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: 28 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

The State Hospital is the national high-secure forensic hospital for individuals from Scotland and Northern Ireland. All individuals in the hospital are subject to 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 closed and now is being used as a staff training space.

On the day of our visit, we met with individuals in Iona 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 111 individuals in the hospital, with 50 individuals in the Arran and Iona Hubs.

We last visited Arran and Iona Hubs in November 2024 during an announced 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 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. We also wanted to speak with relatives of individuals, to gather their reviews on the care being provided.

On our last visit, we made four recommendations. These were that all clinical team meetings should note who was in attendance, that training was made available for staff on the use of specified persons, that use of soft restraint kits (SRKs) were applied based on clinical presentation and that this was reviewed on a daily basis and there was clear care planning for the removal of these restrictive measures.

Who we met with

We met with 11 individuals and reviewed the care of 16 people. We spoke to one relative.

On the day of the visit, we spoke with the chief executive, senior charge nurses, psychology and occupational therapy members of staff.

Prior to the visit, we held virtual meetings with, the associate nurse director, the lead nurse and the senior charge nurses for the hubs.

Commission visitors

Justin McNicholl, social work officer

Gemma Maguire, social work officer

Lesley Paterson, senior manager (east team)

Anne Craig, social work officer

Susan Hynes, nursing officer

Mary Hattie, nursing officer

Gordon McNelis, nursing officer

What people told us and what we found

Feedback from individuals about staff was generally positive, where individuals described staff as “helpful”, “great”, “really nice”, “respectful” and “approachable”.

One individual praised the staff for managing a conflict that they had with a member of staff which they described as being dealt with “quickly”, which resolved their anxieties. We heard from several individuals regarding the importance of “getting on well” with various members of staff which was linked with staff members caring and considerate approaches towards them.

All the individuals that were well enough to speak with us indicated that they had regular one-to-one meetings with their named nurse. Individuals noted the importance of these meetings and having a shared, trusting relationship. A few individuals were able to tell us about involvement in their care and treatment. They told us how they felt listened to, as they were able to meet with their doctor regularly to discuss aspects of their recovery and discharge planning.

People told us that it was easy to raise complaints and seek support from advocacy services while addressing any issues they had faced. We heard from individuals and staff that there were very few complaints about the standard of care received.

We did hear significant frustration and annoyance regarding the staffing levels in the hospital. Several individuals noted that consistently, their time out of the hubs was compromised by the lack of available staff. We noted that some individuals who were confined to the ward had limited activities due to staffing levels. One individual noted, “there is not enough to do when stuck in the ward”.

We were aware of the increased acuity with individuals’ mental health across the hospital site, due to changes in the patient population, including the opening of Mull 3 to females. Throughout the visit we saw staff and individuals moving throughout the hospital for various activities and meetings. Despite how busy the wards seemed, we noted that many of the people were relaxed and comfortable with the staff on shift.

The change in the hospital configuration does appear to be having a direct impact on most of the wards. One individual commented, “staff are really nice but there is just not enough of them available”. Individuals reported that there were days that they noted a decrease in staff availability, particularly Sundays. One individual stated, “we are not allowed out of our rooms until 10am on the weekends”. One individual commented that they felt “rushed” to eat their food as staff are “shuffled” around the hospital to meet the acuity.

A few individuals that we spoke to who had been admitted to the hospital from a prison setting highlighted the lack of access to physical activity when confined to the

ward. They described how in prison they would be able to access the gym in their halls, but they had to wait several weeks before getting access to the gym at the Skye Centre. Most staff that we spoke to agreed on the issues regarding the lack of staff; one commented “it’s the worst it has been in 30 years”.

We noted the implications for individuals subject to enhanced care plans who had reduced activity or therapeutic intervention because of their observation levels. Non-ward-based members of staff were required to support ward openings which then had an impact on their ability to deliver their usual therapeutic interventions. One member of staff, from an allied health professional background, noted that the lack of staffing had a direct impact on achieving the aims of their employed role.

In our pre-meeting with the hospital managers, they acknowledged vacancies in healthcare support workers and nursing staff. They discussed the recruitment steps they had undertaken and some of the challenges they faced. They acknowledged that most wards across the hospital site were equally affected by vacancies.

Recommendation 1:
Managers should continue to address the ongoing staffing challenges in the hospital to minimise any impact on patient care and access to activities. Managers should keep the Commission informed of progress.

Individuals and staff spoke of the increased offerings of ‘Room for You’ which is a voluntary opportunity for individuals to spend time alone in their bedrooms instead of being in the day room of the ward. From those that we spoke to it seemed that Room for You was being offered to meet the demands on staffing levels. Hospital managers disputed this, who were clear that Room for You was to allow people time to relax and undertake meaningful activities away from the day room.

The management team advised that any use of daytime confinement was being used as a last resort to manage staffing gaps. The use of confinement during the day and overnight remains an issue that the Commission are aware of and continue to monitor. We commented previously on the use of daytime confinement (DTC) during our visits in 2022, 2023 and 2024. We noted there had been a significant increase in DTC during the month of December 2025 across the hospital site with 2000 hours implemented. We heard from staff and management of the various plans to increase recruitment and staffing levels to address this practice.

Recommendation 2:
Managers should continue to address the ongoing use of daytime confinement across the hospital to minimise any impact upon individuals’ care and access to meaningful activities.

During our last visit, individuals had reported being unhappy with their doctors. We were pleased to see that there were no negative comments raised regarding the relationship individuals had with their doctors during this visit.

We received several positive comments about the food on offer with individuals describing it as “excellent”.

We spoke to one relative of an individual who expressed their frustration at feeling ignored and not engaged with by the hospital staff. They did advise that this may have been due to them not being appointed as a named person under the Mental Health Act, or having a signed mandate from their relative to obtain answers to their enquiries. We discussed with the relative how families should be able to speak to staff to ensure their concerns and information is gathered. We advised them that a good practice guide *Carers, consent, and confidentiality* for relatives, carers and professionals had been published to aid in addressing these matters.

We spoke to managers about the lack of recording which captured the views of relatives and carers on the electronic case record system, RIO. Managers agreed that steps would be taken to improve this recording by introducing a new form on the system which would help to ensure that relatives views were recorded and clear to staff.

Recommendation 3:
Managers should improve the recording of relatives and carers views on the RIO electronic case record system.

Care, treatment, support, and participation

From reviewing the care records, we found detailed daily entries by nursing, occupational therapy, pharmacy and medical staff that were meaningful, relevant, and provided an update on the progress of the individual’s care and treatment. We saw that all staff were continuing to gather people’s views about their care and treatment and recorded these in their care records. This was also evident in the notes of regular one-to-one discussions that people had with nursing staff.

Care plans

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

Compared to our last visit to the wards, we found that all individuals in the hospital had care and treatment plans in place to support admission goals, outcomes and identified plans of care. These were stored on RIO.

We had no concerns with the quality of the care plans; we found them to be comprehensive, with a clear focus on risks and physical health care. We found clear evidence that they were regularly reviewed and reflected the individual's progress.

Risk assessments were completed on all people admitted to the hospital by ward staff in the first 12 weeks. We reviewed several risk assessments and found the quality of information contained in these completed to a high standard. We found these to have detailed information on historical risk, current risks and safety plans to manage and support identified risks. We found a small number of individuals who were new admissions to the hospital did not have any initial risk assessments in place.

In other hospital settings we would tend to see risk assessments completed in the first 72 hours. Despite this gap we found evidence of risks in the individuals' daily notes. We raised this gap in the risk assessment and management plans with the hospital managers on the day. They advised that steps would be taken to address this gap in recording. We look forward to seeing this when we next visit.

Participation

As highlighted in our previous visit reports, we heard positive comments on the patient partnership group (PPG). This is a group of individuals, who are representatives for the ward they are based in; the PPG chair is elected by their peers. This appears to be working well and ensures participation. The group meets weekly to consider any issues, concerns, or suggestions they have. There are then regular community meetings that take place on each ward. The PPG meetings were minuted and the group allows all individuals to discuss issues and make suggestions that relate to their particular ward.

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. The Hospital Electronic Prescribing Medicines Administration (HePMA) system was in place across all wards. From the records we accessed, recordings were found to be clear and accurate.

Multidisciplinary team (MDT)

The wards that we visited 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 recorded information detailed clearly and concisely. Each ward CTM includes nursing staff, psychiatrists, social work, occupational therapy, speech and language therapy, physiotherapy, dietetics, psychology, and pharmacy staff.

For individuals who required urgent health care, this is provided through a contracted general practitioner, who visits the hospital twice a week. The GP service provides several primary care functions including the treatment of minor ailments, which reduces the number of times individuals have to leave the hospital to access secondary care.

After a recommendation made following on our last visit, we found clear recordings on which members of staff were in attendance.

The CTM notes highlighted the commitment to adopting a holistic and recovery-based approach. During previous visits we recommended that individuals should attend MDT 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 found evidence that individuals were met with before and after each meeting by their keyworker to ensure their views and requests could be discussed at the MDT. We found clear recorded evidence of discharge planning in the CTM notes.

Individuals at the State Hospital have their care and progress reviewed using an enhanced care programme 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.

We received several positive comments about discharge planning including the clarity and communication from the CTM.

We found evidence of relative or carer involvement which allowed them to express their views at CPA meetings, with most of these meetings taking place on a six-monthly basis. One relative told us that despite these arrangements, they felt there was a direct impact on them obtaining regular updates.

Use of mental health and incapacity legislation

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.

The majority of 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 three, were found to be in order. One T3 was found to be out of date. We addressed these errors in recording on the day of the visit.

From our discussions with some of the ward staff, it was clear there was a reliance on pharmacy and medical staff to check and ensure appropriate authority was in place for psychotropic medication. We found no system in place for nursing staff who administered the medication to individuals. We noted that some of the nursing staff did not know or could not locate the applicable T2 or T3s forms.

Recommendation 4:
Managers should ensure that a robust system is in place for nursing staff to identify when a T2 or T3 certificate is authorising treatment for patients.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. On this occasion we found two individuals who did not have a treatment plan attached to their section 47 certificate. We addressed this lack of documentation on the day of the visit.

Recommendation 5:
Managers should ensure that treatment plans (Annex 5 forms) are completed and located with section 47 certificates.

Rights and restrictions

People in the State Hospital are highly restricted in relation to freedoms that would normally be expected by individuals in other hospital or community settings. At the time of our visit, as we expected, all whose care we reviewed had access to legal representation and had ready access to advocacy support.

During our previous visits we had concerns regarding the significant restrictions that some individuals faced in Iona hub. It was positive to see a significant improvement in this area with a few individuals having increased grounds access, which previously had been restricted. This was proving to be a successful outcome for these individuals, and we hope that this remains a positive and meaningful development for them.

When we are reviewing files, we look for copies of advance statements. The term ‘advance statement’ refers to written statements made under s275 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. Where people had opted to make advance statements, we were able to view copies in the care records.

Bed capacity in the hubs was not reported to be 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 was published in February 2021. The Commission will continue to monitor and contribute to any work in this area.

The exact number of individuals waiting to move to a lower level of security regularly changes. During our visit, we found only one individual who was found to be in conditions of excessive security. We continue to monitor all those who are progressing with appeals against excessive security to ensure that they are supported to move on to the most appropriate level of security.

In the State Hospital, soft restraint kits (SRK) are used to manage those who were deemed to pose a significant risk to themselves, others or both. Compared to our last visit there were no individuals subject to SRKs on the day of the visit.

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 past visits we noted concerns regarding the lack of understanding of this area of restriction by nursing staff and the responsibilities this placed on their roles. During this visit, staff appeared clearer on these restrictions and how to manage them in their roles.

Activity and occupation

We were pleased to find that there remains a strong focus on activity in the hospital, supported by the occupational therapy staff, Skye Centre, and nursing staff.

The majority of individuals had access to a range of recreational and therapeutic activities through the Skye Centre, which is adjacent to the hubs. Facilities include:

- learning centre,
- vocational room,

- gym,
- recreational hall,
- hairdresser suite,
- Gardens and Animal Assisted Therapy Centre,
- patient library,
- patient bank, and
- café.

The centre provides the opportunity for people to undertake Scottish Vocational Qualifications (SVQs) in volunteering as well as other subjects.

The Skye Centre maintains a welcoming atrium area that provides individuals with the opportunity to be in an environment where they can meet for a chat with staff and have a refreshment. On the day of our visit, we observed people undertaking a variety of activities including attendance at church services, pickle ball, table tennis, cleaning of the greenhouse, information technology classes, studying for open university courses, planting seeds and feeding the animals.

We were able to observe the work completed by people who attended the arts and crafts class which included painting, drawing and making clay moulds. Individuals' artwork can be considered for the Koestler arts awards, which takes place on an annual basis. These activities provided positive outcomes for the people taking part.

Similar to our previous visits, we noted that staff were aware of the importance of physical exercise as well as healthy eating and nutrition to increase mental wellbeing and physical health. On the day of the visit, the staff spoke of plans to hold a 'Couch to 5k' run for charity.

The feedback from individuals was that they benefitted from the input of the various members of staff and that the Skye Centre provided a therapeutic environment which helped to take their minds off being subject to the high levels of restrictions of the hospital.

For those individuals whose care we reviewed and who were confined to the hubs, they spoke of their frustration and annoyance at the lack of activities available in the wards. We heard from some that they were "bored", while others indicated that they were not allowed to write or draw due to their current levels of restrictions.

We observed the wards throughout the day and note that there was limited meaningful activities available. Most people who were confined had to rely on watching television or to have conversations with fellow patients or members of staff. We did not see evidence that there was a focus on therapeutic activities that could have helped those who were confined to the hubs. Managers reported that

there were high levels of occupational therapy clinical activity across the hospital site which helped to provide therapeutic interventions for all individuals.

Recommendation 6:
Managers should seek to ensure that those confined to the hubs are provided with increased meaningful activities.

The physical environment
The physical environment of the hubs was unchanged from previous visits. The units comprise of a nurses' area, offices and side rooms.

The wards have single en-suite bedrooms and access to a secure garden area. During this visit we found the wards to be clean and tidy.

Similar to our last visit, a number of the walls in the day room area and at the nurses' stations required painting. Several of the walls in the day rooms had old sticker marks as well as cracked paint on them. We heard from managers about the steps taken to employ a permanent member of staff whose role was to ensure that all walls had scheduled painting work undertaken.

We noted that in one of the nurses' stations there was a significant rip in the carpet which had been taped over by staff. We advised managers that this should be addressed to avoid any risks to staff and visitors.

Summary of recommendations

Recommendation 1:
Managers should continue to address the ongoing staffing challenges in the hospital to minimise any impact on patient care and access to activities. Managers should keep the Commission informed of progress.

Recommendation 2:
Managers should continue to address the ongoing the use of daytime confinement across the hospital to minimise any impact upon individuals' care and access to meaningful activities.

Recommendation 3:
Managers to improve the recording of relatives and carers views on the RIO electronic record system.

Recommendation 4:
Managers should ensure that a robust system is in place for nursing staff to identify when a T2 or T3 certificate is authorising treatment for patients.

Recommendation 5:
Managers should ensure that treatment plans (Annex 5 forms) are completed and located with section 47 certificates.

Recommendation 6:
Managers should seek to ensure that those confined to the hubs are provided with increased meaningful activities.

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.

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