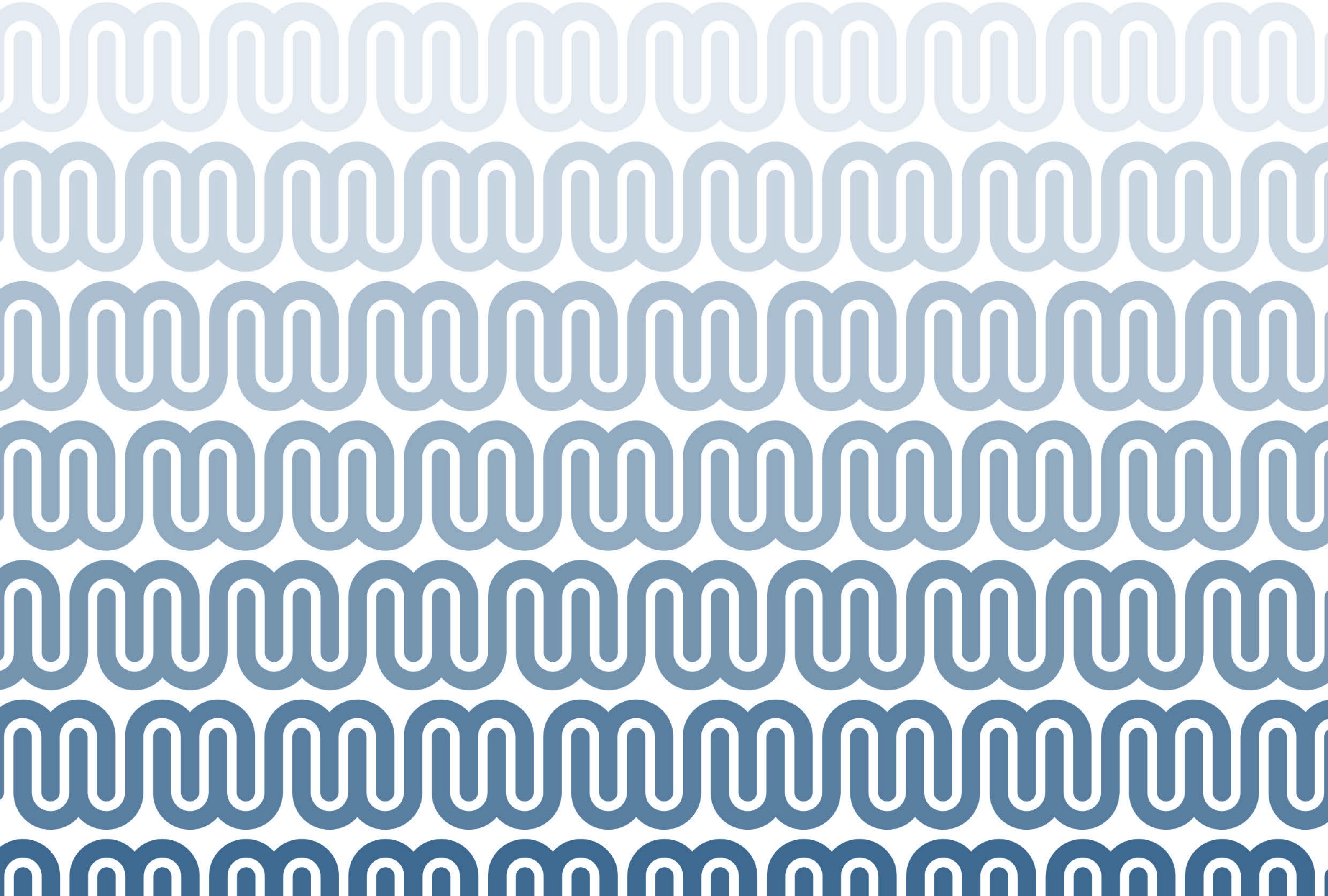
mental welfare
commission for scotland

Hospital is not home

The circumstances of people with learning disability and complex needs who have been in hospital for 10 years or more

---

January 2025



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Contents

Introduction

In order to support the Scottish Government to improve their monitoring of people with learning disabilities and complex care needs who are in hospital, in out-of-area placements and whose current support arrangements are at risk of breaking down, Public Health Scotland (PHS) published a statistical report, *Insights into Learning Disabilities and Complex Needs-Statistics for Scotland*,[1] in December 2023. The PHS data identified, amongst other things, that 30 people with a learning disability had remained in either a learning disability or a mental health hospital for more than 10 years.

As a consequence of the information provided within the PHS report, the Scottish Government asked the Mental Welfare Commission for Scotland (the Commission) to review the care and treatment of the 30 people referred to and to confirm whether all appropriate safeguards were in place.

This report sets out the Commission's findings in relation to the 30 people identified within the PHS report in addition to a further 25 people in long term hospital placements identified by health and social care partnerships (HSCPs).

---

[1] Insights into Learning Disabilities and Complex Needs: Statistics for Scotland

Background

It is well documented that people who remain in long-term hospital placements are adversely impacted, including the loss of independent living skills which often results in the person’s inability to manage or cope with day to day living outside of an institutionalised setting.[2]

Every person in Scotland has the qualified Article 8 human right to respect for their private and family life, home and correspondence.[3] This right includes “a right to identity and personal development, and the right to establish and develop relationships with other human beings and the outside world”.[4]

The rights of people who remain long term in hospital settings are clearly recognised in the Scottish Government’s 2022 Coming Home Implementation report, where the then Minister stated:

> “it is completely unacceptable that people are spending time in hospitals or other care settings when they are medically fit for discharge. For every day spent unnecessarily in hospital, a person loses part of their connection with their community, their family, and their friends. We are not protecting the rights of people with learning disabilities and complex needs if they remain in hospital when they should be living at home, or in a homely environment with the right support.”[5]

One of the key actions identified in the Coming Home Implementation report was the establishment of a new national register to improve national and local monitoring of those at risk of hospital admission or inappropriate placements. This register, called the Dynamic Support Register[6] (the Register), was launched in May 2023 and was one of the actions set out to ensure that by March 2024, people remain in hospital only for as long as they need assessment and treatment.[7]

The Register is a tool which is intended to support local planning and decision making to improve the visibility of this group of people at local and national levels with a strategic and anticipatory focus.

---

[2] Chow, W.S., Priebe, S. Understanding psychiatric institutionalization: a conceptual review. BMC Psychiatry 13, 169 (2013)

[3] Human Rights Act 1998

[4] R (Razgar) v Secretary of State for the Home Department [2004] 2 AC 368

[5] https://www.gov.scot/news/coming-home-implementation-report/

[6] 4. Dynamic Support Register - Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge - gov.scot

[7] 4. Dynamic Support Register - Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge - gov.scot

The Register applies to adults with a learning disability whose support is funded by a Scottish local authority or health board, who are within one of the following groups:

- Currently admitted to hospital-based assessment and treatment units.
- Living in an unsuitable/inappropriate out-of-area placement.
- At risk of placement breakdown - current living situation is becoming unsustainable.

The 2023 PHS information, including the identification of the 30 people who had been in hospital for ten years or more, was gathered from these local registers in non-identifiable form.

What we did

In order to review the care and treatment of the 30 people referred to above, and to confirm whether all appropriate safeguards were in place, we took the approach outlined below.

Stage 1: Initial data collection, n=55

We wrote to all health and social care partnerships (HSCPs).

We asked for the details of people who were:

- on their dynamic support register
- had been in hospital for over 10 years

Including people who were:

- receiving active treatment
- considered to be ready for discharge ('delayed discharges')

All HSCPs responded.
They told us about 55 people.
The majority of the people had learning disability, as expected.

We also heard about people with mental ill health and people in forensic services who are not included in the dynamic support register.

Not visited, n=37

We chose not to visit people we had already visited:

- in the last 12 months (n=25)
- during the Commission's Out of Area themed visit in 2022 (n=6)
- people who were discharged during the project (n=6)

Stage 2: Pilot study, n=6

We visited six people in three separate services in different parts of Scotland.

We chose to visit people we had not recently visited.

During the pilot study we:

- reviewed care records
- met with the person, their families and carers
- spoke with health and social care teams
- recorded information about the person's diagnosis, legal status, and care and treatment on the Commission's standard individual visit report

We then developed an additional form for the subsequent visits at stage 3 to record information about discharge processes for each person we visited.

Stage 3: Visits n=12

We visited 12 more people.

We completed the Commission's individual visit report and themed visit form for each person.

The information that was gathered about the 18 individuals we met in the pilot and subsequent visits was then reviewed.

Stage 1 results

Total numbers

- Following contact with HSCPs in March 2024, we were told about 55 people who had been in hospital over 10 years.
- We reviewed the documentation held by the Commission for all 55 people.
- 52.7% of this group were aged between 45 and 64 years. 38.2% of this group were in the younger age category but likely to progress to the 45-64 age group given the reported lengths of stay.
- 44 of the 55 individuals (80%) were identified as male.
- Demographic information for the 55 people is compared with that from the pilot and visits part of this work further on in this report.

We expected to only hear about the 30 people with learning disability identified by PHS data in 2023. However, the information we received during the initial data collection phase included more than 30 people with learning disability and other people who had mental health conditions, an additional 25 of whom were relevant to this project. We also heard about people in forensic hospitals who are not included in the PHS reporting. One consultant psychiatrist told us "…it is far from clear why those individuals with forensic needs are not included. Without the forensic cohort being clearly identified, and the barriers to discharge being considered in a systematic way, it is difficult to see how significant progress could be achieved to end years of delayed discharge".

We noted that the number of people with learning disability living in hospital for over 10 years, is growing from subsequent PHS reports. The number of people recorded as being in hospital for over 10 years rose from 30 people in September 2023, to 44 people in December 2023 and 45 people in March 2024.[8]

Location

The majority of the 55 people we were told about were in hospitals on mainland Scotland, but we also heard about a small number of people who were in hospitals out with Scotland.

Length of admission

As we show below, the average length of stay was 18 years and two months in hospital with 10 people recording lengths of stay exceeding 25 years.

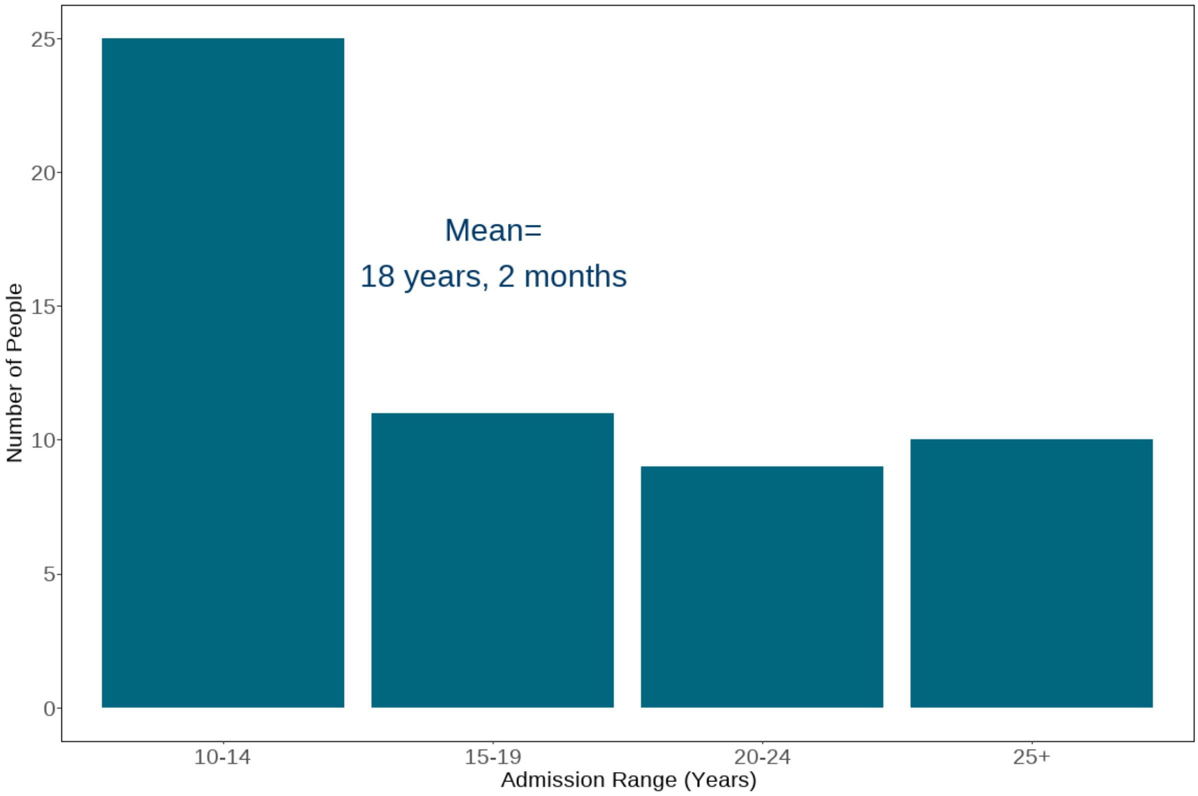
---

[8] Reference Insights into Learning Disabilities and Complex Needs: Statistics for Scotland March 2024

Table 1: Length of admission

Admission Length (years)	Stage 1 n=55	Stage 1 Descriptives
10-14	25 (45.5%)	Mean: 18 yrs 2 months Median: 16 yrs 3 months
15-19	11 (20.0%)	
20-24	9 (16.4%)	
25+	10 (18.2%)	

Graph 1: Length of admission



Mental Health (Care and Treatment) (Scotland) Act 2003 status

Over two thirds of people (39 people, 71%) were subject to compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). 11 people (20%) were subject to the Criminal Procedure (Scotland) Act 1995 (the Criminal Procedure Act). Five people were not subject to the Mental Health Act, of whom some but not all were subject to the Adults with Incapacity (Scotland) Act 2000 (the AWI Act).

Adults with Incapacity (Scotland) Act 2000: welfare guardianship orders

In addition to compulsory treatment under the Mental Health Act, 34 people had a welfare guardian or the application was underway. For 22 people the welfare guardian or applicant was a family member.

Table 2: Guardianship

Guardianship and type		Stage 1 n=55	Stages 2 & 3 n=18
Yes	Private	18 (32.7%)	7 (38.9%)
	Local authority	12 (21.8%)	≤3 (≤16.7%)
Applications underway	Private	4 (7.3%)	≤3 (≤16.7%)
No		21 (38.2%)	6 (33.3%)

Risks

Risk to self and others is one of the criteria for detention under the Mental Health Act. Risk is often highlighted as a barrier to discharge from hospital.

Table 3: Risks

Risks	Stage 1 n=55
Physical aggression	39 (70.9%)
Self-injury	25 (45.5%)
Sexual risks	12 (21.8%)
Property destruction	8 (14.5%)

**Multiple responses possible so will add up to more than n=55*

During our visits, both multidisciplinary teams and family members repeatedly raised the topic of risks. There was a lack of confidence in risks being managed in the community and reference to high staffing ratios required to even begin to consider this. Positive risk taking/risk management strategies were less likely to be actively under consideration to support discharge for those with forensic histories. This was particularly marked for people subject to compulsory orders with restrictions, with one person having committed the index offence nearly 40 years ago.

Mental Welfare Commission visits

The Commission regularly visits mental health and learning disability services and meets with people, their care teams, and families and carers at such times.

The Commission also undertakes themed visits which have included visiting people in out of area services and visits to autistic people in inpatient settings.

We found that over two-thirds of the 55 people highlighted in the Register had been visited by the Commission within the preceding two-year period, with

- 24 individuals (43%) having had a Commission visit within the past one year
- 14 individuals (25%) having had a Commission visit between one-two years ago.

Mental Health Act safeguard (designated medical practitioner)

The Mental Health Act provides that a person can be given medication as treatment for their mental health condition without consent in the first two months of treatment if it is in the person's best interests. After two months of medication, if a person is still not able to consent, or does not agree with the treatment, the doctor must arrange for certain safeguards to be put in place, including a second opinion from an independent doctor known as a designated medical practitioner (DMP); the Commission organises these independent doctor visits.

The DMP's role is to decide whether the treatment plan the person's doctor has suggested is in line with the law and is in the person's best interests. The DMP can only give an opinion on the specific medical treatment. The DMP cannot give a second opinion on diagnosis or general treatment.

We found that over 90% of the 55 people had previously been visited by a DMP.

Stages 2 and 3 results

Person, family, and carer involvement

We aimed to visit 18 people and were able to do so face to face with 10 people during our visits. We reviewed the hospital-based care records of all 18 people and spoke with their care teams. We also spoke with 10 family members. We were unable to contact one family member.

In five cases there were no family members actively involved.

Table 4: Demographics of the individuals identified from the dynamic support register

Category	Levels	Stage 1 n=55	Stages 2 and 3 n=18
Gender	Female	11 (20.0%)	5 (27.8%)
	Male	44 (80.0%)	13 (72.2%)
Age group	25-44	21 (38.2%)	6 (33.3%)
	45-84	34 (61.8%)	12 (66.7%)
Care experienced	Yes	-	≤3 (≤16.7%)
	No	-	9 (50.0%)
	Unknown	55 (100%)	6 (33.3%)
Diagnosis*	Mental illness	30 (54.6%)	8 (44.4%)
	Learning disability	50 (90.9%)	15 (83.3%)
	Acquired brain injury	4 (7.3%)	≤3 (≤16.7%)
	Alcohol related brain damage	≤3 (≤5.5%)	≤3 (≤16.7%)
	Autism spectrum disorder	24 (43.6%)	8 (44.4%)
	Personality disorder	10 (18.2%)	≤3 (≤16.7%)
	Other	23 (41.8%)	≤3 (≤16.7%)
Act*	Mental Health Act	38 (69.1%)	10 (44.4%)
	Criminal Procedure Act	11 (20.0%)	≤3 (≤16.7%)
	AWI Act	30 (54.6%)	8 (44.4%)
	Informal	5 (9.1%)	≤3 (≤16.7%)
	No info or other	≤3 (≤5.5%)	≤3 (≤16.7%)

**Multiple responses possible so will add up to more than n=55 and n=18*
Note: care experienced only available in stages 2 and 3.

23 people (41.8%) were noted to have ‘other’ diagnoses. This category included specific behaviours (such as physical aggression, destructiveness, sexual behaviour and swallowing inedible objects) and the use of restrictive interventions (such as increased observation practice, the use of seclusion or segregation and the use of CCTV).

The Coming Home Report reminds us that:

> “challenging behaviour is understood as a communication from the individual and as product of the environment they live in and of the support they receive. It is not a diagnosis, and although it is associated with certain conditions and syndromes, it is not innate to the individual, but rather an expression of their unmet need.”[9]

Therefore, the Commission would question to what extent some of the behaviours described under the ‘other’ diagnostic category may be as a consequence of the person’s environment and/or prolonged period of hospital admission. Further exploration of this point is beyond the scope of this report.

Communication

We found that 14 people had significant communication conditions due to a combination of their learning disability and additional health conditions, of which nine people had no verbal communication.

Of the people that we met with, four people were able to talk to us about their time in hospital and their future. Advocacy support was available for those able to engage verbally. We did not find evidence of significant attempts made to seek people’s views through non-verbal means, the involvement of speech and language therapists or non-instructed advocacy. Maximum support should be given to people to enable their participation in decision making about their future; however, we did not always find this.

Delayed discharges

Information about whether people were considered to be ready for discharge and how this related to their delayed discharge status over time was hard to find.

Of the 18 people visited, 10 (55.6%) were recorded as delayed discharges.[10]

In nine cases it was not clear how long the person had been in delayed discharge.

Where we had information about when the person was first considered to be a delayed discharge, the dates ranged over a 10-year period from 2013 to 2023. That is, some people had been deemed clinically well enough to leave hospital 10 years previously.

We were only able to ascertain the reason for the delayed discharge (the delayed discharge code) in one case.

Recorded delayed discharges were found in six out of 14 health boards.

---

[9] https://www.gov.scot/publications/coming-home-complex-care-needs-out-area-placements-report-2018/pages/9/

[10] NHS Scotland Delayed Discharge Definitions Manual (NHS National Services, 2016)

Of the eight people who were not considered a delayed discharge, some previously had delayed discharge status. Of the 10 people who were delayed discharges, some had previously been considered a delayed discharge. No further information was available as to whether the change in status related to clinical decision making or administrative processes.

Hospital-based complex care [11]

Where individuals are considered to require hospital-based complex care, the relevant guidance aims to ensure that no one is in hospital for longer than is needed to support them to get well enough to return to an appropriate community setting.

Four of the 18 people (22.2%) we visited were considered as having hospital-based complex care status, some of whom were also delayed discharges.

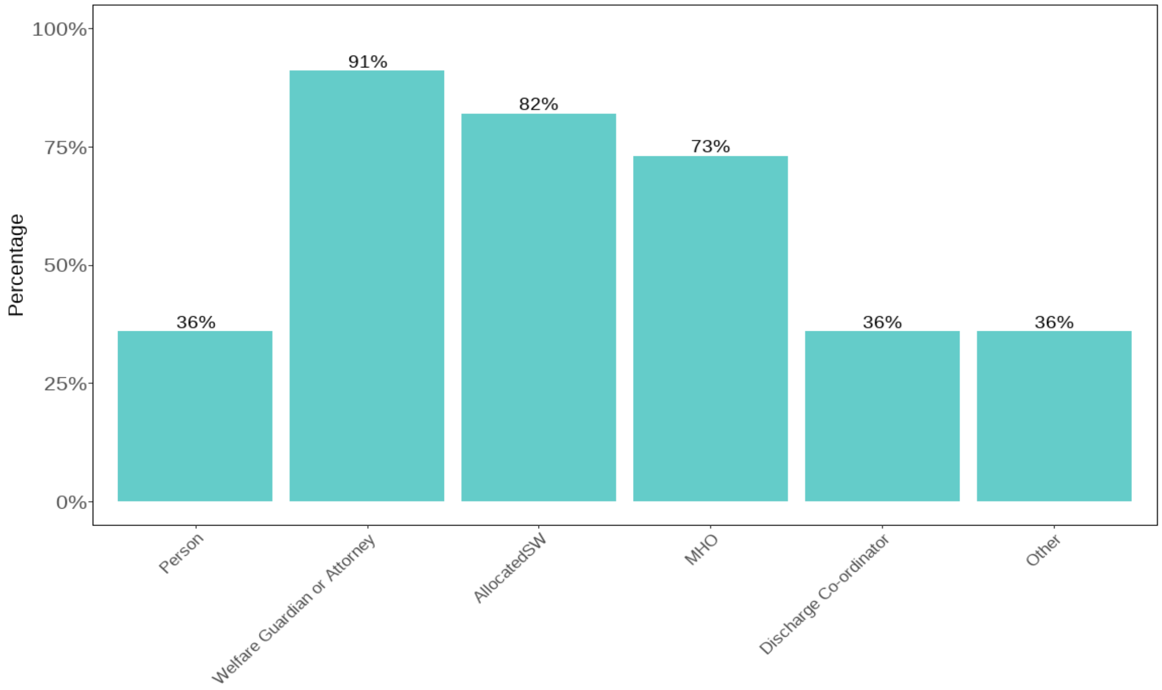
Where we had information about how long the person had hospital-based complex care status this ranged from three to 15 years. We continue to visit to review the care and treatment of these individuals.

Discharge planning

During our visits we reviewed the discharge planning for each individual with regards to who was involved and what had been put in place to date.

Discharge planning was in progress for 11 people.

Graph 2: Involvement in discharge planning



---

[11] DL(2015)11 - Hospital based complex clinical care (scot.nhs.uk)

There was a clearly identified professional responsible for discharge planning for eight individuals, an allocated social worker in three cases, a discharge co-ordinator in three cases, and the responsible medical officer (RMO) in two cases.

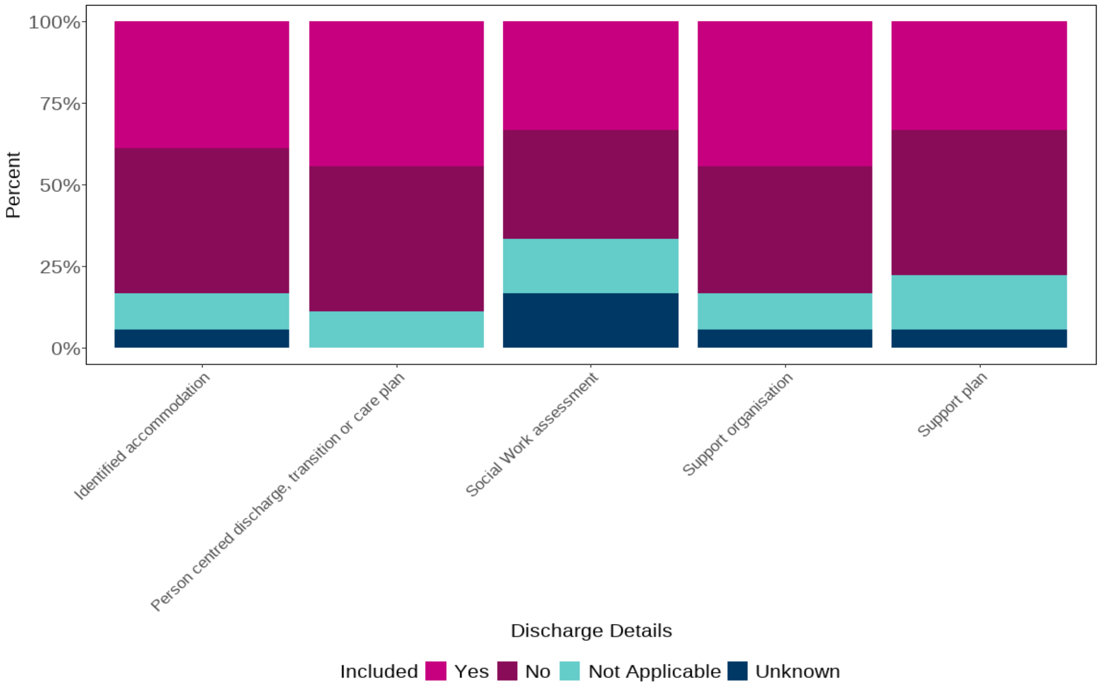
In 18.2% of cases discharge meetings are held weekly, in 45.5% of cases, discharge meetings are monthly and for 36.4% of cases meetings are held quarterly.

All the weekly meetings were led by discharge co-ordinators. We also heard that discharge meeting frequency increased closer to a person's intended discharge date.

In some cases, there were no formal discharge meetings and discharge planning happened during Care Programme Approach[12] (CPA) meetings. CPA meetings are structured meetings to ensure multi-agency collaboration for people with complex health and social care needs through their time in hospital and in the community. The frequency of CPA meetings varied from three to six monthly. In three out of four cases where the RMO was the discharge lead, discharge discussions occurred as part of the quarterly CPA meetings.

Forth Valley was the only health board area where discharge planning was underway for everyone in their care.

Graph 3: Further details of the discharge planning



---

[12] Scottish Office Circular SWSG 16/9 1996

What did we learn?

We learned about the people behind the figures. Michael’s story and John’s and Tina’s stories later in this report, do not relate to individuals we met but are based on the very real experiences and feedback we were given as part of this project.

Michael’s story

Michael has just celebrated his 40th birthday in hospital. He was admitted to hospital 15 years ago.

Michael is autistic and has severe learning disability. Michael enjoys engaging with his care team, he likes to have the same conversations every day and he can quickly become upset when things don’t go as he expects. When he is upset, he can harm himself by banging his head and harm others by hitting and biting them. Michael’s behaviour can sometimes result in him being placed in seclusion for short periods of time.

Michael has been ready for discharge for many years. His Dad is his welfare guardian and said that they were now on to the fifth house that had been looked at and spoke about his disappointment when things had “fallen through, over and over.” He felt that Michael was “institutionalised now” and not enough had been done in the hospital setting to maintain his skills.

Michael’s Dad was worried about the cost of his community care preventing his son from leaving hospital. Or that Michael might have to share with other people when “15 years of living with other people has only increased his distress”. He said that “even now I don’t know if discharge will ever happen for him.”

Discharge planning

We learned that, in the majority of the cases we looked at, all appropriate health and care teams were involved.

In some cases, there had been delays in involvement of social work teams due to staff vacancies or a lack of clarity as to the responsible local authority for people who had been in a hospital setting out of area for many years.

In a few cases, we heard from care teams that people who were out of area in a hospital may be a lower priority in terms of eligibility criteria and access to finite community resources.

We also heard about people not being able to access nearby community services when they were commissioned by a different local authority.

In most cases, funding for community care packages had been approved. In the two cases where this was not the case, identifying community resources appeared to be the main barrier.

Restrictive interventions

We learned that after living in hospital for over 10 years, nearly 78% (n=14) of the 18 people we visited were subject to restrictive interventions. We were concerned to find that the protocols, care plans, and environments were not always fit for purpose, and it was necessary for us to raise concerns in relation to the care and treatment of 13 people.

Table 5: Restrictive interventions

Do any of the follow apply?	Yes	No or unclear
Restrictive interventions in place	14 (77.8%)	4 (22.2%)
Adequate legal authority regarding restrictive interventions	11 (61.1%)	7 (38.9%)
Restrictive interventions required post discharge	13 (72.2%)	5 (27.8%)

John’s story

John is in his 70s. He lives in a rehabilitation ward within a larger psychiatric service. He has been in hospital for many years due to his mental health. John does not have a diagnosis of learning disability. He is not subject to the Mental Health Act, although has been in the past.

John uses a wheelchair due to his increasing physical frailty. John now struggles to talk and there are concerns that his memory is failing.

John can make some of his needs and wishes known, especially when he is unhappy about something. At times when John is particularly noisy and agitated, he can be taken to his room so that he does not disturb other people.

John’s care team consider that John continues to require hospital-based complex care. There was one previous attempt to discharge John to supported accommodation in the community, but this failed due to his levels of agitation and aggression.

John’s son has “peace of mind that he is in a safe environment” and feels stressed when people talk about him moving on from hospital. The care team have not thought about discharge for John in recent years and John does not have a social worker.

When we visited, we asked the care team about the possibility of John being discharged to a more appropriate community setting. We also spoke about the restrictions that John faced day to day living in a locked ward, being unable to move around without help from others and at times being taken to his room.

Following our visit the care team referred John to the local social work team. We will keep in touch with the team to see how things progress for John.

Findings

1. The Commission was asked to request individual case details from Scotland's health and social care partnerships on the 30 cases highlighted by PHS who had been in hospital over 10 years and to examine the cases at an individual level.

   Outcome: We were instead told about 55 individuals who had been in hospital for over 10 years and during our visits noted groups of people who were not on a delayed discharge list, nor the dynamic support register and not subject to any legislative safeguards. They too had been in hospital for many years.

   We found that there is a lack of a consistent approach across Scotland to coding and rationale for placing some people on delayed discharge and dynamic support registers and not others. There was a lack of recorded information, in most cases, as to why some people had been placed on these lists and for how long they had been there. These findings are similar to those reported in our *Out of NHS area placements themed report*, published in September 2023[13].

2. The Commission was also asked to confirm that all safeguards are in place and care and treatment is being provided appropriately within the context of current law and service provision.

   Outcome: Safeguards and legislation in place were considered in relation to all 55 people.

   We found that although funding of community care packages was not said to be a challenge, barriers included the availability of specialist community resources and a strategic approach across health and social care partnerships to address this.

   Living in hospital for over 10 years brought with it its own challenges, a loss of independent living skills, a loss of confidence, added distress living in a group ward situation, frustration, and repeated disappointment when discharge plans fell through, a paternalistic approach borne out of genuine concern and perhaps lack of understanding of how community arrangements can and do manage risk and positive risk taking.

   However, we welcomed where active discharge planning was being progressed, represented by Tina's story, and we continue to follow up where we noted concerns that this was not happening, as expected, for others.

---

[13] Out of NHS area themed report: https://www.mwcscot.org.uk/node/2059

Tina’s story

Tina is in her mid-50s. Tina has lived in NHS settings since she left school at the age of 19 years. Tina has severe learning disability and is non-verbal in her communication. Tina really enjoys engaging with people and often wants to hold the hands of people who are with her.

Tina has struggled with her mental health all her life and she has periods of time every day where she becomes really upset.

Tina has epilepsy. When she has a seizure, she needs urgent medication. Sometimes an ambulance is called.

Tina’s family are her welfare guardians. They go to her meetings and have good relationships with the care team.

Tina’s relative said that she was “surprised at the suggestion that Tina would leave hospital” as the “care in hospital has been brilliant.” Another relative said that “there was no reason for her to move out of hospital. It is the best place for her to be.” They call the care team “Tina’s other family.”

At the same time Tina’s family recognised the challenges that Tina has faced living in a noisy ward and spoke about times when other people had hurt Tina.

A flat has now been found for Tina, next door to someone she knows. They can share a care team which means there will be extra carers available for Tina when she needs them.

A specialist care provider has been working with the hospital care team, taking time to get to know Tina. They have done extra training so they can look after Tina. The community learning disability team has helped with this.

Initially there were monthly planning meetings led by the local discharge co-ordinator and attended by the hospital care team, Tina’s family, her allocated social worker, the community care provider, and members of the community learning disability team. As Tina’s discharge gets closer the meetings are now happening every week.

Tina’s family were nervous about Tina leaving hospital. When the meetings started the social work team and the care provider “knew only the most basic information about Tina. It has taken a lot of work for them to understand her complex needs.”

Tina’s sister said she was “looking on the bright side” and hoped that Tina would have more opportunities when she was in her new home as she spent a lot of time in hospital just sitting in her room with the television on.

Conclusion

We considered the circumstances of 55 people who were identified as having been in a learning disability or mental health hospital for over 10 years.

We found that people are staying in hospital for too long; on average 18 years and 2 months. Despite previous policies (including The Keys to Life,[14] Coming Home 2018 Report,[15] and the Coming Home Implementation Report[16]) the right to live independently and to be included in the community is not being realised for a small but significant group of people.

There is no doubt that the PHS data shines a light on people with learning disabilities and complex care needs in Scotland. Whilst the Register brings this group into further sharp focus, there is inconsistent interpretation across Scotland as to who should or should not be on the Register. This is not dissimilar to the delayed discharge lists and codes which were very difficult to locate and analyse for this group of 55 people.

There was evidence of some good, collaborative practice in place committed to inclusive and active discharge planning. At the same time there was reluctance and concern regarding the capacity of community care resources to safeguard the person and meet their needs. After so many years in institutionalised care and some believing "there is no need to leave hospital," progressing alternatives to hospital is a challenge in some areas.

What we had not fully anticipated was that there are other groups of patients in the same services who have not made it onto any list. We were told these patients would not be leaving hospital and that hospital was their home. This was a concern and highlighted the need for us to review our Commission visiting programme to ensure that those people who are not on any lists and are not subject to any legal safeguards are not hidden nor forgotten.

What next?

The relatively narrow focus of our work meant that we did not examine how the Dynamic Support Register is being implemented in different areas. Nor did we explicitly review the local strategic planning and commissioning of community services to meet the needs of other groups of individuals to prevent them having lengthy hospital admissions and becoming the next group of people in hospital over 10 years. Such groups include children and young people, people at risk of

---

[14] The keys to life: Improving quality of life for people with learning disabilities

[15] Coming Home: A Report on Out-of-Area Placements and Delayed Discharge for People with Learning Disabilities and Complex Needs

[16] Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge - gov.scot

placement breakdown in the community, people in forensic settings, and people who have been in hospital less than ten years.

We also did not explore how the information held in local registers is shared at regional and national levels to support a collaborative strategic approach to commissioning community resources for individuals who require highly specialist care. However, it is clear, as stated in our *Out of NHS area placements report*, that there is a significant gap in national strategic oversight and the lack of a national body to drive forward change.

The framework to support the Register originally included a peer support network. We would argue that it is critically important to bring key partners together, as proposed, to share challenges, share learning and to develop creative solutions to support people to leave hospital and to flourish. The clinical teams we met with had not heard of this network. This may be because it is still in its infancy having first met towards the end of 2024. Shared commitment to the peer support network and its ongoing development has the potential to ensure a shift away from hospital care as the default so we look forward to its impact.

This small project answered the questions posed by the Scottish Government at the outset but has raised many more. We have found that the implementation of the Dynamic Support Register has yet to ensure that “people are only in hospital for as long as they require assessment and treatment” and that further work must be done to address why the intentions of this tool have yet to be realised for people including those with forensic needs.

As shown in Tina’s story, everyone has a right to live at home, not in a hospital.

Acknowledgements

We wish to thank Dr Matthew Beattie, for his significant contribution to this project during his psychiatry higher trainee placement at the Commission.

We would also like to thank all the people who met with us and contributed their time, experiences, and views.

npm
national
preventive
mechanism

If you have any comments or feedback on this publication, please contact us:

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