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National Collaborative
Commissioning Unit

Making Days Count

**National Review of
Patients Cared for in
Secure Mental Health Hospitals**

APRIL 2022

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Foreword

I commend the publication of this much needed and comprehensive National Review of Patients Cared for in Secure Mental Health Hospitals 'Making Days Count', which highlights key issues about the care and treatment of individuals admitted to secure hospitals.

Often when we think about mental ill health we think about people at home or in the community, less often do we consider those in the most restrictive of environments. However, it is these individuals, often admitted for years, and sometimes far from their home and families, that have the most complex needs and require the maximum levels of oversight.

The report highlights several areas of concern, which will need immediate and urgent action. From the number of people being admitted for more than four years to the level of aggression and disturbance within hospitals, there is a need to understand how these situations occur

and how we can reduce their frequency. Ensuring people in hospitals are listened to and activities and therapies are tailored to their needs is an important part of this.

I was surprised to see low secure not classed as a specialist service alongside medium secure and, as Wales is a country which is the right size to do things on a national basis, it would seem sensible to bring all these services together if it results in a better pathway and outcomes for patients. There are some key recommendations within this report on how improvements can be made through greater integration and I would urge that these are noted.

We often promote equity of access to mental health services, however the inequalities the report has uncovered with people from diverse background being more likely to be admitted into secure hospitals needs to be urgently examined and addressed.

Although it is a complicated area, with most patients treated in secure hospitals having complex presentations, it is concerning to see dozens of individuals being admitted to secure hospitals for more than four years.

This is a long time to be separated from the community and we must do everything possible to make admissions into secure hospitals as short as possible and encourage families to stay connected through technology and facilitated visits.

Ensuring that people are safe, supported and able to improve whilst in secure settings should be something that is at the top of everyone's agenda. Also ensuring that staff and patients are being offered well-being support and debriefing in the context of the aggression and disturbance this review highlights. This report provides a timely reminder of the need to ensure we have a consistent and detailed

scrutiny of people's experiences, responding with compassion and action. I was particularly pleased to see that the voice of patients and their families was included in the review and we need to ensure this continues and is responded to positively.

I would hope that this report marks a moment where all involved recognise the issues within our secure hospitals in Wales and work collectively to address the recommendations and insight within this report. I look forward to seeing determined and focussed action based on the findings within 'Making Days Count'.



SUE O'LEARY
DIRECTOR MIND CYMRU



About this National Review

Note: This National Review has been commissioned by Welsh Government as part of the Together for Mental Health Delivery Plan 2019–2022¹.

This National Review was commissioned to achieve greater understanding of the issues relating to secure mental health hospital care. This National Review was initially to be published in April 2021 but has been delayed due to the disruption in the ability of the audit team to undertake on-site reviews caused by the Coronavirus pandemic. Unfortunately, omitted from this National Review, also due to the disruption caused by the Coronavirus pandemic, are on-site interviews of patient's families, planned to be undertaken to better understand their experience.

Data: The information within this National Review relates to circumstances and records available on the day of the audit. All audits were completed between August 2020 and November 2020, although follow-up questions and clarifications continued into June 2021.

There were 312 patients under the scope of this National Review, although information for only 280 could be audited due to Covid 19 Pandemic disruption. Information for 5 children and young people has been excluded from Parts B–D of this National Review due to service model consistency and included in Part E.

All data is written percentage first then the number in parenthesis, for example 99% (123), if both are available. Numbers in discrete boxes are rounded to nearest 'in 10'/'in 5' number such as '1 in 10'. Numbers have been rounded to one decimal point. Note that small numbers can exaggerate percentiles.

Patient Safety: Any issues that immediately impacted on patient safety were raised with hospital staff on the day of audit.

People not Numbers: Whilst this National Review has many graphs and statistics, we note that behind every number is a person who deserves individual, high quality and safe care.

Terms: The following terms are used in this National Review:

Term	Description
Adolescents	Individuals aged between 15 and 19 years of age.
Commissioner	The NHS organisation funding placements in a secure hospital.
Provider	The NHS or independent sector organisation managing a secure hospital.
Secure hospitals	Inpatient facilities in high secure, medium secure or low secure hospitals that care for patients with a primary diagnosis of mental illness or that undertake patient assessments to determine diagnosis.
NHS Wales Patients	Patients whose responsibility for care, either directly or commissioned is a Health Board in Wales.
NHS Wales Hospitals	Medium and Low secure hospitals directly managed by Health Boards in Wales.
Non-NHS Wales Hospitals	Secure hospitals managed by the independent sector or NHS England, either in Wales or England.
Wards	Hospital space consisting of a suite of rooms shared by patients who need a similar kind of care.

‘Regular staff are very good, however there is a lot of agency [staff] that do not interact or speak with patients and that can be intimidating and unnerving’.

Comment from patient in a secure hospital made during this National Review

Executive Summary

This National Review found no immediate safety concerns. However, it has highlighted a number of issues that need to be considered and addressed.

This National Review found secure hospitals to be a challenging place to work, with high incidents of verbal aggression, violence and sexual disinhibition towards staff. This challenge was compounded by a high number of staff vacancies and inadequate access to a full multi-disciplinary team in some hospitals.

This National Review confirms that most patients being treated in secure hospitals have complex presentations, with the majority having concurrent psychosis, personality disorder and trauma. For many patients this complexity included the regular display of challenging behaviours, which required

restrictive interventions. Some patients also have additional complexities due to gender, trauma, disabilities and vulnerabilities.

This National Review found disproportionality in the number of Black and Ethnically Diverse patients admitted to secure hospitals.

This National Review found significant differences between male and female patients, with female patients having a greater prevalence of trauma, violence and self-harm.

This National Review found many patients with long lengths of stay and indications some patients may be ready for discharge, it found most, but not all, patients had a care coordinator assigned.

This National Review found many patients transferred from other secure hospitals, some from the same level of security.

This National Review makes the case for a community first approach by continuous review and recommends introducing a 'patient passport' to minimise duplication of assessment, promote continuity of care and remove barriers to progress.

This National Review found most patients prescribed psychotropic medication, many prescribed multiple types and many prescribed this medication for several years.

This National Review found patient participation in therapies and activities was variable. In some hospitals, the environment of care was found to be a noisy and challenging place in which patients could recover from mental illness.

This National Review found ensuring access to primary healthcare was essential and examined aspects of physical health such as weight and smoking.

This National Review found differences between medium and low secure hospitals, but there were many areas where the difference was marginal and makes the case for new models of care for specific groups.

This National Review found that both NHS medium secure hospitals in Wales required modernisation and explores the impediment to the effective use of resources and the benefits of consolidating commissioning responsibilities within a single organisation.

This National Review found that there may be a requirement to consider expanding some areas of secure provision.

My thanks to the members of the expert reference group, the auditors and audit planners and especially the staff and patients who participated in this National Review.



SHANE MILLS
DIRECTOR OF QUALITY AND
MENTAL HEALTH



Part A

Background and Methodology

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1. Background

Healthcare for mental illness should be delivered within the community whenever practicable², however, despite these aspirations, for some individuals, a hospital admission may be required.

When this happens, patients have the right to receive safe, effective, compassionate, evidence-based and outcome-focused care. Such tragedies as Whorlton Hall³ and Winterbourne View⁴ demonstrate the catastrophic consequences of poor hospital care. The Welsh Government Together for Mental Health Delivery Plan 2019–2022⁵ directed the National Collaborative Commissioning Unit to undertake an audit of secure mental health hospitals (henceforth called ‘secure hospitals’). This National Review was to include all patients cared for in such hospitals whether provided by NHS Wales or commissioned by NHS Wales from NHS England or the Independent Sector.

The Welsh Government expected that this National Review would provide information and assurance on the state of care, quality of care and patient experience. The National Review was originally proposed to be published in April 2021 but was unfortunately delayed due to the Coronavirus pandemic.

2. Scope

This National Review specifically includes patients with a primary diagnosis of mental illness in high secure, medium secure or low secure hospitals. Those patients with a primary diagnosis of intellectual disability in secure hospitals are not covered in this National Review but in a 2020 National Review entitled ‘Improving Care, Improving Lives’⁶.

This National Review excludes all patients not in hospitals classified as secure, such as acute hospitals and psychiatric intensive care units.

This National Review covers patients of any age, however, the differences in provision and model of care for those under 18 in secure hospitals is so distinct as to warrant a standalone Part in this National Review.

**‘In 30 months
I’ve done nothing
to assist my prospects
after discharge’.**

Comment from patient in a
secure hospital made during
this National Review

3. Methodology

In order to ensure that this National Review was evidenced based, cognisant of lived experience and took account of expertise and knowledge the following were established or undertaken:

- An on-site audit of all secure hospitals sites currently caring for one or more patients of NHS Wales. A summary of all the information requested during the site audit for each patient can be found in **Part G**.
- Patients currently being cared for in a secure hospital were invited to onsite focus groups facilitated by independent advocates. A summary of the questions posed at these focus groups can be found in **Part G**.
- An Expert Reference Group was established to provide expert advice on the key issues and to highlight relevant practice. Membership of the Expert Reference Group is detailed in **Part G**.
- Collaboration with Adferiad Recovery, a mental health charity, to understand the views of families of patients currently cared for within secure hospitals. Unfortunately, this engagement was disrupted due to the Covid 19 pandemic as hospital visiting restrictions meant no meaningful information could be collected. As a consequence, the audit, patient surveys and staff enquiries were modified to include questions on family involvement. Adferiad Recovery provided invaluable advice on relevant patient questions.

4. Secure Hospitals

Secure hospitals provide care, treatment, and support for people with complex mental disorders who pose a risk to themselves or the public⁷.

Typically, patients in secure hospitals also have co-morbid substance misuse and personality disorders⁸, may have been imprisoned or admitted directly to hospital after committing a criminal offence⁹, and are usually detained under a Section of the Mental Health Act¹⁰.

The general differences between secure and non-secure, or acute, mental health hospitals for adults, with much of the data taken from the latest NHS benchmarking reports¹¹, can be seen in Figure 1.

‘[We need] less agency [staff] and patients placed on appropriate wards to meet their needs’.

Comment from patient in a secure hospital made during this National Review

Figure 1 – General Differences Between Secure & Non-Secure Mental Health Hospitals For Adults

	Adult non-secure mental health hospitals	Secure Hospital
Average length of stay	25 days	2 years
Patients staying longer than 90 days	6%	70%+
Patients subject to a Section of the Mental Health Act	25%	98.9%
Environment	Some wards have locked entrance doors but many do not. Normal fenced perimeter	All wards have locked entrance doors. High fenced secure perimeter

Across the UK the term ‘secure hospitals’, normally defines three different hospital types ‘low’, ‘medium’ and ‘high’¹².

- High secure hospitals care for people who require a very high level of security due to their propensity to engage in dangerous, violent, or criminal behaviour. High secure hospitals have security arrangements that are equivalent to a Category ‘B’ prison but admit patients who would normally be in a Category ‘A’ prison.
- Medium secure hospitals provide a level of security suitable for public protection. In most cases, patients in medium security will have committed an offence and present a serious risk to themselves or others, combined with the potential to abscond.
- Low secure hospitals care for patients whose level of risk is greater than that which can be safely managed in general mental health services. Studies have stated that low secure is more of a ‘concept’ than a defined service and that some low secure hospitals are similar to medium secure care and others are closer in design and model to rehabilitation units¹³.

The basis for these three types of secure care was largely influenced by the Butler Report¹⁴, where regional secure hospitals, later to be renamed ‘medium secure’, were established to bridge the gap between high secure and acute mental health hospitals.

Two decades later the Reed Report¹⁵ suggested that care should be based on individual need and that mentally ill offenders should be diverted out of the criminal justice system and into healthcare¹⁶.

The core objectives of secure hospitals are to assess and treat complex mental disorder, reduce the risk of harm that the individual exhibits to others and to support recovery and rehabilitation¹⁷. Secure hospitals provide a range of evidence-based care and treatment, facilitated by mental health practitioners from a range of professions.

A range of specialist treatment programmes should be available which are delivered either individually or within groups.

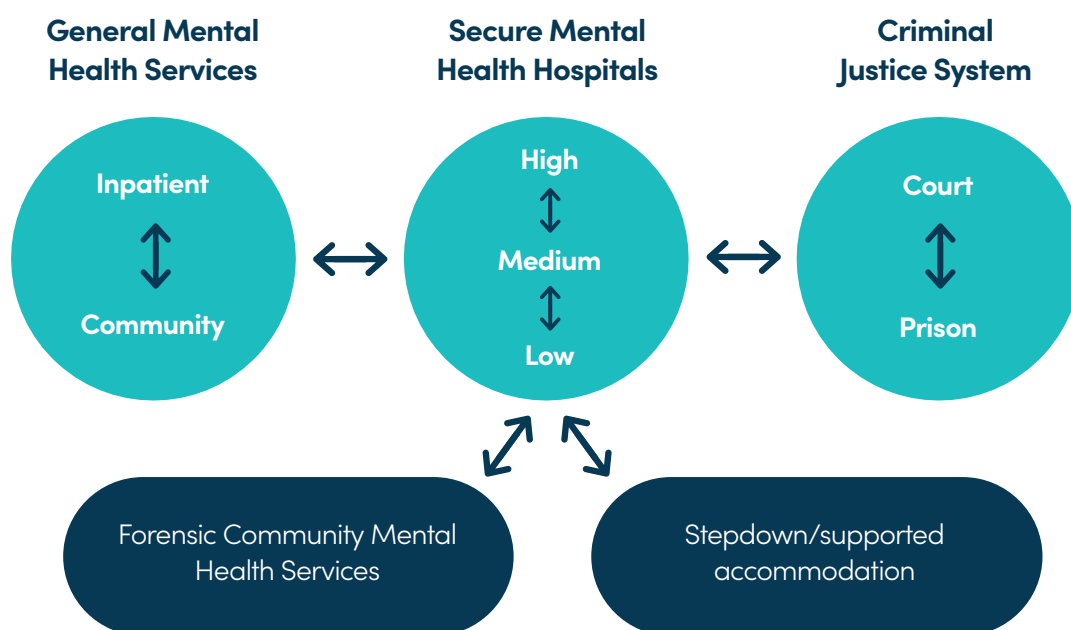
The aim is to reduce recidivism and for the individual to safely return to the community, to prison or to transfer out of secure services¹⁸.

5. Secure Services

Secure hospitals often form one part of a 'secure pathway', in some areas called 'forensic services' or 'secure services'. The extent that such a pathway is available to patients in all areas of the UK is dependent on service provision, organisational structure and commissioning arrangements.

The secure pathway can include a number of different services as shown in Figure 2¹⁹. As well as the low, medium and high secure hospitals, the pathway can also include community forensic mental health services, prison health services, probation services and police and court diversion services²⁰.

Figure 2 – Illustration of a Secure Pathway



A patient's referral to a service within the secure pathway will be determined by the level of risk, as well as the degree, nature and impact of the patients' mental illness.

Progress and transition along the pathway will be determined by engagement with services, response to treatment, and the reduction in risk to others and the need for supervision.

It is expected that services along the secure pathway work collaboratively with each other in order to ensure that any transfer within the secure pathway is achieved seamlessly and efficiently, and promotes continuity of care²¹.

6. Restrictions And Security

For secure hospitals to be effective in the promotion of safety and the prevention of harm they must restrict freedom of movement, egress, access and communication²². The extent of any restrictions should match the risk that the patient poses to themselves or to others, and should be in place for the shortest possible period. The maintenance of restrictions in secure hospitals is seen as crucial to the provision of effective therapeutic interventions²³.

Restrictions can create a safe environment for therapeutic interventions to take place, which ultimately promotes mental health, autonomy and responsibility. Restrictions normally comprise aspects of relational, procedural and environmental security²⁴, although any distinction between these three can be viewed as artificial because security should be viewed as an indivisible whole²⁵.

6.1. Relational Security Approach

Relational security is a feature of secure hospitals that emphasises the rapport between staff and patients. In building and maintaining therapeutic relationships with patients, staff members can facilitate appropriate interventions in the event of, and prior to, incidents taking place that effect safety or security²⁶.

An important element of relational security is the co-produced patient care and treatment plan²⁷. Care and treatment plans should include the patient's personal information, historical and current risks, their goals, strengths and detail interventions that will support the patient to recover²⁸.

The care and treatment plan should be regularly reviewed by the patient and the multidisciplinary team caring for them, to understand progress and to describe the journey to discharge.

'I do not feel really safe, due to unpredictable behaviour from others but staff support and reassure me'.

Comment from patient in a secure hospital made during this National Review

6.2. Procedural Security Approach

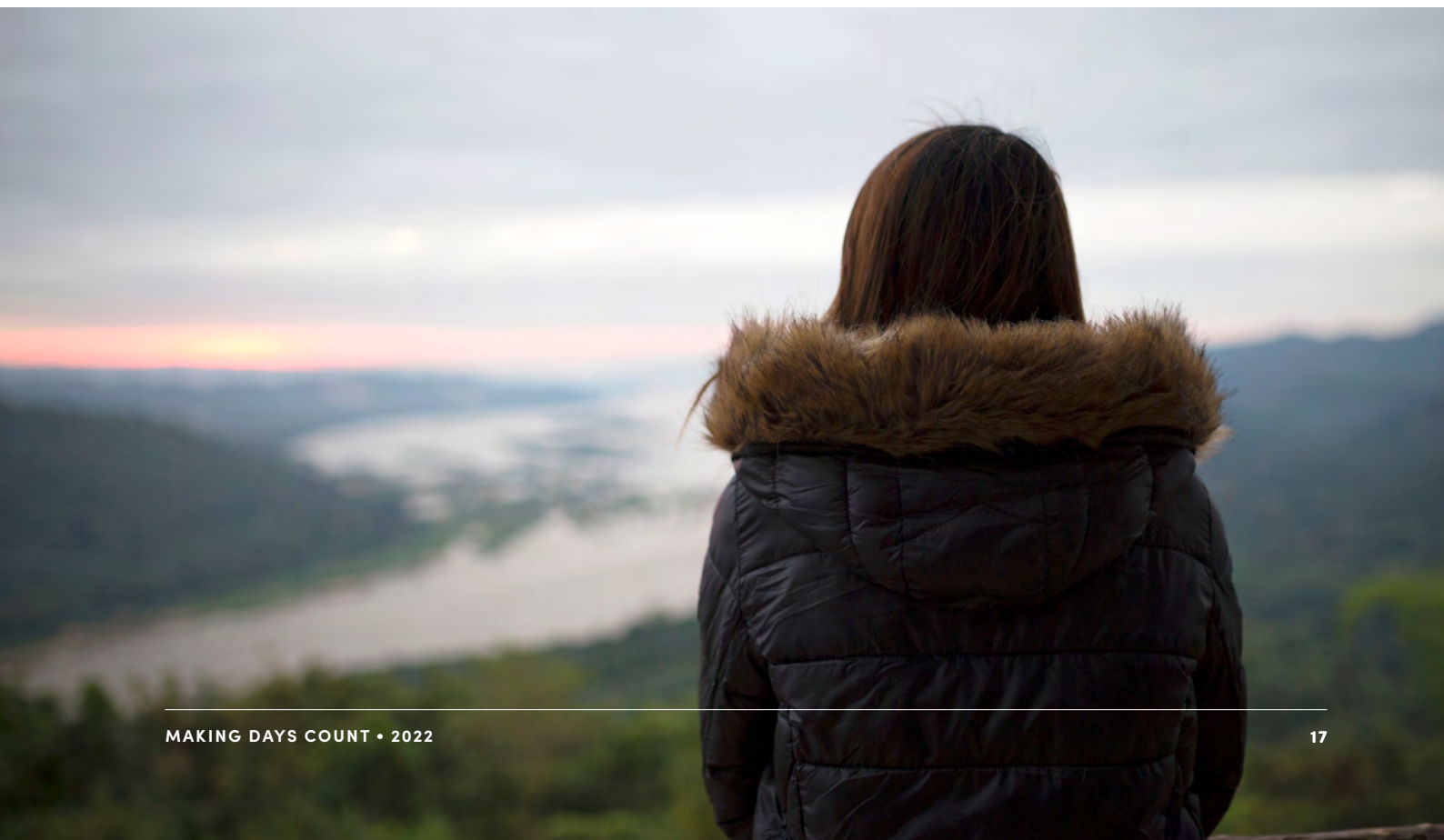
Procedural security relates to the application of set procedures and routines. These procedures are largely based upon hospital policies, mental health legislation, regulations and governmental directive²⁹. This element of security can include policies on contraband or which restrict patient's access to communication devices, finances and possessions.

Procedural security can also cover information management, legal obligations, audit, research and human resources³⁰. An important aspect of procedural security include policies and practice which support staff to safely reduce the risk to the patient and others in the event of an incident. A main benefit of implementing procedural security measures is that they allow patient care to be structured and establishes clear boundaries for the benefit of both staff and patients³¹.

6.3. Environmental Security Approach

The environment in which care is delivered should be safe, secure, and therapeutic, and it should protect and promote the privacy and dignity of patients. Environmental restrictions relate to the building layout, perimeter and construction such as windows, doors, external fences or to the provision, maintenance and correct application of appropriate equipment and technology by trained staff³².

The main aspects of environmental restrictions in secure hospitals are perimeters, windows and entrances/exits doors, which minimise the ability to abscond, and the provision of observed outdoor spaces. Secure hospitals often have facilities to safely care for individuals in isolation from other patients. The furniture and fittings in secure hospitals should minimise the opportunity for patients to use them to harm themselves or others.



7. Commissioning Arrangements

In Wales, high secure hospitals are commissioned from NHS England by the Welsh Health Specialised Services Committee (WHSSC) through a national contract.

Medium secure hospitals are commissioned by WHSSC, either directly from two NHS hospitals in Wales, from NHS England or from the independent sector through the NHS Wales National Collaborative Framework. Low secure services are provided directly by some Health Boards and/or commissioned from the independent sector, normally through the NHS Wales National Collaborative Framework.

Figure 3 shows the commissioning arrangements and the number of hospitals and wards across each type of secure hospital. Caring for people as close to their community as possible is the policy direction in Wales³³, although it may not always be possible when accessing specialised services such as high secure.

This National Review shows that, at the time of audit, the proportion of patients cared for in Wales was 72.4% (199) whilst the proportion of patients cared for in England was 27.6% (76).

7.1 Demand

Patients can be cared for in hospitals managed by the NHS or by the Independent hospital sector. The definition 'independent sector' is broad and includes private sector, charities, and social enterprises³⁴.

The reason a patient may be cared for in a non-NHS Wales hospital is the availability of appropriate beds in an NHS Wales hospital or the absence of a specific specialist bed. This National Review shows that, at the time of audit, the proportion of patients cared for in NHS Wales hospitals was 43.6% (122) whilst the proportion of patients cared for in non NHS Wales hospitals was 56.4% (158).

The NHS Wales National Collaborative Hospital Framework is the mechanism in use in Wales to commission a placement that cannot be managed in an NHS Wales hospital.

Figure 3 – Commissioning Arrangements by Type of Secure Hospital Audited in this National Review

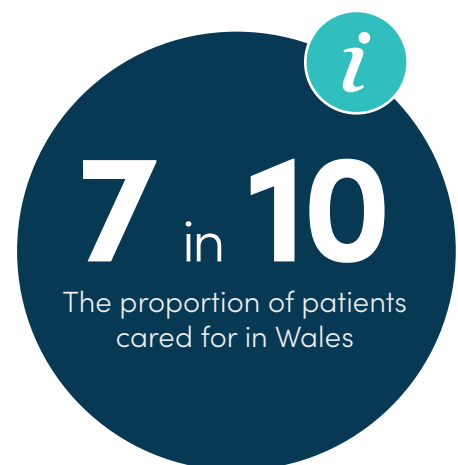
Type of Secure Hospital	Number of wards audited	Number of hospitals audited	Commissioner of these hospitals	Providers of these hospitals
High Secure	4	1	WHSSC	NHS England
Medium Secure	16	6	WHSSC	NHS Wales/ Independent Sector
Low Secure	20	15	Health Boards	NHS Wales/ Independent Sector

Figure 4 shows that from 2013–2021 there have been on average 107 patients placed in independent hospitals or NHS England hospitals on a census day, March 31st, each year over the last 9 year under the terms of the NHS Wales National Collaborative Hospital Frameworks, of these:

- On average 17 male patients have been placed in non-NHS Wales medium secure hospitals.
- On average 10 female patients have been placed in non-NHS Wales medium secure hospitals.
- On average 53 male patients have been placed in non-NHS Wales low secure hospitals.
- On average 27 female patients have been placed in non-NHS Wales low secure hospitals.

Figure 4 — Patients Placements Commissioned Through the NHS National Collaborative Hospital Framework at March 31st Each Year by Type of Secure Hospital

Type of Non-NHS Wales Secure Hospital	2013	2014	2015	2016	2017	2018	2019	2020	2021
Medium Secure For Male Patients	24	25	16	16	7	16	13	15	23
Medium Secure For Female Patients	10	16	16	9	9	6	13	6	5
Low Secure For Male Patients	67	64	61	41	42	49	39	50	66
Low Secure For Female Patients	23	24	21	32	28	29	31	30	24
Total Number Of Patients At March 31st Each Year Placed in a Non-NHS Wales Hospital	124	129	114	98	86	100	96	101	118



In 2017, across Wales and England, there were 7,950 beds in secure hospitals split between 750 beds in high, 3,500 beds in medium and 3,700 beds in low secure³⁵. The number of psychiatric hospital beds in the UK has declined by 23% between 2010 and 2021³⁶.

Understanding the number of secure hospital beds required to meet the needs of the current and future Welsh population is complex and should be based on a comprehensive, multi-agency needs assessment. This assessment must take into account the known and predicated prevalence and incidence of mental illness, as well as geography and demographics. Any consideration of investment in additional secure hospital beds within NHS Wales should be considered alongside the value of investment in enhanced community services and difficulties in recruiting and retaining specialist and experienced staff in secure hospitals. Investment in additional secure hospital beds within NHS Wales should only be considered if it can be determined that the current provision is efficient and effective, and all extant patients are being cared for at the appropriate level of secure care.

Proposals have been put forward to expand the provision of low secure hospitals in NHS Wales in 2005³⁷ and 2009³⁸ and the Welsh Government has stated that developing 'local secure services' could reduce the level of out of area placements which 'take people away from their families, carers and local communities'³⁹. There is at least one business case currently submitted to Welsh Government from NHS Wales to develop additional low secure provision. Studies have stated that secure care needs to be commissioned 'from end to end', rather than each part of the

pathway being contracted separately⁴⁰ and that the separate development of medium and low services hospitals and their separate commissioning arrangements have led to challenges as to their effectiveness⁴¹. New models of commissioning in NHS England bring NHS and Independent sector secure hospitals, within a defined geographical area, into 'Provider Collaboratives' which aim to improve quality of care and outcomes, improve pathway cohesion and reduce transition, length of stay and out of area placements⁴².

A recent report in Scotland recognised that, as each health body in Scotland is responsible for medium and low secure services, this had led to 'disparity' of provision, 'inequality of access' and that services have become a 'collection of distinct services' rather than 'one integrated system where a system wide view of services, standards and resourcing can be achieved'. This same report recommends simplifying the system by bringing all 'forensic mental health services', including both hospital and community services under the management of a new 'Forensic Board'⁴³.

A previous report in Wales recommended that an 'Integrated Commissioning Framework' should be established for secure care and that this 'would be more likely to develop step down facilities' and 'remove current incentives to place and retain patients at higher levels of security than required'⁴⁴. The NHS Wales National Collaborative Hospital Framework has been successful in 'improving quality', 'enhancing assurance' and 'reducing costs' for those patients placed in non-NHS Wales facilities and shares standards and outcomes across both medium and low secure hospitals and the NHS and independent sector⁴⁵.

The separate development of medium and low services hospitals and their separate commissioning arrangements have led to challenges as to their effectiveness⁴¹.



7.2. Expenditure

The cost of care is the amount of money paid for such things as lighting, heating, staff, training, staff pay, food, and medication. The cost of care charged may differ from the actual cost of care as it may include such things as management overheads and, in some cases, profit. Costs of care for a patient varies between providers and may be influenced by aspects of the patients care such as being on enhanced observations.

For the patients included in this National Review the cost of their total current admission, from point of admission to time of audit and noting the majority had been admitted from another secure hospital, was between £77 million and £135 million. The estimated costs for NHS Wales of all placements in secure hospitals for the year 2020 was circa £85 million.

Studies have indicated that placements in secure hospitals are 'expensive' and for NHS England possibly consume 20% of the mental health budget⁴⁶ and 1% of the entire NHS budget⁴⁷.

Calculations show that, in 2020, NHS Wales spent circa 10% of its £809 million mental health budget⁴⁸ on secure hospitals and circa 1% of the entire £7.3 billion NHS budget⁴⁹.

In Wales, in 2020, a single patient having a one-year admission to a medium secure hospital is equivalent to 62 people being on the caseload of a community mental health team for a year and, for a low secure admission, equivalent to 43 people being on the caseload of a community mental health team for a year⁵⁰.

i

£85 million

The approximate cost of
secure care for NHS Wales
in the year 2020

7.3. Quality Assurance

Quality assurance is concerned with monitoring an organisation so it delivers the expected standard of care, ensuring staff identify and correct defects and that an organisation promotes a positive patient experience. Secure hospitals are subject to a number of external quality assurance and improvement mechanisms such as:

- Quality Network for Forensic Mental Health Service, a voluntary quality improvement network for low and medium secure hospitals.
- National inspectorates/regulators, either the Care Quality Commission, if a provider is based in England, or Healthcare Inspectorate Wales, if based in Wales. All providers must get permission from the applicable regulator to open a service, are subject to regular review and monitoring and can be closed by them if they deliver an inadequate standard of care. The Care Quality Commission rates providers across 4 levels from 'inadequate' to 'outstanding'.
- If a patient is admitted to a non-NHS Wales secure hospital on the NHS Wales National Collaborative Framework (over 96% of placements in NHS Wales were made through this mechanism in 2020), the hospital is subject to regular review by the NHS Wales Quality Assurance Improvement Service which sets and monitors standards of care and rates providers through a bespoke '3Q' quality assurance rating system, see **Box 1**.

Box 1. NHS Wales Quality Assurance Improvement Service Objectives

Ensure safe, effective and high quality care is delivered that improves patient experience.

- Robustly challenge substandard provider performance.
- Provide oversight, advice and support to improve the quality of care.
- Facilitate collaborative working between providers and commissioners with the patient as the focus of care delivery.
- Ensure all procured services deliver value for money for the public purse.

- The NHS Wales Quality Assurance Improvement Service also reviews the two NHS Wales medium secure hospitals and all high secure hospitals on behalf of the Welsh Health Specialised Services Committee on, at least, an annual basis.
- Local care coordinators and/or case managers will undertake regular progress reviews of patients and may, through this mechanism, identify deficits in care provision.
- In some parts of the UK improvement is being supported through transparent reporting, such as restrictive intervention dashboards being made available to the public⁵¹.

Part B

Care in Numbers

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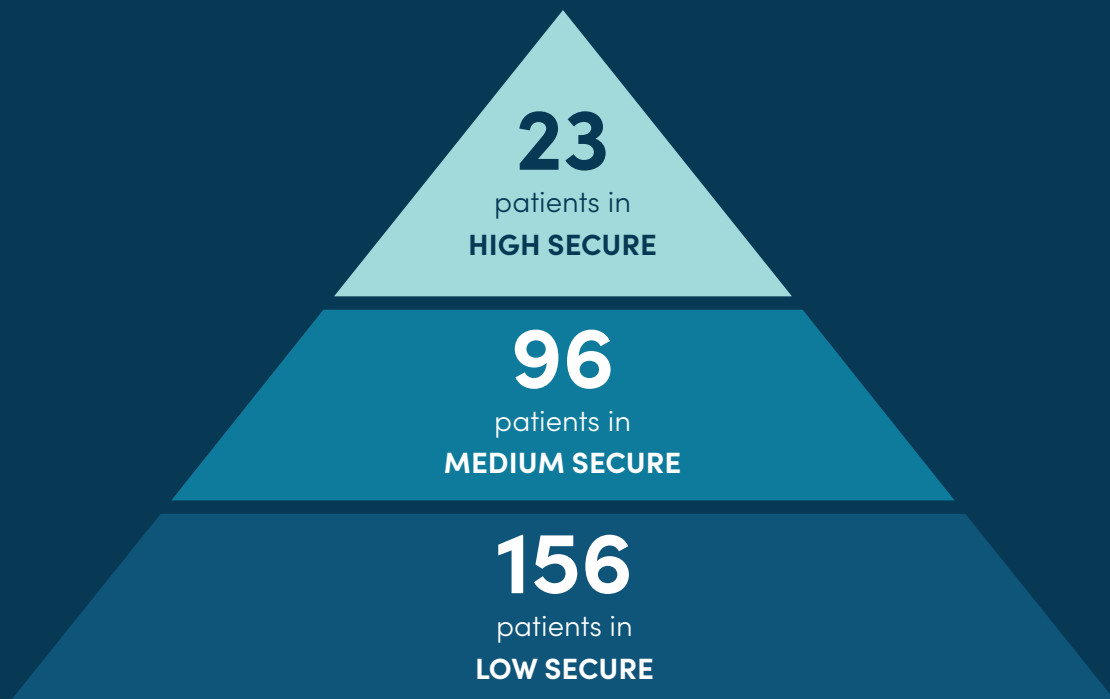
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8. Overview

At the time the audits for this National Review were undertaken there were 312 patients of NHS Wales cared for in secure hospitals and the information in Part B of this National Review relates to 88% (275) of these patients. For the 37 patients excluded from Part B, 5 were under 18 years old and are examined in Part E, and 32 were not subject to an

on-site audit due to the disruption caused by the Covid 19 pandemic. For the 275 patients included in this Part of the National Review, 8.4% (23) were being treated in high secure hospitals, 34.9% (96) were being treated in medium secure hospitals and 56.7% (156) were being treated in low secure hospitals as shown in Figure 5.

Figure 5 — Patients by Type of Secure Hospital



Note: throughout Part B of this National Review the number of patients referred to will be 275 unless otherwise stated.

9. Patient Characteristics

In order to prevent discrimination the Equality Act (2010) sets out nine protected characteristics, listed below:

1. Age.
2. Sex.
3. Religion or belief.
4. Sexual orientation.
5. Marriage or civil partnership.
6. Pregnancy and maternity.
7. Disability.
8. Race.
9. Gender reassignment.

In this National Review, a number of protected characteristics⁵² were identified within the patient population including age, sex, gender, race, religious beliefs, sexual orientation, marital status, pregnancy and disability, each of which are detailed below.

9.1. Age

Patients under 18 years of age are normally admitted to specialist secure hospitals for children and young people, whilst those over 18 are admitted adult secure hospitals.

Excluding children and young people, this Part of the National Review found that age range of the patient population was between 18 and 79 years old. The average age of a patient was 40 years old.

For male patients, the average age was slightly higher, at 41 years old, than females at 36 years old. The largest proportion of patients were between 30 and 34 years old, with 34.6% (48) of patients falling within this age range.

Figure 6 shows the average age, age ranges and number of patients within these defined age ranges by type of secure hospital. The average age was not dissimilar across all three types of secure hospital.

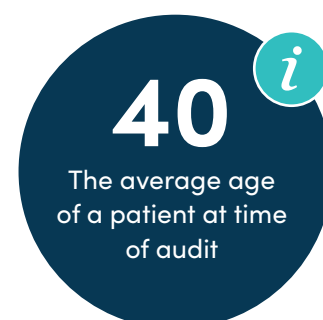


Figure 6 — Patient Age Details by Type of Secure Hospital

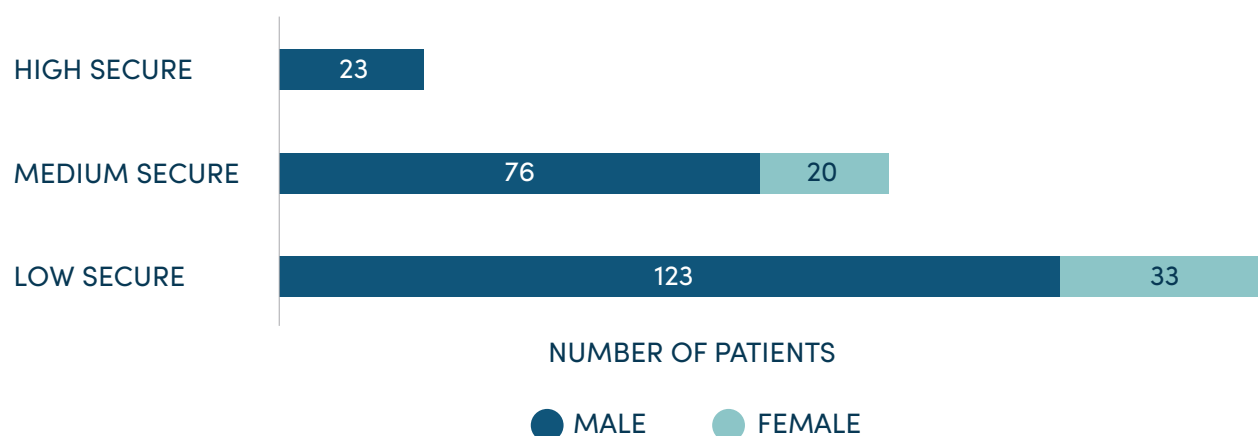
	Average Age (in years)	Age Range (in years)	Patients aged 18–24 yrs	Patients aged 25–64 yrs	Patients aged 65+ yrs
High Secure	40	26–75	0	95.7% (22)	4.3% (1)
Medium Secure	39	18–79	10.4% (10)	84.4% (81)	5.2% (5)
Low Secure	41	19–78	12.8% (20)	81.4% (127)	5.8% (9)

9.2. Sex

There are differences between male and female patients with mental illness in terms of their physical needs, mental health presentations and care needs⁵³.

Whilst positive emotional support and staff relationships are associated with better clinical outcomes for all patients in secure hospitals, research has shown the impact of these is greater for female patients. Female patients may also prefer to be treated in single-sex environments, as they feel safer and more comfortable⁵⁴ although these environments are not necessarily safer or more gender-sensitive⁵⁵. Specific issues for male and female patients are highlighted throughout this National Review. Figure 7 shows the sex of patient by type of secure hospital and shows that the majority, 80.7% (222), of patients were male and 19.3% (53) were female.

Figure 7 – Sex of Patients by Type of Secure Hospital



9.3. Gender & Transgender

Sex refers to the different biological and physiological characteristics of males and females, whilst gender refers to the socially constructed characteristics of women and men. When individuals do not 'fit' established gender norms they often face stigma, discriminatory practices or social exclusion⁵⁶. 'Transgender' is an umbrella term used to describe people whose identification with, or expression of gender, is different from the sex assigned at birth. Transgender people can express their identity in many different ways.

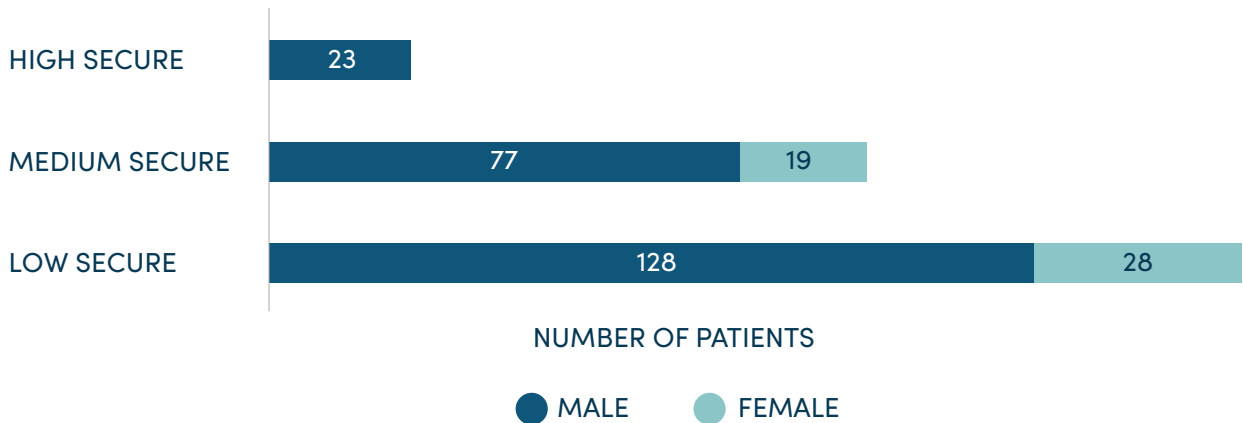
All healthcare providers must uphold the requirements of the Equality Act [2010], the Human Rights Act [1998] and the Gender Recognition Act [2004] when treating transgender patients⁵⁷.

It is also important that the associated risks for a transgender person, as well as other patients, is considered before their admission to single-sex wards in secure hospitals⁵⁸. It is estimated that between 0.3 and 0.7% of the United Kingdom population are transgender.

In this National Review, it was found that 2.2% (6) of patients, being cared for in secure hospitals, identified as transgender⁵⁹. Henceforth in this National Review the terms ‘male’ and ‘female’ will refer to the patients stated gender identity and the word ‘gender’ will be used instead of ‘sex’.

Figure 8 highlights the gender of patients by type of secure hospital and shows the total number of patients for this Part of the National Review, based on gender, is 82.9% (228) male patients and 17.1% (47) female patients.

Figure 8 – Gender of Patients by Type of Secure Hospital



9.4 Ethnicity

The terms ‘Black’, ‘Asian’ or ‘Ethnically Diverse’ are in use in this section although we recognise these terms homogenise a range of identities, ethnicities, cultures, and heritages. Research has shown that individuals who are Black are more likely to be admitted to secure hospitals⁶⁰, and are four times more likely to be detained under the Mental Health Act [1983], than individuals who are white⁶¹. Figure 9 below compares the proportion of Black, Asian and Ethnically Diverse patients to those within the general Welsh population⁶². Although actual numbers are small, it shows that 9.1% (25) of patients in secure hospitals were Black, Asian or Ethnically Diverse, over twice the population proportion.

Figure 9 – Welsh Population & Patients in Secure Hospitals by Ethnicity

Ethnicity	Welsh Population	Secure Hospital Patients
Black	0.6%	2.9% (8)
Asian	2.3%	1.1% (3)
Ethnically Diverse	1%	5.1% (14)
Total	3.9%	9.1% (25)

9.5. Religious Beliefs

The population of Wales has a diverse range of religious beliefs, with the largest, (57.6%) being Christianity, although 32% had no religious belief⁶³.

This National Review found that 56% (117) of patients declared no religious belief. Figure 10 shows the religious beliefs of the Welsh population and the secure hospital population, for the 76% (209) of patients who disclosed this information.

Figure 10 – Welsh Population & Patients in Secure Hospitals by Religious Belief

Religious Belief	Welsh Population	Secure Hospital Patients
Christianity	57.6%	36.4% (76)
Islam	1.5%	4.8% (10)
Buddhism	0.3%	1% (2)
Other Religion	0.9%	1.9% (4)
No Religious Belief	32.1%	56% (117)

9.6. Sexual Orientation

Sexual orientation refers to the gender, or genders, that an individual is attracted to and, regardless of sexual orientation, all patients deserve the same good quality care⁶⁴. Figure 11 shows the sexual orientation of the Welsh population⁶⁵ and secure hospital population for the 86.2% (237) of patients who disclosed this information.

Figure 11 – Welsh Population & Patients in Secure Hospitals by Sexual Orientation

Sexual Orientation	Welsh Population	Secure Hospital Patients
Heterosexual	94.4%	78.5% (216)
Gay/Lesbian	1.9%	2.9% (8)
Bisexual	1%	4.7% (13)
Not disclosed	0	13.8% (38)

9.7. Marital Status

In the UK around 35% of the adult population are not married, 50.4% are married, 8.2% are divorced/separated and 6.5% are widowed⁶⁶.

Information on marital status in this National Review was collected for 98.9% (272) of patients and found that 90.1% (245) of this population were not married, 1.5% (4) were married, 8.1% (22) were divorced/separated and 0.4% (1) were widowed.

9.8. Pregnancy

This National Review found that 0.4% (1) of patients were pregnant and being cared for in a secure hospital.

9.9. Disability

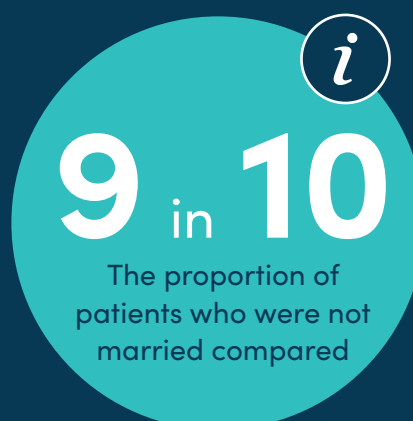
Some patients may have an additional needs which require recognition, adaption or support. It is essential that these additional needs are identified within secure hospitals so that patients can be appropriately supported through a strengths-based approach.

Additional needs generally fall into one of three categories:

- Communication and/or cognitive needs.
- Sensory needs.
- Physical and/or mobility needs.

Meeting these needs is fundamental to ensuring that safe services and high-quality clinical outcomes are delivered and that people with disability are able to access the care, support and advice they need to live independent and healthy lives⁶⁷.

In Wales about 25% of the population have a form of disability⁶⁸. In this National Review 22.5% (62) of patients had one of the three additional needs listed previously, 7.6% (21) had two and 1.5% (4) had all three. In this National Review it was identified that 17.5% (48) of patients in secure hospitals had communication and/or cognitive needs, 9.1% (25) had sensory needs, and 13.8% (38) had physical and/or mobility needs.



10. Diagnosis



A diagnosis is a label that describes the symptoms of ill health that an individual is experiencing that can be used to guide treatments and interventions. Patients being treated in secure hospitals have usually received one or more psychiatric diagnosis, of which the most common are psychotic disorders and personality disorders⁶⁹.

This National Review found that 95.3% (262) of patients were diagnosed with a psychiatric disorder, although 4.7% (13) of patients had no psychiatric diagnosis, of which 38.5% (5) of

these 13 patients had admissions of more than one year. Figure 12 shows the prevalence of diagnosis in secure hospitals and shows that the most common diagnosis, 75.4% (172), for male patients was psychotic disorder and for female patients it was personality disorder, 55.3% (26).

Many patients had more than one diagnosis and therefore the total number of disorders presented in Figure 12 may exceed the number of patients.

Figure 12 — Prevalence of Diagnosis by Gender

Psychiatric Diagnosis	 Male Patients	 Female Patients	Overall
Psychotic Disorders	75.4% (172)	31.9% (15)	68% (187)
Personality Disorders	19.7% (45)	55.3% (26)	25.8% (71)
Affective Disorders	4.4% (10)	17.0% (8)	6.5% (18)
Intellectual Disabilities	4.8% (11)	8.5% (4)	5.5% (15)
Neuro-diverse Disorders	5.7% (13)	2.1% (1)	5.1% (14)
No Diagnosis	4.8% (11)	6.4% (3)	5.1% (14)
Neurotic/Stress-related Disorders	3.1% (7)	8.5% (4)	4.0% (11)
Behavioural/Emotional Disorders	3.1% (7)	6.4% (3)	3.6% (10)
Organic Mental Disorders	0.9% (2)	4.3% (2)	1.5% (4)

This National Review found that 26% (72) of patients in secure hospitals had more than one diagnosis. The most common co-occurring diagnosis was personality disorder with 60% (43) of patients having this as a secondary diagnosis.

Figure 13 shows the prevalence of primary diagnoses by the type of secure hospital. It shows a higher prevalence of patients diagnosed with disorders due to psychoactive substance in high secure hospitals, affective disorders in medium secure, and intellectual disabilities, and behavioural/emotional disorders in low secure.

Figure 13 – Prevalence of Diagnosis by Type of Secure Hospital

Primary Diagnosis	High secure	Medium secure	Low secure
Organic Disorder	0	1.0% (1)	1.9% (3)
Disorders due to Psychoactive Substance Use	30.4% (7)	1.0% (1)	9.6% (15)
Psychotic Disorders	78.3% (18)	70.8% (68)	65.4% (102)
Affective Disorders	4.4% (1)	9.4% (9)	5.1% (8)
Neurotic/Stress-related Disorders	0	4.2% (4)	4.5% (7)
Personality Disorders	30.4% (7)	21.9% (21)	28.2% (44)
Intellectual Disabilities	4.4% (1)	0	9.0% (14)
Neuro-diverse Disorders	4.4% (1)	5.2% (5)	5.8% (9)
Behavioural/Emotional Disorders	0	1.0% (1)	5.8% (9)
No Diagnosis	0	3.1% (3)	3.8% (6)

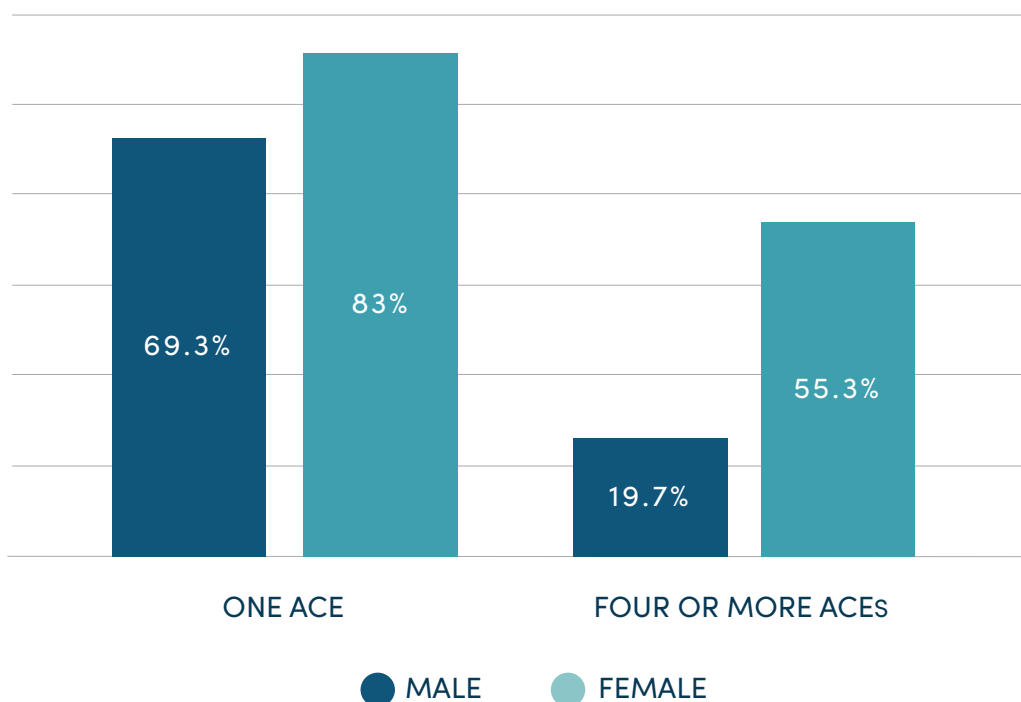
11. Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are highly stressful, and potentially traumatic, experiences that occur during childhood or adolescence such as abuse or neglect⁷⁰. Research has suggested a link between ACEs and the development of mental illnesses⁷¹ and that having four or more ACEs is predictive of a range of health harming behaviours^{72,73,74,75,76,77}.

A history of childhood abuse is common for patients in secure hospitals and using restrictive interventions with patients with such histories can be 'particularly traumatic', as they may reactivate their unpleasant childhood experiences. Patients may self-harm to 'communicate' and 'cope' with these experiences^{78,79,80,81}. Research suggests that 47% of the Welsh population have experienced at least one ACE and 14% have experienced four or more ACEs. This National Review found that 71% (196) of patients in secure hospitals had at least one ACE, and 27.6% (76) had four or more ACEs. The average number of ACEs across both genders was 2.8, with female patients having on average 4 ACEs and male patients having 2.8 ACEs⁸².

Research has also shown that in secure hospitals there is a greater prevalence of ACEs amongst female patients compared to male patients⁸³ and Figure 14 shows that this National Review found that female patients were more likely to have both 1 ACE and 4 or more ACEs.

Figure 14 — Percentage of ACEs by Gender



This National Review also examined linking factors between ACEs and other issues and found that if a patient had a diagnosis of personality disorder, they were 2.5 times more likely to have one or more ACE.

12. Reason for Admission

Individuals can require secure care as they pose a risk to the public⁸⁴, or they require a specialist environment that can provide care and treatment designed to improve mental health and facilitate recovery⁸⁵. There may be several reasons for admission but this National Review has separated them into a 'primary' reason for admissions, with additional reasons being referred to as 'secondary reasons'. Figure 15 shows the primary and secondary reasons for admission into secure hospital by gender and listed by greatest proportion. For male patients the most common reason for admission was 'risk to others', and for female patients was 'risk to both themselves and others'.

For both genders the three primary reasons for admission were:

- The patient is assessed to be a risk to others.
- The patient is assessed to be a risk to both themselves and others.
- The patient to engage in therapy in a managed environment.

Figure 15 — Primary & Secondary Reasons for Admission by Gender





	 Male Patients	 Female Patients	Overall
Primary reason for admission			
Risk to others	39.9% (91)	19.1% (9)	36.4% (100)
Both risk to self and others	25.0% (57)	68.1% (32)	32.4% (89)
Therapy in managed environment	13.2% (30)	0	10.9% (30)
Assessment	8.8% (20)	4.3% (2)	8.0% (22)
Complex treatment	3.9% (9)	4.3% (2)	4.0% (11)
Non-adherence with medication regime	3.1% (7)	0	2.5% (7)
Step down to lower tier of security	2.2% (5)	0	2.2% (5)
Risk to self	1.8% (4)	2.1% (1)	1.8% (5)
Risk of absconding	0.9% (2)	0	0.7% (2)
Ongoing treatment	0.4% (1)	0	0.4% (1)
Substance misuse	0.4% (1)	0	0.4% (1)
Vulnerability due to psychosis	0	2.1% (1)	0.4% (1)
Unknown	0.4% (1)	0	0.4% (1)

Figure 15 Continued — Primary & Secondary Reasons for Admission by Gender








	 Male Patients	 Female Patients	Overall
Secondary reason for admission			
Therapy in managed environment	23.2% (53)	8.5% (4)	20.7% (57)
Complex treatment	17.5% (40)	19.1% (9)	17.8% (49)
Risk to others	18.4% (42)	2.1% (1)	15.6% (43)
Both risk to self and others	10.1% (23)	10.6% (5)	10.2% (28)
Assessment	7.9% (18)	21.3% (10)	10.2% (28)
No secondary reason	5.3% (12)	8.5% (4)	5.8% (16)
Risk to self	5.3% (12)	6.4% (3)	5.5% (15)
Non-adherence with medication regime	3.1% (7)	10.6% (5)	4.4% (12)
Risk of absconding	2.2% (5)	6.4% (3)	2.9% (8)
Repatriation	2.2% (5)	4.3% (2)	2.5% (7)
Sexual assault, violence or offenses	1.3% (3)	0	1.1 % (3)
Step down	0.4% (1)	2.1% (1)	0.7% (2)
Substance misuse	0.9% (2)	0	0.7% (2)
Physical aggression	0.4% (1)	0	0.4% (1)
Breakdown in staff-patient relationship	0.4% (1)	0	0.4 % (1)
Fire in previous hospital and required relocation	0.4% (1)	0	0.4 % (1)
Ministry of Justice recall	0.4% (1)	0	0.4 % (1)
Risk to children	0.4% (1)	0	0.4% (1)

13. Admission Pathway

Studies have shown that patients are most commonly admitted to secure hospitals from prison⁸⁶. This National Review examined where patients had been admitted from, and found that the majority, 72% (199), of patients had been admitted from another mental health hospital.

Figure 16 shows, as a proportion of patients admitted, where patients have been admitted from, for each type of secure hospital, by gender and shows that 26% (60) of male patients were admitted from Prison or Court, compared to 6% (3) of female patients.

Figure 16 – Admission Pathway by Type of Secure Hospital & Gender

Admitted into ► ▼Admitted from (as a proportion of those admitted into)	Male High Secure 	Male Medium Secure 	Male Low Secure 	Female Medium Secure 	Female Low Secure 	Total Male Patients 	Total Females Patients 	Overall
Medium secure	39.1% (9)	46% (35)	18.6% (23)	52.6% (10)	10.7% (3)	29.4% (67)	27.7% (13)	29.1% (80)
Prison or court	56.5% (13)	25% (19)	22.7% (28)	0	10.7% (3)	26.3% (60)	6.4% (3)	22.9% (63)
Non-secure hospital (including PICU)	0	7.8% (6)	27.6% (34)	15.8% (3)	57.1% (16)	17.5% (40)	40.4% (19)	21.5% (59)
Low secure		6.5% (5)	17.0% (21)	21.1% (4)	0	11.4% (26)	8.5% (4)	10.9% (30)
Locked rehabilitation	4.3% (1)	0	7.8% (10)	0	17.9% (5)	4.8% (11)	10.6% (5)	5.8% (16)
High secure	0	13.0% (10)	1.6% (2)	0	0	5.3% (12)	0	4.4% (12)
Community (not home)	0	1.3% (1)	3.1% (4)	5.3% (1)	3.6% (1)	2.2% (5)	4.3% (2)	2.6% (7)
Home	0	0	4% (5)	0	0	2.2% (5)	0	1.8% (5)
Children & Adolescents Mental Health Hospital	0	1.3% (1)	0.8% (1)	0	0	0.9% (2)	0	0.7% (2)
Supported living accommodation	0	0	0	5.3% (1)	0	0	2.1% (1)	0.4% (1)






14. Secure Hospital to Secure Hospital Admissions

A care journey should end with discharge to the community, although some patients are discharged to another secure hospital, at a higher, lower, or matching level of security.

Studies have found that ‘a third of women’ are discharged to a hospital of the same level of security⁸⁷. Other studies have shown that the ‘significant’ proportion of patients discharged to the same level of security suggests that the ‘ideal’ pathway of moving from higher to lower levels of security is not achieved for ‘many’ patients⁸⁸. Discharges of patients to hospitals with the same level of security may be thought appropriate for reasons of repatriation to NHS care or moving closer to home but can also add to the ‘complexity of the patient journey’ and cause delays in community discharge⁸⁹. A significant proportion, 44.4% (122) of patients were admitted to their current placement from another secure hospital, of the same or different level of security. 46.1% (105) of male patients and 36.2% (17) of female patients were admitted from another secure hospital. Figure 17 shows that as a proportion of overall patients, 24% (66) were admitted from a secure hospital of the same level of security.

Of these 7.6% (21) of patients had moved from low secure to another low secure hospital and 16.4% (45) of patients moved from a medium secure to another medium secure hospital. 20.3% (56) of male patients and 21.3% (10) of female patients were admitted to a hospital of the same level of security.



Figure 17 — Admissions to Other Secure Hospitals by Gender

Current Admission ► (as a proportion of those in that type of hospital at time of audit)	Male High Secure 	Male Medium Secure 	Males Low Secure 	Female Medium Secure 	Female Low Secure 
▼Admitted From					
Male High Secure	0	13% (10)	1.6% (2)	0	0
Male Medium Secure	39.1% (9)	45.5% (35)	3.9% (5)	0	0
Male Low Secure	0	29.9% (23)	16.4% (21)	0	0
Female Medium Secure	0	0	0	52.6% (10)	14.3% (4)
Female Low Secure	0	0	0	15.8% (3)	0

There are initiatives in other parts of the UK that are seeking to reduce transitions for women by 'blending' medium and low secure services in a single hybrid model and to improve their experience and outcomes by focusing on relational security and a trauma-informed approach ^{90,91,92}.

Figure 18 shows the reasons for admission for the 122 patients admitted from another secure hospital, of the same or different level of security and shows that, for both genders, 'Both risk to self and others', was the most common reason for admission.

Figure 18 — Reason for Admission, for Patients Admitted From Another Secure Hospital by Gender

Reason for admission	 Male Patients	 Female Patients	Overall
Both risk to self or others	61.9% (65)	88.2% (15)	65.6% (80)
Therapy in managed environment	16.2% (17)	0	13.9 (17)
Complex treatment	6.7% (7)	5.9% (1)	6.6% (8)
Assessment	6.7% (7)	0	5.7% (7)
Stepdown	4.8% (5)	0	4.1% (5)
Ongoing treatment	1.0% (1)	0	0.8% (1)
Absconding risk	1.0% (1)	0	0.8% (1)
Substance misuse	1.0% (1)	0	0.8% (1)
Vulnerability due to psychosis	0	5.9% (1)	0.8% (1)
Unknown	1.0% (1)	0	0.8% (1)

15. Legal Status

The Mental Health Act [1983], amended in 2007, is the main piece of legislation that covers the assessment, treatment and rights of individuals with a mental illness. When patients are treated in hospital they can consent to treatment or, under some circumstances, they can be detained, also known as ‘Sectioned’, under the Mental Health Act [1983].

The Mental Health Act [1983] has over one hundred sections and those most relevant to patients cared for in secure hospitals are as follows:



- **Section 3.** This is a treatment Section. The initial period for which detention is authorised is six months, but it can be renewed for a further six months, then for further periods of 12 months.
- **Section 36.** This is a section imposed by the Crown Court, whereby the Court can send an individual for treatment while they are awaiting trial, on trial, or in custody for an offence punishable with imprisonment.
- **Section 37.** This is a Section imposed by a Crown Court after an individual has been convicted of an imprisonable offence, other than murder. The stipulations are generally the same as an admission under Section 3, and is usually for treatment.
- **Section 37/41.** This Section has the basis of a Section 37, but does not require renewing as it continues indefinitely until discharged. The Ministry of Justice is responsible for granting leave and allowing discharge from hospital.
- **Section 38.** This Section is imposed by either a Crown Court or Magistrates Court. It is usually given after conviction but before sentence. It is an ‘interim’ order and it can last for an initial period of 12 weeks and then, if necessary, be extended up to 12 months. It is usually for assessment.
- **Section 45a.** This Section is imposed by the Crown Court at the same time as imposing a prison sentence, except where the sentence is fixed by law, such as murder. Once the individual has completed their treatment, they can then be transferred to prison to serve the remainder of the sentence.
- **Section 47.** This is a Section for an individual who has received a sentence from a court and been imprisoned. The Section transfers the individual from prison to a hospital for treatment.
- **Section 47/49.** This is a Section for an individual who has received a sentence from a court and been imprisoned. The Section transfers the individual from prison to a hospital for treatment and means that the Ministry of Justice is responsible for granting leave and allowing discharge from hospital.

This National Review found that 98.5% (271) of patients were admitted to secure hospitals under a Section of the Mental Health Act [1983]. For those 1.1% (3) patients not detained it is possible that they had capacity to make decisions regarding their care although this could not be confirmed.

Figure 19 shows the details of patients on a Section of the Mental Health Act [1983] and shows that the most common Section under which patients in high secure were detained was Section 47/49, in medium secure it was Section 37/41 and for patients in low secure services it was Section 3.

The most common Section under which male patients, 36.4% (83), were detained was Section 37/41, whilst for females, 51.1% (24), it was Section 3.

Figure 19 — Patients on Section of the Mental Health Act by Type of Secure Hospital & Gender

	High Secure	Medium Secure	Low Secure	 Male Patients	 Female Patients	Overall
Section 37/41	26.1% (6)	37.5% (36)	32.7% (51)	36.4% (83)	21.3% (10)	33.9% (93)
Section 3	4.3% (1)	15.6% (15)	42.9% (67)	25.9% (59)	51.1% (24)	31.2% (83)
Section 47/49	47.8% (11)	22.9% (22)	6.4% (10)	17.5% (40)	6.4% (3)	15.7% (43)
Section 37	13.0% (3)	15.6% (15)	12.8% (20)	13.2% (30)	17% (8)	13.8% (38)
Section 47	0	4.2% (4)	2.6% (4)	3.5% (8)	0	2.9% (8)
Section 45a	8.7% (2)	3.1% (3)	0	1.8% (4)	2.1% (1)	1.8% (5)
Not detained under the MHA	0	0	1.9% (3)	0.9% (2)	2.1% (1)	1.1% (3)
Section 38	0	1.0% (1)	0	0.4% (1)	0	0.4% (1)
Section 36	0	0	0.6% (1)	0.4% (1)	0	0.4% (1)

16. Care Coordination

A care coordinator manages the relationships between all members of the patients care team. A care coordinator is responsible for working collaboratively with the patient and the patient's family and ensuring any service, in which the patient is being treated, is suitable. They may also be responsible for planning the patient's accommodation needs following discharge and supporting the patient as they transition out of secure hospital⁹³.

This National Review found that 88% (242) of patients had a care coordinator assigned, 39.1% (9) in high secure, 89.6% (86) in medium secure and 94.2% (147) in low secure.

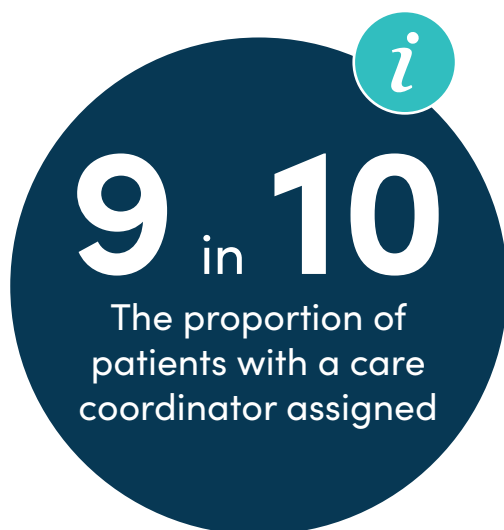
The proportion of patients in medium secure hospitals not assigned a care coordinator at the time of audit is higher in NHS Wales hospitals at 14.8% (9) than in non NHS Wales hospitals 2.9% (1). The proportion of patients in low secure hospitals not assigned care a coordinator at the time of audit is higher in NHS Wales hospitals at 8.2% (4) than in non NHS Wales hospitals 4.6% (5).

This National Review found that 82.6% (200) of care coordinators were community nurses, 15.7% (38) were social workers and 1.6% (4) were other professionals such as psychiatrists, psychologists, or occupational therapists. It is common for patients in high and medium secure hospitals to have a case manager assigned, this designated professional periodically undertakes a systematic review of a patient's placement to determine if the patient still requires the current level of security and to support effective discharge.

17. Care Plans

A care plan, also referred to as a 'care and treatment plan', 'nursing plan', or 'support plan', is a written record outlining the patient's needs, planned treatment and treatment goals and should be clear and easily understood by the patient. The process of developing a care plan should be done collaboratively between the patient and the therapeutic team. It should enable patients to receive personalised care which focusses on and maximises achievement and social integration⁹⁴.

This National Review found that 100% (275) of patients had a care plan in place developed after they had been admitted to the hospital. To support continuity of care it is good practice for the patient's community care coordinator to develop the care plan with the patient. This National Review found that 30.5% (84) of care plans had been developed by the patient and their community care coordinator.



18. Length of Admission

Admission length is the time period the patient remains in hospital between arrival and discharge. The length of admission for each patient can vary depending on the patient's presentation and risk, the type and duration of therapy, interventions required and the availability of suitable support on discharge. However, it is important that patients are not admitted for longer than necessary because they will experience a loss of privacy, repetitive daily routines and a lack of stimulus⁹⁵. An admission that is longer than necessary, can also result in a poor experience for the patient and promote dependency⁹⁶. Systems are used in many physical health hospitals to identify 'wasted time' in a patient's journey such as Red Days/Green Days⁹⁷.

The average length of secure hospital admissions can be as much as twelve times that of acute mental health hospitals⁹⁸. This, coupled with the restrictions that are inherent in secure hospitals, has raised concerns regarding the lengths of admissions of some patients^{99,100}. Nearly 1 in 4 patients in high secure spend ten years as inpatients and nearly 1 in 5 in medium secure spend five years or more as inpatients^{101,102}. Furthermore, a 'large proportion' of individuals remain 'two years longer' than 'recommended' as patients in secure hospitals^{103,104}. Research suggests that patients stay longer in secure hospitals compared to prison services, even when the offence is the same¹⁰⁵.

Despite the lengthy stay of patients within secure care, there is evidence to suggest that treatment in these hospitals leads to positive clinical and risk-related outcomes for both males and female patients^{106,107,108,109}.

There are a number of factors which contribute to a patient's length of stay, including the nature of the index offence and the complexity and severity of the patient's mental illness^{110,111}.

These findings may explain why there are associations between improvements in mental health and patient progress through the secure pathway^{112,113}. Other research has found that therapeutic engagement by the patient was a significant predictor of potential patient discharge^{114,115,116}. The extent of a patient's engagement in therapy also has implications for recovery, readmission to hospital¹¹⁷ and recidivism¹¹⁸. 'Self-stigmatisation' has been defined as the process in which a person with a mental health diagnosis becomes aware of public stigma, agrees with those stereotypes, and internalises them by applying them to themselves¹¹⁹. The extent of a patient's engagement in therapy^{120,121}, the severity of symptoms of mental illness¹²² and concordance with pharmacotherapy¹²³ can all be negatively influenced by self-stigma. When medium secure services were first established, they were to provide care for patients for whom there was a 'good prospect of discharge' after between eighteen months to two years of admission¹²⁴.

Recent data from across the UK has shown the average length of admission for patients in a high secure hospital was eight years¹²⁵, medium secure was two years and in low secure was one year and eleven months ¹²⁶.

Due to this National Review looking at extant patient admissions and not patients already discharged, length of admission is based on the time period between the patient's admission to the current provider and the date the placement was audited as part of this National Review.

Figure 20 shows the length of the admission by type of secure hospital and gender and shows that 27.3% (75) of patients had been admitted for between 1 and 2 years at the time of audit, the most frequent time period.

This time period was also the most frequent for male patients 27.2% (62), female patients 27.7% (13), patients in medium secure 31.3% (30), and low secure 25.6% (40). For patients in high secure the most frequent, 26.1% (6), time period was 2–3 years.

Figure 20 — Length of Admission at Time of Audit by Type of Secure Hospital & Gender

	High Secure	Medium Secure	Low Secure	Male Patients	Female Patients	Overall
Up to 3 months	4.3% (1)	9.4% (9)	10.9% (17)	10.5% (24)	6.4% (3)	9.8% (27)
4–6 months	4.3% (1)	18.8% (18)	18.6% (29)	16.2% (37)	23.4% (11)	17.5% (48)
7–11 months	13.0% (3)	14.6% (14)	12.2% (19)	12.2% (28)	17.0% (8)	13.1% (36)
1–2 years	21.7% (5)	31.3% (30)	25.6% (40)	27.2% (62)	27.7% (13)	27.3% (75)
2–3 years	26.1% (6)	13.5% (13)	19.2% (30)	18.4% (42)	14.9% (7)	17.8% (49)
4–7 years	17.4% (4)	10.4% (10)	12.2% (19)	12.3% (28)	10.6% (5)	12.0% (33)
7–9 years	13.0% (3)	2.1% (2)	1.3% (2)	3.1% (7)	0	2.5% (7)



18.1. Extended Lengths of Admission

Some studies have raised concerns that the length of admission for some patients is ‘unnecessarily long’^{127,128}, although there is no accepted definition of ‘long-stay’ and studies have defined this point as anywhere between 2 and 15 years¹²⁹.

Studies have shown that the factors most frequently associated with extended admissions include seriousness of index offence, history of psychiatric treatment, cognitive deficit, and severity of illness, diagnosis of a psychotic disorder and history of violence¹³⁰.

Studies has shown that between 10–20% of patients stay 5 years or longer in secure hospitals¹³¹ and this National Review found 14.5% (40) of patients had been admitted for over 4 years at the time of audit. The care of individuals in secure hospitals differs between NHS Wales patients and other European countries as shown in **Box 2**.

Box 2. Differences in care of individuals in secure hospitals between NHS Wales patients and other European countries.

The care of individuals in secure hospitals differs between NHS Wales patients and other European countries in a ways which may affect length of admission, such as:

- Unlike in most other European countries, NHS Wales patients can be admitted to secure hospitals without having offended.
- Unlike other European countries the sentencing court plays no further role in decisions about the patient once admitted. For NHS Wales patients decisions about discharge predominantly lies with clinicians, although in some cases the Ministry of Justice is involved.
- NHS Wales patients often move between hospitals of different levels of security. In many European countries different levels of security are provided within the same hospital allowing for easier transfer from one to another and resulting in shorter admissions.
- NHS Wales patients can remain in secure hospital beyond the time they would have been incarcerated had they received a prison sentence. In other European countries they restrict the length of admission to the same period an individual would remain if convicted for the same offence¹³².

Reason for extended admissions are likely to include poor response to treatment, ongoing safety issues, and lack of a suitable step-down facility¹³³. Also to be considered is that in an increasing risk-averse society, taking therapeutic risks becomes difficult to achieve, which could lead to patients being detained for longer than needed¹³⁴.

Studies have also highlighted that to avoid extended admissions there should be closer collaboration between hospitals across tiers of secure care¹³⁵. Studies have also stated that sometimes patients transfer from one secure hospital to another, duplicating therapy or activity programmes¹³⁶.

This National Review found that of the 14.5% (40) patients were being treated in secure hospitals for more than four years, 87.5% (35) were male and 12.5% (5) were female. 30.4% (7) of patients in high secure had been admitted for over four years, 12.5% (12) in medium secure and 13.4% (21) in low secure.

The proportion of patients in medium secure hospitals admitted for over 4 years at the time of audit is higher in NHS Wales hospitals at 16.3% (10), than in non NHS Wales hospitals, 8.3% (2). The proportion of patients in low secure hospitals admitted for over 4 years at the time of audit is higher in NHS Wales hospitals at 20.4% (20), than in non NHS Wales secure hospitals, 12.4% (15).

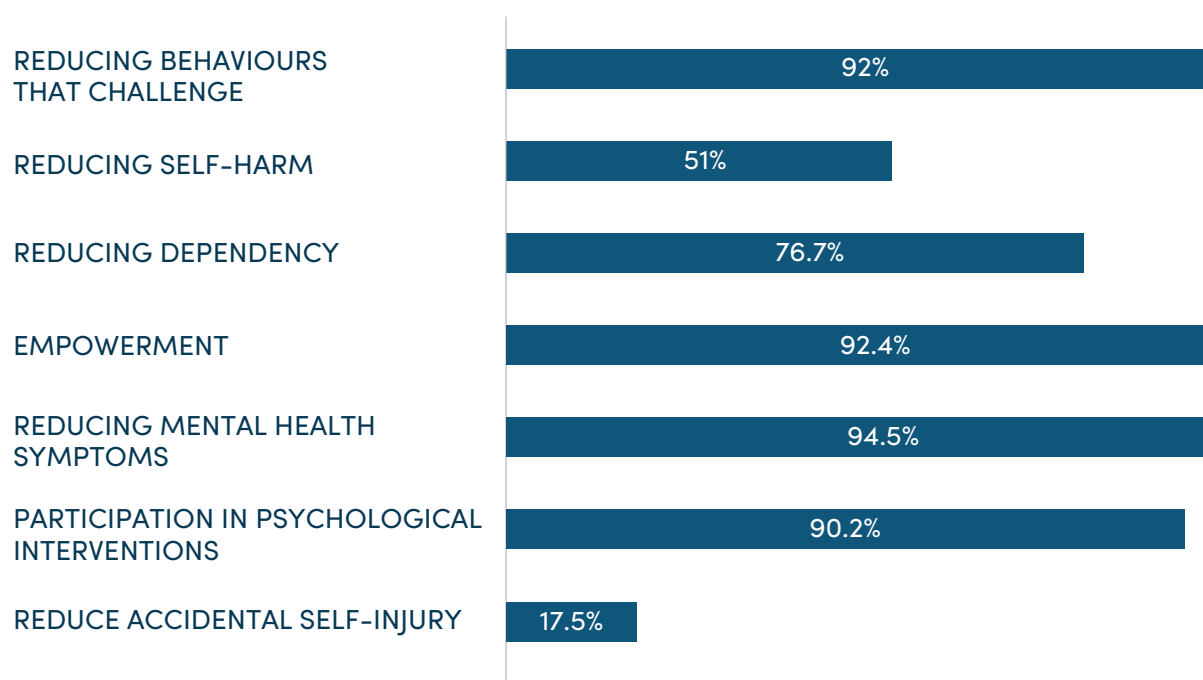
19. Outcomes

Outcomes are a measure of what happens, or is planned to happen, to the health or well-being of the patient as a result of the treatment and care they receive or will receive. Quality services should focus on realising positive outcomes for all patients. For the benefit of the patient all admissions into secure hospitals should be supported by a clear rationale of planned assessment and treatment with measurable outcomes¹³⁷.

In order to enable comparison, the methodology supporting this National Review grouped outcomes into the following seven areas:

1. Reducing behaviours that challenge.
2. Reducing self-harm.
3. Reducing dependency.
4. Empowerment.
5. Reducing symptoms through medication.
6. Participation in psychological interventions.
7. Reduce accidental self-injury.

Each of these seven outcomes will be discussed separately later in this Section. Figure 21 shows the proportion of patients with each of the 7 outcomes listed previously.

Figure 21 — Proportion of Patients with a Specific Outcome

A higher number of outcomes could be considered an indicator of a greater degree of complexity. This National Review found a total of 1,416 outcomes recorded for the 275 patients, an average of 5 outcomes per patient.

This National Review looked at each patient's care plan or admission assessment to identify the outcomes that were present on admission and whether any outcomes had been achieved during the current admission. This National Review found that, 4% (11) of patients remained in hospital despite having achieved all of their admission outcomes, whilst 64.4% (177) had achieved none of their treatment outcomes.

There should not be an expectation that outcomes will be met soon after admission. Conversely, there may also be an expectation that most outcomes would be met after a long period of time and, examining the 64.4% (177) of patients who had not achieved any of the outcomes, the length of admission was as follows:

- 77.8% (21) of patients admitted for up to 3 months had not achieved any of their outcomes recorded on admission.
- 85.4% (41) of patients admitted for 4–6 months had not achieved any of their outcomes recorded on admission.
- 61.1% (23) of patients admitted for 7–11 months had not achieved any of their outcomes recorded on admission.
- 64.0% (48) of patients admitted for 1–2 years had not achieved any of their outcomes recorded on admission.

- 53.1% (26) of patients admitted for 2–3 years had not achieved any of their outcomes recorded on admission.
- 45.5% (15) of patients admitted for 4–7 years had not achieved any of their outcomes recorded on admission.
- 42.9% (3) of patients admitted for 7–9 years had not achieved any of their outcomes recorded on admission.

Figure 22 shows the specific outcome and the number of patients with that outcome on admission and their achievement rate by length of admission. The reasons for not achieving outcomes could include patient complexity, patient acuity, patient presentation, intrinsic risk, insufficient time, staff availability, staff skill mix, staff experience or the environment of care being unable to meet the patient's needs.

Figure 22 — Lengths of Admission for Patients by Outcome Achieved

▼Outcome on admission	Patient with this outcome on admission	Patients achieving this outcome with a length of admission of 2 years or less	Patients achieving this outcome with a length of admission that is more than 2 years	Not achieving outcome
Reducing behaviours that challenge	92.7% (255)	9.8% (25)	12.9% (33)	77.3% (197)
Reducing self-harm	51.3% (141)	14.2% (20)	17.0% (24)	68.8% (97)
Reducing dependency	76.7% (211)	6.6% (14)	6.6% (14)	86.7% (183)
Empowerment	92.4% (254)	2.8% (7)	6.3% (16)	90.9% (231)
Reducing symptoms through medication	94.5% (260)	7.7% (20)	8.1% (21)	84.2% (219)
Participation in psychological interventions	89.8% (247)	5.7% (14)	7.7% (19)	86.6% (214)
Reduce accidental self-injury	17.5% (48)	4.2% (2)	4.2% (2)	91.7% (44)

19.1. Outcome

Reducing Behaviours That Challenge

Full outcome: The patient is supported and enabled to reduce/minimise violence, aggression or challenging behaviour through proactive risk management and strengths-based approach and with the minimal use of restrictive interventions.

This National Review found that this outcome was recorded for 92.7% (255) of patients on admission. The proportion of male patients with this outcome on admission was 91.7% (209) and for female patients it was 97.9% (46). The proportion of patients in high secure with this outcome on admission was 100% (23), for medium secure it was 89.6% (86), and for low secure it was 93.6% (146).

19.2. Outcome

Reducing Self Harm

Full outcome: The patient is supported and enabled to reduce/minimise occurrences of deliberate self-harm through proactive risk management, strengths-based approach and the minimal use of restrictive interventions.

This National Review found that this outcome was recorded for 51.3% (141) of patients on admission. The proportion of male patients with this outcome on admission was 43.9% (100) and for female patients it was 87.2% (41). The proportion of patients in high secure with this outcome on admission was 52.2% (12), for medium secure it was 47.9% (46), and for low secure it was 53.2% (83).

19.3. Outcome

Reducing Dependency

Full outcome: The patient is supported and enabled to reduce dependency and independence is maintained and promoted through positive life skills and safe access to community services.

This National Review found that this outcome was recorded for 76.7% (211) of patients on admission. The proportion of male patients with this outcome on admission was 75.4% (172), and for female patients it was 83% (39). The proportion of patients in high secure with this outcome on admission was 73.9% (17), for medium secure it was 75% (72), and for low secure it was 78% (122).

19.4. Outcome

Empowerment

Full outcome: Empower the patient through hope, positive regard and psychosocial interventions.

This National Review found that this outcome was recorded for 92.4% (254) of patients on admission. The proportion of male patients with this outcome on admission was 90.8% (207) and for female patients it was 100% (47). The proportion of patients in high secure with this outcome on admission was 100% (23), for medium secure it was 94.7% (91), and for low secure it was 89.7% (140).

19.5. Outcome

Reducing Symptoms Through Medication

Full outcome: Reduce or minimise symptoms of mental illness through pharmacology.

This National Review found that this outcome was recorded for 94.5% (260) of patients on admission. The proportion of male patients with this outcome on admission was 93.9% (214) and for female patients it was 97.9% (46). The proportion of patients in high secure with this outcome on admission was 100% (23), for medium secure it was 93.7% (90), and for low secure it was 94.2% (147).

19.6. Outcome

Participation in Psychological Interventions

Full outcome: The patient is supported and enabled to achieve positive outcomes through specific individual, or group, evidence based, psychological interventions.

This National Review found that this outcome was recorded for 89.8% (247) of patients on admission. The proportion of male patients with this outcome on admission was 89.0% (203) and for female patients it was 93.6% (44). The proportion of patients in high secure with this outcome on admission was 100% (23), for medium secure it was 89.6% (86), and for low secure it was 88.5% (138).

19.7. Outcome

Prevent Accidental Self Injury

Full outcome: The patient is cared for in an environment that prevents accidental injury whilst maximising of personal freedoms.

This National Review found that this outcome was recorded for 17.5% (48) of patients on admission. The proportion of male patients with this outcome on admission was 18.0% (41) and for female patients it was 14.9% (7). The proportion of patients in high secure with this outcome on admission was 17.4% (4), for medium secure it was 10.4% (10), and for low secure it was 21.8% (34).

20. Medication

One of the most prevalent forms of treatment for patients in secure hospitals is psychiatric medication.

This National Review examined the prescription records of each patient to determine the types of medications being prescribed. Medications prescribed for physical health conditions were not considered as part of this National Review.

Medication was categorised into four areas:

- Antipsychotics.
- Antidepressants.
- Mood stabilisers.
- Anxiolytics, sedatives and hypnotics.

This National Review found that 95.6% (263) of patients were prescribed at least one type of these medications.

These types of medication can collectively be categorised as 'psychotropic'. The phrase 'psychotropic' is a technical term for a group of medicines that affect mental function, behaviour, and experience. Research has shown that a large proportion of patients in secure hospitals are prescribed psychotropic medication¹³⁹. Studies have shown a number of factors associated with multiple psychotropic medication prescriptions including younger age, male sex, schizophrenia and psychotic disorders, longer inpatient stay, and greater number of hospital admissions^{140,141}.

Figure 23 shows the details of the prescription of multiple psychotropic medication types, for the 273 patients where this was recorded.

Figure 23 shows that a majority, 56.4% (154), of patients, were prescribed more than one type of psychotropic medication whilst 39.2% (107), were prescribed only one type and 4.4% (12), were not prescribed any. Where patients were prescribed more than one type of psychotropic medication the three most common combinations were:

- 17.6% (48) of patients were prescribed an antipsychotic and antidepressant.
- 10.6% (29) of patients were prescribed an antipsychotic and anxiolytic/sedative/hypnotic.
- 8.1% (22) of patients were prescribed an antipsychotic, a mood stabiliser and an anxiolytic/sedative/hypnotic.

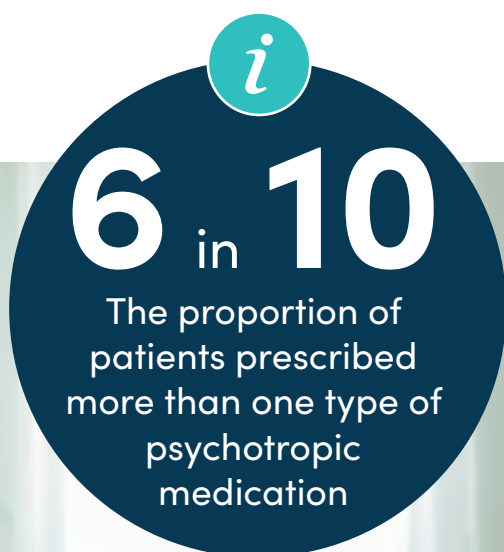


Figure 23 — Patients Prescribed Multiple Psychotropic Medication Types

No psychotropic medication 4.4% (12)	Prescribed a single type of psychotropic medication 39.2% (107)	Prescribed two types of psychotropic medication 35.2% (96)	Prescribed three types of psychotropic medication 18.7% (51)	Prescribed four types of psychotropic medication 2.6% (7)
No medication [4.4%] [12]	Antipsychotic only [35.5%] [97]	Antipsychotic + antidepressant [17.6%] [48]	Antipsychotic + antidepressant + mood stabiliser [3.3%] [9]	Antipsychotic + antidepressant + mood stabiliser + anxiolytic/sedatives/hypnotics [2.6%] [7]
	Antidepressant only [2.2%] [6]	Antipsychotic + mood stabiliser [5.9%] [16]	Antipsychotic + antidepressant + anxiolytic/sedatives/hypnotics [7.0%] [19]	
	Mood stabiliser only [0%] [0]	Antipsychotic + Anxiolytic/sedatives/hypnotics [10.6%] [29]	Antipsychotic + mood stabiliser + anxiolytic/sedatives/hypnotics [8.1%] [22]	
	Anxiolytic/sedatives/hypnotics only [1.5%] [4]	Antidepressants + mood stabiliser [0.4%] [1]	Antidepressants + mood stabilisers + anxiolytic/sedatives/hypnotics [0.4%] [1]	
		Antidepressants + Anxiolytic/sedatives/hypnotics [0.7%] [2]		
		Mood stabiliser + Anxiolytic/sedatives/hypnotics [0%] [0]		

Psychotropic medications should be prescribed only after other approaches, such as therapies, have failed to produce the desired benefits. A full multidisciplinary review should be conducted three months after prescribing any psychotropic medication and then at least every six months, and only those medicines that have shown a therapeutic benefit should be continued¹⁴². Specialist mental health pharmacists can individualise treatments to deliver the best outcomes for patients¹⁴³.

While the main use of psychotropic medication is to reduce the symptoms of mental illness, they can also be administered to 'subdue disturbed behaviour'¹⁴⁴. The use of psychotropic medications for the management of such behaviour should only be used as an intervention of last resort, after de-escalation techniques and positive support approaches have been attempted. This National Review found that of the 95.6% (263) of patient's prescribed psychotropic medication, 79.8% (210) had exhibited challenging behaviour during the current admission.

For the majority, 94.5% (260), of patients an outcome on admission was to 'reduce symptoms through medication'. This National Review found that, for the patients who had this outcome, 1.9% (5) were not prescribed any psychotropic medication. Furthermore, of the 5.5% (15) of patients where 'reduce symptoms through medication' was not recorded as a planned outcome, over half, 53.3% (8), were prescribed a psychotropic medication.

20.1. Antipsychotics

Antipsychotics are prescribed for patients diagnosed with psychosis or affective disorders, such as bipolar disorder or severe depression. Antipsychotics do not cure these conditions but are used to relieve symptoms and improve the patient's 'quality of life'¹⁴⁵.

Figure 24 shows prescribed antipsychotics by gender. This National Review found that 92% (253) of patients were prescribed these medications, either as a regular prescription, an unscheduled prescription available as required, or both.

Figure 24 — Patients Prescribed Antipsychotic Medication by Gender

Number of antipsychotics prescribed	Regular			As required		
	Male Patients	Female Patients	Overall	Male Patients	Female Patients	Overall
0	1.1% (23)	8.5% (4)	9.8% (27)	79.4% (181)	46.8% (22)	73.8% (203)
1	64.5% (147)	61.7% (29)	64.0% (176)	20.2% (46)	46.8% (22)	24.7% (68)
2 or more	25.4% (58)	29.8% (14)	26.2% (72)	0.4% (1)	6.4% (3)	1.5% (4)

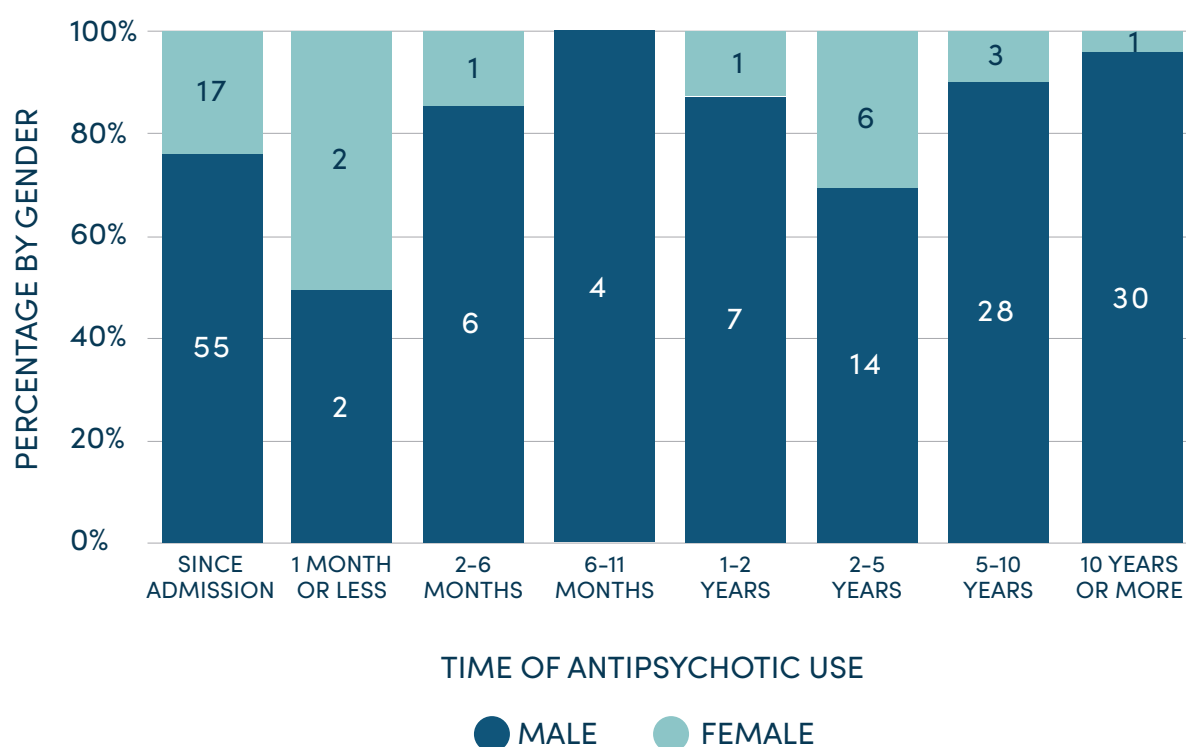
This National Review also found that 4.7% (12), of the 253 patients who were prescribed antipsychotics, had no recorded primary or secondary diagnosis of mental illness. The most common reason for the prescribing of antipsychotics, where no mental illness is diagnosed, is the management of behaviours that challenge. Studies have shown that for 19%–58% of patients, antipsychotics are prescribed for the purpose of behaviour management¹⁴⁶.

The optimal length of time someone should use antipsychotics is complex¹⁴⁷, however it has been suggested that, particularly in first episodes of psychosis, treatment should continue for up to one year following

improvements in symptoms¹⁴⁸. There are side-effects that are associated with antipsychotic use¹⁴⁹, which may be exacerbated when treatment is prolonged, or prescribed doses are higher than recommended¹⁵⁰.

Figure 25 shows the period of time that patients had been prescribed antipsychotics for the 177 of patients where this information was collected. It shows that 32.8% (62) of these patients had been prescribed antipsychotics for five years or more. Whilst this may seem like a long period of time, it has been proposed that some patients may have to continue to use antipsychotics for 'prolonged periods'¹⁵¹.



Figure 25 — Antipsychotic Use by Time Period & Gender



20.2. Antidepressants

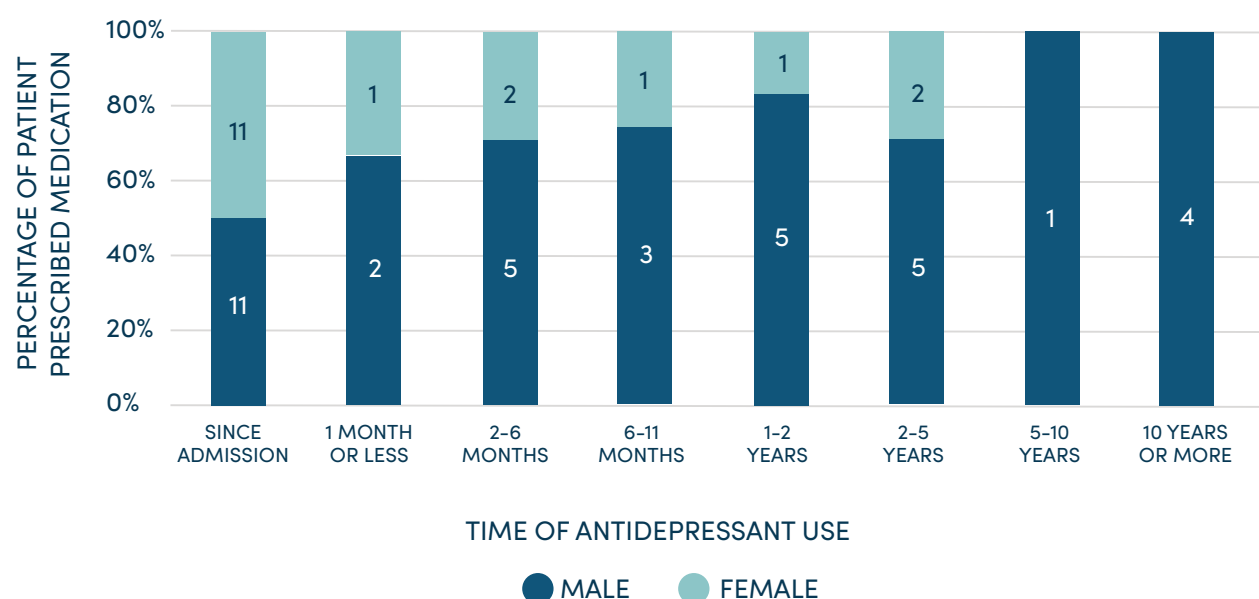
Antidepressants are prescribed for patients diagnosed with mood disorders such as depression and anxiety. Studies have reported the population prevalence of mood disorder at 5.4%¹⁵² and the prevalence of mood disorders in patients in secure hospitals at 9.5%¹⁵³. Studies have shown 4 in 10 patients in secure hospitals are prescribed antidepressants¹⁵⁴. Figure 26 shows prescribed antidepressants by gender. This National Review found that 33.8% (93) of patients were prescribed these medications as a regular prescription.

Figure 26 – Patients Prescribed Antidepressants Medication by Gender

Number of antidepressants prescribed	 Male Patients	 Female Patients	Overall
0	71.9% (164)	38.3% (18)	66.2% (182)
1	28.1% (64)	53.2% (25)	32.4% (89)
2 or more	0	8.5% (4)	1.5% (4)

This National Review also found that 4.3% (4), of the 93 patients who were prescribed antidepressants, had no recorded primary or secondary diagnosis of mental illness. There is evidence of adverse effects of long-term antidepressant use¹⁵⁵. Figure 27 shows the period of time that patients had been using antidepressants for the 54 patients where this information was collected. It shows that 9.3% (5) of these patients had used antidepressants medication for five years or more.

Figure 27 – Antidepressant Use by Time Period & Gender



20.3. Mood Stabilisers

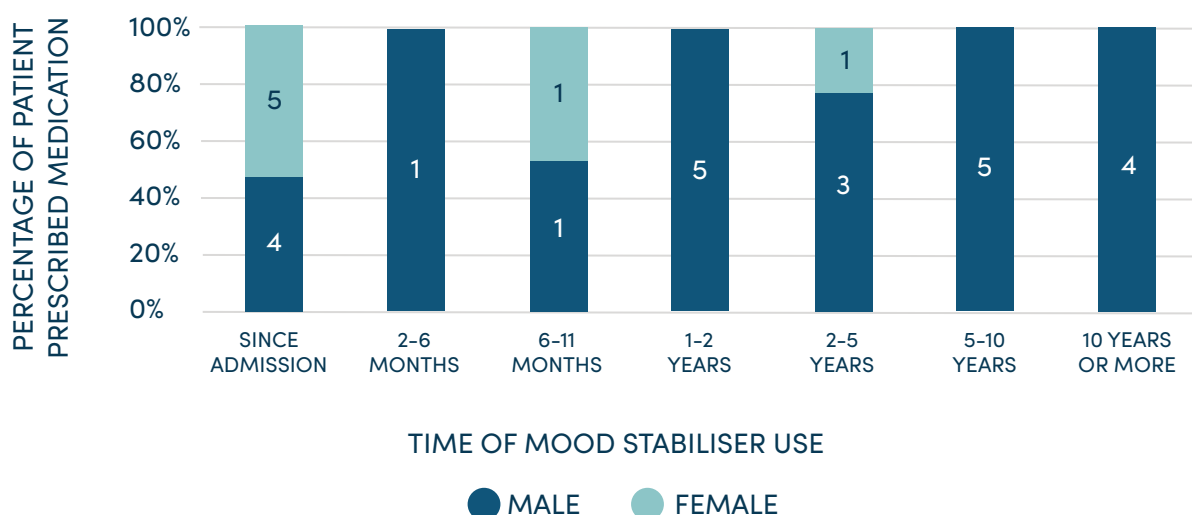
Mood-stabilisers are typically used for the treatment of such disorders as bi-polar or mania. Figure 28 shows prescribed mood-stabilisers by gender. This National Review found that 21.5% (59) of patients were prescribed these medications either as a regular prescription, an unscheduled prescription available as required, or both.

Figure 28 – Patients Prescribed Mood-stabilisers by Gender

Number of mood stabiliser prescribed	Regular			As required		
	Male Patients	Female Patients	Overall	Male Patients	Female Patients	Overall
0	81.1% (185)	72.3% (34)	79.6% (219)	99.1% (226)	93.6% (44)	98.2% (270)
1	16.2% (37)	27.7% (13)	18.1% (50)	0.9% (2)	6.4% (3)	1.8% (5)
2 or more	2.6% (6)	0	2.2% (6)	0	0	0

This National Review also found that 5.1% (3), of the 59 patients who were prescribed mood-stabilisers, had no recorded primary or secondary diagnosis of mental illness. There is evidence of adverse effects of long-term mood-stabiliser use¹⁵⁶. Figure 29 shows the period of time that patients had been using mood-stabilisers for the 30 patients where this information was collected. It shows that 30% (9) of patients had used mood-stabilisers medication for five years or more.

Figure 29 – Mood-Stabiliser Use by Time Period & Gender



20.4. Anxiolytics, Sedatives & Hypnotics

Anxiolytics can be effective in relieving symptoms of anxiety, sedatives are used to induce sleep when given at night and most hypnotics will sedate when given during the day. Research has shown that, in those treated in secure hospitals, the prevalence of anxiety disorders is 40%¹⁵⁷ and that of sleep disorders at 30%¹⁵⁸.

Figure 30 shows prescribed anxiolytics, sedatives or hypnotics by gender. This National Review found that 69.5% (191) of patients were prescribed these medications either as a regular prescription, an unscheduled prescription available as required, or both.

Figure 30 — Patients Prescribed Anxiolytics, Sedatives or Hypnotics by Gender

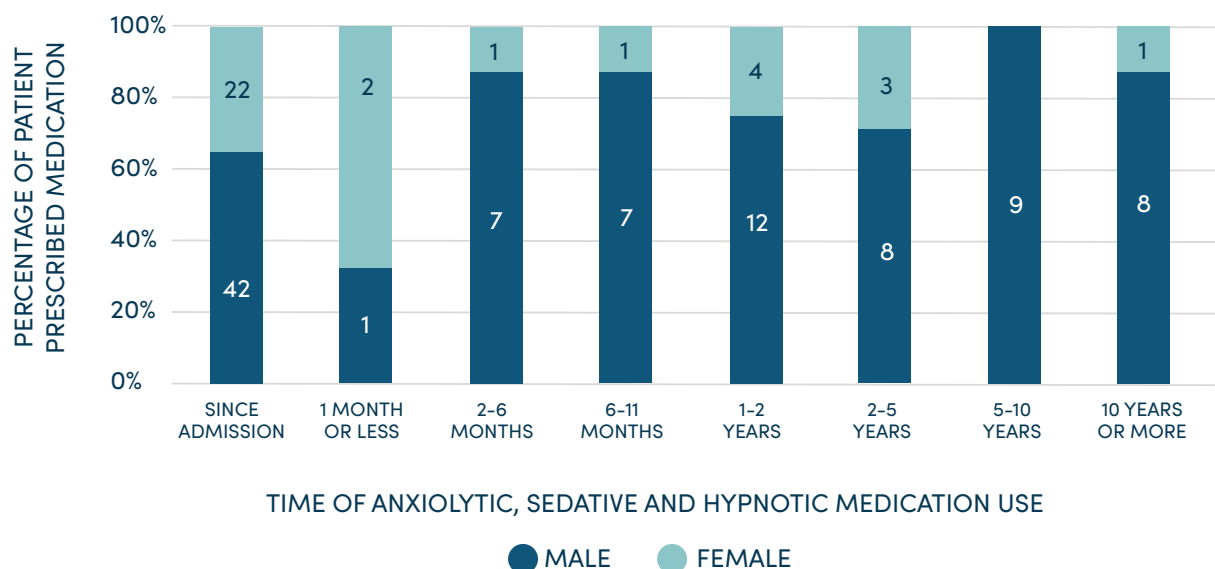
Number of anxiolytics, sedatives and hypnotics prescribed	Regular			As required		
	Male Patients	Female Patients	Overall	Male Patients	Female Patients	Overall
0	74.1% (169)	44.7% (21)	69.1% (190)	38.6% (88)	10.6% (5)	33.8% (93)
1	19.7% (45)	42.6% (20)	23.6% (65)	46.5% (106)	25.5% (12)	42.9% (118)
2 or more	5.7% (13)	12.8% (6)	6.9% (19)	14.5% (33)	63.8% (30)	22.9% (63)
Unknown	0.4% (1)	0	0.4% (1)	0.4% (1)	0	0.4% (1)

This National Review also found that 2.6% (5), of the 191 patients who were prescribed anxiolytics, sedatives or hypnotics, had no recorded primary or secondary diagnosis of mental illness.

After a patient has been prescribed anxiolytics, sedatives or hypnotics regularly for more than a few weeks, physical and psychological dependence can occur. Therefore, this type of medication in particular should be reserved for short course prescribing for the purpose of relieving short-term symptoms¹⁵⁹.

Figure 31 shows the period of time that patients had been using anxiolytics, sedatives or hypnotics for the 128 patients where this information was collected. It shows that 14.1% (18) of patients had used anxiolytics, sedatives or hypnotics for five years or more.

Figure 31 – Anxiolytics, Sedatives or Hypnotics Use by Time Period and Gender



20.5. Adherence To Medication Regime

Adherence should be an equal agreement, reached after negotiation, between a patient and prescriber on whether, and what, prescribed medicines will be accepted¹⁶⁰, although some patient rights to refuse medication can be affected by the Mental Health Act [1983]. Adherence with medication is associated with reductions in violent behaviour¹⁶¹.

‘Non-adherence’ means the patient has wilfully refused to follow a prescribed medication regime¹⁶². The reason for non-adherence could be because of a lack of understanding, lack of trust, choice, motivation, and past poor experience¹⁶³. ‘Non-adherence’ has significant implications for patients with psychosis as it is associated with relapse and rehospitalisation, self-harm, increased inpatient costs and overall lower quality of life¹⁶⁴.

Non-adherence should not be seen as the patient's fault. It represents a fundamental limitation in the delivery of healthcare, often because of a failure to identify and provide the support that patients need to understand the benefits and risks of medication adherence¹⁶⁵.

Figure 32 shows that proportion of patients who adhered to their regular prescribed medication regime and shows both male and female patients were less likely to adhere to a mood-stabiliser medication regime.

Figure 32 — Adherence to Prescribed Medication Regime by Gender

		Antipsychotics	Antidepressants	Mood-Stabilisers	Anxiolytics, Sedatives Or Hypnotics
Male	Prescribed This Type Of Medication	89.9% (205)	28.1% (64)	18.9% (43)	25.4% (58)
	Adherence Rate as a proportion of patients prescribed this medication	84.3% (173)	84.4% (54)	79.1% (34)	81.0% (47)
Female	Prescribed This Type Of Medication	91.5% (43)	61.7% (29)	27.7% (13)	55.3% (26)
	Adherence Rate as a proportion of patients prescribed this medication	65.1% (28)	58.6% (17)	46.2% (6)	73.1% (19)
Total	Prescribed This Type Of Medication	90.2% (248)	33.8% (93)	20.4% (56)	30.4% (84)
	Adherence Rate as a proportion of patients prescribed this medication	81.0% (201)	76.3% (71)	71.4% (40)	78.6% (66)

For this National Review an analysis was conducted to explore what factors predicted adherence with prescribed psychotropic medication. The analysis found that the less a patient engaged in physically violent behaviour towards staff and exhibited disruptive or intimidating behaviour, the more likely they were to adhere. This finding suggests that, when a patient does not adhere to a prescribed medication regime, they are more likely to engage in violent or disruptive behaviour.

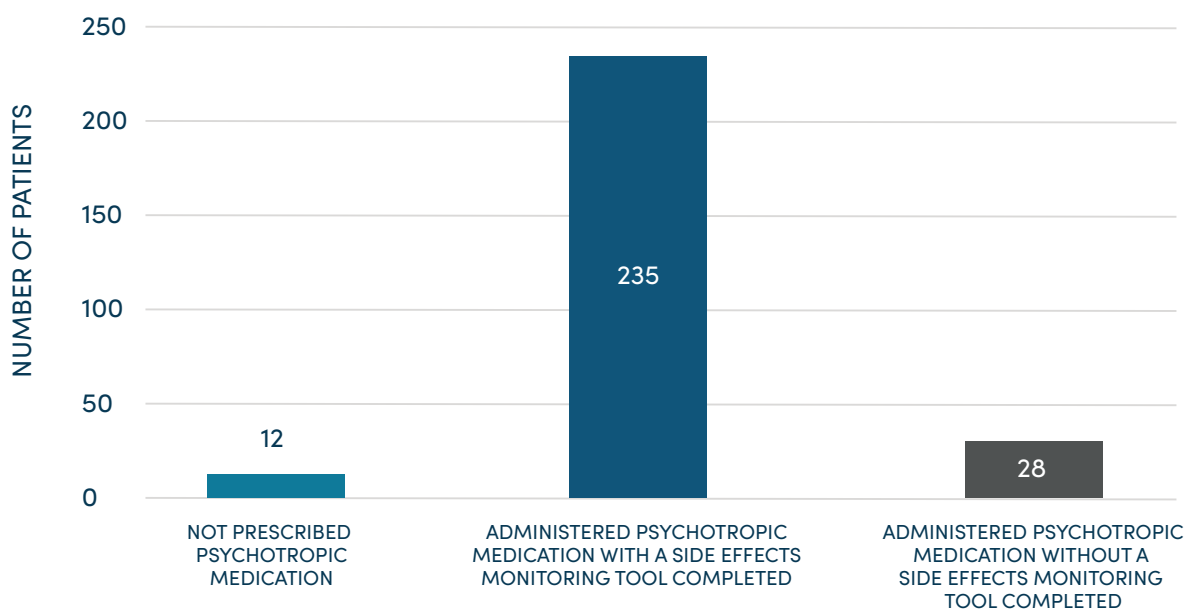
20.6. Medication Side-Effects Monitoring

As well as potential benefits, many medications, including psychotropic medications, can have adverse side-effects that may have an impact on an individual's quality of life¹⁶⁶. Prescribed medication should be monitored regularly for efficacy, side effects, effect on physical health and impact on daily life¹⁶⁷. The patient's past experience of adverse reactions should always be considered when prescribing medications¹⁶⁸.

Staff administering medications have a responsibility for monitoring their effectiveness. Monitoring can be carried out using specifically designed checklists, through questionnaires or by undertaking physical monitoring such as blood tests or electrocardiograms. This National Review looked at whether a side-effects monitoring tool had been completed for those patients prescribed a psychotropic medication. The staff may be monitoring side effects without using a recognised tool and instead entering professional judgements into contemporaneous care notes.

Figure 33 shows the number of patients prescribed a psychotropic medication and for whom a side-effects monitoring tool had been completed. It shows that 10.6% (28) of the 263 patients prescribed psychotropic medication did not have a side effects monitoring tool completed.

Figure 33 — Patient's Prescribed Psychotropic Medication Where a Side Effects Monitoring Tool Had Been Completed



The National Review examined the type of secure hospital and whether a side-effects monitoring tool had been completed for those prescribed psychotropic medication and found that 50% (12) of eligible patients in high secure services did not have such a tool completed, 8.3% (8) in medium secure and 6.7% (10) in low secure.

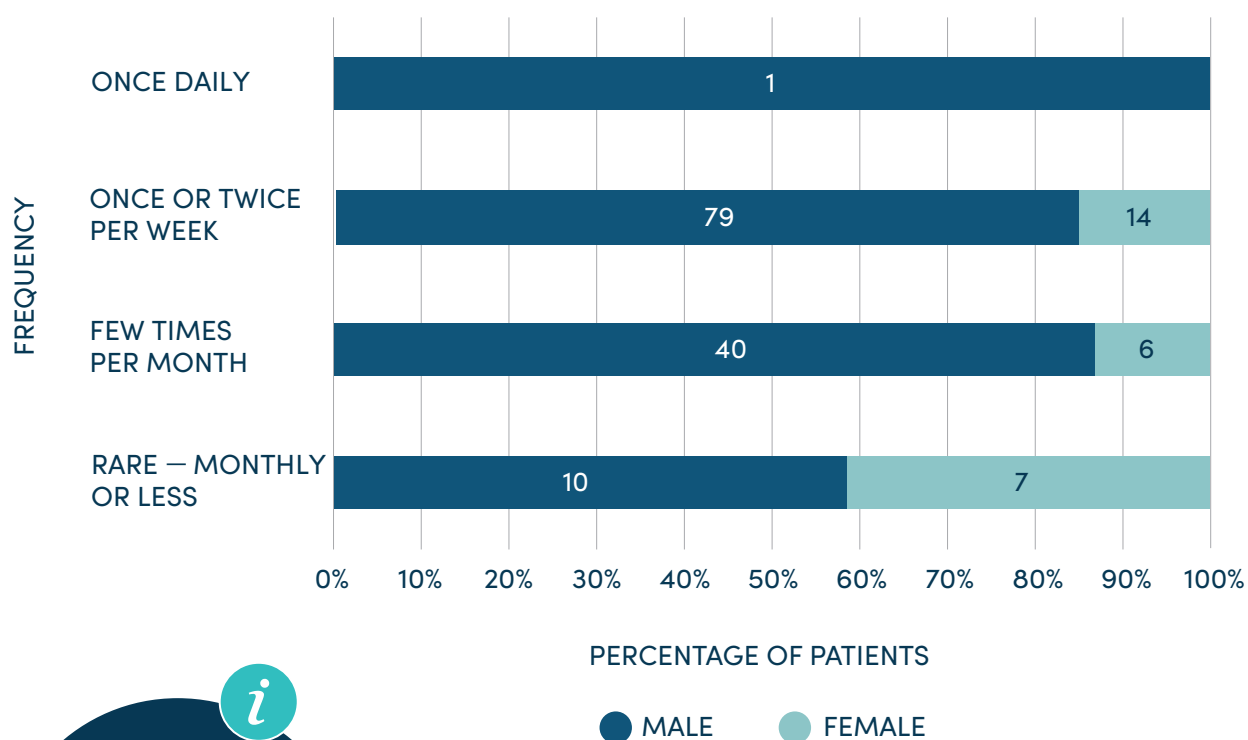
21. Psychological Interventions

An approach which relies on pharmacological interventions alone will be unhelpful in dealing with behavioural problems of complex causation¹⁶⁹. The availability and engagement with therapies in secure hospitals is essential in order to promote long-lasting, positive effects to patient's mental health and well-being. The provision of a full therapy programme in secure hospitals is essential both for treatment purposes¹⁷⁰, and as a significant part of the creation of a secure and safe environment¹⁷¹.

This National Review found that 89.8% (247) of patients had 'Participation in Psychological Interventions' recorded as an outcome on admission and that 57.1% (157), of patients were recorded as attending therapy sessions at the time of audit.

Figure 34 shows the frequency of attendance at an individual or group therapy session for those recorded as attending and that the most common attendance frequency was 'once or twice per week' for both male 60.8% (79), patients and female patients, 51.9% (14).

Figure 34 — Frequency of Recorded Attendance at Therapy Sessions by Gender



6 in 10

The proportion of patients recorded as attending therapy sessions

This National Review found that, of the 99.3% (273) of patients for which information was available, 42.5% (116), were not recorded as attending any type of therapy session at the time of audit.

Engaging patients in treatment in secure hospitals is a 'major challenge' although engagement is associated with a shorter length of stay, whereas non-engagement is associated with an increased risk of recidivism¹⁷². Studies have shown that patients in secure hospitals typically exhibit 'little desire' to engage in therapy¹⁷³. Some patients have low motivation to progress and exhibit 'tokenistic' engagement¹⁷⁴. Patients staying for shorter periods in secure hospitals have been shown to have higher levels of therapy engagement¹⁷⁵.

This National Review audited the recorded attendance at therapy sessions by type of secure hospital and found 34.8% (8) of patients in high secure were not recorded as attending therapy sessions, 43.8% (42) at medium secure and 42.3% (66) at low secure.

The proportion of patients in medium secure hospitals not recorded as attending therapies at the time of audit is higher in NHS Wales hospitals at 49.2% (30) than non NHS Wales hospitals 34.3% (12). The proportion of patients in low secure hospitals not recorded as attending therapies at the time of audit is lower in NHS Wales hospitals at 32.7% (16) than non NHS Wales hospitals 40.7% (44).

Some patients may require a period of adjustment on admission or they may require assessment prior to the development of an appropriate therapy programme. Trying to engage patients in therapy programmes too soon can exacerbate feelings of powerlessness¹⁷⁶. Patients with extended lengths of admissions may have successfully or unsuccessfully completed the appropriate therapy programmes.

Figure 35 compares the recorded attendance at therapy sessions with the patient's length of admission at the time of audit. Figure 35 shows that the proportion of patients not recorded as attending therapy was greater than for those recorded as attending therapy if the admission had been for more than 4 years, possibly denoting completion of a therapy programme.

Figure 35 — Frequency of Recorded Attendance at Therapy Sessions by Length of Admission

Length of Admission	Attending therapy sessions	Not attending therapy sessions
Up to 3 months	50% (13)	50% (13)
4-6 months	64.6% (31)	35.4% (17)
7-11 months	61.1% (22)	38.9% (14)
1-2 years	60.8% (45)	39.2% (29)
2-3 years	59.2% (29)	40.8% (20)
4-7 years	42.4% (14)	57.6% (19)
7-9 years	42.9% (3)	57.1% (4)

This National Review examined the factors that may affect therapy attendance and found that patients were more likely to be attending therapy if they were:

- Recorded as attending activities (2 times as likely).
- Prescribed antidepressants (1.8 times as likely).
- Documented to have an outcome on admission of 'Participation in Psychological Interventions' (1.7 times as likely).
- Infrequently displaying disruptive and intimidating behaviour (1.3 times as likely).

22. Meaningful Activities

Whilst admitted to a secure hospital patients should have the opportunity to engage in a range of activities as they promote relaxation and the sense of community¹⁷⁷. Engagement in meaningful activities provide patients with daily structure¹⁷⁸, has been linked to significant reductions in adverse incidents¹⁷⁹, and reduces the risk of recidivism on discharge or readmission¹⁸⁰.

Providing, and supporting patients to engage with, meaningful activities can reduce stress, frustration and boredom. It can also help to increase social interactions, relieve anxiety and improve well-being. Being engaged in meaningful activities can help to foster an atmosphere of hope and optimism which can enhance recovery¹⁸¹. Engaging patients in activities may alleviate the feeling of containment¹⁸².

This National Review found that all secure hospitals offered a range of activities to patients, although the variety and availability of activities differed between hospitals. Activity choice for patients in secure hospitals can be limited as they may not have the same degree of access to community facilities as patients in other environments, and public protection and safeguarding arrangements may impact the activities available¹⁸³.

This National Review found that 67.8% (185) of patients, of the 99.3% (273) where information was available, were recorded as having attended at least one activity.

Figure 36 shows the proportion of patients recorded as having attended a range of activities. The most frequently attended activities by male patients were 'ward community groups', 'exercise groups' and 'outdoor groups' whilst the least frequently activity was 'animal care', however this is may be due to the accessibility of this type of activity. The most frequently attended activities by female patients were 'ward community groups', 'cooking groups' and 'exercise groups', whilst the least frequently attended activity was 'numeracy groups'.

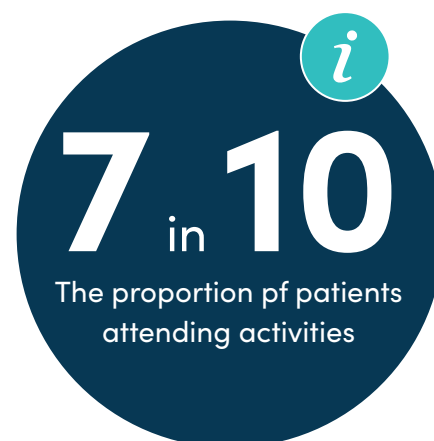
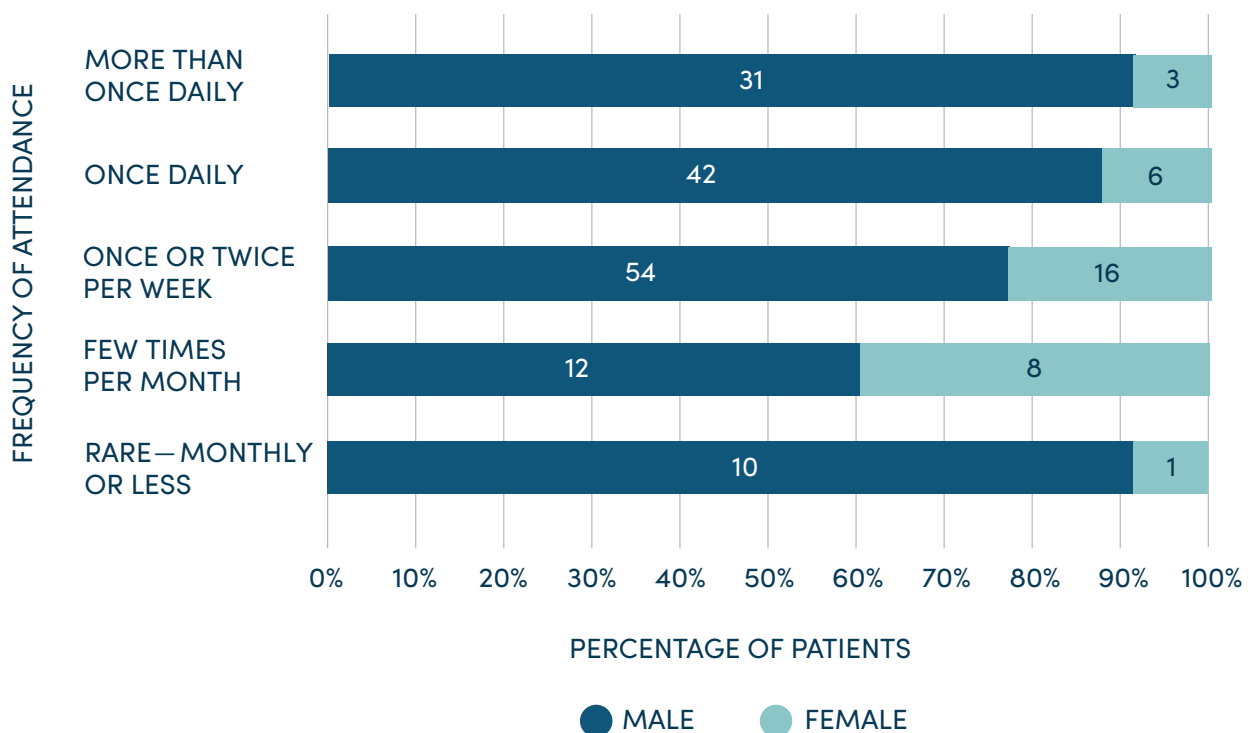


Figure 36 — Activities Recorded as Having Been Attended by Gender

Type of Activity	Male Patients Attending	Female Patients Attending
Arts & crafts	23.7% (54)	42.6% (20)
Cooking groups	41.2% (94)	53.2% (26)
Ward community groups	53.9% (123)	59.6% (26)
Exercise groups	45.2% (103)	48.9% (23)
Outdoor groups	24.6% (56)	27.7% (13)
Reading/Literacy groups	24.1% (55)	17.0% (8)
Computer use	34.2% (78)	44.7% (21)
Numeracy group	6.6% (15)	6.4% (3)
Animal care	1.8% (4)	8.5% (4)
Other unspecified	23.2% (53)	14.9% (7)
No activities	32.9% (75)	27.7% (13)

Figure 37 shows the frequency of attendance for the 66.5% (183), of patients who were recorded as having attended at least one activity. Figure 37 shows that the most common attendance frequency was 'once or twice per week' for both male patients, 36.2% (54), and female patients, 47.1% (16).

Figure 37 — Frequency of Recorded Attendance at Meaningful Activities by Gender

Patients in secure hospitals may have the inability to find meaning or interest in activities or they may have difficulty in identifying personal goals or set 'unrealistic' goals. Patients who have been admitted to a secure hospital for longer than five years have been found to be more challenging to engage in activities than those with shorter lengths of admission¹⁸⁴. Some patients may be restricted in activity choice due to risk or legal constraints.

This National Review found that 33.2% (88) of patients were not recorded as having attending any activities, including 32.9% (75), of male patients and 27.7% (13) of female patients. The proportion of patients in medium secure hospitals not recorded as having attended planned activities at the time of audit is higher in NHS Wales hospitals at 96.7% (59) than in non NHS Wales hospitals 5.7% (2).

The proportion of patients in low secure hospitals not recorded as having attended planned activities at the time of audit is higher in NHS Wales hospitals at 18.4% (9) than in non NHS Wales hospitals 7.4% (8).

The difference between NHS Wales and non NHS Wales could be due to recording stipulations and methodologies. This National Review examined the factors that may affect activity attendance and found that patients were more likely to be attending activities if they were:

- Documented to have an outcome on admission of 'Empowerment' and to of achieved that outcome (2.9 times as likely).
- Documented to have an outcome on admission of 'Reducing Self Harm' and to of achieved that outcome (2.1 times as likely).
- Recorded as attending therapy (1.9 times as likely).
- Adhering to a prescribed antipsychotic medication for at least two years (1.1 times as likely).

**'[We need]
less noise, more
activities and more
community leave.'**

Comment from patient in a
secure hospital made during
this National Review

23. Challenging Behaviour

Behaviour can be described as challenging when it is of such an intensity, frequency, or duration as to threaten the quality of life and/or the physical safety of the individual or others and it is likely to lead to responses that are restrictive¹⁸⁵. Challenging behaviour can represent a form of communication, be used to compensate for a skills deficits, or be associated with mental or physical illness. They can also be the result of learned behaviours with the function of getting needs/wants¹⁸⁶. Some examples of challenging behaviour are; aggressive, destructive, disruptive or self-injurious behaviour¹⁸⁷. It is important that the term 'challenging behaviour' is not misused as a diagnostic label, which can lead to stigmatisation and exclusion¹⁸⁸. This National Review recorded frequency and intensity of challenging behaviours and grouped them into the following 12 categories:

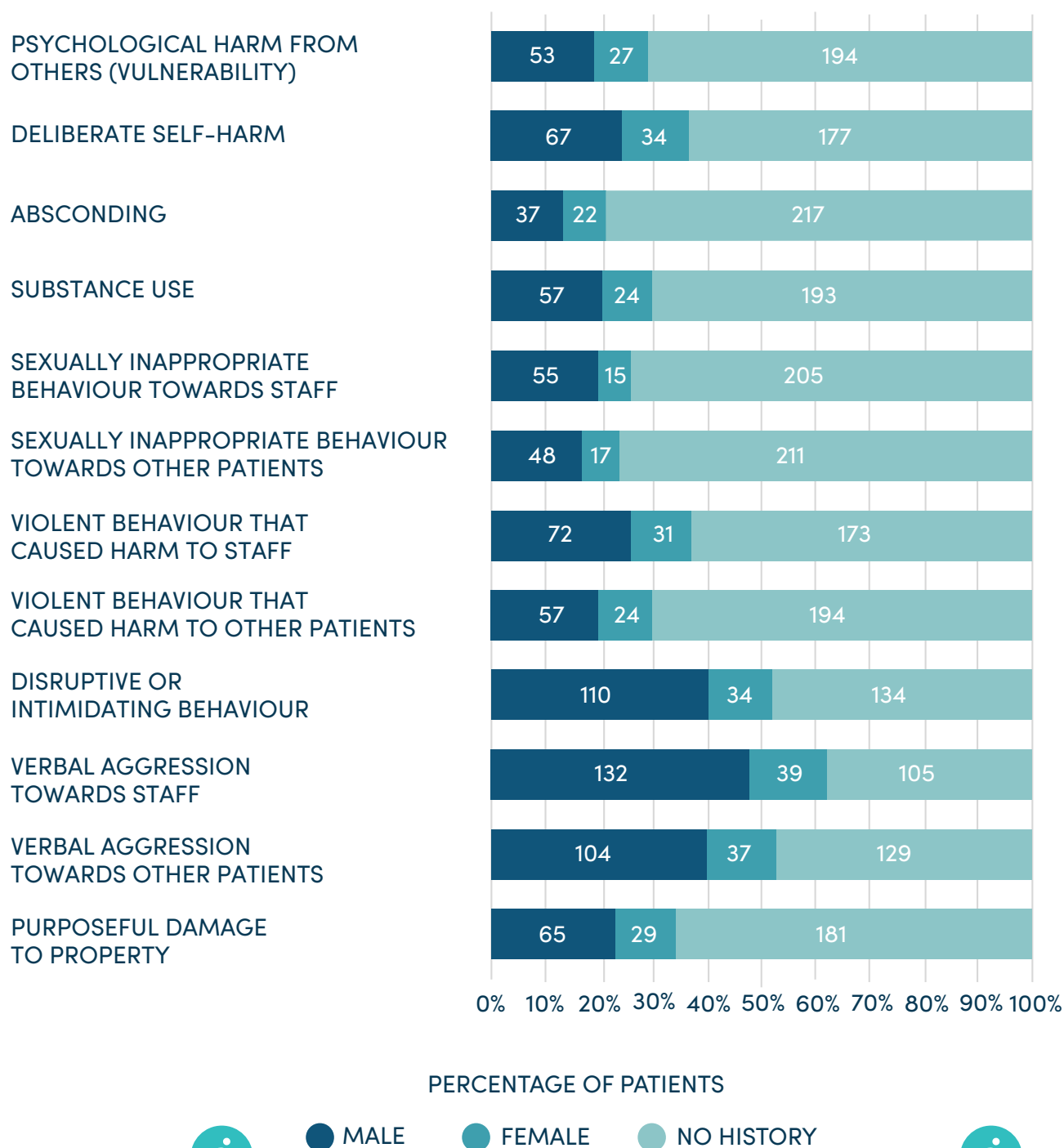
1. Purposeful damage to property.
2. Verbal aggression towards other patients.
3. Verbal aggression towards staff.
4. Disruptive or intimidating behaviour.
5. Violent behaviour that caused harm to other patients.
6. Violent behaviour that caused harm to staff.
7. Sexually inappropriate behaviour towards other patients.
8. Sexually inappropriate behaviour towards staff.
9. Substance use.
10. Absconding.
11. Deliberate self-harm.
12. Psychological harm from others (vulnerability).

Each of these behaviours will be examined individually in this Section of the National Review. The decision regarding what type of secure hospital a patient requires is often complex, but the nature and degree of historical or current challenging behaviour is often a factor. Staff numbers, experience and skills, and the environment of care all contribute to the effective management of challenging behaviour. This National Review characterised the intensity of the challenging behaviour as 'no history', 'low intensity', 'medium intensity' and 'high intensity'. The frequency of the behaviours were typified as 'no history', 'historical with no record in last ninety days', 'once/twice in last 90 days', 'at least monthly', 'at least weekly' or 'at least daily'.

Challenging behaviours have been found to be 'highly prevalent' in secure hospitals with studies showing 8 in 10 patients had engaged in at least one challenging behaviour¹⁸⁹.

This National Review found that 74.9% (206) of patients had a history or current (previous 90 days) record of challenging behaviours. 71.9% (164) of male patients and 89.4% (42) of female patients had a history or current record of challenging behaviours.

Figure 38 shows the prevalence of challenging behaviours by specific behaviour and gender. Figure 38 shows that the most common challenging behaviours exhibited by male patients were verbal aggression towards staff, disruptive or intimidating behaviour and verbal aggression towards other patients. For female patients the most common challenging behaviours exhibited were verbal aggression towards staff, verbal aggression towards other patients and deliberate self-harm.

Figure 38 – Number of Patients with Specific Challenging Behaviours by Gender

9 in 10

Female patients with a history or current record of challenging behaviour

7 in 10

Male patients with a history or current record of challenging behaviour

23.1. Purposeful Damage To Property

Behaviour examples: *Breaking, or otherwise damaging, furniture, fixtures and appliances*

Some patients may experience elevated levels of anger or distress because of their mental illness and as a result may cause damage to their surroundings^{190,191}. This National Review found that 32.4% (89) of patients had at least one recorded incident of purposeful damage

to property and 62.9% (56) of these 89 patients had exhibited this behaviour in the previous 90 days.

Figure 39 presents the number of patients who purposefully damaged property, according to intensity and frequency of the behaviour. It shows that the most common form of this behaviour displayed in the previous 90 days was once or twice of medium intensity.



Figure 39 — Frequency & Intensity of Patients Purposefully Damaging Property

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
Intensity ▼						
No history	67.6% (186)	0	0	0	0	0
Low intensity	0	1.5% (4)	1.8% (5)	0.4% (1)	0	0
Medium intensity	0	8.4% (23)	9.1% (26)	1.5% (4)	1.1% (3)	1.8% (5)
High intensity	0	2.2% (6)	1.8% (5)	2.2% (6)	0.4% (1)	0

An important consideration that should be made when deciding on an appropriate placement for a patient is the durability of furniture and accessibility of appliances which all contribute to the effective management of challenging behaviour.

Figure 40 shows the number of patient's purposefully damaging property by type of secure hospital and gender and shows that 21.7% (5) of patients admitted to high secure had exhibited this behaviour in the previous 90 days, 16.7% (16) of patients in medium secure and 22.3% (35) of patients in low secure. Figure 40 shows that 17.5% (40) of male patients exhibited this behaviour in the previous 90 days and 34.0% (16) of female patients.

Figure 40 – Patients Exhibiting Purposefully Damaging Property by Frequency, Type of Secure Hospital & Gender

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
High secure	73.9% (17)	4.3% (1)	8.7% (2)	4.3% (1)	0	8.7% (2)
Medium secure	70.8% (68)	12.5% (12)	8.3% (8)	5.2% (5)	2.1% (2)	1.0% (1)
Low secure	64.7% (101)	12.8% (20)	16.7% (26)	3.2% (5)	1.3% (2)	1.3% (2)
 Male Patients	71.9% (164)	10.5% (24)	11.0% (25)	3.5% (8)	0.9% (2)	2.2% (5)
 Female Patients	46.8% (22)	19.1% (9)	23.4% (11)	6.4% (3)	4.3% (2)	0

23.2. Verbal Aggression Towards Other Patients

Behaviour examples: *Shouting, swearing, screaming and generally exhibiting verbal aggression towards other patients.*

Responding to aggressive behaviour is a key activity for staff in secure hospitals¹⁹². Patients treated within secure hospitals may experience interpersonal difficulties, which may result in maladaptive coping mechanisms when engaging in disputes with other patients¹⁹³.

Studies suggests that about half of secure hospital patients exhibit verbal aggression¹⁹⁴. Studies has attempted to explore what factors predict verbal aggression within secure hospitals and have found that gender, insight into illness, number of prior psychiatric admissions and insight into iniquity of their offence are reliable predictors of this type of challenging behaviour¹⁹⁵.

This National Review found that 52% (143) of patients had at least one recorded incident of verbal aggression towards other patients, and 60.8% (87) of these 143 patients had exhibited this behaviour in the previous 90 days.



Figure 41 presents the number of patients who exhibited verbal aggression towards other patients, according to intensity and frequency of the behaviour. It shows that the most common form of this behaviour displayed in the previous 90 days was once or twice in the last 90 days of low intensity.

Figure 41 — Frequency & Intensity of Patients Exhibiting Verbal Aggression Towards Other Patients

Frequency ► Intensity ▼	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
No history	134 (48.7%)	0	0	0	0	0
Low intensity	0	7.6% (21)	8.0% (22)	3.6% (10)	1.8% (5)	0
Medium intensity	0	9% (25)	6.2% (17)	4.0% (11)	6.2% (17)	0.7% (2)
High intensity	0	3.3% (9)	0.4% (1)	0	0.7% (2)	0.4% (1)

Figure 42 shows the number of patients exhibiting verbal aggression towards other patients by type of secure hospital and gender and shows that 30.4% (7) of patients admitted to high secure had exhibited this behaviour in the previous 90 days, 26.0% (25) of patients in medium secure and 35.9% (56) of patients in low secure. Figure 42 shows that 27.6% (63) of male patients exhibited this behaviour in the previous 90 days and 53.2% (25) of female patients.

Figure 42 — Patients Exhibiting Verbal Aggression Towards Other Patients by Frequency, Type of Secure Hospital & Gender

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
High secure	56.5% (13)	13.0% (3)	17.4% (4)	0	8.7% (2)	4.3% (1)
Medium secure	57.3% (55)	16.7% (16)	13.5% (13)	6.3% (6)	5.2% (5)	1.0% (1)
Low secure	42.3% (66)	21.8% (34)	14.7% (23)	9.6% (15)	10.9% (17)	0.6% (1)
 Male Patients	52.6% (120)	19.7% (45)	11.8% (27)	6.1% (14)	8.8% (20)	0.9% (2)
 Female Patients	29.8% (14)	17.0% (8)	27.7% (13)	14.9% (7)	8.5% (4)	2.1% (1)

23.3. Verbal Aggression Towards Staff

Behaviour examples: *Shouting, swearing, screaming and generally exhibiting verbal aggression towards staff.*

Verbal abuse experienced by staff members from patients within secure hospitals is a common occurrence and as a result staff members have an increased risk of psychological distress¹⁹⁶.

This National Review found that 61.1% (168) of patients had at least one recorded incident of verbal aggression towards staff and 72.6% (122) of these 168 patients had exhibited this behaviour in the previous 90 days. Figure 43 presents the number of patients who exhibited verbal aggression towards staff, according to intensity and frequency of the behaviour.



It shows that the most common form of this behaviour displayed in the previous 90 days was weekly of medium intensity.

Figure 43 — Frequency & Intensity of Patients Exhibiting Verbal Aggression Towards Staff

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
Intensity ▼						
No history	38.5% (106)	0	0	0	0	0
Low intensity	0	6.9% (19)	6.5% (18)	5.5% (15)	2.9% (8)	0.7% (2)
Medium intensity	0	6.5% (18)	6.9% (19)	6.9% (19)	8.0% (22)	4.7% (13)
High intensity	0	3.3% (9)	0	0	1.8% (5)	0.4% (1)

Figure 44 shows the number of patients exhibiting verbal aggression towards staff by type of secure hospital and gender and shows that 39.1% (9) of patients admitted to high secure had exhibited this behaviour in the previous 90 days, 33.3% (32) of patients in medium secure and 52.6% (82) of patients in low secure. Figure 44 shows that 40.4% (92) of male patients exhibited this behaviour in the previous 90 days and 66.0% (31) of female patients.

Figure 44 — Patients Exhibiting Verbal Aggression Towards Staff by Frequency, Type of Secure Hospital & Gender

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
High secure	52.2% (12)	8.7% (2)	13.0% (3)	8.7% (2)	8.7% (2)	8.7% (2)
Medium secure	46.9% (45)	19.8% (19)	11.5% (11)	5.2% (5)	12.5% (12)	4.2% (4)
Low secure	31.4% (49)	16.0% (25)	14.7% (23)	17.9% (28)	13.5% (21)	6.4% (10)
 Male Patients	42.1% (96)	17.5% (40)	12.7% (29)	11.8% (27)	11.4% (26)	4.4% (10)
 Female Patients	21.2% (10)	12.8% (6)	17.0% (8)	17.0% (8)	19.1% (9)	12.8% (6)

23.4. Disruptive Or Intimidating Behaviour

Behaviour examples: *Excessive noise, shouting, antisocial behaviour or conduct which disturbs the hospitals therapeutic milieu. Bullying or behaviour which frightens or alarms other patients.*

Studies have shown that a quarter of patients have witnessed other patients being bullied in secure hospitals¹⁹⁷.

Violence among patients in such secure hospitals may be used to establish dominance and territorial boundaries¹⁹⁸.

Excessive noise can produce an undesired physiological or psychological response in an individual and it has implications in mental and physical health¹⁹⁹.

This National Review found that 50.5% (139) of patients had at least one recorded incident of disruptive or intimidating behaviour and 72.7% (101) of these 139 patients had exhibited this behaviour in the previous 90 days.

Figure 45 presents the number of patients who exhibited disruptive or intimidating behaviour according to intensity and frequency of the behaviour. It shows that the most common form of this behaviour is weekly of medium intensity.



Figure 45 – Frequency & Intensity of Patients Exhibiting Disruptive or Intimidating Behaviour

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
Intensity ▼						
No history	49.0% (135)	0	0	0	0	0
Low intensity	0	4.0% (11)	5.1% (14)	1.8% (5)	2.2% (6)	0
Medium intensity	0	7.3% (20)	5.5% (15)	4.4% (12)	8.0% (22)	5.8% (16)
High intensity	0	2.5% (7)	0.7% (2)	0.4% (1)	2.2% (6)	0.7% (2)

Maintaining a calm, therapeutic atmosphere and minimising potential negative social interactions between patients are important considerations when deciding on an appropriate placement in a secure hospital.

Figure 46 shows the number of patients exhibiting disruptive or intimidating behaviour by type of secure hospital and gender and shows that 26.1% (6) of patients admitted to high secure had exhibited this behaviour in the previous 90 days, 32.3% (31) of patients in medium secure and 41.7% (65) of patients in low secure. Figure 46 shows that 34.2% (78) of male patients exhibited this behaviour in the previous 90 days and 51.1% (24) of female patients.

Figure 46 – Patients Exhibiting Disruptive or Intimidating Behaviour by Frequency, Type of Secure Hospital & Gender

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
High secure	65.2% (15)	8.7% (2)	4.3% (1)	0	4.3% (1)	17.4% (4)
Medium secure	50.0% (48)	17.7% (17)	8.3% (8)	5.2% (5)	13.5% (13)	5.2% (5)
Low secure	46.2% (72)	12.2% (19)	14.1% (22)	8.3% (13)	12.8% (20)	6.4% (10)
 Male Patients	52.2% (119)	13.6% (31)	7.9% (18)	6.6% (15)	13.6% (31)	6.1% (14)
 Female Patients	34.0% (16)	14.9% (7)	27.7% (13)	6.4% (3)	6.4% (3)	10.6% (5)

23.5. Violent Behaviour That Causes Harm To Other Patients

Behaviour examples: *Punching, biting, kicking, pulling and pushing otherwise causing physical pain or injury to other patients.*

Violent behaviour within secure services is common and some research suggests that a quarter of patients commit acts of violence against other patients²⁰⁰.

Similar prevalence rates were found in this National Review found, with 27.3% (75) of patients having had at least one recorded incident of violent behaviour that caused harm to other patients and 38.7% (29) of these 75 patients had exhibited this behaviour in the previous 90 days.



Figure 47 presents the number of patients who exhibited violent behaviour that caused harm to other patients according to intensity and frequency of the behaviour. It shows that the most common form of this behaviour is once or twice in the last 90 days of medium intensity.

Figure 47 — Frequency & Intensity of Patients Exhibiting Violent Behaviour That Caused Harm to Other Patients

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
Intensity ▼						
No history	73.1% (201)	0	0	0	0	0
Low intensity	0	0.7% (2)	1.5% (4)	0	0	0
Medium intensity	0	12.0% (33)	4.0% (11)	1.8% (5)	0	0
High intensity	0	4.0% (11)	1.5% (4)	0.7% (2)	1.1% (3)	0

Figure 48 shows the number of patients exhibiting violent behaviour that caused harm to other patients by type of secure hospital and gender and shows that 4.3% (1) of patients admitted to high secure had exhibited this behaviour in the previous 90 days, 8.3% (8) of patients in medium secure and 12.2% (19) of patients in low secure. Figure 48 shows that 7.8% (18) of male patients exhibited this behaviour in the previous 90 days and 21.2% (10) of female patients.

Figure 48 — Patients Exhibiting Violent Behaviour That Caused Harm To Other Patients by Frequency, Type of Secure Hospital & Gender

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
High secure	82.6% (19)	13.4% (3)	4.3% (1)	0	0	0
Medium secure	78.1% (75)	13.5% (13)	5.2% (5)	2.1% (2)	1.0% (1)	0
Low secure	68.6% (107)	19.2% (30)	8.3% (13)	2.6% (4)	1.3% (2)	0
 Male Patients	75.0% (171)	17.1% (39)	4.8% (11)	1.8% (4)	1.3% (3)	0
 Female Patients	63.8% (30)	14.9% (7)	17.0% (8)	4.3% (2)	0	0

23.6. Violent Behaviour That Causes Harm To Staff

Behaviour examples: *Punching, biting, kicking, pulling and pushing otherwise causing physical injury to staff.*

The World Health Organisation estimate that between 8% and 38% of health workers suffer physical violence during their careers²⁰¹. Fear of being assaulted by patients is likely to increase the possibility that staff 'distance themselves', both physically and emotionally from patients, which may result in increases in restrictive intervention²⁰². In secure services specifically, research has reported that 16% of patients commit violent behaviour towards staff members²⁰³.

A greater prevalence of violent behaviour towards staff members were found in the current National Review which found that 35.3% (97) of patients had at least one recorded incident of violent behaviour that caused harm to staff and 46.4% (45) of these 97 patients had exhibited this behaviour in the previous 90 days.



Figure 49 presents the number of patients who exhibited violent behaviour that caused harm to staff according to intensity and frequency of the behaviour. It shows that the most common form of this behaviour is once or twice in the last 90 days of medium intensity.

Figure 49 — Frequency & Intensity of Patients Exhibiting Violent Behaviour That Caused Harm to Staff

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
Intensity ▼						
No history	64.7% (178)	0	0	0	0	0
Low intensity	0	1.1% (3)	0.7% (2)	0	0	0
Medium intensity	0	10.5% (29)	8.0% (22)	2.2% (6)	1.1% (3)	0.7% (2)
High intensity	0	7.3% (20)	0.4% (1)	1.5% (4)	1.5% (4)	0.4% (1)

Figure 50 shows the number of patients exhibiting violent behaviour that caused harm to staff by type of secure hospital and gender and shows that 17.4% (4) of patients admitted to high secure had exhibited this behaviour in the previous 90 days, 11.5% (11) of patients in medium secure and 20.5% (32) of patients in low secure. Figure 50 shows that 11.8% (27) of male patients exhibited this behaviour in the previous 90 days and 42.6% (20) of female patients.

Figure 50 — Patients Exhibiting Violent Behaviour That Caused Harm To Staff by Frequency, Type of Secure Hospital & Gender

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
High secure	65.2% (15)	17.4% (4)	8.7% (2)	4.3% (1)	4.3% (1)	0
Medium secure	74.0% (71)	14.6% (14)	4.2% (4)	3.1% (3)	3.1% (3)	1.0% (1)
Low secure	57.7% (90)	21.8% (34)	13.5% (21)	3.8% (6)	1.9% (3)	1.3% (2)
 Male Patients	68.4% (156)	19.7% (45)	6.6% (15)	3.1% (7)	1.3% (3)	0.9% (2)
 Female Patients	42.6% (20)	14.9% (7)	25.5% (12)	6.4% (3)	8.5% (4)	2.1% (1)

23.7. Sexually Inappropriate Behaviour Towards Other Patients

Behaviour examples: *Sexual disinhibition or sexual aggression towards other patients.*

Secure hospitals must prevent, report and proactively respond to sexual safety incidents. It is essential that staff recognise the physical and psychological harm caused from sexual abuse and harassment. It is important staff recognise that some patients may have experienced sexual incidents of an abusive

nature in the past, and ensure that they are trained to follow the principles of trauma informed care²⁰⁴.

This National Review found that 21.8% (60) of patients had at least one recorded incident of sexually inappropriate behaviour towards other patients and 51.7% (31) of these patients had exhibited this behaviour in the previous 90 days. Figure 51 presents the number of patients who exhibited sexually inappropriate behaviour towards other patients according to intensity and frequency of the behaviour. It shows that the most common form of this behaviour is once or twice in the last 90 days of low intensity.



Figure 51 — Frequency & Intensity of Patients Exhibiting Sexually Inappropriate Behaviour Towards Other Patients

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
Intensity ▼						
No history	78.2% (215)	0	0	0	0	0
Low intensity	0	2.9% (8)	4.0% (11)	0.7% (2)	0	0.4% (1)
Medium intensity	0	5.1% (14)	2.9% (8)	1.1% (3)	1.5% (4)	0.4% (1)
High intensity	0	2.5% (7)	0	0	0.4% (1)	0

Figure 52 shows the number of patients exhibiting sexually inappropriate behaviour towards other patients that caused harm to staff by type of secure hospital and gender and shows that 4.3% (1) of patients admitted to high secure had exhibited this behaviour

in the previous 90 days, 10.4% (10) of patients in medium secure and 12.8% (20) of patients in low secure. Figure 52 shows that 10.5% (24) of male patients exhibited this behaviour in the previous 90 days and 14.9% (7) of female patients.

Figure 52 — Patients Exhibiting Sexually Inappropriate Behaviour Towards Other Patients by Frequency, Type of Secure Hospital & Gender

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
High secure	91.3% (21)	4.3% (1)	0	4.3% (1)	0	0
Medium secure	78.1% (75)	11.5% (11)	8.3% (8)	0	2.1% (2)	0
Low secure	76.3% (119)	10.9% (17)	7.1% (11)	2.6% (4)	1.9% (3)	1.3% (2)
 Male Patients	78.9% (180)	10.5% (24)	6.1% (14)	1.8% (4)	2.2% (5)	0.4% (1)
 Female Patients	74.5% (35)	10.6% (5)	10.6% (5)	2.1% (1)	0	2.1% (1)

23.8. Sexually Inappropriate Behaviour Towards Staff

Behaviour examples: *Sexual disinhibition or sexual aggression towards staff.*

Staff must feel safe from unwanted sexual behaviour, confident that their safety is protected and know that if they report a sexual safety incident, it will be acted on²⁰⁵.

This National Review found that 23.6% (65) of patients had at least one recorded incident of sexually inappropriate behaviour towards staff and 56.9% (37) of these 65 patients had exhibited this behaviour in the previous 90 days.

Figure 53 presents the number of patients who exhibited sexually inappropriate behaviour towards staff according to intensity and frequency of the behaviour. It shows that the most common form of this behaviour is once or twice in the last 90 days of low intensity.

Figure 53 — Frequency & Intensity of Patients Exhibiting Sexually Inappropriate Behaviour Towards Staff

Frequency ► Intensity ▼	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
No history	76.4% (210)	0	0	0	0	0
Low intensity	0	2.5% (7)	4.4% (12)	1.5% (4)	0	0.4% (1)
Medium intensity	0	5.5% (15)	1.8% (5)	1.5% (4)	3.3% (9)	0
High intensity	0	2.2% (6)	0.4% (1)	0	0	0.4% (1)

Figure 54 shows the number of patients exhibiting sexually inappropriate behaviour towards staff by type of secure hospital and gender and shows that 8.7% (2) of patients admitted to high secure had exhibited this behaviour in the previous 90 days, 17.7% (17) of patients in medium secure and 11.5% (18) of patients in low secure.

Figure 54 shows that 13.2% (30) of male patients exhibited this behaviour in the previous 90 days and 14.9% (7) of female patients.

Figure 54 — Patients Exhibiting Sexually Inappropriate Behaviour Towards Staff by Frequency, Type of Secure Hospital & Gender

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
High secure	91.3% (21)	0	0	8.7% (2)	0	0
Medium secure	72.9% (70)	9 (9.1%)	10.4% (10)	3.1% (3)	4.2% (4)	0
Low secure	76.3% (119)	19 (12.2%)	5.1% (8)	1.9% (3)	3.2% (5)	1.3% (2)
Male Patients	75.9% (173)	11.0% (25)	6.1% (14)	3.1% (7)	3.5% (8)	0.4% (1)
Female Patients	78.7% (37)	6.4% (3)	8.5% (4)	2.1% (1)	2.1% (1)	2.1% (1)

23.9. Absconding

Behaviour examples: *Purposefully going absent without permission from the hospital. Not returning from leave as planned.*

Absconding from secure care is a cause for concern for the service, community and patient. Although definitions and populations differ, studies have shown absconding rates from secure hospitals to range from 14% – 20% ^{206,207}.

This National Review found that 17.5% (48) of patients had at least one recorded incident of absconding and 29.2% (14) of these 48 patients had exhibited this behaviour in the previous 90 days.

Figure 55 presents the number of patients who absconded according to frequency of the behaviour. It shows that the most common form of this behaviour is once or twice in the last 90 days.



Figure 55 – Frequency of Patients Absconding

Frequency ► Intensity ▼	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Very Frequent: Weekly	Extremely Frequent: Daily
No history	82.5% (227)	0	0	0	0
Low intensity	0	4.7% (13)	2.2% (6)	0	0
Medium intensity	0	5.8% (16)	2.5% (7)	0	0
High intensity	0	1.8% (5)	0.4% (1)	0	0

For patients at risk of absconding, it is important to consider the security measures in place in the secure hospital that can actively obstruct absconding such as locked doors or perimeter fences. All leave should be carefully planned and, if required, patients accompanied by skilled and experienced staff.

Figure 56 shows the number of patients absconding by type of secure hospital and gender and shows that 0% of patients admitted to high secure had exhibited this behaviour in the previous 90 days, 3.1% (3) of patients in medium secure and 7.1% (11) of patients in low secure. Figure 56 shows that 4.8% (11) of male patients exhibited this behaviour in the previous 90 days and 6.4% (3) of female patients.

Figure 56 – Patients Absconding by Frequency, Type of Secure Hospital & Gender

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Very Frequent: Weekly	Extremely Frequent: Daily
High secure	100% (23)	0	0	0	0
Medium secure	86.5% (83)	10.4% (10)	3.1% (3)	0	0
Low secure	77.6% (121)	15.4% (24)	7.1% (11)	0	0
 Male Patients	83.8% (191)	11.4% (26)	4.8% (11)	0	0
 Female Patients	76.6% (36)	17.0% (8)	6.4% (3)	0	0

23.10. Illicit Substance Misuse

Behaviour examples: *The possession or use of illegal substances.*

Studies have shown illicit drug use is prevalent in mental health hospitals^{208,209,210}. In secure hospitals drug misuse is perceived as a significant risk factor for violent incidents²¹¹.

This National Review found that 24.4% (67) of patients had at least one recorded incident of illicit substance misuse and 14.9% (10) of these 67 patients had exhibited this behaviour in the previous 90 days. Figure 57 presents the number of patients who used illicit substances according to intensity and frequency of the behaviour. It shows that the most common form of this behaviour is once or twice in the last 90 days with medium or high intensity.



Figure 57 – Frequency & Intensity of Patients Using Illicit Substances

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Very Frequent: Weekly	Extremely Frequent: Daily
Intensity ▼					
No history	75.6% (208)	0	0	0	0
Low intensity	0	5.5% (15)	1.1% (3)	0	0
Medium intensity	0	7.6% (21)	2.5% (7)	0	0
High intensity	0	7.6% (21)	0	0	0

Figure 58 shows the number of patients using illicit substance by type of secure hospital and gender and shows that 0% of patients admitted to high secure had exhibited this behaviour in the previous 90 days, 4.2% (4) of patients in medium secure and 3.8% (6) of patients in low secure.

Figure 58 shows that 3.5% (8) of male patients exhibited this behaviour in the previous 90 days and 4.3% (2) of female patients.

Figure 58 – Patients with Illicit Substance Misuse by Frequency, Type of Secure Hospital & Gender

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
High secure	87.0% (20)	13.0% (3)	0	0	0	0
Medium secure	79.2% (76)	16.7% (16)	4.2% (4)	0	0	0
Low secure	71.8% (112)	24.4% (38)	3.8% (6)	0	0	0
 Male Patients	75.9% (173)	20.6% (47)	3.5% (8)	0	0	0
 Female Patients	74.5% (35)	21.3% (10)	4.3% (2)	0	0	0

23.11. Self-harm

Behaviour examples: *Cutting self, hitting self, biting self, pulling own hair, falling to the floor or banging head.*



Patients in secure hospitals have a very high incidence of self-harm²¹². Studies have indicated that the use of restrictive interventions may result in an increase in self-harming behaviour due to patients feeling ‘frustrated’^{213,214}. This National Review found that 35.3% (97) of patients had at least one recorded incident of self-harm and 56.7% (55) of these 97 patients had exhibited this behaviour in the previous 90 days. Figure 59 presents the number of patients who self-harmed according to intensity and frequency of the behaviour. It shows that the most common form of this behaviour is once or twice in the last 90 days of medium intensity.

Figure 59 – Frequency & Intensity of Patients Self-harming

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
Intensity ▼						
No history	64.4% (177)	0	0	0	0	0
Low intensity	0	1.5% (4)	0.7% (2)	0.7% (2)	0	0
Medium intensity	0	9.8% (27)	5.1% (14)	4.7% (13)	3.3% (9)	1.8% (5)
High intensity	0	4.0% (11)	0.4% (1)	1.1% (3)	2.2% (6)	0

Figure 60 shows the number of patients self-harming by type of secure hospital and gender and shows that 17.4% (4) of patients admitted to high secure had exhibited this behaviour in the previous 90 days, 16.7% (16) of patients in medium secure and 22.4% (35) of patients in low secure. Figure 60 shows that 12.7% (29) of male patients exhibited this behaviour in the previous 90 days and 55.3% (26) of female patients.

Figure 60 — Patients Self-harming by Frequency, Type of Secure Hospital & Gender

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
High secure	65.2% (15)	17.4% (4)	0	8.7% (2)	4.3% (1)	4.3% (1)
Medium secure	66.7% (64)	16.7% (16)	5.2% (5)	4.2% (4)	5.2% (5)	2.1% (2)
Low secure	62.8% (98)	14.7% (23)	7.7% (12)	7.7% (12)	5.8% (9)	1.3% (2)
 Male Patients	71.1% (162)	16.2% (37)	4.4% (10)	4.4% (10)	2.2% (5)	1.8% (4)
 Female Patients	31.9% (15)	12.8% (6)	14.9% (7)	17.0% (8)	21.3% (10)	2.1% (1)

23.12. Psychological Harm From Others (Vulnerability)

Behaviour examples: *Bullying, extortion, emotional harm from other patients.*

Studies have shown high rates of patient-patient bullying in secure hospitals^{215,216}.

Neurodiverse patients may particularly be vulnerable²¹⁷.

This National Review found that 27.3% (75) of patients had at least one recorded incident of psychological harm from other patients and 44% (33) of these patients had exhibited this behaviour in the previous 90 days.



Figure 61 presents the number of patients who had experienced psychological harm from other patients according to intensity and frequency of the behaviour. It shows that the most common form of this behaviour is once or twice in the last 90 days of medium intensity.

Figure 61 — Frequency & Intensity of Psychological Harm from Other Patients

Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
Intensity ▼						
No history	72.7% (200)	0	0	0	0	0
Low intensity	0	2.9% (8)	1.8% (5)	0.4% (1)	0	0
Medium intensity	0	9.5% (26)	5.1% (14)	0.4% (1)	1.1% (3)	0.4% (1)
High intensity	0	2.9% (8)	2.2% (6)	0	0.4% (1)	0.4% (1)

Figure 62 shows the number of patients who had experienced psychological harm from other patients by type of secure hospital and gender and shows that 4.3% (1) of patients admitted to high secure had exhibited this behaviour in the previous 90 days, 8.2% (8) of patients in medium secure and 15.4% (24) of patients in low secure. Figure 62 shows that 10.1% (23) of male patients exhibited this behaviour in the previous 90 days and 21.3% (10) of female patients.

Figure 62 — Patients experiencing Psychological Harm from Other Patients by Frequency, Type of Secure Hospital & Gender

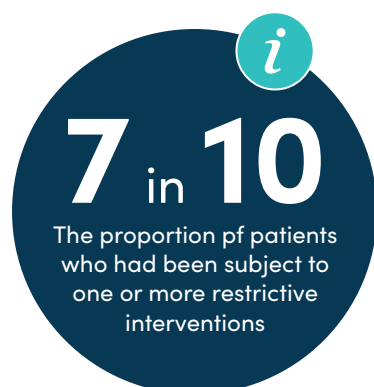
Frequency ►	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
High secure	78.3% (18)	17.4% (4)	4.3% (1)	0	0	0
Medium secure	81.3% (78)	10.4% (10)	6.3% (6)	0	1.0% (1)	1.0% (1)
Low secure	66.7% (104)	17.9% (28)	12.2% (19)	1.3% (2)	1.3% (2)	0.7% (1)
 Male Patients	77.2% (176)	12.7% (29)	7.5% (17)	0.9% (2)	1.3% (3)	0.4% (1)
 Female Patients	51.1% (24)	27.7% (13)	17.0% (8)	0	2.1% (1)	2.1% (1)

24. Restrictive Interventions

As discussed previously in this National Review, challenging behaviour can threaten the emotional and/or physical safety of the patient and/or other patients, visitors, staff.

The prevention of such harm requires a response from staff that may restrict the patient's individual's movement, liberty or freedom to act independently, called 'restrictive interventions'. Restrictive interventions should only be used when all other strategies have been exhausted or, in an emergency, when the risks of not employing a restrictive intervention are greater than the risks of using them²¹⁸. Restrictive interventions should never be used to punish, inflict pain, suffering or humiliation, or establish dominance²¹⁹. Some restrictive interventions, such as restraint and seclusion, can be potentially dangerous and have in the past been a contributing factor in fatalities²²⁰. Restrictive interventions should involve the minimum degree of force, for the briefest amount of time and with due consideration for the self-respect, dignity, privacy, cultural values and the individual needs of the patient.

Recently in Wales the Welsh Government has launched a Reducing Restrictive Practices Framework in an endeavour to reduce the use of restrictive interventions²²¹, see **Box 3**.



Box 3. Reducing Restrictive Practices Framework

The framework is intended to promote measures that will lead to the reduction of restrictive practices and seeks to ensure that where restrictive practices are used, as a last resort, to prevent harm to the individual or others, that this is informed by person centred planning, within the context of the service setting and in a way which safeguards the individual, those whom they interact with, and those who provide services to them.

The therapeutic objective with most restrictive interventions is that of 'regaining a sense of control'. Legal and ethical justifications, such as necessity, reasonableness and proportionality should support the clinical team to undertake risk-benefit analyses, although this can be complex, especially in the context of an immediate response²²².

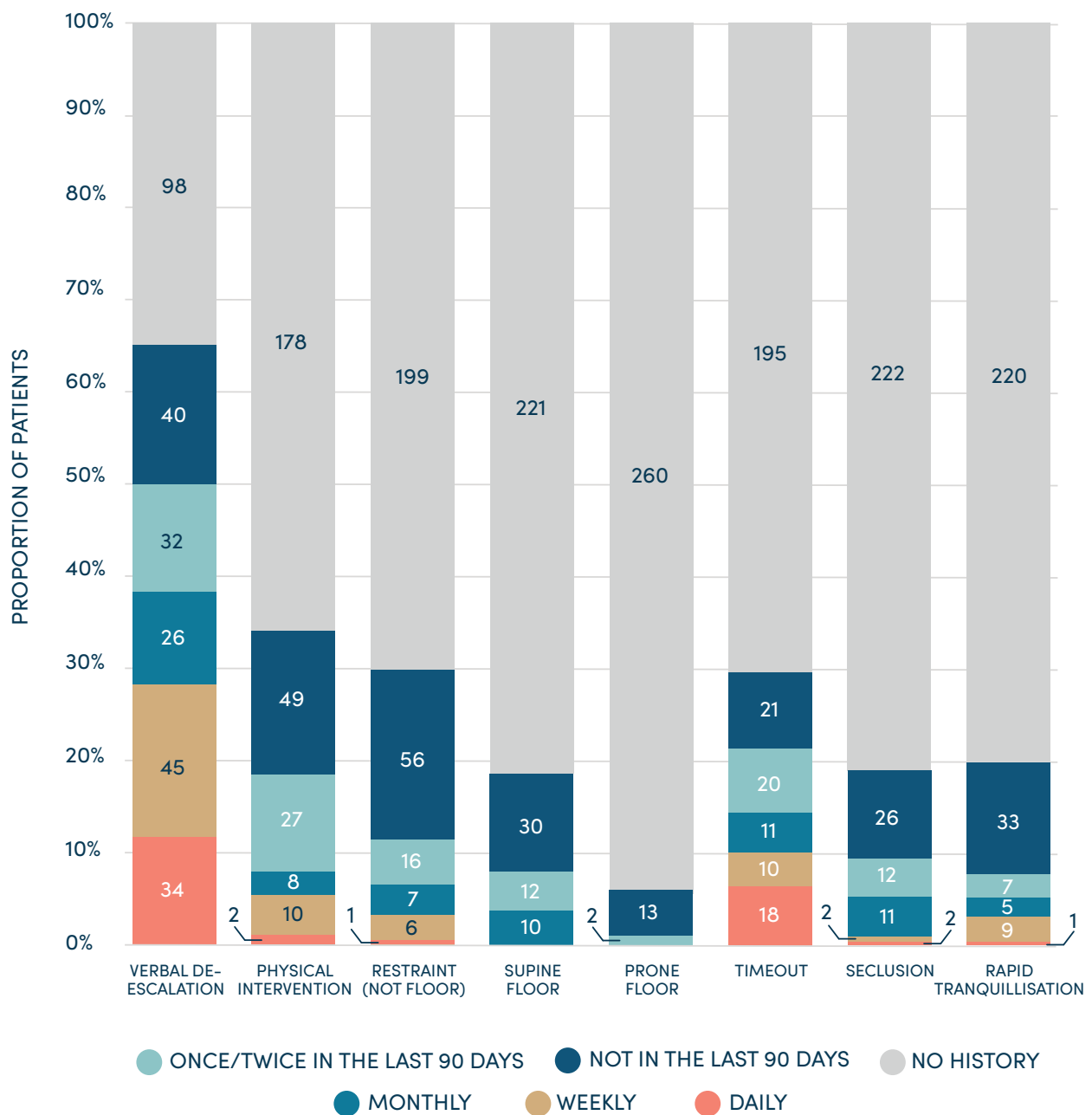
This National Review examined the following 7 interventions used to address challenging behaviours dependant on risk and response. 'Verbal de-escalation' is not classed as a restrictive intervention but is included for completeness:

1. Verbal de-escalation.
2. Time out.
3. Restraint (not floor).
4. Supine Restraint.
5. Prone Restraint.
6. Seclusion in specialised facility.
7. Rapid tranquilisation.

This National Review found that 68% (187) of patients had been subject to one or more restrictive interventions and 13.1% (36), had been subject to one or more restrictive interventions in the previous 90 days.

Figure 63 shows the number of patients subject to each of the eight restrictive interventions, and shows that verbal de-escalation was the intervention most frequently used in the previous 90 days, with 49.8% (137) of patients subject to it.

Figure 63 – Restrictive Interventions by Type & Proportion of Patients



The number of patients subject to one or more restrictive interventions, by type of secure hospitals were:

- 39.1% (9) of male patients in high secure had been subject to one or more restrictive interventions in the previous 90 days.
- 40.0% (30) of male patients in medium secure had been subject to one or more restrictive interventions in the previous 90 days, and 60% (12) of female patients.
- 59.3% (73) of male patients in low secure had been subject to one or more restrictive interventions in the previous 90 days, and 72.7% (24) of female patients.

24.1. Verbal De-Escalation

Intervention: *This intervention involves using non-physical skills such as body language, calm language and communication techniques to prevent or de-escalate a threatening situation. Such communication techniques include distraction, encouragement and reassurance.*

De-escalation is the use of verbal and non-verbal communication skills to defuse anger and avert aggression²²³. De-escalation should be the first-line response to potential violence and aggression²²⁴. There is increasing focus on the use of preventive approaches and de-escalation for managing challenging behaviour²²⁵.

This National Review found that 64.7% (178) of patients had been subject to verbal de-escalation, 50.2% (138) in the last 90 days. Figure 64 shows patients subject to verbal de-escalation according to the frequency, type of secure hospital and gender.

Figure 64 — Patients Subject to Verbal De-Escalation by Frequency, Type of Secure Hospital & Gender

	Male			Female	
Frequency▼	High secure	Medium secure	Low secure	Medium secure	Low secure
No history	60.9% (14)	48.1% (37)	32.5% (40)	25% (5)	3% (1)
History: Not in last 90 days	8.7% (2)	15.6% (12)	16.2% (20)	15% (3)	9% (3)
Infrequent: Once/twice in last 90 days	4.3% (1)	7.8% (6)	11.3% (14)	20% (4)	18% (6)
Frequent: Monthly	4.3% (1)	6.5% (5)	13.8% (17)	5% (1)	6% (2)
Very Frequent: Weekly	0	14.3% (11)	19.5% (24)	20% (4)	18.1% (6)
Extremely Frequent: Daily	21.7% (5)	7.8% (6)	10.5% (13)	10% (2)	30.3% (10)

Figure 65 shows the number of patients, as a proportion of all patients who had been subject to verbal de-escalation by gender and shows that female patients, 74.5% (35), had been subject to this type of intervention more frequently than male patients, 45.1% (103) in the last 90 days.

Figure 65 — Patients Subject to Verbal De-Escalation by Frequency & Gender

	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
Male Patients	39.9% (91)	14.9% (34)	9.2% (21)	10.1% (23)	15.4% (35)	10.5% (24)
Female Patients	12.8% (6)	12.8% (6)	21.3% (10)	6.4% (3)	21.3% (10)	25.5% (12)

24.2. Time-Out

Intervention: Staff manage the patient's risk through separating them from other patients or areas of the ward, but not staff.

'Time out' is a planned intervention which restricts the patient's access to certain spaces and/or activities²²⁶. Time-out should be implemented as part of a structured behaviour plan to achieve a change in a patient's behaviour over a period of time. The difference between time-out and seclusion is that staff remain with the patient during time out, and time-out is not contingent on placing a patient in a specialist room²²⁷.

This National Review found that 29.5% (81) of patients had been subject to time-out, 21.5% (59) in the last 90 days. Figure 66 shows patients subject to time-out according to the frequency, type of secure hospital and gender.

Figure 66 — Patients Subject to Time-out by Frequency, Type of Secure Hospital & Gender

	Male			Female	
Frequency▼	High secure	Medium secure	Low secure	Medium secure	Low secure
No history	73.9% (17)	76.6% (59)	74.2% (95)	47.4% (9)	50.0% (14)
History: Not in last 90 days	4.3% (1)	6.5% (5)	7.8% (10)	10.5% (2)	14.3% (4)
Infrequent: Once/twice in last 90 days	0	5.2% (4)	6.3% (8)	10.5% (2)	21.4% (6)
Frequent: Monthly	4.3% (1)	1.3% (1)	4.7% (6)	10.5% (2)	0
Very Frequent: Weekly	0	5.2% (4)	3.9% (5)	5.3% (1)	0
Extremely Frequent: Daily	17.4% (4)	5.2% (4)	3.1% (4)	15.8% (3)	14.3% (4)

Figure 67 shows the number of patients, as a proportion of all patients who had been subject to time-out by gender and shows that female patients, 38.3% (18), had been subject to this type of intervention more frequently than male patients, 18% (41) in the last 90 days.

Figure 67 — Patients Subject to Time-out by Frequency & Gender

	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
Male Patients	75.0% (171)	7.0% (16)	5.3% (12)	3.5% (8)	3.9% (9)	5.3% (12)
Female Patients	48.9% (23)	12.8% (6)	17.0% (8)	4.3% (2)	2.1% (1)	14.9% (7)

24.3. Restraint (Not Floor)

Intervention: This restrictive intervention involves staff managing the patient's risk through the use of taught, hands-on methods of physical restraint whilst the patient is either standing, sitting or kneeling.

This National Review found that 28.7% (79) of patients had been subject to restraint (not floor), 12% (33 in the last 90 days). Figure 68 shows patients, as a proportion of patients in that setting, subject to restraint (not floor), according to the frequency, type of secure hospital and gender.

Figure 68 — Patients Subject to Restraint (Not Floor), by Frequency, Type of Secure Hospital & Gender

	Male			Female	
Frequency▼	High secure	Medium secure	Low secure	Medium secure	Low secure
No history	73.9% (17)	85.7% (66)	74.2% (95)	47.4% (9)	39.3% (11)
History: Not in last 90 days	13.0% (3)	10.4% (8)	17.2% (22)	31.6% (6)	25.0% (7)
Infrequent: Once/twice in last 90 days	8.7% (2)	1.3% (1)	6.3% (8)	0	21.4% (6)
Frequent: Monthly	13.0% (3)	1.3% (1)	0.8% (1)	10.5% (2)	7.1% (2)
Very Frequent: Weekly	0	1.3% (1)	0.8% (1)	10.5% (2)	7.1% (2)
Extremely Frequent: Daily	0	0	0.8% (1)	0	0

Figure 69 shows the number of patients, as a proportion of all patients, who had been subject to restraint (not floor), by gender and shows that female patients, 29.8% (14), had been subject to this type of intervention more frequently than male patients, 7.5% (17) in the last 90 days.



Figure 69 — Patients Subject to Restraint (Not Floor), by Frequency & Gender

	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
Male Patients	78.1% (178)	14.5% (33)	4.8% (11)	1.3% (3)	0.9% (2)	0.4% (1)
Female Patients	42.6% (20)	27.7% (13)	12.8% (6)	8.5% (4)	8.5% (4)	0

24.4. Supine Restraint

Intervention: This restrictive intervention involves staff managing the patient's risk by a hands-on method of physical restraint with the patient on their back, normally on a floor or bed.

Information pertaining to supine restraint was collected for 273 patients. This National Review found that 19.4% (53) of the 273 patients had been subject to supine restraint, 8.4% (23) in the last 90 days. Figure 70 shows patients, as a proportion of patients in that setting, subject to supine restraint, according to the frequency, type of secure hospital and gender.

Figure 70 — Patients Subject to Supine Restraint, by Frequency, Type of Secure Hospital & Gender

	Male			Female	
Frequency▼	High secure	Medium secure	Low secure	Medium secure	Low secure
No history	73.9% (17)	89.5% (68)	82.8% (106)	68.4% (13)	57.1% (16)
History: Not in last 90 days	4.3% (1)	10.5% (8)	11.0% (14)	10.5% (2)	17.9% (5)
Infrequent: Once/twice in last 90 days	17.4% (4)	0	4.7% (6)	5.3% (1)	7.1% (2)
Frequent: Monthly	4.3% (1)	0	0.8% (1)	15.8% (3)	17.9% (5)
Very Frequent: Weekly	0	0	0	0	0
Extremely Frequent: Daily	0	0	0	0	0

Figure 71 shows the number of patients, as a proportion of all patients who had been subject to supine restraint, by gender and shows that female patients, 23.4% (11), had been subject to this type of intervention more frequently than male patients, 5.3% (12) in the last 90 days.

Figure 71 — Patients Subject to Supine Restraint, by Frequency & Gender

	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
Male Patients	84.5% (191)	10.2% (23)	4.4% (10)	0.9% (2)	0	0
Female Patients	61.7% (29)	14.9% (7)	6.4% (3)	17.0% (8)	0	0

24.5. Prone Restraint

Intervention: *This restrictive intervention involves staff managing the patient's risk by a hands-on method of physical restraint with the patient 'face down', normally on a floor or bed.*

There must be no planned or intentional restraint of a person in a prone position²²⁸. The Mental Health Act Code of Practice for Wales states that prone restraint is only to be used in 'exceptional circumstances' and where it is essential to maintain the safety of the patient and others²²⁹.

Sometimes during a restraint/incident the patient may unintentionally attain a prone position.

When a prone restraint is utilised, the patient should be moved into a supine restraint as soon as possible in order to avoid injury.

This National Review found that 5.1% (14) of patients had been subject to prone restraint, 0.7% (2) in the last 90 days. Figure 72 shows patients, as a proportion of patients in that setting, subject to prone restraint, according to the frequency, type of secure hospital and gender.

Figure 72 — Patients Subject to Prone Restraint, by Frequency, Type of Secure Hospital & Gender

	Male			Female	
Frequency▼	High secure	Medium secure	Low secure	Medium secure	Low secure
No history	95.7% (22)	93.5% (72)	95.3% (122)	89.5% (17)	100% (28)
History: Not in last 90 days	0	6.5% (5)	4.7% (6)	5.3% (1)	0
Infrequent: Once/twice in last 90 days	4.3% (1)	0	0	5.3% (1)	0
Frequent: Monthly	0	0	0	0	0
Very Frequent: Weekly	0	0	0	0	0
Extremely Frequent: Daily	0	0	0	0	0

Figure 73 shows the number of patients, as a proportion of all patients, who had been subject to prone restraint, by gender and shows that female patients, 2.1% (1), had been subject to this type of intervention more frequently than male patients, 0.4% (1) in the last 90 days.

Figure 73 — Patients Subject to Prone Restraint, by Frequency & Gender

	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
Male Patients	94.7% (126)	4.8% (11)	0.4% (1)	0	0	0
Female Patients	95.7% (45)	2.1% (1)	2.1% (1)	0	0	0

24.6. Seclusion

Intervention: *This restrictive intervention involves staff managing the patient's risk by isolating the patient away from other patients, normally in a designated area, from which they are subsequently prevented from leaving.*

Seclusion is the retention of a patient in a low stimulus area to contain a situation where there is a high risk of injury to staff or other patients²³⁰. Seclusion should never be used to manage self-harm or suicidal behaviour²³¹. Rooms used for seclusion should be purpose built with separate bedroom, lounge and bathroom area, and direct access to outdoor space²³².

Seclusion is seen as short-term, up to 48 hours, and the term 'segregation' has been used to describe longer term separations.

This National Review found that 19.3% (53) of patients had been subject to seclusion 9.8% (27) in the last 90 days. Figure 74 shows patients, as a proportion of patients in that setting, subject to seclusion, according to the frequency, type of secure hospital and gender.

Figure 74 — Patients Subject to Seclusion, by Frequency, Type of Secure Hospital & Gender



	 Male			 Female	
Frequency▼	High secure	Medium secure	Low secure	Medium secure	Low secure
No history	87.0% (20)	81.8% (63)	79.7% (102)	57.9% (11)	89.3% (25)
History: Not in last 90 days	4.3% (1)	9.1% (7)	9.4% (12)	26.3% (5)	3.6% (1)
Infrequent: Once/twice in last 90 days	0	5.2% (4)	6.3% (8)	0	0
Frequent: Monthly	0	3.9% (3)	3.1% (4)	15.8% (3)	3.6% (1)
Very Frequent: Weekly	0	0	0	0	3.6% (1)
Extremely Frequent: Daily	8.7% (2)	0	0.4% (1)	0	0

Figure 75 shows the number of patients, as a proportion of all patients who had been subject to seclusion, by gender and shows that female patients, 10.6% (5), had been subject to this type of intervention more frequently than male patients, 9.6% (22) in the last 90 days.

Figure 75 — Patients Subject to Seclusion, by Frequency & Gender

	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
Male Patients	81.6% (186)	8.8% (20)	5.3% (12)	3.1% (7)	0	1.3% (3)
Female Patients	76.6% (36)	12.8% (6)	0	8.5% (4)	2.1% (1)	0

24.7. Rapid Tranquillisation

Intervention: *This restrictive intervention involves staff administering particular medication when required immediately to manage challenging behaviour. This medication can be administered orally, or via an injection.*

Rapid tranquillisation is the administration of medication to induce a state of ‘calmness’ without unconsciousness, thereby reducing risk while maintaining communication. When rapid tranquillisation is used it is recommended that a senior doctor reviews the prescription daily, and that there is clarity about the rationale and circumstances for use²³⁴.

This National Review found that 20% (55) of patients had been subject to rapid tranquillisation 8.4% (23) in the last 90 days. Figure 76 shows patients, as a proportion of patients in that setting, subject to rapid tranquillisation, according to the frequency, type of secure hospital and gender.

Figure 76 — Patients Subject to Rapid Tranquillisation, by Frequency, Type of Secure Hospital & Gender

	Male			Female	
Frequency▼	High secure	Medium secure	Low secure	Medium secure	Low secure
No history	100% (23)	85.7% (66)	80.5% (103)	73.7% (14)	50.0% (14)
History: Not in last 90 days	0	9.1% (7)	10.2% (13)	10.5% (2)	35.7% (10)
Infrequent: Once/twice in last 90 days	0	0	3.1% (4)	5.3% (1)	10.7% (3)
Frequent: Monthly	0	1.3% (1)	1.6% (2)	10.5% (2)	0
Very Frequent: Weekly	0	2.6% (2)	4.7% (6)	0	3.6% (1)
Extremely Frequent: Daily	0	1.3% (1)	0	0	0

Figure 77 shows the number of patients, as a proportion of all patients who had been subject to rapid tranquillisation, by gender and shows that female patients, 14.8% (7), had been subject to this type of intervention more frequently than male patients, 7% (16) in the last 90 days.

Figure 77 — Patients Subject to Rapid Tranquillisation, by Frequency & Gender

	No history	History: Not in last 90 days	Infrequent: Once/twice in last 90 days	Frequent: Monthly	Very Frequent: Weekly	Extremely Frequent: Daily
Male Patients	84.2% (192)	8.8% (20)	1.8% (4)	1.3% (3)	3.5% (8)	0.4% (1)
Female Patients	59.6% (28)	25.5% (12)	8.5% (4)	4.3% (2)	2.1% (1)	0

25. Patient Observations

'Observation' is the term used when one or more staff watch, support, escort or engage with a specific patient for the purpose of risk mitigation or management. Observation should be seen as a partnership between the multi-disciplinary team and the patient and carers and must not be punitive or custodial²³⁵. Observation should also be seen as an integral aspect of patient engagement and not simply as a 'task'²³⁶, as it affords patients and staff an opportunity to build trusting therapeutic relationships²³⁷.

Observations can be at different 'levels', denoting different time periods or staff intensity such as 'intermittent observations' or 'constant observations'.

Some studies have stated that intermittent observations have 'unproven benefit' and their use should be 'discontinued'²³⁸, as being aware of the patients 'whereabouts supports good nursing practice but should not be considered part of the observation process'²³⁹.

Some areas have proposed moving away from observations and instead using proactive, responsive and personalised care focusing on prevention and early intervention²⁴⁰.

Figure 78 shows the number of patients that were subject to observations by frequency, type of secure hospital and gender. Figure 78 shows that 59.6% (28) of female patients were subject to observations on the day of audit compared to 25.9% (59) of male patients. More patients, 41.7% (40), in medium secure were subject to observations compared to high secure, 30.4% (7), and low secure, 25.6% (40).

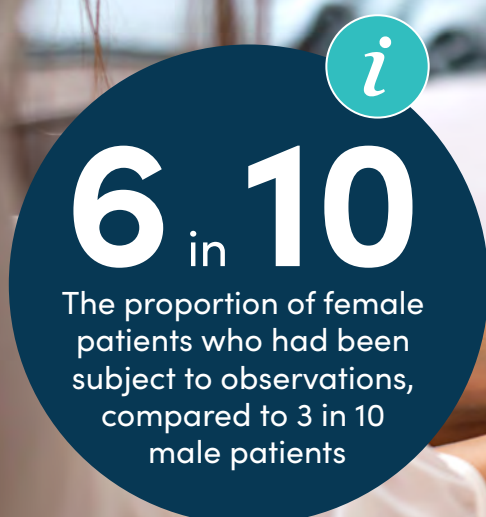


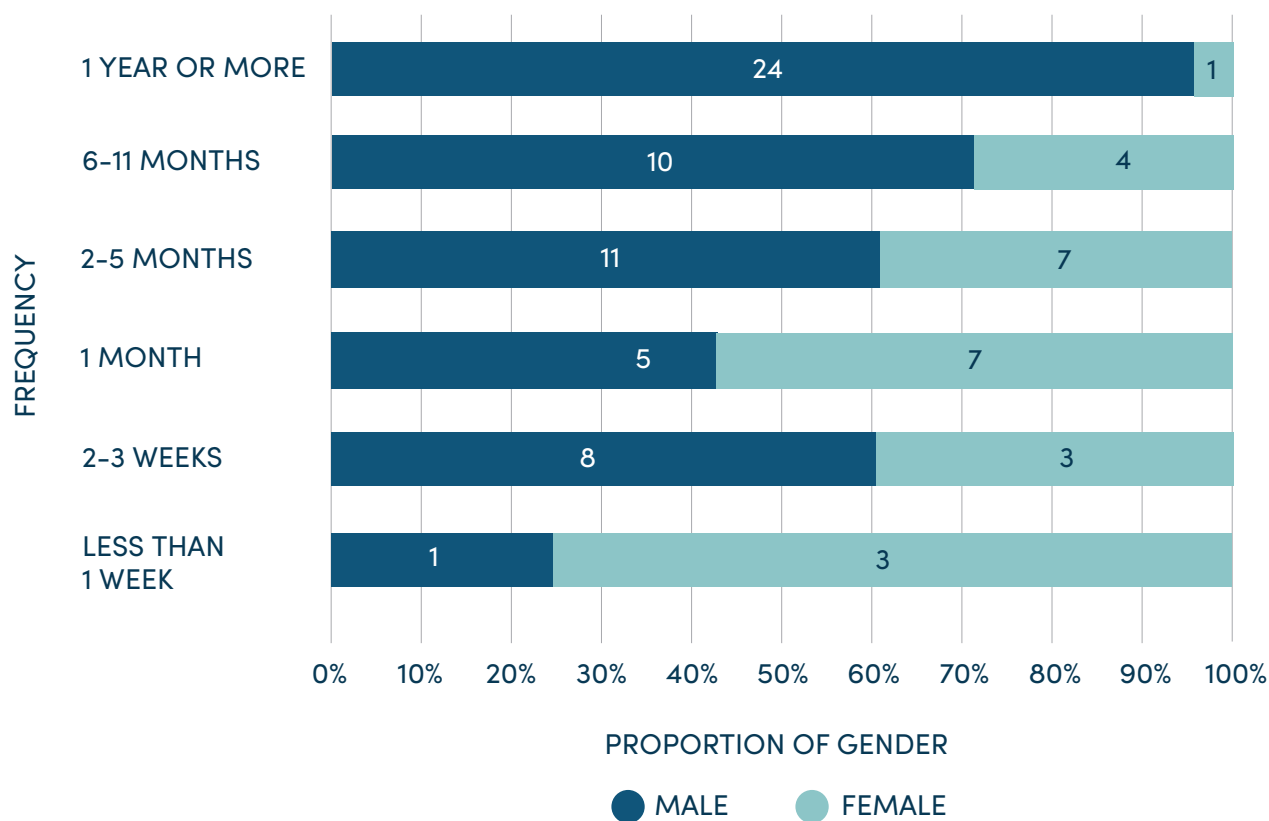
Figure 78 – Number of Patients Subject to Observations by Level, Type of Secure Hospital & Gender

Type of Observations	Male			Female		Overall
	High secure	Medium secure	Low secure	Medium secure	Low secure	
Not subject to observations	69.6% (16)	62.3% (48)	82.0% (105)	42.1% (8)	39.3% (11)	68.4% (188)
Subject to intermittent observations more frequently than hourly	0	3.9% (3)	3.9% (5)	10.5% (2)	3.6% (1)	4.0% (11)
Subject to intermittent observations less frequently than hourly	26.0% (6)	29.9% (23)	9.4% (12)	21.1% (4)	39.3% (11)	20.4% (56)
Subject to constant observations from one member of staff	0	2.6% (2)	3.1% (4)	21.1% (4)	10.7% (3)	4.7% (13)
Subject to constant observations from two or more members of staff	4.3% (1)	1.3% (1)	1.6% (2)	5.3% (1)	7.1% (2)	2.5% (7)

Some studies have stated that observations are ineffective, contribute to impersonal care, and reinforce the perception of a custodial environment²⁴¹, therefore observations should be set at the least restrictive level and for the least amount of time²⁴².

Figure 79 shows the length of time patients, for the 272 patients where this information was available, had been subject to observations up to the day of the audit. Figure 79 shows that 29.4% (25) of patients had been subject to observations for one year or longer, and, as a proportion of patients on observation, 76.3% (45), of male patients and 48% (12), of female patients had been subject to observations for longer than one month.

Figure 79 — Number of Patients Subject to Observations by Time Period & Gender



26. Levels of Care

The Nurse Staffing Levels (Wales) Act requires the Welsh Government to set out methods that the NHS is expected to use when determining the nurse staffing levels required to meet the needs of patients within services they commission and provide²⁴³.

In order to determine appropriate staffing levels, it is essential to understand the intensity of care required by individual patients and the overall patient cohort being managed by a staff group.

To determine the intensity of staff input required to meet patient's needs the National Collaborative Commissioning Unit has developed two 'Levels of Care' measures, which are:

- The 'Safety' Levels of Care which measure and scores the intensity of staff input required to ensure that patient safety is maintained.
- The 'Activity' Levels of Care which measure and score the intensity of staff input required to ensure that patients are supported and enabled to engage in activities.

The National Collaborative Commissioning Unit uses these 'Levels of Care', to trace patient progress, as a proxy for acuity, to benchmark similar wards and ensure adequate staffing numbers and experience. Both Levels of Care are scored from 5 (highest level of staff input required to meet the patient's needs) to 1 (lowest level of staff input required to meet the patient's needs).

26.1. Safety-Levels of Care

Patient safety is the avoidance of unintended or unexpected harm to patients²⁴⁴. In order to deliver high-quality care to patients it is essential that staff have a firm understanding of patient safety issues²⁴⁵.

The Safety-Levels of Care describes the staff involvement required to minimise the possibility of the patient harming themselves or others. The Safety-Levels of Care also describes the staff input required to ensure that the patient can access the community safely. This National Review recorded the Safety-Levels of Care for each patient on the day of audit, although the Levels of Care can change depending on the presentation and needs of the patient.

Figure 80 shows the number of patients, of the 92.4% (254) where information was recorded, within each level of the Safety-Levels of Care, by type of secure hospital and gender and shows the highest proportion of patients (50.0%, 127) across secure hospitals were at Level 2.

Figure 80 shows that the majority, 54.3% (114) of male patients were at Level 2 and female patients at Level 3, 36.4% (16). The type of secure hospital with the largest proportion of patients in the highest, 4 or 5, Levels of care was in low secure, 16.9% (24) compared to medium secure, 10.1% (9), or high secure, 8.7% (2).

Figure 80 — Safety-Levels of Care by Type of Secure Hospital & Gender

Level	Safety-Levels of Care Area	High Secure (23 patients)	Medium Secure (89 patients)	Low Secure (142 patients)	Male Patients (210 patients)	Female Patients (44 patients)	Overall (254 patients)
5	Continuous observation/support — 1:1 or above — for 24 hours/day due to risk of harm to self, risk of harm to or from others or vulnerability.	0	9.0% (8)	7.0% (10)	4.3% (9)	20.5% (9)	7.1% (18)
4	Observation within the ward during specific periods or specific areas (daytime/night time/ communal areas/ bedroom, etc) — 1:1 or above — due to risk of harm to self, risk of harm to or from others or vulnerability.	8.7% (2)	1.1% (1)	9.9% (14)	5.7% (12)	11.4% (5)	6.7% (17)
3	Potential risk of harm to self, to or from others and requires prescribed intermittent observation. Community access requiring dedicated support at 1:1 or above due to risk to self/others.	13.0% (3)	37.1% (33)	19.7% (28)	22.9% (48)	36.4% (16)	25.2% (64)
2	Escorted community access only. Individual requiring cohorted (group) supervision. Requires minimal/ general observation, ongoing support, reassurance or intervention.	30.4% (7)	38.2% (34)	60.6% (86)	54.3% (114)	29.5% (13)	50.0% (127)
1	Unescorted community access. Requires no specific supervision within the ward.	47.8% (11)	14.6% (13)	2.8% (4)	12.9% (27)	2.3% (1)	11.0% (28)

26.2 Activity — Levels of Care

Enabling patients the opportunity to do meaningful activities can help provide a structure to their day and reduce stress, frustration and boredom. It can also help to increase their social interactions, relieve anxiety and improve well-being.

Being engaged in meaningful activities can help to foster an atmosphere of hope and optimism, which can enhance recovery. Activities can help maximise therapeutic benefits and prevent a ward from being seen as a place of containment²⁴⁶. The Activities-Levels of Care describes the staff involvement required to ensure that the patient's personal care needs are met. It also describes the staff input required for the promotion of independence and self-resilience.

This National Review recorded the Safety-Levels of Care for each patient on the day of audit, although the Level of Care can change depending on the presentation and needs of the patient.

Figure 81 shows the number of patients, of the 127 where information was recorded, within each level of the Activity-Levels of Care, by type of secure hospital and gender and shows the highest proportion of patients across secure hospitals were at Level 3. Figure 81 shows that the majority, 41.7% (48), of male patients were at Level 3.

For females there were an equal number of patients within Levels 1, 2 and 3, 33.3% (4). No patients included in this National Review were in the highest Activity-Levels of Care.

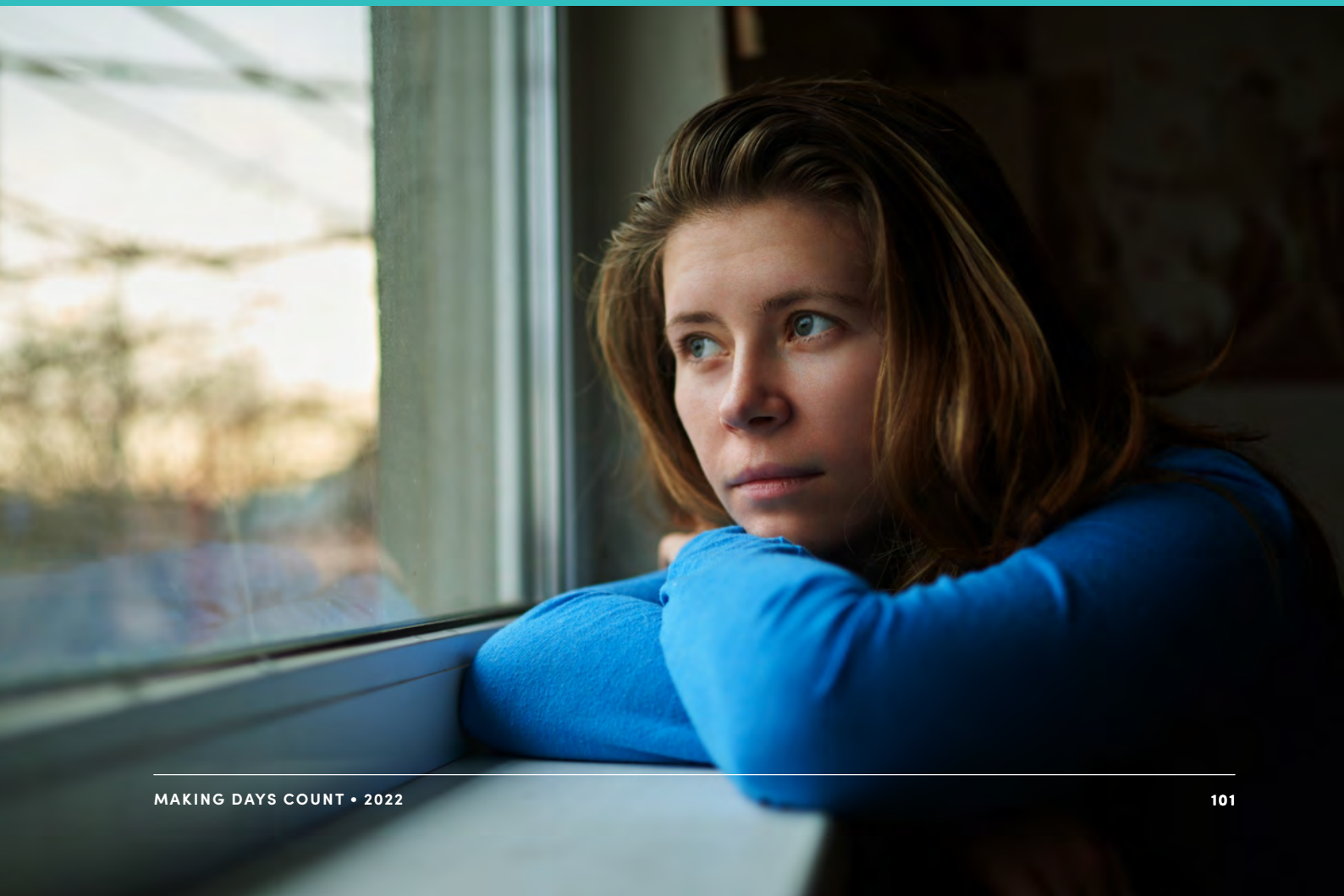


Figure 81 – Activity-Level of Care by Type of Secure Hospital & Gender

Level	Activity-Level of Care Area	High Secure (2 patients)	Medium Secure (59 patients)	Low Secure (68 patients)	Male Patients (115 patients)	Female Patients (12 patients)	Overall (129 patients)
5	Totally dependent for all activities of living as unable to participate in own care.	0	0	0	0	0	0
4	Requires care from minimum of 2 staff for nearly all activities of daily living.	0	0	0	0	0	0
3	Requires care from 1 staff for nearly all activities of daily living. Requires assistance with personal care lasting more than 30 minutes.	0	33.9% (20)	47.1% (32)	41.7% (48)	33.3% (4)	40.3% (52)
2	Requires assistance with some activities of daily living. Individual requiring prompting with most or all activities of daily living.	50% (1)	35.6% (21)	36.8% (25)	36.5% (42)	33.3% (4)	36.4% (47)
1	Individual requiring prompting with some activities of daily living or is self-caring/independent.	50% (1)	30.5% (18)	16.2% (11)	21.7% (25)	33.3% (4)	23.3% (30)

26.3. Safety & Activity–Levels Of Care

In order to get a general overview of the patient needs which require staff input, the Safety–Levels of Care and Activities–Levels of Care can be cross-referenced as shown in Figure 82 for the 257 patients where this information was recorded.

Studies have shown about ‘one third’ of patients in high or low secure to be in an ‘inappropriate level of security’, with most thought to require a lower level²⁴⁷.

Figure 82 shows that of the 106 patients who had Safety and Activity Levels of Care recorded, the majority of patients, 23.6% (25), have a cross-referenced Safety and Activities Level of Care 2/2 or lower. These Levels of Care could be considered ‘low’, with the patient essentially self-managing and may indicate that the patient could be considered for an alternative environment of care, however many other factors should also be taken into account when determining the patients appropriate level of security or type of care.

Figure 82 – Patients in Each Level of Activity & Safety Levels of Care

		Activity Level of Care				
		5	4	3	2	1
Safety Level of Care	5	0	0	0	0	0
	4	0	0	0	0	0
	3	0	0	17.9% (19)	11.3% (12)	0.9% (1)
	2	0	0	18.9% (20)	23.6% (25)	14.2% (15)
	1	0	0	0	1.9% (2)	11.3% (12)

27. Physical Health

Individuals with mental illness, particularly severe illness, are at a much higher risk of a range of physical health conditions. The life expectancy of individuals with bipolar disorder or schizophrenia is 15 to 20 years below that of the general population, largely as a result of raised rates of cardiovascular disease and other physical health conditions^{248,249}. Individuals diagnosed with mental illness have higher rates of alcohol and substance misuse than the general population²⁵⁰.

People diagnosed with serious mental illness are at greater risk of developing type two diabetes and life-shortening respiratory diseases^{251,252}, and obesity and smoking are key contributors in these health conditions.

27.1. Patient Weight

Obesity is a major physical health issue for many patients in secure hospitals. Weight gain can be caused by side-effects of medication, lack of exercise or poor diet or a combination of all of these. It is therefore important that staff promote healthy living through exercise and educate patients about healthy food²⁵³. High obesity rates have been documented in psychiatric populations in the UK and patients in mental health hospitals have, on average, gained three to five pounds a month during initial admission period^{254,255}. Those most at risk of weight gain are newly admitted patients with a lower body weight²⁵⁶, however patients who are overweight and obese on admission still gain clinically significant amounts of weight during treatment.

A two-way association has been identified between mental health problems and obesity, with conditions such as depression often leading to weight gain and obesity leading to depression²⁵⁷. Whilst the perceived stigma and body image issues of weight gain can negatively affect mood, in mentally ill individuals, food can be used as a coping strategy and low mood can affect adherence to weight management regimes²⁵⁸.

Rates of obesity are also high in people with mental illness due to the effects of medication, poor diet, alcohol misuse and less active lifestyles^{259,260}.

In this National Review, patient weight on admission, and at the time of audit was examined. Body Mass Index at time of audit was also examined, see **Box 4**.

Figure 83 shows the average difference in weight on admission and at time of audit, for the 250 patients where this information was recorded, by type of secure hospital and gender. Figure 83 shows that male patients in high secure patients had, on average, gained the most weight and male patients had gained more weight than female patients in all types of secure hospital.

Box 4. Body Mass Index

Body Mass Index is measured by weight in kilograms divided by the square of height in metres (kg/m²). A BMI of over 30 is classed as obese.

Determining healthy weight must also take other factors into account.



Figure 83 — Difference in Average Weight on Admission & at Time of Audit Type of Secure Hospital & Gender





	 Male	 Female
High secure	+15.6kg	n/a
Medium secure	+11.2kg	+2.2kg
Low secure	+6.5kg	+5kg
Overall	+8.7kg	+3.7kg

Figure 84 shows the average Body Mass Index, for the 237 patients where this was recorded, at the time of audit and shows that the average measurement for both genders and for patients in all types of secure hospital is within the obesity range of 30kg/m² to 39.9kg/m²²⁶¹. Figure 84 shows that on average, female patients had higher Body Mass Index measurement than male patients.

Figure 84 — Body Mass Index at Time of Audit by Type of Secure Hospital & Gender

	 Male	 Female
High secure	32.9	n/a
Medium secure	33.9	34.6
Low secure	32	33.2
Overall	32.7	33.9

The number of Adverse Childhood Events (ACEs) is associated with a higher risk of engaging in health harming behaviours, including unhealthy diet²⁶². This National Review found that those patients with a greater number of ACEs also had a higher Body Mass Index.

27.2 Patient Smoking

Smoking is the leading cause of premature death in Wales and 14% of the population of Wales are smokers. Smoking rates are higher in some groups including amongst the socio-economically deprived, the unemployed, and those with mental illness²⁶³. Studies have shown that 64% of patients in mental health hospitals are smokers²⁶⁴.

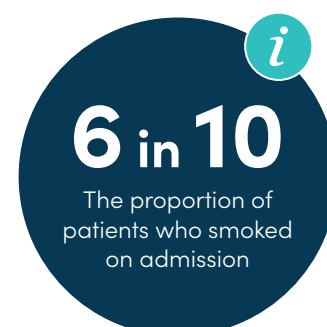
This National Review found that 57.5% (158) of patients in secure hospitals smoked on admission although 13.5% (21) of patients had ceased at the time of audit.

Figure 85 shows the smoking status of patients on admission and at time of audit and shows that similar numbers of male patients, 57.5% (131), smoked on admission than female patients, 57.4% (27). Figure 85 shows that more patients smoked in low secure, 64.1% (100) than both medium secure, 50.1% (48), and high secure, 43.5% (10), although more patients had ceased smoking in high secure at the time of audit. Significantly more male patients had ceased smoking since admission than female patients.

Figure 85 – Smoking Status on Admission & at Time of Audit by Type of Secure Hospital & Gender

	High secure	Medium secure	Low secure	Male Patients 	Female Patients 	Overall
Not a smoker	56% (13)	50% (48)	35.9% (56)	43% (98)	40.4% (19)	42.5% (117)
A smoker on admission and at time of audit	8.7% (2)	38.6% (37)	52.6% (82)	41.7% (95)	55.3% (26)	44% (121)
A smoker on admission but not at time of audit	34.8% (8)	11.5% (11)	11.5% (18)	15.8% (36)	2.1% (1)	13.5% (37)

This National Review examined the availability of nicotine replacement resources and smoking cessation support and found, of the 44% (121) of patients who were smokers at the time of audit, 100% (121) had access to nicotine replacement resources and 84.2% (102) had access to smoking cessation support.



27.3. Access to Primary Healthcare

Access to primary healthcare for patients in secure hospitals presents unique challenges for primary healthcare professionals. Patients in such environments often have multiple complex physical health, mental health and substance misuse needs that exceed those of people living in the community. These issues can be compounded by a reluctance to engage with physical health services²⁶⁵. High quality primary healthcare has the potential to improve the management, health and well-being of patients with mental illness²⁶⁶.



This National Review examined access and the barriers to access to General Practitioners, Dentists, Podiatrists and Opticians.

27.3.1. Access To A General Practitioner

A general practitioner is a medical doctor who treats common medical conditions and can refer patients to hospitals and other medical services for urgent and specialist treatment. They focus on the health of the whole person combining physical, psychological and social aspects of care²⁶⁷.

Figure 86 shows patients' access to a general practitioner by type of secure hospital and gender and shows that, 42.9% (118) of patients required this service and that 0.7% (2), of patients could not attend for legal, risk, staffing or transport issues. Figure 86 shows that more male patients, 42.1% (96), accessed a general practitioner than female patients, 27.7% (13), and that males in low secure were most likely to access this aspect of primary healthcare.

Figure 86 – Patients Access to a General Practitioner by Type of Secure Hospital & Gender



Access to a General Practitioner	 Male			 Female		Overall
	High secure	Medium secure	Low secure	Medium secure	Low secure	
Not needed	56.5% (13)	61.0% (47)	50.8% (65)	63.1% (12)	71.4% (20)	57.1% (157)
Refused	0	6.5% (5)	1.6% (2)	0	0	2.5% (7)
Not attended due to legal or risk issues	0	0	0	0	3.6% (1)	0.4% (1)
Not attended due to staff or transport issues	0	0	0	0	3.6% (1)	0.4% (1)
Attended	43.5% (10)	32.5% (25)	47.7% (61)	36.8% (7)	21.4% (6)	39.6% (109)

27.3.2. Access To A Dentist

A dentist is a doctor who prevents and treats dental and/or oral disease, corrects dental irregularities and treats dental or facial injuries²⁶⁸. Patients with mental illness are subject to a greater number of risk factors for oral and dental disease than the general population. This is mostly caused by the side effects of the medications that they receive, lack of self-care, difficulty to access health services, a negative attitude towards healthcare providers, anxieties and dietary habits, including the heavy consumption of sugary drinks, tobacco and alcohol^{269,270}.

Figure 87 shows patients' access to a dentist by type of secure hospital and gender and shows that, 73.5% (202) of patients required this service and that 21.8% (60), of patients could not attend for legal, risk, staffing or transport issues. Figure 87 shows that more male patients, 50% (114), accessed a dentist than female patients, 17% (8), and that males in high secure were most likely to access a this aspect of primary healthcare.

Figure 87 — Patients Access to a Dentist by Type of Secure Hospital & Gender

Access to a Dentist	 Male			 Female		Overall
	High secure	Medium secure	Low secure	Medium secure	Low secure	
Not needed	13.0% (3)	20.8% (16)	28.1% (36)	31.6% (6)	48.8% (12)	26.5% (73)
Refused	0	3.9% (3)	9.4% (12)	0	14.2% (4)	6.9% (19)
Not attended due to legal or risk issues	0	0	0.8% (1)	0	7.1% (2)	1.1% (3)
Not attended due to staff or transport issues	4.3% (1)	15.6% (12)	22.7% (29)	36.8% (7)	28.5% (8)	20.7% (57)
Not attended due to undisclosed issue	4.3% (1)	0	0	0	0	0.4% (1)
Attended	78.3% (18)	59.7% (46)	39.1% (50)	31.6% (6)	7.1% (2)	44.4% (122)

27.3.3. Access To A Podiatrist

A podiatrist is a medical professional who have been trained to diagnose and treat abnormal conditions of the feet and lower limb and prevent and correct deformity, relieve pain and treat infections²⁷¹. Studies have shown that individuals with mental illness have elevated rates of podiatric problems when compared to the general population²⁷².

Figure 88 shows patients' access to a podiatrist by type of secure hospital and gender and shows that, 15.3% (42) of patients required this service and that 4.7% (13), of patients could not attend for staffing or transport issues. Figure 88 shows that more male patients, 8.7% (24), accessed a podiatrist than female patients, 0.4% (1), and that males in low secure were most likely to access a this aspect of primary healthcare.

Figure 88 — Patients Access to a Podiatrist by Type of Secure Hospital & Gender



Access to a Podiatrist	Male			Female		Overall
	High secure	Medium secure	Low secure	Medium secure (18 patients)	Low secure	
Not needed	78.3% (18)	80.7% (67)	80.5% (103)	94.4% (17)	96.4% (27)	84.7% (232)
Refused	0	1.3% (1)	1.6% (2)	0	3.6% (1)	1.5% (4)
Not attended due to legal or risk issues	0	0	0	0	0	0
Not attended due to staff or transport issues	0	0	10.3% (13)	0	0	4.7% (13)
Attended	21.7% (5)	11.7% (9)	7.8% (10)	5.6% (1)	0	9.1% (25)

27.3.4. Access To An Optician

Opticians, which includes ophthalmic practitioners for the purpose of this National Review, are trained to recognise abnormalities and conditions of the eye, such as cataracts or glaucoma, and to test eyesight and fit glasses and contact lenses. If necessary an optician will refer patients to a GP, hospital eye clinic or specialist optometrist for further investigations or treatment²⁷³.

Figure 89 shows patients' access to an optician by type of secure hospital and gender and shows that, 43.6% (120) of patients required this service and that 14.5% (40), of patients could not attend for legal, risk, staffing or transport issues. Figure 89 shows that more male patients, 29.4% (67), accessed an optician than female patients, 6.4% (3), and that males in high secure were most likely to access this aspect of primary healthcare.

Figure 89 – Patients Access to an Optician by Type of Secure Hospital & Gender

Access to an Optician	 Male			 Female		Overall
	High secure	Medium secure	Low secure	Medium secure	Low secure	
Not needed	47.8% (11)	61.0% (47)	53.1% (68)	94.7% (18)	39.3% (11)	56.4% (155)
Refused	0	1.3% (1)	4.7% (6)	0	10.7% (3)	3.6% (10)
Not attended due to legal or risk issues	0	0	1.6% (2)	0	7.1% (2)	1.5% (4)
Not attended due to staff or transport issues	0	3.9% (3)	18.0% (23)	5.3% (1)	32.1% (9)	13.1% (36)
Attended	52.3% (12)	33.8% (26)	22.7% (29)	0	10.7% (3)	25.5% (70)

27.4. Access To Emergency Healthcare

Studies have shown that individuals with mental illness have high rates of hospital emergency department attendance^{274,275,276}. Some patients in secure hospitals may require emergency support either from an ambulance or an emergency departments due to, ligature injuries, self-cutting or purposefully swallowing of objects, or for urgent physical health issues.

This National Review examined the frequency that patient's in secure hospitals required external emergency support, either from an ambulance or by attendance at an emergency department. This National Review excludes internal secure hospital emergency responses due to definitional issues. Figure 90 shows that 20.4% (56) of patients required emergency support. Figure 90 show that a greater proportion of female patients, 17% (8), required an ambulance, compared to male patients, 4% (9). Also, a greater proportion of female patients, 31.9% (15), attended an emergency department, than male patients, 11.4% (26).

Figure 90 – Patients Access to Emergency Support by Type of Secure Hospital & Gender

Access to Emergency Support	Male			Female		Overall
	High secure	Medium secure	Low secure	Medium secure	Low secure	
Not required	95.7% (22)	90.9% (70)	78.9% (101)	47.4% (9)	64.3% (18)	80.0% (220)
Ambulance required	4.3% (1)	1.3% (1)	5.5% (7)	21.1% (4)	3.6% (1)	5.1% (14)
Emergency department attendance required	0	7.8% (6)	15.6% (20)	31.6% (6)	32.1% (9)	14.9% (41)



28. Community Access/Leave

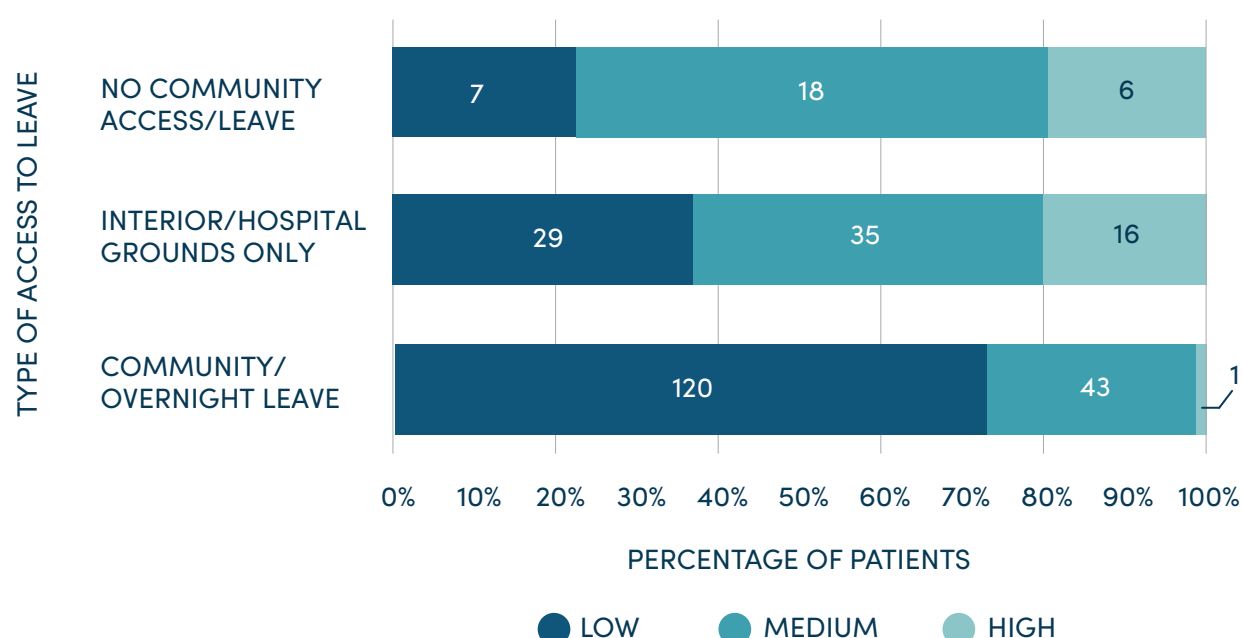
Secure hospitals should be preparing patients for successful return of greater independence, and periods of overnight leave or community access can form an essential component of that preparation.

Any decision to agree a period of community access has to balance the contribution that this makes to the individual's recovery against considerations for the well-being of both the individual and others. For patients detained under the Mental Health Act it is a requirement for 'leave' to be authorised, and certain Sections require authorisation from the Ministry of Justice. Each decision to authorise leave requires a careful assessment of the risk of reoffending or absconding, and comprises a crucial decision process²⁷⁷.

As the patient progresses through their care journey, community access may progress from interior gardens spaces, unescorted hospital grounds, escorted then unescorted leave in the local area, to overnight leave at home or to another care facility.

Figure 91 shows the patients who had community access/leave by type of leave and type of secure hospital, and shows that 164 patients (59.6%) had some form of community access or overnight leave within the previous ninety days.

Figure 91 — Patients With Community Access/Leave by Type of Leave & Type of Secure Hospital



This National Review found that of the 88.7% (244) of patients who had access to leave, 20.5% (50) had their leave suspended after the last leave period. It could not be ascertained whether this was due to changes in patient's clinical presentation, or due to other reasons. This National Review examined whether community leave was disrupted or cancelled due to the Covid 19 pandemic, and found that, 44.7% (123), of patients had some leave disrupted or cancelled due to the pandemic.

It is normal practice to ensure the patient has trial periods out of hospital before discharge, this is particularly important for people who have been in hospital for an extended period and people who have had restricted access to the community²⁷⁸.

29. Nurse Staffing

Nurses in secure hospitals work as part of the multi-disciplinary team, they may assess patients prior to admission and develop plans of care with the patient.

Nurses build therapeutic relationships with patients and work with them to gain insight into their past and build hope for the future²⁷⁹. Secure hospitals can be amongst the most challenging arenas in which any nurse can work.

The environments of care and patient presentations pose 'intense demands' upon nurses who are required to maintain empathic relationships while focussing on risk management²⁸⁰. The Covid 19 pandemic has added to the stress on nursing staff due to the difficulties in implementing infection control strategies whilst responding to incidents of violence or self-harm²⁸¹.

This National Review examined actual staffing, as opposed to established posts or planned staffing, across a weekly average, of wards in each type of secure hospital by 'day' and 'night' shifts. The number of staff required each shift can be affected by the ward function such as high dependency, acuity and complexity of patients and ward activity such as team meetings, escorts, admissions.

Figure 92 shows the average actual staffing, for one week prior to audit, per shift and by type of secure hospital and shows that staffing is similar across types of secure hospital although medium secure had slightly lower staff during the day and high secure had slightly lower staffing at night. All types of secure hospital had higher staffing during the 'day' shift.



Figure 92 – Average Actual Staffing Per Shift & by Type of Secure Hospital

Nurse Staffing	High secure	Medium secure	Low secure
Average number of registered nursing staff per day shift	2.5	2.5	2.5
Average number of support staff per day shift	6	5.4	5.5
Average total number of staff per day shift	8.5	7.9	8

Average number of registered nursing staff per night shift	1.2	1.4	1.4
Average number of support staff per night shift	2.8	3.8	3.7
Average total number of staff per night shift	4	5.2	5.1

Workforce shortages are widespread in mental health services with many nurses working in settings with 'rota gaps'²⁸². Shortages in staffing result in stressed services and a reliance on locum or agency staff, which influence integration and knowledge of patients, which in turn may impact the ability for services to operate in a safe manner²⁸³. Mental health care has, on average, higher turnover of staff than other parts of the NHS²⁸⁴.

This National Review examined 'vacancy rates', the difference between the staff establishment and staff in post, in each hospital and found the average vacancy rate for registered nurses was 11.2% and for support staff it was an average of 3.3%.

Studies have shown that mental health services have faced challenges in their ability to attract and retain nurses in the context of an overall nursing shortage. Mental health services need to develop strategies to attract and retain skilled nurses and avoid future shortages such as balanced workloads, safe staffing levels and a positive working environment²⁸⁵. Studies have suggested that as many as 25% of mental health nurses working in hospitals have been subject to a violent incident resulting in a serious injury²⁸⁶ and that being assaulted, or a perceived risk of being assaulted, effects recruitment and retention²⁸⁷.

Figure 93 shows the average length of service for nursing staff at their current hospital, where the information was available, and shows that low secure had the lowest length of service on average for registered nurses and support staff.

Figure 93 – Average Registered Nursing Staff Employment Time at Current Hospital by Type of Secure Hospital

Nurse Retention (years)	High secure	Medium secure	Low secure
Average length of service at current hospital for registered nurses	14.2	6	4.5
Average length of service at current hospital for support staff	13.4	5.4	4.3

30. Multi-Disciplinary Team

Nursing staff make up just one component of the multidisciplinary team. A multidisciplinary team is where professionals from different disciplines, such as nursing, psychiatry, psychology, social care and occupational therapy, which may otherwise operate in a stratified and delineated manner, work together to deliver care²⁸⁸.

Multidisciplinary teams in mental health were established to deliver comprehensive treatment and care for people with mental illness following a Department of Health strategy published in 1984²⁸⁹, this way of working is now the standard approach in secure hospitals to address patient's complex needs²⁹⁰.

Multi-disciplinary team working is more than having a group of professionals present in meetings²⁹¹, as attachment to existing boundaries can hinder communication and coordination at the expense of patient safety²⁹². Sometimes confusion regarding individual roles, leadership, and clinical accountability between professionals can be an issue²⁹³.

Multidisciplinary teams can improve the quality of care by including the perspectives of multiple professionals into the patient's care planning discussions²⁹⁴. Multi-disciplinary team working and specialist skills are considered essential to understanding, assessing and managing risk and complex needs and delivering appropriate care to patients in secure hospitals²⁹⁵. The composition of the multi-disciplinary team is not identical in each secure hospital, and accessibility, experience and skills of each team member will differ. Some hospitals may not employ certain professions, some patients may refuse to engage with members of the multi-disciplinary team or have completed a therapy programme.

This National Review audited each patient's access to professional groups who form part of the multi-disciplinary team. For the purpose of this National Review, staff were grouped into the following ten professions:

1. Psychiatrist.
2. Clinical Psychologist.
3. Assistant Psychologist.
4. Counsellor.
5. Occupational Therapist.
6. Occupational Therapist Assistant.
7. Social Worker.
8. Speech And Language Therapist.
9. Physical Health Nurse.
10. Dietician.

Each profession is discussed later in this National Review. Figure 94 shows the various professions which may constitute a multi-disciplinary team with the proportion of patients in contact with that profession at the time of audit.

Figure 94 shows that all patients had contact with a psychiatrist, and a majority of patients had contact with an occupational therapist, clinical psychologist, occupational therapist assistant, social worker, physical health nurse, and assistant psychologist.

Figure 94 – Proportion of Patients In Contact With Specific Professions by Type of Secure Hospital

Profession	High secure	Medium secure	Low secure	Total
Psychiatrist	100% (23)	100% (96)	100% (156)	100% (275)
Clinical Psychologist	82.6% (19)	90.6% (87)	66% (103)	76% (209)
Assistant Psychologist	69.6% (16)	66.7% (64)	41.7% (65)	52.7% (145)
Counsellor	4.3% (1)	1% (1)	1.9% (3)	1.8% (5)
Occupational Therapist	39.1% (9)	86.5% (83)	80.8% (126)	79.3% (218)
Occupational Therapist Assistant	30.4% (7)	81.3% (78)	75.6% (118)	73.8% (203)
Social Worker	69.6% (16)	95.8% (92)	53.2% (83)	69.5% (191)
Speech & Language Therapist	13% (3)	1% (1)	3.8% (6)	3.6% (10)
Physical Health Nurse	69.6% (16)	68.8% (66)	48.1% (75)	57.1% (157)
Dietician	13% (3)	7.3% (7)	9.6% (15)	9.1% (25)

31.1. Psychiatrist

Forensic psychiatrists deliver treatment, manage care and provide expert advice and support to other professionals through a holistic and multidisciplinary approach²⁹⁶. Figure 95 shows that 100% (275) of patients had a recorded contact with a psychiatrist, of which the most common form of contact, 52.3% (144), was through regular multi-disciplinary meetings.

Figure 95 – Frequency of Patient Contact With a Psychiatrist

Frequency of contact	High secure	Medium secure	Low secure	Total
1:1 at least weekly	34.8% (8)	33.3% (32)	31.4% (49)	32.4% (89)
1:1 less often than weekly	17.4% (4)	15.6% (15)	14.1% (22)	14.9% (41)
Regular 1:1 and group sessions	0	0	0	0
Group sessions more often than weekly	0	0	0.6% (1)	0.4% (1)
Group sessions less often than weekly	0	0	0	0
At multi-disciplinary meetings only	47.8% (11)	51% (49)	53.8% (84)	52.3% (144)
Therapy complete	0	0	0	0

31.2. Clinical Psychologist

Clinical psychologists breadth of psychological skills and knowledge enables them to treat complex cases and provide specialist treatment²⁹⁷. Figure 96 shows that 76% (209) of patients had recorded contact with a clinical psychologist, of which the most common form of contact, 33.9% (71), was through one-to-one sessions less often than weekly.

Figure 96 – Frequency of Patient Contact With a Clinical Psychologist

Frequency of contact	High secure	Medium secure	Low secure	Total
1:1 at least weekly	47.8% (11)	30.2% (29)	15.4% (24)	23.3% (64)
1:1 less often than weekly	21.7% (5)	33.3% (32)	21.8% (34)	25.8% (71)
Regular 1:1 and group sessions	0	1.0% (1)	2.6% (4)	1.8% (5)
Group sessions more often than weekly	0	2.1% (2)	1.9% (3)	1.8% (5)
Group sessions less often than weekly	0	0	0	0
At multi-disciplinary meetings only	4.3% (1)	21.9% (21)	20.5% (32)	19.6% (54)
Therapy complete	8.7% (2)	2.1% (2)	3.8% (6)	3.6% (10)

The proportion of patients in secure hospitals with access to a clinical psychologist is higher in NHS Wales hospitals at 90.2% (101) than non NHS Wales hospitals at 71.5% (108).

31.3. Assistant Psychologist

Assistant psychologists work under the supervision of a clinical psychologist to undertake assessments, formulations and interventions²⁹⁸.

Figure 97 shows that 26.5% (73) of patients had recorded contact with an assistant psychologist, of which the most common form of contact, 42.5% (31), was through one-to-one sessions more often than weekly.

Figure 97 — Frequency of Patient Contact With an Assistant Psychologist

Frequency of contact	High secure	Medium secure	Low secure	Total
1:1 at least weekly	4.3% (1)	5.2% (5)	16.0% (25)	11.3% (31)
1:1 less often than weekly	8.7% (2)	3.1% (3)	6.4% (10)	5.5% (15)
Regular 1:1 and group sessions	0	2.1% (2)	2.6% (4)	2.2% (6)
Group sessions more often than weekly	0	3.1% (3)	0.6% (1)	1.5% (4)
Group sessions less often than weekly	0	1.0% (1)	0.6% (1)	0.7% (2)
At multi-disciplinary meetings only	0	8.3% (8)	2.6% (4)	4.4% (12)
Therapy complete	0	0	1.9% (3)	1.1% (3)

The proportion of patients in secure hospitals with recorded access to an assistant psychologist is lower in NHS Wales hospitals at 19.2% (19) than in non NHS Wales hospitals at 35.2% (62).

31.4. Counsellor

Counsellors are trained professionals that, through group or individual sessions will support patients to explore their thoughts, feelings and behaviours in order to develop a greater understanding of themselves²⁹⁹.

Figure 98 shows that 1.8% (5) of patients had recorded contact with a counsellor, of which the most common form of contact, 1.1% (3), was through one-to-one sessions less often than weekly.

Figure 98 — Frequency of Patient Contact With a Counsellor

Frequency of contact	High secure	Medium secure	Low secure	Total
1:1 at least weekly	0	1.0% (1)	0	0.4% (1)
1:1 less often than weekly	4.3% (1)	0	1.3% (2)	1.1% (3)
Regular 1:1 and group sessions	0	0	0	0
Group sessions more often than weekly	0	0	0.6% (1)	0.4% (1)
Group sessions less often than weekly	0	0	0	0
At multi-disciplinary meetings only	0	0	0	0
Therapy complete	0	0	0	0

The proportion of patients in secure hospitals with recorded access to a counsellor is lower in NHS Wales hospitals at 2% (2) than in non NHS Wales hospitals at 2.3% (4).

31.5. Occupational Therapist

Occupational therapists can have a positive impact on a patient's recovery and transform a patient's experience of their admission³⁰⁰. Occupational therapists enable patients to achieve health, well-being and optimum function in their daily lives. Occupational therapists assist patients to become more self-aware, and develop their interpersonal capacity, pro-social values, meaningful routines, their personal identity and skills for meaningful life participation³⁰¹.

Figure 99 shows that 79.3% (218) of patients had recorded contact with an occupational therapist, of which the most common form of contact, 31.3% (86), was through one-to-one sessions less often than weekly.

Figure 99 – Frequency of Patient Contact With an Occupational Therapist

Frequency of contact	High secure	Medium secure	Low secure	Total
1:1 at least weekly	4.3% (1)	13.5% (13)	21.8% (34)	17.5% (48)
1:1 less often than weekly	21.7% (5)	36.5% (35)	29.5% (46)	31.3% (86)
Regular 1:1 and group sessions	4.3% (1)	8.3% (8)	7.1% (11)	7.3% (20)
Group sessions more often than weekly	0	2.1% (2)	3.2% (5)	2.5% (7)
Group sessions less often than weekly	0	5.2% (5)	5.1% (8)	4.7% (13)
At multi-disciplinary meetings only	8.7% (2)	20.8% (20)	12.8% (20)	15.3% (42)
Therapy complete	0	0	1.3% (2)	0.7% (2)

The proportion of patients in secure hospitals with recorded access to an occupational therapist is higher in NHS Wales hospitals at 80.8% (80) than in non NHS Wales hospitals at 79% (139).

31.6. Occupational Therapy Assistant

Occupational therapy assistants support occupational therapists in their day-to-day duties. They encourage and assist patients to engage in activities, either in the hospital or in the community, and report on their progress³⁰².

Figure 100 shows that 73.8% (203) of patients had recorded contact with an occupational therapist assistant, of which the most common form of contact, 28% (77), was through 1:1 sessions less often than weekly.

Figure 100 – Frequency of Patient Contact With an Occupational Therapy Assistant

Frequency of contact	High secure	Medium secure	Low secure	Total
1:1 at least weekly	4.3% (1)	10.4% (10)	10.9% (17)	10.2% (28)
1:1 less often than weekly	17.4% (4)	22.9% (22)	32.7% (51)	28% (77)
Regular 1:1 and group sessions	0	11.5% (11)	17.9% (28)	14.2% (39)
Group sessions more often than weekly	0	6.3% (6)	2.6% (4)	3.6% (10)
Group sessions less often than weekly	0	16.7% (16)	6.4% (10)	9.5% (26)
At multi-disciplinary meetings only	8.7% (2)	13.5% (13)	3.8% (6)	7.6% (21)
Therapy complete	0	0	1.3% (2)	0.7% (2)

The proportion of patients in secure hospitals with recorded access to occupational therapy assistants is lower in NHS Wales hospitals at 71.7% (71) than in non NHS Wales hospitals at 76.1% (134).

31.7 Social Worker

Social workers focus on bringing a social perspective into the multi-disciplinary team, delivering social interventions and discharging statutory duties, including working with a wide range of stakeholders and agencies to ensure that effective bridges are built between hospital and community³⁰³.

Figure 101 shows that 69.4% (191) of patients had recorded contact with a social worker, of which the most common form of contact, 53.5% (147), was through regular multi-disciplinary meetings.

Figure 101 – Frequency of Patient Contact With a Social Worker

Frequency of contact	High secure	Medium secure	Low secure	Total
1:1 at least weekly	21.7% (5)	14.6% (14)	6.4% (10)	10.5% (29)
1:1 less often than weekly	4.3% (1)	5.2% (5)	1.9% (3)	3.3% (9)
Regular 1:1 and group sessions	0	0	1.3% (2)	0.7% (2)
Group sessions more often than weekly	8.7% (2)	0	0	0.7% (2)
Group sessions less often than weekly	0	2.1% (2)	0	0.7% (2)
At multi-disciplinary meetings only	34.8% (8)	74.0% (71)	43.6% (68)	53.5% (147)
Therapy complete	0	0	0	0

The proportion of patients in secure hospitals with recorded access to a social worker is lower in NHS Wales hospitals at 66.7% (66) than in non NHS Wales hospitals at 74.4% (131).

31.8. Speech And Language Therapists

There is a high incidence and prevalence of speech, language and communication and swallowing difficulties associated with mental health in adults. Specific mental health problems have communication and eating, drinking and swallowing difficulties commonly associated with them, for example, schizophrenia, psychosis, dementia and depression. However, often problems are not recognised and there is a risk that they may be masked by the mental health symptoms³⁰⁴.

A speech and language therapist is a trained professional who will assess and support patients with speech, language and communication and swallowing difficulties.

Figure 102 shows that 4% (11) of patients had recorded contact with a speech and language therapist, of which the most common form of contact, 1.8% (5), was either through regular multi-disciplinary meetings or one to one sessions less often than weekly.

Figure 102 – Frequency of Patient Contact With a Speech & Language Therapist

Frequency of contact	High secure	Medium secure	Low secure	Total
1:1 more often than weekly	0	0	0	0
1:1 less often than weekly	13.0% (3)	0	1.3% (2)	1.8% (5)
Regular 1:1 and group sessions	0	0	0	0
Group sessions more often than weekly	0	0	0	0
Group sessions less often than weekly	0	0	0	0
At multi-disciplinary meetings only	0	1.0% (1)	2.6% (4)	1.8% (5)
Therapy complete	0	0	0.6% (1)	0.4% (1)

The proportion of patients in secure hospitals with recorded access to a speech and language therapist is higher in NHS Wales hospitals at 5.1% (5) than in non NHS Wales hospitals at 4.5% (8).

31.9. Dietitian

A Dietitian supports patients to eat well and develop a positive relationship with food as good nutrition is important for both mental and physical health. Dietitians also work to improve catering and menu planning³⁰⁵. Figure 103 shows that 9.1% (25) of patients had recorded contact with a Dietitian, of which the most common form of contact, 6.9% (19), was through regular multi-disciplinary meetings.

Figure 103 – Frequency of Patient Contact With a Dietitian

Frequency of contact	High secure	Medium secure	Low secure	Total
1:1 more often than weekly	0	1.0% (1)	1.3% (2)	1.1% (3)
1:1 less often than weekly	0	1.0% (1)	0.6% (1)	0.7% (2)
Regular 1:1 and group sessions	0	0	0	0
Group sessions more often than weekly	0	1.0% (1)	0	0.4% (1)
Group sessions less often than weekly	0	0	0	0
At multi-disciplinary meetings only	13.0% (3)	4.2% (4)	7.7% (12)	6.9% (19)
Therapy complete	0	0	0	0

The proportion of patients in secure hospitals with recorded access to a dietitian is lower in NHS Wales hospitals at 8.1% (8) than in non NHS Wales hospitals at 9.7% (17).

31.10. Physical Health Nurse

Individuals with mental illness, are at much higher risk of a range of physical health conditions. As discussed previously in this National Review, the life expectancy of individuals with mental illness is below that of the general population. It is therefore vital that secure inpatients have regular contact with physical health nurses, to minimise poor physical health outcomes whilst they are admitted to hospital.

Many patients in secure care may not be registered with a local primary healthcare service and have high rates of undiagnosed hypertension, cardiovascular disease and diabetes. Studies suggests that the provision of primary healthcare and proactive disease management can be highly effective within secure hospitals³⁰⁶.

Figure 104 shows that 57.1% (157) of patients had recorded contact with a physical health nurse, of which the most common form of contact, 45.5% (125), was through regular multi-disciplinary meetings.

Figure 104 — Frequency of Patient Contact With a Physical Health Nurse

Frequency of contact	High secure	Medium secure	Low secure	Total
1:1 more often than weekly	13.0% (3)	7.3% (7)	8.3% (13)	8.4% (23)
1:1 less often than weekly	0	4.2% (4)	1.3% (2)	2.2% (6)
Regular 1:1 and group sessions	0	0	0.6% (1)	0.4% (1)
Group sessions more often than weekly	0	0	0	0
Group sessions less often than weekly	0	0	0	0
At multi-disciplinary meetings only	56.5% (13)	57.3% (55)	36.5% (57)	45.5% (125)
Therapy complete	0	0	1.3% (2)	0.7% (2)

The proportion of patients in secure hospitals with recorded access to a physical health nurse is lower in NHS Wales hospitals at 54.4% (54) than in non NHS Wales hospitals at 60.2% (106).

31.11. Discharge

Hospital discharge describes the point at which the admission to a particular hospital ends, with ongoing care transferred to another hospital, a community placement, or home. Reflecting this, hospital discharge is not an end point, but rather one of multiple transitions within the patient's care journey.



Planning for discharge is an opportunity to verify the outcomes set at the time of admission and achieved at the time of discharge and referrals should be completed to appropriate community services. The patient and their families should be actively involved in the discharge planning process³⁰⁷. Poor transition between hospital and community can have a negative effect on patients and their families and one key issue

affecting transition is the lack of integration between health and social care services, and between hospital and community services.

This lack of collaborative working can often result in inadequate and fragmented support for patients. To mitigate these issues planning for discharge should begin at the point of admission³⁰⁸.

Figure 105 shows the frequency of discussions on discharge arrangements by type of secure hospital and gender and shows that 75.6% (208) of patients had discharge discussed in multi-disciplinary meetings or care and treatment planning meetings. Figure 105 shows that male patients in high secure were least likely to have had a documented discussion on discharge at the time of audit.

Figure 105 — Frequency of Discussions on Discharge Arrangements by Type of Secure Hospital & Gender

	 Male			 Female		Overall
	High secure	Medium secure	Low secure	Medium secure	Low secure	
Discussed at regular multi-disciplinary meetings	60.9% (14)	55.8% (43)	64.8% (83)	57.9% (11)	64.3% (18)	61.5% (169)
Discussed at 6 monthly care & Treatment Planning meeting only	4.3% (1)	18.2% (14)	15.6% (20)	21.1% (4)	0	14.2% (39)
No documented discussion of discharge	34.8% (8)	26.0% (20)	19.5% (25)	21.1% (4)	35.7% (10)	24.4% (67)

At some point in the care journey a patient will be ready for discharge to a lower tier of security, a community placement or home. Understanding when a patient is ready for discharge is complex, involving the patient's response to treatment, patient outlook, risk factors and judgement of the wider multi-disciplinary team.

This National Review used the professional judgment of three clinical teams to suggest the stage the patient was on in their care journey. This is for indicator purposes only as full knowledge of the patient's history, response to treatment and discharge plans

may not have been known, in full, by all three clinical teams. Figure 106 shows the stage the patient is on in their personal care journey in the opinion of the National Review auditor, the staff at the patient's current placement and the patient's care coordinator/local care team. In not all circumstances was the opinion able to be given.

Figure 106 shows that the staff at the patient's current placement felt the greatest proportion of patients were ready for discharge at the time of audit than either the National Review auditor or the patients care coordinator/member of the local care team.

Figure 106 – Indicator Only – Patients Stage of Their Personal Care Journey by Opinion of Specific Clinical Team

	National Review Auditor	Staff At The Patients Current Placement	Care Coordinator/ Local Care Team (38 patients)
Patient is ready for discharge immediately	10.9% (30)	14.2% (38)	2.6% (1)
Patient may be ready for discharge is less than 6 months	11.3% (31)	14.5% (40)	26.3% (10)
Patient may be ready for discharge in between 6 and 12 months	53.1% (146)	35.6% (98)	39.5% (15)
Patient will probably require at least another 12 months in hospital	24.7% (68)	36% (99)	31.6% (12)

Of the 38 patients where the staff at the current placement thought the patient may be considered ready for discharge immediately:

- 5.1% (2) of the patients were in high secure.
- 35.9% (14) of the patients were in medium secure.
- 56.4% (22) of the patients were in low secure.

Some patients may express to staff members that they wished to be discharged from the service. In this National Review it was found that 72% of patients had expressed their wish to be discharged.

Part C

Patient Satisfaction and Experience

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32. Patient Satisfaction and Experience

How satisfied patients are with the care they are receiving is widely regarded as a quality indicator in mental health care³⁰⁹. Patient participation is encouraged within secure hospitals because it is associated with greater patient satisfaction, treatment adherence and quality of care³¹⁰.

This National Review found that 80% (222) of patients had participated in the development of their care plan.

32.1. Patient Survey

This National Review examined the patient satisfaction through a questionnaire, which was offered at nine hospitals of differing level of security, with a possible 134 patients participating. The questionnaire comprised 11 questions, scored 1–5, with the higher score indicating a higher level of satisfaction with that particular aspect of care.

There were also opportunities for ‘free text’ so that patients could comment on aspects of care. After one month, 38.8% (52) of patients, 40 male patients and 12 female patients had completed a questionnaire.

There are some limitations to consider when interpreting the results from the questionnaire such as:

- There may have been sampling bias if some patients supposed that taking part would have a positive impact on how they are perceived by staff³¹¹.

- There may have been social desirability bias if patients were assisted by staff to complete the questionnaires as this may have provided more positive responses, especially those that focused on an aspect concerning staff.
- There may have been timing effect, as patients were subject to infection control and societal restrictions as a consequence of the Covid 19 pandemic. This may have affected family visits or available activities, see **Box 5** for patient comments on the pandemic.

BOX 5. Patient comments on Covid 19

“It will be better when Covid ends”

“[Family visits] have been hard because of lock down”

“At the moment we can’t see anyone due to Covid”

“Covid restrictions had a big impact on activities”

Figure 107 shows a summary of the statements included in the questionnaire and the average level of patient satisfaction, scored between 1 and 5 and listed by lowest score first.

Figure 108 shows the highest average score was the ‘kindness and politeness of staff’ and the lowest was ‘opportunities to learn new skills’, which may have been effected by the Covid 19 pandemic.

Figure 107 – Patient Satisfaction Questionnaire Average Score from 1, Lowest, to 5, Highest

OPPORTUNITY'S TO LEARN NEW SKILLS	3.2
SUPPORT PROVIDED TO EXPRESS SPIRITUAL BELIEFS	3.3
COMFORTABILITY AND HOMELINESS OF THE HOSPITAL	3.5
PATIENT FELT 'SAFE'	3.7
PARTICIPATION IN CARE	3.7
SUPPORT PROVIDED TO IMPROVE PHYSICAL HEALTH	3.7
INFORMATION REGARDING PROGRESS IN THEIR CARE JOURNEY	3.7
HOW MUCH SUPPORT WAS PROVIDED ON ADMISSION	3.8
EASE OF COMMUNICATION AND ENCOURAGEMENT TO ENGAGE WITH FAMILY AND FRIENDS	3.8
PATIENT FELT 'SUPPORTED' BY STAFF	4.2
KINDNESS AND POLITENESS OF STAFF	4.4

The proportion of patients rating areas 'very good' were;

- Kindness and politeness of staff, 50% (26).
- Patients felt 'supported' by staff, 46.2% (24).
- Patient felt 'safe', 44.2% (23).
- Ease of communication and encouragement to engage with family and friends, 36.5% (19).

No areas were rated 'bad' or 'very bad' although the lowest scoring area was 'the opportunity to learn new skills', which 30.8% (16) of patients rated 'neither good nor bad'.

32.2. Patient Suggestions

It is important to listen to the voice of the patient in secure hospitals, even though this may at times be difficult³¹². The patient satisfaction questionnaire offered opportunities for 'free text' comment on aspects of care and in total there were 88 comments on aspects of care.

These comments have been themed into three areas:

1) Environment to be more 'comfortable' or 'homely', such as:

- Hospital to have 'softer furnishings'.
- Decoration of the hospital to be 'improved'.
- Bedrooms to be 'upgraded'.

2) Patients to have greater patient autonomy or access, such as:

- Patients wanted access to 'better technology'.
- Patients wanted access to the internet.
- Patients wanted access to their mobile phones.
- Patients wanted access to the gym 'more often' or to 'better' gym equipment.
- Patient wanted more activity options.
- Patient wanted more leave or community access.
- Patients wanted access to 'more practical learning'.

3) Patients' suggestions on staff attitudes or care quality, such as:

- More 'permanent' staff and 'less agency'.
- Staff to be 'more honest'.
- Staff to be 'more positive'.
- Staff to 'listen to patients more'.
- Staff to give more information on progress and future placements.

The patient satisfaction questionnaire undertaken as part of this National Review had similarities to one undertaken as part of a previous review into secure care in Wales undertaken in 2009³¹³.

The differences where the two exact same questions were asked were:

- How much support was provided on admission, average score in 2010 was 3, 'neither bad nor good' and in this National Review it was 4, 'good'.
- Patient felt 'supported' by staff, average score in 2010 was 3, 'neither bad nor good' and in this National Review it was 4, 'good'.

32.3. Patient Complaints

There is a growing interest in promoting the rights of patients, especially psychiatric patients³¹⁴. A complaint is the expression of dissatisfaction, displeasure, disapproval or discontent about services expressed by a patient.

Complaints are a valuable resource for monitoring and improving patient safety and experience³¹⁵. Studies have found that staff working in mental health services were more likely to be the subject of to a complaint than staff working in physical health services³¹⁶, and that complaints were more frequently made by patients admitted to hospital than those treated in the community^{317,318}. As may be expected coercive treatment and the perception of a negative therapeutic relationship are strongly associated with lower satisfaction with care³¹⁹.

This National Review examined the proportion of patients would had made a verbal or written complaint at their current placement. Not examined during this National Review was the nature of the complaint or whether the complaint was upheld. Verbal complaints may be, although not necessarily, viewed as less severe than a written complaint. Figure 108 shows the proportion of patients making a written or verbal complaint by type of secure hospital and gender and shows that the majority of patients had not made any verbal or written complaint.

Figure 108 shows that more patients had made a verbal than written complaint, that the group of patients most likely to have made a written complaint were female patients in medium secure, and the group most likely to of made a verbal complaint were female patients in low secure.

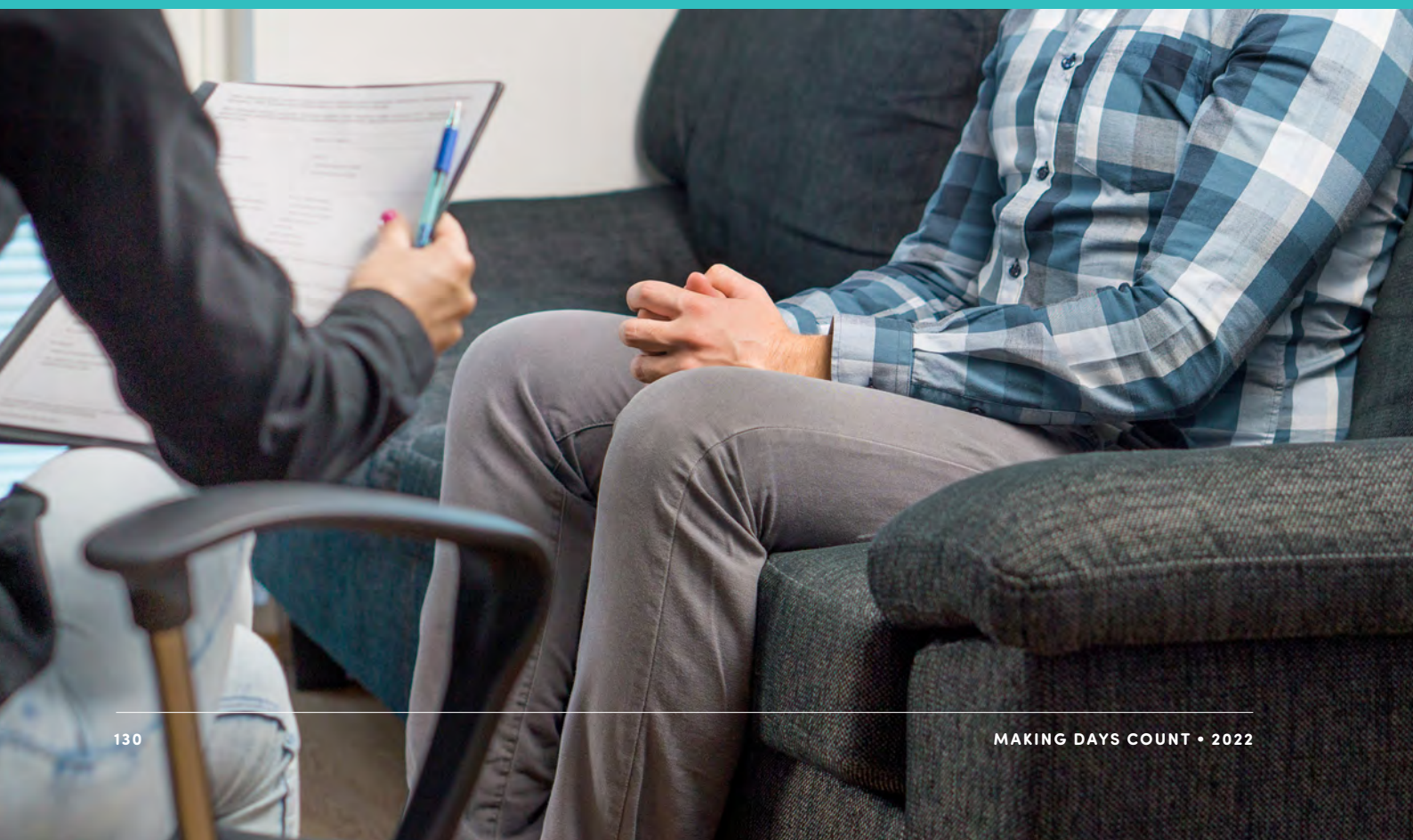




Figure 108 — Frequency of Written & Verbal Complaints by Type of Secure Hospital & Gender

	 Male			 Female		Overall
	High secure	Medium secure	Low secure	Medium secure	Low secure	
Patient <u>had</u> made a written complaint during the current placement	8.7% (2)	15.6% (12)	20.3% (26)	42.1% (8)	35.7% (10)	21.1% (58)
Patient <u>had not</u> made a written complaint during the current placement	91.3% (21)	84.4% (65)	80.5% (103)	57.9% (11)	60.7% (17)	78.9% (217)
Patient <u>had</u> made a verbal complaint during the current placement	21.7% (5)	45.5% (35)	45.5% (58)	57.9% (11)	57.1% (16)	45.5% (125)
Patient <u>had not</u> made a verbal complaint during the current placement	78.3 % (18)	54.5% (42)	55.5% (71)	42.1% (8)	39.2% (11)	54.5% (150)

32.4. Staying Connected Remotely

It is important to support patients to maintain relationships with family and friends. Some guidance promotes the use of mobile phones or the internet for patients to keep in contact with family and friends³²⁰, although with due regard to legal restrictions, risk and security³²¹.

The audits that form part of this National Review were undertaken when visiting restrictions were in place, due to the Covid 19 pandemic, and some secure hospitals accelerated the introduction of mobile phones for patients or digital devices which enabled remote visual contact such as a laptop, tablet or webcam.

This National Review found the following proportion of patients had access to specific types of telephone:

- 52.7% (145) of patients had access to a hospital telephone landline.
- 12% (33) of patients had access to a shared hospital mobile phone.
- 35.3% (97) of patients had access to a private mobile phone.

This National Review found the following proportion of patients had access to digital devices which enable remote visual contact:

- 88% (242) of patients had access to a hospital remote visual contact device.
- 7.3% (20) of patients had access to a private remote visual contact device.
- 4.7% (13) of patients did not have any access to a remote visual contact device.

32.5. Visits

The information in this Section of the National Review is likely to be affected by the national hospital visiting restrictions in place due to the Covid 19 pandemic. Carers or family members can provide important information about the patients behaviour and key life events and how these may have contributed to the circumstances leading up to the patients admission. This information should be seen as vital to the recovery of their relative³²².

When carers are involved in treatment, patients are less likely to need frequent inpatient admissions and are more likely to experience significant improvements in their symptoms and quality of life³²³.

This National Review found the following proportion of patients had visits from family or friends, from the 274 patients where this information was recorded:

- 43.6% (120) of patients did not receive any hospital visit from family or friends.
- 1.5% (4) of patients were not permitted to receive hospital visits from family or friends.
- 39.3% (108) of patients received supervised hospital visits from family or friends.
- 15.3% (42) of patients received unsupervised hospital visits from family or friends.



When carers are involved in treatment, patients are less likely to need frequent inpatient admissions and are more likely to experience significant improvements in their symptoms and quality of life³²³.

Part D

Environment of Care

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33. Secure Hospital Design

As well as ensuring the environment enables the application of appropriate restrictions where necessary, the physical environment and design of secure hospitals have important implications for the quality of life, physical and mental well-being as well as treatment outcomes for patients.

Department of Health 'design guides' provide specifications for room sizes, entrances, personal security systems, internal walls, corridors, roofs and fencing. For an example of a detail in these specifications see **Box 6**.

Secure hospital design should take into account the full therapeutic and social purpose of the service recognising that patients may stay for extended lengths of time. The design should enable a full range of social, clinical and therapeutic spaces to be provided in addition to a range of core areas that staff will need to support the operation of the service. There should be a range of communal areas, spaces for quiet reflection, rooms for therapy, treatment, education and leisure; designed in a way that provides hope, calms, supports and empowers patients. In terms of maximum capacity, guidance suggests no more than 15 patients per ward.

Outdoor gardens and other elements of nature can serve as positive distractions. Exposure to nature reduces stress and fatigue and may facilitate recovery. There is also evidence that access to outdoor areas and views of 'greenspace' may positively impact recovery time and alleviate patient distress.

Box 6. Example of Secure Hospitals Specification

Medium Secure Perimeter Fencing

- Fence must be at least 5.2 metres in height.
- Fencing should be mesh.
- Mesh should be 3mm diameter, 13mm vertically and 75mm horizontally.

Access to 'greenspaces' can also be used as an alternative to coercive measures of patient behaviour management such as restraint.

The proximity of seclusion rooms to ward offices should be carefully considered. Close proximity may promote safety but may raise concerns over disruption, whereas greater distance may reduce environmental disruption but decrease staff responsiveness and available staffing resources.

A call system should be in place to enable patients and visitors to alert staff to their need for support. The call system may be either a mobile or fixed system using buttons installed in the building or a personal call system carried by patients or visitors. The system should be tested regularly and tests recorded for auditing purposes.

The presence of a staff lounge or similar congregate space can improve morale and job satisfaction and encourage professional communication. Studies have shown the importance of reducing the institutional feel of the facility and incorporating a homelike environment whenever possible. This type of atmosphere has been associated with enhanced emotional and intellectual well-being and reduced challenging behaviour.

Patients may prefer familiar rooms over 'decorative' or 'stylish' rooms. Upholstered furniture should be included whenever feasible. Although furniture can be used as a weapon and should not be easy to lift or throw, it should not be too heavy to allow for movement. Furniture resistant to damage is also important. Calming artwork is recommended and images of nature can reduce anxiety. Some studies have suggested installing carpeting to enhance comfort and appearance, although this must be balanced against the likelihood of soiling. To promote safety, shatterproof windows, breakaway curtain rods, tamper-proof electrical outlets, stainless-steel mirrors, and lockable water taps are recommended.

Blind corners should be avoided for staff safety reasons as well as highly polished floors or other reflecting surfaces because of glare. Natural wood veneer has been used to soften the look of doors and corridor rails. Studies of wall colour choices are contradictory, however, there are four general recommendations. First, monochromatic, bland colour schemes and fashionable or trendy palettes or pastels should be avoided. Brighter colours may be preferred for patients with depression but they could be overstimulating for highly agitated patients.

Second, warm blue tones often have a soothing effect because of their shorter wavelengths, and they may be particularly suitable for the calmest areas. Using closely related colours of the same intensity has been reported to have a calming effect.

Third, blue-green colours can have a negative effect on mood for patients with depression and less energy. And finally, seclusion room walls should be a 'calm', but definitive colour, not white or grey.

Patients should have the ability to control their level of social contact. Designing sanctuary spaces, away from noise and general ward clamour and spaces where patients can interact and form social relationships, is recommended. Privacy may increase environmental satisfaction and place attachment. Day rooms should be open and flexible and encourage interaction with staff, while also allowing for personal autonomy. In particular, secure hospitals should encourage safety and promote the needs of women and vulnerable people. In particular, this will include the provision of separate single-sex accommodation and spaces. It has been suggested that the use of single-occupancy rooms promotes patient autonomy and may increase therapeutic engagement. Patients reported more privacy, dignity and felt more able to disclose 'sensitive information' to staff, and had improved sleep when single bedrooms were provided.

Regulators have stated that patients should not 'be expected' to share sleeping accommodation with 'strangers', some of whom may be agitated.

Hospitals should have a high level of cleanliness and promote a healthy lifestyle such as ensuring there are a wide variety of healthy and appetising food and drink available for patients.

In terms of the location of secure hospitals there is some debate surrounding the preference of locating them within urban versus rural settings. For example, there are some concerns surrounding placement in urban areas due to possible risks to patients of access to substances and antisocial interactions. However, urban areas have greater accessibility to forms of rehabilitative stimuli that may not be available in rural environments. It has been recommended that secure services are located as close as possible to general population services to enable patients to maintain contact with their family and friends, general psychiatric services, out-patient care and the wider community. ^{324,324,325,326,327,328,329,330,331,332,333,334,335,336,337,338,339,340,341,342,343,344,345,346.}

34. Extant Estate

This National Review examined 43 different hospitals wards, including:

- 4 wards in high secure hospitals.
- 16 wards in medium secure hospitals.
- 20 wards in low secure hospitals.
- 3 wards in CAMHS low secure hospitals.

Studies have shown that patients appear to make better progress in newer, purpose-designed mental health hospitals rather than in older, out-dated facilities. Studies have also found that in the purpose-built mental health facilities, patient recovery times were reduced, and that the number of serious cases of verbal abuse and threatening behaviour were

significantly reduced^{347,348}. Of the 43 wards reviewed as part of this National Review, 81.4% (35) were purposely built for the current level of security and 18.6% (8) had been repurposed and not purposely built. Of the two NHS medium secure hospitals, the one in South Wales was opened in 2004 and the one in North Wales was opened in 1998, both had been designed many years prior to opening. Where it could be determined, 46.5% (20) wards examined during this National Review had been built at least 20 years previously. Refurbishment and redecoration is often necessary in secure hospitals due to property damage, intentional or unintentional soiling and high use. This National Review found that 72% (31) of the wards had an ongoing refurbishment programme in place and that 61% (25) of wards had been refurbished within the 12 months prior to audit.

This National Review requested the auditors to determine whether the ward was in a 'good' state of repair or a 'poor' state of repair in terms of decoration, cleanliness and furniture or fitting damage. This National Review found that 85.4% (35) of the wards had been classed as being in a 'good' state of repair during the audit.

34.1 Seclusion Facilities

Seclusion refers to the supervised confinement of a patient placed in a specifically designated room³⁴⁹. The sole aim of seclusion is to contain severely disturbed behaviour which is likely to cause harm to others^{350,351}. It is essential that seclusion is only used as a last resort, and that guidelines are followed to protect patient liberty and maximise their freedoms while providing a safe environment³⁵². Alternative

terminology such as ‘therapeutic isolation’ should not be used to deprive patients of the safeguards established for the use of seclusion³⁵³. Those staff without access to seclusion facilities were more likely to use rapid tranquilisation³⁵⁴, although conversely, surveys have rated seclusion as less ‘acceptable’ to staff than observations, medication, and restraint and the use of seclusion has been shown to increase when a seclusion room is available³⁵⁵.

This National Review requested the auditors to determine whether the seclusion facilities, if present, were ‘compliant with best practice’^{356,357}, in terms of location and environment and found:

- 55.8% (24) of the wards had seclusion facilities determined to be fully compliant with best practice.
- 4.7% (2) of the wards had seclusion facilities determined to be partially compliant with best practice.
- 39.6% (17) of the wards did not have seclusion facilities.

34.2. En suite

An en suite is a bathroom, normally in secure hospitals consisting of a shower, sink and toilet, immediately adjoining the patient’s bedroom which may, or may not, be able to be closed off if required for safety reasons. Welsh building guidance for mental health wards state that all bedrooms should be provided with an en suite³⁵⁸. Some older facilities may not have been built with en suite facilities although they should have an established maintenance programme to introduce them^{359,360}.

This National Review examined the availability of en suite facilities for patients and found:

- 80.5% (33) of the wards had en suite facilities in all bedrooms.
- 2.4% (1) of the wards had en suite facilities in some bedrooms.
- 17% (7) of the wards had en suite facilities in no bedrooms.

34.3. Ensuring Safe Environments

A ligature anchor point is anything which can be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature anchor points include shower rails, coat hooks, pipes and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges and closures³⁶¹. ‘Three quarters’ of patients who kill themselves while on a mental health ward do so by hanging or strangulation³⁶².

Managing ligature risks means staff need to be vigilant and undertake regular assessments of ward areas in order to identify and remove ligature anchor points.

Many wards have ‘ligature maps’ on each of their wards. These maps provide staff with an immediate visual indication of potential ligature areas that are higher risk to patients. Ligature anchor points can be introduced by accident or inattentiveness and daily or weekly ward checks are recommended. Undertaking an extensive assessment, preferably by someone external to that ward to eliminate ‘familiarity blindness’, every 6 or 12 months helps identify, manage and remove, where possible, ligature anchor points.

This National Review examined when the latest comprehensive ligature anchor point assessment had been undertaken on the ward and found:

- 27.9% (12) of wards had undertaken a ligature anchor point assessment within 3 months prior to the audit.
- 53.5% (23) of wards had undertaken a ligature anchor point assessment between 3 and 12 months prior to the audit.
- 16.3% (7) of wards had undertaken a ligature anchor point assessment over 12 months prior to the audit.
- 2.3% (1) of wards could not evidence that a ligature anchor point assessment had been undertaken.

Healthcare Inspectorate Wales have recently noted inconsistent practice in relation to ligature anchor point risk assessments, especially in the NHS, and have found hospitals where action had not been taken to reduce or remove identified risks, and assessments that were undertaken over 12 months previously³⁶³.

34.4. Access

Prompting independence is an important aspect of good quality care in secure hospitals^{364,365}.

34.4.1. Access to Hot and Cold Drinks

Mental illness can impact a person's ability to carry out their activities of daily living, such as cleaning and cooking and therefore, it is important that secure hospitals provide facilities that encourage independence such as

a kitchen area and a space to make their own refreshments. Providing a safe area where patients can make their own refreshments is also an effective method of promoting social activities^{366,367}. This National Review examined whether there were facilities on each ward for patients to make their own hot or cold drinks and found:

- 67.4% (29) of wards had facilities where a patient could make their own hot drinks.
- 90.7% (39) of wards had facilities where a patient could make their own cold drinks.

34.4.2. Access to a Gym

Individuals with mental illness engage in 'significantly less' physical activity than the general population. Due to the restrictive environment, patients in secure hospitals may not be able to access suitable equipment or outdoor spaces that facilitate exercise. As many patients in secure hospitals are unable to leave in order to participate in regular exercise or attend a gym, providing access to these facilities within the hospital is important^{368,369,370}.

This National Review examined whether patients had access to a gym and found:

- 74.4% (32) of the wards had gym facilities sited on the ward.
- 23.3% (10) of the wards had gym facilities sited within the hospital site.
- 2.3% (1) of the wards did not have access to gym facilities.

34.4.3. Access to a Secure Garden

Access to outdoor spaces, and the opportunity for reflection and social engagement, all play a significant role in supporting well-being and recovery. An external space, accessed from the ward, is viewed as a functional and therapeutic part of the service³⁷¹.

This National Review examined whether patients had access to a secure garden facility and found: 100% (43) of the wards had a secure garden space available for patients of which: 27.9% (12) of the secure garden spaces were open access, although at set times. Open access in this context means unfettered access straight from the ward which can be accessed without staff agreement. 72.1% (31) of the secure garden spaces were not open access and patients had to request that staff provide access.

34.3.4. Access To Multi-Faith Room

As shown previously in this National Review there are many patients within secure hospitals from various religious backgrounds and therefore it is important facilities are made available to enable worship. These 'multi-faith' rooms should provide patients with access to faith-specific materials and a space designed to support the undertaking of cultural or spiritual practices³⁷².

This National Review examined whether patients had access to a 'multi-faith room' and found:

- 100% (41) of wards had a 'multi-faith room' either on the ward or within the hospital.
- 1.5% (4) of patients stated they were not able to access a multi-faith room at the time of audit although this could be due to legal restrictions or clinical risk.

34.5. Cleanliness

Maintaining a clean and hygienic environment in secure hospitals is essential for preventing the spread of disease and infection and to protect the safety of staff and patients³⁷³. This National Review examined whether, at the time of audit, the wards had an adequate level of cleanliness, and found:

- 88.4% (38) of wards were assessed to be in an 'adequate', 'good' or 'very good' state of cleanliness.
- 11.6% (5) of the wards were assessed to be in an 'inadequate' state of cleanliness.

34.6. Noise

Noise is an environmental stressor and has the potential to cause both psychological and physiological harm. Previous patient surveys have found that 'opening and closing of doors' and the ward 'entry warning' signal were found to be the 'most disturbing' noises in mental health hospitals. Other sources of noise include telephones, food trolleys, call alarms and incident alarms. Guidance has stated that sources of noise should be monitored and minimised at night.

Secure hospital design should ensure that patient areas are located away from external sources of noise, such as road traffic and that internal spaces more prone to noise, such as day rooms and dining areas should not be located next to bedrooms or quiet rooms^{374,375,376,377,378}.

This National Review, were all audits were undertaken during daytime, examined whether, at the time of audit, the wards had an 'undesirable' level of noise, and found:

- 79.1% (34) of the wards did not have an 'undesirable' level of noise at time of audit.
- 20.9% (9) of the wards had an 'undesirable' level of noise at time of audit.

34.7. Closed-Circuit TV

Closed-circuit television (CCTV), is non-public video surveillance by cameras which is displayed on a limited number of monitors. Guidance has stated that CCTV cameras can be an effective measure for security as it can enhance observations, provide patients with greater freedom and deter antisocial behaviour.

The use of CCTV should never replace sufficient staff numbers, staff-patient observations and patient engagement and should be used with due regard to data protection, human rights and privacy. Studies have shown no evidence to suggest that introducing CCTV will reduce violence^{379,380,381,382,383,384}.

This National Review examined whether CCTV was present on the wards/hospitals and found:

- 46.5% (20) of wards had CCTV in internal communal areas.
- 32.6% (14) of wards only had CCTV in external areas, such as hospital entrance doors.
- 20.9% (9) of wards had no CCTV in external or internal areas.

This National Review found the use of CCTV and the understanding of its benefits and risks was inconsistent across secure hospitals.

34.8. Electronic Health Records

Electronic Health Records are a digital record of a patient's healthcare interventions. Studies have shown the deployment of Electronic Health Records improve the quality of care for mental health patients by; preventing loss of records, increasing accessibility of the records to remote staff, improving multi-disciplinary working, improving medication management, reducing medical and medication errors and empowering patients through greater engagement in their care^{385,386,387,388,389,390}. Studies have found information held in Electronic Health Records, compared to paper based records, have been shown to be '40% more complete' and '20% quicker' for staff to access³⁹¹.

This National Review found that most wards used a combination of Electronic Health Records and paper based records. It was noted that, of the two NHS Wales hospitals, one had an outdated hybrid electronic/paper based system in place and the other had no Electronic Health Record system in place.

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Part E

Adolescents

35. Adolescents — Overview

The United Nations defines a child as an individual aged between birth and 18 years of age³⁹², and adolescents as between 15 and 19 years of age³⁹³. Since all children were aged 15 years or over at the time of audit the term ‘adolescent(s)’ has been used in this National Review. Part E of this National Review is focused on the care provided to adolescents, although many of the studies and findings cited in this National Review relate to individuals of all ages.

Children and Adolescents Mental Health Services (CAMHS) are the health services that assess and treat children with emotional, behavioural, intellectual or mental health difficulties. CAMHS secure hospitals are at the medium and low secure level although it is very rare for an adolescent to be admitted to medium secure, with no patient of NHS Wales being admitted to such a facility for at least 18 months prior to this National Review. The majority of NHS Wales patients requiring care in a CAMHS hospital are admitted to acute or general units, with only around 10% requiring admission into a secure hospital³⁹⁴.

36. Adolescents — Background

Studies have shown that 22% of females and 13% of males aged between 16 and 24 years old self-reported having had ‘at least one’ mental health diagnosis in their lifetime³⁹⁵.

Adolescents with mental health issues need to be treated in the ‘right place’, at the ‘right time’ and as ‘close to home as possible’, and although the majority will be treated in

the community, there will always be some individuals who require specialised hospital care³⁹⁶. As they may experience ‘fear and intimidation’ if they are treated alongside adults, the World Health Organisation recommends separate CAMHS mental health hospitals³⁹⁷.

CAMHS secure hospitals, whether provided by NHS Wales, NHS England or the independent hospital sector are commissioned in Wales by the Welsh Health Specialised Services Committee. Adolescents admitted into a mental health hospital must have access to appropriate care in an environment suited to their age and development³⁹⁸. Admission to hospital should only be considered when the level of risk, complexity and/or severity of the individuals mental health need cannot be safely or appropriately managed in a community setting³⁹⁹.

The benefits of hospital care should be weighed against possible negative consequences of admission such as;

- It can be frightening or disturbing and involve witnessing high levels of disturbance, such as deliberate self-harm.
- Exposure to disturbance can potentially reinforce negative behaviour.
- Separating the adolescent from their home environment may undermine their parents' ability to provide support.
- It risks institutionalisation.
- They could be missing out on social educational and occupational opportunities.
- There are perils of stigma and labelling.

For all these reasons, if admission cannot be avoided, then it should be for the shortest possible period^{400,401,402,403}.

37. Adolescents — Care by Numbers

At the time of audit there were 5 adolescents admitted to a low secure hospital, and, given these very small numbers, caution should be used when interpreting any of the following information.

Given this caveat this National Review will focus on providing a summary of findings.

- **80%** (4) of adolescents were female and **20%** (1) were male.
- **60%** (3) of adolescents were 17 years old, **20%** (1) was 16 years old and **20%** (1) was 15 years old.
- **100%** of adolescents were white.
- **80%** (4) of adolescents stated they were heterosexual and **20%** (1) stated they were gay/lesbian.
- **60%** (3) of adolescents had additional needs, with **20%** (1) having needs related to communication/cognition, **20%** (1) having needs related to sensory/hearing issues and **20%** (1) having mobility issues.
- **80%** (4) of adolescents had a had a psychiatric diagnosis as the time of audit, with **40%** (2) having a primary diagnosis of an emotional/stress related disorder, **20%** (1) a developmental disorder and **20%** (1) a psychotic disorder.
- **80%** (4) of adolescents had experienced adverse childhood events (ACEs). The range of ACEs was between 1 and 4, with the average number of ACEs being 2.5.
- **60%** (3) of adolescents were admitted into the secure hospital from home and **20%** (2) from a non-secure hospital.
- The reason for admission for **60%** (3) of adolescents was for a period of assessment, **20%** (1) as they were a risk to self and others and **20%** (1) as they were a risk to self.
- The length of admission, at the time of audit, for **40%** (2) of adolescents was for up to 3 months and for **60%** (3) it was for a period of between 1 and 2 years.
- **60%** (3) of adolescents were engaging in psychological therapy once or twice per week and **40%** (2) were not engaging in psychological therapy at the time of audit.
- **80%** (4) of adolescents had a programme of activities in place in which they were engaging and **20%** (1) were not engaging.
- Weight gain from admission to audit, for the 4 adolescents where this information was available, was, on average, 5.3kg.
- Body Mass Index on audit, for the 3 adolescents where this information was available, was, on average 38 (obese).
- **40%** (2) of adolescents were on enhanced observations.

- Average number of outcomes on admission was **4.2**, with a range of 4 to 7. The most common outcomes were 'Reducing self-harm', 'Empowerment', 'Reducing symptoms through medication' and 'Participation in psychological interventions', with **100%** (5) of adolescents having these outcomes on admission.
- **100%** (5) of adolescents were prescribed psychotropic medication with a range of between 1 and 3 types of psychotropic medication. **80%** (4) of adolescents were prescribed antidepressants, **80%** (4) were prescribed antipsychotics and **60%** (3) were prescribed anxiolytics either as a regular or as required prescription.
- **100%** (5) of adolescents had a history of challenging behaviours and **60%** (3) had exhibited challenging behaviour within 90 days prior to audit. The most common challenging behaviour was self-harm with **80%** (4) of adolescents having a history of this behaviour.
- **60%** (3) of adolescents had been subject to restrictive interventions and **40%** (2) had been subject to such restrictions within 90 days prior to audit. The most common restrictive intervention was verbal de-escalation with **60%** (3) of adolescents being subject to this intervention.
- There was an average 2 registered nurses and 7 support staff per day shift and average 1 registered nurses and 8 support staff per night shift.



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Part F

Conclusion and Recommendations

38. Recommendation 1

Maintaining Focus on Secure Care

This National Review has shown that most patients being treated in secure hospitals have complex presentations, with the majority having concurrent psychosis, personality disorder and trauma and with an average of five outcomes to be achieved on admission. For many patients this complexity includes the regular display of challenging behaviours, which require restrictive interventions and/or enhanced observations.

1.1. Welsh Government, Health Boards and Commissioners must continue to recognise the specialist nature of secure hospital provision through such focus as development of a WHSSC Five Year Specialised Services Strategy for Mental Health and the Welsh Governments forthcoming renewal of the Together for Mental Health Strategy.

38.1 Recommendation 2

Avoiding Admission

The prevalence of adverse childhood events in the secure hospital patient population is evident, as is the frequency of psychosis and personality disorders. An assessment as to the capability of primary and community services to meet the needs of individuals with these issues was not within the scope of this National Review, but strengthening the ability of them to do so may, in the longer term, reduce demand on secure services.

A number of patients were admitted into secure hospitals from acute hospital services and improving the ability of these services to safely retain those patients who pose a risk to themselves or others may avoid admission into higher levels of security. Although the number of Black and Ethnically Diverse patients was low, the proportion of patients of these ethnicities in secure hospitals was twice as high as the general population, which may demonstrate systemic inequalities.

2.1. Health Boards must endeavour to reduce admissions into secure hospitals in the longer term by strengthening primary and community services, especially in the areas of personality disorders, trauma support and early intervention in psychosis.

2.2. Health Boards must endeavour to build resilience in acute mental health hospital services to improve their ability to care for patients who pose a risk to themselves or others.

2.3. Welsh Government, Health Boards and Commissioners must examine the issues of inequality of admissions of Black and Ethnically Diverse patients.

38.2. Recommendation 3

Improving NHS Capacity & Integration

Understanding the number of secure hospital beds required to meet the needs of the current and future Welsh population is complex. There has been a consistent use of non-NHS Wales secure hospital provision to meet placement requirements over the last ten years, especially for patients requiring admission to a low secure hospital. Any consideration of commissioning additional capacity from current NHS Wales hospitals should be predicated by the requirement to ensure all extant patients are receiving care in the appropriate level of security.

Whilst there are some differences between medium and low secure, there are many areas, such as patient presentations, environment, interventions and staffing models in which the differences are marginal. There are new models of care emerging for certain groups, such as female patients, which combine medium and low secure provision, and which aim to improve patient outcomes and experience.

The commissioning organisational infrastructure in NHS Wales differs from other areas of the UK as NHS Wales low secure hospitals are managed by individual Health Boards and not as part of an integrated pathway with medium and high secure hospitals. This fragmented approach also applies to the commissioning of placements external to NHS Wales, which is split nationally and locally dependent on the level of security.

The amalgamation of commissioning responsibilities within a single organisation may remove a significant impediment to the effective use of resources and improve, and possibly expedite, the patient's journey through secure care.

3.1. WHSSC should explore how to maximise the extant NHS Wales medium secure hospital capacity to safely and appropriately minimise external placements.

3.2. Welsh Government and Health Boards should consider how to expand the low secure provision in Wales, including acceleration of any extant business cases.

3.3. Welsh Government, WHSSC and Health Boards should consider the benefits of a single national organisation commissioning integrated secure services.

3.4. WHSSC and Health Boards should consider adopting a combined low and medium secure model for specific patient groups such as female patients.

38.3. Recommendation 4

Improving Service Capability

The two NHS Wales medium secure hospitals were planned and built over fifteen years ago. Both require environmental modernisation and a review of staff skill mix, and staffing levels to ensure they meet the current patient population needs. The two hospitals also lack modern electronic healthcare record systems, which impede effectiveness and efficiency.

Acuity and complexity of patients admitted to secure hospitals may have increased over the last decade, due in part to the proportion of patients admitted from prison, the reduction in acute mental health beds and the development of community services. One in four patients are admitted to a secure hospital at the same level of security as their previous placement, some of these transfers will be appropriate repatriations, but some will be due to the hospitals inability to manage patient risk. These transfers can disrupt patient progress and lead to poor patient experience.

Compared to male patients, female patients had a greater prevalence of trauma, violence, self-harm and were more likely to be subject to enhanced observations, restrictive interventions and transfers to a secure hospital at the same level of security.

4.1. WHSSC and Health Boards should undertake an urgent modernisation programme for the two NHS Wales medium secure hospitals, this should include estate improvement, staffing review and the introduction of electronic healthcare records systems.

4.2. WHSCC and Health Boards must monitor and reduce transfers between hospitals of the same level of security and ensure they are only undertaken for repatriation purposes or extraordinary clinical reasons to prevent disruption to the patients care journey.

4.3. WHSSC should consider how to enhance specialist female secure services to manage high acuity and highly complex patients.

38.4. Recommendation 5

Supporting Staff

A secure hospital is a challenging place to work, with the majority of patients displaying verbal aggression towards staff and a significant number being violent or sexually disinhibited towards staff. This challenge is compounded by the high number of staff vacancies in some hospitals. Ensuring adequate levels of staff are deployed on the wards to deliver safe and effective care is multi-factorial and effected by patient presentation and planned activity.

The use of agency staff, unfamiliar to the patient, was highlighted as a negative patient experience. Having systems in place to record and report deficits in staffing to senior management and commissioners, and to have these deficits addressed, will promote safe care and improve the patient experience. Not all patients had access to the range of professionals which represent a full multi-disciplinary team, although this could be effected by patient choice or clinical presentation. Access to a full multi-disciplinary team is a vital component of effective care in secure hospitals and even a small number of vacancies can disrupt patient care.

5.1. Providers and Commissioners need to recognise the challenge of working in a secure hospital and ensure staff are supported and offered regular supervision and dedicated emotional support.

5.2. Providers and Commissioners must have systems in place to monitor and address deficits in safe staffing levels and access to a full multi-disciplinary team.

38.5. Recommendation 6

Improving the Patient Care Journey

Patients are regularly subject to reassessment when transferring between mental health hospitals. This is because the patients comprehensive care records are not always transferred on admission, or because of inflexible organisational processes.

During this reassessment period, leave permitted at the previous hospital can be suspended, the patient can be subjected to assessments previously completed, progress can be delayed and the information on patient preferences, strengths and outcomes acquired in the previous placement can be overlooked or unavailable. Introducing a 'patient passport' to record assessments and interventions, personal strengths and preferences, initial purpose of admission and progress to date that accompanies the patient across all secure placements will improve patient experience, minimise duplication of assessment, promote continuity of care and remove barriers to progress. Implementation of systems to identify and record 'value added' days to the patient's progress should be considered.

An effective care coordinator or case manager, working collaboratively with the patient can provide consistent and constant support to the patients as they progress through their personal care journey. They should ensure effective community support is available as soon as the patient is clinically ready for discharge. The Mental Health (Wales) Measure stipulates a requirement for patients in hospital to have a care coordinator, which some currently do not, and for their care and treatment to be subject to regular review. Many patients are subject to progress reviews only annually or bi-annually. One in ten patients are admitted for four or more years and some patients may require a longer period of care in a secure hospital than others, due to such factors as response to treatment and risk issues. Being cared for in high quality therapeutic environments by compassionate staff from a range of professions who support their engagement in treatment, therapies and activities will expedite the patient's progress to discharge.

Providers and commissioners must adopt a community first approach of continuous review and a drive to safe and timely discharge. Discharge should take effect as soon as it is clinically and legally endorsed and, to prevent delay, accommodation requirements or community support should be planned before discharge is envisaged. The provider's care teams identified a number of patients who may be considered for discharge, either immediately or in a short period.

6.1. WHSSC and Health Boards must ensure that all patients requiring hospital care are admitted into the least restrictive environment by effective gate-keeping, are regularly reviewed by local and specialist staff and, when safe to do so, repatriated or discharged.

6.2. Welsh Government should introduce standards that stipulate the timely transfer of specific patient information.

6.3. Welsh Government should develop and implement a 'patient passport' that accompanies the patient across the secure pathway. This document should detail outcomes to be achieved to effect safe and timely discharge.

6.4. WHSSC and Health Boards must review all extant patients and effect, for all appropriate patients, timely discharge to more appropriate level of security.

6.5. Health Boards must ensure all patients have an assigned care coordinator and monitor the frequency and effectiveness of progress reviews.

6.6. Welsh Government should implement systems to identify and record daily 'value' added to the patient's progress to make every day count.

6.7. Commissioners should minimise the number of patients with extended lengths of admission by undertaking such actions as full reviews, case conferences, 'stranded' patient audits, and transparent reporting.

38.6. Recommendation 7

Improving the Patient Experience

Patients are individuals with unique personal histories, strengths, needs and desires. Some patients may have additional complexities due to gender, trauma, disabilities and vulnerabilities and the requirement for staff to identify and address these is crucial to compassionate and personalised care.

Some patients have been prescribed psychotropic medication for several years, with one in three prescribed them for over five years, and many were prescribed multiple types and some were prescribed them who had no recorded diagnosis of mental illness. Medication is an important component in mental health treatment alongside therapy, meaningful activity and compassionate staff support. All prescribed medication should be at the minimum dosage to alleviate the verified symptoms, continually reviewed, discontinued if ineffective and monitored for potential side effects. The multi-disciplinary team should include a specialist mental health pharmacist. Supporting unmotivated patients to participate in therapies and activities can be difficult and should not be affected by staff vacancies. Patients engaging in activities improves their attendance at therapy sessions and vice versa. Access to internal gardens or to the community are important to patient experience and outcomes and should never be impeded due to staff availability.

Patients have little choice about who they share their environment of care with, and secure hospitals can be noisy, unsafe and challenging places in which patients can recover from mental illness. Half of all patients had been verbally aggressive to other patients, half had been intimidating or disruptive, a third had been violent towards other patients, one in five had been sexually disinhibited towards other patients and one in five had used illicit substances. Patient privacy and dignity should be protected, independence should be promoted and everything possible should be done to sustain a calm, therapeutic and safe atmosphere on the ward including, if necessary, safely separating disruptive patients. Patient's complaints are an important indicator of poor experience and care quality and should be recorded and actioned as such.

7.1. Providers must ensure staff training, organisational processes, and the environment of care protect and promote the dignity and safety of transgender patients.

7.2. Providers must ensure all staff are trained to recognise and support patients with trauma.

7.3. Providers must ensure the environment of care, information materials and communication devices are suitable for patients with additional communication, cognitive, sensory, and physical or mobility needs.

7.4. Providers must ensure all medication is prescribed at the minimum dosage to alleviate symptoms, is regularly reviewed and discontinued where efficacy is not demonstrated. Side effect monitoring tools should be used.

7.5. Providers should undertake a systematic medication review, where patients have been prescribed psychotropic medication for over five years.

7.6. Providers should ensure the multi-disciplinary team available to patients includes specialist mental health pharmacists.

7.7. Providers and Commissioners must endeavour to ensure staff availability does not impact on patient access to therapy and activities programmes, outdoor spaces and community leave.

7.8. Welsh Government should set an end date by which all patients bedrooms in secure hospitals will be en suite.

7.9. Welsh Government should, if merited after patient and family consultation, consider standards for the use of CCTV in secure hospitals.

7.10. Providers must ensure that the environment of care, in addition to staff availability, protects patient's safety, including adequate seclusion areas and quiet areas and the prevention of bullying and illicit substance misuse.

7.11. Providers must ensure that, with due regard to risk and security, the environment of care promotes independence, a positive patient experience and protects patient privacy such as noise reduction, open secure gardens and unfettered access to hot and cold drinks.

38.7. Recommendation 8

Improving the Patient Experience

Note: All other recommendations also apply to secure hospitals caring for adolescents.

Adolescents cared for in secure hospitals had a similar degree of complexity to adults with many having a history of trauma, challenging behaviours, and numerous outcomes to be achieved. Unlike adults, the most common diagnosis tended to be emotional or developmental disorders. All adolescents were prescribed psychotropic medication and tended to be more engaged with activity and therapy programmes.

Many adolescents were admitted direct from the community so the transition from home to secure hospital may be, even more so than with adults, disorientating and distressing. Adolescents tended to be admitted for shorter periods but the immense impact of staying in hospital for a year or more on a young person's life must be recognised.

8.1. WHSSC must ensure that all adolescents requiring hospital care are admitted into the least restrictive environment by effective gate-keeping, are regularly reviewed by specialist staff and, when safe to do so, discharged or repatriated.

8.2. Health Boards must endeavour to reduce admissions of adolescents into secure hospitals by strengthening community services, especially in the areas of emotional dysregulation and trauma support.

38.8. Recommendation 9

Promoting Good Physical Health

The care of physical health must have parity with mental health in secure hospitals. Access to primary healthcare was essential, with seven in ten requiring a dentist, four in ten a GP, four in ten an optician and two in ten a podiatrist and many patients could not attend these appointments due to legal, risk, staffing or transport issues. Two in ten patient's required an emergency ambulance or attendance at an emergency department. Most patients gained weight post admission and were obese. Despite this, only one in ten had access to a dietician. A quarter of smokers quit post admission but the majority continued to smoke, all smokers had access to nicotine replacement resources but not all had access smoking cessation support. The majority of patients had access to a physical health nurse but four in ten did not.

The prevalence of trauma, high prescription rates of psychotropic medication and illicit drug use will also impact on physical health.

9.1. Providers must ensure access to primary healthcare is not impeded due to staff or transport availability.

9.2. Providers must ensure patients, especially those at highest risk of weight gain, are supported through weight management interventions including access to a dietician.

9.3. Providers and Commissioners should ensure that secure hospitals are promoted as positive physical health environments with regular health checks, healthy eating campaigns, smoking cessation support and routine access to a physical health professional.

38.9. Recommendation 10

Improving the Quality of Care

The application of restrictive interventions is sometimes necessary to prevent harm and protect the safety of the patient, other patients, visitors and staff. Any restrictive interventions utilised should involve the minimum degree of force, for the briefest amount of time and with due consideration of the self-respect, dignity, privacy, cultural values and individual needs of the patient.

Secure hospitals are subject to multiple oversight regimes, and, although these provide patient and commissioner assurance, they need to align to avoid duplication and ensure proportionality. The transparency of reporting is important for public and patient confidence in effective care systems, especially in public interest areas such as inequalities, restrictive interventions and length of admissions.

10.1. The leaders of quality assurance oversight regimes for secure hospitals should work in partnership to avoid duplication and ensure efficient oversight.

10.2. Providers should adopt, without delay, the Welsh Government Reducing Restrictive Practices Framework.

10.3. Welsh Government should consider imposing standards for transparent reporting in specific areas, such as length of admissions, inequalities and restrictive interventions.

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Part G

Methodology Appendix and References

39. Methodology

This Part of the National Review summarises the methodologies used to inform previous Sections.

39.1. Audit Team

The audits that gathered the patient specific information for this National Review were undertaken by skilled and experienced clinicians from the NHS National Collaborative Commissioning Unit – Quality Assurance and Improvement Service. The team consisted of social workers, registered nurses and registered occupational therapists. The audits were undertaken between 9am and 6pm onsite between August 2020 and November 2020. Follow up queries and clarifications continued until June 2021. 32 patients were unable to be seen as Covid 19 restrictions or Covid 19 outbreaks prevented the audit team from accessing the hospital site, multiple attempts were made.

39.2. Audit Questions

The National Review audit consisted of 2 segments:

- 1. The Provider Environment Survey**
- 2. The Individual Patient Review**

A summary of each segment is provided below

1. Provider Environment Survey Summary of questions:

- General state of repair of the wards.
- General cleanliness of the wards.
- Background noise on the wards.
- Access for patient (beverages, telephony, outdoor spaces, patient kitchen).

2. Individual Patient Review

- Commissioning Health Board.
- Ethnicity, gender identity, sex, sexual orientation, marital status, religion, age.
- Type of care setting (high, medium or low).
- Private or NHS provider.
- Hospital name.
- Length of stay.
- Diagnosis.
- Admitted from.
- Reasons for admission.
- Admission outcomes.
- Any additional care needs.
- Patient, family and care coordinator involvement in care.

- Availability of care plans.
- Levels of care: general and activities.
- Enhanced and night time observations.
- Challenging behaviours.
- Restrictive interventions.
- History and number of ACEs.
- Medication regime.
- Weight and BMI.
- Contact with clinical staff members.
- Activities (what activities and frequency of attendance).
- Therapies (what therapies and frequency of attendance).
- Primary healthcare and secondary healthcare attendance.
- Ambulance and emergency department attendance.
- Type and frequency of leave from hospital.
- Disruption of leave due to Covid 19.
- Restricted access to items.
- Complaints.
- Smoking status.
- Discharge information.

39.3. Patient Questionnaire

The patient satisfaction questionnaire was distributed at nine sites, all in Wales and a mix of NHS/independent sector and medium and low secure. There were 134 Welsh patients admitted to these 9 hospitals at the time the questionnaire was distributed in October 2020. Patients were given 1 month to complete and the surveys were gathered in December 2020.

Participation rate was 38.8% with 52 questionnaires returned. It was indicated that some staff or advocates had supported the patients to complete the questionnaire giving rise to possible positive bias and social desirability bias. During November 2020 the Covid 19 pandemic restricted onsite visits by family and restricted the community access of some patients and this may have affected results. The 9 patient satisfaction questionnaire areas were:

- Comfortability and hominess of the environment.
- Information.
- Family/friends/carers contact and contact facilitation.
- Physical health.
- Spiritual needs.
- Involvement in care.
- Staff support and Staff attitude.
- Support on admission.
- Feeling safe.

Patients were given a free text space under each question asking for suggestions on improvement and a large free text space at the end of the questionnaire asking for any thoughts on their experience in hospital.

39.4. Expert Reference Group

The Expert Reference Group was established to:

- Inform the approach for the National Review.
- Provide expert advice on the key issues.
- Highlight relevant practice.
- Provide peer feedback prior to publication.

The group met 3 times and, although more were invited to participate, the following attended at least one meeting:

- Dr Ruth Bagshaw, Cardiff Metropolitan University.
- Mr Andrew Pryse, Healthcare Inspectorate Wales.
- Mr Mark Warren, Cardiff and Vale University Health Board.
- Dr Alberto Salmoiraghi, Betsi Cadwaladr University Health Board.
- Mr Iorwerth Harding, Powys Teaching Health Board.
- Mr Philip Lewis, Cwm Taf Morgannwg University Health Board.
- Mr Phil Chick, NHS Wales Delivery Unit.
- Mr Paul Hanna, Betsi Cadwaladr University Health Board.
- Ms Lesley Singleton, NHS Wales Mental Health Network.
- Mr Dave Semmens, NHS Wales Delivery Unit.
- Mr Alun Thomas, Chief Executive Adferiad Recovery.
- Ms Jenifer French, Royal College of Nursing.

The group was chaired by Mr Shane Mills and in attendance were Mr Joseph Davies and Mr Adrian Clarke. The group was also sent the National Review in pre-publication draft to provide comments and opinions.

39.5. Technical Area

In some Sections of this National Review, logistic regression analyses were conducted to predict therapy attendance and activity attendance. Specific variables were included in these analysis based on a review of the literature and pre-analysis logistic regression assumption checks. Presented below is a brief summary of the methodology and statistics from the two logistic regression analyses:

Therapy Attendance

To explore what factors predicted therapy attendance, an analysis that included the following four predictor factors was conducted; (1) whether patients attended activities, (2) the frequency in which patients displayed disruptive or intimidating behaviour, (3) the number of antidepressant medication they were prescribed, and (4) whether the treatment outcome of achieving positive outcomes through specific psychological therapies was met at the time of audit. The model significantly predicted 12% of therapy attendance ($P = <.001$, Nagelkerke $R^2 = .119$). Odds ratios for the above factors are highlighted below:

- Did patient attend activities — OR = 2.147.
- Frequency of disruptive and intimidating behaviour — OR = .786.
- The number of antidepressant patients were prescribed — OR = 1.857.
- Achieve positive outcomes through specific psychological therapies — OR = 1.754.

Activity Attendance

To explore what factors predicted activity attendance, an analysis that included the following five predictor factors was conducted; (1) whether patients attended therapy, (2) whether patients had been fully concordant with their prescribed antipsychotic medication over the past 2 years, (3) the type of provider in which they were being treated, (4) whether the treatment outcome of empowerment through hope, positive regard and psychosocial interventions was met at the time of audit and, (5) whether the treatment outcome of reduction or minimisation of the risk of harm to self from vulnerability due to impaired cognition was met at the time of audit. The model significantly predicted 17% of activity attendance ($P = <.001$, Nagelkerke $R^2 = .171$). Odds ratios for the above factors are highlighted below:

- Does patient attend therapy — OR = 1.944.
- Concordance with antipsychotic medication — OR = 1.199.
- Provider type — OR = .425.
- Empowerment — OR = 2.987.
- Reduction in risk of harm to self, due to vulnerability — OR = 2.175.



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