Mental Welfare Commission for Scotland

Report on announced visit to:
The Bella Centre, Community Custody Unit, 81 Ann Street, Dundee, DD3 7TF.

Date of visit: 16 December 2024

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

The Bella Centre in Dundee is one of two female community custody centres (CCU) that have been established in Scotland. Along with the Lilias Centre in Glasgow, it was designed to be a stepping stone between prison and the community, providing safe and secure accommodation for women who would benefit from closer community contact and access to local services as they prepared for their liberation.

The Scottish Prison Service (SPS) women's strategy is founded on the principle that all aspects of care of women in custody should be designed for women and consider their likely experience of trauma and adversities. The CCUs are gender specific and adopt a trauma-informed approach with wellbeing at the core. Drawing on international best practice, this new model of custody aims to increase opportunities for individuals to explore and understand the life circumstances and choices that led them to being in prison. A key aim of this model of custody is to reduce the cycle of reoffending.

The development of CCUs provides facilities for prisoners who are approaching the end of their sentences of 12 months or longer, helping them to better prepare for life in the community on liberation. They rely heavily on collaboration between a wide range of partners to enable an approach that will support the rehabilitative needs of women supporting them to reintegrate back into their communities. The combined resource provides a further 40 low-supervision placements, with increased access to local services and amenities that are geographically closer to individual's original communities and links.

The Bella Centre (Bella) opened in August 2022, a few months before the Lilias Centre making it the first facility of its kind in the UK. It was built in a residential setting in the Hilltown area of Dundee. We were told that when the unit was first proposed there had been apprehension and some local opposition from the community. However, collaboration with external agencies along with support from the appointed member of the Scottish parliament (MSP) had helped to foster positive links with local business and charities.

Bella has a resource hub, administration offices, health facilities and three houses with the capacity to accommodate 16 women. On the day of our visit there were 11 women, with another expected later in the day and a further admission planned towards the end of the week.

The Mental Welfare Commission's themed visit and report *Mental health support in Scotland's prisons 2021: under-served and under-resourced* made 10 recommendations to the Scottish Government, NHS Scotland and the Scottish Prison Service on changes that were needed to improve mental health services across the prison estate. Recommendations included the need for a training analysis

and a training implementation plan to support all staff to feel confident in responding to and having appropriate knowledge of prisoner mental health issues, addictions, trauma and corresponding behaviours. A further recommendation was that SPS and NHS should audit and review the operation of MDT meetings and care planning processes and be satisfied that individual needs and outcomes were being identified, addressed and reviewed for all prisoners experiencing poor mental health.

Who we met with

This was our first visit to Bella having visited the Lilias Centre in Glasgow in April 2024. The primary focus of our visit was to meet with individuals and find out how care and treatment was being delivered to women experiencing poor mental health in the CCU. In addition to speaking to individuals and professionals, we wanted to review the health records of those interviewed.

Prior to our visit we were able to meet with the senior charge nurse (SCN), senior nurse and service manager during an MS Teams call to get an overview of the service. During the visit we spoke with some of the women in Bella, SPS staff and health staff.

Four women were happy to meet with us in an informal group setting in the lounge area of their house and we also had an opportunity to speak briefly with one of them when she was showing us her individual living space and ensuite bedroom.

Additionally, we were given a tour of the facility by staff to get a clearer picture of how it operated on a day-to-day basis. Following this, we reviewed the care records of four people we met.

Commission visitors

Denise McLellan, nursing officer

Claire Lamza, executive director (nursing)

What people told us and what we found

Those that we spoke with told us they had experienced some trepidation about the move and that a change of environment, coupled with regime change contributed to these feelings; we heard from one woman that she had felt “broken and traumatised” by her time at another prison prior to the transfer to Bella. She said this was due to the “noise and being locked up 23 hours a day”. Despite their earlier anxiety, each person told us that they had found the move to be a positive experience for them and we heard “it’s very quiet here, with much more space”.

Some found the support of their peers helpful, and another told us that access to the gym had been beneficial during the transition. We heard from some women that there could be delays in receiving medication where methadone was not always given timeously. Occasionally it was missed, where an individual was transported to court before the nurses had visited the unit to administer it.

The women valued the activities and groups available, and it was evident that they had gained a positive benefit from these when they told us and could show some examples of what they had achieved. We were pleased to see the impact of this on the women’s self-esteem through their engagement with the activity described. As well as enjoying being creative, it was evident that some were able to use these activities therapeutically and how they helped the women stay connected with loved ones, with women telling us of the “opportunities to get support”.

One individual recounted her journey in prison and contact with mental health services including the help she had received and progress made. She was optimistic about being referred to and accepted for a residential substance abuse treatment programme in the coming months. She added that regular family visits had helped to maintain relationships and the environment was more pleasant and calmer.

Contact with visitors could be either in person or by virtual means in the hub, dependent on individual circumstances. We saw positive interactions between professionals and residents and individuals told us they were treated with respect and dignity in this less formal environment.

We heard from some SPS staff that a different NHS staffing model was being provided in Bella in comparison to that with the Lillias Centre. We understood that there had been discussions with SPS and NHS Tayside around the different approach and the inequities between the services; we were advised that Scottish Government had been made aware of this. This main difference with the models were that a health care support worker (HCSW) was based in Lilias over the seven-day period between 8am and 4pm but healthcare professionals providing input to Bella – the primary care team, the addiction staff and a registered mental health nurse - did so by visiting on a daily basis only. We understood from SPS staff that the

Lilias' model would be preferred, as when someone needed support during these hours, they could be seen and referred to mental health nursing for urgent review where required. The health care team for Bella had a different approach and attended Bella when there was a referral with an identified need. We were informed that although there were some differences, what was required had been provided with the daily visits.

We were also told by SPS that there had been no trauma informed training delivered since Bella opened however, the steering group planned to commence this training initially to the leadership team. We have since been advised by NHS Tayside that while NHS staff complete trauma- informed e-learning modules from NHS Education for Scotland, this type of training had been provided for SPS staff prior to the opening of the Bella centre.

We were advised that women were referred to Bella from HMP Stirling and HMP Polmont following a risk and needs assessment appraisal. We also heard that occupational therapy (OT) completed a familiarisation visit for those individuals that would benefit from this and that this supported the assessment of occupational needs prior to transfer. Where identified, input from OT would then continue after a woman was transferred.

The unit provided a low level of supervision for women and young people; many of the individuals had complex needs and experience of deliberate self-harm (DSH). Individuals were encouraged to take responsibility for their own reintegration through community contact and access to local services. Developing independence was critical for successful reintegration and each person was assigned a personal officer for additional guidance and support.

The women were allocated a weekly budget to develop skills in managing meal planning or to help enhance the skills that they may have lost during their custody. They cooked in the communal kitchen of their shared house and were responsible for maintaining a safe and hygienic environment; we heard "food here is great and there are lots of options to cook for yourself". There was unrestricted access to sharp cooking utensils and knives subject to mandatory security checks. Welfare checks were completed four times daily by SPS and we were pleased to hear that there had been no episodes of violence towards others.

The women enjoyed the more relaxed regime and had possession of a keycard enabling them to move freely between the residential area and the hub at the designated times.

Care, treatment, support, and participation

Health care was delivered to the Bella unit by a cohort of NHS staff from prison healthcare that also covered HMP Castle Huntly and HMP Perth and who visit across

the seven-day period. This included occupational therapy (OT), psychology, pharmacy and mental health nurses (RMN). Primary care nurses visited daily and there was input from a trainee advanced nurse practitioner (ANP). A substance misuse caseworker visited weekly to deliver harm reduction education.

At the point of transfer to Bella, this process was undertaken by primary care nursing and included screening for suicidal ideation and deliberate self-harm (DSH), learning disability, autistic spectrum disorder, mental health, medication, physical observations recording, addictions, sexual health and physical health screening. We were advised that any needs that were identified on admission would result in a referral to the appropriate team. In addition to this, we heard that the mental health team also completed any background checks on those individuals who were awaiting transfer into the Bella to ensure there were no immediate or acute concerns in relation to their mental health.

When we visited HMP Stirling in December 2023 we observed this being completed by RMNs, as was the case with other prisons. We were told that when the SPS women's case management board identified individual females that were suitable for transfer, one week's notice was given to the mental health team. Given that transfers were planned with this much notice, we would suggest that this could be coordinated to facilitate an RMN undertaking the assessment, which would ensure an equitable approach.

Referral for mental health care and treatment was based on an open self-referral system for anyone seeking nursing input and they would be referred to an appropriate service depending on need. We were told that the nursing team had links to community services for people being liberated or moved to other services that required ongoing involvement including transfer to hospital or prison.

There was no segregation and reintegration room (SRU) or safe room in the unit and we were told that 'talk to me' (TTM), the SPS suicide prevention strategy continued to be used along with the NHS model of care for anyone experiencing episodes of DSH. We were advised that phase one psychological interventions, such as safety and stabilisation, were offered to help manage complex PTSD symptoms and that there was therapeutic work in relation to emotional dysregulation and anxiety management.

Many of the women had experience of significant trauma. We were told one woman was waiting to see a clinical psychologist for more complex therapy; we heard that this would be available within one month. The collective view was that the women would benefit from additional resources, as although the Scottish Government NHS resource allocated two sessions of psychology to the Bella Centre there was concern expressed that only one session was allocated. We have been advised by NHS Tayside that the clinic held by the principal clinical psychologist at Bella is one

session a week with another for undertaking indirect care duties. Psychological therapies included bereavement counselling, short-term cognitive behavioural therapy (CBT), schema therapy, eye movement desensitisation and reprocessing therapy (EMDR).

We heard that health outcomes for women in custodial settings are poor, with many experiencing illnesses and morbidity as much as ten years younger than the general population. Additionally, here is a high prevalence of mental health problems including DSH and suicidal thoughts in comparison to men in the prison system. Often, women have experienced trauma, domestic violence and substance misuse. Adversity in life such as poverty, relationship difficulties, isolation, lack of education, as well as the impact of being imprisoned can further negatively impact on their physical and mental health. We were pleased to hear there was a drop-in clinic focussing on health promotion and further appointments could be made for any concerns. There was a service level agreement in place for GP provision.

There were weekly in-reach visits from the substance abuse team based in HMP Castle Huntly offering harm reduction education, recovery planning, community referrals, one-to-one support, smoking cessation information and condom provision. The primary care team visited daily to administer some medication prescribed on a supervised only basis. We heard that occasionally there could be delays receiving this medication, especially if individuals had to leave the unit to attend court.

The Scottish Government prison to rehab protocol sets out the process for SPS, residential rehabilitation providers and individuals on accessing the pathway to support individuals leaving custody who would benefit from abstinence-based treatment on release. Funding is provided for residential recovery services across Scotland; we saw information displayed regarding this. We spoke with one woman who had been accepted for treatment.

During our visit, we heard from SPS staff of their concern that further challenges were envisioned as the service at Bella becomes more well established. There was an awareness that individuals transferring into the unit in the future would have increasingly complex mental health needs and concerns that the current level of provision for these needs would not be able to meet them. Relationships between NHS and SPS appeared somewhat strained around these different opinions and this was a concern.

Care records

Health documentation was recorded in the NHS prison service electronic information system ‘Vision’ and we were told that in addition to this system, health care staff could access NHS Tayside’s electronic information system ‘EMIS’ and the clinical portal, to obtain any additional background information that was required.

Unfortunately, the systems were non-interoperable. GPs had access to Vision's functionality in that they could input clinical information onto Vision.

Assessments and letters could be uploaded onto the 'Docman' feature on Vision, however due to a processing backlog, not all information was accessible.

One woman was on a list pending review, and although a referral could be made, there was nothing that indicated current mental health involvement. As screening assessments were not completed by mental health nurses, coupled with the low frequency of RMN visits, we felt that there were risks with women's mental health, given the potential for deterioration during transition periods which we heard about from those that we spoke with, who told us how stressful this could be.

We were told there were no mental health care plans as there was no one assigned to the mental health team caseload on the day of our visit. We were shown a copy of an old care plan written to manage and monitor an individual's medication reduction.

The PT team do not complete care plans, although their plan of care is documented in clinical letters, in keeping with approach used by NHS Tayside PT teams. The psychological therapies team complete risk assessments where required.

For those who were prescribed psychotropic medication, this was managed by the GP for the service and not psychiatry; this is also in-keeping with GP led care in Tayside.

We were concerned to find that individuals did not have a formalised care plan in place when many of them were prescribed psychotropic medication and low intensity psychological interventions. We considered that there should have been care plans to evaluate these interventions and promote a participatory approach to achieving an individual's goals.

Recommendation 1:
Managers should ensure there are person-centred care plans written in collaboration with an individual. They should focus on needs and preferences and have clearly identified goals.

Recommendation 2:
Managers should ensure that care plan reviews are regular and meaningful. They should include summative evaluations clearly indicating the effectiveness of the interventions and reflect any changes in the individuals care needs.

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.

Unfortunately, we were unable to review any recent mental health assessments; we were advised that this was because there had been no recent referrals or assessments for the mental health team. We were made aware that assessment and discharge letters by the PT team are stored in the health care record.

Many of the women had previously had extensive support from mental health services for problems including suicidal thoughts and DSH and we saw some entries where self-referrals had been made to prison mental health care prior to transfer to Bella. After the visit, we heard from the NHS health care team that for any women who had been reviewed by the mental health teams in previous establishments, and who had subsequently been discharged with no further input required prior to transfer to the Bella, no referrals had been received by the mental health teams since the individual's admission to the Bella Centre.

One of the women told us she had previously received compulsory care and treatment under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). We did not see any evidence of regular one-to-one discussion specifically about mental health, despite records indicating that there were women with diagnoses of bipolar affective disorder, personality disorder and historical drug induced psychosis. We heard from NHS staff that as there were no women actively open to the mental health team at the time of our visit, there would not be one-to-one sessions, although individuals could be referred to the mental health team if required.

The Commission would suggest that given where there has been input, past and current, as a result of the women's mental health, that more preventative engagement should be considered, particularly around the times where reviews and plans for liberation are taking place.

We did not see any contact with family or carers nor find documentation to indicate consent had been withheld.

There was evidence of GP consultations for chronic conditions and gynaecological investigation; this included cervical and breast screening as well as perimenopausal symptoms. There were referrals to specialist services such as SPHERE bladder and bowel service for menopause related problems such as incontinence and prolapse. Bloods would be obtained by the local phlebotomy service with a GP request and attendance at this clinic was facilitated by SPS escorted visits where required.

For one person, treatment of blood borne virus (BBV) that had commenced in HMP Stirling was ongoing. There was also access to community optometry and dentistry. Additionally, many of the women had ongoing treatment for substance misuse and were prescribed opioid replacement therapy (ORT). The substance misuse SCN had made referrals to psychology for individuals with experience of trauma.

The OT was involved with one individual experiencing pain and reduced mobility, and we saw assessments and referrals for equipment such as alarms for falls, an accessible toilet and referrals to physiotherapy and the gym. There were further assessments of occupational need recognising the necessity for meaningful activity to help people adapt to their new environment and progress with rehabilitation.

Multidisciplinary team (MDT)
We were told that the team was nurse led for mental health care and treatment and the senior charge nurse (SCN) of the health care team was an RMN. A consultant forensic psychiatrist from the medium secure unit in Perth visited monthly. An RMN met with the psychiatrist monthly however, we would not consider this to be an MDT meeting given the lack of involvement of other health disciplines, such as OT, psychology, substance misuse team, physiotherapy and pharmacy. We were advised after the visit that NHS clinicians meet to discuss medical markers for those in Bella on a monthly, or as needed, basis. The MDT regularly communicate on an informal basis and will discuss any issues or concerns in a timely manner. If there is involvement of other disciplines with one of the women who is on a caseload, and where they have given consent, information is shared to support joint working for the individual.

Multidisciplinary care delivered in this way seemed fragmented and reduced opportunities for improved communication, collaboration and a holistic approach to health outcomes. Primary care nursing staff from the prison service visited daily to administer controlled drugs. Individuals could also access the local GP service either by telephone consultation or appointment at the GP clinic if indicated. It was unclear how frequently individuals were reviewed and discussed and there did not appear to be regular input from social work or housing providers.

Recommendation 3:
Managers should ensure a more collective and collaborative approach to influence decision making to maximise outcomes for those receiving care and treatment.

Use of mental health and incapacity legislation

On the day of our visit no individuals were subject to the Mental Health Act or the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act).

Rights and restrictions

We discussed access to independent advocacy services for individuals who may become subject to mental health or incapacity legislation. The Commission is aware that advocacy will not have a role for everyone however, we consider that access to this could be helpful for those prisoners who are potentially being transferred to a hospital from custody under the Mental Health Act or the Criminal Procedures (Scotland) Act 1995.

Independent advocacy can provide support and have a positive impact in establishments where it is used well. Prisons in the NHS Tayside area do have access to several independent advocacy services in the Dundee, Angus, Perth and Kinross areas but we were told that this had been overlooked when establishing Bella. Managers agreed to address this deficit.

Recommendation 4:
Managers should ensure access to advocacy provision within the Bella Centre for all prisoners requiring this support is equitable with other custodial settings.

The women told us that they benefited from increased freedoms that the unit afforded and although they were still in custody, this felt less institutional. They had access to designated areas at set times which was managed by electronic swipe cards. This enabled more freedom of movement in the unit, allowing unimpaired access to facilities in the hub, as well as access to the enclosed garden area. SPS also used this system, and the lack of traditional keys was viewed as positive in terms of their symbolisation.

Some individuals had community access and work placements in preparation for their liberation and ingress and egress was managed by SPS to ensure safety and security was maintained.

Activity and occupation

We were pleased to find a wide variety of activities offered in the unit and there was a focus on learning skills supported by the Community Justice partnership and Dundee health and social care partnership (HSCP).

There were links to education delivered by Fife College, vocational courses, support groups and chaplaincy arrangements available. Local charities involved included arts projects such as 'shaper caper Dundee,' jewellery making classes from Dundee Community Craft and RecoverZine the recovery focussed magazine facilitated by Dundee volunteer and voluntary action.

In addition to SPS providing a weekly budget to the women to purchase groceries and cook their own meals, a local chef visited the centre weekly to support additional skill acquisition. One individual told us that their personal officer had successfully matched her with a community arts group and that another had identified a work placement in a local garage. Other women spoke proudly of items they had made in the jewellery making group. The purpose of these activities is to teach participants skills whilst promoting recovery and supporting their mental health and wellbeing.

Other opportunities in the unit comprised of family visits and there was also a residents weekly community group. There was a plentiful supply of jigsaw puzzles, DVDs and reading resources available as well as a gym, yoga studio and laundry.

The physical environment

The centre is situated in the heart of a small residential community and although there were necessary security features, these were not overtly intrusive. There were no bars on windows or high walls and the perimeter fencing was sympathetic to the environment. The addition of a landscaped forecourt made it less conspicuous in the surroundings and it was designed to blend into the local community. The design gave a sense of a small community connecting with a wider one.

Comprising of a central hub building, an administration suite with housing leading off from it, Bella felt more akin to modern housing than a traditional custodial setting. Individuals could meet visitors, participate in educational groups and access a range of activities and local services to help them develop skills and support networks necessary for successful reintegration. The unit also provided facilities to enable virtual visiting where in person visits were not possible. We were shown the housing area, gym, yoga studio and health assessment facilities, including the dispensing and treatment rooms.

The buildings were of a modern design and the use of large windows and high ceilings in the hub promoted natural light and a sense of airiness and calm. It was a non-smoking environment, but the women could use vapes or be prescribed nicotine replacement therapy (NRT) if they chose.

The brightly coloured furnishings and décor were in a good state of repair as was expected for a new building. The hub facility enabled contact with peers from the different houses and we saw an 'affirmation station' with numerous positive supportive affirmations written by the women.

Each house comprised of individual bedrooms which were comfortably furnished with sufficient storage including a wardrobe and drawers. The bedrooms had en-suite shower facilities which were ample in size. The bedroom we viewed was personalised with pictures and photographs and had fresh décor and curtains. There was a television and a small safe to store valuables and medication where required. Individuals had their own key card individually programmed to allow access to their own room as well as communal areas within set times.

The women cooked in the communal dining kitchen and socialised in the adjoining lounge. As well as cooking, they were responsible for cleaning, which we observed to be of a high standard and could sense the pride they took from caring for their environment. There was a garden space to hang washing out for each of the houses and additionally, the houses had an annexe for people with disability including wheelchair access. The annexes could also be used as mother and child facilities.

Bella benefitted from landscaped communal grounds which included a play park area for family visits. There was plentiful seating and bedding plants to soften areas

but given that some of the young plants had still to be established we felt there was a lack of privacy from the houses bordering the garden. Overall, it appeared to be a nurturing and comfortable environment.

Any other comments

We were pleased to note the optimism of people who told us they found this new model of custody to be a positive experience. There was a sense of confidence from them as they were being supported to accomplish reintegration into the community which differed to their previous experiences.

We saw people being treated with dignity and respect and it was evident staff were invested in nurturing a culture of encouragement and commitment to achieve this outcome.

There was a noticeable tension arising from the different perspectives about the service being delivered to SPS by the NHS; there was a different expectation on the part of SPS as to what the NHS should provide. For Bella, the NHS worked on a referral basis, whereas SPS were of the view that this should focus on a service provision where there was more of a health care presence in the unit.

This was our first visit to Bella, which as a service was still in its relative infancy. We are aware it can take time to resolve challenges and agree direction to achieve the most satisfactory health outcomes for individuals. We are interested to know how these differences will be resolved and will continue to monitor this.

Summary of recommendations

Recommendation 1:
Managers should ensure there are person-centred care plans written in collaboration with an individual. They should focus on needs and preferences and have clearly identified goals.

Recommendation 2:
Managers should ensure that care plan reviews are regular and meaningful. They should include summative evaluations clearly indicating the effectiveness of the interventions and reflect any changes in the individuals care needs.

Recommendation 3:
Managers should ensure a more collective and collaborative approach to influence decision making to maximise outcomes for those receiving care and treatment.

Recommendation 4:
Managers should ensure access to advocacy provision within the Bella Centre for all prisoners requiring this support is equitable with other custodial settings.

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 an individual's care, treatment, and support are 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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