Mental Welfare Commission for Scotland

Report on announced visit to:

HMP and YOI Stirling, Cornton Road, Stirling, FK9 5NU

Date of visit: 7 December 2023

Where we visited

HMP Stirling and young offenders' institution is the national facility housing both remand and convicted female prisoners. It was built on the site of the former HMP Cornton Vale which closed in April 2023. Its purpose is to provide a safe and secure environment for women in custody who present a significant risk to the public and we were told that it had adopted a trauma-informed, gender specific approach to reflect the assets, needs, and risks of these women. It opened on 19 June 2023 with phase one becoming operational in July 2023. It has a maximum capacity for 104 prisoners with single room only use. The population limit for the entire HMP Stirling is 104 but we were informed that the operational capacity is between 80 and 90 prisoners.

In addition to the reception area, where the health facility is located, the prison is formed of units where individuals are held in custody. This includes the separation and segregation unit (SRU) and the enhanced needs unit (ENU). HMP Stirling has a total of 17 'safer rooms' across the site, including those in the SRU and the ENU. Phase two, which centres on a 'wellness' area, is underway and is expected to be ready by November 2024. This facility will have a therapeutic focus and will include chaplaincy services, an animal sanctuary, group rooms, meditation, yoga, and other therapies.

The estate population are received initially from court, where they were then processed and accordingly, sent on to other facilities. The original planning proposed site was Inverclyde, which was the preferred location for the new prison and where there would have been an expanded population, however the establishment of community custody units have provided additional facilities for prisoners serving sentences of 12 months or longer. The Lilias Centre in Glasgow and HMP Bella in Dundee enable prisoner reintegration back into the community. This combined resource provided a further 40 low supervision placements, with increased access to local services and amenities that are geographically closer to individuals' original communities and links.

The Mental Welfare Commission's themed visit and report *Mental health support in Scotland's prisons 2021: under-served and under-resourced* made ten recommendations to the Scottish Government, NHS Scotland and the Scottish Prison Service (SPS) on changes that were needed to improve mental health services across the prison estate. Recommendations included the need for care plans and SPS training. We visited HMP Cornton Vale, as it was formerly known, as part of this themed visit and did a local visit in 2017.

The purpose of this visit was to find out how care and treatment was being delivered to individuals experiencing poor mental health in the new prison setting. We wanted to meet individuals and review the health records of those interviewed. We were given an overview of the units noted detailed below, however our visit focussed on the Wintergreen Unit, the SRU and ENU.

This visit was jointly completed with the Scottish Human Rights Commission, who were interested in undertaking their own review alongside our visit, to look specifically at the SRU and the ENU.

Thistle - assessment centre

This unit houses recently convicted female prisoners who remained there for a period of assessment prior to moving out to other prisons such as HMP Greenock or HMP Grampian, depending on their sentence. All prisoners spend their first night in custody here. Although some prisoners in the unit had experience of mental health difficulties, they were mostly regarded as higher functioning and able to be managed safely in the unit during the assessment period.

Wintergreen

There are 21 cells in the Wintergreen Unit housing a mixture of remand and convicted individuals, where there are significant concerns about their mental health. This unit is categorised as high needs and high risk, and there were several individuals who were on a 'caseload' and who were regularly reviewed due to ongoing concerns; for others, the visiting psychiatrist had recommended transfer to a hospital setting for further assessment and treatment of their illness. The ENU and SRU are attached to Wintergreen.

Heather (SRU)

There are four cells in this unit, which were used predominantly for prisoners who had displayed episodes of violence and were referred to as 'rule 95' prisoners. The 'Prisons and Young Offenders Institutions (Scotland) Rules 2011' gives authority to the prison governor to make a ruling for them to be removed from association with other prisoners, either generally, or to prevent participation in a prescribed activity or activities. We were told that where prisoners were experiencing poor mental health and required increased observation, this would normally be managed in the ENU, but if more staff were needed, they could be moved to SRU. There was one individual in the SRU on the day of our visit who met with us.

Enhanced needs unit (ENU)

The ENU unit adjoins Wintergreen and has three cells, with the majority used for 'rule 41' prisoners, or for those who required additional support. Rule 41 in the 'Prisons and Young Offenders Institutions (Scotland) Rules 2011' allows a prison governor to order that an individual in prison be accommodated in specified conditions due to a health condition where they are a risk to themselves or others following advice from a healthcare professional. The aim is that once they are more stable, they would eventually be reintegrated into Wintergreen. There were no individuals in ENU on the day of our visit.

Begonia

This is a mainstream remand unit for up to 21 individuals where there were no initial concerns in relation to an individual's mental health.

Myrtle – young offenders' unit

There are a total of 12 cells, three of which were described as 'safer cells' in the young offenders' unit. It held a mixture of remand and convicted offenders ranging from 16 to 21 years of age. There were three individuals in the unit on the day and we were able to meet with one person from the unit.

Iris
This is a mainstream area of 21 cells, mainly for the population who had work placements in the prison, such as hairdressing.

Bluebell
This is the pre-progression unit and had eight cells for individuals who were making progression towards the Bella and Lillias community custody units.

Primrose
This is the mother and baby unit and although empty on the day of our visit, it could accommodate two mothers and their babies.

Who we met with
Prior to the visit, we were able to have online discussion with the team leader of the prison mental health team (MHT) for an overview of the team and treatment offered.

During the visit, we had continuous access to the deputy team leader along with the primary care team leader. We met the service manager and health care manager for the three prisons in the Forth Valley area, the prison governor, head of residential services, and other members of SPS staff.

We also met and reviewed the care of nine prisoners who had been referred to the MHT following concerns about their presentation in prison. A miscommunication between SPS and health staff resulted in the advocacy worker waiting in the wrong area, however we were able to have a post-visit phone discussion. We were also supplied with details of psychological input and support for staff by the consultant clinical psychologist, post-visit.

Commission visitors
Denise McLellan, nursing officer

Juliet Brock, medical officer

Justin McNicholl, social work officer

Cathy Assante, Scottish Human Rights Commission

What people told us and what we found

Care, treatment, support and participation

During our visit, we met with four prisoners who were being managed under rule 41, one of whom had recently been assessed by psychiatry and was awaiting transfer to a mental health hospital for assessment and treatment. The other women we met had previously been managed under rule 41 but following improvement in their mental health, this was no longer necessary. Two women had had extensive input from psychiatric services in the past, however, were stable enough to remain in prison in this unit. We also met with one individual on rule 95 in the SRU.

We heard mixed reports about activities that were available, with some women saying they had regular access to outdoor space for exercise and games in the unit. For others, we were told that this was dependent on staffing levels. Two people said that they would like to have had access to the library, which they did not currently.

One person felt that the prison had opened too early, as there was "nothing to do; no psychological therapies". We also heard mixed reports about access to mental health services, with another saying she had had an initial assessment but no further input despite having a diagnosis. She confirmed that she has regular psychotropic medication prescribed and available and that she would know how to refer herself to the mental health team if she felt her mental health was deteriorating. Another told us of accessing speech and language therapy (SLT) however, felt she would benefit from further psychology input, as she had received this in another establishment.

One prisoner spoke positively about the support from nursing staff and spoke particularly of specific nurses who had provided this promptly and regularly; she compared the environment favourably with two other custodial settings.

All prisoners we spoke to were aware of the self-referral process for mental health input and told us that they could complete a referral form in the hall and place it in the box for collection.

An individual we met in Myrtle said that it felt "more like a hospital than a prison". She said that she found it "boring" as there were only three people in the unit. Her view was that there was "more happening in Polmont" but praised the nursing team, telling us that she saw them at least weekly where they worked with her on decider skills, which she found helpful. She also informed us of access to prison psychiatry.

Overall, feedback was largely positive from the number of individuals that we met with.

We heard from SPS staff who were concerned in relation to the volume of prisoners who experienced poor mental health, and who had behavioural challenges and distress from unresolved trauma and guilt. One member of SPS staff commented that they had never known such a high incidence of mental illness in the prison. Another concern raised with us was that the background and historical information about prisoners should be available to staff sooner, especially for rule 41 prisoners. SPS staff spoke of occasions where helpful background information was not known until three days later, which could be challenging for staff. We were told there was a very positive relationship with healthcare staff and that there was a

reliance on co-working and good communication. We also heard that education was offered by the MHT to SPS staff to promote greater understanding and awareness of individual prisoner presentations and communication difficulties.

An area of ongoing concern, highlighted by healthcare staff, was in relation to difficulties experienced where people were remanded to prison as a 'place of safety'. We were told that this has been escalated to the Crown Office and Procurator Fiscal Service (COPFS). The consensus was that there was a lack of understanding regarding the assessment process for remand prisoners and limitations around treatment provision. Recent statistics have indicated that while there had been a 37% decrease in short term sentences, the remand population was high.

Further issues that were raised with us included the national shortage of psychiatrists who were available to write court reports, coupled with a shortage of beds in medium secure in-patient services, resulting in delays. With this being a national facility, access to mental health officers (MHO) was difficult due to the prison not being in an individual's own health board. Additionally, if high secure care was required, individuals must be transferred to Rampton Hospital in England, but this would not happen unless an individual had been convicted.

It was noted that as prisoners were regarded to be in a place of safety, there was less urgency to have a transfer take place to an appropriate mental health facility. This is in contrast to an individual who is mentally unwell in the community and who presents at hospital where access to a bed is prioritised. The Commission had previously discussed a particular case with the MHT manager regarding one acutely unwell remand prisoner who was liberated following a virtual hearing. The individual required to be detained in hospital shortly after liberation and despite specific concerns being raised prior to the hearing, regarding her fitness to be bailed, the sheriff took the decision to release them. We were told this was not an uncommon situation and that despite efforts made by the MHT to secure mental health provision on release, the time frame to arrange this was limited due to release being authorised on that day.

Mental health team (MHT)

We were pleased to hear that there had been an increase in funding for each discipline in the team, however there were still some vacancies at the time of our visit. The MHT was a multidisciplinary (MDT) team consisted of allied health professionals (AHPs) including a speech and language therapist (SLT), 10.8 whole time equivalent (WTE) registered mental nurses (RMN) with four vacancies, and 3.6 WTE healthcare support workers (HCSW). Forensic psychiatry input was provided by a visiting consultant psychiatrist who provided three half day sessions weekly and additionally, there was also a GP out of hours arrangement. Clinical psychology consisted of one consultant clinical psychologist, one clinical psychologist, and one assistant psychologist. There were vacancies for 0.8 WTE clinical psychologist and one assistant psychologist. We were advised that both posts had been recruited to, with expected commencement in February 2024.

Care and treatment

Assessment

We were told that all prisoners had their healthcare needs assessed on admission, which included screening for addiction, physical health, and mental health risks, including suicidality and deliberate self-harm (DSH). Assessments were carried out in a specifically designated room close to the nurse's station in the reception area and there was always a nursing member of MHT available to undertake this.

We viewed this room, which was noted to be quite clinical, although afforded privacy for the sharing of confidential health information in a more appropriate setting. There was a cubicle in this room to maximise privacy and dignity, where tests could be undertaken if indicated from the screening assessment. We were also able to review the NHS admission assessment tool used; it was comprehensive and covered areas including communication, mobility, and support needs. There were prompts around adult support and protection, learning difficulties, interpreter requirements, and disabilities. The health care assessment section focussed on obtaining physical health measurements, allergies, sexual health including blood-borne virus status (BBV), self-reported medical history, drug and alcohol use, and smoking status. There was also a female specific physical health section that considered factors such as pregnancy, menopause, and cervical screening. The mental health section covered diagnosis, self-harm/suicide and risk, as well as community key contact details. Information gathered could prompt initiation of the SPS 'talk to me' suicide initiative and rule 41, where required. Additional clinical tools were available, such as the clinical opioid withdrawal scale, benzodiazepine and alcohol scale and a long-term condition pathway. A patient group directive (PGD) for the detoxification regime allowed detoxification medications to be administered if required.

A GP service was available from Tuesday to Friday, with input from the GP and advanced nurse practitioner (ANP). Monday was an on-call service and on Saturdays the GP or ANP reviewed admissions from the Friday. Registered adult nurses provide regular clinics where care is provided for physical health and sexual health and blood borne virus testing. Substance use and recovery (SRT) caseworkers and nurses were available Monday to Friday between 08:00 to 16:00. Where someone needed urgent review out with these hours, this would be done over the telephone by SPS staff to the nurses in the police custody service. In the event of a medical emergency overnight, SPS would call for an emergency ambulance. There was also an SPS trained first aider available.

Referral process

Referrals to the MHT were primarily by self-referral, but they could also be made by nursing and SPS residential officers. The aim is to see routine referrals within seven days and urgent referrals within 48 hours, so that mental health needs could be triaged and then discussed at the next clinical team meeting (CTM) and allow a treatment plan to be put in place.

Multi professional meetings

The MDT met weekly and was attended by health staff including the team leader (TL) or deputy team leader (DTL), psychiatry, SLT, mental health occupational therapy (MHOT), and RMNs. There was also a weekly SPS-led multidisciplinary mental health team meeting (MDMHT) attended by the deputy governor or residential manager, the TL or representative from the MHT, first line managers from each area being discussed, chaplaincy, prison-based social

work, health and wellbeing officer, and residential staff members. We were informed that clinical psychology attended both meetings when they had capacity to do so, and the new psychologist will attend regularly in the future.

Treatment
In addition to psychology providing individual sessions to prisoners, decider skills groups were ongoing with most nursing and MHOTs trained in this intervention. The MHT were looking to roll out decider skills groups into Wintergreen but had started the group in the other units first. Medication was provided in regular rounds three times daily and there were no issues regarding access to medication that were highlighted to us. For those in SRU and ENU, we were told the aim was always to move people back to the more mainstream environment when risk was reduced.

Training
SLT and clinical psychology delivered specific training to NHS staff which included trauma informed training, communication skills for neurodevelopment disorders, and safety and stabilisation training. Clinical psychology provided psychologically informed care sessions (PICS) to NHS staff, as well as monthly supervision for NHS staff delivering low intensity psychological interventions. They also provided monthly skill sessions to help staff keep up their confidence and competence in safety and stabilisation, as well as offering monthly reflective practice group sessions to NHS staff.

Relationships between SPS staff and NHS staff was described as good, but there was an acknowledgement that SPS staffing levels had been poor. However, we were pleased to hear that there had been an emphasis on NHS staff supporting SPS staff with awareness sessions, for example, the provision of training on communication difficulties for prisoners with mental illness and learning disability; there had been some other, more formal training offered too. Clinical psychology had delivered ad hoc training to SPS and NHS staff on subjects they had requested, such as managing challenging interpersonal dynamics and complex case discussion/formulation sessions for NHS and SPS staff. Further training had been planned however, SPS staff sickness levels had had an impact on this. Clinical psychology has committed to delivering trauma informed leadership training to senior NHS and SPS staff in 2024.

SPS staff could access other training, such as the five day 'women in custody' training and they also had access to trauma informed training available through NHS Education for Scotland (NES). Additionally, we were told of simple, yet effective measures adopted, such as changes in t-shirt colours so there was less association with police uniforms and recognition of the influence that the physical environment had on individuals.

In keeping with the SPS strategy for women, the aim was to enhance outcomes for women during their time in custody. 'Open Secret' was available for the general prison population to provide trauma informed support for individuals who had experience of adverse life events such as poverty, surviving abuse, and addiction issues. It focused on building skills and confidence with the goal of helping women to feel safe and healthy, with improved wellbeing. Other initiatives that we were told of were the suicide and self-harm prevention initiatives 'choose life', the 'listener service' and 'talk to me'.

Care plans

At our pre-visit meeting, we were informed that prisoners on rule 41 would have a care plan available on the Care Partner electronic information system that is used throughout NHS Forth Valley. The template was available to health staff to review and update. HMP Stirling planned to trial new support plan paperwork and there was MDT agreement that anyone on the MHT caseload would have a care plan on Care Partner. Difficulties have arisen from the population being transient, with individuals moving on before a comprehensive mental health assessment could be completed. We were told that the timeframe from allocation to completion of a care plan was four weeks and that individuals were invited to participate and were offered a printed copy of the completed record.

Alongside Care Partner, there are SPS vision health care record and NHS clinical portal information systems that were used, but we heard that there were difficulties when trying to access information due to the lack of interoperability between the systems. With the prison being a national facility, this issue would be amplified when considering all the other information systems used by different health boards across the country.

On reviewing the records, we were disappointed to see that one individual who had been subject to rules 41 and 95 did not have a care plan or evidence of the functional analysis of care environments (FACE) risk assessment. We were told that SPS completed their own risk assessments. We would have liked to have seen a care plan for their current mental health provision. Other care plans were generic, with one containing copy and paste errors and appeared to be written by the staff, rather than being done in collaboration with individuals. Another record did note that the individual had not consented, however, there was no signature or record of refusal to sign. For another, who was receiving decider skills intervention, there was no corresponding care plan.

We found good evidence of daily notes with case discussion having taken place where applicable, as well as mental health case conference reviews and regular reviews by the consultant psychiatrist. One person on rule 41 was awaiting transfer to hospital and there was documentation in relation to her plan and management. Each patient allocated to the MHT caseload should have a care plan completed, however we did not find this to be the case on the day.

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 ensure person-centred, individualised care plans are in place for all individuals with complex mental health needs and compliance with these should be audited.

Recommendation 2:

Managers should ensure mental health risk assessments and risk management plans are in place for all individuals who require these and should ensure there is clarity regarding who is responsible for their completion.

Rights and restrictions

The prison had regular input from Forth Valley Independent Advocacy Service. We had arranged to speak with a representative on the day, however due to a communication mix up this did not happen. We were able to have a telephone discussion following the visit and the representative told us this service was firmly established in HMP Stirling. They described a clear referral pathway with referrals being made in a timely way by nurses and MHOTs. Advocacy considered that the staff in HMP Stirling were communicating well as a team and noted that referrals were being made by team members other than nursing, which indicated awareness had increased. We were advised that once referrals were accepted, prisoners were seen quickly. Visits were conducted in the visits area, where safety and privacy were respected, and all staff had been found to be supportive of the visits, which usually occurred every three or four weeks but could be more frequent if required. We were pleased to see posters advertising advocacy in the prison.

Prisoners informed us that they had access to phones in their cells and were permitted up to 200 minutes each month. They also had access to kettles and televisions and were able to use their vapes in their cells and in the prison grounds. One told us that she accessed chaplaincy services on a weekly basis and felt she was treated with dignity and respect and her specific dietary requirements were being met. Prisoners were also informed about their right to legal advice, advocacy, attendance at case conferences, and had child and family social work involvement.

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

Activity and occupation

Employment skills and opportunities could be sought in the prison hairdresser facility, in the kitchen and central dining area, as well as domestic cleaning positions. We spoke to one woman in Wintergreen who received a wage for her cleaning job which, as well as being financially rewarding, she said it helped to keep her occupied.

Recreational activity included access to a small gym, a library, walking groups, ball games with physical training instructors and arts and crafts. We were also informed by the governor of educational links with Fife College, a recovery café, and projects such as knitted poppies and bonnets for neonates to promote a sense of community. We received mixed feedback from prisoners about access being dependent on the availability of staff. During our visit to Wintergreen, we observed a games table in the main concourse however, this was not being used at the time. The women in the SRU and ENU had access to a separate small exercise area which faced onto a pond and garden.

The physical environment

The environment was clean, modern, light and airy, as expected for a new building. However, there were some concerns expressed in relation to the layout of the buildings, with a degree of restricted visibility in some areas that could increase risk. Some people said that they did not feel entirely safe. Vandalism would potentially be an ongoing issue requiring regular

maintenance and we already noted damage in some cells; we will continue to review this over the next few years. The prison was defined by two specific areas, front of house and reception. The former was the public accessible areas and latter referred to the prisoner facilities.

The grounds were of a landscaped design, and were spacious, pleasant, and welcoming. Despite this being a custodial facility, it felt open and very different to traditional prisons. It was evident that a great deal of consideration had been given to building design and functionality during planning. Facilities included a therapeutic area, a bright and clean lunch hall, and a separate family centre. The family help hub was open between 12:00 to 18:00 most days and we were told the visits room was less intrusive than in other establishments, due to having more camera coverage. We were also aware of there being gym and library provision.

We were shown around the SRU and ENU, which were of a modern design however some of the cells felt cold, including an occupied cell. We were told there was no extra bedding, and this was confirmed by staff in the unit. We discussed this with SPS staff at the end of the day and were told that this would be rectified.

Summary of recommendations

Recommendation1:
Managers should ensure person-centred, individualised care plans are in place for all individuals with complex mental health needs and compliance with these should be audited.

Recommendation 2:
Managers should ensure mental health risk assessments and risk management plans are in place for all individuals who require these and should ensure there is clarity regarding who is responsible for their completion.

Service response to recommendations

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

A copy of this report will be sent for information to 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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