# Approved procedure 8

Controlled Document

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| **Target Audience** | Approved Treatment Facilities under the Mental Health and Related Services Act |
| **Jurisdiction** | Northern Territory |
| **Document Owner** | Chair Mental Health and Related Services Act Approved Procedures and Quality Assurance Committee |
| **Approval Authority** | Chief Executive |
| **Author** | Approved Procedures and Quality Assurance Committee |

# Purpose

To outline the requirements for managing leave for involuntary inpatients under section 166 of the *Mental Health and Related Services Act 1998* (the Act).

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| **Patients who have failed to return from leave or are absent without approved leave**  Guidance on the management of inpatients who fail to return from leave or are absent without approved leave can be found in **Approved Procedure 166A –Inpatients Absent without Approved Leave or Missing** |

# 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.

It is a requirement that approved treatment facility (ATF) policies and procedures regarding leave align with the Act and the National Standards for mental health services to ensure that leave procedures are respectful, therapeutic and legal.

This procedure endeavours to enumerate the elements of good practice and lists indicators for ATFs to check that procedures accord with the Chief Executive’s expectations.

The Act requires:

* The provision of a “least restrictive” “least intrusive” service environment possible (section 8(a));
* The maintenance of the safety and welfare of patients (section 3(a)); and
* Achievement of positive outcomes for the patient (section 9(c)).

The Mental Health Statement of Rights and Responsibilities provides an overarching framework to guide policy and practice and addresses eight domains where rights and responsibilities are relevant to mental health, these rights include, the right for consumers/patients to:

* be considered capable of making a decision (by the service or person providing care);
* have their wishes respected and taken into account;
* have their lived experiences respected and taken into account;
* have families, carers and support persons involved in their assessment, support, care, treatment, recovery and rehabilitation to the extent requested by them; and
* signify their wishes and preferences in regard to future treatment, support and care.

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

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| **Practice Note**  Under section 8(b), the safety of members of the public, should also be considered when determining whether leave should be granted to a person under section 166 of the Act.  A new/separate approval process is required for each instance of leave i.e. the leave process must be repeated prior to each episode of leave from the facility.  When leave is granted in the form of ongoing daily leave (i.e. regular smoking breaks), for each leave occasion, there is a requirement for clear documentation of the person’s current behaviour, conversations and the assessed risk (also refer to practice note below on Smoking Leave). |

## Risk

A risk assessment needs to be undertaken prior to any patient leave request being approved. Where there is any significant risk, the effectiveness of proposed mitigation treatments are to be assessed prior to the decision to grant leave. Risks must be weighed carefully, preferably in discussion with the patient and their carers. Risks include absconding, suicide, harm to others including carers (and children), substance abuse, exploitation by others, physical deterioration and damage to the patient’s reputation.

The duty to the patient is not transferred while on leave. It is therefore incumbent on the ATF to ensure there is a proper appreciation of the circumstances the patient will be in while on leave and a fulsome handover of information and strategies to those who are being tasked to escort the patient.

Things to consider when assessing risk:

* Is the patient actively psychotic?
* Is the patient at risk of suicide/self-harm/harming others?
* Has the patient been trialled in a Low Dependency Unit?
* Does the patient have insight as to why they should remain at the ATF?
* Has the patient been seeking leave since their admission?
* What phase is the patient in towards recovery?
* Has the discharge planning process commenced for the patient?

A thorough review needs to be undertaken by the treating team with the patient, their carer(s), and/or the responsible adult who will be accompanying the person while on leave. This review needs to occur prior to the leave been granted to enable any subtleties to be understood. As part of the risk assessment, the treating team needs to have a full understanding of what the potential supervisor is feeling about their willingness and capacity to fulfil the supervisor responsibilities.

The whole process should be explored with the patient and their primary carer/responsible person including:

* discussion about diagnosis, nature of the illness and any risk that it would bring, ongoing treatment of the illness, and where relevant, information about medications to be taken by the patient whilst they are on leave;
* the reason for the leave, the possible period of the leave and leave conditions;
* education or advice in relation to the family’s/guardian/carer’s/responsible adult’s ongoing monitoring, observation and supervision of the patient whilst they are on leave;
* risks associated with the leave being approved including risk of the patient harming themselves or others and identification of possible/sufficient risk mitigations;
* whether or not the carer/responsible adult have any apprehensions or reservations about the leave being granted;
* what to do if the patient does not wish to return to the hospital at the end of their leave;
* what to do and who to call if there are problems encountered while the patient is on leave.

Ideally discussions around the prospect of leave will include all people involved in the leave decision, including the patient. However there may be clinical circumstances, where having the patient present will cause the family to feel pressured to accept care of them while on leave. Under these circumstances, the discussion between the treating team and the primary carer/responsible adult may need to occur out of hearing of the patient due to the potential for it to be destabilising to the relationship between the carer/supervisor.

Ideally the treating team will explore possible scenarios with the carer/responsible adult, like:

1. What happens if the patient walks or runs off?
2. Are they confident that they can manage that?

And explain what they should do if this does happen.

Where possible, the carer/responsible adult should be provided with information about these scenarios in writing in a language and at a level that they understand.

# Procedure

## Requirements under the Act

### Granting leave

Under section 166 of the Act, an authorised psychiatric practitioner (APP) may grant an involuntary inpatient leave from the ATF if they are not a prisoner.

The leave of absence:

1. must not be granted except in accordance with this approved procedure; and
2. must be recorded in the approved form; and
3. is subject to the conditions determined by the APP.

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| **Leave considerations**  Consideration of leave from the facility should be made with reference to the ATF’s internal procedures and following an appropriate risk assessment. When making decisions about leave, the APP must consider:   * the patient’s views and preferences about leave, including any views and preferences expressed in an advance statement * the views of the patient’s nominated decision maker or guardian * the views of the patient’s nominated decision maker 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/guardian for patients aged under 16 years * the views of the Adult Guardians if the patient is the subject of Adult Guardianship Order * whether the leave is requested for smoking and what support is available to the person is the leave is not granted * offering interpreters for support persons to be provided when needed/requested/available * whether carer/support persons understand the responsibility of supporting patients on leave.   The following are considered appropriate reasons to grant leave:   * a period of leave is likely to benefit the health and wellbeing of the person; * it contributes to the person’s individual discharge plan; and/or * it is for the person to undergo surgical or medical treatment.   Any decision to allow a person to take leave should take into account the reason for which they have been admitted and the principle of the least restrictive alternative.  As soon as practicable after the APP grants or varies leave, reasonable steps must be taken to notify the patient and, where appropriate, those listed above.  Whilst ‘on authorised leave’ the person’s legal status will continue to be that of an involuntary admitted patient. The APP authorising the period of leave may impose certain conditions considered appropriate to the leave and may also extend the period of leave if necessary. Whenever an involuntary patient is given leave of absence, they should be provided with information on their rights and entitlements with regard to the period of leave. Their responsible adult and/or carer should also be provided with hard copies or details of where to source information on consumer and carer’s rights under the Act.  An APP must record the details of the leave and provide the person and any accompanying adult with information which outlines any conditions upon which the leave has been granted as well as the date and time the leave starts and ends.  An involuntary patient granted leave will in most cases require a responsible adult to take care of them for the duration of their leave.  The APP must ensure that the responsible adult reads and understands the requirements and responsibilities placed upon them and is clear that the granting of leave does not mean the person has been discharged or their legal status (involuntary) has changed. This conversation with the responsible adult is also to be documented in the person’s clinical record.  The responsible adult must also understand why the leave has been granted to the person and what steps should be taken to ensure the person’s safety while they are on leave from the facility.  **NB: It is unreasonable and impractical to expect the carer/responsible adult to keep the patient in view at all times while they are on leave. If this level of supervision is required for the patient, then the approval of leave may not be in the best interests of the patient**.  An entry is to be made in the person’s clinical record that leave of absence has been granted The actual date and time of commencement of leave and the date and time of return to the ATF are to be recorded. Where possible, ensure the message is understood by the patient e.g. information is communicated in an accessible way – language, interpretation, pictorial etc. |

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| **Leave for newly admitted patients**  Newly admitted involuntary patients i.e. those patients that have been admitted for 72 hours or less should not be granted leave, even for brief periods, until the treating team has formed a clinical view 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. |

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| **Smoking leave**  Patients who request leave to smoke should be provided with advice on the effect of smoking on their mental health and offered nicotine replacement aids and information on appropriate smoking cessation programs. Once a patient has been placed on nicotine replacement aids, this should be continued for the duration of the person’s stay in hospital.  It is at the discretion of the treating doctor to assess if a patient may have unaccompanied ground leave for smoking and to document this in case notes on a daily basis. Specific times for Smoking Leave should then be scheduled, ensuring that it will not interrupt or detract from the meaningful activity programs or other therapeutic priorities. The period of absence from the ward should not extend beyond 15 minutes. |

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| **Refusal of leave**  A refusal of leave can precipitate distress, threatened or actual self-harm, aggression and absconding.  The decision should be communicated as tactfully and sensitively 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). |

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| **Recording in the approved form**  **Form 51 - Leave Approval and Agreement** is the Approved Form for the recording of leave details. Other forms of recording leave are required to be approved by the Chief Executive of NT Health under the provisions of section 4 of the Act. |

### Cancellation of leave

Under the provisions of section 166(4), an APP may cancel an involuntary patient’s leave, if they are satisfied, on reasonable grounds, that:

1. the person is likely to suffer from serious mental or physical deterioration as a result of a change in the person's mental state; or
2. the person is likely to cause harm to himself or herself or to someone else; or
3. the person has failed to comply with a condition of the leave.

The patient must be notified as soon as practicable of this decision, and told of its purpose and effect.

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| **Practice Note –Cancelling leave**  If a period of leave is cancelled, the APP must ensure that the following people are notified of this, as appropriate:   * The patient; * The patient’s primary carer; * The patient’s representative; and/or * The patient’s Adult Guardian.   The following people should also be notified:   * The PIC of the ATF; and * The Clinical Nurse Manager or on call delegate.   If the patient fails to comply with a condition of leave or fails to return to the facility, following notification of the cancelation of leave, or they cannot be contacted to advise of cancellation of leave, they will be considered to be on leave without approval (absconded), refer to **Approved Procedure 166A – Absconded or Missing Inpatient**. |

## Operational requirements not prescribed by the Act

### Recovery-oriented practice

The National standards for mental health services (which is available from the Northern Territory Department of Health website) requires clinical policies and practices to align with the principles of recovery-oriented mental health practice.

This style of practice:

* supports and empowers individuals to make their own choices about what recovery means to them;
* 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; and
* ensures a balance between duty of care and support for individuals to take positive risks and to make the most of new opportunities.

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 are important to them.

### 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 decision maker in situations where patients cannot communicate this information themselves
* subject to consent, carers and significant others, nominated decision maker, 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.

Refer to ***Approved Procedure 25 – Working with Families and Carers*** for further information on the expectations of mental health clinicians in working with families and carers

### Assessing risk

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 there are no risks present.

Risks must be weighed carefully, in discussion with patients and carers. Risks include absconding, suicide, harm to others including carers (and 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, in discussion with the APP if leave should be withdrawn. As per the requirements of section 166(4), the APP must authorise the cancellation of leave. Refer to previous section “Cancellation of Leave” for further information.

### 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.

Regardless of when the request has been made, an APP should discuss the appropriateness of the request with clinicians who are familiar with the patient’s mental state, treatment plan and risk issues (the treating team).

If an APP is of the opinion that the person should be approved for leave that has not been endorsed by the treating team (i.e. a sudden and/or unexpected recovery or in circumstances where there is insistence by the family to take the patient out and approval of leave would preserve the therapeutic relationship between the patient and the family), then this must be approved with the on-call Consultant (Level 1 APP).

### 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 the following, where relevant:

* a carer or other nominated decision maker if the decision affects the carer or other nominated decision maker and the care relationship
* the guardian or a parent if the patient is under the age of 16 years
* the Adult Guardian if the person is subject to a guardianship order
* the proposed accompanying adult (if not already informed)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, the circumstances of leave (for example, if weapons or toxic medications will be available to the patient) will be discussed and they may be 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 the relevant approved forms.

The completed form should be handed to the patient and any accompanying adult 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 for the patient to 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 adult 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 adults

Consideration should be given to the appropriateness of any accompanying adult 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 adult as part of the plan, these must be clearly communicated to both the patient and the other person through appropriate and accessible information.

The accompanying adult should be given reasonable information about the patient’s mental state and level of risk to enable them to make an informed decision about taking on the responsibility.

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 adult 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.

### Return from leave

When patients return to the ward, the leave should be reviewed with the patient and their accompanying adult. 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 patient has the capacity to consent, then a search cannot be undertaken without their consent. If they lack capacity to consent, then a search can be conducted only if there are lawful grounds to do so.

**Approved Procedure 31 - Personal Search and Seizure** details the lawful basis for the conduct of searches on patients. This Approved Procedure should be referred to for further information.

# Document Quality Assurance

|  | **Method** | **Responsibility** |
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| **Implementation** | Document will be accessible via the MHARS Act internet and intranet pages and the PGC. | Senior Compliance and Clinical Policy Co-ordinator MHAOD Branch |
| **Review** | Document will be reviewed within a period of 4 years. | Approved Procedures Quality Assurance Committee |
| **Evaluation** | Document will be informally evaluated at time of review. | Approved Procedures Quality Assurance Committee |

# Key Associated Documents

All related material produced by the Northern Territory Department of Health is available from: **https://health.nt.gov.au/professionals/mental-health-information-for-health-professional/office-of-the-chief-psychiatrist**

Mental Health and Related Services (MHARS) Act 1998 – available from: **https://legislation.nt.gov.au/en/LegislationPortal/Acts/By-Title#**

# Definitions and Search Terms

| **Preferred Term** | **Description** |
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| **Accompanying adult** | The responsible person who is accompanying or escorting a patient while they are on leave. The ‘accompanying adult’ is required to agree to accept responsibility for the patient and accept the conditions of their leave. The ‘accompanying adult’ may or may not be a carer, guardian or nominated decision maker. |
| **APP** | Authorised Psychiatric Practitioner |
| **ATA** | Approved Treatment Agency |
| **ATF** | Approved Treatment Facility |
| **Carer** | A person who looks after someone with a mental illness |
| **CMO** | Community Management Order |
| **Guardian** | A person chosen to make decisions on behalf of someone who is unable to make decisions for themselves to make sure their needs are met and their interests protected.  *Refer to* [*https://nt.gov.au/law/processes/adult-guardianship-and-orders*](https://nt.gov.au/law/processes/adult-guardianship-and-orders) *for further information* |
| **MHARS Act** | *Mental Health and Related Services Act 1998* |
| **Nominated decision maker** | A person who makes decisions on another person’s behalf under an Advance Personal Plan or enduring Power of Attorney. |
| **Patient** | A person who is being assessed or receiving treatment under the Mental Health and Related Services Act 1998 |
| **PIC** | Person in Charge |
| **Senior RNOD** | Senior Registered Nurse on Duty |

#### Alternative Search Terms

Absence, smoko, smoking, break, leaving, sectioned, patient