NHS Mental Health Services' policies on leave for detained patients in England and Wales: a national audit

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ABSTRACT

Introduction: Considerable guidance is available about the implementation of leave for detained patients, but individual mental health services are free to determine their own policies.

Aim: To determine how consistent leave policies of NHS mental health services in England and Wales are with relevant guidance and legislation.

Method: A national audit of NHS mental health services' leave policies. Data were obtained through web searching and Freedom of Information requests. Policies were assessed against 65 criteria across four domains (administrative, Responsible Clinician, types of leave, and nursing). Definitions of leave-related terms were extracted and analysed.

Results: Fifty-seven (91.9%) policies were obtained. There were considerable inconsistencies in how policies were informed by relevant guidance: Domain-level consistency was 72.3% (administrative), 64.0% (Responsible Clinician), 44.7% (types of leave), and 41.9% (nursing). Definitions varied widely and commonly differed from those in the guidance.

Discussion: Mental health professionals are inconsistently supported by policy in their leave-related practice. This could potentially contribute to inconsistent practice and leave-related patient outcomes.

Implications for Practice: To ensure patients are treated fairly clinicians need to be aware of their responsibilities around leave. In some services they will need to go beyond their organisation's stated policy to ensure this occurs.

200 Words

Keywords: Mental health nursing, detained patients, therapeutic leave, mental health legislation

Accessible summary

What is known on the subject?

- 'Leave' is a common occurrence for patients detained in mental health settings. The term covers multiple scenarios, for example short periods to get off the ward through to extended periods at home prior to discharge.
- Despite the frequency and importance of leave there is very little research about how it is implemented and whether, and in what circumstances, it is effective.
- While there is legislation about leave in the Mental Health Act (1983) mental health services are free to implement their own policies or not to implement one at all

What the paper adds to existing knowledge?

- The leave policies of NHS mental health services in England and Wales are highly inconsistent.
- The extent to which policies are consistent with guidance differs depending on which service is providing care.

What are the implications for practice?

- It is very likely that, because of inconsistencies between services and policies, practice also differs.
- Clinicians need to understand their responsibilities in the leave process to ensure that patients are supported in their recovery journey.
- Policymakers need to revisit leave policies in the light of evidence from this study.

169 Words

Relevance statement

'Leave' is a central part of practice in inpatient mental health settings. It is a practice in which mental health nurses may be involved in decision-making as a responsible or Approved Clinician or, more commonly, in facilitating its implementation. Despite this, current leave-related practice is based on a palpable absence of research evidence. We have conducted a national survey of leave policies to determine how clinicians are supported in their leave-related practice. The policies are very inconsistent, those related to nurse-specific responsibilities especially so, and there are clear implications for mental health nursing practice.

96 Words

1. Introduction

'Leave' is defined as '*a. permission to do something; b. authorized especially extended absence from duty or employment*' (Merriam-Webster https://www.merriam-webster.com/dictionary/leave). In mental health care leave occurs when an inpatient exits their hospital ward having received the appropriate and/or necessary authorisation; and it has been studied internationally, most frequently in the UK, but also in the US, Australia, and the Netherlands (Barlow & Dickens, 2018). For detained patients in England and Wales, their responsible clinician may grant [them] "leave to be absent from the hospital subject to such conditions (if any) as that clinician considers necessary in the interests of the patient or for the protection of other persons" (Mental Health Act, 1983 17(1)). Without such authorisation, legal powers are available to return them to hospital or to a place of safety. Leave applies across multiple scenarios involving varying durations and destinations, and differing complexity in terms of purpose or aim. Leave is used to facilitate short trips to walk in the hospital grounds or to go to the local shops, and extended periods at home prior to discharge from hospital (Department of Health, 2015a: p. 316). Leave should be recognised not only as a sanctioned activity, but as a therapeutic endeavour with potential restorative properties, aligned with modern conceptualisations of recovery-focussed mental health services (Anthony, 1993) and as an exercise in therapeutic risk-taking (Felton et al., 2017).

Granting of leave is common in mental health services across the western world, albeit governed by different legislation and national guidance. Reports of the incidence of leave are rare but across four studies the median rate of all escorted and unescorted leave within or outside of hospital was 575.8 (range 204.5 to 782.8) incidents per 100 beds per month (Barlow & Dickens, 2018). In this paper, we focus on leave policies in England and Wales where the relevant legislation is section 17 of the Mental Health Act (1983), commonly

referred to as ‘section 17 leave’ including in information for patients and carers (e.g., Rotherham, Doncaster and South Humber NHS Foundation Trust, 2014). Under this legislation, a detained patient’s Responsible Clinician, this being the Approved Clinician with overall responsibility for the patient, is the only person who has the authority to grant and revoke section 17 leave (Mental Health Act, 1983). The detained patient is allocated to their Responsible Clinician by the managers of that mental health hospital. In the absence of the Responsible Clinician, another Approved Clinician has the authority to implement section 17 leave (Mental Health Act, 1983). The Approved Clinician role, and by extension that of Responsible Clinician, can be undertaken by a medical registered practitioner, chartered psychologist, relevantly trained nurse, occupational therapist, or social worker. Uptake of these roles by non-medical staff has been limited with only 56 becoming Approved Clinicians in England and Wales in the decade to 2017 (Oates et al., 2018).

In England, the Mental Health Act Code of Practice (Department of Health, 2015a: p.316), which interprets Mental Health Act legislation for professionals, patients and their families and carers, directs readers to understand the principles of leave. Leave is viewed as an important part of a patient’s care plan with potential recovery-related benefits but also potential risks (p. 317). The Welsh Assembly Government (WAG; 2016) echo these principles in the Mental Health Act 1983 Code of Practice for Wales, within which there is an identical chapter on ‘Leave of Absence’ (p.193).

In a systematic review of empirical studies of leave, those that focused on non-forensic patients were dated (median date of publication 1998, range 1968 to 2013) (Barlow & Dickens, 2018); as a result, the contemporary evidence base about almost all aspects of leave is lacking. The best evidence relates to the use of leave compared with community treatment orders in a randomised controlled trial to successfully reintegrate detained patients back into

the community (Burns et al., 2013); neither intervention was superior on any outcome. Otherwise, the scant evidence indicates that patients can be unaware of leave-related aspects of their care plan (Atkinson et al., 2002ab), staff-patient communication around leave is a concern, and there is insufficient monitoring of leave (Barre, 2003). In forensic settings, studies have reported that patients' psychiatrists endeavoured to involve the wider multi-disciplinary team in leave decision-making processes and that disagreement within the team about leave decisions were uncommon (Lyall & Bartlett, 2010; Stacey *et al.,* 2015). Based on observations of team discussions about leave, Lyall and Bartlett (2010) concluded that decisions about the use of unofficial 'trial' periods of leave were largely ritualistic rather than evidence-based. Similar issues have been raised in studies conducted in the US (Donner et al., 1990), Australia (Walker et al., 2013), and the Netherlands (Schel et al., 2015).

Pressures on mental health services are ever increasing (Lamb *et al.,* 2019) and, regrettably, failures in mental health care occur (British Medical Association, 2018), including those related to discharge provisions and associated risk management decisions (Parliamentary and Health Service Ombudsman, 2018). Section 17 leave practices could be applicable to such failures. Suicide statistics consistently demonstrate that the immediate post-discharge phase from a mental health hospital is a critical time of risk (National Confidential Inquiry into Suicide and Safety in Mental Health, 2018) and therefore well-timed and well-risk assessed discharge processes are imperative. It is undoubtedly a well-intentioned assumption that graduated exposure outside of a hospital ward is beneficial for assisting a patient back to community living (Newman *et al*., 1988), however, section 17 leave's therapeutic potential is largely unevidenced.

The National Institute for Health and Care Excellence (2018) have produced clinical guidelines for the NHS since 2002 and have over 80 publications guiding practices embedded

in the UK's mental health services. Their guidelines communicate the best available evidence and give direction to mental health clinicians. However, there are currently no guidelines in situ for leave, thus there is no national guidance mandating a standardised approach to its use. Instead, in England and Wales, direction on the use of leave occurs within the boundaries determined by local NHS Trust / Health Board policies in the light of their own interpretation of relevant guidance in documents including the Mental Health Act Code of Practice (Department of Health, 2015a; WAG, 2016). While such policies are not an obligatory requirement of NHS Trusts and Health Boards, their presence and content will indicate how clinicians are being supported to deliver leave-related practice. Thus, as a first step in the development of an empirical body of work about the issue of leave, in the current study we aimed to establish the prevalence of leave policies in those NHS Trusts and Boards in England and Wales which deliver inpatient mental health services, and to ascertain the consistency of those policies with key aspects of relevant guidance. The study concentrates on policies related to services provided for civil (i.e., non-forensic) patients.

The aim of the study was to measure policy content against notional gold standards derived from relevant legislation and guidance, and from our own reading and clinical experience . We acknowledge that it is legitimate to ask whether, if the gold standard is defined in legislation and guidance, then could a leave policy that simply says "adhere to the Mental Health Act and the related Code of Practice" be sufficient. We suspect that it would not and that gaps would still remain. One purpose of the current study was to examine the content of policies in order to inform precisely this kind of debate. Design, data extraction and analysis were guided by principles of policy audit. Policy audit involves a systematic review of a set of policies and usually focuses on a particular policy area to aid understanding of their content and scope (Bull et al., 2014).

2. METHODS

2.1 Design

The study applied a census survey approach to identifying and obtaining data and a policy audit approach to data analysis.

2.2 Sample

The study examined policies pertaining to leave for patients detained under civil legislation in NHS mental health services in England and Wales; thus inclusion criteria included policies covering leave made by any NHS provider of relevant services. Included policies could be out of date (requiring review), and, while they did not have to be explicitly identified as a 'leave policy', it was a requirement that inclusions contained at least one section dedicated to leave. Policies were eligible irrespective of length (including appendices) or the purpose of the leave covered. Policies from independent sector providers of mental health services, for services outside of England and Wales, and those pertaining to patients in non-mental health services only were excluded. Policies from Community Health Trusts, Acute Trusts, Ambulance Trusts, Children's Trusts, and Special Health Authorities were also excluded. The study focused only on leave for patients detained under civil legislation and therefore we did not include policies that dealt exclusively with leave for patients detained under forensic sections or for non-detained informal patients. Where policies covered these in addition to leave for patients detained under civil sections then only information relating to the latter was extracted.

2.3 Procedure

Data were obtained through web searching and a Freedom of Information (FOI) request which allows anyone to be informed, in writing, as to whether a public authority holds

information as specified in a designated request (Freedom of Information Act, 2000). This method of data collection is well suited for obtaining information held by public authorities including NHS Trusts (Savage & Hyde, 2014).

The study protocol was approved by Abertay University's ethics committee. All individual NHS Trust/Board information has been anonymised. NHS Mental Health Trusts and Health Boards in England and Wales were identified (Care Quality Commission, 2017; Office for National Statistics, 2017). At the point of the FOI request (the census date) there were *n*=54 NHS Mental Health Trusts in England; a further *n*=7 Health Boards in Wales provided mental health services. Internet searching was conducted to locate policies available in the public domain resulting in acquisition of *n*=12 policies. A FOI request was sent to all Trusts and Boards whose policy was not retrieved in the web search (*n*=50). Further clarification was provided when requested by the Trust or Board FOI team. Each policy was screened on receipt from the FOI team to confirm it met the inclusion criteria. All policy material provided to us including appendices and forms were scrutinised for information.

2.4 Data extraction

Data extraction involved a purpose designed tool (Leave Policy Index [England & Wales Civil Version)] or LPI. Items were derived from the England & Wales Mental Health Act (1983), the Mental Health Act Code of Practice (Department of Health, 2015a; WAG, 2016), and other sources including our clinical and academic experience, and from examination of leave policies. Three phases of development involved random selection of policies (*n*=10, *n*=4, *n*=5) from which information was extracted using the developing LPI. At each phase items were refined, re-worded or removed when found to be inappropriate. At phase 2 data was independently extracted by both authors and discussed to ensure consistency of approach. The initial version of the tool comprised 128 items; after the 3-phase development

it comprised 101 items. Four items detail facts about the policy itself including word count, number of appendices, other policies referred to, and citations of sources including legislation and literature. Sixty-five items are rated dichotomously Yes/No (e.g., 'does the policy contain a definition of short-term leave?') and are non-contingent on responses to other items, i.e., they could be measured for all included policies and were not dependent on a previous item having been answered affirmatively. These 65-items were organised into four domains (see Table 1) to facilitate comparisons across different policy areas, namely: administrative (11 items), Responsible Clinician responsibility (19 items), types of leave (24 items), and nursing responsibility (11 items). The final included items were derived from the Mental Health Act Code of Practice (Department of Health, 2015a; WAG, 2016; *n*=34), the Mental Health Act (1983; *n*=6), and from other sources but deemed to be 'of interest'. In effect the audit instrument comprised 40 items that should be considered as 'gold standard' derived from legislation and a further 25 which could be considered as good practice. The remaining LPI items were supplementary to and contingent on responses to dichotomous questions and involved the verbatim extraction of definitions or other material from the policy. For example, an item supplementary to that for short-term leave was 'provide definition if yes').

2.5 Data analysis

Data analysis involved calculation of the number and proportion of policies judged to be consistent with each of the 65 audit criteria. The mean percentage policy consistency across the data set per domain in terms of both audit standards derived from the Code of Practice or Mental Health Act and of those derived from and the number of policies deemed to achieve <50% compliance per domain were calculated (see Table 1). Regarding definitional items relating to short and long term leave and escorted leave we judged whether each policy met or partially met definitions included in the Mental Health Act Code of Practice (Department

of Health, 2015a; WAG, 2016) or whether they were absent. For terms including 'ground leave', which is not explicitly defined in the Code of Practice, we recorded simply whether it was mentioned and, if so, how it was described.

3. RESULTS

In total, 57 policies were retrieved through the search strategy for a response rate of 91.9%. The policies came from NHS Trusts in England (*n*=51) and NHS Boards in Wales (*n*=6). The policies drew on a range of references, most frequently cited were the Mental Health Act Code of Practice (Department of Health, 2015a and WAG, 2016; *n*=48), the Mental Health Act (1983; *n*=40), the Department of Health Reference Guide to the Mental Health Act 1983 (Department of Health, 2015b; *n*=21), and Jones' Mental Health Act Manual Guidelines (Jones, 2016; *n*=19). All policies bar one, which contained no references at all, cited at least one of these four documents. The most common recommended period of policy review was 3-yearly (*n*=35; 61.4%; range 1 to 5 yearly). Median word count of policies including appendices was 5,355 words (range 1,048 to 74,987 words).

The number and proportion of policy items deemed to be consistent with audit criteria are presented in Table 1. All were specifically titled as 'leave' policies; eight (14.0%) were out of date. The mean number of dichotomous items deemed consistent with guidance was 35.4 (62.1%; SD=10.9, range 3 to 55). Across the four domains, consistency with audit principles was greatest for the administrative items (72.3%), followed by the Responsible Clinician items (64.0%) while those for types of leave (44.7%) and nursing responsibility (41.9%) were lower. Two thirds or more of policies failed to achieve more than 50% consistency in the types of leave and nursing domains while around a quarter of policies in the Responsible Clinician and administrative domains were similarly inconsistent.

While the items from the Responsible Clinician and recording leave domains were better represented within policies, there were still a significant number of items where consistency was low. Notably, stipulating recording of consideration of various potential risks and recovery-related benefits of leave in the Responsible Clinician domain fell below 50% as did items in the administrative domain related to ensuring accurate descriptions and photographs are held in medical notes.

In the nursing domain, the scope of responsibility of nurses in the leave process was inconsistently addressed. Three policies failed to even mention nursing staff, and increasing numbers of policies omitted to state that the circumstances of non-implementation of leave should be considered (54.4% consistent with the audit definition), that the policy should identify which nurses can rescind leave (43.9%), and that nurses have broad responsibility for implementing leave (35.1%). No policies included appendices which outlined separate nursing procedures for these issues.

Fourteen of twenty-two audit items within the Types of Leave domain were unrepresented in half or more of policies. While most policies mentioned specific terms that are defined within the Mental Health Act Code of Practice (Department of Health, 2015a; WAG, 2016) including ‘short term leave’ (*n*=38; 66.7%), ‘long term leave’ (*n*=43; 75.4%), and ‘escorted leave’ (*n*=50; 87.7%), fewer offered definitions or partial definitions of these terms. Where they were defined there was inconsistency among those definitions. The most common definition of short term leave, defined by the Code of Practice (Department of Health, 2015a; WAG, 2016) as occurring “when a mental health in-patient exits the hospital ward with the appropriate authorisation and then returns within a seven- day time period”, comprised elements relating to duration, frequency, geography, time of day, and responsibility, for example: “Short periods of local leave granted on a regular basis (during the day) at the

discretion of nursing staff i.e. 2 hours per day to the shops". To iterate, this definition is not found in either the Code of Practice (Department of Health, 2015a; WAG, 2016) or Mental Health Act (1983).

Long term leave, defined in the Code of Practice as occurring when a mental health in-patient exits the hospital ward with appropriate authorisation, for a time period which extends beyond seven consecutive days was defined or partially defined in *n*=40 (70.2%) policies, of which we judged *n*=21 to be wholly consistent with the Code of Practice definition.

Section 17 leave can be authorised with conditions attached by the Responsible Clinician. 'Escorted' is one such condition, whereby the patient must remain in the legal custody of a member of hospital staff, or any person authorised in writing by the hospital managers [i.e., the 'escort'] (Department of Health, 2015a, WAG, 2016). Thirty-six 63.2%) policies contained a definition of escorted leave. Six different definitions of escorted leave were identified, with the most frequent (25%; *n* = 14) reflecting that of the Code of Practice (Department of Health, 2015a, WAG, 2016): "the patient must remain in the legal custody (during leave) of staff, or of any other person authorised in writing by the managers of the Trust". Anomalously, one policy coined the term 'shadowed leave' which is described as occurring when a staff member observes and follows a patient at a discreet distance. This term is not identified or described within any national leave document that we are aware of. A range of other relevant information on escorted leave was captured from policies. While there was no clear pattern, individual policies variously stipulated that escorted leave should only be authorised in hour long time slots; that authorisation should involve consideration of the escort's need to use the toilet; that the Responsible Clinician mandate the escort's gender; and that the Responsible Clinician should mandate the escort's gender *and* ethnicity. The rationale for these provisions was not described. Individual policies provided direction about

escorts' conduct and behaviour during leave including their use of eye contact; prohibited the escort from smoking; stated that the escort should walk with the patient, rather than ahead or behind; required that the escort should "re-capture" a patient should they "escape"; and required escorting staff to carry 'complaints cards', to be offered to the public should there be an incident during leave. The skillset of the escorting staff member was mandated in *n*=8 policies.

Two terms which are not defined in the Code of Practice, 'ground leave' and 'accompanied leave', were commonly mentioned in policies (*n*=42; 73.7% and n=*3*4; 59.6% respectively). Most (*n*=32; 56.1%) offered no formal procedure for ground leave, only *n*=8 (14.0%) defined the relevant geographical area, and just one (1.8%) provided a map or diagram. For accompanied leave, around half of policies defined it explicitly as different to escorted leave (*n*=27; 47.4%) and provided guidance on who could facilitate it (*n*=29; 50.9%), while a minority (*n*=11, 19.3%) explicitly stated that the person completing the leave with the patient should understand and accept their legal responsibility for the patient during the event.

4. DISCUSSION

In the current study we aimed to identify the presence of leave-related policies in all NHS Trusts and Health Boards in England and Wales that provide inpatient mental health services and to evaluate their consistency with key aspects of published legislative guidance. It is important to recognise that there may be other sources of guidance for specific clinical areas which feed into policies, for example the 'Quality Network for Inpatient Working Age Mental Health Services' (2019) include standards in their 'acute inpatient services' standards, which that would likely feed into policies.

We retrieved policies from 57 (91.9%) of 62 relevant NHS Trusts and Health Boards. While it is not obligatory for NHS Trusts and Health Boards to have a leave policy in place the vast

majority did. Neither is it mandated what the content of leave policies should be and, hence, we have used the term ‘consistent with’ rather than ‘compliant with’ relevant guidance. Perhaps unsurprisingly then, there were considerable variations in the policy content in most respects, and in the level of consistency with guidance across all four domains studied; mean rates were from 41.9% to 86.0% for items derived by ourselves and 43.4% to 64.4% for the gold standard items derived from legislation and guidance. Taking the level of consistency with individual items as an index of item importance, i.e., high presence of consistency indicates high importance, the leave policies of some organisations were lacking in respect of even basic aspects such as being in date, stating that a copy of leave authorisation should be provided to the patient, and that the Responsible Clinician should record the conditions of leave. Upwards of 20% of policies failed to state that a copy of the leave authorisation should be recorded in the clinical record, that the outcome of leave should be recorded, that the patient’s wishes regarding leave should be considered, and that a risk assessment should be undertaken prior to leave being taken. On the other hand, items with relatively low representation in policies are presumably viewed as being of lower priority or, perhaps, considered to be self-evidently an existing part of practice such that their need to be articulated in policy is redundant. However, while it is possible that certain aspects might well be embedded in practice without representation in policy, it does not seem prudent to take this for granted. For example, just 19.3% of policies contained reference to the need to ensure that a person completing accompanied leave with a detained patient understands and accepts their legal responsibilities, but it is not immediately obvious why this would not be included in policy. Other items, including maintaining an accurate description and photograph of the patient in their records, approached representation in around half of policies. This suggests a distinct lack of consensus about what should and should not be included in leave policy. Of course, the absence of various aspects of guidance in policies is

no guarantee that they are not enacted in practice, nor does their presence indicate that they are. However, what we can say with some certainty, is that the extent to which the stated policies of NHS Trusts and Health Boards in England and Wales supports their clinicians to deliver section 17 leave in accord with principles outlined in the Mental Health Act (1983) and the associated codes of practice is vastly inconsistent. It would be highly surprising if this did not translate into variations in practice, effectively ensuring a postcode lottery for detained patients in terms of how they are supported to take steps towards recovery (Russell et al., 2013).

Unwarranted variations in practice, such as those described above, are not unusual in health care (Westert et al., 2018) and the key driver appears to be the shaping of policies over time according to local capacity (Mulley, 2009). This goes some way to explaining the manifest variations in how leave practices are, at least, *defined* at a local level. For example, we found 'short term leave' to be inconsistently defined with the most common definition incorporating multiple clauses including duration, frequency, geography, time of day, and responsibility which do not appear in the definition in the Mental Health Act Code of Practice (Department of Health, 2015a; WAG, 2016). Presumably, this will reflect the unique situations of individual services in respect of, inter alia, their location, topography, and resources. Given this, it is quite surprising that those unique aspects were very rarely operationalised in terms of actual quantification or by inclusion of a map of the relevant areas for ground leave. The variation evidenced here could also lead to difficulties when staff change jobs or when different organisations take over the responsibility of service provision.

Consistency of related guidance of 64.0% in the Responsible Clinician responsibility domain was high relative to the levels achieved in the nursing and types of leave domains. This reflects the centrality to, and legal responsibility of this group in the leave process,

theoretically anyone from a range of disciplines but, in reality, almost always a medic. The policies' representation of the Responsible Clinicians' role in leave to a significantly greater degree than other healthcare professionals, notably nurses who do have clear responsibilities in the leave process as established both in guidance and previous leave-related literature, reflects that found in the national leave documents, (Department of Health, 2015a; WAG, 2016). Nevertheless, a considerable number of policies failed to include guidance aimed at Responsible Clinicians including the need to consider the recovery related benefits of leave for the patient, and the need to balance the benefits of leave versus any risk to others. It could be argued that those who are Responsible Clinicians will, of course, consider these issues as part of their role and that a mechanistic policy written against a checklist will merely be an attempted proactive defence against litigation (Ho et al., 2018) rather than something which bolsters recovery-oriented practice. It was striking, however, that only a quarter of policies stipulated that the circumstances in which leave should not go ahead should be made explicit. *If* the lack of representation in policy really does impact on practice then this would seem to place an unnecessary burden on those who are responsible for implementing leave, chiefly nursing staff, if they have not been provided with clear boundaries to work within.

This issue then extends to the poor explication of nurses' responsibility in the leave process more generally. Only three items, one of which merely required nurses to be mentioned in the policy, were present in more than half of policies. Again, this must reflect the dearth of literature regarding leave as a specific nurse-facilitated practice (Barlow & Dickens, 2018). There are well developed literatures on other specific aspects of the mental health nursing role in relation to seclusion (Muir-Cochrane et al., 2018), restraint (Hawsawi et al., 2020), and harm minimisation practices for self-harm (Dickens & Hosie, 2022). It is curious that this simply is not the case for leave. With virtually zero high quality evidence to draw on in relation to the implementation of leave, nor about its effectiveness as a therapeutic

endeavour, this issue is long overdue for a programme of systematic investigation. An initial programme of research should primarily address aspects of service user experience of leave and perception of its importance or otherwise. Of course, investigation of the perceptions of various disciplinary groups involved in the granting and implementation of leave, primarily medical and nursing staff, are important. In terms of addressing potential variations in practice, leave is so utterly unexplored that it warrants mapping in order to better understand how and when it is used, in what circumstances, and how successful it is (Sutherland & Levesque, 2019).

When policymakers wrote original content in policies then, on occasion, it was factually inaccurate and in direct conflict with existing leave guidance (Department of Health, 2015a; WAG, 2016). The impact of such negligence undoubtedly could create confidence issues with policy-making processes. In addition, conflicting inter-policy guidance exists around the documenting of escorted leave; whether the Responsible Clinician should personally see the patient prior to authorising their leave; if and how carers are involved in leave; and staff training needs around leave. If the policies do serve as a mechanism to shape the behaviour and conduct of staff, then it is to some extent sheer chance what policies staff in different services are exposed to. Ambiguous guidance was also problematic in respect to leave documentation; the results cannot conclusively determine a consensus of how to record leave progress or outcomes, such as what to write, where to write it, or who is responsible for documenting what. It is highly probable that, without explicit guidance on what salient leave details to record, that documentation is open to inconsistency as is reflected in the background literature (Donner et al., 1990; Kasmi & Brennan, 2015). Both the policies themselves and the background literature suggest that successful leave episodes are indicative of future leave authorisation (Lyall & Bartlett, 2010) and, for that reason, failure to accurately document a patient's leave events could disadvantage their future leave episodes because

documentation is evidence, without which it may be difficult to clinically demonstrate progression-based decisions for leave (Mathioudakis et al, 2016).

This study found various definitions of leave, despite definitions serving to establish a collective understanding of a word or phrase (Stichler, 2018). Short-term leave was described as all the following: 'overnight leave at home', 'weekend leave', 'week's leave', 'therapeutic community leave', 'court attendance', 'emergency leave' and 'special leave'. This is despite 'short-term leave' being executively defined in mental health legislation, i.e., 'leave up to 7 consecutive days' (Mental Health Act, 1983). Confusion around leave definitions intensifies when the policies communicate conflicting leave practices. For instance, one policy provides incongruous time restrictions with the use of 'short-term leave'.

The definitions of 'accompanied leave' and 'escorted leave' were also problematic, illustrated by the two policies which erroneously suggested these disparate terms have the same meaning. The policies did not provide consensus about the responsibility held by any person facilitating an episode of accompanied leave, despite this information already being detailed in the Code of Practice (Department of Health, 2015a; WAG, 2016).

Health care providers are expected to provide services that are underpinned by a commitment to respect and dignity (e.g., National Health Service, England, 2014). Practising with value-based principles proves advantageous for patient outcomes (Delaney, 2018) which should underpin all processes in mental health care delivery, including that of leave. Not all leave policies reflected such values, with one of the most striking examples occurring when escorted staff were advised to "re-capture" a patient should they 'escape' while on leave. Further examples in the policies include reference to the practice of 'shadowed leave'; the use of 'complaints cards' for the public; and failure to provide guidance about patients receiving their own leave paperwork. While these were isolated instances, this policy language does not

reflect a collaborative and empowering relationship between the clinical team and the patient utilising leave.

While we have identified a serious lack of evidence for the value and practice of leave in civil settings, we note that patients in forensic settings identify it as an important factor for improving their quality of life (Schel et al., 2015; Vorstenbosch et al., 2014), that it relieves boredom and provides enjoyment (Rees and Waters, 2003). While there is an urgent need to develop the evidence base, the default position should be to facilitate leave.

4.1 Limitations

While the study obtained over 90% of leave-related policies from NHS providers of mental health services in England and Wales we were unable to ensure blanket coverage despite repeated communication to FOI officers in non-responding Trusts and Health Boards. We did not attempt to obtain policies from non-NHS providers and doing this would present an opportunity to extend the current work. Further, we excluded some Trusts, notably acute Trusts and Community Health Trusts, that may hold some responsibilities for mental health patients on leave. We do not consider this a major limitation since there is no reason to believe that they would perform any better in terms of representing legal requirements in policy. The methodology chosen can only inform us about policy content, and all inferences about associated practices are essentially speculative. Further, the results of this study are limited to the data obtained, which was acquired by virtue of FOI processes and web searching We acknowledge that FOI teams do not employ mental health professionals who understand legislation and leave processes and who may have high workload demands. As a result, we do not know if there was additional relevant information that could have been provided. To mitigate this risk, we gave clear instructions about our criteria and offered clarification where required. Finally, the study was conducted in England and Wales only and

therefore within the context of legislation from these jurisdictions only. However, we note that leave has been addressed in the international research literature (Barlow & Dickens, 2018) and it is likely that similar issues are relevant. We encourage researchers to adapt our data collection instrument to suit the details of their own legislative guidance in order to conduct further studies.

4.2 Conclusion

This study found serious inconsistencies among the leave policies of NHS Mental Health Trusts and Health Boards in England and Wales. This suggests a high probability that practice deviates from established principles, and to combat such dissonance there is a need to transition leave into an intervention which operates consistently nationally while accounting for the relevant local variations which may constrain or facilitate its use. Literature suggests that policy-making customarily occurs within administrative siloes despite those very policies affecting a range of external parties (Hudson et al., 2019). If mental health service users had the opportunity to be involved in policy-making, they would have the opportunity to communicate the importance of being empowered by leave processes and demonstrate how this impacts on their quality of life.

Table 1: Consistency of NHS England & Wales Trusts and Health Board Leave policies with audit criteria

Item	Policy content	Origin of audit criterion	n (%) Consistent	Mean consistency %	n (%) <50% consistent
Administrative					
1	Specific Leave Policy	Of interest	57 (100.0)	86.0	9 (15.8%)
2	Policy in date	Of interest	49 (86.0)		
3	Training recommended	Of interest	36 (63.2)		
4	Policy addresses revoking leave	Of interest	54 (94.7)		
5	Copy of leave authorisation provided to patient	CoP	51 (89.5)	64.4	
6	Other relevant parties to receive copies	CoP	44 (77.2)		
7	Copy in notes	CoP	44 (77.2)		
8	Up to date description of patient in records	CoP	26 (45.6)		
9	Photograph of patient in records	CoP	21 (36.8)		
10	Outcome should be recorded	CoP	42 (73.7)		
11	Patients views on outcome to be recorded	CoP	29 (50.9)		
RC Responsibility					
12	RC to record conditions of leave	Of interest	45 (78.9)	78.9	16 (28.1%)
13	RC responsible for granting leave	MHA	55 (96.5)	63.2	
14	AC responsible in RC absence	CoP	46 (80.7)		
15	RC responsible for leave conditions	MHA	51 (89.5)		
16	Consider benefits/ risks for health and safety	CoP	27 (47.4)		
17	Consider recovery related benefits	CoP	25 (43.9)		
18	Consider balance of benefits vs. risk to others	CoP	27 (47.4)		
19	Consider child welfare issues	CoP	29 (50.9)		
20	Consider patient's wishes	CoP	44 (77.2)		
21	Consider wishes of carers, friends, and others	CoP	47 (82.5)		
22	Consider support required and availability	CoP	34 (59.6)		
23	Ensure need to know of community services	CoP	44 (77.2)		
24	Ensure patient aware of contingency plans	CoP	37 (64.9)		
25	Liaise with relevant agencies	CoP	30 (52.6)		
26	Undertake a risk assessment	CoP	45 (78.9)		
27	Enact safeguards from risk assessment	CoP	22 (38.6)		
28	Consider issues related to non-consent to inform carers	CoP	29 (50.9)		
29	Specify circumstances in which leave should not go ahead	CoP	14 (24.6)		
30	Mention team discussion in decisions	CoP	42 (73.7)		
Types of Leave					
31	'Short term leave' defined/[partially defined]	Of interest	34 [25+9] (59.6)	47.0	12 (21.1)
32	'Longer term leave' defined/ [partially defined]	Of interest	39 [21+18] (68.4)		
33	'Ground leave' or 'Hospital leave' mentioned	Of interest	42 (73.7)		
34	Policy quantifies the geographical area of the hospital grounds	Of interest	8 (14.0)		
35	Map/diagram provided	Of interest	1 (1.8)		
36	Only hospital staff or those authorised by managers permitted to complete an escorted leave	Of interest	27 (47.4)		
37	Accompanied Leave mentioned	Of interest	34 (59.6)		
38	Defined as different from escorted leave	Of interest	27 (47.4)		
39	Guidance about who can facilitate	Of interest	29 (50.9)		
40	Meets MHA definition of 7 days to section expiry	MHA	8 (14.0)	43.4	
41	Section 17a (CTO) to be considered before granting longer term leave	MHA	46 (80.7)		
42	Above decision to be explained to the patient (CTO or S17)	CoP	14 (24.6)		
43	Above decision to be fully documented	CoP	35 (61.4)		

Item	Policy content	Origin of audit criterion	*n* (%) Consistent	Mean consistency %	*n* (%) <50% consistent
Types of Leave continued					
44	Indicates RC should be satisfied that the patient can manage outside the hospital before granting leave	CoP	16 (28.1)	43.4	40 (70.2%)
45	Policy states no formal procedure required	CoP	32 (56.1)		
46	'Escorted leave' defined/ [partially defined]	MHA	36 [31+5] (63.2)		
47	Person completing accompanied leave must understand and accept legal custody	CoP	11 (19.3)		
48	Policy covers leave to other hospitals	MHA	35 (61.4)		
49	Policy says a transfer should be considered	CoP	16 (28.1)		
50	Policy reflects that RC at Hospital 1 retains overall charge	CoP	24 (42.1)		
51	Policy states RC responsibility remains the same while patient on leave	CoP	25 (43.9)		
52	Patient granted leave under s.17 remains liable to be detained	CoP	34 (59.6)		
53	To be aware of patient's address	CoP	21 (36.8)		
54	Carers and professionals should have access to RC while patient on leave	CoP	18 (31.6)		
Nursing					
55	Mentions nursing staff	Of interest	52 (91.2)	41.9	37 (64.9)
56	Indicates implementation is nursing responsibility	Of interest	20 (35.1)		
57	Nurse assesses mental state prior	Of interest	25 (43.9)		
58	Nurses assesses risk prior	Of interest	24 (42.1)		
59	Nurse confirms leave arrangements	Of interest	19 (33.3)		
60	Nurse ensures contact details known	Of interest	6 (10.5)		
61	Nurse ensures patient knows contact details	Of interest	5 (8.8)		
62	Circumstances for non implementation identified	Of interest	39 (68.4)		
63	Policy stipulates procedures for non-implementation	Of interest	31 (54.4)		
64	Policy states which nurses can rescind leave	Of interest	25 (43.9)		
65	Indicates nursing role to evaluate leave with patient	Of interest	17 (29.8)		

RC – Responsible Clinician; AC – Approved Clinician; MHA – MHA 1983/2007; CTO – Community Treatment Order; MHA Mental Health Act; CoP Code of Practice

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