Policy Analysis: The Prevalence of Leisure-related Concepts Found in Mental Health Legislation

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Abstract

Background. There appears to be limited investigation on the impact mental health acts have on the implementation of therapeutic modalities such as leisure or recreation in acute settings. This policy analysis explores Australia, New Zealand, and the United Kingdom's documents as they share similar principles on service delivery for mental health. This paper explores 33 mental health act legislation and supporting documents within Australia, New Zealand, and the United Kingdom, in comparison with international (WHO, UN) recommendations, to explore their alignment with the promotion of access to meaningful leisure activities.

Methods. A checklist was developed from the literature on ideal criteria that can facilitate leisure engagement and best-practice standards for leisure delivery. Each document was hand-searched and scored.

Results. Some documents did not contain any leisure related language and received a score of 1. Leisure-related language was typically associated with the built environment. Australia was the only country to contain high-quality leisure-related language in their policy. New Zealand presented with the lowest scores overall and lacked meaningful use of leisure-related language throughout its reviewed documents.

Conclusion. The legislation and supporting documents reviewed do not include sufficient language to support therapeutic engagement in inpatient units.

Background

Mental health trained allied health such as psychologists, social workers and occupational therapists, nurses and medical professionals typically practice under governing documents for consumer care such as the Mental Health Act (MHA). A common understanding of the MHA is it is a method of restrictive practice that supports with treatment in the community and facilitating admission for consumers who lack capacity due to acute mental illness [1]. Often, governing documentation and provide limitation or restriction for staff providing direct service-provision. They are also a very important guide provide safe and ethical practice.

Consumers who are admitted to inpatient services are typically found wandering, bored, and sitting [2, 3]. In public health settings, there is typically limited access to organised activity to prevent boredom [3, 4]. Boredom is closely linked with poor impulse control, hostility, and restlessness as the brain requires stimulation [5]. Participation in leisure can reduce overall risks to self and others, as it assists with cognitive stimulation and a reduction in boredom [5]. Engagement can also increase therapeutic opportunities and promotes overall health and wellbeing [6]. Lack of leisure participation can be particularly profound in acute inpatient units due to a variety of reasons including funding, environment, acuity, and lack of resources [7]. While access to leisure is a human right, a person's ability to participate is influenced by societal, economic, and political factors [8].

Participation in leisure can assist to reduce overall risks to self and others; increases therapeutic opportunities and promotes improvement in overall health and wellbeing. In recent years, a focus of health care has been on least restrictive practice in mental health settings and advocacy for consumer rights [9]. Leisure may be a strategy to reduce the need for restrictive practice [9].

A study completed by [4] noted that consumers spend approximately ninety minutes engaging in any organised activity in a week over a 35 hour working week, in a general adult mental health inpatient unit (MHIU) which they received mental health support or care. High dependency units frequently offer limited access to leisure occupations due to the nature of the consumer acuity, furthermore persons in seclusion are highly restricted to access activity [10, 11]. This situation is unlikely to change unless access to leisure occupations is supported by policy and legislation.

The World Health Organization [12] developed an action plan advocating for consumer rights. One of these basic rights is access to leisure and recreational activity programmes in MHIUs. This action plan states that consumers should have adequate day treatment facilities and access to engage in an activity [12]. However, it is unknown if the World Health Organization recommendations are reflected in the MHA and associated policies that guide clinical mental health and govern ethical restrictive practice. In 2019, the World Health Organization launched a special initiative for Universal Health Coverage [13]. Within this strategic plan, stage one part three states "mental health policies, strategies, and laws are developed and operationalized based on international human rights standards." This plan is particularly focused on 'priority countries' but can be applied to all mental health systems.

The guidelines provided by the World Health Organization [12] support the assertion that it is critically important to attempt to review and update the Mental Health legislation in ways that are more aligned with the abovementioned national and international standards. This would more effectively support health promotion, illness prevention, and quality health care for this vulnerable group, instead of being primarily oriented toward punitive strategies [14, 15]. For example, sometimes, consumers may feel coerced or pressured into being admitted into an inpatient unit because of the application of a MHA. Some factors that can contribute to agitation and even aggression by consumers in a mental health inpatient unit can include the acuity of their condition (such as schizophrenia or bipolar affective disorder) coupled with a lack of preoccupation or boredom [1]. Lack of activity or support to occupy their time in an inpatient unit has also been associated with higher levels of aggression and risk [1]. According to The Sainsbury Centre for Mental Health [16] there has been increased mental health care in acute inpatient units.

Most countries, particularly Western countries, have a MHA. While most countries have a national or federalised act, in Australia each state has its own MHA creating a potential discrepancy for care between regions [17]. Countries such as the United Kingdom and New Zealand have nationalised MHAs. These three countries have similarities including universal free health care and delivery of their mental health acts and may have comparable experiences. Scoping the current leisure discourse in mental health policies and supporting documents (such as national mental health plans) could support the development of healthier policies and legislation in the future.

This study compares the quality of leisure focussed concepts between Australia, New Zealand, and the United Kingdom MHA's, national policy documents, and international recommendations (UN, WHO) to ascertain whether health policy can act as a barrier or facilitator to engagement in leisure activity.

Methods

This is a qualitative document review analysing all current mental health acts from the states and territories of Australia, New Zealand, and the United Kingdom (England, Wales, Northern Ireland and Scotland), from an occupational lens. The methodology for this study was based on an integrated method using a grounded theory approach [18]. Supporting policies from at state, national and international levels were also analysed.

Sample

A total of 33 documents were semantically analysed. The decision to select each of the countries included was due to the use of a MHA for treatment purposes, they are predominately English-speaking populations with similar leisure discourse, and all have free universal health care systems. Documents for analysis were sourced from publicly available locations such as government websites. These documents included current MHAs from each respective country, as well as associated documents (e.g., national standards and frameworks, international conventions) identified by two of the authors who are experienced, mental health practitioners. Previous versions of MHAs were excluded from this study. Documents included those that inform inpatient clinical care.

Procedure

Each document was manually reviewed and scored against a checklist created by the authors. The checklist consisted of six qualities including 'environment/accessibility', 'human rights', 'multidisciplinary team approach', 'patient centred-care', 'quality of life' and 'therapeutic aim' (see Table 1). The checklist involved a 1 to 5 Likert scale of inpatient leisure treatment principles for optimum care (1 indicating no or limited leisure-related principles present and 5 indicating optimum leisure-related principles) which was developed based on current literature (see Table 2 for criteria). Leisure was defined as *a chosen activity conducted in spare time that is not work-related, that can be enjoyable, relaxing, and/or fun and that can support the creation of personal health and wellbeing.* The checklist aimed to determine whether the legislation or policy analysed assists to facilitate leisure participation in mental health inpatient units.

Table 1
Leisure checklist qualities

Qualities	Definition	Reference
Environment / Accessibility	The physical environment of the inpatient unit facilitates the ability to engage in meaningful occupation. The environment should encourage social interaction and autonomy that increases the chance of natural engagement in occupation.	(Christiansen, 1999; Shepley et al., 2016; Triguero-Mas et al., 2015)
Human Rights	Leisure is considered a human right and all patients should have the right to access meaningful occupation whilst receiving treatment. The legislation or mental health document encourages patients to exercise their human right to engage.	(Assembly, 1948; Townsend & A. Wilcock, 2004; World Health Organization, 2013a)
Multidisciplinary Team Approach	Consumers are provided with a multidisciplinary team (psychiatry, nursing, social work, psychology, occupational therapy, non-clinical) approach in their treatment and care which facilitates recovery.	(Ahmead, Rahhal, & Baker, 2010; Chiu-Yueh, Huei-Lan, & Yun-Fang, 2015; Garman, Corrigan, & Morris, 2002; Radcliffe, Adeshokan, Thompson, & Bakowski, 2012; Whittington & McLaughlin, 2000)
Patient Centred Approach	The care provided by the treating team is a consultative approach with the patient and carers/family with treatment. Consumers have the opportunity to voice their interests and preferences in treatment and programmes offered (e.g. interests in leisure activity).	(Evatt, Scanlan, Benson, Pace, & Mouawad, 2016; Todman, 2003)
Therapeutic Aim	The multidisciplinary team provide goal directed treatment whilst inpatient, which includes but is not limited to, engagement in meaningful activity, stimulation and social engagement. Access to leisure occupation that is meaningful. Leisure occupation is often used in mental health settings as a therapeutic tool, to support development of coping skills and manage the effects of stress. Patients should have the ability to participate in meaningful occupation based on their own volition.	(Caldwell, 2005; Department of Health and Ageing, 2013; Ponde & Santana, 2000; World Health Organization, 2013a)
Quality of life	The care provided in the inpatient setting should enhance quality of life and overall health and well-being. The therapeutic goal is to improve quality of life through treatment.	(Christiansen & Matuska, 2006; Russo et al., 1997)

Table 2
Criteria scale of checklist qualities

Quality / Score	1	2	3	4	5
Environment / Accessibility	There is no inclusion of the phrase within the document.	There is sparce inclusion of the phrase within the document.	There is occasional inclusion of the phrase within the document that is mostly used within the context of leisure or provides thoughtful discussion of the included quality within the document.	There is regular mention of the phrase in the context of leisure within the document.	The document explicitly discusses the quality and provides thoughtful discussion on how the quality supports consumer care.
Human Right					
Multidisciplinary Team Approach					
Patient Centred Approach					
Therapeutic Aim					
Quality of life					

There were inclusion and exclusion criteria for the literature used to develop the leisure principles checklist. This included criteria such as studies with a focus on adult (18–65 years) mental health inpatient units; studies specifically exploring leisure occupation; interdisciplinary studies with a focus on therapeutic modalities (this may include recreational therapy); evidence-based approaches to the leisure activity and therapeutic programs in mental health settings. Studies that were excluded included other age groups such as paediatric or geriatric; a primary focus on other occupational areas such as self-care or productivity; and other therapeutic settings such as physical rehabilitation or aged care. Checklist items were developed through discussion between two researchers, based on a review of current literature, and included environment, human rights, multidisciplinary team approach, client-centred approach, quality of life, and therapeutic aim.

Data Analysis

Semantic analysis was conducted on each text and provided a score. Each document was read and a manual search of phrases from the criteria checklist allowed examples from the text. If limited examples were present within the document, the author read the document to determine if any similar discourses were used to meet the checklist criteria for scoring. Example text from all of the documents was placed into a spreadsheet [19]. These examples were then placed into the most appropriate category and scored based on the criteria (between 1 and 5) (see Table 2). Author two then supported with cross-checking the analysis and scoring of the checklist data.

Throughout each of these countries, multiple concepts or terms have been used to describe like meanings which narrowed the scope of appropriate leisure discourse used within the documents. Researchers hand-checked all 33 documents using the checklist to identify how the

leisure discourse is used uniquely in that country or document. This analysis explored the use of different discourses based on geographical location, context, and application to clinical settings.

Results

There were sparse quality concepts used within the 33 documents to explore and facilitate leisure participation (see Table 3). An example of text that was awarded each score in the six quality categories can be seen in Table 4. For example, in the human rights category, the Australian National Mental Health Policy was provided a score of five and the example of this text is within the table. In each category, the number of documents that were provided for each score is represented in a percentage. For example, 6% of the 33 documents analysed were given a score of five in the human rights category.

Table 3
Checklist results of policy analysis.

	Document	Quality Scores (1 indicating limited concepts present and 5 indicating high quality of concepts present)					
		Environment / Accessibility	Human Rights	Multidisciplinary Approach	Patient Centred Approach	Therapeutic Aim	Quality of Life
AUSTRALIA	National Mental Health Policy (D. o. H. Australian Government, 2014)	2	5	3	4	3	4
	National Recovery Framework (Commonwealth of Australia, 2013)	2	3	2	3	5	3
	National Standards for Mental Health Services 2010 (Australian Government, 2010)	4	5	4	3	2	4
	Australian Capital Territory Mental Health Act 2015 (Australian Capital Territory Government, 2015)	4	2	2	4	2	5
	New South Wales Mental Health Act 2007 (New South Wales Government, 2007)	2	1	2	5	2	3
	New South Wales Mental Health Act Regulation 2013 (New South Wales Government, 2013)	1	2	3	2	1	2
	Northern Territory Mental Health Act 1999 (Northern Territory Government, 2002)	2	3	2	4	3	1
	Queensland Mental Health Act 2016 (Queensland Government, 2016)	1	3	2	2	3	3
	Queensland Public Health Act 2005 (Queensland Government, 2017)	1	1	1	3	1	1
	Connecting Care to recovery 2016–2021	2	3	3	4	2	3
	South Australia Mental Health Act 2009 (South Australian Government, 2009)	1	1	1	1	3	2
	Tasmanian Mental Health Act 2013 (Tasmanian Government, 2013)	5	3	2	1	3	1
	Victoria Mental Health Act 2014 (Victorian Government, 2014)	5	3	3	4	4	3
	Western Australia Mental Health Act 2014 (Western Australia Government, 2014)	2	3	2	2	3	1
NEW ZEALAND	Health and Disability Commissioner Act 1994 (Ministry of Health, 2018a)	1	2	1	2	2	1
	Human Rights Act 1993 (Ministry of Justice, 2018)	1	2	1	1	1	1
	Rising to the Challenge 2012–2017 (Ministry of Health, 2012)	1	2	2	2	3	1
	Mental Health Compulsory Assessment and Treatment Act 1992 (Ministry of Health, 2018b)	1	2	2	1	3	1
THE UNITED KINGDOM	The Mental Health (Northern Ireland) (Amendment) Order 2018	1	1	1	1	1	1
	Mental Health Act 2007 UK (Parliament of the United Kingdom, 2007)	1	2	1	3	1	1
	Mental Health Act 1983 (Parliament of the United Kingdom, 1983)	1	2	1	3	1	1
	Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Welfare Commission for Scotland, 2003)	3	2	1	1	2	1
	Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales	2	2	1	1	3	3

	(Welsh Government, 2012)						
	Mental Health Strategy: 2017–2027 (Scotland) (Scottish Government, 2017)	2	2	4	1	2	2
	Achieving Better Access to Mental Health Services by 2020 (England) (Department of Health, 2014)	2	2	1	1	1	3
	The Mental Health (Wales) Measure 2010 (Parliament of the United Kingdom, 2012)	1	1	1	1	1	1
	Mental Health Commission Strategy Plan 2016–2018 (Ireland) (Mental Health Commission, 2017)	2	2	2	3	2	2
	Suicide Prevention: Policy and Strategy (Mackley, 2018)	3	2	1	2	2	1
	Reform of Mental Health Legislation in the UK (Northern Ireland Assembly, 2008)	3	2	3	4	1	2
	Mental Capacity Act 2005 (Parliament of the United Kingdom, 2005)	2	2	1	1	1	1
	Mental Health (Discrimination) Act 2013 (Parliament of the United Kingdom, 2013)	2	1	1	1	1	1
WORLD	European Convention for the Protection of Human Rights and Fundamental Freedoms (Council of Europe, 2010)	1	2	1	1	2	1
	United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2007)	2	2	3	1	2	1
	World Health Organization Action Plan 2013–2020 (World Health Organization, 2013)	4	2	2	1	1	2

Table 4
Examples of checklist applied to review documents.

Quality		Score				
		1	2	3	4	5
Human Rights	Document		Reform of Mental Health Legislation in the UK	Australian National Recovery Framework	World Health Organization Action Plan 2013–2020	Australia National Mental Health Policy
	Example	No examples of quality present in legislation	The United Nations Principles for the Protection of Persons with Mental Illness are based around human rights promoting community care in the least restrictive environment.	Upholding the human rights of people experiencing mental health issues and challenging stigma and discrimination; advocating to address the poor and unequal living circumstances that adversely impact on recovery.	Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.	People with mental health problems and mental illness have the same rights as other Australians to full social, political and economic participation in their communities.
	% of documents with this score	18%	48%	24%	3%	6%
Patient Centred Approach	Document	World Health Organization Action Plan 2013–2020	Western Australia Mental Health Act 2014 (AUS)	Open Minds, Healthy Strategy (AUS)	Australian Mental Health Policy	New South Wales Mental Health Act 2007 (AUS)
	Example	Regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.	The person in charge of the voluntary inpatient's ward must ensure that the inpatient has the opportunity and the means to contact any carer, close family member or other personal support person of the inpatient, a health professional who is currently providing the inpatient with treatment and the Chief Mental Health Advocate	The group's multidisciplinary team-based approach makes all the difference – it involves the youth's current and future service providers working together to meet their needs and their family's	It recognises the importance of maintaining the momentum created by the COAG process to support a vision of a seamless and connected care system which is consumer focussed and recovery oriented and where people are supported to engage with the community and participate to their full potential.	Care and treatment in the least restrictive environment enabling the care and treatment to be effectively given, (b) people with a mental illness or mental disorder should be provided with timely and high quality treatment and care in accordance with professionally accepted standards, (c) the provision of care and treatment should be designed to assist people with a mental illness or mental disorder.
	% of documents with this score	58%	12%	15%	12%	3%
Quality of life	Document	European Convention for the Protection of Human Rights and Fundamental Freedoms	South Australia Mental Health Act 2009 (AUS)	Achieving Better Access to Mental Health Services by 2020 (UK)	Australian National Mental Health Policy	Australian National Standards for Mental Health Services 2010

	Example	Any service exacted in case of an emergency or calamity threatening the life or well-being of the community	Receive a comprehensive range of services of the highest standard for their treatment, care and rehabilitation with the goal of bringing about their recovery as far as is possible	Prevention and early intervention to support children and young people with mental illness can dramatically improve the quality of their lives and future.	These interventions should address biological, psychological and social factors and aim to intervene early to prevent or reduce individuals' symptoms, improve their functioning and increase quality of life.	Recovery oriented mental health practice: recognises that recovery is not necessarily about cure but is about having opportunities for choices and living a meaningful, satisfying and purposeful life, and being a valued member of the community accepts that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life empowers individuals so they recognise that they are at the centre of the care they receive.
	% of documents with this score	55%	18%	21%	3%	3%
Therapeutic Aim	**Document**	**Mental Health Act 2007 (UK)**	**United Nations Convention on the Rights of Persons with Disabilities**	**Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales**	**Victoria Mental Health Act 2014 (AUS)**	**Australian National Recovery Framework**
	Example	References in this Part of this Act to the approved clinician in charge of a patient's treatment shall, where the treatment in question is a form of treatment to which section 58A above applies and the patient falls within section 56(5) above, be construed as references to the person in charge of the treatment.	States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life.	Exercise on prescription schemes and inclusion in Care and Treatment Plans should enable people with mental health problems to more easily access leisure and recreational facilities, increasing social engagement for people of all ages.	The adequacy of services and facilities provided at those premises to persons receiving mental health services, including, but not limited to, the appropriateness and standard of facilities provided at those premises in relation to the accommodation, physical wellbeing and welfare of those persons and the adequacy of opportunities and facilities for their recreation, occupation, education, training and recovery	The lived experience and insights of people with mental health issues and their families are at the heart of this framework. Like all members of the community, people with experience of mental health issues desire sustaining relationships, meaningful occupations, and safety and respect in their lives. The focus on people's lived experience, and on their needs rather than on organisational priorities offers a new and transformative conceptual framework for practice and service delivery.
	% of documents with this score	39%	30%	24%	3%	3%
Environment / Accessibility	**Document**	**Human Rights Act 1993 (NZ)**	**New South Wales Mental Health Act 2007 (AUS)**	**Reform of Mental Health Legislation in the UK**	**Australian National Standards for**	**Queensland Mental Health Plan (AUS)**

					Mental Health Services 2010 - Mental health	
	Example	The environment in which the duties of the position are to be performed or the nature of those duties, or of some of them, is such that the person could perform those duties only with a risk of harm to that person or to others, including the risk of infecting others with an illness, and it is not reasonable to take that risk.	Consideration must be given to the least restrictive environment in which care and treatment can be effectively given.	Treatment and care must be provided in the “least invasive manner and in the least restrictive environment compatible with the delivery of safe and effective care”.	The capacity of individuals within The groups and The environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice.	A safe environment, adequate income, meaningful social and occupational roles, secure housing, higher levels of education and social support are all associated with better mental health and wellbeing.
	% of documents with this score	42%	33%	9%	9%	6%
Multidisciplinary Team Approach	**Document**	**Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales (UK)**	**Northern Territory Mental Health Act 2016 (AUS)**	**National Mental Health Policy (AUS)**	**Mental Health Strategy: 2017–2027 (Scotland)**	No examples of quality present in legislation
	Example	Support and advice from physical healthcare teams is also key for inpatient psychiatric units, particularly on older people wards.	the person's treatment is to be carried out, wherever practicable, within a multi-disciplinary framework	Teams which may include: social workers; community psychiatric nurses; consumer and carer consultants; peer support workers; occupational therapists; psychologists and psychiatrists; and Aboriginal mental health workers. Community mental health teams provide a range of services in the community including: individual treatment programs; family interventions; short and long term support; and psycho-education.	Liaison psychiatry is a type of multidisciplinary, mental health specialist service. Such a service can provide advice, assessment, treatment and training, which spans emergency departments, inpatients and some outpatient acute services.	
	% of documents with this score	42%	33%	18%	6%	0%

The Victoria Mental Health Act [20] (78,768 words) presented the highest overall scores per category (scoring between 3 to 5) among all categories on the checklist. The National Standards for Mental Health Services Australia [21] (12649 words) had a comparable level of quality to the Victorian MHA. The lowest scoring document was the Northern Ireland Mental Health Act Amendment 2018 [22](685 words) and The Mental Health (Wales) Measure 2010 (Parliament of the United Kingdom, 2012) (1026 words), however, this is likely due to the small word count in comparison to other documents. Of the 33 documents analysed, 29 documents had a word count was more than 10,000 providing ample opportunity to include leisure-related concepts.

The sparsity of concepts can also be contributed to the differing language discourses between countries and health policies. There was a strong focus among documents for ‘seclusion’, ‘medication’ and ‘restraint’ among all documents. Supporting documents such as standards of services highlighted length of stay with limited focus on recovery-based interventions.

Risk was highlighted in World Health Organization [12] the Mental Health Plan 2013–2020 as a major factor for inpatient treatment when providing safe care. Contributing factors to risk was discussed at length and delivery of care was limited to ‘reducing access’ to items for self-harm or specific to suicide risk. There was limited discussion surrounding risk and delivery of therapeutic interventions in an inpatient setting. This document did however, highlight the need for interventions and programmes to be included in national policy and legislation to assist with implementing recovery oriented practice.

The checklist identified a difference in language amongst documents and was identified within examples, for instance, in Australian documents the phrase ‘health professionals’ was used to describe a multi-disciplinary team; however, ‘multi-disciplinary team’ was used in Scotland.

Leisure and recreation-related language was typically discussed within an environmental context and minimum standards that the inpatient facility would be expected to adhere to. An example of high scoring (5) leisure-related language (see Table 4) is the Victorian MHA [20]: Part 9 section 216 a:

The adequacy of services and facilities provided at those premises to persons receiving mental health services, including, but not limited to, the appropriateness and standard of facilities provided at those premises in relation to the accommodation, physical wellbeing and welfare of those persons and the adequacy of opportunities and facilities for their recreation, occupation, education, training and recovery.

Some documents did not contain any leisure-related language or example to provide which led to an automatic score of 1. This is demonstrated in Table 4 where no example was able to be provided in the human rights category. No text examples were available for a score of 5 in the ‘multidisciplinary approach’ as none of the documents were given this score.

The ‘patient centred’ and ‘human rights’ categories were the highest scoring overall amongst the documents. The lowest-scoring category uniformly was the ‘multidisciplinary approach’

Discussion

Engagement in occupation within an inpatient environment can reduce the need for acute medication use, minimise aggressive incidents that require seclusion [23] and increase the therapeutic alliance with staff. This chapter aimed to explore the quality of leisure-related concepts within health policy to better understand the barriers and facilitators of leisure as a therapeutic modality within acute mental health settings.

The Mental Health Act is legislation used by a range of authorised mental health professionals to support the treatment of a person’s severe and complex mental illness. The data raises concerns that there is a lack of presence of leisure-based language or interventions mentioned other than restrictive practices such as medication, restraint, and seclusion. This raises the question that the language used to describe leisure may not be contemporary and concepts entered may not have adequately captured a different professional’s view of therapeutic landscapes.

The World Health Organization [12] has set a priority in the next seven years to shift the focus of care to the community with a focus on ‘promotion, prevention, treatment, rehabilitation, care, and recovery’. The intention for this action plan was that all international, national, and state-level stakeholders develop key performances indicators to track the progress and effect of programs that services are implementing [12]. When reviewing the prevalence of leisure-related concepts table, strategy policy, and rights documents had a greater focus on leisure access compared with the legislative acts that are legally binding. Therefore, the World Health Organization objectives are not effectively filtering down to country-based legislation.

Overall, Australian documents appeared to have the highest quality of leisure-related concepts amongst all selected documents. Documents from Australia explicitly included mention the therapeutic modalities such as leisure and recreation. There were limited concepts found in New Zealand documents and documents did not score above a three for quality. Quality varied amongst documents from the United Kingdom. Documents from the United Kingdom particularly focussed on creating a safe and ‘least restrictive environment’.

Development of Therapeutic Policy

International standards and expectations of health policy suggest a clear and least restrictive practice that respects the human rights of consumers in inpatient units [12]. Improvements in the discourse used within legislation and policy documents could better support the provision of client-centred and holistic programs within health services; inclusive of support to engage in leisure occupations in acute inpatient units. It is recommended that current policy and legislation benchmark these recommendations and be updated to adopt the international evidence-informed practice in this area to progress the quality of health care [11, 16].

It would be beneficial for policy and legislation to explicitly identify the need for service providers to incorporate activities that enable leisure participation. For example, as part of the Australian National Mental Health Standards [21], section 10.5.12 of Treatment and Support specifically states:

The MHS facilitates access to an appropriate range of agencies, programs, and/or interventions to meet the consumer's needs for leisure, relationships, recreation, education, training, work, accommodation, and employment in settings appropriate to the individual consumer.

Recovery-focussed documents were defined as those that take a more health-promoting approach by focussing on recovery as a primary goal with treatment as support for recovery. Mental health acts and legislation are used to implement treatment. With consideration of the World Health Organization [12] guidelines for recovery-focused treatment which includes a range of modalities including leisure activity, it would beneficial for countries who utilise a mental health act to use clear and directive language around the implementation of leisure within mental health units (see Table 4, examples of text scoring 5).

The data reviewed the same 33 documents by hand-checking the same terms and comparing them to a developed checklist made by the research team. Another consideration is the lack of continuity between policy documents and discourse used to describe like terms. Some of the differences in discourses were particularly around the practical use of the mental health act. In Australia the term 'involuntary' is used to discuss the detainment of a consumer, where 'sectioned' is the term used in the United Kingdom. There were little differences in the leisure-related discourses with similar terms used.

Limitations

This study achieved the desired aims of identifying the quality of leisure related terms in the selected legislation and policy documents. All documents were hand searched by two of the authors and had secondary analysis from the remaining authors. Even though the searching was rigorous there is a potential for missed leisure-related concepts during the analysis. A potential bias in this study is the authors are all Australian based and reviewed the quality of Australian legislation. This was mitigated by blinded review of example text found by the second author which was scored without knowledge of the title.

Future Research

This document analysis has highlighted the difference in occupational discourse, particularly leisure, within mental health-related policy and legislation. Future research may look to analyse the difference leisure-inclusive language has on the implementation of future policy documents and evaluate legislation that includes the implementation of leisure activities within a clinical setting. It is anticipated that this type of study may inform Australia, New Zealand, and the United Kingdom, policymakers, or legislation advisors with future revisions of policy documents that are better aligned with international recommendations.

Evidence-based practice suggests that inpatient mental health facilities would benefit from orientating their services towards leisure-focused or activity-based programs to better facilitate recovery for mental health consumers. Therefore, future research should aim to review the mental health inpatient unit's implementation of the reviewed legislation and the clinical barriers faced.

Conclusion

Legislation and policy in Australia, New Zealand, and the United Kingdom, lack leisure-specific language and inclusion of discourses related to therapeutic engagement of leisure. Mental health legislation and policy may benefit from clearer additional language that supports the recovery of mental health and wellbeing. This includes references to meaningful recreation and leisure activities and occupations within locked mental health units. This is common clinical practice for allied health professionals such as occupational, leisure, and recreation therapists in their day-to-day job. Universal and inclusive language promoting therapeutic modalities within health policy will support clinical professionals to provide evidence-based practice within the scope of treatment.

Key Implications for Health Professionals

- Unification of leisure-related discourse would assist in a global understanding of discourse within policy.
- Leisure discourse within policy and governing documents is sparse and provides little guidance for the least restrictive practice within locked mental health facilities.
- The greater value of therapeutic modalities provided by staff will assist to explore treatment goals within mental health units that align with evidence-based practice. These therapeutic modalities will provide further support to provide alternative therapies to medication or seclusion within locked inpatient units and perhaps explore the need for funding training for staff who don't currently operate in this manner.

Abbreviations

WHO

World Health Organisation
UN
United Nations
MHA
Mental Health Act

Declarations

Ethics approval and consent to participate. Ethics approval was not required for this study as there was no human participants.

Consent for publication. Not applicable.

Availability of data and material. The dataset(s) supporting the conclusions of this article is(are) included within the article (and its additional file(s)).

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