the narrative provided. We found it difficult in some cases to find information on initial health assessments carried out when the person first arrived in prison custody. In general, the notes recorded by OTs and psychiatrists were more detailed.

It was not always clearly stated where prisoners were being held at the time they were being seen, which was especially important for individuals who were in (or had previously spent time in) the restricted confines of the SRU.

For patients subject to rule 41 due to their mental health, we found rule 41 care plans on the separate electronic system. Overall, we found these care plans to be fairly limited in detail about the person's individual needs and the care and treatment plan in place to support them. These care plans were particularly important, as they helped inform SPS staff on how best to support and manage individuals who were experiencing significant distress or mental illness.

Just prior to the visit, we had been contacted by a nursing professional from NHS Lothian who advised us that they were carrying out risk assessment and care planning training across local services, including in prisons, and had just met with the mental health team in HMP Edinburgh and identified areas of improvement work. We welcome this initiative and look forward to seeing the impact on future visits.

The Commission has published a good practice guide on care plans[4]. 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.

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

Recommendation 2:
Managers should review rule 41 care plans and carry out regular audit and improvement work to ensure these meet the expected standards and reflect the treatment, interventions and approaches being recommended by the health team.

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 prison staff we spoke with. There was little available information available about advocacy and the onus appeared to be on prisoners to seek out this support. We discussed this with senior managers at the end of the day and advised that access to advocacy, and information about this, be more widely available.

We asked prisoners how they could raise concerns or complaints. Most were familiar with the process of raising a complaint with the prison service by completing a written PCF1 form. However, there appeared to be a general lack of confidence in this system. We frequently heard reports of complaints going 'missing' or unanswered. Some also raised concerns about making a complaint and were put off the process, citing fear of reprisal from staff. We shared this feedback with senior SPS staff at the end of the visit.

One individual discussed a specific incident of concern with us. With the individual's permission we shared the details with healthcare managers, who gave assurance that the allegation would be looked into with SPS colleagues.

The prison governor confirmed plans that SPS have for prisoners across Scotland to have access to electronic tablet devices in their cells. We were told the infrastructure was being put in place for this. It was envisaged that this new system would enable prisoners to both refer themselves to prison health services, including the mental health team, and to raise issues such as complaints electronically in the future. It was hoped this would provide greater transparency, as well as the ability to accurately track both referrals and complaints. We look forward to updates about progress on future visits.

We were pleased to hear from a number of prisoners that they had spoken with visiting prison monitors when they had concerns and that they had found this supportive.

Use of segregation
When prisoners are held in conditions of segregation and are therefore subject to additional restrictions in custody (whether in their cells within the mainstream prison environment or in an SRU), the Commission takes into account the recommendations of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (the CPT). The CPT recommends

that all individuals, including those in conditions of segregation, should have at least two hours of meaningful human contact each day, in accordance with the requirements of the Mandela Rules, and that individuals held for longer than two weeks in segregation should be offered further supports and opportunities for purposeful activity.

Separation and Reintegration Unit (SRU)
On this visit we took the opportunity to visit the SRU, to speak with staff and to meet with the two prisoners there who were receiving support from the mental health team. One of these prisoners was being held in the SRU under prison rule 41, due to concerns about their mental health.

The SRU had fourteen cells, thirteen of which were in use at time of our visit.

The unit had a secure outdoor area, which allowed some limited space for outdoor exercise. We were advised of an indoor gym that had new exercise equipment; however, this area was out of action at the time of the visit, following a recent incident that had led to environmental adaptions being needed to make it safe. There was a phone booth available, although we were told this was largely redundant, as all prisoners had inbuilt in-cell phones, with each person being able to have up to 20 contacts who they were able to call.

We asked about access to the general prison regime and were advised that prisoners who had spent a prolonged period in the SRU were gradually re-integrated when appropriate, accessing recreation, exercise time and sometimes the recovery café within the wider prison environment. For those not at the stage of being re-integrated into the general regime, we were told there was some access to education; representatives from the education department were able to visit prisoners in the SRU, to explore opportunities available to them and to bring in educational materials as appropriate.

Recommendation 3:
Prison managers should ensure that prisoners in the SRU have at least two hours of meaningful contact each day and access to purposeful activity appropriate to their individual needs. This is especially important for those spending more than two weeks held in conditions of segregation in the SRU.

The SRU was staffed by three prison officers and a manager during the day, with patrol during the night. We found that the staff in the SRU were knowledgeable about those in their care and they spoke positively about the input they received from the mental health team, particularly when supporting individuals with complex mental health needs.

The mental health team held a weekly SRU clinic, run by one of the ANPs, to review prisoners in the SRU who had mental health needs. Individuals requiring enhanced

monitoring or support for their mental health were seen more frequently. The prisoners we spoke with in the SRU told us there was little stimulation and limited human contact or access to the prison regime, with one person explaining "SRU can make your mental health worse…not having company."

The experiences of prison staff were very different between the individuals we spoke with; one felt that staff were supportive and easy to talk to and that they had about an hour of contact with staff each day, while another person had made a number of serious complaints about staff. We discussed these concerns with senior staff on the day.

There was positive feedback about phone access and opportunities to have contact with family, but there was limited access to activity and recreation. Those we spoke with confirmed that they were offered access to outdoor exercise for one hour a day (one person told us they were offered this twice daily) but reported having no access to activity or education. They spent most of the time in their cell watching TV or listening to the radio.

This echoes concerns raised by HMIPS in their report: A Thematic Review Of Segregation In Scottish Prisons, which highlighted the regime and availability of purposeful activity in SRUs as being "too limited and not fit-for-purpose, with prisoners spending 22 hours per day or more alone in their cells with little activity to stimulate them or support their rehabilitation".

The HMIPS report, published in July 2023 and three months prior to the Commission's visit to HMP Edinburgh made a number of recommendations to the Scottish Prison Service for improvement. The Commission fully supports the recommendations made by HMIPS and will liaise with both HMIPS and SPS to seek an update on progress in respect of these recommendations.

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 and that some prisoners struggled with the restrictions placed on their routine.

On this visit, we heard ongoing concerns from prisoners about the length of time spent in their cells. Individuals reported having limited access to work groups, therapeutic groups and recreational activities within the general prison regime. For those experiencing mental health difficulties, and especially those with ADHD who did not have access to treatment, this level of restriction and lack of access to activity and occupation was particularly challenging.

We discussed these concerns with senior prison managers. We heard that staffing challenges had meant that work sheds had been shut, due to many staff being

redeployed to the prison halls. We were told that there had been some improvement in staffing levels, but that there continued to be issues with prisoners accessing time out. This was an area where there was a commitment to continued improvement, particularly as recent staffing pressures eased. We will be keen to review this situation on future visits and note it will be monitored in the interim via HMIPS visits.

Summary of recommendations

Recommendation 1:
Senior health centre managers should review the practice in place for prescribing and dispensing medications, to ensure that the mental health treatment prisoners receive is comparable to that which they would receive if they were not in custody.

Recommendation 2:
Managers should review rule 41 care plans and carry out regular audit and improvement work to ensure these meet the expected standards and reflect the treatment, interventions and approaches being recommended by the health team.

Recommendation 3:
Prison managers should ensure that prisoners in the SRU have at least two hours of meaningful contact each day and access to purposeful activity appropriate to their individual needs. This is especially important for those spending more than two weeks held in conditions of segregation in the SRU.

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 Healthcare 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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