mental welfare
commission for scotland

Mental Welfare Commission for Scotland

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

Date of visit: 26 November 2025

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

HMP Edinburgh is a large prison, receiving prisoners mostly from courts in Edinburgh, the Lothians and Borders, and from Fife. The design capacity of the prison is 870. At the time of this visit we were told the average population was 930.

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 Commission's last local visit to HMP Edinburgh was in October 2023 and we made recommendations at that time in relation to the prescribing and dispensing of medications, care plans for prisoners subject to restrictions due to their mental health, and the provision of meaningful contact and purposeful activity for those held in segregation in the separation and reintegration unit (SRU).

On this visit, we wanted to review the current mental health care and treatment provided in the prison, including the care of prisoners with mental health difficulties who were being held in conditions of segregation.

Who we met with

We met with, and reviewed the care of seven people, all of who we met with in person and reviewed the care notes of. No relatives requested to speak with us on the visit.

We met with the service manager, the senior charge nurse, the consultant clinical psychologist and other members of the mental health team, as well as prison officers, members of the SRU staff team and with the prison governor and their deputy at the end of the visit.

Commission visitors

Dr Juliet Brock, medical officer

Lesley Paterson, senior manager (practitioners)

Justin McNichol, social work officer

What people told us and what we found

We received mixed feedback from the prisoners we spoke with about their experience of mental health support. Some individuals praised the mental health team and the support they had received and gave very positive feedback about their experiences.

Others told us they had had limited benefit from the team's input. This was particularly in relation to their requests for specific medications not being met.

Those we met with did not appear to be aware of their mental health care plans.

When we asked about individual experiences of the general prison regime, again we received mixed feedback. Some spoke positively about their experience and particularly about the support they received from prison staff.

Care, treatment, support, and participation

The mental health team told us that that the demand for health services had increased in response to changes in the number of protection prisoners at HMP Edinburgh (reported to be around 40%). This had meant an increase in the numbers of older prisoners, who generally had higher levels of medical co-morbidity and greater health support needs; this included prisoners with a diagnosis of dementia.

We heard that one of the mental health nurses had an interest in dementia care and had been liaising with other prisons about care pathways for those with the condition. We were told that wider work was underway to develop a dementia pathway for prisoners in Scotland, but that this was still in progress.

At the time of the visit, prison psychiatrists referred individual cases to local specialists in older adult mental health care for diagnosis and advice.

For prisoners who were more physically frail and had care support needs, we heard that staff from a local care agency provided individual support for daily personal care where needed.

We were told that the waiting list for the mental health team had increased, along with the increase in demand. The health team said that this had led to a pressure in delivering services, particularly as protection and non-protection prisoners could not be mixed, so separate clinics had to be held for the different populations.

At the time of our visit, there were two separate waiting lists for the mental health team, with protection prisoners waiting two to three weeks to be seen and mainstream prisoners waiting an average of four weeks.

Mental health referrals could be made by prisoners themselves, by prison officers or any other professionals. We heard that the self-referral process had been improved

and simplified, using an accessible-read format to support those with literacy needs. The triage process remained unchanged. Referrals were reviewed daily and any urgent referrals were prioritised, whereas routine referrals were added to the waiting list.

When prisoners first arrive at HMP Edinburgh, they are seen by primary care staff at reception for initial health screening, then reviewed the following day by either the prison GP or an advanced nurse practitioner (ANP) in the custody clinic. The clinician can then review the initial screening information and where appropriate, access the local NHS electronic record system TRAKCare (for those from Lothian).

Clinicians also have electronic access to a person's emergency care summary (ECS) from their GP practice, which should confirm their medical history and current prescribing. Ongoing prescriptions are then provided by the GP or ANP.

If mental health concerns are identified either at the reception screening or the following day's clinic, an urgent or routine referral can be made to the mental health team.

If there are immediate concerns about a prisoner's risk of self-harm or suicide, they are placed on 'Talk to Me', the SPS suicide prevention strategy. This 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.

One person we spoke with had been placed on 'Talk to Me' observations when they felt suicidal but said they had not felt this was helpful and described experiencing this as a "box ticking" exercise.

When we last visited, concerns were shared by both prisoners and staff about the dispensing of medication in the prison. At that time, nurses carried out medication rounds twice a day, the first round often being late morning, with the second taking place mid-afternoon. This had presented difficulties for those taking twice daily medication (with doses prescribed 12 hours apart), were sometimes receiving treatment with only a four-hour window between doses. This had the potential to both reduce the effectiveness of medications and to cause negative effects. We also heard from prisoners who had received sleeping tablets mid-afternoon, 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.

The mental health team and managers acknowledged these difficulties at the time, which were primarily due to staffing shortages (experienced by both SPS and the

primary care team). A significant review was underway to look at increasing ‘in-possession’ medication for prisoners. This was where 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. This work continued following our visit and was further detailed in the action plan provided by the service.

On this visit we heard there had been challenges to fully progressing this work due to a significant gap in pharmacy provision for an extended period (despite five attempts to recruit). Non-medical prescribers had however been continuing the work during this period.

We were pleased to hear that a new lead pharmacist had joined the team on secondment and that work towards wider use of in-possession medication for up to 28 days had begun. An accompanying policy, a standard operating procedure and risk assessment documentation for this process was being developed.

We heard from prisoners and staff that substance misuse in the prison remained a significant concern, with spikes in mortality due to psychoactive substances. Actions had been taken by the prison to address the risks posed by illicit substances, including investments in window grills to reduce the flow of incoming substances and bans on certain types of vapes to prevent tampering.

We were advised there had been a steady reduction in medical emergencies related to drug intoxication, but this remained a significant area of ongoing challenge.

Multidisciplinary team (MDT)
The prison health service was led by a healthcare manager, with a senior charge nurse responsible for the mental health team.

We were pleased to hear that there were no staffing issues at the time of this visit. The mental health team comprised of six Band 6 nurses. There were also two specialist learning disability (LD) nurses who worked jointly with the primary care team, although due to long term absence only one LD nurse was available to support the team at the time.

We noted the development of several accessible read documents for prisoners as a result of this specialist input. The team were supported by an ANP who also worked in HMP Addiewell.

The prison addictions team comprised of three Band 6 nurses and two Band 5 nurses. Although separate, the mental health team and addictions team worked closely. Mental health nurses were available in the prison from 7am to 5pm on weekdays. Emergency mental health input for out of hours, including evenings and weekends, was provided by the primary care team.

At the time of our visit, there were weekly visits from a consultant forensic psychiatrist, with additional support from two forensic psychiatry higher trainees. Previously, there had been additional sessional input from a psychiatrist with expertise in addictions and a specialist interest in attention deficit hyperactive disorder (ADHD) and autistic spectrum disorder (ASD), who ran a clinic on a fortnightly. Following their retiral, this input had ceased, although there was ANP support that continued running the ADHD clinic, with higher trainee medics seeing new referrals. We heard from the team that there were still issues with access to ADHD medication.

There was no mental health occupational therapy (OT) input following a vacancy. Previously there had been two OTs in post and we heard on the last visit that they were providing vital support, particularly in helping prisoners with mental health difficulties to structure their day and engage in activities. The posts had been funded by money linked to Action 15 of the Scottish Government's Mental Health Strategy 2017-2027. Managers told us that OT provision was an acknowledged gap that was under review.

We were pleased to hear that clinical psychology support was ongoing, with a focus on individual and group work, as well as supporting the mental health team with formulations.

Recent difficulties with pharmacy support were highlighted as above. We were pleased to hear that this had improved, following the recent secondment of the lead pharmacist on a part-time basis, as well as recent restructuring of the service to include three Band 3 pharmacy support workers.

Physical health care was provided by primary care nurses and GPs. Following previous challenges in GP recruitment, it was positive to hear that three new GPs were in post, with GP cover available every day.

MDT meetings were held on a weekly basis with psychiatry, nursing and psychology input. Weekly 'persons of concern' meetings also continued to be held jointly by NHS and SPS staff. We heard that these remained important forums to discuss those prisoners who were at risk.

Care records

Day-to-day health records were stored on VISION, the electronic record system used across Scottish prisons. We found that the recorded contact from the mental health team provided summaries that were brief, although contained key information; assessments by psychiatry and psychology were more detailed.

Mental health care plans were stored separately from VISION records. The mental health care plans we viewed were person-centred, of a good quality and were audited

regularly. Some care plans were signed by the individual, however we considered that participation in care planning could have been improved and better evidenced.

We found Rule 41 care plans in place for those subject to restrictions under this prison rule[1].

Risk management plans were available and regularly reviewed in the cases we looked at, with evidence of case conference discussions with SPS colleagues for individuals who had been subject to 'Talk to Me'.

We noted MDT meetings were documented, with evidence of discussion, although the recording of outcomes and action plans could have been clearer.

We noted that for one person we reviewed, who was subject to welfare guardianship, there was evidence of good contact between the mental health team and welfare guardian regarding care and treatment decisions.

Rights and restrictions

We found there was good access to independent advocacy. The prisoners we met with knew about advocacy support and how to access this.

We were pleased to note the progress made with accessible information for prisoners. The new form for self-referral for health appointments had received positive feedback since its introduction.

Peer support was another area of focus in the prison, with the consultant clinical psychologist supporting the development of peer support networks. This meant that there was informal support available for those experiencing difficulties, such as anxiety or coping with bad news, while in custody.

We were told about the recent appointment of mental health ambassadors, as well as the development of the wellbeing network in the prison. Support from agencies such as the Samaritans and Breathing Space was also accessible to prisoners confidentially via in-cell phones. Spiritual support was available via the chaplaincy service and individual prisoners gave positive feedback about their religious needs being met.

When prisoners had concerns, the prison complaints system was in place. We had heard on previous visits that there was a lack of confidence in complaints being

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[1] 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.

processed or responded to. It was therefore positive to hear that a new complaints procedure was being rolled out in HMP Edinburgh, with a simplified form supported by accessible read information.

We heard that confidential complaints boxes had also been installed, with good uptake. The prison governor advised there had been a reduction in complaints about missing prison complaint form (PCF1) forms. We were told that complaints statistics were reviewed at monthly business meetings to look at the top five topics of complaint each month and over the year. Work was also being undertaken with newer prison line management staff in how to manage complaints. We did continue to hear concerns from prisoners about the handling of complaints with comments such as “you don’t hear back, they just put them in the bin”.

The Governor hoped that responsiveness to individual complaints would be further improved in the future when in-cell technology allowed prisoners to complete forms electronically. HMP Edinburgh had completed the infrastructure of installing data cables for in-cell technology throughout residential areas, although the introduction of this technology in the prison, and across most prisons in Scotland, may be some way off, with centralised funding likely to be an ongoing challenge.

The mental health team told us they also reviewed themes emerging from the complaints they received. Over 90% of complaints related to medication, often when requests for psychotropic, sedative or strong pain medication were refused. We were told that the scrutiny of complaints data had helped generate improvement and change.

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

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)
We took the opportunity to visit the SRU, to speak with staff team and to meet with the three prisoners there who were receiving support from the mental health team. The SRU has 14 cells, all 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, as well as an indoor gym with exercise equipment. 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 found that the SRU staff were knowledgeable about the individuals in their custody who had significant mental health difficulties and demonstrated a compassionate approach.

The team were committed and considerate about how best to support to their most vulnerable prisoners. We heard that the SRU team felt well supported by health staff, with daily engagement from either primary care or mental health nurses. Some of the individuals we met with in the SRU were highly distressed, with significant support needs.

Prison officers had to provide encouragement and a high level of input just to support these prisoners to maintain their basic needs, such as nutrition and self-care. The prisoners we spoke with in the SRU told us they were treated well and that prison officers were approachable. We heard that people also experienced good support from the mental health team.

One person told us that he asked SRU staff to phone the mental health nurse if he was having difficulties, and that someone would come whenever needed. We also heard positive feedback from prisoners in the SRU about support from psychology.

Prisoners in the SRU felt able to have contact with family by phone or through visits. Engagement in meaningful activity was however more difficult, particularly for those who were not at the stage of being re-integrated into the general regime, with access to education and the wider prison regime being limited.

We heard that individuals were able to access educational materials on request and that they had recently started recovery sessions for SRU prisoners. One person we spoke with had applied to work in the recovery café.

Transfers for inpatient mental health care

The Commission has raised repeated concerns about delays in the transfer of mentally ill prisoners requiring inpatient care, due to limited bed capacity in the forensic mental health estate. At the time of this visit two prisoners were awaiting transfer to hospital. The senior charge nurse completes monthly statistics on hospital transfers for the Forensic Network's ongoing data collection in this area.

Activity and occupation

We heard mixed feedback about activity and occupation from those in prison halls. Some shared concerns about the length of time spent in their cells, with complaints of being "locked up for 22 hours a day".

Between the hours of 9am to 12 midday and from 1pm to 4pm, some prisoners had access to education, work placements, gym sessions or therapeutic activities. Those that did not, remained in their cell. Some prisoners said they spent most of their time in their cell watching TV. From others, we heard there was good access to gym facilities and education.

Some individuals were involved in work programmes in the prison and gave positive feedback about their jobs. One young prisoner we met with told us they had applied for educational courses and the recovery café, telling us "I want to have a constructive time in here and have something to show for it".

We were told about a range of additional activities available at the HIVE, a health and wellbeing space, with a programme of sessions including breathing groups, yoga and acupuncture. Therapy dogs were also a popular initiative.

We heard that access to education and activities could be limited at times due to prison numbers and challenges with staffing. Staff also told us that due to the prioritisation of education and health clinic appointments, sometimes there were insufficient staff to enable activities to go ahead. We heard from prisoners that sometimes activities and gym sessions were cancelled due to staffing issues.

The activity building had capacity for 240 prisoners, less than a third of the population in the prison.

We discussed these concerns with the senior management team at the end of the visit. It was explained that even if every activity offered was open and running at full capacity, there was not enough space to offer this to everyone. It was acknowledged that there was an ongoing challenge with equity of access to activities, particularly in view of the population mix, including remand prisoners.

Summary of recommendations

The Commission made no recommendations; therefore, no response is required.

Service response to recommendations

Although no recommendations were made, we would like to hear about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved and will follow up with the service accordingly.

A copy of this report will be sent for information to HM Inspectorate of Prisons.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether 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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