

Who we are and what we do

The Mental Welfare Commission (MWC) is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health and incapacity law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have worked in healthcare, social care or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should:

- Be treated with dignity and respect;
- Have the right to treatment that is allowed by law and fully meets professional standards;
- Have the right to live free from abuse, neglect or discrimination;
- Get the care and treatment that best suits his or her needs;
- Be enabled to lead as fulfilling a life as possible.

Our work

- We find out whether individual treatment is in line with the law and practices that we know work well.
- We challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care.
- We provide advice, information and guidance to people who use or provide services.
- We have a strong and influential voice in how services and policies are developed.
- We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

Our visits

One of the ways in which the Commission monitors individual care and treatment is through our visits programme. We visit people in a range of settings throughout Scotland: at home, in hospital or in any other setting where care and treatment is being delivered. This themed visit was focused on the support and treatment that prisoners with a mental disorder receive in the Scottish Prison system. The aim of national themed visits is to enable us to assess and compare care and treatment for particular groups of people across Scotland. Our aim is to help services learn from good practice and to respond to any issues that are identified. This report details our findings from our visits to all 15 Scottish Prison establishments which took place between January and March 2011.

Why we visited

At the time of our visits mental health services in prisons were provided by the Scottish Prison Service (SPS). This situation was about to change in the autumn of 2011 with local NHS services taking over the responsibility for prison health care. We felt it important to establish a baseline with regard to the services being provided so we can assess the impact of the changes to service delivery for prisoners with mental disorder in the future.

Official statistics on mental health problems in prisons are patchy, but the fact that UK prisons have a much higher rate than the general population of people with a mental disorder has been well documented. Many prisoners have a combination of mental health and other social problems, frequently related to the difficulties they have faced in their lives prior to offending. In his 2008 'Out of Sight' report¹, the Chief Inspector of Prisons for Scotland reported that "a very large number of prisoners have a mental health problem with around four and a half percent experiencing severe and enduring mental health problems." This is likely to be a conservative estimate as the Sainsbury Centre² for Mental Health has recently estimated that about eight percent of the prison population suffer from the most severe mental disorders of schizophrenia and psychosis. The situation regarding very high levels of self harm in women's prisons is also a major concern.

The focus for our visits was not about whether these people should be in prison but about the care and treatment they receive. The services prisoners receive in prison have a big impact on the individual's capacity to recover.

¹ <http://www.scotland.gov.uk/Resource/Doc/244128/0068210.pdf>

² http://www.centreformentalhealth.org.uk/pdfs/briefing_39_revised.pdf

How we carried out the visits

Following a meeting in October 2010 with senior managers in the SPS we wrote a preliminary letter to the establishments we planned to visit. On their advice, Castle Huntly and Noranside Prisons were regarded by us as one prison, the HM Prison Open Estate, as they have been integrated as a single establishment and share the same mental health service. We then wrote to all 15 prison governors in order to ascertain basic facts about the mental health facilities in each prison and to identify key contacts for the visits. From this information we set up our programme of announced visits to each of the Scottish prisons, specifically requesting to see:

- Prisoners with a diagnosis of mental illness, learning disability or other mental disorder who asked to see us;
- Prisoners who regularly use the prison mental health services;
- Prisoners who had been subject to a Transfer for Treatment Direction (TTD and who had subsequently been returned to prison);
- Prison health care staff involved in delivering services to prisoners with mental health difficulties.

Each prison was visited by between two and four MWC visitors depending on its numbers of prisoners. We were able to speak with a variety of health care staff and managers in all the Scottish prisons as well as 101 prisoners. We collected our information systematically using semi-structured interviews. We also gathered information from healthcare records, from speaking to staff and observing the health care environments.

Profile of the people we saw

Of the 101 prisoners who agreed to speak to us, 12 were on remand, 28 were short term (sentenced for up to four years) and 61 were long term prisoners, of whom 25 had life sentences.

We met an average of seven prisoners per prison – actual numbers ranged from three to fourteen.

Five of the prisoners we met were in Cornton Vale; these were the only women prisoners we interviewed.

The majority (64%) of prisoners we met were aged 25-44. Fifteen percent were younger than this and one prisoner was under 18. The age spread was similar for men and women.

A third of the prisoners we met had been in custody for four years or more at the time of our visits. Twenty nine percent had been in for less than six months. The remaining twenty eight percent had been in custody for between six months and four years (this information was missing for six prisoners). More details of demographics of prisoners seen are in the tables in Appendix 1.

What we examined

We focused on the following areas when we carried out our visits:

1. Prisoners' experience of mental health services on coming into prison.
2. Prisoners' experience of mental health services while in prison.
3. Nature of prison mental health services.
4. Who is providing help for prisoners with mental health problems.
5. Managing seriously and acutely mentally ill prisoners.
6. Support for prisoners with learning disabilities.
7. Care planning, coordination and review.
8. Leaving prison.

Summary of findings and recommendations

The experience of prisoners with mental health problems was very variable, many had good experience of services but others had very different stories to tell. Just over half (55%) of the prisoners we spoke to had negative comments about support received for their mental health difficulties while in prison; experiences seemed to vary even within the same prisons.

We found many positive aspects to the care and treatment of prisoners with mental health problems in Scottish prisons, including:

- Many prisoners spoke very positively about the mental health services they received in prison.

- We found that a number of prisoners were getting better access to a psychiatrist in prison than they were in the community.
- Several prisoners reported that due to regularly receiving medication their illness was more controlled.
- A lot of prisoners spoke very favourably about their contact with mental health nurses and psychiatrists.

The major issues raised with us were:

- Delays and difficulties in accessing mental health support;
- Problems in relation to getting medication;
- Lack of specialist help (counselling, therapy and therapeutic programmes);
- Poor response from staff, primarily due to lack of mental health nurses.

Prisoners generally thought these issues impacted negatively on their mental health problems and caused them to suffer needlessly.

We are aware of the very particular difficulties of the prison setting and the potential anger and resentment prisoners may feel towards all prison services. There are also particularly difficult issues about medication in a custodial setting.

Prisoners, however, do have a right to receive good health care, including mental health care, and many of their experiences should help inform prison and health care managers as to how to improve services for other prisoners.

We have developed the following key messages so that the Scottish Prison Service (SPS) and NHS Boards can use them to consider the care they provide and make improvements where necessary.

Key message 1

Prisons should have staff and facilities in place that are able to support prisoners with a wide range of mental health difficulties.

To address this, SPS and NHS Boards should:

- Ensure that prisons have a sufficient complement of registered mental health nursing staff available to meet the needs of their prisoner population. Prisoners need to be able to access help for their mental health problems from trained health staff with the appropriate understanding of mental illness in the same way as treatment would be provided in cases of physical illness.
- Audit and review the operation of Multi Disciplinary Mental Health Teams (MDMHTs) and provide clear operational guidance on their role, process and function.

SPS needs to review its health centre facilities to consider the needs of prisoners with mental health problems. There requires to be sufficient interview rooms to allow prisoners to talk about their issues and appropriate space to deliver therapeutic activities.

Key message 2

Prisoners are particularly vulnerable in the early days of their time in a prison. Skilled staff with knowledge of mental health issues need to be involved from the start.

To address this, SPS and NHS Boards should:

- Improve targeting of registered mental health nurse (RMN) cover at times prisoners are being received into prison.
- Establish at reception interviews whether the new prisoner was receiving care for mental health difficulties from their GP or mental health services prior to custody.
- Ensure protocols are in place to address issues regarding changes in treatment and delays in receiving medication.

Key message 3

Support for people with mental health difficulties needs to be about more than just medication alone. There needs to be a fuller range of supports available and facilities for them.

To address this, SPS and NHS Boards should:

- Audit the availability and use of 'therapeutic activity' for prisoners with mental health problems. A sustainable strategy needs to be developed for such an important aspect of intervention.
- Ensure improved and consistent access to psychological interventions for prisoners with mental health needs. Access to psychological interventions has become an important part of mental health care in the community and should be more available in prison.

- Establish a stepped care approach to mental health care in prisons encompassing mental health promotion, self help options, therapeutic activities, psychological interventions and use of medication.
- Challenge stigma and discrimination in relation to prisoners with mental health problems at all levels.
- Raise access to advocacy with NHS Boards and local authorities for their area and ensure that advocacy services are promoted for prisoners with mental health problems or learning disability.
- Address the issues raised by prisoners in relation to the prison 'Listener Services' and review the operation of these services.

Key message 4

There needs to be a more direct involvement from disciplines beyond the prison health centre in supporting prisoners' mental health issues – we saw little evidence of multidisciplinary working.

To address this, SPS and NHS Boards should:

- Ensure that supporting prisoners' mental health is the responsibility of all disciplines within the prison. There are many professionals working in prisons who could contribute to better mental health care for prisoners. Current contracts appear to be very constricting in terms of addressing wider mental wellbeing for prisoners.
- Address the issue of lack of specialist help identified by many prisoners.
- Ensure there is a clear training strategy in relation to mental health knowledge and awareness required for front line staff in the prison. This then needs to be implemented and monitored.

Key message 5

Prison is not the place for seriously and acutely mentally ill prisoners.

To address this, SPS and NHS Boards should:

- Ensure that there are protocols and policies in place to make sure that seriously and acutely mentally unwell prisoners are moved quickly to be treated in a hospital setting.
- Review the appropriateness of any facilities used to accommodate prisoners with mental health problems as to suitability and purpose.

Key message 6

People with learning disabilities are very vulnerable in prison. They are likely to have difficulty understanding and adjusting to the complex rules and regimes of prison and will require extra support. There need to be systems in place to identify prisoners with a learning disability, help for prison staff in relation to communicating with prisoners with a learning disability and an understanding of the support needs of such prisoners.

To address this SPS and NHS Boards should:

- Ensure that interventions in prisons should be focused on improving ‘choice, control, and participation’ for prisoners with learning disability as emphasised by the Disability Rights Commission (2005)³. This requires the ability of trained staff to identify these prisoners’ needs and support to address them.
- Ensure that the new guide ‘People with Learning Disabilities and the Criminal Justice System’ (Scottish Government 2011)⁴ is available to front line prison staff.

Key message 7

Where mental health difficulties are identified, a specific care plan detailing support should be in place.

To address this, SPS and NHS Boards should:

- Ensure clear guidance and documentation are available to prison managers and health centre staff with regard to the care planning and case management of prisoners receiving mental health care in prison.
- Ensure clear guidance is available for staff in relation to keeping MDMHT records and that records of individual discussions with regard to each prisoner are included in the personal health records for that prisoner. This is likely to be a part of the audit and review of the operation of MDMHTs which is an action recommended to SPS and NHS Boards under key message 1.

Key message 8

Most prisoners return to their communities on release from prison. Proactive contact with community services can help maintain mental wellbeing and reduce the risk of reoffending.

To address this SPS, NHS Boards and Local Authorities should:

- Ensure they have protocols in place for the exchange of information on patients and prisoners to enable good communication and liaison between prison and community services in their areas.

³ http://www.leeds.ac.uk/disability-studies/archiveuk/DRC/Changing_Britain_for_Good.pdf

⁴ People with Learning Disabilities and the Scottish Criminal Justice System

Key message 1

Prisons should have staff and facilities in place that are able to support prisoners with a wide range of mental health difficulties.

What we expect to find

We would expect that the care prisoners with mental health problems receive whilst in custody would be the same as, or equivalent to, the care they would receive in the community.

This should apply to identification and diagnosis of the problem, treatment and care whilst in prison, and consideration of the prisoner's needs on release.

What we found

A. Staffing

In each of the prison health centres we visited there were registered mental nurses (RMNs) providing most of the direct services to prisoners with mental health difficulties. The level of RMN staffing varied considerably between the prisons. Smaller prisons generally had one RMN (or at least a 'share' of one), with larger prisons having three or four RMNs. Cornton Vale with six RMNs had the largest complement of any service, but this was primarily due to the high level of mental health issues among women prisoners and their involvement in reception for new prisoners. Prisons with one or fewer whole time equivalent RMNs were particularly vulnerable in situations where staff move to other posts or are on leave (particularly long term sickness). We encountered two situations where there was no RMN due to such circumstances. We also found that several prisons had vacancies or

were in the process of recruitment which was also putting a strain on the services.

We were informed by both staff and prisoners that services were very stretched to meet demand particularly when prisoner numbers were high, which was the case in many of the prisons. Prisoners also reported that RMNs were often needed to help in other aspects of health care.

Prisoner comments have been varied:

"I found it very difficult to get past the nurse 'triage' system to be able to speak to a psychiatrist, general nurses are not aware of mental health issues"

"The treatment here is very good. I just need to put in a referral form to the mental health nurse and he comes and sees me on the next day he's in if he's got time"

"Mental health staff are very good, they will go out of their way to come and see you and will make time for you, but they are very busy"

B. Health centre facilities

Each of the prisons we visited had a health centre facility which acted as a base for the prison health care team, including those providing mental health care.

Many of the larger prisons had a separate room for the mental health nurses and those with their own staff space found this to be very beneficial to provide a more focused delivery of mental health services in the prison. Most of the health centres were very short of space with one or two interview rooms being shared by various staff in the health centre. A few had additional multi-use rooms that could also be utilised for groups or activities, but rarely were. SPS Health

Standard 11⁵ defines the criteria of health care facilities in prisons but focuses primarily on clinical and dental needs rather than mental health interventions. Staff we spoke to identified lack of appropriate space as a barrier to providing therapeutic activity.

The Scottish Prison Service document 'Positive Mental Health' proposed the development of day care facilities to provide structured, planned interventions for people with mental health difficulties unable to participate in the wider prison regime in all closed prisons. The only evidence we saw of such a facility was in Barlinnie where there is a day care service provision used by prisoners with mental health problems. This is a unit of several rooms dedicated to mental health service provision and is highly valued by those who use it. Rooms in 'Links Centres' and educational facilities are used by some health teams mainly for Art Therapy.

C. Multi Disciplinary Mental Health Team (MDMHT)

SPS Health Standard 3⁶ defines standards in relation to Prison Mental Health⁷ Services and states each establishment will have and operate a MDMHT as stated in 'Positive Mental Health'. These standards also state meetings will be chaired by a Senior Operational Manager and be held at a minimum of every two weeks.

We found that of the 15 establishments:

- 3 MDMHTs met weekly;
- 8 MDMHTs met fortnightly;
- 3 MDMHTs met monthly;
- 1 MDMHT generally met 3 monthly (but had not met for a while).

Thirteen of the 15 were reported to be chaired by operational managers. We found the composition of the teams to be mainly consistent with the 'Positive Mental Health' guidance, with all teams having an RMN presence, nearly all having a Chaplain and most with social work, psychiatrist, residential officer, prison governor/depute, psychologist, addictions nurse and voluntary sector presence.

We formed the impression that some prisons were experiencing difficulties in getting some members of MDMHTs to attend meetings and to actively participate in the work of MDMHTs.

We discuss issues relating to the operation and function of MDMHTs in Key Message 7 of this report Care Planning, Coordination and Review as we have a number of concerns in this area.

⁵ Healthcare Standard 11

⁶ Positive Mental Health

⁷ Healthcare Standard 3

Recommendations

SPS and NHS Boards should:

- Ensure that prisons have a sufficient complement of registered mental health nursing staff available to meet the needs of their prisoner population. Prisoners need to be able to access help for their mental health problems from trained health staff with the appropriate understanding of mental illness, in the same way as treatment would be provided in cases of physical illness.
- Audit and review the operation of MDMHTs and provide clear operational guidance on their role, process and function.

SPS needs to review its health centre facilities to consider the needs of prisoners with mental health problems. There requires to be sufficient interview rooms to allow prisoners to talk about their issues and appropriate space to deliver therapeutic activities.

Prisoners' experience of mental health services on coming into prison

Key message 2

Prisoners are particularly vulnerable in the early days of their time in a prison. Skilled staff with knowledge of mental health issues need to be involved from the start.

What we expect to find

We believe that prisoners should feel sufficiently comfortable to ask for help if they have mental health or learning disability needs and should be able to feel confident that their needs, when raised, will be appropriately addressed. Not all prisoners will identify their own mental health needs and prisons should have procedures in place for prisoners arriving at prison to recognise existing mental health problems or particular vulnerabilities. Prisons need staff available at reception with appropriate knowledge and expertise to identify prisoners who may have mental health problems.

The exchange of information between the services in the community and prison health services is also vital to providing continuity and support for people with mental health problems, particularly in relation to existing diagnoses, ongoing treatment and medication.

What we found

A. Identifying mental health needs on admission to custody

We recognise that prisoners may not want to disclose or accept that they have mental health problems or may not wish to receive mental health services in prison. There is a considerable stigma attached to being diagnosed with mental health problems in society in general; in prison it is possible that prisoners may wish to avoid this label

because of their fears of how other prisoners, or prison staff, may react to them. We thought it important, therefore, to ask about this screening process in more detail.

SPS Health Care Standard 1.1⁸ defines what is expected at admission from the community. An initial screening for mental health needs should be carried out by a nurse on the day of admission. We asked whether mental health trained health care staff were available to conduct the initial health screening.

We were told in each prison that nurses are involved in the screening process, but whether the nurse was mental health trained or not depended on who was on duty.

Four prisons identified that the reception process was hampered by inadequate RMN provision; in particular there is a lack of cover in the evening, when many prisoners are admitted. Shift patterns of RMNs were often more orientated to day provision (7am-3pm, 9am-5pm and 8am-4pm were examples given).

HMP Cornton Vale stated that it felt the involvement of RMNs at reception ensured good service provision. They always have RMNs involved in reception screening, but they have a higher number of RMNs than other prisons.

In all prisons, nurses risk assess prisoners at reception for self harm/suicide risk using an Act2Care Assessment. Prisoners are, however, not routinely asked directly if they were receiving any care for mental health difficulties from their GP or mental health services prior to custody.

⁸ Healthcare Standard 1

Some prisons told us they have incorporated specific mental health questions in their screening and have designed the process to ensure that all mental health problems identified get followed up by the health care team. For instance, HMP Peterhead said that on admission they ask if the prisoner has ever had treatment for mental health problems. HMP Edinburgh and HMP Dumfries told us the screen would only identify mental health problems if disclosed by the prisoner, or if the social worker or court informs them on transfer. HMP Perth told us they rely mainly on self-reporting.

In Polmont YOI we were told primary care nurses carry out the initial reception screening and any mental health concerns are passed to RMNs on the same or next day. The prisoner will be seen on the day they are referred.

HMP Shotts and the Open Estate only take prison transfers; we were informed that any mental health information on prisoners is generally passed between prison health teams at the time of a transfer.

SPS Health Care Standard 1.2 requires that all prisoners are also seen by a GP within the first 24 hours of admission. This seems to generally be being met, though people admitted at weekends may have to wait until Monday to be seen.

In almost all prisons, clear procedures were reported for sharing any concerns arising from a prisoner's first night following admission between prison officers and mental health staff. Three respondents referred to Act2Care as the formal protocol for this to happen.

B. Prisoners' views on admission to prison

A prisoner's experience at reception is important to the way they subsequently adjust to prison life, and for people with mental health problems the early links with mental health staff may affect their wellbeing through the sentence.

There are significant differences between prisons as to how many prisoners pass through reception, differences in the expertise of the reception staff at identifying problems and considerable differences in the amount of information coming with the prisoners about their circumstances and health issues.

We asked prisoners about their experience and many were able to comment perceptively on this early process.

Comments on mental health support at admission:

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|---|-----|
| Positive or fairly positive and helpful | 28% |
| Negative experiences – insufficient support and medication difficulties | 19% |
| Problems relating to prison transfer | 3% |
| Neither positive nor negative and no comment | 50% |

Eighty five percent of prisoners told us they remember seeing a nurse or a doctor, usually both, when they were received into custody. They could not say whether the nurse was an RMN. Several could not remember whether or not they had been seen, but only two mentioned a delay and in both cases they were seen the next working day.

C. Staff views on prison admissions

We asked staff if they had any comments about mental health services provided on arrival at prison. A number of prisons believed they were offering a high standard of care on arrival.

- Polmont YOI told us they provide a rapid response to prisoners presenting with mental health problems and all issues are addressed promptly. As soon as staff are aware of any prior involvement with a mental health service, they will attempt to contact that service for further information.
- HMP Shotts told us prisoners receive a three day induction programme and information on the listener scheme and health promotion on arrival.
- HMP Cornton Vale said they provided a good admission service by having mental health staff leading on reception of prisoners and by ensuring that first night detoxification is in place as required.
- HMP Shotts and Edinburgh prisons told us that induction packs, which include mental health information, are provided to prisoners.
- HMP Addiewell expressed the hope that by advising every prisoner about self-referral, they will then know how to access the mental health service and what to do if they need help.

Other prisons highlighted some of the problems they face when prisoners are admitted, which included:

- Staffing issues – not enough RMNs.
- Many prison staff told us that it would be better if mental health nurses were

available for admissions but quite often the admission occurs in the evenings.

- They had too few RMNs for them to be involved in all new admissions.

D. Medication on admission

This was an issue for many prisoners we saw. Prescribed drugs can be traded amongst prisoners, and some prison health services are reluctant to prescribe certain drugs for this reason.

- 63 of the prisoners we saw told us they were on prescribed medication when they came into prison.
- 43 of these prisoners told us they had experienced some delay in being prescribed the medication they needed after admission.
- About half of this group said it had been less than seven days before their medication had been sorted out, but in many cases even this delay had caused them problems.
- Of the remainder, a quarter of the prisoners who experienced a delay said it took between one week and a month to get it sorted out, while for others it took up to six months.
- A small number of prisoners on sedatives told us their medication was stopped.

A significant number of people talked to us about the negative experience of changes in treatment either on admission from court or on transfer between prisons. This can be destabilising for someone's mental health. One prisoner told us the delay made him feel very ill and during this period he harmed himself.

“It was diabolical. I was on medication for a reason and should not have had it withdrawn. I was doubly punished because I became unwell and was treated very badly.”

“When first taken into custody I was taken off my medication which I had been on for eighteen years. I had bad withdrawals and got punished for being unwell. I had stress, anxiety and sleep disorder. It took months before I was given an anti-depressant and a beta blocker and I was on at them all the time”.

“When I came into prison my nitrazepam medication was stopped. The spiral was terrible. I wanted to kill myself, I broke down for no reason at all, my head was spinning and I felt I couldn’t breathe! I waited a long time before I was able to see a doctor.”

Comments such as the one below were common:

“I was not seen often enough by nurses and was not given the medication I had been receiving in the community”

We do not believe this situation would be acceptable if it were for medication for an ongoing physical illness.

E. Previous mental health issues

Eighty percent of the prisoners we spoke to told us they had experience of mental health difficulties before they came into prison. Eighteen percent of all the prisoners we saw mentioned a history of a psychotic illness such as schizophrenia; some of these said they believed it had been drug induced. Ten percent mentioned a diagnosis of depression, Ten percent mentioned a diagnosis of personality disorder while two percent said they had been

told they had a mild learning disability. This information gives considerable weight to the need to obtain relevant background information on prisoners at reception.

From our staff interviews, prison health staff reported the following when asked if they thought they would know if a prisoner had been receiving support from mental health services in the community. ‘The response in four prisons was ‘mostly’; in nine prisons it was ‘sometimes’; and in one prison ‘rarely’.

- When mental health service users are identified at reception, staff in seven prisons said they would contact the community services concerned, e.g. the GP or a community mental health team, for further information.
- Health staff in the Open Estate receive results of the initial screening from the transferring closed prison which would trigger referrals as required.

Recommendations

SPS and NHS Boards should:

- Improve targeting of registered mental health nurse (RMN) cover at times prisoners are being received into prison.
- Establish at reception interviews whether the new prisoner was receiving care for mental health difficulties from their GP or mental health services prior to custody.
- Ensure protocols are in place to address issues regarding changes in treatment and delays in receiving medication.

Prisoners' experience of mental health services while in prison

Key message 3

Support for people with mental health difficulties needs to be about more than just medication alone. There needs to be a fuller range of supports available and facilities to provide them.

What we expect to find

As previously stated, we would expect to find treatment for mental health problems in prison equivalent to that available in the community. We expected to find individualised care appropriate to the person's needs whilst in prison, with anyone with major illness being transferred to hospital for treatment and care.

The level of mental health resources required in a prison should depend not only on the size of the prison but also on the nature of the prison's population. Some prisons have specific remits, prisoners serving long sentences, female offenders, young offenders or are more general locality prisons. We would expect that prisons have mental health resources to support the mental health needs of their prisoners.

We would expect that each prison has arrangements in place to provide Consultant Psychiatric services to prisoners (SPS Health Standard 3.1.1 (8)).

Prison Officers should have a basic awareness and knowledge of mental health problems, to help manage disruption caused and distress experienced by troubled prisoners, and to guide them as to when to refer to specialist staff.

What we found

A. Prisoners' impressions of prison mental health services

At the start of our interviews with prisoners with mental health problems we asked them for their initial comments about their treatment in prison.

Their responses were as varied as the people seen but we were able to record some common themes in their responses. Even though our interviews came at a later stage for many during their sentence, the responses showed some people retained a clear memory of some of the heartfelt issues experienced during their various stages of custody.

Summary of prisoners' experience of prison mental health services:

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|----------------------|------------------|
| Positive comments | 18% of prisoners |
| Negative comments | 55% of prisoners |
| Neither good nor bad | 27% of prisoners |

Of those prisoners making negative comments issues were:

| | |
|--|-----|
| Significant delay or other barrier to accessing mental health support | 22% |
| Lack of specialist help for a specific problem – e.g sexual abuse support, counselling, bereavement, anger management, group work programmes | 29% |
| Problem related to getting medication | 13% |
| Poor response from staff, e.g. no one-to-one, or staff not having time, poor communication | 24% |
| Other | 12% |

One of the prisoners making negative comments stated “The mental health support in prison is disgraceful. People get tarred with the same brush” (that they are looking for medication, “to get full of drugs”). You’re just put in prison and expected to get on with it; I was sexually abused as a child. If I was in the outside I’d get the help and why should I be denied it because I’m in prison. The judges didn’t sentence me to lack of medical care.”

B. Access to service

All the health centre managers we interviewed stated that there were systems in place for sharing concerns about a prisoner’s mental health and for mental health support to be provided. Nearly all of the prisons had systems where prisoners could fill in a self referral form to ask to see a mental health nurse or could ask a prison officer to contact the health centre for help. In all prisons, prison officers regularly contacted the mental health nurses if they had concerns. There seemed to be a high level of confidence by RMNs in the referrals coming from prison officers:

“Officers are pretty intuitive and act quickly” (RMN – HMP Edinburgh).

One prisoner said that his problems were picked up on admission but it was still very difficult to get to see anyone. However ‘good hall staff will pester and pester to get a nurse to see you.’

This was J’s first time in prison. He did not think there was much information available if you are unfamiliar with prison. ‘It has been a very frightening experience and nothing is explained to you’. He would like staff to be less aggressive and give more information.

Prisons generally encourage family contact regarding any concerns relatives may have. Many involved family contact officers in this process.

Staff at Polmont, Barlinnie and Cornton Vale spoke of the importance of mental health staff having a presence in the halls to give advice and pick up on any issues.

Prisoners also reported that they would often prefer to be able to have a conversation with the nurse in the halls rather than having to go to the health centre.

One prisoner in HMYOI Polmont commented that “being able to see a nurse in the halls is much better than having to have to come up to the health centre. There is less stigma and it is much easier.”

In one prison a prisoner told us how he was spoken to from the top of the stairs in the wing by the MH nurse and not given any privacy. He felt discriminated against.

Prisoners on daily supervised medication commented on the benefit of being able to have face to face contact with a nurse at this time, as this provided a direct access to the service if they were becoming unwell.

We asked the prisoners we saw how they had obtained help for their mental health problems. About 40% had made a self-referral to the health centre and about 30% had been picked up as having difficulties by hall or health staff. The remaining 30% were less clear about how they had accessed services.

People who self-referred had mixed experiences of accessing services; some were seen quickly but others felt the wait for contact over long. A small minority (8%) felt the arrangements for contact were totally unsatisfactory.

One prisoner told us that communication had been a problem. He had been referred to mental health staff but didn't know who referred him or why.

Prisoners' experiences of being referred to the mental health team seem to vary from prison to prison and between individual prisoners. The majority of prisoners we saw felt that their problems had been picked up either right away or in due course during their sentence. The people we interviewed however were already users of the prison mental health services and mainly serving long term sentences. There may be considerable numbers of prisoners, particularly those serving shorter term sentences who never manage to access the mental health support they need.

C. Treatment approaches

We asked prisoners about the treatments they were receiving. Of the 101 people we saw:

- Just over half were currently prescribed medication with no other psycho-social treatment;
- A third were receiving medication along with another type of therapy;
- Four were receiving therapy without medication;

- Twelve reported not getting any treatment;
- A significant number of prisoners were positive about one-to-one contact with someone who listened and understood; these were mostly identified as mental health nurses.

The approaches prisoners said they found most helpful were:

| | |
|--|-----|
| Positive personal contact (usually a member of mental health staff), being listened to | 36% |
| Medication | 35% |
| Creative activities/therapies | 9% |
| Other | 7% |
| Found nothing helpful | 13% |

The barriers to good treatment that the prisoners described were:

| | |
|---|-----|
| Insufficient or delayed input | 20% |
| Lack of input from a specialist | 15% |
| No respect shown by staff | 13% |
| Restrictions placed on drug prescriptions | 8% |

D. Therapeutic activity

Ten out of the 15 prisons we visited stated that they offered some form of therapeutic activity to people with mental health issues but this was generally on a fairly small scale basis.

There were three prisons where no prisoners we interviewed had the benefit of any therapeutic interventions and an additional five prisons where only one of the people we interviewed described involvement in any such activities.

“Hypnotherapy helped the most as I hadn’t shared my problems of sexual abuse with anyone. This enabled me to do that”

A prisoner in Edinburgh recognised that depot medication helped to keep him stable but he also appreciated support from their depot group.

Managers we spoke to value the provision of therapeutic activity but generally seemed to have no real budget to develop this area of activity. It appears that the development of therapeutic activities in prisons is dependent more on creative opportunity than on strategic development, with a heavy reliance on volunteers, student placements and the good will of voluntary groups.

The activities reported to us are probably a snapshot of what is generally available to prisoners and there is no consistency between prisons. Groups and activities are often short lived particularly when provided by students on placement. Prisoners are often disappointed when they start on a therapeutic activity they find beneficial which ends when the therapist moves on, or is transferred.

The following list shows the range of activities experienced at the time of our visits:

| Activity | Prisons |
|-------------------------------------|--|
| Drama | Theatre Nemo – Barlinnie and Glenochil |
| Art | Art therapy – Shotts, Cornton Vale, Polmont, Perth and Edinburgh |
| Music | Polmont – social development programmes |
| Creative writing, reading, poetry | Polmont, read out loud/laughter workshop – Inverness |
| Aromatherapy | Cornton Vale (sensory room) |
| Specific mental health gym sessions | Greenock, Polmont and Edinburgh |
| Movement/dance | Psycho-movement psychotherapist (student) Edinburgh |
| Hobbies | Hobbies workshop for prisoners with mental health problems – Edinburgh |
| Cooking skills | Perth |
| Day care service | Barlinnie – wide variety of activity |
| Activity coordinator | Addiewell (works with mental health staff) |

During our visits we became aware of:

- Speech and Language therapists being used two days per week in HMYOI Polmont and one day per week in HMP Cornton Vale.
- Counselling – HMP Dumfries has managed to secure the services of an NHS counsellor one day per week. The input from a counsellor was highly valued by the prisoners able to use this service.
- HMP Inverness – Video facilities to access external services.

Despite the range of therapies listed most prisons in fact had access only to a few therapeutic approaches and individual needs and preferences were not able to be met. Prisoners said they would have benefitted from more sessions, and others wished they had access to specialist treatments such as for post-traumatic stress disorder, or counselling for childhood sexual abuse.

Several prisoners we spoke to felt that their mental health issues were bound up with their offending behaviour and such interventions would have helped reduce the likelihood of re-offending.

E. Self help

Prisoners generally have a lot of time on their hands and we were surprised how many stated that they would have very much liked to be able get more information on understanding and managing their illness. Many also said they would have liked the opportunity to be able to engage in self help programmes.

We had examples of a very anxious prisoner who said how helpful he found a relaxation CD given to him by a prison officer, and another who went to the lengths of stealing a book from the adult resource centre to find out more about schizophrenia.

A prisoner in HMP Greenock said he found both a relaxation tape and a self help book useful. However, he thought that Act2care involved having to repeat your story many times to different people and suggested that staff could look at notes to get background information.

Most of the managers we saw said they were able to assist with self help approaches. The use of the Moodjuice website⁹ was mentioned by three prisons; three also made references to using 'Living Life to the Full'¹⁰ material. Greenock and Polmont spoke of using book prescription materials with some prisoners but this is not widely used; we would suggest this could be an area for development. Putting book prescription materials in prison libraries, as has been done in some community libraries, may easily be possible in some prisons.

⁹ Moodjuice – self-help resource site

¹⁰ Living Life to the Full

Most health centres had a range of posters and leaflets promoting positive mental health but there was no evidence of self help or any form of stepped care approach to supporting prisoners with mental health difficulties. This would seem to be an area that could be developed to promote a more recovery focused service and to target scarce resources more effectively.

Most prisons, at various times, seem to have health promotion events at which promoting good mental health is a feature. Generally prison induction programmes also include a mental health element and advice on how to seek help.

F. Sleep/anxiety

A number of prisoners specifically referred to sleeping difficulties affecting their mental health. They generally reported increased anxiety, both in relation to their personal situations and also being in a prison environment.

One prisoner told us that he asked for something to help with sleep and was told they don't prescribe sleeping pills and gave him leaflets on insomnia and advice on diet and exercise. However, he raised the real problem that exercise is difficult if you're locked up most of the day.

Another prisoner in Dumfries spoke of his distress at not being able to sleep and the effect this had on his mental health.

HMP Glenochil made reference to an Acupuncture + Relaxation Group run by an RMN to try to address this issue.

G. Stigma

We asked prisoners if they had felt discriminated against due to their mental illness while in prison.

32 prisoners felt that they had faced discrimination from prison staff.

Examples given included:

- *"I got called names"*
- *"I was called dafty and talked to in a bullying way"*
- *"Prison staff had a laugh at my expense"*
- *"They just thought I was after drugs"*
- *"Staff are not trained to help with mental health problems – they don't understand"*
- *"Staff avoid me"*

Several prisoners felt they were excluded from jobs in the prison which affected their money allowances.

28 prisoners felt they had experienced discrimination from fellow prisoners.

Examples given included:

- *"Sometimes other prisoners call me names like loony and schizo and say 'don't attack me' and things like that."*
- *"Some prisoners get taunted and made to do daft things"*
- *"They notice my cuts and make comments"*
- *"Sometimes other prisoners 'keep their distance' from me."*

16 prisoners stated they felt they had experienced discrimination from both prison staff and other prisoners. These prisoners generally felt very vulnerable and low in mood. Comments made were similar to a combination of those above.

Examples given:

- *“I’m a freak show to entertain people”*
- *“I feel insecure”*

Despite the individual and distressing responses of some of the prisoners we spoke to most said they had not experienced stigma in prison and felt there was help to support them. There seemed to be a general view that there was an improving situation with regard to stigma in relation to mental illness.

A prisoner in HMP Shotts said “I have been in prison for fifteen years and the stigma in prison is a good deal less than it used to be.”

It is encouraging that the situation regarding stigma in relation to mental illness in prison seems to be improving but everyone in the prison has to work hard to improve and challenge stigma and discrimination at all levels.

Recommendations

SPS and NHS Boards should:

- Audit the availability and use of ‘therapeutic activity’ for prisoners with mental health problems. A sustainable strategy needs to be developed for such an important aspect of intervention.
- Ensure improved and consistent access to psychological interventions for prisoners with mental health needs. Access to psychological interventions has become an important part of mental health care in the community and should be more available in prison.
- Establish a stepped care approach to mental health care in prisons encompassing mental health promotion, self help options, therapeutic activities, psychological interventions and use of medication.
- Challenge stigma and discrimination in relation to prisoners with mental health problems at all levels.

Who is providing help for prisoners with mental health problems

Key message 4

There needs to be more direct involvement from disciplines beyond the prison health centre in supporting prisoners' mental health issues – we saw little evidence of multidisciplinary working.

What we expect to find

In its standards and strategy the Scottish Prison Service has placed considerable importance in developing multidisciplinary mental health teams in Scottish prisons. We asked the prisoners we interviewed who they were seeing for help with their mental health problems. We expected to find prisoners receiving help from a wide range of disciplines with in the prison as part of a coordinated care plan.

What we found

A. Mental health nurses

The prisoners we saw mainly had contact with the mental health nurses (RMNs) and psychiatrists in relation to their mental health issues. The help received was generally in relation to talking about any issues they may

have with the mental health nurse and medication from the visiting psychiatrist. The service provided by the psychiatrist was generally akin to an 'outpatient clinic' within the prison health centre and often notes were written in the form of a letter.

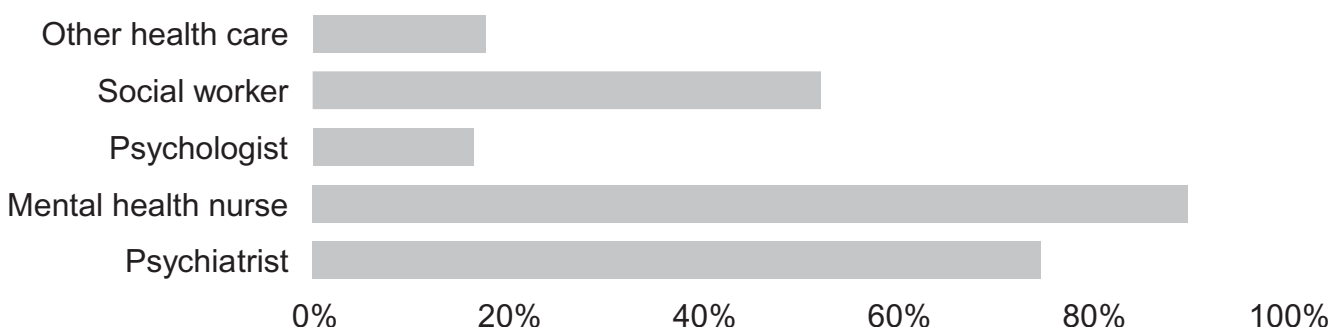
Contact with mental health nurses:

- 86 prisoners visited said they had contact with mental health nurses in prison.
- More than half (45 out of 86) said they were having regular contact, ranging from daily contact to every four months.
- 25 people said they saw a nurse weekly or more often.
- 24 people indicated that they could see the nurse when they needed to.

As stated previously we were informed by both staff and prisoners that services were very stretched to meet demand particularly when prisoner numbers were high.

A prisoner in Castle Huntly said perceptively that he found it was important to find the right person to talk to, as it is the relationship that helps. He had good contact with a mental health nurse in the prison.

Percentage of all prisoners visited who reported contact with health professionals



Prisoners on daily supervised medication commented on the benefit of being able to have face to face contact with a nurse at this time as this provided a direct access to the service if they were becoming unwell.

B. Psychiatry

There were good arrangements for psychiatry input to prison mental health. All units expressed confidence in being able to access advice and assessment quickly in urgent situations should they arise. All closed prisons had at least weekly sessions from a visiting psychiatrist. Larger prisons had two or three sessions a week from visiting psychiatrists. Psychiatrists were generally specialists in forensic mental health and working in specialist forensic facilities but others were working more generally in the community. We spoke to several prisoners who were seeing the same consultant in prison as they were in the community, which provided added continuity. We found that many prisoners were probably getting better access to a psychiatrist in prison than in the community. They certainly seemed more likely, due to a more structured routine, to keep appointments. Many prisoners reported that due to regularly receiving their medication, their illness was more controlled.

Prisoner B had only praise for the health centre staff and psychiatrists. He was also positive about the residential staff.

One man spoke of the difference between psychiatry in the prison and in the community: "They say the treatment is the same but it isn't. I have sleep problems but they won't give me sleeping pills, I can't get medication in prison for my anxiety. I have tried all the programmes but they don't work as well as medication."

C. Psychologists

All prisons have access to psychologists but they are generally involved in focused group work programmes in relation to offending behaviour and associated release planning.

On numerous occasions during our interviews with health staff and prisoners reference was made to difficulties in accessing specialist psychological interventions. We did not get the impression that access to a psychologist for psychological assessment of a prisoner's mental health needs was routinely available to the mental health services in the prison. We felt there is a potential gap in the service between addressing mental health needs and addressing offending behaviour. Psychologists are directly employed by the prison service and are managed independently from the health service staff. Improvements in joint working on mental health issues may maximise benefits to prisoners.

Eight out of the 15 prisons stated that they offered psychological therapies to prisoners but this was mainly led by nurses. Six prisons had nurses trained in Cognitive Behavioural Therapy (CBT).

One prisoner in Addiewell, where a number of therapies were available, told us that he was doing CBT with a nurse and found this helpful. He had also been attending art therapy and was positive about this.

D. Social work

About half of the prisoners we spoke to had recent contact with a social worker while in prison. Most contact with prison social workers had been in relation to parole reports, risk assessments or release planning. A significant number (21) of prisoners had ongoing contact with social workers in community teams, often in relation to child care issues.

We were not aware of any significant role from prison social workers in relation to day to day help or support in relation to mental health needs. Prisoners seemed to value the community social work contacts. Social work was generally well represented at MDMHT meetings. There was no evidence of any consistency of social work contact with individual prisoners as part of their support in relation to mental health issues.

E. Addiction services

Many prisoners with mental health issues also have drug and/or alcohol difficulties which impact on their health.

There was generally good joint working between the Mental Health and Addictions teams, with the lead being taken by the team best placed to address the prisoner's needs. The management of both teams in all but one prison came under the health centre manager's responsibility, so there was a coordinated approach to service delivery which seemed beneficial.

The 13 SPS run prisons now have workers from Phoenix Futures delivering an Enhanced Addiction Casework service. These workers seem able to provide much of the group work and recovery focused therapeutic activity that the mental health teams are struggling to provide for prisoners with mental health difficulties.

We would suggest that RMNs may require similar support in providing recovery focused activity for mentally unwell prisoners.

F. Prison officers

64 prisoners said that they generally found the prison officers supportive with only 30 prisoners saying that they did not. Most prisoners stated that some prison officers were more supportive than others. The most common criticism was that prisoners thought many prison officers did not understand their mental health difficulties.

Prisoners from the Day Unit at HMP Barlinnie were particularly complimentary about the officers working there and appreciated their support and understanding of mental health issues.

Given what prisoners report about lack of understanding of mental health issues this highlights the need to make sure front line officers receive adequate mental health awareness training such as mental health first aid.

G. Mental health training

The situation regarding mental health training in Scottish prisons is variable. There has been an attempt to have trainers in Mental Health First Aid in most prisons and about 75% of prisons have staff trained to deliver Mental Health First Aid. In many prisons these trainers are prison officers rather than mental health nurses.

There seems to have been an initial drive to deliver mental health awareness training to most front line prison staff but this has been difficult to sustain. It would seem that in some prisons about half the staff working with prisoners have received mental health awareness training but the training delivered is generally not sufficient to keep up with staff changes and of the volume required. Several prisons have now lost their trainers as they have moved to other posts and staff they have trained have also moved on. In many prisons staff were struggling to find time to deliver training in amongst their other duties. We did not get the impression of a clear training strategy, including a requirement to undertake mental health awareness training for prison officers.

Some more specialist training such as ASIST has been made available to prison staff, often from local Choose Life networks. 'New to forensics' training is also now being delivered to some prison staff.

There is no doubt that having a staff group with a good awareness and understanding of mental health needs promotes an environment of positive wellbeing and increased support for prisoners with mental health problems. It is also likely to reduce the potential for discrimination and intimidation.

H. Advocacy services

Only seven of the fifteen prisons reported having access to advocacy services. In these cases a referral would be made to a local community advocacy service. There seemed to be no specific funding for these agencies to provide services to prisons and this has created difficulties. SPS Health Standard 3.2.1 states that arrangements should be in place in prisons for the provision of Mental Health Independent advocacy services.

Only two prisoners we spoke to had used advocacy during their sentence, one while in the State Hospital and one in HMP Edinburgh, who had maintained contact with an advocate he had previously been involved with in the community. Only 12 prisoners had even heard of advocacy.

I. Listener/peer support services

Every prison reported operating some form of listener service. The Listener Scheme is a peer support scheme whereby selected prisoners are trained and supported by Samaritans, to listen in complete confidence to their fellow prisoners who may be experiencing feelings of distress or despair, including those which may lead to suicide. Prisons generally reported that in their view the service works well though the number of listeners varied considerably among prisons.

We found prisoners' views of the listening services very polarised between those who found the service helpful and those with a total distrust of the service. Twenty one prisoners we spoke to said they had used the listener services. This covered nine of the fifteen prisons. Sixteen of these prisoners stated that they found speaking to a listener

helpful and in fact four of these prisoners have gone on to become listeners.

Comments included:

- *“I found it very helpful”*
- *“Good”*
- *“Helpful when I first came into prison”*
- *We also had some comments that “some of them are OK but I am very careful which ones I speak to”*

Three (all from different prisons) of the 21 prisoners said they had used the listening service but had not found it helpful as they had not trusted their listener.

Twenty four prisoners we spoke to had very strong views against the listener service but had not used it.

We received comments including:

- *“I’m not interested in talking with other prisoners”*
- *“I’m not happy about sharing worries with other prisoners”*
- *“I wouldn’t trust them. I don’t think they would keep it confidential”*
- *“They would talk about you behind your back”*
- *“You tend to build a shell around you in prison – you do not want other prisoners to know your business”*
- *“I would rather speak to a nurse”*
- *“They are not even qualified”*

Many of these prisoners said they lacked trust in speaking to other prisoners and also would not want to appear vulnerable in prison.

Though this service has a place for some prisoners, the lack of trust which stopped them talking to other prisoners needs to be acknowledged. Access to professional support seems to be the most valued support.

Recommendations

SPS and NHS Boards should:

- Ensure that supporting prisoners’ mental health is the responsibility of all disciplines within the prison. There are many professionals working in prisons who could contribute to better mental health care for prisoners. Current contracts appear to be very constricting in terms of addressing wider mental wellbeing for prisoners.
- Address the issue of lack of specialist help identified by many prisoners.
- Ensure there is a clear training strategy in relation to mental health knowledge and awareness required for front line staff in the prison. This then requires to be implemented and monitored.
- Raise access to advocacy with NHS Boards and local authorities for their area and ensure that advocacy services are promoted for prisoners with mental health problems or learning disability.
- Address the issues raised by prisoners in relation to the prison ‘Listener Services’ and review the operation of these services.

Managing seriously and acutely mentally ill prisoners

Key message 5

Prison is not the place for seriously and acutely mentally ill prisoners.

What we expect to find

A prisoner with serious and acute mental illness should be offered the care and treatment equivalent to that which would be available from the NHS if they were not in custody. They should have access to the full range of treatment options that would be offered if they were in the community. The prison health centre should be the gateway to nursing and medical care, medication, psychological interventions and other therapies. In some circumstances it may be appropriate that a prisoner's care is transferred to an NHS facility. A person should not be discriminated against because of their status as a prisoner.

We would expect that emergency referrals of prisoners with acute mental health needs would be referred to the health team without delay and would receive a rapid response in terms of assessment and medical care.

What we found

A. Seriously and acutely mentally ill prisoners

Prisoners who are severely unwell or at high risk of self harm face particular problems. Many prisons told us that they try to manage these prisoners in their own cell with a "stepped up" care plan; Addiewell and Kilmarnock have cells in the health centre where they can provide a higher observation level. They all follow the Act2Care protocols, apart from HMP Kilmarnock which uses an alternative at present.

We were told that, in some circumstances, a prisoner will be moved to a "safe" or isolation cell where they can be more closely monitored in a safer environment. These cells do not have any personal items or TVs and being placed in them can feel like solitary confinement. If a prisoner is not feeling well, or is feeling suicidal, then being moved into one of these cells can cause further distress. Prisoners told us that they can be bleak and lonely places and they feel as if they are being doubly punished.

All prisons (apart from the Open Estate) reported using safe cells primarily for issues in relation to suicide risk under the Act2care protocols. (The Open Estate would generally transfer prisoners back into the closed prison system if such issues occurred). Most prisons said they try to manage people other than in safe cells wherever possible with a stepped up care plan.

We had a number of comments from prisoners relating to treatment when they had been unwell:

Some were very negative about 'safe cells'.

"How easy it is to put someone in a suicide cell and leave them to their thoughts 24 hours a day."

"The truth is people who are sick the way I've been should be put in hospital. I think the suicide cell has made me feel 10 times worse." (This was a prisoner who tried to hang himself two months before and was in the safe cell for a week.)

Women in Cornton Vale spoke negatively of the 'Black Cells' in Ross House segregation area and these have been recently criticised in a recent HMPI inspection report 2011.

Some prisoners found being in a segregation area of benefit as they were able to be away from other prisoners and felt safer.

One prisoner, who had spent a lot of time in solitary confinement, said that "this is the best time" he had had during his time in prison; before he spoke to the RMN he had "been close to breaking down."

A prisoner in Barlinnie said that the hall he was in was good, as the other prisoners had mental health issues as well, so he felt there was a "shared experience". He said he felt safe there and less anxious and paranoid than when he was in the general population.

Each of the prisons we visited confirmed that there were good relationships with their visiting psychiatrists and that they were able to get advice or a visit, urgently when circumstances required that.

Many of the prisoners we spoke to had a diagnosis of severe and enduring mental illness, which had often caused them to be hospitalised when in the community. Their illness was generally being well managed in prison, mainly by medication, but there were incidents when patients were severely unwell. It was our overall impression that prisons generally have a high threshold in relation to the level of illness managed within the prison setting. MWC figures suggest that only around 30 prisoners are transferred to hospital each year.

We noted that there is a very major focus in prisons on suicide prevention with clear protocols using Act2 Care. This is vitally important but so are wider considerations of a person's overall mental health needs and use of Mental Health (Care and Treatment) (Scotland) Act 2003 provisions.

B. Hospital transfers

Transfer to hospital can also present challenges to the prison service. First of all they have to have arrangements in place for the hand-over of health care and be able to identify a bed in a suitable ward, usually a secure environment. Most staff told us that they have good liaison with hospitals but, despite this, delays can occur and sometimes these can be long, with two or more months delay being cited in rare circumstances.

We asked staff about the arrangements for transferring the prisoner to hospital. Reliance vehicles are generally used for prisoner transport, but Reliance staff will not know the prisoner and they will not generally be trained in mental health care.

In most prisons we were told that staff try to offset the stigma of the prisoner being transferred to hospital, or to community health care appointments, by Reliance. For instance, in HMP Edinburgh they complete an individual risk assessment and use prison transport with MHN escort where possible, but Reliance is used if necessary. In one prison we were told if they have to use Reliance they will try to arrange for an MHN to travel to hospital with the prisoner, but the nurses have to make their own way back. If they can arrange other secure transfer arrangements they would give preference to this. We were pleased to see that considerable efforts were being made in this area.

Six of the prisoners we spoke to had at some stage of their sentence been transferred to a mental health hospital under a section 136 Mental Health (Care & Treatment) (Scotland) Act 2003 transfer for treatment direction. Of these, five had been transferred to the State Hospital and one to a medium security provision. We have no particular comments from these prisoners about their experience which, in most cases, seems to have been at an early part of their sentence and not in the recent past.

Recommendations

SPS and NHS Boards should:

- Ensure that there are protocols and policies in place to make sure that seriously and acutely mentally unwell prisoners are moved quickly to be treated in a hospital setting.
- Review the appropriateness of any facilities used to accommodate prisoners with mental health problems as to suitability and purpose.

Supporting prisoners with learning disabilities

Key message 6

People with learning disabilities are very vulnerable in prison. They are likely to have difficulty understanding and adjusting to the complex rules and regimes of prison and will require extra support. There need to be systems in place to identify prisoners with a learning disability, help for prison staff in relation to communicating with prisoners with a learning disability and an understanding of the support needs of such prisoners.

What we expect to find

We hoped to find expertise in learning disability available in prison health centres and a focus to detect prisoners with learning disability at reception in order to support them in prison.

The prevalence of learning disability seems to be a matter of dispute as there is no formal screening or assessment.

The 'No One Knows: offenders with learning difficulties and learning disabilities – review of prevalence and associated needs' (Loucks 2007 – Prison Reform Trust)¹¹, looked at the issues of offenders with a learning disability. It is known that once people with learning disabilities or learning difficulties reach custody, they are likely to have difficulty understanding and adjusting to complex rules and regimes of prison and are very vulnerable in prison.

What we found

We asked about how services are provided to prisoners with learning disability.

The screening for prisoners with a learning disability appears in general less thorough than for general mental health issues. Seven of the 15 prison managers we spoke to said they thought they would pick up on learning disability issues at reception (hopefully) and five of these prisons have nurses with a learning disability qualification. In three prisons, Polmont YOI, Cornton Vale and Glenochil, we were told that the Hayes Ability Screening Index (HASI) is used or is soon to be used, and any prisoners who are identified as falling within the learning disability range are referred to a learning disability trained nurse. In other prisons the screening is dependent on the skills and the experience of the nurses involved in the screening process on the day, or self reporting.

Prison health centre staff admitted that mild learning disability may be missed by the reception process and they often depended on this information coming from the courts. The new guide 'People with Learning Disabilities and the Criminal Justice System' (Scottish Government 2011)¹² will be of great assistance to prison staff in helping improve knowledge and communication with this group of prisoners.

¹¹ <http://www.ohrn.nhs.uk/resource/policy/NoOneKnowPrevalence.pdf>

¹² People with Learning Disabilities and the Scottish Criminal Justice System

Of the 101 prisoners we saw, three were identified as having mild learning disabilities from their case records but all also had other mental health issues. One of these prisoners commented that he felt staff did not have an understanding of his particular issues.

Polmont YOI received acknowledgement of good practice in the Loucks study for their use of a speech and language therapist for prisoners with learning disability. Intervention through speech and language therapy can mediate the difficulties prisoners have in prison and can help their engagement with education while in custody.

Recommendations

SPS and NHS Boards should:

- Ensure that interventions in prisons should be focused on improving 'choice, control, and participation' for prisoners with learning disability as emphasised by the Disability Rights Commission (2005)¹³. This requires the ability of trained staff to identify these prisoners' needs and support to address them.
- Ensure the availability of the new guide 'People with Learning Disabilities and the Criminal Justice System' (Scottish Government 2011) to front line prison staff.

¹³ http://www.leeds.ac.uk/disability-studies/archiveuk/DRC/Changing_Britain_for_Good.pdf

Care planning, coordination and review

Key message 7

Where mental health difficulties are identified a specific care plan detailing support should be in place.

What we expect to find

Given the complex needs of most of the prisoners in contact with the prison mental health services, we would expect that care plans would be in place for most of the prisoners we saw. For prisoners currently managed by the MDMHT, we would expect to see care plans that have been developed in partnership with other participants in the care of the prisoner and been agreed with the prisoner.

What we found

A. Care plans

We only found care plans in the files of 41 of the 101 prisoner records we looked at. Eleven out of the 15 prisons said that prisoners would have a care plan if managed under MDMHT.

The provision of care plans in files was very prison specific, with care plans generally being in health files in Edinburgh, Shotts, Glenochil, Greenock, Open Estate and Polmont prisons. In other prisons we often found a good account of care being provided in case notes and often good summaries of care in psychiatrists' letters, but no formal care plans.

There seems to be no consistency or standard care plan document used between prisons. Most plans we saw were very basic and were in reality nursing plans rather than multi-disciplinary care plans. It also seems that responsibility for drawing up care plans is left to mental health nurses. We saw very limited evidence of multidisciplinary involvement in care planning and only the Open Estate and HMP Edinburgh showed evidence that care plans were completed with involvement from the prisoner.

We found it very difficult to identify from health care files which prisoners were being managed by the MDMHT. There seemed to be separate notes for MDMHT meetings and health care records. There were some entries in nursing notes that cases had been discussed at the MDMHT, but no formal inclusion of discussions held at the MDMHT or any decisions or plans made. We established that MDMHT notes are based on a collective minute of discussions and held in a central folder. There seemed to be no dissemination of planning for individual prisoners into their personal health care records. This did not seem to cause concern to prison staff we spoke to as they seemed to be familiar with the process, but it does cause concern for us in terms of individualised care planning and the ability to share and disseminate information to those involved in these prisoners' care.

B. MDMHT operation and function

The operation and function of MDMHTs seemed to vary considerably between prisons. This is impacting on care planning and review of prisoners' mental health needs. There seems to be a considerable drive for the meetings to take place and be chaired by a senior operational prison manager as per SPS Health Standards 3.1.1.6 and 3.1.2.1, but not a clear vision of its function. The way MDMHTs operate, attendance and the frequency of meeting also seems to vary considerably between prisons.

The remit and the process for MDMHTs was proposed in the SPS Positive Mental Health (2002) document. We would recommend a review of current operations of this core component of multidisciplinary working and the introduction of clear operational standards and guidance. The inclusion of individual discussions and planning for individual prisoners must be contained in individual health records.

Recommendations

SPS and NHS Boards should:

- Ensure clear guidance and documentation is available to prison managers and health centre staff with regard to the care planning and case management of prisoners receiving mental health care in prison.
- Ensure clear guidance is available for staff in relation to keeping MDMHT records and that records of individual discussions with regard to each prisoner are included in the personal health records for that prisoner. This is likely to be a part of the audit and review of the operation of MDMHTs which is an action recommended to SPS and NHS Boards under key message 1.

Key message 8

Most prisoners return to their communities on release from prison. Proactive contact with community services can help maintain mental wellbeing and reduce the risk of reoffending.

What we expect to find

We expected to find good liaison between prison health services and community mental health services in order assist the transition of prisoners back into the community.

What we found

Many of the prisoners we spoke to told us that they felt their mental health difficulties had been part of the reason they were in prison. Some of these people said if they had help in the community they probably would not have been in prison. Other prisoners we saw had been in prison many times and often left prison to very chaotic lives. These were not answers to questions we asked directly but something raised by prisoners themselves.

Over 60 percent of the prisoners we interviewed were long term prisoners who would be subject to supervision conditions on release from prison. As such, considerable preparation and engagement with community services is likely to be part of their conditions for release. Of the short term prisoners we spoke to, none expressed concerns about their situation on release in terms of mental health needs.

Mental health nurses we spoke to were clear that they thought making prisoners aware of local community supports and services was an important part of their job. They said they would try to make contact with a local community mental health team prior to a prisoner they had been working with being released. We were also informed that they would generally make contact with the local GP if known, and most prisons would routinely provide a discharge letter to the GP. There can be difficulties when a prisoner is homeless and the release address changes at the last moment.

In all prisons, prisoners receiving prescribed medication are given a supply of medication (five days in most prisons, seven days in Cornton Vale, Polmont, Shotts and Inverness) to enable them to have a supply of their medication prior to making contact with their doctor in the community. Having a supply of medication is an SPS Health care standard (5.3.2).

Recommendation

SPS, NHS Boards and local authorities should:

- Ensure they have protocols in place for the exchange of information on patients and prisoners to enable good communication and liaison between prison and community services in their areas.

Conclusions and further action

We hope that the key messages in this report help inform the improvement of services to prisoners with mental health problems, based on prisoners' experiences of current services.

We are aware that our recommendations will come at a time of great change in the service, with the transfer of responsibility for mental health services in prisons from the Scottish Prison Service to local NHS Boards.

Prisoners, despite any crimes they may have been sentenced for, have not been sentenced to lack of medical care. Improvements to mental health services in prisons, particularly in relation to short term prisoners, are likely to contribute to a more successful rehabilitation of prisoners and reduce further offending in communities.

Table 1: Number of prisoners visited, by prison and age group

| Prisons | 16-17 | 18-24 | 25-44 | 45-64 | 65+ | All |
|--------------|----------|-----------|-----------|-----------|----------|------------|
| Aberdeen | | | 5 | 1 | | 6 |
| Addiewell | | | 5 | | | 5 |
| Barlinnie | 1 | 1 | 3 | 2 | | 7 |
| Open Estate | | | 6 | 1 | | 7 |
| Cornton Vale | | 1 | 3 | 1 | | 5 |
| Dumfries | | | 2 | 4 | | 6 |
| Edinburgh | | | 7 | 1 | | 8 |
| Glenochil | | 2 | 9 | 2 | 1 | 14 |
| Greenock | | 1 | 4 | 1 | | 6 |
| Inverness | | | 3 | | | 3 |
| Kilmarnock | | 3 | 1 | 2 | | 6 |
| Perth | | | 5 | | | 5 |
| Peterhead | | 2 | 6 | 3 | | 11 |
| Polmont | | 4 | | | | 4 |
| Shotts | | | 5 | 3 | | 8 |
| All | 1 | 14 | 64 | 21 | 1 | 101 |

Table 2: Number of prisoners visited, by prison and time in custody

| Prison | Up to 3 months | 3-6 months | 6-12 months | 1-2 years | 2-4 years | 4-6 years | 6-10 years | 10+ years | All |
|--------------|----------------|------------|-------------|-----------|-----------|-----------|------------|-----------|------------|
| Aberdeen | | | 1 | | | 1 | 1 | | 6 |
| Addiewell | | 1 | | 1 | | 3 | | | 5 |
| Barlinnie | 5 | 2 | | | | | | | 7 |
| Open Estate | | | | | 3 | 1 | 2 | 1 | 7 |
| Cornton Vale | 3 | | 1 | 1 | | | | | 5 |
| Dumfries | 1 | 1 | | 1 | | 1 | | 2 | 6 |
| Edinburgh | 2 | 2 | 1 | | | | 1 | 2 | 8 |
| Glenochil | 1 | | 1 | 2 | 3 | | 4 | 2 | 14 |
| Greenock | 2 | 1 | | 1 | | | | 2 | 6 |
| Inverness | 1 | 1 | 1 | | | | | | 3 |
| Kilmarnock | | | 1 | 1 | 2 | 1 | | | 6 |
| Perth | | 2 | | 1 | 1 | | 1 | | 5 |
| Peterhead | | | | 1 | 6 | 4 | | | 11 |
| Polmont | 1 | 1 | 2 | | | | | | 4 |
| Shotts | | | | 1 | 2 | | 1 | 3 | 8 |
| All | 16 | 11 | 8 | 10 | 17 | 11 | 10 | 12 | 101 |

Table 3: Number of prisoners visited, by prison and sentence length

| Prison | Remand | Short | Long | Life | All |
|--------------|-----------|-----------|-----------|-----------|------------|
| Aberdeen | 1 | 3 | 2 | | 6 |
| Addiewell | | 1 | 2 | 2 | 5 |
| Barlinnie | 3 | 4 | | | 7 |
| Open Estate | | | 5 | 2 | 7 |
| Cornton Vale | 2 | 1 | 2 | | 5 |
| Dumfries | | 2 | 2 | 2 | 6 |
| Edinburgh | 2 | 3 | 1 | 2 | 8 |
| Glenochil | | 3 | 6 | 5 | 14 |
| Greenock | 2 | 2 | | 2 | 6 |
| Inverness | 1 | 2 | | | 3 |
| Kilmarnock | | 2 | 3 | 1 | 6 |
| Perth | | 3 | 2 | | 5 |
| Peterhead | | | 9 | 2 | 11 |
| Polmont | 1 | 2 | 1 | | 4 |
| Shotts | | | 1 | 7 | 8 |
| All | 12 | 28 | 36 | 25 | 101 |

