Mental Welfare Commission for Scotland

Report on announced visit to:
HMP Low Moss, Crosshill Road, Bishopbriggs, Glasgow, G64 2PZ

Date of visit: 31 July 2023

Where we visited

HMP Low Moss opened 2012. The prison has capacity for 784 prisoners and there were 802 prisoners there on the day of our visit. Project 100 had been set up to help deal with the national rise in the prison population, which this increased number of prisoners was part of. HMP Low Moss has male offenders on remand, and others on short- and long-term sentences. Prisoners were mainly from the North Strathclyde Community Justice Authority area. The Commission visitors were cognisant of His Majesty's Inspectorate of Prison for Scotland (HMIPS) report from a recent inspection (February 2022) which highlighted the increased prison population, and challenges around having adequate staffing levels for NHS care, which then had an impact on the ability of mental health nurses to provide mental health care to prisoners.

We lasted visited the prison under our local visit programme in 2018, although we did visit Low Moss 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.

On our visit on 14 August 2018, we made recommendations regarding improving the care planning for prisoners with complex needs and ensuring promotion of access to advocacy services. The response we received from the service was that steps had been taken, including the training of staff and the appointment of a band 7 senior charge nurse to improve care planning. A test of change model has been introduced so that advocacy services to prisoners could be provided.

Since 2021 there has been significant changes in the management and nursing team members, with an entirely new set of staff appointed to the mental health team. We wanted to hear of the impact of these changes on individuals in the prison, and their access to the service.

Who we met with

We met with and reviewed the care of 10 individuals who asked to meet us in person. We also attended a group session with a further eight.

We spoke with the deputy governor, professional nurse lead, operational nurse manager, nursing team leader, clinical psychologist, 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

Gordon McNelis, nursing officer

Neha Bansal, ST6 higher trainee (medical)

What people told us and what we found

Care, treatment, support, and participation

The primary focus of our visit was the specialist care and treatment provided for prisoners who were experiencing mental health difficulties. The prison mental health service is led by a nurse team leader and an operational manager who provide direct supervision and line management to the team. The nursing team consists of one full-time team leader, one full-time senior nurse, two full-time mental health nurses. There is an additional part-time nurse who supports the service once per fortnight. Individuals have access to daily general practitioner (GP) appointments as required in the prison. There are addiction and registered general nurses available on site who specialise in learning disabilities and addictions; this complemented the staffing skill mix and provided support for individuals with a variety of complex presentations. We were informed that none of the mental health nursing team were trained in learning disabilities or used any specific tools when assessing individuals presenting with these conditions. We were advised that, on average, the team supports up to 100 prisoners on an ongoing basis. We heard from managers that, in the last six months over 250 individuals had been assessed by the mental health team, who had been referred from a variety of routes.

During our visit there were three nursing staff available to assist with accessing individuals in the halls and in the prison cells. We were informed by psychology that they provide regular groups and support to the mental health team to aid with risk formulations. Individuals who require psychological input received this on an individual or group basis. Psychiatry input is offered by three permanent visiting psychiatrists, who offer three sessions per week. This ensures that 12 individuals are seen per week and these appointments can vary from initial meetings to review assessments. On the day of our visit, there was a four-week waiting list for routine assessments by psychiatry. When individuals are on the waiting list to be seen by psychiatry, nursing staff will provide ongoing monitoring of their mental state and compliance with any identified treatment. We were informed that anyone requiring to see a psychiatrist is seen quickly. However, the transfer of individuals to hospital for ongoing mental health treatment can result in significant waits. It was reported that this is caused by the lack of intensive psychiatric hospital beds across NHS Greater Glasgow and Clyde (GG&C).

Due to the initial configuration of the mental health team in 2012, there remains a shortage of nurses. We were told by the operational nurse manager that work is being carried out to address staffing issues, and a proposal will be put to the Glasgow Health and Social Care Partnership to increase the ratio of staff in September 2023. 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.

Care and treatment

We met with 10 individuals separately and eight others in a pre-arranged mental health group. Most people we spoke to were very positive about the mental health care they received, they reported that they could talk openly with the mental health nurses. One stated, “Treatment here is second to none….they are caring and will listen to you”. Whilst another stated, “the mental health support here is better than what I was getting out in the community”. However, there were comments made that at the reception area of the prison, there was limited

consideration of how to access mental health support. Currently, due to staffing challenges the nursing team only join SPS staff for assessments when there is a critical need, and this was reflected in the comments shared by individuals. Some described how they had to rely on peers to signpost them to the mental health service. We heard that individuals felt that mental health screening on reception did not cover enough detail, that concerns were missed, and appropriate referrals are not always made.

Many described how self-referral forms had to be completed to in order to gain access to the service but then they had to wait "up to six weeks to be seen". Some people described that they were not keen to ask prison staff for support to complete the referral forms. We were concerned that if someone was unable to understand or communicate, as either English was not their first language or they had a learning disability, this could potentially create a barrier to accessing mental health support. Due to the multicultural background of individuals, the need for regular access to interpreting services is essential. We heard that managers had taken all reasonable steps to address cultural and communication barriers, with all forms being available in a variety of languages and that there were telephone services in place alongside traditional written documentation.

We heard that there were plans to adjust the self-referral forms to include symbols and pictures for those who may present with additional support needs. Managers confirmed that all self-referral forms were triaged and are seen within 48 hours for those in an emergency. Urgent referrals tended to be seen within five days and routine referrals would be seen in 28 days, however this was different from the experience described by those that we spoke with.

The group we attended advised us of their concern regarding the increase in drug use and of individuals becoming seriously unwell as a result. One long-term prisoner described how in previous years it was "rare to see an ambulance coming to prison; now it is commonplace". It is important to note that these comments were shared by staff in the health centre who advised of the high prevalence of substance misuse and the methods by which drugs are able to enter the prison. This, coupled with the levels of violence displayed towards staff, caused concern to all whom we spoke with.

During our previous visit, psychological interventions in the prisons across GG&C remained a key priority. A prison psychology team works between Barlinnie, Low Moss, and Greenock, who provide clinical interventions for anyone requiring psychological assessment and support. Psychologists supervise low-intensity psychological interventions carried out by mental health nurses and also have an individual case load. The psychology service is complemented by a Cognitive Behaviour Therapy (CBT) nurse as well as an assistant psychologist. The nursing team spoke positively of the psychology input provided. Psychologists attend weekly team meetings and nurses reported positive joint working. We heard that the psychology team were about to embark on a pilot which aims to introduce computerised CBT with support from the assistant psychologists based in the prison. It is expected that this will aid individuals through the programme. We look forward to hearing more about this during our next visit, and to find out if this has been a success for those involved.

It was evident during our visit that there were good working links between health centre staff and other prison staff. The mental health nurses were regular visitors to the prison halls, and they had day-to-day contact with the prison officers, allowing concerns about individuals' mental health to be addressed at an early stage. There were apparently no issues with interview facilities in relation to providing mental health support to people. There were interview rooms in the halls, as well as in the health centre; so individuals were not always required to come to the health centre to be seen. We heard that generally, people chose to be seen in the halls rather than attend the health centre.

In speaking with the deputy governor and other prison managers, there was a clear commitment to addressing mental health issues in the prison, and to provide support to the mental health care team. We heard that in previous years, prison officers would receive a range of opportunities to improve their knowledge and understanding of mental health issues, though these opportunities had ceased due to the demand on the service and staffing levels. There remains a prison-wide multidisciplinary team meeting that helps when discussing any concerns relating to mental health in the prison. On the day of the visit, we faced some challenges seeing prisoners in one of the units, but this was addressed with assistance by the deputy governor. This was noted to be common practice in the prison, due to the various demands placed upon each of the units.

Care plans

We reviewed the notes of the individuals we met with. The mental health team use four different electronic systems to gather and record information relating to individuals as approved by NHS GG&C. This includes, Vision, EMIS, a clinical portal, and the online team folder system that holds all care plans. These electronic systems do not directly communicate with each other, which causes challenges when trying to swiftly access information. Like most prisons, HMP Low Moss has individuals from across Scotland and the UK. This causes challenges for staff when trying to locate medical and mental health histories, as regional and national systems do not interact with the prison electronic systems. Despite this, all known prisoners receiving health care were found to have a formalised care plan in place which aimed to ensure a consistent approach and a clear understanding of the needs and goals. This is 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 both on Vision and on the electronic record system in a shared drive. We were unable to find a consistent audit trail of how care plans were updated and any version control. We could find no prior care plans, aside from the current versions found in the system shared folder. It was concerning to note from staff that when care plans were uploaded to Vision, there were issues with how the system stored and managed this information.

In relation to risk assessments and management plans, we noted that the Clinical Risk Assessment Framework in Teams (CRAFT assessment) was the agreed tool to be used in the prison. The CRAFT assessment had been added to the Vision system since our last visit, and is reported to be a new amendment to assist with risk management. Unfortunately, how this risk assessment has been embedded on the system raised a number of concerns. From the risk assessments we reviewed, we found several assessments that did not capture the current risks, or only noted historical risks. Many of the risk assessments were not fully completed and the majority of the content did not make any sense to the Commission visitors. There was

no clarity on who was responsible for the risk assessment, and we found no clear management plans for any individuals. We were concerned that the current arrangements around risk assessment and risk management do not address the aims of an effective risk management system and what is currently stored on the electronic system is not being safely implemented; we were especially concerned about this collated information in the event of any adverse event.

We found the care plans for mental health needs to be variable in terms of quality, with some lacking clarity on whether individuals were receiving medication or not. We found some excellent care plans similar to what we would routinely find in forensic mental health services, whilst others had minimal information.

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 1:
Managers should improve the consistency of care planning for individuals with complex needs.

Recommendation 2:
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 made a recommendation around access to advocacy services. For this visit, we heard that access to advocacy was non-existent and that prisoners were not aware that they would have a right to discuss their circumstances with this service. Prior to our visit to Low Moss, we held a pre-meeting with managers. At that time, it was not clear who was the approved provider for advocacy services. Following our visit in 2018 we were informed that Ceartas Advocacy would be taken on this role, however, we could find no evidence that any steps had been taken to ensure that visits by the advocacy service had ever taken place. We were later informed that there are issues in relation to SPS staff coordinating and agreeing access from advocacy to prisoners on a timely basis. During our focus group this was confirmed with individuals who commented, “advocacy, what is that?” and “I don’t know how to access them”.

The Commission is aware that advocacy will not have a role for everyone however, the service could assist prisoners who are potentially being transferred to a hospital from prison under the Mental Health (Care Treatment) (Scotland) Act 2003 or the Criminal Procedures (Scotland) Act 1995. When we last visited, we discussed this issue, highlighting that independent advocacy can be helpful in supporting individuals and can have a positive impact in establishments where it is well used. We again suggested that there be further discussion with an advocacy service, and that the SPS considers 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 3:
Managers should ensure access to advocacy for all prisoners and better promotion of this service at HMP Low Moss.

We took the opportunity to look at the Separation and Reintegration Unit (SRU) in Low Moss. As one of the more modern prisons in Scotland, the standard of the environment was better than compared to some of the other prisons we have visited, but we remain concerned about the use of SRUs, especially for those prisoners with mental health issues. We were also concerned about length of time some people spend in these units. The SRU at Low Moss is based in the Lomond unit of the prison. We met with two prisoners who were in the SRU at the time of our visit, and there were mixed views on the benefit of this type of environment. One spoke of feeling safe and secure. "It will help me with going back to the community. It's quiet, there's less pressure as I don't want to be in the halls, and the governor seems happy to keep me here. No one is rocking the boat". Whilst another stated, "it is unbelievable in here, I want out and moved to another prison to be nearer my family".

The Prisons and Young Offenders Institutions (Scotland) Rules 2011 sets out that individuals can 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. 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 or placing them in segregation. For people being held in segregation, the Commission applies the recommendations of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) in that all individuals, including those in conditions of segregation, should have at least two hours of meaningful human contact each day. For those that are held longer than two weeks in segregation, they should be offered further supports and opportunities for purposeful activity. The prisoners that we met with had no specific access to any purposeful activities out with the radio, although limited time to walk in the small enclosed outside space was available. Those that we met highlighted that they had no interest in accessing any activities and were "waiting it out".

We met with one person who was confined to his cell, unfortunately due to his mental state he was not able to engage with us in a meaningful way, in order that we could hear his view on what it was like being subject to restrictions. In discussions with managers, the rights and restrictions of individuals, especially for those where use of seclusion had been used, was considered as a last resort. We were informed that nearly all prisoners with mental health conditions were unlikely to be placed in seclusion; this was confirmed by all parties that we met with and spoke to. We were informed that where there is a use of confinement or segregation, this was passed on to the visiting psychiatrist who, along with the mental health nurses, undertook visits to those individuals at a minimum of once a week.

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 that various activities and groups in the prison had to be put on hold; some individuals struggled with the restrictions that were placed on their routine. Now that restrictions are fully lifted, we heard that people had returned to undertaking various activities including working in the laundry, the barbers, attending IT courses, as well as studying various subjects, including social science, English and mathematics.

Those that we spoke with told us that these activities helped them to feel "more stable". Some individuals spoke positively about the relaxation group which is available on a weekly basis, as well as the recovery groups supplied by Sisco and the Scottish recovery network. There was clear acknowledgement that the Healthy Minds group, which was in place during our last visit continues 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 is relevant. These groups are open to all individuals, regardless of legal status. Psychology staff have piloted a 'Safety & Stabilisation' group at Low Moss, and we heard that they are aiming to hold a further session on this to help address individuals' trauma experiences.

Some prisoners made reference to the benefit of the chaplaincy service and the opportunity to have their spiritual and religious needs met. It was clear from our visit that the staff are culturally aware and try to meet the cultural needs of the prisoners as far as possible.

The physical environment

The health centre rooms and nursing stations found in the halls were of a good standard. The rooms, outdoor spaces, and activity areas that we visited were of a good size and were well maintained, appropriately furnished, clean, and hygienic. Each person we met with when in their cell had a bed, bedding and suitable clothing, access to toilets and washing facilities, and were provided with necessary toiletries and cleaning materials.

Any other comments

We were informed by managers that there is a SPS board-wide group working on the use of 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 informed 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 think that steps should be taken with all health and social care partnerships (HSCP) and the Office of the Public Guardian (OPG) to ensure the prison is alerted to anyone in the establishment subject to these measures.

It was noted by the mental health team that, “individuals with mental health conditions are not always being fully assessed” prior to admission to the prison, and this could be improved with work being undertaken by the court system to address this matter. There were views expressed that some people could be appropriately re-directed to mental health wards instead of coming directly to prison. It was noted that some of this was due to resources, or a lack of hospital beds and/or limited awareness by court staff of the presentations of those with significant mental disorder.

Summary of recommendations

Recommendation 1:
Managers should improve the consistency of care planning for individuals with complex needs.

Recommendation 2:
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 3:
Managers should ensure access to advocacy for all prisoners and better promotion of this service at HMP Low Moss.

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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