



Least restrictive practices in acute mental health wards including consideration of locked doors: A literature review and recommendations for future practice

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Table of Contents

Plain Language Summary	3
Recommendations	4
Introduction	7
The Current Project.....	9
Methodology.....	11
Findings	13
Discussion.....	25
Recommendations	30
References	32
Appendix A.....	37
Appendix B	42

Plain Language Summary

The aim of the project is to identify the best ways of working with consumers in acute units, so that care is least restrictive of people's freedoms and is about recovery.

We have reviewed international research and Australian policy, to find out what the best practice is and what the impact of locking doors on the people involved is. Below is a summary of what these documents tell us.

What evidence is there regarding least restrictive practices?

Least restrictive care is an ideology which underpins the delivery of services to consumers across settings, however it is not well researched. Most research about least restrictive strategies has a focus on strategies for an individual, not on practice across a ward. For example, the restriction of the locked ward is avoided by using a Community Treatment Order, instead of admission. One study showed that an , 'anti-absconding program' can reduce the rate of 'absconding' and therefore reduce the need to lock doors.

The small amount of work on recovery-oriented practice in acute wards suggests that it will involve:

- a focus on consumers' strengths
- consumers having choices about what interventions are offered
- good working relationships that shape how interventions are (respectfully) offered
- re-thinking the core business of the unit, away from treat-first-&-then-recover
- promoting consumers' citizenship and connection to the community, whilst in acute units
- staff being educated and knowledgeable about recovery and well supported in recovery-orientation by the organisation

What does research tell us about the impact of locked doors?

The evidence is mixed about how locking doors impacts people. Research has been based on observations, interviews, surveys, a trial and service reports about things like length of admission, 'absconding' or conflict. Some studies suggest that:

- consumers, carers and staff feel relieved and safer (from outsiders) in a locked ward
- consumers feel like prisoners, demoralized and irritable in locked wards

- staff feel that the message of locked doors is un-caring
- consumers 'abscond' at a similar rate from both locked and open wards
- there is slightly more aggression in units that are locked
- rates of suicide are not greater in locked or open wards
- there is less substance use in units that are locked
- in open wards staff are preoccupied with monitoring where consumers are
- consumers have more time talking with staff in a locked ward
- staff tend to prefer the system they know best, whether locked or open

This is a complicated topic. Overall, the research evidence about the benefits and problems of locked doors in acute mental health units is limited in size and not strong. More, well-designed research is needed.

What do the national and state policies say is best practice?

All policies are clear in saying that wards should be recovery-oriented and least restrictive. On that basis it seems that acute psychiatric inpatient units should start from a position of being open, with sound principles and decision processes in place, for times when the most appropriate status for a given period of time may be to lock the ward.

No policies spell out how to decide when a ward is locked or what to do to manage a locked ward for the best benefit to consumers. Local policies may be more specific on this issue.

Recommendations

Recommendations relevant to **risk issues**:

- 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 consumers, close monitoring of people with a history of absconding etc.
- Explicitly ban illicit drugs and alcohol, including making and implementing penalties for bringing these substances on to the ward.

- Provide more support via intensive nursing and/ or peer support to people at risk of suicide or self harm

Recommendations relevant to taking a **recovery orientation**:

- Increase contact between consumers and important others by encouraging the presence of families, friends and other supporters on the ward
- 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 etc available to increase communication)
- Reduce boredom on the inpatient unit by providing more engaging and active programs with a choice of activities
- Include more peer support workers on the ward who have a fundamental role of spending time with consumers and their carers (also relevant to staffing)

Recommendations relevant to **policy and procedure**:

- Actively explain any door locking decisions on a daily basis depending on a transparent set of factors and processes. Provide clear information about the decision plus monitoring arrangements (ie. how long doors are going to be locked for etc) that is communicated to consumers, staff and carers (perhaps through an information or bulletin board)
- Provide a clear explanation of ward rules and daily routines, emphasising consumer priorities of comfort, personal safety and how to access support

Recommendations relevant to **routine and environment**:

- Make initial contact more personable by having a reception/welcome service at each ward that welcomes and monitors all visitors (noting that this may be difficult to incorporate into aged facilities).
- 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
- 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 (noting that this may be difficult to incorporate into aged facilities).

Recommendations relevant to **staffing**:

- 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
- 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)

Introduction

In this report we review the literature relevant to restrictive interventions in acute mental health inpatient units, in particular the evidence regarding the impact of locking the doors in these settings. The literature included also relates to the application of a recovery-oriented approach as it applies to acute inpatient psychiatric settings. We also review national, state and local mental health policies (where available) to provide insight into the extent that door locking and recovery-oriented practices are discussed in relation to acute inpatient psychiatric settings. Conclusions are drawn about the key themes emerging from the review. The report concludes with a set of recommendations regarding the delivery of mental health care in Queensland, with specific reference to least restrictive practices.

Background

In the past decade policy reforms have influenced the restructuring of mental health services in Australia and internationally. In the context of contemporary mental health care service delivery, acute care facilities are part of a wider service network where most care is located in community-based settings. Acute inpatient care is designed to provide systematic assessment and short-term intensive treatment for people who are unable to be treated adequately in a less restrictive, community-based setting. Inpatient psychiatric care focuses on people in crisis who are experiencing acute symptoms of serious mental illness. What is offered is an 'intensive' unit of care. Door locking on acute psychiatric wards is becoming increasingly common in Australia and in a number of other developed countries, such as the UK. While this change may resolve concerns about risk issues and the potential vulnerability of patients, locking doors also leads to many unintended negative consequences.

In 1996 the World Health Organisation (WHO) published ten basic principles regarding mental health care law which have since influenced policy regarding the availability and delivery of mental health care (World Health Organization, 1996). Of particular relevance here is the principle of 'provision of the least restrictive type of mental health care' which intends that, where possible, individuals with a mental health disorder should be treated in the community and when it is deemed necessary for people to receive institution-based treatment that it be delivered in the least restrictive environment. For the purpose of this review we will use the term least restrictive care. In addition, the principle of self-determination articulates that a person's bodily or mental integrity, and their liberty, shall not be interfered with without express consent from the individual, or with consent from another authority in

the rare case where the individual does not have capacity to consent for themselves (World Health Organization, 1996). Although the issue of having locked or unlocked doors to mental health wards is not discussed specifically, it can reasonably be concluded that the locking of wards is also at odds with the guiding principles of mental health care delivery as stipulated by WHO.

While principles such as those defined by WHO have guided the development of mental health services in Australia, they have not prevented a more recent trend toward locking the doors of inpatient units. The main reasons cited in the literature for why doors are locked include to:

- 1) promote safety for patients who might leave (abscond) and harm themselves or others in the community;
- 2) free staff from intensive observation/monitoring/surveillance tasks so they can spend more time performing therapeutic activities;
- 3) protect patients and staff from unwanted visitors, from potential theft and from illegal substances being brought onto the ward;

Changes in characteristics of the inpatient population appear to have influenced the more routine use of locked doors. Much of the current literature notes that only the most severely ill patients are admitted to acute care wards, often involuntarily, and that this change in the patient profile necessitates the locking of doors. Furthermore, 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.

Previous literature regarding locked psychiatric wards

A literature review undertaken by van der Merwe et al (2009) identified 17 empirical studies exploring staff and patient experiences of being on a locked versus open acute psychiatric inpatient ward. Self-administered questionnaires, interviews and medical/administrative records were the primary sources of data. Sample sizes tended to be small and most samples were non-representative. The majority of studies were published more than 15 years ago: eight papers reported on data collected in the 1950's and 60's. The relevance of these findings to mental health care policy and practice today is highly questionable, given the pace of structural change in psychiatric service delivery.

The review found little conclusive evidence to support the practice of locking adult inpatient acute care wards. Overall, the impact of door status on patient and staff experiences was equivocal. Studies on

staff preferences generally favoured an open ward environment, although there was some evidence to suggest that current policy on door status influenced this preference (i.e., those currently working on locked wards preferred this option when asked). Although patient preference was less clear, there was some evidence to suggest that patients perceived the locked door as a security or protective measure, keeping them safe from harms to themselves and the community outside the locked door. Staff also noted this protective effect (van der Merwe et al., 2009).

The review showed little evidence of an impact of door status on patient compliance or safe behaviour. There were no clear associations between having a locked ward and preventing or reducing absconding, in-patient suicide or substance use, even though these factors were commonly cited by staff as reasons for having a locked door. A number of studies showed that absconding incidents occur on both open and locked wards, with little variation between the two. Inpatient suicide is a very rare event and no study included in this review had sufficient data available to analyse the effect of door status on suicides. Although a number of studies reported that substance use was common on psychiatric wards, there was also no evidence to suggest that this was related to having a locked or open ward. One study explored the effect of a locked door environment on aggression and showed a slight increase in aggressive incidents when the doors were locked. This experimental study was carried out in the UK in the late 1950's and as such, the results should be viewed with caution. The most striking conclusion from this review was the lack of recent research into the effects of a locked door policy in acute psychiatric care settings (only seven research papers were published between 1999 and 2009). Given the marked shift in mental health care away from institutional-style, punitive measures to more community-based restorative approaches, there is a clear need to understand this approach to security in the contemporary mental health care context (van der Merwe et al., 2009).

The Current Project

On December 15 2013 Queensland Health made an order that the main entry and exit doors to all acute mental health inpatient units throughout the State be locked. The stated purpose of the new policy is to prevent absconding of involuntary patients and thus reduce the risk of self harm and risk of harm to others. In this context, voluntary patients and involuntary patients with leave entitlements should maintain their right to leave the ward (Director of Mental Health, 2013).

Queensland has 16 mental health hospital inpatient facilities throughout the state. The Queensland Mental Health Commission (QMHC) noted that on 30th June 2013 there were around 600 patients in acute mental health inpatient units in Queensland. The Commission further noted that over 25% of these patients were voluntarily seeking treatment. Also among these patients were 36 forensic patients and 6 'special notification forensic patients' who were accommodated in secure High Dependency Units, i.e. locked wards.

People living with mental health problems are some of the most vulnerable people in our society. As such, it is of paramount importance that their health care be provided in the least restrictive and most recovery-oriented manner possible. It is equally important that the voice of relevant stakeholders is taken into account when significant changes to mental health policy is considered, such as the locking of all acute mental health inpatient units.

The purpose of this project is to provide a review of the literature on the system elements (e.g., legislation, leadership, governance, human resources, workforce, education, training, funding, physical infrastructure, policies, programs, practices and processes) necessary to move towards a least restrictive environment in acute mental health inpatient units in Queensland, particularly in relation to the debate about locked or unlocked facilities. A second aim of the project is to facilitate discussion with consumers, families, carers, support persons and clinical staff regarding the extent to which those system elements are in place in Queensland.

The key questions to be answered by the literature and policy review are:

1. What evidence is there regarding least restrictive practices?
2. What evidence is available regarding the impacts of locked psychiatric wards?
3. What do national, state and local policies indicate is best practice with regard to locked wards?

Methodology

The objective of the literature review was to systematically identify, critically evaluate and synthesise relevant information from refereed journal articles and national, state and local mental health policies.

Search Strategy

The review of literature was conducted by comprehensively searching relevant academic databases (e.g., Medline, PsycInfo, CINAHL) and a range of on-line full text journals in order to identify relevant peer-reviewed literature. The search terms used were: least restrictive care in mental health, recovery-oriented practice, locked ward, open ward, safety and security.

The review of policy documents was conducted by searching each document for key terms: locked door, least restrictive, recovery-oriented, safety, security, access.

Potentially relevant policy documents were examined and the following questions were considered:

- What timeframe does the policy cover?
- What jurisdiction does the policy cover – national, state or local?
- Does the policy mention least restrictive care?
- Does the policy mention recovery-oriented practice?
- Does the policy mention locking doors?

Inclusion and exclusion criteria

Electronic searches of databases were conducted to locate studies that were published after 2000. In the case of literature on locked wards, studies published after 2009 in the first instance were included, as we were using the review published by van der Merwe et al., (2009) as our starting point, however we extended our timeframe when it became apparent that there were other pertinent articles available in the literature which had not been included in the van der Merwe review. Following this initial search, abstracts were searched for relevance.

Papers relating to least restrictive care and recovery-oriented practice were retained when they specifically addressed issues in acute psychiatric wards. In terms of door status, only empirical studies in which the main focus of investigation was door status on acute psychiatric wards were retained. Studies were excluded if door status was only a minor variable in the study and, therefore, did not contribute important information to the review. Qualitative studies were retained when they contributed new information or covered areas that quantitative studies had not fully explored. Reviews of the literature on topics relevant to door status were also included.

All available national, state and local policies that were available were included in order to provide context around the extent of coverage in policy documents on locked doors in acute psychiatric settings and recovery-oriented practice.

Information Sources

The information sources searched include the following:

- Medline
- Psycinfo
- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- Proquest
- Sage Journals on-line
- Google Scholar
- Commonwealth Government Websites
- State Government Websites (NSW, Victoria, Queensland, South Australia, Tasmania, Australian Capital Territory, Western Australia)

Findings

Literature Review

This literature review brings together evidence from the literature regarding the least restrictive care in mental health and the application of recovery-oriented practice within acute inpatient mental health care facilities, as well as empirical studies investigating the use of locked doors in acute inpatient mental health care facilities, with a view to identifying best practice care. We have not solely focused on research with involuntary patients as many acute psychiatric inpatient units have a mix of both involuntary and voluntary patients at any given time and thus the door locking policy affects all patients regardless of their legal status. This process resulted in a total of 47 empirical papers on the topic.

Overview of least restrictive care in mental health

The identified papers were found using 'least restrictive care' as the search term. The five papers included here were selected because they discuss the principle of least restrictive care as it applies in acute psychiatric settings.

Three articles provided information on organisational or treatment models designed to provide care to patients with a serious mental illness in the least restrictive manner. One of these focused on planning and implementation from the system level (Kuno, Koizumi, Rothbard, & Greenwald, 2005); one focused on providing a recovery focused environment (Swarbrick, 2009) and the other on a continuum of least to most restrictive practices to manage aggressive behaviours (Kozub & Skidmore, 2001).

One article focused on the release of patients from acute mental health units using compulsory treatment within the community as the least restrictive form of treatment (Segal & Burgess, 2006). One article discussed the use of advance statements to provide patients with care which they consider to be least restrictive for themselves (Atkinson & Garner, 2002).

Overview of recovery-oriented practice

Two papers assessed the applicability of recovery-oriented practice in acute inpatient mental health care facilities, whilst one focused on the tension for nursing staff between a workplace structure that focused on a medical model of care and staff education and values around providing more person-centred care (Hummelvoll & Severinsson, 2001).

A further two papers sought to understand the experiences of involuntary patients from the perspective of the recovery-oriented approach. One of these was a meta-analysis of qualitative studies and one utilised in-depth interviews with involuntary patients (Wyder, Bland, & Crompton, 2013; Wyder, Bland, Herriot, & Crompton, In press, accepted 2014).

Overview of literature on locked doors

The identified studies were predominantly descriptive. Some studies employed qualitative methods to elucidate patient, staff and visitor experiences and perceptions of locked or open doors in acute psychiatric inpatient wards, or the integration of recovery-oriented practices in acute settings. These made up the bulk of studies included in this review. Four papers reported on interviews with current or former patients about their lived experience (Haglund & von Essen, 2005; Johansson, Skärsäter, & Danielson, 2009; Muir-Cochrane, Oster, Grotto, Gerace, & Jones, 2013; Muir-Cochrane et al., 2011). These papers explored a range of issues for patients including acceptability and perceptions of locked entrance doors; the experience of care in a ward that has a locked door policy and the reasons for absconding from inpatient facilities. A further two papers used participant observation and ethnographic interaction to describe ward environments, the experience of coercion and patient behaviour (Johansson, Skärsäter, & Danielson, 2006; Larsen & Terkelsen, 2013).

Some qualitative work describing patients experiences also explored the views of staff, specifically nurses who work in acute psychiatric settings. Four papers reported on interviews with nurses (Ashmore, 2008; Haglund, Van Der Meiden, Von Knorring, & Von Essen, 2006; Johansson, Skärsäter, & Danielson, 2013; Muir-Cochrane et al., 2011). These papers explored acceptability of locked doors among nurses, the experience of working on a locked ward and their views on advantages and disadvantages of having doors open or locked. All three ethnographic observational studies of patients also described nurses' behaviour, their experiences of coercion and the ward environment from a staff perspective.

Eight papers reported cross sectional surveys soliciting patient, staff or visitor opinions on various aspects of door status in inpatient psychiatric wards (Baker, Bowers, & Owiti, 2009; Bowers et al., 2002; Bowers et al., 2010; Haglund, Van Der Meiden, Von Knorring, & Von Essen, 2007; Middelboe, Schjødt, Byrstring, & Gjerris, 2001; Müller, Schlösser, Kapp-Steen, Schanz, & Benkert, 2002; Nijman et al., 2011;

Simpson et al., 2010). These papers focussed on the prevalence of locked doors, the role of locked doors in providing safety and security, views regarding the acceptability of locked doors, effectiveness in preventing absconding, satisfaction with treatment and relationships and effects on behaviour, such as medication refusal, rates of drugs and alcohol use and aggression.

Two further papers used clinical audit as a means of data collection (Adams, 2000; Bowers, Simpson, & Alexander, 2005). These studies primarily involved measuring current patient care and outcomes against explicit audit criteria or standards. One study utilised a descriptive audit retrospectively over a 10-year period related to all absent without permission (AWOP) incidents associated with patients leave from a secure inpatient unit (Scott, Goel, Neillie, Stedman, & Meehan, 2014).

One paper described a natural experiment in which data were collected on absconding from one ward where the door was locked for 6 months and open for another six months (Lang et al., 2010).

Only one study described an intervention program: a before-after controlled trial design of an anti-absconding package implemented in acute inpatient psychiatric wards where the doors were partially locked (Bowers, Alexander, & Gaskell, 2003). Of particular note are the findings that have emerged from this program of work.

Key themes regarding least restrictive care in mental health

Least restrictive care - an individual concept

The bulk of the literature on least restrictive care in mental health focuses on care delivered in the community. In comparison to inpatient hospital care, community-based treatment is the least restrictive option. The available literature highlighted that while least restrictive care is described as a philosophical imperative in the provision of mental health care and is key in policy and legislation underlying treatment; it adds little by way of context for those admitted to acute mental health units. When least restrictive care is discussed in the context of acute inpatient settings, most literature describes care from the perspective of individual treatment or describes the way in which patients move from more restrictive (ie., hospital-based) to less restrictive care options (ie., community-based)

The evaluation of a system planning tool concluded that planning and modelling how patients move through treatment would provide the best framework for ensuring patients received the least restrictive care (Kuno et al., 2005).

In an analysis of data from the Victorian psychiatric case register from 1990-2000 it was found that whilst some patients were released from hospital conditionally by being placed on a Community Treatment Order (CTO), those patients in effect experienced a doubling in the number of days they were on restrictive care when compared with their counter parts who remained in hospital until they were released unconditionally (Segal & Burgess, 2006).

The review by Kozub and Skidmore (2001) assessed research and conceptual literature in order to establish a continuum of interventions in acute mental health units for managing violence or aggression, with the most restrictive interventions being seclusion and restraint. They did not, however, consider the status of the ward as locked or unlocked as a factor.

Atkinson and Garner (2002) note that whilst many countries around the world are adopting the principal of least restrictive care in legislation, by and large there is little to no documentation that provides a hierarchy of restrictive practices. Thus in the context of the current review which is focused on the literature around having locked or unlocked acute mental health units, it could be argued that a locked ward is a restrictive practice that is applied to all patients within the ward, as opposed to seclusion which is a restrictive practice applied to an individual under specific circumstances.

Key themes regarding recovery-oriented practice

Defining recovery-oriented practice

Recovery-oriented practice is a relatively new concept in mental health care. It is not always well understood and has been difficult to incorporate into the practice of delivering mental health care (Tickle, Brown, & Hayward, 2014). Davidson and colleagues (Davidson, Drake, Schmutte, Dinzeo, & Andres-Hyman, 2009) published a discussion paper about recovery-oriented practice and how it aligns with evidence-based practice. Importantly, they make a distinction between the traditional conceptualisation of recovery as an outcome -- being one where a person is free from all symptoms of their mental illness and all deficits caused by the illness have been ameliorated, relying mostly upon medication and cognitive therapy (Davidson et al., 2009) – and the concept (borrowed from the addiction self-help movement) of being ‘in recovery’ which is more process-based and recognises that mental illness may be an enduring part of a person’s life. Within this context a person chooses to reclaim their own life, despite ongoing symptoms. Davidson et al (2009) argue that “this sense of recovery refers to learning how to live a safe, dignified, full, and self-determined life, at times in the face of enduring

symptoms of a serious mental illness” (Davidson et al., 2009, p. 324). Recovery-oriented practice has therefore been “defined as person-centered, 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 use of recovery-oriented practice to underpin the philosophy of treatment in mental health services has gained momentum in many countries including Australia; however the development of practices within mental health settings that follow a recovery-oriented approach has been difficult. Where recovery-oriented practices do exist with empirical support, they have mostly been in the context of community mental health settings, which differ significantly from acute settings. This is particularly important in relation to how a recovery orientation is practised in an acute setting where many, and sometimes the majority, of people are experiencing acute symptoms, are in crisis and on involuntary orders (Slade et al., 2014).

Recovery-oriented practice in acute psychiatric settings

Research into recovery-oriented practice in the context of acute inpatient psychiatric care is scarce and focuses mainly on nurses. One study, conducted by McLoughlin and colleagues, involved 105 registered nurses working in acute inpatient mental health services who completed the Recovery Self Assessment-Registered Nurse version (RSA-RN), a tool designed to measure recovery-oriented practice (McLoughlin, Du Wick, Collazzi, & Puntill, 2013). One of the main findings was significantly higher RSA-RN scores among nurses who “(a) had a formal education in mental health recovery, (b) considered their place of work to be “recovery-oriented” and (c) considered themselves knowledgeable about recovery” (McLoughlin et al., 2013, p. 157).

Acute psychiatric inpatient units create a specific set of circumstances that have been reported by some to result in a reliance on a medical model of treatment at the expense of taking a more person-centred recovery approach (Hummelvoll & Severinsson, 2001). In this observational study of nurses working in acute psychiatry, the researchers concluded that there is a “reluctant acceptance of therapeutic superficiality” in inpatient settings where staff don’t have the time to engage with the patient from a more person-centered approach (Hummelvoll & Severinsson, 2001, p. 23). According to the researchers,

this is brought about in part by the combination in most inpatient units of structural models that are not compatible with a person-centred approach, and the short stays of patients which prevent nursing staff from having the necessary time to focus on anything beyond medication compliance. The authors concluded that this creates tension for nursing staff who have an educational background, highlighting a more humanistic person-centred approach to care than they are able to deliver (Hummelvoll & Severinsson, 2001). An analysis by Slade et al (2014) highlights that committing to a recovery orientation is not always evident in practice, such as in acute settings, if there is very limited scope for consumers to exercise agency, and instead a focus on decisions and control being exercised by the 'experts'.

One narrative review included seven qualitative papers that focused on patients' experiences of being on an involuntary admission order. The authors concluded that "At the heart of involuntary treatment is the restriction of personal freedoms, coercion of treatment, and denial of autonomy" (Wyder et al., 2013, p. 579). They added, however, that if involuntary treatment is handled in a supportive and inclusive way it is an opportunity for patients to feel hope that they may be able to redefine themselves and manage their illness. The review illustrated that patients can gain a subjective sense of control through the way staff work with them, for example "treating consumers with respect, giving appropriate information about their treatment and hospital admission, allowing whatever choices were possible within clear and defined boundaries, being invited to participate as much as possible in their own care as well as encouraging consumers to continue to have input in treatment decisions" (Wyder et al., 2013, p. 579). An internal sense of control also comes from consumers understanding of their rights and having the opportunity to pursue legal avenues if necessary. Another study utilising in-depth interviews with patients who were on an Involuntary Treatment Order (ITO) found that patients who reported having mixed or negative feelings regarding their ITO were less likely to understand why they had been placed on an ITO, and less likely to understand the legal procedures in place to support them (Wyder et al., In press, accepted 2014).

Patients' sense of power may be increased if health care professionals work with them to understand the ITO and work together to have the ITO removed, in short utilising a recovery-oriented approach. This approach requires a shift in staff and organisational perceptions and practices (Wyder et al., In press, accepted 2014). According to Wyder et al it may be more pertinent for staff and patients to conceptualise a recovery journey that includes the involuntary admission as a small part, and enables staff to shift their focus from the narrow view of containing risky behaviours, to helping consumers

regain power and agency. This may be achieved with a greater emphasis by staff on building sustaining relationships with patients and supporting family and friends to continue their support roles during the involuntary stage of treatment (Wyder et al., 2013)

Key themes in the literature regarding locked wards

Experience for patients

Patients have reported both advantages and disadvantages of being on a locked ward. Advantages from the patient perspective include protection from 'outside', a sense of safety, more time for nurses to spend with them, and relief for families (Haglund & von Essen, 2005). Negative experiences of being on a locked ward include lower self-esteem, a sense of being excluded from the world, confinement, and irritability (Bowers et al., 2010; Haglund & von Essen, 2005; Muir-Cochrane et al., 2011). A common theme in research exploring patient views is that the locked ward is likened to a prison. Middelboe et al (2001) showed that patients on locked wards displayed more aggressive behaviours and perceived less autonomy than those on open wards.

Overall, studies of patient experiences generally point to more disadvantages than advantages of being on a locked ward (Bowers et al., 2010; Haglund & von Essen, 2005). Studies on the impact of locked doors on more objective patient outcomes are less common and most use cross-sectional designs, making it difficult to determine whether the observed outcomes were caused by (or caused) locked doors. Despite the limitations of this literature, there is some evidence to suggest that locked wards are associated with lower satisfaction with treatment (Müller et al., 2002) and higher rates medication refusal (Baker et al., 2009).

Absconding

Absconding from an acute psychiatric inpatient unit, that is being absent from the ward without official permission, is a significant clinical issue with serious social, economic and emotional costs by potentially placing patients and others at risk. Studies of absconding from psychiatric facilities suggest that between 2.5% and 34% of all psychiatric admissions abscond. Australian studies have typically reported low rates of absconding. A 2010 a study undertaken in Australia reported an event-based rate of 13% (Mosel, Gerace, & Muir-Cochrane, 2010). Event-based measures tend to be higher than patient-based measures of absconding because an 'event' does not capture repeated episodes by the same patient. A recent

study in Queensland found that there were 24 incidents where patients were 'absent without permission' from one secure mental health inpatient service in Brisbane over a ten year period, and of these episodes a total of 12 patients were involved – that is, “repeat” episodes (Scott et al., 2014).

A number of studies have explored why patients abscond. The most commonly cited reasons are: because they feel unsafe in the ward, which may be due to the effects of mental illness, but also due to the relationships with staff and other patients (Muir-Cochrane et al., 2013), isolation from family and friends, feeling trapped, confined, bored, or frustrated (Bowers et al., 2003; Bowers, Jarrett, Clark, Kiyimba, & McFarlane, 1999). Psychiatric or clinical reasons may also contribute to the decision to leave a ward without permission. For example, patients at higher risk of absconding include those with a diagnosis of schizophrenia, males, those aged less than 35 years, and those with a previous history of absconding (Bowers et al., 2003). In the study of absconding from a secure mental health inpatient service in Brisbane, 12 patients accounted for the 24 incidents of absconding (Scott et al., 2014).

A systematic review of the literature by Muir-Cochrane and Mosel (2008) identified a body of work describing the characteristics of patients who abscond, what precipitates absconding and the risks associated with the behaviour. The review noted that patients most likely to abscond were young males with a diagnosis of schizophrenia. Most absconding events occurred within the first three weeks of admission. The review also highlighted deficiencies in the literature primarily that a single definition of absconding was lacking. For example, variations in the time period a patient could be absent before being classified as an absconder ranged from 1 to 72 hours.

Another review of the literature published in 2011 showed that rates of absconding were higher in open wards and lower in locked wards. A review of the circumstances in which patients absconded, however, showed that a large proportion of absconding incidents occurred when patients were outside the unit, such as during transfer from one facility to another or when they were on permitted, unaccompanied leave. Similar to the previous review, these authors also noted that one of the main limitations of the research on absconding is the variation in definitions used to describe the population of interest (Stewart & Bowers, 2011).

The aforementioned study of a Brisbane secure (ie forensic) inpatient unit found that all absconding incidents occurred during some form of leave: 14 AWOPs occurred during unescorted ground leave

(meaning leave from the secure unit into the larger grounds of the hospital complex) and nine AWOPS occurred from unescorted, off-ground leave (meaning leave into the wider community). No AWOPS occurred when leave was escorted either in the hospital grounds or in the community (Scott et al., 2014).

One study employing a natural experimental design noted that significantly more absconding events occurred in the six months in which doors to the facility were locked in comparison to the previous six months when the doors were open. The authors hypothesised that the personal freedom associated with an open door environment and changes to therapeutic relationships that necessary follow were the key to changes in rates of absconding (Lang et al., 2010). Another study suggested that locked doors may increase motivation to abscond and found that boredom, as a result of being cut-off from the outside world, can increase the desire to abscond (Muir-Cochrane et al., 2013).

The best available evidence on ways to reduce absconding is from a controlled trial by Bowers et al (2003). Bowers et al found a package of anti-absconding measures reduced the rate of absconding by 25% during the intervention period. Of note is that over the same time period the frequency of door locking was also reduced. The anti-absconding package included:

- The use of sign in and out books for patients
- Careful and supportive breaking of bad news to patients
- Post ward incident debriefing of patients
- Multidisciplinary review
- Identification of patients at high risk of absconding
- Targeted nursing time daily for those high absconding risk patients
- Facilitated social contact for those at high risk of absconding

Experiences for nurses including workload

To date, there is no clear evidence that locking doors impacts on staff workload. Studies exploring nurses' perceptions suggest that some locking doors contributes to reduced workload because it eliminates the need for staff to monitor patient whereabouts and frees them to partake in other, more therapeutic activities such as building relationships with patients (Cleary, 2004). Nurses have also expressed concerns over the need to monitor an unlocked door, which results in divided attention (Muir-Cochrane et al., 2011). Some studies noted that nurses perceived that their jobs were easier with

respect to having control when the ward doors were locked (Due, Connellan, & Riggs, 2012; Johansson et al., 2013). Haglund et al., (2006) similarly reported that wards may need fewer staff if the doors are locked. Nurses have reported other benefits to locking doors such as providing a safe and secure place, protecting patients from outsiders, and relief for significant family/friends who may be worried about their family member (Ashmore, 2008; Haglund et al., 2006).

While some studies have shown that nurses perceive reductions in workload and associated benefits from locking ward doors, there is also evidence that nurses believe locked doors can contribute to increased workload. Among the main drivers of increased workload, as reported by nurses, are having to attend to the locked door, and having to let patients/visitors/other staff in and out (Haglund et al., 2006). Some staff have reported that locked doors result in increased aggressive confrontations at exit points (Muir-Cochrane et al., 2011).

Conflict/aggression

Aggressive and violent behaviour on acute psychiatric wards is a critical issue. Conflict among patients and staff can occur for many reasons but is most commonly linked to rule breaking, use of alcohol or illicit drugs, medication refusal and absconding or attempts to abscond (Victorian Government Department of Health, 2011b).

There is some correlational evidence of a relationship between having doors locked and aggressive incidents (Bowers, 2009). Bowers noted increased rates of verbal abuse on wards where doors were only locked some of the time, suggesting that uncertainty among patients regarding the status of the door may affect levels of conflict. Lang et al., (2010) found significantly more aggressive incidents happened during the six months that the wards doors were locked in comparison to the previous six months when the ward doors were open.

Nurses also perceive that door locking increases conflict and confrontation on acute care wards, particularly around exit points (Muir-Cochrane et al., 2011). Nijman et al., (1997) showed that a significant number of violent incidents happen near the ward door. There is evidence that locked doors are associated with more medication-related conflict and that this relationship is more evident when doors are permanently locked (Baker et al., 2009). This observational study had limited capacity to

examine causal relationships; that is, it is unclear whether locking doors caused medication refusal or whether conflict around medication accounted for the doors being locked.

Suicide

To date there is limited evidence regarding the relationship between door locking and suicide. The available evidence suggests that suicides in mental health patients is relatively rare and may be linked to particular facilities. Generalisable evidence about the effectiveness of strategies such as locking doors is not available. The suicide of an inpatient is a catastrophic event, and may indicate a breach of duty of care by the service. Ethnographic work suggests that intensive observation and engagement can function as an effective alternative or addition to locking wards, to prevent suicidal activity among people with the greatest suicidal intent (Hamilton & Manias, 2008). "Attempts to exert influence on the surrounding environment appear to be more difficult to achieve since dangers may be in areas that are private property or outside the hospital's sphere of influence" (Lock, 2013, p. 5).

Use of illicit drugs and alcohol on wards

Research from the UK suggests that admission into acute psychiatric facilities for drug and alcohol-related disorders has substantially increased (Simpson et al., 2010). However, less is known about the extent to which patients use illicit drugs and/or alcohol while they are inpatients. A review of the literature by Bowers and Jeffery (2008) on the use of drugs and alcohol by patients during admission found varying incidence and prevalence rates, with most variation explained by local context. That is, while the problem appears to exist to some extent in all facilities, some hospitals and inpatient facilities have much higher rates of drug and alcohol use than others.

Generally the consensus among different stakeholder groups (patients, staff, families, visitors) is that locking doors can reduce access to illicit drugs and alcohol on the ward (Bowers et al., 2012). However, evidence from cross-sectional studies suggests that the use of alcohol and illicit substances on wards by patients is relatively uncommon (although still problematic), and is not influenced by door status (Simpson et al., 2010). Simpson et al. (2010) found that alcohol was related to conflict/aggression and absconding, but that door status did not mediate this relationship.

Policy Review

In addition to reviewing the peer-reviewed literature, we obtained and reviewed 35 Australian policy documents related to mental health. Of these, four were from Queensland, three from South Australia, three from Tasmania, four from Victoria, five from the Australian Capital Territory, six from New South Wales, three from Western Australia, and a further six were national (see Appendix A for summary table).

The timeframes of the policies varied, covering between one and ten years; 11 of the policies specified no time frame. In relation to acute mental health services, only one policy specifically mentioned 'door locking', 24 mentioned 'recovery-oriented practice', 13 mentioned 'least restrictive care', 9 mentioned 'safety', and 2 mentioned 'security.' With regard to locked or unlocked doors to acute in-patient units, 4 of the policies mentioned 'access', 6 mentioned 'risk' regarding suicide or self-harm and/or risk to the community, and 2 mentioned 'aggression'.

In general the policies tended to discuss the philosophy underpinning workplace practices in acute mental health (for instance, many described a recovery-oriented framework operating in a least restrictive manner) rather than advice regarding specific workplace practices. It is assumed that local policy and other documents would shed more light on specific practices in relation to acute inpatient psychiatric units having doors open, locked or partially locked. However, at the time of this review we did not have access to any local policies or documents, despite repeated efforts to access these documents from services in a number of states. This suggests that door locking appears to be subject to very localised decision making that – where specific directives are not in place – may be discretionary and more closely aligned with clinical decision making than policy and procedure.

Discussion

The current review of literature and policy documents sought to answer three key questions each of which are addressed below:

What evidence is there regarding least restrictive practices?

Literature that was found specifically via the search term 'least restrictive care in mental health' highlights that the concept is a philosophical imperative in many policy documents around the world. In practice least restrictive care is almost solely utilised from an individual's perspective. That is various treatment options for the individual, such as CTOs and advance statements, which offer an alternative to hospitalisation, which is considered to be more restrictive. In the context of acute inpatient units the literature offered some minor detail regarding a continuum of least to most restrictive consequences for managing aggressive behaviour, but did not consider any ward conditions that may be applied to all patients on a given ward, for these types of considerations we must look to the literature on locked wards.

Whilst there is a gap in research regarding the concept of least restrictive care this intersects very clearly with the concept of recovery-oriented practice which has been operationalised and studied to a greater extent in the acute mental health literature. Recovery-oriented practices in acute mental health settings have at their core the philosophy of least restrictive care and contribute more substantially to the knowledge base.

Both in Australia and internationally, from an organisational perspective the adoption of a recovery-oriented approach has been slow and in some cases non-existent. However, there are four levels of practice for transforming services that have been highlighted to support recovery-oriented practice: (1) "Supporting personally defined recovery (what interventions are offered), (2) Working relationships (how interventions are offered), (3) Organisational commitment (what is the core business of the mental health system?), and (4) Promoting citizenship (supporting the experience of wider entitlements of citizenship)" (Slade et al., 2014, p. 17). Slade et al (2014) noted that the first two of these are addressed in many of the articles they reviewed, however ultimately there needs to be organisational commitment to move away from the guiding principle of treat-and-recover in order to truly foster the concept of an individual's full entitlement to citizenship.

Many of the themes raised in the review can be incorporated under the theme of risk: for example, absconding, drugs and alcohol on the ward, and aggression. Risk is commonly thought about in terms of risk to others and/or self, and risk arising from vulnerability, but less commonly includes consideration of risk arising from stigma, loss of dignity, discrimination, social exclusion, racism, sexual abuse or iatrogenic effects of psychiatric treatment (Tickle et al., 2014). A blaming culture drives anxiety for staff and increases preoccupation with risk, whereas a learning culture may help increase the potential for positive risks to be taken to promote recovery (Tickle et al., 2014). A recovery-oriented approach would consider that measured risk taking is a positive part of treatment and enabling patients to be part of their family and community. The Victorian Recovery-Oriented Framework discusses the concept 'Dignity of risk' highlighting that self-determination and self-responsibility are the corner stone of a recovery-oriented-approach and that from this stand point consumers should be supported to take calculated risks that they are comfortable with regarding their own health and wellbeing. Notwithstanding the need for risk management and duty of care to be considered to ensure that consumers are in a safe environment. Ultimately the orientation should primarily be about restoring or maintaining consumer choice (Victorian Government Department of Health, 2011a).

Environmental factors, the quality of relationships between staff and patients and the milieu of psychiatric wards were also recurrent themes in the literature, although not necessarily the primary focus of many studies. It appears that how wards look, access to pleasant spaces such as gardens, patients' proximity to doors and the potential to hear conflict or be in close proximity to the conflict that can occur around locked doors influences the impact locked doors have on the mental health of patients and their experience of the ward. Studies investigating nurses' perceptions often describe that one of the disadvantages of a locked door is that it creates a non-caring environment and further amplifies their custodial and medical role rather than their preference to be seen as person centred and caring. The mismatch between taking a recovery orientation and supporting choice and control and empowerment of patients stands in stark contrast to the rather blunt instrument of a blanket door-locking approach. It appears that this minimises opportunities for sharing responsibility between nurses and patients about activity towards recovery, including periods of 'leave' from the ward (to meet needs, e.g., for exercise). There is also the issue of stigma and fear surrounding mental illness being further exacerbated by being in a locked environment. Material surroundings are also relevant, with high walls and obvious security measures serving to reinforce negative perceptions of people with mental illness

and such features may potentially increase negative feelings and aggression in those who feel judged or dehumanised by these interventions. For those who feel they were treated as an individual human being, the evidence suggests that their experience was more positive compared with those who felt that they were defined by their illness by staff. The flexible application of “corrections and house rules” were more likely to be experienced positively by patients in comparison to when rules were made specifically for one patient or enforced rigidly (Larsen & Terkelsen, 2013).

What evidence is available regarding the impact of locked wards?

The profile of patients admitted to acute psychiatric care has changed over time in the context of a growing emphasis on community base care. Patients in acute psychiatric care today are experiencing more severe illness and are more often in crisis (Bowers, 2005; Hamilton & Manias, 2008). Mental health care units are perceived and experienced differently by those with a lived experience. For some the lack of freedom is perceived as unsafe and fear-inducing, while for others it can be a marker of safety. Often, patients’ experiences on wards are difficult to disentangle from their experience of illness (Muir-Cochrane et al., 2011).

Methodological issues of reviewed literature

A number of key issues need to be kept in mind when considering research outcomes based on cross sectional survey or clinical audit methods. First and foremost, the research is correlational, and cannot therefore determine "cause and effect" relationships. To be confident about causal connections, research would require experimental manipulation under tightly controlled conditions - an approach not usually feasible/ethical in this area of research. Nevertheless, the correlational research is able to demonstrate significant statistical associations. Second, data collected via self-reported questionnaires may be subject to self-enhancing bias and social desirability. This was highlighted by Larsen & Terkelsen (2013) who noted that nurses expressed differing views of the locked door when asked individually as opposed to when other nurses were present. In addition, many studies were undertaken in one unit, such that the findings may not be generalisable to other settings.

The strength of much of the cross-sectional survey research in this review is that primary outcome measures, such as absconding, violent and/or aggressive incidents, medication refusal, confrontation, drug and alcohol use were obtained by using objective checklists of incidents that occurred each shift.

A recent Cochrane review reported that there were no randomised controlled trials (RCTs) of locking ward doors, and argued that with appropriate safeguards, RCTs in this area are both ethical and urgently required (Muralidharan, 2012). The most rigorous study we are aware of evaluated the impact of an anti-absconding package in the UK; introduction of the package was associated with a reduction in absconding and a parallel *reduction* in the locking of ward doors. Surveys of consumers suggest that although locked doors have both advantages and disadvantages, the disadvantages typically outweigh the advantages. Conversely, when staff are surveyed on the same issue the advantages are often seen to outweigh the disadvantages. Significantly, many of the advantages of door locking cited by staff relate to risk management for staff or the organisation, rather than maximising treatment or recovery outcomes for the patient. It appears that staff perceptions of locked doors are influenced by past or current experience: those working in settings where doors are locked are more likely to support locked doors; those working in settings where doors are unlocked tend to support less restrictive practices.

What do the national, state and local policies indicate is best practice with regard to locked wards?

The review of national and state mental health policy documents highlighted that most policies include broad guiding principles for the delivery of all mental health services and most include a vision that services should foster a recovery-oriented approach to service delivery. About half note the need for services to be delivered in the least restrictive manner. However, only two policies mentioned locked wards specifically, and not in relation to when an acute psychiatric inpatient unit should be locked. It is most likely that service-specific policies, in jurisdictions where the decision to lock wards is made at a local level, would highlight specific guidelines and decision making tools regarding the process and rationale for locking doors. Unfortunately, the requests we made to specific services regarding accessing such policies did not amount to any policies being provided in time for inclusion in this review. Local policies were not accessible via websites in the same way that state and national policies are.

Conclusion

Overall the concept of least restrictive care is focused on individual treatment options at any point through the patient's journey. Therefore even literature that discusses various options for care and treatment including hospitalisation in an acute setting do not highlight any consideration of the acute ward being open or locked and the impact of this on the consumer's experience of hospitalisation. Therefore consideration of door locking as a concept which impacts on individuals experience of treatment needs to be considered separately.

The guiding principle for the delivery of mental health care is that it be recovery-oriented and be provided in the least restrictive manner. In light of research evidence it is reasonable to interpret this to mean that, by and large, acute psychiatric inpatient units should operate from a basis of being open with sound guiding principles in place for times when the context of the ward dictates the most appropriate status for a given period of time is to lock the ward. To this end we have provided some recommendations below for consideration in the Queensland context.

Recommendations

Appendix B provides a table which indicates the specific part of the literature which we utilised to develop each recommendation, in most cases the recommendations consist of multiple sources.

Recommendations relevant to **risk issues**:

- 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 consumers, close monitoring of people with a history of absconding etc.
- Explicitly ban illicit drugs and alcohol, including making and implementing penalties for bringing these substances on to the ward.
- Provide more support via intensive nursing and/ or peer support to people at risk of suicide or self harm

Recommendations relevant to taking a **recovery orientation**:

- Increase contact between consumers and important others by encouraging the presence of families, friends and other supporters on the ward
- 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 etc available to increase communication)
- Reduce boredom on the inpatient unit by providing more engaging and active programs with a choice of activities
- Include more peer support workers on the ward who have a fundamental role of spending time with consumers and their carers (also relevant to staffing)

Recommendations relevant to **policy and procedure**:

- Actively explain any door locking decisions on a daily basis depending on a transparent set of factors and processes. Provide clear information about the decision plus monitoring arrangements (ie. how long doors are going to be locked for etc) that is communicated to consumers, staff and carers (perhaps through an information or bulletin board)
- Provide a clear explanation of ward rules and daily routines, emphasising consumer priorities of comfort, personal safety and how to access support

Recommendations relevant to **routine and environment**:

- Make initial contact more personable by having a reception/welcome service at each ward that welcomes and monitors all visitors (noting that this may be difficult to incorporate into aged facilities).
- 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
- 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 (noting that this may be difficult to incorporate into aged facilities).

Recommendations relevant to **staffing**:

- 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
- 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)

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Appendix A

Summary of policy documents reviewed and the relevance of their content

Policy Name	Date of publication	Policy Timeframe	National or State or Regional	Mention 'door locking'	Mention 'recovery-oriented practice'	Mention 'least restrictive care'	In the context of acute mental health services		In the context of locked or unlocked doors to acute in-patient units		
							Mention 'safety'	Mention 'security'	Mention 'Access'	Mention 'risk' regarding suicide or self harm &/or risk to community	Mention 'Aggression'
Queensland Plan for Mental Health (Queensland Health, 2011)	Jun-08	2007-2017	Queensland	no	yes	yes	yes	no	no	no	no
Sharing responsibility for recovery: creating and sustaining recovery-oriented systems of care for mental health (Queensland Health, 2005)	Jun-05	not stated	Queensland	no	yes	no	no	no	no	no	no
Strategic directions for mental health promotion (Queensland Health, 2009)	Aug-09	2009-2012	Queensland	no	no	no	no	no	no	no	no
Queensland plan for mental health 2007 - 2017: Four year report (Queensland Health, 2008)	Oct-11	not stated	Queensland	no	yes	no	no	no	no	no	no
South Australia's mental health and wellbeing policy (South Australian Health, 2010)	Feb-10	2010-2015	South Australia	no	yes	yes	yes	no	no	no	yes
Stepping up: a social inclusion action plan for mental health reform (South Australian Social Inclusion Board, 2007)	not stated	2007-2012	South Australia	no	yes	no	yes	no	no	no	no
South Australian suicide prevention strategy 2012-2016 (Government of South Australia, 2012)	Sep-12	2012-2016	South Australia	no	no	no	no	no	no	no	no

Policy Name	Date of publication	Policy Timeframe	National or State or Regional	Mention 'door locking'	Mention 'recovery-oriented practice'	Mention 'least restrictive care'	In the context of acute mental health services		In the context of locked or unlocked doors to acute in-patient units		
							Mention 'safety'	Mention 'security'	Mention 'Access'	Mention 'risk' regarding suicide or self harm &/or risk to community	Mention 'Aggression'
Building the foundations for mental health and wellbeing (Statewide and Mental Health Service & Department of Health & Human Services, 2009)	Jun-09	not stated	Tasmania	no	yes	no	no	no	no	no	no
Mental Health Services, strategic plan (Department of Health and Human Services, 2006; Statewide and Mental Health Service & Department of Health & Human Services, 2009)	Feb-06	2006-2011	Tasmania	no	yes	yes	no	no	no	no	no
Mental Health Services, strategic plan. Taking stock and moving forward progress report (Department of Health and Human Services, 2008)	Dec-08	2006-2011	Tasmania	no	yes	no	no	no	no	no	no
An introduction to Victoria's public clinical mental health services (Victorian Government Department of Human Services, 2006)	Jan-06	not stated	Victoria	no	yes	yes	no	no	no	no	no
An analysis of the Victorian rehabilitation and recovery care service system for people with severe mental illness and associated disability (Victorian Government Department of Human Services, 2007)	Aug-07	not stated	Victoria	yes	yes	yes	no	no	no	no	yes

Policy Name	Date of publication	Policy Timeframe	National or State or Regional	Mention 'door locking'	Mention 'recovery-oriented practice'	Mention 'least restrictive care'	In the context of acute mental health services		In the context of locked or unlocked doors to acute in-patient units		
							Mention 'safety'	Mention 'security'	Mention 'Access'	Mention 'risk' regarding suicide or self harm &/or risk to community	Mention 'Aggression'
Because mental health matters. Victoria Mental Health Reform Strategy. (Victorian Government Department of Human Services, 2009)	Feb-09	2009-2019	Victoria	no	yes	yes	no	no	no	yes	no
Improving mental health outcomes in Victoria (Boston Consulting Group, 2006)	Jul-06	not stated	Victoria	no	no	no	no	no	no	yes	no
NSW: A new direction for mental health (NSW Health, 2006)	2006	2006-07 - 2010-11	NSW	no	yes	no	no	no	no	no	no
NSW Suicide Prevention Strategy 2010-2015: A whole of Government strategy promoting a whole-of community approach (NSW Health, 2010)	2010	2010-15	NSW	no	yes	no	no	no	no	no	no
Multicultural Mental Health Plan 2008-2012 (NSW Health, 2008a)	Dec-08	2008-12	NSW	no	no	yes	no	no	no	no	no
Mental Health Clinical Care and Prevention Model 1.11 (New South Wales Health Department, 2001)	2001	not stated	NSW	no	no	no	no	no	no	no	no
New South Wales Interagency Action Plan for Better Mental Health (New South Wales Government, 2005)	2005	2005-2010	NSW	no	yes	yes	yes	no	no	yes	no
New South Wales Community Mental Health Strategy 2007-2012 (NSW Health, 2008b)	2008	2007-2012	NSW	no	yes	yes	no	yes	no	no	no

Policy Name	Date of publication	Policy Timeframe	National or State or Regional	Mention 'door locking'	Mention 'recovery-oriented practice'	Mention 'least restrictive care'	In the context of acute mental health services		In the context of locked or unlocked doors to acute in-patient units		
							Mention 'safety'	Mention 'security'	Mention 'Access'	Mention 'risk' regarding suicide or self harm &/or risk to community	Mention 'Aggression'
National Mental Health Report 2013: Tracking progress of mental health reform in Australia, 1993-2011 (Department of Health and Ageing, 2013)	2013	1993-2011	National	no	no	no	yes	no	no	no	no
A contributing life: The 2012 National Report Card on Mental Health and Suicide Prevention (National Mental Health Commission, 2012)	2012	2011-12	National	no	yes	yes	yes	no	no	no	no
A contributing life: The 2013 National Report Card on Mental Health and Suicide Prevention (National Mental Health Commission, 2013)	2013	2012-13	National	no	yes	yes	no	no	no	no	no
National Mental Health Policy 2008 (Commonwealth of Australia, 2009b)	2009	not stated	National	no	yes	no	yes	no	no	no	no
The Roadmap for National Mental Health Reform 2012-2022 (Council of Australian Governments, 2012)	not stated	2012-2022	National	no	yes	no	no	no	no	no	no
Fourth National Mental Health Plan: An Agenda for Collaborative Government Action 2009 – 2014 (Commonwealth of Australia, 2009a)	2009	2009 - 2014	National	no	yes	yes	yes	no	no	yes	no

Policy Name	Date of publication	Policy Timeframe	National or State or Regional	Mention 'door locking'	Mention 'recovery-oriented practice'	Mention 'least restrictive care'	In the context of acute mental health services		In the context of locked or unlocked doors to acute in-patient units		
							Mention 'safety'	Mention 'security'	Mention 'Access'	Mention 'risk' regarding suicide or self harm &/or risk to community	Mention 'Aggression'
ACT - Building a Strong Foundation: A framework for promoting mental health and wellbeing in the ACT 2009-2014 (ACT Health, 2009b)		2009-2014	Australian Capital Territory	no	yes	no	no	no	yes	no	no
ACT Consumer Participation and Carer Participation across Mental Health ACT: A Framework For Action (ACT Health, 2007)	2007	2007-2009	Australian Capital Territory	no	yes	no	no	no	yes	no	no
ACT- Managing the risk of suicide: A Suicide Prevention Strategy for the ACT 2009 – 2014 (ACT Health, 2009c)	no date	2009 - 2014	Australian Capital Territory	no	no	no	no	no	no	yes	no
Mental Health Recovery in the ACT (ACT Health & Mental Health Community Coalition ACT, 2003)	no date	not stated	Australian Capital Territory	no	yes	no	yes	no	no	no	no
ACT - Mental Health Services Plan 2009 – 2014 (ACT Health, 2009a)	Jun-09	2009-2014	Australian Capital Territory	no	yes	yes	yes	yes	yes	yes	no
Mental Health 2020: making it personal and everybody's business (Mental Health Commission, 2011b)	not stated	not stated	Western Australia	no	no	no	no	no	no	no	no
Mental Health 2020 - Action Plan (Mental Health Commission, 2011a)	Mar-12	not stated	Western Australia	no	no	no	no	no	no	no	no
Western Australian Suicide Prevention Strategy 2009-2013 (Department of Health, 2009)	2009	2009-2013	Western Australia	no	no	no	no	no	no	no	no

Appendix B

References related to each recommendation and where they appear in the literature review

	Recommendation	Page	Paragraph	Citation
	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 etc.	21 22	3 3	(Bowers et al., 2003; Victorian Government Department of Health, 2011b)
2	Explicitly ban illicit drugs and alcohol, including making and implementing penalties for bringing these substances on to the ward.	22 23	3 3,4	(Victorian Government Department of Health, 2011b)
3	Provide more support via intensive nursing and/ or peer support to people at risk of suicide or self harm	19 23	1 2	(Bowers & Jeffery, 2008; Hamilton & Manias, 2008; Simpson et al., 2010; Wyder et al., 2013)
	Recovery orientation			
4	Increase contact between consumers and important others by encouraging the presence of families, friends and other supporters on the ward	19 20	1 2	(Bowers et al., 2003; Bowers et al., 1999; Wyder et al., 2013)
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 etc available to increase communication)	19 20	1 2	(Bowers et al., 2003; Bowers et al., 1999; Wyder et al., 2013)
6	Reduce boredom on the inpatient unit by providing more engaging and active programs with a choice of activities	20 21	2 2	(Bowers et al., 2003; Bowers et al., 1999; Muir-Cochrane et al., 2013)
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)	17 18 19	4 1 2	(Bowers et al., 2010; Haglund & von Essen, 2005; Hummelvoll & Severinsson, 2001; Muir-Cochrane et al., 2011)
	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 plus monitoring arrangements (ie. how long doors are going to be locked for etc) that is communicated to patients, staff and carers (perhaps through an information or bulletin board)	22	4	(Bowers, 2009; Lang et al., 2010)
9	Provide a clear explanation of ward rules and daily routines, emphasising consumer priorities of comfort, personal safety and how	22	3	(Victorian Government Department of Health, 2011b)

	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	19 20	2 2	(Bowers et al., 2003; Bowers et al., 1999; Middelboe et al., 2001)
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.	20	2	(Muir-Cochrane et al., 2013)
	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	22	5	(Muir-Cochrane et al., 2011; Nijman et al., 1997)
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)	17 18	3 1	(McLoughlin et al., 2013) (Hummelvoll & Severinsson, 2001)