Mental Welfare Commission for Scotland

Report on announced visit to:
HMP & YOI Grampian, South Road, Peterhead, AB42 2YY

Date of visit: 25 June 2024

Where we visited

HMP and YOI Grampian is a high security prison in Peterhead, Scotland. It is the only such facility in the northeast of the country, having replaced the former HMPs in Aberdeen and Peterhead in 2014. Grampian Prison houses male and female adults from the North of Scotland community justice authority.

The Commission was informed on the day of our visit that the prison, including prison healthcare services, had recently undergone an inspection by His Majesty's Chief Inspector of Prisons (HMIPS), jointly with Health Improvement Scotland (HIS) in June 2024. Senior managers from the Aberdeenshire Health and Social Care Partnership (AHSCP) shared with us some of the concerns that had been raised by the inspectors, in particular around prison healthcare. Managers had informed us that prior to the inspection, the AHSCP had set up a dedicated inspection group to look at prison healthcare and that this group would continue to remain in place post inspection as part of an overall service improvement framework for healthcare services in HMP Grampian. Senior managers informed us that a draft action plan had been devised to address the improvements that were needed.

We last visited this service in 2021 as part of our prison themed visit programme, which we reported on here: Mental health support in Scotland's prisons 2021: under-served and under-resourced. A number of recommendations were made to the Scottish Government, NHS Scotland, and the Scottish Prison Service to deliver changes needed to improve services for individuals. The Commission received a response from the service with regards to the recommendations and how the service planned to meet these. As this had been the Commission's first visit since the recommendation made by the themed visit report, we wanted to follow up as to how the service had implemented the recommendations.

Senior managers told us that the AHSCP had recently appointed a lead nurse to work alongside the prison and custody management teams that were hosted in the north partnership location of Aberdeenshire. We were told that the lead nurse worked under the direction and professional leadership of the AHSCP chief nurse, having the responsibility for the standard of nursing practice across prison and custody services in Grampian, with a particular focus on the provision of professional workforce standards and safe, quality care.

Who we met with

We met with seven individuals and reviewed their care records.

We spoke with the healthcare manager, lead nurse, forensic consultant psychiatrist, clinical psychologist, HSCP managers, prison governor, deputy governor, healthcare staff, and Scottish Prison Service (SPS) staff.

Commission visitors

Tracey Ferguson, social work officer

Denise McLellan, nursing officer

Dr Juliet Brock, medical practitioner

What people told us and what we found

Care, treatment, support and participation

The primary focus of our visit was to review the specialist care and treatment provided for individuals who experienced mental health difficulties while in prison. Managers told us that there had been a significant number of vacant nursing posts across the healthcare team for some time and that agency staff were being used.

The healthcare manager told us that the mental health nursing team had consistently being relying on agency staff to fill two posts for the past two years. We were advised that the substance misuse service had two whole time equivalent (WTE) Band 6 nurses, and the primary care team consisted of only 1.6 WTE Band 6 nurse.

We had been made aware of the staffing challenges following our themed visit, and at that time, the service had informed us how they had planned to address this. However, we heard on this visit that they had been unable to recruit to posts and the staffing situation had worsened.

We were informed by the lead nurse that the primary care nursing staff continued to play a critical role at the reception area of the prison, where screening for mental health conditions, learning disability and autism of all individuals was carried out on admission and anyone identified was referred to the mental health team. The nurse would also make links with any of the community teams that the individual was receiving care from.

We were told that individuals were able to self-refer to health care services at any time.

We had noted from the action plan that we received that anyone who required mental health services would be followed up within seven days. However, we were informed that those standards were consistently not met, due to the impact of staffing shortages.

The recent inspection by HMIPS and HIS found that because of the impact of staffing shortages, individuals had to wait a significant number of weeks and/or months before referrals were actioned. We were told at the time of the inspection that there were approximately 150 referrals that had not been actioned, which was extremely concerning.

The AHSCP managers provided us with an update with regards to actions that had been taken since the inspection. We were told that immediate supports were put in place from community mental health services to the prison healthcare staff and that on the day of our visit there were no referrals that required to be actioned by the mental health team. We spoke to one of the community nurses who told us that

three nurses from the community mental health services had continued to provide input to the prison mental health team since the inspection, one day per week. This involved screening, triaging and actioning referrals, along with following up on appointments with individuals on the mental health caseload. We were of the view that prior to the inspection, there appeared to have been no clear triage or processes in place to assess where there was an urgency of need. However, senior managers told us that processes were now being developed in order to improve standards, and that the lead nurse would be taking this work forward with support from senior managers.

Some individuals we spoke with told us that they did not always know what was happening with their referral, but they were able to tell us that they knew they were able to self-refer and how to do this. From discussion with staff, we were told that individuals used to be notified in writing when the referral was accepted however, this had not been happening for some time.

Recommendation1:
Managers must develop a triage system to ensure that all mental health referrals are actioned, and that timely feedback is given to individuals regarding their referral.

One individual told us about medication dispensing errors, where they were given the wrong medication. Managers told us that this was another area that the inspectors raised concerns about which required improvements.

The lead nurse told us that she had completed a training matrix with each staff member to identify learning needs. We were told that the healthcare team had all completed trauma informed training.

Multidisciplinary (MDT) input
Forensic psychiatry input to the prison was provided by psychiatrists from the Blair Unit at Royal Cornhill Hospital. We were told that the waiting time to be seen by psychiatry was approximately two to three weeks for a routine appointment, but an individual could be seen more urgently, if required.

We heard that appointments were mainly carried out remotely via ‘attend anywhere’, but face-to-face appointments were still offered, dependent on the situation. We gained the sense from speaking to staff that psychiatrists were readily available and that there were good links between the services. However, it was also apparent from discussion with staff that there was a heavy reliance on psychiatry input for many of the mental health referrals; it was unclear if this was due to the lack of available nursing staff and available interventions.

Where an individual required support from the substance misuse team, we were told that they were offered a range of addiction services, support and that there were good links with the community addictions services. The health team had dedicated input from a GP, with a clinic which was held daily. We were advised that there was no dedicated pharmacy input to support addiction services in the prison.

There was a clinical psychologist worked in the prison, with additional psychology input from the neuropsychology service, as well as input from older adult services and from the learning disability psychology service. The psychologist told us about the plan to enhance psychological services by using 'Action 15' monies to appoint an assistant psychologist to deliver groupwork. Individuals could also self-refer to the psychological therapies service.

The Scottish Government's Mental Health Strategy 2017-2027 sets out a clear 10-year vision of the approach and improvement needed across mental health services. One of those improvements was for HSCPs to increase access to dedicated mental health professionals in mental health settings including prisons, by using Action 15 monies.

The psychologist told us that they delivered online safety and stabilisation training and were looking to set up a trauma informed training strategy. The psychologist offered reflective practice to prison officers twice monthly.

Individuals who required psychological input received this on an individual basis and some individuals told us about this input. We were advised that the waiting list for psychology input was approximately 16 to 17 weeks and that referrals were discussed at the monthly psychological therapy referral meeting. The psychologist shared with us the information leaflets, including an easy read format, informing individuals who had been referred to psychology of what to expect.

We were told about the weekly MDT team meetings that took place with the mental health and substance use service and that the consultant forensic psychiatrist also attended the meeting. We were told that the staff had regular contact with the forensic psychiatrist and felt able to raise any concerns. The service did not use a specific template to record the weekly MDT meeting, and we were told nursing staff recorded these meetings on daily recording sheets. When we reviewed some of these entries, we saw there was no specific format, and we found that information was limited, with few recorded actions outcomes.

Recommendation 2:
Managers should ensure that there is a robust MDT recording template/format in place that records attendees and provides a detailed account of the multiprofessional discussion, along with recorded action/outcomes.

Transfer of prisoners to NHS inpatient psychiatric care
We discussed the issue of the transfer of individuals who required inpatient NHS psychiatric care. We were told that when an individual required to transfer to a low secure bed, then they would be admitted to the forensic unit at Royal Cornhill Hospital. Managers and the prison governor told us that there had been no significant issues with transfer to this unit and that the communication was good between the prison and hospital staff. We were advised that when an individual was assessed as requiring inpatient treatment in a high secure facility, they would be transferred to the State Hospital.

Liberation procedure
The prison had devised a standard operating procedure that was in place for the liberation of individuals who were deemed to have significant mental health, substance use or primary care input and needs, including liberation from court (virtual court), out of hours and any other unplanned liberations, as well as those who may be deemed vulnerable due to the distance from their home address or having no fixed abode (NFA) to go to. These liberation pathways were to ensure that individuals had the support, including social supports, to maximise their mental health and wellbeing upon release.

Care plans
We were unable to directly gain access to the mental health team's electronic care records on the day of our visit, although we were able to view the care plans and daily recordings for the individuals we met.

We were concerned to find that those individuals did not have a formalised care plan in place. We discussed this with the lead nurse and managers and were told that care planning documentation and processes required urgent improvement, as most of the individuals who were open to mental health services did not have a mental health care plan. For the individuals we reviewed in the separation and reintegration unit (SRU), we found that they did have a care plan, but on reviewing these, we were concerned to find that these were basic, lacked detail and any evidence of review.

We would expect to see that all individuals referred to the mental health team would have a documented mental health assessment and outcome-focused plan of care, underpinned by regular reviews and ongoing discussions with the wider mental health team. Unfortunately, we did not find any specific mental health assessments. In relation to risk assessments and management plans we found that there was no specific documentation in place, and no apparent policies underpinning care planning or the assessment and management of risk, which concerned us.

We were told that individuals with mental health needs faced a long wait and there was a need for formal assessment and improved care plans for all individuals, including individuals who were in the SRU, as these plans did not identify how

individuals would reintegrate back into mainstream prison accommodation. Senior managers told us that the service was currently reviewing the documentation that was used in community mental health services, in order to introduce similar into the prison mental health care service.

The Commission has published a good practice guide on care plans[1]. 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.

Recommendation 3:
Managers should ensure that everyone who has been referred to the mental health team has an assessment in place along with a detailed care plan and ensure that the service has processes in place for regular review and audit of these documents.

Recommendation 4:
Managers should ensure that all individuals who have been referred to the mental health team have a risk assessment in place, along with risk management plan, where necessary and ensure a process is devised for auditing and review.

Recommendation 5:
Managers must devise a standard operational policy which covers processes such as the screening, triage, referral process, care planning, risk assessment and the general provision of mental health care and treatment for prisoners who experience mental ill health.

Rights and restrictions

The Prisons and Young Offenders Institutions (Scotland) Rules (2011) enable individuals to 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 with 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 person to their own cell or placing them in segregation. For people being held in segregation, the Commission supports the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (the CPT) recommendations that all individuals, including those in conditions of segregation, should have at least two hours of meaningful human contact each day and that individuals held for longer than two weeks in segregation should be offered further supports and opportunities for purposeful activity.

From discussions with the managers, the process of reviews for individuals in the SRU and how often they would be seen by the mental health team was unclear.

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

Recommendation 6:
Managers must ensure that each individual who is in separation and reintegration unit (SRU) has an individualised care plan in place that is detailed and regularly reviewed.

Access to Advocacy
The Commission is aware that advocacy will not have a role for everyone however, we consider that access to advocacy could be helpful for those 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.

Independent advocacy can provide support and have a positive impact in establishments where it is used well. The prison healthcare staff had leaflets about advocacy services that were available to the prison, however from speaking to some individuals, they were unable to tell us about this service or even aware that it was in place. We felt that the service needed to promote access to advocacy in the prison service better.

Recommendation 7:
Managers should ensure access to advocacy for all prisoners requiring this support and better promotion of advocacy services within HMP Grampian.

Activity and occupation

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

Although restrictions had lifted, we heard that people were still spending large amounts of time in their cells. One individual who we spoke with told us that the regime was restrictive and that they spent most of the day in their cell, with only one hour each day out with their cell. Managers told us that this was an area of concern due to the increase in prisoners, but no additional prison officers.

The prison had a separate female wing that we visited on the day of our visit. All the women were out on work placements or on activities. Prison officers told us that the women tended to be out of the unit quite a lot and that there were many activities in place. We viewed some of the accommodation on this wing, including the two self-contained, mother and baby flats on the upper floor.

The prison had an outreach team that supported individuals transitioning back to community and some of this work included arranging temporary accommodation, mental health support and attending appointments. We heard from staff that the throughcare support officers made an important contribution to the resettlement of

prisoners in the community and that multi-agency, partnership working was central to the planning for the release of both short-term and long-term prisoners.

The physical environment

Initially, the plan was for the prison to hold male prisoners, female prisoners and young offenders; however, at the time of our visit, HMP Grampian did not hold male young offenders, due to the change in Scottish Government sentencing policy, and the reduction in young offenders at HMYOI Polmont.

The establishment had five main accommodation blocks. Ellon Hall housed male offenders; Banff Hall housed female offenders. Cruden Hall which previously housed male young offenders was out of use. Aberlour Unit housed prisoners who had community access and Dyce Hall was the SRU.

The prison had a purpose-built family centre and help hub located outside HMP & YOI Grampian and supported families affected by imprisonment. The prison offered a wide range of educational opportunities available through the learning centre and workshops.

Any other comments

It was clear on this visit that there had been a significant shortage of mental health nursing input in HMP Grampian for an extended period of time and that this had impacted on the ability to deliver a robust mental health service and healthcare to individuals who required this while in prison.

This service required to implement clear processes and procedures in order to ensure the mental health needs of individuals are addressed while they are in prison.

From the discussions we had on the day of our visit, we felt confident that there will be a strong emphasis on learning and development in the mental health team based in the health centre and that progress, which has already been made, needs to continue. However, the recruitment of the staffing establishment requires to be addressed and the input and oversight of the AHSCP leadership team will be necessary to ensure the ongoing delivery of a safe and effective mental health service which individuals have a right to receive while in prison.

Summary of recommendations

Recommendation1:
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Recommendation 2:
Managers should ensure that there is a robust MDT recording template/format in place that records attendees and provides a detailed account of the multiprofessional discussion, along with recorded action/outcomes.

Recommendation 3:
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Recommendation 4:
Managers should ensure that all individuals who have been referred to the mental health team have a risk assessment in place, along with risk management plan, where necessary and ensure a process is devised for auditing and review.

Recommendation 5:
Managers must devise a standard operational policy which covers processes such as the screening, triage, referral process, care planning, risk assessment and the general provision of mental health care and treatment for prisoners who experience mental ill health.

Recommendation 6:
Managers must ensure that each individual who is in separation and reintegration unit (SRU) has an individualised care plan in place that is detailed and regularly reviewed.

Recommendation 7:
Managers should ensure access to advocacy for all prisoners requiring this support and better promotion of advocacy services within HMP Grampian.

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 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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk