Mental Welfare Commission for Scotland

Report on announced visit to:
HMP & YOI Polmont, Redding Road, Brightons, Falkirk, FK2 0AB

Date of visit: 27 August 2024

Where we visited

HMP & YOI Polmont is in the Brightons area of Falkirk and is Scotland's national holding facility for young male offenders aged 18-21 years. Prisoners include those sentenced to short-term, long-term and life sentences, as well as individuals on remand. Although originally a young offenders' institution for males, it now holds adult male and female prisoners over the age of 21 years and has capacity for 580 people in total.

On the day of our visit, there were 470 prisoners, of which 55 were over 21. It previously held males from 16-21 years, however, with the enactment of the Children (Care and Justice) (Scotland) Act 2024 (Commencement No 1 and Transitional Provision) Regulations 2024, those under 18 are no longer remanded or sentenced to young offenders' institutions after 28 August 2024. If the courts required confinement, this would be to an appropriate secure care environment specifically for children.

The process of transferring the existing under 18s had commenced, and we were told this would be completed by 3 September. Of the seven 16 and 17-year-olds in custody on the day we visited, secure placements were identified for five. We were told that arrangements for the other two would be finalised, subject to court proceedings later in the week. Significant work was undertaken between NHS, social work, Scottish Prison Service (SPS) and community services to achieve this.

An additional planned change included the provision of 210 single cells for pre progression adult males into custody with effect from January 2025. By the end of September 2024, the adult male population was forecast to increase. We heard however there had been some reticence, as adult male single cells were not ensuite, so there remained a reluctance to transfer.

The Mental Welfare Commission's themed visit and report *Mental health support in Scotland's prisons 2021: under-served and under-resourced* made ten recommendations to the Scottish Government, NHS Scotland and the Scottish Prison Service on changes that were needed to improve mental health services across the prison estate. Recommendations included the need for mental health care plans for those who required them and SPS training to support frontline staff to feel confident and competent in responding to prisoner mental health issues, addictions, trauma and corresponding behaviours. We last visited HMP & YOI Polmont as part of our local visit programme in October 2016 and made no recommendations.

The purpose of this visit was to find out more about how care and treatment was being delivered to offenders experiencing poor mental health. We wanted to meet with them and review health records of those interviewed.

The prison facility had three main accommodation blocks referred to as halls with an additional segregation unit.

Iona Hall
This unit accommodated male prisoners and consisted of two wings with three floors. Floors one and two housed adult males and floor three, 'top end' prisoners (those preparing for release), young offenders, prisoners who have home leave and those engaged in education and work skills acquisition referred to as 'work parties.' On the ground level, prisoners accessed communal dining and activities, including a gymnasium and table tennis. Cells had toilet and sinks; however, shower facilities were communal.

Monro Hall
This hall held a more vulnerable group of offenders including under 18s, those spending their first night in prison, those on remand, and convicted sex offenders, as well as others requiring protection. Offenders who needed to be more isolated around others were also accommodated in this block.

Blair House
On our last visit in 2016 we found that female prisoners were transferred on a temporary basis from the former HMP Cornton Vale to allow redevelopment of the site for the building of the new HMP Stirling. Female prisoners now formed part of the establishment. This accommodation was of a higher standard, and more aesthetically decorated, than seen in the other halls and the women had ensuite facilities in their cells.

Dunedin Hall
There were 14 individual cells in this unit, and it was used for periods when individuals could not be safely managed along with the main population. Transfer to this unit was authorised in accordance with specific SPS regulations.

Rule 41 in The Prisons and Young Offenders Institutions (Scotland) Rules (2011) allows a prison governor to order that an individual in prison be accommodated in specified conditions due to a health condition where they are deemed to be a risk to themselves or others, following advice from a healthcare professional. The aim is that once more stable, they will eventually reintegrate. There was no one managed under rule 41 on the day of our visit, however, there was one individual managed under rule 95. This rule gives authority to the prison governor to make a ruling for the prisoner to be removed from association with other prisoners, either generally or to prevent participation in a prescribed activity or activities.

Who we met with

We met with eight prisoners in person and reviewed the care notes of 11 in total. We also spoke with NHS staff, the prison governor, and SPS staff during our visit. Prior to the visit we had a virtual meeting with the mental health team leader.

Commission visitors

Denise McLellan, nursing officer

Lesley Paterson, senior manager (practitioners)

Kathleen Liddell, social work officer

What people told us and what we found

Every prisoner we spoke with told us that where they had been involved with a mental health nurse, this had always been helpful and positive. Individuals told us nursing and occupational therapy (OT) staff were “helpful, friendly, supportive and approachable.” Mental health treatment provided included medication which individuals found had reduced symptoms. One person we spoke with had previous input from mental health services, and they had been allocated a named nurse in prison. Contact with the nurse was weekly and said they felt “listened to and supported.” We spoke with one person who described increased observation by SPS staff during a period when their mental health had been poor, as having been beneficial.

We spoke with another who told us of a delay experienced when receiving treatment for a physical health issue however, this had been addressed, and they had since been given a specialised diet as recommended.

There was an acknowledgement that SPS staff had different levels of understanding about mental health with some being more perceptive and sensitive. We heard that some individuals felt they would benefit from increased psychiatric involvement, and they had requested this. For those still waiting to be seen, they were unclear about progress and whether this would happen. Another spoke of a delay in being seen and told us this was due to “staffing issues.”

Individuals were able to maintain contact with their families through visits and there were phones available in their cells that contributed to the quality of contact, due to increased privacy and less background noise. Many prisoners had concerns about the widespread and pervasive access to illicit substances. Food was described as “okay.”

We were told that work activity was rewarding in terms of learning skills and structuring the day. Additionally, it provided an opportunity to spend time out with the cell, however, access was not equitable. If not working, people spent most of their time in the cells, only having two periods of recreation during the day. We also heard that although there was opportunity for education and numerous work parties available, those on remand were not permitted to engage, as they could be transferred to a different prison at any time, leading to a lack of structure and this negatively impacting mental health. There was a concern that any increase to the prison population would detrimentally impact this further. We were told that work was also considered by some as a helpful distraction from thoughts about self-harming.

Although viewing transfer of under 18s from YOI to secure care as positive, there was a degree of apprehension that this could be unsettling as it may incur additional moves back to prison once individuals turned 18.

Care, treatment, support, and participation

Care records

Health documentation was recorded in the NHS prison service electronic information system 'Vision' and SPS records were located separately in 'PR2'. NHS staff could also access NHS Forth Valley's electronic information system 'Care Partner'. Vision and Care Partner notes were shared at the NHS multidisciplinary team (MDT) meeting. The multidisciplinary mental health team (MDMHT) meeting chaired by the SPS deputy governor could share information held on PR2, while NHS Forth Valley could share relevant information in line with patient confidentiality and the general data protection regulation (GDPR).

We found examples of detailed assessments in Vision with information on past and current mental health presentation, including information from discussions with family. Where prisoners had been subject to 'talk to me' (TTM) the SPS suicide prevention strategy, we found nursing assessments that had been completed prior to individuals being placed on this pathway. The records were mostly detailed, but we did find one example where an individual remained on TTM, but we were unable to find any details regarding follow up. When we visited, 15 people were subject to TTM. Where there had been a change in circumstances or presentation, a TTM case conference could be convened quickly, which would involve SPS managers, the prisoner, residential officers and NHS staff.

The person moved into segregation under rule 95 had been assessed by psychiatry. Although not requiring diversion to hospital, they would continue to be monitored in accordance with the process where all individuals held in Dunedin Hall were reviewed weekly. For those managed under rule 41, we were told individuals could be managed in the halls or could go into the segregation area for a lower stimulus environment. We were told a care plan would be written and kept in their hall, in addition to being documented in the Care Partner and Vision systems.

Mental health assessments included comprehensive detail on diagnosis, history, substance misuse, family circumstances, physical health problems, as well as activities engaged in and overall presentation. There had been regular case conference meetings, and we saw examples of frequent reviews by the mental health team providing information on presentation, strategies that worked and whether there remained a need for ongoing increased observation.

Action plans were written in response to ongoing needs however, we found an example where a review meeting had been arranged but did not take place.

Unfortunately, we were unable to find any update that would have been provided to the mental health team by SPS prison officers undertaking the monitoring. This would have been useful in terms of informing the assessment of risk.

Weekly MDT meeting records were informative, evidencing holistic care accounting for both physical and mental health needs. There were examples of comprehensive physical health follow up. Liaison between services in preparation for liberation and transfer of care was documented. We could clearly see which disciplines attended meetings, and these included psychiatry, nursing, psychology, and occupational therapy.

Where prisoners were due for release, liaison between relevant services would be made to ensure risk and ongoing care needs were communicated for the transition. Sometimes where individuals attended court, communication could be challenging and nurses told us they contacted the police for welfare checks and information on their whereabouts in these circumstances.

Assessments informed which support would be beneficial for individuals, including medication and psychological therapies. Where mental health referrals had been made, we found regular clinical team discussion was documented and involved several disciplines. The records evidenced improvements in physical and mental health as well as consideration being given to individuals and their families' views on progress.

We did find that despite input from the team, there was some inconsistency in nursing care planning. We were unable to find person-centred care plans available for several individuals, despite them being offered treatment, including the need to monitor effects of psychotropic medication. We raised this with the nurse team leader who confirmed those highlighted should have had corresponding care plans. Where available, we found the care plans to be strengths-based, evidencing person-centred interventions, however, they had not been reviewed regularly, and we learned that there was a lack of audit.

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

Recommendation 1:
Managers should ensure care plans for prisoners receiving mental health care and treatment are regularly reviewed. They should be person-centred and include summative evaluations that clearly indicate the effectiveness of interventions being carried out and any required changes to meet care goals.

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

Recommendation 2:
Managers should ensure regular auditing of care plans to ensure consistency in recording and availability.

Care and treatment
Physical healthcare was delivered by the primary health care team, with input from the general practitioner (GP). Prisoners could register with the GP in prison and for some of the prison population, it was found that they had improved access to healthcare quite often due to availability, and in part due to the consequences of restrictions on their liberty from imprisonment.

Three advanced nurse practitioners (ANPs) provided a service across the three Forth Valley prisons visiting two to three times weekly. We found examples of regular physical health monitoring for asthma, diabetes and epilepsy. Other programmes included drug and alcohol work.

Appointments were arranged with out-patient departments, for further investigations including scans with results reviewed by the GP and ANPs. There was also pharmacy and sexual health provision available to support healthcare needs. The substance recovery team could make referrals to specialist services. Opticians, dentists and podiatry operated a visiting service.

The mental health team comprised of two visiting forensic psychiatrists, mental health nursing (RMN), health care support workers (HCSW), OT, psychology, and speech and language therapy. Psychology provision for the three prisons in NHS Forth Valley covered complex case consultation and therapies, such as dialectical behavioural therapy and silver clouds.

Enhanced psychological practitioners (EPP) provided treatment, including decider skills and safety and stabilisation. Decider skills provided by OT was also available via a TV channel which could be accessed on a loop in the cells. Recruitment was ongoing for an additional two RMNs and there remained a consultant clinical psychology vacancy. We were told that the waiting list for clinical psychology complex cases and therapies requiring consultant clinical psychology input had increased significantly with the increase in the adult male population.

Nursing provision was available between 07:00-21:30 across the two-shift pattern Monday to Friday and 08:30-18:00 at weekends. Forensic psychiatrists visited on a Tuesday and Thursday to review prisoners and again on a Wednesday for the MDT meeting. There were also links with NHS Forth Valley learning disability service for additional support.

In addition to the weekly MDT, the mental health team met fortnightly with the SPS MDMHT meeting. This also included prison based social work, the deputy governor, chaplaincy, inclusion officers and first line managers from the halls. Referrals could

be made by any of the disciplines involved to discuss areas where general concerns arose.

Access to mental health assessments could be made by self-referral, health professionals or SPS officers; similarly for other services, access was also on a self-referral basis using the same health centre referral A4 proforma held in wall mounted storage pockets in the halls. Located alongside the forms were a variety of other leaflets, such as the NHS Forth Valley prisoner healthcare feedback, comments, concerns and complaints form, social work duty referral form, handmade greeting card ordering forms which could be ordered from the arts and crafts group, electricals/accessories ordering forms and make up and beauty products ordering form.

Referrals could also be made to Forth Valley Advocacy, an independent advocacy service working alongside vulnerable individuals to advocate for their rights.

RMNs and OTs were based in the healthcare centre and would visit the halls to meet prisoners. RMNs would screen all new admissions for the risk of suicide on arrival at the reception area, taking physical observations, pregnancy testing where appropriate, and drug screening for detoxification. Assessments would then be uploaded onto the Vision system. The deadline for commencing assessment was 20:45hrs, but there could be occasions where delays meant that people were not assessed until the following morning. In these instances, they would be placed on TTM with 15-minute observation and moved to Monro Hall, which held the more vulnerable offenders.

We were told that medication was administered in the halls in two separate drug rounds at 07:00 and 16:00. At the most recent inspection by His Majesty's Inspector of Prisons (HMIP), it was considered that the timing of administration was dictated by when SPS officers took breaks rather than prisoners receiving medication at optimum times. With the changes being introduced to lower the working week to 35 hours, this will be reviewed, and changes may be adopted. Some offenders could administer their own medication following a risk assessment process and their medication was stored in a lockable safe in their cell, with spot checks being carried out by HCSWs.

Activity and occupation

There was a range of work placements in the life skills and learning centres, including training in brick laying, forklift truck operating, painting, plumbing and hairdressing. There was also 'paws for progress', a dog training course. Job Centre Plus provided in-reach to those nearing liberation and there was input from social work throughcare support. Other opportunities available included peer mentoring, parenting classes and the performing arts.

Work opportunities in the prison included the laundry, cook house, and waste management. Those who chose to learn about waste management and industrial cleaning were paid £11 per week but would receive an additional £5 for incidents where biohazard cleaning was required.

Education was also available and there was access to a chaplain for spiritual needs. Fife College provided activity packs and Arts and Crafts in Prison supplied colouring pencils. Additionally, Kinetic Youth delivered informal education and activity, such as quizzes held in the halls, following the contract ending with former provider, Barnardo's Youth Work.

Physical activity could be taken by accessing the gyms in the halls which had a rowing machine and treadmill, as well as fixed push up/pull up equipment. There was also a large indoor games hall, as well as outdoor exercise areas and large football pitches.

The physical environment

There was a total of 12 safer cells throughout the establishment designed to reduce the risk of self-harm. The cells contained anti-ligature clothing, blankets and a mattress. Each cell had a television fixed to the wall. There was a sink and toilet in the cell which was in place for monitoring purposes and could be viewed by SPS staff from outside the cell. There was an alarm to request assistance, if needed.

In the main accommodation, male cells had toilets and a sink however, these prisoners were required to share showering facilities. Each cell had a TV, phone, kettle, a fixed workspace to use as a desk, some storage for clothing and a lockable safe for medication and small personal items.

We noted a stark contrast between the female accommodation and the male blocks. The rooms in Blair House had been personalised and the environment was softer, appeared cleaner and had en-suite showering facilities. In the segregation area, furniture was at a minimum with no bed and a mattress had been placed on the floor. Access to a pay phone was in the corridor outside the cell.

Emergency medical equipment was stored in each hall with medical emergency response guidance. Information about services offenders could self-refer to was displayed on whiteboards in the halls. There was also a prisoner complaints box and post box available.

Summary of recommendations

Recommendation 1:
Managers should ensure care plans for prisoners receiving mental health care and treatment are regularly reviewed. They should be person-centred and include summative evaluations that clearly indicate the effectiveness of interventions being carried out and any required changes to meet care goals.

Recommendation 2:
Managers should ensure regular auditing of care plans to ensure consistency in recording and availability.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland and HM Inspectorate of Prisons.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

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

The Commission visits people in a variety of settings.

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

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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