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Abstract

There is disagreement amongst psychiatric professionals about whether the doors of acute psychiatric wards should be kept locked to prevent patients from leaving and harming themselves or others. This study explored patient, staff and visitor perceptions about the acceptability of locking the ward door on acute psychiatric units. Interviews were conducted with 14 staff, 15 patients and 6 visitors from three different acute wards. Findings revealed commonalities across all groups with general agreement that locking the door reduced absconding. Staff expressed feelings of guilt embarrassment and fear of being blamed following an abscond. Staff also reported that open wards created anxious vigilance to prevent an abscond and increased workload in allocating staff to watch the door whereas staff on partially locked doors also perceived an increased workload in letting people in and out of the ward. Patients had mixed feelings about the status of the door, expressing depression, a sense of stigma, and low self esteem when the door was locked. The issue of balancing safety and security on acute psychiatric wards against the autonomy of patients is not easily resolved and requires focussed research to develop innovative nursing practices.

Key Words:

Acute psychiatric in-patient units, locked doors, absconding, least restrictive environment

Introduction

Door locking on acute psychiatric wards is becoming increasingly common in the UK, Australia and around the world. Adams (2000) has suggested that whilst locked doors ought not be the norm they can be a useful adjunct in the provision of therapeutic care, freeing up nursing staff so they can spend more time with patients in therapeutic activity. The rationale for locking doors involves a number of factors. First that the door being locked will maintain safety for patients who may otherwise leave and harm themselves or be a danger to the community. Second that it is more convenient for staff to monitor patients' whereabouts and frees staff from observations of patients at risk allowing them time to perform therapeutic activities. Third that locking ward doors prevents patients and staff from unwanted visitors, theft and illegal substances being brought into the ward. Studies have revealed that both patients and staff feel that a locked door can promote safety for all concerned (Ashmore 2008; Haglund et al. 2007) and that it reduces the traffic of unwanted drugs and alcohol on the ward (Adams 2000; Haglund & Von Essen 2005). In some circumstances, mental health services are reluctant for safety and legal reasons to keep psychiatric wards open which further potentiates the notion of psychiatric patients as dangerous and to be feared (Gudeman 2005). In a review of the empirical literature concerned with locked doors in acute psychiatry (Van Der Merwe et al. 2009), disadvantages of locking doors included patients feeling trapped, passive and scared (Haglund & Von Essen 2005), confined, depressed and discouraged (Adams 2000; Dumont et al. 1960; Sacks et al. 1982). Staff cited disadvantages as extra work created by having to lock and unlock doors (Ashmore 2008) and the negative effect on the ward atmosphere (Haglund et al. 2006).

Materials and Methods

Aim of the study

The aim of the study was to investigate the acceptability of door locking to staff,

patients and visitors. The research reported here is part of a larger study investigating

locked doors and security measures on acute psychiatric wards in the UK. Interviews

were conducted with 14 staff, 15 patients and 6 visitors from three different acute wards

within one National Health Trust (NHS) during 2007 – one ward locked i.e. visitors and

patients have to be let in and out, one locked sometimes and open others (at nursing

staffs' discretion) and one open at all times, except at night for security.

Method

Patients were randomly selected and approached to be interviewed if staff agreed the

patient was well enough to be invited to take part in the research. Fully informed written

consent was gained prior to interview. Subject to patients' consent, their visitors were

also approached for interview. All interviews were conducted on the wards by a trained

researcher, were taped and transcribed. Visitors were the most difficult group to recruit,

as there were very few (even though we accessed the wards during the evenings and at

weekends). Signed consent from the patient who was being visited was obtained before

asking the visitor to participate, and this further reduced the numbers available to

interview. Full ethical approval was gained from the local Research Ethics Committee.

The interview schedule was developed based on the work of Haglund et al. (2007; 2006;

2005).

Data Analysis

NVIVO was used to analyse data. At the first level of reading it was recognised that the raw content of interviews between the three groups was indistinct so the sample was then analysed together and most coding categories were present in all interviews. Free nodes were generated and presented to the whole team who made suggestions about how they related to each other. From this tree nodes were developed and organised hierarchically under the headings of locked or open in regards to the status of the door. From this codes were rearranged and consolidated around generic themes around feelings, behaviours, identities and roles. This analysis led to the construction of representative diagrams for staff and patients whose structure of thinking and relevance was perceived to be separately nuances. Visitor findings could not be treated in the same way, due to low participant numbers and limited diversity.

Results

Knowledge of the door status

Patients generally found out whether the door was locked or open through observation, they knew the door was locked because it had to be unlocked to allow them in on admission (11/15), and experience, because they tried to leave and couldn't open the door (4/15). However there was also evidence that on the open ward some patients were deliberately allowed to remain ignorant of the fact that they could open the door. None said they had been informed by the staff, although one staff member on the open ward said that giving such information on admission was routine.

> *Generally locked. [How did you find that out?] Because I couldn't get*
>
> *out once I was brought in. (Patient)*

The complexity involved in describing the precise door status could lead to confusion

for both staff and patients, and was reflected in how they answered interview questions.

This lack of clarity was particularly apparent on the open ward in this study, and was

sometimes exploited by staff, who appear to have allowed some patients to believe that

the ward door was locked and prevented them from leaving. On this ward three of the

five patients interviewed believed the door was locked, because they had tried to

abscond without noticing the large green button that released the door, and had not been

subsequently informed about it:

> *It's open mostly. [How did you find this out?] I didn't find out. I'm just*
>
> *finding out right now. No, the staff don't tell us anything. (Patient)*

Absconding and the door

The majority of all respondents (patients 14/15, staff 13/14, and visitors 4/6) believed

that locking the main ward door prevented patients from leaving without permission:

> *You can't do it no (sic) other way I don't think. Because if you leave*
>
> *the door open they'll only pass you, they'll only brush you, push you*
>
> *over and then pass through. They won't even think of it twice. (Staff)*

> *If they're mentally sick and they're not allowed out then if that's the*
>
> *only way to prevent them getting out then yes by all means lock the*
>
> *door. (Visitor)*

However more staff (9/14) than patients (3/15) and visitors (3/6) recognised that this method of prevention was far from totally effective. All three groups gave accounts of how patients absconded even when the door was locked:

Yes I managed to get all the way home. There on the way to chapel and I ran for it. And the trolleys going down to the canteen were downstairs in security door downstairs. I pushed myself out of the trolley way and I ran all the way to my house. (Patient)

When the door was locked and a patient absconded? Oh patients have kicked the door, yeah. Kicked the door open … maybe it's happened once in the last year. Yeah. No, if they want to get out, the door is not very strong. It's just held together with two small bolts and very flimsy bolts at the top and at the bottom. (Staff)

Of course they can get out if they want to. I'm sure they could, I'm sure if you were really determined it's hardly Colditz is it? This is not a police station. I don't know, I haven't, perhaps I'll plot an escape route. I'm not a patient, but I'm sure you'd work out a way, if you wanted to get out. (Visitor)

Many subjects from all three groups mentioned the risks associated with absconding, but with differences in emphasis. The risk of absconded patients harming others was recognised equally by all groups. However the risks to others mentioned by staff were more extreme, with two mentioning murder and another, serious assault with a knife.

Staff had a clearer view than others of the most serious risks associated with an abscond, however it was patients who most clearly indicated how vulnerable the absconded patient was, with fewer staff and visitors mentioning this:

> *For those patients who are not allowed leave, and who are on*
> *medication which is making them very drowsy or unmanageable, for*
> *them it is safe, safer to have the door locked. (Patient)*

Staff also spoke about a sense of dread due to the appearance of staff incompetence and blame when patients abscond;

> *At the end of the day, you don't want to go thinking, oh it was my fault.*
> *And you don't want to put this on even your worst enemy because it's a*
> *nightmare. Supposing the person goes and kills themselves? (Staff)*

About half of the interviewed staff considered that having the door open led to aggressive confrontations around the exit. These aspects of an open door policy were not mentioned in interviews.

Locked doors and patient aggression

Staff (10/14) and patients (8/15), but few visitors (2/6) recognised a connection between the door being locked, patient anger and non cooperation. The connection was

recognised equally across all three wards with their differing approaches to

locking/opening the ward door, as well as by male and female patients. Patients

experienced a sense of constraint and frustration from being locked in. Even patients

who were of voluntary status or who had permission to come and go felt this sense of

constraint on a locked ward, because they have to ask to be let out, and were sometimes

reluctant to bother staff. This sense of restriction led to complaints directed at staff, bad

behaviour, medication refusal, anger and sometimes actual aggression:

> *Yeah. I've noticed that if the door is closed, and patients are not*
>
> *allowed to go outside, they behave badly. I notice that. (Patient)*

By contrast, an open door was reported to generate co-operation and better behaviour:

> *Well the advantage is less confrontation between the nurse and the*
>
> *patient because they know it's an open ward, and so that's one good*
>
> *advantage and it puts a, it's more relaxing for everyone when the door*
>
> *is open. (Staff)*

> *But I do realise that sometimes when people are very ill they can*
>
> *behave in a very devious way. They can actually look for every angle so*
>
> *that they can escape because they can't bear the curtailment and*
>
> *sometimes I think giving freedom actually leads to better co-operation.*
>
> *(Visitor)*

Locked doors and patient low self-esteem/mood

The capacity of the locked door to affect patients' views of themselves and their mood

was equally recognised by the patients (9/15), staff (7/14) and visitors (4/6), by male

and female patients, and by subjects from each of the three wards. However patients

made more references to it, and in more detail than the other two groups. The locked

door engendered a sense of stigma, coupled with shame on the part of patients, and a

perception that they were pitied by others:

> *The point is your locked door, the card is being swiped and instantly*
>
> *the message is going into your head that the person you're seeing at the*
>
> *other end is mad … There's a security camera and they are pressing a*
>
> *bell and having to wait and then a nurse comes and swipes the card,*
>
> *and you look at the nurse and, so it's just a reminder of the fact that*
>
> *your relative's screws are a bit loose right now. So yes, it's an*
>
> *underlining of the stigma of mental illness. (Patient)*

Together with this go feelings of depression and sadness:

> *It's made me; it's very depressing, very depressing. (Patient)*

> *It's the locked door that makes them depressed. (Patient)*

Factors exacerbating patient anger and depression

Locking the door changed patient perceptions of the psychiatric service, the staff and

their own identity from hospital-nurse-patient to prison-guard-criminal. These changes

in perception were accompanied by changes in the terminology of patients, who talked

of being 'arrested', 'charged', 'banged up', 'locked up', 'sentenced', 'cell', 'cage',

'camp', 'imprisoned' by 'warders' and the like. In one sense this fed anger and

resentment if the status as criminal was rejected, in another it fed a sense of depression

and isolation. This change was recognised and reported by all three groups of subjects,

in all three settings, and by both voluntary and detained patients.

> *The fact that it's locked gives me the creeps, I don't want to think of my*
>
> *husband being in a bloody prison, and he doesn't need to be, he's not a*
>
> *criminal, he's done nothing wrong. (Visitor)*

This realignment of power led some of the staff to report that locking the door made

them feel more in control of the ward. However the patients' view was very different,

instead seeing the staff as enjoying that power and the sense of superiority it gave them.

> *I think it's safer when the door is locked, in a sense, like I said, you can*
>
> *control who comes onto the ward and you can control who leaves the*
>
> *ward. (Staff)*

> *I think they enjoy using their swipes. Because they've got a sense of*
>
> *power. (Patient)*

In response to this, some patients (5/15) adopted a posture of subservience towards

staff, rather than anger and aggression, probably feeding their sense of low self-esteem

and depression:

> *I'm a little bit apprehensive [when the door is locked] but it doesn't*
>
> *affect me too much. I can be a little bit like, I think about what I'm*
>
> *going to say before I speak. (Patient)*

So my behaviour towards staff is very polite, I don't misbehave because

I know that I can't get out of there without them (Patient)

Some staff were aware of how some patients viewed them, and how this might hinder

positive relationships with patients.

They call us prison guards. Yeah, they can be more negative towards

us, yeah. And comments about the keys and not being, and us being in

control, and it's being like being in prison. So we do get comments like

that, yeah. They view us more as jailers than anything that could be

therapeutic. (Staff)

Another process feeding patients' feelings of anger and depression was a claustrophobic

sense of lack of access to fresh air. This was mentioned equally by patients (6/15), staff

(6/14) and visitors (3/6); but less so by patients from the locked ward, probably because

that ward had a small secure garden area freely accessible to the patients, whereas the

other two wards did not.

Locked doors as exclusion from the everyday world

The third factor that accentuated patients' feelings of anger and depression was the

perception of the locked door separating and excluding them from the normal, everyday

world. Three of the staff respondents argued that locking the door was itself a sign of

normality, just the same as you would do at home. However, in these cases the staff

only referred to the door being locked to prevent outsiders coming in, rather than the

reverse. The patients' view was different, to them the locked door symbolised their

outcast status, and an open door inclusion in the normal everyday world.

Locked doors as a symbol of mistrust

Finally, for patients the locked door was a symbol of being mistrusted by the staff. This

factor was also linked to the nature of the relationships possible between staff and

patients, with the locked door and its implication of mistrust undermining those

relationships:

> *I understand the nature of the ward in terms of the Mental Health Act*
>
> *and all the rest of it, but I just find it an abomination being locked. To*
>
> *me it signifies a level of distrust of both the people coming in and*
>
> *people's likelihood of leaving, which is unwarranted and distrust*
>
> *breeds more distrust in my view. (Visitor)*

Both patients and staff made reference to the positive value of the locked door in

preventing undesirable visitors from entering the ward. Patients made reference to

vague senses of threat from or vulnerability to people outside, sometimes of a paranoid

nature, which meant that when the door was locked to people coming in, they felt more

safe and secure. This was reported by 6/15 patients, recognised by 8/14 staff, and 2/6

visitors. Staff perceived the threats posed by outsiders in more specific terms,

particularly the easy importation of drugs and alcohol to patients on the ward. However

another member of staff did not consider that locking the door was going to make much

difference to this:

> *I don't think when you open the door it is then people will bring in stuff.*
>
> *Whether you lock it or open it regularly. You see when it is locked they*
>
> *still allow you to bring stuff in... If it is stopped it causes problem for*
>
> *patients... So whether you lock it or not, you're going to have, if there*
>
> *is any affect it is going to be very, very minute, nothing too big. (Staff)*

In addition, there were patients (2/15) who thought blocking access to outsiders was a means to keep staff mistreatment of them secret. The ability of the locked door to convey that impression was also recognised by some staff (3/14) and visitors (2/6).

> *For other patients I would say that sometimes the staff can misbehave*
>
> *at night time because the ward doesn't have a camera so if they were*
>
> *scared with an open door about a relative or someone coming in*
>
> *without asking, then they might not misbehave at night time like what,*
>
> *like even speaking in a harsh voice. Because you will think twice that*
>
> *somebody might come in and observe you. (Patient)*

> *I think for visitors and people from outside it gives a very bad*
>
> *impression because it reminds them of the times when people were*
>
> *locked up and they might even think that we are locking the door to do*
>
> *something to the patients, their relatives or things like that, we don't*
>
> *want them to see what goes on in here. (Staff)*

Staff activity in relation to the door

14

On open wards, staff referred to being committed to a process we have termed 'anxious

vigilance'. They were concerned about preventing absconds because of the risks

associated with them, and that meant that their observation of patients and the ward

exist was imbued with an underlying anxiety.

> *Whereas, when the door is not locked, you've just got that element of,*
>
> *right I've got to keep an eye on this person, I've got to keep an eye on*
>
> *this person. So you've got one eye on the door. You've got to sit and*
>
> *you've got to sit somewhere where you can see everything. You can see*
>
> *the patient you're talking to, you can see the door and you can see the*
>
> *patients that are an absconsion risk, so it's quite a juggling act. (Staff)*

The need to watch patients and the open door meant that staff's attention was divided,

even when trying to have attentive and supportive conversations with other patients. If a

nurse had to be stationed by the door or allocated to watching the corridor, then the total

nursing resource for patient care was significantly depleted.

> *You would focus more on patients' care rather than focusing on the*
>
> *door. Focus on having one to one with the patient, you give the patient*
>
> *more concentration and listen more because sometimes you are in the*
>
> *corridor standing there, looking for, the patient will come to you and*
>
> *start asking you, but it's like you're not paying attention, you have*
>
> *divided attention, looking at the door and at the same time trying to*
>
> *focus on what the patient is saying. So I think we'd be able to give the*
>
> *patients undivided attention, especially when they approach you when*
>
> *you're standing by the door. (Staff)*

These aspects of having an open door and the impact on staff and workload were not perceived by any of the patients we interviewed, and were only partly appreciated by visitors (2/6), although almost all staff made reference to these issues (13/14). The connection between keeping the door open and nursing workload meant that debates on whether the door should be kept open were entangled with those on staffing levels and the role of nurses. Some staff regarded watching the door as a non-nursing duty, and this was seen as an argument in favour of locking the door. However, locking the door was also far from unproblematic in these respects. Although staff could eliminate one element of their anxious vigilance of patients (the door) they still had to supervise a large number of disturbed and vulnerable patients for other reasons.

> *Obviously people who are locked or people who are trying to abscond,*
> *is if we keep the door locked we will still observe them. We would still*
> *keep maintaining the same level of observation. But a locked door is*
> *like small, like a back up system, but we will keep observing the*
> *patients. (Staff)*

In addition, locking the door also created the extra work of unlocking and locking the door to let people in and out. That process meant that sometimes people inside and outside were kept waiting for a member of staff to be available, or that whatever task staff were undertaking was interrupted by the need to deal with the door. This aspect of locking the door was only perceived by those staff on the partially locked ward. All of them (6/6) mentioned this issue, probably because they had day to day contrasting experiences of the effects of opening or locking the ward upon their workload. This also could make nurses feel like security guards undertaking non nursing duties.

On wards that were sometimes locked and sometimes not, the status of the door

conveyed a powerful message to staff coming on duty. If locked, they knew the ward

was disturbed with some difficult to manage patients, hence they were already

psychologically preparing themselves (possibly adding to the sense of tension on the

ward). If open, they could relax, knowing that their shift was likely to be more pleasant

and less marred by potential confrontations with disturbed patients.

Discussion

The concealment of the open ward door status by nursing staff is notable. It is

impossible to know from the interview data how widespread this practice is. It may be

limited to the specific ward included in the study, or may be more common. Further, the

number of patients on this open ward who were interviewed was small, so the

proportion of patients treated like this is unknown. However, it is hard to see how this

would be any different from really locking the door, as the impact on patients would be

the same. The only people who gain here are the nurses, who are able to slightly reduce

their anxious vigilance of the door, whilst still being able to portray to others within and

outside the organisation an appearance of libertarian psychiatry.

Given the strength of belief that the locked doors prevent absconding, it seems likely

that locking the door leads to many patients giving up the idea of absconding. Thus the

efficacy of the locked door is partly psychological as well as physical. That this is the

case, and is appreciated by staff, is revealed by their concealment of the door status on

the open ward. However neither is the locked door a perfect barrier, and patients can

still abscond (Muir-Cochrane & Mosel 2008; Bowers et al 2003). This indicates two

things: first that absconding reduction through physical security methods introduces a

potential ratchet, with one escape route being plugged after another and second that

locking the door provides staff with a defensible position from criticism. If the abscond

(and maybe a tragedy) still occurs, staff are not then easily blamed for insufficient

vigilance or care. This study confirms existing research indicating that patients'

experience of locked doors is a depressing and frustrating one (Ashmore 2008; Haglund

et al. 2006; Sacks et al. 1982). Further that locking the ward door makes overt the power

imbalance between staff and patients as reported in another study (Haglund et al. 2006).

It is impossible to determine from this data what relative impact on staff workload

locking or opening the door has. Research has not yet been undertaken to provide

evidence about this. The interviewees provided evidence of increased burden for both

open and locked wards. Open wards led to anxious vigilance, allocation of staff to

watch the door, risky staff-patient confrontations by the exit and increased

administrative work associated with absconding. Locked wards may have reduced some

of these burdens, but introduced the need to open and close the door for visitors and for

those patients who were free to come and go as they pleased. Meanwhile anxious

vigilance continued for those patients on the ward due to other risks and considerations,

with only one element being reduced. It is possible to think of ways in which the

workload effects of locking the door could be ameliorated. Official visitors could be

given keys/swipe cards, or be allocated them at the unit main reception, patient visitors

could be restricted to certain hours, and selected patients could be given keys/swipe

cards. All of these could reduce the need for the nursing team to open and close the door

continuously. Research conducted utilising anti-absconding interventions has shown

that with such interventions it is possible to have an open door policy (Bowers et al.

2003), however this also requires a time and effort commitment from staff. Other easy

solutions to the workload impact of opening the ward door are more difficult to think of

and would incur greater expense, such as a staffed ward receptionist or security guard,

or a general increase in nurse staffing levels to ease the burden of observation. Creative

alternatives such as the use of technologies, electronic tagging of patients, and even

facial recognition software may allow high levels of surveillance in the future but

without the existing negative perception of locked ward doors. The use of closed circuit

television may be a solution but can increase staff time in watching screens rather than

being in physical contact and spending time with patients.

Putting to one side questions of risks to patients and staff workload, it is clear that the

emotional burdens of the locked door fall on patients (anger and depression) whereas

those of the open door fall on staff (anxiety).While it seems acceptable for an emotional

burden on staff employed and trained for such work, it may not be considered

acceptable that patients experience an emotional impact in addition to their illness for

which they have been hospitalised. As Clearly et al (2009, p. 644) point out in a

critique of values associated with locked psychiatric ward doors, 'staff need to be aware

of their practice values, be able to access education and supervision and negotiate

apparent contradictions'.

The negative and claustrophobic impact of locking the door is removed with the

provision of a secure garden area for patients, and patients on this ward did not mention

being claustrophobic. In the UK prisoners have "a right to one hour's physical exercise a

week and it is aimed to allow one hour's exercise in the open air a day if circumstances permit. Health care advice is that this period should not normally be reduced to less than half an hour a day". (The liberty guide to human rights 2010, p. 1). It seems strange that while many if not most prisoners get daily access to fresh air, patients suffering from mental disorders may not. Every effort should be made by hospitals choosing to lock their ward doors to provide access to the outside and fresh air for patients, as it would appear to ameliorate some of the negative psychological impacts as well as being important for physical health.

It is harder to see how other negative psychological impacts of locking the door can be modified or minimised. Mistrust, stigmatisation, separation from normality and the identification of the hospital with a prison appear to be inextricably linked with the act of locking the door. Whether the locked or open door is advantageous in terms of risks of harm to patients and others also cannot be answered from this relatively small study. Whilst the opinion that locking the door reduced absconding and therefore risk was unanimous, this has to be offset against the negative psychological impacts and their expression in aggression and self-harm on the ward (Bowers et al. (in press); Haglund et al. 2006). Clearly, the issue of balancing safety and security on acute psychiatric wards against the autonomy of patients and care provided in a recovery approach is not easily resolved and requires focussed research conducted in collaboration with service users and staff to create effective and contemporary care practices within a least restrictive environment.

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