Government of **Western Australia**
Department of **Health**

Best Practice Guideline: Mental Health Consumers Who Are Missing or Absent Without Leave

WA Public Mental Health Services

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Contents

1 Introduction

This best practice guideline provides guidance to Western Australian public mental health services for the development of policies and procedures and protocols to:

a) reduce the likelihood of mental health consumers going missing from services or becoming absent without leave (AWOL)
b) guide the response of services when a mental health consumer is determined to be missing or AWOL
c) guide the response of services when the consumer returns to the service
d) learn from AWOL or missing person incidents to inform practice improvement.

The risk of self-harm and suicide is increased when a mental health consumer goes missing from a health service, as is the risk of exposure to undesirable or unsafe situations[1]. The wellbeing and safety of others, particularly the carers/family or personal support person, may also be compromised.

AWOL or missing person incidents disrupt the mental health consumer's treatment and care and place additional demand and/or stresses on health services, other agencies and staff members. This guideline promotes practical measures to minimise such incidents, including the systematic use of knowledge and experience gained from the analysis of missing person or AWOL events.

2 Scope

This guideline is applicable to Health Service Providers (HSPs) that provide public mental health services, including emergency departments (EDs), general hospitals, and rural nursing posts that may have a duty of care to mental health consumers.

The guideline is relevant to mental health consumers of all ages who access public health services, regardless of their status under the *Mental Health Act 2014*. This includes people referred for assessment who are not active with a public mental health service.

3 Values

This section outlines the principal values underpinning this guideline.

3.1 Duty of care

HSPs have a duty to ensure that assessment and treatment of mental health consumers entrusted to their care is undertaken in a safe environment. All people who go missing from a health service need to be followed up, regardless of their legal status. However, the level of urgency and type of response should be

[1] Stewart, D. and Bowers, L. (2010). Absconding from psychiatric hospitals: a literature review. *London: Institute of Psychiatry, King's College London*.

guided by the existing care plan and risk management plan. It should also be guided by a further timely risk assessment which considers not only harm to self and others, but the range of risks such as sexual vulnerability and any considerations of abduction/coercion. Carers/family and personal support people should be kept informed of developments in a timely way, unless there are explicit, documented reasons why they should not be contacted.

3.2 Person-centred care

Person-centred care[2] is fundamental to safe, high-quality healthcare. It is respectful of, and responsive to, a person's needs, including their culture, beliefs, values, traditions, family situation, social circumstances, sexual and gender identity, lifestyle and preferences. It involves fostering trust and empowering mental health consumers to participate in decision-making regarding their care.

Mental health consumers may become AWOL or go missing from health services for many reasons, including concerns about the therapeutic milieu or physical environment, communication difficulties with staff, reluctance to participate in treatment, and personal or family relationships and responsibilities.[3] A sudden or unresolved social stressor, or drivers from mental illness itself, can also be significant contributing factors. The mental health consumer, their carers/family and personal support person can provide valuable information and advice from their lived experience, and their views should be given appropriate weight in the planning and delivery of their care.

Key dimensions of person-centred care include respect, consideration of autonomy and self-agency, emotional support, physical comfort, appropriate and timely information and communication, continuity and transition, care coordination, involvement of carers/family and personal support people, and access to care.

Respect for individual preferences, strengths and abilities will reduce the likelihood of a mental health consumer going missing or becoming AWOL from services.

3.3 Recovery-focus

Personal recovery is defined within the *National Framework for Recovery-oriented Mental Health Services*[4] as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.' A recovery orientation requires services to confront the tension between maximising choice and supporting positive risk-taking on one hand and duty of care and promoting safety on the other.

Involuntary treatment orders for inpatient admissions, particularly a first admission, can arouse fears and create a sense of powerlessness. It is important

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[2] Person centred care, in Standard 2, Partnering with consumers, National Safety and Quality Health Service Standards. Available from: https://www.safetyandquality.gov.au/our-work/partnering-consumers/person-centred-care

[3] Stewart, D. and Bowers, L. (2010). Absconding from psychiatric hospitals: a literature review. *London: Institute of Psychiatry, King's College London*.

[4] A national framework for recovery-oriented mental health services: guide for practitioners and providers. Available from: https://www.health.gov.au/resources/publications/a-national-framework-for-recovery-oriented-mental-health-services-guide-for-practitioners-and-providers

that care is provided in the least restrictive environment and that mental health consumers are given as much choice and control over what happens to them as is possible, while protecting their safety and that of others. Increasing a mental health consumer's sense of autonomy can engender trust and reduce their likelihood of going missing or becoming AWOL.

3.4 Recognition of carers/family and personal support person

Engaging the carers/family and personal support person at all stages of the mental health consumer's treatment and care should be routine unless the consumer declines to consent to their involvement. The carers/family and personal support person can play an active role in reducing the risk of a mental health consumer going missing or becoming AWOL and can encourage their return to care.

Health professionals should be sensitive to the consumer's safety needs when making decisions about sharing information with or involving family or a particular family member in the person's care. In addition, health professionals should be sensitive to the safety needs of the family or carers when considering this.

3.5 Trauma-informed care and practice

Consumers of mental health services who have experienced previous trauma in childhood and adulthood are at high risk of re-traumatisation. Trauma-informed services seek to avoid re-traumatisation by embedding trauma-informed care and practice into all aspects of service delivery and providing a therapeutic milieu or physical environment that is physically and psychologically safe.[5] This can reduce the likelihood that mental health consumers will attempt to leave a service due to psychological distress.

3.6 Culturally secure service delivery

Cultural safety has been defined as an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge to or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and the experience of learning together.[6]

Culture and language differences create difficulties in delivering or receiving appropriate mental health care, support and services. People from ethnoculturally and linguistically diverse backgrounds are overrepresented in involuntary admissions and acute inpatient units and are more likely to be exposed to quality and safety risks.[7]

The right of Aboriginal people to be treated in a culturally appropriate way when receiving mental health care is provided for in the *Mental Health Act 2014* (see Charter of Mental Health Care Principle 7, along with sections 50, 81 and 189 regarding collaboration with Aboriginal mental health workers and significant

[5] Trauma informed Care and Practice Organisational Toolkit

[6] Williams, R. (1999). Cultural safety – what does it mean for our work practice? *Australian and New Zealand Journal of Public Health*, 23(2), 213-214

[7] Divi, Koss, Schmaltz, & Loeb, 2007; Johnstone & Kanitsaki, 2005, 2006; Pirkis, Burgess, Meadows, & Dunt, 2001; Stolk et al., 2008; Suurmond, Uiters, de Bruijne, Stronks, & Essink-Bot, 2011

members of the consumer's community).

Some of the complex issues surrounding Aboriginal mental health and culturally appropriate services are outlined in the publication *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, which notes that 'Management of the issues of mental illness requires a strong emphasis on cultural safety, along with the recognition of family, culture and community in any healing process'.[8]

3.7 Developmentally appropriate care

Planning services and approaches should respond to the needs of children and young people. Developmentally appropriate care considers a child's level of physical, social, emotional and intellectual development. This is especially important in circumstances where children under the age of 18 are cared for in adult environments, such as emergency departments (EDs) and adult wards.

3.8 Continuous improvement

Clinical risk management[9,10] plays a vital role in supporting and informing decision-making to provide a safe and secure health service environment for consumers, carers/family, personal support people and staff members. It is part of a good clinical governance system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.

Services should foster a safety culture in which health professionals seek to learn from AWOL and missing person incidents and near misses to improve the care of individual mental health consumers, to improve the quality of the overall service, and reduce the likelihood of future AWOL and missing person incidents.

Team review and periodic audits that consider aggregated information from multiple AWOL or missing person incidents can identify patterns and broader lessons learned, to inform service improvement.

4 Prevention

When developing procedures and protocols to reduce the risk of mental health consumers going missing or becoming AWOL, the following factors should be considered:

4.1 Risk assessment and safety planning

Whether in an inpatient unit, in the community, in a clinic or in an ED, an early assessment with regular reassessment (particularly during transitions in care and when there has been a change in the consumer's clinical state) should be made to

[8] Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice (2nd edition). Available from: https://www.telethonkids.org.au/our-research/early-environment/developmental-origins-of-child-health/expired-projects/working-together-second-edition/
[9] Department of Health Clinical Risk Management. Available from: Clinical risk management (health.wa.gov.au)
[10] Clinical Incident Management Policy 2019 (MP 0122/19). Available from: Clinical Incident Management Policy 2019 (health.wa.gov.au)

determine the risk of the mental health consumer going missing or becoming AWOL. This should include consideration of the possible consequences if they do.[11] Safety planning should be, wherever possible, implemented in partnership with the consumer and documented in the consumer's clinical file and made readily available to staff members.

Practical advice and strategies should be identified and implemented in discussion with the consumer, carers/family and personal support person, to help reduce the likelihood that the person will go missing and maintain the consumer's safety.

4.2 Care partnerships

Prevention of AWOL or missing person incidents involves partnerships in care between the consumer, their carers/family and personal support person, their mental health team, and other relevant departments or individuals involved in the person's care planning and delivery across all stages of care.

The quality of communication and relationships established are key to understanding the person and their situation and developing effective care and treatment approaches.

Mental health services should foster a culture where consumers are treated respectfully, welcomed and fully oriented to their environment, and where practices and routines are explained, so that consumers know what to expect.

4.3 The clinical environment

Consideration should be given to environmental factors to ensure that the surroundings are safe and culturally appropriate, clean and welcoming and provide adequate privacy. Wherever and whenever possible, a person's choices on matters such as visiting, access to personal belongings, cultural or religious practice, relationships and leave arrangements should be respected.

Consideration should be given to the suitability and duration of stay in an environment such as an ED, as there is evidence that mental health consumers kept in EDs for extended periods are more likely to go missing or become AWOL.

4.4 Decisions about leave

As soon as a mental health consumer is admitted to an inpatient unit, a decision should be made by the treating psychiatrist, in consultation with the treating team, about the type of leave that is to be available. This decision should be made in partnership with the consumer, carers/family and their personal support person. Consistent with the principles of duty of care and least restrictive practice, a person should be allowed as much autonomy as is reasonably possible.[12] The decision should be based on an assessment of their clinical state, consideration

[11] Bartholomew D., Duffy D. and Figgins N. Strategies to reduce missing patients. National Mental Health Development Unit. 2010. Department of Health, England.

[12] Muir-Cochrane E., van der Merwe M., Nijman H., Haglund K., Simpson A. and Bowers L. Investigation into the acceptability of door locking to staff, patients, and visitors on acute psychiatric wards. *International Journal of Mental Health Nursing.* 2012 21; 41-49.

of factors detailed in the existing care plan, risk management plan and most recent risk assessment, and capacity for informed consent and decision-making. It should have regard to the consumer's and carer's/family's and personal support person's needs, wishes and preferences, and actively consider residual and more immediate stressors. In addition, where leave is to be restricted, clear decisions should be made about the type and timeframe of any response by staff members should the consumer go missing or become AWOL. The consumer should be advised of when the leave restrictions are to be reviewed.

Information about leave should be documented in the consumer's clinical file and be readily available to staff members. It should be regularly reviewed in consultation with the consumer and amended if circumstances change for the consumer or the inpatient unit in general, to ensure that it is neither inappropriate nor obsolete. The carers/family and personal support person should be notified, and their views considered in any review.

5 When a consumer goes missing or absent without leave

The following actions should be undertaken when a mental health consumer goes missing or becomes AWOL:

5.1 Risk assessment

As soon as it becomes apparent that the whereabouts of a mental health consumer should be known and cannot be determined, staff members should first determine the level of risk to the mental health consumer and others. This risk assessment will determine the extent of the diligent efforts to locate a person who is missing or AWOL and when to call police.

Risk assessment can include (but is not limited to):

- consideration of the mental health consumer's clinical history, including the existing care plan and risk management plan
- their mental state and risk at the last point of contact
- collateral information from a carer/family or personal support person.

5.2 Diligent efforts to locate a person who is missing or absent without leave

In accordance with the accompanying mandatory, staff members must undertake diligent efforts, as per local policy, procedures and protocols, to locate and/or contact a mental health consumer as soon as it becomes apparent their whereabouts should be known by the service but cannot be ascertained. This includes mental health consumers who leave the care of a service without prior notification or agreement or authorisation, regardless of their mental health, legal or leave status. It may also include mental health consumers who fail to attend a community-based appointment.

The WA Police Force expects that reporting parties will undertake diligent efforts to locate such a person as appropriate to their capacity prior to and after notifying police. Diligent efforts should not delay a report to the police in a serious and/or emergency situation.

Examples of diligent efforts may include, but are not limited to, some of the following strategies:

a) an immediate search of the health facility and local health campus
b) contacting and enquiring with the consumer's carers/family and personal support people
c) contacting the consumer's phone, leaving voice and text messages, and asking a personal support person whether they have access to information on their whereabouts via phone location services
d) if risk assessment of staff safety permits, consider a home visit (applicable to community mental health services)
e) door knocking of neighbours, associates, and friends, if appropriate
f) visiting commonly frequented places (applicable to community mental health services). Alternatively, staff members may ask a personal support person to consider undertaking this activity
g) asking a carer/family member or personal support person to:
    - enquire with the consumer's workplace/s
    - check any activity by the consumer on their social media accounts
    - check linked online banking accounts for any activity and locations.

5.3 Reporting to the WA Police Force

Refer to Procedures for Involving Police When Mental Health Consumers Are Missing or Absent Without Leave.

Staff members may revise an initial determination that police involvement is not required (for example, based on additional information that becomes available or if an extended absence increases the risk of clinical deterioration). Staff members should continually assess risk and notify police of any changes (increase or decrease).

5.4 Carers/family and personal support people

The important role of a missing or AWOL mental health consumer's carers/family and personal support person should be recognised in local service policies, procedures and protocols in terms of:

a) their significant relationship with the consumer
b) their right to be notified of current events impacting the consumer
c) their potential value in helping to locate the consumer and persuading them to contact mental health services
d) the assessed or expressed issues regarding safety needs for the carers/family and personal support person.

5.5 Notification

The maintenance of ongoing communication with the carers/family and personal support person, health services and other agencies should be made clear to staff

members. Expectations should be clarified about persistence by staff members in sustaining attempts to contact the person in the case of a prolonged absence.

In addition to notifying the WA Police Force, procedures and protocols for responding to an AWOL or missing person incident should include processes for notifying key staff members (e.g. service manager, treating doctor, case manager, Aboriginal liaison officer) in a timely manner and must include an escalation process based on the assessment of the consumer's risk.

The Chief Psychiatrist must be notified of AWOL or missing person incidents, as defined in the *Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist*, as soon as practicable, ideally within 48 hours of the event.

6 When a consumer returns to the service

Staff members should conduct the following measures once the mental health consumer has been located:

a) notify external stakeholders and the mental health consumer's carers/ family or personal support person

b) determine whether the consumer needs to be returned to the service, and decide on the appropriate application of powers under the *Mental Health Act 2014*

c) conduct a physical health check and mental state assessment of the returning consumer. Discussions should take place with the consumer (and with their personal support person or culturally appropriate appointed support person, if possible) to determine the reasons why they went missing or AWOL and to review care arrangements, as required. The Treatment, Support and Discharge Plan should be updated in collaboration with the consumer

d) update the consumer's Risk Assessment and Management Plan to document identified risk factors and management strategies to help prevent future AWOL or missing person incidents

e) update risk alerts in webPSOLIS or other associated platforms.

Inpatient services will have existing guidelines dealing with security and prohibited items that are applicable to the returning consumer, and these should be applied as appropriate.

7 Routine investigation and analysis

Where possible, investigations of AWOL or missing person incidents should include consideration of lessons learned from post-return interviews with the mental health consumer and their carers/family and personal support person.

There should be formal, routine review and analysis of AWOL and missing person incidents, which should be conducted by a standing group, including representation from mental health service management, staff members,

consumers, and carers/family and personal support people. The goal should be one of learning, with the process focusing on potential systemic improvements and safety for consumers and staff members. Importantly, a mechanism for feedback to staff should be included in the process.

Consideration should also be given for the provision of support and de-briefing of staff members when a person goes missing or becomes AWOL.

Periodic reviews of AWOL and missing person incidents should be incorporated into service governance reviews to identify patterns or factors. This information should be made available for analysis at a state level to inform changes to treatment processes and the treatment environment and to provide feedback to all public mental health services.

8 Relevant legislation

- *Carers Recognition Act 2004*
- *Mental Health Act 2014*, including
    - Part 7, Division 5. Absence Without Leave from a Hospital or Other Place; Section 97 to 102
    - Part 7, Division 6. Leave of Absence from Detention at a Hospital Under Inpatient Treatment Order; Section 103 to 112
    - Schedule 1. Charter of Mental Health Care Principles

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