**Mental Welfare Commission for Scotland**

**Report on announced visit to:**
HMP Perth, 3 Edinburgh Road, Perth, PH2 8AT

**Date of visit:** 29 May 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 Perth is a large community facing prison. It receives prisoners predominantly from courts in Perth and Kinross, Dundee, Angus and Fife. The prison accommodates adult males, including those on remand, short term sentences (serving less than 4 years), long term sentences (serving 4 years or more), life sentence prisoners, sexual offenders and extended sentence prisoners, including those subject to orders of lifelong restrictions (OLRs). The design capacity of the prison was 630 and the prison population during our visit was 680.

The Commission's last local visit to HMP Perth was in December 2018 on an announced visit; we made a recommendation that NHS Tayside should ensure that plans to increase the mental health workforce in HMP Perth were progressed. The response we received from the service was that an audit to support future workforce planning and skill mix would be completed and that two cognitive behavioural therapists (CBT) were to be recruited.

We visited HMP Perth 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.

On the day of this visit, we wanted to find out about the mental health team workforce and skill mix and the current care and treatment provided for individuals who were experiencing mental health difficulties in the prison. We also wanted to look specifically at care of prisoners with mental health difficulties who were being held in conditions of the segregation and reintegration unit (SRU).

### Who we met with

We met with and reviewed the care of 17 prisoners, nine who we met with in person and a further eight who we reviewed the care notes of.

We spoke with the newly appointed prison health service manager, the senior charge nurse (SCN) for mental health, registered mental health nurse (RMN), principal clinical psychologist, occupational therapy (OT) team lead as well as other healthcare staff, and Scottish Prison Service (SPS) staff.

### Commission visitors

Gordon McNelis, nursing officer

Sandra Rae, social work officer

Susan Hynes, nursing officer

Justin McNicholl, social work officer

Kirsty MacLeod, engagement and participation officer (carer lived experience)

## What people told us and what we found

The individuals we spoke with on the day of our visit gave positive feedback and praised the staff involved in their care. They told us the mental health team were appreciated and that they were grateful of the impact that staff had on their wellbeing and recovery. We heard comments such as, “staff are helpful”, “thankful for their support” and “they go out their way to help”. We heard that the mental health team and the SPS staff worked in partnership, which made individuals feel supported.

Other views we heard were that it could be “difficult to see a psychiatrist” and there was a sense of being “fobbed off” at times. We also heard from individuals about how difficult it could be to access to the mental health team and that there were delays with nursing input.

### Care, treatment, support, and participation

At the time of this visit we were advised that 55 prisoners, including three individuals held in the SRU, were receiving input from the mental health team that included RMNs, psychiatry, psychology and OT. The mental health team provided assessment and treatment to prisoners Monday to Friday across the three Tayside prison sites – HMP Perth, on site team model, HMP Castle Huntly and HMP Bella both receiving an in-reach model. HMP Perth, HMP Castle Huntly and the Bella Centre. Prisoners on the mental health caseload, with identified risks of self-harm/suicide, were managed by SPS staff by using the ‘Talk to me’ strategy.

We wanted to follow up on our previous recommendation of plans to increase the mental health workforce in HMP Perth and see if this had been progressed. We were advised that staffing had improved over the last five years although we found there was a general view amongst staff that they were spread thinly with covering all three prisons in the Tayside area. We were told there remained RMN vacancies however, at the time of our visit it was planned that these posts would be filled in summer 2025.

HMP Perth operated an open referral system that allowed anyone to refer a prisoner to the mental health team. Referrals were made by SPS staff, other prisoners, and by individuals themselves via self-referral. These were discussed at the weekly multidisciplinary team (MDT) meeting and during complex case discussions. Assessments, completed by the nursing team, were categorised using a RAG (red, amber, green) status system and prioritised on their level of urgency / risk. We were advised that emergency (red) assessments took place between 24 and 72 hours of referral, while urgent assessments (amber) were completed within five days. We were told prisoner waiting times for routine (green) assessments were within the

12-week HEAT Target with prisoners waiting an average of eight to nine weeks to be assessed by an RMN.

The mental health team that provided support across all three prison services had caseloads and waiting lists that appeared to exceed their capacity. At the time of our visit, the mental health nursing team had 50 prisoners on their caseload, with a further 37 on the waiting list for assessment. Visiting forensic psychiatrists from Rohallion Secure Care Clinic attended HMP Perth weekly and had 20 prisoners on their caseload and 5 on their waiting list. The HMP Perth based psychology team had 15 prisoners on their caseload and a further 20 on their waiting list. In addition to this we were told that OT team were actively involved with 20 prisoners.

**Recommendation 1:**
Despite additional recruitment with RMN posts scheduled to begin in June 2025, managers should consider further staffing measures to ensure the mental health team can provide appropriate care and treatment to the needs of the prison population across all three HMPs in Tayside.

## Care records

Information on individuals' care and treatment was held electronically and located on the NHS prison service electronic information systems Vision and Docman. Our review of the daily RMN entries on Vision showed that although some included a clinical description of an individual's observed mental state and associated symptoms, this information was often brief or in some cases not included at all. We believe it is necessary for health professionals to be descriptive when recording clinical information and to give a clear account of an individual's mental health and whether it showed signs of improvement, deterioration or is unchanged.

**Recommendation 2:**
Managers should ensure nursing staff document clinical descriptions of an individual's presentation in care records and that all recorded clinical entries include the clinician's designation.

Our review of the routine entries made on Docman by members of the MDT showed that only staff names were recorded, without professional designations attached. This made it difficult for us, and potentially others who were unfamiliar with the team, to identify who had written the information.

Although we found the assessments of individuals consistently identified appropriate and detailed care and treatment for the MDT to deliver, we found minimal evidence in the care records to indicate that these had taken place. From the documented outcomes of care and treatment, it was clear the RMNs had applied effective care and treatment including safety and stabilisation interventions however,

the rationale or delivery of these were not consistently documented in the case records.

**Recommendation 3:**
Managers should ensure that RMNs record evidence of care and treatment interventions that take place.

Our review of the OT entries showed they were robust, gave a rationale for the activity of daily living being delivered and included good use of clinical language to describe the presentation of the individual during the session.

During our visit we took the opportunity to visit the SRU and to meet with prisoners and staff. Individuals held in the SRU had come under Rule 41 of 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. Individuals had also been held in the SRU under rule 95 which permits the governor to order, in writing, that a prisoner must be removed from association with other prisoners, either generally or to prevent participation in a prescribed activity or activities.

We reviewed the care records of individuals being held in the SRU and despite the well-established risks to themselves and others due to their mental health difficulties, we were concerned about the lack of information on historical or current risks and that no risk assessment or risk management plans were in place. This was flagged with the SCN with a view to be actioned. It is essential that clinicians understand and put in place risk assessment and risk management plans, especially when an individual's circumstances warrant specific risk management in specialised areas such as the SRU.

**Recommendation 4:**
Managers must ensure that all individuals referred to the mental health team have a risk assessment and risk management plan in place where necessary.

## Care plans

We reviewed a number of care plans and found the quality of these to be variable, including a care plan that was partially completed. While generally there was reasonable content contained in the care plans, we found the identified needs were minimal and didn't link with the associated risks established during the initial assessment.

In addition to the input from the MDT, we that across the care plans there was an emphasis placed on promoting the individual's independence by encouraging them to use self-help techniques, such as practicing mindfulness and breathing exercises.

We found evidence of regular one-to-one discussions taking place between individuals and RMNs that were recorded in the care plan reviews. It would be helpful for these discussions to be included in the Vision system as a recorded entry with additional signposting to the care plan review.

**Recommendation 5:**
Managers should ensure that that all individuals referred to the mental health team have care plans that are person-centred and detail the individual's identified needs and subsequent interventions. These should be regularly reviewed and their quality audited.

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)

Care and treatment was delivered by a range of professionals in the mental health team. This included (RMNs) Bands 5-7, learning disability nurse, forensic consultant psychiatrists, principal clinical psychologist, forensic psychologist and psychology assistant, OT, assistant practitioner, specialist pharmacist and pharmacy technician in addition to the wider primary care healthcare staff. At the time of our visit there were two vacancies for RMNs in the mental health team.

We did hear that there were lengthy waiting times for individuals being able to see a member of the psychology team; some were liberated before being assessed. A care pathway was in the process of being developed with community services to provide follow up psychology interventions to support them in the community.

The psychology team comprised of experienced practitioners, including those with a forensic background, as well as an assistant psychologist. They provided therapies such as eye movement desensitization and reprocessing (EMDR) therapy, schema therapy, anxiety management and CBT however, there was a 31-week waiting list to access these. We heard that a computerised CBT model had been developed and was available to guide individuals in using self-help techniques.

We were told the mental health team had been provided with specialist training from the Tayside adult psychological therapies with safety and stabilisation and a formulation-based approach to suicide risk assessment. Staff also received training that was in line with the medication assisted treatment (MAT) standards to address substance misuse. Training was delivered by Tayside drug and alcohol recovery services and included safety and stabilisation, and motivational interviewing. Specific mental health training was not delivered by the mental health team to the

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

SPS staff, but mental health education was provided. We were told there were plans for trauma informed leadership training to be delivered later this year to SPS and NHS staff by psychology, and there were plans for further trauma informed training to be delivered to SPS staff over the next five years. In the meantime, SPS staff were encouraged to access NHS Education for Scotland's e-learning of trauma informed care.

MDT meetings were held weekly and attended by the mental health team, psychiatry and GP. The meeting included discussion of referrals and allocating individuals to caseloads. Complex case discussions also took place during the MDT meeting.

Our review of the MDT meeting documents showed the names of those in attendance, however their specific roles were not included. We would like to see these documents fully completed at our next visit.

The information from the meetings showed the MDT appear to support each other and communicate well.

## Rights and restrictions

We were told that information about accessing advocacy services was available and visible in the consultation rooms and a service level agreement was in place with an independent advocacy service, who visited HMP Perth regularly. However, the individuals we spoke with had mixed awareness of advocacy services. We were told that some had previously accessed these services, whereas others were unaware of their availability. We feel access to independent advocacy services should be available to assist individuals who may require transfer to a hospital from prison under the Mental Health (Care Treatment) (Scotland) Act, 2003 or under the Criminal Procedure (Scotland) Act, 1995.

**Recommendation 6:**
Managers should ensure access to advocacy for individuals and better promotion of this service at HMP Perth.

## Activity and occupation

We were told about the activities and resources that were available for individuals to access in HMP Perth, including in the recovery hub. These sessions were well attended and included educational and training programmes, life skills training that focused on self-help, as well as support groups that promoted an understanding of mental health and wellbeing. There was also the opportunity for individuals to participate in barber training and having pass jobs. We were also told groups facilitated by SPS staff provided additional support and were well received by the individuals who attended; we heard that these groups had contributed to a reduction in mental health referrals to the mental health team.

## Any other comments

During our walk round of HMP Perth we were concerned to overhear instances of swearing and derogatory language used in conversation between SPS staff and individuals. While we recognise the influence of prison culture and use of such language in these environments, this type of communication can have a detrimental impact on team dynamics, staff cohesion and may contribute to splitting staff. We would like to add that on the day of our visit, we also observed numerous examples of positive staff engagement, where interactions promoted supportive and constructive communication.

## Summary of recommendations

**Recommendation 1:**
Despite additional recruitment with RMN posts scheduled to begin in June 2025, managers should consider further staffing measures to ensure the mental health team can provide appropriate care and treatment to the needs of the prison population across all three HMPs in Tayside.

**Recommendation 2:**
Managers should ensure nursing staff document clinical descriptions of an individual's presentation in care records and that all recorded clinical entries include the clinician's designation.

**Recommendation 3:**
Managers should ensure that RMNs record evidence of care and treatment interventions that take place.

**Recommendation 4:**
Managers must ensure that all individuals referred to the mental health team have a risk assessment and risk management plan in place where necessary.

**Recommendation 5:**
Managers should ensure that that all individuals referred to the mental health team have care plans that are person-centred and detail the individual's identified needs and subsequent interventions. These should be regularly reviewed and their quality audited.

**Recommendation 6:**
Managers should ensure access to advocacy for individuals and better promotion of this service at HMP Perth.

## 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 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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