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EDITORIAL

'Trust me, I'm a patient': locked doors, absconding and PICU

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Within the UK, absconding is a core admission criterion to PICU. The National Minimum Standards for referral to PICU include: 'Patients who are detained under the MHA 1983, for whom the consequences of persistent absconding are serious enough to warrant treatment in the PICU' (NAPICU 2014).

The extent to which people are motivated to abscond from general adult acute wards and the associated levels of disturbance, can have a direct impact on the referrals PICUs receive.

Common sense would suggest that in order to prevent or diminish the extent to which people are able to leave a ward or building in which they are expected to remain, one should simply lock the door. It makes sense, many would argue, that in order to keep people in, there ought to be a physical barrier preventing them getting out. This barrier of course, will need to be controlled by the staff alone.

This logic defined the basis on which much of the Mental Health inpatient estate in the UK and elsewhere around the world operated up until the 1960s. Before the 1960s, it made good sense that those who were 'mentally infirm', or in other ways could not be trusted to protect themselves or others, required support in conditions with some perimeter security. Further, it was held, this is what the patient, their family and society expected.

Virtually all mental health inpatient facilities were locked up until around the mid-twentieth century. Around then, for a number of reasons, something of a mental health spring had occurred. This was represented by a much more open approach and general policy to diminishing restriction, particularly the extent to which facilities were locked. Over a period of a few years, after more than a century of being closed, virtually all general mental health facilities within the UK had opened their doors. This also occurred within a background of diminishing

institutionalisation and affording patients opportunities to take part in their own recovery and, most importantly, to become worthy recipients of trust from the staff within mental health facilities. At some point during the 2000s – we cannot be sure precisely when – things changed.

Within five years after the millennium, many mental health facilities within the UK once again had locked their doors. This did not seem to occur as part of a centralised policy, but may have occurred organically in something akin to a 'domino effect'. Legitimate concerns had been levelled at services, that patients could too easily leave mental health inpatient facilities and had very often come to harm. There were a number of press and other reports of tragic losses of mothers, fathers, sons and daughters who had left facilities and taken their own lives or come to serious injury. There were also examples of others coming to serious harm because of the actions of someone who had unexpectedly left hospital. Motivated by a genuine intention to reduce harm and apply common-sense, seemingly one encouraged by the

example of another, many hospitals once again locked their doors.

The UK Mental Health Act Code of Practice (DH 2015) principle 1 requires that a person is subjected to no greater levels of restriction than their condition warrants. The principle of 'least restriction' is a central foundation on which modern mental health practice is built. For informal patients (voluntary) the Code paragraph 8.11 advises that 'a patient must be able to leave at any time they wish to unless they are being detained'.

Around the UK, wards were locked, and signs appeared next to exits advising patients what to do if they wished to leave, which inevitably involved asking the staff for the door to be opened. While well intentioned, the locking of mental health facilities in this way must lead to some serious reflection as to just how liberty is truly maintained if one must ask permission to leave whether legally detained or not.

Beyond the innate serious questions as to the appropriateness of locking-in voluntary patients with the belief that signs and requests to leave are adequate protection of liberty, is the plight of the formally detained mental health patients.

Patients detained under the power of law present another set of issues with regard to absconding. For locked units like PICUs, absconding may be too simple a term to describe the daily experience of PICU patients and staff. At times, without lawful authority, patients may transgress the perimeter of a facility and be thought to have 'escaped'. By far the most common experience within facilities are those who 'fail to return from leave'.

Absconding may be represented by those who decide to leave an escort or fail to adhere to the boundaries of agreed freedoms assigned within the care plan. For these and other reasons, doors remain locked within the Mental Health inpatient estate. For more than a decade, the logic has prevailed that people in mental health facilities are vulnerable and represent risks, doors are justifiably locked and therefore the situation for all is safer.

A significant challenge to the current natural order came when Professor Len Bowers and colleagues published the City 128 study (Bowers et al. 2008). A direct comparison was made between locked and unlocked hospitals to determine the extent to which locking the doors had achieved the expected outcomes of improving safety. What was revealed seriously challenged the underpinning logic for locking doors. Locked hospitals showed a marginal reduction in absconding from open hospitals although this was not the biggest concern. Locked hospitals showed significantly higher rates of dissatisfaction, complaints, self-harm and other negative effects than open hospitals. Beyond this, suicide rates remained similar between locked and unlocked hospitals, and locked doors did not prevent the ingress of alcohol, drugs or other undesirables within the Mental Health estate.

Even bigger cause for concern was highlighted by Huber et al. (2016) who studied 349 574 patients for over a decade within the German mental health estate. A direct comparison was made between locked and unlocked hospitals by pairing patients to their clinical and personal characteristics. No difference was shown between absconding from locked or unlocked hospitals although other negative effects for locked hospitals were proposed.

Commenting on this study the lead author, Dr Christian Huber, reported that: 'These findings suggested that locked-door policies may not help to improve the safety of patients in psychiatric hospitals, and are not generally successful in preventing people from absconding... A locked door policy probably imposes a more oppressive atmosphere, which could reduce the effectiveness of treatments, resulting in longer stays in hospital. The practice may even lend motivation for patients to abscond.' [news release 28 July 2016]

What may all this have to do with PICUs? Afterall, PICUs not only lock their doors, but also have a defined level of security including an airlock. We are reminded that absconding from acute wards is a core admission criterion to PICU. The extent to which hospitals are able to manage the issue of absconding and produce an environment in which the associated disturbance is diminished is of central concern to PICUs.

As compared to locked hospitals, open hospitals have been empirically shown to benefit from reducing negative experiences which culminate in poor outcomes for patients as well as more disturbance. Also, when directly compared to locked ones, open hospitals do not produce higher levels of suicide or necessarily absconding. With this established then why not just reopen the doors? For many this simply does not seem to pass the 'common sense test'. Families of inpatients who have come to serious harm or even death would struggle to understand the logic of vulnerable people seemingly being allowed to wander freely.

In contrast to the common sense view, it has been demonstrated through the most robust of studies that lowered risk is not achieved by locking the door. Further, higher levels of dissatisfaction and disturbance are unintended consequences of locking doors.

Is the whole situation truly a binary choice between locking doors and passing the common-sense test or opening the doors in tune with the evidence? Maybe there is another way.

Recently, the *Journal of Psychiatric Intensive Care* (*JPI*) has reconnected with the Acute Inpatient and PICU service in Leeds which is based within the Newsam Centre and Becklin Centre.

The Acute Inpatient Service operated an entirely open-door policy up until the mid-2000s. During the time when units were being locked around the country, consideration was given to the possibility of a different path.

It was accepted that the 'common sense test' was difficult to pass when patients often had the opportunity to leave without the knowledge or agreement of staff. In 2006, following a year of public consultation, the decision was taken to implement a system that allows staff to control both access and egress to the general adult wards. Like elsewhere in the country, the Acute Inpatient Service was focused on improving the safety of patients. The belief propagated that simply locking the doors was not the solution. A system was contemplated that by design could improve safety for patients while at the same time promoting human rights and civil liberties. There would be increased control over who could enter or leave the building, although this would not be achieved by a simple blanket policy of locking all the doors, which would remain under staff control.

A system was introduced to secure ward doors using electronic locks and a swipe card mechanism. This system allowed for monitoring who left and entered via electronic as well as observational means. Account was taken of the differences in the care and treatment that individual patients were receiving and the different stages of recovery including legal status was also considered.

Individual risks were assessed and electronic cards were allocated to individual patients on the basis of risk assessment, trust and mutual respect to allow those eligible to leave and enter the wards. Informal patients (voluntary) would automatically be eligible to receive a card. As part of the allocation process a discussion would first take place with an informal patient. This was to explore whether they felt confident about their own safety as an informal patient to leave the ward. If they did, then a card would be issued unless a risk assessment indicated otherwise, although some patients valued the security of not being issued a card until they felt better able to manage their own situation.

With the exception of locking all doors during the COVID pandemic, this system has operated successfully for more than a decade. On occasion there have been cases of people leaving without authorisation, for example by means of following people out of the ward. However, no system can be perfect and no system can manage all of the risks all of the time.

At the time the Acute Inpatient Service in Leeds implemented their creative and trust-based system, strong evidence about the effects of blanket locking of doors was not available. This is not the case today.

We now know that blanket locked door policies do not achieve the expected outcomes and, much worse, can have seriously detrimental consequences. They may lend fuel to the disturbance that the PICU is often tasked to resolve. The Mental Health inpatient estate must now reconcile the high quality and persuasive evidence that blanket locking of doors does not solve problems but creates them, and serious problems too. The approach developed in Leeds is not, and cannot be, perfect. It must be borne in mind that a situation in which one group of people (the staff) is trying to control the movements of another group of people (the patients) is enormously complex. That said, the value of simply locking doors has now been tested and the demonstrable negative effects cannot be ignored.

Trusting patients to manage their own access and egress via individual assessment and the swipe card system has many advantages. One of these advantages may well even be to achieve increased physical 'common-sense' security while at the same time significantly diminishing the negative effects of blanket locked door policies. All this in turn should have an effect on the extent to which referrals are received by PICUs.

The Editors of the *JPI* would like to see more papers exploring absconding, its characteristics and reduction. One approach to this could be to reinstate much of the trust-based engagement for inpatient mental health that existed between the 1960s and early 2000s. The seeming current culture of risk adversity, fear of litigation, and resort to simple binary solutions may now be losing utility.

Inpatient mental health work in general, and PICUs in particular, may create a curious dynamic in which patients are consistently asked to trust the staff while at the same time many policies continually demonstrate that they themselves are untrustworthy. The underpinning principles of productive therapeutic relationships in no small part dependent upon trust can be enhanced by structural policies of which the access control system at the Becklin and Newsam centres may be an example for others.

We will hear more about absconding, trust, and opportunities for improvements in practice within the pages of the *JPI* in future. If you have any experiences within these domains we would be very pleased to hear from you.

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