The built environment

This section covers how to minimise harm associated with the use of ligatures in the care environment for inpatients, which is often described as the 'built environment'.

As ward or care environments vary, this guidance should be adapted to local contexts. And because environments change – with new items being brought in and others removed or damaged – risk assessments need to be reviewed continually. Organisations should have a consistent approach to the task.

Ligature harm reduction needs to balance providing a care environment that is as safe as possible with maintaining people's privacy and dignity to aid their recovery. It needs to go hand in hand with other aspects of mental health care, including workforce planning, supportive observation and engagement, and therapeutic relationships between patients and staff.

The built environment should also be considered with other forms of risk assessment to reduce ligature harm risk. The National Institute for Health and Care Excellence (NICE) recommends collaborating and agreeing on individual risk assessments with patients, instead of using risk assessment tools and scales to predict future suicide and treatment.

What we mean by the built environment

We define the built environment as the structure of the inpatient care environment (the buildings and wards) along with fixtures, fittings and furniture. It includes the surrounding areas that patients could access, such as communal reception areas, gardens and other outside spaces.

Patients' possessions and items that could be used as ligature material or to provide ligature anchor points are also included.

Why the built environment is important

Controlling the built environment reduces opportunities for a patient to use fixtures, fittings, furniture or their personal items (such as clothing) as ligatures or ligature anchor points to cause harm to themselves or attempt suicide.

Examples of safety interventions include:

- collapsible furniture
- reduced ligature fixtures and fittings (that make it difficult to attach a ligature)
- the removal of fixed ligature points where possible.

Current guidance already requires the use of some vital measures to reduce ligature harm risk in mental health inpatient settings.

For example, providers must use collapsible shower and curtain rails. Any incident involving a rail that does not conform to this is reportable as a Never Event.

Mental health inpatient services must also regularly assess ward areas to identify and remove ligatures and ligature anchor points, where possible.

The care environment is important in the context of harm reduction and recovery-oriented practice by:

- providing a safe space to aid recovery

- enhancing opportunities for patients to build therapeutic relationships with staff and peers

- providing opportunities for therapeutic risk-taking

- affecting the extent to which patients experience privacy and dignity (for example, opportunities to have their own space).

Ligature types

Patients use a variety of materials as ligatures in attempts to harm themselves.

Clothing and other items commonly available in hospital wards and in the home are the main materials used.

Most items are not dangerous in everyday use and, as a result, services should avoid taking a blanket approach to restrict items associated with ligatures risks. Individual risk assessments (discussed below) should be carried out to determine the extent to which items that are capable of being used for self-harm are removed from the patient. This should be regularly reviewed and monitored. What may be a protective factor or positive risk for one patient will not be for another. Services should only deny patients access to items of clothing as a last resort.

Services need to keep risk assessments under continual review because risk factors will vary over time, even sometimes during a shift.

People with lived experience of self-harm should be involved in developing policies to help prevent or reduce the likelihood of harm in inpatient care.

Ligature points

Patients may use a variety of ligature anchor points to secure ligatures. Some ligatures and anchor points are obvious and easily accessible; some are less obvious and less easy to reach. As a result, it is vital that ligature risk assessments include both known and new forms of ligature points.

In all cases and contrary to previous guidance, low-lying ligature points **should not be judged as low risk and should be removed where possible.**

Staff should remain vigilant for all forms of ligature risk when assessing the care environment. Environmental risk assessments should include seeking out new ligature points or those that have been manipulated or subject to wear and tear, which may introduce new risk factors.

Where there are limited environmental controls or these impinge on the patient's care, privacy and dignity, staff should ensure that both individualised and system controls reduce ligature risk.

Controls include a level of observation and supervision based on individualised risk assessments, combined with processes that support these controls (for example, multidisciplinary team working and sharing of risk information in handovers and huddles).

Ward layout and design

Ward design and how well staff are able to observe patients are contributory factors for a proportion of suicides. An ideal ward design provides maximum opportunity to observe patients. Locations with a good line of sight reduce the need for restrictive intrusions and support a non-institutional 'home-like' environment.

Private spaces are important for providing patients with a greater sense of control, identity and dignity. They can also help improve people's wellbeing and positive behaviour, and can play a significant role to their recovery journey.

Some patients, for example autistic people, may benefit from space to avoid bright lights, noise and physical contact.

However, research has shown that almost all deaths by suicide happen in places where patients have privacy in bedrooms and bathrooms (with a minority of 8% happening in shared or communal areas).

Safe and effective mental health care relies on a careful balance between safety, privacy and dignity, ensuring individual patient needs are met in line with the Equality Act 2010 and patients' Human Rights.

As a result, services need to make sure that they have appropriate systems and controls in place to keep people safe while balancing the need for privacy.

Therapeutic environment

It's not just about the ward layout, but about the whole environment. Creating a therapeutic environment focuses on the balance between patient safety, privacy and dignity. It maximises opportunities to focus on strengths-based and recovery-oriented practices. Well-designed environments also aid in fostering enhanced therapeutic relationships between patients and staff, and contribute to patients' feelings of safety and control.

In contrast, ward designs that have an overly strong emphasis on patient safety foster more institutionalised restrictive environments. This can lead to negative behaviours, patients feeling disempowered, and increasing the risk of self-harming behaviours.

Positive features in the ward design, such as artwork and landscapes, can reduce stress levels and symptoms of mental ill-health.

Outdoor spaces, such as gardens and the integration of nature-based activities, provide several benefits to patient experience and outcomes.

People with lived experience of self-harm, including carers, can help services understand the challenges of creating the right environment for therapeutic care. Environments should always be co-designed with them.

Observations

In its [2021 annual report](#), the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) found that 41% of patients who died by suicide were cared for using medium or high-level therapeutic observations.

Factors associated with an increased risk of suicide during observation include staff attending to multiple duties, poor ward design, lower staff levels, and observations by less senior or experienced staff and by those unfamiliar with patients.

When supportive levels of therapeutic engagement and observation are required, the extent to which these are therapeutic is vital to patient recovery and managing ligature harm risk.

Dynamic approaches to engagement during observations (for example, judged distance) are essential and support patients to feel safe.

Observations are a skilled intervention that should be carried out by skilled staff who are familiar to the patient and encourage therapeutic, recovery-oriented approaches.

Individual risk assessment

Predicting suicide risk through verbal disclosure and using predictive tools is difficult and unreliable. Many patients that die by suicide deny or do not explicitly indicate having suicidal thoughts before death. Tools to assess risk in a non-individualised way have poor predictive values.

Risk formulation should consider more dynamic and individualised approaches, such as psychosocial forms of assessment that are collaborative with patients and carers and that build therapeutic relationships.

During individualised risk assessments, several factors should be considered, such as demographics, clinical features, personal circumstances and patient history.

Data from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) further supports these findings. This found that 67% of people who died by suicide in an inpatient setting (on the ward) from 2008 to 2018 were deemed as having no or low risk at last contact, and 31% were judged as having low or no immediate long-term risk.

Clinical messages

NCISH have set out some [key clinical messages for personalised risk assessment](#) in mental health services:

1. Risk assessment tools should not be seen as a way of predicting future suicidal behaviour.

2. Risk is not a number, and risk assessment is not a checklist. Tools, if they are used (for example as a prompt or a measure of change), need to be simple and accessible, and should be considered part of a wider assessment process. Treatment decisions should not be determined by a score.

3. There is a growing consensus that risk tools and scales have little place on their own in preventing suicide. This study suggests ways in which clinical risk assessment processes might be improved. The emphasis should be on building relationships, and gathering good quality information on (i) the current situation, (ii) past history, and (iii) social factors to inform a collaborative approach to management. Staff should be comfortable asking patients about suicidal thoughts.

4. Risk assessment processes are an intrinsic part of mental health care, but they need to be consistent across mental health services. Staff should be trained in how to assess, formulate and manage risk. Ongoing supervision should be available to support consistency of approach. There is little place for locally developed tools.

5. Families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risk. The management plan should be collaboratively developed. Communication with primary care may also be helpful.

6. Managing risk should be personal and individualised, but it is one part of a whole system approach that should aim to strengthen the standards of care for everyone, ensuring that supervision, delegation and onward referral are all managed safely.

Patient pathway

Inpatients are at high risk of suicide, but individual level of risk varies depending on where they are in the patient pathway.

Approximately 25% of all suicide behaviours (typically ligature harm) occur during the first week of admission, and 21% of patients who completed suicide on the ward from 2008 to 2018 died within the first 7 days of admission.

Further on in the admission, 48% of deaths occurred in the first 4 to 5 weeks and 31% of deaths after 10 weeks from admission date.

Further considerations are required as patients move towards discharge to ensure that they have the right level of preparedness when transitioning from a relatively safe environment to a less controlled one.

It is vital to understand risk indicators alongside the patient history and to maximise engagement through therapeutic relationships. It informs individualised risk assessment to support staff in managing potential ligature harm risk.

Key considerations

- Can I identify potential ligature points and risks to safety?

- Is the layout sufficiently documented (for example, annotated ward layout, photos of areas, photos of ligature points)?

- Are there mitigations to minimise or eliminate potential areas of risk?

- Would I be happy/comfortable staying here (in other words, will the environment aid recovery)?

- Have I collected feedback from patients, experts by experience, staff, families and carers on the therapeutic value of this built environment?

- Are all staff familiar with their environment, aware of ligature points and how these may change over time (for example, because of wear and tear or damage) and aware of the mitigating controls (for example, collapsible furniture)?

- Are staff aware of the ligature risk of each patient in the context of each room or areas accessible by patients? Is this assessed, documented, and communicated within the team through individualised risk assessment and management plans?

- Are staff considering differing areas or rooms when assessing and assessing risk and responding to this by subsequent care planning (for example, differing levels of therapeutic engagement and observation dependent on the patients and the location)?

For the built environment, we have developed specific guidance that includes an recording template that you can use to help identify ligature risk points and take action to mitigate these depending on the level of risk and the areas to which they might apply.