



Options for Reform

MOVING TOWARDS A MORE RECOVERY-ORIENTED, LEAST RESTRICTIVE APPROACH

In acute mental health wards including locked wards

December 2014

About this report

The Queensland Mental Health Commission was established to drive reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system¹.

One of its functions in achieving reform is to undertake and commission research in relation to mental health and substance misuse issues (section 11(1)(f)) and to review, evaluate, report and advise on the mental health and substance misuse system (section 11(1)(d)).

This report examines and outlines options for reform to support the implementation of recovery-oriented and least restrictive practices in acute mental health wards in Queensland, with a particular focus on locked wards. It is intended to enhance understanding of a complex situation that balances the rights of individuals with concern for their safety, and in some circumstances, the safety of others.

The report will be provided to the Minister for Health, the Director-General of the Department of Health and the Director of Mental Health and made publically available. However, it does not make specific recommendations, as the day to day operations of the public health system is outside the mandate of the Commission.

Feedback

We value the views of our readers and invite your feedback on this report. An evaluation form can be found on the Commission's website www.qmhc.qld.gov.au along with the electronic copy of this report.

Translation



The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the report, you can contact us on 1300 855 945 and we will arrange an interpreter to effectively communicate the report to you.

Licence



This report is licensed by the State of Queensland (Queensland Mental Health Commission) under a Creative Commons Attribution (CC BY) 3.0 Australia licence. To view a copy of this licence, visit <http://creativecommons.org/licenses/by/3.0/au/>. In essence, you are free to copy, communicate and adapt this report, as long as you attribute the work to the Queensland Mental Health Commission.

© Queensland Mental Health Commission 2014

Published by the Queensland Mental Health Commission, December 2014

ISBN 978-0-9942063-1-2

Queensland Mental Health Commission

PO Box 13027, George Street QLD 4003

Phone: **1300 855 945**

An electronic copy of this document is available at www.qmhc.qld.gov.au

¹ Section 4 of the *Queensland Mental Health Commission Act 2013*.



CONTENTS

ACKNOWLEDGEMENT	2
COMMISSIONER'S MESSAGE	3
REPORT SUMMARY	4
Options for reform	5
INTRODUCTION.....	7
Developing options for reform	7
Recovery-oriented mental health services	9
Least restrictive practices in acute mental health wards	10
A RECOVERY-ORIENTED APPROACH IN MENTAL HEALTH WARDS	11
Supportive relationships	11
Changing culture	13
Organisational policy and procedures	13
Routine and environment.....	15
Staffing.....	18
Monitoring and review	18
REFERENCES	20



ACKNOWLEDGEMENT

We wish to pay respect to Aboriginal and Torres Strait Islander Elders, past and present, and acknowledge the important role of Aboriginal and Torres Strait Islander people, their culture and customs across Queensland.

We also acknowledge the people living with mental health and drug and alcohol problems, their families and carers. We can all contribute to a society that is inclusive and respectful, where everyone is treated with dignity and able to focus on wellness and recovery and have fulfilling lives.

COMMISSIONER'S MESSAGE

Every person's journey to recovery from mental illness or problems with drugs and alcohol is different. Treatment in hospital is often a necessary and important part of this journey but it can be a very distressing time in their lives and in the lives of their family, friends and carers.

This report has been prepared in the context of public acute mental health wards being locked across Queensland in December 2013. Immediately after, and in the months following this action, the Commission received several submissions and heard the views of people including consumers, families and carers and professional bodies in relation to the care and treatment of people in our mental health facilities.

Views about security varied, with some indicating that locking wards was essential to ensure safety, and others expressing concern that the action was inconsistent with a recovery-oriented, least restrictive approach to mental health care.

This report outlines options for reform towards a more recovery-oriented and least restrictive approach to mental health services delivered in acute mental health wards. It is intended to provide a balanced view of a very complex situation and to assist mental health services to move towards a least restrictive environment. It is also important to note that in all likelihood, many of the practices underpinning these options are already in place in some services. The challenge is to make good policies and practices routine on all wards, all the time, across the State.

The report is based on a literature review and facilitated forums undertaken on our behalf by The University of Melbourne, consultation with the Queensland Mental Health and Drug Advisory Council, consumers, families and carers and senior clinicians. It does not focus solely on locked wards. Rather it takes a more comprehensive approach to supporting recovery-oriented, least restrictive practices in acute mental health wards, whether they are locked or not.

I am grateful to the people, including those with a lived experience, their families and carers, and the staff employed in acute mental health units who shared their perspectives and provided invaluable insights to inform this report. Their views are a reminder to us all that much work remains ahead to ensure we continue to move towards recovery-oriented practice in the care and treatment of people with mental illness.

I hope that this report will provide useful input for consideration at the system level, as well as among all acute public mental health services, to ensure the best outcomes for Queenslanders requiring care and treatment provided in the least restrictive manner possible and firmly focused on recovery.



Dr Lesley van Schoubroeck
Queensland Mental Health Commissioner



REPORT SUMMARY

A cornerstone of recovery-oriented practice is the recognition that people requiring care and treatment for their mental illness are provided with care in as least restrictive manner as possible. Recovery-oriented mental health service delivery is defined by *A National Framework for recovery-oriented mental health services: Guide for practitioners and providers* as the ‘application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.’

Least restrictive practices form an essential foundation to a recovery-oriented approach. Implementing least restrictive practices has been accepted internationally and nationally as best practice. The World Health Organisation’s *Mental Health Care Law: Ten Basic Principles* include the provision of least restrictive practices and indicate that institution-based treatments should be provided in the least restrictive environment.

Queensland, like all other Australian States and Territories, enshrined commitments to implementing least restrictive practices in their legislation² and has been working towards a recovery-oriented approach, and implementing least restrictive practices in its mental health wards. The focus of these efforts however has been largely on the treatment of individuals.

Few policies adopt a ‘whole-of-ward’ approach to least restrictive practices or recovery-oriented services. Of particular note is the lack of practical recommendations in the literature for least restrictive care in acute mental health units.

This report outlines options for reform to support recovery-oriented practice and the implementation of least restrictive practices in acute mental health wards, with a particular focus on the role of locked wards. It sets out evidence-informed reforms which aim to strengthen recovery-oriented approaches and least restrictive practices under three areas: supportive relationships; organisational culture; and monitoring and reviewing elements of a recovery-oriented approach.

The report has been developed in the context of significant debate following a move initiated by a directive from the Director of Mental Health in December 2013 to lock all publicly operated acute mental health wards in Queensland following concern regarding the number of people being absent without permission (AWOP)³.

From time to time, and in certain circumstances, wards may need to be locked, however there is a need to continue to adopt a recovery-oriented, least restrictive approach when these decisions are made. It also outlines options for ensuring safety in acute mental health wards and approaches to reducing absences without permission.

Developed based on research undertaken by The University of Melbourne, the views expressed to the Commission by consumers, families and carers and other stakeholders and in consultation with the Queensland Mental Health and Drug Advisory Council, this report sets out 15 options for reform to enhance recovery-oriented, least restrictive approaches in acute mental health wards in Queensland.

2 Section 9 of the *Mental Health Act 2000*.

3 A patient is considered to be absent without permission in certain circumstances, for example if they are an on: an in-patient involuntary order and they leave an acute mental health ward without approval; or is on leave in the community but does not return to the ward when required.

Options for reform

1. Investigate options to enable consumers to communicate with families and friends through greater access to phones and the internet, subject to treatment plans, and by encouraging the presence of families, friends and other supporters on the ward.
2. Enhance peer support worker programs in Hospital and Health Services by:
 - involving peer support workers in each stage of a consumer's treatment from admission to discharge
 - providing appropriate training to assist peer support workers to undertake their roles
 - involving peer support workers as part of the treatment team.
3. Policy and procedures to adopt a risk management approach which enable consumers to take measured risks as part of their recovery.
4. Hospital and Health Services and the Director of Mental Health to provide clear and timely advice to staff and consumers, families and carers regarding decisions to lock doors. Decisions are to be made on the basis of clear and stated factors and processes including a set time for review of a decision to lock ward doors.
5. To reduce absence without leave, an approach be implemented by Hospital and Health Services which includes developing a plan for individuals based on recovery-oriented practice and addressing the issues leading to their absence. This plan should be regularly reviewed and monitored and its development should involve peer support workers.
6. Decrease impersonal and custodial features (or non-caring environment) of the ward through creating more appealing and liveable spaces in the ward via decor, family friendly spaces, tea and/or coffee making facilities including a welcome or reception area.
7. Where access to outdoor or recreational spaces has been limited including as a result of locking the ward, appropriate action be taken in a timely manner to make the entire ward freely accessible to consumers.
8. Provide face-to-face orientation for consumers, and involving families and carers where appropriate. The orientation process should include information about the ward rules and daily routines and emphasising consumer comfort, personal safety and how to access support and involve peer support workers.
9. Hospital and Health Services, in consultation with consumers, families and carers, provide opportunities for consumers in mental health wards to undertake activities to reduce boredom, including those that promote physical health.
10. Wherever possible, women and children and young people should be accommodated separately in wards. Any future refurbishments or construction should take into account the need to have capacity to separate consumers on the basis of age and gender.
11. Staff, including nursing staff and allied health workers as well as casual/agency staff working in the acute inpatient wards to be trained in mental health.

- 12. Provide on-going training and professional development opportunities focused on recovery-oriented practice to nursing staff.**
- 13. An audit be undertaken in each ward to identify the extent to which options outlined in this report are being implemented and additional steps that should be taken to enhance recovery-oriented services adopting a least restrictive approach.**
- 14. To understand the full extent of unintended consequences that have been highlighted in the literature, but as yet remain undocumented, conduct a comparative analysis of data from before and after the introduction, where possible, of the new policy regarding:**
 - the rate of voluntary admissions
 - the rate of self-harm in inpatient settings
 - the rate of aggressive incidents in inpatient settings
 - the rate of illegal drug use
 - smoking related incidents (including fire setting)
 - the use of seclusion and restraint in inpatient settings
 - use of recreational areas
 - visits by family, friends, carers.
- 15. Audit and monitor data relating to Absences Without Permission including:**
 - conducting a quality audit of AWOP data to ensure that the data are being captured accurately and within the expected parameters
 - conducting an analysis of AWOP data taking into account any issues identified with data integrity
 - monitoring the levels of AWOP including by comparing levels from locked and unlocked wards.



INTRODUCTION

Recovery-oriented practice has been a key principle in mental health policy in Australia and internationally for over 20 years. While the implementation of recovery-oriented approaches is encouraged in various policy frameworks, there is insufficient evidence regarding their practical application in acute mental health wards.

A cornerstone of recovery-oriented practice is the recognition that people requiring care and treatment for their mental illness are provided with care in as least restrictive manner as possible. This was seen as a key reason for shifting care to the community when countries around the world, including Australia, moved to deinstitutionalise mental health care. People, who require care in acute inpatient units, whether as a voluntary or involuntary patient, must be afforded this care in the least restrictive manner possible.

This report outlines options for reform to support recovery-oriented practice and the implementation of least restrictive practices in acute mental health wards, with a particular focus on the role of locked wards.

It has been developed in the context of significant debate following a move initiated by a directive from the Director of Mental Health in December 2013 to lock all publicly operated acute mental health wards in Queensland following concern regarding the number of people being absent without permission (AWOP)⁴.

Following this action, and in the subsequent months, the Commission received several submissions and heard the views of many people including consumers, families and carers and professional bodies in relation to the care and treatment of people in our mental health facilities.

In order to provide a considered response to the debate, the Commission determined that the most constructive direction was to identify evidence locally and from other jurisdictions about the use of locked wards and their place in contemporary practice. The scope of the research was to look comprehensively at the key elements that constitute a least restrictive environment in the delivery of acute mental health care and treatment and the role of locked wards in that care.

This report acknowledges that from time to time, and in certain circumstances, wards need to be locked. However it also highlights the need to continue to adopt a recovery-oriented, least restrictive approach when these decisions are made. It also outlines options for ensuring safety in acute mental health wards and approaches to reducing absences without permission.

Developing options for reform

This report has been developed based on research undertaken by The University of Melbourne, the views expressed to the Commission by consumers, families and carers, senior mental health clinicians, the Queensland Mental Health and Drug Advisory Council and other stakeholders.

⁴ A patient is considered to be absent without permission in certain circumstance for example if they are on an in-patient involuntary order and they leave an acute mental health ward without approval; or is on leave in the community but does not return to the ward when required.

The University of Melbourne's research

The Commission engaged The University of Melbourne's Centre for Mental Health in the Melbourne School of Population and Global Health and the Department of Nursing in the School of Health Sciences to undertake research into least restrictive practices in acute mental health wards including locked wards. The research team was led by Dr Lisa Brophy, Research Fellow at the Centre for Mental Health and Director of Research at Mind Australia.

The research sought to identify system elements necessary to move towards a least restrictive environment in acute mental health inpatient units including whether the ward or unit doors were locked or unlocked. The research was undertaken in two stages:

- a literature review including a review of relevant Australian state and national policy documentation
- forums with consumers, families and carers and hospital staff.

Possible recommendations were developed by The University of Melbourne based on the literature review. The recommendations were then tested with forum participants.

Five forums were conducted in three locations involving the following stakeholders:

- people with lived experience in Rockhampton
- hospital staff in Rockhampton
- carers on the Gold Coast
- hospital staff on the Gold Coast
- people with lived experience in Logan.

The report *Least restrictive practices in acute mental health wards including consideration of locked doors: Facilitated forums and options for the future* (Fletcher, Hamilton, King, Sutherland, Kinner & Brophy, 2014) was provided to the Commission in August 2014 and is available on the Commission's web-site at qmhc.qld.gov.au.

The University of Melbourne's report outlined 21 recommendations in six inter-related areas for reform:

- recovery-orientation
- policy and procedure
- routine and environment
- organisation and staffing
- discretionary door locking
- universal precaution of locking wards.

The Queensland Mental Health and Drug Advisory Council

Members of the Queensland Mental Health and Drug Advisory Council have made a significant contribution to the development of options for reform.

On 14 October 2014, the Advisory Council indicated that they supported the Commission's proposed options for reform.

The Advisory Council also requested the Commission to consider how it might review the extent to which these options are implemented in 12 months' time. The Advisory Council indicated that it was committed to ensuring it exercises its influence to eliminate any locking of wards that is not in the best interest of consumers, consistent with recovery-oriented practice.

Clinician roundtable

The Commission hosted a roundtable of several leading mental health professionals on 4 September 2014 to discuss the research team's findings and recommendations. At the conclusion of the Roundtable, participants agreed that:

- efforts must be increased to ensure the recovery-oriented practice becomes the standard
- least restrictive practices are an important element of recovery oriented practice
- the culture within mental health organisations needs to change to support recovery oriented practice
- mental health services need to provide confidence in the system so that Hospital and Health Services are able to shift to a tiered discretionary approach to locking of doors.

Recovery-oriented mental health services

While there is no single definition of recovery, all descriptions focus on consumer empowerment, self-determination, hope and inclusion.

This report adopts the definition outlined in *A National Framework for recovery-oriented mental health services: Guide for practitioners and providers*. The National Framework defines personal recovery as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues'.

Recovery-oriented mental health service delivery is defined by the National Framework as the 'application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.'

This report acknowledges that each person's recovery journey will be different based on their personal circumstances and aspirations. Further, a person's recovery needs will evolve over time and may include treatment in an acute mental health ward.

At the centre of recovery is the person themselves. However many others including family, carers, friends, treating teams and the wider community may also be involved and impacted.

The University of Melbourne's literature review identified that recovery-oriented practice has been implemented mainly in the context of community mental health settings and there is very limited research on recovery-oriented practice in acute mental health wards particularly focused on the experience of consumers.

Least restrictive practices in acute mental health wards

Least restrictive practices form an essential foundation to a recovery-oriented approach. Implementing least restrictive practices has been accepted internationally and nationally as best practice. For example, the World Health Organisation's *Mental Health Care Law: Ten Basic Principles* include the provision of least restrictive practices and indicate that institution-based treatments should be provided in the least restrictive environment.

Queensland, like all other Australian States and Territories, has been working towards implementing recovery-oriented approaches, and least restrictive practices in its mental health wards is enshrined in legislation⁵. However the focus of policies, legislation and services has been on applying these approaches to the treatment of individuals, such as the use of seclusion and restraint.

Similarly, most literature regarding least restrictive practices describes care from the perspective of individual treatment, or describes the way in which patients move from more restrictive (hospital-based) to less restrictive care options (community-based).

Few policies adopt a 'whole-of-ward' approach to least restrictive practices or recovery-oriented services. Of particular note is the lack of practical recommendations in the literature for least restrictive care in acute mental health units.

⁵ Section 9 of the *Mental Health Act 2000*.



A RECOVERY-ORIENTED APPROACH IN MENTAL HEALTH WARDS

The options for reform are divided into three categories:

- supportive relationships
- organisational culture which encompasses policies and procedures, ward routine and environment and staffing
- monitoring and reviewing elements of a recovery-oriented approach.

Supportive relationships

Increasing contact with family, carers and friends

It is universally accepted that supportive relationships are essential to recovery. While receiving treatment in an acute mental health ward there is an ongoing need to continue to develop and maintain relationships with families, carers and friends.

During the facilitated forums, staff agreed that the role of families and carers was important to maintaining continuity of care and treatment when the consumer is discharged. Consumers however were more cautious, with some feeling that, while families and carers played a positive role in recovery if they were supportive, any contact should be agreed by the consumer. As noted by one consumer:

And I think that's an important one that people's rights are considered there, if you're of age and you don't want mum and dad on the ward, well it should be respected, if they are going to be, if your treating team feels that you do need, they need to take well they need to go elsewhere to do so, I think that can be quite intimidating. You should be able to have the choice of yay or nay with that sort of thing.

These relationships can be impacted by the rules and regulations applying in acute mental health wards which limit communication with family, friends and carers to physical visits, phone conversations and letters.

Some hospital staff indicated during the facilitated forums that the application of these rules resulted in consumers from rural and remote areas having little contact with family, carers and friends. This situation could be assisted by offering a broader range of contact options including use of the internet and Skype.

As noted by some hospital staff this may involve a degree of risk with one staff member noting: 'People are sharing pictures because they have anorexia or bulimia, self-harming sites'. However, they expressed the view that many of these risks can be managed by using current technology to block access to certain sites and closely monitoring use.

- 1. Investigate options to enable consumers to communicate with families and friends through greater access to phones and the internet, subject to treatment plans, and by encouraging the presence of families, friends and other supporters on the ward.**

Peer support workers

Peer support workers are people with lived experience of mental health problems who are employed to provide support to consumers. There are many definitions of the role of peer support workers although they are widely recognised as playing a critical role in recovery.

The University of Melbourne noted that increasing the number of peer support workers in inpatient settings would enable recovery-oriented care⁶. This research was supported with facilitated forum participants indicating a need to include more peer support workers on wards.

As one hospital staff member noted:

I think it's the lived experience that you cannot get from staff. The staff get their knowledge from their training but they don't have the experience of it and sometimes what you want to hear is someone who's actually experienced this and that's very, very important whether you've got a mental illness or you break your leg you know whatever condition you have that's really crucial.

Those participating in the facilitated forums also suggested that the most effective way a peer support worker can provide support included sharing their story of recovery, modelling hope and providing advocacy. Peer support workers were also seen to be providing consistent support from when a consumer is admitted until they are discharged.

One consumer advised at the facilitated forums:

...there's nothing better than lived experience to go with people and be able to say hey I've been here, I've been on these meds and you know this is where I've gotten now through recovery and having people around that have faith in you and say you can do it, rather than oh don't try.

Nonetheless, as The University of Melbourne noted, peer support workers need to be appropriately trained and supported in their role.

The Mental Health Peer Workforce Study recently undertaken by Health Workforce Australia examined the mental health peer workforce in public, non-government and private mental health sectors. The study found that there were a number of barriers faced by peer support workers, which included poorly defined roles, negative attitudes from non-peer workers, role conflict and confusion, lack of clarity around confidentiality and limited opportunities for networking and support. The need for training which focuses on specific skills and tasks was also identified by the study.

2. Enhance peer support worker programs in Hospital and Health Services by:

- **involving peer support workers in each stage of a consumer's treatment from admission to discharge**
- **providing appropriate training to assist peer support workers to undertake their roles**
- **involving peer support workers as part of the treatment team.**

6 Cited Holmes, Molloy, Beckett, Field and Stratford, 2013.

Changing culture

The University of Melbourne⁷ research indicated that patients are more likely to have hope of recovery if involuntary treatment is handled in a supportive and inclusive way. Importantly, the culture of a mental health ward has a direct impact on the recovery journey experienced by consumers. The culture of a ward is influenced by a wide variety of factors including:

- organisational policy and procedures
- the routine and environment of the wards
- staffing.

Organisational policy and procedures

Enabling consumers to set and achieve their goals

Self-determination and goal setting are inherent in a recovery-oriented approach. Measured risk taking is also considered a positive part of treatment and recovery and enables consumers to remain part of their family and community.

To enable this The University of Melbourne identified a need to change the culture in mental health wards from being strongly risk-averse to being more prepared to manage risk, to enable greater consumer choice and support a more recovery-oriented practice.

The University of Melbourne noted that a shift in policy will support staff to change their practice. However any policy also needs to acknowledge the particular pressures and demands placed on an acute mental health service, particularly the need to maintain a safe environment for consumers, their family and carers, staff and the wider community.

One consumer discussed their experiences in a more relaxed ward environment:

It was really good, I enjoyed it there, for a short time, it was really good because you could go for a walk and then come back whenever you wanted to, staff were just as long as you were there for tea you know, that was the way that it should be you know with everybody feeling at home sort of thing, more relaxed.

Staff during the facilitated forums spoke of a 'risk-averse' culture that, in their view, came from senior government policy messages. One staff member highlighted that the 'predominant approach is one that protects the state or organisation as opposed to the consumer within it, because consumers are used to that, so they don't rebel against it.'

3. Policy and procedures to adopt a risk management approach which enable consumers to take measured risks as part of their recovery.

⁷ Cited Wyder et al., 2013.

Discretionary approach to locking wards

The University of Melbourne indicated that even though locking wards was not consistent with a recovery-oriented least restrictive approach to mental health treatment, consumers, families and carers and staff all commented at facilitated forums that at times a locked ward can be helpful.

As noted by one consumer:

I think that in certain ways it's good to be locked, because if you're in a deep psychosis, either you're dangerous or you're not aware of your situation, you need to be closely monitored.

However, both carers and consumers commented that once an acute situation begins to be resolved, or if the consumer is voluntarily being treated, an unlocked door is likely to be more beneficial. As noted by one consumer:

I think there are occasions when we do need locked wards and certainly in my experience I think that there are times when I needed to be in a locked ward, but I think that time is really short and really specific.

The basis upon which wards are locked needs to be carefully considered and should be subject to local considerations including consumer, staff and community safety, and identifying other ways to address the issues that have led to the locking of wards.

Not understanding why they are confined to a locked ward contributes to feelings of disempowerment. One of the issues identified by The University of Melbourne was the need to explain the reasons to consumers behind decisions to lock wards based on transparent criteria which are communicated in a timely manner. Further, they identified a need to set clear parameters around these decisions including a clearly stated and definitive time period after which a decision to lock a ward is reviewed.

Although not highly rated as a priority by many participants in the facilitated forums, clear and transparent decision making regarding the routine changes on the ward can support a more recovery-oriented approach.

- 4. Hospital and Health Services and the Director of Mental Health to provide clear and timely advice to staff and consumers, families and carers regarding decisions to lock doors. Decisions are to be made on the basis of clear and stated factors and processes including a set time for review of a decision to lock ward doors.**

An approach to absences without permission

One of the rationales for locking wards has been to reduce the number and frequency of consumers being absent from wards without permission, and concerns regarding their safety and the safety of the community.

The University of Melbourne identified a wide range of reasons for consumers leaving wards without permission including social factors such as wanting to have contact with family and friends. Staff commented that there was a need to consider the 'real root cause' noting that a 'small core group of consumers ... are constantly absconding ...'.

Consumers noted that there is a need to think about whether the ward environment was helpful and stimulating, whether contact with family was enabled and also the importance of finding out what

wasn't helpful for the consumer. One consumer commented that 'every time I absconded no one ever asked me the question "what wasn't helpful here?"'.

There is a clear need to identify and address issues for consumers who are absent without permission. Developing an individualised plan founded on recovery is likely to reduce repeated incidence of AWOP.

- 5. To reduce absence without leave, an approach be implemented by Hospital and Health Services which includes developing a plan for individuals based on recovery-oriented practice and addressing the issues leading to their absence. This plan should be regularly reviewed and monitored and its development should involve peer support workers.**

Routine and environment

Environmental factors and the routine in a ward can have a significant impact on the recovery of people experiencing mental illness in a mental health ward. As indicated by The University of Melbourne and others it can also impact on the number of consumers leaving mental health wards without permission.

Reducing the custodial features of the ward

Locking wards has the potential to increase the custodial feel of the ward environment. As one consumer indicated: '[it's a] custodial rather than therapeutic environment'.

Reducing the custodial feel of mental health wards is one strategy that promotes recovery and could potentially reduce AWOPs. During the facilitated forums, staff indicated that the custodial features of the ward had a negative impact upon consumers and at times may have perpetuated stigmatising views of people with mental illness as needing to be contained because they are perceived to be 'dangerous'.

Staff also commented that locking wards can have a negative impact on the atmosphere of the ward. As one staff member indicated:

I think from the feedback that I've got now the change is we're more restrictive inside the ward. Although we've always been locked we seem to have these more restrictive processes now. Like it was quite relaxed a consumer would come to the desk and say I'm going out, fine I'll press the button to buzz you out and now there's a lot more structure around well no you can't we have to look at this we have to do that, we have to physically walk you to the door, it's a lot more strict than it used to be.

While consumers gave this issue some importance during the facilitated forums they considered being treated with respect and care as being more important.

The University of Melbourne noted that a good balance has been struck between maintaining consumer safety and reducing the custodial feel in some of the new mental health wards in Queensland.

Apart from the physical and design features of wards, other factors lend themselves to a more custodial feel in acute mental health wards. For example, consumers, families and carers and staff also commented in the facilitated forums on the culture of wards. This can impact on how controlled and restricted a ward seems regardless of whether the doors are locked or unlocked. As noted by staff:

little things can make a big difference so I don't know, having a rule around when you can access tea and coffee, you can still have the feeling of restricted environment inside.

- 6. Decrease impersonal and custodial features (or non-caring environment) of the ward through creating more appealing and liveable spaces in the ward via decor, family friendly spaces, tea and/or coffee making facilities including a welcome or reception area.**

As noted by The University of Melbourne, a significant consequence reported by those who participated in the facilitated forums was that many indoor and outdoor recreational spaces were no longer being used as intended because a staff member is required to be present at all times. Further, some involuntary patients without leave entitlements are not allowed to access these spaces as the fence is not the regulation height.

This issue increases boredom, enhances the custodial features of wards and has the potential to impact on recovery.

- 7. Where access to outdoor or recreational spaces has been limited including as a result of locking the ward, appropriate action is taken in a timely manner to make the entire ward freely accessible to consumers.**

Orientation

Being admitted to a mental health ward, particularly as an involuntary patient can be a distressing and disempowering event. Families, carers and friends can also feel distressed and on some occasions can feel discouraged from visiting mental health wards.

Consumers and staff at facilitated forums considered that an orientation process could offer a constructive way of engaging consumers in a meaningful way, and is a way of ensuring they have shared knowledge with staff, promoting a sense of control over their situation. As one consumer indicated: 'Even if you don't have control or choice, at least you share that information; you're not being kept in the dark'.

One staff member saw the importance of involving peer support workers in the admission process and that this may support consumers to understand and comply with ward rules:

... peer support workers can not only be there from admission, so it's that face that they get to know and that support person they could have throughout their admission, so if you know they could start building up a relationship with that person, or people, that they can go to when they're having urges that they want to abscond or they want to use or, somebody else other than just the nursing staff that they might feel comfortable talking to about... they would be a link to...helping in a less restrictive way.

For voluntary patients, this orientation process could commence prior to admission.

- 8. Provide face-to-face orientation for consumers, and involving families and carers where appropriate. The orientation process should include information about the ward rules and daily routines and emphasising consumer comfort, personal safety and how to access support and involve peer support workers.**

Purposeful activities

The University of Melbourne's literature review identified a number of strategies to better promote recovery in acute mental health wards which included the need to reduce boredom on the inpatient units by providing more engaging and active programs.

This was confirmed during the facilitated forums with consumers, families and carers and hospital staff all rating the need to provide more activities as their top priority. They identified the benefits associated with having meaningful activities to participate in, such as reducing the feeling of being restless, 'reducing boredom', assisting in managing the bad days, providing consumers with choices in their day and reducing the desire of consumers to leave wards without permission.

As one forum participant noted in a facilitated forum:

I mean to be honest as a consumer I've been in locked wards and I've been in different hospitals around different states and the ones where you know the thought of actually leaving the hospital didn't cross my mind was the ones where, I won't say where it was, but from the time you woke up in the morning to the time you went to bed at night there was non-stop things happening and they were not just oh yeah here's a couple of pencils, they were so well resourced.

Consumers, families and carers and hospital staff also emphasised the need for activities that were purposeful and promoted healthy living including physical activities, creative activities and learning new skills. As noted by The University of Melbourne consumers raised the need for 'dignity of choice' and having a variety of activities to choose from.

While some hospitals were providing activities, the research indicates that more can be done. For example, during the facilitated forums, hospital staff indicated that more use could be made of outdoor spaces. This view was confirmed at the roundtable of senior clinicians, however resources were identified as a barrier to implementing an activities program.

- 9. Hospital and Health Services, in consultation with consumers, families and carers, provide opportunities for consumers in mental health wards to undertake activities to reduce boredom, including those that promote physical health.**

Consumer safety

Feeling safe and supported is an essential part of recovery. As noted by clinicians, in some wards in Queensland, due to their design and the number of people being treated, a wide variety of people with differing needs and circumstances are accommodated together.

Senior clinicians at the roundtable raised concerns about the appropriateness of this situation.

The facilitated forums identified the need for providing a sense of privacy and safety, such as considering factors such as gender and age in the allocation of bed rooms. Carers most frequently endorsed this requirement with a number of staff also rating this as an important factor in managing a ward.

There were also suggestions that not feeling safe was a factor in some consumers leaving mental health wards without permission. As one staff member indicated:

the reasons for absconding are they didn't feel safe, particularly women run away because they didn't feel safe in units with men running around. So safety and keeping you feeling safe in a psychiatric unit so whether the door is locked or not safety's an issue.

- 10. Wherever possible, women and children and young people should be accommodated separately in wards. Any future refurbishments or construction should take into account the need to have capacity to separate consumers on the basis of age and gender.**

Staffing

The literature on recovery-oriented practice in acute mental health wards highlights the important role played by nursing staff. Nurses, allied health workers and others interact with consumers on a day to day basis and are a critical part of the treating team.

Participants during the facilitated forums indicated that it was important that staff working in acute mental health wards have specific mental health training, because casual staff may not have any specific knowledge of mental health problems, and therefore may lack the skills to interact well with consumers.

As one staff member noted:

...experience of staff on unit is an issue and we seek that in [Ward name] where we get now a lot of nurses who are not mentally health trained coming into the unit and a lot of the senior staff have left because it's too dangerous and it's too risky. So I think the issues around... we do have to look at staffing as well and the experience of staffing and train staff better.

11. All staff, including nursing staff and allied health workers as well as casual/agency staff working in the acute inpatient wards to be trained in mental health.

Conversely, some staff during facilitated forums noted that sometimes restrictive and controlling practices are initiated by long-term nursing staff. One staff member commented:

I think when staff have been there too long to be moving them on and rotate them out, I think that's a huge issue as well, because sometimes it's their restrictive practices that are, they're the ones that are saying no.

During the facilitated forums staff suggested that absences without permission could be reduced through skilled nursing:

If you've got more support and intensive nursing with incredibly skilled persons and not just someone that's come off the pool for the day then you've got really good care and recovery is going to improve a lot quicker I think. You're going to manage situations better, things like AWOP, suicide risk, self-harm they're going to drop off because people will know what they're doing in an environment they can manage.

12. Provide on-going training and professional development opportunities focused on recovery-oriented practice to nursing staff.

Monitoring and review

Monitoring and review is an essential part of continuing improvement in recovery-oriented practice. As noted in this report, there is very little evidence in the research about what practices in acute mental health wards support a 'whole-of-ward' recovery-oriented least restrictive approach to treatment.

A process of continuous monitoring and review can be implemented to further develop this area. Currently processes and reviews such as the Consumer Perceptions of Care report which is prepared annually will provide a valuable starting point for this review, however other elements need to be considered.

13. An audit be undertaken in each ward to identify the extent to which options outlined in this report are being implemented and additional steps that should be taken to enhance recovery-oriented services adopting a least restrictive approach.

Locking wards has been identified as having potential unintended negative consequences. As indicated by many stakeholders, and identified by The University of Melbourne, these may include a reduction in the number of people seeking voluntary admission, an increase in aggression possibly leading to increased use of seclusion and restraint, and smoking on wards.

At this time these issues have not been examined and further investigation is needed to inform future policy and practice.

14. To understand the full extent of unintended consequences that have been highlighted in the literature, but as yet remain undocumented, conduct a comparative analysis of data from before and after the introduction, where possible, of the new policy regarding:

- **the rate of voluntary admissions**
- **the rate of self-harm in inpatient settings**
- **the rate of aggressive incidents in inpatient settings**
- **the rate of illegal drug use**
- **smoking related incidents (including fire setting)**
- **the use of seclusion and restraint in inpatient settings**
- **use of recreational areas**
- **visits by family, friends, carers.**

It is also important to examine the number of consumers leaving mental health wards without permission and the reasons for this occurring.

15. Audit and monitor data relating to Absences without Permission including:

- **conducting a quality audit of AWOP data to ensure that the data are being captured accurately and within the expected parameters**
- **conducting an analysis of AWOP data taking into account any issues identified with data integrity**
- **monitoring the levels of AWOP including by comparing levels from locked and unlocked wards.**



REFERENCES

- Health Workforce Australia 2014, Mental Health Peer Workforce Study, Health Workforce Australia, Adelaide.
- Queensland Health 2014, Consumer Perceptions of Care statewide report 2013, Queensland Health, Brisbane.
- Australian Health Ministers' Advisory Council 2013, A national framework for recovery-oriented mental health services: Guide for practitioners and providers, Commonwealth of Australia, Canberra.
- Australian Health Ministers' Advisory Council 2013, A national framework for recovery-oriented mental health services: Policy and Theory, Commonwealth of Australia, Canberra.
- Fletcher, J., Hamilton, B., King, K., Sutherland, G., Kinner, S., Brophy, L. 2014, Least restrictive practices in acute mental health wards including consideration of locked wards: Facilitated forums and options for the future, report prepared for QMHC by The University of Melbourne, Melbourne.
- Holmes, D., Molloy, L., Beckett, P., Field J., and Stratford, A. 2013, Peer support workers hold the key to opening up recovery-orientated service in in-patient units, *Australasian Psychiatry*, 21(3), 282-283. Cited in Fletcher et al. 2014.
- Wyder, M., Bland, R., Crompton, D. 2013, Personal recovery and involuntary mental health admissions: The importance of control, relationships and hope, *Health*, (05)(03), 574-581. doi: 10.4236/health.2013.53A076. Cited in Fletcher et al. 2014.



Queensland Mental Health Commission

Level 30, 400 George Street
Brisbane QLD 4000

PO Box 13027, George Street QLD 4003

Phone: **1300 855 945**
info@qmhc.qld.gov.au
www.qmhc.qld.gov.au