

## Title Page

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Working towards least restrictive environments in acute mental health wards in the context of locked door policy and practice

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## **Working towards least restrictive environments in acute mental health wards in the context of locked door policy and practice**

### **ABSTRACT**

There has been a shift towards provision of mental health care in community-based settings in Australia. However, hospitals continue to care for people in acute mental health wards. An increasing proportion of the people in wards are admitted involuntarily, subject to restrictions of movement to minimise risk of harm to self and others. In response to concerns about the safety of people absconding from care, Queensland Health introduced a policy requiring all acute mental health wards in the State to be locked. In response, the Queensland Mental Health Commission funded a project to understand the impact of this policy and develop evidence-based recommendations regarding provision of least restrictive, recovery-oriented practices in acute wards. Facilitated forums were conducted with 35 purposively-selected participants who identified as consumers, carers or staff of acute mental health hospital wards, to test the acceptability, feasibility and face validity of a set of evidence-informed recommendations for providing least restrictive, recovery-oriented practices. Participant responses were recorded, and data analysed through an inductive, thematic approach. A recovery-oriented approach was supported by all stakeholders. Reducing boredom and increasing availability of peer support workers were considered key to achieving this. Focusing less on risk aversion was reported as central to enabling true recovery orientation. This project enabled recognition of the perspectives of consumers, carers and staff in the consideration of evidence-informed recommendations that could be implemented to provide least restrictive care in the context of locked doors.

## KEYWORDS

Locked wards, recovery, risk, coercion, absconding

## INTRODUCTION

In 2013 the Queensland Department of Health (known as Queensland Health) introduced a policy directive that required the main entry and exit doors to all acute wards throughout the State to be locked (Queensland Mental Health Commission, 2013).

Queensland has a population of approximately 5 million people and is the third most populous state of Australia. It includes urban, rural and remote communities. The stated purpose of the new policy was to prevent people on involuntary orders from absconding from the ward and thus reduce the risk of self-harm and harm to others. This policy shift had a significant impact on this community of consumers and the delivery of care. It also led to significant criticism from stakeholders (Australian Association of Social Workers, 2013; Australian College of Mental Health Nurses, 2013).

The principle of ‘provision of the least restrictive type of mental health care’ is one of ten basic principles regarding mental health law (World Health Organization, 1996). This principle underlies the current emphasis in Australia, and internationally, on providing care and treatment in the community. If hospital-based treatment is required, service providers also need to consider this principle and attend to the potential to reduce restriction on consumers (World Health Organization, 1996). However, this shift in policy, practice, and law has not prevented a more recent trend toward the locking of acute mental health wards, such as occurred in Queensland (Bowers et al., 2010; Muir-Cochrane et al., 2011).

More routine use of locked doors may be driven by changes in the characteristics of inpatient populations, in the context of ongoing intense pressure on acute beds. Only those with the most serious mental health issues are admitted to hospital as a consequence of this bed pressure, often involuntarily, in acute distress, and then for relatively short stays (Allison & Bastiampillai, 2015). A shift towards locked doors is potentially an unintended consequence of this changing population of people admitted to acute wards.

To understand the impact of locking wards, and to gather perspectives on ‘least restrictive practices’, the Queensland Mental Health Commission (QMHC) commissioned a

two-phase project conducted by the authors in 2014. The first phase was a scoping review of the literature that synthesised available evidence and policy regarding locked wards. The main outcome from the literature review was a set of recommendations about providing least restrictive care in the context of locked doors. The second phase involved facilitated forums with stakeholders, including consumers, carers and staff, about the evidence-informed recommendations. The focus of this paper is the stakeholder forums, but as background, we provide a summary of the literature review.

### Evidence regarding locked doors

Literature included in phase one of the project spanned the years 2000 to 2014. Twenty articles were identified that referred to locked doors or wards. The literature indicated that the practice of door locking is a response to the pressure on services to prevent and manage risk, including consumers harming themselves or others, and in particular to prevent absconding or consumers leaving the ward without permission (Cleary et al., 2009).

Other justifications identified in the literature included releasing staff from spending time on surveillance (Cleary, 2004; Muir-Cochrane et al., 2011), protecting the inpatient community from unwanted visitors and theft, and improving the ability to prevent illegal substances being brought on to the ward (Ashmore, 2008; Haglund et al., 2007; Muir-Cochrane & Mosel, 2008). Even on open wards, there may be circumstances where policy or practical considerations dictate that the doors be locked for all or part of the day or night (Nijman et al., 1997).

However, evidence on the benefits to consumers and staff of locked wards was mixed. Some studies with consumers reported advantages of locked doors such as: protection from outside, a sense of safety, more time for nurses to spend with them, and relief for families concerned about safety (Haglund & von Essen, 2005). Disadvantages of locked wards, reported from the consumer perspective, include lower self-esteem, a sense of being excluded from the world, confinement, and associated irritability (Bowers et al., 2010; Haglund & von Essen, 2005; Muir-Cochrane et al., 2011). Middelboe et al (2001) showed that consumers on locked wards displayed more aggressive behaviours and

perceived less autonomy than those on open wards. Further, there is some evidence to suggest that locked wards were associated with lower satisfaction with treatment (Müller et al., 2002) and higher rates of medication refusal (Baker et al., 2009). Studies that included the staff perspective showed some negative impacts, including the potential for increased workload when staff were required to frequently open the door for consumers and others to enter and leave the locked ward (Haglund et al., 2006; van der Merwe et al., 2009), and increased aggressive confrontations at exit points (Muir-Cochrane et al., 2011).

Despite Queensland Health highlighting prevention of absconding as the primary purpose for its policy change to locked wards, our review of the literature highlighted a lack of evidence that rates of absconding are reduced on locked wards (see for example (Lang et al., 2010)). A review comparing locked and unlocked doors found that rates of absconding were higher on open wards, but that incidents of absconding occurred mostly when consumers were on leave from the ward (Bowers & Stewart, 2011). One study about absconding conducted in an Australian secure locked ward highlighted that a majority of consumers who abscond, do so when they are on unescorted leave from the ward either within hospital grounds or out in the community (Scott et al., 2014). The commonly cited reasons for absconding while on unescorted leave include consumers feeling unsafe in the ward, potentially due to the effects of mental illness, but also due to the relationships with staff and other consumers (Muir-Cochrane et al., 2013), isolation from family and friends, feeling trapped, confined, bored, or frustrated (Bowers et al., 2003; Bowers et al., 1999).

The final task within phase one was to review policy documents. Australian policies regarding acute mental health services make little mention of ‘door locking’ policies and procedures in services (ref our report here). By contrast, key policies devote considerable space to recovery-oriented practice and least restrictive care (Commonwealth of Australia, 2009a, 2009b, 2013). Recovery-oriented practice has been defined as:

“person-centred, strengths-based, collaborative and empowering. Consistent with the goals of self-determination and enabling people to pursue meaningful lives in the community despite the lack of a cure for their condition, advances in psychiatric rehabilitation focus on enhancing functioning and supporting people in taking part in routine adult roles in the community such as employment, education, and socialization” (Davidson et al., 2009, p. 326).

The review of literature and policy resulted in the development of preliminary evidence-informed recommendations for the provision of least restrictive care in the context of locked doors under five key themes. The themes; risk issues, recovery orientation, policy and procedure, routine and environment, and staffing, were derived from evidence about perceived disadvantages of locked doors from the perspectives of consumers and staff, whilst incorporating policy directions of recovery-oriented care. Within each theme were two to four recommendations. Informed by findings from the review phase, the second phase of the project involved seeking stakeholder perspectives on the preliminary recommendations.

The aim of this paper is to describe the research process and findings from stakeholder facilitated forums that revised and approved a set of evidence-informed recommendations, to improve the least restrictive practices of acute mental health wards within the context of a locked doors policy in Queensland, Australia.

[Insert Table 1 here]

## METHODS

### Study design

This study used facilitated forums to gather the perspectives of people with lived experience (hereafter referred to as consumers); carers, family members, and support persons (hereafter referred to as carers) and staff with experience of mental health wards about moving toward least restrictive, recovery-oriented practices, considering the policy shift towards having permanently locked doors. Forums were held in regional and urban locations of Queensland.

### Sampling and recruitment

Participants were initially recruited using a purposive sampling frame. Eligible individuals had relevant experience of acute wards as a consumer, carer, or staff member, and were willing and able to participate in a forum about least restrictive practices, including locked and unlocked wards. Additional participants were recruited via snowball sampling, whereby those already contacted agreed to contact others who might be interested and able

to participate. In the initial stages, the QMHC Advisory Group members and forum facilitators contacted eligible individuals who they thought would like to participate and provided them with information about the study via email and/or telephone. Efforts were made to ensure that a diverse range of people were approached including a mix of gender, age, cultural background (although participants needed to be able to contribute to the discussion in English), and experience across Queensland's mental health system.

Potential participants were asked to contact the researchers if they were interested in being involved, at which point they were given further information including a Plain Language Statement to assist them in deciding whether to participate. Consistent with the UNCRPD (United Nations, 2006) and local mental health legislation and policy (Victorian Government, 2014), participants were presumed to possess the legal capacity to consent if they chose to participate after receipt of this statement emphasising voluntary participation and their right to withdraw at any time. Each forum included either consumers, carers, or ward staff from any of the following professions and roles: medical, nursing, allied health, leadership, administrative, peer worker and/or security staff. Each forum was open to a maximum of 10 participants. All participants other than paid staff received an AUD \$60 shopping voucher, in recognition of their time.

## Data collection

Each forum was led by two facilitators. The facilitators of the staff forums were from the research team. The forums involving consumers or carers were facilitated by a member of the research team, together with a locally-based facilitator with lived experience. The inclusion of lived experience co-facilitators was designed to improve recruitment and engagement with participants, and enhance the quality of the discussion. The co-facilitators also assisted in data analysis, thus enabling an ongoing lived experience perspective during the analysis and identification of findings.

A summary of findings and recommendations from the literature review (as shown above, Table 1) was sent to participants prior to each facilitated forum. The summary document was used as the basis for the group discussion. The forum process was informed by a nominal group technique (Gallagher et al., 1993) in which participants were requested

to prioritise their most preferred and least preferred recommendations (described as their 'top three' and 'bottom three') and explain their choices. Facilitators ensured that all participants had the opportunity to share their initial individual opinions and then discuss these as a group. These discussions generated both quantitative and qualitative data.

Prioritisation of the three most or least preferred recommendations was used as a guide only. Participants could discuss as many or as few recommendations as they thought appropriate. Consequently, many participants did not identify any of the recommendations as their bottom three, and several participants identified a top five or six recommendations. Forums were free flowing: if a theme emerged that was not captured in the preliminary recommendations, the facilitators allowed the discussion to develop and asked follow-up questions. Forums were audio-recorded and transcribed verbatim. Ethics approval for this project was provided by The University of Melbourne's Human Research Ethics Committee (Project number: 1442150.1).

## Data analysis

A priori codes were developed in line with the recommendations from the literature review. Additional themes were developed using an inductive process as transcripts were coded (Thomas, 2006). The coding was then analysed to identify patterns across and within the groups. NVivo software (QSR International Pty Ltd, 2012) was used to manage and code the data. Coding was conducted by two members of the team (authors one and five) to ensure consistency and accuracy. Transcripts were also analysed to identify key themes regarding participant perspectives on each of the recommendations. These were used to revise and refine the preliminary set of recommendations. To extend the rigour of analysis, the lived experience co-facilitators and the QMHC Advisory Group members, in addition to the researchers, were given the opportunity to comment on the preliminary results. This interpretive triangulation enhanced the analysis to enable a 'comparison and convergence of perspectives to identify corroborating and dissenting accounts, and so as to examine as many aspects of *the research issue as possible*' (Fossey et al., 2002, p. 728).

## RESULTS

In total, 35 people participated in five forums. Two staff groups and two consumer groups were conducted: one each in a regional centre and a metropolitan area. One carer forum was conducted in a metropolitan area. Table 2 shows the demographic characteristics of participants from each stakeholder group.

[Insert Table 2 here]

### Prioritising the recommendations

Figure 1 shows the proportion of participants who rated each recommendation in their top three.

[Insert Figure 1 here]

All participants endorsed the recommendation that acute wards should take a recovery-oriented approach. This was discussed at length in every forum, with many of the recommendations in the Recovery Orientation category (see Table 1) rated highly by participants. Reducing boredom (recommendation 6) was the most highly rated recommendation across all groups. It was the most frequently endorsed by staff and consumers, and the second most frequently endorsed by carers. No participant rated this recommendation in their bottom three.

[Y]ou know you might be having a really crappy day, but you can sit and get lost in [an activity] and you don't want to sit in a group, and you don't want to sit in the courtyard and talk, you don't want to converse with a nurse or whoever, but you want to get lost in whatever you're doing, whether you're beading or drawing or painting or, and it might be a dark painting but hey this is how I feel on the day. (consumer)

Meaningful activities were an important aspect of reducing boredom for many participants. Meaningful activities also assisted to reduce the feeling of being restless, manage the 'bad days', reduce the desire of consumers to abscond, and provide consumers with choices in

their day. Aside from general support for this recommendation, there were also comments regarding the types of activities that may be useful. Many participants emphasised the importance of engaging in purposeful activities and healthy living. Participants discussed the need for opportunities to include physical and creative activities and learning new skills. The ‘dignity of choice’ for consumers was also raised in terms of having the choice at any time to engage in an activity and to have breadth of choice in the types of activities available.

I probably look at it that you’ve got a choice, you could sit and watch telly if you want, you can sit out in the courtyard, but a lot of the time when you're on a ward your choices are taken away from you, you know you're medicated, you know you're there sometimes under your, you don't want to be there, so it's about having that choice. (consumer)

Many participants focused on the need for wards to have peer support workers who spend time with consumers and their families. Participants representing all groups endorsed increased peer support (recommendation 7), making it the second most highly rated recommendation. Staff specifically focused on the need for peer support workers to be appropriately trained and supported in their roles. Further, they highlighted the value placed on having someone who has their own lived experience to support consumers.

I think it's the lived experience that you cannot get from staff. The staff get their knowledge from their training but they don't have the experience of it and sometimes what you want to hear is someone who's actually experienced this. (Staff)

Participants suggested that the most effective way a peer support worker can provide support is by listening and sharing their recovery story, providing advocacy, and being a consistent support person for individual consumers from admission to discharge.

Continuity, quality and experience of staff (recommendation 14) was the third-highest rated recommendation. Participants placed a great deal of importance on having consistent nursing staff who had specific mental health training, and who could offer

continuity of care for consumers. Continued professional development (PD), particularly around recovery-oriented practice, was also seen as important. Yet for staff who had worked in a non-recovery way for many years, it was anticipated that this would require a significant shift in thinking.

I want to qualify that, you know, saying you want quality and experience of nursing staff doesn't mean you want someone who's been doing it for 40 years and very dated because some of the best experiences that I've had either as a patient or as a carer when family have been in has been actually from quite young and passionate and enthusiastic and really caring young new staff. (Carer)

In contrast, management of ward entry and exit (recommendation 13) was universally regarded as the lowest priority recommendation. Staff believed it was deskilling and demoralising, and consumers thought that it would increase the custodial feel of the ward. It was acknowledged by many that managing the door in the context of the locked door policy was challenging. Staff highlighted various difficulties that may adversely affect consumer care, including an increased need for surveillance and an increase in the custodial feel of the ward.

Recommendations in the Routine and Environment category; reception and welcome service (recommendation 10); decrease custodial features (recommendation 11); increase privacy and safety (recommendation 12), received a moderate degree of endorsement from participants. Carers were much more likely than staff or consumers to endorse these recommendations as a priority. There was recognition that gender-specific areas would increase consumers' sense of personal safety on the ward and may help to reduce any absconding caused by the threat or experience of sexual harassment and assault. Some staff noted that the custodial features of the ward had a negative impact on consumers and that these features may have perpetuated stigma, as one staff member explained things consumers had said in the past:

[T]he custodial features of the ward is a huge thing, it's probably the biggest, is [comments made by consumers] “I feel I’ve been in prison”, “I feel like I’m being punished”, “why am I being treated this way”, yeah that’s probably – if I was going to start anywhere it would definitely be there. (Staff)

One of the key themes that emerged from the forums was in relation to the environment; specifically, the impact that changing one aspect of the environment, such as permanently locking the doors, has on the use of space. In particular, participants noted that locked doors restricted access to outdoor and other recreational and therapeutic spaces, and increased difficulties for visitors.

Overall, participants did not endorse recommendations in the Risk Issues category anti-absconding program (recommendation 1); ban illicit substances (recommendation 2); more intensive support (recommendation 3), even though issues around risk and safety on inpatient wards were embedded in many of the other recommendations. Participants noted that the use of inappropriate, criminalising and blaming language in the recommendations resulted in them not endorsing the recommendations.

And you know again we look at the language, if we look at the risk issues number 1 says you know close monitoring of people with a history of absconding, that’s criminalising language. (Carer)

Some parts of these recommendations were more positively received by participants, such as the careful and supportive breaking of bad news (part of recommendation 1) and providing more intensive nursing and peer support staff on the ward (part of recommendation 3).

The reality is you never stop it [absconding], someone will always find a way. I agree with the careful and supportive breaking of bad news to patients. (consumer)

In contrast with the consumers' and carers' views that more supportive contact was needed, staff participants typically believed that to some extent this recommendation was already part of everyday practice with nursing staff.

There was a rejection of the proposal to closely monitor people with a history of absconding or at risk of suicide or self-harm, specifically from the carer group, who seemed to be reluctant to endorse the singling out of individuals.

It's part of the culture that peer support workers go in naturally normally for the psychiatric conditions that are there in each person and if I want to self-harm or if I want to commit suicide that peer support person is going to be able to talk me through that and get my trust and be able to overcome that. I don't like the idea that I'm the only person who has a special intensive peer person who's good at self-harm and suicide. (Carer)

The recommendations in the Policy and Procedure category; explain door locking decisions (recommendation 8); and ward rules and routines (recommendation 9), received a low degree of endorsement, even though a small number of staff and consumers rated them as a high priority. As one consumer pointed out, *'Even if you don't have control or choice, at least you share that information; you're not being kept in the dark'*. The tenor of the discussion, however, was that this recommendation should be more about providing a formal orientation to the ward policies and procedures for all consumers at or as close to their admission as possible.

I think it'd be important like an orientation, you know, first day, come in, these are our policies here and you can read them, doors locked between these times, within reason. To be able to go in the first day, rather than getting in there and slowly finding out more and more things you can't do, yeah. (consumer)

Another emerging theme that arose from discussions with carers and consumers about ward policies and procedures was having a tiered or discretionary approach to locking doors. They proposed that a locked ward could be available for consumers who are either in crisis or at risk of harming others, but that this should be for as short a time as possible.

Consumers agreed that there '*needs to be alternatives*' to permanently locking wards, however both staff and carers acknowledged that a tiered approach, with more of a focus on recovery 'requires more staff, more resources and more money'.

At the intersection of themes of risk, policy and staffing was the emergent theme of the culture of wards and the overall culture of the organisation – specifically, how the culture can impact upon the experience of consumers and staff from a recovery-oriented perspective. There was a sense from all participants that to have a truly recovery-oriented service, changes needed to occur at the organisational level. Staff described the current tension between recovery-oriented practice and organisational risk aversion.

On one hand, [the government is] saying we need to give people freedom to experience recovery to make mistakes to learn from those mistakes and on the other hand they're saying lock the doors put monitors on people make sure nobody escapes because the Minister doesn't like it. And so as a result of all of that we've got this very risk-averse organisation that we work for. So there's mixed messages one day we're recovery orientated and the next day lock the doors. (Staff)

Carers were clear in their preference for a recovery-oriented culture.

We've got to focus on hope and recovery and not risk aversion at the cost of everything else. (Carer)

## Revision and endorsement of recommendations

Forum participants provided suggestions about reorganising and rewording recommendations. Three overarching themes emerged:

1. Organisational culture
2. A tiered or discretionary system of care
3. The value of peer support

These themes underpinned new recommendations that were more specific than those in the preliminary recommendations. Taking account of these and the priority coding of recommendations by participants, the preliminary recommendations summarised in Figure 2a were amended and are presented in Figure 2b. New recommendations are highlighted in the darker boxes, as is the new group of recommendations grouped into a category 'Organisation and Staffing'. The most notable change from the preliminary recommendations was that, based on stakeholder feedback, recommendations in the 'Risk Issues' category were removed. Issues around risk and safety were thought to overlap with many of the other recommendations, which tended to be more recovery-oriented and positively framed. In this context, the recommendation regarding extra support for suicide and self-harm was also omitted. The findings instead suggested the need for new recommendations focussed on staffing, such as peer support workers being clearly part of the staff team in wards and having access to training and supervision. In addition, a stronger organisational focus on recovery-oriented practice was key. Part of this was the recommendation to ensure a growing presence of peer workers on all wards for more of the time.

[Insert Figure 2a here]

[Insert Figure 2b here]

## DISCUSSION

This paper described the findings of stakeholder facilitated forums to revise and approve a set of evidence-informed recommendations, to improve the least restrictive practices of acute mental health wards within the context of a locked doors policy in Queensland, Australia. Recovery orientation was highlighted by consumers, carers, and staff as the most important factor in supporting least restrictive practices; reducing boredom was the highest rated recommendation. The terminology of 'reducing boredom' and 'meaningful activity' is intrinsically linked to a recovery orientation because it emphasises choice and involvement in something which is personally meaningful (Le Boutillier et al., 2011).

Although initial recommendations were based on a review of the evidence, those that were not endorsed by participants tended to be those that were not recovery-oriented and seemed custodial – such as the anti-absconding program. Further, having a recovery orientation and a focus on reducing boredom was viewed as the highest priority for change, as this was seen as likely to impact upon other recommendations. For example, ‘risk issues’ such as absconding, suicidality and illicit drug use may be reduced when there is a strong commitment in the ward to meaningful activities and assisting consumers to stay connected and engaged. This notion is supported by research in an Australian forensic setting, which highlights that the physical, mental and social wellbeing of consumers may be enhanced when consumers have more choice and control to engage in meaningful activity (Farnworth et al., 2004). Furthermore, positive interactions with other consumers and good therapeutic relationships with staff enhance consumers’ perception of the inpatient unit as a safe place, and reduce the likelihood of consumers attempting to abscond (Muir-Cochrane et al., 2011).

Participants highlighted that restrictive practices were at odds with recovery-oriented practice (Curie, 2005; Huckshorn, 2004). Stakeholders agreed that embedding a recovery-oriented approach in practice would require organisational commitment, training and potentially changes to the staff profile. Research has highlighted that ultimately organisational commitment is required to fully embed a recovery-oriented approach (McKenna et al., 2014; Slade et al., 2014).

Strengthening the presence of peer support workers in wards was highly valued by all participants, who agreed that all consumers should have access to a peer support worker during their inpatient admission, including at the time of admission. Research highlights that the addition of peer support workers to wards supports a shift to recovery-oriented services (Holmes et al., 2013). Further, ‘leadership towards organisational change’ and ‘consumer roles in inpatient settings’ are two of six strategies recommended by the US National Association of State Mental Health Program Directors for reducing restrictive practices, such as seclusion and restraint, in inpatient settings (National Association of State Mental Health Program Directors, 2006). Locking doors of wards is clearly a kind of restriction, though not one of the restrictive practices explicitly within focus of the 6 core

strategies. Emerging research suggests that this and similar multi-level strategies may be effective in reducing restrictive practices, including the use of locked doors (Azeem et al., 2011; Bowers et al., 2015; Fletcher et al., 2017).

The use of positive and non-blaming versus criminalising language was discussed at length in all forums. Through this lens, all recommendations were reviewed to ensure that they were framed using positive, inclusive and respectful language. This added further weight to removing the 'risk issues' recommendations, as stakeholders believed that risk and safety were already embedded in many other recommendations. A recovery perspective encourages a shift from being strongly risk averse to being more prepared to tolerate risk, as this enables more consumer choice and empowerment in the context of a recovery-oriented approach (Commonwealth of Australia, 2013). Stakeholders' focus on recovery orientation and the need to move away from practices that originated from a risk averse perspective are in keeping with the arguments presented by Slemon et al. (2017), who propose that the risk management culture which currently drives acute mental health wards needs to shift. Evidence suggests that practices dominated by safety and risk perspectives, such as door locking, perpetuate harmful practices and prevent meaningful therapeutic engagement between consumers and staff (O'Hagan, 2004; Slemon et al., 2017).

The present study built on a review of the evidence, by incorporating the voices of a diverse range of stakeholders, adding consumer, carer and staff perspectives to synthesised evidence-based recommendations. One notable limitation of the study is that recruitment was limited to a small number of consultations in a short timeframe. Therefore, despite efforts to include a diverse range of participants, we may not have sufficiently captured the perspectives of some groups in the community, including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse populations, young people, and those in regional and remote locations.

## CONCLUSION

This project enabled the perspective of consumers, carers, and staff to be recognised in the consideration of evidence-informed recommendations that could be implemented to provide least restrictive care in the context of locked doors. A universal approach to locking

wards as a solution to the problem of people being absent without permission (or absconding), following critical events such as suicides, has been adopted in some jurisdictions including Queensland, Australia. However, the available evidence does not provide strong support for this policy. For example a 15-year multi-site observational study conducted in Germany has found that compared to open wards locked wards may not be able to prevent absconding (Huber et al., 2016). The current project suggests that many key stakeholders also prefer alternative approaches, that, if implemented, could support progress towards alternative solutions. To support a less restrictive environment, this project has identified a set of recommendations informed by a literature review and the perspectives of consumers, carers and staff who have lived experience of acute mental health wards. The stakeholder forums highlighted the importance of having a culture that rejects restrictive and coercive practices and embraces recovery-oriented practices.

## RELEVANCE TO CLINICAL PRACTICE

Addressing the issue of boredom may be key to providing a safe and recovery-oriented environment on acute mental health wards. To enable this, it appears that the culture in these wards needs to shift from being strongly risk averse to being more prepared to tolerate risk and promote safety and therapeutic relationships, as this enables more consumer choice and empowerment (Slemon et al., 2017). Consumers on wards need to feel more connected to their friends and family. The introduction or increased presence of peer support workers was strongly supported as a strategy to enable a less restrictive environment and a more recovery-oriented approach on acute mental health wards.

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## TABLES

Table 1. Preliminary recommendations informed by review of literature and policy documents.

<b>Recommendation Category</b>	<b>Number</b>	<b>Recommendation description</b>
Risk issues	1	Each inpatient unit to develop an anti-absconding program that may include strategies such as using a sign-in and sign-out book, careful and supportive breaking of bad news to patients, close monitoring of people with a history of absconding.
	2	Explicitly ban illicit drugs and alcohol, including making and implementing penalties for bringing these substances on to the ward.
	3	Provide more support via intensive nursing and/or peer support to people at risk of suicide or self-harm.
Recovery orientation	4	Increase contact between patients and important others by encouraging the presence of families, friends and other supporters on the ward.
	5	Increase and encourage opportunities for people to stay in touch with their informal support network and homes (may relate to issues like having phones, internet access, Skype, computers available to increase communication). Use technology to stay connected.
	6	Reduce boredom on the inpatient unit by providing more engaging and active programs with a choice of activities.
	7	Include more peer support workers on the ward who have a fundamental role of spending time with patients and their carers (also relevant to staffing).
Policy and procedure	8	Actively explain door locking decisions on a daily basis depending on a transparent set of factors and processes. Provide clear information about the decision and monitoring arrangements that is communicated to patients, staff and carers (perhaps through an information or bulletin board).
	9	Provide a clear explanation of ward rules and daily routines,

		emphasizing patient priorities of comfort, personal safety and how to access support.
Routine and environment	10	Make initial contact more personable by having a reception/welcome service at each ward that welcomes and monitors all visitors.
	11	Decrease impersonal and custodial features (or non-caring environment) of the ward through creating more appealing and liveable spaces in the ward via décor, family friendly spaces, tea/coffee facilities.
	12	Increase the sense of privacy and safety through strategies, such as considering factors such as gender and age in the allocation of bedrooms. This may include having women only areas.
Staffing	13	Manage safe entry and exit to the ward without delay by having one nurse or other mental health practitioner on duty who negotiates exits and entry so that others do not have this impinging on their work.
	14	Improve the quality and experience of nursing staff on the ward and ensure more continuity of staff in teams (keeping casual/agency staff to a minimum).

Table 2. Participant demographics.

	<b>Patients n=9</b>	<b>Carers n=9</b>	<b>Staff n=17</b>	<b>Overall n=35</b>
<b>Gender</b>				
Male	5	1	6	12
Female	4	8	11	23
<b>Aboriginal or Torres Strait Islander</b>				
Yes	2	0	0	2
No	7	9	17	33
<b>Age</b>				
Mean	44	61	40	45
Range	29-62	46-73	23-56	23-73

Figure 1. Percentage of participants who endorsed each recommendation, by group.

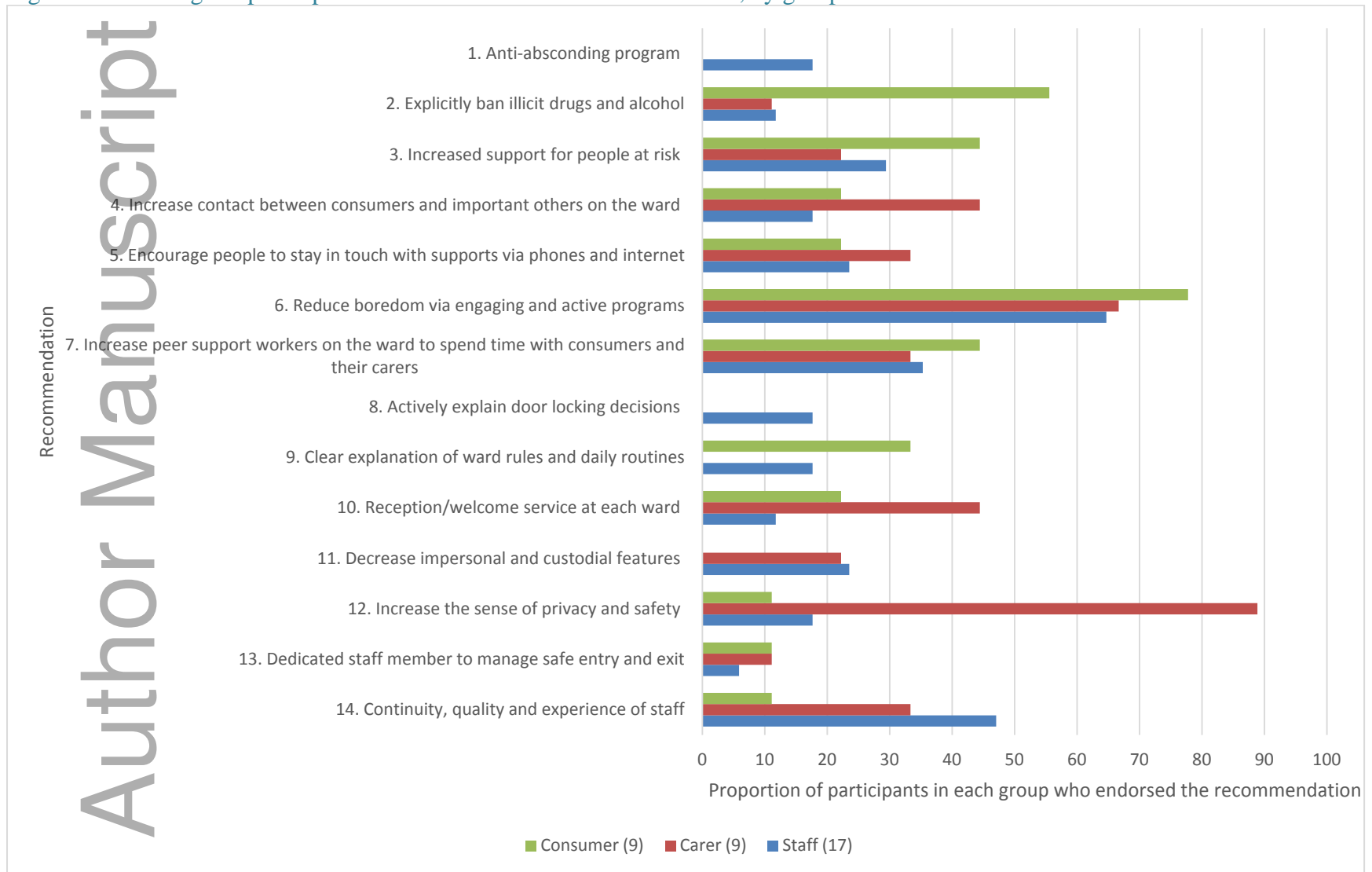


Figure 2a. Summarised preliminary recommendations informed by review of literature and policy documents.

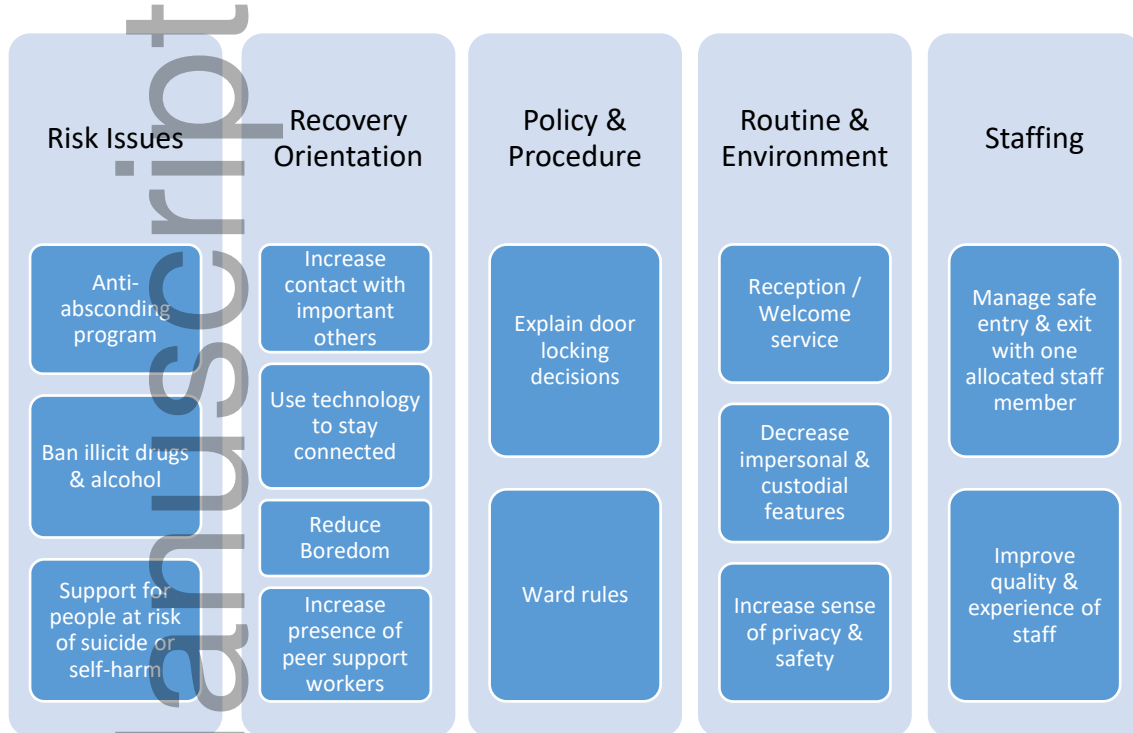
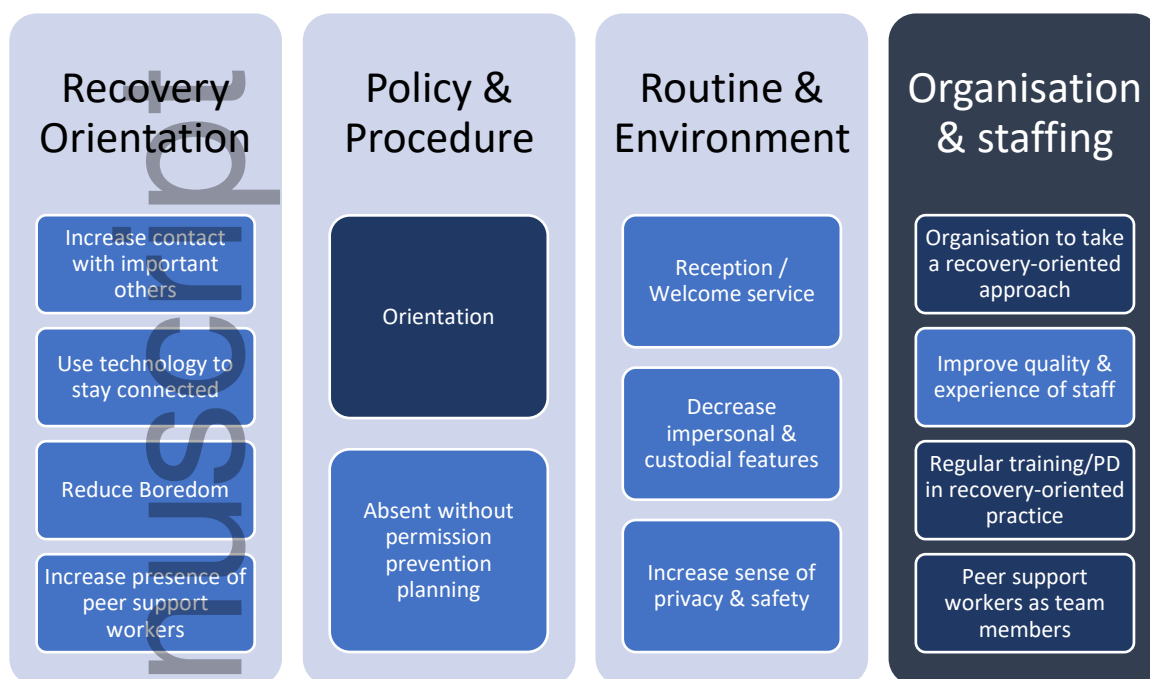


Figure 2b. Revised recommendations.



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