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Leave for informally admitted patients: a review of written guidance produced by mental health services in England and Wales

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Abstract

Purpose - To report on the use and content of written guidance produced by mental health services in England and Wales describing hospital leave for informally admitted patients.

Design/methodology/approach - Guidance on leave was requested from NHS mental health trusts in England and health boards in Wales (n = 61) using a Freedom of Information submission. Data were analysed using content analysis.

Findings - Thirty-two organisations had a leave policy for informal patients. Policies varied considerably in content and quality. The content of policies was not supported by research evidence. Organisations appeared to have developed their policies by either adapting or copying the guidance on section 17 leave outlined in the Mental Health Act Codes of Practice for England and Wales (DH, 2016; WG, 2016). Definitions of important terms, for example *leave* and *hospital premises*, were either absent or poorly defined. Finally, some organisations appeared to be operating pseudo-legal coercive contracts to prevent informal patients leaving hospital wards.

Research implications - Research should be undertaken to explore the impact of local policies on the informal patient's right to life and liberty.

Practical implications - All NHS organisations need to develop an evidence-based policy to facilitate the informal patient's right to take leave. A set of national standards, that organisations are required to comply with, would help to standardise the content of leave policies.

Originality - This is the first study to examine the use and content of local policies describing how informal patients can take leave from hospital.

Keywords Informal inpatient, leave policies, legal rights, safety.

Paper type Research paper

Introduction

Despite annual increases in admissions (NHS Digital, 2022; StatsWales, 2021) under the Mental Health Act (Department of Health (DH), 2007), there are still a significant number of people admitted to hospital as informal patients. That is: "Someone who is being treated for a mental disorder and is not detained under the Act" (DH, 2015, p. 412; Welsh Government (WG), 2016, p. 280). In Wales informal patients accounted for 71.8 per cent (n = 5,482) of all admissions (n = 7,639) to National Health Service (NHS) mental health facilities for the period 2020-2021 (StatsWales, 2021). England does not report annual statistics on the number of informal hospital admissions (NHS Digital, 2022). However, for the period 2020-2021 14,327 detentions occurred following admission, that is after patients were admitted informally (NHS Digital, 2022). There are two other possible categories of informal admission for which statistics are not available: (1) patients who are admitted informally and remain so for the duration of their admission; and (2) patients who, following discharge from their section, remain in hospital informally until discharge.

Despite hospital admission being beneficial for some people, it may also result in some unintended consequences (Bowers, 2005; Bowers et al., 2005). For example, a person may experience a loss of independence and disruption to personal, family, social and work relationships. One strategy used to mitigate the impact of admission is for patients to take periods of leave from the inpatient environment. Leave as a therapeutic intervention has a long history in mental health care (for example Landor, 1876) and is recognised in the mental health legislation of many countries (Salize et al., 2002; Government of Western Australia, 2014; Gray et al., 2016). Despite its use as an intervention, there is a paucity of evidence reporting on how often patients take hospital leave (Barlow and Dickens, 2018). However, the findings of one study suggest that it is not an insignificant event. Bailey et al. (2016) reported that over a 17-week period there was an average of 165 periods of leave per week, that is 24 episodes per day.

In the literature a variety of terms, often poorly defined, are used to describe this practice, for example "leave", "sanctioned leave", "therapeutic leave", "parole", "pass", "therapeutic pass", and "furlough" (Barlow and Dickens, 2018; Dickens and

Barlow, 2018). The Mental Health Act Codes of Practice for England (DH, 2015) and Wales (WG, 2016) use the terms "leave of absence" or "leave" when referring to detained patients. In relation to informal patients, they only use the word "leave"; therefore, this term will be used throughout the article.

Simply, leave means "to go away… depart… or …exit …from a place" (Collins Dictionary and Thesaurus). In a mental health context, the English Code of Practice (CoP) (DH, 2015) suggests that leave takes place when an inpatient departs the ward "to move within a hospital or its grounds" ("ground leave"), or leaves the hospital grounds for a length of time (p. 316, 27.5). Leave can be for short periods, for example to go for a walk, or longer periods of time (not normally exceeding 7 days), for example to go to the cinema or spend the night at home. Leave might be undertaken alone; escorted, for example by a nurse "either in the patient's own interests or for the protection of other people" (DH, 2015, p. 320, 27.27; WG, 2016, p.196, 27.23); or accompanied "by a friend or relative" (DH, 2015, p. 320, 27.29; WG, 2016, p.196, 27.25).

The purpose of leave is also poorly defined (Barlow and Dickens, 2018); however, its benefits are reported by both patients and mental health practitioners (see for example, Walker et al., 2013). The benefits of leave are also recognised in both codes of practice. The Welsh CoP (WG, 2016) asks clinicians to "consider the benefits of… leave to assist the patient's recovery and/or the maintenance of their independence" (p. 193, 27.7). The English CoP (DH, 2015) also recognises leave as "an important part of a… patient's care plan" (p. 317, 27.10) and as having benefits for their recovery. Writing specifically about detained patients, but equally relevant to those admitted informally, Murphy and Wales (2013) propose that for a:

"…person to recover and take control of their own life they will need time to re-establish their daily routines and reconnect with their social networks. This may mean reconsidering many aspects of their life including hobbies, employment, housing and social activities. All of these will require time off the ward to develop them" (p. 108).

Notwithstanding these potential benefits, concerns about patients leaving hospital premises were raised as early as 1876. Landor (1876) reported that psychiatrists were concerned that if patients were allowed to take leave, they might undertake acts of, "arson, suicide, homicide…and create an unsound public opinion regarding asylums." Landor (1876) challenged these concerns by reporting that of 114 patients taking leave over a 5-year period in Canada, "…no evil [had] resulted, either to the patients or to the asylum, or to its officers…" (p. 486). However, leave is not without risk.

The National Confidential Inquiry into Suicide and Safety in Mental Health (2019) reported that for the period 2007-2017, 52 per cent (n = 470) of inpatient suicides in England and 63 per cent (n = 31) in Wales had occurred when patients were on agreed leave or had left with staff agreement. A further 16 per cent (n = 142) of inpatient suicides in England and 10 per cent (n = 5) in Wales occurred when the patient was off the ward without staff agreement or with agreement but failed to return. Not surprisingly, research in this area has focused on preventing unauthorised leave (absconding) from mental health wards and/or minimising risk when the patient is not on the hospital premises (for example, Bowers et al., 2003; Stewart and Bowers, 2011; Voss and Bartlett, 2019).

The risks associated with leave would suggest that there is a need for clear, evidence-based guidance to help practitioners and informal patients make informed decisions about when, where, who with and for how long leave should be taken. However, the available guidance is limited. For example, The Royal College of Psychiatrists Standards for Inpatient Mental Health Services (Chaplin, 2019) acknowledges the importance of leave but offers a limited number of superficial suggestions for facilitating the process. Nor does it distinguish between formally and informally admitted patients.

Turning to the codes of practice for England (DH, 2015) and Wales (WG, 2016), although Chapter 27 provides significant guidance on section 17 leave for detained patients, the same cannot be said for informal patients. In full, the English CoP (DH, 2015) states: "Patients who are not legally detained in hospital have the right to leave at any time. They cannot be required to ask permission to do so, but may be

asked to inform staff when they wish to leave the wards" (p. 322, 27.38). Similarly, the Welsh CoP (WG, 2016) states that: "Informal patients are not subject to leave requirements under section 17. A patient who is not detained has the right to leave, other than those patients subject to authorisation under the Deprivation of Liberty Safeguards" (p. 193, 27.4).

However, the above guidance appears problematic following the Supreme Court of the UK's ruling in the Rabone and another v Pennine Care NHS Foundation Trust [2012] case. In summary (based on the Supreme Court ruling), 24-year-old Melanie Rabone had a 5-year history of depression. In March and April 2005, she was admitted to Stepping Hill hospital, Stockport as an informal patient following suicide attempts. Following her second admission on 11 April she was assessed as being a moderate to high risk of suicide and placed on 15-minute observations. Her father contacted the ward on 13 April and "expressed his grave concern… about Melanie's condition and urged that she should not be allowed home on leave or discharged too soon." On 18 April he telephoned the ward to report that she was expressing suicidal thoughts. Melanie requested home leave on 19 April and her consultant agreed a period of two days and nights. On 20 April, after spending most of the day with her mother, Malanie said that she was going to visit a friend. Sometime after 5 p.m. she died by suicide. On 21 August 2005, Melanie's father wrote to Pennine Care NHS Trust ("the trust") criticising the decision to allow her to take leave on 19 April.

Melanie's parents brought a negligence's claim against the trust and alleged a breach of Article 2 of the European Convention on Human Rights 1998. Article 2 states that "Everyone's right to life shall be protected by law". Article 2 also imposes an operational duty – an obligation – on the state to take reasonable measures when a real and immediate risk to life exists to an identified person to avoid that risk becoming a reality. The trust admitted negligence but argued that an operational duty under Article 2 did not apply. Both the High Court and the Court of Appeal agreed with them. However, a further appeal was allowed to the Supreme Court, which ruled that the trust did have an operational duty under Article 2 to protect Malanie's life. In addition, it was also ruled that they had failed to take reasonable measures to do so when there was a real and immediate risk of suicide. The

Supreme Court ruling also stated that the difference between an informal patient and a detained patient was "one of form, not substance". This seems to work against the intentions of the 1959 Act that sought to ensure that patients admitted informally for the care of mental and physical health conditions were legally treated in the same way. This principle, at least in theory, and the legal rights associated with it remains in place in the 1983 Act. Currently, it is unclear how organisations caring for informal patients have addressed the Rabone ruling. Nor is it known what advice, if any, is offered to practitioners about resolving the challenges associated with protecting the patient's safety while preserving their right to liberty.

Despite the limited guidance provided, the English CoP (DH, 2015) makes it clear that mental health trusts should have "…a written policy that sets out precisely what the ward arrangements are and how patients can exit from the ward, if they are legally free to leave and given to all patients in the ward" (p. 73, 8.58). The Welsh CoP (WG, 2016, p.49, 8.55) contains a similar statement. However, neither code offers guidance on what the content of any such policy should consist of. Furthermore, a systematised search of the health science databases (ASSIA, CINAHL, Lawtel, MEDLINE and PsycINFO) for the period 2012-2020 (and repeated at regular intervals for the period 2020-January 2023), using combinations of the synonyms of the search terms "informal inpatient", "hospital" and "leave" failed to identify any research reporting on the content of leave policies for informally admitted patients. Searches were limited to peer reviewed papers written in English. Considering the issues discussed above and growing concerns about the rights of informally admitted patients (see for example Prebble et al., 2015; Ashmore and Carver, 2017) it seems timely to establish the availability and content of local-level guidance on leave.

Aim

To determine the use and content of written guidance produced by mental health services in England and Wales describing how informal patients can take leave from hospital.

Method

Pragmatism was chosen to guide the generation and analysis of data in this study. Pragmatism does not adhere to one ontological and epistemological position, instead it takes the stance that the most appropriate methods for achieving a study's aim should be chosen, regardless of their philosophical tradition (Creswell, 2009; O'Reilly et al., 2018; Allemang et al., 2022). This position is supported by Patton (2002) who states, "…in real-world practice, methods can be separated from the epistemology out of which they have emerged (p. 136).

Sample

The target population of this study was all NHS mental health trusts (MHTs) in England and health boards (HBs) in Wales providing adult (18 years and over) inpatient care. As the study sought to undertake a national census of the use and content of written guidance describing leave processes for informal patients, a decision was made to approach all MHTs and HBs in the target population. This can be described as a whole or total population sample (Alexander, 2015). A list of the population used in this study was compiled by consulting relevant documents (for example, Care Quality Commission, 2017) for MHTs and the Welsh Government website for HBs (https://www.gov.wales/nhs-wales-health-boards-and-trusts). Fifty-four MHTs and 7 HBs were identified, a total of 61 organisations.

Procedure

A Freedom of Information (FOI) Act 2000 request was submitted to all 61 organisations. Organisations were asked to supply an electronic copy of any documents (policies, procedures, or guidelines) that described the process by which informal patients could take leave from hospital wards.

The rationale for using the FOI Act 2000 was that many organisations do not make their policy documents publicly available, for example on their organisational webpages (Ashmore and Carver, 2017; Clifton-Sprigg et al., 2020), as was the case in this study. Researchers (for example, see Savage and Hyde, 2014) have used the FOI Act 2000 to addresses this type of problem, as it gives interested parties a statutory right to access information held by public authorities (including MHTs and HBs). Applicants do not need to provide an explanation for why they are requesting the information. On receiving a FOI request an organisation must disclose, "whether

or not it holds the information being requested and must disclose that information, unless the data are exempt, within 20 working days" (Fowler et al., 2013, p. 1).

Ethics

NHS ethical approval was not required as the study did not involve patients, NHS staff or premises or seek access to care records or other confidential information. Nevertheless, the study was considered and approved by a university ethics committee. Although the FOI Act 2000 does not require it, all the findings reported in this study have been anonymised by giving each organisation (O) a code number.

Analysis

Documents were analysed using summative content analysis (Hsieh and Shannon, 2005; Bengtsson, 2016). This approach examines both the manifest and latent content of the data and "…involves counting and comparisons, usually of keywords or content, followed by the interpretation of the underlying context" (Hsieh and Shannon, 2005, p.1277).

Each document was read and re-read to identify words, sentences and paragraphs (meaning units) relevant to the study's aim. Meaning units were coded and grouped into preliminary categories. Meaning units identified in subsequent documents were compared to those previously generated. This process led to some preliminary categories being refined to produce the minimum number discussed below. Following previous studies (for example, Barnicot et al., 2017; Ashmore, 2020), and consistent with both summative content analysis (Hsieh and Shannon, 2005; Humble and Mozelius, 2022; Namazi and Taak, 2022) and the principles of pragmaticism, the number of organisations providing the same information is given to demonstrate the convergence and divergence of content. Finally, data analysis did not identify any significant differences between documents provided by English and Welsh organisations that necessitated the need to report the findings separately.

Findings

Responses

A FOI response was received from all 61 organisations. Twenty-two organisations did not supply a document. Of these, 12 did not have a leave document for informal patients and 7 replied that they expected the multi-disciplinary team (MDT) to follow the organisation's clinical risk management procedures before deciding on leave. The final 3 replied: "There is no policy for granting leave as you can't grant leave to an informal patient as they are free to come and go as they please".

Thirty-nine organisations *did* supply a leave document, which was described by all as a policy. Of these, 7 were excluded as the policy focused solely on section 17 leave. Therefore, the final sample consisted of 32 policies (MHTs = 31, HBs = 1), 52.5 per cent of all organisations contacted. Of the 32 documents, 30 focused specifically on informal patients and 2 were integrated leave policies covering all inpatients. The 2 integrated policies were included in the study because they contained a significant amount of content focusing solely on leave for informal patients.

Characteristics of policies

Policies varied considerably in quality, length (one half to 14 pages) and content. Some would have benefitted from closer proof reading to correct errors of spelling, grammar and punctuation. All policies included an implementation and up-to-date review date (2 or 3 years following the implementation date). There was no evidence of patient involvement in the creation of the policies.

Supporting literature

Seventeen pieces of literature were cited on 69 occasions (range 1-8 per policy) in support of the content of policy documents. References were cited accurately and in full on 13 occasions. Eight organisations did not cite any literature. The literature cited and the number of occasions it was referred to is reported in Table 1.

De facto section 17 leave policies

The documents provided were de facto section 17 policies written for informal patients. That is, organisations had either adapted, paraphrased or copied exactly content from Chapter 27 of the codes of practice (DH, 2015; WG, 2016) outlining section 17 leave. For example, policies simply replaced the word "detained" with

"informal." Two organisations referred practitioners to their section 17 policies with the instruction that "…the principles outlined [there] should be followed when discussing an informal service user leaving the ward" (O3, O27).

The purpose of policies

Twenty-six organisations specified the purpose of their policy. Generally, policies sought to ensure:

- "…that all clinicians were aware of their responsibilities [to informal patients] …prior to, during and on returning from leave" (O55).
- "…an effective, standardised and consistent approach" [to leave] based on "current good practice" (O33).
- leave was "…safe, therapeutic and part of a planned process" (O48).

In addition, others stated that their policy aimed to:

- "…establish a lawful framework" (O27) that complied with "the Mental Health Act and the guidance of the Code of Practice" (O39).
- strike the "…right balance between respecting the rights of informal patients… to leave the hospital, and the need to protect people who may be vulnerable and at risk of harm to themselves" (O16).

Defining leave

Seventeen policies provided a definition of leave. Seven defined it as, "any period of time, however short or for whatever purpose, spent outside of the hospital and its grounds" (O44). For the remaining 10 leave "…constituted all time off the ward, whether or not the patient remains within the hospital grounds" (O5). In addition, 5 of the organisations also defined leave as an "…authorised period of absence". One policy stated that any informal patient leaving without authorisation was "…not 'on leave' [but] absent without leave (AWOL)" (O41). Finally, one organisation used

different terminology to make a clear distinction between leave for detained and informal patients:

"'Leave and the granting of leave are terms used in relation to detained patients and as such the term 'time way from the ward' will be used… to make clear that informal patients are not subject to the same procedure as detained patients" (O16).

Types of leave

Five organisations identified leave options available to the informal patient. Each option consistent of the following elements: (1) whether leave was to be taken within the hospital buildings, within the hospital grounds or outside of the hospital grounds; (2) whether leave was to be *escorted* by one or more mental health professional (usually nurses), *accompanied* by a relative, friend or carer or whether leave was to be *unescorted* or *unaccompanied*; and (3) whether leave was to be short- or long-term.

Short-term leave was defined by three organisations (O10, O13, O48) as, "…an agreed period of absence from the hospital grounds during daytime hours." The same organisations proposed that long-term leave was, "…an agreed period of absence from the hospital grounds that includes overnight stay or longer (but no more than 7 days)."

Hospital buildings and grounds

None of the policies named the hospital buildings they were referring to. Two policies attempted to define what they meant by hospital grounds. The first policy stated that "…the grounds are defined as the perimeter of the hospital" (O11) and the second declared it was, "…that area of connected grounds and incorporated buildings that is controlled by [the Trust]" (O13). None of the policies included a map showing the perimeter of hospital buildings or grounds.

The benefits of leave

Fourteen organisations referred to the benefits of leave, albeit in most cases very briefly. Leave was seen as having "therapeutic benefit" (O3), being an important part of the patient's "…process of recovery… [and] treatment plan" (O16, O26). Another

saw it as, "…both a therapeutic development for the patient, and an extension of responsibility" (O33). One provided a fuller statement, "…hospital leave is key to; assessment, rehabilitation, risk management, family engagement, continued contact with external agencies and community support and developing and maintaining social contacts" (O6).

Interpreting the right to leave the ward

All policies accepted the definition of an informal patient as it appears in the codes of practice (DH, 2015, p. 412; WG, 2016, p. 280). Twenty-three organisations paraphrased or quoted the CoP for England (DH, 2015) that informal patients, "…have the right to leave at any time. They cannot be required to ask permission to do so, but may be asked to inform staff when they wished to leave the ward" (p. 322, 27.38). Two organisations interpreted this to mean that there was, "…no provision for the actual granting of leave for informal patients, as such patients are not subject to statutory powers…" (O18) and therefore they are "…. free to come and go as they please" (O46).

Other organisations interpreted the meaning of the English CoP (DH, 2015) differently. One organisation interpreted it *incorrectly* to mean, "…patients …*may not leave* (author's emphasis) …until they have informed a member of clinical staff" (O13). Another stated that: "When an informal patient asks a member of staff to leave the ward, the member of staff will take this request to the nurse in charge of the ward" (O32). Nineteen policies required that any leave from the ward had to be "agreed", "approved", "authorised" or "granted".

There was a consensus that firstly: "The fact that the patient is not detained under the Mental Health Act does not necessarily imply that they are well enough to leave the in-patient area without the knowledge of the staff… providing their care" (O14) as "…leave can be a potentially high-risk period for patients" (O55). Secondly, that there were "some very important issues to consider" (O46) when an informal patient wanted to leave. That is, a need to "…strike the right balance between respecting the rights of informal patients [to leave hospital]" (O15) with the organisation's duty of care to, "…protect people who may be vulnerable and at risk of harm to themselves" (O15). Therefore, organisations agreed that, "…clinicians must always consider risk

to life before allowing an informal patient to exercise their right to leave the ward" (O4).

Organisations also interpreted the Rabone ruling to mean that effectively there was no difference between informal and detained patients. One organisation went further and asserted that informal patients should be "managed as if detained" (O39). In summary, there was a consensus that informal patients could only "…leave the ward subject to reasonable requirements" (O29).

Facilitating leave

Thirty organisations provided guidance on the leave process. There was agreement that leave should be jointly planned between the patient and their named nurse. That it should be, "…graded and progressive in line with the [patient's] condition… starting with short periods… (which may be accompanied) and building up to longer periods of unaccompanied leave preceding discharge" (O48). There was also a consensus that carers and/or relatives should be consulted before formalising the leave plan. However, policies did not make clear whether this referred to all types of leave or only when the patient intended to leave the hospital grounds. Nor did they provide any information on how carers and/or relatives would be consulted.

All 30 policies required leave plans to be discussed and approved by the MDT. In addition, 5 policies stated that the responsible clinician "…has a statutory responsibility for the proper care of all informal patients admitted under their care" (O55); therefore, they had the final decision in approving any leave plan. Two policies also stated that nurses could "…act within [an] agreed framework, varying the agreed leave plan" (O55) without consulting the MDT if authorised to do so by the responsible clinician if, "…a risk assessment has been undertaken **and** leave is not overnight" (O11).

Regardless of any leave plans agreed by the MDT, one organisation reminded practitioners that:

"It is important to note that conditions and parameters of leave cannot be imposed on an informal patient. They can seek to leave the ward, [even if] such action would contravene an agreed leave plan" (O3).

In addition, three policies noted that patients should not be threatened with sectioning if they did not conform to the leave plan, as this would constitute a de facto detention. However, all policies were clear that should any concerns be raised and the patient could not be persuaded to stay on the ward, nurses and medical practitioners were advised to consider whether the patient should be prevented from leaving by implementing their holding powers (sections 5(2) and 5(4)).

Permission to leave documents

Fourteen organisations required the patient's consultant (or member of the medical team) to complete and sign a "permission to leave" document before a patient could exit the ward. Organisations used different terms to describe their document. For example, "leave prescription" (O3), "leave entitlement form" (O9) and "leave of absence form" (O13). Documents required medical practitioners to state when leave could be taken (for example, day or overnight), where it could be taken (for example, within or outside of the hospital grounds), for how long (for example, overnight leave) and who with (for example, alone or escorted by nurses, carers or relatives).

Contracts

Eleven policies referred to either written and/or verbal contracts of leave. Seven organisations required patients to sign a written contract either during the admission process or before leave could be taken. Of these, 1 organisation asked patients to sign a contract that required them to remain on the ward until, "leave arrangements had been discussed and approved at ward round" (O5). This contract also informed the patient that: "If you do not comply with the arrangements set out [in the contract] then it may be necessary to review your care and treatment…" Two policies stated that the document was a, "…formally binding written contract with the patient…" (O1, O23).

Two organisations referred to verbal "informal contracts" (O29, O42) and 1 to an "agreement of leave" (O41). However, none of these organisations provided any

further explanation about the meaning of these terms. Another organisation appeared to be operating a de facto contract system, noting that patients should be reminded of the "potential consequences of failure to comply with the conditions of the agreed leave" (O33). Lastly, 1 policy stated they used contracts but did not provide any further information.

Only 2 organisations offered any further information on the use of contracts. Using identical wording they commented that there is, "…nothing… contrary to the status of an informal patient in a contract voluntarily entered into. Such contracts can help a patient's motivation and improve their ability to refrain from certain behaviours" (O4, O29). In relation to a no-leave contract, they argued that, "…if this is freely entered into it is acceptable practice albeit one that should be used with due care and consideration." However, they did caution that: "Care needs to be taken to prevent contracts being imposed upon patients who are not genuinely and voluntarily agreeing to them." For example, by threatening to detain them under the Act if they do not.

Pre- and post-leave meetings

Before leave 11 organisations, in addition to assessing the patient's mental health, required practitioners to record the date and time the person was leaving the ward, where they would be residing during leave and the date and time of their expected return. Documents also required nurses to determine that the patient: (1) could access their residence and that it was habitable, for example that there was heating and water; (2) had (or will have) enough food, beverages and medication for the period of leave; and (3) had been provided with a name and contact telephone number in case of a crisis.

Following leave, 13 organisations required practitioners to meet with patients and, "…where possible all relevant individuals including carers/relatives" (O38) to obtain feedback on its success. During the meetings practitioners were expected to undertake a "structured assessment" (O38) to determine whether the risk management needed amending and what support would be required to facilitate any future periods of leave. Details of what a structured assessment might consist of was limited; however, one organisation (O38) stated that practitioners: assess

"mood, behaviour and mental state"; check "adherence with and side-effects of medication; ensure that all leave medications had been returned; and enquire about "issues relating to the misuse of alcohol and illicit substances".

Failure to return to the ward

Should the patient not return from leave at the agreed time, 16 policies required practitioners to follow the hospital's absence without leave/missing person policy. One organisation was clear that: "Informal patients should be considered as "missing patients" rather than being absent without leave" (O50). In general, policies advised practitioners to: (a) consider the possible risk to the patient should they not return to the ward; (b) inform the patient's consultant; (c) attempt to contact the patient and/or their relatives to establish their mental health status; (d) determine by telephone why the patient has not returned and when they intend to return; and (e) consider discharging the patient if there were no potential risks.

Informing patients of their rights

As reported above, all organisations identified the informal patient's legal right to leave hospital. However, only 2 policies explicitly stated that practitioners must inform patients of this right. In both cases practitioners were referred to an appendix containing an information sheet. However, neither provided any details about how this information was to be given, for example verbally and/or in writing. Nor did the policies ask practitioners to record whether the information had been given to a patient and importantly, whether they had understood it or not.

Training

Few (n = 7) organisations required practitioners to undertake any education and/or training in order to implement their leave policy. Two policies provided basic information about what this might consist of. They simply informed the reader that: "This procedure will be included in the Mental Health Act training session" (O23), and: "The Ward Manager will ensure that all nursing staff are aware of this policy…" (O34).

Discussion

Despite concerns about its use, leave from the hospital environment is recognised as an important part of the patient's progress towards discharge (DH. 2015, WG, 2016). The codes of practice for England (DH, 2015) and Wales (WG, 2016) require organisations to develop local leave policies for informal patients but offer little information on what their content should be. This is the first study, to the author's knowledge, to report on the use and content of local leave policies for informal patients produced by mental health services in England and Wales.

Turning to the findings, only 32 (52.5 per cent) organisations had a leave policy for informal patients. This figure is surprisingly low considering the codes of practice require organisations to develop a leave policy (DH, 2015; WG, 2016). The number of organisations with a leave document can also be considered low when compared to studies reporting on clinical policies for inpatients in England and Wales. For example, it has been reported that all MHTs and HBs had an engagement and observation policy (Ashmore, 2020) and 67.2 per cent a policy on implementing section 5(4) (nurses' holding power) of the Act (DH, 2007) (Ashmore and Carver, 2016). Although this apparent lack of guidance is of concern, it is important to acknowledge the possibility that some organisations might provide information on leave in other policy documents, for example, those focusing on locked ward doors. However, if guidance does not exist there is an urgent need to address this deficit to ensure that informal patients can exercise their right to take leave in a timely manner. In addition, the development of clear guidance has the potential to help clinicians prevent a repeat of previous tragedies, for example, the death of Melanie Rabone.

The aim of evidence-based practice is to produce the best possible clinical outcomes for the patient (Lehane et al., 2019). Therefore, good-quality policy directing the behaviour of practitioners ought to "…accurately reflect the most up-to-date scientific evidence" (De Brún, 2013, p. 3); something that was absent from the documents examined in this study. This could explain the inconsistencies in both content and advice given to practitioners reported in the findings; however, this does not mean that evidence relevant to the development of leave policies does not exist. For example, see the assessment tools developed by Bowers et al. (2011b) and Chu et

al. (2020). Both are potentially useful for monitoring the progress of informal patients and supporting decision making regarding the type and duration of leave.

Previous research has reported wide variations in the terminology used by organisation in local policies written with the purpose of ensuring patient safety (Bowers et al., 2000; Gournay and Bowers, 2000; Ashmore, 2020). The findings of this study are no different. That is, there was little consensus on the terms used to describe the leave process. In addition, terms were either poorly defined or not defined at all. This is perhaps not surprising when, as noted above, the codes of practice for England (DH, 2015) and Wales (WG, 2016) provide little guidance on the content of leave policies for informal patients and less still on an appropriate language for describing it. Commenting on observation policies but equally relevant here, Bowers et al. (2000) suggested that a lack of consensus on terminology can "…only provoke confusion, lack of clarity, and reduce patient safety" (p. 442). This lack of consensus on terminology might explain why organisations adapted, paraphrased and copied the language (and content) used in Chapter 27 of the codes of practice (DH, 2015; WG, 2016) to describe the leave for informal patients. It is suggested there is a need to create a vocabulary to describe leave for informal patients. Such a vocabulary could help practitioners to make clear distinctions between how they perceive and manage leave for informal and formal patients, therefore reducing the potential for subjecting the former to unnecessary restrictive practices

Policies that reminded practitioners that informal patients were free to leave at any time were correctly following the guidance given in the codes of practice (DH, 2015; WG, 2016). However, the extent to which patients can exercise this right has been questioned for over two decades, Houlihan (2000) has gone so far as to suggest that the rights of the informal patient are "…no more than a legal fiction" (p. 865). This assertion is supported by the content of the policies. For example, policies stated that leave had to be "agreed", "approved", "authorised" or "granted" by the MDT and/or responsible clinician. Policies also required nursing and medical staff to assess any informal patient who wished to leave the ward and establish whether they meet the criteria for detention under the Act (DH, 2007). This means that a patient may only leave the ward if they do not meet the criteria for detention under

legislation. This is likely to be a direct response to the ruling in the Rabone case. The Supreme Court of the UK "… ruled that the state has a special operational duty to protect the right to life in informal psychiatric patients…" (Szmukler et al., 2013). As Ashmore and Carver (2017, p. 58) have noted: "This seems to represent organisations attempting to balance the safety of patients… against their right to freedom of movement but simply results in an apparent contradiction." There is an urgent need to address this apparent contradiction between the need to protect the safety of both the informal patient and others while preserving their right to freedom of movement; an opportunity missed in the recent review of the Act (DH, 2018).

Another restriction on the informal patient's right to leave is contracts. Approximately a third (n = 11) of organisations required patients to verbally agree to or sign a leave contract on admission that restricted their right to leave. Two stated their document was a "formally binding written contract" (O1, O23). Another organisation (O5) implied they would withdraw inpatient care if the patient failed to comply with the contract. Although organisations provided little detail of the purpose or content of their leave contracts, some general observations can be made.

Firstly, the contracts described in the policies are not legally binding documents. Therefore, informal patients can withdraw their consent to comply with the conditions of the contract whenever they want. Secondly, *it appears* from the policies that organisations are using behavioural contracts masquerading as therapeutic contracts. The latter is an "explicit bilateral commitment to a well-defined course of action" (Berne, 1966, p.362) and involves a collaborative plan developed between patient and practitioner. On the other hand, behavioural contracts target specific behaviours, often identified by practitioners (for example, not leaving the ward without permission) and aim to improve adherence to those behaviours (Lederer et al., 2021).

Furthermore, the behavioural contracts described in the study resemble what is known in the legal profession as an adhesion contract. That is a, "standardized contract, which imposed and drafted by the party of superior bargaining strength, relegates to the subscribing party only the opportunity to adhere to the contract or reject it" (Sacopulos and Segal, 2009, p. 429; also see Lieber et al., 2011). In

everyday life a person is free to decline such a contract. However, in mental health care the patient, due to their psychological vulnerabilities, are at a disadvantage in any proposed contract. As Cooper et al. (2019) note, "…patients may feel pressured to sign them and fear that if they do not their health may be compromised or access to care terminated" (p. 98). Potentially, this means that informal patients are presented with a Hobson's choice; that is, they sign away their right to leave or risk the offer of care being withdrawn. Another possibility exists: they are prevented from leaving under the Act (DH, 2007). In addition, as discussed above, policies were not supported by empirical evidence, therefore organisations may not have been aware that, "…despite some limited benefits, there [is] not enough reliable evidence to recommend the use of contracts in healthcare" (Cooper et al., 2019, p. 99), for example see Bosch-Capblanch et al. (2007) and McMyler and Pryjmachuk (2008).

Finally, it is assumed that leave contracts are an attempt to maintain patient safety. If so, a more positive alternative would be for organisations to support practitioners to work collaboratively with patients to develop personal security plans (Barker and Buchanan-Barker, 2005). This approach encourages the patient to recognise any emotional insecurities that might impact on their safety and identify what they might do to reduce the likelihood of harming themselves or others. The personal security plan also identifies what support might be required from practitioners to enact the plan. Encouraging patients to invest in this arrangement, it is argued, is more likely to be successful than any contract that the patient is pressured or coerced to complying with by an organisation.

Limitations

There are limitations to this study. Firstly, it is possible that information explaining leave arrangements for informal patients is outlined in documents not considered as relevant to the FOI request, for example locked door policies. Secondly, it is not known whether the existence of a policy or its content has any impact on the informal patient's right to leave the ward.

Conclusion

This study has examined the use and content of policies produced by mental health services in England and Wales detailing how informally admitted patients can take

leave. Despite the requirement that MHTs and HBs in England and Wales have a policy that sets out precisely the arrangements by which informal patients can take leave (DH, 2015; WG, 2016), the findings of this study show that high numbers of organisations did not produce such documents. Where policies did exist, there was considerable variation in quality, content and the use of empirical evidence to support the practices recommended. Policies also focused on safety and risk avoidance rather than therapeutic risk taking, and in some cases, coercive/restrictive practices at the expense of more recovery-based approaches. Overall, the findings of this study suggest the need for the development, in collaborations with patients and other stakeholders, of a national, evidenced-based, recovery focused policy template that should be adopted by all mental health services in England and Wales. It is recommended that the items identified in Table 2 should be included in the policy template. Finally, a national policy could be audited against good practice standards and monitored by organisations such as the Care Quality Commission.

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Table 1 Literature supporting policy documents.
(n, number of times cited)

Books

- Fennell (2007) Mental Health: The New Law (Jordans New Law Series) (n = 1).
- Jones (2014) Mental Health Act Manuel (17th edition) (n = 4).
- South London and Maudsley NHS Foundation Trust (2013) The Maze: A Practical Guide to the Mental Health Act 1983 (Amended 2007) (3rd Edition) (n = 1).

Case law

- Rabone and another v Pennine Care NHS Foundation Trust [2012] UKSC 2 [2012] MHLO 6 (n = 3).
- Regina v Hallstrom and another, ex parte W (No 2): 1986 (n = 1).
- Savage v South Essex Partnership NHS Foundation Trust [2010] EWHC (QB) (n = 1).

Guidelines

- Department of Health (2007) Best Practice in Managing Risk. Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services (n = 1).
- Department of Health (2012). Preventing suicide in England: A cross-government outcomes strategy to save lives (n = 1).
- Department of Health (2013) Mental Capacity Act: Code of Practice (n = 4).
- Department of Health (2015) Mental Health Act 1983: Code of Practice (n = 20).
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Primary research

- Bowers et al. (2011a) Learning from prevented suicide in psychiatric inpatient care: An analysis of data from the National Patient Safety Agency (n = 2).

Reports

- The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: England, Northern Ireland, Scotland, Wales. October 2019. University of Manchester (n = 3).

Source: Table by author

Table 2 Some recommended items for inclusion in NHS organisations' leave policies for informal patients.

- Statement of stakeholders (for example, patients) involved in the development of the policy.
- Date of policy creation and date of review (within 2-3 years).
- Identification of those responsible for ratifying, monitoring and evaluating the policy.
- Aims of the policy.
- The evidence used to support items included in the policy. All references should be cited correctly with no omissions.
- Key duties and expectations of staff.
- Definition of an informal patient (DH, 2015, p. 412; WG, 2016, p. 280).
- Statement of the informal patient's right to leave hospital (DH, 2015, p.322; WG, 2016, p. 193) and how it will be communicated both verbally and in writing.
- Statement on how the organisation intends to balance its operational duty to informal patients under article 2 (right to life) of the Human Rights Act 1998 with those described in article 5 (right to liberty).
- Statement of the term(s) to be used to describe hospital leave for informal patients. For example, Devon Partnership NHS Trust (2023) have adopted the phrase "time away from the ward" to distinguish between the leave processes for informal and formal patients.
- Definition of leave. This should cover: (1) Leave within hospital buildings, hospital grounds and that taken outside of hospital premises; (2) Escorted, accompanied, unescorted and unaccompanied leave, and who can undertake the first two; and (3) Short- and long-term leave.
- Map showing buildings and hospital boundaries referred to in the policy.
- The therapeutic benefits of leave for the patient's recovery and for maintaining or re-establish daily routines and social networks.

- The reasons patients abscond from hospital and the interventions that can be used to address them and other risk related issues (Bowers et al., 2003; Barker and Buchanan-Barker, 2005).

- The process by which informal patients can exercise their right to leave hospital, and how this will be communicated to individuals.

- Actions to be considered should there be any concerns about the patient taking leave. For example, the use of section 5 holding powers (DH, 2015; WG, 2016).

- Commitment to regular training and what its content might consist of (including the items mentioned in this table). The interval for refresher training should be specified. The training must not simply consist of reading the policy document.

Source: Table by author