

Mental Welfare Commission for Scotland

Report on announced visit to:

The State Hospital, Interim High Secure Female Service, 110
Lampits Road, Carstairs, Lanark, ML11 8RP

Date of visit: 22 January 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

In 2009 the female high secure service at the State Hospital was closed; this was due to proposals and plans for a reconfiguration of secure services for women who required the range of high, medium and low secure care. Since the closure, there have been a small number of women who have required high secure care and who have been referred and transferred to Rampton Hospital in Nottinghamshire, England.

The closure of the service for women at the State Hospital created a challenge with access to appropriate services for those individuals who are on remand or who require levels of enhanced care in Scotland.

There are a small number of women who remain in Rampton Hospital, receiving high secure care and treatment. In 2024 and in response to recommendation three of the published independent review into the delivery of forensic mental health services, the Scottish Government committed to delivering high secure care and treatment for women in Scotland.

A new interim service model for female high secure patients opened at the State Hospital in July 2025 with the first admission taking place in August 2025.

There are further plans to develop an outreach service model based at the State Hospital which will assist medium secure services and the Scottish Prison Service (SPS) to support individuals as they move through the different levels of secure care.

The aim of the current service is to focus on safety, stabilisation and the development of positive therapeutic relationships, with an emphasis on staff delivering trauma-informed, evidence-based, collaborative and individualised care while managing any risks posed.

Currently, there are ongoing plans to build a purpose built hub on the hospital premises, with construction expected to start in 2032 if funding becomes available. This would host a new national High Secure Service for Women who are on remand, post-conviction and those who are subject to civil orders.

The interim service which we visited is based in Mull 3 ward. This is located in the Mull hub with Mull 1 and 2 accommodating male patients. Mull 3 is a distinctively separate service which could accommodate up to six females. On the day of the visit there were vacant beds in the ward.

As this was our first visit to Mull 3, the purpose of this visit was to find out how care and treatment was being delivered to women who have a range and diversity of differing clinical needs and who have been assessed and required to need this level of care.

We wanted to meet with the women, where possible and, where appropriate, speak to their relatives; we also reviewed the health records of those interviewed.

We were given an overview of the service and the various steps being taken to improve what is available for individuals.

Who we met with

Prior to the visit, we were able to have an online discussion with the associate director of nursing, the lead nurse, the senior charge nurse and one of the consultant psychiatrists for an overview of the care offered.

During the visit, we met with the senior charge nurse, charge nurse, the consultant clinical psychologist, the medical director and various members of the nursing team.

We met with three people and reviewed the care notes of these three individuals. We also spoke with two relatives.

Commission visitors

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

Claire Lamza, executive director (nursing)

Inez Kohls, student nurse

What people told us and what we found

For most individuals in Mull 3 we were unable to have detailed conversations due to the complexity of their illness and associated needs. We introduced ourselves and were able to have brief interactions with some.

We observed individuals engaging and responding to staff throughout the day. Some were on continuous interventions, and we saw staff supporting and responding to their needs in a calm and considerate manner.

Individuals that we met spoke positively about the care they were receiving from the staff group. They stated, "they are great", "they are a good team" and "they are nice". One of the individuals we met with described the support they received from advocacy advising us that "she has been very good". One individual advised that they felt that they were able to exercise their legal rights and had support from a solicitor.

We received positive feedback regarding the doctors' input to the ward. One individual spoke of meeting with their doctor every second week and described them as "nice".

We heard about and observed the various activities that were available in the ward. Two individuals in the ward had escorted time off the ward, with one describing the opportunities outside of the ward as "good". One individual told us that they had a good relationship with their social worker and psychologist. The input from psychology staff was noted to be "helpful" and we heard "they understand illness and how it affects you".

Feedback from relatives we spoke with was generally positive. All indicated that they had regular access to their relatives and all visits were accommodated either in the ward or at the visitors' centre which was described as "nice". Relatives told us that they were made to feel welcome by staff and that they felt listened to. They described that since the service opened the staff had gotten to know them on a personal level which helped to ease any worries they had.

Relatives praised the care being provided and spoke of nursing staff being "caring", "calm", "pleasant" "very good" and "helpful". We heard that since the service has opened, questionnaires have been sent to relatives to gather their views on how they have been communicated with.

One relative told us that they had never been invited to any meetings or had not spoken with a psychiatrist; they were signposted to raise this issue directly with the team. Another relative indicated that they had attended a care programme approach (CPA) meeting and were clear on future care planning for their relative. One relative raised a concern regarding the visiting times to the hospital and described how it was not ideal due to taking place midafternoon and having to travel from a distance.

No relatives raised any concerns regarding the environment, activities or care delivered.

We heard no concerns regarding discharge planning from individuals, relatives or staff. We heard that individuals had access to finances which they could spend as required in the hospital.

We heard that all pre-admission assessments were carried out in prisons or hospitals from which the individuals were transferred. This approach should promote continuity when there is a transfer of care and create opportunities for the service to plan care and treatment in advance of any individual's move to the ward. Pre-admission assessments were undertaken by the designated psychiatrist and senior charge nurse from the ward, who both had experience in working across the wider forensic mental health estate.

We discussed with staff and managers about the need for the new service to have a clear focus, from an early point during the admission stage, on discharge planning for those who are admitted. We raised this as we are mindful that care and treatment in the high secure setting, which is the most restrictive environment can result in lengthy hospital stays; this is particular issue due to the lack of gender-specific female secure care services. We stressed that it would be helpful to have clear pathways developed to avoid any unnecessary delays between high, medium and low secure services.

We met with staff who clearly demonstrated their care, compassion and positivity about the opening of this new service. There were core staff available on the day of our visit who explained that they had applied to work in the ward and were excited about how the service could develop and grow in the coming months and years. We were pleased to hear about the initial investment in supporting training and education for staff who work with women and the use of a trauma informed, gender-sensitive model of care. This was evident to the Commission visitors on the day, as was the strong and positive leadership from senior management in the hospital and in the unit.

Staff that we spoke with acknowledged the complexity of the group of individuals, due to the differing diagnoses and clinical needs of the women; we heard about some of the challenges the staff team had initially faced in ensuring that individuals in the ward were provided with equitable access to activities in the hospital. Staff commented positively about the hospital senior management team for the support provided to them. This has ensured the service to develop and meet the needs of the women in a flexible way.

We heard from members of the core staff team about the impact of enhanced observations. For some of the women in the unit, they required two or three

additional staff to provide support. We noted that staff from across the hospital would be directed to work in the service for a variety of reasons. This, coupled with several vacancies in Band 5 nurses across the hospital site, has placed additional pressure on the service. We heard from managers that steps have been taken in relation to recruitment with the aim to address current vacancies and meet the demands across the hospital site.

Advocacy and staff advised us about the ongoing staffing pressures faced by the hospital. This was a particular problem during the month of December which resulted in a significant increased usage of daytime confinement (DTC) to manage staffing gaps. We have previously reported on staffing pressures facing the hospital in our local visit reports for 2023 and 2024. From reviewing the individuals in Mull 3 the staffing gaps appear to be having some impact. We heard from one individual who has been subject to DTC as they are not subject to enhanced levels of observations; the individual raised no concerns about being made subject to DTC.

We observed those subject to enhanced levels of care and we could see the direct impact that inconsistent staffing was having on their levels of engagement and trust towards staff that they did not know. When we next visit the service, we hope to see how these matters have been addressed.

We were told that there had been a few challenges that the ward faced when it first opened. This included the lack of a browsing tablet for individuals. These tablets are intended to allow the ordering of items across the hospital site. The ward initially was the only ward without a tablet due to technological infrastructure issues. Fortunately, steps have been taken to address this.

We heard that there remains a challenge surrounding the availability of female clothing for sale in the hospital shop. Advocacy have raised this concern, and we were assured that steps are being taken to address this to ensure options is available for the women in the unit. On the day, we noted that the option of having access to select clothing had a positive impact on one of the women and this helped staff to engage with her.

When the ward opened, there was no working video conferencing equipment which would have allowed individuals and staff to actively participate in meetings. We were pleased to hear of the steps taken to overcome this in recent weeks.

Initially, when the service was due to open, it intended to only accept pre-trial individuals from the courts or prisons. Subsequently this has changed and now the service accepts individuals who are pre-trial but also those who do not necessarily have a forensic background but require a level of restrictions and specialist care that is more regularly found in a high secure setting.

We heard some frustrations surrounding the restrictions, including the lack of access to vapes, the level of noise in the ward when people become distressed and some complaints about the food options available. One individual was signposted to the patient participation group (PPG) to highlight their food preferences. This group meets regularly and helps to influence menu options available in the hospital.

During the visit we met with the head of psychology for the hospital. The psychology team have a specific remit for the female service as it develops and expands. The psychology team is made up of 33 members of staff that includes forensic clinical psychologists, principal clinical psychologists, clinical psychologists, assistant psychologists, nurse therapists, health psychologist and specialist nurse practitioners. We heard from staff about the positive impact of reflective sessions being delivered by the psychology team to the core staffing group that has aided with debriefs and in addressing themes that relate to practice. We heard that nearly all females in the unit were receiving regular input from psychology.

Care, treatment, support, and participation

Care plans are a tool that set out detailed interventions and how they will be delivered; 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 unit had care and treatment plans in place to support admission goals, outcomes and identified the plan of care. These were stored on the electronic recording system, RIO.

We had no concerns with the quality of the care plans; we found them to be comprehensive, with a clear focus on risks. In the State Hospital there is an expectation that all care plans are reviewed monthly; we found this target was being achieved. On speaking to individuals, we found that due to the symptoms and the effect of their illness, we were unable to ascertain whether they had seen or been consulted on their care plans. We will review this when we next visit the ward to identify if there is an understanding from individuals on the impact of these plans.

From reviewing the care records, we found detailed consistent recording of daily entries by nursing and medical staff that were meaningful, relevant, and provided an update on the progress of the individual's care and treatment. We saw that nursing and medical staff continued to gather people's views about their care and treatment wherever possible and these were then recorded in their care records. Individuals' input was also evident in the regular one-to-one discussions that they had with nursing staff.

On the day of our visit, we saw individuals and staff engaging in activities on a one-on-one basis. Staff who were part of the team based at the Skye centre had regular sessions in Mull 3 and we could see clear evidence of the benefit that this input had

in supporting the individuals, where a dedicated person-centred approach was being delivered by the staff.

Due to this being a new service, we wished to review the level of detail in the risk assessments and risk management plans in place. We found these to be completed sufficiently and we saw that those documents had been updated in line with the hospital policies.

While meeting with the lead psychologist for the hospital, we were informed that there are plans to adopt Dialectical Behaviour Therapy (DBT) for the service. DBT is an intensive psychological therapy for people who experience significant dysregulation of their emotions. It can help individuals to understand and accept their responses while learning the required skills needed to manage their own emotions. The use of DBT has been adopted in medium and low secure services in Scotland and in the women's service in Rampton Hospital. The aim of training staff in Mull 3 in DBT is to ensure a consistent approach that individuals will manage and understand as they progress through different levels of security. When consistently applied, DBT can achieve successful outcomes for individuals. We look forward to seeing how this has progressed when we next visit the ward.

We were pleased to see that trauma informed practice was integral to staff's clinical practice; due to the history and life events of this patient population, for the work that is required to build trust and avoid retraumatising those individuals with complex histories, staff must have the required training and skills to support women in this setting.

Some staff had specific training and experience in working with individuals with learning disabilities. We were pleased to see that there were supports in place to adopt the ladder approach which is designed to support adults, teens and children with sensory integration difficulties. This helps to create the right space, to do the right thing, to be in the right place and at the right time. If applied appropriately, it can help to de-escalate situations and can quickly improve circumstances for individuals.

Care records

Information on individuals' care and treatment was 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. The Hospital Electronic Prescribing Medicines Administration (HePMA) system was used the ward. From the records we accessed, recordings on this were found to be clear and accurate.

We were told that the hospital carries out annual health checks of all the individuals. We found detailed recordings in relation to physical healthcare monitoring and

intervention. The importance of physical healthcare was evident through the assessments, care planning, and daily observations.

Multidisciplinary team (MDT)

The ward held regular multidisciplinary team (MDT) meetings, which the service refers to as clinical team meetings (CTM). We found these meetings to be well structured, with decisions taken in a timely way, with all recordings detailed clearly and concisely. The CTM includes nursing staff, psychiatrists, social work, occupational therapy, speech and language therapy, physiotherapy, dietetics, psychology, and pharmacy staff. From the meeting notes on the RIO system, it was recorded who attended the CTM. We noted that all new admissions to the ward had pre-admission assessments conducted by the CTM, where they were screened for risks associated with addiction, epilepsy and mental health, including suicidality and deliberate self-harm (DSH).

The CTM notes highlighted the commitment to adopting a recovery-based approach. During our previous visits to the hospital, we recommended that individuals should attend CTM discussions, so that they could contribute to the decisions about their ongoing care and treatment. The hospital position remains that this arrangement cannot be facilitated. Despite this, we heard positive suggestions regarding one of the psychiatrists aiming to do all they could to allow individuals to attend the CTM if well enough to do so. We look forward to seeing if this progress in the future.

We found evidence of relative or carer involvement since the service opened; this had been encouraged by the staff. Managers advised us that they ensure relatives are provided with the opportunity to express their views at care programme approach (CPA) meetings, with most of these meetings taking place on a six-monthly basis. We did hear from relatives that these arrangements did not have an impact on them obtaining regular updates. No relatives or carers routinely attend the CTM throughout the hospital.

We heard that there continued to be good links between the social work department based in the hospital and with regional health and social care partnerships.

Use of mental health and incapacity legislation

In line with the other wards, all individuals at the State Hospital are subject to restrictions of high security. Individuals require to be detained either under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act).

Due to how unwell many of the individuals were, there was limited understanding of their detained status. 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 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 read were found to be in order. The rest of the forms that we reviewed were completed by the responsible medical officer (RMO) to record non-consent and were up to date.

Any individual who receives treatment under the Mental Health Act or Criminal Procedure Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found copies of this on the individual's record. Where individuals were subject to a guardianship order under the AWI Act, staff had a clear understanding of these orders.

Rights and restrictions

Due to its high secure status, The State Hospital operates airport-style security checks for all visitors with all visitors to the hubs being escorted on the grounds of hospital. All wards operate a locked door policy which is commensurate with the level of risk identified with the individual group.

All movement in the wards is closely monitored and agreed upon by the nursing team, the lead psychiatrist and the hospital management. Due to these levels of restrictions, there are extensive policies and procedures in place which authorise these measures along with the use of closed-circuit television (CCTV). CCTV is located in all communal areas of the wards but not in individual bedrooms unless individuals are being nursed in any modified strong room (MSR).

When we visit other hospitals across Scotland where the use of CCTV cameras is in place, we have received feedback from individuals and staff about the benefit of these cameras to address any allegations of harm and that they have provided a quick response in investigating incidents, enabling protection of all. We received no concerns from people or staff on the use of CCTV.

Some of the individuals we met with were subject to enhanced levels of observation through continuous intervention. Some of these individuals were being nursed separately for the safety of themselves or others. Observations that we witnessed on the day of our visit were being delivered in line with the established guidance. It was noted that for those individuals who were subject to an enhanced level of observations, they were nursed in side rooms. Some of these individuals would

return to their bedrooms at night-time while others would remain in the side room and slept there due to their level of distress and care required.

Some individuals in the ward are subject to levels of soft mechanical restraint (SMR). In the hospital this is called the soft restraint kit (SRK). On the day of the visit, we found the use of cuffs in place to prevent incidents of self-harm and harm to others. The Commission is required to be informed of all use of SMR, and we reminded the service to maintain these notifications for the ward.

There were no individuals subject to seclusion on the day of the visit, and the ward staff spoke of the steps they had taken to ensure this practice is considered as the last resort when managing those who presented with extreme cases of distress, self-harm or violence towards themselves or others. We have requested that the Commission be kept informed of all occasions when seclusion has been used in the hospital.

Advocacy in the State Hospital is delivered by the Patient Advocacy Service (PAS). Individuals reported to us that they found the advocacy service to be helpful, responsive and personalised to their circumstances. We met with the advocacy service and heard that it continues to be a well-used, valued service.

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 274 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.

Given that the unit has only been open to admission since August 2025, there were no individuals that we reviewed who required a lower level of security and no appeals against excessive security were in place.

The Commission has developed [*Rights in Mind*](#).¹ 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

Since the ward has opened, a few individuals are restricted to the hub due to their levels of distress. To ensure that these individuals have regular access to a range of recreational and therapeutic activities there is specific input from ward-based staff as well as occupational therapists (OT); where possible, the individuals had a personalised activity programme.

¹ *Rights in Mind*: <https://www.mwscot.org.uk/law-and-rights/rights-mind>

We found one individual who had clearly benefitted from an increase in clear and recorded structured activities due to their status. Managers advised that there are plans in place to increase this further depending on the individual's level of distress.

The staff have designed a sensory room which has a light feature, sensory chair, sensory matts, projector and access to relaxing music. This room, along with ward-based activities, have provided positive outlets for individuals. On the day of the visit, we observed individuals participating in art and craft activities which they appear to enjoy.

We were keen to explore how the ward ensured that women in the hospital had parity of access to activities, as was provided for the male population. We noted that those who were assessed as able to visit the Skye Centre, which was adjacent to the hubs, were supported to do so; the risk assessment process extended to activities where both female and male patients could attend at the same time. This included attending religious services and the art service. We were pleased to hear and see that individuals were able to access the hospital grounds when accompanied by staff and also to see the success of this achievement as for some who had been significantly restricted prior to their move to Mull 3.

During the visit, we found the hubs to be calm. We found a core group of staff who knew the individual patients well and were able to describe activities that were available and the success of these activities since the service opened.

We were shown the large garden area which can be accessed by individuals when allowed to do so. The garden, unlike the other wards, has been fenced off to ensure privacy for the female group. We heard of various plans to redesign the garden area, including painting the fence, the building of a new path and new grass and flowerbeds being installed to improve the therapeutic benefits of this area.

The physical environment

The ward environment was clean, modern, light and airy. The ward has a nurses' station, a dining room, kitchen, day room area, offices and side rooms; there are single en-suite rooms, access to a secure garden area, and areas that supported safe and secure care. We found most bedrooms were personalised and provided a comfortable and relaxing environment for the individuals with whom we met.

Some individuals were being nursed between their bedrooms and side rooms 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.

We were pleased to find that our poster notifying people of our visit was displayed in the ward. During this visit we found the ward to be clean and tidy. The ward had been freshly painted with décor which was noted to be calm and relaxing.

From the individuals that we met, they raised no concerns about the physical environment of the ward. It was acknowledged that as the ward was early in its development, occasionally it had been necessary to address issues reported by staff members and individuals.

There were some concerns expressed in relation to the layout of the ward with not enough space to nurse more individuals if patient number were to be increased.

Summary of recommendations

For this visit, the Commission makes no recommendations.

Service response to recommendations

Although no recommendations were made, we would 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 an 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.

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