MANDATED LOCKED WARDS AND MENTAL HEALTH NURSING

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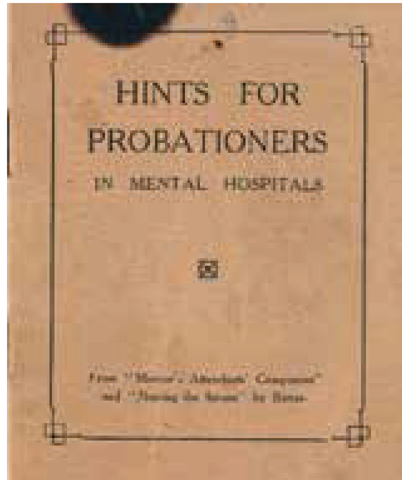
A few years ago I re-discovered a collection of professional souvenirs in a small forgotten box – assorted nursing medals, identity badges and service keys for a psychiatric hospital I had worked at. An inquiry of mental health nurse colleagues revealed that many had also held onto the keys (some of which are pictured above). According to the authoritative 'Hints for Probationers in Mental Hospitals' reprinted by Gladesville Hospital in 1944 amongst other sage advice was "Never let a suicidal patient out of your sight…Never allow your key to go out of your own possession" and "Never fail to report immediately a lock out of order". This enlightened document also exhorted nurses to never treat patients as one mass but to respect their individuality, to maintain optimism and to regard every patient as curable. The charge nurse was uncontestably responsible for the maintenance of the therapeutic milieu of the ward, whether locked or closed.

That many nurses who worked in these old, now largely closed down psychiatric hospitals held onto their keys may say something about the subversive nature of psychiatric nurses of the time. There is also something highly symbolic about "the keys" which swipe cards, code locks and future technologies like fingerprint and iris scanning technologies lack. The keys granted the holder access to special areas and were a symbol of status. Students and junior staff often had no access to keys and even today according to various state regulations only senior registered nurses may hold the keys to the scheduled or dangerous drugs (although the arrival of apparently failsafe computerised dispensing systems will no-doubt force an end to this).

For some service users, especially those who were or are "locked in" to seclusion or secure units the keys may represent a symbol of oppression. For others they may symbolise safety, resistance or privacy. In response to the picture of keys (in figure one) a service user commented to me that she felt unsafe on an acute ward and wanted to be able to lock her door. In a hospital I worked in, a particularly despotic charge nurse kept the keys to a store room and was rather precious about maintaining well-stocked stores for any eventuality. He often became incensed when he found a teaspoon missing. On the imminent closure of the hospital one long term patient opened his padlocked bedside locker and liberating five years of collected teaspoons (many hundreds) to the delight of nursing staff and patients alike who appreciated this act of resistance.

In December 2013, the then Queensland Director of Mental Health issued a directive to hospitals to lock all acute mental health wards to prevent people from being absent without leave. This stated aim of this was to prevent involuntary patients from absenting themselves without authority from wards and placing themselves at a serious risk to their own life, health or safety or a serious risk to public safety. However, it is difficult not to perceive this as symbolic of, if not actually facilitating imprisonment of people. At a stroke of a pen nurses were essentially relegated to gaolers, their professional voice ignored, and their professional agency undermined. The move was widely criticised at the time by peak mental health bodies, the Queensland Mental Health Commission[1], the Royal Australian and New Zealand College of Psychiatrists (RANZCP)[2], the



Australian College of Mental Health Nurses[3] and the Australian Association of Social Workers[4]. In a rare show of solidarity the popular press also widely condemned the decision[5] in recognition that essentially incarcerating people who had committed no crime is a breach of fundamental human rights, is an anathema to recovery focused practice and is in opposition to the intent of national and international mental health reform agendas. One can only suppose that imposing this edict on patients and requiring highly trained and skilled staff to operate in a manner often contrary to their better judgement, and in conflict with their standards of professional practice, was intended to keep people safe. However, there is no robust evidence that locking doors has had any positive impact at all on the ethos of wards or the safety of people who use inpatient mental health services. Indeed the opposite may well be the case.

The directive to lock the doors was a metaphorical slap in the face to the tradition of nursing governance of the day to day operation of wards, although it is entirely in keeping with trends towards centrally micromanaging the day to day interactions between health professionals and service users. For over 100 years it has been largely nurses who have been responsible for the management or maintenance of the ward milieu, decisions to lock or unlock doors and determining how to work therapeutically with groups of people in various states of distress or recovery.

Arguably this management of the ward environment is the only uniquely nursing role in modern mental health industry. No other professional group can lay claim to a 24 hour a day presence in mental health inpatient settings. Whilst there may be times when it is prudent and sensible to lock doors, mandating that all inpatient units lock patients is grossly disrespectful not only to service users but to the profession which is charged to care for them and keep them safe.

A recent large scale research project comparing rates of absconding and suicide completion in Germany and published in the prestigious medical journal, The Lancet Psychiatry[8] robustly demonstrates that compared to locked wards, open wards were actually associated with a decreased probability of suicide attempts and absconding. The authors conclude that estimates of the effectiveness of locking doors to reduce self-harm, suicide and absconding are over estimated. Commentators have suggested that locked doors reflect a more oppressive culture.

Some mental health services are attempting to shape in-patient culture so that there is the right balance of engagement, judicious surveillance, respectful interactions, medical treatment and nursing care. These diligent and careful attempts at practice development will no doubt demonstrate good results regardless of locked doors. This does not however, mean that a directive to lock all doors to in-patient units is a good thing or ought to go unchallenged. It will be interesting observing Dr John Allan's response as Chief Psychiatrist in Queensland to the issue of mandatory locked doors as he is also president elect of the RANZCP which has expressed an unambiguous position about the matter[2].

In the evidence based model called safewards[6] which was derived from a series of rigorous studies about conflict and containment on inpatient units locking doors is not a recommendation to reduce conflict, absconding or reduce containment interventions. With some exceptions[7] much of the rest of the developed world appears to be genuinely engaged in attempting to address the reasons for conflict and unnecessary coercion whilst Queensland's policy is an archaic reminder of the worst of times past. To date Queensland Health has been remarkably resistant to the opinion of its employees, advocates, ethicists, media commentators, and international experts on the matter of mandatory locking of mental health wards, although to the credit of many services they have attempted to do the best they can and introduce positive reforms despite this dictate. Services in my own region have seen an escalating problem with people deemed absent without authority since the locked ward policy.

The matter is complex and involves consideration of what counts as absent without leave, how it is reported, recorded, rescinded as well as how taking leave from an inpatient unit is negotiated. What is however abundantly clear is that the locked door edict does not make things better. I understand that districts are to outline about how they might open the doors safely, if at all. In light of recent findings[8] a more reasonable and evidence based approach might be for districts to justify the exceptional case why they might wish or need to lock particular units or facilities.

[1] Queensland Mental Health Commission. Decision to lock Adult Acute Mental Health facilities in Queensland's public hospitals. 2013 8/6/2016; Available from: https://www.qmhc.qld.gov.au/wp-content/uploads/2013/12/QMHC-statement-201213.pdf.

[2] The Royal Australian & New Zealand College of Psychiatrists. Psychiatrists welcome recommendation to open locked wards 2014 8/6/2016; Available from: https://www.ranzcp.org/News-policy/News-archive/Psychiatrists-welcome-recommendation-to-open-locke.aspx.

[3] The Australian College of Mental Health Nurses. Blanket decision to lock mental health units a draconian step backwards. 2013 8/6/2016; Available from: http://www.acmhn.org/images/stories/News/RestrainingClientsinQLD.pdf.

[4] Australian Association of Social Workers. AASW Statement on the Queensland Government's Mental Health 'Locked Wards' Dircective. 2014 8/6/2016; Available from: http://www.aasw.asn.au/document/item/6718.

[5] Magarey, J., Curbs on mental patients 'harmful', in The Australian. 2013.

[6] Bowers, L., et al., Reducing conflict and containment rates on acute psychiatric wards: the Safewards cluster randomised controlled trial. International journal of nursing studies, 2015. 52(9): p. 1412-1422.

[7] Higgins, N., et al., The Safewards Program In Queensland Public Hospital Acute Mental Health Settings. Australian Nursing and Midwifery Journal, 2016. 23(11): p. 4

[8] Huber, C.G., et al., Suicide risk and absconding in psychiatric hospitals with and without open door policies: a 15 year, observational study. The Lancet Psychiatry, 2016

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