Mental Welfare Commission for Scotland

Report on announced visit to:
HMP Barlinnie, 81 Lee Avenue, Glasgow, G33 2QX

Date of visit: 14 August 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 Barlinnie was first opened in 1882 and is located in the northeast of Glasgow. The prison has capacity for 987 prisoners; there were 1420 prisoners on the day of our visit. Overcrowding in Barlinnie has been well documented for many years by His Majesty Inspectorate of Prison for Scotland (HMIPS), which has meant many prisoners having to share cells as a result of an increase in the prison population.

The Commission visitors were aware of the latest HMIPS annual report (2024) that raised concerns regarding the process for completing and accessing individual's clinical healthcare assessments, care plans and risk assessments, which were found to be complicated and difficult to navigate for the wider healthcare team.

HMP Barlinnie has adult male remand and short-term prisoners who were sent there by the west of Scotland courts. There are also long-term prisoners who have just been sentenced and are awaiting transfer to other prisons or have been located there for a specific management reason. The prison accommodates male prisoners who are nearing the end of medium to longer term sentences.

It has been documented that there are plans for HMP Barlinnie to close, and a new prison to be built which will be named HMP Glasgow. The plan for the closure of HMP Barlinnie is reported to be happening in 2028. Our last local visit to HMP Barlinnie was in 2023. We also visited the prison in 2021 as part of our themed visit report, 'Mental health support in Scotland's prisons 2021: under-served and under-resourced'. This report 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.

Our local visit in 2023 made seven recommendations about delays in accessing medication upon admission, consistency in care planning, clarity on the completion of risk assessments, clarity on psychiatric follow-up, access to advocacy services, consistent access to physical and recreational activities and wait times for admissions to hospitals from safe cells and the separation and reintegration units (SRU).

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

Who we met with

We met with and reviewed the care of 16 individuals who asked to meet us in person, and we reviewed care records of 14 of the 16 people that we spoke with. We attended the well-being and resource hubs to observe activities and to speak with those in attendance.

We met with the prison governor, one of the unit managers, the operational nurse manager, the nursing team leader, members of the mental health nursing team, the principal clinical psychologist and other members of Scottish Prison Service (SPS) staff.

Commission visitors

Justin McNicholl, senior manager (projects)/social work officer

Mary Leroy, nursing officer

Sheena Jones, consultant psychiatrist

Sandra Rae, social work officer

Graham Morgan, engagement and participation officer

What people told us and what we found

Many people we spoke with were positive about the mental health care they had been receiving from the mental health team. The comments we received included, “the nursing staff have been great”, “the support is much better here compared to the last prison”, “I get seen consistently once per month and that helps me to know that they are taking me seriously”, “they are here for me and give me reassurance” and “she is really helpful…non-judgemental and is always listening to what I have to say, I have confidence and trust in her.”

These comments were echoed by people who advised that psychology and the nursing staff working together had been of benefit since their admission to the prison; we heard “they give me a platform to speak, that gives me a release and I can start with a clean slate” and “I always have a good chat with them and it helps”.

We noted that people had been informed of their diagnosis and that their treatment and care had been explained to them in language that was meaningful and relatable. Most of the individuals we spoke with reported no issues with access to their medication and praised the regular opportunities to access nursing, psychology or psychiatry staff. The majority of the individuals we spoke with had an established diagnoses that required monitoring and review by the mental health team; we heard from those that we spoke with about a consistent level of care being provided that supported their recovery.

We heard from some people who described the mental health care as “so-so”. Some individuals told us that they had not seen a doctor or nurse since admission but also said that they had not self-referred to the service. They discussed how they were keen to access the mental health service moving forward.

Compared to our previous visit we received no significant concerns from individuals or their relatives about accessing assessments in the prison.

During our visit to the well-being and resource hubs we heard from individuals who explained, “I think here [wellness hub] is very good but there are nowhere near enough resources for the mental health team…lots of people have problems here, but you never get to see them. You can wait months to see someone”.

It was noted that many of the people we met with were affected by significant life events which included family deaths, witnessing overdoses in the prison, incidents of trauma and suicide attempts. We received feedback that the staff would point out that they would like to work to address all the themes noted by individuals but there was a general acceptance that it was not possible due to the demands on the service.

We heard from one individual who described issues with accessing their prescribed medication from the community since their admission to the prison. “I had major issues with my medication when I first came in, they stopped my sleeping tablets for weeks and then I had to wait for the GP to re-prescribe…it was terrible, it affected my sleep, and it wasn’t dealt with quickly”. We heard from another about their frustration with the delay in accessing a psychiatric assessment. Despite this, the majority of the people we spoke to advised that they were able to access assessments and reviews easily in the prison.

We heard from some people that they were receiving support from the addictions team in the prison, and they reported no issues with this service. Many of the individuals and staff we spoke with raised their concerns regarding the high levels of substance misuse affecting the prison. Individuals commented, “I’m feeling down, struggling with drugs”, “there are lots of drugs all around us” and “it’s having an impact on the staff as they are called to overdoses all the time…its frightening and out of control”. Another individual commented, “I nearly died from a legal high. If wasn’t for another prisoner who alerted the staff…I didn’t want to die”. We discussed this with SPS staff on the day of the visit, and they acknowledged the impact of drugs was having a direct effect upon all people in the prison. SPS staff told us of the various steps planned to address this but acknowledged it was a complex issue that could not be solved easily or quickly. Managers of the mental health team also provided information to the Commission visitors that they had regularly escalated their concerns of those in the prison and the impact on staff with what appeared to be the uncontrolled flow of substances into the prison.

We heard from those that we met with that there was regular support from the primary care health team. We were advised that although this was an established team, the prison no longer had a permanent full time general practitioner. As a result of this, agency and bank staff were providing cover to fill this gap. We were told that appointments were routinely cancelled. We were advised of plans to employ two advanced nurse practitioners to address the gap in the service and to ensure that individuals were assessed and treated promptly. We look forward to hearing how this change impacts upon the prison during our next visit.

When we last visited the prison, we were told that work had been carried out by Glasgow Health and Social Care Partnership (HSCP) to increase the number of staff. This was to improve the triage process and waiting times for those who were most in need. We found that the increased staffing level appeared to be working well in ensuring individuals were prioritised and seen in a timely manner. We were pleased to hear from staff that previous gaps no longer had an effect on the nursing team. We were aware that one psychiatrist was absent however, we heard that steps were being taken to address this gap in the service.

We asked about timescales for transfer to hospital for those who were acutely mentally ill and required inpatient care. Delays in this process have been an ongoing concern, highlighted repeatedly by both the Commission and the National Preventive Mechanism (NPM) in Scotland in recent years.

On the day of the visit, it was positive to note that there were no individuals requiring inpatient admission to a mental health ward. We met with one individual in the SRU who was being seen by nursing and psychiatry staff in the unit. Due to their presentation, it was difficult to fully establish their views on the care being delivered, although we were still able to note adjustments that had been made by SPS staff to accommodate the person's wishes and preferences while in the SRU.

The staff we met with had a good understanding of the reasons for individuals' placement in the SRU and they discussed the positive links they had with the mental health team. Prior to our visit to the SRU, there had been three individuals requiring a move under the Mental Health (Care and Treatment) Scotland Act 2003 (Mental Health Act) to hospital for assessment and treatment. It was positive to hear that these individuals had been transferred to an environment where they could receive the care and treatment they needed.

Care, treatment, support, and participation

Care records

We reviewed the notes of the individuals we met with. The mental health team use five different electronic systems to gather and record information relating to individuals as approved by NHS Greater Glasgow and Clyde (NHS GGC). This includes VISION, EMIS, Doc-man, clinical portal, and the online team folder system that holds all care plans and risk assessments.

The Commission found VISION to be a difficult system to navigate. The information recorded on it was condensed into small boxes on the screens which made it difficult to read. All four of the electronic systems do not directly communicate with each other, which causes challenges when trying to access information quickly. Like most prisons, HMP Barlinnie has individuals from across Scotland and the UK. This causes challenges for staff when trying to locate medical and mental health histories, as regional and national systems do not interact with the prison electronic systems.

For those records that we were able to view, we found that the daily entries provided a summary of the input the person was receiving, with a sense of continuity between contacts and where there was a focus on the individual's diagnosis or treatment plan. We found that there was a reasonably clear summary of the individual's history, but this required the Commission visitors to look across the five recording systems in order to gather information.

Of the records we reviewed, we found contacts by all visiting psychiatrists recorded on the Doc-man system which held all clinical letters detailing assessments, treatment and follow up actions. This provided a helpful summary for those who were most unwell and in the SRU.

The mental health team managers have adopted the clinical risk assessment formulation toolkit (CRAFT) as the agreed tool to be used in the prison. The CRAFT is stored on the shared folder next to the care plans. We heard of staff concerns that the CRAFT tool did not feel as applicable in a prison setting, compared to a hospital or community setting.

During our last visit, we found that the forms were not clear as to who was responsible for the risk assessment and management plans. We were concerned that the arrangements around risk assessments and the management of risks did not address the identified aims and were not being safely applied, especially in the event of any adverse event. Staff used CRAFT to summarise risks and to identify how to manage these in a prison setting. It was positive to note that compared to our last visit, we found all risk assessments for the individuals we met with on the day. It was clear to Commission visitors that staff in the team were aware that there remains work to be done to improve the CRAFT for use in prisons. For example, we found from the records we reviewed that some contained limited person-centred information and there was a lack of clarity on the management of the risks.

We noted one individual who had been subject to an adverse event two weeks prior to our visit and this was not captured in the risk management plan. It was also unclear whether the management plans devised were shared with the people involved or the wider healthcare teams to understand how it related to care. We believe this matter requires more careful consideration and a review of the risk management plans to ensure that all parties, including the individuals involved, understand the role of these plans.

Recommendation 1:
Managers should ensure that the risk management plans link with the care plans, are audited, easily accessible the healthcare team.

Care plans
All individuals in HMP Barlinnie who were receiving mental health care were found to have a formalised care plan in place. Care plans aimed to ensure a consistent approach was taken, with an understanding of the needs and goals. This is particularly important where individuals were being seen by several services, such as nursing, psychology, addictions nursing, psychiatry, and other agencies. The care plans that we examined were stored in a shared drive which were accessible by all staff.

The care plans made a direct reference to “What matters to me?” which provided a helpful approach as it summarised the views of the individual in their own words, with goals set out to be achieved by the care team involved. We found that where required, there was reference to the physical health care needed that would have an impact upon the individuals’ mental health.

Compared to our last visit, we found all the care plans were dated, current and accessible. We found most of these to be of reasonable quality and covered the main themes. From those that we met with, there was a clear link between what the care plans discussed and their understanding of the interventions being delivered by the team. When individuals were on a waiting list to be seen by psychology this was clearly detailed in the care plans. We found examples of when anxiety management strategies were in place, which included links to relaxation, mindfulness, stress reducing habits, education and input on the impact of substance misuse.

We noted that the HMIPS inspection in 2024 found that individuals were unable to sign care plans to confirm that they had been involved in the development of these. The report further pointed out that risk management plans should be integral to the care planning process. The care plans we examined were limited in terms of the detail they provided and were not interlinked to the individual’s risk assessment or accessible to the wider healthcare team, as care plans were not recorded electronically on the individual’s VISION healthcare record.

This lack of joined up working remains the case across the prison mental health teams that we visit. Of those individuals we spoke with only two were aware that they had a care plan. Both commented that they had never seen it in person.

Recommendation 2:
Managers should ensure care planning is regularly audited, easily accessible to individuals and their healthcare team.

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.

On the day of the visit, there were no individuals who were subject to rule 41 of the Prisons and Young Offenders Institutions (Scotland) Rules 2011.

Multidisciplinary team (MDT)
The MDT for HMP Barlinnie’s prison mental health service includes nursing, psychiatry, psychology, addictions and primary care staff with input from other professionals where required.

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

The service is led by a nurse team leader and an operational manager who provide direct supervision and line management to the team. The nursing team consists of one full-time team leader, one full-time senior nurse, two full-time and one part-time mental health nurses. We were advised that, on the day of our visit that the mental health nursing team were supporting 130 prisoners on an ongoing basis. We were told that individuals were able to self-refer to health care services at any time.

Psychiatry input to the prison is offered by three permanent visiting doctors, who provide a total of four sessions per week. Currently one of the psychiatrists is absent which has had an impact on the number of sessions offered and has reduced the psychiatric capacity for the prison. There are no current cover arrangements for this gap. We did not hear directly from individuals that this had resulted in any specific issues for care or treatment.

When individuals are on the waiting list to be seen by psychiatry, nursing staff can provide ongoing monitoring of their mental state and compliance with any identified treatment. We were informed that anyone requiring to see a psychiatrist is seen quickly.

The prison psychology team works between HMP Barlinnie, Low Moss, and Greenock, and provide clinical interventions for anyone requiring psychological assessment and support. Psychologists supervise low-intensity psychological interventions carried out by mental health nurses and also have an individual case load. The psychology service is complemented by a cognitive behaviour therapist (CBT) as well as an assistant psychologist and mental health therapists.

The nursing team spoke positively of the psychology input provided. The psychology team currently have psychology vacancies that has had an impact on one-to-one sessions and groupwork. We heard from staff that the service has a 27-week wait for assessments for those sentenced. We heard from managers that steps were already being taken to fill one of the consultant clinical psychology posts. We were advised that the psychology team aim to run a safety and stabilisation group in the well-being hub of the prison in the near future. This is for individuals to help them feel safe and grounded, with clear coping strategies established to help manage their emotions. When we next visit, we look forward to seeing if this group has been implemented and if this has had a positive impact upon people in the prison.

Since our last visit there has been the establishment of multidisciplinary team (MDT) meetings which take place every two weeks. Attendance at the meeting consists of the mental health nursing lead, psychiatry, psychology, addictions, primary nurse, mental health charge nurse and other disciplines as required. We were able to access the MDT records. No individuals or their relatives attended the MDT and their views, nor those of their nearest relative was captured in the recordings that we reviewed.

The MDT meets to screen, triage and action referrals, along with following up on appointments with individuals on the mental health caseload. Information was recorded about which team or discipline maintained responsibility for the individuals discussed. We were informed that this new MDT process was helping to improve standards. We highlighted that not all individuals who were on the caseloads of all disciplines were discussed regularly. i.e. once every 12 weeks. Managers advised that they were working through this new process, and we look forward to seeing how this develops on future visits.

Use of mental health and incapacity legislation

We were not alerted to any people who were subject to the Mental Health Act or the Adults with Incapacity (Scotland) Act, 2000 on the day of our visit.

Rights and restrictions

The Advocacy Project is the approved provider for advocacy provision to the prison. We found some evidence that advocacy was promoted in the halls with small posters on display in the nurses' stations.

Similar to our last visit, we heard from prisoners that they were not aware of advocacy. Staff informed us that they promoted the role of advocacy for those who were being considered for transferred to hospital under the Mental Health Act. The Commission continues to advise that all prisoners should have a right to discuss their circumstances with an advocacy worker where applicable; we are aware that advocacy will not have a role for everyone however, we consider that access to advocacy can be helpful in addressing very specific issues relating to individuals' journey through the prison system.

We heard from staff that there was good engagement with the visiting independent prison monitors (IPMs), who were said to be visible and who had good engagement with prisoners. We discussed with that access to advocacy support be prioritised, with information about this being made widely available.

Recommendation 3:
Managers should ensure effective promotion of advocacy for all prisoners in HMP Barlinnie.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

There was an acknowledgement from most people that we spoke to that there was access to some form of meaningful work and activities that they clearly benefited from. We received some reports that access to the well-being hub was a significant challenge and one individual spoke of waiting 10 weeks and was still not sure if he would ever be allowed to attend. We raised this with the governor on the day.

We heard that some individuals benefitted from religious input to the prison as it helped to improve their emotional wellbeing.

While visiting the well-being hub we received a number of positive comments of the benefit of this service. “The wellness hub is really good and the resource hub is even better with its library” and “I do art here. I am making these for my family; coming here is very good, it gets you away from rattling round your cells”.

All the staff that we talked to spoke about how good it was to work in the hubs due to the difference in the atmosphere, compared to the halls. We found the hubs were painted in bright colours with a variety of murals and pictures on the walls, as well as a ‘café’ type area.

We observed a wellbeing group undertaking an IT recycling scheme, a yoga class, music group, art group and a sensory relaxation room. We were informed that the third sector presence and activities included men’s matters, speaking out, creative writing, talking groups and there are plans to set up a cooking group.

While visiting the resource hub we observed the two gyms which we were told 300 prisoners can use every day. We observed the forklift truck training, the horticultural project, the bike repair shop, the radio and tv studio, pool tables, the library and office space. We heard how activity and gaining skills was promoting good mental health and rehabilitation. We heard that an annual mental health week takes place each year which is celebrated throughout the prison with a five kilometre run, a sports day as well as quizzes and activities throughout the week. For those in the halls and the SRU we found evidence that exercise was promoted.

The physical environment

There remains ongoing concern that the buildings, accommodation, and facilities in HMP Barlinnie are not fit for purpose. We heard from individuals of the benefits of both sharing cells but also in having a cell to themselves. Those who preferred their own space highlighted how they found single cells positive. We heard from some that they benefitted from sharing a cell to have someone there on a day-to-day basis for support.

As noted back in 2023, significant refurbishment work has been undertaken to the reception and the health centre. This had ensured two large treatment rooms and

improved facilities for staff and individuals visiting the health centre. We observed that the health centre and nursing stations were of a good standard. The rooms, outdoor spaces, and activity areas that we visited were spacious, well maintained, appropriately furnished, clean, and hygienic.

We heard from staff that the main drawback to the current prison is the lack of available rooms for interviews and meetings. We heard that prior to our visit, appointments had to be cancelled by psychology staff as the prison safety alarms were not working as rats had chewed through the cables. These cables had been repaired and the alarm system was working well on the day of our visit.

Some individuals raised concerns regarding the conditions of the prison. This included the noise in the halls and the impact this had on their sleep patterns.

Summary of recommendations

Recommendation 1:
Managers should ensure that the risk management plans link with the care plans, are audited, easily accessible the healthcare team.

Recommendation 2:
Managers should ensure care planning is regularly audited, easily accessible to individuals and their healthcare team.

Recommendation 3:
Managers should ensure effective promotion of advocacy for all prisoners in HMP Barlinnie.

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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