AASW Statement on the Queensland Government's Mental Health 'Locked Wards' Directive

AASW Position Statement

Introduction

The Australian Association of Social Workers (AASW) is the key professional body representing more than 7000 social workers throughout Australia. Social work is the profession committed to the pursuit of social justice, the enhancement of the quality of life, and the development of the full potential of each individual, group and community in society.

Mental health social workers are employed in a wide range of settings including health services, non government organisations and private practice. They acquire a deep understanding of the emotional situation of people with whom they engage, their families, their social condition and other circumstances as well as the best practice ways of working with them.

Although this position statement concerns the public mental health system in Queensland, it has application across other states and territories where similar policy concerns occur.

The profession of Social Work plays an important part in the delivery of mental health services across the public, not for profit and private sectors. In 2010, the then Commonwealth Department of Health & Ageing noted that social workers made up a third of the allied health workforce for public mental health services and comprised the fourth largest professional group in the public mental health workforce. The issue of locked wards is a crucial one for the social work profession which champions social justice and human rights.

The 'Locked Wards' directive

The AASW is very concerned about the continuing directive by the Queensland state government issued in late 2013 to lock all inpatient mental health facilities. This internal directive is explained to be a response to concerns about the safety of the minority of people who are both involuntary patients and who abscond, and about the safety of the community. It has been reported that the 2008 NSW coronial recommendations following the death of a patient absent without leave also influenced the decision to formulate the directive. The matter of safety will be examined later in the document.

The Association is also concerned about the lack of public consultation prior to the 2013 decision, and the minimal consultation with Queensland Hospital and Health Services' mental health services. There is a risk that the Queensland government directive may set a trend for decreased freedoms for patients in other states' public mental health settings. Our professional colleagues, represented by the Australian and New Zealand College of Psychiatrists[i] and the Australian College of Mental Health Nurses[ii], have also expressed regret at the Queensland Government directive.

To set the context for the AASW position, relevant aspects of Queensland mental health legislation and recent Commonwealth and Queensland policy directions will be examined for their compatibility with the 'Locked Wards' directive.

Legislative and policy framework

Queensland's *Mental Health Act 2000*[iii] states that people experiencing mental illness:

- have the same basic human rights in relation to human worth and dignity (S8a)
- are presumed to have capacity to make decisions for themselves and those who are assessed as requiring involuntary treatment for reasons of health and safety, are deemed to have capacity to make decisions in matters other than treatment, and
- that treatment, whether voluntary or involuntary, operates under the principles of being person-centred and least restrictive (S8 and 9).

Part of the Queensland government directive states that 'in particular, voluntary patients, visitors, persons who are not involuntary patients or involuntary patients who have a valid basis for departing the unit should be allowed to move freely in and out of the units subject to all appropriate steps being taken to ensure that persons who do not fall into one of these categories do not depart the unit.' However, even with procedures to allow voluntary patients to come and go, this is clearly contrary to the principles and intent of the Queensland's Mental Health Act, which applies to involuntary patients.

The broad reforms promoted in the National Mental Health (NMH) Strategy, in place since 1992[iv], and in the Roadmap for National Mental Health Reform[v] (endorsed by the Council of Australian Governments in 2012) reflect the growing body of knowledge about mental health care and the experiences of people using these services. In essence, the service improvement aims of these documents are to enhance:

- prevention and early intervention activity
- access to treatment and support services
- the quality of treatment and support services
- social and economic engagement by people with a mental illness.

The Commonwealth and state governments have endorsed efforts across the government and non-government sectors to reduce the isolation and stigma encountered by consumers that impede recovery from mental illness. To this end, the AASW applauds the positive media campaigns promoted by consumer groups and non-government organisations such as BeyondBlue, Sane and Mental Illness Fellowship that have worked to promote the dignity and rights of people who have a mental illness with governments and the public.

The philosophy supporting all the above endeavours implies an optimistic, humane and inclusive view of people with a mental illness and their potential. This is very much in keeping with the growing implementation of recovery based approaches to mental health treatment and care, a position supported in the Queensland Plan for Mental Health 2007-2017[vi].

Unintended consequences of the directive

Although continuing effort is needed to create an optimal mental health system, much has already been achieved at both national and state levels. The Queensland directive appears to step away from not only the intent of mental health legislation but also the national and state reform goals and strategies. It will exacerbate stigma for people with a mental illness by signalling what appears to be a return to former discredited psychiatric practices where asylum doors were secured.

It is timely to be reminded that mental health consumers frequently report that the impact of mental illness is more intrusive than the symptoms themselves[vii]. The universal, therapeutic principles of recovery and person-centred care are considerably weakened by changes that impinge on a person's freedom and override the judgment of professionals working with people who have a mental illness.

The AASW is concerned by the possibility that people with a severe mental illness or disorder living in Queensland may avoid seeking treatment as a result of this directive. The *2013 National Report Card on Mental Health and Suicide Prevention*[viii] highlights that '65% of the estimated 3.2 million Australians who have experienced a mental health problem in the past 12 months have not sought help'. This situation could become exacerbated in Queensland where people may experience fear and distress at the prospect of being in a locked environment. Inevitably the safety of the person with a mental illness would be compromised and possibly that of others in the community.

The directive to prevent involuntary patients from absconding may be motivated by safety considerations and even a wish to increase the chances of uninterrupted treatment and care, however, evidence suggests that even by locking wards absconding behaviour cannot be entirely eliminated[ix]. Van Der Merwe et al also concluded that 'locked wards were associated with increased patient aggression, poorer satisfaction with treatment and more severe symptoms'. The adverse consequences for consumer and staff health and safety are obvious.

Safety of the person receiving involuntary mental health treatment and care

An inpatient environment that conveys safety to an acutely unwell person relies on good design, caring staff as well as appropriate policies and procedures to manage risk within a safe environment and within the parameters of duty of care. Such an environment takes time and effort to build, maintain and improve. More investigation is needed and a more considered response is required to the matter of absences. By comparison, the locked wards directive appears to be a knee jerk reaction in stark contrast to the gains made at a legislative and policy level over the last 20 years. There are unanswered questions relevant to this issue such as:

- What can be learned from inpatient facilities, in Queensland, interstate and overseas, where there are low rates of absconding?
- Are there common characteristics of people who abscond, for example are they frustrated by the lack of review of their involuntary status?
- Are there common circumstances under which involuntary patients abscond, for example when there are reduced levels of staffing?
- Have the optimal interventions, including recovery approaches, been used to engage with these patients, for example, are there sufficient community based early intervention services to avoid inpatient admissions; are advanced directives routinely negotiated with people who have a severe mental illness to plan responses in the event of an acute episode?

Without an understanding of these and related matters, other possible responses to the issue of consumer or community safety are neglected.

Consultation – the preferred process

The AASW is aware that a recent review of the directive undertaken by the Office of the Chief Psychiatrist found a significant reduction in absences. This is a rather narrow view of the directive's success. As an alternative, the Association supports robust consultation with stakeholders from the mental health sector including consumers, carers, non-government and public mental health service to inform current and future mental health policy and practice development. An open consultation process enables a decision making process that reflects appropriate evidence and best practice. There are potentially wide-reaching consequences of locked wards that should be carefully considered, and reviewed regularly in a collaborative way with key stakeholders. This includes Psychiatrists, Social

Workers, Nurses, Psychologists, Indigenous Mental Health Workers and Operational Managers who for the most part successfully manage individual and community risk every day. Voluntary and involuntary inpatients and their families are known to clinical staff and this knowledge partly informs the decision as to whether a person needs a secure or non-secure inpatient setting. The mental health treating team considers the person as being central to the decision making process while simultaneously balancing community health and safety issues. The Association hopes that the review of the directive authorised by the Queensland Mental Health Commissioner, and being undertaken by Melbourne University, adopts the above approach. Until the directive is rescinded, any move to restrict people's rights must be carefully considered and the outcomes monitored regularly by all stakeholders, especially by mental health consumers themselves.

Conclusion

The AASW wants to avoid the Queensland government 2013 directive setting a trend of decreased freedoms for patients in other states' public mental health settings. This government decision is in direct contradiction to established principles in mental health legislation as well as the promotion of recovery and rehabilitation. Such restrictive practices take the path to the revival of unpleasant and dangerous custodial practices and incarceration that characterised abusive mental health treatment in the past.

Recommendations

In addition to the Queensland Mental Health Commissioner's Review, the AASW urges the Queensland government to:

- appoint a group of all key stakeholders to:
  - investigate the consequences of the directive
  - undertake a thorough assessment of the root causes of absconding and the implementation of remedial actions, consistent with a human rights perspective
  - recommend evidence based, best practice interventions to reduce absconding to replace the Locked Wards directive
- fund ongoing and improved training consistent with the national recovery framework[x] approved by the Australian Health Ministers Advisory Council for all professions working with people who have a mental illness and are acutely unwell.

Endnotes

[i] Royal Australian and New Zealand College of Psychiatrists. 2013. 'Locking-up patients a step back into history'. https://www.ranzcp.org/News-policy/News/Locking-up-patients-a-step-back-into-history.aspx

[ii] Australian College of Mental Health Nurses. (2013). *Blanket decision to lock mental health units a draconian step backwards*. http://www.acmhn.org/images/stories/News/RestrainingClientsinQLD.pdf

[iii] *Queensland Mental Health Act 2000* (2002). Brisbane: Queensland Government

[iv] Australian Government (2008). *National Mental Health Policy.* Canberra: Commonwealth of Australia

[v] Council of Australian Governments (2012). *Roadmap for National Mental Health Reform 2012-22.* Canberra: Commonwealth of Australia

[vi] Queensland Government (2008). *Queensland Plan for Mental Health 2007-2017*Mental Health Branch, Queensland Health

[vii] Bland, R. (2014). *Editorial,* Australian Social Work. 67, 2, p. 159-161

[viii] National Mental Health Commission (2013). *A Contributing Life: the 2013 National Report Card on Mental Health and Suicide Prevention*. Canberra: Commonwealth of Australia

[ix] Van Der Merwe, M, Bowers L, Jones J, Simpson A & Haglund K. (2009). *Locked doors in acute inpatient psychiatry: a literature review*. Journal of Psychiatric and Mental Health Nursing, 16, pp. 293-299

[x] National Mental Health Strategy (2013). *A National Framework for Recovery-oriented Mental Health Services*, Australian Health Ministers Advisory Council

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