mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on enhanced visit to:

The State Hospital, Arran and Iona Hubs, 110 Lampits Road, Carstairs, Lanark, ML11 8RP

Date of visit: 20–22 July 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.

About this visit

The State Hospital is a psychiatric hospital, located in South Lanarkshire, which provides care and treatment in conditions of high security for people from Scotland and Northern Ireland. It is a Special Health Board, part of NHS Scotland and the only hospital of its kind within Scotland.

The hospital comprises of four units (hubs), Arran, Iona, Lewis and Mull, with either two or three wards in each.

There are 140 beds for male patients (12 specifically for people with a learning disability), and 6 beds for female patients. All individuals are subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedure (Scotland) Act 1995; they are highly restricted in relation to freedoms that would normally be expected by individuals in other hospital or community settings.

The State Hospital aims to provide specialist care to meet individual support, treatment and rehabilitation needs to enable people to move to lower levels of security as and when appropriate.

We last visited Iona and Arran wards in January 2026 and made six recommendations relating to staffing challenges, daytime confinement (discussed later in this report), access to meaningful activities, certificates for authorising treatment and recording of carer/relatives' views in the electronic information system.

In July 2026, we undertook an unannounced, enhanced visit. We wanted to follow up on the issues identified from previous visits, particularly in relation to the ongoing use of daytime confinement and the failure to remove this practice. Further matters had also been brought to our attention since our last visit and we were keen to make additional enquiries.

Our enhanced visit approach differs from our usual visit arrangement by extending our presence in a particular setting to more than a single day. We want to receive feedback from families, staff, patients, mental health officers (MHOs) and advocacy workers who cannot always make themselves available to engage with us on a single day or may not feel able to meet us on that day. More than one day in a setting helps to build up familiarity and trust and it also allows us to review more care records.

Where we have identified concerns or made multiple recommendations that have not been met, an enhanced visit helps us to build a more detailed, comprehensive report on the individuals, their families/carers and the staff teams' experiences of delivering care in a specific setting.

Experience of care and treatment

What the Commission did

While the Commission's usual approach involves visiting a setting on one day, on this occasion we visited the State Hospital over a three-day period on 20, 21 and 22 July 2026. Our team comprised of 10 staff who are registered mental health officers (social workers), registered mental health nurses and a consultant psychiatrist.

We visited Arran 1, Arran 2/Iona 1, Arran 3, Iona 2 and Iona 3.

Arran 1 is an admission and assessment ward. Arran 2 is a treatment and recovery ward which, during the majority of our visit, was decanted to Iona 1. By the end of the third day people had returned to Arran 2. Arran 3 is a treatment and recovery ward. While Arran, 1, 2 and 3 primarily care for people with mental health conditions, Iona 2 and Iona 3 are part of the learning disability provision at the hospital[1]. There were 50 people receiving care, treatment and rehabilitation across the Iona and Arran wards during our visit, one person was admitted whilst we were visiting.

The length of stay for people in these wards ranged from around 2 months to over 35 years. The youngest person was under 20 years old and the oldest was in their 60s.

The majority of people were receiving care and treatment on a compulsory basis according to the Criminal Procedure (Scotland) Act 1995 and others according to the Mental Health (Care and Treatment) (Scotland) Act 2003.

All 50 health records were reviewed by Commission staff.

24 people receiving care and treatment agreed to engage with us.

30 nursing staff, 12 of whom described themselves as the person's key worker/named nurse, also engaged with us.

We had contact with the relatives/carers of 14 patients.

24 of the multidisciplinary staff (psychiatry, nursing, occupational therapy, medical, psychology, social work) also provided us with additional information.

We received feedback from 33 mental health officers.

Two responses were received from the Patient Advocacy Service (PAS) working with those on the wards at the time of our visit.

[1] While the State Hospital use the terminology of intellectual disability, this report uses learning disability.

What we heard

People receiving care and treatment

What we expect:

We would expect individuals in the Iona and Arran wards to receive holistic, person-centred care delivered by an experienced, specialist, multidisciplinary team which is inclusive and recognises the person as a unique individual. We would expect the person to have a key worker/named nurse with whom they have built or can build a therapeutic and trusting relationship. We would expect communication to be tailored to individual needs to support the individuals receiving care to be fully aware of their rights, to be treated with dignity and respect, for there to be access to educational and recreational services and for all interventions to be lawful.

What we heard:

There were 50 individuals in the hubs when we visited; 24 (48%) had a confirmed diagnosis of mental illness, 12 (24%) had a confirmed diagnosis of learning disability and 11 (22%) had more than one diagnosis.

We received feedback from 24 people aged between 21 and 65 years.

The majority of those we spoke with (20 people; 83%) told us that they had been given information about the ward at the point of admission; “a lot of paperwork”.

For most of those in the Arran and Iona wards (19 people; 79%), we heard that information had been explained in a way that helped understanding of legal status, how to access advocacy, information about their diagnosis, their medication and any tests or assessments that would be carried out. One person on Arran ward commented that they felt “very informed”.

Nearly all of the people who engaged with us (21 people; 88%) understood that they had a named member of staff to support them while they were in the State Hospital. (We heard directly from 12 named nurses but none from Iona 2 or Iona 3, intellectual disability wards). This was described by individuals as “excellent” with regular contacts “2-3 times a week”.

> *“Here has given me hope and saved my life, I can talk to the nurses about anything.”*

21 people (88%) told us they knew why they were in hospital, 15 of whom said that they were also aware of a plan to make them well so that they can leave the State Hospital. 11 people said that they had contributed to their care plan.

We asked people what would happen if they chose to refuse the medication that was prescribed, and nearly all said that this was 'not applicable' with some explanation provided as follows:

> *"Agree with taking medication currently."*
>
> *"I'm pretty sure if I refused they wouldn't let me out to grounds. It's not in my best interests to refuse."*
>
> *"They would force me either way."*

We asked if staff talked regularly to people on Arran and Iona wards. 17 (71%) people said yes and that they were able to ask questions and felt listened to. This was also evidenced in case notes.

> *"I feel I can speak up here and don't get closed down, I know about my plan, nurses speak to me all the time and I am in very capable hands."*
>
> *"Staff are very supportive and do everything they can to lessen the impact of the environment."*
>
> *"I am making lots of complaints about things here."*

Nursing staff told us that if someone refused medication, the reasons for this would be listened to and discussed. For example, one person refused medication as the tablets were different in colour or shape to previous. Staff explained that the colour and shape of medication can differ from manufacturer or medication dose. In this circumstance, full discussion took place and we were told that if this did not help, the med box could be shown and dispensed in front of the person to give assurance.

17 out of the 24 people we had contact with said they could see their relatives, family or carers whenever they wanted to. The distance that some relatives had to travel made in person contact more complicated and less regular, however.

All individuals are automatically designated as specified persons at the State Hospital[2]. When asked about any limits that had been put in place for people, for example being allowed freely off the ward or other restrictive practices such as people and/or their items being searched, most reported an acceptance and understanding "due to level of security".

10 (20%) people told us about their experience of being restrained, primarily early on in their admission. One person intends to pursue a complaint; another talked about how "sore" this was and another person told of the need to seek medical assessment for a resultant injury. One relative told us about raising a complaint due to seeing bruising post restraint. Six of the 10 people told us that they did think staff

[2] Specified persons good practice guide

managed this intervention as best they could noting that staff had followed the care plan in place and provided reassurance to them throughout.

Seven (29%) of the people we met with had some difficulties with communication. We were told that easy read information helped, as did speech and language therapy involvement and just giving some other people enough time to process information. There were also people for whom English was not their first language, but they mentioned having access to interpreters. One of the mental health officers (MHOs), however, explained that one interpreter is only available at weekends and whilst the doctor made the effort to meet at weekends, the MHO questioned holding weekday care programme approach meetings in such circumstances.

We also asked if any individuals had been looked after or accommodated by the local authority (i.e. care experienced). Four (17%) people confirmed that this was their experience, 11 (46%) answered no to this question and others did not respond/preferred not to say.

For those able to understand the question of discrimination or of being treated differently to others, no one said that they felt discriminated against.

We asked if it was quiet enough for people to sleep in the wards. Most (21 people; 88%) said yes and the majority felt safe (20 people; 83%) although there was a comment that it was frightening to see others be restrained.

The majority of those in the ward at the time of our visit told us that they liked the food (17 people; 79%), with one person describing it as “disgusting” and another telling us about “having to eat out of paper boxes” due to confinement.

Confinement was a regular theme arising when talking to individuals. While there was discussion about some activities such as x-box, Skye Centre (the onsite activity and rehabilitation service), board games, there was felt to generally not be enough activities but this was made much worse by daytime confinement (DTC).

> *“Impact of DTC interferes with activity as we are locked in rooms due to staffing issues.”*
>
> *“Impacting activities and my mental health.”*

There was overwhelming feedback about DTC impacting on the lives of those who have a right to therapeutic care, treatment and recovery support. We were told that DTC was directly related to a lack of staffing, meaning people found themselves confined to their rooms/ward for prolonged periods with no ground access.

> *“I actually would get more freedom in prison, especially at weekends where at least your cell door is open.”*

> *"Daily confinement needs to stop; staff try their best to break the monotony."*
>
> *"DTC is a killer, I would rather be back in prison, as you have more choice and more freedom!"*

People told us that DTC means there is no progression, the previously welcomed "therapeutic model" no longer exists and "now we are just getting fat and demotivated".

Named nurses agreed that the use of regular daytime confinement (due to lack of staff) impacted negatively on the mental health and wellbeing of patients and on the nurses' ability to undertake assessments.

We asked individuals how well they thought they were looked after overall in the hubs.

We gave patients a range of scores to choose from ranging from fantastic (two people; 8%) to really good (four people; 17%) to okay (nine people; 38%) to not very good (one person; 4%) to awful (no one chose this option). Eight people (33%) did not answer this question.

Carers/Relatives

What we expect:

The Carers (Scotland) Act 2016, implemented in 2018, defines young carers and adult carers and sets out their rights to support, information and inclusion. The Commission's good practice guide titled Carers, consent and confidentiality (updated in 2024) emphasises the importance of carers knowing their rights when navigating health, social work, and social care services.

Our 2025 report *Not on the radar* highlighted the challenges faced by carers day to day and the importance of carers being recognised as equal partners in care.

We expect therefore that families should always be allowed and encouraged to offer information to professionals involved in a person's care and treatment. In all situations, and regardless of the person's consent or capacity, families can give information to the professionals involved and staff should listen to them. Families and carers often know the person best and can provide valuable information that does not breach the confidentiality of the relationship between the person and the professional team.

What we heard:

We found that 37 (75%) care plans in files evidenced that relatives/families/informal carers were involved in a person's care. Some people, however, did not have any family with whom they were in contact.

We heard from 14 people who were carers/family members of individuals in Iona and Arran hubs.

Eight carers/relatives (57%) told us that staff involved them in decisions about the person they cared for and they received enough information to do so meaningfully.

Communication was, however, frustrating for some:

> *"Don't have a lot of say in anything. Feel fobbed off."*
>
> *"Don't get regular updates."*
>
> *"People don't always get back to you."*
>
> *"I ask questions…not responded to."*

We asked carers if they had confidence and trust in the staff. 11 carers (79%) responded positively, for example:

> *"I have visited over many years. I notice a change in staff. More approachable, warmer easier to speak with."*
>
> *"Can't praise them enough."*

Whilst others had less confidence:

> *"Staff don't want to talk really they just make excuses about not having enough staff. The place has gone right downhill, it's awful, [patient] is not getting better."*

We heard about a significant incident under investigation which had impacted negatively on the carer's trust in the care provided.

Once again, the practice of daytime confinement (DTC) was also consistently highlighted as a significant concern:

> *"This locked up all day is messing with his head he has come such a long way I am worried he will slip right back."*
>
> *"He is regressing p***** off about the lock down. He told dad he has too much time to think and it's making him worse. Can be in a room for most of the day due to staffing issues. Going back the way."*

The experience was contrary to the 2025 Patient Visitor Information Pack which states that "Patients are encouraged to access outdoor spaces including ward and hub gardens. There are also extensive grounds with walking paths and sports facilities for patients who are able to access outdoor areas within the wider Hospital environment".

Nine (65%) carers said they were satisfied or very satisfied with the overall care in place for their relative. And six carers said that a carers assessment had been discussed with them.

Staff working directly in the wards

What we expect:

One of the aims of the core mental health standards (Scottish Government, 2023) is to ensure that a consistent, high-quality service is provided to everyone who needs it. The standards acknowledge that the workforce plays a critical part in how safe, effective, timely, trauma informed and compassionate based services are delivered.

We therefore expected to find a multidisciplinary approach to the care and treatment of people across the Iona and Arran hubs, underpinned by respect for individual roles and contributions and characterised by positive collaboration between professionals.

What we heard:

We heard from a range of multidisciplinary staff; nursing, health care support staff, psychiatry, psychology, social work, occupational therapy, general practitioner, allied health professional lead and staff from the Skye Centre.

We heard about staff enjoying their roles and being able to make a difference in people's lives. We heard about good teamwork which had been reinforced by the move to hub working.

> *"Really good team in Arran 1, we listen and support each other, even when we may not agree, there is respect between us."*
> *(staff nurse)*

> *"Iona MDT [multidisciplinary team] are very ID [intellectual disability] focused, advocate well for needs of ID patients, it's a forward-thinking team, they work hard to get voices of people heard."*
> *(psychologist)*

It was good to hear of the attention given to physical health care:

> *"From my perspective people here are getting the best primary care and health care compared to any other part of Scotland. They have immediate access to dietitian, physiotherapy, nursing etc. They receive the best of care."*
> *(GP) This was also evidenced in the case records that we reviewed.*

There have been recent incidents of concern, involving patients, and staff who engaged with us described a lack of communication from those in managerial roles. There were concerns about the level of staff turnover particularly in relation to allied

health professionals and nursing staff. It was felt that there were a lot of new nursing staff who are inexperienced and that the nursing leadership structure did not lend itself well to joined up working with other multidisciplinary professional groups, indeed a disconnect and defensiveness was described here.

> *"Not always comfortable that issues are acted on when I raise them".*

Whilst there was feedback that staff felt able to speak up, they did not always have confidence that they would be listened to or that action would be taken.

> *"Management [lead nurses] are reluctant to accept or listen to us, put back on us all the time".*

> *"Senior management have no idea of the reality on the ground".*

Lack of staffing was consistently raised as a barrier to being able to do the best job possible. We heard that there is insufficient psychology staff to meet the needs of the patient group and that due to nursing shortages, psychology staff (and OT staff) were 'filling these gaps' and, in effect, "making up staff numbers" to support the functioning of a ward.

The strength of feeling regarding routine daytime confinement (DTC) was reported across all staff groups. This was said to be directly linked to a lack of nursing staff (including the appropriate mix of male and female staff).

> *"I am frightened that we are giving too much time to patients in their rooms and this could all collapse."*

> *"Some patients in Iona are only allowed to have phone calls, but these have not occurred due to DTC. This included people not being able to phone their fathers on Father's Day."*

> *"The difference and 'dip' in their [patients'] mood is notable- some experience a dramatic increase in symptoms such as delusional beliefs."*

> *"I have been advised to complete unsafe/unacceptable practice forms by union which are discussed at meetings every Sunday, but I don't see the point as nothing changes. The service is on its knees, and unwell people can't just come here to sit in their room with nothing."*

> *"The patients can't even get fresh air some days. Many came from prison where they are treated better, have TV, kettles…and they are supposed to come here for treatment, but we are not able to give them what they need."*

> *"It's not fair on the patients, that breaks my heart most of all."*

The impact on patients, their mental health, their activity (lack of), weight gain, their therapeutic interventions were all highlighted. Commission visitors also observed the impact on the morale of staff with tearful exchanges during interviews.

Advocacy

What we expect:

The Mental Health (Care and Treatment) (Scotland) Act 2003 is clear about the vital importance of independent advocacy to support people to understand and exercise their rights, ensuring their views, wishes, and concerns are heard and taken into account in decisions that affect them.

This right to advocacy applies to everyone with a mental illness, personality disorder, learning disability, dementia or related condition, and to all types of independent advocacy.[3]

Section 259 of the Act enshrines this in law. We therefore expect that all patients in the State Hospital are offered independent advocacy support.

What we heard:

The Patient Advocacy Service (PAS) provides independent advocacy only to those within the State Hospital. It is a small charitable organisation which has not grown to reflect demand, complexity nor the increase in patient numbers (for example, when the new female ward was opened in 2025).

31 out of the 50 case records we reviewed had a named advocacy worker recorded on file for the person.

It was noted that due to staff absence within PAS, some drop in sessions were not happening as per usual practice, and written reports were not being completed, in favour of targeting finite resources towards one-to-one contacts with patients instead.

It was good to hear that social work and clinical teams encourage the take up of advance statements and that 8 people across the Arran and Iona hubs have an advance statement with two more in the process of being completed. We heard that advance statements are regularly referred to at care programme approach meetings.

We heard that daytime confinement has presented a significant challenge to the timely delivery of independent advocacy in recent months. We learned that access to individuals can be delayed or restricted, and there have been occasions where insufficient staffing has meant individuals have been unable to leave their rooms to

[3] Principles and Standards for Independent Advocacy Reflecting Commissioners' Statutory Responsibility - Independent advocacy: guide for commissioners - gov.scot

meet privately with an independent advocate. Whilst efforts have been made to identify alternative solutions, such as communicating through a bedroom door, these arrangements do not provide the level of privacy and confidentiality required for effective independent advocacy.

Daytime confinement has also led to several complaints from those able to raise concerns. It was explained that the impact spans multiple areas of a person's life – no phone calls, meals in rooms from polystyrene boxes, people cannot get out to the grounds or attend placements/learning opportunities. PAS are aware that this confinement is impacting individuals' mental health and the well-being of staff.

While it was reported that people generally like the food at the State Hospital, especially the theme nights, the use of polystyrene boxes with food all jumbled up when daytime confinement is in place is far from appealing. It was explained to us that these polystyrene boxes are sometimes even used when daytime confinement is not in place, pre-empting that it might be put in place at any time.

Mental Health Officers

What we expect:

Mental health officers (MHOs) have statutory powers under both criminal procedures and mental health acts to protect and promote rights and support the care and treatment of people whose mental health condition requires the protection afforded by legislation.

As social workers, MHOs' responsibilities include care planning, assessing mental health needs and whether compulsory intervention may be required, as well as ensuring that the rights and welfare of individuals are protected. The role of the MHO does not end once the court or tribunal has made a disposal. It is a critically important continuing role, and we would expect active involvement by designated MHOs.

We would also expect that each person has a current and relevant social circumstances report (SCR) on file which has been sent to the key recipient, the responsible medical officer and copied to the Commission (section 231 Mental Health Act). The content of an SCR is clearly set out in the Mental Health (Social Circumstances Reports) (Scotland) Regulations 2005 and their purpose in the Code of Practice (Volume 1 Chapter 11). The Commission has published good practice guidance in relation to SCR[4] and also monitors the provision of these statutory reports.

What we heard:

49 out of the 50 patients in the hubs had a named MHO in their case records.

[4] SocialCircumstancesReports_GoodPracticeGuide_2022_1.pdf

We heard from 33 MHOs, most of whom had been working in partnership with people on the wards since 2025-26. It was really good to hear that some designated MHOs had been involved for longer periods and developing long standing relationships since 2018-19.

Given that the State Hospital is a national resource, MHOs from the person's local area may be at a significant distance.

> *"It is challenging undertaking the MHO role at a distance."*
> *(MHO)*

MHOs described visits based on the person's individual needs and respecting the person's wishes. For example, one person had refused to engage in the previous three visits suggested by the MHO, in another case, the MHO attended and the person was too unwell to meet. The MHO stayed over that evening in the locality to make a further attempt to meet the person the next day.

Reported in person visits by MHOs ranged from once every couple of months, to quarterly visits to only one contact in 18 months. This was often supplemented by virtual or in person attendance at care programme approach meetings. However, most MHOs were not routinely invited to regular multidisciplinary team (MDT) meetings; only nine MHOs told us that they had received an invitation to attend. Others felt that they would be able to attend if they needed to and others would like to attend:

> *"Did ask re attending the MDT meetings but they said it would be tricky as they cannot give an exact time when [the person] will be discussed."*

25 of the 33 MHOs who engaged with us confirmed that they had completed an SCR with the others explaining that, either there was already a current SCR on file completed by a colleague or completion of an SCR would serve no practical purpose. Most confirmed that they would, however, be updating the existing SCR on file given some recent developments.

Review of records confirmed that there were in fact 24 SCRs within patient files; our analysis of records suggested that there should have been 36 current SCRs located in files.

All MHOs verified their competence in adult support and protection and child protection. They said that they were fully aware of their responsibilities to report any harm witnessed, including within health settings. The majority view of MHOs was very positive in relation to the care they witnessed and the partnership working they experienced. Concerns were however raised in relation to restraint that possibly "could have been avoided", failure to alert an MHO to a significant incident and subsequent use of soft restraints and the use of daytime confinement due to a lack of staff.

What else did we hear and learn?

What we expect:

We expect a culture of openness and respect for the Commission's duty in law to seek and receive a wide range of information, including access to patient records. We also expect leaders and managers of services to help facilitate a Commission's visit and to support their staff during the time the Commission is on and off site.

What we found:

One of the reasons the Commission visited the State Hospital on an unannounced, enhanced basis in July 2026 was the failure of the State Hospital to alert the Commission to a significant incident. Transparency is critically important to ensure trust and confidence and avoid the perception of a 'closed culture' as described by one member of staff.

The Commission was grateful to the people receiving care and treatment, their relatives, all staff working across the hubs, advocacy staff and mental health officers for engaging in and facilitating this unannounced enhanced visit over three days.

Spending three days on site allows for observation of interactions; Commission staff described nursing team interactions with people on the wards as warm and supportive.

The following information is what emerged from what we heard, what we observed and what we read in case records.

Key findings

Multidisciplinary Team (MDT)

We heard about good MDT working although there was a view held by some that there was a need to challenge the medical model to ensure staff across all disciplines "had their voices heard". The MDT was not as inclusive as it could be, with no regular invitations to those receiving care and treatment, their families nor MHOs involved.

Care records and care plans

There was clear evidence of individuals being supported to contribute to care planning with 49 (98%) care plans found to be written in a way that was understandable to the person (some easy read versions, some with symbols and some with speech and language therapy involvement).

35 (70%) care plans evidenced plans for people to step down or move away from the State Hospital.

We found robust pharmacy involvement via care programme approach meetings with oversight of medication, rationale for prescribing, physical health needs in relation to medication and high dose medication use. There was also thorough psychological formulation in care programme approach documents that gave rich detail in relation to each individual's past experiences and how this impacted on their mental health, risk profile and care needs.

Care programme approach paperwork linked well with nursing care plans, clinical team meetings and risk profiles.

Mental Health Act legislation/authority to treat

The Mental Health Act provides the authority for compulsory treatment of individuals under strict circumstances and describes important safeguards for individuals as to how medical treatment, such as medication, naso-gastric tube (NGT) feeding and electroconvulsive treatment (ECT) may be lawfully authorised.

We audited 23 patient care records in Arran 1 and Arran 2 and found that authority was in place for 18 (78%) people and further action was required for the remaining five.

We would expect services to routinely audit to ensure authority to treat is in place and that nursing staff have received appropriate training so that they are informed at the point of administering medicines.

Daytime confinement (DTC)

For the purposes of this report, it is important to clarify that DTC refers to periods during the day when a person is required to remain in their bedroom and prevented from accessing the usual ward areas, hub, grounds or therapeutic activities. This is not because of the individual risk or clinical needs of the person but is directly related to insufficient staffing and associated operational pressures at the State Hospital. This is distinct from seclusion[5] which may be imposed on an individual following assessment of their individual, clinical needs or risks (link to guidance).

We were told that the impact of routine DTC was not only on freedom of movement but access to therapeutic activity, contact with members of the multidisciplinary team, advocacy, family, social work and outdoor space. We learned that the hospital was attempting to maintain ward staffing by drawing staff away from therapeutic services. Skye Centre staff, allied health professionals and psychologists were repeatedly redeployed to nursing duties. This, in turn, meant reduced opportunities for therapeutic engagement and for the safe testing and extension of individual freedoms potentially delaying progression to a less restrictive setting or towards discharge**.** We heard that this repeated confinement was adversely affecting individuals' mental state and recovery. Routine DTC therefore raises significant human rights concerns.

We requested and received 6 months of DTC data up to May 2026 to gain a deeper understanding of the extent of this practice. Figures confirmed that DTC has become a routine feature of service delivery linked to insufficient staffing. We have therefore alerted Healthcare Improvement Scotland given their role to monitor adherence to the Health and Care (Staffing) (Scotland) Act 2019.

The obvious risks include restriction of liberty, institutionalisation, deterioration in mental state and functioning, reduced rehabilitation, prolonged admission, interference with therapeutic care, cumulative impact on individuals subjected to repeated confinement, and the possibility that an emergency response to staffing pressures is now becoming normalised at the State Hospital. Risks also relate to staff morale, ability to practice, recruitment and retention.

[5] https://www.mwcscot.org.uk/sites/default/files/2019-10/Seclusion_GoodPracticeGuide_2019

Recommendation

The practice of daytime confinement (DTC) had been raised during previous Commission visits to the State Hospital. We found no progress in July 2026 and noted that DTC continued to have significant and broad impact across all areas of work within Arran and Iona wards. It is difficult to improve other areas we identified while DTC remains in place. On this occasion, we therefore make only one recommendation to the Board of the State Hospital.

Recommendation: The State Hospital Board should take urgent action to reduce and eliminate the routine use of daytime confinement arising from staffing or operational pressures. It should develop and implement an improvement plan, informed by staff and with senior management and Board oversight, setting out how and when this will be achieved.

A copy of this improvement plan should be shared with the Commission by 16 November 2026.

The Hospital should record and monitor the frequency and duration of DTC, the reasons for its use and its impact on individuals, including access to therapeutic activity and clinical contact, mental health and wellbeing, rehabilitation and progression to less restrictive settings. Where DTC results in a person being confined to their room, or otherwise substantially restricted for a prolonged or repeated period, there should be a clear process for individual review of the necessity, proportionality and impact of that restriction.

Evidence of this activity and governance should be shared with the Commission by 31 December 2026.

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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