# Approved procedure 8A

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 voluntary inpatients under the provisions 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 explanation**  Guidance on the management of inpatients who fail to return from leave or are absent without explanation can be found in **Approved Procedure 166A –Inpatients Absent without Approved Leave or Missing** |

# Introduction

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 adequate treatment is not available in the community.

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.

This procedure endeavours to enumerate the elements of good practice and lists indicators for Approved Treatment Facilities (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 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 cannot be denied to patients unless it is in accordance 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.  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

Patients should be allowed to make decisions about their treatment and recovery that involves a degree of risk. It is not permissible therefore to grant leave only if there are no risks at all.

There are risks involved in both granting and restricting 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.

Risks are to be weighed against the positive benefits of empowering the patient to take more responsibility and control of their life with recognition of the cultural, social, and individual needs of the patient, carer and family. Particular consideration may be needed for people of Aboriginal or Torres Strait Islanders descent who may require cultural leave, e.g. Sorry Time.

A risk assessment needs to be undertaken prior to any patient leave request being approved. Where there is any significant risk, the effectiveness of the 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 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 APP, if leave should be withdrawn or cancelled (refer “Cancellation of Leave” section below).

The ATF’s 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 responsible adults who are being tasked to accompany the patient.

Prior to granting leave, consideration is to be given to the patient’s:

* Risk to self;
* Risk to others;
* Risk/vulnerability from others;
* Assessment of clinical state; and
* Physical health status.

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 patient while on leave. This review needs to occur prior to the granting of leave 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 accompanying adult is feeling about their willingness and capacity to fulfil their responsibilities.

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

* discussion about diagnosis, nature of the illness and any unpredictability 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 recommendations or advice;
* education or advice in relation to the carer/accompanying 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/accompanying 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 may 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/accompanying 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/accompanying adult, like:

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

And explanations should be provided detailing what they should do if this does happen.

Where possible, the carer/accompanying 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

Voluntary patients may discharge themselves from an Approved Treatment Facility (ATF) at any time under the provisions of section 29(1).

Section 29(3) also requires that an Authorised Psychiatric Practitioner (APP) discharge a voluntary patient if they are of the opinion that:

1. it is in the patient's best interest to do so; or
2. the patient will not obtain any benefit by prolonging their admission.

*Refer to* ***Approved Procedure 5 – Voluntary Admission*** *and* ***Approved Procedure 7 – Discharge Planning*** *for further information concerning voluntary admission and discharge.*

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| **Granting leave rather than discharge**  While the APP may determine that it is not currently in the person’s best interest to be discharged from the ATF, they might determine it to be in the best interest of the person to have a period of leave for an agreed duration, under agreed advice. Relevant approved procedures and ATF internal policies should be followed where leave arrangements for a voluntary patient are being contemplated.  **Assessment prior to leaving the ward/granting leave**  While voluntary patients can leave the ward at any time, it is reasonable to ask them not to do so until an APP 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.  **When leave has been granted**  Once the APP’s review is complete, patients should be encouraged to make well-considered leave plans, in discussion with clinicians, carers and accompanying adults. The leave plan can be entered in electronic record systems.  These discussions, and the resulting decisions, should be documented in the patient’s clinical file.  Where a leave of absence is to occur for a voluntary patient, the APP must document their approval of such, including advice or recommendations for the person who has been granted leave, and the date and time the leave starts and ends.  The APP or delegate must then ensure that the person understands the advice, recommendations and responsibilities placed upon them during their leave of absence.  Given that section 29(5) requires for notification to a patient’s adult guardian or decision maker of the discharge of a voluntary patient admitted under section 27 (i.e. via an application from an adult guardian or decision maker), the APP must also, as soon as possible notify the patient's adult guardian or decision maker about the approval of leave.  If the APP determines that the person requires an accompanying adult or escort while on leave, the details of the ‘accompanying adult’ must also be documented. The ‘accompanying adult’ is required to agree to accept responsibility for the person and acknowledge the Clinician’s advice or recommendations regarding the person’s leave. The ‘accompanying adult’ may or may not be a carer, adult guardian or decision maker.  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. |

### Where the patient is insistent on taking leave

If a voluntary patient insists on leaving the ward before their review or without leave being granted, they should be either

* discharged against medical advice; or
* if the Senior RNOD of APP believes that the person’s condition has deteriorated since their admission to the point that they may fulfil the criteria for admission on the grounds of mental illness or mental disturbance, Section 30 may be used to detain them.

The person must then be examined and assessed by an APP under the provisions of section 38. *Refer to* ***Approved Procedure 6 – Involuntary Admission*** *for further information on the outcomes of a section 38 examination and assessment.*

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| **Where a voluntary patient is insisting on leaving**  If a voluntary patient is seeking periods of authorized leave that the APP considers is not in their best interests or not agreeing to the restriction of leave as part of their treatment and care, the senior nurse on duty (Senior RNOD) should discuss this with the APP. Similarly, if a voluntary patient is consistently not adhering to agreed leave provisions, the APP will need to consider if involuntary treatment or discharge is warranted.  If there are significant concerns for the patient’s safety or the safety of others, the Senior RNOD and/or APP should consider if criteria in the Act are satisfied to detain the patient under section 30, pending a section 38 assessment. To apply the provisions of section 30, evidence of deterioration in the person’s condition since admission is required to be thoroughly documented.  The power to detain a person under section 30 is to be exercised on the basis of a real time assessment of the person’s condition, rather than by an advanced directive. If the person, detained under section 30 leaves the ward, ***Form 52 Inpatient Absent without (Approved) Leave or Missing is to be completed***.  If the criteria for the application of section 30 is not satisfied at the time, the person must be allowed to leave.  Voluntary patients cannot be coerced to remain on the ward by threats to detain them pending an examination and assessment by an APP.  *Refer to* ***Approved Procedure 5 - Voluntary Admission*** *for further information on the requirements for care and treatment of voluntary patients.* |

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| **Strategies to be put in place when refusing leave**  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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| **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.  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. |

## Operational requirements not prescribed by the Act

### Recovery-oriented practice

The National standards for mental health services 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 and define their own recovery
* 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 decision makers in situations where patients cannot communicate this information themselves
* subject to consent, carers and significant others, nominated decision makers, 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*

### 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 should be discussed (for example, if weapons or toxic medications will be available to the patient) and if appropriate they may be asked to make the premises safer.

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

### 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).

### Leave plans

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)

### Completing the leave form

Details of the leave plan should be documented on a leave form, with details provided to the patient and any accompanying adult prior to leaving the ward. The plan should be updated as circumstances change.

**Form 51A Leave of Absence – Voluntary Patient** has been developed to assist ATFs record details of voluntary patient leave.

Any recommendations for the patient to be accompanied by a family member, staff member or other person while on leave should be documented, whether in a form or communication book, together with the name and/or designation of the individuals concerned.

Other recommendations and advice to note should also be documented such as, 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, noted and documented.

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 provided to the person (and accompanying adult if applicable).

### 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/or 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.

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 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 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, where applicable. 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.

### Non-return from leave

*Guidance on the management of inpatients who fail to return from leave can be found in* ***Approved Procedure 166A – Absconded or missing inpatients***.

### 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, 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.

### Cancellation of leave

Although not specifically prescribed in the Act, an APP (or Senior RNOD) may cancel a voluntary patient’s leave, if they are satisfied, on reasonable grounds, that:

* 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
* the person is likely to cause harm to himself or herself or to someone else; or
* the person has failed to comply with a condition of the leave.

If the leave is cancelled by the Senior RNOD, they must advise the APP within one (1) hour of this decision. The patient must also be notified as soon as practicable of this decision, and told of its purpose and effect.

If the patient is insistent on taking or remaining on leave following cancellation, the APP or Senior RNOD should consider the application of section 30 of the Act (refer to previous section - Where the patient is insistent on taking leave against advice).

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| **Practice Note: Cancelling leave**  If a period of leave is cancelled, the following people are to be 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. |

# 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 acknowledge the advice or recommendations provided about the 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 nominated 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