1. **Policy Statement and Scope**

This overarching statewide policy provides direction and guidance to public mental health services across Western Australia on the development of guidelines and procedures to address situations when a mental health service consumer goes missing.

- The policy relates to consumers of all ages who are under the care of public mental health services.
- It is applicable across all mental health settings to those persons who:
  a) have involuntary status under the Mental Health Act, or
  b) have voluntary status under the Mental Health Act where there is sufficient concern about their safety or welfare or the safety or welfare of others, or
  c) have been assessed and referred for examination by a psychiatrist.
- It is applicable in some non-mental health settings (e.g. Emergency Departments (ED), general hospitals, rural nursing posts) if the person has been accepted under mental health service care.
The policy will find greatest application in inpatient units and hence context and reference within the policy most commonly relates to that environment.

Legislation determines predominantly the responsibilities of services concerning restrictions that may be imposed on the movement of involuntary consumers, however the principles and objectives expressed within this policy are relevant to all missing person events (i.e. for both voluntary and involuntary consumers and those people referred for assessment) under the mental health service’s duty of care.

The policy offers a philosophy promoting the use of proactive measures for the prevention of missing person events and provides guidance in considering how the probability these events may be minimised, how they should be managed and how knowledge may be gained from events that occur. The fundamental purpose being to improve the experience of the consumer, their family or carer and mental health service staff while endeavouring to provide safe and effective care and treatment.

When someone goes missing from a mental health service without notice, their safety and welfare or the safety and welfare of others may be at risk. As a result there are often implications for their care and treatment and additional demands are placed on mental health services and other agencies

   **Absconding patients can be at risk of self-harm, suicide, physical health problems and offending.**
   (Stewart & Bowers, 2010; 36).

This policy does not describe the fine detail of services’ guidelines and procedure documents, as it is intended that these are defined and developed by individual services to meet their specific requirements. The principles and objectives with which local guidelines and processes should align are expressed within the policy and it is envisaged that it should be the trigger for services to review their existing documentation and then develop or amend it as required.
2. Defined Terms

2.1. Missing Person
The single term used throughout this document to describe someone who has gone missing from the care of mental health services is ‘missing person’ regardless of their legal or leave status. Some terms which may be used by other agencies (e.g. ‘absconder’) have negative connotations and therefore have not been used to describe the person.

2.2. Personal Support Person
Where the term ‘personal support person’ is used this can be taken to mean a close family member, a parent or guardian of a child, a guardian or enduring guardian of an adult, a carer or a nominated person as appropriate. There may be more than one personal support person.

3. Purpose
This policy provides direction on the development of guidelines and procedures that should be in place to reduce the probability of missing person events, to determine how these events should be managed and to suggest how information and knowledge may be gained from events that occur. Importantly it discusses a philosophy that promotes the use of proactive measures to assist prevention, risk minimisation and maintenance of safety.

The benefits if consumers do not go missing during their treatment include:

- maintained continuity of care thus affecting the consumer’s treatment or therapy and helping to maximise the benefits of achieving clinical outcomes.
- maintained effort on recovery focused care.
- minimised exposure to potentially undesirable or unsafe situations for some consumers and others.
- avoidance of anxiety for their personal support person, thereby assisting them in providing planned support.
- avoidance of health service and other agency staff resources being diverted and consequentially aiding a productive focus on patient management.
4. **Values Underlying the Policy**

The principal values underpinning this policy are:

4.1. **Respect for the Consumer as a Person**

Mental health services should have clearly articulated philosophical statements in place that are reinforced to all staff to encourage respect for the consumer as an individual and promote a viewpoint that genuinely attempts to understand their circumstances. This is one of the most difficult objectives to achieve because it relies, not on compliance with checklists or tasks but, on the maintenance and improvement of a culture of respect and genuinely placing the patient at the centre of care decisions and actions.

4.2. **Person Centred Care**

The experience of the consumer as an individual should be central in all interactions. This should be the primary consideration while contemplating precautionary measures to dissuade the person from going missing and also in any analysis after the event. Clinicians should reflect genuine concern for the individual and their wellbeing.

Mental health consumers may choose to separate from services for a variety of reasons. In many cases the motivation for a person’s action is reasonable and has little to do with their mental state but more to do with meeting everyday needs (Stewart & Bowers, 2010). While someone may be receiving suitable treatment for their mental health condition, sometimes the factors that are really responsible for them going missing may not be known to the service or may have been overlooked or ignored.

4.3. **Recovery Focus and Least Restrictive Practice**

The consumer and their personal support person should be routinely involved in all phases of the planned course of recovery focused care. Towards this aim the consumer should be supported to have current awareness of intended timeframes around their treatment (e.g. discharge date, potential change of leave or legal status) and should not be subject to unnecessary restrictions while receiving care.
4.4. **Provision of Responsive Care**
A consumer who is actively receiving treatment has obviously raised the concerns of clinicians about their mental health. Any unplanned disruption to their treatment, especially if this is initiated by the consumer, should further raise concerns to the extent that they are actively engaged, prompting a case review as necessary. Essentially the incident must be regarded as clinically significant in the consumer's care and a trigger for re-appraisal.

4.5. **Duty of Care**
By going missing the person may be placed in a position that reduces their safety, or the safety of others. Organisations and clinicians have a duty of care to ensure that the consumer’s safety and welfare and that of others are considered, even though the consumer may be in a potentially hazardous situation as a direct result of their own actions.

4.6. **Service Improvement**
If a person goes missing, then possibly their intentions, feelings, problems or priorities have not been well understood.

*Some of these patients described repeated thoughts of absconding in the preceding weeks but acted only when an opportunity arose. There was evidence that patients had expressed difficulties in communicating anxieties to staff, considered themselves ready to leave hospital and were reluctant to participate in treatment options.*

(Stewart & Bowers, 2010; p15).

Services should aim to engender a culture in which clinicians seek to learn from the consumer and their situation, regarding these events as opportunities to improve understanding and evolve practice as a means of quality improvement, rather than merely focusing only on process compliance.

5. **Objectives**
The aim of this policy is to encourage local mental health services to devise practical ways to achieve the following objectives:
5.1. ***Engagement With Consumers***  
Services should reduce the risk of consumers becoming missing persons by encouraging routine, everyday, proactive engagement by staff to settle the consumer on the ward (or address treatment or social issues if in the community) and to ensure that the consumer and their personal support person are involved in care planning. Clinicians should have a close understanding of the individual's concerns, ambitions and plans as well as their needs, resourcefulness and individual strengths (Bartholomew et al, 2009).

Equally, this degree of awareness about community clients' circumstances may help in creating proactive interventions to reduce the likelihood of the person going missing in difficult or exceptional situations.

5.2. ***Risk Minimisation***  
Strategies should be developed and operationalised to proactively reduce the risk of patients going missing from inpatient units, clinics and Emergency Departments. Attention should be paid to the suitability of the environment as a favourable treatment setting and what processes and measures are in place to avert missing person events in high risk situations. Importantly any potential for misunderstandings the consumer may have about expectations and responsibilities should be addressed.

5.3. ***Reporting and Notification***  
Efficient and uncomplicated reporting and notification processes should be developed using standardised reporting structures with supporting documentation to enable the escalation of an effective response by the mental health service, police and other services or agencies when required. Clear processes should exist to ensure the personal support person is notified, consulted and kept up to date about events in a timely way.

5.4. ***Improvements to Practice***  
There should be provision at both local service and state levels to learn from all missing person events to better inform policy and practice.
6. Procedures and Guidelines
Mental health services are required to develop their own procedures, guidelines and documentation to align with this policy. The factors discussed below are examples of those issues that should be considered in providing guidance to clinicians.

6.1. Risk & Safety
Whether on a ward, in the community, in a clinic or in an ED an early assessment should be made about the risk that the person will go missing, this should include consideration of the possible consequences if they do (Bartholomew et al, 2009). Practical, proven advice and strategies should be provided to clinicians about the specific environment in question to help them reduce the likelihood that the person will go missing and maintain the consumer’s safety where risk exists. When a person goes missing a risk assessment should be completed at that time and used to inform notification and reporting processes and the level of response.

6.2. The Team
A positive team model, where staff genuinely engage with consumers and have good relationships with them will foster:
- concern for the consumer as a person, endeavouring to understand the impact that life events may have had and may currently be having on them.
- a culture where the consumer is welcomed and fully orientated to the environment, where service practices and routines are explained so that they know what to expect, why and when (e.g. what is required of the patient if they wish to leave the ward).
- full and early involvement of the consumer and personal support person in the planning of care and support.
- setting aside times for clinicians to meet with the consumer on a regular scheduled basis.
- staff working together as a team to ensure consistency of care.
- examples of good practice and consumer interaction by senior or experienced staff.
- the maintenance of the ward or team ideology with attention being paid to how staff members are seen to handle conflict and difficulty in a positive way.
• in both inpatient and community settings, staff being known to those people that are important to the consumer and being aware of conflicts and difficulties, for example knowing about debts or threats from others and being aware of domestic or social factors in the home setting.

6.3. **The Ward, Clinic or ED Environment**
Consideration should be given to environmental factors for example the appearance and impact of a ward with broken furniture or tired décor. A consumer may have difficulty in adjusting to sudden changes for example fear or shock about a strange environment or threatening patients, particularly soon after admission. Also enforced changes to life choices may make the patient consider leaving, for example not being able to consume alcohol or smoke freely. Possibly a change in the person’s relationships could also have a negative effect. They may be unwilling to stay due to restricted contact with their family, personal support person, community or group. Particular consideration should be given to cultural and social diversity requirements in this respect.

6.4. **Decisions About Leave**
As soon as the patient is admitted to the ward a decision should be made by the treating psychiatrist, in consultation with the treating team, about the type of leave that will be available. This decision should normally be made in partnership with the personal support person and the patient, who should be allowed as much autonomy as reasonably possible (Muir-Cochrane, 2012).... The decision should be based on clinical assessment, risk factors and regard for the patient’s individual needs, their safety and their legal status. In addition, where leave is restricted, clear decisions should be made about the type and timeframe of any response by staff should the patient go missing.

This information should be documented in the patient’s clinical file and be readily available to ward staff. It should be regularly reviewed and amended if circumstances change for the patient or the ward in general to ensure that it is neither inappropriate nor obsolete.

6.5. **Before, When and After a Consumer Goes Missing**
The guidelines should specify the philosophy and practice of welcoming, informing and settling a consumer into the care setting. They should
highlight the importance of genuine engagement to enable an accurate assessment of the person’s situation and any anxieties to better inform judgements about maintaining the person’s safety.

If a consumer goes missing from either a clinic, inpatient or community setting or ED there should be guidelines to clearly indicate the processes to be followed (both initial and ongoing) and also the steps to be taken when the person is subsequently located.

Requirements for reporting and notification to the personal support person, services and other agencies (including timeframes) and the maintenance of ongoing communication with those parties should be made clear to staff. Also expectations should be clarified about persistence by the ward and / or treating team in sustaining attempts to contact the person in the case of a prolonged absence.

The returning patient should be interviewed (with their personal support person if possible) to determine the reasons why they went missing. A physical health check and a full risk assessment should be conducted and there should be a review of the care plan with the patient.

Inpatient services will have existing guidelines dealing with security and prohibited items that are applicable to the returning patient and these should be reviewed in the light of this policy.

7. **Routine Investigation and Analysis**

A timely post return interview should always be conducted with the missing person and personal support person as a normal event to examine the reasons and any contributing factors.

There should be formal, routine review and analysis of missing person events which should be conducted by a standing group including representation from mental health service management, ward staff, consumers and carers. The goal should be learning and the process should focus on potential systemic improvements and safety for patients and staff.
A similar process should also be applied to missing person events that occur in community, clinic or ED settings. Importantly a mechanism for feedback to staff should be included in the process.

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

8. **Responsibilities**
   All mental health services across Western Australia have responsibility to ensure that they develop procedures and guidelines to address the requirements in Section 6 above in order to comply with this policy.

   Fresh approaches should be developed to stimulate a culture among staff that recognises the consumer as an individual and considers their everyday experience, their aspirations and their concerns as an important aspect of how they will benefit from their treatment.

9. **Policy and Guidelines Review and Evaluation**
   The policy should be reviewed and evaluated after three years or earlier if significant amendments become necessary.

   Local services should also review and evaluate the guidelines that they introduce to align with this policy by monitoring the number of missing person events that have occurred at twelve months and again at twenty four months after those guidelines have been implemented. Comparing these figures with former levels could provide an indicator of the effectiveness of the policy and also the guidelines.
10. References and Suggested Reading


11. Related Material
Local service processes and guidelines should include reference to:


11.2. The Western Australia Patient Identification Policy, WA Department of Health (2014).

11.3. The Western Australia Clinical Incident Management Policy. WA Department of Health (2015).


11.5.1. Part 7, Division 5. Absence Without Leave from Hospital or Other Place; Section 97 to 102.
11.5.2. Part 7, Division 6. Leave of Absence from Detention at a Hospital Under Inpatient Treatment Order; Section 103 to 112.

Supporting Documents