Mental Welfare Commission for Scotland

Report on announced visit to:
HMP Greenock, Old Inverkip Road, Greenock, PA16 9AJ

Date of visit: 29 September 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 Greenock was first opened in 1910 with two residential units, Ailsa Hall and Darroch Hall, with a third unit, Chrisswell House that opened in 1996. Chrisswell House was built with the specific remit of housing long-term prisoners.

HMP Greenock's main purpose is to hold prisoners who are on remand and sentenced from courts in Greenock, Campbeltown, Oban, Dunoon, and the surrounding Inverclyde and North Strathclyde areas. It provides a national facility for selected long-term and life sentenced prisoners

It holds all categories of male and female prisoners. Greenock was initially for male prisoners until the introduction of females in 2002.

The prison has two community integration units, one for up to eight men and one for up to six women. These accommodate those serving short-term sentences who are assessed as low risk and suitable for community access.

The prison has capacity for 263 prisoners. On the day of our visit, there were 245 individuals housed in HMP Greenock.

We last visited the prison in 2023 and prior to this in 2021 as part of our themed visit to prison. The report, Mental health support in Scotland's prisons 2021: underserved and under-resourced report made a number of recommendations to the Scottish Government, NHS Scotland and the Scottish Prison Service (SPS).

The Commission's last local in 2023 visit resulted in six recommendations regarding the lack of psychiatry provision, the lack of interview facilities, the promotion of advocacy, the auditing of care plans, risk assessment and management plans and staff training in mental health to support individuals with learning disabilities.

There is a planned inspection due to take place in 2026 from His Majesty's Chief Inspector of Prisons (HMIPS). We were aware that the inspection from HMIPS in 2023 raised concerns regarding the lack of psychiatry provision from a collaborative multidisciplinary team or for complex case discussions. The inspection also found that individuals had not agreed with the plans found on file, there were no processes in place to record the supply of medications to the residential areas or to record when medication was given to individuals. The HMIPS inspection highlighted that learning from complaints was not routinely shared with the healthcare team.

NHS Greater Glasgow and Clyde (NHS GGC) is the healthcare provider for all three prisons in this catchment area. For this visit, we wanted was to review the 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 seven people, all of whom we met with in person. We were unable to meet or speak with any family members or relatives.

We spoke with the governor, the deputy governor, the mental health team leader, the charge nurse, various SPS and nursing staff.

Commission visitors

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

Margo Fyfe, senior manager (west team)

Rachael Lee, ST6 Psychiatry of intellectual disability

What people told us and what we found

Half of the people that we spoke with were positive about the care they received from nursing and psychology staff in the mental health team. Individuals made the following comments, “she is brilliant”, “I see her (the psychologist) every Friday and it has really helped me”, “they always make time for me… they will see me on the day if I need them”, “she has helped me with my anger issues” and “the mental health staff are great”.

One individual spoke of the move to HMP Greenock being “great” as the staff were “caring” and “knew what they were doing”. Three individuals highly praised the psychology input which they said was making a significant difference to their lives in preparation for their return to the community.

We received a number of comments that were less positive from individuals about their access to psychiatry staff. This included, “I can’t see one”, “I’ve never seen one”, “I’ve been waiting three weeks to be reviewed and I have to wait until the doctor returns from annual leave…I just want to get better”, “I had to put in a complaint about the psychiatrist as he thinks I’m drug seeking…when all I want is a sleep”, “I feel dismissed” and “I feel neglected by the psychiatrist”.

We also received comments from individuals regarding their experiences with Scottish Prison Service (SPS) staff which included, “they blocked me from accessing the mental health team initially”, “being locked up in here 21 hours per day…they make you feel more suicidal” and “I feel belittled by them” and “they laugh at me, they have no training on how to support my needs”. However, we also received a number of positive comments about SPS staff which included, “I get on much better with them now” and “they are supportive and speak with the nurses to make sure that my health is looked after”.

We heard from someone that the service from the mental health team was “alright” and they were happy to see the nurses when they visited. The individual spoke of their experience of being in a safer cell earlier in the year and how this made them feel “worse” rather than helping them. The individual spoke of how the introduction of new medication had changed their mental state. This resulted in both the individual feeling calmer and SPS staff treating them better. Since then, the individual praised the mental health nursing staff visits as “supportive”.

We spoke with the mental health team leader and the charge nurse. They told us that staffing has been a challenge since our last visit, but the recruitment of a full time dedicated mental health charge nurse, and two registered mental health nurses has helped to provide stability to the service. It was acknowledged that the one session of psychiatric input which lasts two-hours per week was a challenge both for individuals and staff. This amount of time does not provide the input for all that

needs to be seen and there are no cover arrangements in place when the psychiatrist is on leave. On the day of the visit, it had been over 2 weeks since any individuals could access a psychiatric review. This gap in the service was reflected in the various comments we received from the individuals that we met with on the day. This arrangement is different from other prison mental health teams in NHS GGC, where psychiatric cover arrangements are in place.

Recommendation 1:
Managers should ensure that there is a review to address the lack of psychiatry provision to the prison.

We had no significant concerns raised with us about access to nursing assessments in the prison. We were advised by staff that on average since 2023, they receive between 50 and 60 referrals per month to the team. We heard that all routine assessments were completed within the 28-day NHS GGC timeframe, while emergency and urgent assessments were also delivered in the approved timescales.

Many of the people we met with were affected by adverse life events which included family deaths, being victims of harm, witnessing overdoses, histories of childhood trauma and suicide attempts. We received feedback from the staff that they have received training in trauma informed care but there was a general acceptance that it was difficult to address all these matters as a team, due to the demands on the service.

Compared to our previous prison visits this year to other prisons in Greater Glasgow and Clyde area, we heard very few concerns regarding the levels of substance misuse affecting people in HMP Greenock. 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.

We asked about timescales for transfer to hospital for those who were acutely mentally ill and required inpatient care. Only one individual was noted to be waiting for a transfer and we followed this up with the receiving hospital to clarify the wait. Since our last visit in 2023 only four diversions from prison to hospital have been consented to by the medical staff in the prison. This is notably lower than the other prisons in the NHS GGC area; it may be that individuals are transferred to another prison in the area to be managed in Separation and Reintegration Units (SRU) before then moving onto a suitable hospital.

We were informed that there were issues regarding individuals who required their supervised medication to be administered by nursing staff. It was reported that on occasion, a small number of individuals were receiving their evening medication at 3.30pm. We raised our concerns regarding this practice with managers due to the impact upon individuals' medication regime as well as their sleeping patterns; there

are certain medications have time sensitive implications for individuals and their subsequent routines.

Recommendation 2:
Managers should ensure that medication is administered to individuals at their prescribed time. When this does not occur, this should be reported to the prescriber for clear advice and guidance.

Care, treatment, support, and participation

Since our last visit the prison, the mental health service is now led by a newly appointed charge nurse as well as the nurse team leader who provide direct supervision and line management to the team.

The charge nurse and team leader both undertake direct clinical work with individuals as and when required. The nursing team consists of one full-time charge nurse, one full-time team leader and two mental health nurses. We were advised that on the day of our visit, the mental health nursing team were supporting 29 prisoners on an ongoing basis.

We were told that individuals were able to self-refer to health care services at any time. Referrals were triaged on an emergency, urgent or routine basis. Psychiatry input to the prison is offered by one visiting doctor who offers one session per week, however, we were told that half of the session is taken up by the psychiatrists travel time to and from the prison.

On the day of our visit, there were no individuals on the waiting list for routine first time assessments by psychiatry. When individuals are on the waiting list to be seen by psychiatry, if required, nursing staff will provide ongoing monitoring of an individual's mental state and compliance with any identified treatment. We were informed that anyone requiring to see a psychiatrist must wait for the return of the psychiatrist from any period of leave due to the lack of cover arrangements. This is a clear identified gap in the service which senior managers are aware of, and we were advised that a review of these arrangements are underway.

The prison clinical psychology intervention service (CPIS) works between HMP Barlinnie, HMP Low Moss and HMP Greenock; they provide clinical interventions for anyone requiring psychological assessment and support. This peripatetic service provides psychological assessment, treatment and consultation for individuals with mental health difficulties residing in prison.

Individuals have access to evidence-based psychological interventions, as guided by the psychological therapies matrix. This can be on a one-to-one basis or in a group. In line with Scottish Government recommendations and community services, the

CPIS aims to start psychological treatment within 18 weeks from referral. The psychologists provide two sessions per week to the prison, on a Tuesday and Friday.

The psychology service is complemented by mental health therapists. The nursing team and individuals that we met with spoke positively of the psychology input that was provided. The psychology team currently only provide one-to-one sessions; at present, there is no groupwork.

Care plans

All individuals in HMP Greenock who receive mental health input should have a formalised care plan in place. Care plans aim to ensure a consistent approach is undertaken by staff and this should provide a clear understanding of the person's 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 in the team.

The care plans were all date and provided a set of goals detailing what needed 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 on the individuals' mental health.

We compared the current care plans to previous versions completed by the team. These could not be located during the visit and there was no evidence that there was any version control which is an issue if these are required for subsequent enquiries or investigations by outside agencies.

Recommendation 3:

Managers should ensure that previous versions of care plans are safely stored and retained.

Most of the care plans we examined were limited in terms of the detail they provided and did not link to the individual's risk assessment, nor were they 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 visited in the last year.

Recommendation 4:

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

We looked at the care plan reviews. These reviews are designed to capture how an individual's care goals are being achieved and their progress towards these. The care plan reviews should have a consistency in recordings and approach. Unfortunately, many of the care plan reviews were being used by the staff for journal

entries which meant that every time a member of staff met with an individual, they would record a descriptive outcome of their contact. The care reviews were not being updated, and some were not being completed at all. Of those individuals we spoke with only three were aware that they had a care plan but had never seen it.

Care records

We reviewed the notes of all 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 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 five of the electronic systems do not directly communicate with each other, which causes challenges when trying to access information quickly. The chronology of the information that we reviewed was not always clear when recording the individuals' transitions of care from one prison mental health team to another. On occasion, we could see that this caused some confusion and uncertainty for the visiting officers.

For those records that we were able to view, we found that the daily entries provided a brief summary of the input the person was receiving and helped to summarise when they would be next seen. When we read the records across the recording systems we were able to get a sense of some of the plans in place for people. This was not always the case and on occasions, we had to follow up with the individual members of staff to clarify matters.

Of the records we reviewed, we found no contacts by the visiting psychiatrists recorded on VISION. In other prisons across Scotland, we have found entries by psychiatry staff which help provide clarity on assessments and follow up treatments.

The mental health team managers have adopted the clinical risk assessment formulation toolkit (CRAFT) as the agreed tool to be used in the prison. Recently, NHS GGC have updated the CRAFT form which has expanded aspects of the previous form and removed other aspects. The latest form does not specifically highlight direct risks to the individual or others.

From the CRAFT forms we reviewed, we found that there was a lack of depth and clarity on risk management plans and how strategies like 'Talk to Me', the utilisation of prison 'Rules' or hospital admissions may need to be considered by the treating staff. We found some forms had not been completed at all and were empty.

We compared the current CRAFT forms to previous versions completed by the team; however, these could not be located. We discussed this with managers and advised

that this needs to be addressed. It was acknowledged that this is a new form, and staff are still coming to terms with the changes embedded. Managers advised that there is follow up work planned with the NHS practice development nurses to train the prison mental health nursing staff on the form implementation. We look forward to seeing how the use of this form develops when we next visit the prison.

Recommendation 5:
Managers should ensure that all CRAFT risk assessment forms are regularly reviewed, audited and safely stored and retained.

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)
At present there is no multidisciplinary team (MDT) chaired and led by the mental health team. There are other meetings that take place throughout the prison which the mental health team attend. These include referrals meetings, which only nursing or psychology staff attend, or a monthly prison-wide multidisciplinary team meeting to discuss themes or specific issues.

There are quarterly suicide risk management meetings, as well as regular case conferences regarding specific individuals which are chaired SPS staff. These various meetings have as required attendance from the nursing team leader, psychology, addictions nursing, primary care nursing and other disciplines.

The other prisons in the NHS GGC area have routine mental health MDT's which are attended and minuted to reflect discussions and plans for individuals' care. We believe that the lack of MDTs, where attendance is noted and the discussion on specific individuals is recorded, is a gap in the service at HMP Greenock and one which must be addressed.

Recommendation 6:
Managers should establish regular multidisciplinary team (MDT) meetings which are chaired and minuted to reflect discussions and planning for individuals' mental health care.

Use of mental health and incapacity legislation

We were not informed of anyone being subject to the Mental Health (Care and Treatment) (Scotland) Act, 2003 or the Adults with Incapacity (Scotland) Act, 2000 on the day of our visit.

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

Rights and restrictions

The Prisons and Young Offenders Institutions (Scotland) Rules (2011) enable individuals to be restricted in certain situations. If there are concerns from prison staff and/or health professionals about a person's behaviour due to their mental health, restrictions can be placed on their movements and social contacts with the use of Rule 41.

A health professional must make a request to the prison governor to apply a Rule 41; use of this rule can include confining a person to their own cell or placing them in segregation. For people being held in segregation, the Commission gives consideration to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (the CPT) recommendations that: all individuals, including those in conditions of segregation, should have at least two hours of meaningful human contact each day and that individuals held for longer than two weeks in segregation, should be offered further supports and opportunities for purposeful activity.

There were no individuals on this visit who were confined to safe cells. We were informed by managers that the majority of prisoners with mental health conditions will not be placed in a safe cell, although we heard from one individual who had been placed in a safe cell. We were informed that any use of confinement would be highlighted to the visiting psychiatrist who, along with the mental health nurses, would undertake a visit to those individuals, at minimum, on a weekly basis.

During our visit it was reported that that Circles Advocacy had been the approved provider of advocacy services. This has now ceased and there is no provision of advocacy services commissioned by NHS GGC to the prison. This is a significant gap in service provision which is concerning for the Commission. We met with a number of individuals during this visit who we identified would benefit from advocacy support to address their individual circumstances. We discussed this lack of advocacy input to the prison with managers and again, we recommend that access to advocacy is commissioned and should be made widely available.

Recommendation 7:
Managers should ensure that advocacy services are commissioned and accessible to all in the prison.

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

Most people that we spoke to told us that in the prison, there was access to some form of meaningful work and activities that they benefited from. This included working in the laundry, attending religious services, watching television and reading.

Since our last visit, a well-being hub has been the established; this was created from repurposing a closed painting workshop. We visited the hub and were informed of the planned mindfulness sessions due to occur that day. In each of the areas there were various activities available, including access to games and the opportunity to play musical instruments.

The hub is painted in bright colours with a variety of murals and pictures on the walls, as well as a 'café' type area. This service was created with a minimal budget but appears to be having a significant positive impact on people in the prison. We had sight of the weekly timetable which supplies dedicated sessions for the male, female and protected population. We noted that various third sector groups attended the hub; these included alcoholics anonymous and narcotics anonymous.

We received reports that some individuals had not been successful in accessing the wellbeing hub since their admission. We raised this with the deputy governor on the day who acknowledged the demand was high and individuals were required to get their names on the list for the hub as quickly as possible to ensure access.

We heard that some individuals benefitted from religious input to the prison as it helped to improve their emotional wellbeing. This included access to wide variety of faiths. One individual commented, "it's the best and the most important to me, I don't know what I do if I wasn't able to go along".

The physical environment

Towards the end of 2024, the health centre once again discovered a leak to the flat roof which resulted in all staff having to be relocated to Bute House. This relocation was supposed to be for one month but ended up lasting for 11. Following this the staff returned to the health centre only to discover another leak in the general practitioner's (GPs) office which is now currently out of use. This has resulted in reduced space in the health centre to see people.

The health centre was small, and managers advised us that they regularly have to utilise the Link Centre as a non-clinic-based area, which then has an impact on recording information.

Since our last visit there has been no change to the ongoing issues with the interview facilities in the Link Centre, which does not provide sound proofing or privacy for individuals and staff to undertake interviews, assessments and therapeutic interventions. These concerns were raised in our 2017 report and there has been no

improvement noted. We heard from managers that despite previous reports, there are no plans to redesign the Link Centre.

In their last visit, HMIPS highlighted an ongoing area of serious concern related to the buildings, accommodation, and facilities in HMP Greenock not being fit for purpose. Many areas of concerns and issues have been raised repeatedly, including dampness in the cells, mainly found on the west facing wall of Ailsa Hall. In 2021, there were 45 cells out of use due to dampness.

On the day of our visit, we were alerted to one individual who was recovering from significant surgery and was being cared for in an adapted cell. We were advised that there was no heating in the cell. This concerned the Commission visitors and we requested that suitable heating was provided to ensure the individual was not subject to inhumane conditions.

Any other comments

We noted that there has been high staff sickness with SPS staff over the last year which has had a direct impact upon individuals accessing the health centre. This is due to individuals requiring SPS staff to assist with escorting. SPS managers advised that the staff sickness rates have been steadily improving which was slowly helping to reduce disruption to this area of work.

We were pleased to hear that the prison has established a health and wellbeing co-ordinator since our last visit, which has helped to prioritise this area of work.

Also, since our last visit, there has been a significant adverse event review (SAER) carried out in response to an untimely release of a prisoner which resulted in fatal consequences. The Commission has been liaising with senior managers regarding this event and the learning from this.

We made a number of recommendations regarding their SAER and continue to monitor the impact of this as part of our wider enquiries. We heard from managers about the steps they have taken through the prison risk management meetings and with links to the local community mental health teams to timeously address referrals and follow up, as appropriate.

Summary of recommendations

Recommendation 1:
Managers should ensure that there is a review to address the lack of psychiatry provision to the prison.

Recommendation 2:
Managers should ensure that medication is administered to individuals at their prescribed time. When this does not occur, this should be reported to the prescriber for clear advice and guidance.

Recommendation 3:
Managers should ensure that previous versions of care plans are safely stored and retained.

Recommendation 4:
Managers should ensure care planning is regularly audited and easily accessible to individuals and their healthcare team.

Recommendation 5:
Managers should ensure that all CRAFT risk assessment forms are regularly reviewed, audited and safely stored and retained.

Recommendation 6:
Managers should establish regular multidisciplinary team (MDT) meetings which are chaired and minuted to reflect discussions and planning for individuals' mental health care.

Recommendation 7:
Managers should ensure that advocacy services are commissioned and accessible to all in the prison.

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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