Mental Welfare Commission for Scotland

Report on announced visit to:
HMP Glenochil, King O Muir Road, Tullibody, Clackmannanshire, FK10 3AD

Date of visit: 6 February 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

HMP Glenochil, located near Tullibody in Clackmannanshire, was originally built in 1966 as a detention centre. In 2010 the prison was rebuilt on the existing site with capacity for 665 adult male prisoners. Accommodation is based in two main residential blocks; Abercrombie which houses offence protection prisoners and Harviestoun for mainstream prisoners. Abercrombie also provided some facilities for frail and elderly prisoners. The separation and reintegration unit (SRU) was in a smaller building (Devon Hall).

HMP Glenochil does not accept prisoners directly from court. Instead, prisoners are transferred from across the prison estate. This could be because of the type of conviction or, as part of wider management plans. Over the years, the intake has been revised to include convicted prisoners who have various lengths of sentence. These range from short-term, long-term or life sentences, to order of lifelong restriction (OLR). HMP Glenochil is one of the main establishments in Scotland managing prisoners with a conviction for sexual offences and prisoners with OLR sentences.

The primary focus of our visit was to review the specialist care and treatment provided for individuals experiencing mental health difficulties while in prison. NHS Forth Valley is the healthcare provider for all three prisons in the Forth Valley area.

On the day of our visit, there were 706 prisoners which were told was a decrease of 57 from the previous year. The target operating capacity was 660 and the prison population age range was between 23 and 89 years of age.

We last visited in August 2019 and made recommendations on the need for NHS Forth Valley to progress plans to increase the workforce, increase promotion of independent advocacy for prisoners and for improvement to be made in the care planning for prisoners with complex needs.

We visited again in 2021, as part of our national themed visit on prisons. Our report *Mental health support in Scotland's prisons 2021: under-served and under-resourced* 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. We wanted to review how this report had influenced practice in HMP Glenochil.

Who we met with

Prior to the visit, we had a virtual meeting with the service manager (SM), the lead nurse, and senior charge nurse (SCN) to obtain an overview of the care and treatment provided.

During our visit we met with and reviewed the care records of eight people and care records of a further two. One further prisoner had indicated he would like to meet us during the visit, but this could not be facilitated due to prisoner movement on the day. Healthcare staff agreed to supply our telephone details so he could contact us if he still wished to do so.

We also met nursing staff, SPS staff, the chief nurse and the healthcare manager. The SCN, the deputy SCN and the SM were available for any queries we had throughout the day of the visit. In addition to this, we met the deputy governor of the prison as part of the initial introduction.

Commission visitors

Denise McLellan, nursing officer

Lesley Paterson, senior manager (practitioners)

Sandra Rae, social work officer

Paul MacQuire, nursing officer

Justin McNicholl, social work officer

Jenn McIntosh, student nurse (mental health)

What people told us and what we found

Overall, individuals spoke positively about the care and treatment they received from the mental health team. One person told us about an initial delay in being seen by the team but that they were now accessing helpful input. They described psychology as "excellent" going as far as to say, "it changed my life" and said they continued to practise skills learned. Another told us of ongoing support from a learning disability nurse whom they found "very supportive."

We were told that support was always available when needed from mental health nursing, as well as access to psychology. We were pleased to be told that one individual considered the support received in prison to be "best I have ever had" and that input would help them move towards release.

Another person said "psychology, it's the best input ever" but felt that overall, the healthcare team was understaffed, saying they had found it difficult to access a GP and podiatry. In addition to this, they told us that the food was "terrible." They said that had no awareness of the role of independent advocacy within the prison setting or if this may be helpful for them.

One person spoke of finding the team supportive but felt input had ended abruptly after three months, without any communication. Again, psychology was described as helpful and we heard that the strategies that they had learned could be valuable in the future. They added that additional mental health team staff were needed, although engagement was compassionate.

We heard from someone who described their experience of prison healthcare as mixed. In terms of input for mental health, this was viewed as helpful. They found the 'managing relationships' work worthwhile, however they said that the treatment for their physical health was unacceptable. Their dissatisfaction arose from being unable to access specialist treatment in hospital, as had been recommended by the prison healthcare team. They told us about being unable to attend more than 40 hospital appointments because transport was not prioritised.

We were advised that the primary healthcare team had continued to actively liaise with the local NHS hospital to ensure the individual remained eligible for treatment due to the frequency of missed and cancelled appointments. Despite sufficient notice being given to arrange prisoner attendance, the individual concerned had missed 42 appointments. This was unacceptable in terms of the effect on the individual who had concerns about the long-term health implications, as well as the ongoing pain and detrimental impact on their mental health. It was also concerning in relation to the negative impact on NHS resources.

We were concerned to hear this, so raised it with managers who confirmed ongoing issues with cancelled appointments due to problems facilitating transport. Sometimes bookings would be cancelled ahead of scheduled appointments and on other occasions, confirmed transport would fail to arrive when expected without prior notification. As this function is contracted out to GeoAmey, there was no alternative to facilitate safe and secure transportation of prisoners. We were told this has been escalated to the Scottish Government, but no other provider had been identified.

We heard from one person who spoke positively about weekly multidisciplinary input including psychology, nursing and occupational therapy (OT). They commended the strategies that they had been taught to help manage self-harming behaviours. Overall, they were positive about the role of the prison mental health team in supporting them to manage their thoughts and found this helpful for their life long mental health problems.

We heard that work opportunities in the prison were limited and there was a waiting list; this resulted in extended periods of time spent in cells. There were only 300 places available for over 700 men, so more than half the prison population had no job and their regime was subsequently curtailed. People spoke of this having a negative effect on their mental health and wellbeing.

We were able to speak with an individual in the separation and reintegration unit (SRU) who was being supported by mental health nursing and had been referred to psychiatry. They did not raise any specific concerns about the conditions or treatment received and indicated that they felt secure since moving there and having been commenced on psychotropic medication.

Meals were prepared by general population prisoners, and some concerns were expressed that food provided for those in the sex offender hall could be tampered with. We discussed this with staff who informed us of measures taken to tackle this, such as testing. We also heard that the variety offered on the canteen list was limited.

One prisoner was unhappy that the colour of the clothing that they wore was easily identifiable for them as a sex offender which they viewed as discriminatory and felt this should be changed.

SPS and healthcare staff informed us about the prevalence of illicit drug use in Harviestoun and of incidents resulting in prisoners requiring medical treatment in hospital. Use of novel psychoactive substances (NPS), including ‘spice’, had caused episodes of drug induced psychosis in a number of cases. None of these incidences required transfer to a mental health unit for treatment. The media had also reported on the widespread drug use, weapons and mobile phones being seized in security

routines and there had been protests by prisoners about the conditions in the prison, including a lack of activity and limited time out with their cells.

According to SPS, the single biggest challenge was the availability of staff. An increase in SPS sickness and absence had led to inconsistencies in the prison regime; this had created an increase in the undercurrent of tension. Recreation and association had stopped in the evenings, and this had led to a series of protests. Subsequently, some individuals reported that the lack of consistency was more problematic and that they would have accepted a reduction in activity providing they were able to still have this provided with some regularity.

We heard about difficulties that some experience in gaining access to healthcare at weekends, due to SPS staff absence. Managers said this issue was being escalated.

Care, treatment, support, and participation

Assessment and treatment

On transfer into HMP Glenochil, an assessment of global health care needs was completed and information uploaded onto the prison healthcare information system 'Vision'. If mental health concerns were highlighted, a referral would be made to the mental health team for initial review and follow up, where indicated. Referrals for psychiatry and psychology would also be made during this review.

Self-referral, feedback and complaint forms were available in six languages. Links with community mental health and addiction teams were maintained for those nearing liberation to enable the continuity of care. At the time of our visit, the mental health team had 37 people on the caseload.

In addition to prescribed psychotropic medication, the psychological treatments that were offered included decider skills and safety and stabilisation, delivered by nursing staff. Silver cloud therapy for helping individuals experiencing anxiety and depression was provided by psychology assistants. More intensive psychological therapy was provided by clinical psychology who also facilitated complex case discussions with the multidisciplinary team (MDT) and reflective practice sessions for nursing, in collaboration with the lead nurse.

Psychiatry input to HMP Glenochil consisted of four sessions per week and we were told that this ensured prisoners were reviewed quickly. We also heard that the visiting consultant psychiatrist had effective links with wider psychiatric services, and this was beneficial if prisoners required to be transferred out of prison to NHS facilities for care and treatment, including a transfer to the State Hospital.

We heard that three of the psychiatry sessions were for clinical work and the other session included supporting quality improvement initiatives.

Any individuals identified as being at risk of suicide or self-harm were placed on the SPS national suicide prevention pathway 'talk to me' (TTM). This strategy involved multidisciplinary collaboration to support and provide intervention. There was a requirement to regularly review any ongoing risks and needs through case conferences, which included the involvement of the person at risk.

Four people were subject to TTM on the day of our visit. All SPS and mental health staff were trained in TTM. There was no mandatory mental health training for SPS staff and any mental health related concerns were referred to the mental health team. Prisoner listener services were also available, and each cell had the telephone number in their in-cell phone to make access easier.

When we visited, two prisoners were managed under 'Rule 41'. In accordance with 'The Prisons and Young Offenders Institutions (Scotland) Rules, 2011', Rule 41 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. We were told that a copy of the care plan would be provided to the SPS first line manager and those being managed in this way could be seen daily if needed, depending on risk and changes in their presentation.

We heard of an increased demand on care and treatment for those who had a cognitive decline and frailty; this corresponded with the ageing population and trends across Scotland. However, substance misuse and poverty contributed to poorer health outcomes from a younger age groups experiencing these symptoms than would be seen in the general population. Dementia in prison is rising, and we were pleased to learn that cognitive assessments were being carried out for those over the age of 60, 12 weeks after their transfer.

In Abercrombie, we saw facilities for those who were older and more frail. These included wheelchair access and hoists, as well as equipment for physiotherapy for those experiencing mobility problems. For those who required support with personal care, this was contracted out to an external provider. Providing this input ensured that individuals' dignity was respected, despite the environment. The HMP Glenochil prison health care team had developed a working relationship with Strathcarron Hospice in Falkirk for those who required palliative or end-of-life care.

Although NHS Forth Valley did not undertake assessments for attention-deficit/hyperactivity disorder (ADHD), we were told that support would be put in place for those with these additional needs. The addition of learning disability nursing had been beneficial given that there were people with intellectual disability across both halls. We heard about opportunities for nurses to develop their practice and become 'champions'. One example of this was the deputy SCNs interest in the transgender population.

Care records
Health documentation was recorded on Vision. We were told this system was going into administration and there would be a tendering process for its replacement. NHS staff could also access NHS Forth Valley's electronic information system 'Care Partner' as well as a clinical portal for additional health information. SPS records were located separately in 'PR2'. Unfortunately, these systems were non-interoperable, which led to duplication and conversely, a risk of other information not being transferred from system to system where needed.

When reviewing records, we found that situation, background, assessment, recommendation (SBAR) was used as the framework to structure assessments and promote consistent and clear documentation. Handover information from the previous prison transfer was recorded. We found physical health investigations and associated hospital appointments for one person, along with their positive view on the care and treatment, which had been documented.

Where people had used illicit substances, there were records of them being placed on 'management of offender at risk due to any substance' protocol (MORS). Eight people had 'do not attempt cardiopulmonary resuscitation' (DNACPR) certificates in place, which was in keeping with their clinical presentation.

We were informed that three individuals were subject to welfare guardianship powers in accordance with the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act). Unfortunately, we were unable to locate copies of the powers that would have been set out in the order for two of the individuals, one of whom was subject to local authority guardianship. We were unable to see information on Vision for one individual and did not have sufficient time to review Care Partner to get the information for the person.

Recommendation 1:
Health service managers should ensure that when an individual is subject to the Adults with Incapacity Act, that the legal proxy is asked for a copy of the guardianship order or power of attorney and that this is kept in the individual's care records.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under Section 47 of the AWI legislation must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. We were unable to locate a copy of the s47 certificate authorising medical treatment for one individual and were informed by the DSCN that this was being addressed as a matter of urgency. We found a s47 certificate in place for another individual however, there was no corresponding treatment plan attached. For the third individual we found an expired s47 on file.

Recommendation 2:
Health service managers should ensure where an individual lacks capacity in relation to decisions about medical treatment, section 47 certificates, and where necessary, treatment plans must be completed in accordance with the Adults with Incapacity Act Code of Practice and cover all relevant medical treatment the individual is receiving.

Overall, there was evidence of recording on both Care Partner and the Vision systems, and we found examples of robust person-centred care planning that had been regularly reviewed. We were also able to see participation in reviews that included an individual's view of the progress that was being made towards their goals.

Generally, rule 41 care planning was updated regularly, with case conferences in place to monitor individuals' presentation. We spoke with one individual when visiting Devon SRU and saw evidence of uneaten food in the cell. Although there was information about medication and the risks associated with this, we were unable to find information about this individual's current risk associated with poor dietary intake and the need to monitor this; we highlighted this concern. The individual's care plan captured the identified risks and needs, with evidence of daily entries on Care Partner and we saw that the person had been seen quickly by nursing staff after an emergency referral, following a deterioration in their mental health. A referral had also been made for a psychiatry review.

There was documentation in the care plans about risk and how to address this, although we saw that one did not reflect the current prescribed medication. We also saw an error in the recording of an individual's personal details and highlighted this.

We unable to find a care plan for one individual, despite them having been commenced on an antidepressant and where they had requested psychiatry involvement after previously being placed on TTM. This individual reported being at risk of suicide/self-harm if they did not receive a medication that they felt was required. We spoke with nursing staff on the day to highlight what had been reported.

Recommendation 3:
Health service managers should ensure that care plans reflect any changes in care, treatment or identified risks and include a summative evaluation indicating the effectiveness of the recorded interventions.

The Commission has published a good practice guide on care plans[1]. 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.

Multidisciplinary team (MDT)
The prison consisted of two separate populations that could not mix. This had to be managed carefully with the healthcare centre operating two separate waiting areas to meet this requirement. The model of care was nurse-led, and the team consisted of primary care, mental health and learning disability nursing. The mental health nursing team was available from Monday to Friday, between the hours of 08:00 to 16:00. We were told that although staff numbers had improved since our last visit, additional staff were needed, and a business case was being made. There were two advanced nurse practitioners (ANPs) for primary care and the service was looking to have mental health ANP in the future.

The wider healthcare team included psychiatry, psychology, OT, health care support workers (HCSWs) sexual health, substance and recovery, speech and language therapy (SALT), pharmacy, dentistry, podiatry, optician and physiotherapy. Additional input was provided by a visiting general practitioner (GP) and ANPs.

Clear communication between NHS and SPS was paramount to ensure the system for providing healthcare in a prison setting operated effectively for prisoners' attendance. We heard that generally this operated well apart from weekends.

Multidisciplinary meetings with health professionals were referred to as clinical team meetings (CTMs). These occurred each Tuesday and had SALT, psychiatry, psychology, nursing, OT and substance and recovery team representation. We were told that SALT also supported frailty projects in the prison.

We were informed that multidisciplinary mental health team meetings (MDMHT) between health and SPS health and wellbeing officers had not taken place since May 2024. We were told that this was due to competing demands on SPS staff. To counter this, the healthcare manager met with the deputy governor monthly to discuss individuals subject to TTM, those who were on rule 41 and any other issues arising.

Rights and restrictions

Independent advocacy can provide support and have a positive impact in establishments where it is used well. The Commission is aware that advocacy may not have a role for everyone in prison however, we consider that access to advocacy could be helpful for those prisoners who are potentially being transferred to a

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

hospital from prison under the Mental Health (Care Treatment) (Scotland) Act, 2003 or the Criminal Procedures (Scotland) Act 1995.

We previously made a recommendation about advocacy provision in prison. One person told us this service had been offered to them, and they had declined input, but we learned from speaking to others that there was a lack of awareness about it. Some people were familiar with advocacy from previous engagement with NHS services, however they seemed unaware that they could access this in prison. We felt there was an ongoing need to better promote access to advocacy in the prison, so will repeat our previous recommendation.

Recommendation 4:
Health service managers should ensure better promotion of independent advocacy services at HMP Glenochil.

Activity and occupation

We were shown around the facilities which included the link education centre, workshops and the health and fitness centre. We were told that prisoners had access to the library and there was an established throughcare support officer (TSO) service available to assist with those on shorter sentences; this service was to help individuals to engage with community support, in preparation for liberation. Help was offered to resolve any issues with rent arrears, bank accounts, and gas and electricity service providers. Translator services and job centre plus were also available.

There were peer supporters and easy-read materials for those with literacy problems available in the learning centre and SPS provided funding for education programmes that were delivered by Fife College.

We saw individuals participating in barbering, art projects and newspaper groups; we also heard that others enjoyed gardening. Unfortunately, due to prisoner movement and time constraints, we were unable to visit the garden but were informed that in addition to poly tunnels for growing plants and vegetables, the prisoners had developed a memorial garden dedicated to individuals who had died whilst serving their sentence. Given that this prison had the highest number of people on OLRs, along with an ageing population, this was a thoughtful gesture. Prisoners were able to use this area as part of work activity but also used it recreationally to walk in, where they could have time for reflection, which could benefit their mental wellbeing.

Work placements included engineering and wooden garden furniture production in the dedicated workshop facilities. Other work available in the prison included the kitchen, laundry and health and fitness centre. We were told that social prescribing of activities for mental health and other ailments could result in up to 200 people having access to the gym daily and that all prisoners got an opportunity to use the

gym if they wished. The gym was well equipped and facilitated competitions such as ‘strongman’ events.

For a significant number of individuals in the prison who had experienced previous and ongoing issues with substance misuse, we heard of initiatives such as the recovery café and serenity café. This peer-led recovery service was in its infancy but was already providing invaluable support. We were told that one peer mentor from HMP Castle Huntley had been supported by Recovery Coaching Scotland on placement at HMP Glenochil and that after completion of their training, this could lead to a community coaching qualification. Another initiative ‘fighting for freedom’ was provided by a voluntary agency and available from a Monday to a Friday. The initiative’s workshops combined physical exercise and boxing, in conjunction with education and support regarding substance use and the cycle of offending. HMP Glenochil has been the first prison in Scotland to pilot this enterprise.

Accessing placements and recreation remained a problem given that more than half the population had such a restricted regime. The benefits to mental health and wellbeing were clear and we hope to see increased opportunity for all when we next visit.

The physical environment

The areas that we visited in the accommodation blocks were kept clean and tidy. Some facilities had been adapted in Abercrombie Hall to cater for the frail and elderly and for those experiencing mobility problems; this included physiotherapy equipment for rehabilitation exercise.

There were several information notice boards with leaflets attached in the communal areas of the halls. There was information displayed about health conditions and the monitoring of these.

We visited the health centre and saw that this functioned well as a clinical environment, providing care for the two distinct prison populations. On entering the clinic, we found it to be bright, clean and well organised. We were able to see some clinical rooms and the pharmacy store where the medication prescriptions were held along with medication that was delivered by a local community pharmacy. The healthcare staff were located in offices upstairs and this helped to facilitate multidisciplinary working.

We were unable to go out into the garden but instead viewed this from the offices. It looked spacious and well maintained and was a good resource for those able to use it. We found the family centre beyond the main prison reception to be brightly decorated and welcoming. It was a comfortable environment for families waiting to visit and it had facilities including a children’s play area, toilets, vending machines, seating and a kitchen area.

Summary of recommendations

Recommendation 1:
Health service managers should ensure that when an individual is subject to the Adults with Incapacity Act, that the legal proxy is asked for a copy of the guardianship order or power of attorney and that this is kept in the individual's care records.

Recommendation 2:
Health service managers should ensure where an individual lacks capacity in relation to decisions about medical treatment, section 47 certificates, and where necessary, treatment plans must be completed in accordance with the Adults with Incapacity Act Code of Practice and cover all relevant medical treatment the individual is receiving.

Recommendation 3:
Health service managers should ensure that care plans reflect any changes in care, treatment or identified risks and include a summative evaluation indicating the effectiveness of the recorded interventions.

Recommendation 4:
Health service managers should ensure better promotion of independent advocacy services at HMP Glenochil.

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 Healthcare Improvement Scotland and 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 an individual's care, treatment, and support are 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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