Mental Welfare Commission for Scotland

Report on announced visit to:
Low Moss Prison, Crosshill Road, Bishopbriggs, Glasgow, G64 2PZ

Date of visit: 8 July 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 Low Moss opened 2012. The prison has capacity for 784 prisoners and there were 792 prisoners in their care on the day of our visit. Project 100 was set up in 2020 to help address the national rise in the prison population; there was an increase in the number of prisoners across the estate with an impact on Low Moss as a result of this change.

Greater Glasgow and Clyde Health Board (NHS GGC) provides a mental health team to the prison to meet the needs of the people in their care.

HMP Low Moss has male offenders on remand, on short and long-term sentences. Prisoners were mainly from the North Strathclyde Community Justice Authority area.

The Commission visitors were cognisant of His Majesty's Inspectorate of Prison for Scotland (HMIPS) report from their last inspection (February 2022) and Independent Prison Monitoring (IPM) findings report (2024), which highlighted the increased prison population, concerns with personal safety, the use of illicit substances and the cancellations of external appointments. On reviewing the Scottish Prison Service (SPS) publication on deaths in custody, Low Moss had two individuals who had died in 2023, seven in 2024 and a further six in 2025. The deaths were related to a number of reasons including suicide, physical health-related conditions and the use of illicit substances. HMIPS are due to inspect the prison in August 2025.

We lasted visited the prison under our local visit programme in 2023 and in 2021 as part of our themed visit report: Mental health support in Scotland's prisons 2021: under-served and under-resourced. We 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 our visit on 31 July 2023, we made recommendations regarding improving care planning for prisoners as well as risk assessments and access to advocacy. The response we received from the service advised that steps had been taken, including auditing of care plans and risk assessments as well as the promotion of advocacy.

On this visit we wanted to find out about the current mental health services in the prison, whether in the mainstream population or for any that were subject to any prison rules.

Who we met with

We met with and reviewed the care of 11 individuals who asked to meet us. We spoke with the governor, deputy governor, operational nurse manager, principal clinical psychologist, members of the mental health nursing team, and members of Scottish Prison Service (SPS) staff.

Commission visitors

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

Lesley Paterson, senior manager (East team)

Audrey Graham, social work officer

Denise McLellan, nursing officer

What people told us and what we found

The primary focus of our visit was to review the care and treatment provided to prisoners who were experiencing mental health difficulties.

During our visit there were three nursing staff along with the operational lead available to assist with meeting individuals in the halls and in the Separation and Reintegration Unit (SRU).

We met with 11 individuals who told us that they had good relationships with the nursing staff. Comments included, “she comes to see me, as agreed, once a week”, “she treats me well”, “the nurse was helpful to start out with and now they are all working together to help me” and “the nurse is respectful and wants to help”.

We heard some mixed views about psychiatry including “we just don’t connect” and “we don’t agree, he treats me differently”. Whilst others indicated that they had a good rapport with their psychiatrist and spoke of them being “skilled” and “wanting me to get better”. We spoke to one individual who told us that they had been seeing their psychiatrist for several weeks but did not understand why they were still waiting for a clear diagnosis. The individual found this frustrating and confusing as they wanted to commence suitable treatment for their symptoms. We agreed to feed this back to managers for follow up action.

It was clear to the Commission staff that a relaxed, flexible rapport was delivering positive outcomes for the individuals that we met with. This approach complemented a focus on all key areas including reviewing sleep patterns, physical health, risks, treatments and wellbeing. One individual stated that; “this mental health team are second to none”.

We heard from individuals that they did not have a long wait to be seen by the mental health team, both for nursing and psychiatry input. We were told “I was referred and seen pretty quickly” and “it was straightforward”.

Individuals have access to daily general practitioner (GP) appointments, as required, in the prison. There are addiction and registered general nurses available on site, who are co-located with the mental health team; this added to the staffing skill mix and provided support for individuals with a variety of complex presentations.

We were informed by the operational nurse manager that the primary care nursing staff continued to play a critical role at the reception area of the prison, where screening for mental health conditions, learning disability and autism of all individuals is carried out on admission and anyone identified was referred to the mental health team at this time. The mental health nurse would then make links with any of the community teams that the individual was receiving care from prior to coming into the prison.

We were informed that since our last visit that the mental health nursing team now employ a nurse trained in learning disabilities which has helped to support assessing individuals presenting with these conditions. We believe that this skilled support, especially in prisons, is essential to ensure that for those with a variety of additional support needs, these are considered at all stages of their journey through the system. This specialist nursing provision can ensure that careful consideration is given in how to communicate and engage with those with both learning difficulties and disabilities.

The mental health lead nurse was responsible for screening, triaging and actioning referrals on a daily basis, along with setting up follow-up appointments with individuals. We were pleased to see that the triage process continues to function well in prioritising those who were most in need of urgent care.

We met with one individual in the SRU who spoke of their journey from the halls into the unit. They advised of receiving regular visits from the nursing staff and psychiatry. We heard that they had been subject to the 'Talk to Me' strategy which helps to monitor those at risk of suicide. They spoke of having their spiritual needs met with visits from a priest, which helped provide them with religious reassurance. The individual highlighted adjustments made by Scottish Prison Service (SPS) staff to accommodate their wishes and preferences while they were in the SRU. Staff that we met with had a clear and consistent understanding of the reason for individuals' placement in the SRU and they discussed the positive links they had with the mental health team.

The staff in the SRU discussed a number of challenges in the prison. When we met with the governor and deputy governor, they described some of the significant implications for prisoners due to high levels of illicit drug use which has resulted in violence. We were shown video footage of a pilot study that has been deployed in the prison, where the use of body camera has been used to record the response to those who were ill due to the consumption of illicit substances. This footage was stark. The level of unresponsive presentation from individuals and associated risks to all staff was a significant cause for concern.

We heard of the various steps being taken to address illicit substances that are coming in to the prison. We heard that staffing levels meant that prison officers and nursing staff had a difficult job responding to individuals becoming acutely unwell and who required immediate treatment, sometimes up to three or four times per day. This then required immediate admissions to hospital for these individuals which left both SPS and NHS staff fatigued from the risks associated when dealing with these unpredictable presentations.

Prisoners we spoke with who had a history of addiction and were seeking help with this, reported good access to the addiction service in the prison. One individual

stated, “the recovery café is the best thing about this jail, they really want to help”. Another reported “I get my medication from the nurses when I need it and this keeps me stable”. We had the opportunity to visit the recovery café in the prison which was set up to provide a shared space for all prisoners, to visit and engage with relevant services. This provided access to narcotics anonymous, alcoholics anonymous and other Christian recovery services. It was hoped that this service would help to improve integration between third sector addiction services in the community and those in prison. The Commission found the recovery café to be a significantly helpful asset to the prison, which should serve to improve the lives of individuals with mental health and addictions in the prison.

Care, treatment, support, and participation

The prison mental health service is led by a nurse team leader and an operational manager who provide direct supervision and line management to the team. The team leader and operational manager both undertake direct clinical work with individuals as and when required. The nursing team consists of one full-time team leader, one full-time senior nurse and two full-time mental health nurses. There was an additional part-time nurse who works between the Lilias Centre, based in Glasgow and the prison. This nurse supplies additional support to the service at a minimum of once per week.

We were advised that on the day of our visit, the mental health nursing team were supporting 53 prisoners on an ongoing basis. We were told that individuals were able to self-refer to health care services at any time. We heard from managers that in the last six months, over 1000 individuals had been referred to the mental health team from a variety of routes. 429 of these individuals were being assessed on an emergency, urgent or routine basis.

Psychiatry input to the prison is offered by three permanent visiting doctors, who each offer one session per week. Currently one of the psychiatrists is absent which has had an impact on the sessions offered and is reducing the psychiatric capacity for the prison. There are no current cover arrangements for this gap in service which is resulting in longer waits for the prison population. We did not hear directly from individuals that this had resulted in any specific issues for their care or treatment.

On the day of our visit, there was 20 individuals on the waiting list for routine assessments by psychiatry. Five of these individuals were waiting for assessments for their attention deficit hyperactivity disorder (ADHD).

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 is seen quickly.

The prison psychology team works between HMP Barlinnie, HMP Low Moss and HMP Greenock; they 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 that was provided. The psychology team currently have psychology vacancies which is having an impact on one-to-one sessions and groupwork occurring. Despite this, the team have been supporting the service by piloting input on the NHS Education for Scotland (NES) trauma skilled training to upskill primary care staff. The psychology manager spoke of the intention to recruit staff in the coming months which should help to improve provision to the prison.

Care plans

All prisoners receiving mental health care were found to have a formalised care plan in place which was clearly dated. The care plan aimed to ensure a consistent approach, 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 records that we examined were stored in a shared drive that were accessible by all staff. Care plans made a direct reference to “What matters to me?” which is a helpful approach as it summarised the views of the individual with goals that were in place.

Compared to our last visit, we found that all the care plans were accessible and up to date. However, we found that there was a lack of consistency in the reviews of the care plans across the staffing group. Many staff had completed these with a succinct summary with a summary of individuals’ progress linked with the goals identified in the plans, however some staff were not completing these on a consistent basis. Some staff were recording care plan reviews as one-to-one meetings with the individuals, providing an entire summary of their contact. The understanding of the role of care plan reviews by staff was discussed with managers at the end of day feedback session of our visit.

Recommendation 1:

Managers should ensure that staff and individuals understand the role of care plan reviews and the importance of these taking place on a consistent basis.

We were advised that prisoners subject to rule 41 of the Prisons and Young Offenders Institutions (Scotland) Rules, 2011, due to mental health reasons, had a care plan. These were then updated by the mental health team and any prisoners

requiring transfer to hospital for mental health care were automatically placed on a rule 41. We were able to access rule 41 care plans held on file. We found these to be appropriate and linked with the role of the rule.

We asked about timescales for transfer to hospital for prisoners who were acutely mentally ill and required inpatient care, as 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, there was only one individual who had recently required an inpatient admission to a mental health ward; this individual was currently being cared for out with the prison in a general admission ward in the NHS and was subject to the Mental Health (Care and Treatment) (Scotland) Act, 2003. We were able to confirm that this individual was known to the forensic network.

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.

Care records

We reviewed the notes of the individuals we met with. The mental health team use four different electronic systems to gather and record information relating to individuals as approved by NHS GGC. This includes, Vision, EMIS, a clinical portal, and the online team folder system that holds all care plans and risk assessments.

The Commission found Vision to be a clunky system that is not easy to read. The information recorded on Vision was condensed into small boxes on the screens. All four of the electronic systems do not directly communicate with each other, which causes challenges when trying to swiftly access information. Like most prisons, HMP Low Moss 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 supplied a summary of the input the individual was receiving, with some sense of continuity between contacts and a focus on the individual's diagnosis or treatment plan. We did find on occasion, that there was not always a clear summary of the individuals' history. The Commission staff had to look across the four recording systems to gather information.

We found recorded contact by the majority of visiting psychiatrists was more detailed than the nursing records and showed clear plans for treatment and follow up, where appropriate. We did however find one psychiatrist's records which lacked

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

detail and did not provide any clarity on their assessment and treatment for the individuals in their care. We raised this directly with managers on the day of the visit and advised that this should be addressed. We found good evidence of psychology input, when it was provided. There was very little in the way of care plans for prisoners who were recorded as having contact only with the visiting psychiatrists.

The managers of the service have decided to adopt the CRAFT risk assessment tool which is used in the prison to assess risk. This assessment had previously been added to the Vision system during our last visit but when it was added there were some concerns highlighted. As a result of this, the latest CRAFT assessments were stored on the shared folder next to the care plans. We noted staff concerns that the CRAFT tool did not feel as applicable in a prison setting compared to a hospital or community setting. Despite this, staff had taken steps to embrace its use.

It was positive to note that in comparison to our last visit, we found risk assessments for those open to the nursing team, although there remains work to be done to improve the CRAFT assessments. This area of risk assessing is particularly important in the event of any adverse event.

We found from the records we reviewed that the CRAFT assessments that were in place were not clear regarding the management of the risks. We found that all risk management plans were not meaningful and were not clearly owned by either SPS or the NHS. It was not clear that the risk management plans were shared with the people involved to understand how it related to their care. We believe this matter requires more careful consideration and review of the risk management plans to ensure that all parties including the individuals involved understand the role of the risk management plan.

Recommendation 2:
Managers should regularly review risk management plans to ensure they are meaningful and shared with all relevant parties on a consistent basis.

Multidisciplinary team (MDT)
Since our last visit there has been the establishment of multidisciplinary team (MDT) meetings which take place once per week. Those attending the meetings included the mental health nursing lead, psychiatry, psychology, addictions charge nurse, primary care charge nurse, mental health charge nurse and other disciplines as required. We had access to review these MDT records and found that no individuals attended the MDT and neither their views, or that of their nearest relative were 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. We were informed that this new MDT process was helping to improve standards. We did point out that not

all individuals who were on the caseloads of the range of disciplines were discussed on a minimal standard basis. i.e. once every 12 weeks. Managers advised us that they were working through this new process and would take this feedback into consideration as the MDT developed in the future. We look forward to seeing how this has progressed when we next visit.

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.

Rights and restrictions

When we last visited HMP Low Moss it was not clear who was the approved provider for advocacy services. During our pre-meeting with the service, it was confirmed that Ceartas Advocacy were now the approved provider.

During the visit no individuals we spoke with were aware of advocacy. We found no promotion of the service in the prison or the health centre. We spoke with a number of individuals due to their personal circumstances or concerns who would have benefitted from input from advocacy to address their concerns. Individuals stated "advocacy what's that?", "I've never heard of them?" and "I would like to link in with them, but I don't know how to".

The Commission is 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 an individual's 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 this with managers at the end of the day and as in our previous visit report, we again recommended 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 Low Moss.

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

No specific issues were raised in relation to accessing activities, daily recreation and/or education. There was an acknowledgement from people that there was access to meaningful work and activities that clearly benefited their mental and physical health. From some, we heard that religious input to the prison had helped to improve their emotional wellbeing. It was clear from our visit that the staff were culturally aware and tried to meet the cultural needs of the prisoners as far as possible.

We had positive feedback in relation to the Life Skills base at Low Moss, which allows people to self-refer to aid with their rehabilitation back to the community.

For those in the halls and the SRU we found clear evidence that exercise was promoted.

The physical environment

The health centre rooms, and nursing stations were in good condition. The rooms, outdoor spaces, and activity areas that we visited were a good size and were well maintained, appropriately furnished, clean, and hygienic.

No one raised any concerns regarding the conditions of the prison.

Summary of recommendations

Recommendation 1:
Managers should ensure that staff and individuals understand the role of care plan reviews and the importance of these taking place on a consistent basis.

Recommendation 2:
Managers should regularly review risk management plans to ensure they are meaningful and shared with all relevant parties on a consistent basis.

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

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk