Mental Welfare Commission for Scotland

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

Date of visit: 25 March 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 under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (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 who require care and treatment for either a mental health or learning disability, in other hospital or community settings.

The Commission visits the units in 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 hub.

Since our last visit, the hubs have changed with Mull 3 now accommodating the new interim high secure female service; our visit to Mull 3 earlier this year has since been published on the Commission's website.

Mull Hub comprises of two transition wards while Lewis has one admission/assessment ward with two treatment and recovery wards. At the time of our visit, there were over 58 individuals in the hubs.

We last visited Lewis and Mull Hubs in May 2025 for 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 also wanted to give individuals and their relatives 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 on a human rights compliant model.

On our last visit, we made recommendations relating to the clinical team meeting records noting who was in attendance and that work in the wards should be undertaken to ensure that they remain welcoming for individuals and staff. We recommend that a repair in Lewis 3 was undertaken to the blind in the modified strong room. The response we received from the service was that steps were taken to ensure that these matters were addressed.

Who we met with

We met with and reviewed the care of 13 people. We reviewed the care notes of a further three people. We also spoke with one relative.

Prior to the visit, we held virtual meetings with the director of nursing, the associate medical director and the senior charge nurses for the hubs.

On the day of the visit, we met with the senior charge nurses (SCNs), various allied health professionals (AHPs), the visitors' centre manager and nursing staff on each of the wards we visited.

Commission visitors

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

Anne Craig, social work officer

Karen Beattie, nursing officer

Denise McLellan, nursing officer

Alison Thomson, nursing officer

What people told us and what we found

During our meetings with individuals, we discussed a range of topics that included contact with staff, participation in their care and treatment, activities that were available to them, their views on how their individual needs were being met, support with their cultural and spiritual needs and their views about the environment.

Similar to our last visit to the hubs, people were either in the wards due to their level of restriction or undertaking activities in the Skye Centre. We were able to observe and visit people in all of the hubs except Lewis 3; no individuals wished to meet with us.

Most of the people that we spoke with praised the staff describing them as “lovely”, “excellent” and “caring”. We did hear from two individuals who wished to raise complaints regarding their experiences. We advised of the local processes that they could access and how to receive support from advocacy to address the matters raised.

Of the positive comments we received, the majority of these were about the support individuals were receiving from staff. These included, “the nursing staff are very good”, “my doctor is a very good psychiatrist”, “ the staff are brand new”, “I trust my doctor”, “I see my doctor at least once a month and I know what I’m getting”, “you never see the staff having a bad day” and “she is the best nurse in this hospital”. We heard from one patient who had nominated their nurse for an award due to the high level of care they had been receiving.

There were several positive comments about the staff at the Skye Centre. These included, “they don’t judge you for not being able to do things”, “they work with you and have patience to show you the correct way to learn” and “there is one particular male nurse in the PLC and he is great at showing you how to use the computers”.

In previous visits to the State Hospital, concerns were raised about people being confined to their bedrooms due to staff shortages. This was defined as daytime confinement (DTC). During this visit we received several comments and found evidence of increased use of DTC. We consider this practice to be harmful in that it restricts an individual’s liberty, imposing them to use their bedrooms due to the lack of appropriate staffing. One individual stated, “they are still continuing to enforce daytime confinement…this is preventing my move to one of the recovery wards”. Another individual stated, “us being locked away all day is not good and this happens all the time due to staffing”. This was a significant concern and having reviewed the incidents of DTC we noted an increase in this practice since the introduction of the interim high female secure service in Mull 3.

We heard from non-nursing staff that their ability to meet their professional roles was compromised by the DTC practices. Managers advised us previously of their

plans to end the use of DTC by 1 October 2025. This goal has not been achieved and instead we found there to be a marked increase in the use of DTC which was of significant concern.

Recommendation 1:
Managers must take proactive steps to eliminate the use of daytime confinement in the hospital.

Since 2023, staffing pressures throughout the hospital have remained a key factor that has had an impact and this now appears more acute since the opening of the interim high secure female service. We received several comments regarding the lack of staff or the changes in staffing: “my progress has been delayed. I’ve had two changes of psychologists and it’s just slowing everything down. I have to restart again; I don’t know if I’m coming or going”.

In relation to nursing staff we heard, “they are great but there is just not enough” and “as there are fewer staff we are just not getting out as often as we should”. We spoke to several staff about these concerns and they were clear, “staffing levels are clearly compromised and it’s affecting our ability to do our jobs”. One staff member commented, “my role is being completely diluted as I’m being deployed to cover in a nursing assistant role due to the lack of staff”. We heard from a member of staff who stated “I cannot complete my professional role; important psychological work is not being prioritised” while another stated, “my occupational therapy work cannot be completed on occasion due to lack of staff”. One staff member noted, “important group work has been cancelled due to having to respond to Mull 3, this is frustrating”.

From this visit, we could see that the lack of staffing was clearly having a direct impact upon individuals care and treatment as well as the overall offerings in the hubs.

Recommendation 2:
Managers must take proactive steps to address the staffing issues facing the hospital which is compromising individuals care and treatment.

We received a few negative comments about the environment and lack of activities and facilities when individuals were confined to the hubs. The issues primarily related to video conferencing equipment not working property due to them being behind a protective screen. Managers spoke of the steps that were being taken to address this matter.

A number of people in the admission wards commented, “there is nothing to do in the ward, I’m living in my head to manage”, “ there is not much to do”, “I have no TV in my room so it’s kind of boring” and “I just wish there was more to do”. We discussed this with managers who acknowledged that due to staff demands across

the hospital site, activities in the hubs were compromised. We heard positively of the significant steps being taken to pilot a new project which included the purchase of new televisions for all individuals in the hospital. These televisions will be behind secure cabinets. These will be larger in size, compared to the current provision and individuals will be able to access more channels to increase what is on offer. This could provide a significant improvement and is due to be consulted on with the patient groups in the coming weeks. These steps will help to replace the television rental scheme in the hospital which aids those who either have very little income or subject to transfer for treatment directives who have been admitted from prison.

Despite these plans, there were clear themes emerging from the patient group about the lack of meaningful activities while confined to the hubs. Managers spoke of the transition service, trying new opportunities with a new lunch club being established, along with tea and coffee making facilities being made available, which will help to improve the patient experience. We believe more work needs to be undertaken to address the lack of activities. If the service provides an increase in the number and range of activities on offer for individuals, this will promote better outcomes for all.

Recommendation 3:
Managers should take steps to address the lack of activities in the hubs for those confined to the wards.

Several individuals spoke of hearing about their care plans but never seeing them physically on paper or via electronic means. In other hospitals, it is routine practice for care plans to be shared and on occasion, signed by people, but this is not the practice in the State Hospital. Despite this, most individuals were able to speak about the key outcomes that were identified in their care plans.

We spoke to one relative who visited the hospital regularly. They praised the staff as being “helpful”, “welcoming”, “kind” and “informed”. The relative singled out the positive work of the psychiatrist allocated to work with their family member. They went on to discuss the importance of the visitors’ centre and the staff who were based there. We provided the relative with advice on how to get information to some other outstanding questions they had regarding their family member’s legal status and their future, while being subject to mental health legislation.

We received several positive comments regarding the provision of advocacy services to the hospital. These included “advocacy are great”, “they are quick to visit”, “I know she will be down to see me quickly” and “great”.

Care, treatment, support, and participation

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.

There have been some improvements since we last visited, which included clear recording on who attends the hospital equivalent to multidisciplinary team (MDT) meetings, which are called clinical team meetings (CTM). There have also been steps taken for visiting staff from the Commission to have easy access to records surrounding treatment forms.

We found the majority of care records were detailed and comprehensive. There were some minor issues with the records from one CTM having only been partially completed and one individual's care plan having not been reviewed.

There was evidence of one-to-one sessions that occurred between individuals and their named nurse. This was reflected in the feedback we received from individuals who were clear on who their named nurse was.

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

We found that the risk assessments we reviewed in the wards were undertaken to a high standard, which included detailed recording in the historical, clinical and risk management-20 (HCR -20) reports, as well as the protocol for the risk of sexual violence (RSVP) reports, when appropriate, which assisted with the transfer of individuals moving to a lower level of security where deemed appropriate.

Due to the level of restrictions in the hospital, there was the potential to have in place the most restrictive means of supporting those specific needs for people, i.e. the use of enhanced levels of direct observation, soft mechanical restraint or seclusion. During the visit we found one individual who was subject to continuous interventions, and this was being completed to an acceptable standard.

We found good evidence and record keeping relating to the input provided by occupational therapy, psychology, physiotherapy and psychiatry.

In the State Hospital, there is an expectation that all nursing care plans are reviewed monthly. We found for all, except one, that they were completed in line with the hospital policy. The care plans related to all key themes including monitoring of physical health care, mental health recovery, rehabilitation and meaningful fulfilments. We were pleased to see this area of work was completed to a high standard and related to what individuals told us.

Multidisciplinary team (MDT)
Lewis and Mull Hubs held regular clinical team meetings (CTM). We found these to be well structured, with decisions taken in a timely way, and all recordings detailed clearly and concisely.

Each ward CTM was made up of nursing staff, psychiatrists, social work, occupational therapy, speech and language therapy, physiotherapy, dietetics, psychology, and pharmacy staff. It was clear from the thorough CTM meeting notes that all professionals were involved in an individual's care and treatment, and professionals were invited to attend the meetings, where they provided comprehensive updates on their involvement.

Individuals or relatives did not attend the CTM. Instead, each individual's keyworker met with the person prior to and following on from the CTM, to ensure their views and requests were discussed.

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

Use of mental health and incapacity legislation

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. All individuals we met with during our visit had a clear understanding of their detained status and advised us that they had choice over whether to access advocacy support and/or legal representation.

We heard from individuals who told us about their anxieties of where they would be moving on to next. We spoke to some who were subject to excessive security appeals. One stated, "I've been offered to go to England. I don't want to, but I'm concerned if I refuse what will happen next". We raised this with managers and signposted them to their lawyer and psychiatrist to seek further clarity on the matter. Another advised "I have my appeal in place and hopefully I'll be moving shortly to medium secure. My lawyer, my doctor and advocacy have all helped with this".

All documentation relating to the Mental Health Act, the Criminal Procedure Act, and Adults with Incapacity (Scotland) Act, 2000 (AWI Act), including certificates around

capacity to consent to treatment as well as suspension of detention, were found on RIO and were up to date.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Medication was recorded on HePMA and matched what was recorded on the consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act.

Any individual who receives treatment under the Mental Health Act or the 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 in their file.

Rights and restrictions

Due to its high secure status, the State Hospital operates airport-style security checks for all visitors, along with strict monitoring of all movements around the hospital via CCTV overseen by the hospital security staff.

All hubs operate a locked door policy which is commensurate with the level of risk identified with the individual group.

Advocacy in the State Hospital continues to be delivered by the Patient Advocacy Service (PAS). We saw from the care records that advocacy attended the ward regularly and supported individuals who were involved in tribunals, in their discharge planning and care programme approach (CPA) meetings.

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

The Commission has regularly highlighted the significant difficulties with regard to 'individual flow' across the forensic estate. The situation of individuals in the hospital awaiting moves to lower levels of security remains an issue that continues to be addressed by Scottish Government and the Forensic Network in terms of a capacity review. The Commission has produced Appeals against detentions in conditions of excessive security good practice guidance which can help individuals, their named person, relatives and staff navigate this complex area.

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 stay in hospital. We have a Specified persons good practice guide for clinicians to access.

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

We were pleased to find that for those not confined to the hubs, there remains a strong focus on activity, supported by the occupational therapy staff, the staff in the Skye Centre and nursing staff.

From those that we spoke with, we heard that they were encouraged to participate in a variety of activities, in and outside of the hubs. All of the people we spoke to in the hubs praised the activities that were available to them.

Individuals spoke of the regular activities that occurred throughout the year at the Skye Centre to promote healthy eating and exercise. We did not visit the centre on this occasion but are aware from previous visits of the range of facilities available which include a learning centre, greenhouse, a vocational room, gym, recreational hall, a hairdresser suite and an animal care centre. The centre continues to provide the opportunity for people to undertake Scottish Vocational Qualifications (SVQs) in volunteering as well as other subjects.

As previously highlighted, we heard several comments regarding the lack of activities for those confined to the hubs. When we next visit, we hope to see an improvement on the availability of activities for this group of individuals.

Throughout this 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 physical environment

The physical environments of Lewis and Mull Hubs were unchanged from previous visits. The units compromise of a nurses' station, a dining room, kitchen, day room area, offices and side rooms. The wards have single en-suite bedrooms and access

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

to a secure garden area. We heard from individuals that depending on the weather and their security status, they were allowed use of the patio area and dedicated garden space. We heard from individuals in Lewis 1 that despite recent good weather and their security statue they were still prevented from having access to the 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 attention due to paint cracking. We found a hole in the carpet of the flooring in Mull 2 which had been temporarily taped over to cover the area.

We received several comments regarding the video conferencing (VC) units not working properly in the wards. This was due to the units being behind screens to protect the equipment. The result of this approach to storage of the VC units was that individuals and their relatives could not hear each other correctly. We were informed by managers that they were aware of this issue and steps were being taken to address this issue.

We received comments on the fact that many of the vertical blinds in the day room of the wards were either broken or missing slats which affected those who spent most of their day confined to this area. Individuals and staff advised us that despite many years of reporting issues with the slats, they were either not replaced or repaired.

We were pleased to see since our last visit that the modified strong room (MSR) blind had been repaired since our last visit.

Recommendation 4:
Managers must prioritise the redecoration of the wards to ensure the environment remain welcoming for both individuals being cared for in the hospital and staff.

The importance of relatives and named persons is critical for those who find themselves subject to detention in hospital. Many of the individuals we met with during this visit had no named person or relative involvement. Of those that do, they utilise the visitors' centre, which is based on site, close to the reception of the hospital.

On this occasion we chose to visit the centre to gain a greater understanding of how this works and functions on a daily basis. We met with the centre manager who took us through the booking system and the arrangements taken to safeguard individuals, relatives, staff, and children visiting the hospital.

The environment was found to be safe and comfortable, which allowed for visits to the hospital six days a week. The centre allowed for multiple visitors to meet with

their relatives. The centre offered the option to have children visit their relatives in an open space, with toys on offer for younger visitors.

The centre has side rooms as well as a garden area with tables to sit and have lunch. We heard that visitors are allowed to bring food to the centre and throughout the year the environment is personalised to the seasons. There was artwork on display in the centre which had been produced by those who attended the Skye Centre.

Summary of recommendations

Recommendation 1:
Managers must take proactive steps to eliminate the use of daytime confinement in the hospital.

Recommendation 2:
Managers must take proactive steps to address the staffing issues facing the hospital which is compromising individuals care and treatment.

Recommendation 3:
Managers should take steps to address the lack of activities in the hubs for those confined to the wards.

Recommendation 4:
Managers must prioritise the redecoration of the wards to ensure the environment remain welcoming for both individuals being cared for in the hospital and staff.

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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