Leave of absence from a mental health inpatient unit

Chief Psychiatrist's guideline

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Contents

Key messages

- Decisions about leave from mental health inpatient units must consider patients' rights and recovery goals and the risks and anticipated benefits of leave to patients, carers and the community.
- Leave policies and processes should be communicated to patients and carers in simple, clear terms, verbally and in writing, at the beginning of an admission.
- Leave should be planned in advance following discussion within the clinical team, in conjunction with patients and carers.
- For compulsory patients, leave is regulated by the *Mental Health Act 2014*. Decisions about leave are the responsibility of the authorised psychiatrist.

Definitions

Authorised psychiatrist: A person (or delegate) appointed under s. 150 of the *Mental Health Act 2014* to exercise duties and functions under the Act.

Carer: A family member or friend, including someone under the age of 18 years, who provides care to another person with whom he or she is in a care relationship.

Purpose and scope

The purpose of this guideline is to assist clinicians to adhere to the legislation concerning leave of absence from an inpatient unit.

The guideline is specific to mental health inpatient units and secure extended care units (SECUs).

Continuing care units (CCUs) and prevention and recovery care (PARC) facilities are expected to have their own leave guidelines (which, if considered appropriate, might be identical in most respects to the ones described here).

Specific provisions exist under the Mental Health Act regarding leave for security patients (s. 281) and forensic patients (s. 312). Discussion of these is outside the scope of this guideline.

Terminology

People admitted to inpatient units on a compulsory basis are often termed ‘patients’. Those receiving treatment voluntarily are often termed ‘consumers’.

In the interests of brevity, the term ‘patient’ is used throughout this document to refer to people in both categories.

Introduction

Most patients desire or need leave from a mental health inpatient unit at points throughout their admission to attend to family, work or social obligations, to resolve housing or financial issues, or to spend time with family or friends. Later in the admission, leave provides an opportunity for patients, carers and the treating team to evaluate the patient's recovery prior to discharge.

The Chief Psychiatrist requires that services' policies and procedures regarding leave align with the Mental Health Act and the *National standards for mental health services* to ensure that leave procedures are legal, respectful and therapeutic.

This guideline enumerates the elements of good practice and lists indicators for services to check that procedures accord with the Chief Psychiatrist's expectations.

Patients' rights

The Act states in its list of principles that people receiving mental health services should:

- be provided assessment and treatment in the least restrictive way possible, with voluntary assessment and treatment preferred
- be provided with services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life
- be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, respecting their views and preferences
- be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk
- have their rights, dignity and autonomy respected and promoted.

Leave is not a privilege to be granted by clinicians as a form of reward or punishment. It is a right that can be denied to compulsory patients only in circumstances that accord with the Act (see page 7 of this document).

Advance statements

The Act stipulates that patients can set out in writing their preferences in relation to any future episodes of compulsory treatment (ss. 19–22). This is referred to as making an 'advance statement'.

It is helpful if this statement describes ways in which periods or types of leave from inpatient units will assist or hinder their recovery.

Nominated persons

Under the Act, patients can nominate in writing a person who will provide support, represent their interests, receive information about them from a service and assist them to exercise their rights under the Act (ss. 23–27).

It is helpful if patients inform their nominated person of their preferences regarding leave.

Recovery-oriented practice

The *National standards for mental health services* <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-servst10> require that clinical policies and practices align with the principles of recovery-oriented mental health practice.

This style of practice:

- supports and empowers individuals to make their own choices about how they want to lead their lives
- acknowledges that choices need to be meaningful and explored creatively
- supports individuals to build on their strengths and to take as much responsibility for their lives as they can at any given time
- ensures there is a balance between duty of care and support for individuals to take positive risks and to make the most of new opportunities (see pages 42–43 of the standards).

Leave from inpatient units is a positive practice. It provides the means for people to maintain important connections while in hospital, to exercise autonomy and to attend to matters that they deem to be important.

Supported decision making

Patients must be assisted to participate in decision making to the greatest extent possible. Supported decision making requires that:

- clinicians engage actively with patients, make efforts to understand what issues regarding leave are important to them and seek to involve them in decision making
- subject to consent, information about patients' values and preferences regarding leave is sought from carers, significant others and nominated persons in situations where patients cannot communicate this information themselves
- subject to consent, carers and significant others, nominated persons, independent advocates and legal advisers can assist patients to present their views regarding leave
- decisions about leave might vary with time in line with changes in a patient's capacity to understand, remember and weigh up issues regarding leave and to communicate their decisions.

For a more detailed discussion of this topic, see the Department of Health and Human Services' *Framework for recovery-oriented practice* <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/service-quality/recovery-oriented-practice-in-mental-health>.

Compulsory patients can seek support in decision making from the Independent Mental Health Advocacy service.

Leave for voluntary patients

People are typically admitted to inpatient units when their level of distress is so high, and their capacity to manage daily activities so compromised, that treatment in the community cannot be delivered safely.

Even those admitted on a voluntary basis are likely to be significantly unwell, making it important that discussions about leave are carefully considered, especially in the early stages of admission.

While voluntary patients can leave the ward at any time, it is reasonable to ask them not to do so until an authorised psychiatrist has reviewed their mental state and level of risk. This is important since their level of risk may have changed since their admission. The reasons for this request should be communicated to the patient and carers, both verbally and in the ward information pack.

If a voluntary patient insists on leaving the ward before their review, the senior nurse should discuss the matter with the authorised psychiatrist. If there are significant concerns for the patient's safety or the safety of others, the senior nurse should consider if criteria in the Act are satisfied to make an Assessment Order.

Under section 29 of the Act, for a person to be made subject to Assessment Order:

- the person must appear to have a mental illness
- the person must appear to need immediate treatment because of this illness to prevent serious deterioration in their mental or physical health or serious harm to the person or to another person
- if the person is made subject to an Assessment Order, the person can be assessed
- there is no less restrictive means reasonably available to enable the person to be assessed.

If these criteria are *not satisfied*, the person must be allowed to leave. Voluntary patients cannot be coerced to remain on a ward by threats to complete an Assessment Order.

Once the authorised psychiatrist's assessment is complete, patients should be encouraged to make well-considered leave plans, in discussion with clinicians and carers. The leave plan can be entered on form MHA 120 (*Leave of absence for compulsory patients*) after deleting the word 'compulsory'.

These discussions, and the resulting decisions, should be documented in the patient's clinical file.

Leave for compulsory patients

Mental Health Act

Under s. 64 of the Act, an authorised psychiatrist may grant leave to a compulsory patient so they can receive medical treatment or for any other purpose that is considered appropriate.

The leave can be for any period, and subject to any conditions that are considered necessary, if the health and safety of the person, and the safety of others, will not be seriously endangered.

When making decisions about leave, the authorised psychiatrist must consider:

- the patient's views and preferences about leave, including any views and preferences expressed in an advance statement
- the role of leave in promoting the patient's recovery outcomes
- the views of the patient's nominated person or guardian
- the views of the patient's carers if the decision will directly affect the carers and the care relationships
- the views of a parent for patients aged under 16 years
- the views of the Secretary to the Department of Health and Human Services if the patient is the subject of a custody to Secretary order or a guardianship to Secretary order.

As soon as practicable after the authorised psychiatrist grants or varies leave, reasonable steps must be taken to notify the patient and, where appropriate, those listed above.

Leave for newly admitted patients

Newly admitted compulsory patients should not be granted leave, even for brief periods, until the treating team has developed enough familiarity with them to make a valid assessment of their mental state and risk.

An explanation of this policy and its rationale should be communicated verbally and in the ward information pack.

Patients who request leave to smoke should be offered nicotine replacement aids.

Assessing risk

The Act states that patients should be allowed to make decisions about their treatment and recovery that involve a degree of risk. It is not permissible therefore to grant leave only if risks are negligible.

Risks must be weighed carefully, preferably in discussion with patients and carers. Risks include absconding, suicide, harm to others including carers (and especially children), substance abuse, exploitation by others, physical deterioration and damage to the patient's reputation.

The patient's mental state and level of risk should be reviewed immediately before starting leave. It is not appropriate to proceed with leave that was approved some days before without considering the current situation.

If the patient's mental state and level of risk have changed significantly, clinicians should consider, preferably in discussion with the authorised psychiatrist or on-call consultant, if leave should be withdrawn.

Very brief periods of leave

Leaving the ward for brief periods – for example, to visit the hospital café – can present just as much risk as other types of leave and warrants just as much consideration, including a risk assessment.

Requests made out of working hours

Planned leave is preferable, but requests for leave are sometimes made at short notice after hours or on weekends.

A clinician who is familiar with the patient's mental state, treatment plan and risk issues must discuss all requests with the authorised psychiatrist. If this information is not available, the authorised psychiatrist should defer the decision until a later time.

Preparing for leave

Discussions about leave should occur early in the admission. Ideally, participants in these discussions should include the patient and carer (where a decision about leave will directly affect the carer and the care relationship).

These discussions should explore the patient's own views, plans and preferences about leave, the goals and benefits of leave, and any risks, and the carer's own viewpoints and circumstances. The resulting decisions should be documented in the clinical file.

Once a leave plan is developed, reasonable steps must be taken to inform the patient of the plan, together with:

- a carer if the decision affects the carer and the care relationship
- the nominated person
- the guardian or a parent if the patient is under the age of 16 years
- the Secretary to the Department of Health and Human Service if the person is subject to a custody or guardianship order.

Carers' involvement

Carers' views about leave should be sought whenever leave arrangements affect the carer and the care relationship.

They may have views on the appropriateness and safety of leave, and seek support from the service to facilitate or modify leave.

Where relevant, they should be questioned about the circumstances of leave (for example, if weapons or toxic medications will be available to the patient) and asked to make premises safer.

Clinicians should speak with carers about ways to make the leave experience more therapeutic.

Developing a leave plan

Details of the leave plan should be entered on form MHA 120 (*Leave of absence for compulsory patients*).

To provide more writing space, services are encouraged to provide a digital version of the form that expands on screen.

The completed form should be handed to the patient and any accompanying person prior to leaving the ward.

While the form can be applied to multiple episodes of leave if indicated, the plan should be updated as circumstances change.

Completing the leave form

Any requirement that the patient must be accompanied by a family member, staff member or other person while on leave should be documented on the leave form, together with the name and/or designation of the individuals concerned.

Other conditions to note on the form include abstaining from drug and alcohol use, driving a motor vehicle or supervising children. If applicable, patients can be asked to undergo an alcohol breath analysis or urine drug screen when they return to the ward. Refusal to comply with testing should prompt a review of the leave plan.

Any medication required while on leave should be arranged prior to leave and noted on the leave form. There should be a discussion with the patient (and carer if applicable) about the nature and role of any 'as needed' (PRN) medications.

The patient (and accompanying person if applicable) should be told they can return to the ward at any time of the day or night. The ward's contact details should be listed on the form.

Accompanying persons

Consideration should be given to the appropriateness of any accompanying person in terms of their capacity to exercise appropriate responsibility while on leave with the patient (for example, to abstain from drugs and alcohol). If the person is unable or unwilling to exercise this responsibility, the leave should be reviewed.

Where expectations are placed on an accompanying person as part of the plan, these must be clearly communicated to both the patient and the other person.

The accompanying person should be given reasonable information about the patient's mental state and level of risk to enable them to make an informed decision about participating in the period of leave.

They should be encouraged to think about ways to make the period of leave a positive experience, how to avoid stressful situations, and how to respond to concerns about the patient's wellbeing and their own safety.

If the accompanying person cannot come to the ward to take the patient on leave, reasonable attempts should be made to communicate this information by telephone.

Securing possessions while on leave

While patients are on leave their personal belongings should be stored safely. If possible, their room should be locked and valuable items secured in a locker.

Refusing leave

A refusal of leave can precipitate distress, threatened or actual self-harm, aggression and absconding. The decision should be communicated as tactfully and positively as possible at an appropriate time and in a suitable setting.

If leave is not considered appropriate, alternative strategies should be devised to address the patient's expressed needs (for example, if spending money is required, a family member can be asked to bring some to the ward).

Revoking leave

Under s. 64 of the Act, a leave of absence may be revoked if the authorised psychiatrist is satisfied that revocation is necessary to prevent:

- serious deterioration in the person's mental or physical health
- serious harm to the person or another person.

The patient must be notified as soon as practicable of this decision, and told of its purpose and effect. The following people should also be notified:

- a carer if the decision affects the carer and the care relationship
- the nominated person, guardian or parent if the patient is under the age of 16 years
- the Secretary to the Department of Health and Human Services if the person is subject to a custody to Secretary order or guardianship to Secretary order.

The authorised psychiatrist must complete form MHA 122 (*Compulsory patient leave of absence revocation*).

Return from leave

When patients return to the ward, they should be asked how the leave went. Any issues or concerns should be identified and documented, together with a mental state assessment and risk assessment.

Carers and other accompanying people should also be asked for feedback, with an opportunity to speak confidentially. This information provides useful information regarding issues to be resolved prior to discharge.

Searching patients on return from leave

If a clinician has reason to believe that a patient returning from leave is carrying anything that presents a danger to the health and safety of the person or another person (for example, illicit substances or weapons), the patient may be searched under certain circumstances.

If the person has the capacity to consent, they must consent to the search. If they lack capacity to consent, clinicians can conduct a search only if they have lawful grounds to do so. For more details, see the Chief Psychiatrist's guideline *Criteria for searches to maintain safety in an inpatient unit* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/criteria-or-searches-maintain-safety-in-inpatient-unit-for-patients-visitors-staff>.

Failure to return from leave

If a patient fails to return from leave at the agreed time, the senior nurse and authorised psychiatrist must be notified as soon as practicable.

All reasonable attempts should be made to contact the patient, an accompanying person or carer (where the failure to return from leave is likely to affect the carer and the care relationship).

The decision to notify police must be made by senior staff after considering the patient's goals and duration of leave, their mental state and risk assessment prior to leave, and previous issues with leave.

If police are notified, form MHA 124 (*Absent without leave patient apprehension*) must be completed and sent to the nominated police station. This permits the police to return the patient to the ward.

The triage service and community team should also be notified.

All contacts, or attempted contacts, with the patient, carers, nominated person, guardian, police or other agencies should be documented in the clinical record.

Unauthorised leave

Unauthorised leave (absconding) from a ward is always concerning. Most people return safely to the ward but some do not.

All reasonable attempts should be made to contact the patient and carer (where the unauthorised leave is likely to affect the carer and care relationship).

The decision to notify police must be made by senior staff after considering the patient's goals and duration of leave, their mental state and risk assessment prior to leave, and previous issues with leave.

If police are notified, form MHA 124 (*Absent without leave patient apprehension*) must be completed and transmitted to the nominated police station. This permits the police to return the patient to the ward.

The triage service and community team should also be notified.

Debriefing after returning to the ward

Most people who abscond do so impulsively in response to high, persistent levels of distress. Factors that might contribute to this distress include:

- withdrawal from alcohol or other drugs
- delayed or inadequate treatment of their mental illness
- a perception of poor engagement by clinicians
- a lack of meaningful activity on the ward
- conflict with a co-patient
- an urgent need to attend to matters at home.

Upon returning to the ward, a senior clinician should spend time with the patient to understand the reasons for absconding and what factors might, from the patient's perspective, reduce the likelihood of further episodes. This information should inform a review of the treatment plan.

Once the reasons for unauthorised leave have been identified, the treatment and leave plans should be modified to address them.

Service policies and forms

Each mental health service should prepare a policy and procedure document that applies this guideline to local circumstances. Key elements include escalation procedures when:

- newly admitted voluntary patients wish to leave the ward against medical advice
- compulsory patients take unauthorised leave from the ward
- patients fail to return to the ward at the agreed time.

Leave policies and practices should be described in simple, clear language in the ward admission pack.

Services should develop a digital version of form MHA 120 (*Leave of absence for compulsory patients*) that expands on screen and allows more space for detailed leave plans.

Service self-assessment tool

Indicators of compliance with this guideline can include the proportion of selected inpatient clinical records that include:

- reference to suitability for leave in the authorised psychiatrist's initial clinical assessment
- evidence of subsequent discussion(s) between the authorised psychiatrist and the patient regarding leave goals, risks associated with leave, proposed leave arrangements and conditions of leave
- evidence of discussions about leave arrangements with carers (where leave is likely to affect the carer and care relationship) or any accompanying person
- evidence that leave plans, including safety plans, were completed prior to leave and handed to the patient (and any accompanying person)
- evidence that anyone accompanying the patient on leave was informed of the patient's mental state and level of risk
- evidence that information was sought after leave about the patient's and the accompanying person's experiences of leave
- evidence of discussions with patients after episodes of absconding regarding the reasons for leaving the ward and factors that might reduce the risk of further absconding.

Information resources

Department of Health 2011, *Framework for recovery-oriented practice*, State Government of Victoria, Melbourne.

Commonwealth of Australia 2010, *National standards for mental health services 2010*, Australian Government, Canberra.

Acknowledgement

This guideline was developed with the assistance of the Victorian Mental Health Inter-Professional Leadership Network.

Guideline update

The Deputy Chief Psychiatrist will review this guideline in three years' time.