Securing Better Outcomes for Youth with Substance Use Disorders: Considering Locked *vs.* Unlocked Treatment Facilities

ADAI | ALCOHOL & DRUG ABUSE INSTITUTE

Susan A. Stoner, PhD, Research Consultant

Substance use remains a significant problem for Washington's youth. According to the Center for Behavioral Health Statistics and Quality of the U.S. Substance Abuse and Mental Health Services Administration, among those in the state of Washington in 2014, 6.6% of adolescents reported binge alcohol use, 11.4% reported illicit drug use, and 5.2% reported nonmedical use of pain relievers, within the preceding month.[1] Each year, a subset of these individuals develops substance use disorders, and there is a keen interest in identifying the most effective forms of treatment for those who need it.

Residential treatment facilities are frequently sought for adolescents with severe substance use and/or behavior disorders, yet it remains hotly debated whether residential care is superior to community-based care.[2] Among residential treatment facilities, there is a question of whether locked or unlocked (i.e., secure or non-secure) units are better in terms of benefits or outcomes. Thus, we conducted a literature review to examine this question.

Search Strategy

We searched both PubMed and Google Scholar with the following search terms: *(effectiveness OR benefits) AND (alcohol OR drug OR substance) AND (adolescents OR youth OR adolescence) AND (secure OR locked) AND (residential OR institutional OR inpatient)*. We found no research studies directly comparing locked versus unlocked treatment facilities for adolescent substance use disorders. The search was repeated omitting the following search phrase: *AND (alcohol OR drug OR substance)*. We found no research studies directly comparing locked versus unlocked treatment facilities for any disorders of adolescence or youth. The original search was repeated omitting the following search phrase: *AND (adolescents OR youth OR adolescence)*. We found no research studies directly comparing locked versus unlocked treatment facilities for substance use disorders among individuals of any age. Finally, we repeated the search with the following terms: *(effectiveness OR benefits) AND (secure OR locked) AND (residential OR institutional OR inpatient)*. This search yielded some articles on whether locked treatment facilities are better than unlocked facilities with regard to absconding and suicide.

Are locked facilities beneficial in terms of absconding and suicide?

A study published in *The Lancet Psychiatry* in 2016[3] compared hospitals with and without locked wards to establish whether hospital type has an effect on absconding, suicide attempts, and death by suicide. They found that compared to unlocked wards, locked wards averaged a 65.8% lower incidence of suicide attempts and 62.9% lower incidence of absconding with return but no lower incidence of completed suicide. To the authors' knowledge, this was the first study to compare locked versus unlocked facilities.

A 2010 study[4] examined pre- and post-transition outcomes of a single psychiatric ward from being primarily locked to being primarily unlocked. In the first six months of the study, the ward entrance door was open on 8.6% of days; in the second, it was open on 75.6% of days. The authors reportedly found no evidence that a

locked door reduces absconding. Rather, they found that the rate of absconding was significantly lower in the time period during which the entrance door was mostly open. To the authors' knowledge, this was the first study showing the effects of opening doors in an otherwise unchanged therapeutic setting.

What other evidence speaks to the benefits versus drawbacks of locked facilities?

A 2009 review[5] of locked doors in inpatient psychiatry identified 11 published articles on the topic, including ten descriptive research studies and one randomized controlled trial. Findings from the review of the descriptive research studies indicated that patients identified both benefits and drawbacks of locked facilities. Some patients indicated that locked doors made them feel safe, particularly those who felt unable to control themselves. Locked doors were viewed as providing protection against unwanted visitors, stealing, and the import of alcohol or drugs. On the other hand, patients also indicated that locked doors made them feel trapped, highlighted the power of staff, and made them feel depressed and anxious. Similarly, a 2011 qualitative study[6] found that patients expressed negative feelings when the door was locked, including depression, a sense of stigma, and low self-esteem. In contrast, staff reported that unlocked doors created anxious vigilance to prevent absconding and increased workload due to the need to watch the door.

A 1994 randomized controlled trial[7] investigated the effects of door status on female psychiatric patients' symptoms. Fifty patients on the same locked ward were randomly assigned to control and experimental groups. The experimental group was given as much freedom as possible, including the freedom to leave the ward and take part in activities, while the control group was not permitted to do so. Although the effect of the door status is confounded with the effect of the activities, it is noteworthy that, after 6 months, the experimental group showed greater improvement in physical energy, psychomotor activation, and hostility/suspiciousness.

The 2009 review[4] found no empirical evidence on substance misuse and door status for wards in the UK but noted evidence that 83% of inner-London psychiatric inpatients with a history of alcohol or drug use reported that they continued to use illegal substances while they were inpatients on psychiatric wards.[8]

In a community mental health context, a 2008 randomized trial[9] compared the effectiveness of an unlocked crisis residential program (CRP) to a locked, inpatient psychiatric facility (LIPF) on outcomes among adults who were facing civil commitment for severe psychiatric problems. Participants randomly assigned to the CRP experienced significantly greater improvement on interviewer-rated and self-reported psychopathology than did those assigned to the LIPF condition, and service satisfaction was dramatically higher in the CRP condition.

Ethical Issues

Cleary and colleagues[10] discussed ethical issues raised by locking facilities in the provision of mental health care. They pointed out that the practice highlights the issue of paternalism in mental health care, which undermines patients' autonomy. While the practice may be beneficent in some ways (e.g. in reducing absconding), the stigma associated with needing mental health treatment is presumably exacerbated by receiving such treatment in a locked setting. When treatment is sought voluntarily, one must ask whether it remains voluntary when provided in a locked facility. The authors assert that locked facilities need to provide clear ethical justification commensurate with perceived risks to patients.

Muir-Cochrane and colleagues[6] point out that "the emotional burdens of the locked door fall on patients (anger and depression), whereas those of the open door fall on staff (anxiety). While it seems acceptable for an emotional burden on staff employed and trained for such work, it might not be considered acceptable that patients experience an [additional] emotional impact" that a locked door appears to have.

Conclusions

While we could find no literature on locked versus unlocked treatment facilities with regard to outcomes or benefits in the adolescent substance use disorder or dual disorder context, we found some literature in the inpatient psychiatry context. Many of the lessons learned from research in that context would seem to translate. In any context, there are important ethical considerations in regard to locking treatment facilities; loss of autonomy must be balanced against any possible benefits. While there appeared to be some benefits of locked doors, there were also noteworthy drawbacks in terms of the emotional burden on patients. With a dearth of controlled studies comparing locked to unlocked facilities, whether there are effects on treatment outcomes remains in question.

References

1. Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Washington, 2015. HHS Publication No. SMA–16–Baro–2015–WA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.
2. Strijbosch, E. L. L., Huijs, J. A. M., Stams, G. J. J. M., Wissink, I. B., Van der Helm, G. H. P., De Swart, J. J. W., & Van der Veen, Z. (2015). The outcome of institutional youth care compared to non-institutional youth care for children of primary school age and early adolescence: A multi-level meta-analysis. Children and Youth Services Review, 58, 208-218.
3. Huber, C. G., Schneeberger, A. R., Kowalinski, E., Fröhlich, D., von Felten, S., Walter, M., ... & Lang, U. E. (2016). Suicide risk and absconding in psychiatric hospitals with and without open door policies: a 15 year, observational study. The Lancet Psychiatry, 3(9), 842-849.
4. Lang, U. E., Hartmann, S., Schulz-Hartmann, S., Gudlowski, Y., Ricken, R., Munk, I., ... & Heinz, A. (2010). Do locked doors in psychiatric hospitals prevent patients from absconding? The European Journal of Psychiatry, 24(4), 199-204.
5. van der Merwe, M., Bowers, L., Jones, J., Simpson, A., & Haglund, K. (2009). Locked doors in acute inpatient psychiatry: a literature review. Journal of Psychiatric and Mental Health Nursing, 16(3), 293-299.
6. Muir-Cochrane, E., van der Merwe, M., Nijman, H., Haglund, K., Simpson, A., & Bowers, L. (2012). Investigation into the acceptability of door locking to staff, patients, and visitors on acute psychiatric wards. International Journal of Mental Health Nursing, 21(1), 41-49.
7. Jin Z. (1994) Effect of an open-door policy combined with a structural activity programme on the residual symptoms of schizophrenic inpatients. British Journal of Psychiatry, 165(suppl. 24),52–57.
8. Phillips, P., & Johnson, S. (2003). Drug and alcohol misuse among in-patients with psychotic illnesses in three inner-London psychiatric units. The Psychiatrist, 27(6), 217-220.
9. Greenfield, T. K., Stoneking, B. C., Humphreys, K., Sundby, E., & Bond, J. (2008). A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. American Journal of Community Psychology, 42(1-2), 135-144.
10. Cleary, M., Hunt, G. E., Walter, G., & Robertson, M. (2009). Locked inpatient units in modern mental health care: values and practice issues. Journal of Medical Ethics, 35(10), 644-646.

Citation: Stoner SA. Securing Better Outcomes for Youth with Substance Use Disorders: Considering Locked vs. Unlocked Treatment Facilities. Alcohol & Drug Abuse Institute, University of Washington, January 2017. URL: http://adai.uw.edu/pubs/pdf/2017lockedfacilities.pdf.

This report was produced with support from the Washington State DSHS Division of Behavioral Health and Recovery (DBHR)