



mental welfare
commission for scotland

Concerns about the care of women with mental ill health in prison in Scotland

An analysis of the records
of nine women in custody

July 2021



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

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Foreword – Julie Paterson, chief executive



This document is a review of the records of nine women who received mental health care in prison custody in Scotland between 2017 and early 2020.

We decided to pursue this subject after the publication of a report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (the CPT) in October 2019¹ about their visit to police and prison premises in Scotland in October 2018.

The CPT carry out visits to all "places of detention" including police cells, prisons, closed psychiatric institutions and immigration detention centres. After each visit, a report with findings and recommendations is sent to the respective government for response. The findings mainly focus on identifying situations at risk that may lead to torture.

Article 3 of the European Convention on Human Rights (ECHR) provides that "No one shall be subjected to torture or to inhuman or degrading treatment or punishment". The rights contained in the ECHR were enshrined in UK law in The Human Rights Act 1998. If a person is deprived of their liberty, they should be treated in a way that respects their dignity. This includes receiving medical care and treatment if they have mental ill health.

Serious concerns

The CPT's report on their visit to Scotland raised serious concerns about the wellbeing of women with mental ill health in HMP YOI Cornton Vale,² the only prison in Scotland exclusively for female offenders. The delegation reported visiting at least five women in HMP Cornton Vale with severe mental health issues who they considered required hospital treatment, care and support. They highlighted concerns about the segregation of women who were significantly mentally unwell and who were placed in solitary confinement for extended periods. Their report also raised concerns about delays in accessing inpatient treatment, and about women with personality disorder not being eligible for transfer to a psychiatric hospital.

The UK Government's response, incorporating the Scottish Government response, to the CPT report's concerns and recommendations was published concomitantly in October 2019³.

Whilst we in the Mental Welfare Commission had been aware of difficulties with access to inpatient beds in the forensic mental health estate - an issue that was being looked into by the Independent Forensic Review set up by the Scottish Government⁴, - the serious welfare concerns raised by the CPT about women in custody were new and deeply concerning.

¹ <https://rm.coe.int/1680982a3e>

² Her Majesty's Prison and Young Offender Institution Cornton Vale (HMP Cornton Vale)

³ <https://rm.coe.int/1680982a02>

⁴ <https://www.gov.scot/groups/forensic-mental-health-services-independent-review/>

Because of this, and given our role in protecting and promoting the human rights of people with mental ill health, we decided to carry out this retrospective review of the prison health records of the women whom the CPT had raised concerns about, and broaden this review to include a number of other women whose mental health care in prison was being followed up by us as part of our routine duties.

This review sets out our findings in response to the CPT's serious concerns.

Scotland as a society needs to do more

We agreed with the CPT on many issues, particularly related to the environment of the separation and reintegration unit (SRU).

We also highlight issues related to a lack of available beds in various key units within Scotland's mental health facilities.

Our review also raises critical questions about missed opportunities with early intervention, pathways from prison to the community, and the revolving door of prison for some women.

This document opens a window on the lives of some of the most marginalised women in society. It gives some insight into the irreparable damage that is being done to those individuals, and we can only imagine the wider impact on their families and communities.

We really hope this detailed review will be read and acted upon by those who are examining Scotland's future approach to the best ways to care for mentally unwell individuals in prison. While changes are being made at HMP Cornton Vale, the wider situation needs to be addressed, and Scotland as a society needs to do more.

We aim to use this review to open up that discussion, and we hope readers will also do so.

Executive Summary

The Mental Welfare Commission for Scotland (the Commission) works to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions. Individuals who experience mental ill health in places of detention, such as prison, can be particularly vulnerable and it is important that their rights are safeguarded. Within its range of work, the Commission looks at the mental health care and treatment that people receive in prison.

We present here the findings of a retrospective analysis of the health records of nine women who experienced mental ill health while in prison custody in Scotland between 2017 and February 2020. Five of the women whose care we reviewed had met with the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (the CPT) when the delegation visited HMP YOI Cornton Vale in October 2018. It was the concerns raised about these women in the subsequent CPT report⁵ that led to this review.

Summary of findings

The women whose care we reviewed were either acutely mentally ill or experiencing significant mental health difficulties in the context of personality disorder and complex mental health issues during the episode of custody examined.

1. Health assessment on admission to prison: identifying & addressing mental health issues

- There was evidence of women's mental health needs being identified at the initial nursing screening assessment or at the GP assessment.
- Most of the women we reviewed were seen by the prison mental health team during their first few days in custody and within 24 hours of a referral being made.
- Accessing background information about women's health could be a challenge and there were barriers to information sharing.
- This report recommends improvements in prison health service processes, with clear policies to ensure information sharing is carried out in a timely, secure manner that improves continuity of care for individuals between custody and the community. For more permanent solutions, we welcome the Scottish Government's 2019 commitment to improve clinical IT systems in prisons to make services safer and more efficient and we request an update on the progress of this work.

⁵ <https://rm.coe.int/1680982a3e>

2. Access to mental health support in prison

- The care prisoners with mental health problems receive whilst in custody should be equivalent to the care they would receive in the community. We found that in some areas there was parity between the mental health support women received in custody and the level of support that would be accessible to them in the community. However in other areas, such as psychology and occupational therapy, we found access to support in prison was very limited.
- Of significant concern were issues we found relating to women's access to medication and the recording of this. This included omissions in the dispensing of medications for physical and mental health in individual cases, which amounted to significant gaps in treatment. We have recommended that there is a review undertaken by managers of prescribing and dispensing in HMP Cornton Vale and a regular audit programme established.
- The establishment of electronic prescribing in prisons was recommended by the CPT and we have supported this recommendation. The Scottish Government had also tasked NHS National Services Scotland (NSS) to look at the delivery of electronic prescribing in prisons. We are requesting an update on this work and clarification of the current timescale for providing this technology across prisons in Scotland.

3. The prison environment for care of acutely mentally unwell women

- This section highlights the impact of the environment and the approaches to care in custody for the women that we reviewed. We found specific areas of concern in the management of women who were acutely distressed as a result of their poor mental health, and in the use of restrictions and more notably, segregation.
- We looked specifically at care in the Separation and Reintegration Unit (SRU). The findings from the records indicated that several women were acutely unwell with psychosis whilst in segregation, where the regime meant they were locked alone in a cell for up to 22 hours a day.
- The records of all the women we examined indicated they were highly distressed whilst in the SRU. The severity of women's symptoms and level of their behavioural disturbance appeared to worsen in this environment, as did their self-care and the opportunity for any meaningful interaction with others.

4. Delays transferring mentally unwell prisoners to hospital

- Where we found delays in transferring mentally unwell prisoners to hospital, the records evidenced patterns of escalating symptoms, indicating that each woman's acute illness was evolving whilst they were not receiving the inpatient care and treatment they urgently required.
- In a few cases we thought that women should have been referred for admission to hospital at an earlier stage. The added delay in then accessing a bed was often unacceptable.
- We found examples of repeated inequalities, with women in prison being unable to readily access intensive psychiatric care unit (IPCU) beds or secure forensic female beds due to bed pressures in local services and a lack of provision of female medium secure facilities.

5. Missed opportunities for earlier interventions: Court Liaison

- In a number of cases we found that women showed signs of being acutely unwell at the point of arrival in prison custody. In each of the cases the woman's mental state deteriorated further and there were challenges and delays in transferring them for inpatient mental healthcare. While this review has highlighted a few cases, the healthcare team at HMP Cornton Vale advised us that this situation continues to occur. This is a serious concern.
- The Commission recognises the importance of the clinical assessments carried out by health professionals providing liaison custody support. However the availability of this support, and access to mental health expertise, varies between regions and between urban centres and rural areas. Arrangements must be put in place in each region to ensure that appropriate medical assessment is available for individuals who present with signs of mental ill health whilst in police custody. When a person is assessed as being mentally unwell in custody the medical practitioner should always consider making a recommendation to the court for hospital care. If this is not done, the reasons must be justified.

6. Concerns about aftercare: pathways from prison to community

- It was evident from reviewing individual records that transition planning and arranging supports in the community could be challenging, particularly for women on remand.
- We noted that healthcare plans put in place by the psychiatrist and mental health team were frequently accompanied by caveats regarding women's upcoming court hearings.
- In individual cases we found gaps in communication, a lack of clarity around transfers and limited evidence of robust aftercare planning. These could be addressed with improved multiagency planning between prison and locality mental health and social care services.

7. Supporting women with complex needs: the "revolving door" of prison

- While these findings relate to just a few of the women whose care we reviewed, these women appeared to represent some of the most vulnerable and challenging for both the prison service and community services to support.
- As set out in the Commission on Women Offenders report in 2012⁶, this group of women in the criminal justice system are frequent reoffenders with complex needs that relate to their social circumstances, previous histories of abuse and mental health and addiction problems. Our findings from the review of the records supported this.
- We saw evidence of the challenges that community services can face in supporting women with personality disorder, complex mental health issues and social care needs when they leave prison, and how the use of substances as a coping strategy can lead to repeat offences that result in further episodes in custody. Breaking this cycle appears difficult, and custody appears to offer the women little benefit in terms of recidivism.

⁶ <https://www.webarchive.org.uk/wayback/archive/3000/https://www.gov.scot/Resource/0039/00391828.pdf>

Summary of recommendations

1. Health assessment in prison: identifying and addressing mental health issues

To Health Managers - HMP Cornton Vale/ all prisons

- Health managers in HMP Cornton Vale/ all prisons should ensure that:
 - All people arriving in custody receive an initial review by a GP and any required medication is prescribed without delay.
 - When additional information about a person's health is required, this is requested from local NHS services without delay.
- Managers of all prison health services should ensure there is a local policy in place with clear processes for requesting health information about prisoners from NHS services that ensures this data is obtained in a secure and timely way.

2. Access to mental health support in prison

To Health Managers - HMP Cornton Vale

- Health Managers at HMP Cornton Vale should carry out an urgent review of current prescribing/dispensing and establish a programme of regular audits.

To Scottish Government

- The Commission repeats the CPT's recommendation to Scottish Government for the establishment of an electronic prescribing system in Scottish prisons.

3. The prison environment for care of acutely mentally unwell women

To Health Managers - HMP Cornton Vale

- Psychology input should be available to support care planning, behavioural approaches and reflective practice for all women subject to Rule 41 due to their mental health needs. In HMP Cornton Vale, this support should be prioritised for women in the Separation and Reintegration Unit (SRU) and Scottish Prison Service (SPS) staff should be actively involved in care discussions.

To the Scottish Prison Service

- The Women's Strategy Team should consider the findings of this report when taking forward the new model of care at HMP Cornton Vale. Careful consideration should be given to the final details in the design of the new enhanced needs area to create an environment that is therapeutic and does not add to women's experience of trauma. We recommend that the mental health specialists who developed a Trauma Informed Strategy for HMP Cornton Vale are involved and there should be a specific focus on the development of a training programme for staff.

- When carrying out its review of Separation and Reintegration Units, Scottish Prison Service should consider adopting an approach that is modelled on the NHS use of seclusion, for individuals held in segregation for mental health reasons.

To Scottish Prison Service and HMP Cornton Vale

- For people being held in segregation, the Commission supports the CPT's recommendations that all prisoners, including those in conditions of segregation, should have at least two hours of meaningful human contact each day and that individuals held for longer than two weeks in segregation should be offered further supports and opportunities for purposeful activity.

To NHS Forth Valley

- NHS Forth Valley should work with local advocacy services to improve access to ensure that the views of women in HMP Cornton Vale are expressed and heard and their rights are respected.

4. Delays transferring mentally unwell prisoners to hospital

To Scottish Government

- The Commission supports the following recommendations of the Independent Forensic Mental Health Review⁷:
 - The Short Life Working Group set up in response to the Forensic Network's report on the Women's Service and Pathways should reform to complete its work related to women's pathways across forensic settings and "its work must ensure a pathway for women to transfer from prison for forensic mental health care and treatment when required" (Recommendation 4)
 - The system of multiple assessments to facilitate transfers from prison should be reviewed to streamline the process. (Recommendation 21)
 - The Scottish Government should "commission the Information and Statistics Division (ISD) of NHS National Services Scotland to develop a data management system to accurately collect, monitor and report on performance across forensic mental health services, including on service capacity and the timeliness of people's transitions" (Recommendation 5). This data management system "must be able to collect, monitor and report on transfers and delays to transfers into forensic mental health services from prisons." (Recommendation 20)

⁷ Independent Review into the Delivery of Forensic Mental Health Services. *What we think should happen*. Final Report, February 2021

<https://www.gov.scot/publications/independent-forensic-mental-health-review-final-report/>

5. Missed opportunities for earlier interventions: Court Liaison

To the Scottish Health in Custody Network

- The Commission recommends that the Scottish Health in Custody Network considers the issues raised in this report about the assessment of mentally unwell offenders in custody and engages with NHS Boards and IJBs to review whether there are areas of improvement work that could support a more consistent national approach.

6. Concerns about aftercare: pathways from prison to community

To Prison Mental Health Teams

- The Commission strongly recommends the use of the Care Programme Approach to support transitions in care between prison and community services and to co-ordinate the planning of multiagency supports, particularly when the person has complex mental health and social care needs.

7. Supporting women with complex needs: the “revolving door” of prison

To Scottish Government

- The Commission supports recommendation 4 of the Independent Review of Forensic Mental Health Services that the Short Life Working Group, re-established to review women’s services, should also “consider the care needs of the group of women who may not meet the definition of ‘forensic’, but who are subject to conditions of security as their behaviour has not been able to be safely managed by generic services.”

Background

Female prison population in Scotland

Over the past 20 years the Scottish prison population has been increasing⁸. The number of women in prison doubled between 2000-2010 to a daily average of over 400 and has remained around this level for most of the last decade.

Scotland has had the second largest female prison population in Northern Europe since 2010⁹. In 2019-20, the average daily prison population in Scotland was 8198, of which 402 prisoners were women (4.9%).

Prison numbers reduced following the onset of Covid-19. At the time of writing this report, 291 women were in custody, of whom 207 were convicted prisoners, 73 were untried (on remand) and 11 were in custody awaiting sentence¹⁰ (SPS data, 02.04.21)¹¹.

Female prison estate

HMP & YOI Cornton Vale (HMP Cornton Vale) is the national facility for female offenders in Scotland for both remand and convicted prisoners. A number of other - predominantly male - prisons also provide care for women in custody: HMP Greenock, HMP Edinburgh, HMP & YOI Polmont and HMP & YOI Grampian. HMP Inverness has a small community integration unit for women.

The current capacity across the female prison estate accommodates up to 472 women, divided across the six sites as shown below:

Name of prison	Design Capacity (female)
HMP & YOI Cornton Vale	109
HMP Edinburgh	114
HMP & YOI Grampian	56
HMP Greenock	52
HMP Inverness	6
HMP & YOI Polmont	135

Most women are initially received into custody at HMP Cornton Vale for a brief period of assessment, after which many women are transferred to other establishments. HMP YOI Grampian is the only other prison that admits women directly from court, providing this service for the north of Scotland.

Women identified as having mental health needs usually remain in custody at HMP Cornton Vale, which has a care suite for vulnerable female offenders.

⁸ The average daily prison population in 2000-2001 was 5868; in 2019-2020 it was 8198.

<https://www.sps.gov.uk/Corporate/Information/SPSPopulation.aspx>

⁹ World Female Imprisonment List, 4th Edition.

https://www.prisonstudies.org/sites/default/files/resources/downloads/world_female_prison_4th_edn_v4_web.pdf

¹⁰ A person may be in prison custody either on remand, awaiting sentence or serving a custodial sentence. Someone who has been charged with a criminal offence attends a pre-trial court hearing, at which they either receive bail or are remanded in custody until their trial. If subsequently convicted and given a custodial sentence, the person will return from bail/remand to prison to serve their sentence.

¹¹ <https://www.sps.gov.uk/Corporate/Information/SPSPopulation.aspx>

In recent years a number of reports and policies have led towards an agenda of prison reform. These have included initiatives to reduce the prison population, and to reduce the number of people on remand in Scotland.

A key driver to re-imagining women's services and redesigning the female prison estate was the findings of the Commission on Women Offenders, established by the Scottish Government in 2011 and chaired by Dame Elish Angiolini, former Lord Advocate. This Commission published its report in April 2012¹².

Following the recommendations from this report, the Scottish Prison Service (SPS) and Scottish Government consulted with partners, and key stakeholders to develop a new model of custody for women in Scotland. In 2015 plans for a new National Women's Facility (WNF)¹³ at HMP Cornton Vale, were unveiled by the Cabinet Secretary for Justice. Plans were also announced for five smaller community custody units to be built around Scotland, each accommodating up to 20 women¹⁴. The vision was that these units would support women's rehabilitation nearer their home, family and community.

The Women's Strategy Team at SPS are involved in the development of these plans and new services. A new strategy for women in custody is due to be published by SPS later in 2021. At the present time, HMP Cornton Vale is undergoing a major rebuilding programme and the number of women held in custody there has been greatly reduced. The new reduced sized prison will have capacity for up to 80 women, with the remaining women being managed in existing prisons and the community custody units, once established.

Building of the new WNF at HMP Cornton Vale was delayed during 2020 due to Covid-19. The new facilities are due to open in spring 2022.

Mental health care in prisons

In 2011, the responsibility for healthcare in prisons transferred from the Scottish Prison Service to the NHS.

Since then there have been changes in the governance arrangements for delivering healthcare in prisons. Two NHS boards have retained responsibility, whilst others have delegated this to Health and Social Care Partnerships / Integration Joint Boards.

Health centres in prisons comprise mainly input from general nurses and GPs. Mental health support is provided by mental health nurses and visiting forensic psychiatrists. Prison health services are designed to provide parity with the health support that would be available to an individual in the community. The level of mental health support available varies across prisons in Scotland, with differences in both the number of mental health nursing staff employed and the number of clinic sessions from visiting psychiatrists.

¹²Scottish Government information on the Commission on women offenders:

<https://www.parliament.scot/parliamentarybusiness/CurrentCommittees/70346.aspx#:~:text=The%20Scottish%20Government%20established%20a%20Commission%20on%20Women,Read%20the%20Commission%20on%20Women%20Offenders%20Final%20Report>

Final report: <https://www.webarchive.org.uk/wayback/archive/3000/https://www.gov.scot/Resource/0039/00391828.pdf>

¹³ <https://www.sps.gov.uk/Corporate/Information/NationalFacility.aspx>

¹⁴ <https://www.sps.gov.uk/Corporate/Information/CommunityCustodyUnits.aspx>

Prisons are inspected by Her Majesty's Inspectorate of Prisons for Scotland (HMIPS). Inspection visits are often carried out in conjunction with Healthcare Improvement Scotland (HIS), with a review of the delivery of health care in detention incorporated in this.

The Mental Welfare Commission is a member of the UK National Preventive Mechanism (NPM)¹⁵, which is composed of 21 independent bodies that monitor places of detention in the UK. The Commission visits most prisons every two to three years. During these visits we review mental health care provision and monitor the support and treatment that prisoners with a mental disorder receive. We do this by meeting with individual prisoners, speaking with families/carers and staff and reviewing health records. Visits reports are published on the Commission website¹⁶.

The Commission previously carried out a national themed visit looking at prison mental health care in Scotland in 2011. The findings were published in the report "Mental Health of Prisoners"¹⁷. A further national Commission themed visit was due to take place in 2020, but was delayed due to restrictions in visiting prisons during Covid-19. This visit will now commence in July 2021.

The Commission has undertaken other work in relation to the care of offenders with mental health needs in recent years. This includes national themed visits looking at the mental health of women detained by the criminal courts (2014)¹⁸ and the care of people in medium and low secure forensic wards (2017)¹⁹.

Inpatient mental health care for mentally unwell offenders

People who experience mental health difficulties in prison are supported by the health services on the prison site. When a prisoner becomes severely or acutely mentally unwell, a transfer to hospital care may be recommended. When this happens, an assessment is carried out by a forensic psychiatrist to decide the most appropriate inpatient setting for the person to be referred to. Assessment of risk helps determine the level of hospital security required.

In Scotland, forensic patients may receive care in high, medium or low secure forensic mental health settings. Individuals assessed as low risk may sometimes be transferred from prison to an intensive psychiatric care unit (IPCU), which does not have the specific requirements of a forensic setting.

It is widely recognised that there is currently a lack of female provision in the forensic estate in Scotland in comparison with the male estate. There are no female high secure beds in Scotland at the present time. Women requiring the highest level of security are referred to Rampton Hospital in England (over 200 miles away).

Currently only two of the three medium secure units in Scotland are able to admit women. Rowanbank Clinic in Glasgow has a 6-bed female only ward, providing regional medium secure care for women offenders with mental illness or learning disability. The Orchard Clinic in Edinburgh has an acute ward which can admit a small number of women in a mixed-sex facility. For women who are vulnerable and may have experienced abuse or trauma, admission

¹⁵ <https://www.nationalpreventivemechanism.org.uk/>

¹⁶ <https://www.mwscot.org.uk>

¹⁷ <https://www.mwscot.org.uk/sites/default/files/2019-06/Mental%20health%20of%20Prisoners%202011.pdf>

¹⁸ https://www.mwscot.org.uk/sites/default/files/2019-06/women_offenders_final_report.pdf

¹⁹ https://www.mwscot.org.uk/sites/default/files/2019-06/medium_and_low_secure_forensic_wards.pdf

to this facility can pose concern. We, at the Commission, have raised significant concerns about this issue on successive visits. One of the two rehabilitation wards in the clinic is also mixed.

Low secure care provision is diverse across NHS boards, with units often offering care, treatment and rehabilitation in mixed sex settings.

The Forensic Network were commissioned to carry out a review of women's secure services in Scotland and reported in March 2019, making recommendations for the national development of services²⁰. The Minister for Mental Health then commissioned the Independent Review of Forensic Mental Health Services in Scotland, which began in June 2019, chaired by Derek Barron. The Review's interim findings highlighted deficiencies in the female forensic estate and acknowledged this led to inequity in care for women²¹.

The final report, published in February 2021²², made wide ranging recommendations for the reform of forensic mental health services in Scotland. These included recommendations for the establishment of a national Forensic Board in Scotland which would oversee, and provide central governance for, all inpatient and community forensic mental health services. It also recommended that the Scottish Government re-establish female high secure provision at the State Hospital within 9 months of the report being published. The Scottish Government's response to these recommendations is awaited.

How this review is structured

The review summarises the findings from the nine cases we examined.

The structure follows the women's journeys through custody, from arrival in prison to transfer to hospital or liberation. Using anonymised examples, we discuss the mental health difficulties, and in some cases acute illness, women experienced and we look at the course of their presentation over time.

We make a series of recommendations to the Scottish Government, the Scottish Prison Service (SPS), NHS and Integration Joint Boards (IJBs), to improve the provision of mental health care for women offenders.

The findings of this report will inform the Commission's future visits to prisons, including our forthcoming national Prison Themed Visit.

Covid-19

This review does not focus on the recent impact of Covid-19 on prison mental health care. The episodes of women's care we reviewed took place before the pandemic.

The Commission has maintained regular contact with prison health services, SPS, HMIPS and HIS since the onset of Covid-19. The Commission intends to explore the impact of Covid-19, and the heightened restrictions implemented in Scottish prisons during this period, when we carry out our forthcoming prison themed visit. In the themed visit we will consult with men

²⁰ <https://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/Womens-Report-Public.pdf>

²¹ <https://www.gov.scot/publications/independent-forensic-mental-health-review-interim-report/>

²² <https://www.gov.scot/publications/independent-forensic-mental-health-review-final-report/>

and women in prison, their families and professionals delivering care, to find out about their experiences and the impact of Covid-19 on mental health provision in prisons.

The onset of the pandemic coincided with the early stages of this review and had some impact on the project, delaying completion and publication by several months. This did however enable us to consider and include the findings from the follow-up CPT visit and report²³, published in October 2020 and the recent publication of the final report of the Independent Review of Forensic Mental Health Services (the Barron Review) in February 2021²⁴.

How we carried out this review

We carried out a retrospective examination of the **prison** health records of nine women – five from the CPT report, and a further four.

Case selection

We wanted to conduct an examination of the care and treatment of the five women interviewed and reported upon in the CPT report. With input from the SPS and health staff at HMP Cornton Vale, we identified the women whom the CPT had met. A sixth woman was initially identified in error (it transpired that she had been liberated shortly prior to the CPT visit taking place and was not one of the cases in the CPT report). As her prison health records had indicated concerns about her mental health in custody, her case was however included in this review.

The remaining three cases were identified through casework and concerns raised directly with the Commission between August 2019 and February 2020. The common theme with all of these women related to the transfer of mentally unwell women from prison to hospital.

Data Collection

Examination of health records

We reviewed each woman's care for the single custody episode in question.

We did this by conducting a detailed retrospective examination of prison health records. The nine episodes of custody we examined took place between 2017 and February 2020.

In three cases, where questions arose about women's inpatient care following transfer from prison, we requested additional information from their **NHS** records. In a further three cases we carried out a retrospective review of women's **NHS** mental health notes, looking in detail at the care the women had received over time. These women all had complex longstanding mental health needs, social vulnerabilities and were repeat offenders. We wanted to understand more about the mental health care and support they had received in the community.

We also wanted to visit the prison accommodation in HMP Cornton Vale. Due to Covid-19 restrictions at the time, we arranged to conduct a virtual visit to Ross Hall and to Dumyat, which is the Separation and Reintegration Unit (SRU). This was facilitated by SPS staff at HMP Cornton Vale.

²³ <https://www.coe.int/en/web/cpt/-/council-of-europe-anti-torture-committee-publishes-report-on-the-united-kingdom-focusing-on-scottish-prisons>

²⁴ <https://www.gov.scot/publications/independent-forensic-mental-health-review-final-report/>

We attempted to contact the women whose care we had examined after carrying out the review. We did this via their mental health teams, offering women the opportunity to speak with us about their experiences, if they wished.

Analysis and further consultation

Our analysis of case records identified a range of common themes which warranted further enquiry.

As the majority of women within our sample had received care in custody in 2018, during the CPT's visit to HMP Cornton Vale, we recognised that there may have been changes in the prison's mental health service since this time. We wanted to offer the opportunity to update the Commission on any recent improvement work. We also wanted to clearly identify areas of ongoing concern where change was needed.

We consulted a range of stakeholders to gather further information, discuss and explore areas of concern.

Professionals we consulted with:

- HMP Cornton Vale/NHS Forth Valley: Prison Governor, deputy and other senior SPS staff; mental health managers, prison mental health nursing team and visiting psychiatrists.
- Operational leads at the Scottish Prison Service
- Forensic Network representatives
- Her Majesty's Chief Inspector of Prisons in Scotland
- Chair of the Independent Review of Forensic Mental Health Services
- National Preventive Mechanism representatives
- Principal Medical Officer, Restricted Patient Team, Scottish Government
- Individual consultant forensic psychiatrists working in prisons.

Additional data and documents reviewed:

We also requested and reviewed further data relating to aspects of women's care in custody, including the use of segregation and the transfer of mentally unwell prisoners to hospital. This came from:

- Forensic Network
 - Prison to hospital transfer monitoring data 2018-2020 (unpublished).
- Scottish Prison Service
 - Data on numbers of women in prison custody across female prison estate.
 - Data on women held in segregation in HMP Cornton Vale for mental health (Jan-Dec 2020).
 - Data on prior custody episodes for the women reviewed (numerical only).
 - Draft documents on the design of the new women's prison service at HMP Cornton Vale and proposal for a policy of trauma informed care.
- Mental Welfare Commission
 - Data on Assessment Orders (AO), Treatment Orders (TO) and Transfer for Treatment Directions (TTD) granted over the past five years.

Demographic data

The nine women whose care we reviewed were aged between 30–55 years at the point of their admission to custody, with the majority aged 40–49.

Eight women had a past history of contact with mental health services and were under the care of mental health services in their local area when they entered custody.

Previous diagnoses recorded for the women included schizophrenia, schizoaffective disorder and bipolar disorder. Six women had a co-morbid diagnosis of personality disorder and had previously received compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003.

Six women were in prison on remand and three were serving a custodial sentence.

The number of previous custody episodes experienced by the women we reviewed ranged from 0 to just over 40.

Seven women received care in HMP Cornton Vale throughout the episode of custody we examined. Two women were held in custody in other prisons in Scotland. One woman was subsequently transferred to HMP Cornton Vale when she became mentally unwell.

All nine women were in custody in a prison outside their home health board area. For women with family at home, visits to prison would have required family members to travel out with their own area; in some cases this would have been a journey of several hours.

Findings

1. Health assessment in prison: identifying and addressing mental health issues

When a person arrives in prison custody, the reception process includes assessment and health screening by a member of the prison nursing team; either a registered general nurse or a mental health nurse. After initial screening, a GP review is carried out, usually the morning after arrival in custody.

1.1 What we found

Health screening on admission

Health screening questionnaires in prison asked about women's physical and mental health history, previous contact with services and any medication prescribed. Previous and/or current alcohol or drug use were also enquired about.

It was not always clear from the records whether the admission assessment was carried out by a general nurse or a mental health nurse.

In the screening assessments we reviewed, women were being offered support in relation to substance misuse. Several women had a history of polysubstance abuse. We saw evidence that review by the harm reduction team, who provided advice and support on substance misuse issues, including naloxone training, was being offered, though only a few women took this up.

Health screening was completed at the point of reception to custody in most, but not all of the cases we examined. One woman initially refused assessment on arrival at reception, but then engaged with the screening assessment the following day. Two other women refused the assessment process at reception. Both women were known to the staff and both had been liberated from HMP Cornton Vale during the previous five days. Each woman was seen by the prison GP the following day and received follow up from the mental health team. One of the women was taken straight to the Separation and Reintegration Unit (SRU) from reception. We discuss this later in the report.

In all but one of the cases we examined, women were reviewed by a GP the day after they arrived in custody. The one case where we could find no record of initial GP review is discussed further below.

Identifying mental health needs

Women were asked at the initial screening stage about their mental health, including any previous history of mental illness, self-harm, prior contact with mental health services, previous admissions and medication. An assessment was made of each woman's risk of self-harm or suicide.

In the records we viewed, when this screening identified mental health issues, we found details were clearly, if briefly, documented.

It was evident that a few women who had significant history of mental illness did not disclose this at initial health screening. One woman who had been receiving inpatient treatment prior to entering custody and had a background of support from mental health services, reported having no history of mental health difficulties. For women already known to the prison service, nursing staff carrying out the screening interview made a note of any established mental health history and previous medication (which could be found on the woman's electronic prison health record). However, for some women it was sometimes days or weeks before relevant mental health information was then obtained from their GP or locality mental health service.

When women presented in a way that suggested they were experiencing mental health difficulties, this was identified either at the point of reception by nursing staff, or at initial GP contact the following day, with a referral being made to the mental health team.

Concerns about risk of self-harm were assessed at the point women entered custody and were identified in two cases that we reviewed. In one case, and this had been noted in the CPT report, the woman had severely bitten her arm while in police custody. Both women were initiated on Talk to Me²⁵, a programme for preventing suicide in custody, as soon as concern about risk became evident, and 15 minute observations were initiated.

When medication for mental illness was identified at initial screening, this was usually reviewed and prescribed by the GP.

In one case where we could not find a record of initial GP review, the nurse carrying out the health screen had noted the woman's past history of severe mental illness and her previous treatment with antipsychotic medication. A plan was made to confirm her prescription with the GP. However, antipsychotic medication was not started until the seventh day of custody, at a GP review. Assessments by the mental health team during the interim period noted that the woman was responding to unseen stimuli and appeared distracted, distressed and, at times, verbally aggressive. The absence of medication did not appear to have been raised during this time.

We found it concerning that someone with a serious mental illness appeared to have remained in prison for a week without treatment or confirmation of their usual medication.

Barriers to information sharing

We saw evidence that accessing background information about a woman's mental health history and treatment could be a challenge and sometimes took a significant time. Most requests for background information were made by phone to either the GP or mental health service.

²⁵http://www.sps.gov.uk/nmsruntime/saveasdialog.aspx?fileName=Talk+to+Me+Strategy4679_2187.pdf

We saw one example where communication via email was used and this worked swiftly and effectively. In this case the prison health team had concerns about a woman when she arrived in custody and contacted her GP practice when it opened the following morning. The surgery sent an immediate electronic message to the GP who responded within minutes, confirming that a confidential summary could be sent via secure email to the prison health service.

In another case, urgent patient information was requested from a GP surgery but there was a delay in receiving this due to differing approaches to data sharing. The GP surgery was not comfortable emailing confidential information and preferred to use fax, which the health service was unable to accept due to local NHS policy. Eventually agreement was reached to use secure email.

1.2 Discussion

Health screening on admission

Initial screening carried out by nursing staff at reception appeared to be of a good standard in the cases we reviewed.

We were told that women entering custody in HMP Cornton Vale should be seen in the GP clinic the morning after they arrive in custody. A prompt GP review is important, particularly to ensure continuity of prescribing between the community and prison.

If women entering custody are well known to the prison staff and have only recently been released from custody, it is important they still receive routine health assessment when they arrive.

Identifying mental health needs

In general the identification of women's immediate mental health needs on admission to custody appeared to be responsive and well-coordinated.

When concerns emerged about mental health, either during reception screening or at the initial GP review, we saw swift referral to the mental health team. When women presented with evidence of risk to themselves on entering custody, we saw appropriate actions being taken with the use of Talk to Me.

It was evident that some women did not, or could not, give a full account of their mental health history at initial screening. People with mental ill health, and particularly more severe illness, may lack insight into their mental health difficulties and may deny they have an illness, require treatment, or could benefit from support. It is a concern if a person's mental health record in custody relies solely on self-report. Timely access to information from primary and/or secondary care services is essential.

We discussed concerns about prescribing and potential delays in confirming medication with the health team at HMP Cornton Vale. Managers told us there is now electronic access to the Emergency Care Summary (ECS) for every woman admitted to custody. The ECS is an electronic document, held by GPs, which provides core health information about a person, including their current prescription. This means that if a person arrives in prison custody out of hours, urgent information about their medication can be obtained prior to their GP surgery re-opening. Women should now be able to be prescribed their usual medication on entering prison custody.

Barriers to information sharing

Where background information about a woman's health history needs to be obtained, currently this has to be requested on a case by case basis. This process may be quick and straightforward, or not.

We are advised that the current procedure at HMP Cornton Vale is for nursing staff to contact external agencies by email or telephone to request additional information about a person within 24-48 hours of their arrival in custody.

Health records in Scottish Prisons are held digitally on the Vision system. Individual patient medical records in many NHS Boards are also now held electronically, but the clinical IT systems in use vary between regions (TRAK and EMIS are two examples used in different NHS boards). Whilst GP practices also use electronic patient records, they do not all use the same software and social work and criminal justice records are held on separate systems again. Currently these electronic systems do not interface in a way that patient data can be shared through a single platform. This adds to barriers in effective information sharing.

The issue of lack of information being available at the point of reception from key services was something highlighted previously by HMIPS in their inspection report on a visit to HMP Cornton Vale in 2016.²⁶

The NHS Scotland Digital Health and Care Strategy (2018)²⁷ highlighted the importance of accessing health and social care information at the point of care, with a vision that data sharing in the future could be achieved through a single platform.

Concern was again raised by the CPT in their 2019 report, with a recommendation for improved information technology (IT) in this area, including the development of an electronic prescribing system.

The UK Government's response to the CPT's recommendation advised:

"The Scottish Government has made a commitment in its 2018-19 Programme for Government to improve clinical IT systems in prisons to make services safer and more efficient. An NHS National Services Scotland (NSS) review of the use of clinical IT across all prisons and NHS Boards will include options for delivering electronic prescribing in prisons as part of its wider work to address national barriers to improvement of services."

We have been advised that Clinical IT is a focus of current work streams being progressed by both the Prison Care section of the Scottish Health in Custody Network at NHS National Services Scotland (NSS) and the Health and Social Care in Prisons Programme Board²⁸.

We understand that progress on these work streams, and that of NSS Digital and Security, which is looking at delivering electronic prescribing in prisons, has been delayed as a result of

²⁶https://www.prisoninspectoratescotland.gov.uk/sites/default/files/publication_files/HMP%20YOI%20Cornton%20Vale%20-%20Review%20Inspection-%2011-13%20October%202016.pdf

²⁷ <https://www.gov.scot/publications/scotlands-digital-health-care-strategy-enabling-connecting-empowering/>

²⁸ The Health and Social Care in Prisons Programme Board was established by Scottish Government in 2018, with the aim of "driving improvement in health and social care in prisons by removing structural barriers to delivery". The Programme Board have set out plans to provide a clinical IT system in prison "which supports the Delivery of health and social care, including transitions to and from the community that provides data to measure key indicators and drives improvement".

Covid-19. We will follow up with the Scottish Government to ensure that actions to progress this critical work are back on track.

While clinical IT systems are being reviewed and developed, it is important that health service managers in prisons ensure there is a local policy and process in place for obtaining the health information about individual prisoners. This should provide clarity on:

- Timescale by which health information is obtained following initial screening (e.g. within 2 working days)
- Who will request and collate this information
- Data sharing arrangements. To avoid confusion or differences in local practice in the secure sharing of confidential information, a brief document outlining this process which can be shared with GP/specialist health services in an individual's health board, may be helpful.

1.3 Health assessment in prison: identifying and addressing mental health issues - recommendations

To Health Managers - HMP Cornton Vale/ all prisons

- Health managers in HMP Cornton Vale/ all prisons should ensure that:
 - All people arriving in custody receive an initial review by a GP and any required medication is prescribed without delay.
 - When additional information about a person's health is required, this is requested from local NHS services without delay.
- Managers of all prison health services should ensure there is a local policy in place with clear processes for requesting health information about prisoners from NHS services that ensures this data is obtained in a secure and timely way.

2. Access to mental health support in prison

We focus here primarily on the support women received in HMP Cornton Vale, as women entering custody with significant mental health needs are most likely to receive care in this prison. Where we reference care women received in other prisons, this is clearly stated.

2.1 What we found

Referrals

Referrals were made to the mental health team by nursing staff carrying out the initial admission assessment, by the prison GP or, on occasion, by SPS staff when they had concerns about a woman they were supporting in custody.

Assessments

Following mental health referral, initial assessments were carried out by a member of the mental health nursing team. This usually took place within 24 hours, or on the same day if this was urgent.

When there was concern about an individual's risk, they were placed on Talk to Me. We saw examples where this had been initiated by prison staff when they had concerns about a woman's presentation. We saw evidence of regular review for women placed on Talk to Me, with multidisciplinary discussions taking place, including consultation before observations were discontinued.

In all cases we reviewed, women were seen by the visiting psychiatrist for further assessment and review. In a few cases, where urgent concerns were highlighted by mental health nurses, psychiatric review took place within the first week. In most cases women saw a psychiatrist in the second week.

One woman, who had presented with signs of mental illness and significant risk on arrival in custody, was assessed by mental health nurses and seen daily, but was not seen for psychiatric review until day 13, at which point referral to hospital was considered. At that time the visiting psychiatrist had weekly sessions.

It was unclear why there was a delay in this case, but we believe psychiatric review should have taken place sooner.

For the women who received care in other prisons, records indicated that initial assessments for mental health concerns were prompt, responsive and resulted in a clear action plan.

Monitoring, treatment and therapeutic support

When the mental health nurses at HMP Cornton Vale identified concerns about a woman's mental state, daily reviews then took place. Sometimes women were seen more than once a day by mental health nurses (RMNs) when there were acute concerns.

The majority of women we reviewed received daily nursing input throughout their time in custody.

Following initial psychiatric assessment, most women were also seen for weekly psychiatric review. This enabled the prescribing of medication and review of treatment response, as well as the opportunity to refer for inpatient care when this was indicated. In several cases, there were however significant delays in accessing a hospital bed.

For the two women who spent time in custody in other prisons (not HMP Cornton Vale), we found that mental health monitoring and support differed.

In one case the response of the prison mental health team was swift: risks were immediately identified and close monitoring followed, with evidence of good liaison between staff and monitoring of risks.

The second case related to a woman who was in custody in a different prison. After reporting difficulties with anxiety she was referred for psychological therapy and psychiatric review. The psychiatrist prescribed antidepressant medication, which was increased to the maximum dose over two appointments. Prison health records suggested that the woman's mental health deteriorated significantly over the following two months, with signs of an evolving manic psychosis. This was not picked up by the other health professionals she had contact with until prison officers raised concerns. When she was seen by the psychiatrist for routine follow up, she was noted to have active psychosis and was considered to be at risk. The psychiatrist prescribed treatment with antipsychotic medication and hospital transfer was considered. This woman's case is currently the subject of further Mental Welfare Commission enquiries.

There was evidence of input from allied health professionals such as occupational therapy in only one of the nine cases we reviewed.

We saw only one reference to psychology input among the cases we reviewed and this support ceased when the woman became acutely mentally unwell.

Medication

We were able to carry out a review of prescription sheets for most of the women who had received treatment in HMP Cornton Vale.

When women became acutely mentally unwell, we saw that psychotropic medication was usually prescribed, with dose increases as required. Compliance with medication was however variable. A few women consistently refused the psychotropic medication prescribed.

In one case, a woman with acute psychosis refused medication for eight consecutive days prior to her transfer to hospital. This included medication for a physical health condition as well as the antipsychotic drugs she was prescribed.

There was no reference to 'as required' (prn) medication being prescribed in any of the cases we reviewed. In a few cases we saw a record of 'once only' medication for mental health. In one example, a single one-off dose was not dispensed; in another, only one of the two prescribed doses was given.

When a dose of medication had been refused, or missed for another reason (for example, when a woman was attending court), this was usually recorded by nursing staff on the prescription sheet. However we found instances of omissions in some dispensing records:

- In three of the prescription records examined, a single day's dispensing was missing, without obvious explanation.
- In a fourth record six dispensing days were missing across a three month period.
- In a fifth record there was no record of dispensing for five separate days in a single month.

This was a significant concern, especially given the number of discrepancies found in a very small sample of records.

2.2 Discussion

Assessment

Mental health care in prison is expected to deliver parity with the mental health care a person would otherwise be able to access in the community were they not in custody.

In the cases we examined we found that mental health nursing assessments in HMP Cornton Vale were responsive and timely, comparing favourably with access that might be available in the community. Risks were promptly identified and appropriate risk management initiated.

Monitoring, Treatment and therapeutic support

The opportunity for daily nursing review and weekly reviews by a consultant psychiatrist for women in prison would compare favourably with mental health supports available in most community settings. This level of support might only be matched in the community by a mental health crisis response team or home treatment team.

In their 2016 inspection report to HMP Cornton Vale²⁹, HMIPS highlighted a number of areas of good practice in the mental health team, including weekly team meetings (to discuss existing patients and new referrals), the introduction of peer clinical supervision and line management supervision for all nursing staff with the mental health lead. The nursing team and clinical nurse manager confirmed that these practices continue. We have maintained contact with HMIPS throughout our enquiries and since their last visit to HMP Cornton Vale in 2020, in which the inspectors were positive about their findings and progress being made, as outlined in their recent visit report³⁰.

Nursing

The CPT had raised concerns about mental health nursing vacancies in their follow up visit to HMP Cornton Vale in October 2019 (as published in their 2020 report)³¹. This is not an issue unique to HMP Cornton Vale, but reflects wider challenges for mental health services across

²⁹https://www.prisoninspectoratescotland.gov.uk/sites/default/files/publication_files/HMP%20YOI%20Cornton%20Vale%20-%20Review%20Inspection-%2011-13%20October%202016.pdf

³⁰ <https://www.prisoninspectoratescotland.gov.uk/publications/prison-monitoring-summary-hmp-cornton-vale-jult-september-2020>

³¹ <https://www.coe.int/en/web/cpt/-/council-of-europe-anti-torture-committee-publishes-report-on-the-united-kingdom-focusing-on-scottish-prisons>

Scotland, with large numbers of nursing and medical posts remaining unfilled across the NHS at the present time.

Previous Commission visits to prisons across Scotland suggested that the level of mental health nursing support available at HMP Cornton Vale was greater than that available in most other (male or mixed) prisons, reflecting the increased mental health needs of its female population³².

In December 2020, the nursing team comprised three full time RMNs, including a learning disability nurse, with two vacant posts being re-advertised. Shift patterns had continued to enable daytime RMN presence in the prison seven days a week and evening shifts from Monday to Friday had also continued to enable RMNs to carry out admission assessments for women arriving in custody.

We heard from the range of SPS staff we spoke with at HMP Cornton Vale that mental health nursing colleagues were often present and visible around the prison hall during the day. The prison staff spoke positively about this support, describing the mental health team as accessible and supportive, particularly in the management of women with acute or complex mental health needs.

Psychiatry

The provision of consultant forensic psychiatry input to HMP Cornton Vale has changed in recent years. In 2018 a service agreement was in place with the State Hospital to provide medical support. This is now provided by NHS Forth Valley by two part-time consultant forensic psychiatrists, offering input across three sessions each week (approximately 1.5 days per week). Managers told us this arrangement works well. With both psychiatrists working locally, there is also improved access to urgent advice and support if needed.

Psychology

The main input lacking in the cases we reviewed was psychology support.

Support from psychology is still limited, but we are told that clinical psychology time has been increased, with HMP Cornton Vale now receiving up to four sessions of psychology input per week. We were advised that the psychologist working with the team holds a caseload, accepts new referrals for assessment and also provides training for health and SPS staff. We discuss the importance of the role of psychology for women who are mentally unwell in prison in section 3.

Other multidisciplinary support

Interventions from other healthcare professionals, such as occupational therapy (OT) who could have offered support with therapeutic activities or in helping women to structure their day, was also notably absent in almost all cases we viewed.

There have been further recent additions to the multidisciplinary team at HMP Cornton Vale. Following a pilot of mental health OT input, funding was put in place to continue this support.

³² <https://www.mwscot.org.uk/sites/default/files/2019-06/Mental%20health%20of%20Prisoners%202011.pdf>

The provision of further funding, linked to Action 15 of the Mental Health Strategy (2017-2027)³³, had also enabled access to additional speech and language therapy (SALT) support. Mental health managers advised us that SALT input was proving invaluable in helping SPS staff and health professionals to support prisoners with autism or learning difficulties. SALT were also providing communication and literacy support to women in HMP Cornton Vale and helping to develop more accessible information for prisoners. As a result of these positive changes, support from SALT was increased from three days a week to full time.

The Commission welcomes these improvements and the positive impact they are noted to be having on women's care. We look forward to hearing more about these supports and women's experiences when we next visit.

Medication

The recording discrepancies we found were a serious issue. It is not clear whether on some occasions women refused medication and this was not recorded, or whether dispensing was missed for another reason.

This issue required further scrutiny by managers in the prison health service and we requested that senior managers look into this urgently. The Commission will continue to follow up progress on this issue and will review prescribing on future Commission visits to HMP Cornton Vale.

On a national level, the Commission supports the CPT's recommendation for the establishment of an electronic prescribing (e-prescribing) system in prisons to replace the current paper based Kardex system. Electronic prescribing is now in use in many NHS inpatient settings in Scotland. E-prescribing systems automatically alert any discrepancies, such as omissions in a person's dispensing record, and so offer better safeguarding in the delivery of pharmacological treatments.

2.3 Access to mental health support in prison - recommendations

To Health Managers - HMP Cornton Vale

- Health Managers at HMP Cornton Vale should carry out an urgent review of current prescribing/dispensing and establish a programme of regular audits.

To Scottish Government

- The Commission repeats the CPT's recommendation to Scottish Government for the establishment of an electronic prescribing system in Scottish prisons.

³³ <https://www.gov.scot/publications/mental-health-strategy-2017-2027/>

3. The prison environment for care of acutely mentally unwell women

Most women requiring mental health support in prison are likely to be experiencing mild to moderate mental health issues. However, on occasion women may become severely mentally unwell.

The women whose care we reviewed were either acutely mentally ill or experiencing significant mental health difficulties in the context of personality disorder and complex mental health issues.

Here we explore what their records told us about their care. We consider the environment in which women received mental health care in prison and discuss areas of concern. In particular we consider concerns about the segregation of women with acute mental illness in Ross House and the Separation and Reintegration Unit (SRU) as highlighted in the 2019 CPT report.

3.1 What we found

Prison accommodation in HMP Cornton Vale

In HMP Cornton Vale, women experiencing mental health problems are usually housed in the care suite in Ross Hall. Women from other prisons who develop significant mental health needs may also be transferred here.

Ross Hall

Ross Hall is a modern prison building, accommodating women in 29 cells over 2 floors. The cells are arranged on three sides around a large, open plan, glass fronted, double-height concourse. We were told there are usually six SPS staff on duty in Ross House at any one time. Women entering custody are usually housed in the upper, mezzanine, floor of Ross Hall for their first night. Some of the 15 rooms on the upper floor are double occupancy, though most are currently used as single cells. Following an initial 72 hour assessment most women will be transferred to other prison establishments. Untried (remand) prisoners are usually transferred to Edinburgh, Polmont or Greenock, whilst sentenced prisoners may be transferred to other prisons, or to Peebles House in HMP Cornton Vale. Women with heightened care needs may remain in Ross Hall for a period, with a view to transfer to mainstream prison custody. Those with enhanced needs may however remain in Ross Hall and be housed in the care suite.

The care suite comprises of fourteen single occupancy rooms on the ground floor and accommodates women who are more vulnerable. Women who are pregnant, transgender women or occasionally young persons may be cared for here (though most young offenders are admitted to HMP and YOI Polmont). Most women housed in the care suite however are there due to mental illness or distress.

Five of the rooms in the care suite are safe cells; these have anti-ligature bedding and no electrical sockets. All care suite rooms have a call-point system and inbuilt radio. Women not in safe cells can have a TV and kettle in their room. Each room has a sink and a toilet. Showering facilities are communal.

There are some recreational facilities in Ross Hall; the recreation room has a TV, pool table and seating area, there is a small lifestyle kitchen, access to a gym and to a large outdoor exercise area. There is a multi-faith room for pastoral care. Chaplaincy support can be provided on a one to one basis. An art therapist visits twice a week and there is a walking club and a visiting therapist. Pre-Covid, when the women we reviewed were in HMP Cornton Vale, the prison regime allowed women access to communal time during lunch and in the evening, as well as more frequent access to outdoor space.

Dumyat – Separation and Reintegration Unit

The Scottish Prison Service defines a Separation and Reintegration Unit (SRU) as “a small dedicated unit within the establishment, where offenders have been removed from normal association with a view to returning.”³⁴

HMP Cornton Vale is the only prison in the female estate with a dedicated SRU for women prisoners. This unit, adjoining Ross Hall, is known as Dumyat.

In the SRU there are six cells, one of which is a safe cell, with no electrical points. The cells are housed along a single narrow corridor. Each cell contains a bed, basin, toilet and showering cubicle. There is natural light through a window. SPS advise that women are housed in their cell for up to 22 hours a day. There are two small fenced exercise yards, providing enclosed space for time outdoors. The airiness, natural light and feeling of space present in the environment of Ross Hall is notably absent in the SRU.

The unit is staffed by a core team of SPS staff. Staff support is available on the unit during dayshifts. In the evening and overnight, women in the SRU can access staff in Ross Hall via the call system in their room.

Care in Ross Hall

Of the women we reviewed who spent time in custody in HMP Cornton Vale, a few spent the majority, or all of their time in Ross Hall.

Acute symptoms and levels of distress

A number of women, whose care we reviewed, were experiencing acute psychotic illness, or psychotic-type symptoms in the context of personality disorder, whilst in the prison hall setting.

Several women were described as clearly responding to auditory hallucinations. Others experienced persecutory ideas about prison staff and/or other prisoners, such as being spied on, watched by cameras or believing that staff or other prisoners were trying to harm them. One woman believed there were snakes in her cell and in her body. Women experiencing these symptoms were often described as distressed, agitated and behaviourally disturbed. In the records, there were also references to women shouting, becoming verbally aggressive, threatening or physically violent. Sometimes this was directed at other prisoners. Other women who were unwell were described as ‘frightened’, ‘scared’ and ‘confused’.

³⁴ https://www.sps.gov.uk/Glossary/Glossary_AtoZ.aspx

A few women experienced hypomanic symptoms while in Ross Hall. Their notes indicated that they displayed behaviours such as sexual disinhibition (with inappropriate, highly sexualised conversation and sexual accusations made against staff and other prisoners) and irritability, being loud and sometimes shouting and screaming in the prison hall.

At times women were segregated, being kept in their cell behind a locked door due to their level of disturbance.

Reviewing these records raised concerns about issues of privacy and dignity for the women who were unwell. Their distress and level of disturbance would undoubtedly have been evident and audible to other prisoners, even when confined to their own cell.

Self-care

A number of women experienced a significant deterioration in their self-care in the context of their mental disturbance while in Ross Hall. There were references to women neglecting their personal hygiene or refusing to wear clothing. One account referred to a mentally distressed woman urinating on the floor, while another's cell was said to smell of faeces.

Deterioration in the women's care of their immediate environment was also evident. One woman's cell was described by a mental health nurse as having a foul smell due to old food.

Mental health treatment and support

Women received support from the mental health team through regular - usually daily - visits by nursing staff and weekly reviews by the visiting psychiatrist. We saw evidence that mental health nurses tried to spend time offering support, but often women were too distressed or unwell to engage.

Women received weekly psychiatry reviews and medical treatment was often prescribed, but some women refused medication when they were acutely unwell or behaviourally disturbed. Because there was no access to prn medication, pharmacological treatments to help manage distress and acute symptoms were limited.

We did not see evidence of behavioural management plans or psychological interventions to try and support women in managing their distress.

Interpersonal contact and therapeutic activities

During the rare times when women were not described as acutely distressed, in a few cases we saw reference to contact with other prisoners, time spent in outdoor exercise or occasionally other activities.

One woman with a diagnosis of personality disorder had very complex mental health needs, with significant risk behaviours at times when she became distressed in custody. She had been transferred to hospital for a period of inpatient assessment, but was not found to have an acute mental illness and was returned to prison custody. The record of contacts from mental health nursing staff and the visiting psychiatrist suggested that the woman's mental state could fluctuate significantly, often in response to external stressors, resulting in marked changes in her presentation, sometimes from day to day or even hour to hour. She was however able to achieve some periods of stability in custody and during these times there was reference to positive engagement with staff, including a number of allied health professionals. Support workers assisted her with activities of daily living, whilst the occupational therapist engaged her in a range of activities including an art group and craft sessions. The records suggested that these interventions had a positive impact on her mood and sense of wellbeing during the times she was able to engage.

However due to the nature and severity of the mental health difficulties most women were experiencing, their ability engage socially or in therapeutic activities was extremely limited. We saw that some women began to self-isolate when they were unwell, choosing to only leave their cell for medication and food.

Environment and restrictions

The Prisons and Young Offenders Institutions (Scotland) Rules 2011³⁵, enable individual prisoners to be restricted in certain situations. If there are concerns from prison staff and/or health professionals about a person's behaviour due to their health, restrictions can be placed on their movements and social contacts via the use of Rule 41, Accommodation in specified conditions³⁶. A health professional must make a request to the prison Governor to apply Rule 41. Use of this rule can include confining a person to their own cell, placing them in segregation.

All women whose care we examined were subject to rule 41 during at least part of their time in HMP Cornton Vale. When women were acutely disturbed we saw reference to them being confined to their cell environment.

All women placed on Rule 41 were reviewed at least once a day by the mental health team. We saw evidence of Rule 41 care plans being put in place and of Rule 41 case conferences taking place. These involved both health and SPS staff reviewing the woman's care and assessing the need for continuing restrictions under the prison rule.

When prison staff and the mental health team felt that a woman's behaviour was no longer safe or manageable in Ross Hall, a decision to transfer to the SRU was made. This often appeared to be a last resort.

³⁵ <https://www.legislation.gov.uk/ssi/2011/331/contents/made>

³⁶ A health professional can make a request to the prison Governor to apply Rule 41 to authorise accommodation in a specified part of the prison. This may include confining a prisoner to their own cell. Rule 41 can apply for all aspects of healthcare and, for example, has recently been used when prisoners have required to be isolated due to Covid-19. Use of Rule 41 requires regular review by the prison Governor and includes additional safeguards. This rule also makes provision for time spent in association with other prisoners for specified periods or purposes, if this is agreed as appropriate.

Care in Dumyat, the Separation and Reintegration Unit (SRU)

The transfer of any prisoner to an SRU requires the use of either Prison Rule 95 “Removal from Association”³⁷, or, where transfer is required for healthcare reasons, this can be authorised under Rule 41.

Almost all of the women we reviewed who received care in HMP Cornton Vale spent time in the SRU under rule 41. The amount of time these women spent in the SRU ranged from a few days to several months. All of these women were either acutely mentally unwell or had personality disorder and complex mental health needs. One woman from the latter group, who was well known to prison staff, had been transferred directly from reception to the SRU due to her presentation in reception. She remained in the SRU for over a month until her liberation from custody.

Acute symptoms and levels of distress

Whether women were acutely mentally ill, or acutely behaviourally disturbed in the context of emotional dysregulation and personality disorder, we saw descriptions of similar patterns of response to being placed in segregation, particularly in the SRU.

Emotional distress was evident in all the cases we reviewed, whether this was stated explicitly through women’s health records, or was being communicated through their behaviours, such as ‘shouting’ and ‘screaming’. Whilst the descriptions of women in the SRU echoed some of the presentations seen when women were in Ross Hall, the women seemed more disturbed in the SRU environment and accounts of their stress and distressed behaviours more pronounced.

For women who were floridly unwell with acute psychosis or manic psychosis, the severity of their symptoms and level of disturbance significantly worsened in the SRU.

Self-care

Self-neglect was a strikingly common feature in the SRU, and the extent of this also appeared more extreme and pervasive than in Ross Hall.

We saw frequent use of the term ‘dirty protest’. Although a term used by prison staff, it was also being used by nursing and medical staff in the clinical records, as well as in medical correspondence. It appeared to be a shorthand way of describing a range of behaviours, but in itself offered little clinical meaning. When accompanied by description, this term variously referred to a person throwing/discarding food around their cell, urinating or defecating on the floor or smearing faeces or bodily fluids in the cell environment.

There was specific reference to “dirty protests” in relation to elimination and/or smearing behaviours in a concerning number of the cases we reviewed, including in women who were acutely mentally ill. This behaviour is highly unusual, as the following examples help demonstrate.

³⁷ The Prisons and Young Offenders Institutions (Scotland) Rules 2011; Rule 95: <https://www.legislation.gov.uk/ssi/2011/331/article/95/made>

One psychiatrist recorded visiting a woman with psychosis in the SRU:

"Officers reluctant to allow me to interact. Advised that [woman's name] is currently on a "dirty". Room strewn with mess including faeces. Very unusual for [name] as room up until recently was very organised. [Name] would not interact with me. When I asked why she had defecated on the floor, she stated that I knew why. No other interactions at this time as staff closed the door."

One woman who was unwell in the SRU and awaiting inpatient care was refusing to wear clothes, instead remaining naked in her cell. Her mental state continued to deteriorate and after a number of weeks, the mention of "dirty protests" began to appear in the clinical record. Following her subsequent treatment in hospital, her discharge summary noted:

"On admission to the ward, (the patient) appeared more settled than she had in the prison and indeed was no longer dirty protesting or taking off all her clothes."

These distressed (and distressing) behaviours were also documented among women with personality disorder in the SRU.

There were references to prison staff only entering a woman's cell when wearing protective clothing. There was mention of a cell being 'bio cleaned', and to women being moved to other cells, or on occasion back to Ross Hall temporarily, when their cell was undergoing cleaning or was out of commission.

Mental health treatment and support

Women were reviewed by mental health nurses on a daily basis, and usually weekly by a psychiatrist while on rule 41 in the SRU. However health records suggested the clinical contact was often brief, if possible at all.

In some instances women refused to engage, at other times they were too unwell or behaviourally disturbed to enable meaningful contact. On occasion, prison staff did not permit extended contact or physical proximity, due to concerns about risk (either due to violence or an unsanitary cell environment).

We saw references, both in nursing contacts and psychiatric reviews, to women being seen at their cell door, or sometimes only through the small hatch. Comments included:

"too volatile to open door"

"becoming more agitated the longer we stayed"

By the time women were transferred to the SRU, several had poor compliance with medication. When women who were acutely unwell were not receiving treatment, the daily recording from mental health staff painted a disturbing picture of decline into more serious illness and psychosis.

For women with a primary diagnosis of personality disorder, the clinical record also suggested deterioration into what appeared to be described as psychotic symptoms and disturbed behaviour over time in the SRU. When treatment was delivered, this could however make a significant impact in ameliorating symptoms as the following example illustrates:

One woman with a long history of complex mental health problems, including a diagnosis of emotionally unstable personality disorder, was transferred to the SRU after a deterioration in her presentation in Ross Hall. Her mental state was variously described as 'distressed', 'difficult to engage', 'hostile', 'aggressive', 'abusive' and 'threatening'. The psychiatrist noted this was similar to her previous presentations in custody. She refused a trial of antipsychotic medication to help with her labile mood.

By the second week in the SRU, the emergence of possible psychotic symptoms was suggested. Her self-care also deteriorated significantly and her disturbed behaviour meant that there was little meaningful engagement with either prison or health staff. This clinical picture continued until her ninth week in the SRU. She then agreed to start a low dose of antipsychotic medication.

Over the following week there was a noticeable change in recorded contacts with mental health staff, with her presentation variously described as: 'polite', 'pleasant', 'not distressed', 'appropriate' and 'engaging well'.

There was no mention in the clinical records of strategies or behavioural approaches being trialled to manage or attempt to ameliorate women's levels of distress.

In the cases we reviewed, there was no evidence of involvement from psychology whilst women were in the SRU, nor was there evidence of input from allied health professionals.

Interpersonal contact and therapeutic activities

Women in segregation in the SRU appeared to have little opportunity for meaningful interaction with others. There was no reference to contact with other prisoners. In one case we saw a few references to a woman having telephone contact with family members.

There was no reference to therapeutic activities while women were in the SRU. Occasionally there was mention of time spent in the exercise yard.

Environment and restrictions

The regime in the SRU is highly restrictive, with women locked in their cells for up to 22 hours per day. From the descriptions in some women's health records, it was difficult to envisage them at some points having had any time out of their cell.

The physical environment of the SRU, and individual cells, is sparse and lacking in comfort. The narratives in women's notes suggested there was little in the way of positive sensory stimulation in the environment of the SRU. There was limited human contact and if other women in the SRU were distressed or unwell, their vocalisations were likely to be audible, disturbing and distressing. When women's self-care deteriorated, they may also have experienced physical and sensory discomfort in this context.

We heard from health and prison staff that women's environments were often cleaned daily when there were concerns about hygiene. We were advised that full cleaning always took place within 72 hours at a maximum.

Part of the ethos, and indeed the name of SRUs, is that offenders are reintegrated into the mainstream environment after a period of time. Reintegration did not appear to feature in the majority of cases we reviewed. Women were either transferred to hospital care or liberated directly from the SRU. One woman was transferred back to Ross Hall for a period, but only while the SRU was out of commission; she was later returned to the SRU.

Advocacy

We saw no reference to any women accessing advocacy support or advice, either while they were in Ross Hall or the SRU. This was a concern as advocacy is critically important to help women in prison to express their views, wishes and to claim their rights.

3.2 Discussion

The accounts describing these women's distress and mental deterioration in prison were deeply disturbing and echoed the findings from the CPT's visit.

The use of segregation

In their 2019 report, the CPT noted that ***"women were locked alone in their cells for 23 to 24 hours each day"***. The CPT considered that ***"solitary confinement should only be used to an absolute minimum"***.

The findings from our small review of cases appears in line with the evidence subscribed to by the CPT that ***"prolonged isolation can have an extremely damaging effect on the mental, somatic and social health of those concerned"***³⁸. The CPT recommended that Scottish authorities ensure that:

"All prisoners, including those in conditions of segregation, should be afforded, as a bare minimum, at least two hours of meaningful human contact a day, be that on the telephone to family, in appointments with internal or external staff or visitors, in activities, education or exercise with other risk assessed prisoners".

We also agree with concerns raised by the CPT about the use of prolonged segregation for women with mental illness, whether this takes place in Ross Hall or the SRU. We would view the SRU environment as being particularly inappropriate for women with mental disorder and it was concerning to note that one woman with complex needs had been transferred to the SRU directly on arrival at the prison and had remained there until her liberation.

In our discussions with both prison staff and the mental health team at HMP Cornton Vale, all shared their concerns about women with mental health issues receiving care in the SRU. Some health staff described the culture and regime of the SRU being one associated with *"punishment"*, and expressed concern that women's behaviour could sometimes be viewed through the lens of *"bad behaviour"* rather than through one of mental illness, distress or trauma. This however was not the prevailing attitude among the SPS staff we spoke with, who expressed compassion and concern for this vulnerable group of women.

Staff who had worked in HMP Cornton Vale for a number of years said they had noted a marked reduction in SRU use for women with mental health needs and welcomed this change. There was a perception among both health and prison staff that that it was now relatively unusual for women with mental health issues to be placed in the SRU, and when this did happen, it was only in extreme circumstances, with women being quickly re-integrated back into the mainstream hall.

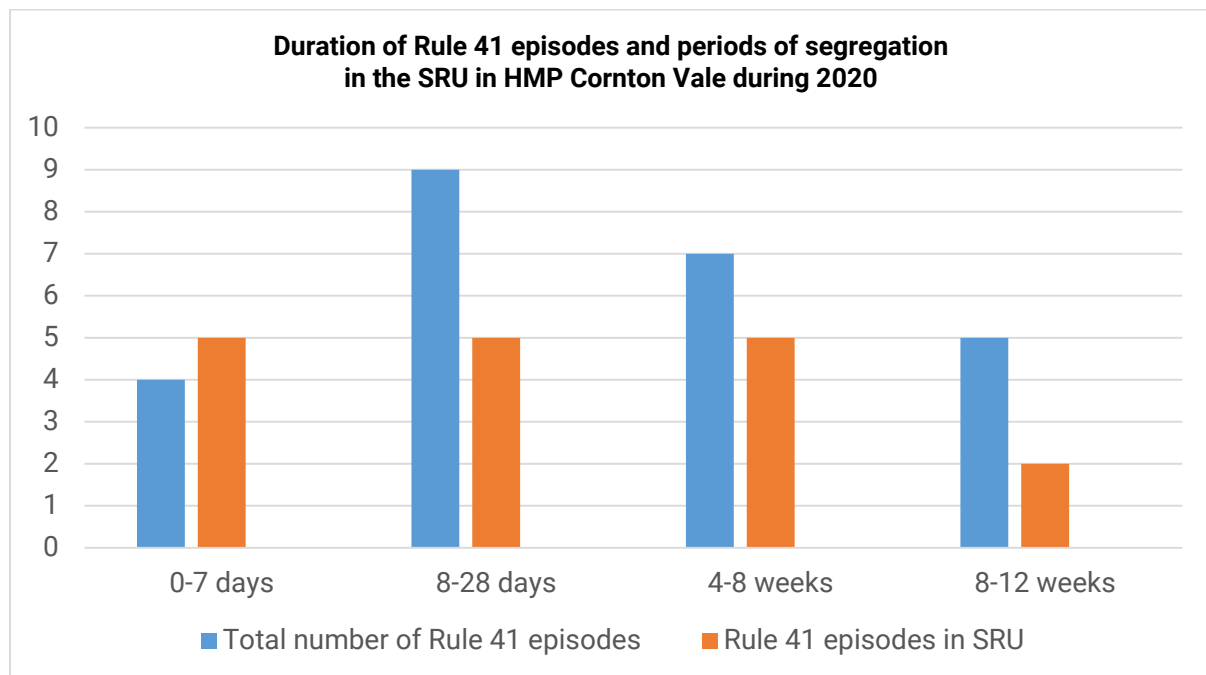
³⁸ See Essex Paper 3 p88-89 "Initial guidance on the interpretation and implementation of the UN Nelson Mandela Rules." Penal Reform International and Essex Human Rights Centre, University of Essex (Feb 2017) https://www1.essex.ac.uk/hrc/documents/practice/Essex_III_2017.pdf

In contrast to these reports, data provided by HMP Cornton Vale on the use of rule 41 during 2020 suggested that segregation in the SRU for women with mental health issues was in fact still being used on a regular basis. The time spent in the SRUs was often prolonged.

From January to December 2020, 23 women were subject to Rule 41 for mental health reasons during their time in custody. A total of 25 Rule 41 episodes were recorded, the duration of which ranged from 1 - 82 days (average 32 days).

In seventeen of these 25 episodes, women were in the SRU for part or all of the time they were subject to this rule. The period of segregation in the SRU ranged from 1 – 70 days (average 23 days).

A summary of this data is shown in the chart below.



It was concerning to see that seven women had spent more than 4 weeks in the SRU on rule 41, with two of these episodes lasting more than eight weeks.

In 2020 the CPT reiterated its recommendation that:

“a psycho-social support system for women prisoners held for longer than two weeks in segregation be established and that prisoners be provided with greater opportunities for association and engagement in purposeful activities, including being offered at least two hours of meaningful human contact every day and preferably even more.”

The Commission fully endorses and echoes this recommendation.

In its response, the Scottish Government confirmed that a Working Group had been set up to look at SRUs and that SPS’ Director of Operations had “agreed that a fresh look at build specifications for SRUs in new prisons will be a requirement of projects”.

We welcome these initiatives and suggest that the principles outlined in the Mental Welfare Commission’s Good Practice Guidance on the Use of Seclusion are considered when the SPS review of SRU practice is undertaken.

Supporting women in the prison environment

It was concerning to see how little mental health staff were sometimes able to engage with and support women who were acutely mentally ill or distressed.

When pharmacological treatments were also not accepted, there appeared to be little in the way of other therapeutic options on offer.

The lack of multidisciplinary input available to women, particularly in segregation, and the absence of psychological therapies or trauma-informed supports was a concern in the cases we reviewed.

For women who were acutely unwell, it was very clear that the need was for them to be transferred to inpatient care at the earliest opportunity.

For those women with more complex mental health problems and vulnerabilities, for whom hospital care was often not an option, segregation appeared to be used as a way to manage their high levels of distress and behavioural disturbance in the custody environment, though it appeared to only lead to escalation. There was little in the way of therapeutic programmes or psychological supports to provide alternatives.

In 2019 the CPT made the following recommendations for these women:

“The Scottish authorities take the necessary steps towards addressing the specific needs of female prisoners with personality/behavioural disorders through introducing therapeutic tailor-made programmes. ”

The Scottish authorities, the SPS, the NHS, the judiciary, and social services need to work together to protect these women inmates, suffering from personality and behavioural disorders, and/or having a history of self-harming, abuse and abandonment. Where such prisoners are not eligible for transfer to a psychiatric hospital, a multi-faceted approach should be adopted, involving clinical psychologists in the design of individual programmes, including psycho-social support and treatment.”

It repeated this recommendation in its 2020 follow up report.

When we asked mental health managers about progress in this area, we were told that one to one psychology support is now offered in individual cases and that referrals can be made for women with complex needs and behavioural disturbance. In these cases, psychology have on occasion been involved in providing formulation and offering consultation and advice to prison and mental health staff.

Health managers told us that enhancement of the multidisciplinary team, and in particular the recent addition of mental health OTs had made a difference, particularly for women held in segregation. We were told the OTs were involved in supporting women through Talk to Me reviews and working with those on Rule 41 where appropriate. This support included sensory work and help with structuring daily activities. The mental health team spoke of this support already having a significant positive impact on women’s experience.

We welcome the reported progress being made, but there is still a lot of improvement work needed. It is hoped that the new Trauma Informed Strategy will begin to better support this vulnerable group of women once it is operational.

The new prison environment

We have received updates from SPS about the design of the new build at HMP Cornton Vale.

The new buildings will provide single storey accommodation across a number of 'houses' on a campus style layout, with views out over the surrounding grounds. There will be no bars on windows and we are told that the buildings have been designed to provide more of a domestic feel, within a trauma-informed custody environment.

It is planned that women with mental health needs will no longer be cared for in the SRU. The new SRU will be used solely for women requiring segregation for disciplinary issues. Instead, women with high care needs due to mental health will be cared for in an Enhanced Needs Area. This unit is separate from the SRU and will provide flexible accommodation for up to three women. This unit is part of House 1, a building designed for the care of women with a high level of need (the population currently cared for on the ground floor of Ross Hall). It is envisaged that the design will provide greater ease of movement between enhanced care and 'step down' care for women in House 1 than is currently provided between SRU and the care suite.

Training and support for staff

There was broad acknowledgement that supporting women in distress could be challenging for all the staff involved. SPS staff in particular have minimal training in mental health, but are providing the first line of support for women around the clock. Concerns were shared with us about the emotional labour involved in providing this support, particularly in the SRU, and the impact this could have on staff stress, sickness levels and burnout.

It is important that SPS staff are equipped with the knowledge to understand the mental health needs of women in custody, particularly in relation to the impact of trauma. They should have the basic skills to be able to offer support and they should themselves feel supported in undertaking this challenging aspect of their work.

Following our last visit to HMP Cornton Vale (2017), the Commission recommended that prison managers should undertake an audit of prison officer training and address any deficiencies in relation to mental health training.

Whilst the new model of care for the women's service is under development, SPS advised us that in autumn 2020 they had made updates to the training programme for newly recruited residential prison officers. This included a more prominent focus on mental health and trauma informed care. For existing staff working in HMP Cornton Vale, we were told that training sessions from psychology and psychiatry had been carried out, including recent training in borderline personality disorder awareness by one of the visiting psychiatrists. Mental health first aid training was being delivered to a group of SPS staff, and a number of prison and mental health staff had also recently completed training in the "Decider Skills"³⁹.

³⁹ "Decider skills" uses a simple visual tool used to support people in developing better coping skills to manage their emotions and offers a common language for professionals from across health and social care settings to work with individuals with mental health difficulties.

The need for trauma informed care

Past experience of trauma is common in the female prisoner population and almost all of the women we reviewed had a history of trauma or abuse. The experience these women had in prison, especially while held in segregation, was likely to be re-traumatising. The SRU environment and regime in particular, may have acted as a trigger for trauma responses in some women. The lack of physical comforts, sensory overstimulation/under-stimulation, paucity of meaningful activity or human contact and long periods spent in isolation would be physically and emotionally challenging for most people. Being locked alone in a cell, while also experiencing acute mental distress or psychotic symptoms may well have felt very unsafe.

The extent of the mental disturbance these women experienced in segregation was evident and particularly stark in the descriptions of their self-neglect. The use of terms such as “dirty protest” failed to acknowledge that women were distressed and that their behaviour was likely a way of communicating this distress. In our experience, it is extremely rare to see these behaviours in adult mental health or forensic inpatient settings. The frequency and degree of these behaviours in this group of women was striking, and suggests that the setting likely had an impact. The remission of some women’s behaviours on transfer to hospital care would also tend to support that this was, to some degree, setting-dependent. SPS staff also told us that so-called “dirty protests” were not an uncommon occurrence in the prison setting.

A Trauma Informed Strategy is being developed for the new women’s service in HMP Cornton Vale. It is envisaged that when the new establishment opens in spring 2022, a trauma informed approach will be embedded throughout the service, supporting women’s journey throughout their time in custody. The Commission welcomes this important development and would like to be kept updated on progress.

We will also seek information on the training to be delivered to HMP Cornton Vale staff in preparation for the opening of the new women’s national facility in spring 2022.

The Commission has recently been advised of the establishment of a group within the Strategy and Stakeholder Engagement Directorate of SPS that will consider Trauma and Trauma informed approaches across the whole of the prison estate. We look forward to following the progress and outcomes of this group’s work.

Advocacy

The lack of access to rights-based advice and advocacy support was also a gap in provision for the women whose care we reviewed.

At present, referral can be made on a case by case basis to advocacy services in Forth Valley. The mental health team acknowledged that access to advocacy in the prison could be improved. We were told that discussions had recently taken place with advocacy managers and there was an interest in looking at the availability of input in a more consistent way to the prison.

3.3 The prison environment for care of acutely mentally unwell women – recommendations

To Health Managers - HMP Cornton Vale

- Psychology input should be available to support care planning, behavioural approaches and reflective practice for all women subject to Rule 41 due to their mental health needs. In HMP Cornton Vale, this support should be prioritised for women in the Separation and Reintegration Unit (SRU) and Scottish Prison Service (SPS) staff should be actively involved in care discussions.

To the Scottish Prison Service

- The Women's Strategy Team should consider the findings of this report when taking forward the new model of care at HMP Cornton Vale. Careful consideration should be given to the final details in the design of the new enhanced needs area to create an environment that is therapeutic and does not add to women's experience of trauma. We recommend that the mental health specialists who developed a Trauma Informed Strategy for HMP Cornton Vale are involved and there should be a specific focus on the development of a training programme for staff.
- When carrying out its review of SRUs, SPS should consider adopting an approach that is modelled on the NHS use of seclusion, for individuals held in segregation for mental health reasons.

To SPS and HMP Cornton Vale

- For people being held in segregation, the Commission supports the CPT's recommendations that all prisoners, including those in conditions of segregation, should have at least two hours of meaningful human contact each day and that individuals held for longer than two weeks in segregation should be offered further supports and opportunities for purposeful activity.

To NHS Forth Valley

- NHS Forth Valley should work with local advocacy services to improve access to ensure that the views of women in HMP Cornton Vale are expressed and heard and their rights are respected.

4. Delays transferring mentally unwell prisoners to hospital

The Commission’s themed report, “Mental Health of Prisoners”⁴⁰ outlined what we expect to find in the management of seriously and acutely mentally ill prisoners noting:

“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.”

Where there is evidence that a person in the criminal justice system has a serious mental illness, learning disability, personality disorder or related condition (whether at the time of the offence or at any point in the judicial process, before or after conviction) there are provisions through the Criminal Procedure (Scotland) Act 1995 (CPSA) to enable the person to receive the appropriate care and treatment required.

4.1 What we found

Among the records we examined, more than half the women had clear evidence of serious and acute mental illness whilst in prison. In each case, the visiting psychiatrist documented the need for the woman to be transferred to hospital for inpatient mental health care.

One woman had been assessed to be at significant risk of self-harm at the point of her arrival in custody. Risk monitoring was put in place and she received daily reviews by mental health nursing staff. After psychiatric review on day 4, an urgent referral was made to medium secure care, with assessment arranged for the next day (which was unusually swift). However, following an episode of serious self-harm, the woman was urgently hospitalised for medical care before this assessment could take place.

The Commission was informed of this woman’s circumstances at the time. We liaised with the clinicians involved and followed her recovery. She was transferred to medium secure care when medically well.

For the other women transferred for inpatient mental health care, the timescale for their transfer to hospital is summarised below.

Delays transferring women with mental illness from prison to hospital

Case	Number of days mentally unwell in custody prior to transfer (calculated from date of first rule 41*)	Number of days from initial hospital referral to inpatient mental health admission	Inpatient mental health setting
1	24	12	IPCU
2	59	22	IPCU
3	41	32	IPCU
4	92	76	Medium Secure

* minimum estimate based on use of rule 41 as a parameter

⁴⁰ <https://www.mwscot.org.uk/sites/default/files/2019-06/Mental%20health%20of%20Prisoners%202011.pdf>

The diagnoses made by the forensic psychiatrists for these women were various including acute psychosis, manic psychosis and psychotic depression.

Descriptions in the clinical records indicated that each woman's mental state deteriorated significantly in prison. Patterns of escalating symptoms in every case suggested that women's acute illnesses were evolving whilst they were not receiving the inpatient mental health care and treatment they required.

Three of the four women received care in the SRU prior to their transfer to hospital.

In two cases, we viewed the women's subsequent hospital records following transfer. It was evident in both cases that when appropriate inpatient mental health care was provided, recovery swiftly followed.

There appeared to be a number of factors leading to delays in women receiving the appropriate hospital care.

Delays in referring to hospital care

In a few cases, it was our view that referral for inpatient care could have taken place sooner. Because visiting psychiatrists provided reviews on a weekly basis, any deferral in the decision to refer added a further seven days to the time a woman remained acutely unwell in custody.

Delays were further compounded by subsequent difficulties accessing a hospital bed.

Delays in accessing an inpatient bed

When a decision was made to refer for inpatient care, the psychiatrist determined the level of security required and discussed the case with the mental health team in the woman's home area.

When a low level of security was needed, referral was usually made to an Intensive Psychiatric Care Unit (IPCU) in the woman's home health board. Where a higher level of security was thought necessary, agreement for referral to one of the two medium secure units, or occasionally to a low secure forensic unit, was obtained.

Direction of the court⁴¹ or Scottish Ministers⁴² is legally required under the CPSA when a person who is unwell needs transfer to hospital from prison for assessment or treatment of mental illness. When this is authorised (under an Assessment Order [AO], a Treatment Order [TO] or Transfer for Treatment Direction [TTD])⁴³ transfer then has to take place within seven days. We saw examples where the making of an application was postponed because no bed was available. Psychiatrists documented that they had prepared paperwork for an application, anticipating that a bed would become available before their next weekly clinic, only for this not

⁴¹ For a person on remand

⁴² For a sentenced prisoner

⁴³ Assessment and treatment orders allow the assessment/treatment of a person prior to trial, or after conviction but before sentencing. It allows courts to remand a person in hospital instead of custody, when it appears the person is suffering from a mental disorder. Both orders allow for the transfer of a person remanded in custody and awaiting court appearance to be admitted to hospital for assessment. An assessment order can last up to 28 days and be extended on one occasion by a further seven days. An assessment order may be followed by a treatment order. A Transfer for Treatment Direction allows for the transfer of a sentenced prisoner from prison to hospital for the treatment of a mental disorder.

to happen. In individual cases we saw reference to repeated CPSA documentation being prepared, as a woman continued to wait for an admission bed.

Access to Intensive Psychiatric Care Unit care (IPCU)

The timescale for transfer to IPCU ranged from 12-32 days in the cases we examined.

One woman was accepted for IPCU admission with a bed due to be available within a few days. However her transfer was cancelled due to another emergency admission. The prison mental health team then contacted the hospital bed manager daily trying to identify a bed. It took over three weeks between the initial referral and the woman's eventual admission to IPCU care. Meanwhile, despite an increase in medication, her mental state and self-care had deteriorated; she became volatile, agitated and aggressive and was moved to the SRU, where she remained until transfer.

Another woman remained on the IPCU waiting list of her local hospital for over four weeks awaiting a bed. Referrals were made to IPCUs in two other health boards; one unit declined, another agreed in principle but had no bed available. The woman was in the SRU, floridly unwell and poorly compliant with treatment throughout this time. During the fourth week it was anticipated that she might be liberated following court proceedings⁴⁴. The psychiatrist made arrangements to attend court and carry out a Mental Health Act assessment if the woman was released from custody. The woman was released, detained on a short term detention certificate and was transferred directly from court to the IPCU in her local area, where a bed became available that day.

⁴⁴ The psychiatrist contacted the Procurator Fiscal, who indicated that the woman was likely to be released from custody.

Access to medium secure care

In one case we examined, the woman required transfer to medium secure care and the delays were extensive. From the point the decision was made that hospital care was needed, the timeline was as follows:

Week 1: Referral to forensic psychiatry in home health board

Week 2: Contact with forensic psychiatry lead in patient's home health board to request medium secure referral

Week 3: Referral to medium secure unit A

Week 4: Awaiting assessment from medium secure unit A

Week 5: Assessment from unit A planned the following week

Week 6: Case discussed with low secure unit in independent sector. Low secure care not thought appropriate. Case discussed again with forensic lead in home health board. Referral to medium secure unit B under consideration.

Week 7: Assessment by forensic psychiatrist from Unit A

Week 8: Accepted for admission to unit A and prioritised for admission. But no beds available.

Week 9: Awaiting bed in Unit A

Week 10: Awaiting bed. Transfer to unit A planned for the following week.

Week 11: Patient transferred to unit A

Throughout this time the woman remained in the SRU whilst her mental state deteriorated. She was described as "highly distressed" and "floridly psychotic".

4.2 Discussion

For women who are acutely mentally unwell, prison - and the SRU in particular - is not an appropriate or therapeutic environment. Women in prison do not have access to the level of 24 hour nursing, medical and therapeutic supports that would be provided in a hospital environment. When lengthy delays are happening, women are being denied their right to access appropriate medical care and treatment they urgently need.

In the cases we examined, the delays women experienced were unacceptable. The only single exception was when a woman required acute physical health care, and hospital transfer took place immediately. This underlines the current lack of parity between physical and mental health care, in both provision and approach.

When we looked at the longitudinal course of each woman's mental illness in prison, it seemed likely that had earlier inpatient care and treatment been provided, such prolonged deterioration could have been avoided before their process of recovery began.

Had these women presented with the same level of mental illness in the community, they would almost certainly have received swifter hospital care. This suggests they were subject to discrimination by virtue of being in prison.

We discussed these issues with the mental health team and senior SPS staff at HMP Cornton Vale as well as a number of consultant forensic psychiatrists for their views.

Delays in referring for inpatient care

When we discussed delays in referral with consultant forensic psychiatrists, several explained that the approach in prison, where clinics usually take place weekly, is often to assess the individual, start a trial of medication then review over a period of one to two weeks to assess the response. At that point a decision is made about whether transfer to hospital is indicated. The rationale was that this approach would also be common practice in the community.

We agree this would be appropriate in the early stages of an illness when a person has mild to moderate symptoms. However, in some of the cases we reviewed there was still a delay in referring, even when a woman was described as acutely unwell and was poorly-compliant with attempted treatments.

It is important that the mental health response in prison is equitable to that in the community. In our view several women would have been referred to hospital sooner had they presented in the same way in the community.

Delays in accessing an inpatient bed

Access to IPCU care

Accessing an IPCU bed in Scotland should not incur significant delays. The availability of IPCU beds can be limited and patients may sometimes need to be referred to other health boards for admission, but the delays experienced by some of the women we reviewed were unacceptable.

These are not isolated cases. The Commission have been contacted about other, more recent concerns, involving both men and women who were unwell in prison.

In clinical practice, when an IPCU bed is urgently needed for a patient in the community, a bed can usually be found, even if at a distance from the person's home. The case cited earlier, in which a bed was identified immediately upon a woman's liberation from court is a good example of this. That she had been on the waiting list for the same IPCU for the previous four weeks whilst in custody, highlights the discrimination that people in prison can experience.

Forensic psychiatrists told us that when there is a pressure on beds, risk management and clinical prioritisation may explain the disparity between prison and the community. The admission of an acutely unwell patient from the community may be prioritised over that of a similarly unwell patient in prison. Prison may be viewed as being a secure setting and one that provides immediate access to healthcare, with someone who is acutely unwell in custody perhaps viewed as "safer", in relative terms, than another person with similar risks who is acutely unwell at home. This, however, does not take account of the potentially negative impact of the prison setting (and SRU in particular) for someone who is acutely unwell; or that prison healthcare equates with that provided in the community, not in hospital. Anecdotally, we heard the same rationale for prioritising admissions to secure care when there were waiting lists.

Clinicians told us that when beds are scarce, prioritising admissions can be a constant challenge. Selectively admitting acutely unwell patients from the community can be understood amid the reality of balancing difficult clinical risks, but it leads to a lack of parity for individuals who are mentally unwell in prison.

The final report of the Barron Review noted: ***“There are concerns that this lack of access to beds for women in lower conditions of security may be creating a higher threshold for referring women out of prison than men, resulting in them potentially carrying a higher degree of psychiatric morbidity.”***

Access to medium secure care

Admissions to medium secure care can incur significant delays when a female bed is required. This is due to a continued lack of beds in the female forensic estate across Scotland. There are often waiting lists for admission to medium secure care and women are sometimes referred to multiple (low and/or medium secure) services before a bed is found, as highlighted in the case we reviewed. Women in this situation are not being afforded the right to access the specialist inpatient mental health they need.

We had concerns that the referral and assessment process for women requiring medium secure care was unnecessarily unwieldy. The two medium secure units that admit women liaise when there is a need for a female bed but their assessment processes and criteria for admission are entirely independent and there is no central referral process. The multiple referrals and repeated assessments sometimes required can lead to delays of weeks or even months. A more centralised, streamlined process would be a solution.

The Barron Review came to a similar conclusion about the complexity of the referral pathway. In its final report it recommended that the Short Life Working Group that had been set up in response to the Forensic Network’s report on the Women’s Service and Pathways (and postponed due to the Barron Review) should reform and complete work on the women’s pathways across secure mental health services.

It added ***“Its work must ensure a pathway for women to transfer from prison for forensic mental health care and treatment when required”***. The Commission fully supports this view.

We looked at Mental Welfare Commission data for certain CPSA orders over the last five years to determine the numbers of Assessment Orders, Treatment Orders or Transfer for Treatment Directions granted. The results are shown below.

Number of CPSA Assessment Orders (Section 52D), Treatment Orders (Section 52M) and Transfer for Treatment Directions (Section 136) recorded over a 5 year period

[1 January 2016 – 31 December 2020]

	Women	Men	Total
AO (Section 52D)	110	528	638
TO (Section 52M)	95	442	537
TTD (Section 136)	24	178	202
Total	229	1148	1377

The majority of orders granted (for both women and men) were pre-trial Assessment or Treatment Orders. It was not possible to determine, from data searches alone, how many of

these orders had been granted at initial court hearings for individuals in police custody, and how many were for those on remand in prison custody.

When we looked at the inpatient mental health units where women placed on these orders were treated, only 26 of the 229 orders (11%) were to medium secure care and fewer than ten were to forensic low secure settings (principally in the independent sector). The majority of women placed on these orders received IPCU care.

None of the orders involved transfer to high secure care. As discussed previously, there is currently no high secure provision for women in Scotland. Women who are on remand, pre-trial, cannot be transferred cross-border for admission to high secure care in Rampton until decisions are reached on their legal issues. The Barron report highlights concerns about the pathway for this small group of women, who sometimes receive care in medium secure settings unsuited to their needs⁴⁵.

Monitoring of delays

There is no clear current standard in Scotland for what constitutes a delayed transfer from prison to hospital.

In both their recent visit reports, the CPT highlighted concerns about the delays in transferring women who were acutely mentally unwell in HMP Cornton Vale to hospital. In 2019 the CPT recommended that **“prisoners suffering from severe mental illnesses be transferred to a closed hospital environment for treatment, without delay”**. In their 2020 report the CPT recommended that transfers should take place within two weeks.

In early 2018 the Scottish Government asked the Forensic Network to begin monitoring the transfer of mentally unwell prisoners to hospital. We liaised with the Forensic Network to discuss the national monitoring of prison transfers that is currently being carried out and review the (unpublished) data collated. The data collected suggests there is no significant problem with delayed transfers for women from prison. The Network recognised that the (voluntary) submissions from prisons across Scotland, providing retrospective data on a monthly basis, may be incomplete and that there were possible inconsistencies in how certain parameters were measured. The low numbers of female prison transfers in the data (5 female transfers from February 2018 to May 2020), suggested there may have been under-reporting by prison services.

This was also a concern of the Barron Review, noting in their final report **“NHS Forth Valley clinicians told the Review that there had been at least another four transfers by May 2020, and 11 altogether in the first 10 months of 2020. They also provided the length of time for referral for five transfers. The average length of time between referral and transfer was 43.2 days”**.

The Barron Review suggested that improved data collection and reporting across forensic mental health services is needed, including to monitor transfers from prisons. The review recommended that the Information and Statistics Division (ISD) of NSS should be commissioned to do this. We support this recommendation.

In individual cases where there are concerns about delays in the transfer of a mentally unwell prisoner to hospital (male or female), clinicians or prison health managers are strongly

⁴⁵ pp26-28 <https://www.gov.scot/publications/independent-forensic-mental-health-review-final-report/>

encouraged to contact the Commission to alert us to the issue. When this has happened we have received positive feedback about the Commission's role and support in helping to progress individual cases.

4.3 Delays transferring mentally unwell prisoners to hospital - recommendations

To Scottish Government

- The Commission supports the following recommendations of the Independent Forensic Mental Health Review⁴⁶:
 - The Short Life Working Group set up in response to the Forensic Network's report on the Women's Service and Pathways should reform to complete its work related to women's pathways across forensic settings and "its work must ensure a pathway for women to transfer from prison for forensic mental health care and treatment when required" (Recommendation 4)
 - The system of multiple assessments to facilitate transfers from prison should be reviewed to streamline the process. (Recommendation 21)
 - The Scottish Government should "commission the Information and Statistics Division (ISD) of NHS National Services Scotland to develop a data management system to accurately collect, monitor and report on performance across forensic mental health services, including on service capacity and the timeliness of people's transitions" (Recommendation 5). This data management system "must be able to collect, monitor and report on transfers and delays to transfers into forensic mental health services from prisons." (Recommendation 20)

⁴⁶ <https://www.gov.scot/publications/independent-forensic-mental-health-review-final-report/>

5. Missed opportunities for earlier interventions: Court Liaison

Although this review only looked at a small sample of nine cases, in a third of the records we examined, there was evidence to suggest that women were already acutely unwell when they first arrived in prison custody from court.

5.1 What we found

The prison health records of all three women showed that concerns about their mental state were present during the first 24 hours –either at the initial nurse screening assessment or at review the following day.

One woman was reported to have bizarre behaviour at initial screening assessment. When seen by mental health nurses the following day she had signs of acute psychosis.

Another woman, who had seriously self-harmed in police custody, described voices telling her to harm herself when she was screened at reception.

A third woman was described at GP review as behaving bizarrely, with inappropriate laughter and pressured speech and was referred to the mental health team.

All three women had been in contact with mental health services in their home area in the days prior to their arrest. Two women had been receiving inpatient mental health care and another woman had repeatedly presented to Accident and Emergency.

These women's subsequent diagnoses in prison were manic psychosis, acute psychosis, and psychotic depression.

One woman severely self-harmed within days of arriving in prison custody and was transferred for medical care, as previously described. Both other women remained acutely unwell, each ultimately spending over a month in custody (including in the SRU) prior to receiving hospital care.

Following her recovery, one woman's community consultant wrote that her arrest and incarceration had been "*in all likelihood secondary to mental illness*". This also raises the issue of prevention, and whether, in some cases, the offences women committed might also have been avoided had they received additional mental health care, treatment and support in the community.

5.2 Discussion

A central question raised by these cases is whether there were missed opportunities for earlier intervention.

If a person in police custody presents with signs of mental illness, assessment by a health professional should be carried out. If a medical recommendation is then made to the court for hospital assessment, an Assessment Order may be granted by the court to allow a period of inpatient assessment.

The lengthy delays the women experienced in accessing the inpatient care they needed from prison could potentially have been avoided had a recommendation for hospital transfer been made to the court at the initial stage.

We raised this issue with the mental health team at HMP Cornton Vale. The team shared concerns about the admission of acutely unwell women to prison custody. Although not a frequent occurrence, they were able to cite other cases where this had happened, including in the recent past. These cases had concerned both health and prison staff, particularly when there were subsequent delays in arranging appropriate inpatient care for the women concerned.

There is, as far as we understand, variation in court liaison services across Scotland and in the availability of mental health professionals to support custody services. In major urban centres, such as Glasgow and Edinburgh, dedicated mental health teams, including forensic mental health professionals, provide input to police custody and court liaison. In smaller health boards and remote and rural areas, sometimes this support is provided on an emergency basis by GPs or other health practitioners.

A range of factors could also potentially influence the assessments themselves and their outcome:

- When a mental health assessment is carried out in police or court custody, the person may not wish to (or be able to) engage, making assessment difficult.
- The person's mental state may fluctuate and symptoms could be missed.
- In some cases substance misuse may complicate the clinical picture, making it difficult to determine the presence or extent of acute mental illness.
- Clinical thresholds for recommending hospital admission from custody may vary between clinicians. There may also be variations in approach in different areas.
- Local resource issues might influence decision making (e.g. availability of inpatient beds at the time of assessment)
- Prison may be viewed as a place of "safety" for mentally unwell offenders.

This raised questions about whether there is a role for awareness raising around this issue.

It is important that there is a consistent approach at a national level of the clinical thresholds on which recommendations to the court for hospital care are made.

5.3 Missed opportunities for earlier interventions: Court Liaison - Recommendations

To the Scottish Health in Custody Network

- The Commission recommends that the Scottish Health in Custody Network considers the issues raised in this report about the assessment of mentally unwell offenders in custody and engages with NHS Boards and IJBs to review whether there are areas of improvement work that could support a more consistent national approach.

6. Concerns about aftercare: pathways from prison to community

A number of women whose care we reviewed, and who were not transferred to hospital for mental health care, were liberated from prison to the community. When we looked at aftercare planning for these women, our findings were mixed.

6.1 What we found

In the case of one woman who had complex mental health needs, and had been in custody for a prolonged period, there was good evidence of transition planning in the weeks prior to her liberation date. The clinical notes indicated that she received harm reduction sessions from the addictions nurse as well as support with smoking cessation; the prison mental health team liaised with services in her locality and plans were made for her to access mental health and addiction supports upon her release.

For another woman, who had well-established links with her community mental health team (CMHT) and spent only a brief episode in custody, contact was made with her CPN when she was liberated and CMHT follow up was arranged.

It was noticeable that for women who were on remand, aftercare plans being put in place by the psychiatrist and mental health team were sometimes tentative and accompanied by caveats depending on the outcome of pending court hearings.

Sometimes there appeared to be failures in communication in transition planning. This was highlighted in one case particularly.

The woman had a long history of complex mental health difficulties and was well known to her community mental health team (CMHT) and to the mental health team in HMP Cornton Vale. This episode in custody began less than a week after her previous liberation. There were concerns about her mental state after a short time in custody and she remained in the SRU for most of her time in prison. After a period of assessment, she was considered by the visiting psychiatrist to have a psychotic illness superimposed on personality disorder. Following liaison with her community psychiatrist, it was planned that her home health board would refer her to low secure inpatient care. Two weeks later, with notes indicating that she was still awaiting low secure care, and daily nursing entries noting that her mental state in the SRU remained changeable, she was liberated by the court.

The forensic psychiatrist later noted that the woman was *'liberated unexpectedly before any follow up could be arranged'*. Subsequent records showed that, in the days following her liberation from custody, she was repeatedly taken to hospital by police on Place of Safety orders due to concerns about her mental wellbeing in the community, before she was eventually admitted for assessment.

The lack of co-ordinated aftercare in this case was a concern and demonstrated how some individuals with complex mental health needs can fall through the gaps between the criminal justice and mental health systems without joined up planning and support.

Another woman whose care we reviewed had similarly complex mental health needs.

She presented as difficult to engage with consistently disturbed behaviour whilst in prison and remained in the SRU throughout the custody episode we examined. She was not felt to be psychotic and her presentation was attributed to personality disorder. Her local CMHT were advised that she was in prison shortly after her admission to custody. The visiting psychiatrist suggested notifying the local crisis team when she was due to be liberated. There was a later reference to the need to request an early Care Programme Approach (CPA) meeting⁴⁷. However this did not appear to take place. Following liberation, her CPN was informed and information was passed to social work. Unfortunately she returned to custody within 10 days.

6.2 Discussion

It was evident from reviewing individual records that transition planning and arranging supports in the community was not always a robust process and that women were sometimes failed in this aspect of their care.

The mental health team at HMP Cornton Vale told us that when women were admitted on remand and had brief custody episodes, the opportunity for multidisciplinary planning to arrange ongoing supports could be challenging. Clinicians were very conscious that if aftercare was not addressed until close to a person's liberation, it was difficult to set up appropriate supports from community services.

For the group of women who were frequently remanded to custody, described by the prison staff as 'revolving door' prisoners, it seemed especially difficult to carry out comprehensive, well-coordinated care planning amid the sometimes perpetual cycle between community and custody. We consider the provision of community services for women with complex mental health needs more in the next chapter.

Effective multiagency planning is essential, particularly for the group of women with complex needs, for whom additional risk factors such as homelessness and substance misuse may also be involved.

Early communication between prison health teams and multiagency community services (health, social care, housing and criminal justice), when women arrive in custody should be part of their care. Prompt information sharing and joint planning for supports on liberation would particularly benefit women who may only be in custody briefly on remand.

It was encouraging to hear from the forensic psychiatrists now providing support in HMP Cornton Vale that they are keen to improve transition planning and aftercare support for women. As well as establishing links with community providers, they are starting to regularly use the Care Programme Approach as a framework for consulting with professionals and planning multiagency care packages for women leaving custody.

We welcome this approach and recommend it continues.

⁴⁷ The Care Programme Approach (CPA) was first adopted in Scotland in 1992. It provides a framework for ensuring co-ordinated multiagency care planning and support for people with complex mental health and social care needs.

6.3 Concerns about aftercare: pathways from prison to community - recommendation

To Prison Mental Health Teams

- The Commission strongly recommends the use of the Care Programme Approach to support transitions in care between prison and community services and to co-ordinate the planning of multiagency supports, particularly when the person has complex mental health and social care needs.

7. Supporting women with complex needs: the “revolving door” of prison

In the course of reviewing women’s mental health care in prison, questions increasingly arose about the supports some women were receiving in the community, particularly those who had complex health and social care needs and were presenting with patterns of repeat offending.

These women appeared to represent some of the most vulnerable and challenging for both the prison service and community services to support.

We wanted to understand more about the long term care these women had received. In a third of cases in this review, we looked at women’s mental health journey over time, by examining their longitudinal NHS mental health records.

7.1 What we found

Background and early experiences

All three women had a history of trauma, including sexual abuse. For two women, their early life was marked by a number of adverse childhood experiences, including witnessing or being the victim of physical violence and spending periods in the care of either extended family, or the local authority. These women went on to have difficulties with alcohol or drug use in early adolescence and began contact with mental health services during their teenage years. In adulthood they experienced challenges forming positive supportive relationships and coping with the demands of parenthood. Their own children had not remained in their long term care. Neither woman had been able to sustain employment in adult life. Both had experienced homelessness at some time.

Contact with mental health services

All three women had been in contact with mental health services for over a decade. All had received a diagnosis of emotionally unstable personality disorder at some point in their mental health journey. For one woman, this was complicated by a co-morbid serious and enduring mental illness, for which she had required medication over many years. For another, co-morbid diagnoses had changed repeatedly throughout the years, having variously included a major mood disorder, a range of psychotic disorders and post-traumatic stress disorder. It was unclear from her medical records what definitive diagnosis had been reached.

All three women had a history of alcohol misuse. Two had an additional background of polysubstance misuse, with chaotic illicit drug use over many years. For these women, their offending was often linked to intoxication or drug-seeking behaviour.

Each woman had received inpatient psychiatric care and all had been subject to compulsory measures under the Mental Health Act in the past. For one woman, this had mainly been in the context of brief crisis admission to hospital. For another, long term compulsory measures in the community had been used to support her engagement with community mental health services and compliance with medication.

Over time, all three women had received support from a range of community mental health services. These included community mental health teams, crisis teams and, in one case, community outreach support.

For the women who had risks associated with substance misuse, support from community addiction services had been offered periodically over a number of years. However, women's contact was often erratic and there was a pattern of repeated disengagement, or discharge from services due to non-compliance with treatment plans. For one woman, support had been withdrawn, at times due to her dangerous use of illicit opiates while on a methadone prescription.

Psychology support was explored for all three women. One woman had engaged well and received long term support from psychology, later being supported by the personality disorder service in her locality. The other women had more chaotic patterns of contact with services and when psychology input was offered, they struggled to engage.

None of the women had received ongoing support from community forensic mental health teams. We saw evidence that forensic input was sought in two cases but, based on the women's offending histories and the predominance of personality disorder influencing this, they were not considered appropriate candidates for this support, unless a pattern of more violent offending arose. Input and advice to community mental health services supporting the women was however offered by the forensic teams concerned.

Challenges of community support

The women often struggled to engage with services, which presented challenges to professionals trying to support them in the community. Sometimes much of their contact was erratic, for example involving crisis presentations to out of hours' services, or the involvement of the police if they were presenting with concerning behaviours in public.

We did see examples of multiagency working. This was usually between mental health and social work, but on occasion included wider networks, including addiction services, housing and, occasionally, the police. There was little reference to the involvement of criminal justice or probation services in the cases we reviewed.

We also saw examples of the positive role of CPA processes in structuring communication between agencies and in the development of action plans across services to try to support women, particularly when their engagement was poor. In one case, the use of mental health legislation had offered one woman a prolonged period of stability in the community, with safeguards for ensuring her engagement with mental health services and compliance with medication, even when her lifestyle was chaotic.

When women's mental health difficulties were complicated by polysubstance abuse however, even these safeguards sometimes failed to prevent cycles of re-offending.

7.2 Discussion

As the Commission on Women Offenders report⁴⁸ stated almost a decade ago:

"Many women in the criminal justice system are frequent reoffenders with complex needs that relate to their social circumstances, previous histories of abuse and mental health and addiction problems."

⁴⁸<https://www.webarchive.org.uk/wayback/archive/3000/https://www.gov.scot/Resource/0039/00391828.pdf>

The mental health team at HMP Cornton Vale know the population of women with complex mental health needs and repeat offending well. The team spoke to us about the challenges community services can face in supporting vulnerable women, particularly with emotionally unstable personality disorder. Women who use alcohol or illicit drugs as familiar coping strategies may be especially difficult to support when they leave prison.

Although repeat offences are often relatively minor (examples including shoplifting or breach of the peace), the result is often further episodes in prison custody and breaking this cycle can be difficult. Custody appears to offer the women little benefit in terms of recidivism. The women with complex needs whose care we reviewed were highly distressed and behaviorally disturbed in prison, sometimes requiring prolonged periods in the SRU. The mental health team confirmed that this was a consistent pattern for a number of women under their care.

The plans in place for the provision of a more trauma-informed approach for women in prison in the future is welcome. It is hoped that this, and the therapeutic programme proposed in custody, could have positive benefits for women with complex mental health needs when they are in prison custody.

The staff in HMP Cornton Vale did have past experience of women who had been able to engage in therapeutic programmes in the community and had managed to break the cycle of repeat offending. In the clinical team's view, a package of robust community support was key to this success.

In some areas of Scotland, specialist community projects have been set up to support women involved in the criminal justice system, particularly those with complex needs and experience of trauma. Initiatives such as the 218 Centre in Glasgow⁴⁹ – a joint initiative between Turning Point Scotland and Glasgow Addiction Service – and the Willow Centre in Lothian⁵⁰ are two widely acclaimed examples. These services offer a range of supports, including in relation to substance misuse, physical and mental health needs and social needs. However, services like these are not available in all health board areas at the present time.

There is also the question of where this group of women 'sit' within forensic services. The Forensic Network guidance on criteria for inpatient forensic care is clear that a person with a primary diagnosis of personality disorder would not be suitable for the service. The Commission has previously highlighted, as has the Barron Review, that many women with a primary diagnosis of personality disorder are currently receiving care in low secure forensic settings under the Mental Health Act and there are widely differing opinions on whether or not this group should be supported by forensic mental health services.

The Barron report recommends that the Short Life Working Group set up to review the women's forensic pathway, should also review the needs of this group of women.

The Commission would welcome this approach and further clarity for the care of these women with highly complex needs who, all too often, are falling through the gaps.

⁴⁹ <https://www.turningpointscotland.com/getting-support/glasgow/218/>

⁵⁰ <https://services.nhslothian.scot/willow/Pages/default.aspx>

7.3 Supporting women with complex needs: the “revolving door” of prison - recommendation

To Scottish Government

- The Commission supports recommendation 4 of the Independent Review of Forensic Mental Health Services that the Short Life Working Group, re-established to review women’s services, should also “consider the care needs of the group of women who may not meet the definition of ‘forensic’, but who are subject to conditions of security as their behaviour has not been able to be safely managed by generic services.”

Acknowledgements

We wish to acknowledge the women whose care we review in this report. The narrative of their experience in custody, as documented from their records, formed the basis of this report and its recommendations and powerfully supports the case for improving services for other women in the future.

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