**Mental Welfare Commission for Scotland**

**Report on announced visit to:**
The State Hospital, Arran and Iona Hubs, 110 Lampits Road, Carstairs, Lanark, ML11 8RP

**Date of visit:** 12 November 2024

## Where we visited

The State Hospital is the national high-secure forensic hospital for individuals from Scotland and Northern Ireland. All individuals in the hospital are under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act); they are highly restricted in relation to freedoms that would normally be expected by individuals in other hospital or community settings.

The Commission visits the State Hospital at a minimum of once per year to give individuals, their relatives, and staff an opportunity to speak with us. The hospital comprises of four units (hubs), with either two or three wards in each.

Since our last visit, the hubs remained broadly unchanged with the only notable change being that Iona 1 has been reopened. On the day of our visit, we met with individuals in Iona 1, 2 and 3, and those in Arran 1, 2 and 3. These hubs comprised of one admission/assessment ward and two treatment and recovery wards. At the time of our visit, there were 101 individuals in the hospital, with 46 individuals in the Arran and Iona Hubs.

We last visited Arran and Iona Hubs in February 2024 during an unannounced visit. We wanted to follow up on the issues identified from the previous visit, and on matters that have been brought to our attention since then. We also wanted to give individuals an opportunity to speak with us regarding their care and treatment, and to ensure that care and treatment was being provided in line with mental health legislation and in a human rights compliant model.

On our last visit, we made two recommendations, that all expired T2 and T3 treatment forms should be stored properly and that treatment plans should be completed for section 47 certificates. The response we received from the service was that steps were being taken to ensure that these matters were addressed.

### Who we met with

We met with and undertook file reviews into the care and treatment of eight individuals. We carried out a further five file reviews into individuals' care and treatment.

Prior to the visit, we held virtual meetings with the director of nursing, the associate nurse director, the social work manager, the advocacy manager, senior charge nurses for the hubs and the Skye Centre manager.

On the day of the visit, we met with the senior charge nurses (SCNs), the allied health professional (AHP) lead and nursing staff on each of the wards we visited.

## Commission visitors

Justin McNicholl, social work officer

Gemma Maguire, social work officer

Lesley Paterson, senior manager (east team)

Anne Craig, social work officer

Denise McLellan, nursing officer

Paul Macquire, nursing officer

Mary Leroy, nursing officer

Kathleen Taylor, engagement and participation team manager

## What people told us and what we found

During our meetings with individuals, we discussed a range of topics that included their legal status, contact with staff, individuals' participation in their care and treatment, activities available to them and their views about the environment. We were also keen to hear from individuals who were subject to enhanced levels of observation and to observe the delivery of care for those subject to restraint procedures.

Many of the individuals that we spoke with were very positive regarding the care they were receiving from staff. We heard comments such as "I feel well treated in hospital", "I have a great relationship with my doctor, I can speak with him once or twice a week" and "I've had a very pleasant stay here". There were positive comments from individuals who reported that they "get on well" with nursing staff and feel that the staff were "considerate and helpful". We also received some comments on the food that was provided, which included, "the food is not the worst but it's not the best either" and "it's decent".

Compared to our last visit we heard no specific issues regarding daytime confinement (DTC). One individual stated, "I hate my doctor, I've repeatedly asked for a change, and I'm being ignored". Whilst another stated, "I want to be out, I shouldn't be here". We followed up on the circumstances for these individuals with the hospital managers and were reassured that steps were being taken to address these concerns and views.

Some of the individuals we spoke to expressed their frustration at only being able to see their named psychiatrists once per month compared to others who were being seen weekly. One stated, "It's like they're scared to meet with me".

Similar to our visits in 2022, 2023 and 2024, many individuals told us that they felt "safe" and "protected" in the hospital compared to their time in other institutions, for example, prison. Some spoke of their anxiety of leaving the hospital and how this could impact upon their future mental health.

Most staff members we spoke with knew the individuals' circumstances well and were able to comment on levels of care, enhanced observations, use of restraint, restrictions, risks and any future plans. This was further evidenced in the interactions we observed and the detailed daily notes we read.

On this occasion, we took the opportunity to meet with the AHP lead appointed to the hospital, to discuss the service being provided by their team. The meeting provided an opportunity to obtain a better understanding of the specific remit of the multiple professionals who work in the AHP team and cover the four hubs of the hospital.

The team comprises of staff that included art therapists, music therapists, occupational therapists, dietitians, physiotherapists, and speech and language therapists. The goal of the AHP team was to ensure ease of access to assessments and therapy for all throughout the hospital.

The Commission found that this team positively impacts on the individuals we met with it, as their work ensures a focus on building self-esteem, the provision of therapeutic activities that delivers goals for the individuals open to the AHP service and has helped to re-establish a sense of empowerment for those who were most unwell. Although the AHP service was the smallest clinical team in the hospital, we felt it delivered a significant and valuable service that promoted and focused on individual empowerment and recovery.

The AHP lead spoke of the focus on participation, maximising engagement and supporting individuals as they progressed through the transitions of assessment, treatment and recovery. We heard from them of plans to continue to redesign aspects of the service which aimed to deliver positive and consistent access to therapists for individuals in the hospital. We look forward to hearing how this progresses during our future visits to the hospital.

Relatives and carers had been made aware of our visit in advance, either via telephone calls, posters placed in the hospital or through the hospital carers group. On the day of the visit, no relatives or carers wished to speak with us.

## Care, treatment, support, and participation

### Nursing care plans

Nursing care plans are a tool that identify detailed plans of nursing care and intervention; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

We found that individuals in the hospital had care and treatment plans in place to support admission goals, outcomes and identified plans of nursing care. These were stored on the electronic recording system, RIO. Similar to our previous visits, we had no concerns with the quality of the care plans; we found them to be comprehensive, with a clear focus on risks.

We were pleased to note that this continued to be the case. In our review of the care plans, we noted that individuals in the hospital had a wide range of complex mental and physical health needs. We found that individuals had multiple plans to support all aspects of their care and treatment in the hospital. The information in these plans comprehensively detailed the care, treatment and support the individual required, providing a clear understanding to staff as to what nursing intervention was necessary to provide the support required.

We saw very good evidence of care plan reviews in place which covered all aspects of care and treatment plans and provided a summative evaluation of the individual's progress. Most individuals appeared to be aware of their care plans and how they related to the care being delivered.

In the State Hospital there is an expectation that all care plans are reviewed monthly. We found this target was being achieved in Arran and Iona hubs, whereas this was not as evident on our visit to Lewis and Mull hubs in our earlier visit in June of this year.

**Participation**

We found clear evidence that the patient participation group (PPG) was continuing to function well in the hospital. This is a group of individuals, who are representatives for the ward they were based in. The PPG chair is elected by their peers. The group met weekly to consider any issues, concerns, or suggestions they had. The PPG meetings were minuted and allowed all individuals to discuss issues and make suggestions that related to their particular ward. We heard that all wards were represented, except for Arran 2 and Iona 1. There was work being undertaken by staff to ensure this group of individuals had ease of access to the group.

There were also regular community meetings taking place on each ward. We found some wards ensured that copies of minutes and actions from the community meetings and PPG groups were well displayed, whereas others did not. We heard from senior managers that steps would be taken to ensure that these minutes were consistently displayed across the hubs. We found evidence of the 'you said, we did' strategy on display in the hubs which promoted how steps have been taken to improve individuals' experiences across the wards.

The Skye Centre continued to provide a space for those individuals with access out with the hubs to link in with the advocacy service, which supports those who may wish to raise complaints or address matters that have not been dealt with at ward level.

Similar to our last visit, we found ease of access to advocacy and that the PPG was clearly being promoted across the hubs.

We are aware through our work that complaints across hospitals helps to address concerns. At the State Hospital, there is a dedicated complaints officer who acknowledges and seeks to address concerns raised by individuals and their relatives. Since our last visit we continued to be informed of some complaints made to the hospital relating to specific topics. We sought to identify if these complaints had led to changes in practice and improved conditions for the individuals noted. It was positive to note that we did find that clear steps had been taken by the hospital to address many of the issues raised, which was providing an improved quality of life

for those in the wards. The individuals and their relatives who had raised complaints had been supported on occasion by the Commission as well as the advocacy service in the hospital.

**Care records**

Information on individuals' care and treatment continues to be held on the fully integrated electronic system, RIO. We found this to be responsive, easy to navigate, and it allowed all professionals to record their clinical contact in one place. Care records were detailed and comprehensive, with clear and consistent recording of care plans, care plan reviews and daily notes.

The detail in the care records ensured that we could obtain a clear sense of the individuals' presentation, risks and progress.

There was clear and consistent evidence of one-to-one sessions occurring between individuals and their named nurse. The risk assessments in the wards were all undertaken to a high standard which included detailed recording of historical, clinical and risk management-20 (HCR -20) reports, as well as the risk of sexual violence protocol (RSVP) reports, when appropriate, which assisted with the transfer of individuals moving to a lower level of security when deemed appropriate.

**Multidisciplinary team (MDT)**

Arran and Iona Hubs held regular multidisciplinary team (MDT) meetings, which the service referred to as clinical team meetings (CTM). We found these meetings to be well structured, with decisions taken in a timely way, and all recordings detailed clearly and concisely.

Each ward CTM was made up of nursing staff, psychiatrists, social work, occupational therapy, speech and language therapy, physiotherapy, dietetics, psychology, and pharmacy staff. It was clear from the thorough CTM meeting notes that all professionals involved in an individual's care and treatment were invited to attend the meetings and provide comprehensive updates on their involvement. The individual's keyworker met with them both prior to and following the CTM, to ensure their views and requests were discussed.

Similar to our visit to Lewis and Mull Hubs in June 2024, we did not find the names of the members of staff who attended the CTM. We had previously made a recommendation about this as it is important that the names of those who are making important decisions about care and treatment are recorded.

**Recommendation 1:**

Managers should ensure that all clinical team meetings record the name and designation of all in attendance.

Individuals at the State Hospital have their care and progress reviewed using the enhanced care programming approach (CPA), which is a framework used to plan and co-ordinate mental health care and treatment. CPA was used for all individuals in the State Hospital.

Of the records we reviewed, the documentation was detailed, and we found evidence relating to individuals' rights. There was a record of the attendance by social workers, mental health officers and other external professionals. The relatives of individuals had the opportunity to the attend CPA meetings and were provided with an update on the care being delivered. The CPA process ensures that nearest relatives and/or named person views are captured and discussed. We did not hear during this visit from relatives or carers as to whether these arrangements had an impact on them obtaining regular updates.

We saw physical health care needs were being addressed and followed up swiftly and appropriately, and all relevant physical health monitoring was in place. The point of access for individuals requiring urgent health care is through a contracted general practitioner (GP), who visits the hospital twice a week. The GP service provided treatment of minor ailments, which reduced the number of times individuals had to leave the hospital to access secondary care. The hospital continued to employ an advanced nurse practitioner (ANP) who was available across the hospital site to address any minor health issues that patients may face on a daily basis. This role ensured that access to the GP was used appropriately.

## Use of mental health and incapacity legislation

As individuals at the State Hospital are subject to restrictions of high security; all individuals require to be detained either under the Mental Health Act or the Criminal Procedure Act 1995.

The individuals we met with during our visit had a clear understanding of their detained status and their right to appeal. All individuals that we spoke with had advocacy support and legal representation.

All documentation relating to the Mental Health Act, the Criminal Procedure Act, and Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), including certificates around capacity to consent to treatment, were in place and were up to date.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. Where appropriate, consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act, should correspond to the medication that is prescribed. All forms that we reviewed, except for one, were found to be in order. We addressed this on the day of the visit.

## Rights and restrictions

Several of the individuals we reviewed and met with were subject to enhanced levels of observation. Some of these individuals were being nursed in their bedrooms, side rooms or the day rooms of the wards; this way of nursing the group of individuals was put in place to support their safety or that of others.

All the enhanced observation that we witnessed on the day of our visit were being delivered to the required standard, in line with good practice. Compared to our last visit, we did not hear of any issues with individuals facing difficulties in leaving their bedrooms.

Advocacy in the State Hospital was delivered by the Patient Advocacy Service (PAS). Individuals continued to tell us that they found the advocacy service to be responsive and easy to access. We heard from some that they knew their advocacy worker and could access them when needed. We met with the advocacy service and heard that they continued to be well-used to promote the rights of individuals and raise concerns or challenges they faced. We saw from our review of the care records that advocacy attended the ward regularly and supported individuals with tribunals, discharge planning, and CPA meetings.

When we are reviewing an individual's records, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. On this visit we found advance statements were in place, where appropriate and when a decision was taken to override the wishes to the individual, this was fully recorded and the appropriate notifications made.

Bed capacity in the hubs was not an issue on the day of our visit. There does however continue to be a significant pressure on medium and low security forensic beds across Scotland, which has been raised with Scottish Government. As previously reported, the recommendations from the commissioned 'Independent Review into the Delivery of Forensic Mental Health Services in Scotland; what people told us' Independent Forensic Mental Health Review: final report - gov.scot which was published in February 2021, are still under consideration by Scottish Government. The Commission will continue to monitor and contribute to this work.

The exact number of individuals waiting to move to a lower level of security changes regularly. During our visit, there were a number of individuals who were found to be in conditions of excessive security. Due to the wait for a lower level of security, some individuals had appealed to the Supreme Court, which is the appropriate legal route to escalate these matters. The Commission remains concerned that the rights of these individuals to move are not being met, and we will continue to follow up on

individual cases, as appropriate. The Commission has regularly highlighted the significant difficulties with regard to 'flow' across the forensic estate. The situation of individuals in the hospital awaiting moves to lower levels of security remains an issue that continues to be addressed by Scottish Government and the Forensic Network in terms of a capacity review.

The Commission has produced good practice guidance on appeals against excessive security.[1]

Since our last visit the hospital has introduced closed circuit television (CCTV) cameras across all hubs in the State Hospital. These cameras are located in all communal areas of the wards, but not in individual bedrooms unless individuals are being nursed in the modified strong room (MSR). We heard no concerns from individuals regarding the introduction of these measures or the impact this was having on their care. One individual spoke of feeling "safer" as a result of the introduction of CCTV, staff reported "feeling protected" by the cameras and recounted when incidents have occurred the CCTV footage helped support their account of evidence.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. By virtue of the high secure environment, all individuals in the state hospital are automatically specified for safety and security, telephones and correspondence.

The individuals we spoke with were aware of these restrictions and the impact on their admissions. During this visit we discussed with nursing staff their role in relation to specified person restrictions. We were concerned to note that many nursing staff did not understand their responsibilities and how this impacted upon their roles.

**Recommendation 2:**
Managers should ensure training for nursing staff on the application and use of specified persons.

The Commission has produced good practice guidance on specified persons[2].

**Use of restraint**
In the State Hospital, soft restraint kits (SRK) were used to manage those who were deemed to pose a significant risk to themselves, others or both. These take the form of mid, top, knee, and foot belts as well as soft cuffs to manage individual stress and

[1] *Appeals against excessive security good practice guide*: https://www.mwcscot.org.uk/node/1674
[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

distress. Mid belts are attached to the individual's abdomen with wrist cuffs attached to prevent self-harming. Top belts are attached to the shoulders of the individual to prevent them raising their arms. Knee belts are attached to prevent harm to others. On the day of our visit there were two individuals subject to SRKs, who we met with and reviewed how these mechanisms were used.

Individuals who were subject to SRK were subject to enhanced observations throughout the use of these measures. This was to ensure the safety of the individual and to allow for additional monitoring of their physical and mental health. We note that the use of SRK results in individuals feeling significantly restricted and this can result in discomfort and undignified positioning for those subject to these most restrictive of measures.

When we reviewed the records of those subject to SRKs, we did not find the detailed recording which we would expect that is commensurate with this level of restriction. Individual care plans referred to the use of SRKs, but we would have expected to see a separate SRK care plan that specifically recorded a clear treatment goal, detailed interventions and most importantly, an exit strategy which would clearly indicate the criteria required for this to be reached.

It is important that individuals and the clinical team providing care are clear on what has to be achieved for these to be removed. The nature and frequency of reviews and the personnel to be involved should also be clearly documented in these plans.

We heard from our discussion with senior managers and saw from our review of the care records that there were daily reviews taking place that included senior managers and medical staff. However, we were concerned that the medical review appeared to be 'tokenistic' and in most cases it would appear that medical staff performing the review did not have the authority to make a clinical decision or recommendation to senior managers that SRK use could be ceased.

Regardless of how an individual presented, the decision to remove the SRKs would have to be made by the responsible medical officer (RMO) at the weekly CTM. It appeared to us that although medical reviews were happening daily, the requirement for and decision to continue using SRKs was only actually reviewed once a week by the individual's RMO, which we did not consider to be acceptable.

**Recommendation 3:**
Manager must ensure that the decision to apply SRKs is made based on clinical presentation and risk, with the requirement for their continued use reviewed at least once per day and in a meaningful way.

**Recommendation 4:**
Managers must ensure that individuals who are subject to SRKs have detailed nursing care plans relating to restraint which are easily located on Rio and record the thresholds on the removal of these measures.

The Commission has developed *Rights in Mind.*[3] 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.

## Activity and occupation

Most individuals continued to have regular access to a range of recreational and therapeutic activities, particularly through the Skye Centre, which was adjacent to the hubs.

During the visit, we found the hubs to be calm, with staff and most individuals moving throughout the areas for various activities, meetings and grounds access. Many of the individuals presented as relaxed and comfortable with the staff on shift. We spoke to a number of individuals who commented, “there is plenty to do here” and “the staff are great as you can get out an about.”

We were aware that many of the individuals we met in the Iona wards were confined to the ward. This was due to challenges with some individuals gaining, and then maintaining grounds access due to clinical presentation or risk. Some of the individuals in Iona that we met told us, “I hate not getting out to the Skye Centre” and “I can’t go anywhere, they just keep me in here”.

We discussed with managers of the ongoing need to ensure that there is equal access to activities for all those who are confined to the wards. We found one individual who would clearly benefit from an increase in clear and recorded structured activities due to their current status. Managers agreed to address this with staff to increase this provision.

## The physical environment

The physical environment of Arran and Iona Hubs was largely unchanged from previous visits to these hubs. The wards had single en-suite rooms, access to a secure garden area, and areas that supported safe and secure care. In Iona 1, a modified bedroom for one individual had reinforced soft walls, beds and furnishing. These adjustments had mitigated incidents of deliberate self-harm occurring in this space.

We found bedrooms across the wards were personalised and provided a comfortable and relaxing environment for the individuals with whom we met. We

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

also found that some individuals were being nursed across two bedrooms as a means to reduce disruption when they were well enough to return to their bedrooms. The hospital continues to have extensive grounds with walking trails; it remains a smoke-free environment. CCTV was in operation in the grounds of the hospital.

During our last visit, we received feedback from several individuals who had transferred to the State Hospital from prison. Many of these individuals would normally have had regular access to a television in their prison cells prior to moving into the hospital. During our last visit we highlighted that the State Hospital did not provide televisions for individuals. It was positive to note during this visit that there was a TV leasing scheme in place to allow those who did not have the funds to purchase a television, the opportunity to have access to one as a temporary arrangement.

## Any other comments

We found clear evidence that the managers of the hospital were regularly reviewing individuals and their relatives' journey through the hospital to ensure that they were supplied with clear and consistence signposting and access to information to ease any worries and/or concerns they had.

This process was being undertaken to ensure there was a carers strategy for the hospital which linked with the forensic network's aim to have a carers toolkit that assists relatives of those who find themselves in the forensic estate.

We look forward to seeing how this will impact upon those in the hospital during our next visits.

## Summary of recommendations

**Recommendation 1:**
Managers should ensure that all clinical team meetings record the name and designation of all in attendance.

**Recommendation 2:**
Managers should ensure training for nursing staff on the application and use of specified persons.

**Recommendation 3:**
Manager must ensure that the decision to apply SRKs is made based on clinical presentation and risk, with the requirement for their continued use reviewed at least once per day and in a meaningful way.

**Recommendation 4:**
Managers must ensure that individuals who are subject to SRKs have detailed nursing care plans relating to restraint which are easily located on Rio and record the thresholds on the removal of these measures.

## 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 Healthcare Improvement Scotland.

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

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