Mental Welfare Commission for Scotland

Report on announced visit to: The Lilias Centre, Community Custody Centre, 41 Shawpark Street, Maryhill, Glasgow, G20 9DR

Date of visit: 16 April 2024

Where we visited

In 2015, the then Cabinet Secretary for Justice announced that Scotland would be taking a new approach to managing female offenders, which included a move towards custody in the community. This was based on an analysis of examples from countries across the world about the arrangements that were effective in supporting and preparing women for a return to their local community. The creation of Community Custody Units (CCUs) was specifically designed to provide safe and secure accommodation, that was trauma-informed and gender specific.

The aim of CCUs is to support the needs of women offenders who would benefit from closer community contact and access to local services. The design of CCUs in Scotland is focused on females living independently in accommodation based on a 'shared house' principle to develop a range of independent living skills, which are reflective of real life.

The Mental Welfare Commission's themed visit and report *Mental Health Support in Scotland's Prisons 2021: Under-Served and Under-Resourced* made 10 recommendations to the Scottish Government, NHS Scotland, and the Scottish Prison Service on changes that were needed to improve mental health services across the prison estate.

There are currently two CCUs in Scotland, the Bella Centre in Dundee and the Lilias Centre in Glasgow. The Scottish Prison Service (SPS) opened the Lilias Centre in October 2022. Originally, there was no plans to have any nursing staff based in the centre. In October 2023, mental health nursing staff were employed to support the individuals in the centre. The Lilias centre is located in the Maryhill area of Glasgow, and the centre's accommodation consists of four 'shared houses' with capacity for 24 individuals. On the day of our visit, there were 18 individuals who were accommodated in the centre.

CCUs are for those females who are nearing the end of their sentences and who are serving sentences of 12 months or longer. The Lilias Centre in Glasgow and the Bella Centre in Dundee provide supervised placements, with increased access to local services and amenities that are geographically closer to individual's original links and communities.

As this was our first visit to a CCU, the purpose of this visit was to find out how care and treatment was being delivered to women who were experiencing poor mental health in this new setting. We wanted to meet with the women, and to review the health records of those interviewed. We were given an overview of the houses and how the health centre staff work with those in their care.

Who we met with

Prior to the visit, we were able to have an online discussion with the operational manager, team leader, and charge nurse of the centre's mental health team (MHT) for an overview of the care and treatment offered.

During the visit, we had access to the charge nurse, along with the centre occupational therapist (OT), and clinical psychologist. We met the unit manager of the Lilias Centre and other members of Scottish Prison Service (SPS) staff.

We also met three individuals and reviewed the care of four prisoners who had been referred to the MHT requiring care and treatment in the CCU.

Commission visitors

Justin McNicholl, social work officer

Mary Leroy, nursing officer

What people told us and what we found

During our visit, those we met with highly praised all staff for the care and treatment they were receiving. We heard comments that included, “the service is amazing”, “I couldn’t be more thankful to be here compared to the prisons” and “the nurses are great, I see them every day and they are always there when I need them.” Individuals told us that the stability of the Lilias Centre was helping them to plan for their futures, to feel independent and in control of what their futures may look like once they left the CCU.

We heard that the centre had been affected by staff shortages due to absences in the Scottish Prison Service. Despite this, individuals advised us that it was a significant improvement in the living conditions compared to being in prison. One stated, “if we have to stay in our houses, it’s fine as you can keep busy and still speak to folk that you share with. It’s not like my time in prison when you are locked in your small room 24 hours per day.” We heard about activities that were available, with all women saying they had regular access to exercise, support groups, the gym, games, and activities in the CCU.

All individuals who were receiving psychological therapies praised the ease of access to this service and described being “grateful” and “thankful” that they were now developing an understanding of how their diagnosis had an impact upon their lives in the past and present. The individuals we spoke with described the strategies they had in place to show themselves “compassion” and “understanding”. They detailed how their diagnosis had educated them on how to cope with previous behaviours and focus on “dealing with my responsibilities which avoids previous arguments and compulsive actions”.

We also heard reports about access to mental health services being “quick”, “responsive”, and “straightforward”. One individual stated that she had regular medication prescribed and available. Another told us of accessing OT staff.

Overall, the feedback we received was positive. We heard comments that SPS staff were “approachable and helpful” although there was a comment that “a couple of staff have closed minds”. We were told there was a very positive relationship with healthcare staff and that there was clear collaborative working and good communication. We also heard that education was offered by the mental health team (MHT) to SPS staff to promote greater understanding and awareness of individual presentations, and on strategies about how to deliver the best outcomes for the individuals in the Lilias Centre.

An area of ongoing concern, highlighted by healthcare staff, was in relation to space in the centre to undertake their work. When the Lilias Centre was first designed, there was no plan to include health staff in the CCU. However, before it was due to open, the NHS were approached to supply staff. As a result of this planning, we heard of some of the difficulties experienced when trying to find confidential spaces to meet with individuals with due to there being only three dedicated office spaces available, and two of these had no access to the NHS system for staff to use. Staff spoke of how they have used laptops to complete work in the centre, however the poor Wi-Fi coverage in the building was an issue.

We heard that when the Lilias Centre first opened, there was no plan to have any prisoners who were on short-term sentences. However, we heard there were instances of individuals

being sent to there, and this was a challenge for some of the prison staff due to having to adapt therapies for this group of individuals. We also heard that some therapy was not commenced due to likelihood that there was no guarantee of follow-up, or the completion of therapy, which could compromise the desired outcomes of the treatment. The consensus was that there was work to be done across the prison estate to ensure that a consistency of those admitted to the CCU was required to ensure the best outcomes for the individuals in the service.

We heard that the appointed psychiatrist and art therapist for the centre were currently on leave; despite this we were advised that there was psychiatric cover available to ensure that individuals could access assessments and treatment without any delay or interruption to their care. The art therapist was due to return to work in July 2024.

Care, treatment, support and participation

We were told that all individuals had their healthcare needs assessed on admission, and these included screening for addiction, epilepsy, and mental health risks, including suicidality and deliberate self-harm (DSH).

There is a charge nurse with training in mental health and addictions who attends the centre at least once per week, from 8am to 4pm. There is a health care support worker who works over 7 days per week from 8am to 4pm. This input ensures that when someone is in need of an urgent review during daytime hours, they are seen swiftly and can be supported. The health care support worker ensures that medication is ordered, assists the allied health professionals, and ensures that all stock supplies are maintained. The health care support worker ensures that when required, the mental health nurse can attend to provide input during daytime hours, if urgent.

A general practitioner (GP) service attends the centre every second Monday for a face-to-face clinic and/or virtual appointments. The GP clinic takes place every other Wednesday. All individuals are triaged by a nurse prior to being listed for a GP appointment. A self-referral system is in place and the forms are available in the residential houses. Non-medical prescribers are available if the GP is unable to attend to re-write medication prescription sheets, to prescribe new medication or to discontinue old medication. There is a GP out-of-hours service available from 6pm to 8am each day. Between the hours of 4pm-6pm, there is a GP based in HMP Barlinnie who is able to assess and treat any individuals who require input.

There is a primary care team in the centre that consists of two full-time nurses who are employed over seven days per week, from 8am to 4pm; this team began working in the unit from November 2023 and works between the centre and HMP Barlinnie. They carry out general nurse triaging, phlebotomy, dressings, and ECGs, and play a key role in liaising with services such as hospitals, dentists, social work services, and allied health professionals to ensure ease of access for the individuals in the centre. This team attends the weekly multi-disciplinary (MDT) meetings and the woman’s case board management meetings.

Referral process

Referrals to the mental health team (MHT) were primarily by self-referral, but other professionals and SPS staff could also make them. There was no waiting list for referrals to the MHT. Referrals were seen in one working day.

Treatment

In addition to psychology providing individual sessions to individuals, there was evidence of therapeutic groups taking place twice a week, which focused on recovery and self-management strategies. There were external agencies, as well as mental health nurses focusing on specific topics, which helped to target the needs of the individuals in the centre.

Training

Psychology were delivering trauma-informed training to NHS and SPS staff that helped staff build and maintain their confidence and competence as to how best to support those in the service. Relationships between SPS staff and NHS staff were described as "very positive".

SPS staff could also access other training, such as suicide and self-harm prevention initiatives such as 'talk to me'.

Care records

The MHT used an approved NHS Greater Glasgow and Clyde (NHS GGC) electronic system, VISION, to gather and record information relating to individuals. The MHT used a separate online share point folder system that held all care plans for the individuals that they support. Managers informed us that there is a plan to have a new version of VISION in years ahead. All known individuals receiving health care had a formalised care plan in place, which aimed to ensure a consistent approach and gave a clear understanding of their needs and goals. The service had adopted the 'What matters to you?' document which the Commission found useful as it set out the individual's care and the goals of the treatment that were in place. This approach is particularly important where individuals are being seen by several services such as nursing, psychology, addictions nursing, psychiatry, and other agencies. The care files we examined were stored in a shared drive, with each individual name noted along with a care plan.

In relation to risk assessments and management plans, the MHT used the CRAFT tool, which is designed specifically by NHS GGC to address specific risks. There were no individuals with risk assessments in place during this visit due to the fact that those experiencing significant risks or crises would be transferred back to HMP Stirling for support and follow up.

We found reasonably consistent information in the daily notes of the care that was being delivered. There were recorded goals in the one care plan we reviewed that was led by the treating clinician, with interventions clearly linking to how the individual was being treated in a meaningful way. We found none of the care plans were signed.

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 review how care plans are completed and shared with individuals.

Multidisciplinary team (MDT)

There has been no multidisciplinary (MDT) team meeting held in the centre since it opened. Despite this, the service consists of allied health professionals (AHPs) including an OT, registered mental health nurses (RMN), an art therapist, psychology, and a health care support worker. There were no vacancies in the MHT. Forensic psychiatry input was provided as and when required, by one visiting consultant psychiatrist. Psychology consisted of one clinical psychologist. There is an art therapist who provides two days input per week, although they are currently on leave and will return to work in July 2024. It was clear from our visit that despite the fact that no MDT existed, there were positive working relationships between all the staff and a clear focus on delivering positive outcomes for the individuals in the centre. We discussed the benefit of introducing an MDT meeting for both individuals and staff with managers; we suggested that this could help with timely discussions and reviews of each individual's care and treatment. The managers of the centre advised that they would consider whether to introduce an MDT, which would be dependent upon how the service develops in the months and years ahead.

Use of mental health and incapacity legislation

On the day of our visit there were no individuals in the centre subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or under the Adults with Incapacity (Scotland) Act 2000 (the AWI Act).

Rights and restrictions

The centre can access advocacy services if required. Despite this, we found advocacy was not promoted in the centre, and there were no posters on display. We did hear from some individuals who had knowledge of advocacy and we were advised that they understood the advocacy role if they were made subject to mental health or incapacity legislation. 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 Act or the Criminal Procedures (Scotland) Act 1995.

Independent advocacy can be helpful in supporting individuals and can have a positive impact in establishments where it is well used. We suggest that there is further discussion on how the mental health team could promote advocacy services to individuals. Individuals informed us that they were generally free to move between their houses and the main building at the centre without any barriers or restrictions. This was a significant change compared to what they may have been used to in a prison, and procedures were in place to ensure they are safe from harm at the centre. The Lilias Centre does not have a separation and reintegration unit (SRU), as can be found in other SPS environments. Some of the individuals that we spoke with had time out of the centre with access to dedicated community placements that focused on their eventual release from the prison estate. It was noted that on a small number of occasions, the centre has experienced staff shortages that had an impact upon individuals accessing time out of their houses. Despite this, all of the individuals we spoke with raised no issues of these restrictions and noted them to be "time limited" and "manageable".

Individuals had access to phones in their houses. They also had access to a shared living room, a quiet room, bathroom, utility room, and their own bedroom. All individuals were able to use vapes in their bedrooms or in the grounds of the centre.

Individuals were informed about their right to legal advice and had child and family contact as well as criminal justice 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

There is significant input to the centre from a range of community groups and third sector providers that focuses on delivering a programme of services for the women. There is attendance from the 'mouth matters' service on the first Friday of the month, and the 'quit Your way' service who attend every alternate Tuesday afternoon.

SPS have a partnership agreement with the Scottish Recovery Consortium who deliver in house training and support to residents of the centre in the form of the Recovery café service, which attends the centre on a weekly basis. 'Heal to thrive' supports each individual's mental health and recovery from addictions by teaching grounding techniques and stress relief through holistic healing methods; they attend fortnightly. Mindfulness Scotland support the centre by teaching each individual mindfulness techniques such as guided meditation, visualisation and whole-body relaxation. They visit the centre on request from the staff. SHINE provide a mentoring service to individuals as well as through-care support. SHINE's one-to-one mentoring supports individuals with both addictions and mental health conditions in the community through signposting and individual contact. The Citizens Theatre provides workshops on various topics that support an individuals' mental health, by building self-esteem and positive mental attitudes. This includes creative writing and giving each individual a safe place to express themselves in an eight-week block. Vox Luminus delivers music and creativity in the centre; this helps to build confidence and provides an outlet for emotions over a six-week period. The Prison Fellowship provides input for individuals whose religion can support their addiction and mental health.

The job centre attends the service to aid individuals with benefits and preparing for work once their time has been served. Fife College visits the centre to provide educational courses in maths, art, and history.

The centre requires that individuals prepare and cook their own meals whilst in their own houses. This requires that individuals order their food shopping online via a large supermarket who then deliver the food with a weekly budget. Over and above this arrangement, individuals still receive a canteen allowance as managed by SPS.

The centre supplies individuals with work opportunities in the community, escorted leave and those who have no community access can undertake work related tasks in the centre. We heard about a range of other activities and events including cookery lessons with the catering

manager, a visit from a celebrity chef, visits from a local radio presenter, creative opportunities with music and song writing, mindfulness, recovery focused opportunities, and fitness classes.

The physical environment

During our visit, we found the centre to be peaceful and quiet, and there appeared to be positive relationships from all of our observations. It was acknowledged that as the centre was early in its development, there were steps that regularly had to be taken to address any issues reported by staff members and individuals.

The environment was clean, modern, light and airy, as expected for a new building. There were some concerns expressed in relation to the layout of the buildings with not enough space for the NHS staff based in the centre. The centre is defined by two specific areas, the main hub and four shared houses, as well as the reception area.

The grounds were a landscaped design, and were spacious, pleasant, and welcoming. The centre felt open and relaxed compared to any other traditional SPS establishment. It was evident that a great deal of consideration had been given to the building design and functionality during planning. Facilities included a visiting area that had several functions, including a space for family contact as well as a therapeutic kitchen and meeting space for the residents. This space was bright and clean.

There is an education suite that staff and visiting services use to deliver training sessions, a treatment room, a multi-purpose room, a gallery and interview rooms. We heard that the gym was too small for staff use when the centre opened but has since expanded into the gallery area of the building. We observed individuals exercising during our visit.

Summary of recommendations

Recommendation 1:

Managers should review how care plans are completed and shared with individuals.

Good practice

We heard that where possible, many pre-admission assessments were carried out in the prisons from which the individuals were transferred to the centre. This appeared to be good practice in ensuring a consistent approach has been taken, with the opportunity for the MHT to plan therapies and treatment in advance of any individual's move to the centre. These assessments were undertaken by the OT from the centre, who had experience in working with those in the wider forensic mental health estate.

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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