Mental Welfare Commission for Scotland

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

Date of visit: 9 June 2026

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 is a mixed-sex prison; it holds prisoners who are on remand and who have been sentenced from courts in Greenock, Campbeltown, Oban, Dunoon, and the surrounding Inverclyde and North Strathclyde areas. It also serves as a national facility for selected long-term and life sentenced prisoners.

While HMP Greenock was initially for male prisoners, women were able to move to the prison in 2002, but only those women who could be transferred from other prisons.

Accommodation comprises of five main residential areas. Ailsa Hall accommodates only males, mainly from the local population and includes remand and short-term convicted prisoners. Darroch Hall and Bute House accommodate a mix of short-term female convicted and untried prisoners. Chrisswell House and Arran House accommodates males who are long-term prisoners and who are on low supervision.

The prison has capacity for 260 prisoners. On the day of our visit, there were 255 individuals housed in HMP Greenock and the prison was described as being on 'divert' as it had reached its maximum capacity for male prisoners.

We last visited the prison in 2025, in 2023 and prior to this in 2021 as part of our themed visit to prisons. 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 visit was in 2025, This visit resulted in seven recommendations regarding the lack of psychiatry provision, the timing of medication administration, retention and audit of clinical records, multidisciplinary team working and the availability of independent mental health advocacy services.

NHS Greater Glasgow and Clyde (NHS GGC) is the healthcare provider for all four prisons in this catchment area. For this visit, we wanted 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 six 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 head of residential services, the deputy governor, the NHS operational manager, the nurse team leader, the mental health charge nurse, the psychologist and various SPS and nursing staff.

Commission visitors

Mark Richards, nursing officer

Lesley Paterson, senior manager

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

Laura Young, nursing officer

What people told us and what we found

We met with six people who were being supported by the mental health team. The people we spoke with were largely positive about the care and treatment they received from nursing, psychiatry and psychology staff.

Individuals' comments included, "she is someone I would like to talk to", "I see her (the psychologist) every fortnight and the sessions are really helping me", "they always make time for me… they will see me quickly if I ask them to", "the mental health staff are really good". We heard feedback that input from psychiatry was ''helpful.'' One person felt that they did not see the mental health team often enough.

One person commented that they had served time in a number of prisons across Scotland and found HMP Greenock to have been the best mental health service they had experienced. They described the staff in the mental health service to be good and that they felt like they were "treated as a patient, not a prisoner". They added that the staff treated them "like a person".

We heard positive feedback about the psychology service which was felt to be accessible and the interventions were helpful. One person felt that there could be better connection between what happened between psychology services in the community and those in prison, so that there was continuity of treatment. Waiting times for access to psychology assessment and interventions are monitored and reported, and we heard that these are no long waits for access.

No concerns or issues were raised with us by individuals about their access to psychiatry and health centre staff reported that there was sufficient capacity to meet demand. We also heard about the positive impact of the advanced nurse practitioners who work across all four of the prisons in NHS GGC. Capacity in psychiatry has been enhanced through the addition of a senior trainee, who works alongside the consultant.

We heard that there is a gap in not having a clinical lead for the service; it is normally a general practitioner (GP) that assumes this role. We were advised that the majority of GPs were contracted on an agency basis but that it was mostly the same GPs who did this work. There were no issues or concerns highlighted regarding the day-to-day service provision.

We spoke with the nurse team leader and the mental health charge nurse. They told us that staffing has improved, and that the recent recruitment of another mental health nurse will help bring capacity and stability to the service.

We had no significant concerns raised with us about access to nursing assessments in the prison. We were advised by staff that on average they complete around 10 new assessments per week. We heard that all routine assessments were completed in

the 28-day NHS GGC timeframe, while emergency and urgent assessments were also delivered within the approved timescale of five days and often responded to on the same day.

Many of the people we met with were affected by adverse life events which included family deaths, being victims of physical violence, witnessing overdoses, histories of childhood trauma and suicide attempts. Psychology staff reported delivering in-house training on trauma informed care and also described bringing a focus to this through their coaching and supervisory roles.

Similar to our previous visit in 2025, 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. There are normally around 50-60 individuals who are directly supported by the addictions team and who are receiving medication on a supervised basis.

We asked about timescales for transfer to hospital for those who were acutely mentally ill and required inpatient care. There were no issues reported and nobody was awaiting transfer. Since our last visit in 2025, there have been no transfers from prison to hospital. This remains notably lower than other prisons in the NHS GGC area. HMP Greenock does not have a Separation and Reintegration Unit (SRU) and it was reported that if this is required then individuals are transferred to another prison to be managed in that setting.

On our previous visit in 2025, we were informed that there were issues regarding individuals who required their medication to be administered by nursing staff and the timing of this. We heard that there have been improvements in this but that there are still some instances where individuals could get medication out with prescribed times. We also heard that the preferred model is for individuals to hold and take their own medication at the prescribed times and that for those who must be supervised, then prescribers would try to ensure medications are administered during periods where staff are available.

Recommendation 1:
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.

Recommendation 2:
Managers should ensure that opportunities for individuals to safely retain their own medication is maximised and, in doing so, reduce the number of individuals dependent on direct medication administration.

Care, treatment, support, and participation

The mental health service is led day-to-day by a mental health charge nurse. There are two part-time nurse team leaders who provide direct supervision and line management to the wider nursing team.

The team leaders and charge nurse both undertake direct clinical work with individuals as and when required. The mental health nursing team consists of one full-time charge nurse post and one full-time mental health nurse. We were advised that on the day of our visit, the mental health nursing team were supporting eight prisoners on an ongoing basis. This is fewer individuals than on our previous visit in 2025 and this was reported to be as a consequence of more comprehensive mental health assessments being undertaken by the mental health charge nurse.

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 two visiting doctors who offer one session per week each.

When individuals are on the waiting list to be seen by psychiatry, if required, nursing staff can 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 would normally wait for the return of the psychiatrist from any period of leave, but if there was an urgent need for assessment, then arrangements were in place to deliver this through the on-call psychiatrist based at Leverndale Hospital or through the NHS GGC psychiatry lead for prisoner healthcare. On the day of our visit, there were no individuals on the waiting list for routine first time assessments by psychiatry.

The prison clinical psychology intervention service (CPIS) works between HMP Barlinnie, HMP Low Moss and HMP Greenock and provides 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 Scottish Government psychological therapies matrix. Individuals can be seen 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 the time of referral; it was reported that there have been no breaches of this target. The psychologists provide two sessions per week to the prison, and their input is complemented by sessions delivered by mental health therapists.

The nursing team and individuals that we met with spoke very positively of the psychology input that was provided. The psychology team currently only provide

one-to-one sessions; at present, there is no groupwork. The care records we examined where individuals had been referred to psychology evidenced that individuals were being assessed and that treatment started well within the 18-week target.

One individual we met with asked that consideration be given to improving continuity of care between community-based psychological therapies and those delivered in prison. They described making good progress in the community but felt frustrated that these therapies did not continue when in prison.

Recommendation 3:
Managers should consider developing and implementing a psychological therapies pathway that better ensures continuity of care between the prison and community settings.

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 taken 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.

Most of the care plans were in date and provided a set of goals detailing what needed to be achieved by the care team involved. The care plans were specific to nursing, so lacked a multiprofessional focus.

Recommendation 4:
Managers should ensure that a care plan audit programme is in place to ensure that there is greater in the consistency in the quality and content of care plans.

We found that where required, there was reference to physical health care needs that would have an impact on the individuals' mental health. Some care plans had longer review dates set - up to 3 months - and some lacked evidence of updates.

Not all individuals who were on high doses of antipsychotic medication had clear plans in place for the physical health checks required as part of high dose monitoring. Information recorded in some of the care plans was less detailed than we would have expected, and there could have been more of a focus on the strengths of the individual.

Recommendation 5:
Managers must ensure that all individuals who are receiving high doses of antipsychotic medication have a care plan that reflects the regular physical monitoring that is required.

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 records of all the individuals we met with. There have been no changes since our previous visit in 2025, and 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 shared folder system that holds all care plans and risk assessments. The systems do not communicate with each other which makes accessing information more challenging. This issue is not unique to HMP Greenock.

For those records that we were able to view, we found that the daily entries provided a brief summary of any input the person was receiving and helped to summarise when they would be next seen. When we reviewed the records across the recording systems, we were able to get a sense of some of the plans that were in place for people.

The mental health team use the agreed clinical risk assessment and formulation toolkit (CRAFT). NHS GGC have updated the CRAFT form, which has expanded some aspects of the previous form and removed other aspects. In our 2025 visit report, we reported that the form does not specifically highlight direct risks to the individual or others; this remains the case. All individuals who were being supported by the mental health team had a completed CRAFT.

From the CRAFT forms we reviewed, we found that there was a lack of detail and clarity on risk management plans for some of these, and how risk management strategies that involve SPS staff like 'Talk to Me', or the utilisation of prison 'Rules' may come into play. Where deterioration in mental health was identified as the risk, some assessments did not describe how a deterioration in mental health may affect the person, and what are the specific risks associated with this that need to be managed. We could not see a multi professional approach to the use of CRAFT. Not all of the CRAFT assessments had been updated in line with the factors which would trigger a review.

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

Recommendation 6:
Managers should ensure that all CRAFT risk assessment forms are regularly reviewed and audited, and that the service works towards this being used as a multiprofessional tool.

Multidisciplinary team (MDT)
As reported in our 2025 visit, 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. We heard from staff that there is an appetite for MDT meetings to be established, and that these would be beneficial for the planning of care and treatment, its delivery and evaluation.

There are quarterly suicide risk management meetings, as well as regular case conferences regarding specific individuals, which are chaired by 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 MDTs, which are attended and minuted to reflect discussions and plans for individuals' care. We noted in our last report in 2025 that the lack of MDTs, where attendance should be noted and the discussion on specific individuals recorded, is a gap in the service at HMP Greenock and one which must be addressed. We were pleased to hear that funding is being actively considered for a psychiatry session which will make this possible. We look forward to hearing that this is implemented and will review at our 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
The Prisons and Young Offenders Institutions (Scotland) Rules (2011) enable individuals to be restricted in certain situations. If there are concerns from prison staff 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.

HMP Greenock does not have segregation facilities, and there were no individuals on this visit who were confined to safe cells. We were advised by managers that the majority of prisoners with mental health conditions will not be 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.

Access to independent mental health advocacy is important in helping ensure that vulnerable individuals have access to the same rights to healthcare as those living in the community. On this and on previous visits, we have met with individuals who we considered would have benefit from advocacy support to address their individual circumstances. We discussed advocacy input to the prison with managers during our visit and were pleased to hear that 'Voiceability' are now the approved provider of advocacy services and are accepting referrals. We look forward to hearing more about the impact of this during future visits.

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 cleaning the halls, working in the laundry, attending religious services, education, attending the gym, watching television and reading.

At our last visit, we heard that a well-being hub had been the established. On this visit, we heard that the hub has been a great success and that it is well used. We heard that there is now a waiting list for prisoners to access this resource, with SPS reporting that they are mindful of the need to ensure equity of access across the prison population.

We heard about the importance of retaining family contact and that the Link Centre was an important resource that enabled this. All of the individuals we met with had in-person contact with family members, including their own children.

The physical environment

When we visited HMP Greenock in September 2025, the health centre had a leak to the flat roof which resulted in all staff having to be relocated to Bute House. This was addressed and the staff returned to the health centre only to discover another leak in the GP's office. This had resulted in there being a reduction in the available

space in the health centre to see people. These issues have now been resolved, and we were advised that all the clinic space was now accessible.

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

We were mindful of previous serious concerns related to the buildings, accommodation, and facilities in HMP Greenock not being fit for purpose. On this visit, no issues were raised regarding dampness in the cells, nor any other concerns expressed about the physical environment.

Any other comments

One individual we met with spoke positively about the involvement of family in 'Talk to Me' sessions and had found this very supportive. This inclusive approach was welcomed as it provided additional support to the individual when in prison and it also enhanced their understanding of mental health and wellbeing support needs as individuals work towards liberation and life in the community.

We explored current practice with regard to planned and unplanned liberation of individuals, and how the continuity of mental health care was achieved. For planned liberations, we heard about a process through which individuals who were open to psychiatry were then referred on to community mental health and/or addiction services. For unplanned liberation, we heard that this is more challenging but follow up is done through community providers whenever possible for those individuals who have been receiving Opioid Substitution Therapy.

Summary of recommendations

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Recommendation 4:
Managers should consider developing and implementing a psychological therapies pathway that better ensures continuity of care between the prison and community settings.

Recommendation 5:
Managers must ensure that all individuals who are receiving high doses of antipsychotic medication have a care plan that reflects the regular physical monitoring that is required.

Recommendation 6:
Managers should ensure that all CRAFT risk assessment forms are regularly reviewed and audited, and that the service works towards this being used as a multi professional tool.

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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