University of Southern Queensland

INVESTIGATION OF STAKEHOLDER PERSPECTIVES ON LEISURE ACTIVITY IN MENTAL HEALTH INPATIENT UNITS

A Thesis submitted by

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For the award of

Doctor of Philosophy

2022

ABSTRACT

This thesis aimed to understand the barriers and facilitators to leisure engagement in mental health inpatient units. Furthermore, this thesis explored the availability of leisure activity, evaluation of a leisure tool to identify preferences, and development of practice principles to improve leisure opportunities in acute settings. This thesis includes two literature reviews and five original research studies. This thesis applied the Model of Human Occupation (MOHO) to gain a greater understanding of consumers, occupations available, and the environment. Section one explored the contextual factors that contribute to the dearth of leisure activity in mental health inpatient units. The first original research chapter (chapter two) in this section explored the general population's value of leisure activities and explored the therapeutic use of leisure. The findings concluded that leisure is an activity most people participate in daily, and a definition of leisure was developed. A scoping review (chapter three) explored the consumer, staff, and carer perspectives of leisure activity offered in mental health inpatient units. The findings suggest that consistently consumers have reported being bored with a limited range of leisure activities offered. The staff (who provide direct service provision) perspective of the barriers and facilitators to consumer engagement was explored through an online anonymous survey (chapter four). Most staff (97%) believe there is a lack of meaningful activities offered to consumers in inpatient units but were unsure how to make changes to this problem. The macro or governance perspective (chapter five) of health was explored through a policy analysis of mental health acts and supporting policies from Australia, New Zealand, and the United Kingdom. A limited number of leisure-related concepts was found across 32 documents. Findings suggest an increase in leisure-related language may assist to facilitate leisure engagement conducive to recovery. Section two of the thesis reviewed methods to evaluate leisure preferences to implement in acute inpatient settings. This included the development of a leisure tool called the Checklist of Leisure, Interest, and Participation (CLIP) (chapter six). The findings suggest that the CLIP is a valid and reliable tool for exploring consumer interests. The consumer perspective (chapter seven) included consumers currently inpatient at the Princess Alexandra Hospital, Brisbane. Consumers completed an anonymous survey that included two standardised tools and a checklist : the Mental Health Satisfaction Improvement Program (MHSIP), Leisure Boredom Scale (LBS), and the Checklist of Leisure Interests and Participation (CLIP). Section three includes the development of practice principles (chapter eight) to facilitate leisure activity in

mental health inpatient units. The practice principles draw from the literature and findings of this thesis.

CERTIFICATION OF THESIS

I declare that this thesis is an original report of my research, has been written by me, and has not been submitted for any previous degree. References have been provided on all supporting literature and resources.

I am aware of and understand the university's policy on plagiarism and I certify that this thesis is my own work, except where indicated by referencing, and the work presented in it has not been submitted in support of another degree or qualification from this or any other university or institute of learning. I declare that this thesis was composed by myself, that the work contained herein is my own except where explicitly stated otherwise in the text, and that this work has not been submitted for any other degree or professional qualification. I have clearly stated which parts of this thesis may qualify for another award.

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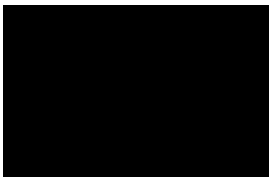

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STATEMENT OF CONTRIBUTION

1. Levick, J., Broome, K., Oprescu, F. & Gray, M. Conceptualisation of leisure and opportunities for mental health salutogenesis. *Submitted to the Occupational Therapy in Mental Health.*

   Levick contributed to 60% of this paper. Collectively Broome, Oprescu, and Gray contributed to the remainder of the paper. Levick was responsible for the concept and design of the study, data collection, data analysis, and writing and editing of the article. Broome, Gray, and Oprescu were all responsible for reviewing drafts.

2. Levick, J., Broome, K., Oprescu, F. & Gray, M. A scoping review: Consumer, carer and multidisciplinary perspectives of consumer leisure time-use on mental health inpatient units. *Submitted to the OTJR: Occupation, Participation and Health..*

   Levick contributed to 60% of this paper. Collectively Broome, Oprescu, and Gray contributed to the remainder of the paper. Levick was responsible for reviewing the literature, data collection, data analysis, and writing and editing the article. Broome and Gray assisted in data analysis. Broome, Gray, and Oprescu were all responsible for reviewing drafts.

3. Levick, J., Broome, K., Oprescu, F. & Gray, M. Staff perspective on barriers and facilitators to leisure engagement on mental health inpatient units. *Submitted to Occupational Therapy in Mental Health.*

   Levick contributed to 60% of this paper. Collectively Broome, Oprescu, and Gray contributed to the remainder of the paper. Levick was responsible for the concept and design of the study, data collection, data analysis, and writing and editing of the article. Broome contributed to the study design and secondary checking of data analysis. Broome, Gray, and Oprescu were all responsible for reviewing drafts.

4. Levick, J., Broome, K., Oprescu, F. & Gray, M. Policy analysis: The prevalence of leisure-related concepts found in mental health legislation. *Submitted to BMC Health Services Research*

   Levick contributed to 60% of this paper. Collectively Broome, Oprescu, and Gray contributed to the remainder of the paper. Levick was responsible for the concept and design of the study, data collection, data analysis, and writing and editing of the article. Broome contributed to the study design and

secondary checking of data analysis. Broome, Gray, and Oprescu were all responsible for reviewing drafts.

5. Levick, J., Broome, K., Ingram, L., Oprescu, F. & Gray, M. The 'Checklist of Leisure, Interest and Participation': Exploring the general population current leisure interests in the 21st century. *Submitted to the OTJR: Occupation, Participation and Health.*

   Levick contributed to 60% of this paper. Collectively Broome, Ingram, Oprescu and Gray contributed to the remainder of the paper. Levick and Broome were responsible for the concept and design of the study. Levick and Ingram were responsible for data collection and data analysis. Levick did the writing and editing of the article. Broome, Gray, and Oprescu were all responsible for reviewing drafts.

6. Levick, J., Broome, K., Gray, M., Theodoros, T., Morrison, T., & Kar Ray, M. Investigation of the Consumer Perspective on Leisure Activity Available in Australian Mental Health Inpatient Units. *Submitted to the OTJR: Occupation, Participation and Health. .*

   Levick contributed to 60% of this paper. Collectively Broome, Gray, Theodoros, Morrison, and Kar Ray contributed to the remainder of the paper. Levick was responsible for the concept and design of the study, data collection, data analysis, and writing and editing of the article. Theodoros and Morrison supported the application of human ethics and data collection. Broome assisted with study design and secondary analysis. Theodoros, Broome, Gray, Kar Ray, and Morrison assisted with analysis and reviewing drafts.

7. Levick, J., Broome, K., & Gray, M. Recommendations: The Development of Practice Principles for Leisure-based Occupational Enrichment in Mental Health Inpatient Units.

   Levick contributed to 75% of this paper. Collectively Broome, and Gray contributed to the remainder of the paper. Levick was responsible for the concept and design of the study, data collection, data analysis, and writing and editing of the article. Broome and Gray were all responsible for reviewing drafts.

ACKNOWLEDGEMENTS

This has been an exciting and challenging experience. I would like to express my gratitude to my supervisors and mentors who guided me through this process. Thank you to Professor Marion Gray, Dr. Kieran Broome, and Associate Professor Florin Oprescu. Without your tremendous wisdom, encouragement, and understanding over the past few years, it would have been impossible to complete my study.

Marion, thank you for your guidance, knowledge, and expansive experience in research. I am immensely thankful for your assistance in the final stages of my Ph.D.

I cannot begin to express my sincere thank you to Kieran for your unwavering support and belief in me over the past 12 years. Thank you for being my biggest cheerleader and an aspirational mentor throughout this process. You embody the occupational therapist, researcher, and clinician that I aspire to be.

I'm grateful to Florin for your insightful comments and suggestions. I appreciate your support, particularly in publication, and endless sugar-filled innovation.

I would like to extend my gratitude to all participants that completed online surveys related to the studies in this thesis. Thank you to the examiners for taking the time to read my thesis and provide thoughtful suggestions. This research has been supported by an Australian Government Research Training Program Scholarship. My Ph.D. journey was very enjoyable, and I had the opportunity to meet some lifelong friends. Thank you to USC for housing me from the beginning of my Ph.D. journey and to USQ for taking me into the final stages of my candidature.

Thank you to my colleagues from the Princess Alexandra Hospital Emergency Department Mental Health Team, Queensland Health. In particular, Dr. Theo Theodoros, Thomas Morrison, and Associate Professor Manaan Kar Ray for the opportunity to collaborate on my final project.

To my parents, Peter Levick, Tracey Thompson, and brother Mitchell Levick; thank you for your encouragement and support. I would also like to thank my friends for your encouragement. I look forward to our free time together. Thank you to my husband Daniel for your consistent belief in me, even when I didn't believe in myself. I appreciate your patience and love during this time. To my beautiful daughter Kelsea, you were the best and worst distraction in the final months of my Ph.D. I hope I have made you proud.

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LIST OF ABBREVIATIONS USED IN THESIS

Abbreviation	Meaning
ADL	Activities of Daily Living
AUD	Australia Dollar
CLIP	Checklist of Leisure, Interests and Participation
COVID-19	Novel Coronavirus Disease 2019
IADL	Instrumental Activities of Daily Living
ICF	International Classification of Functioning
LBS	Leisure Boredom Scale
MHA	Mental Health Act
MHED	Mental Health Emergency Department
MHIU	Mental Health Inpatient Unit
MHSIP	Mental Health Statistics Inventory Program
MIC	Modified Interest Checklist
MOHO	Model of Human Occupation
NLQ	Nottingham Leisure Questionnaire
OMP[A]	Occupational Performance Model (Australia)
QOLI	Quality of Life Interview
UK	United Kingdom
UN	United Nations
WHO	World Health Organisation

GLOSSARY OF KEY THEMES USE IN THESIS

Theme	Meaning
Consumer	A person receiving care from a mental health team (inpatient or community-based). Also known as a patient in a hospital.
Health Professional	A health professional includes but is not limited to, occupational therapists, social workers, or psychologists who deliver care.
Leisure	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.
Meaningful Occupation	An activity that provides significance or contributes to quality of life
Mental Health Act	Is legislation that enables involuntary treatment of persons with mental illness suffering acute mental health issues.
Mental Health Inpatient Unit (MHIU)	A mental health unit or ward that facilitates the recovery of those acutely unwell with mental illness. These settings can be locked units depending on the geographical location.
Model of Human Occupation (MOHO)	MOHO is a conceptual framework or model that explores how and why people engage in occupation (Taylor, 2017). The model was originally developed by Kielhofner and Burke (1980).
Occupational Deprivation	To be restricted in the participation of meaningful occupation due to environmental limitations (Whiteford, 2000; Whiteford et al., 2020).
Occupational Enrichment	The intentional manipulation of the external environment to facilitate engagement in a variety of occupations that a person would typically participate in (as part of their normal routine) (Molineux & Whiteford, 1999).

Occupational Profile	"A summary of a client's (person's, group's, or population's) occupational history and experiences, patterns of daily living, interests, values, needs, and relevant contexts" (American Occupational Therapy Association, 2020).
Participation	To actively engage in activity individually or with others.
Purposeful Activity	Activity that stimulate a person, providing a reason to engage and promote intrinsic motivation.
Recovery	Is a holistic, person-centred approach to mental health care that emphasises support for a person's potential to recover.
Salutogenic / Salutogenesis	An approach to promoting/focusing on health and wellbeing rather than disease within health sciences.
Time Use	How people choose to spend or use their time in a day.
Volition	Intrinsic motivation to participate in a chosen activity (Taylor, 2017).

CHAPTER 1 - INTRODUCTION

People with severe and complex mental health issues admitted to an inpatient unit often find themselves with a limited occupational profile. Accessibility to occupational opportunities for persons with mental health issues are particularly challenging. Limited opportunity to participate in occupation can be due to the constraints of a person's physical or social environment which can lead to occupational deprivation (Whiteford et al., 2020). To make real and adequate changes to consumers' level of participation within MHIU, changes need to be made at multiple levels, including the built and social environment, policy, culture, and practice.

Leisure can be considered an important therapeutic modality to provide an opportunity for recovery and encourage participation. Salutogenesis can be applied to leisure as a health-creating and health-promoting activity (Lindström & Eriksson, 2005). Engagement in leisure can support recovery and assist in improving an individual's health status (Marshall et al., 2020). To provide therapeutic, appropriate, and meaningful services for consumers within public hospitals, there must be evidence to support this. Firstly, the desire of acute mental health consumers to participate in meaningful occupations should be explored alongside consumers unique interests and needs. Secondly, the barriers to implementing leisure programs within Australian MHIUs should be elucidated. These barriers need to be reviewed from a macro (policy); meso (direct service provision), and micro (service user) level. Thirdly, the requirements and solutions to promoting leisure-based changes need to be clearly expressed and consumers should have the opportunity to provide consultation as key stakeholders. Lastly, policy users and hospitals require practical and evidence-based solutions to implement meaningful changes within these environments.

This introduction provides an overview of what will be included in the thesis. Important and key concepts that are applied throughout the thesis are introduced within this chapter including occupational therapy role, occupational deprivation to enrichment, salutogenesis, and mental health. The relevance of this research is discussed in an international, national, and local context. The structure and sections of the thesis are described to orientate the reader throughout the thesis from the context through to evaluation and finally recommendations in the form of practice principles. This thesis aims to investigate the barriers and facilitators to delivering leisure as a therapeutic modality within mental health inpatient units (MHIU). After a review of the literature three key assumptions are made that underpin this thesis including:

1. Participation in occupation is human nature. The ability to participate in a meaningful occupation (i.e., leisure) is possible regardless of acuity, or mental state. A consumer's ability to participate is dependent on occupational opportunity, and their environment (physical and social). Therefore, the research methods are targeted at the environment and opportunity rather than the acuity or mental state of the person participating.
2. Participation in leisure activity is health-creating, building, and promoting (salutogenic) which enhances consumers recovery. Consumers have unique and contemporary interests that are like those of the general population.
3. Providing environments (physical and social) that are conducive to engagement in meaningful leisure activity will provide consumers with the opportunity to improve consumers function and promote recovery.

1.1 Mental Health and Boredom

According to the Australian Institute of Health Welfare (2022), one in five (20%) Australians over the age of 16 experience a common mental health disorder within the last twelve months. These included illnesses such as depression, anxiety, and substance abuse issues. A further 2% of Australians or 800,000 people are considered to have severe and complex mental health issues such as schizophrenia or bipolar affective disorder that require ongoing treatment (Australian Institute of Health & Welfare, 2022). Approximately 1.8 % of the general population utilises mental health support through public health services each year, including inpatient care (Australian Bureau of Statistics, 2022; Australian Institute of Health & Welfare, 2016).

Consumers who present for the first time with acute mental health issues often have mismatched expectations of what the current public health system provides therapeutically. When consumers are inpatient, this is an opportunity for consumers to learn adaptive therapeutic skills to support their ability to cope in the community. The national key performance indicator for MHIUs is currently seven to 14 days for length of stay (Australian Government, 2014). Ideally, consumers would receive pharmacological, psychiatric, and therapeutic support from the multidisciplinary team during their admission.

Consumers are spending large amounts of their time on public MHIU with minimal opportunity to engage in activity (Fraser et al., 2016). Boredom is a typical human experience that people feel even when there is a range of occupational opportunities available (Marshall et al., 2020). However, when consumers are on the MHIU, this environment can amplify their

sense of boredom even though there may be activities on offer. This feeling of boredom can be because the activities offered are not typical activities that consumers would participate in or be interested in. Because of this, occupational deprivation occurs within an MHIU environment. Consumers often report boredom and are observed sitting for most of their day, not doing any activities (Chapman et al., 2016; Fraser et al., 2016; Leufstadius et al., 2006). Boredom can lead to frustration and sometimes aggression around the strong focus of pharmacological interventions associated with the medical model (Lelliott & Quirk, 2004).

In Australia, Canada, and the United Kingdom MHIUs are frequently under-resourced, with limited group activities or activities of interest to the consumer (Cutler et al., 2021; Foye et al., 2020; Lim et al., 2007; Marshall et al., 2020). If there are occupational therapists employed on MHIU (some do not have funded occupational therapists), reports show they typically have limited capacity for extensive individual therapy due to increasing demands on the role (Lim et al., 2007). Often activities offered in MHIUs can be limited in nature and do not meet the interests of all consumers. Some activities that may be offered in MHIUs include puzzles, board games, crafts, and television (Foye et al., 2020). Throughout this thesis, there will be reference to locked units and some of the occupational deprivation issues related to locked facilities.

There is limited literature that describes the barriers and facilitators to mental health staff incorporating appropriate leisure facilitation into the scope of MHIU practice. Studies have found that inpatient nursing staff on average, spend just 6.75% of their time engaged in one-to-one therapeutic engagement with consumers (Whittington & McLaughlin, 2000). This low figure is reported to be due to the high demand for documentation, limited staffing, and an increased level of consumer mental state acuity.

Restricted opportunity for meaningful occupation leads to loss of identity and reduced self-efficacy. Self-efficacy can be explained as the internal belief in the capacity to engage or execute behaviour (American Occupational Therapy Association, 2020). This concept is particularly important to apply when considering consumer engagement and participation in MHIUs. Elucidating the micro (consumer perspective – chapters six and seven), meso (service providers and physical environment – chapter four), and macro (policy/legislative – chapter five) barriers and facilitators to leisure facilitation will support the development of practice principles to advance best practice. It will also identify areas for research that require further investigation.

1.2 Mental Health Occupational Therapy

Occupational therapists hold a core belief that occupational engagement supports psychological, mental, and physical wellbeing (Rebeiro, 1998). Meaningful and purposeful occupations are considered powerful means of therapy (Wilcock, 1999). It is a basic human right and a need for people to participate in occupation (Whiteford, 2000). On an MHIU, an occupational therapist's role is to support people with mental, physical, or psychological ailments that prevent them from engaging in an occupation. Occupational therapists enable persons to participate in an activity through a broad range of interventions and adaptations. Often people with mental illness find it difficult to have a structured routine, maintain employment prospects, and have poor social opportunities within society (Leufstadius et al., 2006). Therefore, admission should be an opportunity to explore individual interests and potential connections to the greater community.

Issues that create barriers to meaningful engagement for consumers can be the acuity of their mental health issues, socioeconomic status, and substance abuse. Acute mental health issues and substance abuse can affect an individual's performance capacity impacting performance. Socioeconomic status can be a barrier due to the available opportunities available (including community access, and available income to use on leisure activity). On an MHIU, consumers' occupational profile is typically centred on the resources available (physical and staff to deliver the activity) and their ability to participate. Marshall et al. (2020) suggests there is a perpetual issue related to boredom in MHIUs due to the limited stimuli environment. Typically, if activities are offered in an MHIU, they are not innovative or meeting the needs or interests of modern consumers (Kontio et al., 2012). There are limited therapeutic occupational and psychological interventions provided to inpatients in mental health units (Fullagar, 2008). This can be because of a lack of resources or limited staffing and may result in occupational deprivation and limited cognitive stimulation (Todman, 2003). This limited stimulation can lead to behavioural disturbances, aggression, and even seclusion.

Occupational therapy theory such as the Model of Human Occupation (Taylor, 2017), occupational deprivation and occupational enrichment (Molineux & Whiteford, 1999) have been applied to the thesis to understand and explain the findings. Elements of public health theory such as salutogenesis has been thoughtfully included to complement the research approach (Eriksson & Lindström, 2008; Lindström & Eriksson, 2005). The theory of salutogenesis supports the concept of occupational engagement which suggests involvement in activity contributes positively to overall health and well-being (Molineux, 2004). The

inclusion of public health principles also supports the view of macro-level health explored in this thesis. Each theory and model has been layered within the thesis to understand the methodological and philosophical basis applied to explain the findings.

In chapter four, the role of an occupational therapist and the responsibility of delivery for leisure activity is further explored.

1.2.1 Occupational Deprivation

Throughout this thesis, the concept of occupational deprivation will be applied. Occupational deprivation is a concept that is typically explored in occupational science (Molineux & Whiteford, 1999; Whiteford, 2000). It is highly relevant and considered applicable to the environmental context that this project is viewing. Whiteford (2000) suggests occupational deprivation is the inability to engage in meaningful or purposeful activity due to external constraints or imposed limitations. Limitations are the occupational, environmental, and/or psychosocial factors that make it difficult, if not impossible, for the person to engage in their chosen occupations. A common example is consumers who are admitted into an MHIU (forensic or general population) and who typically have limited stimuli or activity to maintain their basic occupational identity (Molineux & Whiteford, 1999). To be clear, this is different from occupational disruption which is also identified by (Whiteford, 1997) as a sensory deficiency. A limited sensory environment will lead to poorer mental health. Occupational disruption is a brief or temporary disturbance to a person's typical routine or habits in occupation (Whiteford, 1997). Deprivation is defined as the dearth of external engagement such as technology, employment, and financial support such as social services (Wilcock, 1998).

Internationally consumers are admitted to MHIUs and experience a decline in their occupational profile (a summary of individuals' occupational preferences, values, and interests) (Birken, 2018). When considering mental health units, the physical, cultural, social, and institutional environments have the potential to enhance or restrict leisure participation and thus impact the degree of occupational deprivation experienced by mental health consumers (Birken, 2018; Cutler, Halcomb, Sim, Stephens & Moxham, 2021). Other concepts from this field that apply to this study are the capacity for occupational choice and diminished occupational opportunities within consumers environment (Whiteford, 2000).

The concept of occupational deprivation feeds into the argument of 'is a human being if they are not a human doing'. Christiansen (1999) completed a review discussing the positive relationship between engagement in meaningful, purposeful activity and holistic

wellbeing. Christiansen concluded that reduced or lack of activity could be detrimental to a person's health. Furthermore, evidence suggests that occupational deprivation can lead to deterioration in mental state. Studies with inmates revealed during interviews that many of them admitted to episodes of psychosis and deterioration in mental health due to isolation or seldom occupational opportunities (Craik et al., 2010; Molineux & Whiteford, 1999; O'Connell & Farnworth, 2007).

At times consumers can be admitted to MHIU under a mental health act and have limited choice in the decision for involuntary inpatient treatment, therefore imposing limitations. Evidence suggests that the longer a person is without occupation, the more detrimental it can be to consumers recovery of their mental health (Molineux & Whiteford, 1999; Oakley et al., 1985). In occupational science, it is proposed that occupational deprivation be explored from a positive and solution-focused approach to achieve occupational enrichment (Molineux & Whiteford, 1999).

1.2.2 Occupational Enrichment

Occupational enrichment is creating opportunity to engage in activity in an occupational deprived environment (Molineux & Whiteford, 1999). Occupational enrichment could be considered a deliberate and intentional change of an environment to facilitate and foster engagement in a range of activities a person may habitually engage in (Molineux & Whiteford, 1999).

Occupation in the form of leisure activity is often used as a distraction technique to support the regulation of mood. Engagement in leisure during a challenging time is an excellent example of self-actualisation, the use of leisure as a salutogenic concept, and adapting leisure to create occupational enrichment (Matuska & Christiansen, 2008; Molineux & Whiteford, 1999). Self-actualisation is the realisation of one's abilities and potential. Engagement in activity will allow consumers to understand their true potential to achieve in activity. Occupational enrichment in a MHIU may be group activities, such as exercise to improve social and physical health; reading material to provide cognitive stimulation; or comfortable furniture you would find in a home environment.

1.2.3 Salutogenesis

The concept of salutogenesis has been applied throughout the thesis. This thesis was aimed to inform interdisciplinary health professionals, and particularly occupational therapists working within mental health inpatient contexts. This term directly applies to the theory that leisure can be health-creating and health-promoting, which in turn, is beneficial

for quality of life (Chen, & Chippendale, 2018; Zawadzki, Smyth, & Costigan, 2015). Salutogenesis blends with occupational therapy theory as engagement in activity is considered to be health producing and sustaining.

A public health approach has been applied to the thesis to assist in reviewing macro-level health issues. Salutogenesis also appeals to the broader multidisciplinary team and assists to understand the larger issues that relate to consumer engagement, such as policy.

Table 1.1

Application of Key Themes in Thesis

Concept	Application in Thesis
Occupational Deprivation	A contemporary definition of leisure - Chapter 2 Scoping review – Chapter 3 Policy analysis – Chapter 5 Modernization of a leisure activity tool – Chapter 6 Consumer perspective – Chapter 7 Practice Principles – Chapter 8
Occupational Enrichment	Context of occupational enrichment – Chapter 2 Leisure Occupational Profile – Chapter 6 Consumer Perspective – Chapter 7 Practice Principles – Chapter 8
Salutogenesis	A contemporary definition of leisure - Chapter 2 Staff perspectives – Chapter 4 Policy analysis – Chapter 5 Consumer perspective – Chapter 7 Practice Principles – Chapter 8

1.3 International, National and Local Relevance of Thesis

1.3.1 Mental Health International Context

The World Health Organization has developed an Action Plan 2013-2020 (World Health Organization, 2013) and an updated strategy for universal mental health care 2019-2023 (World Health Organization, 2020), aiming to promote overall mental well-being and human rights while decreasing mortality, co-morbidities, and long-term disabilities for people

with mental health issues. The plan specifically highlights recovery and the importance of individuals engaging in purposeful activity, developing a positive sense of self, social engagement, and meaningful engagement in life. It appears both plans discuss the recovery framework, which is further explored in chapter five (Australian Government, 2014; World Health Organization, 2013).

Internationally, there appears to be a misalignment of leisure interests within the community versus what has, or can be, offered within inpatient settings. Countries such as the United Kingdom (UK) apply similar models to their national mental health plans, such as the recovery model, and aim to provide rehabilitation for mental health issues. Similar issues occur among western countries including funding and resources. Within the UK, rehabilitation day programs are offered by the treating team and are funded by their national funding scheme (NHS; similar to universal healthcare in Australia). Often these programs offer a good range of activities including but not limited to, 'art, music, computer games, gardening, exercise' (Foye et al., 2020). Even though this range of offerings is extensive consumers still reported boredom (Foye et al., 2020).

1.3.2 Mental Health National Context

The literature continues to suggest Australian inpatient services are below national and international therapy standards for the delivery of leisure activity on MHIUs (Australian Government, 2010; United Nations, 2007; World Health Organization, 2013). By improving leisure-availability in inpatient services, it may be possible to enhance the efficacy and cost-effectiveness of these services. Improvement of services may also lead to better outcomes for consumers and reduced time spent in hospitals. Optimally, consumers will have an enhanced quality of life due to the reduction of their acute symptoms.

As part of the Australian National Mental Health Standards (Australian Government, 2010), 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."

1.3.3 Mental Health State and Local Context

In 2019-2020, $11 billion dollars was spent on mental health care in Australia (Australian Institute of Health & Welfare, 2022). Mental health services in Australia consist of inpatient (hospital ward treatment), sub-acute services, such as follow up post hospitalisation, and

community supports (Australian Institute of Health & Welfare, 2022). Mental health services include a combination of government funded public health care, private services (such as psychiatry, inpatient care, and community), and non-government organisations funded through the NDIS (Australian Institute of Health & Welfare, 2022). The most common diagnoses for people receiving mental health care in Australia during 2019-2020 was schizophrenia (22.3%), depressive episode (6.7%), and schizoaffective disorder (6.4%). Consumers were most commonly treated by a community mental health service on a one-to-one basis (Australian Institute of Health & Welfare, 2022). Typically, one in seven consumers (14.7%) were treated under the mental health act as an involuntary consumer (Australian Institute of Health & Welfare, 2022).

In 2020, the Australian mental health workforce included 3,769 psychiatrists, 24,567 mental health nurses, 31,618 psychologists, and 2,555 mental health occupational therapists (Australian Institute of Health & Welfare, 2022).

This thesis includes original research conducted in Metro South Addiction and Mental Health Services in southeast Queensland to explore local issues within their inpatient unit. In chapter seven, consumers were asked to provide feedback on the current level of leisure activity provided through standardised tools, a checklist, and semi-structured questions. These findings, along with the other studies within the thesis, have been used to devise practice principles to promote potential change for local services. This project collaborated with a team of psychiatrists and a psychologist to explore gaps within the service.

Beyond the research, this feedback may provide important information to services within Queensland and Australia that will support local policy and processes used within MHIUs.

1.4 Overview of Thesis

The thesis is divided into three sections (Figure 1.1). Firstly, establishing the contextual factors behind leisure activity. Chapter two explores the importance of leisure and its use as a therapeutic modality. Chapter three includes a scoping review that explores the different perspectives of delivering leisure activity on MHIUs. The remainder of this section explores the barriers and facilitators to providing leisure activity within MHIUs. Chapter four explores barriers to delivering leisure activity from the perspective of staff with direct service provision. Chapter five explores restrictions in facilitation from a macro level of health including policy and legislation.

The second section explores evaluation methods of leisure. The evaluation of a current tool and the development of a new tool are included in chapter six. Leisure activity

was then explored from a consumers perspective. In chapter seven, consumers from an acute mental health unit and emergency department were asked to provide feedback on current services offered within Australia. The delivery of activity should carefully be considered based on the environment.

Thirdly, with the information gathered throughout the thesis, a list of practice principles was established in chapter eight. The practice principles provide suggestion to services on best practice standards for creating therapeutic engagement of leisure in MHIUs. Finally, chapter nine explores the limitations to the thesis research, reflections, future research, and conclusions drawn in this thesis.

As the order of this information is not linear, a flowchart (Figure 1.2) has been created to guide the reader. This flowchart will be at the beginning of each chapter to demonstrate the link between chapters.

Figure 1.1

The Overall Structure of the Thesis

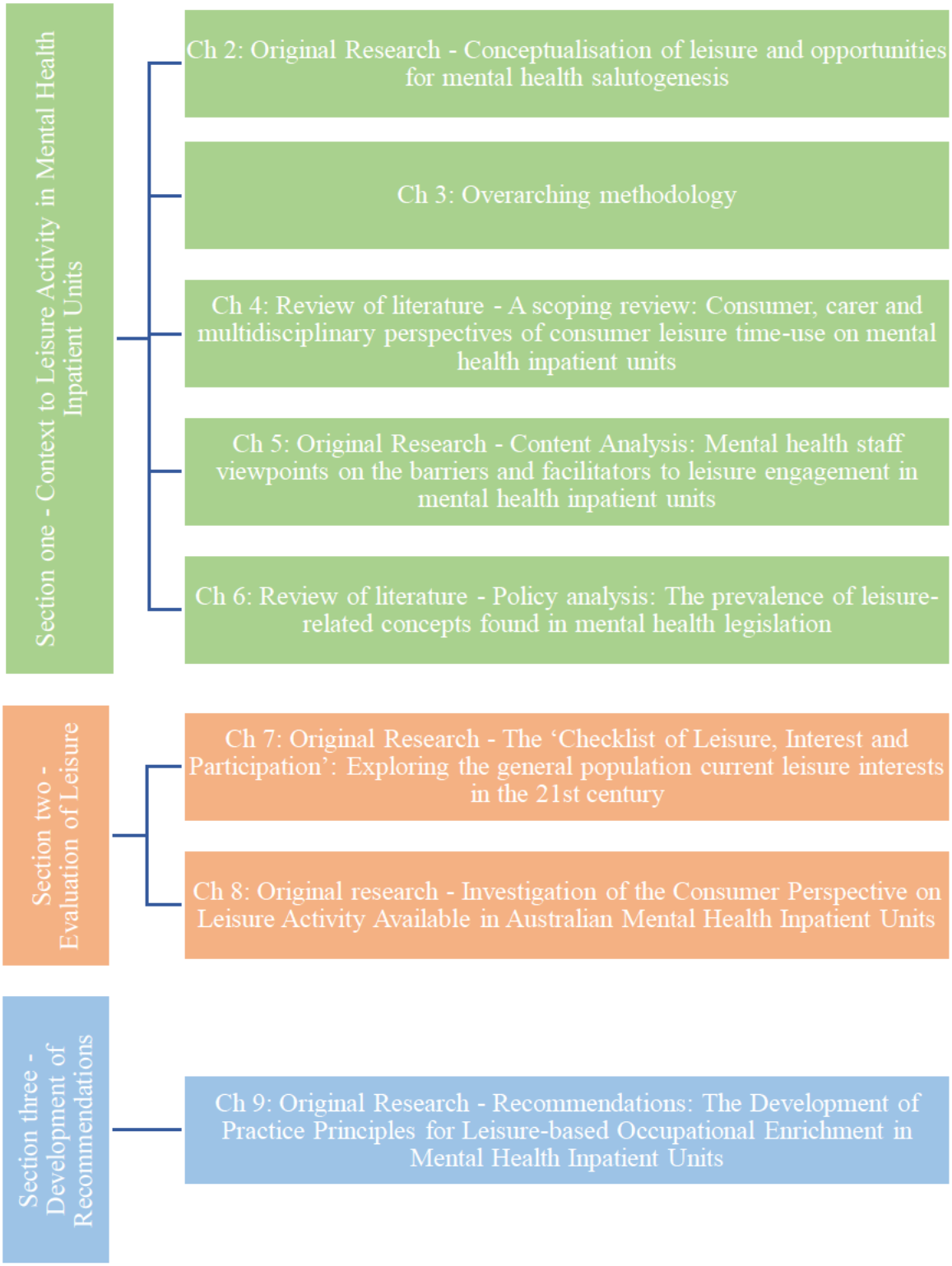
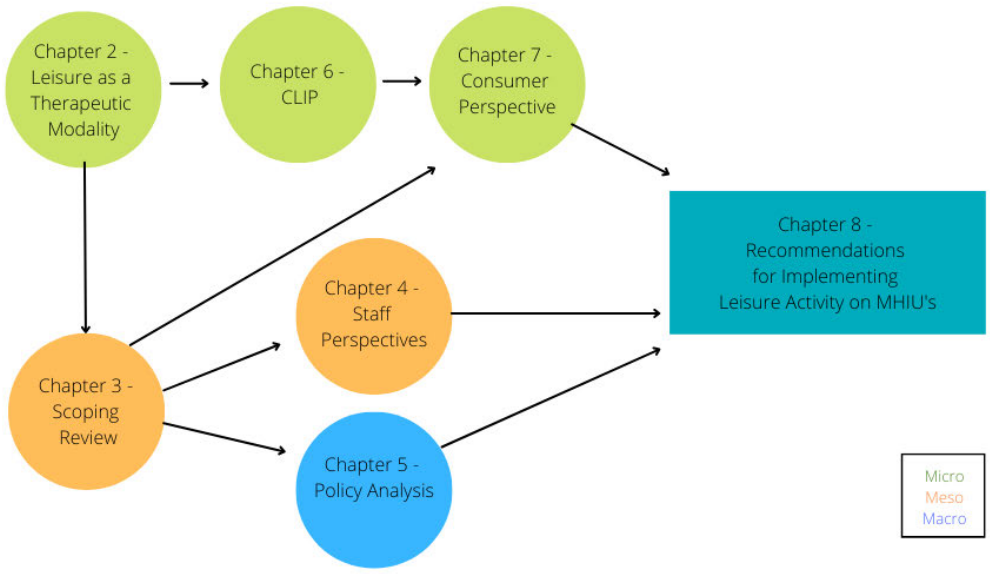


Figure 1.2

A Flow Diagram of the Link Between the Studies within the Thesis



The aims of this thesis are the following:

Section 1: Barriers to Consumer Engagement

1. Examine the dominant discourses of leisure in contemporary Australian society.
2. Examine the literature exploring how consumers utilise their time and potential barriers to engagement on MHIUs.
3. To understand the perceived roles and responsibilities of the multidisciplinary team members within the MHIU concerning consumer engagement in leisure occupation, leisure availability, perceived barriers, and facilitators to leisure facilitation.
4. To review the prevalence of leisure-related concepts within predominate leisure-related concepts within universally free health care countries (Australia, New Zealand, the United Kingdom, and Canada) that are commonly used by mental health professionals.

Section 2: Evaluation of Leisure

5. Establish a psychometrically rated tool to understand consumer interests and participation in leisure in a mental health inpatient unit.
6. To explore the consumer's perspective on barriers to engagement and overall satisfaction with the activities currently offered. Furthermore, this study aimed to understand facilitators to leisure and the activity preferences of adult mental health consumers in Australia.

Section 3: Development of Leisure Framework

7. To provide practical recommendations for Australian Mental Health Inpatient Units to increase leisure activity to promote recovery and well-being.

The primary studies that directly address the thesis' primary research aims are the consumer perspective and stakeholder perspective studies detailed below. This thesis provides examples of occupational deprivation and provides recommendations in the form of practice principles for enabling participation within MHIUs.

Within this thesis, there are two literature reviews and five pieces of original research using qualitative and quantitative methodologies.

The thesis includes manuscripts that have been submitted to journals and have been adapted for journal guidelines. Each manuscript's references can be found at the end of each chapter.

1.5 Outline Order of Information

The submitted thesis will be in the format of the thesis with publication rather than a traditional unpublished thesis. Six of the papers included in this thesis have been submitted for review at once which has delayed the decision for actual publication. Most of the chapters in this thesis have been adapted and submitted for publication as articles. All references for chapters one, eight and nine have been amalgamated at the end of the document. The thesis has been prepared and structured based on the APA 7th referencing style. The thesis consistently uses Australian English spelling.

1.6 Outline of Methodology

The overarching theoretical approach of this thesis was a mixed-methods descriptive study (Creswell et al., 2011; Creswell & Poth, 2017). Studies included in this thesis used a combination of qualitative and quantitative methods.

Figure 1.3 demonstrates the relationship between all paradigms, models, theories, and approaches used in this thesis. Pragmatism is the overarching paradigm that supports the application of methods, and rationale for analysis (Crotty, 1998). The Model of Human Occupation (MOHO) has been applied to provide an occupational therapy specific lens to the research conducted of this thesis (Forsyth & Kielhofner, 2003). The Occupational Therapy Practice Process supports with the application of MOHO and provide a contemporary framework of evidence-based practice (American Occupational Therapy Association, 2020). The recovery frame of reference has been applied to provide a solution-focussed layer to MOHO (Coffey et al., 2019). The recovery frame of reference supports the use of leisure in MHIUs. Occupational deprivation has been applied to provide context to the lack of activity offered on MHIUs. Occupational deprivation is closely linked with recovery and a solution focused approach. Finally, salutogenesis provides a health promoting theory that supports the engagement in meaningful activity (Lindström & Eriksson, 2005, 2006).

1.6.1 Research Method Overview

This research took an epistemological view that the experience of each individual on a MHIU is individual and a unique perspective. The research was carried out using pragmatism. The research design was predominately through literature review, and survey research. The thesis demonstrated a mix of qualitative and quantitative research with varied data analysis approaches including semantic analysis, content analysis, and statistical analysis (Crotty, 1998). Throughout this thesis, there was an integration of ontology and epistemology to explore to understand the barriers and facilitators to leisure activity on MHIUs.

1.6.2 Epistemology and Ontology

The chosen epistemology was an understanding of the knowledge or perspectives of and factors influencing consumers and staff providing direct service provision. Throughout the thesis, the studies were predominately explored from an epistemological approach.

There are five major epistemological paradigms, including constructivism, pragmatism, and positivism (Denzin & Lincoln, 2005). This thesis applies pragmatism as the predominate epistemological view. This in turn typically takes on a mixed methodology approach, though it is argued by Feilzer (2010) that it can be used with many different

research methodologies. Pragmatism combines constructivism and positivism to allow to multiple world views, and assumptions to be held. The paradigm pragmatism is the best fit for this thesis because it supports the inclusion of subjective experiences, thought, and language.

Each chapter of this thesis explores mixed methods research with a combination of qualitative content analysis, and quantitative descriptive statistics, and semantic analysis to best answer the research questions of each chapter. Each consumer's experience is unique and their own. Furthermore, a reality is natural, physical, social, and psychological.

Ontology was focussed on the current MHIU environment that is explored throughout this thesis. This thesis rejects objective reality, as it is impossible to conduct research as health professionals in a detached manner. Furthermore, to understand the consumer perspective with compassion, and empathy, there needs to be inclusion of research emotions, values, and beliefs to carry out the research.

A breakdown of the theory applied throughout this thesis can be seen in Figure 1.3.

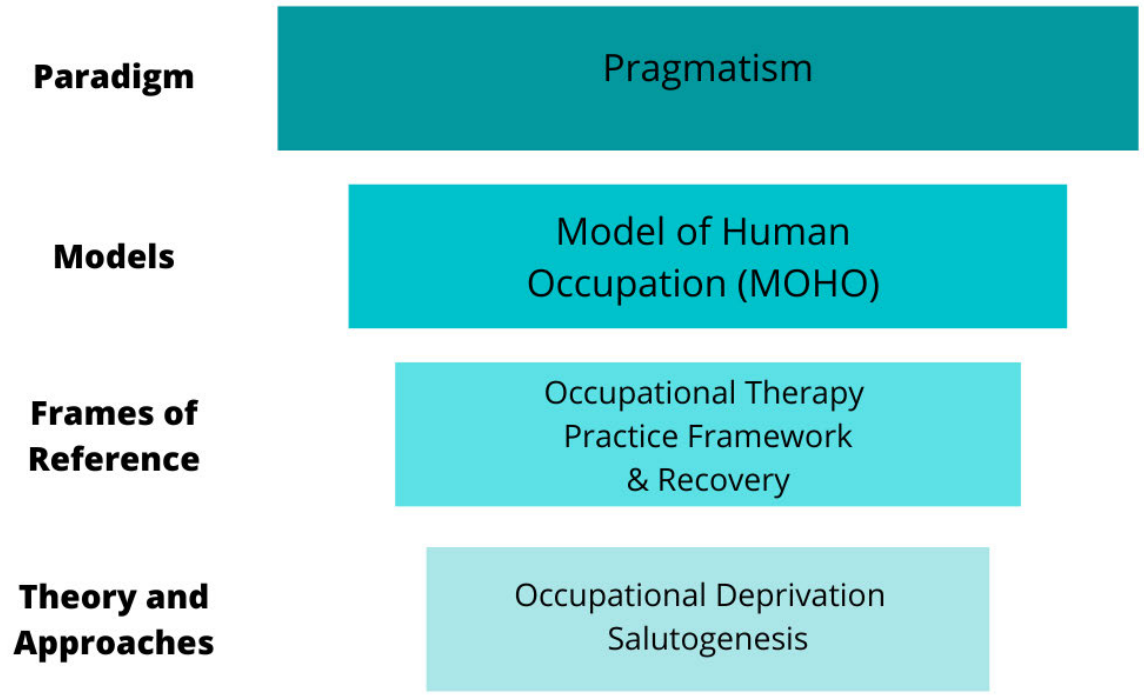
1.7 Occupational Therapy Theoretical Approach

A range of occupational therapy and public health theory has been applied throughout the thesis to provide context to the data collected and analysed. This thesis was explored predominately from an occupational therapy perspective. The public health theory that was applied was used to complement the knowledge of occupational therapists and to appeal to interdisciplinary professionals who also work within these areas.

As an occupational therapist, participation in meaningful occupations to improve quality of life, health and wellbeing is a core belief (Farnworth, 1998; Wilcock, 1999). This provided a basis and reasoning for exploring the concepts of leisure as a therapeutic modality throughout the thesis. The Occupational Therapy Practice Framework (4th ed.) was utilised throughout (American Occupational Therapy Association, 2020).

Figure 1.3

The Theoretical Framework of the Thesis



1.7.1 Paradigm

Pragmatism has been adopted as a primary paradigm using features of constructivism and positivism (Liamputtong, 2017). It offers the perspective of understanding and addressing problems and contexts (Feilzer, 2010). Other paradigms suggest that qualitative and quantitative methods are typically deemed incompatible ways to view the world. However, pragmatism was considered the most appropriate paradigm as it rejects this philosophy, and allows the best methods to be chosen to answer the research questions (Tashakkori & Teddlie, 2016). The use of qualitative methods assisted to strengthen understanding of the participant's perspective from a micro perspective of health and conceptualise consumers environment (Liamputtong, 2017). Qualitative aspects of this research allowed to better explore the individual or micro perspective to provide the individual perspective (consumers, chapter seven, and staff, chapter four). Quantitative data has been included to strengthen the reliability of the data set and provide a macro perspective of health that is generalisable to a broader setting of health. Quantitative research expanded on the broader or macro aspects of health such as updating a leisure related tool (CLIP,

chapter six), policy analysis (chapter five), and the application of standardised tools and a checklist with the consumer perspective (chapter seven).

Pragmatism also features concepts from postmodernism, for example, all individuals have unique perspectives and there is more than one worldview. When postmodernism is applied to health, this adopts the perspective that consumers have individual and unique needs, which is unlike modernism where the 'one-size-fits-all' approach is added (Weinblatt, & Avrech-Bar, 2001).

Much like the findings in the second chapter around consumers having unique perspectives of what they consider leisure, postmodernism provides the lens that treatment modalities should be catered to the individual as best as they can.

1.7.2 Models

The Model of Human Occupation (MOHO) was the theoretical basis and overarching model used throughout this thesis (Forsyth & Kielhofner, 2003; Kielhofner & Burke, 1980). MOHO is an occupational therapy model that describes how people participate in occupations within their environment (Kielhofner & Burke, 1980). The model considers three core elements of participation which includes the environment (and its interaction), feedback of the performance during the activity, and the person as the internal part of the system (Kielhofner & Burke, 1980). The internal system includes volition, habituation, and performance (Kielhofner & Burke, 1980). This model has been applied to this thesis to understand the external factors that impact the person or internal part of the system, which in turn impacts performance or engagement in activity. This model's principles were applied to each chapter as a theoretical underpinning of the core concepts used. Some chapters do not provide explicit MOHO (Forsyth & Kielhofner, 2003) language or jargon as they were submitted to interdisciplinary journals. Therefore, some application of this model has been explored at the beginning of the chapter. All recommendations were informed by the MOHO (Figure 1.4) (Forsyth & Kielhofner, 2003).

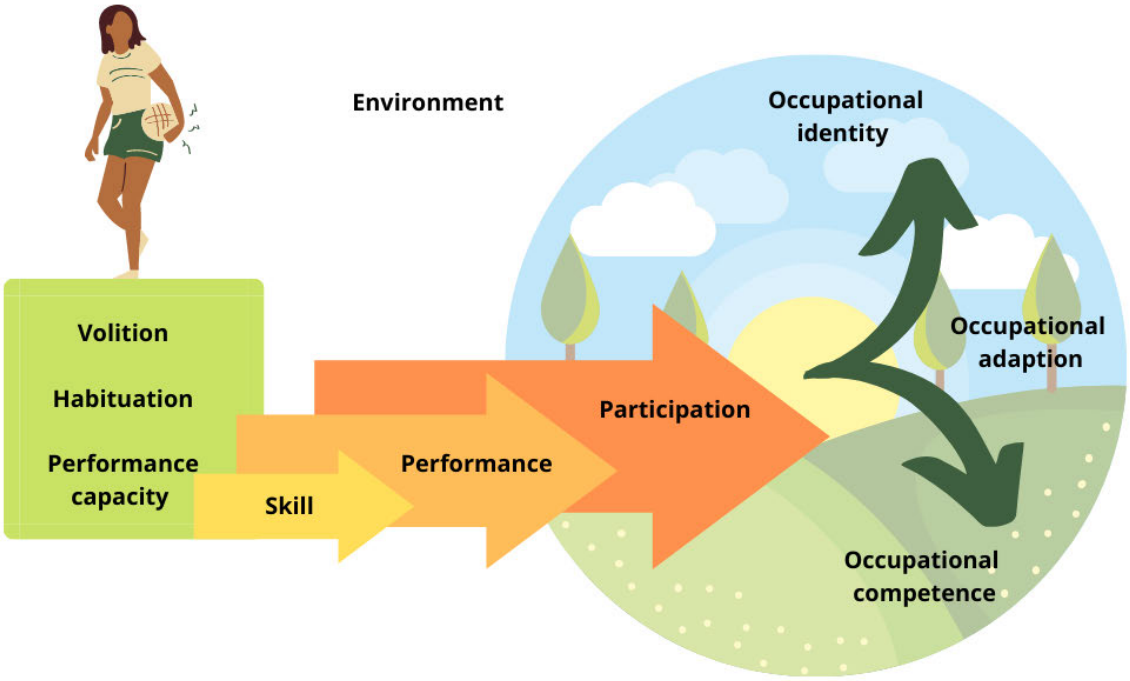
Elements of this model inform the understanding of human behaviour and interaction with leisure activity. Principles of the MOHO (Forsyth & Kielhofner, 2003) that are particularly applied include the belief that human behaviour is context-dependent and dynamic. This principle is applied throughout the thesis and supports theories of occupational deprivation. A mental health unit can be a challenging environment and is atypical to consumers' regular environment in the community. The institutional nature of these environments means there are limited opportunities to engage or participate in occupation.

Therefore, people may engage in mundane activities on MHIUs such as puzzles, colouring, or crafts due to their personal causation and innate drive to seek new opportunities. Similarly, personal causation may also cause some to retreat and avoid challenging circumstances. MOHO suggests that occupation is required to shape a person's abilities, self-concepts, and identity (Forsyth & Kielhofner, 2003). Restrictions within the physical and social environment along with limited occupations result in consumers' inability to reach their full capacity.

MOHO suggests that behaviour assists to maintain, restore, and reorganise (Forsyth & Kielhofner, 2003). Occupation is essential for self-organisation. Through doing you are generating and reshaping motivation (or volition). The concept of volition has been widely used within occupational therapy since the late 60s when it was introduced by Florey (1969), then later discussed by Kielhofner and Burke (1980) during the development of the Model of Human Occupation [MOHO] and labelled 'volition'. Volition can be described as a person's intrinsic motivation to participate in an occupation that is meaningful to them (Kielhofner & Burke, 1980). The notion that volition was an important aspect of engagement in leisure occupation was a common theme among participants who explained that leisure was their activity of choice. Occupational therapists may consider volition when supporting clients with activity choice or engagement. Persons are more likely to engage in an intrinsically motivated activity. This intrinsic motivation can be particularly difficult for those with complex and severe mental health issues such as post-traumatic stress disorder, however, can also be vital for their recovery with secondary benefits of increased function and participation in meaningful occupation (Brooks et al., 2020; Usher et al., 2020). Volition has been applied as a core concept throughout this thesis and is discussed in further depth in the recommendations.

Figure 1.4

Re-illustrated Model of Human Occupation from Taylor (2017)



A range of occupational therapy models were considered as a theoretical basis for this thesis including the Canadian Model of Occupational Performance and Engagement (CMOPE) (Craik, 2009) or the Person-Occupation-Environment-Performance (PEOP) model (Law et al., 1996). Even though the CMOPE provides explicit mention of leisure in the model when exploring occupational elements, the complexity of a consumer's mental health issues and their performance capacity required further exploration. The person factors within MOHO specifically explore elements such as volition (interests), habituation, and performance capacity which are common aspects of a person that can hinder engagement within MHIUs. Further exploration of the person factors was considered important in this thesis. Within MOHO, the interaction between person and environment is highlighted as a key component of participation which is particularly explored in the barriers and facilitators to participation. The MOHO also provides a unique exploration of macro-level issues that may impact consumers' participation in occupation. This was specifically utilised for chapter five, a review of legislation and policy that impacts participation. This element of the model led to an exploration of other contextual factors that impact participation.

1.7.3 Recovery Frame of Reference

Recovery is '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' (Commonwealth of Australia, 2013, p. 2). Recovery-oriented approaches include the experience of those with lived experience of mental illness, and their family (Commonwealth of Australia, 2013). The recovery-oriented care assists to breakdown the traditional power relationship between staff and consumers, and acknowledge the experience, and strengths consumers can contribute to their own care (Commonwealth of Australia, 2013). Recovery-oriented care explores the micro or individual needs of consumers rather than the broader organisational needs (Commonwealth of Australia, 2013). Recovery is considered to be a journey that is not restricted by the constraints of a consumer's diagnosis, but by their own experience (Commonwealth of Australia, 2013).

The recovery frame of reference was selected as it complements the paradigm and model selected within this thesis. The recovery frame of reference utilises elements of the recovery model which has been adopted within Australia and is part of the National Mental Health Plan (Commonwealth of Australia, 2016). In Australia, the recovery model is designed to enhance policy and improve service delivery to consumers with lived experience of mental illness (Commonwealth of Australia, 2013). Recovery was developed by consumers who utilise mental health services and are living a fulfilling and optimistic life regardless of illness (Coffey et al., 2019). Recovery principles include consumers maximising their social interaction with others and engaging in meaningful activities to improve quality of life. This can also be considered salutogenic, as consumers are engaging in meaningful activity to improve their overall health, and quality of life. There are five domains in the recovery model, including domain one promoting culture and language of hope and optimism; domain two person 1st and holistic; domain three supporting personal recovery; domain four organisational commitment and workforce development; and domain five action on social inclusion and the social determinants of health, mental health, and wellbeing, This thesis will particularly applies domain five of the recovery model.

The importance of this frame of reference is the core belief that consumers can improve and hold valid opinions of their own care. This is complementary of post-modernism as it affirms people with lived experience bring consumers own expertise and value to care (Commonwealth of Australia, 2013). This supports the exploration of the consumer perspective within this thesis and as an expert in their care. Recovery-oriented principles have

been applied to the development of the practice principles to support a cultural change and shift in the way MHIU provide care.

1.7.4 Frameworks and Applied Theory

The use of an interdisciplinary approach was applied to appeal to multiple professions. Within the thesis, some chapters were targeted to interdisciplinary journals as the findings applied to more than an occupational therapy audience. This thesis utilises the framework micro, meso, and macro (Coffey et al., 2019). This framework can be used across disciplines to explore the multiple layers of health including micro which indicates consumers and their individual care needs; meso indicates the broader team of staff working with consumers and macro indicates the broader organisation such as Queensland Health or the population of consumers with severe/complex mental health issues (Coffey et al., 2019).

This thesis applies the public health theory of salutogenesis. Salutogenesis is an approach to promoting/focusing on health and wellbeing rather than disease within health sciences (Lindström & Eriksson, 2005, 2006). Occupational enrichment resonates with the public health salutogenic theory, in that leisure can be health-promoting and support a person's wellbeing through social engagement (Håkansson & Ahlborg, 2018). Caldwell (2005) has previously discussed the link between leisure and salutogenesis as a health-promoting principle. Alternatively, there are activities that people participate in that could be potentially harmful to consumers health; even though they consider them enjoyable and pleasurable (Twinley, 2012). This would include activities such as smoking, substance misuse, and high-risk adventure activities. Engagement in self-harm or para-suicidal behaviours is typically frowned upon within society and is often considered a maladaptive coping strategy but provides a sense of relief for the person. Twinley (2012) explored 'dark occupations' that can pose risk or danger but are enjoyable for the person such as sky diving, base jumping, smoking, and drug use. Occupations that pose risk or danger should be handled with caution in a therapeutic setting and health-promoting alternatives should be considered. This theory supports the use of the Model of Human Occupation and provides unique insight into the public health components of this thesis.

1.8 Rigour

This thesis applied various elements of procedural rigour, analytical rigour, trustworthiness, and descriptive clarity to achieve overall rigour.

1.81 Procedural Rigour

Procedural rigour was achieved in each chapter including a procedure of data collection to ensure the reader understands the research approach. Some of the elements included in the procedure are attaining ethics approval, recruitment, data collection, length of time spent completing surveys by participants, and the number of participants that completed a survey.

1.8.2 Analytical Rigour

Each chapter included a description of the data analysis. For example, in chapter two, the meaning units, categories, and themes were described in the results to allow transparency and flow of findings. This allowed the reader to understand how conclusions were drawn.

Analytical rigour was also achieved in chapter five with the use of multiple methods on the same data set. The policy analysis (chapter seven) included the use of text-mining computer software called Leximancer V4 in phase one and semantic analysis through hand searching in phase two. The decision to apply both research methods was to ensure the findings were consistent and contextual.

1.8.3 Descriptive Clarity

All survey responses were anonymous to enable participants the opportunity to freely describe their experiences, perspectives, and opinion. The researcher did not have a relationship with consumers which may impact the credibility of the findings. In chapter one and nine, my assumptions as a researcher on leisure activity in MHIUs is explicit and discussed.

The critical friend approach was applied to qualitative studies to improve rigour (Smith & McGannon, 2018). Supervisors of the thesis assisted with this approach.

1.8.4 Trustworthiness

A range of methods were applied for trustworthiness. Each chapter includes an adapted version of a manuscript that has been submitted for publication. Submission to publication has enabled the peer review process for each chapter and all works of the thesis. Peer review was also used in the ethics application to gain approval to commence the research. This process was part of the trustworthiness of this thesis. Areas of trustworthiness explored in this thesis included credibility, transferability, dependability, and confirmability (Letts et al., 2007),

1.8.4.1 Credibility

Credibility 'refers to the truth or believability of the findings' (Mauk, 2015, p. 236). Data collection occurred over a prolonged period (months or longer) to allow participation from a range of participants. A range of participants including diversity of age and gender was attempted in each chapter.

As there were qualitative and quantitative methods chosen within this thesis, triangulation has been applied to various studies. Triangulation was particularly applied in chapter four when viewing the staff perspectives and chapter seven when exploring the consumer perspectives of leisure activity. Both surveys included qualitative and quantitative components. This was further explored in the methods sections of each chapter. The choice to utilise integrated approaches was to capture a greater range of information during data collection phases with vulnerable groups.

Reviewing multiple perspectives, allowed for conclusions to be drawn and recommendations to be provided.

Each chapter includes clear descriptions of the methods, data collection, and participant experience. Namely, the recruitment method, demographic information about participants, and the open-ended questions asked in surveys were included. This assisted to provide credibility, and trustworthiness for the analysed results. Analysis in each chapter was independently checked by the second author and discussed with the remaining authors. The limitations of each chapter highlight what information is missing that may have impacted the analysis. For example, in chapter seven the mental health act status of participants was not collected due to ethics limitations. The mental health act status may have provided further insight into the consumer experience and reports of feeling incarcerated versus a voluntary participant who may have had increased satisfaction.

1.8.4.2 Transferability

Transferability relates to whether the findings in this thesis can be transferred to like or similar contexts (Mauk, 2015). The findings from this thesis are likely transferable to other mental health inpatient settings in western countries. From a macro perspective, the thesis reviewed leisure concepts in mental health policy and legislation (chapter five) with two different methods. Both methods could be applied to any form of policy or legislation that wishes to explore the leisure principles.

The CLIP (chapters six and seven) has been surveyed by the general population and mental health consumers. This tool explores contemporary leisure interests that could be translated to adolescence, geriatric, and intellectually impaired consumer groups.

In chapter seven, consumers were surveyed to explore their satisfaction and leisure interests in MHIUs. The description of the MHIU, participant information (including demographics), and data analysis would assist other researchers to conduct similar or the same study in other MHIUs to compare findings. The tools and internal consistency were provided along with a comparison to previous studies.

1.8.4.3 Dependability

Dependability addresses whether each chapter's research findings are congruent to the data (Raines, 2011), and if the 'findings are likely to apply at other times' (Bryman, 2016, p. 44). Each chapter includes a reference to the qualitative or quantitative methods used to analyse the data. For example, Graneheim and Lundman (2004) methods for content analysis was applied in chapter two, four, six, and seven. The rationale for how meaning units were condensed into categories and themes were detailed in the methods section of each chapter. Prevalence of like responses and the application of occupational therapy theory assisted to transform the data.

1.8.4.4 Confirmability

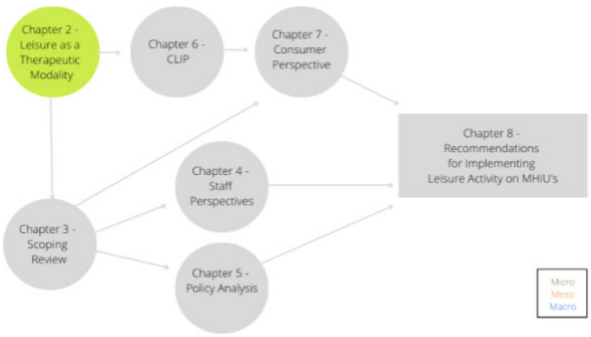
Confirmability explores whether researchers bias, such as values, have impeded on the process to conduct research (Bryman, 2016, p. 44). The researcher acknowledges their own reflexivity whilst carrying out the research (Finlay, 2002). Throughout this journey, reflexivity was explored and utilised as an invaluable tool to guide the research. Reflexivity was also considered, with discussions between students and supervisors (who had differing professional backgrounds) assisting in monitoring for potential biases (Finlay, 2002). This approach was specifically used with content and semantic analysis. Each member of the research team would review the work completed by JL to achieve trustworthiness.

As an occupational therapist, I hold the beliefs that occupation is an important and valid therapeutic modality to utilise within these environments. This led to the research questions due to my values, beliefs, and interests. Assumptions made throughout this research about leisure, mental health consumers, and inpatient units were all made based on my experience and perception of the consumer experience. Reflexivity was utilised as a helpful tool in exploring my understanding of the consumer experience and guided research questions.

As part of the reflexivity process, contextual information, and exploration of the gaps within MHIUs were deemed to be valid and important. All contributors to chapters provided unique perspectives and brought their experience into the development of chapters. This meant that at times an interdisciplinary approach was utilised to shift any bias to professions (for example, chapter seven introduced two psychiatrists and a psychologist to provide a multi-dimensional approach to the analysis of the consumer perspective).

CHAPTER 2 – Conceptualisation of contemporary leisure activities and opportunities for mental health salutogenesis

This chapter provides context to section one of the thesis and addresses aim two listed in chapter one. This chapter includes a manuscript of original research.



Leisure is a term that is commonly used within occupational therapy, health, and recreation. Specifically, this chapter establishes the contemporary definition of leisure used throughout this thesis. Leisure is explored in this chapter more broadly and then is applied to a mental health context in later chapters. Specifically, gaps within the research are identified that this thesis addresses in sections two and three, including the development of a contemporary leisure framework. Leisure is identified as a therapeutic modality and meaningful activity fundamental to occupational therapy.

This chapter includes secondary analysis from chapter six, the development of the Checklist of Leisure, Interests and Participation (CLIP). Qualitative content analysis was used to explore participants' understanding of leisure in modern society (Graneheim & Lundman, 2004). The theoretical framework used in this manuscript and throughout the thesis is the Model of Human Occupation (MOHO). The theory of salutogenesis is also applied throughout as leisure is established as a health-promoting activity.

This manuscript has been submitted to Occupational Therapy in Mental Health. The readership of Occupational Therapy in Mental Health is predominately occupational therapists with an interest in innovative service evaluation and problems identified in psychiatric settings. The impact factor of this journal is 1.12 and is a Q3. Additionally, to maintain consistency between chapters, the referencing and formatting have been adapted.

2.1 Abstract

The aim of this study was to understand the value and meaning of leisure from the general population. A short answer online survey of a general population was conducted via social media. Content analysis was conducted from 145 responses received. Contemporary leisure definitions from the general population were explored. Leisure is considered to have meaningful impact on people’s health and overall wellbeing. A contemporary definition of

leisure provides specific aspects or activities that would indicate engagement in leisure activity. This can also prompt clinicians to explore potential barriers to engagement and highlights the significance of the 'who' in participation.

2.2 Introduction

Leisure is a meaningful activity that can address isolation and has become an important and critical component of the scope of practice of occupational therapists, including in mental health settings (Chen & Chippendale, 2018). A core belief within occupational therapy is that human beings are human doings (Farnworth, 1998; Wilcock, 1998) so one can assume that engaging in occupation can be good for mental and physical health. However, occupational therapists within mental health inpatient units are often seen by the remainder of the multidisciplinary team as being solely responsible for conducting functional assessments. Less emphasis is placed on the provision of therapeutic occupation and the importance of using leisure as a form of treatment (Chen & Chippendale, 2018; Smith & Mackenzie, 2011).

In contemporary society, leisure plays a role in bringing shape and fulfilment to people's lives, complementing productive activities such as paid employment, parenthood, or instrumental activities of daily living (IADL's) (Stebbins, 2018). However, the roles and forms that leisure takes have evolved in response to changes in society, values, roles, technology and economies (Stebbins, 2018).

For example, over the past 50 years, technological advancement has improved the efficiency of some activities such as laundry and washing, leaving more time for leisure (Aguiar & Hurst, 2007). In contrast, other technologies (e.g., smartphones, computers) have imprinted new demands on our time and blurred classic distinctions of work and leisure (Wijesinghe, 2017). New activities, such as video games or social media, may be a trending or a prominent activity in a person's occupational profile whilst others, such as hand embroidery, may become more niche due to industrialism and advancement in technology.

As the roles and forms of leisure have evolved, so too has our understanding of leisure. The language we use and meaning that we ascribe to words reflects our world views. There has been ongoing debate for decades around the definition and meaning of leisure (Iso-Ahola, 1979; Stebbins, 2018; Veal, 1992). Within the profession of occupational therapy, there are various texts that provide a range of definitions (Iso-Ahola, 1979; Stebbins, 2018; Veal, 1992). Various frameworks and models, such as the International Classification of Functioning Disability and Health (2017) (ICF), provide varied definitions for leisure. These

definitions are typically established through theoretical reflection without reference to community understandings of terms. In this chapter, we explore laypersons' understanding of and value given to contemporary and meaningful leisure activities and the use of leisure as therapeutic modality to promote mental health recovery.

There are two main types of leisure definitions (Chapparo & Ranka, 1997; International Classification of Functioning Disability and Health, 2017): those that provide examples of activities and those that proffer only criteria regarding the nature of leisure. Examples of the former category include the ICF (International Classification of Functioning Disability and Health, 2017) and the Occupational Performance Model (Australia) (OMP[A]) (Chapparo & Ranka, 1997). The ICF (International Classification of Functioning Disability and Health, 2017) classifies recreation and leisure (d920) using example activities of "play, sports, physical fitness, relaxation, amusement or diversion, going to art galleries, museums, cinemas or theatres; engaging in crafts or hobbies, reading for enjoyment, playing musical instruments; sightseeing, tourism and travelling for pleasure."

The ICF does offer some criterion reminiscent of other frameworks through exclusions of work, religion, spirituality, political life and citizenship (International Classification of Functioning Disability and Health, 2017). The OPM(A) similarly provides both examples and criteria, describing leisure and play as "those routines, tasks and sub-tasks for purposes of entertainment, creativity and celebration, for example gardening, sewing, games" (Chapparo & Ranka, 1997).

In contrast, most occupational therapy texts (Parham & Fazio, 1997; Townsend & Stanton, 2002) and key leisure theorists (Brown et al., 2017; Hammell, 2008; Townsend & Polatajko, 2007) define leisure via criteria such as enjoyable or not; or work or not work. A number of texts such as the Occupational Therapy Practice Framework: Domain & Process (4th Ed), (American Occupational Therapy Association, 2020) and Occupational Therapy in Australia (Brown et al., 2017) utilise Pahram & Fazio's definition of leisure, as a "non-obligatory activity that is intrinsically motivated and engaged in during discretionary time, that is, time not committed to obligatory occupations such as work, self-care, or sleep" (Parham & Fazio, 1997, p. 252). The Canadian text, Enabling Occupation (Townsend & Stanton, 2002) and Enabling Occupation II (Townsend & Polatajko, 2007), highlight that the occupational groupings of self-care, productivity and leisure are defined by the individual and society based on purpose, where the purpose of leisure activities is to "enjoy life" (Townsend & Stanton, 2002, p. 34).

Hammell (2008) argued against strict occupational grouping classification, as some activities may fit multiple categories or hold different meanings for different people (Hammell, 2004). For example, some people may find gardening pleasurable and a leisure activity, others may find this a chore and would consider this an IADL. Within occupational science and occupational therapy, there is an ongoing debate around the benefits of categorisation of occupations (Jonsson, 2008) versus conceptual fluidity where individuals have self-defined activity profiles (Hammell, 2004). A person's daily occupation profile in the 21st century could be self-defined based on their interests, geographical location, access, and environment, rather than occupational groupings. However, the majority of occupational therapy texts still include conceptualisations of occupational therapy groupings and hence must intrinsically see some benefit in this.

Artful shaping of the leisure profile to the person is important. It has been suggested that the fit between leisure interest and engagement is more predictive of subjective well-being, compared with the pure quantity of leisure engagement (Schulz et al., 2018), reminiscent of the dynamic nature occupational therapy models. People may choose to participate in activities to support mental health (improvement in mood and stress), balance work and life, increase socialisation, increase physical strength (fitness), and support self-efficacy, self-esteem and confidence (Caldwell, 2005).

While there is extensive literature around leisure generally, there is limited literature exploring leisure as a salutogenic (health-creating) concept (Lindström & Eriksson, 2006; Young, McGrath, & Adams, 2018; Peel, Maxwell, & McGrath, 2021). This concept has been particularly highlighted during the global pandemic of COVID-19. This pandemic has forced society to adapt the way in which they engage in occupation to participate. Society has seen previously popular activities become in vogue again such as handicrafts, home decorating, board games and puzzles due to the restriction of environment. The literature also suggests that participation in leisure reduces instances of mental health issues such as anxiety, depression and post-traumatic disorder (Usher et al., 2020; World Health Organization, 2020) making engagement health creating.

There are multiple definitions of leisure that are utilised in clinical practice. This study aimed to understand the value and meaning of leisure from the general population to generate a contemporary definition of leisure.

2.3 Materials and Methods

This study is a mixed methods study. The data was drawn from two online surveys (consisting of short answer questions) aimed at exploring the general population's view of contemporary leisure within an Australian population. Qualitative content analysis was used to analyse all data. Ethical approval was received from the University of the Sunshine Coast Human Research Ethics Committee (S/17/1100).

2.3.1 Participants

Participants were recruited using social media, including Facebook, through a convenience sampling method; researchers sharing a link to access the survey. The posts were shared to groups such as 'MH4OT' which recruited occupational therapists and their networks. Therefore, participants (laypersons; a person without leisure specific knowledge) also accessed the survey. While originally international participation was expected, the scope of the study was honed to Australian participants given the predominance of Australian respondents. The surveys were shared and open for a period of 8 months in 2019. Saturation was reached after 97 responses. Saturation was determined when additional survey responses did not contribute new information or assist with further understanding of contemporary leisure activity (Hennink, & Kaiser, 2021).

Names and other identifying demographics (such as IP address) were not collected in order to ensure anonymity. Before entering the survey, participants were asked to read consent material and only continue if they agreed to participate. Inclusion criteria was specified at the beginning of the survey which included anyone over the age of 18 who had access to social media and viewed the post were invited to participate. Exclusion criteria included those who did not live in Australia and were under 18 years old. a to each survey round and the same participants were not recruited to each round. Participants may have completed both surveys.

2.3.2 Data Collection

The online surveys included demographic information, qualitative questions exploring participants' definition of leisure and a checklist of leisure activities to develop a greater understanding of what contemporary leisure activities meant for respondents.

2.3.3 Procedure

The survey took approximately 10 minutes to complete. Participants completed the survey in their own time. As identifying demographics were not collected, participants were unable to save their responses and return later. The data was collected September 2017 to

May 2018 using the online survey platform Survey Monkey. Participants accessed the survey link shared via social media (e.g. Facebook) and word of mouth/emails from friends. Researchers KB and JL shared the post to social media, i.e. Facebook more broadly and to specific groups. As both authors are occupational therapists, and the post was shared to occupational therapy specific groups. There is a high potential that occupational therapists may have completed the survey. The surveys both explored participants' understanding of leisure within a contemporary context and their personal definition. Each round of surveys, participants were asked 'how do you define leisure' to assist with developing a contemporary definition that also aligned with the literature.

2.3.4 Data Analysis

This study was mixed methods. Qualitative content analysis (Graneheim & Lundman, 2004) was applied to the open-ended questions. The content analysis was completed by the first and second author, and peer reviewed by the third and fourth author. Discrepancies in interpretation from any researchers were discussed as a research team and consensus was reached by the majority. A quantitative element of this study was providing the number of times themes were present in participant responses. This was used to demonstrate how strong the themes were in the analysis to support the qualitative analysis. Researchers involved in data analysis were JL, KB and FO. Responses from the surveys were placed in the category of meaning unit which is designed to include similar phrases, words or sentences that are related to each other (Graneheim & Lundman, 2004). Meaning units were analysed by the researcher and summarised into shortened condensed meaning units. Meaning units were explored response by response, and codes were identified based on like concepts in the meaning units. The coding was inductive based on like responses by participants.

As described by Graneheim and Lundman (2004), this process still protects the core meaning from the original data. The process of aggregation occurred at a category and theme level. Categories were formed and considered meaningful or important when concepts (condensed meaning units) were identified by more than two of the above researchers. These categories provided core elements or a general consensus of what appeared to be critical elements that make up the definition 'leisure'. The categories were then synthesised into overarching themes.

2.4 Results

Across the two surveys, a total of 145 responses provided definitions of leisure from Australian participants. Participants were asked to provide basic non-identifying

demographic information. The median age was 35.5 (Min = 18, Q1= 26, Q3 = 46, Max = 68). Participants were predominately female (75.2%), with around a quarter male (24.8%). Participants provided their relationship status including; 'single' (11%), 'in a relationship' (22.7%), 'it's complicated' (1.3%), 'de facto' (8%), 'married' (53.7%), 'separated' (1.3%), 'divorced' (2%) and 'widowed' (0%). Based on the inclusion criteria, only Australian participants were included in the data analysis.

Participants were also asked about their engagement in leisure occupation to determine whether this was potentially meaningful and an activity that was valued. A total of 49.6 % of participants participated in leisure activity daily. Only two participants (1.3%) stated they did not participate at all. All other participants either engaged 'occasionally' (37.9%) or 'not that often' (11.03%). A small portion of participants identified specific examples of leisure within their definition such as gardening or watching a movie. The categories below best describe the participants' own definitions based on the content analysis.

2.4.1 Fun and Pleasurable

The most common words which were used 53 times included 'fun', 'pleasure', 'pleasurable', 'enjoy' and 'enjoyable'. An example of a participant definition was 'pleasure with no financial gain'.

2.4.2 Not Work Related or Productive

The word combinations 'non-work', 'not-work', 'no-financial gain' and 'non-productive' were used 30 times to define leisure. These were considered as definitions by exclusion, meaning the words provided explanation of what leisure is not. A participant described leisure as 'non-work or IADL'.

2.4.3 Free/spare Time

Participants suggested a modern and contextual definition of leisure included the idea of 'free time'. A total of 25 participants included phrases that included 'free time' or 'spare time'.

2.4.4 Non-obligatory and Own Choice

When considering leisure activities, participants used phrases such as 'non-obligatory', 'own choice', 'activities you choose to participate in' and 'activities choices for enjoyment' a total of 13 times.

2.4.5 Individual or Group Activity

A minor theme throughout the data was that activities would be participated with others or individually. Explicitly it was mentioned 12 times that leisure was an 'individual' or

'group activities for pleasure'. Another example is 'activities that bring meaning, fun with ourselves or other people'. Explicit inclusion of both individual and group pursuits may indicate that participants saw these as distinct concepts.

2.4.6 Relaxing/Therapeutic Activities

A total of 8 phrases were used associated with relaxation and therapeutic value to define leisure. Some believed that leisure was 'therapeutic enjoyment', 'good for body and soul', 'things to centre and ground' and 'activities that achieve flow'. Over 80% of the respondents highlighted leisure activity to be health promoting in nature with examples such as 'something good for the body and soul' or 'activities I choose that lead to re-energisation'.

2.4.7 Emerging Themes

Two themes were developed to summarise the findings of all meaning units and categories that were described in the raw data. The overall themes generated through the content analysis were: 1) *an enjoyable activity that is not work or productive which you choose to participate in your spare time alone or with others,* and leisure can also be 2) *an activity that can be relaxing, fun and support health*.

The first theme emerging was the notion that leisure activity is deemed to be enjoyable. A majority of the participants identified that leisure activity provided meaning and a sense of joy. This was deemed by the research team to be closely linked with the codes of the exclusion criteria of other categories of occupation such as work or self-care. What differentiated leisure from other categories of activity was that it was meaningful with intentional participation of a person's own volition individually or with others.

The second theme was closely linked to the first them that leisure is health promoting due to mental and physical health components, such as, enjoyable, relaxing and provides satisfaction. The idea that leisure can be health promoting or salutogenic is different for individuals. An activity such as yoga or exercise may be leisurable for one, but not for another and deemed as a necessary self-care task. Others may consider computer gaming or circus performing as health promoting due to the mental health benefits and satisfaction.

2.5 Discussion

The results support the view of Shaw (1985) that leisure is uniquely individual to the person. This fits with the view that occupation is user-defined and constructed by the individual who engages in the activity based on their level of ability, intrinsic motivation, volition and satisfaction (Kielhofner, 1980; Kielhofner & Burke, 1980; Shaw, 1985). The proposed leisure definition encompasses elements of existing definitions reviewed in the

introduction. For example, American Occupational Therapy Association, (2020) and Occupational Therapy in Australia (Brown et al., 2017) suggest leisure to be non-obligatory use of time that is not work or self-care. Brown et al., (2017), Hammell (2008), and Townsend & Polatajko (2007) suggests leisure is an activity that is enjoyable in spare time. Unlike the International Classification of Functioning Disability and Health (2017), leisure activities are not specified in the defintion due to occupational shifts within society. Specfying activities reduces the useability of the defintion over time. This study's definition of leisure includes the specification of who may be involved in a leisure activity as this may affect the way in which the activity is engaged in. The 'who' in engagement also supports to identify social relationships, occupational engagement, and occupational form.

Throughout the content analysis, participants described leisure with a sub-text of a health promoting, therapeutic or wellbeing activity. Tinsley and Eldredge (1995) support the idea of leisure as a salutogenic activity which enhances the wellbeing of an individual. However, participants spoke less commonly of health-giving benefits. Participants used exclusion and inclusion criteria to define leisure by using phrases such as 'not work' or 'spare time' as descriptors. This suggests that participants do recognise distinct categories of occupation.

Many of the participants within the study had different views to each other around how to define leisure, which was relevant to their current occupational profile and participation style. Criterion-based definitions (such as 'not work or IADL's') more robustly accommodate continuing societal revolution associated with advancements such as technological advancements (invention of new activity such as social media), societal shifts (politics, values, gender construction associated with activity) and economic changes (socioeconomic status, increased free time). A more contemporary view of leisure can support the use of leisure as a therapeutic modality and support more effective use within therapeutic fields. With a revision of the definition, leisure can be individualised to the person's specific interests, promoting more meaningful engagement.

Based on the literature and data from this study the following leisure definition is proposed: *a chosen activity, conducted individually or as a group, 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*.

2.5.1 Translating Theory to Practice

With a greater understanding of leisure within a contemporary context, the data can also provide insight to the translation of leisure as a therapeutic modality for use by occupational therapists.

Australian Bureau of Statistics (2022) suggest that 61% of adult (18-65) Australians in 2020-2021 have made active steps to improve their mental health such as 37% increased their level of activity (which could be considered leisure or self-care), 29% utilised positive self-talk and 28% increased enjoyable activities (leisure). These statistics suggests that Australians innately shift their occupational profile and routine to meet their mental health needs (Australian Bureau of Statistics, 2022). The increased leisure activity also aligns with the notion that leisure is salutogenic and health promoting.

There has been a large social movement to create leisure routines and increase engagement in activity to promote wellbeing such as meditation, journaling, exercise and do-it-yourself (DIY) activity. This contemporary view of leisure appears to be more significant than ever since the global pandemic (COVID-19). Participants identified key elements of leisure that closely align with existing occupational therapy frameworks such as the Model of Human Occupation (MOHO) (Kielhofner & Burke, 1980). Within MOHO a key occupational domain is leisure. The nature of leisure appears to be linked to a range of precepts from occupational therapy frameworks, including person, environment and occupation factors. Often as therapists, the purpose of rehabilitating or remediating can be to enable participation in an activity and improve function. Encouragement from the World Health Organization has fostered engagement in leisure for wellbeing during the difficult time (World Health Organization, 2020). Leisure can be used as motivation to participate in therapeutic activities which could otherwise be perceived as challenging or boring. For example, if a therapist was attempting to assess function to consider discharge planning, they may use a leisure activity to peak interest and foster engagement.

A majority (80%) of participants highlighted leisure activity to be salutogenic. This demonstrates the importance of health promoting themes during leisure activity. Many provided examples of leisure being ‘therapeutic’ through means of ‘engagement’, ‘grounding’ and ‘mindful[ness]’. This resonates with the public health salutogenic theory, in that leisure can be health promoting and support a person’s wellbeing through social engagement (Håkansson & Ahlborg, 2018). Caldwell (2005) has previous discussed the link between leisure and salutogenesis as a health promoting principle.

Throughout literature (Craik & Pieris, 2006; Crist et al., 2000; Kielhofner, 1980) theorists have focussed on 'how' participants engage in leisure activity. Within this study, some participants also focussed on 'who' leisure activity is done with. Occupation can be a sole or group activity which is typically not commented on within other leisure literature. Within modern society 'who' people spend their free time is perceived to be important and meaningful therefore, this has been included within the findings of this study and leisure definition. A common theme amongst participants was a need for a social element during their engagement such as 'meeting friends for coffee'. Within the Model of Human Occupation [MOHO], Forsyth and Kielhofner (2003) highlighted the importance of quality social environments. Even though leisure can be independent and enjoyable, often people use leisure activities as an opportunity to socialise, thus enhancing connection and wellbeing. Examples might include meeting friends for coffee or participating in a local gym class. Social distancing measures during the COVID-19 pandemic has forced adaption of engagement with an increased use of technology and virtual discussion (Brooks et al., 2020; Van Bavel et al., 2020). Similarly, if someone is detained in an environment such as a prison or mental health inpatient unit, they are limited on who and how they participate in occupation. This in turn can affect their volition, habituation, and level of participation. If the notion that leisure is health promoting and salutogenic, then the who and how people are involved in leisure activity should be equally as important as the benefits to engagement.

With the consideration of a therapeutic context, the occupational therapist can be considered part of the 'who'. Some groups within society can be socially isolated due to geographical location, lack of access to the community or limited social networks. Attending an occupational therapy session may be one of the only social interactions for a consumer in a day within the community. This provides an excellent opportunity for consumers to engage in meaningful occupation, connect socially and engage in therapeutic activity.

Another consideration is mental health consumers may not have a 'who' or 'how' in their day to day lives. Participants indicated that activities can be a sole or group activity which can affect the meaning and benefits of participation. A consideration to how consumers engages is a typical lens for an occupational therapist to assist with grading and adapting activities to meet the individual's needs,

2.5.2 Limitations

There was a disparity between the genders and ages of respondents, and the demographics of the Australian population which may have been influence by the sampling

methods (convenience sampling via social media). Future studies may wish to target a larger sample to ensure generalisability and engage in cross-cultural validation. It is possible that leisure experts may have completed the survey which may have skewed the layperson definitions provided, but data on current profession was not collected for anonymity reasons. The sample is likely to have included occupational therapists due to the networks of the authors that shared the post. As IP addresses were not collected, it was possible for participants to complete multiple rounds of the surveys.

2.5.3 Implications for Practice

Occupation is at the centre of occupational therapy practice. This is often lost with prescriptive modalities rather than recovery-oriented care (Coffey, et al., 2019). Even though each client may not achieve occupational balance, leisure is an important consideration within the therapeutic strategies. Leisure activity can be utilised in any therapeutic context as an opportunity to discuss lifestyle choices, balance, roles and habits. To support the facilitation of leisure, therapists can ask leisure focussed questions to expand on this area of occupation such as:

- 'What types of activities do you currently do outside of work?'
- 'What does a typical day look like for you?'
- 'How do you spend your free time?'
- 'What do you like to do to that is enjoyable or for fun?'
- 'What do you like to do that is relaxing?'
- 'What do you do to take your mind off things that are worrying you?'
- 'Which leisure activities do you do by yourself, and which ones are done with others?'
- 'How much of your day do you spend doing what you feel you have to do versus what you choose to do'?

Occupational therapy programs should ensure graduates understand the contemporary definitions of leisure and its potential applications to the development of salutogenesis in therapeutic settings.

2.5.4 Implications for Research

Further research may explore different uses for a therapeutic use of leisure occupation in modern society. This expanded understanding may support with capacity building of leisure skills for clients who have reduced abilities to develop a habitual routine themselves. In some practice areas, use of leisure inventories or checklists may be required to provide

concrete activity examples for participants to choose from. Furthermore, collecting demographic information, and cultural background of participants may assist in understanding barriers to participation.

2.6 Conclusion

Leisure is largely found to provide enjoyment and can be health promoting. When participating in leisure, the chosen activity needs to be important to the person to provide meaningful and promote intrinsic motivation, but 'who' is involved in the activity and how it is performed are equally as important factors to engagement. Leisure activity can be a powerful tool for occupational therapists to perform assessments, assist with improving function, and develop a routine.

2.7 Key Points for Occupational Therapists

There are multiple definitions of leisure. A survey of the general population suggests that leisure is self-defined, individual and evolves over time. A new definition was proposed that could benefit future practice and research.

There is a strong emphasis on 'who' is participating in leisure activity with consideration for whether the activity is participated in a group or individually. Engagement in group activities can foster positive social relationships and the use of leisure as a therapeutic modality.

Leisure activity may be used as an important therapeutic tool which is meaningful and supportive to a person's health and wellbeing. Most people identify leisure provides meaning and benefit for them, which is important exploration when interviewing for clients/patients/consumers across all professional areas.

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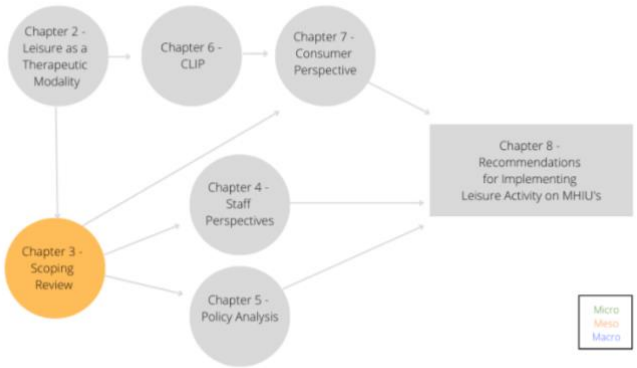
CHAPTER 3 –A Scoping Review: Consumer, Carer and Multidisciplinary Perspectives of Consumer Leisure in Mental Health Inpatient Units

This chapter includes a scoping review of how consumer time use within MHIUs. This scoping review addresses aim two within the thesis and situates the reader to the gaps in mental health inpatient service provision. This chapter also explores the barriers to consumer engagement currently found in the literature which is later explored further in chapter seven.



This scoping review followed the Arksey and O'Malley (2005) methodological five-stage framework to review the data. Elements of the Model of Human Occupation (MOHO) are explored in this review, more specifically the social and physical environment, interests, and personal causation. Personal causation is related to volition (motivation to participate in activity) which aligns with occupational opportunity. Limited opportunity within the physical and social environment, causes consumers to question their capacity and effectiveness (personal causation).

This review assists in further understanding the multiple perspectives on the amount of leisure activity offered and realistic time use opportunities on MHIUs currently found within the literature. Engagement in therapeutic activity can lead to social opportunities, exploration of self-identity, and expansion of self-efficacy (Caldwell, 2005). Leisure activity and social engagement can provide opportunities bring meaning to people during a very difficult time in their life. Many consumers report an episode of severe and complex mental health issues to be challenging and traumatic. Leisure activity could provide some positivity to a perceived negative experience.

This manuscript has been submitted to OTJR: Occupation, Participation and Health. The readership of OTJR: Occupation, Participation and Health is predominately occupational therapists with an interest in innovative service evaluation and problems identified in psychiatric settings. This scoping review highlights the barriers to consumer engagement in leisure identified in literature, and the role occupational therapists play in delivering leisure. The aim of this journal is to disseminate research that explores health and wellbeing, and occupational therapy practice. OTJR Occupation, Participation and Health has an impact

factor of 1.768 and is a Q2 journal. Additionally, to maintain consistency between chapters, the referencing and formatting have been adapted.

3.1 Abstract

Introduction. Consumers often report being bored and sedentary in mental health inpatient units (MHIUs). This literature review aims to examine how consumers utilise their time and potential barriers to engagement in leisure activities on MHIUs.

Method. Data analysis was conducted using a five-stage framework with a combination of quantitative and qualitative data. Nineteen studies were identified as suitable and met the inclusion and exclusion criteria.

Results. Barriers to engagement were identified. Some of the barriers included a lack of resources, limited engagement from the multidisciplinary team, boredom, limited focus on the individual consumer needs, and negative staff attitudes.

Discussion. Consumers would benefit from increased leisure-based activity in mental health inpatient units to support adaptive skill development and overall health and wellbeing.

3.2 Introduction

Leisure is often used as a distraction strategy, creating optimism and a pathway for recovery (Caldwell, 2005; Leufstadius, 2017). Furthermore, engagement in leisure activity supports reduction in stress, social inclusion, connection with the community, and self-efficacy and provides meaningful occupation (Ponde & Santana, 2000). Often, individuals are unaware they are inherently engaging in leisure activities to improve their mood. Leisure activity can be used in mental health settings as a therapeutic tool, to support the development of coping skills and manage the effects of stress (Caldwell, 2005). Though, is not readily available or a common practice. A core principle of occupational therapy is facilitating engagement in leisure activities to promote physical and mental health wellbeing, also referred to as salutogenesis (Hammell, 2004; Rebeiro, 1998). Participation in meaningful occupations is believed to support the development of self-efficacy (Kielhofner & Burke, 1980) and self-esteem. Yet, access to meaningful occupation is heavily dependent on the environmental context and opportunities available (Christiansen, 1999; Marshall et al., 2020).

3.2.1 Mental Health and Leisure

In mental health inpatient units (MHIUs), consumers can be found wandering and bored due to the lack of activity offered (Marshall et al., 2020). Consumers admitted to MHIUs are often found sitting with minimal or no activity, social isolation, and poor occupational balance (Fraser et al., 2016). Periods of isolation or self-quarantine preventing

people from engaging in meaningful occupation outside of their direct environment may reduce typical social interactions, and greatly impact their health (World Health Organization, 2022). The negative impact of isolation also applies to those who suffer from severe mental health issues and require hospitalisation; this shift in consumers typical habituation or routine can result in occupational deprivation (Whiteford et al., 2020).

Occupational engagement and time use could be used as indicators of a person's physical and mental health, quality of life, and fulfillment of being (Christiansen & Matuska, 2006). Time use can be categorised broadly into areas such as self-care, leisure, productivity, and rest (Law et al., 1990). In Western society, life balance is typically viewed from the perspective of work/life balance with frequent prioritisation of income (Christiansen & Matuska, 2006). Some people with chronic illness have the financial benefits of a pension, which enables them to prioritise their occupations and participate in different patterns of activity than others who do not have access to social and financial support.

There appears to be a mismatch between the therapeutic benefits of leisure and the ability to access leisure for persons with severe and complex mental health issues on MHIUs (Leufstadius et al., 2006). Clinically, it is understood by staff there is a lack of leisure activity provided for consumers in public acute MHIUs within Australia. It is believed that consumers have better outcomes when engaged in an activity and activities which can reduce the incidences of aggression, seclusion, and need for medication (Todman, 2003; Wilson et al., 2018). This literature review aims to explore how consumers utilise their time and potential barriers to engagement in leisure on MHIUs. This research aims to answer, 'how do consumer use their time to access leisure activity on MHIUs in Australia?'

3.3 Method

This scoping review was informed by the five-stage approach by Arksey and O'Malley (2005). The five-stage approach stipulates the development of a research question, detecting relevant research, selecting appropriate research for review, charting the data, 'collating, summarising and reporting the data' (Arksey & O'Malley, 2005; Peterson et al., 2017).

3.3.1 Data Sources

During a preliminary search, limited research was found related to the above questions. Thus, a scoping review (Arksey & O'Malley, 2005) was chosen to provide a comprehensive synopsis of the evidence, which will develop further understanding of activity in MHIUs and inform future research. Due to the limited studies available in Australia, the

search was extended to international sources. The core health and medical databases searched were CINAHL, Google Scholar, Medline, and Scopus for qualitative and quantitative studies. Studies reviewed were published from 1980 until December 2021 (which was the finish of my thesis data collection for this component).

Table 3.1

Population, Concept and Context (PCC) Search Terms

PCC element	MESH and ICD Terms
Population	'staff', 'multidisciplinary team', 'interdisciplinary team', 'health professional', 'mental illness', 'schizophrenia', 'depression', 'bipolar affective disorder', 'psychiatrist illness', 'mental health', 'emotional', 'psychological', 'consumer', 'patients'
Concept	'leisure activities', 'time use', 'occupational therapy', 'activity', 'therapeutic engagement', 'physical activity'
Context	'hospitals', 'psychiatric hospital', 'inpatient', 'unit', 'ward'

3.3.2 Search Terms

An initial search was conducted in these databases to implement a consistent search strategy into consumer time-use. The framework of Population, Concept and Context (PCC) is recommended by JBI and has been applied to this study to provide clear direction for selection of search terms (Peters, Godfrey, Khalil, McInerney, Parker, & Soares, 2015). Initial searches identified limited literature for example, 'consumer AND time use' or 'mental health OR consumer AND leisure time use'. Search strategies were identified based on MESH terms and ICF-related terms (International Classification of Functioning Disability and Health, 2017). Initial search terms were established based on the definition of the term 'recreation and leisure' through the ICF. Through the database Medline/Pubmed, MESH terms were used (see Table 3.1). The word 'consumer' can be used across a range of professional areas, which led to more specificity in health-related search terms such as 'patient'. A common finding was 'physical activity' was defined as a 'leisure activity' with limited other leisure activities being listed. These articles were still reviewed though reviewers were mindful of this during the search. This was identified as a significant gap in the literature. All articles screened and reviewed were reviewed according to the inclusion and exclusion criteria (see Table 3.2).

3.3.3 Selection criteria

Article titles and abstracts were reviewed with inclusion and exclusion criteria applied. All full-text articles that met the criteria were obtained for further analysis. Any discrepancies between opinions of inclusion were discussed within the research team. JL conducted the preliminary searching and secondary searches were conducted by KB. FO checked the searches conducted and completed a secondary analysis.

Table 3.2

Inclusion and Exclusion Criteria of Scoping Review

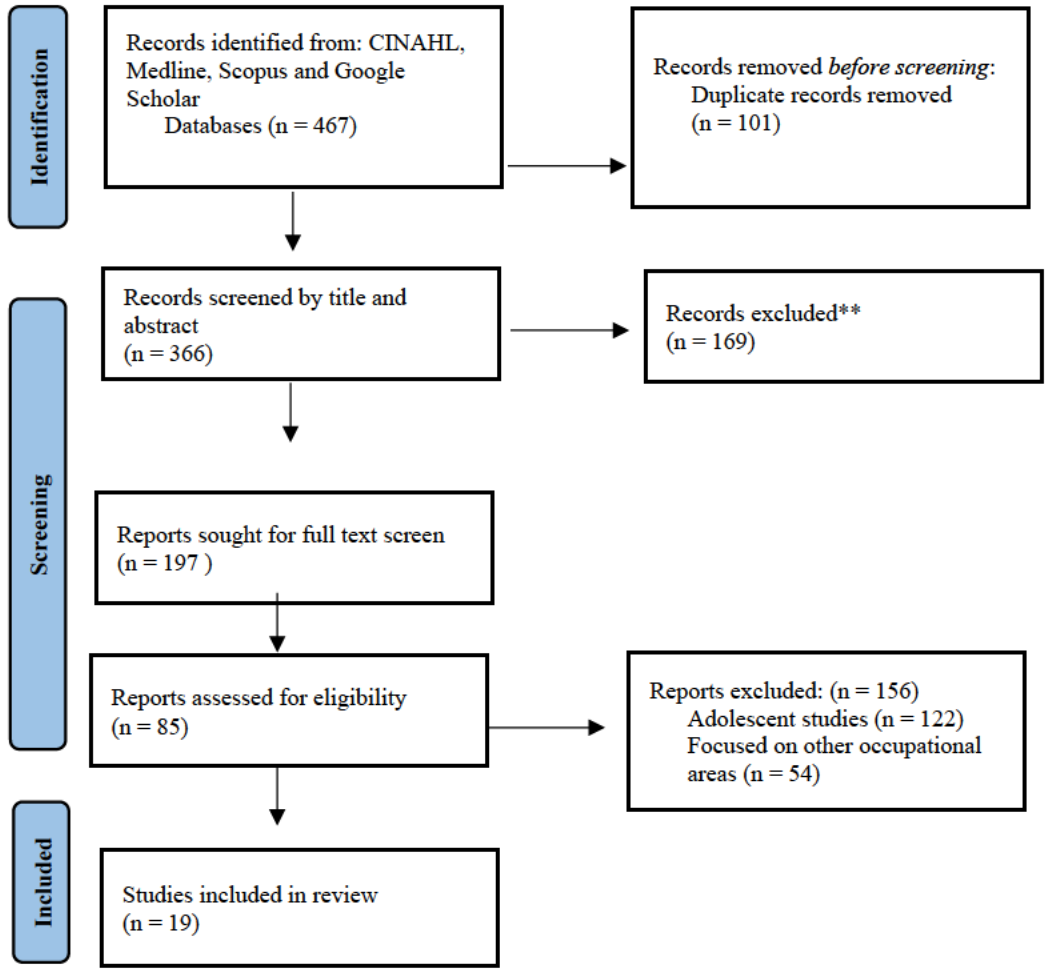
Inclusion Criteria	*Exclusion Criteria*
Empirical literature highlights the following: - Adult consumers (18-65 years) - Leisure occupation with a mental health lens - **Focussed on the inpatient setting or those on MHIUs** - Explore the consumer, carer, multidisciplinary team, OR organisational perceptions of service delivery, leisure activity, and therapeutic programs - Published between 1980 and 2016 - Discusses leisure, activity, or occupation	- Non-empirical literature such as letters, and editorials. - Focussed on other areas of occupation such as rest and self-care - Community, rehabilitation, or other settings that are not an inpatient setting - Studies focussed on children or adolescents (under 18) - Studies particularly focussed on geriatric populations (65 and older only) - The primary focus was on physical health issues or co-morbidities with mental health issues - Primary focus on prison or high dependency units. - Non-English articles or publications

3.3.4 Data Charting

Data charting captured information including the author(s), year of publication, duration of the intervention, study design, the methodology used across studies, data analysis utilised, and primary outcome measures (see Tables 3.3 and 3.4). Analysis was conducted by summarising data that was collated and charted.

Figure 3.1

PRISMA Flow Diagram of Search Strategy Results of Scoping Review



3.4 Results

An initial search yielded 467 citations. After duplicates were removed, 366 articles were screened based on the title and abstract. 197 articles full text articles were reviewed. 85 were assessed for eligibility based on the inclusion and exclusion criteria. A total of 19 articles were considered suitable for this review. In addition, seven articles and policies were also reviewed, though not included due to contextual issues, for example, paediatric or geriatric focussed studies. A PRISMA flow diagram is provided in Figure 3.1 (Page et al., 2021). Each of the 19 articles was analysed and the summary of each study can be seen in Tables 3.3 and 3.4.

Most of the studies were conducted in Australia (n = 6), followed by the United States of America (n = 3), England (n = 2), Denmark (n = 1), Austria (n = 1), Poland (n = 1), Sweden (n = 1), Ireland (n = 1), Taiwan (n = 1), China (n = 1) and Palestine (n = 1).

Most studies explored adult mental health inpatient unit setting (n = 7), followed by a combination of inpatient and community (n = 3). The methods applied to each study varied and included the following: qualitative (5), quantitative (13), and mixed methods (1).

Table 3.3

Data Chart Form of Quantitative Data in Scoping Review

Author(s) / Year	Design	Participants (n)	Outcome Measures	Duration/ Frequency /Intensity	Data Analysis
Oakley et al. (1985)	Survey	13 male and 17 females	Time Reference Inventory (shortened form), The Expectancy Questions, Modified Interest Checklist, the Bay Area Functional Performance Evaluation (BaFPE), Role Checklist, AAMD Adaptive Behaviour Scale, Symptomology of the Modified Brief Psychiatric Rating Scale	3 months	SAS Statistical Software, Multiple regression, two-tailed. Spearman correlation coefficient.
Fraser et al. (2016)	Physical activity group	101 consumers	A modified version of Active Australia Survey, Actigraph GT3x+, Kessler (K6) scale 22.	Five days post-admission (activity diary), Actigraph - 24h/day for one week	Linear regression, bivariate association

Chapman et al. (2016)	Physical activity group	142 consumers	Accelerometer	Consumers wore an accelerometer for 7 days	Chi-Squared, Wilcoxon signed-rank tests to compare frequencies, Mann-Whitney.
Lim et al. (2007)	Occupationa l therapy education	64 consumers	Self-report questionnaire (21 questions -yes/no or Likert scale)	2 hours, once	Non-parametric test, Spearman's Rank Correlation Analysis.
Ng et al. (2020)	Survey and Phone interview	84 patients (35 men and 49 women) aged 16 to 63 years were assessed at the three timepoints	Brief Psychiatric Rating Scale (BPRS), Patient Health Questionnaire-15 (PHQ-15), Pittsburgh Sleep Quality Index (PSQI), the Chinese version of the Short Warwick Edinburgh Mental Wellbeing Scale (C-SWEMWBS), and the Chinese version of General Activity Motivation Measure (GAMM)	Upon discharge and follow-up 1 month post.	Spearman's rho correlation, $p < 0.01$, Wilcox signed rank test,
Radcliffe and Smith (2007)	Observation of consumers engaging in occupation on the ward	16 acute wards in 6 hospitals	Observational	5-days a week, 3 observations per day, 10 minutes per day, 15 minutes per observation	A logistic regression analysis

Leufstadius et al. (2006)	Survey	103 consumers	An activity diary recording the past twenty-four-hours, a Sociodemographic questionnaire, The Interview Schedule for Social Interview, and the Swedish Short Form Health Survey (SF-36)	Not stated	Non-parametric tests
Middelboe et al. (2001)	Survey	Two units with 12 beds and two units with 24 beds	Ward Atmosphere Scale (WAS) and a satisfaction scale. ICD and Global Assessment Scale.	Collected over 3 months, 1 interview per consumer, and the interview duration not stated	Paired and non-paired t-test. One-way ANOVA. Pearson's r. Two-tailed p-values.
Russo et al. (1997)	Survey	981 consumers	Lehman's Quality of Life Interview (QOLI)	20 minutes within 48 hours of admission and discharge (twice)	Cronbach's alpha. Chi-square analyses. Correlations between admission and discharge.
Berghofer et al. (2001)	Interviews	420 consumers	Social Function Questionnaire, Quality of Life Enjoyment, and Satisfaction Questionnaire. Clinical	14 months, six randomised key dates, assessment	Wilks Lambda, chi square

			Global Impressions scale. DSM 1V dx, Global Assessment Scale	duration not stated	
Garman et al. (2002)	Programs	333 staff and 405 consumers	Staff received Maslach Burnout Inventory (MBI). Clients received the Consumer Satisfaction Scale (CSS), a modified version of the Patient Satisfaction Inventory.	Unknown duration, Completed once.	Hierarchical linear modelling analysis, interclass correlation coefficient
Chiu-Yueh et al. (2015)	Survey	180 nurses	5-item Attitudes of Mental Illness Questionnaire. Empathy was measured using the 20-item Jefferson Scale of Empathy–Health Profession version (JSE-HP version).	Not stated	Pearson's product-moment correlation, Student's t-test, one-way ANOVA, and hierarchical multiple regression analysis.
Garman et al. (2002)	Programs	333 staff and 405 consumers	Staff received Maslach Burnout Inventory (MBI). Clients received the Consumer Satisfaction Scale (CSS), a modified version of the Patient Satisfaction Inventory.	Unknown duration, Completed once.	Hierarchical linear modelling analysis, interclass correlation coefficient
Whittington & McLaughlin (2002)	Observational study	20 nurses	Nursing Daily Activity Recording System (NURDARS)	t-test analysis	Descriptive statistics (mean, standard deviation)

Table 3.4

Data Chart Form of Qualitative Data in Scoping Review

Author(s) / Year	Design	Participants (n)	Outcome Measures	Duration/Frequency /Intensity	Data Analysis
Milbourn et al. (2017)	Semi-structured interviews	11 consumers	NA	Monthly over 12 months	Thematic analysis using Nvivo coded using the Occupational Well-being framework
Goodwin and Happell (2007)	Focus group interviews, structured scenario between nurse and consumers, carer to support develop Individual Service Plan	Not stated	NA	Not stated	Research assistant notes, audiotapes transcribed - Nvivo 1.3 from focus groups

Happell et al. (2012)	Focus group interviews	38 nurses	Questionnaire (demographics)	1 month	Thematic analysis. Transcription of audio recordings.
Smith and Mackenzie (2011)	Semi-structured interviews	220 nurses from six mental health services	NA	60 minutes per interview, each participant was interviewed once	Thematic analysis. Interviews were transcribed.
Ahmead et al. (2010)	Survey	78 multidisciplinary	Attitudes Toward Acute Mental Health Scale (ATAMHS).	Not stated	Thematic analysis.

3.4.1 Studies Related to Meaningful Activity

To understand consumer engagement and participation of leisure activity in MHIUs the review explored leisure or activity availability. Key findings from the twelve studies reviewing consumer time use were consumers reported to be bored and sedentary most of the time.

Each of the studies suggested there is a lack of purposeful and meaningful activity offered in acute settings. One of the key issues was a lack of physical activity. Two studies reviewed physical activity programs to determine if there is a correlation with mental health (Chapman et al., 2016; Fraser et al., 2016). Chapman et al. (2016) compared non-institutionalised adults' sedentary behaviour patterns to people with mental illness and Fraser et al. (2016) explored sedentary behaviour in an acute inpatient setting. Both studies found limited differences reported between the intervention and control groups, though they were able to conclude; that those consumers do spend prolonged periods sedentary and activity programs need to be reviewed to increase physical activity.

Ng et al. (2020) had similar findings and highlights positive outcomes for consumers who engaged in physical activities, such as soccer or tai chi. Furthermore, Ng et al. (2020) reported engagement in meaningful activity is conducive to recovery and is an important non-pharmacological intervention. Their study concluded that if there are more occupational opportunities available, consumers are more likely to engage as it is of interest to them.

Fraser et al. (2016) and Leufstadius et al. (2006) suggested that consumers could increase their occupational engagement, which in turn would have better mental health outcomes. This aligns with the concept of salutogenesis, as leisure is health-promoting and health creating. Milbourn et al. (2017) findings support the notion that engagement in an activity is conducive to improvement in the mental state of people with complex mental health issues. Furthermore, Milbourn et al. (2017) highlighted consumers have unique and individual leisure preferences that need to be explored by their treating team (and more specifically an occupational therapist).

A measurable way to explore consumer interests was using time-use diaries, which appeared to be a valuable tool (Fraser et al., 2016; Leufstadius et al., 2006). While Oakley et al. (1985) suggested the use of inventories or checklists to identify interests as an appropriate way to measure leisure interests, such as the Modified Interest Checklist. Leufstadius et al. (2006) found that engagement in activity was important to perceived health status for persons with severe mental illness. Only one paper measured client interests and leisure preferences

with a standardised tool for those who had a psychiatric illness (Oakley et al., 1985). There was a small correlation found in this study between high-level activity and increased social engagement and health (Leufstadius et al., 2006).

Social engagement, meaningful interaction, and encouragement to participate were identified by Goodwin and Happell (2007) and Whittington and McLaughlin (2000). Radcliffe and Smith (2007) identified that 84% of consumers' time was socially isolated and unoccupied. Three studies measured consumer perspectives of time use outcomes, using a quantitative approach with an intervention group (Berghofer et al., 2001; Leufstadius et al., 2006; Russo et al., 1997). A sense of community and respect from the staff was also highlighted by Whittington and McLaughlin (2000) as conducive to the recovery journey in an inpatient setting. Group-based interventions resulted in an improvement in time use and a sense of community.

All studies reviewed found that some consumers participated in group activities that were offered, though ongoing attendance and engagement were often poor. Therapists found that participation was more meaningful when groups were structured, and consumers were interested in the activities. One of the studies that evaluated group programs on MHIUs include an occupational therapy program to measure the importance of occupational therapy role (non-standardised questionnaire) (Lim et al., 2007). Consumers reported a preference for individual therapy rather than group programs on a MHIU. Therapists found groups were more meaningful, though consumers were seeking support on an individual level for the development and implementation of goals. On average consumers spend 4% of their time in structured group activities (Radcliffe & Smith, 2007). One program explored consumer perspectives on the MHIU environment and satisfaction (Ward Atmosphere Scale (WAS), ICD codes, and Global Assessment Scale (GAS)) (Middelboe et al., 2001). This included perceived satisfaction of the environment and provided tangible evidence for unhappiness in the environment.

3.4.2 Studies Related to Key Stakeholders

The gold standard practice, according to the recovery model, is to include family and carers (where possible) in consumers' treatment (Commonwealth of Australia, 2013). Carers and family provide a unique perspective to the consumer experience as they are familiar with a person's likes, dislikes, and level of engagement when well. Consideration of consumer interests is an important aspect of engagement. Carers and families can provide unique insight into building rapport and engagement.

Goodwin and Happell's (2007) study identified that the attitude of staff can act as a major barrier to engaging in occupation on the acute MHIUs. Carers identified the importance of having positive relationships with staff on units, and the limited opportunity for interaction with nursing staff to develop therapeutic relationships to generate genuine interaction with occupation in MHIUs.

Staff in the multidisciplinary team are responsible for delivering direct service provision and facilitating engagement with consumers. Staff play a critical role in the consumer experience and can impact occupational engagement. Staff play an important role in assisting with facilitation but also can act as a barrier to meaningful leisure activity, such as not allowing access to resources. Some of the key barriers to engagement identified by staff were a lack of resources (Happell et al., 2012), staff attitude (Ahmead et al., 2010; Garman et al., 2002), a lack of time allocated to engage with consumers (Whittington & McLaughlin, 2000), and disparity of responsibility for providing leisure activity amongst the multidisciplinary team (Lim et al., 2007).

A review of mental health nurses' attitudes towards psychiatric consumers used standardised measures such as a 20-item Jefferson Scale of Empathy, Health Professional Version (JSE-HP Version) (Chiu-Yueh et al., 2015). The study compared negative attitudes, achieving statistical significance and finding bias towards consumers who had substance abuse issues compared to schizophrenia or depression ($F = 56.44$, $P < 0.001$). Another cross-sectional study examined the attitudes of multidisciplinary professionals, mostly nurses, towards psychiatric consumers through an Attitudes Towards Acute Mental Health Scale (ATAMHS) (Ahmead et al., 2010). Attitudes towards consumers were both positive and negative, though particularly negative towards consumers that had misused alcohol, emotional dysregulation, medication, and genetic predisposition to psychiatric illnesses.

The literature suggests the amount of communication and meaningful engagement nursing staff spends with consumers on an average shift is low (Whittington & McLaughlin, 2000). Twenty nurses were closely observed working across three different mental health units. Only a very small percentage of the working day was found engaged in therapeutic time with consumers (6.75%). The study noted a statistically significant difference between the number of social conversations with colleagues compared with individual therapy with consumers. Whittington and McLaughlin (2000) also identified nurses need to be utilised as a resource and have adequate skills to provide individual psychotherapy and meaningful interpersonal connection.

The existence of team-level burnout was identified through multilevel analyses and a significant relationship with consumer satisfaction with the service (Garman et al., 2002). Along with findings that nurses have high demands and high workload, these factors are likely to contribute to decreased meaningful engagement in MHIUs (Ahmead et al., 2010; Chiu-Yueh et al., 2015; Garman et al., 2002; Whittington & McLaughlin, 2000). This can contribute to negative staff attitudes and poor interpersonal communication.

Smith and Mackenzie (2011) investigated seven nurses' perceptions of the occupational therapist role within a mental health service. The study found that the role of an occupational therapist is important though, it is not clearly understood by the multidisciplinary team, specifically nursing. Findings demonstrated that occupational therapists need to increase communication with multidisciplinary staff. Further definition and promotion of the occupational therapy role may support the allocation of staffing resources and the use of occupational therapy interventions on MHIUs.

3.5 Discussion

This literature review explored how consumers utilise their time and potential barriers to engagement on MHIUs. The studies analysed suggest that MHIU has limited purposeful and organised activity for consumers to participate in (Leufstadius et al., 2006; Radcliffe & Smith, 2007). Consumers are often sedentary, socially disengaged and a substantial portion of their day is spent sitting (Fraser et al., 2016; Leufstadius et al., 2006; Radcliffe & Smith, 2007). Consumers become frustrated by the strong focus on pharmacology and the lack of other therapeutic interventions or rapport building (Lelliott & Quirk, 2004). Groups are considered effective when structured and when found meaningful to the consumer (Lim et al., 2007). Consumers reported a need for balance between individual and group-based therapies (Lim et al., 2007). Occupational therapists need to be more involved in recovery for individual therapy to support consumers' work towards developing goals for a future focus (Lim et al., 2007).

Carers believe that staff can be a barrier to consumers engaging in occupation on MHIUs (Goodwin & Happell, 2007). Studies demonstrated that staff spend a large portion of time engaged with activities non-work-related during work hours, distracting from their ability to deliver the best care for consumers (Whittington & McLaughlin, 2000). This could be a barrier to consumer engagement in meaningful activity. There is limited knowledge within the MDT on the role of the occupational therapist, creating negative views amongst staff when expectations are not matched (Smith & Mackenzie, 2011). With a lack of

consistent understanding for the role of each MDT member, this can lead to gaps in direct service provision. Even though staff attitudes are not a direct barrier (i.e. environmental or lack of physical resources), they can still prevent consumers from engaging in activity. Three studies identified a positive correlation between staff burnout and poor engagement with consumers (Chiu-Yueh et al., 2015; Garman et al., 2002; Whittington & McLaughlin, 2000).

Three studies that viewed time use and consumer engagement had mixed results (Berghofer et al., 2001; Leufstadius et al., 2006; Lim et al., 2007). All studies drew similar conclusions that consumers are generally sedentary on MHIUs with limited access to appropriate resources, though some studies were unable to find positive statistical and at times clinically significant correlations. The studies reviewed consumers' current time use but only one study evaluated interests and valued time use using a modified interest checklist (Oakley et al., 1985). The studies in this review primarily focussed on assessing how consumers use their time, environmental factors, and the stakeholders involved in time use. None of the papers reported changes to therapeutic programs based on client reports of preference for leisure occupations.

One paper discusses the value of meaningful activity in mental health high dependency units (Evatt et al., 2016). The authors suggested the need to evaluate the acuity of the consumer and provide appropriate, interesting scheduled activities to reduce aggression and boredom (Evatt et al., 2016). Withers et al. (2012) evaluated the importance of occupation in medium secure units. A case study of occupational therapy found an improvement in self-esteem, socialisation, and engagement in group activities (Withers et al., 2012). Recovery principles encourage engagement in meaningful activity, social engagement, and goal-directed activity (Commonwealth of Australia, 2013). To remain recovery focussed, a shift needs to occur to become more client centred in MHIUs. Consumers need to be able to voice their interests and preferences in participating in occupations (Evatt et al., 2016).

There is limited research in the field particularly focusing on carer involvement and legislation that may facilitate or hinder consumers' time use on MHIUs, though there are some studies that support the value of carers to support consumer involvement in activities on units. All studies have identified the importance of carers' and family members' involvement in considering holistic care for consumers. However, none of the studies reviewed what consumers would like to do with their time on a MHIU, informing recovering practices and therapy.

3.5.1 Limitations

Limitations include the exclusion of articles from paediatric settings. The review excluded all non-English articles or publications and works that were unpublished or undergoing review. As a result, studies may have not been captured.

The strengths of this review are it provides multifactorial perspectives and analyses of consumer time use and engagement in leisure activities on MHIUs. This scoping review also includes international perspectives. Through conducting this review, it is clear there is limited research exploring consumer engagement in leisure activities on MHIUs. Particularly how consumers would like to use their time during treatment.

3.5.2 Future Research

Further research is required to investigate the interests of consumers and the potential to improve access to meaningful and therapeutic activity in MHIUs. Further research should also focus on the impact of legislation and policy on consumer engagement in activity and recovery of MHIUs, as there seems to be limited or no literature exploring this. Further research is required into how legislation and policy, and the structural hierarchy of a government or system of the health system supports or hinders health consumer time use.

Future research could explore occupational opportunities in high dependency units and the barriers preventing consumers from engaging. Furthermore, it would be useful to explore the impact delivering meaningful leisure activity may have on the rates of aggression, seclusion, and restraint in high dependency units and whether this helps to facilitate earlier discharge.

3.6 Conclusion

This scoping review explored consumer time use on a MHIUs. Findings indicated that consumers are often found sedentary and unoccupied on MHIUs leading to poorer outcomes and potential delay in discharge. There is a current discord between staff time use and consumer satisfaction. The literature suggests staff can be poorly organised and misuse their time for socialising rather than for psychotherapeutic gains for their consumers. Consumers would benefit from an increase in meaningful and purposeful activity on MHIUs that increase their adaptive skills. Occupational therapists can contribute to better use of time in MHIUs via adapted leisure activities. Therefore, occupational therapists should review the amount of leisure activity currently offered in their MHIU and ascertain whether more leisure opportunities can be offered. Health policy and governance structures should work to

improve the prevalence of leisure in their operational guidelines to assist with delivery amongst the entire multidisciplinary team.

3.7 Key Points for Occupational Therapists

- Consumers are often found sedentary and unoccupied on MHIUs
- Further research is required to explore consumer leisure interests on MHIU to guide evidence-informed practice
- Key stakeholders see value in engaging in meaningful activities

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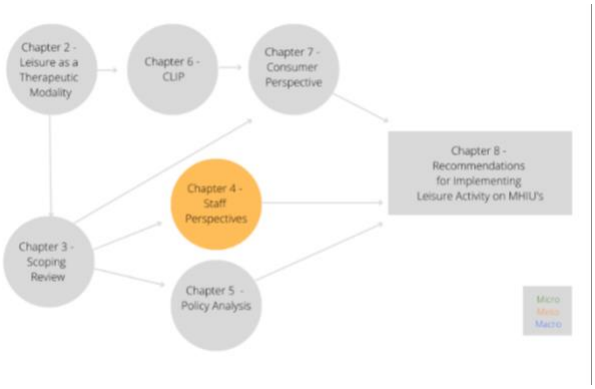
CHAPTER 4 – Content Analysis: Mental Health Staff Viewpoints on the Barriers and Facilitators to Leisure Engagement in Mental Health Inpatient Units



This chapter is part of section one and addresses aim three of the thesis.

Chapter two supported the development of a contemporary definition of leisure. This definition suggested that leisure is health-creating and health-promoting for mental and physical health (or salutogenic). Chapter three established there are limited leisure activity opportunities available for consumers of MHIUs. Furthermore, the scoping review continued to expand on this concept and explored the different perspectives of leisure delivery in MHIUs. The three perspectives explored (consumer, carer, and staff) identified there are many barriers to delivering leisure activity in MHIUs. However, each perspective identified that leisure is conducive to recovery and supports the treating team to establish meaningful treatment goals for consumers.

This chapter explores mental health staff (such as nurses, occupational therapists, psychiatrists, social workers, psychologists, and diversional therapists) perspectives. Staff provided an extensive list of barriers to engagement such as the physical environment, lack of resources, and funding. Participants were also asked what is required to facilitate leisure activity in the future. The staff perspective is considered part of the meso perspective of health that is required to understand service delivery and the unique consumer needs. The staff perspective assists to understand and contextualise some of the barriers reported by consumers in chapter seven. The research in each chapter contributed to the development of recommendations to assist in implementing more leisure opportunities in MHIUs.

The methods used in this chapter include voluntary convenience sampling through social media to target participants globally. Online survey platforms were used to collect the anonymous data to provide participants the opportunity to freely discuss concerns with implementing leisure in their employed inpatient units. The developments and information gained in this chapter support the understanding of the physical and social environment within mental health inpatient settings. The staff perspective or meso perspective is important to understand what changes are required from an organisational or macro perspective to

create a therapeutic environment for consumers such as the built environment. Consumers that are inpatients typically report being bored, and traditional activities such as arts or crafts were the main activities offered, not catering to diverse interests (Marshall et al., 2020) . Therefore, this can impact the consumer experience and in turn, result in prolonged admissions. Boredom and sedentary behaviour impact recovery, and improvements in mental state.

Each perspective explored in this thesis are considered equally important and required to make meaningful recommendations to improve practice (chapter eight).

This manuscript has been submitted to Occupational Therapy in Mental Health. The readership of Occupational Therapy in Mental Health is predominately occupational therapists with an interest in innovative service evaluation and problems identified in psychiatric settings. This manuscript highlights a range of members from the multidisciplinary team's perspective on barriers to engagement, and ongoing issues related to service delivery. The impact factor of this journal is 1.12 and is a Q3. Additionally, to maintain consistency between chapters, the referencing and formatting have been adapted.

4.1 Abstract

This study aimed to explore multi-disciplinary staff's perceptions of the barriers and facilitators of leisure activity offered in inpatient units. A total of 45 participants completed an online anonymous survey through Survey Monkey which explored current barriers and activities offered within mental health inpatient units they currently service. Most participants (97%) described a lack of meaningful occupation offered to consumers. Consumers that are inpatients are typically found bored and traditional activities such as arts or crafts were the main activities offered. This study achieved the intended aims, though most of the participants were occupational therapists.

4.2 Introduction

Meaningful and purposeful occupation are considered a powerful means of therapy (Wilcock, 1998). It is a basic human right and a need to participate in occupation (Whiteford, 2000). Restricted opportunity for meaningful occupation leads to loss of identity and reduced self-efficacy (Kielhofner & Burke, 1980; Marshall et al., 2020; Taylor, 2017). For persons experiencing mental illness, leisure provides a salutogenic (health-creating) effect to support and facilitate healthy coping and recovery (Caldwell, 2005; Lindström & Eriksson, 2005). Engagement in therapeutic activity such as leisure can lead to social opportunities, exploration of self-identity and expansion of self-efficacy (Caldwell, 2005). These are

opportunities for a person to also bring meaning during a very difficult time in consumers lives. Leisure can provide an opportunity to have meaningful and adaptive activity that is health promoting.

For consumers who are admitted to mental health inpatient units, access to leisure can be limited and dictated by the provisions available on that particular unit (Lim et al., 2007). Often a consumer can feel coerced into treatment after being placed under the mental health act (MHA) (Gowda et al., 2017). Some consumers often relate their experience of being in mental health units or being under the MHA as feeling incarcerated (Ashmore, 2008). Occupation is a human right and the inability to engage in occupation due to limitation in your environment is termed occupational deprivation (Whiteford et al., 2020).

A mental health inpatient unit can be a locked facility that is typically funded by the government to assist people with severe and complex mental health issues. Private facilities are available to consumers but for the purpose of this study only public, government funded units will be explored. Countries such as Australia (Medicare), New Zealand (General Medical Service) and the United Kingdom (National Health Scheme) operate with a universal free healthcare system that is funded through income tax. Consumers admitted to these units can be voluntary or under a mental health act (also considered involuntary). The purpose of these units is to provide short-term treatment to stabilise symptoms, and initiate medication (if required). The current literature suggests that most government funded, or public mental health inpatient units have limited meaningful occupations offered and consumers are often found wandering, inactive and bored due to a lack of occupational opportunity (Marshall et al., 2020; Whiteford et al., 2020). Aggression and preoccupation with internal stimuli such as hallucinations, can be challenging issues in mental health inpatient units, often associated with the level of insight and acuity of the consumer (Gowda et al., 2017). Lack of activity or support to occupy consumers time on the ward has been associated with higher levels of aggression and risk (Gowda et al., 2017). High dependency units (a locked mental health inpatient unit with typically five to seven beds that offers more individual care due to level of acuity) frequently restrict access to leisure activity (Evatt et al., 2016). This is even more restricted for those in seclusion. Seclusion is when a consumer is placed into a room of confinement with no exit, at any time of the day or night. This chapter explores the staff viewpoint on leisure availability, barriers, and facilitation to engagement in mental health inpatient units.

4.2.2 Staff's Role in Facilitating Leisure

Mental health staff play an important role in supporting and facilitating therapeutic leisure engagement for persons in mental health inpatient units (Eklund & Bejerholm, 2017). Mental health staff may include nurses, psychiatrists, occupational therapists, social workers, psychologists, diversional therapists, and peer support workers (or also known as consumer companion. In the literature, occupational, diversional and music therapists are the most utilised professions to facilitate leisure activity (Smith & Mackenzie, 2011) along with nurses, psychiatrists, and allied health assistants. Peer support worker roles are becoming more present on MHIUs and are people with lived experience of mental illness supporting those in their recovery journey (Shalaby & Agyapong, 2020).

On a MHIU, an occupational therapist's role is to support people to engage in meaningful activity that supports the improvement of their function in the community (Smith & Mackenzie, 2011) . Occupational therapists play a key role in assisting the multidisciplinary team (MDT) with consumer's function in the community, safety in discharge and providing meaningful occupation. Unfortunately, there is typically one occupational therapist servicing many inpatient units who have limited capacity to engage in individual therapy or perform groups.

4.2.3 Leisure as a Therapeutic Modality

Consumers who are typically admitted to public mental health facilities have severe and complex issues such as schizophrenia, bipolar affective disorder, or depression. From an occupational deprivation perspective, the current level of therapeutic opportunities within inpatient settings can be compared to the forensic mental health facility or 'prison' (Ashmore, 2008; Whiteford, 1997). In Australia, consumers in prison settings (also known as forensic patients) can have lengthy admissions (which can be months or years) and have limited opportunity to access basic occupation (Whiteford et al., 2020). In a mental health inpatient unit, consumers' occupational profiles are centred on the resources available and their ability to participate. In most cases, consumers have access to arts, craft (such as beading), board games and watch television (Marshall et al., 2020). Group activities or therapy are limited and often cancelled due to staff shortages (Whittington & McLaughlin, 2000). These activities may be of interest but are unlikely to be part of consumers typical routine and habituation. Patients with severe and complex mental health issues often have inadequate access to meaningful leisure occupations, leaving them occupationally deprived (Leufstadius, 2017).

Occupational therapists hold a core belief that occupational engagement supports psychological, mental and physical wellbeing (Rebeiro, 1998). During the time of asylums, consumers were engaged in handy crafts for a sense of purpose and to develop skills that could translate into the community due to the prolonged time spent in institutions. The roles of the multidisciplinary team (MDT) within inpatient units have significantly diversified over the past 100 years and have led to the implementation of allied health roles. There has been a change to how care is implemented in line with the introduction of these roles and the shift in mental health care aligning with the World Health Organization (2021) recommendations for reduced inpatient care and increased community support. If there are occupational therapists employed on the units, reports show they typically have limited capacity for extensive individual therapy (Lim et al., 2007). Inpatient units are frequently under-resourced, with limited group activities (Berghofer et al., 2001; Tyrberg et al., 2017a). This problem is not limited to a particular geographical location but appears to be a problem worldwide (Ahmead et al., 2010; Fourie et al., 2005).

The current evidence showed that there is limited knowledge about what activities people enjoy doing in the 21st century within mental health inpatient populations (Bowser et al., 2018; Marshall et al., 2020). If activities are offered in inpatient units, they are not innovative nor do they meet the needs or interests of consumers (Kontio et al., 2012). There are limited therapeutic occupational and psychological interventions provided to inpatients in mental health units (Fullagar, 2008). This can be because of a lack of resources or limited staffing causing occupational deprivation and limited cognitive stimulation (Todman, 2003).

Consumers who present for the first time with acute mental health issues often have mismatched expectations of what the current public health system provides therapeutically (Berghofer, et al., 2001). Often, consumers are seeking therapeutic input in a contained inpatient setting to provide a feeling of safety and review their pharmacological needs (Tyrberg et al., 2017a). Facilitation of leisure activity, and the coping skills that result, may enhance the ability of consumers to cope on return to the community and subsequently reduce the risk of readmission (Tyrberg et al., 2017b).

This study explores the staff perspectives of consumer engagement in leisure activity in mental health inpatient units. This study also aims to understand the perceived roles and responsibilities of staff regarding consumer engagement in leisure occupation, leisure availability, perceived barriers, and facilitators to leisure facilitation.

4.3 Methods

A qualitative descriptive methodology was adopted to elicit staff viewpoints on consumer leisure engagement in inpatient mental health settings. An anonymous survey was conducted with staff who were currently working in mental health inpatient units through an online survey platform (Survey Monkey). Ethical approval was received from the University of the Sunshine Coast Human Research Ethics Committee (project number S191299).

4.3.1 Survey Design

The survey included both qualitative and quantitative components. The survey was designed by all authors based on the research question. Review of the current literature supported the development of questions in gaps of knowledge (Bowser et al., 2018; Marshall et al., 2020).Background demographic information was collected including age, geographical location (Country, State/Province, Post / Zip Code), profession, and length of time in the profession. Participants were asked to rate how much they valued leisure activity, to describe the leisure activities currently offered on inpatient units (including who was responsible and staff satisfaction with the level of activity offered), and potential barriers and facilitators to leisure activity facilitation on inpatient units. Participants were provided with the participant information sheet at the beginning of the survey and answered an informed consent question before proceeding with the survey.

The survey was piloted with two occupational therapists before data collection started. To ensure there was a shared understanding of the term ‘leisure’ the definition was provided for staff at the beginning of the survey. The definition provided was “leisure is considered an enjoyable activity that is not work or productive activity which you choose to participate in your spare time. Furthermore, leisure may also be activity that can be relaxing, fun and support with health in a therapeutic way”. The survey was designed by all authors based off the research question. Review of the current literature supported to develop questions in gaps of knowledge (Bowser et al., 2018; Marshall et al., 2020).

Some of the questions in the survey included:

- What leisure activities does your inpatient unit currently offer?
- What is your role in supporting consumers to participate in meaningful occupation whilst inpatient?
- What barriers can you think of, if any, that impact on leisure activities being offered on your unit?

4.3.2 Sampling

Voluntary convenience sampling was used in this study. Recruitment was conducted through social media advertising (i.e., Facebook) and sharing to target a geographically diverse sample. Invitations to take part in the research were posted on mental health Facebook groups (MH4OT and OT4OT) with permission from group administrators. Multiple attempts were made to share this survey to other health professional groups (such as Mental Health Nursing Australia) via Facebook, but the posts were declined from group administration due to the group rules. To take part in the survey, participants were required to be in current or recent (within 5 years) employment as staff on a mental health inpatient unit worldwide. All persons with any staff role in mental health inpatient units were invited to participate; however, the research questions were biased towards clinical staff. Health professional students (e.g., nursing, social work, occupational therapy) were excluded from data collection given the typically short nature of their exposure to the setting. Most participants provided detailed responses that were typically multiple sentences per questions.

4.3.3 Participants

The survey was completed by 45 participants and most participants currently worked within mental health inpatient settings (93.06%) whilst others previously worked in this setting. On average, the survey took 8 minutes and 45 seconds to complete. Most of the participants were occupational therapists (82.22%), followed by nurses (6.67%), social workers (4.44%), a psychologist (2.22%), diversional/leisure therapist (2.22%), and a music therapist (2.22%).

Participants were from a variety of locations including Australia (28.8%), the United States of America (26.6%), Northern Ireland (13.3%), Canada (6.67%), United Kingdom (17.7%), Trinidad and Tobago (2.2%), Cyprus (2.2%), and South Africa (2.2%).

Participants indicated their level of experience (years) in the profession including 0-1 years (8.89%), 2-5 years (35.56%), 5-10 years (17.78%), 10-15 years (17.78%), 15-20 years (13.33%), 20-25 years (4.44%) and 25 years or more (2.22%).

4.3.4 Data Analysis

Surveys were analysed through a combination of descriptive analysis and qualitative content analysis (Graneheim & Lundman, 2004). Content analysis was conducted on open-ended questions such as “how do you believe therapeutic programs can be improved on acute inpatient units?”. Statistical analysis of participant demographic information and quantitative

responses was completed through the Statistical Package for the Social Sciences Version 24 (SPSS).

Qualitative responses were analysed using Microsoft Excel to code the data. Raw data was placed in a meaning unit category and like terms were condensed into 'condensed meaning units'. Codes were then identified and researchers identified overarching themes. The rigour of qualitative analysis was enhanced through the use of an audit trail and a 'critical friend' approach (Smith & McGannon, 2018). At the conclusion of each content analysis, KB reviewed the analysis critically which prompted discussion of the rationale for each categorisation. Reflexivity was also considered, with discussions between the researchers (who had differing professional backgrounds) monitoring for potential biases (Finlay, 2002). Reflexivity was particularly considered for JL who currently works as a mental health clinician in health services, KB for his research in time use with the elderly population. These people reflected on their prior attitudes through discussion with JL and any prior assumptions were removed to reduce bias.

4.4 Results

4.4.1 Activity Currently Offered

Participants were asked to identify whether it was clinically indicated for consumers to have more leisure opportunities in inpatient units including, but not limited to groups, individual therapy, and independent activity. Over half of the participants (55.56%) indicated 'there definitely needs to be more activity', 42.22% indicated 'a few more activities could be added' and 2.22% indicated there was sufficient activity available.

Participants provided a list of activities that were available on units they currently or have previously worked on (see Table 4.1). All activities were tabulated, and prevalence was documented. The most common activity suggested by participants were arts and crafts (33); board and card games (22); sports (badminton, gym, bowling, hula hooping, yoga, etc) (18); gardening (15), and walking (15). Three respondents suggested that limited to no activity was offered and did not name any activity. Based on the responses, self-directed table-based activities (activities a consumer can independently participate in such as arts, crafts and colouring) were the predominant activities on offer. There were limited suggestions for group activities, with those most often suggested being fitness (13) or cooking (5) related. Other leisure activities may be considered either as a group or solo activity, but this was not explicitly mentioned in their responses.

Within the community and typical life, grocery shopping would be considered an instrumental activity of daily living (IADL). Multiple participants outlined that IADLs were considered a means of reward whilst on the inpatient unit and were considered a leisure activity. Staff who completed the survey predominately (93%) believed that all consumers in the inpatient unit were entitled to equal opportunity and leisure activity. Many participants outlined that 'going outside' or 'grocery shopping' were central leisure activities that consumers would engage in whilst on the unit.

Table 4.1

Survey Responses Exploring What Activities are Currently Offered on Inpatient Units

List of activities currently available collated	N	Percentage (%)
Aerobics	1	2%
Arts and crafts (painting, drawing, tie dye, colouring-in)	33	73%
Billiards / Table Tennis / Ping pong / Pickle Ball	6	13%
Bingo	1	2%
Board and card games	22	49%
Chair exercises	1	2%
Community leave (coffee outing, theme parks)	7	16%
Cooking/baking group	5	11%
Fitness equipment	15	33%
Gardening	13	29%
Grocery shopping	3	7%
Handy Crafts (Jewelry making, leather work)	1	2%
Leisure planning	1	2%

Limited to no activity offered	3	7%
Listening to music	13	29%
Mindfulness / Tai Chi / relaxation	5	11%
Music therapy	1	2%
Musical instruments (piano)	3	7%
Pampering (nail painting and face masks)	2	4%
Pet Care / Therapy farm	2	4%
Quizzes (crosswords, word searches)	7	16%
Reading	9	20%
Sensory based therapies	1	2%
Socializing	1	2%
Sports (badminton, gym, bowling, hula hooping, yoga, football, basketball, volleyball, horse riding)	18	40%
Swimming	4	9%
Television	11	24%
Video games (i-pads, Wii, Xbox Kinnect)	5	11%
Walking	15	33%
Writing	3	7%

4.4.2 Access to Engagement

Participants were asked to consider which consumers had the right to have occupation offered to them as part of their treatment options. Responses indicated that the majority of participants believed ‘all consumers have the right to participate’ (93.33%). Other selected responses included ‘voluntary only’ (4.44%) and ‘involuntary and voluntary’ (2.22%). There

were no responses indicated for ‘involuntary (including forensic) only’ and ‘none, consumers shouldn’t have access to leisure activity on acute inpatient units’.

Participants indicated that a wide variety of staff was responsible for the delivery of leisure activities on inpatient units (see Table 4.2). Participants were able to select more than one answer and 93.33% indicated that occupational therapists were the primary person to deliver activity. More than half of the participants also suggested this was closely followed by diversional/leisure therapists (75.56%), nurses (71.11%), and peer support workers (62.22%). An ‘Other’ category was included to allow participants the ability to indicate any other persons not listed/provided that may be responsible for delivery. Participants indicated a variety of persons are responsible for delivery of leisure activity (28.89% of responses suggested the following) which included ‘mental health workers’, ‘a team approach’, ‘recreation therapist’, ‘art therapist’, ‘music therapist’, ‘dance/movement therapist’, ‘activity coordinator’, ‘allied health assistants’, ‘dietician’ and ‘exercise physiologist’.

4.4.3 Barriers to Engagement

The survey explored staff’s perceived barriers to consumers engaging in occupation (see Table 4.3). A free text option was provided to allow staff to consider a range of issues from micro to macro-level issues such as funding for resources (including staffing and equipment), concerns regarding risk, workplace culture, and perceived boundaries of scope within the MDT, and bureaucracy or management of inpatient units. A content analysis of this question indicated broad themes emerging such as lack of resources, physical environment, staffing, and COVID-19 pandemic.

Often, participants suggested conducting a proposed activity was challenging due to limited resources available in the unit and no additional funding being available for ‘new’ or different activity ideas. Some of the responses included “lack of resources”, “funding for supplies” and “cost-facilities not valuing this component of health and so not prioritising it in the budget for supplies”.

The physical space and environment of the inpatient units were suggested to be problematic for consumers to engage in meaningful occupations. For example, safety risk, sources available, space layout (lack of sensory or outdoor areas), and lack of space to deliver activity safely.

Issues around staffing were suggested to be a problem which included lack of / availability of staff, priorities during shift, ‘staff willingness to engage with consumers’, staff within the multidisciplinary team’s lack of understanding of each other’s roles and splitting

behaviours with consumers. Low staff morale and lack of collegiality within the workplace environment were suggested as ongoing barriers. One respondent suggested 'workplace culture' played an important role. Another participant suggested the value of leisure and recreation may have different perceived importance to other members within the MDT which impacts delivery due to the use of the medical model. There was a suggestion that staff do not provide activity outside of business hours when allied health staff are not present with an indication that the responsibility for structured and unstructured activity was heavily reliant on the occupational therapist's time and availability. The recent worldwide pandemic of COVID-19 was suggested to be a barrier due to infection control and social distancing rules that have been put in place.

Table 4.2

Survey Responses Indicating Persons Responsible for Leisure Activity on Inpatient Units

Discipline	Percentage of participants (%)
Occupational Therapist	93.33%
Diversional/Leisure Therapist	75.56%
Nurses	71.11%
Peer Support Workers	62.22%
Students	51.11%
Psychologist	40.00%
Social Work	40.00%
Other	28.89%
Consumer	28.89%
Medical Team	20.00%
Family/Carers	13.33%
Administration	2.22%

4.4.3 Facilitators in Engagement

Staff were asked to consider methods that could improve leisure access within mental health inpatient units. A range of feedback was provided, such as developing a routine within the unit and buy-in from nursing staff on the value of engagement in meaningful activity on

the wards to promote recovery. Further suggestion was to consider the need for grading and adapting activity that is appropriate to age, culture, cognitive capacity, and acuity.

Staff described the need for more encouragement and participation as a multi-disciplinary team to promote a change in workplace culture and in turn support consumers to engage. Similarly, staff indicated the need for access to training to improve the quality of engagement with consumers to allow therapeutic modalities to be implemented by the entire multi-disciplinary team (including nursing, allied health, and students).

Staff identified a need for 'buy-in' by their colleagues from the entire multi-disciplinary team to have successful delivery of services such as therapeutic groups. This was also linked with a holistic approach to consumers' care and reviewing both physical and mental health considerations. The consideration of evidence-based practice was raised multiple times with the opportunity to up-skill or access training to provide best practice. There was a suggestion from the cohort that interventions for individuals need to be better planned with an understanding of groups for consumers with similar interests rather than a 'one-size-fits-all approach'. Participants expressed frustration with long-term group activities run on inpatient units due to habit, rather than meeting the therapeutic needs of the individuals who are present on the unit. Examples included the long-term arts and crafts groups that are constantly run within inpatient units that are not necessarily meeting the needs of consumers who are currently on the unit.

Table 4.3

Survey Responses Exploring Barriers to Engagement

Concern	N	Percentage (%)
Funding for resources	21	46.67%
Lack of staffing	18	40.00%
Reliance on occupational therapists to provide all leisure activity due to remainder of team believe it's beyond their scope.	14	31.11%
Risk - Security and safety of staff due to aggression from consumers	12	26.67%
Inadequate facilities to implement activity	8	17.78%

High acuity of consumers	5	11.11%
Prioritisation of staff's roles during a shift - 'high demand on paperwork'	5	11.11%
Workplace culture - MDT members not being collegial and do not value therapies offered by others within the team	5	11.11%
Implementing activities during COVID-19 pandemic	4	8.89%
Lack of motivation and desire to participate from consumers	4	8.89%
Lack of encouragement from staff for participants to engage	4	8.89%
Strict timetables. Not specific to the individual	3	6.67%
Perception that clients can't be trusted/safe with supplies	2	4.44%
Lack of education or training within multi-disciplinary team to implement activity	2	4.44%
Lack of scope for self-directed activity	1	2.22%
Mental health act provisions for leave	1	2.22%
MHIU policy – including, but not limited to, the environment, safety, risks.	1	2.22%

4.5 Discussion

This study explored the perspectives of the key stakeholders of consumer engagement in leisure activity and the potential barriers from an inpatient staff viewpoint. Most participants described a need for more meaningful and creative leisure options to be provided to consumers in mental health inpatient units. Consumers are often found bored with limited meaningful occupations to facilitate their recovery. Staff described leisure activities that are typically offered are required to be 'low risk', and funding restricts the breadth of activities provided.

Staff identified discrepancies between the multidisciplinary team in their role to provide leisure activity. Participants particularly described most staff believe occupational and diversional therapists are responsible for delivering activities on the inpatient unit. Participants who were nurses stated they did not have the ability to run groups or deliver leisure activity due to the high number of tasks they need to complete such as documentation.

Some of the barriers provided by staff included consumers mental health act status, staff willingness to facilitate activity, the lack of resources, and the training level of staff. Many staff expressed interests in improving their workplaces but often felt implementation would be challenging due to a lack of 'buy-in' from colleagues.

4.5.1 Consumers Interests in Leisure Activity

Leisure activity can be viewed as a meaningful activity that is engaged in outside of productive activity that is enjoyable to the person. However, in inpatient mental health units there appears to be a lack of exploration of consumers' genuine interests and rather a 'one-size-fits-all' approach to implementation of activities that are deemed to be safe or suitable. There appears to be challenges with implementing contemporary and enjoyable activities that are balanced with the risk factors of harm to self or others. Bacon et al. (2012) explored the implementation of more contemporary-based activities such as Wii-fit (utilising a gaming console) within forensic mental health settings. Consumers were found to enjoy the activity whilst engaging in physical activity. Wii-fit has transferability as an activity that consumers could continue to engage in at home or within the community.

Staff indicated that it is predominately an occupational therapist or leisure therapist that is responsible for facilitating activity within the inpatient unit. However, over 70% of participants also believed that nurses should support with facilitation of leisure activity.

4.5.2 Barriers and Facilitators to Engagement in Leisure Activity

A content analysis of participants' responses was used to identify the barriers to implementing leisure activity. Some of the barriers included:

- There is limited buy-in from the remainder of the multi-disciplinary team to facilitate activity
- There was a disparity in whose responsibility it was to facilitate leisure activity
- The COVID-19 global pandemic posed infection control issues.
- There were limited resources available to offer activities.

The literature provides a similar narrative with a limited range of occupations offered within mental health inpatient units. It appears that many activities that are a part of a typical person's daily routine, habituation, and occupational profile or IADL are now utilised as pseudo-therapeutic activities as part of a reward for good behaviour. Another consideration is the risks of aggression and seclusion can increase for consumers who are poorly occupied; it appears logical that people become frustrated with the occupational deprivation in inpatient

units (Antonysamy, 2013). It appears that a barrier to facilitating engagement could be the way leisure is perceived and viewed within the unit.

Some of the many concerns explored during the survey were around limited direction or instruction on how to implement activities safely in the inpatient unit due to infection control issues such as a global pandemic (COVID-19). Foye et al. (2021) has explored methods of infection control that could be applied to inpatient units and the many challenges faced with COVID-19 in mental health settings, particularly inpatient units. Some of the complexities and examples of these challenges included implementation of treatment plans whilst the MDT were off-site, infection control implementation measures such as personal protective equipment (PPE), social distancing, and mental health consumers' delusional beliefs surrounding government control or disease.

The staff explained there is a need for a variety of resources and activities on offer beyond traditional arts and crafts. The environmental design was highlighted to be a consideration for a barrier to engagement, and staff explored the need for an open space that allows consumers to access space without the requirement for staff supervision. Whilst the environment is often unable to be changed, a review of the space utilised can help create a feeling of safety and reduce incidences of aggression (Antonysamy, 2013). The literature continues to suggest inpatient services are below national and international therapy standards (Australian Government, 2010; United Nations, 2007; World Health Organization, 2021). By improving practice in inpatient services, it may be possible to enhance the efficacy and cost-effectiveness of these services. World Health Organization (2013) has stated that care should be provided outpatient, if possible, to reduce institutionalisation and the further risk of patients being exposed to inpatient treatment.

4.5.3 Suggested activity for implementation

Overall, 97.78% of participants suggested there is a limited contemporary range of activities offered to consumers in mental health inpatient units. The ability for individual therapists to explore the interests of all mental health consumers in an inpatient unit is difficult and likely not possible due to other demands of their role. From a theoretical standpoint, occupational deprivation within prison settings for the general population and mental health consumers is a well-established phenomenon (Molineux & Whiteford, 1999; Whiteford, 2000; Whiteford et al., 2020). Furthermore, this can be closely linked to MHIUs, since units started returning to being 'locked' (Ashmore, 2008). Consumers often express they feel incarcerated in locked MHIUs as their sense of autonomy, choice and freedom is

restricted; there is limited activities on offer (typically arts and craft); and their typical routine is disrupted. Ashmore (2008) suggested some disadvantages of a locked unit were emphasizing nurses' 'power' over the consumers and "producing a non-caring environment". This is consistent with the suggestion that IADLs are used as a means of reward by participants in this study which could be considered a method of control or power.

Rodger et al. (2009) suggested students were considered to be a great asset to running basic therapy groups and support with co-facilitation of programs with staff which may help reduce the burden on clinical staff and reduce frustration for lack of activity.

The utilisation of a checklist or tool to explore current or existing interests may support for mapping/planning of activity in inpatient units to support the implementation of therapeutic modalities (Kielhofner & Burke, 1980; Nakamura-Thomas et al., 2014). This mapping may facilitate a recovery-informed modality for consumers with like-interests. Implementing activities that consumers engage in outside of the bounds of an inpatient unit will increase volition and motivation to participate in an activity (Gohner et al., 2015). Utilising a multidisciplinary approach to explore interests and understand a consumer's current routine, may support a discipline-specific approach during review with the treating team and continued care.

A one-size-fits-all approach does not appear to be an effective implementation method for leisure activity in inpatient units as not all consumers are expected to have the same interests.

4.5.4 Limitations

This study achieved the desired aims. There was an adequate number of participants (n = 45) that completed the survey based on the sample size calculation. A limitation of this study is the large number of occupational therapists that completed the study versus other health professionals. A broader range of participants from a variety of disciplines, genders and a larger sample size may be beneficial to further explore the attitudes of staff that is not biased towards occupational therapists' views. The survey was initially targeted at a broader range of staff including nursing, psychiatrists, and allied health; however, the topic and voluntary nature of the project may have been biased toward occupational therapist participation as it is occupation focused. As leisure can be considered a meaningful occupation, naturally occupational therapists may be more interested in the research question which prompted participation in the study.

The survey was developed based on the literature and research questions. There were no standardised questions or assessments in the survey which reduced rigour. The survey was

designed to provide staff with the opportunity to give free-text answers and responses based on the inpatient unit where they are employed. As suggestions for activities were not provided, some of the activities currently provided such as television and reading are likely to have been available in all MHIU's but was not mentioned by staff as they are considered a minimum inclusion. This study was developed with the consideration that an inpatient unit should be considered salutogenic in nature, which is likely aligned with Western culture and responses are likely to have aligned with this hypothesis. The study aimed to explore the viewpoint of staff that completed the survey and was not expected to be representative of all staff in all inpatient units.

As the survey was administered in English it was expected that participants would be biased towards western populations or those who have English comprehension. The participants were also biased based on convenience sampling within target occupational therapy and health care groups. A different sampling method would potentially provide a wider variety of health professionals.

4.5.5 Future Research

The study design allowed for an understanding of the barriers and facilitators to engagement. This research may provide an initial exploration of the staff perspectives within mental health inpatient units on leisure facilitation which may lead to the addition of a standardised assessment.

Exploration of the consumers' perspectives on meaningful engagement in occupation and their viewpoint of whether activities offered provide any therapeutic benefit may facilitate change to activities scheduled. Furthermore, exploration of current leisure interests within the inpatient population may support mapping activities that align with this population group.

4.6 Conclusion

Participants provided their clinical observations of mental health inpatient units across the globe. A majority of participants suggested there was a lack of meaningful occupation provided by government-funded public health MHIUs that stimulate consumers and promote recovery. Participants were predominately occupational therapists who suggested there is a need for the entire multi-disciplinary team to facilitate purposeful activity in an inpatient unit. Participants suggested a large proportion of activities offered are traditional arts and crafts which are typically not matched to the interests of consumers. There was a suggestion that

consumers can express their leisure interests to staff and activities are catered to the population rather than a 'one-size-fits-all' approach.

Participants suggested there is a need for an overhaul of activity and recreation offered within inpatient units to reduce aggression, boredom, and re-admission rates. The utilisation of free resources such as students can support to facilitate a broader range of activities and explore activity options that target the interests of the inpatient population. Consequences of limited meaningful activity offered within inpatient units can increase aggression towards others, need for medication, or seclusion.

4.7 Key Points for Occupational Therapists

- Inpatient staff have identified that there is a limited range of leisure occupations offered in the inpatient units.
- It is the responsibility of all clinical staff within the multidisciplinary team to facilitate and encourage engagement in meaningful activity with consumers.
- A cultural shift may need to occur to create 'buy-in' from members of the multi-disciplinary team. Furthermore, training opportunities may support staff who lack the skills or knowledge around current evidence-based practice supporting the facilitation of therapeutic modalities in an inpatient unit beyond the role of the occupational therapist. This would also support facilitating activity after business hours.
- Activities predominately offered in inpatient units are arts and crafts, television, or board games which are not likely representative of the activity consumers would engage in within the community and are typically not aligned with their interests.
- To reduce the re-admission rate of mental health consumers, the implementation of meaningful occupations that can be used as a therapeutic modality in the inpatient unit can be translated to the community. This can support the development of beneficial habits and routines whilst providing a starting point for community therapists to continue work upon discharge.
- Students provide a helpful and innovative approach to implementing therapeutic groups alongside the multidisciplinary team.

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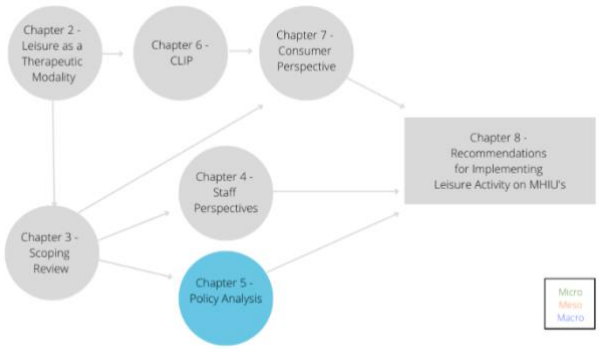
CHAPTER 5 - Policy Analysis: The Prevalence of Leisure-Related Concepts Found in Mental Health Legislation



This chapter explores the macro barriers to engagement in MHIUs due to legislation and policy. This chapter addresses aim four of this thesis and is original research.

Building from the key points found in chapter four, staff described the barriers to consumers engaging in leisure activity is due to some major macro level issues, such as lack of physical resources, funding, lack of staff, risk to staff and other consumers, inadequate built environments to facilitate activity, high staff workloads, and consumer mental health act (MHA) status.

In this chapter, a policy analysis was conducted to explore whether macro level barriers (governance, policy, and legislation) could impact service delivery. This included exploration of the presence of leisure related themes in policy to enable therapeutic engagement in leisure activities conducive to recovery. To make meaningful change for consumers, all levels of health need to include leisure as an important activity in mental health care. Allocation of resources, and operational guidelines are considered based on the national service initiatives and needs. Chapter three and four have identified consumers who are required to be admitted for treatment have limited occupational opportunities and far less than what they would have access to in the community.

This chapter builds on the barriers identified by staff that impact direct service provision and ability to implement leisure as a therapeutic modality. Furthermore, the context to the broader issues in policy / legislation is explored and the prevalence of leisure-related language or substantive content is identified.

This chapter consists of two phases of data. The first phase includes data analysis using Leximancer V4. Leximancer V4 is a text-mining software that automatically generates common concepts or themes within the text. The proceeding stages highlight the limited amount of leisure concepts found in policy from Australia, New Zealand, and the United Kingdom.

The first section of this chapter (5.1) and phase one of the data provides the journey and rationale for conducting phase two analysis which was written in the form of a manuscript.

5.1 Stage One of Policy Analysis

5.1.1 Abstract

Introduction. Mental health act legislation is typically used within the multidisciplinary team to provide treatment for those within acute settings. Within the literature, there appears to be limited exploration of how the mental health act can assist with implementing therapeutic modalities such as leisure. This analysis included policy from Australia, New Zealand and the United Kingdom as they all have universal health care with similar mental health service delivery.

Methods. A total of 33 international legislation, mental health acts, and supporting policy documents were semantically analysed using Leximancer V4. These documents were from Australia, the United Kingdom, and New Zealand. Twenty-four leisure-related terms were included in the analysis to identify concepts within the legislation.

Results. Overall, the policy documents reviewed demonstrated limited leisure related concepts. The highest leisure percentage in recovery-focused documentation were Rising to the Challenge 2012-2017 (1.06%) (New Zealand). From the reviewed mental health acts there was less than 1% of the total words used that related to leisure or engagement in activity.

Discussion. There were limited leisure-related concepts within mental health legislation, policy, and recovery-related documents.

Keywords. Leisure activities, recreation, semantic analysis, health policy, psychiatric care

5.1.2 Introduction

In the United Kingdom, Australia, and New Zealand, around one in five people experiences mental illness (Australian Institute of Health & Welfare, 2014, 2018; Mental Health Services in Australia, 2016; Mind Infoline, 2020; Ministry of Health – Manatū Hauora, 2021). The number of people with mental illness and substance misuse is increasing, being a leading cause of non-fatal disease (Australian Institute of Health & Welfare (2018); (Mind Infoline, 2020; Ministry of Health – Manatū Hauora, 2021). Furthermore, this population is typically more vulnerable to socioeconomic disadvantages including low-socioeconomic status, unemployment, limited occupational engagement, and homelessness (Australian Institute of Health & Welfare, 2018; World Health Organization, 2013). The

World Health Organization (2019) established that ‘there is no health or sustainable development without mental health’. Treatment of mental illness is a priority and a growing concern.

On average, approximately 1.9% of Australians are receiving clinical health care for severe and complex mental illnesses (Australian Institute of Health & Welfare, 2019). According to the Australian Institute of Health & Welfare (2018), approximately 29% of people with severe and complex mental illness were admitted to hospital in 2014 involuntarily, and 70.7% were voluntarily, while 0.3% were admitted privately. Experiences are similar in New Zealand and the United Kingdom (Ministry of Health – Manatū Hauora, 2021; Thompson et al., 2004). On average, the need for overnight admission to a mental health inpatient unit (hospital ward) has increased by 2.1% per year over the past decade in Australia (Australian Institute of Health & Welfare, 2019). The average length of stay in a mental health inpatient unit is 15.1 days (Australian Institute of Health & Welfare, 2019). This aligns with the guidelines from the World Health Organization (2021) to reduce inpatient care and provide community-based treatment. There is an increased demand for public and private services to provide adequate treatment and care for individuals with mental illness (Allison & Bastiampillai, 2015). Countries such as Australia, New Zealand, and the United Kingdom, provide free universal health care. Therefore, citizens are entitled to receive government-funded healthcare.

Typically, consumers are admitted voluntarily unless they are deemed to lack capacity and are unable to consent to necessary treatment. A mental health act (MHA) may be used to provide necessary treatment against a consumer’s consent. A MHA provides clinical guidelines on consumer treatment. Other governing documents may include national mental health policy, and recovery related documents. These documents support the implementation of health care service in mental health, and the utilisation of evidence-informed practice. Commonly, such documents pay little heed to the psychosocial and environmental factors that support the recovery of mental health and wellness. Instead, they tend to focus on guidelines for restrictive practices such as medication and seclusion.

In recent years, a focus within inpatient (hospital) settings has been least restrictive practice and advocacy for consumer rights. Leisure may be a strategy to reduce the need for restrictive practice (Sustere & Tarpey, 2019). Those treated involuntarily under the mental health act, have limited choice to exit the environment and have little control over their opportunities within the environment. The available evidence would suggest that interventions such as access to allied health services, therapeutic engagement in leisure,

medication, and supportive care are helpful with recovery (Radcliffe & Smith, 2007). Leisure can be relaxing, and provides an opportunity for distraction during challenging episodes of poor mental health.

During an inpatient stay, regardless of a consumer's voluntary or involuntary admission status, it is ideal they engage in a level of activity similar to their regular routine to reduce institutionalisation and dependency on the service (Radcliffe & Smith, 2007). Leisure activity can fulfill this role in an inpatient context and may positively impact a consumer's mental health status (Craik & Pieris, 2006). Radcliffe and Smith (2007) conducted a study, which estimated that consumers spend approximately 90 minutes across a possible 35 weekday hours engaged in organised activity per week. This chapter particularly highlights some barriers allied health and nursing staff may have in implementing therapies such as leisure under the mental health act.

Often a consumer can feel coerced into being an inpatient after being placed under the MHA (Gowda et al., 2017; Fiorillo, et al., 2011). Depending on an individual's cognitive capacity, acuity, and insight, this can lead to aggression and poor emotional regulation (Todman, 2003). This means that unless granted permission to leave, consumers are confined to the mental health unit. Some consumers often relate their experience of being in mental health units or being under the MHA as feeling incarcerated (Whiteford et al., 2020). Frustration can occur amongst consumers when they have limited leave conditions. Some states, territories, and countries have MHIUs that are locked. At times, consumers are found bored with limited occupational opportunities and can be found just sitting around (Chapman et al., 2016).

In the early 1900s, nursing staff were the leaders in delivering care for MHIUs. Since the implementation and development of allied health professions such as occupational therapy, the responsibility of delivering these activities have shifted to allied health. Occupational therapy originated in 1917 to support people who were living in asylums with mental health issues to engage in meaningful occupations and earn an income (Kramer et al., 2003). The unique skill-set of occupational therapy is to grade and adapt meaningful activity to provide skills and purpose (Christiansen & Baum, 1997). This unique perspective was developed from a broad range of professions including social work, architecture, psychiatry, a teacher of arts and crafts, and nursing (Duncan, 2011). The profession was created based on the observation from asylums that individuals improve when they are provided with occupational opportunity and a sense of purpose (Duncan, 2011). The 'father of occupational therapy' William Rush Dunton saw a value in art, weaving, handicrafts, metalwork, book

binding and leatherwork, which he believed to be a viable method for teaching residents of the asylum's skills through productive activity (Kramer et al., 2003). These skills were deemed to be useful for people transitioning from institutions to the community to provide unique abilities for employment or income (Kramer et al., 2003). Due to the holistic nature of the profession and broad professional background it has grown beyond the scope of mental health. In the past century, the profession has developed an evidence-base to its practice and is an important perspective within multidisciplinary teams. The core principles of the profession remain unchanged, advocating those with mental illness benefit from engagement in meaningful activity (Duncan, 2011). Of course, mental health clinicians now incorporate their practice with the medical model which includes the requirements of policy and legislation to guide their practice.

Mental health-trained health professionals such as psychologists, social workers, 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 treatment in the community and facilitates admission for consumers who lack capacity due to acute mental illness (Gowda et al., 2017). Often, MHAs are governing legislation that provides limitations or restrictions for staff providing direct service provision due to level of risk, allowed leave, or guidelines on treatment. Policy and legislation are also a very important guide to providing safe and ethical practice.

This study aimed to explore the prevalence of leisure-related concepts in current mental health acts and related policy across Australia, New Zealand, and the United Kingdom.

5.1.3 Methods

This is a mixed methods document review analysing all current mental health acts, and related policy (such as national standards or recovery documents) from the states and territories of Australia, New Zealand, and the United Kingdom, from an occupational lens. Some inclusion criteria for documents included mental health specific policy or legislation, a recovery related document, national mental health standards and any related public health policy that was related to the use of the mental health act. Documents that were excluded consisted of expired legislation that was no longer relevant or health related policy that did not support mental health care. Supporting policies from a state, national and international

levels were also analysed. A total of 33 documents were semantically analysed through Leximancer V4 (Aryal et al., 2015).

5.1.3.1 Sample

Documents were included from Australia, New Zealand, and the United Kingdom. The decision to select each of these countries 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. A total of 33 documents were chosen to be reviewed (see Table 5.1). 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. Documents included those that inform inpatient clinical care.

Table 5.1

Leximancer Analysis of Documents Included in Semantic Analysis

Country	Document reviewed	Sum of all concepts	Word count	Leisure percentage (%) in document
AUSTRALIA	National Mental Health Policy (Australian Government, 2014)	112	10697	1.05%
	National Recovery Framework (Commonwealth of Australia, 2013)	94	29720	0.32%
	National Standards for Mental Health Services 2010 (Australian Government, 2010)	121	12649	0.96%
	Australian Capital Territory Mental Health Act 2015 (Australian Capital Territory Government, 2015)	120	81918	0.15%

	New South Wales Mental Health Act 2007 (New South Wales Government, 2007)	129	48211	0.27%
	New South Wales Mental Health Act Regulation 2013 (New South Wales Government, 2013)	8	9374	0.09%
	Northern Territory Mental Health Act 1999 (Northern Territory Government, 2002)	57	44019	0.13%
	Queensland Mental Health Act 2016 (Queensland Government, 2016)	711	163085	0.44%
	Queensland Public Health Act 2005 (Queensland Government, 2017)	207	100181	0.21%
	South Australia Mental Health Act 2009 (South Australian Government, 2009)	524	28825	1.82%
	Tasmanian Mental Health Act 2013 (Tasmanian Government, 2013)	169	53747	0.31%
	Victoria Mental Health Act 2014 (Victorian Government, 2014)	198	78768	0.25%
	Western Australia Mental Health Act 2014 (Western Australia Government, 2014)	576	98055	0.59%
NEW ZEALAND	Health and Disability Commissioner Act 1994 (Ministry of Health, 2018a)	63	20770	0.30%
	Human Rights Act 1993 (Ministry of Justice, 2018)	134	51110	0.26%
	Rising to the Challenge 2012 – 2017 (Ministry of Health, 2012)	247	23316	1.06%

	Mental Health Compulsory Assessment and Treatment Act 1992 (Ministry of Health, 2018b)	82	45891	0.18%
UNITED KINGDOM	Mental Health Act 2007 UK (Parliament of the United Kingdom, 2007)	163	63708	0.26%
	Mental Health Act 1983 (Parliament of the United Kingdom, 1983)	189	62055	0.30%
	The Mental Health (Northern Ireland) (Amendment) Order 2018 (Parliament of the United Kingdom (2018)	19	685	2.77%
	Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Welfare Commission for Scotland, 2003)	128	111427	0.11%
	Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales (Welsh Government, 2012)	173	24302	0.71%
	Mental Health Strategy: 2017-2027 (Scotland) (Scottish Government, 2017)	110	11060	0.99%
	Achieving Better Access to Mental Health Services by 2020 (England) (Department of Health, 2014)	22	7103	0.31%
	The Mental Health (Wales) Measure 2010 (Parliament of the United Kingdom, 2012)	9	1029	0.87%
	Mental Health Commission Strategy Plan 2016-2018 (Ireland) (Mental Health Commission, 2017)	50	9596	0.52%

	Suicide Prevention: Policy and Strategy (Mackley, 2018)	124	33818	0.37%
	Reform of Mental Health Legislation in the UK (Northern Ireland Assembly, 2008)	57	10325	0.55%
	Mental Capacity Act 2005 (Parliament of the United Kingdom, 2005)	94	37130	0.25%
	Mental Health (Discrimination) Act 2013 (Parliament of the United Kingdom, 2013)	0	1045	0.00%
WORLD	European Convention for the Protection of Human Rights and Fundamental Freedoms (Council of Europe, 2010)	57	12230	0.47%
	United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2007)	99	11303	0.88%
	World Health Organization Action Plan 2013-2020 (World Health Organization, 2013)	241	17628	1.37%

5.1.3.2 Procedure

The first stage of this study involved semantic analysis (Aryal et al., 2015) of all relevant legislation, policy, national standards, publications, and other related sources of evidence such as the World Health Organisation, Human Rights Act, and United Nations International Convention of Disability Act (Ministry of Justice, 2018; United Nations, 2007; World Health Organization, 2013). Semantic analysis is the process of drawing significance or meaning from content and text (Aryal, et al., 2015). During this stage, Leximancer V4 was utilised for automatic text-mining analysis. This analysis provided the number of leisure-related concepts present in each document. A concept is a group of words that are typically used synonymously or in similar ways throughout a text (Sotiriadou et al., 2014). Leximancer was selected due to automation of concepts and themes identification within large documents,

a more efficient method than manual analysis. The relative dominance of each concept can also be explored through Leximancer and each concept's connection to other concepts in the document. This stage aimed to ascertain whether leisure-related concepts identified by the authors were present in the selected documents.

All documents were individually analysed by uploading them to the software tool. The initial analysis of each document did not include any manipulation of settings within the software. Concepts that were mined from Leximancer in the initial analysis did not have any specific settings or manipulation to the data. This allowed the software to provide the most prevalent concepts in each document. A second analysis was then conducted, and 24 concept terms were manually entered into Leximancer to determine the number of times the leisure concepts arose within the documents. The 17 concepts or 24 expanded / plural concepts included: activity/activities, art, craft, engage[ment], exercise, group[s], interest[s], leisure, meaningful, occupation, participate/participation, program[s], programme, recreation[al], social[ising], sport, inpatient. All 24 concepts were inputted into each document individually to determine how many times they were present.

These terms were selected based on two themes: ‘leisure’ and ‘occupation’. Concept terms for analysis were selected based on leisure and occupation definitions from the International Classification of Functioning, Disability, and Health (ICF), American Occupational Therapy Framework, and Canadian Practice Process Framework (American Occupational Therapy Association, 2014; Fazio et al., 2008; International Classification of Functioning Disability and Health, 2017). The number of times that the concept ‘inpatient’ occurred in each document was also tracked, as the inpatient setting is an environment where people are particularly restricted with access to leisure activities.

Subsequently, all the documents were combined into one file for analysis. The Leximancer settings were as follows. Sentences per block were set to one to reflect those legislative documents that often use distinct clauses. During the individual mapping process, no ‘tags’ were used as concepts were only from a single document, though this function was used later in analysis when all documents were included in a single concept map. Maps were presented using the social network mode.

The quantitative data produced by Leximancer was subsequently analysed in Microsoft Office Excel. Leximancer provided the number of times that each concept was found within a document and the percentage of concept use relative to the document size. Concept examples were reviewed manually to ensure fidelity and accuracy of Leximancer V4 findings. Concepts that had poor relevance were excluded from the final data analysis. The

excluded terms were ‘fitness’ and ‘exercise’. Even though these terms were identified by the authors as substantive leisure-related content, they were not utilised in this manner throughout all of the documents. These terms were excluded because the MHA is typically written from a medical model perspective and interrogation of the data suggested these terms were used from medical or legal discourse, for example to ‘exercise’ a legal power, instead of being written from a health-promoting perspective suggesting ‘exercise’ as a form of activity to promote health. Hand searching was included in this stage to determine if there was any overlap between discourses. An example of an overlap between discourses was the multiple contexts in which the word ‘exercise’ could be applied in each document. Exercise could be used to exercise legal powers of the legislation or MHA, similarly, it could be used as content associated with sporting activity. The concepts found were limited in each document, so hand searching was conducted for all texts to ensure concepts were consistent with the intended meaning. These concepts were considered consistent with current leisure definitions.

5.1.3.3 Data Analysis

The concept count is simply the number of times the concept (or word such as ‘leisure’) was present within the document. This number was totalled per document and a percentage was calculated based on the number of times the 24 concepts were present versus the number of words in the document.

5.1.4 Results

Documents with a high prevalence of the concept ‘inpatient’ tended towards a lower prevalence of leisure-related concepts, excluding the World Health Organization (2021) 2019-2023 plan which included both. There was a wide variance in mentions of ‘inpatient’ with the United Nations Convention on the Rights of Persons with Disabilities, Queensland Public Health Act, New South Wales Regulation Act, Australian Capital Territory, New South Wales, and Northern Territory MHAs.

The highest leisure-oriented concept percentage amongst all documents review was found in The Mental Health (Northern Ireland) (Amendment) Order 2018 (2.77%). In contrast, the documents analysed in stage one that lacked inclusion of leisure-related terms were the Northern Ireland MHA (0.01%) (Republic of Ireland, 2001), and the UK Mental Health (Discrimination) Act 2013 (0%) (Parliament of the United Kingdom, 1983, 2007). The relative prevalence of each concept across the acts is shown in Table 5.1. The number of times leisure-related concepts arose in each document, with the document size and percentage is also detailed in Table 5.1.

Table 5.2

Semantic Analysis: Mean and Standard Deviation of Leisure-related Concepts in all Documents

Concept	Mean	STD
Activities / Activity	11.5	12.5
Art	9	5.7
Craft	0	0
Engage / Engagement	6.4	4.1
Group[s]	12.6	17.1
Interest[s]	23.2	22.5
Leisure	9	8.8
Meaningful	13.8	14.8
Occupation	8.0	6.6
Participate/Participation	9.7	6.9
Program[s]/Programme	14.9	19.6
Recreation[al]	5.6	3.4
Social/Socialising	21.2	26.4
Sport	6.7	2.1

Leximancer mapping demonstrated an interesting trend of leisure-related concepts across the documents. For example, ‘recreation’, ‘occupation’, and ‘leisure’ were often used together in the text, and sometimes this was in the context of groups. ‘Meaningful’ was often linked to ‘meaningful participation’ and other times ‘meaningful social relationships’. ‘Engage’ was most linked with ‘interests’ and ‘activity’.

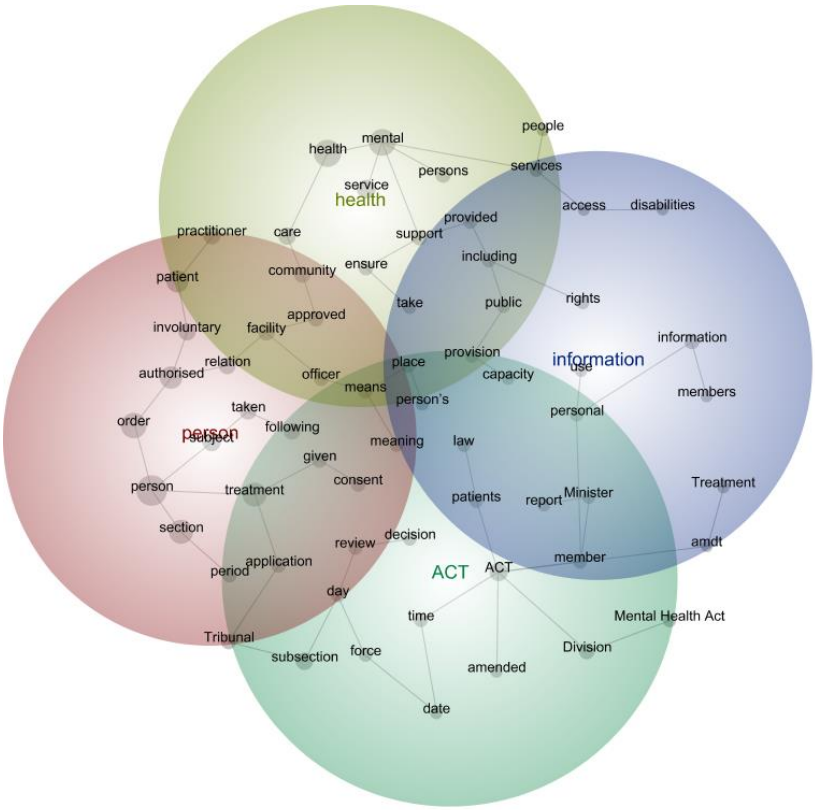
Some concepts were either cursorily or not at all included within the government documents (i.e., the National Standards). For example, art (39 concepts), craft (26 concepts) and sport (22 concepts) were three concepts that appeared the least amongst all 33 documents, even though these are important terms when defining leisure and recreational occupations according to the ICF (International Classification of Functioning Disability and Health, 2017).

After a review of stage one results, the lack of or limited context surrounding leisure-related concepts created some ambiguity and difficulty in ascertaining whether concepts were consistently used throughout documents to support leisure engagement.

The Leximancer V4 mapping (Figure 5.1) of the analysis provides a visual representation of the most prevalent concepts found. Leximancer V4 highlighted key categories within the analysis as ‘person’, ‘health’, ‘information’, and ‘act’ into word clouds (represented as coloured circles). The concepts surrounding these keyword categories are concepts that are typically found or associated. For example, concepts typically related to the person are ‘involuntary’, ‘sectioned’, ‘consent’, and ‘treatment’. Limited leisure concepts are found to be associated with the person.

Figure 5.1

Stage One Leximancer Concept Map



5.1.5 Discussion

The study explored the prevalence of leisure-related concepts present in the current mental health acts, legislation, and policies in Australia, New Zealand, and the United Kingdom. Thirty-three documents were analysed in the review. This included current documents that inform inpatient clinical care in MHIUs. The number of concepts present was low across all documents with particularly a low number of concepts in MHAs. For example, the document 'Tasmania Mental Health Act' was found to have 0% of concepts present. Amongst the 33 documents that were reviewed, leisure-related concepts were largely lacking within policy documents. The discourse to describe profession-based leisure-related concepts was vastly different at times compared to the discourse used to describe legal-based terms. For example, the phrase 'inpatient' was used within Australian policy to describe the environment which was largely different from other policies which used 'centre' (within Northern Irish policy) when referring the MHIUs.

Australian documents have referenced the World Health Organization (2013) as a benchmark standard to work towards. 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. Given that acts and regulations typically hold greater legal weight, it is unfortunate that these documents do not emphasise access to leisure to the extent of national and international documents. The World Health Organization (2013) document is also referenced in documents such as The Mental Health (Northern Ireland) (Amendment) Order 2018 (Parliament of the United Kingdom, 2018) (2.77%), and Australian National Standards for Mental Health Services (0.89%) (Australian Government, 2010), which appeared to have more leisure-oriented concepts present. While internationally, access to leisure is considered a human right (Universal Declaration of Human Rights, Article 24), this has not yet been translated to legislative protections in mental health contexts (United Nations General Assembly, 1948). This affects all levels of the community, from broader public health promotion and prevention activities to various community and inpatient health care and psychosocial support services.

5.1.5.1. Limitations of the Study

A limitation of the study was that all concepts were included verbatim during the analysis. The limitation of using a software package to review concepts in stage one likely resulted in a lack of context to the concepts found. This also could have led to a lack of variation for the 24 identified concepts that were used for the targeted search, meaning, concepts may have only been found by one type of spelling or without plural. As this study

was conducted by Australia researchers, the content / concepts selected to explore were associated with health-related language from this geographical location. Concepts were identified based on current definitions of occupation which may have varied inclusions of contemporary discourse and substantive leisure-related content. During the analysis, it was determined that some concepts have multiple meanings and are used in a range of contexts (for example, legal and occupational). The concept count was still included regardless of the context for words that were not deemed to have a high leisure relationship such as 'inpatient' or 'exercise', due to difficulties separating these uses using computer-assisted analysis such as Leximancer.

5.1.5.2 Future Research

The findings from stage one highlighted the need for further analysis due to the lack of conformity between discourses and countries. This was identified using Leximancer V4 software for data analysis. Leximancer V4 provided an important initial finding that was limited leisure concepts within the documents. Hand checking each document may provide more meaningful analysis as software has not identified varied discourses between documents. A second stage of semantic analysis by hand would provide beneficial context to the concept counts found in stage one.

5.1.6 Conclusion

The initial findings of this study highlight there were limited leisure-related concepts found in mental health legislation and policy. Limited prevalence of leisure-related context can provide limitations to the delivery of leisure in a therapeutic context. From the 33 mental health acts reviewed using the text-mining software, there was limited leisure-related concepts found with contextual meaning that applies to occupational therapy or engagement in meaningful activity for consumers. Due to the lack of context provided or applicable to aims of this study, exploration on the prevalence of leisure-related concepts needs to be further explored. A secondary analysis of the 33 documents reviewed in this phase will provide validation for the findings in phase one.

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5.2 Stage Two of Policy Analysis

Phase two continues to explore the macro barriers to leisure engagement through reviewing legislation and policy. Phase two analyses the same 33 documents (including legislation and policy) through semantic analysis and a checklist (Aryal et al., 2015). The checklist was created by the authors based on the current literature and highlights qualities or principles that are required to implement leisure activity on MHIUs.

Phase one explored concept counting or prevalence through text-mining software Leximancer V4. After conducting phase one, there was a lack of context to the concepts found, which made analysis challenging. This led to the development of phase two and the requirement to add a context to the leisure-related concepts through hand-searching with semantic analysis (Aryal et al., 2015). After completing phase one, it was evident that discourse can be different across each country even with a shared language (English). Further exploration of how the language was used and applied in the legislation was necessary to determine whether leisure-related concepts were included in the development of policy for mental health services.

Computer-assisted analysis methods have the potential to produce data that lacks relevance and context, while manual analysis methods risk the introduction of coder bias (Bryman, 2016). The use of both methods and comparison of findings helps to limit these biases. Based on the findings from stage one, the second stage of analysis was conducted to provide context to the Leximancer V4 data. Findings using Leximancer V4 can be interpreted with caution due to the lack of context to the leisure-related terms found within policy.

Phase two provided a profound value for the need of leisure-related concepts in policy as there was a lack of emphasis on meaningful engagement found. The key difference between each documents findings was the different descriptive discourse used between countries. The differences in the discourse surrounding leisure and recreation throughout the documents are likely the reasoning for low concept prevalence in stage one data.

A checklist was developed which highlights key principles in leisure-related care and ‘best practice’. The checklist was then used to score the concepts found in policy or legislation to ascertain the quality of leisure-related concepts used. Beyond this research, the checklist developed in phase two could be used by mental health services in the future to ensure they have targeted the key areas of leisure-related care in their policy and governing documents. This checklist would also be beneficial for occupational therapists considering

service delivery in the inpatient setting they work in. The checklist provides an evidence base and rationale for future service delivery to meet the needs of consumers.

This manuscript was submitted to the BMC Health Services Research. This journal was selected as the readership is interdisciplinary who will have an interest in the impact policy has on service delivery. The aim of this journal is to disseminate research that influences policy, and mental health services more broadly. The BMC Health Services Research has an impact factor of 2.75 and is considered a Q1 journal. Additionally, to maintain consistency between chapters, the referencing and formatting have been adapted.

5.2.1 Abstract

Purpose. There appears to be limited investigation on the inclusion of leisure-related concepts in mental health acts and the relationship this has on implementation of leisure activities on MHIUs, 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 substantive content and received a score of 1. Leisure-related content was typically associated with the built environment. Australia was the only country to contain high-quality leisure-related substantive content in their policy. New Zealand presented with the lowest scores overall and lacked meaningful use of leisure-related content throughout its reviewed documents.

Conclusion. The legislation and supporting documents reviewed do not include sufficient content to support engagement in leisure activity on inpatient units.

Keywords. Leisure activities, recreation, semantic analysis, health policy, psychiatric care

5.2.2 Introduction

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 MHAs is it is a legislation that supports with treatment in the community and facilitating admission for consumers who lack capacity due to acute mental illness (Gowda et al., 2017). Often, governing documents provide limitation or restriction for staff providing direct service-provision. They are also a very important guide provide safe and ethical practice (Cutler, 2021).

Consumers who are admitted to inpatient services are typically found wandering, bored, and sitting (Chapman et al., 2016; Fraser et al., 2016). In public health settings, there is typically limited access to organised activity to prevent boredom (Fraser et al., 2016; Radcliffe & Smith, 2007). Boredom is closely linked with poor impulse control, hostility, and restlessness as the brain requires stimulation (Todman, 2003). Participation in leisure can reduce overall risks to self and others, as it assists with cognitive stimulation and a reduction in boredom (Todman, 2003). Engagement can also increase therapeutic opportunities and promotes overall health and wellbeing (Chen et al., 2020). 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 (Foye et al., 2020). While access to leisure is a human right, a person's ability to participate is influenced by societal, economic, and political factors (Wilcock, 2005). A primary goal to improve access to leisure in MHIUs is to improve the quality of life for consumers accessing acute services.

In recent years, a focus of health care has been on least restrictive practice in mental health settings and advocacy for consumer rights (Sustere & Tarpey, 2019). Leisure may be a strategy to reduce the need for restrictive practice (Sustere & Tarpey, 2019). A study completed by Radcliffe and Smith (2007) 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 (Evatt et al., 2016; Howard et al., 2003). This situation is unlikely to change unless access to leisure occupations is supported by policy and legislation (Cutler, 2021).

The World Health Organization (2021) 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 (World Health Organization, 2013). 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 (World Health Organization, 2019). 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 (2013) 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 (Antonysamy, 2013; Ashmore, 2008). 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 (Gowda et al., 2017). Lack of activity or support to occupy consumers time in an inpatient unit has also been associated with higher levels of aggression and risk (Gowda et al., 2017). According to The Sainsbury Centre for Mental Health (2002) 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 (Australian Government, 2014). 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.

5.2.3 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. Supporting policies from at state, national and international levels were also analysed.

5.2.3.1 Sample

A total of 33 documents were semantically analysed. Semantic analysis is the process of drawing significance or meaning from content and text (Aryal, et al., 2015). 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.

5.2.3.2 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 5.3). 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 5.4 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.

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.

Table 5.3

List of 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 consumers to exercise their human right to engage in leisure.	(Townsend & A. Wilcock, 2004; United Nations General Assembly, 1948; World Health Organization, 2013)
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, and engagement in leisure activity.	(Ahmead et al., 2010; Chiu-Yueh et al., 2015; Garman et al., 2002; Radcliffe et al., 2012; D Whittington & C 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 et al., 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. Consumers 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, 2013)
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 and engagement of leisure activity.	(Christiansen & Matuska, 2006; Russo et al., 1997)

5.2.3.3 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 documents was placed into a spreadsheet (Aryal et al., 2015). These examples were then placed into the most appropriate category and scored based on the criteria (between 1 and 5) (see Table 5.4). At times example would be suitable for more than one category. Some concepts were rated across multiple categories. Author two then supported with cross-checking the analysis and scoring of the checklist data.

Throughout each of these countries, some of the selected concepts may have other terms or local language used to describe the same word. Concepts or terms selected to describe like meanings potentially narrowed the scope of appropriate leisure discourse within each documents to Australian health-related substantive content. Researchers hand-checked all 33 documents using the checklist to identify how the leisure discourse is used uniquely in that country or document. Hand-checking included word searching of each document and reading relevant sections of the act to further understand the discourse used.

Table 5.4

Criteria Scale of Checklist Qualities

Quality / Score	1	2	3	4	5
Environment / Accessibility Human Right Multidisciplinary Team Approach Patient Centred Approach Therapeutic Aim Quality of life	There is no inclusion of the phrase. within the document.	There is sparse (one to two phrases) inclusion of the phrase within the document.	There is occasional inclusion (four to five phrases) of the phrase within the document that is mostly used within the context of leisure.	There is regular mention of the phrase (five to seven phrases) in the context of leisure within the document.	The document explicitly discussed a (i.e. a section or paragraph) and contributes to the quality supports consumer care.

5.2.4 Results

There were varied quality of concepts used within the 33 documents to explore and facilitate leisure participation (see Table 5.5). An example of text that was awarded each score in the six quality categories can be seen in Table 5.6. For example, in the human rights category, the Australian National Mental Health Strategy (D. o. H. Australian Government, 2014) 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 5.5

Policy Analysis Quality Checklist Results

	Document	Quality Scores (1 indicating limited concepts present and 5 indicating high quality of concepts present)						
		Environment / Accessibility	Human Rights	Multidisciplinary Approach	Patient Centred - Therapeutic Aim		Quality of Life	Median Score
AUSTRALIA	National Mental Health Strategy (D. o. H. Australian Government, 2014)	2	5	3	4	3	4	3.5
	National Recovery Framework (Commonwealth of Australia, 2013)	2	3	2	3	5	3	3
	National Standards for Mental Health Services 2010 (Australian Government, 2010)	4	5	4	3	2	4	4
	Australian Capital Territory Mental Health Act 2015 (Australian Capital Territory Government, 2015)	4	2	2	4	2	5	3

	New South Wales Mental Health Act 2007 (New South Wales Government, 2007)	2	1	2	5	2	3	2
	New South Wales Mental Health Act Regulation 2013 (New South Wales Government, 2013)	1	2	3	2	1	2	2
	Northern Territory Mental Health Act 1999 (Northern Territory Government, 2002)	2	3	2	4	3	1	2.5
	Queensland Mental Health Act 2016 (Queensland Government, 2016)	1	3	2	2	3	3	2.5
	Queensland Public Health Act 2005 (Queensland Government, 2017)	1	1	1	3	1	1	1
	Connecting Care to Recovery 2016-2021 (State of Queensland, 2016)	2	3	3	4	2	3	3
	South Australia Mental Health Act 2009 (South Australian Government, 2009)	1	1	1	1	3	2	1
	Tasmanian Mental Health Act 2013 (Tasmanian Government, 2013)	5	3	2	1	3	1	2.5
	Victoria Mental Health Act 2014 (Victorian Government, 2014)	5	3	3	4	4	3	3.5
	Western Australia Mental Health Act 2014 (Western Australia Government, 2014)	2	3	2	2	3	1	2
NEW	Health and Disability Commissioner Act 1994 (Ministry of Health, 2018a)	1	2	1	2	2	1	1.5

	Human Rights Act 1993 (Ministry of Justice, 2018)	1	2	1	1	1	1	1
	Rising to the Challenge 2012 – 2017 (Ministry of Health, 2012)	1	2	2	2	3	1	2
	Mental Health Compulsory Assessment and Treatment Act 1992 (Ministry of Health, 2018b)	1	2	2	1	3	1	1.5
THE UNITED KINGDOM	The Mental Health (Northern Ireland) (Amendment) Order 2018	1	1	1	1	1	1	1
	Mental Health Act 2007 UK (Parliament of the United Kingdom, 2007)	1	2	1	3	1	1	1
	Mental Health Act 1983 (Parliament of the United Kingdom, 1983)	1	2	1	3	1	1	1
	Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Welfare Commission for Scotland, 2003)	3	2	1	1	2	1	1.5
	Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales (Welsh Government, 2012)	2	2	1	1	3	3	2
	Mental Health Strategy: 2017-2027 (Scotland) (Scottish Government, 2017)	2	2	4	1	2	2	2
	Achieving Better Access to Mental Health Services by 2020 (England) (Department of Health, 2014)	2	2	1	1	1	3	1.5

	The Mental Health (Wales) Measure 2010 (Parliament of the United Kingdom, 2012)	1	1	1	1	1	1	1
	Mental Health Commission Strategy Plan 2016-2018 (Ireland) (Mental Health Commission, 2017)	2	2	2	3	2	2	2
	Suicide Prevention: Policy and Strategy (Mackley, 2018)	3	2	1	2	2	1	2
	Reform of Mental Health Legislation in the UK (Northern Ireland Assembly, 2008)	3	2	3	4	1	2	2.5
	Mental Capacity Act 2005 (Parliament of the United Kingdom, 2005)	2	2	1	1	1	1	1
	Mental Health (Discrimination) Act 2013 (Parliament of the United Kingdom, 2013)	2	1	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	1
	United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2007)	2	2	3	1	2	1	2
	World Health Organization Action Plan 2013-2020 (World Health Organization, 2013)	4	2	2	1	1	2	2

The Victoria Mental Health Act (Victorian Government, 2014) (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 (Australian Government, 2010) (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 (Parliament of the United Kingdom, 2018) (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 of more than 10,000 words 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 (2013) the Mental Health Plan 2013-2020 as a major factor for inpatient treatment when providing safe care. Contributing factors to risk were 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 substantive content 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 content 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 content (see Table 5.6) is the Victorian MHA (Victorian Government, 2014): 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 content which led to an automatic score of 1. This is demonstrated in Table 5.6 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'.

Table 5.6

Examples of Policy Analysis Checklist Applied to 33 Legislation and Policy Documents

Quality		Score				
		1	2	3	4	5
Human Rights	**Document**		Reform of Mental Health Legislation in the UK (Northern Ireland Assembly, 2008)	Australian National Recovery Framework (Department of Health and Ageing, 2013)	World Health Organization Action Plan 2013-2020 (World Health Organization, 2013)	Australia National Mental Health Policy (Australian Government, 2010)
	Example	No examples of quality present in legislation	The United Nations Principles for the Protection of Persons with Ment al 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	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	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.

				adversely impact on recovery.	and regional human rights instruments.	
	% of documents with this score	18%	48%	24%	3%	6%
Patient Centred Approach	**Document**	World Health Organization Action Plan 2013-2020 (World Health Organization, 2013)	Western Australia Mental Health Act 2014 (AUS) (Western Australia Government, 2014)		Australian Mental Health Strategy (Australian Government, D. o. H, 2014)	New South Wales Mental Health Act 2007 (AUS) (New South Wales Government, 2007)
	Example	Regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the	The person in charge of the voluntary inpatient's ward must ensure that the inpatient has		It recognises the importance of maintaining the momentum created by the COAG process to support a	Care and treatment in the least restrictive environment enabling the care and treatment to be effectively given, (b) people with

		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 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		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.	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	South Australia Mental Health Act	Achieving Better Access to Mental	Australian National Mental Health	Australian National Standards for Mental

	Protection of Human Rights and Fundamental Freedoms (Council of Europe, 2010)	2009 (AUS) (South Australian Government, 2009)	Health Services by 2020 (UK) (Department of Health, 2014)	Strategy (Australian Government, D. o. H, 2014)	Health Services 2010 (Australian Government, 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) (Parliament of the United Kingdom, 2007)	United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2007).	Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales (Welsh Government, 2012)	Victoria Mental Health Act 2014 (AUS) Victorian Government, 2014)	Australian National Recovery Framework (Department of Health and Ageing, 2013)

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,	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

					occupation, education, training and recovery	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) (Ministry of Justice, 2018)	New South Wales Mental Health Act 2007 (AUS) (New South Wales Government, 2007)	Reform of Mental Health Legislation in the UK (Northern Ireland Assembly, 2008).	Australian National Standards for Mental Health Services 2010 (Australian Government, 2010)	
	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	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	The capacity of individuals within The groups and The environment to interact with one another in ways that promote subjective wellbeing, optimal	

		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.		delivery of safe and effective care".	development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice.	
	% of documents with this score	42%	33%	9%	9%	6%
Multi-disciplinary Team Approach	**Document**	Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales (UK) (Welsh	Northern Territory Mental Health Act 2016 (AUS) (Northern Territory Government, 2002)	Australia National Mental Health Strategy (Australian Government, D. o. H, 2014)	Mental Health Strategy: 2017-2027 (Scottish Government, 2017)	No examples of quality present in legislation

	Government, 2012).			
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;	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.

			family interventions; short and long term support; and psycho-education.		
% of documents with this score	42%	33%	18%	6%	0%

5.2.5 Discussion

Engagement in occupation within an inpatient environment can reduce the need for acute medication use, minimise aggressive incidents that require seclusion (Kontio et al., 2012) 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 substantive leisure-based content or interventions mentioned other than restrictive practices such as medication, restraint, and seclusion. This raises the question that the substantive content used to describe leisure may not be contemporary or universal, and concepts entered may not have adequately captured a different professional's view of a therapeutic MHIU. From the 33 documents reviewed, four documents explicitly used the word 'leisure' in the document to convey consumer engagement in activity. Nine documents articulated leisure-related principles such as activity. The remaining 20 documents used general principles around engagement in activity or that were not specific to leisure activity.

The World Health Organization (2013) 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 performance indicators to track the progress and effect of programs that services are implementing (World Health Organization, 2013). 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 of 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'.

5.2.5.1 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 (World Health Organization, 2013). 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 (Howard et al., 2003; The Sainsbury Centre for Mental Health, 2002).

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 (Australian Government, 2010), 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 (2013) 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 content around the implementation of leisure within mental health units (see Table 5.6, examples of text scoring 5).

The research reviewed the same 33 documents by hand-checking leisure-related 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.

5.2.5.2 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.

5.2.5.3 Future Research

This semantic analysis has highlighted a lack of occupational discourse, particularly around leisure, in mental health-related policy and legislation. Future research may look to analyse the difference leisure-inclusive content 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 (Chen & Chippendale, 2018). Therefore, future research should aim to review the mental health inpatient unit's implementation of the reviewed legislation and the clinical barriers faced.

5.2.6 Conclusion

Legislation and policy in Australia, New Zealand, and the United Kingdom, lack leisure-specific content and inclusion of discourses related to therapeutic engagement of leisure. Mental health legislation and policy may benefit from clearer additional content 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 content promoting therapeutic modalities within health policy will support clinical professionals to provide evidence-based practice within the scope of treatment.

5.2.7 Key Implications for Health Professionals

- Unification of leisure-related content would assist in a more universal understanding of content within policy amongst health professionals.
- Leisure content within policy and governing documents is sparse and provides little guidance for leisure activity within MHIUs.
- The greater value placed on leisure activity will provide staff to explore treatment goals within mental health units that align with evidence-based practice. These leisure activities will provide further support to offer alternative therapies to medication or seclusion within MHIUs, and perhaps explore the need for funding and training for staff who don't currently operate in this manner.

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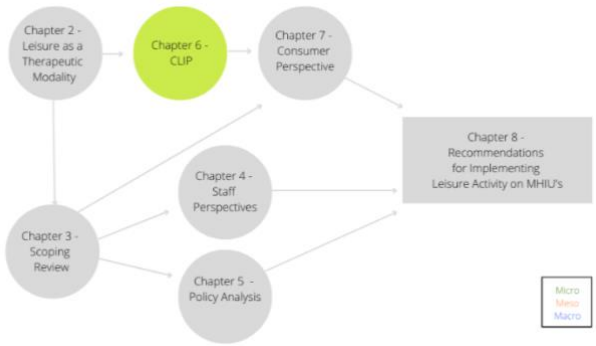
CHAPTER 6 – The 'Checklist of Leisure, Interest and Participation': Exploring the General Population Current Leisure Interests in the 21st Century



The first section of this thesis concluded that there is a lack of leisure activity provided in MHIUs. The first phase included the meso and macro perspectives of health that impact consumer engagement on MHIUs. Section two of this thesis explores the micro perspective including the general populations view of leisure and mental health consumers' engagement in activity. Furthermore, the multidisciplinary team perspective (chapter four) and the governance perspective (chapter five) provide context to the current challenges faced by consumers. The subsequent chapters explore measurable ways to explore current consumer interests and the consumer's perspective on the barriers to engagement. This section was critical to understand what the gaps were to direct service provision to propose appropriate recommendations to improve services.

This chapter explores the availability and development of leisure-based tools to evaluate consumer interests. This manuscript addresses aim five within the thesis and is original research.

The present manuscript explores the preliminary development of a leisure tool adapted from the Model of Human Occupation's iteration of the Modified Interest Checklist (MIC) (Kielhofner & Neville, 1983). To best explore the leisure preferences of consumers of mental health units, it was identified there needs to be an efficient and reliable way to do so. Due to potential cognitive issues and acuity of consumers' mental state, a checklist was deemed the most efficient and effective way to evaluate their leisure preferences.

The decision to utilise a checklist to evaluate consumer interests has led to the evaluation of an existing tool adapted by Kielhofner and Neville (1983) called the Modified Interest Checklist (MIC) in phase one of this manuscript. Four phases within this manuscript target the general population and occupational therapists. One of the many tools currently used by therapists is the MIC (Kielhofner & Neville, 1983). The MIC (Kielhofner & Neville, 1983) provides insight into clients' past, current, and future activity interests. The checklist is

typically used as a formal measure to accompany an interview. This can support the therapist to understand habits, and recent changes in the occupational profile, and support with goal setting or direction of activity-based therapy.

Hitch et al. (2007) conducted a review of six outcome measures that are currently used in mental health settings including interest and role checklists, COPM and DACSA, and described the validity, suitability, and model guiding practice. Their findings stated that the role checklist, interest checklist, AMPS, and COPM have confirmed validity and reliability in psychiatric settings.

The use of leisure-based tools such as the MIC (Kielhofner & Neville, 1983) can assist to explore leisure activities that consumers are currently participating in or what they may be interested in. This tool can facilitate focused goals on leisure activity a consumer would like to engage in or use the activity to achieve a skill. However, many of the activities in the MIC reflect activities available at the time it was developed and have not evolved with society and technology. Phases two, three, and four led to the development of a leisure tool that could be used to accurately direct occupational therapists or members of the multidisciplinary team to scope a consumer's leisure interest in a contemporary context. The data collected in this manuscript was both qualitative and quantitative in nature. All participants were recruited through social media (Facebook) through convenience snowballing and paid advertisements.

The Checklist of Leisure, Interests, and Participation (CLIP) was developed through this research. This tool created a tangible way for occupational therapists to assess mental health consumers' leisure interests to guide achievable therapeutic goals and promote meaning and volition (intrinsic motivation to participate in chosen activity). This manuscript supported research presented in chapters seven and eight.

This manuscript has been submitted to OTJR Occupation, Participation, and Health. This journal is an inter-disciplinary journal with a focus on engagement to leisure behaviours across a broad range of settings such as individual, group, and macro health. OTJR: Occupation, Participation and Health was selected so the CLIP could be accessible for health professionals and have a greater impact across disciplines. OTJR Occupation, Participation and Health has an impact factor of 1.768 and is a Q2 journal. Additionally, to maintain consistency between chapters, the referencing and formatting have been adapted.

6.1 Abstract

Introduction. The Modified Interest Checklist (MIC) is a tool used by therapists to understand past and present occupational engagement, however, is now outdated and lacks contemporary occupations. The aim of this study was to develop an updated valid and reliable tool inclusive of contemporary leisure activities.

Methods. The study consisted of four phases including feedback in relation to the MIC, two phases of development of an updated tool and occupational therapists' opinions on the tool. An updated tool was developed, the 'Checklist of Leisure, Interests and Participation' (CLIP).

Results. More than 50% of participants in phase I and II expressed a need for a contemporary leisure inventory with specific detail to the inclusion of modern activities such as video games.

Discussion. The CLIP presents as a valid and reliable option for leisure profile assessment. Findings suggest that this tool could be used within mental and physical health services.

6.2 Introduction

Occupational therapists frequently use leisure activity as a therapeutic modality because leisure can be a source of purpose and meaning for individuals (Berger et al., 2013). A person is more likely to participate in an activity they enjoy and are interested in (Beard & Ragheb, 1980). Societal changes in opportunities, access, trends and culture have changed the face of leisure (Aguiar & Hurst, 2007). There are a large range of activities associated with a person's daily life. Across the course of the late 20th and early 21st century, leisure appears to feature more strongly in people's day-to-day lives (Caldwell, 2005). Given that interests are an activity, object or an occasion a person enjoys (Kielhofner & Burke, 1980), the full breadth of these interests is difficult to capture. This study describes the development of an updated leisure interest and participation assessment tool that incorporates leisure interests that have emerged in the late 20th and early 21st century.

6.2.1 Literature Review

Occupational therapists use informal and formal assessment methods to explore consumer's leisure profiles (Law, 1987; Unsworth, 2000). The Modified Interest Checklist (MIC) (Kielhofner & Neville, 1983) is one tool currently used within occupational therapy that explores a person's interests. The MIC includes activities which can be classified under the occupational categories of instrumental activities of daily living (IADLs) and under the category of leisure.

The Neuropsychiatrist Institute Interest Checklist was originally developed by Matsutsuyu (1969) and is well known within the occupational therapy profession. The original checklist by Matsutsuyu (1969) featured 80 activities and explored participants' interest in each activity as either 'strong', 'casual' or 'no interest' but did not explore levels of participation. This checklist was subsequently adapted and the subsequent 'Interest Checklist' was developed by Rogers et al. (1978). The Modified Interest Checklist (MIC) became the third version of the checklist and included 68 activities. The MIC asks participants to grade their interest in each activity as 'strong', 'some' or 'none' in a matrix layout (Kielhofner & Neville, 1983). The MIC also explores participation in activity over the past 10 years, one year, current and in the future. The MIC was then adapted to be used in the Model of Human Occupation battery of standardised tools by Kielhofner and Neville (1983).

The MIC incorporates a combination of leisure activities and instrumental activities of daily living (IADLs) such as ironing and housecleaning. The checklist has since been adapted to four different versions since the development of the MIC including the Modified Interest Checklist (UK Version, (Heasman & Salhortra, 2008)), and the Easy Reader Version with pictures, 2014; the Modified Interest Checklist: Diverse Learners (Gentile et al., 2019); and Socially Distanced Modified Interest Checklist (2020), however, there are no links to the literature for any of these tools. These four tools all include a similar activity list to the MIC and include 'degree of interest' and 'participation' categories with a minor change of categorising the activities into groups (Taylor, 2022). Some differences can be seen in The Modified Interest Checklist (UK Version) (MIC-UK) which is broken into 9 subcategories with a summary of selected activities and an 'action plan'(Heasman & Salhortra, 2008). Similarly, the Easy Reader Version provides pictures or drawings of the activity with large text. In 2019, the MIC-UK was adapted into a Diverse Learners in Community Mental Health setting (Gentile et al., 2019) which includes additional categories and the inclusion of 'self-care' and 'education' interests. In 2020, a 'Socially Distanced Interest Checklist' was created and is a modified version of the 2008 MIC-UK for people who are living during the COVID-19 pandemic. This explored activities within a person's 'social bubble' and their environment (indoor or outdoor). All of the MIC checklists have similar qualities and utilise a 3-point Likert scale of 'strong, some or none' for level of interest and 'past, present or future' categories for level of participation. None of these tools specifically focus on a specific category of occupation such as leisure.

More specific versions of the checklist have been created for populations such as the Japanese Interest Checklist for the Elderly (JICE), which included a total of 29 activities (ADL, cultural and leisure) (Yamada, 2002).

A similar tool to the MIC is the Leisure Interest Profile for Adults (Hansen & Scullard, 2002). This tool provides the client with a range of choices between leisure activities (half written and half pictures) and concludes with a ranking of activities at the end. This tool was also created 22 years ago and requires some much-needed updates.

A range of leisure tools are available aside from interest checklists. Some of these tools that are widely used by health professionals include the Canadian Occupational Performance Measure (COPM) (Law et al., 1990) which explores a range of occupational domains and the Leisure Satisfaction Scale (Di Bona, 2000) that rates satisfaction in participation. These tools focus on occupational performance components rather than an inventory of specific activity itself such as the MIC. The Children's Leisure Assessment Scale (CLASS) (Brown & Thyer, 2019) explores categories associated with play and explores participation and engagement within leisure activities. As it explores play specifically, this is not translatable to the adult population due to the difference in occupational engagement between the two groups.

The current MIC was created over 40 years ago and there are limited contemporary (late 20th and early 21st century) activities included (Kielhofner & Neville, 1983). The focus of the tool is interest based, though includes a range of occupational areas such as IADLs. In today's culture, it appears that there has been a shift in how society views and people value their use of time. There has been a recent emphasis on the importance of health, wellbeing, self-care, and satisfaction. This has led greater emphasis on leisure activity and balance in daily activities.

Some theorists create distinctions between categories such as self-care, productivity, and leisure (Jonsson, 2008; Meyer, 1922; Meyer, 1977). Within occupational therapy literature there are diverse perspectives on the usefulness of categorisation of occupation. Alternatively, others posit that occupation can only be defined by the individual and what meaning or purpose this holds to them (Hammell, 2004). These differing opinions make providing a comprehensive tool around 'interests' difficult. Current standardised assessments such as the Nottingham Leisure Questionnaire (Drummond et al., 2001) which is targeted at the brain injury population and consists of 30 activities, is outdated and provides a limited range of contemporary activities.

Colquhoun et al. (2017) found that approximately a quarter of therapists use standardised tools when assessing. Often the lack of formality is due to accessibility, knowledge, and limited understanding of the tools available (Romli et al., 2019). Rouleau et al. (2015) similarly found more than half of Canadian occupational therapists surveyed use standardised assessment in conjunction with informal assessment such as interviewing and task observation.

Standardised tools can be valuable for providing insight into a person's occupational profile when there is limited time or difficulties with interpersonal effectiveness (Kielhofner & Neville, 1983). Conversely, standardised testing can often miss information not described in questions, which prompts the use of parallel assessment as described by The Occupational Therapy Board of Australia (2018). Romli et al. (2019) suggests that there are limited leisure specific inventories/checklists available that are sufficiently modern and updated.

This study aimed to determine if the Modified Interest Checklist (MIC) adequately included contemporary and modern activities available in the 21st century for current occupational therapy practice. Furthermore, this study aimed to develop an updated valid and reliable tool inclusive of contemporary leisure activities. The development of a new tool aimed to be a more leisure specific version of the tool that includes a new rating categories and new leisure activities that meet the adult populations' (18-65) current interests.

6.3 Materials and Methods

The study used an integrated methodology which incorporated both qualitative and quantitative data to inform the development of a new tool (Liamputtong, 2017). It is informed by a pragmatic approach (being both quantitative and qualitative), which elicits the subjective perspective of the participant (Lindström & Eriksson, 2005, 2006; Crotty, 1998). The study was a four-phase online survey (each phase designed to take approximately 15 minutes to complete).

Phase I: Feedback on the contemporary validity of the activities within the MIC

Phase II: Development and piloting of the newly developed CLIP

Phase III: Psychometric testing and general population data of the CLIP with an Australian population

Phase IV: Feedback on utility of the CLIP from the perspective of Australian occupational therapists

Two ethics approvals were granted by the University of the Sunshine Coast Human Ethics Committee (phase I and II - approval number S171100) and (phase III and IV - approval number S181233).

6.3.1 Sample

All participants in each phase were unique as the same cohort was not invited to participate again due to the survey being anonymous. Phases I and II included volunteer convenience and snowball sampling of the general population. Inclusion criteria were persons aged 18 and over. During phases I and II, participants were recruited through social media (sharing on the university Facebook page) with snowball sampling as the advert was shared broadly, as well as face-to-face with interested persons completing the survey on an electronic tablet. Phase I aimed to achieve saturation of activity ideas, and it was estimated that at least 80 participants would be required. The first phase of the research was to validate the original research question and gather some preliminary data, therefore, a minimum sample of 30 would be required. Based on similar studies such as Kielhofner and Neville (1983) the aim of this study was to gain saturation.

In phases II and III, paid Facebook advertising was used to reduce sampling bias (e.g., geographic bias). Since limited changes were made between phase II and III (i.e., addition of "reading" as an activity), both samples were combined for reporting psychometrics of the tool. A sample size calculation required 385 participants to be representative of the Australian population (confidence level 95%, margin of error 5%).

In phase IV, Australian practicing occupational therapists were recruited via advertising through Facebook and the OT professional association. Ninety-six respondents were required to be representative of the broader population (95% confident interval, and 10% margin of error). Participants were not provided with any incentive to participate. Participants did not provide identifiable information such as their name or IP address.

6.3.2 Outcome Measures

Phase I included the use of the MIC (Kielhofner & Neville, 1983) to ascertain the need for development of a contemporary tool. Permission was sought from the Model of Human Occupation Clearinghouse at the University of Illinois Chicago (Taylor, 2022). Based on the qualitative feedback from phase I, the CLIP was developed for phase II as a brief assessment tool to capture consumer's current leisure interests.

Phase II focused on the development of a self-rated tool to better understand the needs of consumers interests. Self-rated tools are considered to be a patient-centred measure to

allow consumers to express their interests without the bias or feeling of judgement from health professionals (Rohrer et al., 2007). Self-rated tools also provide a sense of autonomy and are a pragmatic tool to engage consumers prior to an appointment time. A content analysis (Graneheim & Lundman, 2004) of the participant responses provided essential information on key areas that required updating. These areas included, types of activity listed on checklist, useability of the checklist (format) and inclusion of categories to explore consumer engagement in leisure ('I don't do this, and I don't want to'). COnsensus-based Standards for the selection of health Measurement INstruments (COSMIN) checklist was included for an additional review of study design quality (Prinsen et al., 2018).

6.3.3 Procedures

All surveys were completed on Survey Monkey, an online survey development platform. The survey was open for approximately eight weeks for each phase. All participants were asked to consent before starting the survey.

Phase I survey included a basic non-identifiable demographic questionnaire and the existing MIC (Kielhofner & Neville, 1983) in its current form, along with open-ended questions seeking feedback about the checklist such as 'can you think of any activities that could be missing from the activity list that you or a friend might do?' and how well it captured contemporary leisure activities. All participants were asked 'do you participate in leisure activities?' at the beginning of the survey to understand their current occupational profile and engagement.

Phase II followed a similar method, though a new checklist was developed based on the activities identified in phase one and a modified question structure. Based on this feedback, a five-point rating scale was developed and timeframes for previous participation (e.g., 10 years) were removed from the survey. The new tool was named the Checklist of Leisure, Interests and Participation (CLIP) to reflect the focus on leisure activities. Participants were asked to use nominal categories to describe their current participation in leisure occupations over the past year. This timeframe allowed for participants to consider a specific time in their life that was relevant to their current routine. This included phrases such as; 'I currently do this' or 'I don't do this and I don't want to do this'. An 'other' category for leisure activities was also included to capture leisure activities that may not have arose in phase one. Participants were also be asked to complete a few questions about the format of the survey and if there is any feedback for improvement on the survey, for example the query, 'Do you have any suggestions on how the tool can be improved?'

Discussion within the research team concluded that like activities would be group to capture a broader range of activities (Christiansen, 1994) which consisted of activities such as ‘adventure activities’, ‘individual sports’ and ‘water activities’. Activities were also changed to ascending alphabetical order. The MIC-UK and subsequent checklists have grouped the activities into nine categories or clusters (Heasman & Salhortra, 2008). There was discussion amongst the research team to create a checklist that grouped like activities, though this may create bias when participants complete the tool. Participants may not consider all activities on the checklist if they were clustered, for example if circus was clustered with sports.

Phase III was comprised of demographics from the general population, the CLIP and some additional open-ended questions.

Phase IV was designed for collecting feedback from practicing occupational therapists, which comprised of demographics, the CLIP and questions about the clinical utility of the tool. Based on recommendations by Smart (2006), clinical utility questions covered time taken, ease of use, efficiency of interpretation, instructions and relevance in practice. Participants were asked to rate their opinion on these topics from 0-10. Participants also rated the tool on a scale of 1-10 on its usefulness in potential practice areas (e.g. mental health) and funding schemes (e.g. National Disability Insurance Scheme Australia (NDIS)). Participants were asked to rank several leisure assessments tools to indicate likelihood of clinical application or use from mostly likely (1) to least likely (6). Tools included in this question were an informal interview, the Canadian Occupational Performance Measure (COPM) (Law et al., 1990), MIC (Kielhofner & Neville, 1983) (MIC), Leisure Satisfaction Scale (Di Bona, 2000), Leisure Interest Profile for Adults (J. C. Hansen & M. G. Scullard, 2002) and the CLIP.

Table 6.1

The Checklist of Leisure, Interests and Participation (CLIP)

	I currently do this	I don't do it anymore, but I'd like to	I have never done it, but I'd like to	I dont do this and I don't want to	Personally, I don't consider this leisure
Adventure activities (e.g. climbing, gliding, surfing, skateboarding)	○	○	○	○	○
Animal Husbandry (e.g. bee keeping)	○	○	○	○	○
Art / Craft	○	○	○	○	○
Athletics (e.g., track and field)	○	○	○	○	○
Babysitting	○	○	○	○	○
Board / card games	○	○	○	○	○
Camping	○	○	○	○	○
Checkers/Chess	○	○	○	○	○
Circus/aerial aerobics	○	○	○	○	○
Colouring-in	○	○	○	○	○
Computer related activities (e.g. games, internet browsing)	○	○	○	○	○
Concerts/festivals	○	○	○	○	○
Cooking/baking	○	○	○	○	○
Cosplay	○	○	○	○	○
Cultural activities	○	○	○	○	○
Cycling	○	○	○	○	○
Dancing	○	○	○	○	○
Dating	○	○	○	○	○
Do it yourself "DIY"	○	○	○	○	○
Driving	○	○	○	○	○
Eating out with friends	○	○	○	○	○
Exercise/fitness/gym	○	○	○	○	○
Fishing	○	○	○	○	○
Foreign languages	○	○	○	○	○
Gardening yard work	○	○	○	○	○
Going for a walk	○	○	○	○	○

Going to a party	◯	◯	◯	◯	◯
Hairstlying / Makeup	◯	◯	◯	◯	◯
Hiking	◯	◯	◯	◯	◯
Home brewing	◯	◯	◯	◯	◯
Home decorating	◯	◯	◯	◯	◯
Horse riding	◯	◯	◯	◯	◯
Ice skating	◯	◯	◯	◯	◯
Individual sports (golf, tennis)	◯	◯	◯	◯	◯
Knitting/sewing/crocheting	◯	◯	◯	◯	◯
Listening to music	◯	◯	◯	◯	◯
Martial arts	◯	◯	◯	◯	◯
Meditation	◯	◯	◯	◯	◯
Motor sports	◯	◯	◯	◯	◯
Movies	◯	◯	◯	◯	◯
Painting/Drawing	◯	◯	◯	◯	◯
Pets	◯	◯	◯	◯	◯
Photography	◯	◯	◯	◯	◯
Puzzles	◯	◯	◯	◯	◯
Reading	◯	◯	◯	◯	◯
Religious or spiritual activities	◯	◯	◯	◯	◯
Renovating	◯	◯	◯	◯	◯
Running / jogging	◯	◯	◯	◯	◯
Sailing	◯	◯	◯	◯	◯
Scrapbooking/card making	◯	◯	◯	◯	◯
Sexual activities	◯	◯	◯	◯	◯
Shopping	◯	◯	◯	◯	◯
Singing	◯	◯	◯	◯	◯
Social clubs	◯	◯	◯	◯	◯
Social networking (e.g. Facebook, Twitter, Instagram)	◯	◯	◯	◯	◯
Social visit with friend	◯	◯	◯	◯	◯
Table tennis/pool	◯	◯	◯	◯	◯
Tai Chi	◯	◯	◯	◯	◯
Team sports (e.g. soccer, basketball, hockey, football)	◯	◯	◯	◯	◯
Vacation	◯	◯	◯	◯	◯

Vehicle restoration	○	○	○	○	○
Video games (e.g. playstation, xbox)	○	○	○	○	○
Visiting a museums	○	○	○	○	○
Volunteer services	○	○	○	○	○
Watching television	○	○	○	○	○
Water activities (e.g. standup paddleboarding, kayaking)	○	○	○	○	○
Water Sports (e.g. swimming, water polo, diving)	○	○	○	○	○
Woodwork/Mending/Fixing	○	○	○	○	○
Writing	○	○	○	○	○
Yoga/pilates	○	○	○	○	○

Other (please specify)

6.3.4 Data Analysis

Quantitative data were analysed using IBM SPSS Statistics 24. Demographic information included age (in years), geographical location (state / province / county, country), and gender were analysed through descriptive analysis. Qualitative data from all phases of surveys were analysed using qualitative content analysis to compile feedback from participants (Graneheim & Lundman, 2004). Data were analysed through Graneheim and Lundman's (2004) content analysis method to determine the key themes that emerged from the participants. Content analysis was conducted in phase I to determine if there was need for a new survey with a contemporary lens (Graneheim & Lundman, 2004). Secondly, the content analysis aimed to review the feedback from participants and implement this in the new leisure interest checklist (Table 6.1).

Internal consistency was measured using Cronbach's alpha, a commonly used measurement of reliability when using a Likert type scale for survey question responses (Gliem & Gliem, 2003; Liamputtong, 2010). This study measured face validity through phase III participant response frequencies (%) on how well they thought the CLIP captured their leisure participation and interest (Liamputtong, 2010). Construct validity and underlying leisure profile clusters were measured by hierarchical cluster analysis (Borgen & Barnett, 1987). Clusters included; interested or not interested and current participation or no participation. Ward's hierarchical agglomerative cluster analysis was used to analyse the 70 leisure activities listed on the CLIP (Borgen & Barnett, 1987; Murtagh & Legendre, 2014).

The cluster models were reviewed by members of the research team based on the dendrograms and collective clinical experience. Researchers ascribed a summary descriptor to each cluster based on the included variables.

Table 6.2

Index of Phrases/Terms Changed Between the Modified Interest Checklist and Contemporary Interest Checklist

Changed		Added Words	Removed Words	Edits / Changes to List
Original	**New Word**			
Attending plays	Movies	Animal Husbandry (e.g. bee keeping)	Speeches/lectures	List is now in ascending order
Auto-racing	Motor sports	Adventure activities (climbing, gliding, surfing, skateboarding)		
Barbeques	Eating out with friends	Going to a party	Housecleaning	
Basketball	Team Sports	Running / jogging	Wrestling	
Car repair	Vehicle restoration	Sailing	Handicrafts	
Child care	Baby sitting	Video games (playstation, xbox)	Laundry/Ironing	
Church activities	Religious activities	Volunteer services	Scouting	

Clubs/Lodge	Social clubs	Eating out with friends	Politics	
Concerts	Concerts / Festivals	Circus/aerial aerobics	Hunting	
Exercise	Exercise/fitness/gym	Hiking	Bird watching	
Football	Team sports	Yoga/pilates	Bowling	
Golf	Individual Sports	Tai Chi	Radio	
Hairstyling	Hairstyling/Make up	Horse riding		
History	Visiting a museum	Cosplay	Science	
Holiday	Vacation	Cultural activities	Traveling	Sports are now grouped into like categories
Home repairs	Renovating	Home decorating	Collecting	
Listening to popular music	Listening to music	Computer related activities (games, internet browsing)		
Parties	Going to a party	Sexual activities		
Pool	Table tennis/pool	Ice skating	Clothes	
Pottery	Art / Craft	Scrapbooking/card making		
Sewing/needle work	Knitting/sewing/crocheting	Do it yourself activity	Listening to classical music	

Swimming	Water Sports	Water activities (standup paddleboarding, kayaking)		
Table games	Board / Card Games	Colouring-in	Playing card	
Tennis	Individual Sports	Going for a walk or run		
Visiting	Social visit with friend	Social networking (Facebook, Twitter, Instagram)	Model building	
Woodwork / Mending	Woodwork/Mending/Fixing	Home brewing	Leatherwork	
		Cooking/baking		
		Meditation		

6.4 Results

6.4.1 Phase I

All completed surveys (n = 101), were included in the final analysis. Respondents were primarily female (70.6%), with the remaining men (23.9%), 'preferred not to say' (5.1%) or 'other' (0.5%). The median age of participants was 39.77 (Min = 18, Q1= 28, Q3 = 50, Max = 68). Participants were predominately located in Australia (70.6%); although due to social media sharing, responses were also collected from Canada (7.1%), United Kingdom (6.6%), United States of America (4.6%), New Zealand (2%), Saudi Arabia (1%), Cayman Islands (0.5%), Greece (0.5%), Peru (0.5%) and Scotland (0.5%). Due to funding limitations the survey was only offered in English.

Participants were asked to provide a response to their participation and engagement in leisure activity. Participants had a choice of responses including 'yes, daily' (55.4%), 'yes,

occasionally' (32.2%), 'yes, not very often' (11.3%), and 'no' I don't do any leisure activities' (1.1%). Participants took on average 10 minutes and 22 seconds to complete the survey.

The content analysis provided a concise analysis of participants suggestions on activities to remove, include or change and formatting of the survey. Participant feedback was included if it was mentioned by multiple participants (more than once). The research team discussed these suggestions, and the best way to implement the feedback to the checklist. The feedback included suggestions such as 'this is too long', removal of IADLs with feedback of 'this is not leisure' or 'I don't think this is leisure'. Some participants suggested that some activities (especially sporting) were missing or repetitive. This prompted the use of an existing activity groups to cluster more specific, and like activities into categories (Tinsley & Eldredge, 1995).

Participants' provided feedback particularly that the language within phase I (MIC) was not typically what they would use in a contemporary context. It was outlined that some of the activities were no longer contextual to modern society and was not representative of general population interests such as 'handicrafts', 'bird watching', 'collecting', 'model building', leather work' and 'listening to classical music'. These activities were often re-framed to a more modern context such as 'listening to music', 'animal husbandry', 'woodwork/mending/fixing', and 'arts and crafts'. Further feedback was particularly around sporting activities, which suggested that certain activities could be removed, added or changed.

Based on the content analysis, 47% of participants suggested the MIC did not provide a wide enough range of current or contemporary occupations that a variety of ages would participate in today. Some of these activities of particular noting were social media engagement, video games, 'do it yourself' and sexual activities. The inclusion of sexual activities is intentionally broad and for the interpretation of the consumer. This activity can be considered self-care or leisurable and is individual to the person. Therefore, these activities were included in the CLIP.

6.4.2 Phase II

The MIC included 4 ratings per activity; interest in the past 10 years, interest in the past year, current participation, and likeliness to pursue in the future. Based on survey feedback, a different rating system was developed for the CLIP to improve time efficiency even with the addition of more activities. The simplified rating scale captured interests and

participation simultaneously with five different options; 'I currently do this', 'I don't do this anymore, but I'd like to', 'I've never done this, but I'd like to', 'I don't do this and I don't want to', and 'Personally, I don't consider this leisure'. The language used in the five-point rating scale was language that is commonly used rather than jargon that may be difficult to understand or misinterpreted by the general population.

Current common leisure activities were included such as computer games, yoga, social networking, and sexual activities, that were not included in previous surveys. IADLs were removed (such as ironing) as they were not perceived as 'leisure' or an interest. Activities of like or similar category were introduced rather than individual activities being listed (Tinsley & Eldredge, 1995). In previous checklists, activities were listed individually such as football and basketball, which were grouped together as team sports and included other like activities.

In phase II, participants were asked 'how much do you value leisure as a regular activity?' A total of 79 participants in the second survey responded to the sliding scale question rated subjectively from 'not important, I'm too busy' (subjective rating of 1) to 'very important for life balance (subjective rating of 10) (mean = 8.171, SD = 1.96). Participants on average took 9 minutes and 3 seconds to complete phase II surveys.

In phase I, 49% participants provided feedback such as suggestion to make activity changes, modify the layout of the survey and question wording. In the phase II survey, 39% participants made similar but new suggestions of feedback to the CLIP including change to activity, layout, and checklist questions.

Participants were asked to complete a star rating (1 star indicating a low score to 5 stars indicating a high score) at the end of each survey with the following question: 'how well do you think this captured your leisure interests?'. All participants in phase I (n = 101) and II (n = 79) provided a response. Phase I responses had a mean = 3.57 (SD = 0.94). Phase II responses had a mean = 4.11 (SD = 0.823).

6.4.3 Phase III

Phase III comprised 295 participants (female, n=210; male; n=82; other, n=3) recruited through paid advertising from the general public. The age of the participants ranged from 18 to 83 years, with a mean age of 48.4 and a standard deviation of 17.4.

Reliability. The internal consistency of the CLIP based on the 295 participant responses from phase III was considered high (Cronbach's Alpha .853) (Groth-Marnat, 2009).

Validity. Participants described that the checklist captured their leisure participation and interests; 18.56% described as ‘excellent’, 54.98% described as ‘good’, 24.91% described as ‘average’, and 2.1% described as ‘poor’. Multiple participants suggested including the activity of playing music and inclusion of a 6th response option as ‘I have tried this, and I don’t want to do this again’. Two participants also reported lack of knowledge on listed occupations such as cosplay and identified there was no responses options for this. The research team discussed this suggestion, and it was decided that the activity would remain on the checklist. The category that would apply to this activity is ‘I don’t do this, and I don’t want to’ or ‘personally, I don’t consider this leisure’. Overall, 74% of participants provided positive feedback indicating good face validity surrounding the CLIP and identified it captured their leisure interests well.

Construct Validity. The dendrogram shown in Figure 6.1 displays the results of the cluster analysis of interest in leisure occupations. Fifteen leisure interest clusters emerged (Table 6.3). Research descriptors were used in the table to describe the interests or commonalities between the clusters that emerged. The dendrogram shown in Figure 6.2 displays the results of the cluster analysis of current participation in leisure occupations. Eight clusters emerged (Table 6.4) and research descriptors were provided to describe some of the links that emerged between the clusters. Crochbach alpha scores were included for internal consistency of each cluster.

Figure 6.1

Dendrogram Results from Hierarchical Agglomerative Cluster Analysis on Interested versus Not Interested CLIP Response Data

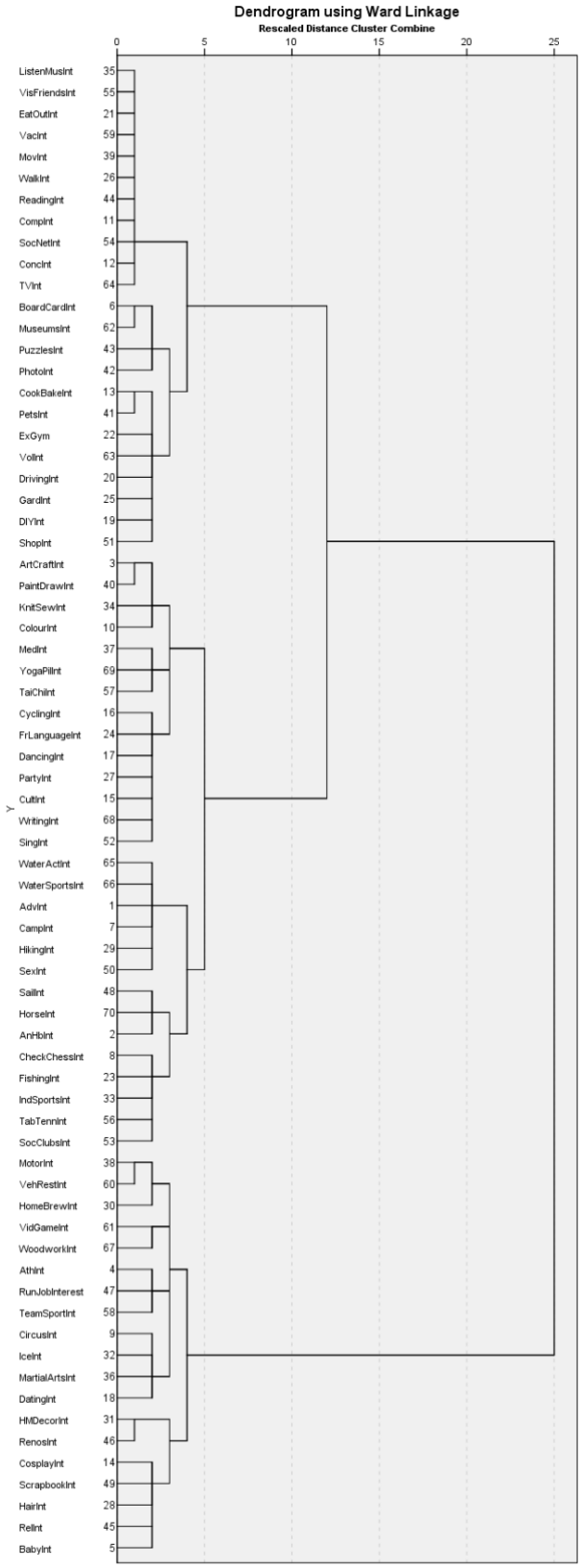
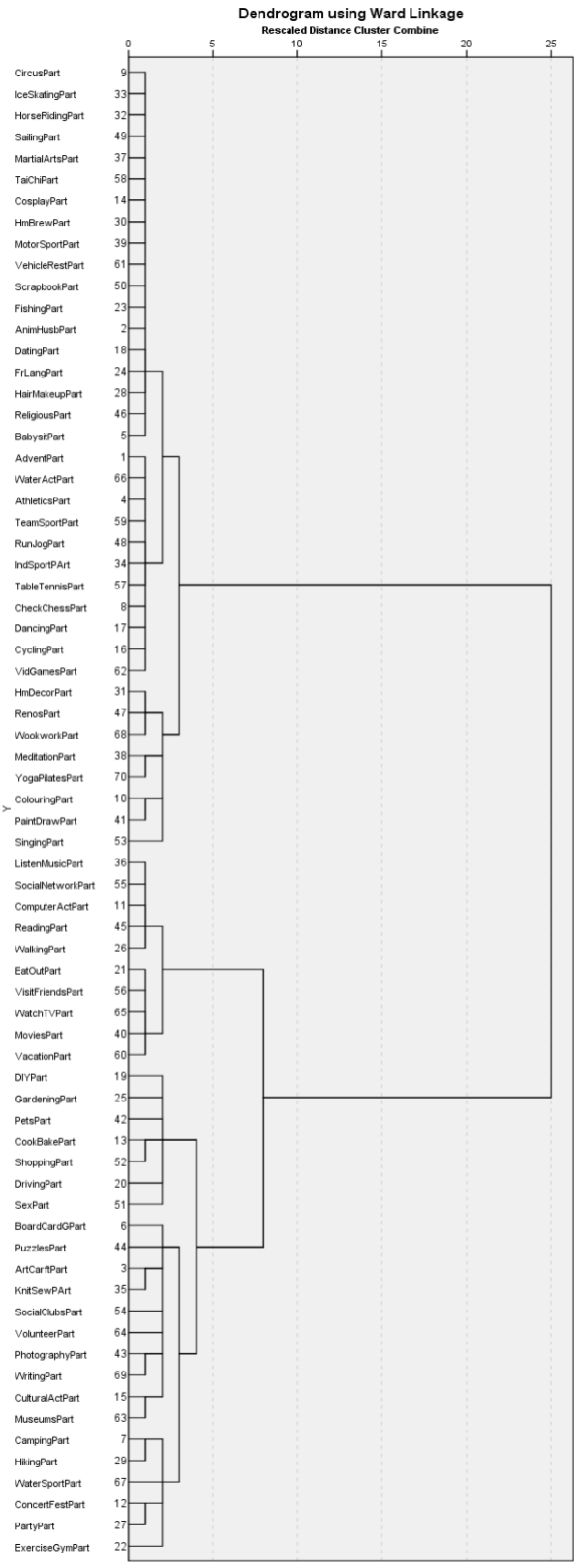


Figure 6.2

Dendrogram Results from Hierarchical Agglomerative Cluster Analysis on Participation versus No Participation CLIP Response Data



6.4.4 Phase IV

Phase IV comprised of 14 practicing occupational therapists (female, n=13). The age of participants ranged from 22 to 60 years (mean age = 31.71; SD = 10.7). The number of years practicing as an occupational therapist ranged from 1 to 16 years (mean = 6.1; SD =6.58). Clinicians were asked a series of questions regarding clinical utility. Occupational therapists indicated the tool had 'ease of use for consumer' (8.1 out of 10), 'complete and clear instructions' (7.8 out of 10) and the lowest rating 'relevance and meaningfulness clinically in contemporary OT practice' (6.8 out of 10).

Occupational therapists indicated a highest confidence and interest in application to clinical practice areas providing a subjective rating of the tool 7 out of 10 or higher. These areas included mental health practice, vocational rehabilitation, and physical disability. Lower ratings (5 out of 10 or lower) for clinical application included paediatric, aged care, intellectual disability, acute physical health hospital and rehabilitation service. There was limited feedback provided on the applicability of the CLIP (or tools alike) in functional assessment for Australian public funded projects (such as NDIS).

Table 6.3

Cluster Results from Hierarchical Agglomerative Cluster Analysis on Interested versus Not Interested CLIP Response Data

Cluster number	Research descriptor	Leisure interests	Cronbach's Alpha
1	Contemporary activities that involve technology, and socialising (n=11)	Listening to music; social visits with friends; eating out; vacations; movies; walking; reading; computer related activities (e.g. internet browsing); social networking (e.g. Facebook); concerts and festivals; watching TV	.511
2	Intellectual and creative activities (n=4)	Board and card games; going to a museum; puzzles; photography	.566
3	Self-improvement based activities (n=8)	Cooking and baking; pets; exercise, fitness or gym; volunteering; driving; gardening; do it yourself; shopping	.594
4	Creative and art-based activities (n=4)	Art and craft; painting and drawing; knitting and sewing; colouring in	.679*
5	Mindful and calming activities (n=3)	Meditation; yoga and pilates; tai chi	.569
6	Activities that include culture, creativity, and	Cycling; foreign languages; going to a party; cultural activities; writing; singing	.569

	the outdoors (n=6)		
7	High-intensity and outdoor based activities (n=6)	Water activities (e.g. kayaking); water sports (e.g. swimming); adventure activities (climbing, gliding, surfing); camping; hiking; sexual activities	.680*
8	Outdoor activities involving nature (n=3)	Sailing; horse riding; animal husbandry (e.g. bee keeping)	.545
9	Activities with competition (n=5)	Chess and checkers; fishing; individual sports (e.g. tennis); table tennis or pool; social clubs	.621*
10	Activities that involve fixing, mending, or creating (n=3)	Motor sports; vehicle restoration; home brewing	.458
11	Activities that include problem solving (n=2)	Video games (e.g. Xbox); woodworking, mending, fixing or furniture restoration	.368
12	Active/exercise based activities (n=3)	Athletics (e.g. track and field); running or jogging; team sports (e.g. soccer)	.636*
13	Physically creative activities (n=3)	Circus or aerial acrobatics; ice skating; dating	.454

14	Home improvement activities (n=2)	Home decorating; renovating	.711*
15	Creative based activities (n=5)	Cosplay; scrapbooking or card making; hairstyling and makeup; religious or spiritual activities (e.g. going to church); babysitting	.393

Table 6.4

Cluster Results from Hierarchical Agglomerative Cluster Analysis on Participation versus no Participation CLIP Response Data

Cluster number	Research descriptor	Leisure interests	Cronbach's Alpha
1	Diverse and varied interests/activities (n=18)	Circus or aerial acrobatics; ice skating; sailing; horse riding; martial arts; tai chi; cosplay; motor sports; vehicle restoration; home brewing; scrapbooking or card making; animal husbandry; fishing; dating; foreign languages; hairstyling and makeup; religion or spiritual activities (e.g. going to church); babysitting	.169
2	Activities with high elements of movement or competition (n=11)	Water activities (e.g. kayaking); adventure activities (climbing, gliding, surfing); athletics (e.g. track and field); individual sports (e.g. tennis); team sports (e.g. soccer); running or jogging; chess or checkers; table	.607*

		tennis or pool; dancing; cycling; video games (e.g. Xbox)	
3	Activities that involve creativity and increased occupational flow (n=8)	Home decorating; renovating; woodworking, mending, fixing or furniture restoration; meditation; yoga or pilates; colouring in; painting or drawing; singing	.599
4	Technology based activities (n=5)	Listening to music; social networking (e.g. Facebook); computer related activities (e.g. internet browsing); reading; going for a walk	.306
5	Activities that are typically enjoyed with others / social (n=5)	Eating out; social visit with friends; watching TV; movies; vacations	.630*
6	Home and self improvement activities (n=7)	Do it yourself; gardening; pets; cooking and baking; shopping; driving; sexual activities	.568
7	Intellectual and creative activities (n=10)	Board and card games; puzzles; art and craft; knitting and sewing; social clubs; volunteering; photography; writing; cultural activities; museums	.678*
8	Outdoor activities (n=6)	Camping; hiking; water sports (e.g. swimming); concert and festivals;	.579

	going to a party; exercise, fitness or gym

6.5 Discussion

6.5.1 Contemporary Tool

This study developed and validated an updated tool inclusive of contemporary leisure activities. The study explored the general population's perspective of a commonly used and existing MIC (Kielhofner & Neville, 1983) standardised tool to determine whether it adequately covers contemporary and modern activities available in the 21st century. During phase I, the content analysis identified there was a lack of contemporary occupation in the current MIC (Kielhofner & Neville, 1983) (Table 6.2). Common feedback regarding the MIC was around the useability and outdated discourse used. For example, often, people continued to engage in activities such as 'listening to popular music' but due to the shift in society's interests, the category of 'listening to classical music' was not a popular choice for most adult participants and there are a diverse range of genres to listen to. The CLIP is targeted at adults aged 18-65 and therefore, activities were combined to simply 'listening to music'. Changes such as 'attending plays' and 'movies' are noted to be different activities but there was a strong indication for the change by participants.

It was also found that some activities had progressed or changed over time due to technological enhancement. In turn, the way the activity is described has also shifted. For example, 'auto-racing' was changed to 'motor sports'. This can be viewed as a minimal change but meets contemporary discourses in today's society.

Other changes such as the introduction of grouping activities into like clusters and ordering the list in alphabetical order of listed activities rather than at random. The introduction of clusters was included in order to facilitate a broader range of activity that may not be listed. The MIC provided specific activities on a list with limited opportunity for consideration of similar or like activities. The clusters assists with discussion with their occupational, leisure or diversional therapists around these preferences. An example of a cluster is 'adventure activities' or 'water sports'. Like or similar activities were grouped into the cluster to reduce repetitiveness.

6.5.2 Construct Validity and Internal Consistency

The CLIP scored very highly compared with previous studies with similar methods including factor analysis and internal consistency on various interest checklists (Heasman & Salhortra, 2008; Kielhofner & Neville, 1983). The majority of the Cronbach's Alphas (17 out

of 23) rated highly for internal consistency (over 0.5). The results of this study indicated that the CLIP demonstrates high internal consistency, good face and construct validity with an emerging trend that the tool will be particularly useful in an Australian occupational therapy context.

Results from analysis provides good evidence for high internal consistency of the CLIP among a sample of adults from the Australian general public. The high internal consistency rating was similar to other versions of an interest checklist (Nakamura-Thomas et al., 2016; Ingeborg Nilsson & Anne G. Fisher, 2006), in addition to and other leisure assessment tools such as the Leisure Interest Questionnaire (Hansen & Scullard, 2002) and the Leisure Satisfaction Scale (Trottier et al., 2002).

There was limited feedback provided regarding improvement of the CLIP which indicated good face validity. Feedback typically suggested removing the category of 'personally, I don't consider this leisure' due to the general assumption that all activities will be considered leisure activities. This category was kept on the checklist to allow people to have a category to indicate activities they are not familiar with or simply not interested in. The 70 included activities were selected based on occupational profiles suggested by members of the general population within an Australian (or western) context. All of the 70 activities included were typically considered leisure and 'common', however, some less popular options such as shopping, or vehicle restoration were still included. This broader inclusion has likely contributed to the high face validity.

The construct validity of the CLIP reveals that while the tool captures interest and participation in discrete leisure activities, there are also 15 clusters of interests and 8 clusters of participation that are both statistically consistent. Most of the Cronbach's Alphas rated with higher internal consistency (over 0.5). Some of the clusters of interests and participation appear to have very diverse interests from a range of leisure activities. These clusters did not rate highly on the Cronbach's Alpha. Clusters that rated highly include activities with high level of competition or outdoor activities. Some of the clusters may also represent the leisure opportunities available in a contemporary or western society. Clusters can be a helpful clinical indicator of other activities individuals may be interested in.

This breadth allows users of the tool to summarise interests within different activity types. Previous studies on interest checklists commonly used factor analysis to reduce the number of variables down to four to six factors (Katz, 1988; Klyczek et al., 1997; Nakamura-Thomas & Yamada, 2011). The only other study that reported higher factors similar to the

clusters found in this study was Norling and Jägnert (1986) (as cited in (I Nilsson & A G Fisher, 2006) who found 18 factors.

There are many assessments that are formalised and currently assess patients' interest or intrinsic motivation to participate in productive and self-care activities (Romli et al., 2019). However, there are limited tools that profile a vast range of leisure occupations that tools that are inventory style offer (Chen & Chippendale, 2018; Yamada, 2002). Standardised assessments are an insightful tool to support clinical reasoning for intervention (Romli et al., 2019). Within the present study, over 98% of participants stated that they currently participate in leisure activities, which supports the need for a leisure tool to further understand a person's occupational preferences, needs and patterns.

6.5.3 Clinical Utility

The cluster analysis may assist practitioners using the CLIP to understand some of the different underlying groups of leisure interests surveyed. Reducing the number of leisure interests' areas from 70 to 15 and participation areas to eight may provide an easier approach to intervention planning. It can be an important consideration when deciding on leisure occupations to include therapeutic goals as consumers may want to participate in leisure occupations based on interest clusters rather than participation clusters.

Previous researchers have highlighted the need for a formal and valid assessment tool for assessing leisure interests and participation (Suto, 1998; Turner et al., 2000). The validity results of this study demonstrate the CLIP's promising contribution to meeting that need. The clinical utility results in the study have shown that the CLIP is a rapid, easy, useful tool that may be especially useful in general or mental health settings. The CLIP can be used as a valid reliable tool for understanding a consumer's leisure profile. Alternatively, as suggested by previous researchers, these leisure interests can be used as a means to meet therapeutic goals (Klyczek et al., 1997; Suto, 1998).

The participant responses from the CLIP could be used to inform leisure, recreation or diversional therapists running leisure programs. Since leisure activities including going to the movies, eating out with friends and computer-related activities had such a high percentage of interest and participation it could potentially be generalised to different populations.

6.5.4 Limitations

The aim of this study was to ascertain the need for a contemporary leisure tool that holds validity within current occupational therapy practice. However, this study is preliminary and further psychometric testing is recommended including validation and

reliability testing. A cluster-analysis with a larger sample from the general population may help to refine the categories of activities and explore relationships between leisure activity interests. This study was a preliminary study generating an updated tool for measuring leisure interests, and participation . Further exploration of other leisure tools such as Leisure Boredom Scale (Iso-Ahola & Weissinger, 1990) and the Nottingham Leisure Questionnaire (NLQ) (Drummond et al., 2001) may also be useful to compare against the CLIP to help confirm its validity to clinical populations and clinical utility.

Within all phases, participants who completed the survey were predominately female which may result in bias toward certain more feminine leisure occupations listed on the CLIP. Cultural diversity and education level were not explored in this study, limiting the ability to conclude leisure preferences associated with the broader general population.

A small sample of occupational therapists participated in phase IV which are unlikely to be a true representation of all occupational therapists in Australia. A potential limitation within was also recruiting occupational therapists only located within Australia. This may skew the data to only show the clinical practice perspective in Australia or a Western perspective rather than a global perspective.

This study used a convenience sampling method through sharing via social media. Those who shared the survey were often occupational therapists and therefore, some participants were likely to also be occupational therapists. Alongside a primarily minority-world sample, this may have culturally biased the tool towards an Australia population that is largely generalised to the Western population (Talbot, & Verrinder, 2017). Furthermore, the recruitment method for all phases will require review in future research and other methods may be more effective for the targeted sample. A suggested recruitment method for future research may include targeted dispersing of the survey for example to occupational therapy professional groups around the world (i.e., World Federation of Occupational Therapy).

Further research within a mental health population would provide insight into the feasibility of the use of the tool within a specific population (Barrios et al., 2018). This tool would be particularly helpful with this population due to the cognitive deterioration and psychosocial issues associated with major mental illness such as schizophrenia and bipolar affective disorder who typically experience functional decline affecting their occupational profile (Barrios et al., 2018; Bejerholm & Eklund, 2004; Bejerholm et al., 2006; Shimitras et al., 2003).

Future use could be using the CLIP as a tool to prompt further understanding on the barriers to participation. Future research should also expand the psychometric analysis of the

CLIP to include different reliability methods such as test-retest and post-hoc analysis to explore relationships within the clusters further.

6.5.5 Clinical Applications

The use of valid and reliable can tools support evidence informed practice (Romli et al., 2019). There is limited range for standardised testing in leisure (Romli et al., 2019; Unsworth, 2000). Therefore, the CLIP is a tool that is likely to have value when part of an informal assessment such as semi-structured interviews. The tool requires further validity testing and generation of normative data to support further research of comparisons of engagement to population norms, but these current results indicate its preliminary applicability to the general adult population within a western context.

Further exploration into targeted groups, such as adolescents / youth (12-17), mental health population, geriatric (65+) populations, and culturally diverse groups would be beneficial. The use of tools and checklists remains relevant for an evidence informed practice that closely aligns with Occupational Therapy Australia practice guidelines (Occupational Therapy Board of Australia, 2018). Ultimately, the role of the occupational therapist is to provide activity-based therapy that is meaningful to the consumer and will be benefit in a therapeutic way. The use of tools such as the CLIP is a pathway to support this practice and sustain consumer-centred practice.

6.6 Conclusion

More than half of participants from survey one provided feedback that there is a need for a contemporary leisure interest checklist with suggestion of specific activities that could be included. The survey was developed called the Checklist of Leisure, Interest and Participation (CLIP), which provides an inventory of modern activities that adults currently participate in. In the second phase, participants provided positive feedback in response to the CLIP with less than 10% suggesting minor changes to the structure of the survey. The CLIP is a leisure inventory that provides a contemporary tool to inform accurate and client-centred information to inform clinical interventions.

6.7 Key Points for Occupational Therapists

- The CLIP may provide insight into current leisure activities interests and participation level.
- The study provides initial evidence that the CLIP is a useful tool for use in Australian context.

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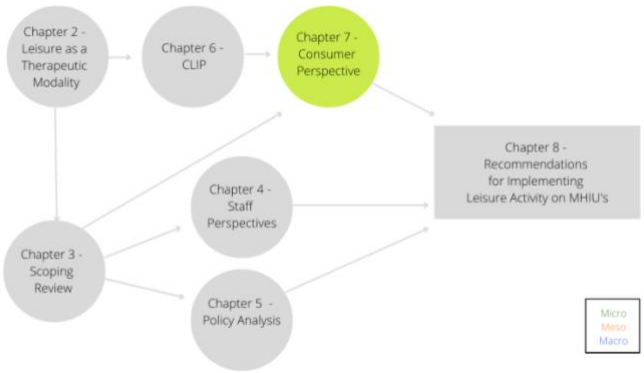
CHAPTER 7 – Investigation of the Consumer Perspective on Leisure Activity Available in Australian Mental Health Inpatient Units



This chapter includes a manuscript of original research of consumer's leisure preferences in MHIUs in southeast Queensland. This chapter is part of section two of the research and addresses aim six in the thesis.

So far in this thesis, it has been established that consumers lack meaningful leisure activity in MHIUs. Consumers with limited activity are found to be bored have prolonged admissions, and slower recovery (Chapman et al., 2016; Chen et al., 2020; Fraser et al., 2016). In chapter four, staff agreed there was limited activity but raised concerns that risk was a major barrier to providing activity. Some staff reported they were unsure how to provide a broader depth of activity beyond arts and crafts.

In this manuscript, consumer's were asked to provide their leisure preferences and provide feedback for improvement in current environments. The two standardised tools and checklist used in the survey included selected questions from the Mental Health Statistics Improvement Program Consumer Survey (MHSIP) (Jerrell, 2006), the CLIP and the Leisure Boredom Scale (Iso-Ahola & Weissinger, 1990).

This project was conducted in collaboration with a team at Queensland Health through Metro South Addiction and Mental Health Services. The team consisted of Dr Theo Theodoros, Thomas Morrison and Associate Professor Manaan Kar Ray. Consumers were surveyed from the Princess Alexandra Hospital, to explore the current leisure preferences, volition, barriers, and facilitators to enable participation. This study reviewed consumers perspectives of leisure activity offered in their locked mental health spaces including the emergency mental health wait room and mental health inpatient unit.

The MOHO explores the individual factors to consumer engagement and the interaction between the individual and environment that impacts engagement (Taylor, 2017). The MOHO model was selected to provide a theoretical understanding of the consumer perspective. With consideration to the MOHO, this manuscript specifically explores the person elements of participation, identity, competence, and the environment. Consumer's provided their perspective of the quantity and range of activities offered in MHIUs which

contribute to their recovery. This chapter contributes to the micro perspective of health which leads into recommendations in the form of practice principles (chapter eight).

This manuscript has been submitted to OTJR Occupation, Participation, and Health. This journal was chosen as the readership is predominately occupational therapists and has a special interest in occupational science. This journal was selected as the readership includes occupational therapists who wish to understand the consumers perspective on barriers to engagement on likely interventions, they provide on MHIUs. OTJR Occupation, Participation and Health has an impact factor of 1.768 and is a Q2 journal. Additionally, to maintain consistency between chapters, the referencing and formatting have been adapted.

7.1 Abstract

Introduction. Engagement in leisure activity can promote wellbeing and recovery of mental health issues. Consumers longitudinally have reported a lack of leisure activity offered in mental health inpatient units and are often found bored which can lead to aggression. This study aimed to explore the barriers to engagement in activity and consumer satisfaction in inpatient settings. Furthermore, the study aimed to understand the facilitators to engagement and identify the leisure interests of consumers in these settings.

Method. Participants who were admitted to mental health inpatient units in Brisbane, Queensland were asked to complete online anonymous surveys to provide feedback on the activities offered. The survey included two standardised tools and a checklist such as the Mental Health Satisfaction Improvement Program (MHSIP), Leisure Boredom Scale (LBS), and the Checklist of Leisure Interests and Participation (CLIP).

Results. A total of 57 participants partially completed the survey with 41 completed responses. The MHSIP achieved high internal consistency (mean = 53.5, SD = 12.52, Cronbach's Alpha = 0.805). The LBS internal consistency was considered moderate (mean = 51.43, SD = 6.447, Cronbach's Alpha = 0.574). Participants reported several barriers to engagement including lack of staff, limited social engagement, limited range of activity, and a lack of resources. The CLIP also achieved high internal consistency (mean = 184.59, SD = 52.419, Cronbach's Alpha = 0.96). The CLIP assisted with collating several suggestions for activities that could be offered in an inpatient setting.

Discussion. Participants reported to be bored due to a limited occupational range offered in the mental health inpatient unit. Consumers can adequately identify leisure interests that are meaningful to them. Participants identified the need for assistance in the facilitation of activity and were more likely to participate with assistance. Student-led clinics targeted

outside of business hours may assist to improve decreased satisfaction and reports of boredom.

7.2 Introduction

Leisure is an activity that is known to be salutogenic (health-creating) and beneficial for one's well-being (Caldwell, 2005; Lindström & Eriksson, 2005). Leisure activity can assist in generating purpose and assist people with consumers recovery from mental health issues (Craik & Pieris, 2006). In this study, we will explore the perspective of consumers regarding the availability and satisfaction of leisure activity in mental health inpatient units (MHIU).

7.2.1 Context of Mental Health Services in Australia

A government-funded or public MHIU provides short-term care for acute consumers with severe and complex mental health issues. Furthermore, MHIUs provide an opportunity for pharmacological review and a place of safety (Scanlan, 2010). There are 161 public and 68 private psychiatric hospitals with MHIUs in Australia (Australian Institute of Health & Welfare, 2022). There are also 1113 public community-based services across the country (Australian Institute of Health & Welfare, 2022). The rate of psychiatric presentations requiring overnight admission within Australia has been increasing by 2.1% per year over the past decade (Health & Welfare, 2022). Since December 2013, according to the Queensland Mental Health Act under sections 309A and 493A, all MHIUs in Queensland are now locked units, irrelevant of whether the consumer has been admitted voluntarily or involuntarily (Queensland Government, 2013).

Mental health inpatient units (MHIU) typically often have limited occupational opportunities to enhance consumers' recovery (Antonysamy, 2013; Marshall et al., 2020). Leisure activity is often used as a distraction technique to support the regulation of mood (Chen & Chippendale, 2018). Currently, in MHIUs, there is little focus outside of pharmacology to reduce symptomology.

7.2.2 Leisure as a Therapeutic Modality

At times, time pressures and self-perceived priority of other activities or tasks in other occupational areas (such as productivity) can create an imbalance in leisure or free time (Yazdani et al., 2018). For people with mental health issues, Craik and Pieris (2006) highlighted that having adequate 'time' was critical for leisure engagement. Some participants in this study reported leisure activities as a regular part of their routine, whilst others used them reactively to avoid stress (Craik & Pieris, 2006). Encouraging consumers to

reflect on their leisure profile and explore meaningful alternatives can be used as a therapeutic modality and an opportunity to open discussion on health-promoting practices (Crosse, 2003; Hammell, 2004; Leufstadius, 2017; Leufstadius et al., 2009). Often, hospitalisation can impact someone's ability to engage in leisure activities from consumers typical occupational profile, forcing them to engage in foreign or personally uninteresting activities that they typically would not do in the community (Foye et al., 2020). Periods of isolation, extended hospitalisation, boredom, or incarceration can impact health and wellbeing due to the reduction of choice and opportunity leading to occupational deprivation (Farnworth & Muñoz, 2009).

7.2.3 Occupational Deprivation

Occupational deprivation can be defined as the inability to engage in meaningful or purposeful activity due to external constraints such as the physical or built environment over an extended period (Wilcock, 2005). This concept is typically applied to forensic mental health settings but can be applied to consumers who are on MHIUs for extended periods and find themselves dissatisfied with their time use (Farnworth & Muñoz, 2009). When a consumer is admitted to a MHIU, there is a sudden shift in their typical routine. Consumers typically find themselves engaging in self-care, rest, or leisure activities on MHIU with limited ability to do productive occupations such as paid employment due to acuity. The choice of activities available may not be aligned with a person's interests, values, or roles. Chapman et al. (2016) found a large portion of consumers' time is described as 'bored' and sedentary.

7.2.4 Literature Review

Consumers who self-rate as being bored and sedentary are more likely to engage in risk-taking behaviours (Farnworth, 1998; Farnworth & Muñoz, 2009; Teychenne et al., 2016). They are also likely to experience increased distress and exacerbation of psychosis or mood disturbances. There is a link in the evidence between lack of cognitive stimulation and increased incidences of aggression, seclusion (Sutton et al., 2013), restraint, and pro re nata (PRN) or intramuscular injection (IMI) medication (Foye et al., 2020). Boredom or lack of activity is closely linked with an increased aggression rate due to a sudden change in cognitive stimulation (Todman, 2003). The Australian Institute of Health & Welfare (2022) reports 8.1 seclusion events per 1000 bed days during 2019-2020 and an average of 4.9 hours in the confined space. This is a decrease from 13.9 seclusion events per 1000 bed days between 2009-2010 as Australia is aiming to eliminate the use of seclusion (Australian

Institute of Health Welfare, 2022). The least restrictive practices are assisting in reducing the rate of seclusion by using this as a last resort (Lombardo et al., 2018; Wilson et al., 2017). Sustere and Tarpey (2019) found consumers believed there was a disparity between staff and consumers on the meaning of least restrictive practices. Consumer recovery was supported through 'positive risk-taking', reduced incidences of seclusion or restraint, and the opportunity to engage in meaningful activities.

Dahlen et al. (2004) established a link between boredom and the external or physical environment. Poorly designed environments can perpetuate the experience of boredom and maladaptive aggressive and sensation-seeking behaviours. This aligns with broader research linking limited occupational opportunity or range of activity and consumer reported boredom (Folke et al., 2018; Foye et al., 2020; Marshall et al., 2020; Wood et al., 2013). Bowser et al. (2018) also suggest there is a variety of reasons that consumers can become bored. One of these is the perception of a monotonous environment, lack of goals or drive, and inability to gain a sense of excitement or enjoyment. Interestingly, their research suggests that boredom in institutional settings (specifically forensic settings) can be from a lack of skills to participate in leisure rather than a limited range of opportunities to engage. The finding from this study indicated barriers to engagement were intrinsic motivation, exacerbated mental health issues, aggression, boredom, and lack of sleep; a restrictive environment, lack of daily responsibilities; and a lack of meaningful activity on offer (Bowser et al., 2018). Over the past 20 years, despite growing evidence linking restrictive environments, boredom, and poorer mental health, there appear to be little change in occupational opportunities provided in locked (mental health or forensic) settings.

Lack of engagement in typical activity (across all domains of occupation including self-care, leisure, and productivity) negatively impacts successful discharge and recovery (Farnworth and Muñoz (2009). There is mixed evidence regarding whether just the availability of allied health influences boredom. Morrison et al. (1996) and Foye et al. (2020) found incidences of boredom were worse on weekends due to the lack of formal activities planned and allied health only available during business hours. Morrison et al. (1996) report consumers remain bored with limited engagement in activity even with access to allied health professionals such as occupational therapy. Further attention to the types of support, environment, and opportunities for occupational engagement may be warranted.

Ng et al. (2020) found sedentary behaviour, increased consumption of tobacco, and unhealthy lifestyle habits can increase the risk of non-communicable diseases. Their study concluded that people with severe and complex mental health issues should engage in

outdoor recreation and sports to increase motivation and participation. However, outdoor activities are rarely viable in inpatient units due to the built environment. There is limited research to explore the specific activities that consumers would like to participate in whilst on MHIUs and the overall impact this would have on consumer experience (Ng et al., 2020). A variety of studies have highlighted the lack of physical activity (Korge & Nunan, 2018) or a variety of meaningful activities (Farnworth & Muñoz, 2009) with a strong emphasis on arts and crafts (Ng et al., 2020). While the arts have an established therapeutic role (Van Lith, 2016), leisure availability should be broad and tailored toward the needs of the consumers.

As a health care system, a cultural shift in the physical and social environment of MHIUs needs to occur to create occupational opportunity that is essential for mental health recovery (Whiteford et al., 2020). The literature suggests there are many barriers to engagement in meaningful occupations resulting in occupational deprivation and boredom. Some of the barriers found in the literature were a lack of allied health provided beyond business hours, a monotonous environment, and a limited range of activity provided. This research aimed to explore consumer's perspective on barriers to engagement and overall satisfaction with the activities currently offered. Furthermore, this study aimed to understand facilitators to leisure and the activity preferences of adult mental health consumers in Australia.

7.3 Materials and Methods

This study used a mixed-methods approach to explore consumers' perspectives (Creswell et al., 2008) of leisure on MHIUs. Current consumers in MHIUs completed an online survey. Ethical approval was received from Queensland Health, Metro South Health Ethics Committee (project number HREC/2021/QMS/76198), and the University of Southern Queensland (USQ) Human Research Ethics Committee (project number H21REA304).

7.3.1 Sample

Participants were recruited from the MHIUs at the Princess Alexandra Hospital, Brisbane, Queensland, Australia. Participants were surveyed across the five MHIUs, including emergency mental health, a mixed gender unit, one female only unit, one male only unit, and a high dependency unit. Data was collected in mixed and single-gender (male or female) MHIUs and the emergency mental health wait room. Consumers were invited to participate in the survey and participation was voluntary. No incentive was given for participation. It was the assumption that all consumers who were admitted to the public MHIU had severe and complex issues due to the threshold of admission criteria for public

health facilities. Consumers were not assessed for suitability prior to completing the survey. Inclusion criteria required participants to be over 18 years old; with experience of being a consumer on a MHIU and having stayed overnight for more than 48 hours in a locked MHIU within the past five years. Participants were excluded from participating under the age of 18 (considered child, youth, or adolescent).

A sample size calculation was completed using the methods described by Charan and Biswas (2013). The standard normal variate selected was 1.96 (i.e., corresponding to a type 1 error of 5%). The sample size based on these parameters was 36 participants. As the survey is lengthy and is targeting acutely unwell consumers, this was considered adequate.

7.3.2 Survey Design

Participants were asked to complete a survey through an online survey platform, Survey Monkey. The research participant information was provided at the beginning of the survey. Consumers were asked a question related to consent to continue. Participants' IP addresses and names were not recorded for anonymity. Demographic data included information such as their age, geographical location (Country, State/Province, Post / Zip Code), and mental health diagnosis. Consumers' responses were anonymous which allowed them to provide feedback on the inpatient unit without bias or judgement. We believe this assisted to provide authentic feedback.

Participants were provided with a definition of leisure to provide context and meaning to the questions. The definition provided was “leisure is considered an enjoyable activity that is not work or productive activity which you choose to participate in your spare time. Furthermore, leisure may also be activity that can be relaxing, fun and support health in a therapeutic way”.

The surveys included a combination of tools and open-ended questions. This included:

- The Mental Health Statistics Improvement Program (MHSIP) 21-Item Consumer Survey (Howard et al., 2003)
- Checklist of Leisure Interests and Participation (CLIP)
- Leisure Boredom Scale (Iso-Ahola & Weissinger, 1987, 1990)
- Open-ended questions regarding participants perception of activities available in an inpatient unit

The open-ended questions to gain consumers’ perspectives included:

- How did you keep yourself engaged in leisure on the inpatient unit or in the mental health wait room?

- What activities were available to you whilst you were inpatient or in the mental health wait room?
- What stopped you from engaging in leisure activities on the inpatient unit or in the mental health wait room?
- What changes would most improve your access to leisure activity on the mental health inpatient unit or in the mental health wait room?

7.3.3 Tools and Checklist Used

Two standardised tools and a checklist were used in this survey. The first tool was the MHSIP which explored the contextual factors of participation. The Mental Health Statistics Improvement Program (MHSIP) 21-Item Consumer Survey has shown acceptable reliability and validity for eliciting consumer perspectives on the overall quality of care (Howard et al. (2003). This was important to understand consumer satisfaction on MHIUs and whether this meets what service is currently being delivered.

The second tool was the Checklist of Leisure Interests and Participation (CLIP). This checklist was adapted from the Modified Interest Checklist (MIC) (Kielhofner, & Neville, 1983) and explored the interests of consumers within the past year. The CLIP was developed by the authors to elicit information about leisure interests and participation across a comprehensive range of contemporary activities. In developing this checklist, previous studies identified good reliability (n=295 healthy controls, Cronbach's Alpha = 0.853) and good validity (n=14 practising occupational therapists). The CLIP asked consumers to consider their leisure interests over the past twelve months.

The Leisure Boredom Scale is also considered to be a valid and reliable tool (Iso-Ahola & Weissinger, 1990). Iso-Ahola and Weissinger (1990) conducted three studies to reach this conclusion. Study one consisted of 171 participants (mean = 2.89, SD = 0.869, Alpha = 0.850); study two consisted of 164 participants (mean = 2.10, SD = 0.555, Alpha = 0.879) and study three consisted of 344 participants (mean = 2.10, SD = 0.474 and Alpha = 0.863.

7.3.4 Procedures

All recruitment was at the mental health wait room or in the MHIUs at the Princess Alexandra Hospital. Consumers in these locations were acutely unwell with severe and complex mental health issues. All of these locations were considered 'locked' and there was a mixture of voluntary and involuntary consumers (Queensland Government, 2016).

Initially, posters were placed in all the MHIUs with a QR code asking for volunteers to complete the survey. There was little uptake with this method, so consumers were directly offered the opportunity to participate with an electronic tablet by JL. Many consumers asked for a reward for participating and opted to not engage when learning there wasn't one. Consumers' capacity to participate was assessed by nursing staff on the MHIUs in conjunction with the first author. Consumers completed the survey at their own pace through an electronic tablet or on their own device.

7.3.5 Data Analysis

Statistical analysis of participant demographic information and questionnaires was analysed through Statistical Package for the Social Sciences (SPSS) version 26. Descriptive statistics were used to analyse standardised questionnaires.

Qualitative data which included the open-question responses were analysed through content analysis in Microsoft Excel. Content analysis was chosen to identify like concepts and themes in the data (Graneheim & Lundman, 2004). All responses were collated in Microsoft Excel. Raw data was placed in a meaning unit category and further condensed or paraphrased. The first author then coded the condensed meaning units into categories and then like themes.

Primary descriptive statistics assisted to analyse like terms or frequency of concepts such as suggested activities by participants. These responses were tabulated and concept counting occurred.

Rigour was enhanced through the use of an audit trail and 'critical friend' (i.e., review of coding by other authors) methods during the analysis of qualitative data (Deuchar, 2008).

7.4 Results

7.4.1 Participants

The survey was completed with 57 partial responses by participants and 41 completed responses. Partial responses included consumers who entered the survey but had spent less than 48 hours in the inpatient unit, so the survey ended after question two. Other partial responses were due to consumers entering the survey and stopping. On average, the survey took 14 minutes and 30 seconds to complete. All participants identified they were in Brisbane, Queensland. Participants identified as female (51.52%), male (45.45%), and other (3.03%). Most consumers were between the age of 18-24 (34.38%), followed by 25-34 (21.88%), 35-44 (25%), 45-54 (9.38%), 55-64 (6.25%) and 65+ (1%).

Participants were asked ‘what is your understanding of your mental health diagnosis?’. This was a multiple-choice answer. Responses included depression (18.75%), anxiety such as generalised anxiety and obsessive compulsive disorder (15.63%), personality disorders such as borderline type (6.25%), schizophrenia (6.25%), schizoaffective (3.13%), bipolar affective disorder (25%), other mood disorders (6.25%), other psychotic disorders (9.38%) and none of the above (9.38%). Participants could also include a free text option. Some of the written responses included ‘human’(1), ‘opinionated’(1), ‘anorexia nervosa’ or ‘eating disorder’ (4), ‘post-partum depression’(1), ‘paranoia’(1), ‘mania’(1), and ‘ADHD’(1).

7.4.2 Consumer Perspectives

Most consumers reported they were dissatisfied with the leisure activity available on the MHIU (average rating of 4.5 out of 10 on leisure availability with 0 indicating no opportunity). A majority of consumers reported leisure to be of high value to them. Participants rated the value based on a sliding scale from 0-100 (mean = 79.97, SD = 27.92). Participants identified some of the current activities available included 'walking the hallways', 'talking to others', 'basketball', 'listening to music', 'watching television', 'board games', and utilising their mobile phones for activities such as Netflix (television streaming service) or games. On average, participants identified three activities currently offered on the MHIUs. All participants except one, provided activities currently available on the MHIU.

A summary of the results for the MHSIP is collated in Table 7.1. Responses have been categorised as positive (‘strongly agree’ or ‘agree’), neutral, or negative (‘strongly disagree’ or ‘disagree’). The internal consistency of the MHSIP was calculated in Howard et al. (2003) study using Cronbach’s Alpha (0.96). This study has comparative findings and also achieved high internal consistency (mean = 53.5, SD = 12.52, Cronbach’s Alpha = 0.805).

A summary of the responses associated with the Leisure Boredom Scale can be found in Table 7.2. Similar to the table relating to the MHSIP, responses were categorised from the 5-point Likert scale to positive, neutral, and negative. Iso-Ahola and Weissinger (1990) reported a high internal consistency in their study (mean = 2.10, SD = 0.474, Cronbach’s Alpha = 0.86). The internal consistency for this scale was considered moderate (mean = 51.43, SD = 6.447, Cronbach’s Alpha = 0.574).

A summary of the CLIP can be seen in Table 7.3. Internal consistency was also considered high in the CLIP (mean = 184.59, SD = 52.419, Cronbach’s Alpha = 0.96).

Table 7.1

Mental Health Statistics Improvement Program Results

	Positive	Neutral	Negative
Satisfaction			
If I had other choices, I would still get services from this agency.	10 (31.3%)	14 (43.8%)	8 (25%)
I liked the services that I received there.	10 (31.3%)	16 (50%)	6 (18.8%)
I would recommend this agency to a friend or family member.	8 (25%)	14 (43.8%)	10 (31.3%)
Access			
Staff were willing to see me as often as I felt it was necessary.	10 (31.3%)	17 (53.1%)	5 (15.6%)
Services were available at times that were good for me.	8 (25%)	19 (59.4%)	5 (15.6%)
I was able to get all the services I thought I needed.	6 (18.8%)	18 (56.3%)	8 (25%)
Appropriateness			
I was encouraged to use consumer-run programs (support groups, drop-in centres, crisis phone line, etc.).	7 (21.9%)	16 (50%)	9 (28.1%)
Functioning			
I did things that were more meaningful to me.	11 (34.4%)	15 (46.9%)	6 (18.8%)

I am better able to take care of my needs.	8 (25%)	19 (59.4%)	5 (15.6%)
Outcomes			
I deal more effectively with daily problems.	8 (25%)	18 (56.3%)	6 (18.8%)
I deal better in social situations.	9 (28.1%)	21 (65.6%)	2 (6.3%)
My symptoms are not bothering me as much.	10 (31.3%)	17 (53.1%)	5 (15.6%)
I am better able to do things that I want to do.	9 (28.1%)	17 (53.1%)	6 (18.8%)
Participation			
I, not staff, decided my treatment goals.	8 (25%)	15 (46.9%)	9 (28.1%)

7.4.3 Barriers

Participants were provided a sliding scale (rated from 0 indicating 'limited activity' to 100 indicating 'a lot of activity)) on their ability to currently engage in leisure activity on MHIUs (mean = 45.73, SD = 31.96). Some of the barriers suggested by participants that prevented them from engaging in leisure activity included lack of motivation, drowsiness or sedation, no one to do an activity with, poor attention span, staff limitations or restrictions (i.e., not enough staff, or eating disorder consumers not being allowed to engage in activity) and time. Most of the participants believed 'it would be great' to have more variety of activities. Four participants reported there was limited activity to engage in with eating disorder related issues. On average, participants provided one to two barriers they could identify that prevented them from engaging in activity. Participants typically indicated the factors preventing them from engagement were either internal (e.g. motivation, mental illness, sedation) or external factors (e.g. environment, time, lack of activity offered, mental health act). An equal number of participants indicated internal and external factors as barriers to engagement which aligns with the findings from Bowser, et al. (2018). One participant reported:

> "Weekends are very boring here on the ward because there are no activities, no rec officers, the day is sluggish because there is nothing to break the day up or look, forward to, [and] the nurses are too busy to interact or chat with patients."

Throughout multiple free-text options, participants suggested their mental health act status as a barrier to engagement with an example such as limited community treatment preventing them from leaving the inpatient unit. Some compare their experience to a prison stating, *"less of making us feel we are in prison[ment]"*. This is consistent with findings from the literature (Whiteford et al., 2020).

7.4.4 Satisfaction

Interestingly, a majority of participants reported to be either 'very satisfied' (24.24%) or 'somewhat satisfied' (36.36%) with the level of activity. The remainder of consumers were 'neither satisfied nor dissatisfied' (15.15%), 'somewhat dissatisfied' (12.12%), or 'very dissatisfied' (12.12%). A participant stated:

> "There are craft activities however they are only run for approximately an hour each and it is very repetitive, and for someone who stays here for a long duration the range of activities can be very boring and you begin to become disengaged."

All variables were tested to determine potential associations. Associations were conducted against like variables for example satisfied versus dissatisfied and engaged versus disengaged. All questions that explored these factors were analysed using Somers'd in SPSS. There was a statistical significance between participants who selected disagreed with the statement 'if I had choices I would still get services from this agency' and 'I am better able to do the things I want to do' in the MHSIP ($t = 3.426$, $p = <0.001$). This was also relevant for the association between participants who disagreed with 'I liked the services I received there' and 'I am better able to do the things I want' ($t = 3.577$, $p = 0.001$) in the MHSIP. Similarly, participants who reported being dissatisfied with the level of activity offered (in the MHSIP) also reported being unable to engage with the activity available (in the LBS) ($T = 3.677$, $p = <0.001$). There was statistical significance of participants who disagreed with the statement 'I am better able to take care of my needs' in the MHSIP and agreed 'during my leisure time, I feel like I'm just spinning my wheels' in the LBS ($T = 2.962$, $p = <0.03$). Other associations that were expected to be statistically significant but weren't included 'overall, how satisfied or dissatisfied were you with the level of leisure activities offered on the mental health inpatient unit or in the mental health wait room?' and 'how would you rate your ability to engage in leisure activity on the inpatient unit or in the mental health wait room?' ($t = 10.996$,

p = <0.001). Another result that was not statistically significant was ‘I liked the services that I received there’ and ‘I am better able to do things that I want to do’ (t = 3.577, p = <0.001).

Table 7.2

Leisure Boredom Scale Results

Criteria	Positive	Neutral	Negative
For me, leisure time just drags on and on.	8 (25%)	10 (31.3%)	14 (43.8%)
During my leisure time, I become highly involved in what I do.	21 (65.6%)	9 (28.1%)	2 (6.3%)
Leisure time is boring.	4 (12.5%)	10 (31.3%)	18 (56.3%)
If I could retire now with a comfortable income, I would have plenty of things to do for the rest of my life.	19 (59.4%)	8 (25%)	5 (15.6%)
During my leisure time, I feel like I'm just ‘spinning my wheels	8 (25%)	14 (43.8%)	10 (31.3%)
In my leisure, I usually don’t like what I'm doing, but I don’t know what else to do.	8 (25%)	12 (37.5%)	12 (37.5%)
Leisure time gets me aroused and going.	15 (46.9%)	14 (43.8%)	3 (9.4%)
Leisure experiences are an important part of my quality of life.	23 (71.9%)	7 (21.9%)	2 (6.3%)

I am excited about leisure time.	18 (56.3%)	12 (37.5%)	2 (6.3%)
In my leisure time, I want to do something, but I don't know what to do.	14 (43.8%)	12 (37.5%)	6 (18.8%)
I waste too much of my leisure time sleeping.	9 (28.1%)	9 (28.1%)	14 (43.8%)
I like to try new leisure activities that I have never tried before.	18 (56.3%)	10 (31.3%)	4 (12.5%)
I am very active during my leisure time.	16 (50%)	9 (28.1%)	7 (21.9%)
Leisure time activities do not excite me.	5 (15.6%)	10 (31.3%)	17 (53.1%)
I do not have many leisure skills.	12 (37.5%)	7 (21.9%)	13 (40.6%)
During my leisure time, I almost always have something to do.	18 (56.3%)	11 (34.4%)	3 (9.4%)

7.4.5 Facilitators

Facilitators or changes that would most improve consumer engagement identified by participants at the time of the data being collected included having others to engage in activities with them, more freedom to use the spaces, more activities, more music, more staff, introducing physical activities such as gym equipment or daily walks, more encouragement to engage and more opportunity to engage in therapies such as art therapy, or mindfulness. Each participant provided one to two suggestions on average. One participant stated:

> "There needs to be special activities for those with eating disorders that are therapeutic to the disorder such as cooking (they do this is other inpatient facilities

> and it can greatly help overcome textures with food, teaches life skills, and is an exposure technique that can also be made fun, I've done it in the last and it teaches you a lot and gives you ideas for when you are discharged)."

Another participant stated "better support and encouragement. More space."

Participants provided feedback, in the free-text options of the survey, for leisure activities they would like to see in the MHIUs. Suggestions included group sessions to improve coping strategies; cooking groups (which would assist to improve community-based skills); gardening groups (this could have a sensory informed approach with herbs and flowers); music in the courtyard; increasing the number of group sessions per day (to more than one); independent activity resources (such as pencils, colouring-in books, sudoku, crosswords, word searches, chalk, etc), 'game nights' such as bingo or trivia; photography and golf. This is consistent with the findings from the CLIP (see table 7.3). 53.33% of participants indicated they currently engage in colouring in, 10% stated they 'don't this but they'd like to', and 10% said 'I have never done this, but I'd like to'. 70% of participants indicated they enjoy computer games. 93% of consumers indicated they enjoy social visits with friends, and they currently or would like to do this. 75.86% of participants indicated an interest in photography. The preferences from the CLIP indicate this cohort of consumers activity preferences which would assist with planning and development of activities on MHIUs.

Participants were given a free text option to provide general and overall feedback on the MHIU after the survey. Suggestions were analysed using content analysis to generate themes (Drisko & Maschi, 2015). 54% of participants had no further feedback. Some of the feedback from participants was not able to be interpreted (reflecting the cognitive challenges of the participants, and cognitive fatigue by the end of the survey) and was excluded from the analysis. The remainder of the feedback (46% of participants) provided one to two suggestions such as more activity or more engagement with staff. The general theme from the feedback provided was the need for more variety of activities and more physical activity. One participant suggested the use of volunteers or students to assist with the implementation of these groups. Another major theme that arose from the feedback was the need for more staff.

> "I would like to have more physical activity and introduce safe programs. Help the patients to participate with volunteers or students. This study should implement recommendations and I wish to see change on this unit to promote leisure activities."

Table 7.3

Results from Checklist of Leisure Interests and Participation Based on Consumer Interests in the Past Year

Activity	I currently do this	I don't do it anymore, but I'd like to	I have never done it, but I'd like to	I don't do this, and I don't want to	Personally, I don't consider this leisure
Adventure activities (e.g. climbing, gliding, surfing, skateboarding)	22.58%	25.81%	19.35%	19.35%	12.90%
Animal Husbandry (e.g. beekeeping)	9.68%	19.3%	29.03%	29.03%	12.90%
Art / Craft	38.71%	22.58%	12.90%	19.35%	6.45%
Athletics (e.g. running, track and field)	29.03%	22.58%	6.45%	25.81%	16.13%
Babysitting	19.35%	12.90%	9.68%	29.03%	29.03%
Board/card games	54.84%	12.90%	9.68%	12.90%	9.68%
Camping	22.58%	38.71%	16.13%	9.68%	12.90%
Checkers/Chess	35.48%	19.35%	9.68%	22.58%	12.90%
Circus/aerial acrobatics	10.00%	13.33%	23.33%	36.67%	16.67%
Colouring-in	53.33%	10.00%	10.00%	13.33%	13.33%
Computer-related activities (e.g. games, internet browsing)	70.00%	10.00%	10.00%	10.00%	0.00%
Concerts/festivals	33.33%	43.33%	10.00%	10.00%	3.33%
Cooking/baking	56.67%	23.33%	6.67%	10.00%	3.33%

Cosplay	10.00%	0.00%	20.00%	40.00%	30.00%
Cultural activities	33.33%	16.67%	23.33%	16.67%	10.00%
Cycling	20.00%	20.00%	16.67%	20.00%	23.33%
Dancing	30.00%	26.67%	16.67%	16.67%	10.00%
Dating	20.00%	10.00%	26.67%	20.00%	23.33%
Do it yourself activity	56.67%	3.33%	20.00%	10.00%	10.00%
Driving	51.72%	17.24%	13.79%	0.00%	17.24%
Eating out with friends	41.38%	20.69%	13.79%	13.79%	10.34%
Exercise/fitness/gym	48.28%	17.24%	17.24%	10.34%	6.90%
Fishing	10.34%	10.34%	20.69%	13.79%	44.83%
Foreign languages	31.03%	6.90%	13.79%	17.24%	31.03%
Gardening yard work	31.03%	24.14%	20.69%	10.34%	13.79%
Going for a walk or run	75.86%	10.34%	6.90%	3.45%	3.45%
Going to a party	48.28%	20.69%	10.34%	10.34%	10.34%
Hairstyling / Makeup	27.59%	13.79%	24.14%	17.24%	17.24%
Hiking	24.14%	27.59%	13.79%	10.34%	24.14%
Homebrewing	6.90%	6.90%	20.69%	24.14%	41.38%
Home decorating	20.69%	48.28%	17.24%	6.90%	6.90%
Horse riding	10.34%	34.48%	34.48%	6.90%	13.79%
Ice skating	13.79%	27.59%	24.14%	17.24%	17.24%
Individual sports (e.g. golf, tennis)	25.00%	35.71%	17.86%	7.14%	14.29%
Knitting/sewing/ crocheting	13.79%	20.69%	13.79%	20.69%	31.03%

Listening to music	72.41%	10.34%	13.79%	3.45%	0.00%
Martial arts	13.79%	13.79%	27.59%	20.69%	24.14%
Meditation	31.03%	20.69%	17.24%	17.24%	13.79%
Motorsports	10.34%	17.24%	13.79%	20.69%	37.93%
Movies	65.52%	17.24%	6.90%	6.90%	3.45%
Painting/Drawing	44.83%	20.69%	6.90%	13.79%	13.79%
Pets/livestock	34.48%	24.14%	13.79%	6.90%	20.69%
Photography	41.38%	20.69%	13.79%	10.34%	13.79%
Puzzles	48.28%	3.45%	13.79%	20.69%	13.79%
Religious activities	34.48%	6.90%	10.34%	20.69%	27.59%
Renovating	24.14%	24.14%	17.24%	13.79%	20.69%
Running/jogging	34.48%	17.24%	10.34%	10.34%	27.59%
Sailing	13.79%	6.90%	24.14%	20.69%	34.48%
Scrapbooking/card making	20.69%	20.69%	13.79%	17.24%	27.59%
Sexual activities	44.83%	20.69%	6.90%	6.90%	20.69%
Shopping	57.14%	17.86%	17.86%	0.00%	7.14%
Singing	41.38%	13.79%	17.24%	10.34%	17.24%
Social clubs	37.93%	10.34%	27.59%	13.79%	10.34%
Social networking (e.g. Facebook, Twitter, Instagram)	62.07%	6.90%	6.90%	10.34%	13.79%
Social visit with a friend	72.41%	13.79%	6.90%	6.90%	0.00%
Table tennis/pool	44.83%	24.14%	17.24%	6.90%	6.90%

Tai Chi	20.69%	6.90%	17.24%	27.59%	27.59%
Team sports (e.g. soccer, basketball, hockey, football)	27.59%	27.59%	10.34%	17.24%	17.24%
Television	58.62%	10.34%	6.90%	13.79%	10.34%
Vacation	53.57%	25.00%	10.71%	0.00%	10.71%
Vehicle restoration	17.24%	10.34%	13.79%	20.69%	37.93%
Video games (e.g PlayStation, Xbox)	37.93%	6.90%	6.90%	20.69%	27.59%
Visiting a museum	31.03%	17.24%	10.34%	17.24%	24.14%
Volunteer services	24.14%	31.03%	17.24%	6.90%	20.69%
Water activities (stand-up paddleboarding, kayaking)	17.24%	17.24%	27.59%	17.24%	20.69%
Water Sports (e.g. swimming, water polo, diving)	31.03%	20.69%	10.34%	10.34%	27.59%
Woodwork/Mending/Fixing	17.24%	17.24%	20.69%	10.34%	34.48%
Writing	34.48%	17.24%	13.79%	20.69%	13.79%
Yoga/pilates	24.14%	24.14%	17.24%	17.24%	17.24%

7.5 Discussion

This study explored consumer preferences to leisure activity on MHIUs. This study supported findings from Bowser et al. (2018) that there are multiple factors that impact consumer engagement in leisure activity on MHIUs. Several barriers were listed by participants including staff (time availability and shortages), limited range of activities beyond crafts, and lack of activity beyond business hours, to name a few. This was particularly highlighted in the findings of the MHSIP (Table 7.1) and LBS (Table 7.2) tools.

Participants tended to provide a positive (34.4%) or neutral (46.9%) response to question 'I did things that were more meaningful to me' on the MHSIP. This may be due to ambivalence around what is offered or may indicate that internal factors are a larger issue than the limited activities offered.

Participants highlighted difficulty engaging in activities with limited people able or willing to enjoy activities. Participants also indicated there were multiple internal factors that are barriers to engagement boredom. This was also demonstrated during the recruitment of surveys. Participants were more likely to complete the survey if someone was assisting them and facilitating the activity. Participants listed some barriers to participating including drowsiness and lack of motivation. An important finding during the data collection and reports from participants was consumers were more likely to engage when encouraged or assisted. Therefore, regardless of the activities on offer, consumers may be more likely to engage in activity with prompting or someone to participate with. Even though consumers reported there was a lack of available activity to participate in, the internal factors may need to be considered as equally important. Staff may be able to assist with some of these factors and focus therapy towards improving intrinsic motivation, reviewing levels of sedation, and provide encouragement.

Participants indicated they were mostly satisfied with the level of activity offered on MHIUs but in free-text options indicated they were 'bored' or 'there's nothing to do'. There was some disparity between what was reported in the free-text boxes and what participants indicated on the tools or checklists. Some of consumers reported they enjoyed the lack of stimuli or need to engage in activity as this supported their ability to improve in their mental state. Others suggested that this was a barrier for their recovery.

Participants also reported a lack of leisure activity available on weekends or outside of business hours which was consistent with the findings of Morrison et al. (1996) and Foye et al. (2020). One of the potential solutions that is low to no cost for an inpatient setting is utilising interdisciplinary students to host 'clinics' during their placement. Kent and Keating (2013) explored the benefits of an after-hours interprofessional student-led clinic with consumers who were recently discharged from the hospital. The results indicated consumers who participated in the study were satisfied with their experience and believed the service to be patient-centred (Kent & Keating, 2013). The use of interdisciplinary students (such as occupational therapy, exercise physiology, social work, and nursing) may assist with the facilitation of activity and likely improve the engagement of consumers without placing a further burden on the multi-disciplinary staff. Furthermore, a student clinic targeting out-of-

hours care may assist in filling a gap of limited activity offered beyond business hours. Additionally, social engagement was identified as meaningful and purposeful for consumers. Engagement and facilitation of activity with consumers should be considered an essential part of each member within the multi-disciplinary team. Students may assist to fill the void of social engagement some participants reported.

Consumers report a need for greater support from staff and improved social connectedness. Consumers also reported a barrier to engagement was the built environment and more time allocated from staff. Wilson's et al. (2018) findings suggested the need to review the role of staff, the built environment, and the need to provide occupational opportunity on MHIUs. Furthermore, Wilson's, et al. (2018) conclusions suggest improvements in the environment like access to meaningful activity and improvement of communication from staff, may lead to reducing the necessity for seclusion and restraint.

Often nursing staff report they are inundated with their documentation and other responsibilities which reduces their capacity to engage with consumers in a meaningful capacity (Whittington & McLaughlin, 2000). Conclusions can be drawn that consumers would benefit from more meaningful engagement and social connection with staff to create a recovery-oriented environment. Facilitation and exploration of the nursing role from a governance or macro perspective would assist nurses to provide meaningful engagement within the scope of their role.

Consumers should be provided with occupational opportunity that facilitates recovery and engages them. The CLIP was used to gain tangible leisure preferences from consumers to understand what leisure activity could be offered on MHIUs. The CLIP provided insight into leisure interests that most of the participants reported being interested in (Table 7.3). A recommendation for some activities that could be offered has been included to provide services an opportunity to explore what they currently offer and potential resources. The CLIP is a useful tool for consumers to complete to cater for individual needs whilst on the MHIU. Some of the activities that would be realistic and suitable to implement in an Australia MHIU based on the CLIP are cooking/baking; computer-related activities (this could include simulated or virtual reality with a particular interest in golf, exercise, and driving); eating meals with friends (family and friend mealtimes could assist in increasing social opportunity); going for a walk or run, listening to music; meditation; movies; painting and drawing; pets (animal-assisted therapy); puzzles; religious activity; singing; table tennis (competitions could be used to create a sense of community and improve social engagement);

television; writing and yoga or Pilates. Each of the tools presented valid findings on the issues present in MHIUs.

7.5.1 Limitations

This study had some limitations but overall, achieved the aims of the study. The data in this study was collected at one hospital in Brisbane, Australia, therefore the results may not be generalised to all mental health inpatient units or the consumer population in Australia. Consumers were considered acutely unwell whilst completing the surveys which may have influenced their perspective of the services and it may differ post hospitalisation. Consumers' interests were explored over the past year. A limitation of this was consumers length of hospitalisation or mental health act status was not collected, so consumers with lengthy hospitalisations may have reported less variety of activity than other consumers. Potential confounding factors (such as education level, acuity, previous occupational history, socioeconomic status, and typical environment) may have contributed to selection bias of activities on the CLIP and the suggested activities in the qualitative data.

The survey was lengthy which may have contributed to many consumers not completing the entire survey.

7.5.2 Future Research

Participant uptake was low unless consumers were directly asked and offered a device to complete the survey, some of which required support to use the device due to acuity and skill level. Future research may review the data collection method for a higher uptake of responses and consider face-to-face interviews. Participants requested a reward for participation which may assist with recruitment. Remuneration of $5AUD may be considered in future ethics applications as a small payment for engagement as there is no direct benefit to engagement otherwise.

A deeper exploration of leisure activities that consumers with an eating disorder can participate in would provide more occupational opportunities for this cohort.

An exploration of leisure activities that can be offered by students or volunteers on MHIUs and the successful implementation of student-led programs. Finally, exploration of the relationship between the built environment and contextual factors that impact boredom can lead to an improvement consumer experience.

There is a link between boredom or lack of cognitive stimulation and aggression (Todman, 2003). Further exploration on providing leisure activity in high dependency units would ascertain the benefits to recovery of leisure in potentially restrictive environments.

This may assist understanding the relationship between boredom, and incidences of aggression and seclusion in MHIUs. In turn, this may assist to reduce the need for PRN medication, and rates of seclusion.

7.6 Conclusion

Leisure activity is an often undervalued therapeutic modality within mental health (Chen & Chippendale, 2018). During consumers admission, engagement in occupation in an inpatient environment can reduce the need for acute medication use, minimise aggressive incidents that require seclusion (Kontio et al., 2012) and increase the therapeutic alliance with staff.

Harnessing a person's interest in leisure activity can be health creating, a concept aligned with the health promotion principle of salutogenesis (building peoples' capacities and resources to improve health) (Caldwell, 2005; Lee & Hwang, 2018). The use of standardised tools and checklists can help therapists to build an occupational profile as well as identify opportunities for an enhanced leisure profile to support therapeutic goals.

7.7 Key Points for the Multidisciplinary Team

- Consumers have the capacity to report their interests to engage in meaningful activity which impacts their care. Consumers provide powerful insights into their needs and recovery journey.
- Standardised tools and checklists are a suitable and helpful way to assess the leisure interests of consumers on acute MHIUs. Furthermore, the use of tools upon triage or discharge could assist in developing focused therapeutic goals in the community.
- Consumers report having someone to participate in an activity with is just as important as the need for the opportunity to engage. Consumers at times, lack the motivation to participate or initiate activity. The use of volunteers or students can provide the opportunity for engagement without detracting from the multi-disciplinary team's workload.

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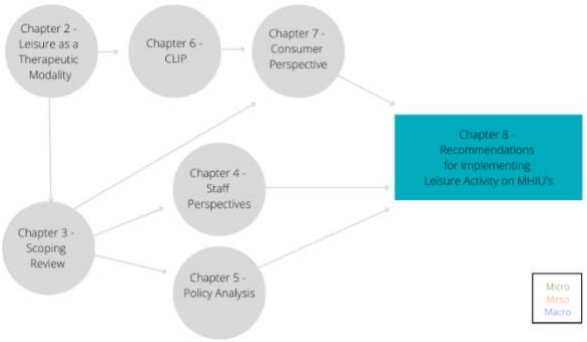
CHAPTER 8 - Recommendations: The Development of Practice Principles for Leisure-based Occupational Enrichment in Mental Health Inpatient Units



In section one and two, consumers and staff have established there is limited leisure activity offered on MHIUs. Consumers provided their feedback and a range of leisure activities that present as viable and appropriate activities to be offered on MHIUs. Some of the barriers to engagement from consumers' perspective included a lack of motivation, and consequently a lack of encouragement by staff to participate; limited activity offered beyond business hours; a lack of activities provided; belief staff 'do not have the time'; limited scope under the MHA and limited individuals to participate in activity with.

The major barriers to participation identified by staff overlapped many of the barriers identified by consumers. Some of these barriers included a lack of resources, a lack of time to provide activity, and poor workplace culture which lacks value in leisure activity. Facilitation of leisure can be provided on MHIUs by targeting some of the key barriers identified so far in this thesis.

Due to the number of barriers identified, a cause for action seemed the appropriate conclusion to this research. A few small changes have been identified to provide meaningful activity to consumer's who are admitted to MHIUs. The simple but complex task of providing leisure activity on MHIUs may be the difference for a consumers experience whilst admitted. In turn, this could impact consumers (from a micro and individual perspective) and the greater consumer population (a review of MHIUs and policy more broadly in a macro sense). The recommendations developed in this chapter have been considered practice principles that MHIUs can individually adopt to meet the needs of their consumers and services to create meaningful change. This will assist with consumers who have brief stays to those who have prolonged admissions.

This chapter is designed to draw together the findings from sections one and two of this thesis. Furthermore, chapter eight addresses aim seven of the research outlined in chapter one. Chapter eight has not yet been submitted for publication.

8.1 Introduction

Leisure activity is known to be salutogenic (health-creating) and contributes to individuals' quality of life (Chen & Chippendale, 2018). For the past 30 years, leisure has been identified in the literature as important and health-promoting in mental health settings (Chen & Chippendale, 2018). It is acknowledged the link between leisure and mental health is an emerging field, which is no less than any other areas in mental health. This thesis provided a number of valid arguments that leisure is salutogenic and beneficial for peoples mental health. There has been minimal change to the current problems faced by consumers in public mental health facilities. A lack of leisure activity continues to be an ongoing problem, fostering boredom and in turn creating occupational deprivation for those with prolonged admissions. The World Health Organization (2021) suggests leisure activity and recreation are integral to inpatient care. Similarly, the National Mental Health Standards (Australia) (Australian Government, 2010) indicate leisure and recreational opportunities should be available for all consumers.

In occupational therapy, leisure is a powerful therapeutic modality with efficacy in mental health inpatient settings (Cutler et al., 2021; Lloyd et al., 2010; Marshall et al., 2020). The core scope of practice of an occupational therapist is to utilise meaningful occupation to improve occupational performance and participation. The key to leisure being used effectively as a treatment modality is targeting activity that is meaningful to the individual, which focuses on the individual interests, volition, and values (MOHO). Engagement in meaningful activity can assist in reducing incidences of aggression, seclusion, and restraint. Findings can be related to the clinical practice of mental health occupational therapists and their delivery of care within locked mental health units (emergency, acute or rehabilitation settings). There is an increase in the emphasis and importance of leisure time in acute mental health settings, which is considered health creating and health-promoting. Therefore, MHIUs should consider broadening their leisure programs to daily activity and expanding resources available as the bare minimum to improve the consumer experience.

This thesis established that staff and consumers would benefit from more occupational opportunities, social connections, and a sense of community in locked settings. With consideration of the MOHO, the built and social environment are key barriers to engagement in meaningful occupation.

8.2 Development

This chapter focuses on the development of practice principles, which is a list of key values and learnings to support the implementation of leisure activity in mental health inpatient units. This thesis adopted similar practices from Brown et al. (2013) who developed a list of evidence-based recommendations for adult physical therapy patients and Brownie (2011) who created the Eden Principles for aged care. A list of practice principles has been developed based on the findings of this thesis to guide clinicians and governing bodies on how to improve service delivery of leisure. The key findings from each chapter have been collated, condensed into recommendations, and discussed with the research team.

In chapter one, the concept of occupational enrichment was introduced. Occupational deprivation has been highlighted as an issue in chapter one, two, three, four and seven. Occupational enrichment is considered the goal for optimal function if a person is experiencing occupational deprivation. The practice principles will be based on the concept of occupational enrichment and be supported by the feedback from consumers (chapter seven – a micro perspective of health), stakeholders (chapter four – meso perspective of health), and policy/legislation (chapter five– a macro perspective of health). The concept of occupational enrichment (Whiteford et al., 2020) is the intention and goal of the principles. All practice principles will be informed by the MOHO model, which has been used as a theoretical framework for this thesis (specifically in chapter two, six and seven) (Taylor, 2017).

A review of the Australian National Mental Health Standards Australian Government (2010) and recovery model principles (Commonwealth of Australia, 2013) ensured the practice principles complemented mental health models/frameworks currently in place across acute settings. The development of the practice principles aims to generate discussion amongst policymakers and change in governing policy and legislation.

The goal of compiling the practice principles was to generate recommendations that governing bodies could implement in MHIUs to create immediate change. Some key areas that MHIUs may focus on are the built environment, social connection (Wilcock, 1998), policy and legislation, and promotion of occupational opportunity (Molineux & Whiteford, 1999). The practice principles will support and promote consumers to engage in their environment and aim to understand their perspective (ethnography) (Brown et al., 2013; Liamputtong, 2017).

8.3 Pilot

The practice principles were shared with a group of stakeholders to ascertain feedback on whether the recommendations were practical, realistic, and meaningful to the context. The mental health clinicians who provided feedback consisted of seven nurses, one occupational therapist, two psychologists, and two psychiatrists (registrar and consultant). All stakeholders identified the practice principles as "crucial", "necessary, and important". Some of the key themes in the feedback included concerns with the shared responsibility of facilitating activity; support from a governance structure to implement activity and longevity of implementing the practice principles.

All of the nursing staff noted concern with the entire multidisciplinary team being responsible for providing leisure activity. Nurses report being overwhelmed with their current duties, raising concern they cannot do more with their time. All stakeholders suggested concern with support from their governance structure, in particular, funding resources or staff.

One staff member stated she did not like the inclusion of words such as 'should' or 'must'. This suggestion was discussed with other stakeholders who believed 'should' is an important inclusion to provide urgency and a sense of need behind the principles.

Staff discussed concerns on the rollout and implementation of practice principles. Some suggested the need for people to 'take ownership'. The psychiatrists identified the environment, positive risks, and consumer involvement in treatment goals as highly important.

8.4 Practice Principles

Ten principles have been formed more broadly so mental health inpatient units can interpret, adapt, and implement meaningful leisure activities for their consumers. The principles should cater to the individual needs of the consumers and aim to improve the consumer experience.

1. Leisure is a health-creating and health-promoting activity that brings meaning and purpose to life. *Engagement in activity assists with recovery. Leisure is an important therapeutic modality.*
2. A variety of activities should always be on offer and beyond business hours. *Activity should be as readily available as it would be in the community.*

3. A positive amount of risk should be taken to allow participation. *Activities should be freely available to consumers to provide opportunity to engage in meaningful leisure activity that they would typically have in their home environment.*
4. Scheduled activities, including individual and group programs, should be offered every day. *The responsibility of engagement should be shared amongst the entire multi-disciplinary team to provide optimal care. A champion from each discipline should support the facilitation of leisure.*
5. Social engagement and meaningful conversation with consumers are invaluable. *This should be considered a necessary part of staff's roles.*
6. The governance structure should reflect these leisure-related principles as necessary and important evidence-based care. *Some of the areas this could be reflected include policy, strategic and operational plans, and role descriptions.*
7. A monotonous and uninviting built environment inhibits engagement, fosters boredom, and delays recovery. *The built environment should be inviting and 'home-like' to promote recovery.*
8. Consumers should be involved in developing their treatment goals. *A consideration of consumers interests, likes, and ambitions should be included to motivate and encourage participation.*
9. Documentation needs to reflect meaningful engagement and leisure preferences to support treatment. *Leisure-related standardised tools and checklists should be used at intake and discharge as best practice.*
10. Acute environments need to have the necessary resources to provide genuine participation. *Resources should include physical materials and staff to support facilitation of leisure activity.*

8.4.1 Principle 1: Leisure is a Health-creating and Health-promoting Activity that Brings Meaning and Purpose to Life

The first principle sets the tone and establishes cause for the remainder of the principles. Throughout this thesis, leisure is salutogenic and health-creating has been established along with the many benefits of engagement (Caldwell, 2005; Lindström & Eriksson, 2005). The remainder of the principles suggests action and change that are required to create optimal care based on the evidence.

8.4.2 Principle 2: A Variety of Activities Should Always be on Offer and Beyond Business Hours

Activity should always be on offer for consumers to have the freedom to engage in meaningful activity, particularly beyond business hours. Activities should closely represent the variety we would expect to see in the community (within reason) to promote volition, a sense of agency, and promote recovery. Participation in an activity of choice assists in developing healthy habits and routines in the community. Wykes et al. (2018) found consumers were more positive about their inpatient experience when presented with the opportunity to engage in meaningful activity, regardless of the severity of their illness.

8.4.3 Principle 3: A Positive Amount of Risk Should be Taken to Allow Participation

Risks can present as a perceived challenge and barrier to engagement. The elements of risks that were identified by participants in chapter four included perceived risk by staff and risk aversion from the organisation. Positive risk-taking suggests a small number of necessary risks improves the quality of life of consumers (Carr et al., 2004; Robertson & Collinson, 2011). Consumers can be enabled to engage in activities with small amounts of risk which promotes personal growth, autonomy and opportunity for success (Robertson & Collinson, 2011). Risk is a part of everyday life and should be assessed, evaluated, and carefully considered as a normal part of operating a MHIU (Just et al., 2021). At times, in the attempt to reduce risks, occupational opportunities can be minimised leading to occupational deprivation. Strategies to reduce risk should thoughtfully be considered and evaluated however, a level of risk can be tolerated without causing serious harm (Just et al., 2021).

Just et al. (2021) suggest organisations can support positive risk with training staff; supervision and reflective practice; a culture shift for new practice; review of policy and guidelines; review of workload demands and improve therapeutic relationships with consumers.

8.4.4 Principle 4: Scheduled Activities Including Individual and Group Programs Should be Offered Every Day

Consumers (chapter seven) and staff (chapter four) both reported a lack of group activity offered which reduces the social opportunities. Lim et al. (2007) found there is limited group activity offered on MHIUs which can contribute to boredom and seldom activity. Furthermore, more than half of the consumers that participated in this study stated engagement in occupational therapy (individual or group programs) contributed to improved function in their daily life. There is varied evidence on the benefits of group-based activity in

inpatient settings. However, Lloyd et al.'s (2010) findings suggest individual and group activity is a core domain for mental health occupational therapists. Evaluation and reflection of a group's value is critical to providing effective treatment. Ultimately, consumers will gain a range of skills, social engagement, and meaningful engagement in any form of participation (Lloyd et al., 2010).

The multidisciplinary team need to value the time, effort, and importance of engagement. To provide the opportunity for success in implementing a leisure program, a member or delegate from each discipline (psychiatry, nursing, occupational therapy, social work, and psychology) should champion and take lead to represent their discipline. A delegate from each discipline should be involved to plan the successful implementation of activity. A cultural shift needs to occur for this to be successful and support the quality of care for consumers (Lloyd et al., 2010).Consumer engagement in therapies with all disciplines should be considered equally important. A suggestion is to schedule medical reviews and nursing-related tasks (such as blood work or observations) to provide consumers with the opportunity to engage without concern of missing out on leisure activities available. Clear appointment and routine times of engagement with the treating team may assist consumers to plan their day and reduce or frustration when waiting to be seen.

8.4.5 Principle 5: Social Engagement and Meaningful Conversation are Invaluable

Engagement in leisure activity is an important and adequate goal to have as part of treatment whilst inpatient. Staff should prioritise engagement with individual consumers as a necessary part of their role. Meaningful engagement and conversation were one of the main leisure activities identified by consumers (chapter seven). Leisure and social engagement should be prioritised as much as documentation, medication management, and other duties for all staff.

8.4.6 Principle 6: The Governance Structure Should Reflect these Leisure-related Principles as Necessary and Important Evidence-based Care

To make a change, the governance structure needs to reinforce the importance of leisure and recreation. The governance structure may include local, state, and national macro levels of health. Local governance structures can make meaningful and immediate changes to their staff's role descriptions, strategic plans, incorporation of daily operations, and priorities to provide therapeutic modalities. In chapter five, findings suggested there is limited leisure-related language found in Australian and international legislation, which could be a barrier to engagement.

A balance between a top-down and bottom-up approach needs to occur to make a cultural shift. A top-down approach would include the governance or directors of a mental health service filtering down changes to policy, procedures, and practice. This needs to occur to make meaningful change in mental health units and create influence over policymakers (McDermott et al., 2015). Directors and leaders need to identify leisure engagement as an important factor in consumers' recovery to facilitate a culture change from the bottom level. The governance structure can assist with ongoing momentum for the multidisciplinary team to reduce the risk of failure or programs ceasing due to lack of interest. A bottom-up approach would include ground level staff or those with direct service provision of consumers. Staff would suggest necessary changes needed to assist staff with their role, specifically with increased resources, training opportunities, and staff 'buy-in' (McDermott et al., 2015).

8.4.7 Principle 7: A Monotonous and Uninviting Built Environment Prevents Engagement and Fosters Boredom

The environment encompasses the physical environment (Taylor, 2017). Consumers have longitudinally reported an environment with no stimulation or meaningful activity is harmful to their mental state (Cutler et al., 2021). Typically, MHIUs are found to be dull with a limited occupational opportunity to occur naturally (Cutler et al., 2021). Suggestion for improvement on the built environment was highlighted in chapter four and seven where staff and consumers stated this was a barrier to engagement. Liddicoat et al. (2020) stated there is a strong link between the built environment and wellbeing. Contemporary and good architectural design are known to provide better clinical outcomes, support recovery, and reduce stress for staff (Liddicoat et al., 2020). Key built environmental design elements should consist of access to natural light, artwork involving nature, outdoor areas or interior green spaces, sensory stimuli, ambient lighting (which has been shown to reduce anxiety), and a range of furniture to choose from (Liddicoat et al., 2020). The built environment should have adequate space to conduct group activities as well as an opportunity for self-directed individual activities.

Cutler et al. (2021) concluded consumers feel safer and there are reduced incidences of aggression when they have a sense of privacy (with locked bedroom doors) and good environmental design. Having the opportunity to engage in meaningful activity provides choice, promotes autonomy, and improves personal causation. Consumers report leisure activity improves the consumer experience, and assists with staff satisfaction.

8.4.8 Principle 8: Consumers Should be Involved in Developing their Treatment Goals

As part of recovery-oriented practice, consumers need to be involved in their treatment goals to support their recovery and wellbeing. Consumer involvement allows the expression of their 'goals, wishes, and aspirations' (Commonwealth of Australia, 2013). Consumer involvement in their goals is essential for successful treatment as it allows choice and personal causation which builds capacity to make informed choices of their own care. Of course, consumers involvement may differ at different stages of their care, for example at the beginning of involuntary treatment due to duty of care. Coffey et al. (2019) identified a strong link between perceived quality of care and recovery-oriented practice. Ultimately, the goal of recovery-oriented practice is to provide quality care and improve mental health outcomes and quality of life for consumers with mental health issues (Commonwealth of Australia, 2013).

8.4.9 Principle 9: Documentation Needs to Reflect Meaningful Engagement and Leisure Preferences to Support Treatment

Recovery and participation should be measurable and specific as a record to support the development of therapeutic goals and considerations for discharge. Recovery-oriented language should be exemplified through all areas of documentation including clinical notes, mental health act paperwork, and policy/procedures (Coffey et al., 2019). Implementing and utilising standardised tools and checklists as part of the admission process will support treating teams to make informed choices for consumer care. Many treating teams currently utilise checklists and structured proforma documentation as part of the admissions process including belongings lists, general demographic information, risk assessment (including static and dynamic risk factors) (Desmarais et al., 2012), initial assessment (which may include the presenting problem, previous mental health history), physical health screens (such as metabolic screening tools), recovery goals and the list goes on. There is often limited discussion regarding the person's current routine, habits, and interests that may assist in developing a rapport and understanding of the person-centred factors. Not only are leisure interests helpful to assist in the creation and development of meaningful treatment goals; but can be used to guide therapy beyond an admission. At times there is limited meaningful information provided to a community health team regarding the contextual person factors that assist in treatment planning when discharged from an MHIU.

The findings from the CLIP in chapter six may provide insight into activities for consumers. Individual inpatient units are encouraged to utilise tools or checklists such as the CLIP to explore occupational opportunities in their setting.

8.4.10 Principle 10: Acute Environments should have the Necessary Resources to Provide Genuine Participation

Resources are inclusive of an adequate built environment, social environment (staff with appropriate level training), and equipment to engage in an activity.

Staff should be considered an important and critical resource (Brownie, 2011). Training should be offered to assist with group facilitation with consideration of specific therapies or skills required to host groups. Supervision and reflective practice should be considered an important tool for staff to consider improvement on facilitation of groups and fostering meaningful individual participation. The multidisciplinary team should consider their interests and skills as valuable therapeutic tools for facilitation.

A range of indoor activities should be always available for consumers. Consideration for funding to provide adequate resources and replacement if any are broken. Resources for daily activity should extend beyond board games and television (Cutler et al., 2021).

8.5 Importance of Knowledge Gained

This thesis has already established the importance of leisure as a therapeutic modality and the ongoing benefits in the inpatient unit and community. These recommendations suggest an increase in meaningful leisure activity may assist with the recovery of acutely unwell consumers. The principles aim to provide an evidence base and guidance on key areas required for meaningful leisure engagement. Macro-level changes may include improvements to local policy, service goals, risk assessment, and operational guidelines. Meso-level changes may include staff training and changes to the built environment. Micro-level changes may include further exploration of the consumer's interests and evaluate methods to implement the activity in each MHIU.

8.6 Clinical Application

A requirement is there must be a cultural shift in the way mental health inpatient units are run to make meaningful change. The cultural shift required to make this change needs to be adopted in a top-down approach starting from a director-level shift. This means directors need to believe this is important for consumer recovery and assist with the necessary resources or funding to make a change. For successful implementation, staff should be included for collaboration and discussion on potential challenges of implementing the leisure

principles. This collaboration allows staff the opportunity to air grievances and express interest in development.

The principles should be considered a starting point for improving leisure in MHIUs. Further research of implementation of leisure programs and evaluation of the principles included in this chapter in clinical settings such as MHIUs, would assist to establish their usability and efficacy for practice. In particular research should explore the impact the practice principles may have on consumer experiences, and the impact on instances of aggression, seclusion, and use of PRN medication. Future research is further explored in chapter nine.

8.7 Conclusion

The consumers experiences can be improved through the implementation of leisure activity on MHIU. Ten leisure principles were developed based on the literature reviewed and the findings of research conducted in this thesis. Each principle aims to target an aspect of this thesis and relevant aspects of the literature that contribute to creating a recovery oriented MHIU. The principles provide health services an opportunity to review the service they currently provide to consumers and determine whether they are providing a therapeutic service. The practice principles target the built environment, social environment, resources and funding that is available, review of documentation styles, risk management, and the need for scheduled activities.

Leisure engagement is considered salutogenic and meaningful. Consumers should be provided the opportunity to engage in leisure activity as they would in their home environment. Cognitive stimulation and supportive staff are conducive to positive recovery opportunities.

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CHAPTER 9 – Implications, Lessons, Limitations, Future Research, and Conclusion

9.1 Implications of Findings

In occupational therapy, leisure is seen as a meaningful, enriching activity that promotes wellbeing. However, leisure is not exclusive to occupational therapy and is promoted as a therapeutic modality through a range of disciplines and clinical settings, such as psychiatry (Barrios et al., 2018), aged care (Lee et al., 2018), sports and exercise science (Stanescu & Vasile, 2014), health promotion (Lee & Hwang, 2018; Stebbins, 2018), arts, and education (Schwan et al., 2018). Key messages that are promoted throughout the literature suggest that leisure particularly supports persons with severe and complex mental health issues by; becoming more active (Lee et al., 2018), improving their mental state, and overall wellbeing (Lee & Hwang, 2018). It is suggested that sedentary behaviour can be negatively associated with mental health (Fine, 2001), especially in elderly populations. Other areas of the literature suggest that engagement in leisure activity can have a salutogenic effect with a positive impact on overall health and wellbeing (Iwasaki et al., 2018; Layland et al., 2018). This thesis defined leisure from a contemporary viewpoint and established the benefits of leisure as a therapeutic modality. This thesis answered the primary research aim which explored the barriers and facilitators to delivering leisure activity at MHIUs. The results indicated that consumers felt bored in MHIUs and there was limited occupational opportunity available to consumers. The outcomes from this thesis include a contemporary definition of leisure, a reliable tool to explore leisure interests for mental health consumers, established leisure interests of Australian mental health consumers, and practice principles that guide practitioners to implement leisure-related programs in MHIUs.

9.1.1 Assumptions

The findings of this thesis have supported the first assumption that engagement is mostly dependent on the opportunity in the built and social environment. However, participants self-reported in chapter seven that person factors such as volition, sedation or drowsiness also affect their ability to engage in leisure. Consumers reported the ability to engage in leisure was meaningful and necessary for their overall wellbeing. Consumers identified the built environment did not support engagement in leisure. The thesis also explored staff as a key part of consumer engagement. This assumption was also challenged as many ‘person factors’ contribute to engagement. Some of the person-centred factors that

prevent engagement include volition, performance capacity, skills, interests, and goals (Taylor, 2017).

The second assumption of this thesis affirms leisure can be health-creating and health-promoting (salutogenic). This assumption was supported by the findings in chapters two, four, and seven. Consumers supported the notion that engagement is conducive to their recovery and is of benefit to their overall mental health and wellbeing. Many consumers reported leisure to be of high value/importance to their daily routine and quality of life. Consumers were also able to identify leisure activities of interest to them and preferences that they wished to engage in. Associations were established surrounding their leisure preferences and most consumers shared like interests. The use of the standardised tools and checklists in chapter seven assisted consumers to explore interests they currently do but had not thought of sharing and new interests they would like to explore. A major finding of this research was that leisure inventories or checklists assist consumers to explore interests and directing therapeutic goals to more meaningful and purposeful activities. The leisure activities suggested by consumers to implement in MHIU are aligned with those of the general population. However, consumers also identified the potential to engage in new activities if given the opportunity. Barriers to engaging in new or interesting activities include socioeconomic status, opportunity, culture, geographical location, and resources.

The third assumption of this thesis are affirmed that there is a need to provide social and physical environments that are conducive to engagement in leisure activity. This assumption was supported by the research explored in chapters three, four, and seven. Explicitly in chapter seven, consumers reported there was a lack of stimulation in the environment, a lack of engagement with nursing staff, and limited scheduled activity offered. The social environment incorporates the staff who have direct-service provision, co-consumers, and any visitors (this may include family, friends, or carers) who are on the MHIU. A major finding of this thesis was the need to acknowledge the 'who' in participation of leisure activity. For some, having another person to engage with an activity is critical. Consumers suggested that participation on MHIUs would increase if staff were assisting to facilitate activity. On the other hand, staff stated they were overburdened with documentation to facilitate participation. They also reported limited resources or funding to provide activity. There were many barriers to engagement reported by both consumer and staff to enable leisure activity on MHIUs.

9.1.2 Definition of leisure

This thesis proposes a definition of leisure as; *a chosen activity, conducted individually or as a group, 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*.

Each chapter of the thesis required an established definition of leisure to set the tone for the reader, provide parameters for the methods, and create a shared understanding for participants of survey research. The definition of leisure in this thesis aims to challenge others' understanding and practice. The contemporary definition also aims to add to the body of research surrounding leisure in the occupational science field.

9.1.3 Identifying the 'Who' in Leisure

Consumers reported occupational opportunity in the built environment is not the only factor in engagement. This supported assumptions one and three. Participants across chapters two and eight suggested engagement is dependent on 'who' they do an activity with. Participants suggested that activities such as board games or basketball can be available but having others to participate with was key. The level of acuity, limited interest in a particular activity, difference in personality or likeness, and cognitive capacity to engage all impacted the ability to engage. The social environment appeared to have equal weighting on engagement to the built environment.

9.1.4 Barriers and Enablers for Leisure Activity

A list of recommendations has been compiled based on the findings of this thesis to provide the practical implications and steps for facilitation. The findings of the thesis included a review of the literature to explore the gaps in leisure-based service provision; a review of current legislation; an exploration of staff and consumers' perspectives on the value of the activity and barriers; and a tool that can be used clinically to explore the leisure preferences of consumers.

This thesis explored the barriers and contributors to the facilitation of leisure activity in MHIUs. Furthermore, the thesis involved the development of a leisure tool that could be applied to mental health settings to provide activities catered to individual and group needs. Exploration of consumer and staff perspectives, review of policy, and development of a leisure-based tool, led to the development of recommendations to improve/increase leisure activity within mental health inpatient units.

9.1.5 Policymakers and Governance Structures

Policy and legislation have been highlighted as a barrier to facilitating leisure activity due to the very limited language and attention paid to non-pharmacological therapies (Bee et al., 2015; Wilson et al., 2018). Wilson et al. (2017) established a link between boredom and aggression which typically leads to seclusion and restraint. A key factor established in the literature to reducing seclusion and restraint is providing meaningful activity to consumers (Lombardo et al., 2018; Wilson et al., 2017).

The many barriers to engagement included the limited number of staff, staff having limited time to facilitate leisure activity, lack of buy-in from staff, limited resources, risks, and the built environment not being adequately designed. The practice principles are an opportunity for change under the Australian National Standards (Australian Government, 2010). The current Australian National Standards 10.5.12 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."

The findings of this thesis suggest this standard is not being upheld by MHIUs. Governance structures and policymakers are urged to consider the necessity of resources to implement these principles in public MHIUs.

9.2 Reflections and Lessons from Candidature

There are many things I have learned from undertaking a Ph.D., some I may not realise I have gained yet. I believe I have vastly improved my knowledge and ability to conduct qualitative and quantitative analysis, manage multiple human ethics applications and collect data, engage with mental health consumers, project management, and developed a deeper understanding of occupational therapy theory; to name a few. I will briefly touch on each of these points.

9.2.1 Qualitative and Quantitative Analysis

I finessed my skills in qualitative and quantitative methods that were used to analyse the research in this thesis. The methods learnt include content analysis (chapters two, four, and seven) (Graneheim & Lundman, 2004), semantic analysis (chapter five) (Aryal et al., 2015), rigour using the 'critical friend' method (Deuchar, 2008), quantitative descriptive analysis and statistical analysis including Somers'd, Cronbach's Alpha and cluster analysis (chapter seven and eight).

Chapter five used reflexivity to explore different data analysis methods and improve the quality of the research outputs included in this thesis. Initially, I only analysed documents associated with the Australian mental health act using Leximancer V4. After learning the program, I decided to expand this beyond Australia to similar countries to explore the discourse of leisure language in legislation. I encountered a difference in the discourse of policy across the countries whilst attempting to semantically analyse concepts with Leximancer V4. The software does not provide context to the concepts found during the text-mining process. This led to exploring other methods of analysis and hand-searching became the most rigorous method to effectively contextualise found terms. I am confident in my ability to adequately conduct mixed methods research, analyse and interpret the data.

9.2.2. Research with Mental Health Consumers

As a mental health clinician, I am well versed in working with complex mental health issues. During my data collection, I encountered difficulty with recruitment and engaged with consumers in a new way. The recruitment methods chosen for most of the studies were via social media sharing as after the global pandemic (COVID-19) it was challenging to gain ethics approval for face-to-face studies. Therefore, for some of the studies, survey responses were lower than anticipated.

In chapter seven, posters were placed in communal areas of the MHIU but there was little uptake. Consumers did not complete the survey unless offered or required assistance to complete it. Some consumers reported they would participate with incentives or remuneration. In a world where we are expected to be paid for work, it appears only fair that consumers would a be offered reward for contribution to research as they had no direct benefit for completing the survey. For future research, a small reward, such as cash or a gift card, for participating may assist in data collection and provide thanks for participation.

The surveys consumers completed were quite lengthy upon reflection. Some consumers would partially complete the survey and then report cognitive overload due to internal psychotic stimuli or other acute symptoms. Some consumers were persistent and took over an hour to complete the survey with many non-sensical responses. Future considerations will be for reducing the length of the survey to a more feasible five minutes rather than the 14 minutes it took to complete on average.

9.2.3 Ethics

To conduct the research for my thesis, I completed five ethics applications including a collaboration with Metro South Mental Health Services. Each ethics application posed

challenges and delays in my proposed thesis timeline. I embodied pragmatic reasoning to complete my thesis and overcome these challenges. Some of the issues I encountered were working with vulnerable populations (acutely unwell mental health consumers). Through this process, I learned how to convey my research plans and adequately articulate the risks they posed. Ethics approval is an important part of the research process which I can now do confidently.

The initial ethics application exploring the consumer study in 2017 was originally blocked by a person in a director position. Upon reflection, the application may have been blocked due to the director's perceived professional vulnerabilities. This is potentially due to the risk of the research exposing sub-optimal practice and concern of reflection on staffsstaff's skills. The success of the ethics application (in chapter seven) was due to the support of those who valued research and change. Working with people who support a culture of change is critical to conducting research that is both valuable and needed.

9.2.4 Occupational Therapy Theory

As an occupational therapist, I have always valued leisure as part of my practice. Through the findings of this thesis, I have developed a greater appreciation for the theory and its application to clinical settings. I will utilise my research skills to inform and apply best-practice standards in the future to my clinical work.

9.2.5 Project Management

My skills in research and project management have exponentially improved during my candidature. My final project included a collaboration between three organisations that required site-specific agreements, approvals, and ethics. During my candidature, I would often have multiple projects running simultaneously, submitting papers, and supervised students with related projects. These skills are invaluable and necessary for my future career endeavours.

9.3 Limitations

The research contained in this thesis presents an understanding of consumer boredom and the dearth of activities offered on MHIUs in the public system.

Each study highlighted some limitations that were unable to be avoided. Methodological limitations included limited opportunity to conduct face-to-face interviews or focus groups with consumers or staff (chapters four and seven) due to COVID-19 restrictions in health care settings, small sample sizes (chapters four and eight), recruitment of participants (chapters two, four, six and seven), consumer surveys were lengthy and acutely

unwell consumers may have found this challenging (chapter seven). Furthermore, face-to-face interviews may have assisted in targeting consumers who did not have literacy skills or who reported to be too unwell to complete a survey. The opportunity to collect data from more than one hospital may have included different consumers' perspectives, demographics, and leisure interests.

This thesis was confined to completing studies that provided a major contribution to the final recommendations. Some perspectives were unable to be explored due to the limitations of time and size of this thesis. Other key perspectives may include family or carers, peer support workers (sometimes referred to as peer companions), and students.

This thesis achieved its aims and has contributed to the broader body of knowledge exploring leisure activity on MHIUs. An exploration of the staff perspectives (chapter four) provides insight to those who provide direct service provision, and the need for a culture change amongst staff. Furthermore, exploration of the consumer perspectives (chapter seven) including their opinion on the amount of activity offered, identified interests and feedback that further activity is required, ascertains the need for change on the day-to-day running of MHIUs in Australia. The development of a leisure tool (chapter seven), and the implementation with a mental health population (chapter seven) provides an opportunity for treating teams to explore contemporary leisure interests with a valid and reliable tool. There has not been a contribution to the literature to update leisure checklists/inventories since the 1980s, which provides significant input to exploring consumer interests in clinical settings.

9.4 Future Research

The findings of this thesis pertain to the development of practice principles (see Appendix 1) to improve the leisure opportunities of consumers on MHIUs. Health services should implement the practice principles to make an immediate change to conform to best-practice standards found in this thesis. Evaluation and implementation of the practice principles in clinical settings are required. The issue of a lack of leisure activity in MHIUs has been discussed in the literature for more than 20 years and limited clinical guidelines or references to the application in clinical settings (Foye et al., 2020; Morrison et al., 1996). A focus in MHIUs is to reduce seclusion and restraint with ‘least restrictive practices’, but a key factor to consumers reporting boredom is they remain unoccupied with the dearth of activity offered (Marshall et al., 2020; Wilson et al., 2018). Wilson et al.’s (2017) findings support the need for improved staff communication, increased meaningful occupation, and improvement to the built environment to make meaningful changes.

The practice principles should be applied to an Australian adult mental health context for implementation and evaluation. Future research may include a case study of one or more inpatient units over a set period (for example two years) to explore contextual factors and ease of application with the practice principles. Some factors to be considered in future research may be an improvement of the application of leisure as a therapeutic modality (reviewing levels of engagement in proposed activity and an increase in meaningful occupation). It could be hypothesised that if there is an increased leisure activity resulting in improved consumer engagement, there would be a reduced readmission rate and a reduction in serious aggression such as seclusion and restraint. The successful implementation of the practice principles will assist policymakers to determine the need for change to overarching legislation and policy that may be limiting meaningful engagement. Furthermore, this would assist policymakers and governance structures to determine the benefit of resources and funding necessary for improvements to units.

Beyond the implementation of practice principles, future research may also look at the use of students providing clinics to assist the multi-disciplinary team with the delivery of leisure activities. Evaluation of a student-led program during and after business hours when there are limited activities provided (such as evenings and weekends) may lead to greater success in implementing these programs. The recommendation of students should not take away from the need for all members of the multidisciplinary team to be involved and included in the delivery of activity.

The recovery model places importance on family and carers as key stakeholders in consumer care (State of Queensland, 2016). There was limited evidence within the literature exploring the family and carers' perspectives specifically on leisure activities available at MHIUs. Future research exploring how families can be included in the facilitation of leisure activity and families perspective on what leisure activity is available may assist in providing leisure activity for consumers during this acute time.

Investigation and observation of how consumers use their time in MHIUs would provide an objective understanding of the boredom described. Furthermore, if treating teams understand the benefit of developing meaningful routines and engagement in leisure whilst consumers are inpatient, this may have a flow-on effect for treatment to continue in the community. The current government is prioritising in mental health care, and more specifically treatment and preventative care. The Federal Budget 2022-2023 is divided into five pillars highlighting treatment (pillar 3), and workforce and governance (pillar 5) as priorities (Austalian Government, 2022). Therefore, health policy and the federal budget

around the provision of leisure activities in inpatient mental health should stipulate the need for increased occupational therapy in mental health inpatient services. Leisure as a therapeutic modality should be implemented as a routine aspect of care. The salutogenic effect of engagement in meaningful activity has suggested that changes to policy, with the inclusion of leisure-related terms, and culture, may enhance health outcomes for clients.

A list of future research questions has been comprised in table 9.1.

Table 9.1

Future Research Priorities Proposed from this Thesis

Topic	Research Questions
Implementation of recommendations	- What are the barriers and enablers for service providers to implement the practice principles? - Do the practice principles assist with consumers experience, and overall rapport built with the hospital and health care service? - Has the implementation of the practice principles and leisure activity impacted the instances of aggression, seclusion, and the need for PRN medication? - How do the practice principles support consumers' recovery? - Are the recommendations transferrable to other countries' MHIUs?
Consumers	- Does structured (or scheduled) activity improve consumer engagement in leisure on MHIUs? - What impact, if any, do eating disorder guidelines have on leisure engagement in MHIUs? What are some appropriate and meaningful leisure activities that can be offered to consumers with an eating disorder?
Carers/family involvement	- Does carer involvement assist in the implementation of the practice principles for leisure? - Do family and carers wish to be involved in leisure activities on the MHIUs?
CLIP	- Is the CLIP a valid and reliable checklist for adolescents or the elderly? - How does the CLIP assist community treating teams to direct goals and therapy?

Staff (with direct service provision)	- Do the practice principles assist staff in facilitating leisure activity on MHIU? - Do clinical staff utilize leisure-related language in their clinical documentation? What impact, if any, does this have on consumer care?
Students as emerging practitioners	- Do student-led leisure programs improve the implementation of leisure-based therapies in MHIUs? - Do after-hours programs delivered by students assist consumers to engage in leisure activities?
Legislation and Policy	- Does the inclusion of leisure-related language assist in the delivery of non-pharmacological therapies in mental health inpatient units? - What are the clinical barriers to implementing leisure activity in related policy and legislation?

9.5 Conclusion

Leisure activity is considered a valid, therapeutic, and meaningful activity to support the recovery of consumers with mental health issues. Leisure is salutogenic and provides a meaningful occupation that promotes recovery. This thesis aimed to identify the barriers and facilitators to leisure activity in mental health inpatient units. All of the aims were answered in the included studies. Throughout this thesis, it was established there is a lack of leisure activity offered in MHIU to support consumers' habituation and functioning in the community. Consumers that regularly engage in leisure occupations may support decreased rates of aggression, violent outbursts, the need for seclusion, and PRN medications.

This thesis applied multiple approaches to develop the practice principles, and this should be considered best practice for future development. Approaches included a review of current legislation, literature and exploring a range of perspectives in which the practice principles will impact including consumers and staff (with direct service provision). Consumers have an important voice and are essential to the development of practice principles that will impact their care. Consumers adequately identified their leisure interests and expressed it is highly important for their quality of life.

This thesis applied the concept of occupational deprivation to understand the occupational deficits that are currently seen in MHIUs. A solution-focused approach has been taken to provide functional recommendations and best-practice standards. The goal of developing practice principles is to aim for occupational enrichment to support the recovery of those with acute mental health issues in MHIUs.

It is beneficial to use valid and reliable leisure assessment tools that are contemporary to understand what leisure activity can be offered in MHIUs. The CLIP was developed as a leisure inventory to assist consumers to identify current, previous, and future interests to support their recovery goals. Understanding the needs of the consumer and their interests will shape participation and delivery of occupation.

The thesis explored the concept of occupational deprivation and applied this to MHIU. The application of this theory suggested more occupational opportunities may enhance consumers' recovery from mental illness on MHIU. Support to develop ground-level changes such as routine, access to a safe environment, and engagement in meaningful occupation can promote a therapeutic environment. The practice principles have the potential to be applied to MHIUs across Australia or in similar countries. Occupational therapists should harness and champion the rollout of the practice principles in their respective units to

enhance occupational opportunities. For successful implementation of the practice principles, consumers, service providers (staff with direct service provision) and policymakers need to be involved in implementation and evaluation.

For a MHIU to not provide meaningful and purposeful leisure activity to consumers who are receiving treatment on their inpatient units could be compared to a tradesman attending work without any equipment and expecting them to complete their tasks for the day. Consumers require stimulation and purpose to improve their mental state for their recovery journey and rehabilitate. This thesis provided clear guidelines and support to governance structures and clinicians wishing to improve the leisure activity offered through the development of the practice principles. Policy should embody the ten practice principles and become a minimum standard for care.

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APPENDICES

APPENDIX 1 – 10 Practice Principles to Improving Leisure Activity on Mental Health Inpatient Units

Ten principles have been formed more broadly so mental health inpatient units can interpret, adapt, and implement meaningful leisure activities for their consumers. The principles should cater to the individual needs of the consumers and aim to improve the consumer experience.

1. Leisure is a health-creating and health-promoting activity that brings meaning and purpose to life.
2. A variety of activities should always be on offer and beyond business hours.
3. A positive amount of risk should be taken to allow participation.
4. Scheduled activities including individual and group programs should be offered every day.
5. Social engagement and meaningful conversation are invaluable.
6. The governance structure should reflect these leisure-related principles as necessary and important evidence-based care.
7. A monotonous and uninviting built environment inhibits engagement, fosters boredom, and delays recovery.
8. Consumers should be involved in developing their treatment goals.
9. Documentation needs to reflect meaningful engagement and leisure preferences to support treatment.
10. Acute environments need to have the necessary resources to provide genuine participation.

APPENDIX 2 – Chapter 2 and Chapter 6 (round 1) Leisure Definition Online Survey Questions

Modified Interest Checklist

What are you interested in?
This is a 14 question survey about your leisure interests (BYO snacks).

* 1. Do you consent to participate in this research?

- [ ] Continue
- [ ] No, thank you

Modified Interest Checklist

2. What is your age?

3. What is your gender?

- ◯ Male
- ◯ Female
- ◯ Other

4. What is your relationship status?

- ◯ Single
- ◯ In a relationship
- ◯ It's complicated
- ◯ De facto
- ◯ Married
- ◯ Seperated
- ◯ Divorced
- ◯ Widowed

5. Where do you live?

State/Province/County

Country

6. How would you define 'leisure activities'?

7. Do you participate in 'leisure activities'?

- ◯ Yes, daily
- ◯ Yes, occasionally
- ◯ Yes, not very often
- ◯ No, I don't do any leisure activities

Please complete the Modified Interest Checklist below.

8. In the past 10 years, what has been your level of interest in this activity?

	Strong	Some	No
Gardening yardwork	◯	◯	◯
Sewing/needle work	◯	◯	◯
Playing cards	◯	◯	◯
Foreign languages	◯	◯	◯
Church activities	◯	◯	◯
Radio	◯	◯	◯
Walking	◯	◯	◯
Car repair	◯	◯	◯
Writing	◯	◯	◯
Dancing	◯	◯	◯
Golf	◯	◯	◯
Football	◯	◯	◯
Listening to popular music	◯	◯	◯
Puzzles	◯	◯	◯
Holiday activities	◯	◯	◯
Pets/livestock	◯	◯	◯
Movies	◯	◯	◯
Listening to classical music	◯	◯	◯
Speeches/lectures	◯	◯	◯
Swimming	◯	◯	◯
Bowling	◯	◯	◯
Visiting	◯	◯	◯
Mending	◯	◯	◯
Checkers/Chess	◯	◯	◯
Barbecues	◯	◯	◯
Reading	◯	◯	◯
Traveling	◯	◯	◯
Parties	◯	◯	◯

Wrestling	○	○	○
Housecleaning	○	○	○
Model building	○	○	○
Television	○	○	○
Concerts	○	○	○
Pottery	○	○	○
Camping	○	○	○
Laundry/Ironing	○	○	○
Politics	○	○	○
Table games	○	○	○
Home decorating	○	○	○
Clubs/Lodge	○	○	○
Singing	○	○	○
Scouting	○	○	○
Clothes	○	○	○
Handicrafts	○	○	○
Hairstyling	○	○	○
Cycling	○	○	○
Attending plays	○	○	○
Bird watching	○	○	○
Dating	○	○	○
Auto-racing	○	○	○
Home repairs	○	○	○
Exercise	○	○	○
Hunting	○	○	○
Woodworking	○	○	○
Pool	○	○	○
Driving	○	○	○
Child care	○	○	○
Tennis	○	○	○
Cooking/Baking	○	○	○
Basketball	○	○	○
History	○	○	○
Collecting	○	○	○
Fishing	○	○	○
Science	○	○	○
Leatherwork	○	○	○
Shopping	○	○	○
	○	○	○

Photography			
Painting/Drawing	◯	◯	◯

* 9. In the past year, what has been your level of interest in this activity?

	Strong	Some	No
Gardening yardwork	◯	◯	◯
Sewing/needle work	◯	◯	◯
Playing cards	◯	◯	◯
Foreign languages	◯	◯	◯
Church activities	◯	◯	◯
Radio	◯	◯	◯
Walking	◯	◯	◯
Car repair	◯	◯	◯
Writing	◯	◯	◯
Dancing	◯	◯	◯
Golf	◯	◯	◯
Football	◯	◯	◯
Listening to popular music	◯	◯	◯
Puzzles	◯	◯	◯
Holiday activities	◯	◯	◯
Pets/livestock	◯	◯	◯
Movies	◯	◯	◯
Listening to classical music	◯	◯	◯
Speeches/lectures	◯	◯	◯
Swimming	◯	◯	◯
Bowling	◯	◯	◯
Visiting	◯	◯	◯
Mending	◯	◯	◯
Checkers/Chess	◯	◯	◯
Barbecues	◯	◯	◯
Reading	◯	◯	◯
Traveling	◯	◯	◯
Parties	◯	◯	◯
Wrestling	◯	◯	◯
Housecleaning	◯	◯	◯
Model building	◯	◯	◯
Television	◯	◯	◯
	◯	◯	◯

Concerts	○	○	○
Pottery	○	○	○
Camping	○	○	○
Laundry/Ironing	○	○	○
Politics	○	○	○
Table games	○	○	○
Home decorating	○	○	○
Clubs/Lodge	○	○	○
Singing	○	○	○
Scouting	○	○	○
Clothes	○	○	○
Handicrafts	○	○	○
Hairstyling	○	○	○
Cycling	○	○	○
Attending plays	○	○	○
Bird watching	○	○	○
Dating	○	○	○
Auto-racing	○	○	○
Home repairs	○	○	○
Exercise	○	○	○
Hunting	○	○	○
Woodworking	○	○	○
Pool	○	○	○
Driving	○	○	○
Child care	○	○	○
Tennis	○	○	○
Cooking/Baking	○	○	○
Basketball	○	○	○
History	○	○	○
Collecting	○	○	○
Fishing	○	○	○
Science	○	○	○
Leatherwork	○	○	○
Shopping	○	○	○
Photography	○	○	○
Painting/Drawing	○	○	○

* 10. Do you currently participate in this activity?

Yes	No

Gardening yardwork	◯	◯
Sewing/needle work	◯	◯
Playing cards	◯	◯
Foreign languages	◯	◯
Church activities	◯	◯
Radio	◯	◯
Walking	◯	◯
Car repair	◯	◯
Writing	◯	◯
Dancing	◯	◯
Golf	◯	◯
Football	◯	◯
Listening to popular music	◯	◯
Puzzles	◯	◯
Holiday activities	◯	◯
Pets/livestock	◯	◯
Movies	◯	◯
Listening to classical music	◯	◯
Speeches/lectures	◯	◯
Swimming	◯	◯
Bowling	◯	◯
Visiting	◯	◯
Mending	◯	◯
Checkers/Chess	◯	◯
Barbecues	◯	◯
Reading	◯	◯
Traveling	◯	◯
Parties	◯	◯
Wrestling	◯	◯
Housecleaning	◯	◯
Model building	◯	◯
Television	◯	◯
Concerts	◯	◯
Pottery	◯	◯
Camping	◯	◯
Laundry/Ironing	◯	◯
Politics	◯	◯

Table games	◯	◯
Home decorating	◯	◯
Clubs/Lodge	◯	◯
Singing	◯	◯
Scouting	◯	◯
Clothes	◯	◯
Handicrafts	◯	◯
Hairstyling	◯	◯
Cycling	◯	◯
Attending plays	◯	◯
Bird watching	◯	◯
Dating	◯	◯
Auto-racing	◯	◯
Home repairs	◯	◯
Exercise	◯	◯
Hunting	◯	◯
Woodworking	◯	◯
Pool	◯	◯
Driving	◯	◯
Child care	◯	◯
Tennis	◯	◯
Cooking/Baking	◯	◯
Basketball	◯	◯
History	◯	◯
Collecting	◯	◯
Fishing	◯	◯
Science	◯	◯
Leatherwork	◯	◯
Shopping	◯	◯
Photography	◯	◯
Painting/Drawing	◯	◯

* 11. Would you like to pursue this in the future?

	Yes	No
Gardening yardwork	◯	◯
Sewing/needle work	◯	◯
Playing cards	◯	◯
Foreign languages	◯	◯
	◯	◯

Church activities	○	○
Radio	○	○
Walking	○	○
Car repair	○	○
Writing	○	○
Dancing	○	○
Golf	○	○
Football	○	○
Listening to popular music	○	○
Puzzles	○	○
Holiday activities	○	○
Pets/livestock	○	○
Movies	○	○
Listening to classical music	○	○
Speeches/lectures	○	○
Swimming	○	○
Bowling	○	○
Visiting	○	○
Mending	○	○
Checkers/Chess	○	○
Barbecues	○	○
Reading	○	○
Traveling	○	○
Parties	○	○
Wrestling	○	○
Housecleaning	○	○
Model building	○	○
Television	○	○
Concerts	○	○
Pottery	○	○
Camping	○	○
Laundry/Ironing	○	○
Politics	○	○
Table games	○	○
Home decorating	○	○
Clubs/Lodge	○	○
Singing	○	○
Scouting	○	○

Clothes	○	○
Handicrafts	○	○
Hairstyling	○	○
Cycling	○	○
Attending plays	○	○
Bird watching	○	○
Dating	○	○
Auto-racing	○	○
Home repairs	○	○
Exercise	○	○
Hunting	○	○
Woodworking	○	○
Pool	○	○
Driving	○	○
Child care	○	○
Tennis	○	○
Cooking/Baking	○	○
Basketball	○	○
History	○	○
Collecting	○	○
Fishing	○	○
Science	○	○
Leatherwork	○	○
Shopping	○	○
Photography	○	○
Painting/Drawing	○	○

12. How well do you feel that the checklist captured your leisure participation and interests?

☆ ☆ ☆ ☆ ☆

13. Do you have any suggestions for how this checklist can be improved?

14. Can you think of any activities that could be missing from the activity list that you or a friend might do?

APPENDIX 3 – Chapter 4 Staff Perspectives Online Survey Questions

1. Do you have experience working with people who have a mental illness?

- ◯ Yes, I currently work in the clinical area of mental health.
- ◯ I dont currently work in the clinical area of mental health but have held a position in the past 5 years in this area.
- ◯ No, I have never worked in the clinical area of mental health.

* 2. I have read and understood the above project information. I consent to participate and for my anonymous data and information to be used for this project and future related ethics approved projects undertaken by this research team.

- ◯ Yes, Id like to continue
- ◯ No, thank you

This survey is seeking participants who are currently work in a mental health service (such as, nurse, psychologist, occupational therapist, social worker, psychiatrist, peer worker). If this does not apply to you, you may be interested in another survey we are currently surveying for that is more relevant.

A consumer of mental health services

A carer of a person with a mental illness

A manager or director working in the area of mental health

* 3. What is your current profession?

- ◯ Medical (e.g., RMO, JHO, SHO, Registrar, Consultant)
- ◯ Nursing (e.g., AIN, EN, EEN, RN, CN, NUM)
- ◯ Social Work
- ◯ Occupational Therapy
- ◯ Psychology
- ◯ Other (please specify)
- ◯ Diversional/Leisure Therapy
- ◯ Administration
- ◯ Peer Support
- ◯ I'd prefer not to say

* 4. How many years have you been in the profession? (optional)

- ◯ 0-1 years
- ◯ 2-5 years
- ◯ 5-10 years
- ◯ 10-15 years
- ◯ 15-20 years
- ◯ 20-25 years
- ◯ 25+ years

* 5. What is your geographical location? (State/Province/Territory, Country)

Leisure is considered an enjoyable activity that is not work or productive activity which you choose to participate in your spare time. Furthermore, leisure may also be activity that can be relaxing, fun and support with health in a therapeutic way.

* 6. Do you value leisure activity?

Not really | In moderation | Absolutely

* 7. What leisure activities does your inpatient unit currently offer?

* 8. Do you believe more leisure activities (including groups, individual therapy and independent activity) should be offered on acute inpatient units?

- ◯ No, I think what is available is more than enough
- ◯ No, I think patients should be sedentary
- ◯ I'm not sure
- ◯ Yes, a few more activities could be added
- ◯ Yes, there definitely needs more activity

* 9. Who do you think is responsible for providing activity on the inpatient unit? (you may select more than one answer)

- ☐ Nurses
- ☐ Occupational Therapist
- ☐ Diversional/Leisure Therapist
- ☐ Social Work
- ☐ Psychologist
- ☐ Administration
- ☐ Other (please specify)
- ☐ Peer Support Worker
- ☐ Consumer
- ☐ Medical Team
- ☐ Family/Carers
- ☐ Students

* 10. What is your role in supporting consumers to participate in meaningful occupation whilst inpatient?

* 11. Which consumers do you think should be included in participation in leisure activity on acute inpatient units?

- ◯ All consumers have the right to participate
- ◯ Voluntary only
- ◯ Involuntary and voluntary
- ◯ Involuntary (including forensic) only
- ◯ None, consumers shouldn't have access to leisure activity on acute inpatient units

* 12. Do you believe the acute inpatient unit you currently work for (or previously have) deliver adequate therapeutic activity (such as leisure groups or have activity readily available for individual participation) to support the needs of consumers daily?

- ◯ Yes
- ◯ No

* 13. If no, could you please explain why you believe how there is not adequate activity delivered on acute inpatient units?

* 14. How do you believe therapeutic programs can be improved on acute inpatient units?

* 15. What barriers can you think of, if any, that impact on leisure activities being offered on your unit?

* 16. What strategies do you use to de-escalate a consumer when aggressive or agitated?

* 17. Imagine someone was about to be admitted to your unit for the first time. They have never been admitted to a public mental health unit before. They ask, 'What does an average day look like here?' How would you respond?

* 18. In a broader sense, do you have any suggestions for what would improve leisure access on acute inpatient units?

Thank you for completing our survey! If you need to talk to someone you may wish to contact family or friends, your General Practitioner, Lifeline (131114), Beyond Blue (1300 224 636) or your local mental health support services.

APPENDIX 4 – Chapter 6 (round 2) CLIP Online Survey Questions

1 Do you consent to participate in this research?

- ☐ Continue
- ☐ No, thank you

* 2 What is your age?

3 What is your gender?

- ◯ Male
- ◯ Female
- ◯ Other

4 What is your relationship status?

- ◯ Single
- ◯ In a relationship
- ◯ It's complicated
- ◯ De facto
- ◯ Married
- ◯ Seperated
- ◯ Divorced
- ◯ Widowed

* 5 Where do you live?

State/Province/County

Country

* 6 How would you define 'leisure activities'?

Please complete the Contemporary Interest Checklist below.

* 7 How much do you value leisure as a regular activity?

Not important, I'm too busy — **Very important for life balance**

8 Do you participate in 'leisure activities'?

- ◯ Yes, daily
- ◯ Yes, occasionally (a few times per week)
- ◯ Yes, not very often (once a week or fortnight)
- ◯ No, I don't do any leisure activities

* 9 In the past year, how would you rate the following leisure activities?

	I currently do this	I don't do it anymore, but I'd like to	I have never done it, but I'd like to	I dont do this and I don't want to	Personally, I don't consider this leisure
Adventure activities (e.g. climbing, gliding, surfing, skateboarding)	◯	◯	◯	◯	◯
Animal Husbandry (e.g. bee keeping)	◯	◯	◯	◯	◯
Art / Craft	◯	◯	◯	◯	◯
Athletics (e.g., track and field)	◯	◯	◯	◯	◯
Babysitting	◯	◯	◯	◯	◯
Board / card games	◯	◯	◯	◯	◯
Camping	◯	◯	◯	◯	◯
Checkers/Chess	◯	◯	◯	◯	◯
Circus/aerial aerobics	◯	◯	◯	◯	◯
Colouring-in	◯	◯	◯	◯	◯
Computer related activities (e.g. games, internet browsing)	◯	◯	◯	◯	◯
Concerts/festivals	◯	◯	◯	◯	◯
Cooking/baking	◯	◯	◯	◯	◯
Cosplay	◯	◯	◯	◯	◯
Cultural activities	◯	◯	◯	◯	◯
Cycling	◯	◯	◯	◯	◯
Dancing	◯	◯	◯	◯	◯
Dating	◯	◯	◯	◯	◯
Do it yourself "DIY"	◯	◯	◯	◯	◯
Driving	◯	◯	◯	◯	◯
Eating out with friends	◯	◯	◯	◯	◯
Exercise/fitness/gym	◯	◯	◯	◯	◯
Fishing	◯	◯	◯	◯	◯
Foreign languages	◯	◯	◯	◯	◯
Gardening yard work	◯	◯	◯	◯	◯
Going for a walk	◯	◯	◯	◯	◯

8 Do you participate in 'leisure activities'?

- ◯ Yes, daily
- ◯ Yes, occasionally (a few times per week)
- ◯ Yes, not very often (once a week or fortnight)
- ◯ No, I don't do any leisure activities

* 9 In the past year, how would you rate the following leisure activities?

	I currently do this	I don't do it anymore, but I'd like to	I have never done it, but I'd like to	I dont do this and I don't want to	Personally, I don't consider this leisure
Adventure activities (e.g. climbing, gliding, surfing, skateboarding)	◯	◯	◯	◯	◯
Animal Husbandry (e.g. bee keeping)	◯	◯	◯	◯	◯
Art / Craft	◯	◯	◯	◯	◯
Athletics (e.g., track and field)	◯	◯	◯	◯	◯
Babysitting	◯	◯	◯	◯	◯
Board / card games	◯	◯	◯	◯	◯
Camping	◯	◯	◯	◯	◯
Checkers/Chess	◯	◯	◯	◯	◯
Circus/aerial aerobics	◯	◯	◯	◯	◯
Colouring-in	◯	◯	◯	◯	◯
Computer related activities (e.g. games, internet browsing)	◯	◯	◯	◯	◯
Concerts/festivals	◯	◯	◯	◯	◯
Cooking/baking	◯	◯	◯	◯	◯
Cosplay	◯	◯	◯	◯	◯
Cultural activities	◯	◯	◯	◯	◯
Cycling	◯	◯	◯	◯	◯
Dancing	◯	◯	◯	◯	◯
Dating	◯	◯	◯	◯	◯
Do it yourself "DIY"	◯	◯	◯	◯	◯
Driving	◯	◯	◯	◯	◯
Eating out with friends	◯	◯	◯	◯	◯
Exercise/fitness/gym	◯	◯	◯	◯	◯
Fishing	◯	◯	◯	◯	◯
Foreign languages	◯	◯	◯	◯	◯
Gardening yard work	◯	◯	◯	◯	◯
Going for a walk	◯	◯	◯	◯	◯

Vehicle restoration	◯	◯	◯	◯	◯
Video games (e.g. playstation, xbox)	◯	◯	◯	◯	◯
Visiting a museums	◯	◯	◯	◯	◯
Volunteer services	◯	◯	◯	◯	◯
Watching television	◯	◯	◯	◯	◯
Water activities (e.g. standup paddleboarding, kayaking)	◯	◯	◯	◯	◯
Water Sports (e.g. swimming, water polo, diving)	◯	◯	◯	◯	◯
Woodwork/Mending/Fixing	◯	◯	◯	◯	◯
Writing	◯	◯	◯	◯	◯
Yoga/pilates	◯	◯	◯	◯	◯

Other (please specify)

10 Do you want to tell me more about some of the activities you do that may or may not be listed above?

Thank you for completing the Contemporary Interest Checklist. Please provide us with some feedback on the checklist.

*11 How well do you feel that the checklist captured your leisure participation and interests?

*12 Do you have any suggestions for how this checklist can be improved?

13 Can you think of any activities that could be missing from the activity list that you or a friend might do?

APPENDIX 5 – Chapter 7 Consumer Perspective Online Survey Questions

* 1. In the last 5 years, have you been admitted to a mental health inpatient unit for longer than 48 hours?

- ◯ Yes, in the past 12 months
- ◯ Yes, in the past 5 years but not in the past 12 months
- ◯ No, but I have been admitted to a mental health unit before
- ◯ No, I have never been admitted to a mental health unit before

* 2. I have read and understood the above project information. I consent to participate and for my anonymous data and information to be used for this project and future related ethics approved projects undertaken by this research team.

- ◯ Yes, I'd like to continue
- ◯ No, thank you

* 3. What is your gender?

- ◯ Female
- ◯ Male
- ◯ Other

* 4. What is your age?

- ◯ Under 18
- ◯ 18-24
- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55-64
- ◯ 65+

* 5. What is your geographical location? (State/Province/Territory, Country).

In completing this section, please do not provide personal information about any other person, for example by including their name, in your response.

* 6. What is your understanding of your mental health diagnosis, if any?

- ◯ Depression
- ◯ Anxiety such as generalised, obsessive compulsive
- ◯ Personality disorder (such as borderline type)
- ◯ Schizophrenia
- ◯ Schizoaffective
- ◯ Bipolar Affective Disorder
- ◯ Other mood disorders
- ◯ Drug induced psychosis
- ◯ Delusional disorder
- ◯ Other psychotic disorders
- ◯ None of the above

Other (please specify)

Leisure can be considered an enjoyable activity that is not work or productive activity, which you choose to participate in your spare time. Furthermore, leisure may also be activity that can be relaxing, fun and support with health in a therapeutic way.

* 7. How did you keep your self engaged in leisure on the inpatient unit or in the mental health wait room?

In completing this section, please do not provide personal information about any other person, for example by including their name, in your response.

* 8. What activities were available to you whilst you were inpatient or in the mental health wait room?

In completing this section, please do not provide personal information about any other person, for example by including their name, in your response.

* 9. Overall, how satisfied or dissatisfied were you with the level of leisure activities offered on the mental health inpatient unit or in the mental health wait room?

- ◯ Very satisfied
- ◯ Somewhat satisfied
- ◯ Neither satisfied nor dissatisfied
- ◯ Somewhat dissatisfied
- ◯ Very dissatisfied

* 10. How would you rate your ability to engage in leisure activity on the inpatient unit or in the mental health wait room?

Limited activity | Average | A lot of activity

* 11. What stopped you from engaging in leisure activities on the inpatient unit or in the mental health wait room?

* 12. What changes would most improve your access to leisure activity on the mental health inpatient unit or in the mental health wait room?

Mental Health Statistics Improvement Program (MHSIP)

* 13. Please answer the following questions based YOUR MOST RECENT INPATIENT EXPERIENCE. Indicate if you Strongly Agree, Agree, are Neutral, Disagree, or Strongly Disagree with each of the statements below. If the question is about something you have not experienced, fill in the answer for 'Not Applicable' to indicate that this item does not apply to you.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not applicable
If I had other choices, I would still get services from this agency.	○	○	○	○	○	○
I liked the services that I received there.	○	○	○	○	○	○
I would recommend this agency to a friend or family member.	○	○	○	○	○	○
Staff were willing to see me as often as I felt it was necessary.	○	○	○	○	○	○
Services were available at times that were good for me.	○	○	○	○	○	○
I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	○	○	○	○	○	○
I did things that were more meaningful to me.	○	○	○	○	○	○
I deal more effectively with daily problems.	○	○	○	○	○	○
I deal better in social situations.	○	○	○	○	○	○
I am better able to take care of my needs.	○	○	○	○	○	○
My symptoms are not bothering me as much.	○	○	○	○	○	○
I am better able to do things that I want to do.	○	○	○	○	○	○
I was able to get all the services I thought I needed.	○	○	○	○	○	○
I, not staff, decided my treatment goals.	○	○	○	○	○	○

* 14. Please answer each of the following questions by filling in the circle that best describes your most recent inpatient experience and how you felt. Please fill in only one circle for each question. For some questions, you may choose 'Not Applicable' if the question does not apply to you.

Think about how you spend your spare time. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The way you spent your spare time?	○	○	○	○	○	○	○
B. The chance you had to enjoy pleasant or beautiful things?	○	○	○	○	○	○	○
C. The amount of fun you had?	○	○	○	○	○	○	○
D. The amount of relaxation in your life?	○	○	○	○	○	○	○

Checklist of Leisure Interests and Participation (CLIP)

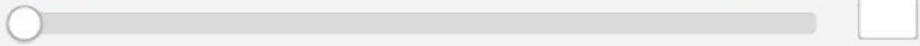
In this section, we would like you to complete a checklist to give us more information about what your current leisure interests are.

* 15. Do you typically participate in 'leisure activities'?

- ○ Yes, daily
- ○ Yes, occasionally (a few times per week)
- ○ Yes, not very often (once a week or fortnight)
- ○ No, I don't do any leisure activities

* 16. How much do you value leisure as a regular activity?

Not important, I'm too busy — Very important for life balance



* 17. In the past year, how would you rate your engagement in the following leisure activities?

	I currently do this	I don't do it anymore, but I'd like to	I have never done it, but I'd like to	I don't do this and I don't want to	Personally, I don't consider this leisure
Adventure activities (climbing, gliding, surfing, skateboarding)	○	○	○	○	○
Animal Husbandry (e.g.	○	○	○	○	○

bee keeping)					
Art / Craft	○	○	○	○	○
Athletics (running, track and field)	○	○	○	○	○
Babysitting	○	○	○	○	○
Board / card games	○	○	○	○	○
Camping	○	○	○	○	○
Checkers/Chess	○	○	○	○	○
Circus/aerial acrobatics	○	○	○	○	○
Colouring-in	○	○	○	○	○
Computer related activities (games, internet browsing)	○	○	○	○	○
Concerts/festivals	○	○	○	○	○
Cooking/baking	○	○	○	○	○
Cosplay	○	○	○	○	○
Cultural activities	○	○	○	○	○
Cycling	○	○	○	○	○
Dancing	○	○	○	○	○
Dating	○	○	○	○	○
Do it yourself activity	○	○	○	○	○
Driving	○	○	○	○	○
Eating out with friends	○	○	○	○	○
Exercise/fitness/gym	○	○	○	○	○
Fishing	○	○	○	○	○
Foreign languages	○	○	○	○	○
Gardening yard work	○	○	○	○	○
Going for a walk or run	○	○	○	○	○
Going to a party	○	○	○	○	○
Hairstlying / Makeup	○	○	○	○	○
Hiking	○	○	○	○	○
Home brewing	○	○	○	○	○
Home decorating	○	○	○	○	○
Horse riding	○	○	○	○	○
Ice skating	○	○	○	○	○
Individual sports (golf, tennis)	○	○	○	○	○
Knitting/sewing/crocheting	○	○	○	○	○
Listening to music	○	○	○	○	○
Martial arts	○	○	○	○	○
Meditation	○	○	○	○	○

Motor sports	◯	◯	◯	◯	◯
Movies	◯	◯	◯	◯	◯
Painting/Drawing	◯	◯	◯	◯	◯
Pets/livestock	◯	◯	◯	◯	◯
Photography	◯	◯	◯	◯	◯
Puzzles	◯	◯	◯	◯	◯
Religious activities	◯	◯	◯	◯	◯
Renovating	◯	◯	◯	◯	◯
Running / jogging	◯	◯	◯	◯	◯
Sailing	◯	◯	◯	◯	◯
Scrapbooking/card making	◯	◯	◯	◯	◯
Sexual activities	◯	◯	◯	◯	◯
Shopping	◯	◯	◯	◯	◯
Singing	◯	◯	◯	◯	◯
Social clubs	◯	◯	◯	◯	◯
Social networking (Facebook, Twitter, Instagram)	◯	◯	◯	◯	◯
Social visit with friend	◯	◯	◯	◯	◯
Table tennis/pool	◯	◯	◯	◯	◯
Tai Chi	◯	◯	◯	◯	◯
Team sports (soccer, basketball, hockey, football)	◯	◯	◯	◯	◯
Television	◯	◯	◯	◯	◯
Vacation	◯	◯	◯	◯	◯
Vehicle restoration	◯	◯	◯	◯	◯
Video games (playstation, xbox)	◯	◯	◯	◯	◯
Visiting a museums	◯	◯	◯	◯	◯
Volunteer services	◯	◯	◯	◯	◯
Watching television	◯	◯	◯	◯	◯
Water activities (standup paddleboarding, kayaking)	◯	◯	◯	◯	◯
Water Sports (swimming, water polo, diving)	◯	◯	◯	◯	◯
Woodwork/Mending/Fixing	◯	◯	◯	◯	◯
Writing	◯	◯	◯	◯	◯
Yoga/pilates	◯	◯	◯	◯	◯

Other (please specify)

* 18. Do you want to tell me more about some of the activities you do that may or may not be listed above?

In completing this section, please do not provide personal information about any other person, for example by including their name, in your response.

* 19. Based on your current leisure interests you have identified, how would you feel about having access to these activities on an inpatient unit or in the mental health wait room?

In completing this section, please do not provide personal information about any other person, for example by including their name, in your response.

Leisure Boredom Scale

This section gives us more information about your current leisure activity.

* 20. Rate the following items from 1 to 5 according to the extent to which you agree. A rating of "1" indicates that you strongly disagree and a rating of "5" indicates that you strongly agree.

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
For me, leisure time just drags on and on.	○	○	○	○	○
During my leisure time, I become highly involved in what I do.	○	○	○	○	○
Leisure time is boring.	○	○	○	○	○
If I could retire now with a comfortable income, I would have plenty of exciting things to do for the rest of my life.	○	○	○	○	○
During my leisure time, I feel like I'm just "spinning my wheels."	○	○	○	○	○
In my leisure, I usually don't like what I'm doing, but I don't know what else to do.	○	○	○	○	○
Leisure time gets me aroused and	○	○	○	○	○

going.					
Leisure experiences are an important part of my quality of life.	◯	◯	◯	◯	◯
I am excited about leisure time.	◯	◯	◯	◯	◯
In my leisure time, I want to do something, but I don't know what I want to do.	◯	◯	◯	◯	◯
I waste too much of my leisure time sleeping.	◯	◯	◯	◯	◯
I like to try new leisure activities that I have never tried before.	◯	◯	◯	◯	◯
I am very active during my leisure time.	◯	◯	◯	◯	◯
Leisure time activities do not excite me.	◯	◯	◯	◯	◯
I do not have many leisure skills.	◯	◯	◯	◯	◯
During my leisure time, I almost always have something to do.	◯	◯	◯	◯	◯

* 21. Would you like to provide us with any feedback on other ways mental health inpatient units can be improved?

In completing this section, please do not provide personal information about any other person, for example by including their name, in your response.

Thank you for participating in this survey. If you need to talk to someone you may wish to contact family or friends, your General Practitioner, Lifeline (131114), Beyond Blue (1300 224 636) or your local mental health support services.

APPENDIX 6 – Academic Service & Engagement

Role	Committee / Institution	Period
HDR Student Representative	Misconduct Hearing (USC)	2019 - 2020
Presenter	Consecutive Presenter at HDR (Higher Degrees Research) Orientations (USC)	2017-2019
Co-chair	Post Graduate Student Association (PSA) (USC)	2017-2019
Co-presenter	Two HDR PSA forums (USC)	2017-2019
HDR Student Representative	Student Governance Group for the Student Senate (USC)	February 2018 to June 2019
HDR Student Representative	Student Representative Council (USC)	June 2017 to June 2018
HDR Student Representative	Research Degrees Committee (RDC) (USC)	January to December 2018
HDR Student Representative	Student Mental Health and Wellbeing Committee (USC)	October 2017 to December 2018
HDR Student Representative	Council Australia Postgraduate Association (CAPA) Annual Council Meeting - Newcastle, Australia	4-day conference, December – 2018
Volunteer	USC G-Day	2018
Panellist	USC HDR Program Review	2018
Panel Member	‘3-minute thesis’ competition (USC)	2018
Presenter	‘3-minute thesis’ competition (USC)	2017

Presenter	Queensland Health Occupational Therapy District Meeting of current research outputs	2017
HDR Student	HDR Write Club (USC)	2017 – Current

Achievements and Awards

- Occupational Therapy Australia (OTA) Postgraduate Research Award - USC (2019)