Mental Welfare Commission for Scotland

Report on announced visit to:

HMP Barlinnie, 81 Lee Avenue, Glasgow, G33 2QX

Date of visit: 14 August 2023

Where we visited

HMP Barlinnie was first opened in 1882 and is located in the northeast of Glasgow. The prison has capacity for 987 prisoners; there were 1396 prisoners on the day of our visit. Overcrowding in Barlinnie has been well documented for many years by His Majesty Inspectorate of Prison for Scotland (HMIPS), which has meant many prisoners having to share cells as a result of an increase in the prison population. The Commission visitors were aware of the latest HMIPS annual report (2023) that raised concerns regarding the lengthy wait for mental health assessments, the under resourcing of staff for the mental health team, and the views of individuals, who felt the NHS complaints process was poor and that their complaints were never dealt with.

HMP Barlinnie had adult male remand and short-term prisoners who were sent there by the west of Scotland courts. There were also long-term prisoners who had just been sentenced, and were awaiting transfer to other prisons or, had been located there for a specific management reason. The prison accommodated male prisoners who were nearing the end of medium to longer term sentences that were located at the prison.

It has been documented that there are plans for HMP Barlinnie to close, and a new prison to be built which will be named HMP Glasgow. The plan for the closure of HMP Barlinnie is reported to be happening in 2027.

Our last local visit to HMP Barlinnie was in 2016, although we did visit the prison in 2021 as part of our themed visit report, *Mental health support in Scotland's prisons 2021: under-served and under-resourced*. This report made a number of recommendations to the Scottish Government, NHS Scotland and the Scottish Prison Service (SPS) on changes that were needed to improve mental health services across the prison estate.

Our local visit in 2016 made one recommendation about mental health records being audited along with care plans that were to focus on individual needs, with clear goals recorded.

Since 2016, there has been a number of nursing staff and managers appointed to the mental health team. We wanted to hear how the service has adapted over the last seven years, including how the Covid-19 pandemic had impacted on the service, and those who had received care from the team.

Who we met with

We met with and reviewed the care of nine prisoners who asked to meet us in person. We also attended a group session with three others.

We spoke with the unit manager of the prison, who was also appointed as the mental health lead for suicide prevention, the operational nurse manager, the nursing team leader, members of the mental health nursing team, and other members of Scottish Prison Service (SPS) staff.

Commission visitors

Justin McNicholl, social work officer

Gemma Maguire, social work officer

Douglas Seath, nursing officer

Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support, and participation

This visit, we wanted to find out about the specialist care and treatment provided for those prisoners who were experiencing mental health difficulties in the prison. The prison mental health service was led by a nursing team leader and an operational manager, who provided direct supervision and line management to the rest of the team.

The nursing team consisted of one full-time team leader, one full-time senior nurse and two full-time mental health nurses; there was one part-time nurse. Prisoners had access to daily GP appointments on an as-required basis. There were nurses with knowledge of addiction issues and registered general nurses available on site with knowledge of working with people with learning disabilities and who had defined training in addictions. This complemented the staffing skill mix and helped to support those prisoners with varied and complex presentations. We were informed that none of the mental health nursing team were specifically trained in learning disabilities or could use any specific tools when assessing those who presented with these conditions. We were advised that the team support up to 80 individuals on an ongoing basis. On a weekly basis, the team can receive up to 90 new referrals from a variety of routes, which places a significant demand on the team.

During our visit, there were three nursing staff available to assist with accessing prisoners in the halls and in the prison cells. We were informed that psychology provided regular groups and supported the mental health team with risk formulations. Individuals who required psychological input received this on an individual or group basis. Psychiatry input was offered by three visiting psychiatrists who offered four sessions per week. This ensured that up to 18 individuals are seen per week and these appointments can vary from initial to review assessments. On the day of our visit, we were advised that there was no waiting list for routine assessments by psychiatry.

We met with individuals who received care from the mental health team and heard from them that they were not clear on what input they were able to access from psychiatric services. One individual expressed the following, “I am on a regular depot but unlike the community I never get to see a psychiatrist. I don’t understand why I am not regularly reviewed and seen by a doctor to discuss my mental health. This would help and would be the same in the community”. Those individuals who were seen by psychiatry received nursing staff input. The nursing staff provided ongoing monitoring of mental state and compliance with any identified treatment.

Recommendation 1:
Managers should ensure there is clarity to all individuals working with the mental health team when they will receive psychiatric follow-up.

We were informed that anyone who required an urgent psychiatric assessment was seen upon admission to the prison. Individuals we met with advised us that they were only seen by mental health staff at the reception area of the prison if they “felt like self-harming or were suicidal”. Many of those that we met with advised that they would not admit to having thoughts of suicide at reception, as it would result in them being automatically placed in the Segregation

and Reintegration Unit (SRU) with no access to any activities. We heard "you don't even get a TV and the place is horrible so it's not worth it". From their perspective, being "honest" at reception about their mental health was counterproductive and would only result in perceived punishment or reduced access to opportunities that could potentially minimise their thoughts of suicide or self-harm.

Prior to our visit to the prison, we had been alerted to concerns about the lengthy waits experienced by those who were most unwell in HMP Barlinnie. We were alerted to three separate individuals presenting with significant mental health difficulties who had been placed in the SRU for extended periods of time while awaiting admission to various hospitals across Scotland. While two individuals had been admitted to hospital, another had been moved out of the SRU and back into one of the halls to continue their wait. The lengthy wait for care and treatment in a health care setting was of significant concern to us and needs to be addressed locally in NHS Greater Glasgow and Clyde, as well as nationally. All health boards need to ensure that there is prioritisation given to those who are most mentally unwell in a prison setting. We were concerned to learn that the transfer of individuals to hospital for ongoing mental health treatment can result in significant waits and that it is deemed acceptable that those most unwell remained in the inappropriate environment of the SRU.

The mental health team was initially configured in 2012, and with current need, there remains a shortage of nurses. We were told by the operational nurse manager that work has been carried out to address staffing issues, with a proposal about to be put to the Glasgow Health and Social Care Partnership to increase the ratio of staff by September 2023. The aim of this was to improve the triage process and waiting times for those who are most in need. When we next visit, we look forward to seeing if this proposal has been implemented and if this positively impacts upon the delivery of care.

Recommendation 2:
Managers should address the excessive wait times for individuals requiring hospital admission that find themselves in a safe cell or in the SRU.

Care and treatment

We met with nine prisoners separately, and three others in a pre-arranged mental health group. Those that we spoke with were very positive about the mental health care they had received; they reported that staff were "brand-new", "approachable", "friendly and you can talk to them openly". We also observed this through the interactions that took place between individuals and the mental health team on the day of our visit. However, we were also told that accessing mental health services was "slow", "unclear", difficult and confusing". Some recounted to us how they had been "spotted" in the prison halls by nursing staff who had previously worked with them in community or prison, and this resulted in them accessing the service. We heard about a lack of consistency in getting community treatment re-started once in prison. One person told us, "I informed them of the medication I was prescribed, however it took almost four weeks for the medication to be prescribed and given in the prison. During this time I became unwell and developed paranoid delusions and was abusive to other prisoners and staff. This could have been avoided if I had been given medication quickly and as requested".

Currently, due to staffing pressures, the nursing team only undertook joint assessments with SPS staff when there was a critical need, and this was reflected in the comments offered by individuals. Some described how they had to rely on peers to signpost them to the mental health service.

The group we attended advised us of their concerns regarding the conditions and restrictions in HMP Barlinnie, compared to other prisons they have spent time in across Scotland. They spoke of how these conditions had a negative effect on their mental health. We heard the experience in the prison had been "negative and difficult" because of the environment and the lack of resources. This included the layout of buildings, size and conditions of the cells, the lack of activities and access to prison services, including mental health and wellbeing services. We heard from those we spoke with that the majority of wellbeing services or opportunities were "limited to 20, therefore if you are number 21, or you miss the call then that's it, you miss out and you could be really struggling, and it would help you to go along".

During our previous visit in 2016, the role of psychological interventions was not discussed. On this visit, we were keen to hear about the provision of these therapies. There was a prison psychology team working between Barlinnie, Low Moss, and Greenock prisons that provided interventions for anyone requiring psychological assessment and support. Psychologists supervised low-intensity psychological interventions that were carried out by the mental health nurses; they also held an individual caseload that focused on complex casework. The psychology service was complemented by a Cognitive Behaviour Therapy (CBT) nurse, as well as an assistant psychologist. The nursing team spoke positively of the psychology input that was provided although told us that the referral criteria for psychology was more specific than the open referral process that was used by the mental health team. We heard that there were forensic psychologists employed by the SPS who worked in the prison with those who had committed sex offences. Their focus was on specific treatment programmes and risk management. Some prisoners who were on remand spoke of the "barriers" they found in trying to access clinical psychology swiftly. A number of prisoners spoke of feeling "disadvantaged due to status as a remand person" and expressed their views of feeling discriminated against due to their status.

We observed good working links between health centre staff and other prison staff throughout the visit. The mental health nurses were regular visitors to the prison halls and they had day-to-day contact with the prison officers, allowing discussions and concerns to be raised about prisoners' mental health, so that this could be addressed at an early stage.

There were some issues with the interview facilities in the halls and the SRU. We heard from a few prisoners who did not feel there was enough privacy when being interviewed. Most prisoners were seen in the interview rooms in the halls, or if required, the health centre. We heard that people chose to be seen in the halls, rather than attend the health centre. From speaking with the residential unit manager, there was a clear commitment to addressing mental health issues in the prison, and to support the mental health team. We heard that in previous years, prison officers had received a range of opportunities to improve their knowledge and understanding of mental health issues, though these opportunities had stopped due to other demands in the service and because of the staffing levels. There were no issues seeing prisoners during our visit, and which was fully supported by SPS staff.

Recommendation 3:
Managers should address the significant delays for individuals requiring access to medication and treatment upon admission to the prison.

Care plans

We reviewed the notes of the individuals that we interviewed. The mental health team used four different electronic systems to gather and record information on prisoner healthcare, as approved by NHS Greater Glasgow and Clyde. This included Vision, EMIS, clinical portal and the online team folder system that held all care plans. These electronic systems did not directly communicate with each other, which caused challenges when trying to swiftly access information. Like most prisons, HMP Barlinnie had individuals from across Scotland and the UK. This caused challenges for staff when trying to locate medical and mental health histories, as regional and national systems did not interact with the prison system. Despite this, we found that prisoners who received health care had a formal care plan in place, which aimed to ensure a consistent approach and a clear understanding of their needs and care goals. This was particularly important where individuals were being seen by several services such as nursing, psychology, addictions nursing, psychiatry, and other agencies. The care files we examined were stored on the shared drive, with each individual name noted along with care plan, if they were subject to rule 41 measures of the Prisons and Young Offenders Institutions (Scotland) Rules 2011. There was a lack of a consistent audit trail as to how care plans were updated and we did not find any version control. There were no previously drafted care plans, aside from the current versions that we found in the system shared folder. We were concerned to hear from staff that when care plans were uploaded to Vision, there were known issues with how the system stored and changed this information.

The prison risk assessments and management plans were developed using the Clinical Risk Assessment Framework in Teams (CRAFT). The CRAFT assessment had been added to the Vision system since our last visit and it was to be a new amendment to assist staff manage risk. Unfortunately, how this risk assessment has been embedded on the system raised some significant concerns. From the risk assessments examined, we found that none of them captured the current risks, only historical risks were noted. Many of the completed risk assessments had content that did not provide useful information to the Commission visitors. There was limited information on who was responsible for the risk assessment, and management plans were unclear. We were concerned that the existing arrangements around risk assessments and the management of risks did not address the identified aims and were not being safely administered especially in the event of any adverse event.

Care plans for mental health needs lacked detail and the interventions proposed were generic, with little update or evaluation on whether or not the plan was working. There was variation in the recordings made by nursing staff, with a lack of clarity as to whether individuals were receiving medication or not. While the daily notes provided details of the care that was being delivered, this was not fully reflected in the care plans. It was unclear if an individual would receive a copy of their care plan or if they were involved in the completion of it. We found goals that were recorded in the care plans that were person-centred, but the interventions were not linked, and it was difficult to see how these were to be achieved in a meaningful way. Due to the lack of consistency in the recording of this, we would recommend the use of audit to improve consistency in care planning.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/node/1203

Recommendation 4:
Managers should improve the consistency of care planning for individuals with complex needs.

Recommendation 5:
Managers should urgently address the current mental health risk assessments and management plans for all individuals who require these to be in place and should ensure there is clarity regarding who is responsible for their completion.

Rights and restrictions

When we last visited, we heard that Circles Advocacy had just been introduced to the prison and there was limited knowledge of its existence. Seven years on, we heard from both prisoners and staff that access to advocacy was non-existent. Every prisoner we spoke with was unaware that they would have a right to discuss their circumstances with an advocacy worker. We were informed that there was an issue for SPS staff who had to coordinate and enable access to advocacy, to prisoners in a timely way. During our focus group this was confirmed by those that we spoke with who said “advocacy, what’s that?”.

The Commission is aware that advocacy will not have a role for everyone however, the service should be available to assist prisoners who are potentially being transferred to a hospital from prison under the Mental Health (Care Treatment) (Scotland) Act 2003 or under the Criminal Procedure (Scotland) Act 1995. Independent advocacy can be helpful in supporting individuals and can have a positive impact in services where it is accessible. We think that there is a need for further discussion between the mental health team, advocacy services and the SPS to consider how a service can be delivered in a timely and effective manner. We look forward to hearing how this has progressed when we next visit.

Recommendation 6:
Managers should ensure access to advocacy for individuals and better promotion of this service at HMP Barlinnie.

We took the opportunity to look at the Separation and Reintegration Unit (SRU) in the prison. As HMP Barlinnie is one of the oldest prisons in Scotland, we wanted to see how the unit compared to some of the more modern prisons we have visited. We remain concerned about the use of these units, especially for those individuals with mental health conditions. We were also concerned about the length of time some people spend in these units. We visited the SRU to review the conditions that individuals were being held in, and to meet with anyone waiting on a hospital admission. We met with one individual in the SRU who was experiencing poor mental health but understood why he was in the SRU and that there was a plan in place for him to be admitted to hospital. We found that the staff in the SRU were knowledgeable about those in their care and had a good understanding of how transfers to hospital took place.

However, all parties were clear that the ongoing wait for hospital beds was challenging and that many prison staff felt "ill-equipped" to support those that were experiencing severe mental ill health in the prison.

The Prisons and Young Offenders Institutions (Scotland) Rules 2011 enables restrictions to be put in place in certain situations. If there were concerns from prison staff and/or health professionals about a person's behaviour due to their health, restrictions could be placed on their movements and social contacts by the use of rule 41. A health professional must make a request to the prison governor to apply a rule 41. Use of this rule can include confining a prisoner to their own cell and placing them in segregation. For people being held in segregation, the Commission takes into account the recommendations of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (the CPT). The CPT recommends that all individuals, 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. The prisoner whom we met with had no specific access to any purposeful activities out with free time to exercise, in a small, secluded yard attached to the SRU. When we next visit, we hope to see how the CPT recommendations would be applied to ensure meaningful activities are available for all individuals who find themselves within the SRU.

We met with two prisoners who were confined to safe cells in the prison. One told us "I like my own company and it works for me", whilst another stated, "I'm here because of self-harming and it is not right." We were pleased to note that the vast majority of prisoners with mental health conditions were not placed in a safe cell or SRU, and this was confirmed by the staff that we met with. We were informed that any use of confinement or segregation would be communicated to the visiting psychiatrist, who, along with the mental health nurse undertakes visits to those individuals at minimum on a weekly basis.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:

https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

We were aware that during the pandemic, restrictions were put in place that meant various activities and groups in the prison had to be put on hold and that some prisoners struggled with the restrictions placed on their routine.

Now that restrictions have fully lifted, we heard that people have returned to undertaking various activities. The issue raised by individuals whom we met with was that only those in D hall had "good access" to recreational activities every day, such as the pool table. In other halls, only 20 people were able to access recreation on a first-come, first-served basis. We were advised that some prisoners who were defined as "protected" received less access to recreational and wellbeing activities when their needs often required more support and activities in order "to get better". All of those that we met with advised us that having equal

and increased access to wellbeing groups, activities, daily recreation and/or education would improve their overall mental health. They all shared the view that there were significant restrictions on access to physical exercise opportunities in the prison. Some individuals reported that more activities would "stop most folk coming back into prison". There was acknowledgement of a new Healthy Minds group, which had been introduced to benefit prisoners. The group offers psychoeducation on a variety of topics, including mental health awareness, emotions, grief, trauma, and sleep. Individuals can self-refer to this group and attend any of the sessions that they feel are relevant. These groups are open to all individuals, regardless of legal status.

Many of the prisoners referred to the benefit of the chaplaincy service and the opportunity to have their spiritual, cultural, and religious needs met. We found that staff were culturally aware and tried to meet the cultural needs of the prisoners as far as possible.

Recommendation 7:
Managers should seek to improve consistent access to physical and recreational activities that focus on better outcomes for individuals.

The physical environment

On their last visit, HMIPS highlighted their ongoing concerns relating to the buildings, accommodation, and facilities in HMP Barlinnie not being fit for purpose. Many of these concerns and issues had been raised repeatedly. In 2023, significant refurbishment work had been undertaken to the reception and the health centre. This had ensured two large treatment rooms and improved facilities for staff and individuals visiting the centre. The health centre and nursing stations were of a good standard. The rooms, outdoor spaces, and activity areas that we visited were spacious, well maintained, appropriately furnished, clean, and hygienic. Since we last visited, a resource hub had been introduced, along with a wellbeing hub; prisoners spoke positively about these areas.

Any other comments

We were informed by managers that there was a working group for training in British Sign language (BSL) and how this can be adopted by health centre staff to support individuals. We look forward to hearing how this will improve care for those who communicate using BSL on our next visit.

We were made aware that there was no mechanism to alert the prison to the existence of a welfare guardianship order or Power of Attorney for anyone subject to the Adults with Incapacity (Scotland) Act 2000. We suggested that steps should be taken to ensure the prison is alerted to anyone in the establishment subject to these measures by either the health and social care partnerships (HSCP) and/or the Office of the Public Guardian (OPG); we look forward to seeing improvement in this area when we next visit.

Summary of recommendations

Recommendation 1:
Managers should ensure there is clarity to all individuals working with the mental health team when they will receive psychiatric follow-up.

Recommendation 2:
Managers should address the excessive wait times for individuals requiring hospital admission that find themselves in a safe cell or in the SRU.

Recommendation 3:
Managers should address the significant delays for individuals requiring access to medication and treatment upon admission to the prison.

Recommendation 4:
Managers should improve the consistency of care planning for individuals with complex needs.

Recommendation 5:
Managers should urgently address the current mental health risk assessments and management plans for all individuals who require these to be in place and should ensure there is clarity regarding who is responsible for their completion.

Recommendation 6:
Managers should ensure access to advocacy for individuals and better promotion of this service at HMP Barlinnie Prison.

Recommendation 7:
Managers should seek to improve consistent access to physical and recreational activities that focus on better outcomes for individuals.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report.

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

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

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

The Commission visits people in a variety of settings.

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

When we visit:

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

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

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

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

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

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

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

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

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

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