mental welfare commission for scotland

Closure report

Concerns about the care of women with mental ill health in prison in Scotland

October 2022

Our mission and purpose

Closure report:

Concerns about the care of women with mental ill health in prison in Scotland

Executive lead:
Claire Lamza

Date of executive leadership team approval of project mandate:
Project Mandate was agreed in March 2020.

Date of commencement:
May 2020

Date of publication:
July 2021

Date of closure report:
17 October 2022 (12-month target not met)

Purpose of a closure report
The purpose of a closure report is to assess whether the Commission has achieved its objectives (including outcomes, learning, quality and impact) and completed all deliverables on time and as planned.

The report must summarise the findings and recommendations made in themed visit report and identify the organisations and individuals to whom the recommendations were made.

The report should also identify the follow up actions and activities of the Commission in gathering in responses to the recommendations, and once in, identify how these responses were evidenced, assessed for impact and their success measured.

The report should assess theme in terms of impact, resource commitment and outcomes and met organisational standards and expectations.

1. Summary of recommendations made in the report

This report was a review of the records of nine women who were receiving mental health care in HMP Cornton Vale during the time of a visit by the European Committee for the Prevention of Torture (CPT) in 2019. The Commission began to carry out initial enquiries with Scottish Prison Service (SPS) following the publication of the CPT report. In 2020, we began a retrospective review of the individual cases referred to in the report. Themes emerged which linked with casework the Commission was already carrying out, particularly in relation to delays in transferring women with acute mental illness from prison to hospital care. We broadened the scope of our review to include these cases.

We conducted a review of each woman's prison health record for the episode of custody in question. In a few cases we carried out an additional review of NHS health records.

In total, there were 15 recommendations which included nine recommendations for health centre managers and Scottish Prison Service (SPS), and four that were specifically for HMPYOI Cornton Vale. The remaining six recommendations were directed at Scottish Government (two), National Services Scotland (one), the Forensic Network (one), NHS Forth Valley health board (one) and the national custody network (one).

These were:

1. All people arriving in custody receive an initial review by a GP and any required medication is prescribed without delay. When additional information about a person's health is required, the records are requested from local NHS services without delay.
2. Managers of all prison health services should ensure there is a local policy in place with clear processes for requesting health information about prisoners from NHS services that ensures this data is obtained in a secure and timely way.
3. When carrying out its review of Segregation and Reintegration Units (SRUs), SPS should consider adopting a seclusion approach for individuals held in segregation for mental health reasons, that replicates the model used in the NHS.
4. All prisoners, including those in conditions of segregation, should be afforded, as a bare minimum, at least two hours of meaningful human contact a day.
5. The Commission strongly recommends the use of the Care Programme Approach to support the transition of individuals between prison and community services, and co-ordinate the planning of multiagency supports, particularly when the person has complex mental health and social care needs.
6. Health Managers at Cornton Vale should carry out an urgent review of current prescribing/dispensing and establish a programme of regular audits.

7. Psychology input should be available to support care planning, behavioural approaches and reflective practice for all women subject to Rule 41 due to their mental health needs. In Cornton Vale, this support should be prioritised for women in the SRU and SPS staff should be actively involved in care discussions.
8. The Women's Strategy Team should consider the findings of this report when taking forward the new model of care at Cornton Vale. Careful consideration should be given to the final details in the design of the new enhanced needs area to create an environment that is therapeutic and does not add to women's experience of trauma. We recommend that the mental health specialists who developed the trauma care pathway should be included in this consultation, and that there should be a specific focus on the development of a training programme for staff.
9. A psycho-social support system for women prisoners held for longer than two weeks in segregation be established and that prisoners be provided with greater opportunities for association and engagement in purposeful activities, including being offered at least two hours of meaningful human contact every day and preferably even more.
10. The Commission repeats the CPT's recommendation to Scottish Government for the establishment of an electronic prescribing system in Scottish prisons.
11. The Scottish Government should commission the Information and Statistics Division (ISD) of NHS National Services Scotland to develop a data management system to accurately collect, monitor and report on performance across forensic mental health services, including on service capacity and the timeliness of people's transitions.
12. The data management system developed for forensic mental health services by the Information and Statistics Division (ISD) of NHS National Services Scotland (NSS) must be able to collect, monitor and report on transfers and delays to transfers into forensic mental health services from prisons.
13. The Short Life Working Group set up in response to the Forensic Network's report on the Women's Service and Pathways should reform to complete its work related to women's pathways across medium secure, low secure and community forensic settings. The Commission supports the recommendation of the Independent Review of Forensic Mental Health Services that the Short Life Working Group re-established to review women's services should also: "consider the care needs of the group of women who may not meet the definition of 'forensic', but who are subject to conditions of security as their behaviour has not been able to be safely managed by generic services". Its work must ensure a pathway for women to transfer from prison for forensic mental health care and treatment when required. The system of multiple assessments to facilitate transfers from prison should be reviewed with the aim of streamlining the process to the benefit of the person in need of forensic inpatient services. At the latest this should be reviewed by the new Forensic Board, however the Barron Review considers that this could be reviewed sooner than that.
14. NHS Forth Valley should work with local advocacy services to improve access to ensure that the views of women in Cornton Vale are expressed and heard and their rights are respected.

15. The Commission recommends that the National Custody Network considers the issues raised in this report about the assessment of mentally unwell offenders in custody and engages with NHS Boards and Integration Joint Boards (IJBs) to consider whether there are areas of improvement work that could support a more consistent national approach.

2. Summary of responses

Feedback was received in response to the nine recommendations for health centre managers (HCMs), and specifically for the services at HMP Cornton Vale, in a letter and attached action plan from SPS, received in January 2022. This was a joint response from SPS/Cornton Vale; what was unclear at the point where the closure report was due, was whether the response was from all prisons across Scotland. Further follow up was undertaken, with a request to all HCMs on the progress of actions 1 to 3, and where appropriate for prisons that use SRU's and segregation (as in recommendation 4 and 5), as to whether these have been progressed.

Feedback from some of the HCMs was provided in a written response (8), and the remaining through direct verbal feedback (6). The feedback clearly indicated that all of the prisons have processes in place, where they have prisoners arriving from custody – not all prisons have direct admissions, some only take inter-prison transfers – and an initial review is undertaken, primarily by nursing staff, but involving the GP assessment where treatment is required. We were advised that for some prisons, there is a standard operating procedure in place, for others, clinics at the time of arrival meet the initial screening and review requirements, as set out in recommendation 1. Recommendation 2 has been progressed through SPS' update of the Sharing Information Policy (SAPSI) with NHS; work on this commenced in September 2021, with an agreed process across the prison estate that now has clearly set out timescales, a follow up system where there are delays identified and explicit arrangements for reporting problems. As recommendations 3, 4 and 5 were not applicable to all the prisons, those where SRUs and segregation was used responded detailing the clearly defined approaches where segregation/SRUs were used. SPS head of health, prison governors and NHS managers began a review of the use of seclusion practice (NHS policy) for consideration of learning and to produce a local product detailing the arrangements for rule 41 care planning and management of segregation/SRU use.

In the response from SPS in January 2022, the actions that had been taken/were scheduled to be taken were set out, with timescales and the lead for each recommendation. Where the recommendation noted another organisation's responsibilities i.e. SG or the Custody Network, this was noted in the action plan with comments and the timescale that these had been achieved by. Overall, it was clear from the action plan of the activity around the recommendations for Cornton Vale to complete, with some starting in September 2021. However, in order to gather more detail on the comments and timescales noted in the action plan, further follow up with the HCM for Cornton Vale took place in July 2022 and at this time, the responses for Corton Vale indicated that the recommendations and actions from the CPT report are either actively being progressed, or have been completed. Overall, after reviewing the previously returned, and recently gathered updates, we are reassured that recommendations 1 to 9, and 14 have all been actioned by NHS and SPS.

For the remaining recommendations where action was required, we again had to recently follow up with Scottish Government, NSS and the National Custody Network on recommendations 11, 12 and 15. Because there is link with the work that SG, NSS and NCN are undertaking, driven in part by the recommendations from the Barron review, we were advised that the work to be progressed in the CPT recommendations will be

undertaken more broadly through the SG “Forensic Mental Health Reform Team”, (lead department on the Barron review) but linking in with the Mental Health Reform team at SG, and the Mental Health in Prisons and Criminal Justice team lead, also at SG. We have been advised there are working groups established, but progress has been delayed due to the focus of meeting other recommendations from Barron that have been the priority. We continue to liaise with the key staff from each of these teams.

3. Summary of Commission follow up activity and actions

The report was posted on our website on 8 July 2021. There was good media interest and comments at this time.

The initial follow up involved a letter to all Prison Governors, via SPS, which is the identified route to contact SPS. The Governors were requested to share the recommendations (which were included in the letter) with health centre leads and staff (July 2021)to make them aware that we would be following up on these recommendations after a period of 3 months. At the same time, the recommendations that were specific to Scottish Government and the Custody Network were to be sent out through the Commission's usual process, which is through casework admin (CWA), who support each project.

A summary was due to the Chief Executive in October, 2021 which triggered a review of the responses that had been returned at that time. There was no further contact from external services involved in responding to the recommendations until March 2022, where it was noted that there was a response from SPS, but further responses were still awaited. In June 2022, when the final review of the CPT report was undertaken and the recommendations and action plans that had been received were fully reviewed, there was recognition that further contact with the services was required. This took place from July to September 2022.

4. Summary of the impact of themed report and wider learning

The report was well-received by the women's prison estate, where many of the concerns raised had been identified previously. We have been impressed to hear that HMP Cornton Vale (which will change to HMP Stirling when the new prison opens in 2023) have been developing systems to address restrictive and fragmented care. There has also been significant investment in additional staff resources and the specific training and therapeutic intervention that will meet women prisoner's needs.

5. Conclusion – was themed visit worth doing?

There have been some learning points from this report given its unique nature with its focus on investigation into specific cases and also highlighting themes and recommendations.

The report focussed on nine individual cases and established deficiencies in care, discriminatory practices and inequalities in terms of women prisoners; these findings have been further supported by the recent publication of the MWC's report on prison healthcare across all 15 prisons in Scotland, where again women in prison were interviewed and the findings incorporated into the report.

6. Outstanding actions and recommendations, and any future activity or options to satisfy these

The CPT report was a precursor to the Commission's report on health care across all 15 prisons in Scotland in 2022. The follow up work that is being undertaken as part of the broader prison themed report undertaken by the Commission will include the recommendations and actions from this CPT report to ensure momentum continues. The Commission will continue to monitor the use of Rule 41, the use of SRU and of segregation when a prisoner has acute mental health symptoms as per both reports. Ongoing review of these, in relation to women will therefore be linked with the activities related to the Prison report of 2022 including ongoing quarterly meetings with all key stakeholders to monitor progress.

If you have any comments or feedback on this publication, please contact us:

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