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Therapeutic leave from secure mental health inpatient services: a review

Geoffrey L. Dickens and Emily-May Barlow

Introduction (GLD)

I am delighted to have been invited to contribute a paper to this *liber amicorum* for Prof. dr. Frans Koenraadt in honour of his lifetime's contribution to clinical and theoretical advances in forensic psychology, law, mental health, and education. I first had the pleasure of meeting Frans in Toronto when both he, I, and Lydia Dalhuisen, Frans' then PhD student, were all presenting work on firesetters and firesetting. Our mutual interest led to further contact and an invitation was extended to me to join the examination panel for Dr Dalhuisen's PhD thesis defence in Utrecht, a fascinating experience for me since it is not our tradition in the UK to conduct such a public defence. Since then, I have read with great interest and admiration the outputs of the PhD. It was my impression that Prof. Koenraadt provided a highly constructive and flexible educational experience which allowed the PhD room to breathe and grow. My acquaintance with Frans has been short, but I can say with sincerity that his natural curiosity, intellectual openness, and willingness to share his vast accumulated knowledge should serve as a model for us all. In this spirit of sharing, my colleague, Emily-May Barlow, and I have chosen to address an issue which we feel passionate about. It is also an issue that lies firmly in those intersections between law, criminality, psychology, risk, and clinical practice in which Prof. Koenraadt excels. That issue is the use of therapeutic leave by patients in secure, forensic mental health care.

Background

In United Kingdom forensic mental health inpatient settings 'leave' occurs when a patient exits the hospital ward with appropriate authorisation, either alone, or accompanied by staff, family, or friends.¹ Leave can be granted for short periods, for example to go to the shops or spend a weekend at home, or

1 Department of Health, *Mental Health Act*, London: Department of Health 2007.

for much longer periods such as a period of trial leave prior to full discharge.² While no legal distinction exists between leave that is granted for an immediate, practical purpose (e.g., to attend a medical appointment outside of the secure unit of residence) and leave that is granted in the longer term pursuit of rehabilitation and recovery, our main concern in this paper is with leave that has been authorised with the intention of facilitating the latter goals, however long term. Such leave may – indeed, we argue it should – have explicit aims; for example, it should provide opportunities for the patient to practice social or other life skills, and should provide an arena in which the clinical team can progressively test out risk.

In this paper, we use the terms ‘leave’, ‘sanctioned leave’, and ‘therapeutic leave’ interchangeably. In doing so, we also avoid the largely custodial connotations of terms like ‘parole’, ‘pass’, or ‘furlough’. Leave is commonly employed in forensic services as the mechanism with which to structure transitions between security levels (supervised transfer), or from hospital to the community (supervised discharge). During such episodes of leave the patient can be returned to his previous placement, or can be recalled to hospital in the event of treatment breakdown, relapse, or non-compliance. Such arrangements are common for patients who have a history of unsuccessful discharge or transition.³ We recognise such supervisory leave as a type of therapeutic leave because it is intended, at least in part, to play a role in recovery and rehabilitation. We are, however, writing primarily for an audience of forensic mental health nurses, a professional group who are tasked with the day-to-day management of therapeutic leave from secure forensic mental health units. As a result, we do not cover in any depth the important issues relating to the use of leave for the purposes of managing a supervised discharge.

Therapeutic leave from secure units employs comparable principles across the native-English-speaking world and much of Western Europe. Research attention has almost exclusively focused on *unauthorised* leave, its causes, antecedents, consequences, and prevention. In effect, the evidence base for managing therapeutic leave is largely constructed around incidents involving escapes from conditions of security or failures to return from sanctioned leave. It is worth restating this in a different way: therapeutic leave-related practice is largely based on evidence from studies about events, which, in the main, were never intended as a planned part of therapeutic care. Since unauthorised leave is associated with danger to others, harm to self, reputational damage for forensic mental health services, and loss of trust with key stakeholders

2 Care Quality Commission, *Monitoring the Mental Health Act in 2015/16*, 2010; see www.cqc.org.uk/sites/default/files/20161122_mhareport1516_web.pdf (accessed: 20 September 2017).

3 D. Mohan, J. Jamieson & P. Taylor, The use of trial leave for restricted special hospital patients, *Criminal Behaviour and Mental Health* 11 (2001), p. 55-62.

this is, perhaps, understandable.⁴ Nevertheless, sanctioned, therapeutic leave can itself have very serious adverse consequences: for example, a fifth of all inpatient suicides in England occurred during sanctioned leave.⁵ We think it quite possible that policy and practice decisions about *therapeutic* leave that are based on evidence from unauthorised leave can only ever have marginal relevance to the management of the former. In this paper, we argue that an alternative perspective – one aiming to maximise the therapeutic potential of sanctioned leave – might be more appropriate. Indeed, we contend that a continued focus on risk over rehabilitation and recovery could reflect risk-averse or even coercive approaches that indicate interpersonal professional-patient mistrust.⁶

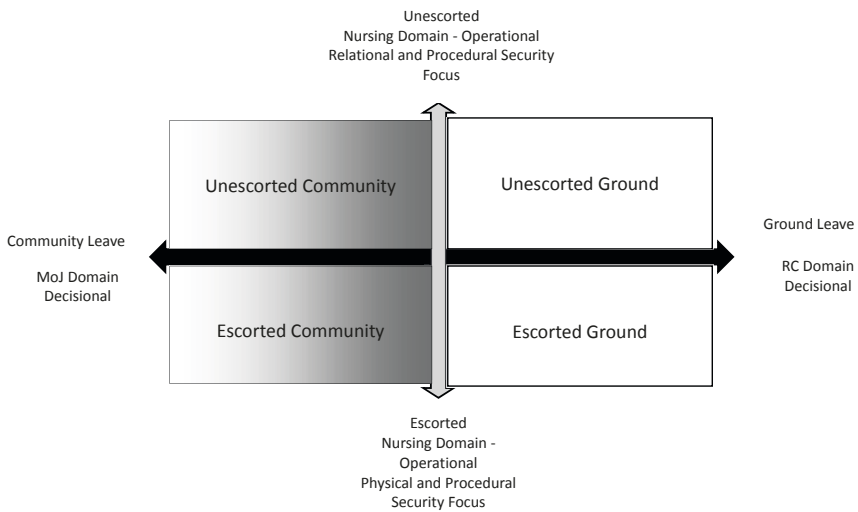
In England and Wales, legal direction on leave from forensic mental health services is provided by the Mental Health Act [MHA], 1983 (as amended in 2007). It extends the provisions, made in the same Act, for civilly detained patients, decisions about whose leave are made by their responsible clinician, usually their consultant psychiatrist (Department of Health 2007). Mentally disordered offenders who are detained in hospital may be subject to additional ‘restriction orders’ (Section 37/41; Section 47/49 MHA) applied by the Court due to the risks posed by the individual. For such offenders, guidance is explicit: the National Offender Management Service⁷ outlines legal provisions, specifies the types of leave available, and details how clinicians can rescind leave. For patients subject to additional restrictions, the Secretary of State for Justice has ultimate responsibility for decisions about leave and the responsible clinician must provide a robust account of the proposed leave, its context, purpose, potential risks, and proposed therapeutic benefits.

A number of terms are used in the literature including ‘therapeutic pass’⁸ and ‘community pass’.⁹ Common to all is specification about i) whether the leave is to be taken within (*Ground Leave*) or outside of the hospital grounds

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- 4 D. Stewart & L. Bowers, *Absconding from psychiatric hospitals: A literature review. Report from the Conflict and Containment Reduction Research Programme*, London: Section of Mental Health Nursing, Institute of Psychiatry 2010.
 - 5 I. Hunt, H. Bickley, K. Windfuhr, J. Shaw, L. Appleby & N. Kapur, Suicide in recently admitted psychiatric in-patients: A case-control study, *Journal of Affective Disorders* 144 (2013) 1-2, p. 123-128.
 - 6 J. Robertson & C. Collinson, Positive risk taking: Whose risk is it? An exploration in community outreach teams in adult mental health and learning disability services, *Health, Risk & Society* 13 (2011) 2, p. 147-164; D. Smith, *Mood state changes in psychiatric ward residents that are correlated with a weekend pass* (PhD), Stillwater, OK: Oklahoma State University 1976.
 - 7 National Offender Management Service, *Mental Health Casework Section. Section 17-Leave of Absence*, Ministry of Justice: National Offender Management Service 2017.
 - 8 D. Cronin-Stubbs, L. Donner, S. McFolling, E. Kopytko, S. Pasch & S. Szczesny, Discharge planning for psychiatric inpatients: Evaluation of one technique, *Applied Nursing Research* 1 (1988) 2, p. 72-79.
 - 9 L. Donner, E. Kopytko, S. McFolling, D. Cronin-Stubbs, S. Szczesny, K. Mayton & S. Pasch, Increasing psychiatric inpatients’ community adjustment through therapeutic passes, *Archives of Psychiatric Nursing* 4 (1990) 2, p. 93-98.

(*Community Leave*); and ii) whether, for the duration of the leave, the patient is to be *escorted* by clinic staff (and, if yes, how many and under what arrangements) or whether the patient will be *unescorted*. This can be simply conceptualised as a taxonomy of leave defined on axes of community-ground and escorted-unescorted (see Figure 1). Each of four possible combinations of conditions results in a unique leave scenario: escorted ground leave, escorted community leave, unescorted ground leave, and unescorted community leave. Only the community variants of leave are subject to the further restrictions requiring Ministry of Justice approval; for this reason, the Ground-Community axis can be seen also as a decisional axis denoting where responsibility lies for the overall decision about the patient's leave. Management of individual episodes of leave can also be understood on an operational axis: this represents the therapeutic and security concerns relevant at the time of each individual episode of leave. Management of each episode generally falls to forensic mental health nurses.

Figure 1: Conceptual map of types of therapeutic leave in inpatient forensic mental health services



The black arrow axis represents the underlying legal or *decisional* domain denoting where ultimate responsibility falls for decisions about the level, type, frequency and circumstances of therapeutic leave: it is essentially dichotomous (indicated by shading) with decisions about leave within the hospital falling to the Responsible Clinician and those outwith the hospital falling ultimately to the Ministry of Justice. The grey arrow represents the underlying *operational* domain denoting the focus of decision-making for managing leave: this is continuous and will involve consideration of individual patients and their circumstances in terms of their physical, procedural, and relational security needs. Decisions are likely to be multidisciplinary in nature, and management of individual instances will invariably fall under the aegis of the nursing team.

Methods and results

We searched the electronic databases CINAHL, MEDLINE, and PsycINFO for relevant empirical papers. Papers were included where they described an empirical account of some aspect of therapeutic leave from a secure/forensic mental health unit or hospital. We extracted all relevant information from the included papers and organised it thematically. In total, we identified fourteen empirical papers concerning therapeutic leave conducted in secure mental health inpatient settings.

Incidence and characteristics

Very few statistics have been published about how much, and what type of, leave is taken by forensic patients. From the data in eight published studies, we have calculated indices based on either Leave Events (events per 100 beds or 100 admissions per month) or Patients With Leave (Patients with leave per 100 beds or 100 admissions per month). Event-based rates of total leave episodes (i.e., all episodes of escorted and unescorted community and ground leave) range from 204.5 in a high security hospital¹⁰ to 902.5¹¹ events per 100 beds/month in a medium/low secure setting (*Mdn* = 575.1). These numbers incorporate all incidents of leave whether inside or outside hospital, and whether escorted or unescorted. Rates of Unescorted Community Leave range from 191.9 to 414.8 events per 100 beds/month.¹² A patient-based leave rate was calculable from only one study: Green and Baglioni reported a rate of 2.4 patients with ‘Overnight conditional leave’ per 100 beds/month.¹³

Studies in forensic units report a *Mean* admission-to-first leave episode duration of 8.4 months.¹⁴ However, there is little evidence about how and why access to leave is granted at this point rather than earlier or later. Lyall and Bartlett¹⁵ reported that it was the clinical team’s tacit understanding that patients must serve a suitable period in hospital – an ‘unofficial qualifying period’ – in

10 N. Claxton, S. Husain & A. Tomison, Monitoring leave in a secure unit: A clinical performance indicator?, *Journal of Forensic Psychiatry and Psychology* 17 (2006) 1, p. 32-36.

11 J. Tully, A. Cullen, D. Hearn & T. Fahy, Service evaluation of electronic monitoring (GPS tracking) in a medium secure forensic psychiatry setting, *Journal of Forensic Psychiatry and Psychology* 27 (2015) 2, p. 169-176.

12 R. Scott, V. Goel, D. Neillie, T. Stedman & T. Meehan, Unauthorised absences from leave form an Australian security hospital, *Australasian Psychiatry* 22 (2014) 2, p. 170-173; R. Scott & T. Meehan, Critical incidents during leave from an Australian security hospital – A 12-year audit, *Psychiatry, Psychology and Law* 24 (2016) 1, p. 47-60.

13 B. Green & A. Baglioni, Length of stay, leave and re-offending by patients from a Queensland security patient’s hospital, *Australian and New Zealand Journal of Psychiatry* 32 (1998), p. 839-847.

14 Green & Baglioni, 1998.

15 M. Lyall & A. Bartlett, Decision making in medium security: Can he have leave?, *Journal of Forensic Psychiatry and Psychology* 21 (2010) 6, p. 887-901.

which therapeutic and educational groups are attended, a negative urine screen is achieved, and mental state is assessed as appropriate. However, they found that there was no obvious formula that reliably led to first leave episode-approval. Patients have reported that their suitability for leave rests on similar factors.¹⁶

Regarding the characteristics of patients granted leave, statistics are also sparse. Of the seven studies involving patient participants – in which demographic information was provided – all involved a majority or exclusively male sample (*Mdn* = 85.7%, range 50-100%); four included a sample with a preponderant diagnosis of schizophrenia/psychosis (*Mdn* = 63.4%, range 38%-100%).

Responsibility and understanding

In studies, leave initiation was the onus of the responsible clinician, with additional home secretary approval where required.¹⁷ There is limited evidence about the involvement of non-medical professionals in decision-making. One direct-observation study conducted in multidisciplinary ward rounds in a medium-secure setting¹⁸ reported that the responsible clinician actively involved the team in such decision-making; discussions of the patient's mental state were central, and there was little within-team disagreement. Other reported influences on leave-related decision-making include: admission length; trust with the patient; human factors; external resources; time restraints during the decision-making process, and public safety.¹⁹

Walker et al. report a shared staff-patient understanding that the ultimate purpose of leave is to encourage reintegration and rehearse daily living skills, but neither group identified episode-specific objectives.²⁰ In contrast, Lyall and Bartlett identified that leave was more likely to be granted where an episode-specific purpose was identified.²¹ Walker et al. reported inadequate preparation and planning prior to escorted leave episodes by nursing staff, and an absence of record-keeping about patient presentation and functioning during leave.²² Instead, nurses emphasised risk assessment prior to leave as the main task.

16 G. Rees & R. Waters, *'Lost and Locked In': Patients Perspectives on Leave Under Section 37-41*, Cardiff: The Mental Health Foundation 2003.

17 Green & Baglioni, 1998; Lyall & Bartlett, 2010; Mohan et al., 2001; P. Murphy, L. Potter, J. Tully, D. Hearn, T. Fahy & P. McCrone, A cost comparison study of using global positioning system technology (electronic monitoring) in a medium secure forensic psychiatric service, *Journal of Forensic Psychiatry and Psychology* 28 (2017) 1, p. 57-69.

18 Lyall & Bartlett, 2010.

19 Green & Baglioni, 1998.

20 A. Walker, L. Farnworth & S. Lapinski, A recovery perspective on community day leaves, *Journal of Forensic Practice* 15 (2013) 2, p. 109-118.

21 Lyall & Bartlett, 2010.

22 Walker et al., 2013.

Risk assessment and clinical decision-making

Of fourteen studies, most described individualised violence or offending-related risk assessment for leave purposes.²³ Hilterman et al.'s²⁴ examination of their own 17-item 'Leave Risk Assessment' (LRA) for serious reoffending by forensic inpatients on leave revealed large effect sizes for prediction of general and serious offending for various subscales compared with the moderate effect sizes of the HCR-20.²⁵ The mean period from the start of leave to offending was 134 days; 26.9% of offenders re-offended on the first day of leave. 'Taking responsibility for their index offence' was the only LRA item without significant predictive value; alcohol use was the most significant predictor for general offending during leave.

Walker et al. highlighted the complexity of clinical decision-making required of escorting nurses during leave.²⁶ They explained how an escorting nurse failed to explore opportunities that could have facilitated the patient's goals, as he perceived them to be unrealistic. The authors suggest that an inflexible approach undermined recovery principles, disrespected patient autonomy, and was non-therapeutic; they concluded that flexibility and professional judgement are key to the success of escorted therapeutic leave.

Outcomes

Proposed therapeutic leave outcomes included reduced admission length, transfer to voluntary status, rehabilitation, and re-integration into the community.²⁷ No study actually addressed any of these outcomes as a direct result of leave.

23 D. Hearn, Tracking patients on leave from a secure setting, *Mental Health Practice* 16 (2013) 6, p. 17-21; Lyall & Bartlett, 2010; Walker et al., 2013; Scott et al., 2014; Claxton et al., 2006; Scott & Meehan, 2016; E. Hilterman, M. Philipse & N. Dirk de Graff, Assessment of offending during leave: Development of the Leave Risk Assessment in a sample of Dutch forensic psychiatric patients, *International Journal of Forensic Mental Health* 10 (2011) 3, p. 233-243; Tully et al., 2016.

24 Hilterman et al., 2011.

25 C. Webster, K. Douglas, D. Eaves & S. Hart, *HCR-20: Assessing risk for violence (Version 2)*. Vancouver, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University 1997.

26 Walker et al., 2013.

27 Walker et al., 2013; A. James, J. Smith, R. Hoogkamer, J. Laing & W. Donovan, Minimum and medium security; the interface use of Section 17 trial leave, *Psychiatric Bulletin* 20 (1996), p. 201-204; Mohan et al., 2001; Hilterman et al., 2011; Lyall & Bartlett, 2010; Scott et al., 2014; Scott & Meehan, 2016.

Subjective experience

Young²⁸ explored clinicians' views on the management of forensic mental health patients' leave where they were detained with further restrictions imposed by the mental health unit (MHU) at the UK Ministry of Justice. For these patients, initiation of and changes to the amount and conditions of, leave must be approved by the unit. There was a perceived disconnect of the MHU from local realities due to a reported lack of recognition that the nature of leave differs according to placement-geography and environment; subsequently, patients, who strongly rely on successful leave to demonstrate progress, may be unable to do so simply because the placement is unsuitable for supporting that leave, for example remote or inaccessible. Further, Young suggested a perceived disempowerment by the MHU of local clinicians and an insulation from the 'clinical fall out' (p. 401) of their decisions; and that MHU caseworkers tended to overreact to patients' aggressive or angry response to a denial of leave leading to a vicious circle of further leave denial. Staff also expressed that patients need to be realistic about their applications for leave and take responsibility for maintaining their leave status.

A Netherlands-based study of long-term, male forensic patients' investigated 'leave' as one of fifteen domains of their quality of life.²⁹ For the 'leave' domain, the researchers asked patients to rate their satisfaction related to whether or not they were allowed to leave the facility on a regular basis, the frequency they were allowed to leave, and the activities they were allowed to undertake whilst on leave. The subjects' self-ratings and case managers' proxy-ratings for the 2-item 'Leave' domain of the Forensic inpatient Quality of Life scale³⁰ did not differ significantly; both groups rated patient satisfaction with leave-related care poorly, and it was the lowest ranked of the tool's 15 domains, beneath nutrition, hygiene, social relations, and affection.

Walker et al. reported that both staff and patients felt community day leave facilitated reintegration and provided an opportunity to practice daily living skills.³¹ However, neither group identified the specific objective of any single leave episode. Rees and Waters found that detained forensic patients believed that leave prepared them for life outside hospital, relieved boredom, aided

28 A. Young, Deconstructing imposed recovery – clinical perceptions of the legal and administrative framework for managing restricted mental health patients – the experience of one hospital in the independent sector, *Journal of Nursing and Healthcare of Chronic Illness* 3 (2011) 4, p. 397-406.

29 S. Schel, Y. Bouman & B. Bulten, Quality of life in long-term forensic psychiatric care: Comparison of self-report and proxy assessments, *Archives of Psychiatric Nursing* 29 (2015) 3, p. 162-167.

30 E. Vorstenbosch, Y. Bouman, P. Braun & E. Bulten, Psychometric properties of the forensic inpatient quality of life questionnaire: quality of life assessment for long-term forensic psychiatric care, *Health Psychology and Behavioral Medicine* 2 (2014) 1, p. 335-348.

31 Walker et al., 2013.

social network development, helped them cope with their current restricted situation, and provided enjoyment.³² This echoed findings from a study in a civil hospital setting: nurses and physicians were surveyed on their views about aspects of the treatment program that most successfully promoted discharge-readiness and community-adjustment. Results revealed community leave to be the seventh most highly ranked of 26 alternatives.³³ Subsequent interviews revealed the ranking to be attributable to the perceived suitability of leave for testing the effectiveness of hospitalization, for promoting coping behaviours, easing the hospital-to-home transition, and maintaining social networks. Patient respondents identified the purposes of leave as testing out-of-hospital functioning, building relationships, and evaluating coping ability.

Novel interventions

A two-year pilot study of remote electronic monitoring of patients on unescorted leave from a UK secure forensic unit via a Geo-Positioning Satellite device resulted in an increase in the amount of unaccompanied leave for patients but not a convincing economic case either for or against the technology.³⁴ Prior to each leave episode the patient was fitted with a tamper-proof anklet tracking device. Once activated, nurses remotely monitored the patient's whereabouts in real time, and were alerted of any attempted device removal, or transgression of agreed geographical boundaries.

Discussion

Our findings confirm that leave occurs in forensic inpatient mental health services internationally and that most patients and clinicians believe it offers therapeutic benefits. The evidence, however, about such basic information about the duration of leave, what inpatients do while on leave, or about any objective outcomes is very thin. Further, information about ideal ways of introducing leave, indicators for leave termination, or staff training for facilitating therapeutic leave as opposed to preventing unauthorised leave are largely non-existent. Limited evidence was available about the characteristics of patients using leave other than that, like the inpatient population in general, they are predominantly male and experiencing a psychotic illness.³⁵

32 Rees & Waters, 2003.

33 Cronin-Stubbs et al., 1988.

34 D. Hearn, Tracking patients on leave from a secure setting. *Mental Health Practice* 16 (2013) 6, p. 17-21; Tully et al., 2016; Murphy et al., 2017.

35 Health and Social Care Information Centre, *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment Uses of the Mental Health Act: Annual Statistics, 2014/15, 2015*; see <http://content.digital.nhs.uk/catalogue/PUB18803/inp-det-m-h-a-1983-sup-com-eng-14-15-rep.pdf> (accessed: 20 September 2017).

The wide variation in reported leave rates reflects that those in higher security settings will have very limited community leave, and those in lower secure care preparing for discharge might have significant amounts of leave. Unescorted ground leave rates in forensic settings ranged from 2.2 to 6.3 episodes per 100 occupied bed days (*Mdn*=4.3) or three episodes per week in total in a 10-bed unit. While the number of leave episodes that *should* occur will vary across patients, wards, circumstances, and time, this rate does seem very low, primarily suggesting that ground leave is under-recorded in studies. As a result, we are almost entirely ignorant of the scope or extent of its actual use. We suggest that this might partly be a consequence of the Responsible Clinician having responsibility for its authorisation; as ground leave does not require MOJ sanction, records do not reflect the legislative requirements of off-ground leave. However, given that ground leave could justify the Responsible Clinician's later application to the MOJ for initiation of off ground leave, robust record keeping would be advantageous.

To our knowledge, this review is the first to present standardised leave rates. Future studies should report on rates of leave as part of routine practice. This would generate new data to facilitate exploration of relationships between leave and important variables including quality of life indicators, ward environment, or adverse incidents.

It is an un-evidenced assumption that graduated exposure to leave is most beneficial and assists in the return of the patient to the community.³⁶ From the available evidence, we cannot pinpoint how and what impact leave has upon discharge readiness, mental state, and quality of life. There is some stronger evidence relating to the use of leave as a form of supervised discharge. Burns et al. adequately demonstrated that the use of leave legislation was as effective as a community treatment order for prevention of readmission.³⁷ The simple lesson from this is that new restrictive practices are not necessarily justified nor required. Furthermore, this fell outside the scope of our current review.

Research into quality of life in a forensic psychiatric unit revealed lowest satisfaction of all by patients was with arrangements for leave.³⁸ Quality of life is a recognised component of forensic psychiatric care, indicated by the long term nature of care that these patients often require.³⁹ Patient's satisfaction with arrangements for leave were much lower than satisfaction with the social domain of care and lower even than satisfaction with the sexuality domain. Case managers' proxy ratings of leave-related satisfaction were concordant with patients' self-ratings whereas in other domains the former significantly

36 L. Newman, M. Bohles & C. Becker, Evaluating the Therapeutic Leave of Absence: A tool that meets needs, *Rehabilitation Nursing* 13 (1988) 4, p. 195-197.

37 T. Burns, J. Rugkasa, A. Molodynski, J. Dawson, K. Yeeles & M. Vazquez-Montes et al., Community treatment orders for patients with psychosis. (OCTET): a randomised controlled trial, *The Lancet* 381 (2013), p. 1627-1633.

38 Schel et al., 2015.

39 Vorstenbosch et al., 2014.

over-estimated patient satisfaction. A related antecedent study describing development of the Forensic Quality of Life tool⁴⁰ confirmed that leave is a very distinct and important aspect of quality of life for forensic inpatients. Unfortunately, other quality of life studies conducted in forensic settings have not measured leave-related satisfaction in isolation, and this is an area requiring further exploration. Findings from studies beyond the scope of this review suggest leave is a high priority for patients in forensic psychiatric units⁴¹ and this may explain Schel et al.'s findings.⁴²

Length of stay in hospital, severity of offending history,⁴³ and a period of concordance⁴⁴ are considered important considerations for clinicians before initial leave authorisation. These seem reasonable heuristics on which to base decisions. Nevertheless, there is little supporting empirical evidence. Indications by clinicians and patients that leave is important and therapeutically beneficial⁴⁵ are essentially anecdotal value judgements rather than indications of efficacy. Therefore, we suggest that the onus lies with health professionals to articulate and evidence why requested leave not be permitted rather than rely on un-evidenced assessments. Note that this is not necessarily an argument for greater liberality around the use of leave; rather it is the prioritisation of transparent decision-making.

Studies reported the onus of leave initiation to be on the responsible clinician while other professionals' roles were unclear. Lyall and Barlett identified multi-disciplinary team meetings as the key forum for leave-related decision-making, reporting that responsible clinicians welcomed others' input.⁴⁶ This is consistent with Stacey et al.'s finding that psychiatrists try to involve other professionals in decision-making processes but are conscious of their responsibility for definitive decisions including granting leave.⁴⁷ In reality, factors including the idiosyncratic collective functioning of each multi-disciplinary team, power struggles, individual confidence, and role-perspectives are likely to influence decisions.

Although, in England and Wales, there are standardised processes *in situ* when applying for a restricted patient's leave, we are unaware of any national standards or guidelines for measuring and recording leave progress and outcomes. Our experience suggests that, at team level, leave parameters are highly idiosyncratic reflecting the local environment, including the location of

40 Vorstenbosch et al., 2014.

41 E.g. G. Parry-Crooke & P. Stafford, *My life: in safe hands? An evaluation of dedicated women's medium secure services in England*, London: Department of Health 2009.

42 Schel et al., 2015.

43 Green & Baglioni, 2004.

44 Lyall & Bartlett, 2010.

45 E.g., Cronin-Stubbs et al., 1988.

46 Lyall & Barlett, 2010.

47 G. Stacey, A. Felton, A. Hui, T. Stickley, P. Houghton & B. Diamon et al., Informed, involved and influential: Three I's of shared decision making, *Mental Health Practice* 9 (2015) 4, p. 33-37.

amenities such as shops or cafes. This is reflected in literature which recognises that documentation of leave is often simplistic, with little justification of decision-making,⁴⁸ and poor recording of its purpose or outcomes.⁴⁹ Since successful leave episodes support future leave-authorisation,⁵⁰ documentation failure may well disadvantage the patient.

Leave-related risk assessment instruments generally aim to assist professionals to understand the individual's risk of taking 'unauthorized leave' and thus were ineligible for inclusion in the review. Of tools not focusing on unauthorised leave, the Leave Risk Assessment⁵¹ focused on general and serious recidivism *during* leave, finding it more accurate in prediction of those outcomes than the HCR-20.⁵² The Leave/Abscond Risk Assessment⁵³ has been developed but the tool constitutes little more than a checklist of actions to perform prior to and post leave rather than an attempt to inform a formulation about probability of leave having positive or negative consequences.

Nurses generally facilitate and co-ordinate individual leave episodes; given the delicate balance between therapeutic benefits and risks, their decisions require clinical justification.⁵⁴ Some opinion papers have claimed that nurses prepare patients for leave via clear instructions on how to manage whilst away from hospital;⁵⁵ however, this was not reflected in included studies. By facilitating and documenting leave, nurses can provide evidence about the patient's ability to cope with the responsibility of managing his or her own safety. There is currently no evidence available to indicate what, if any, impact nurses' leave-related decisions have upon a patient's recovery despite the potential practical, legal, and ethical implications.⁵⁶

Leave is not a recognised therapeutic nursing intervention,⁵⁷ yet a systematic review to identify nursing interventions in inpatient psychiatry determined that exploring and reducing the rates of absconding *was* a nursing intervention.⁵⁸ From this, one may conclude that the nurses' role in leave is assumed largely

48 Y. Kasmi & D. Brennan, Developing a patient leave request form for a secure setting, *Mental Health Practice* 18 (2015) 5, p. 30-35.

49 Donner et al., 1990.

50 Lyall & Bartlett, 2010.

51 Hilterman et al., 2011.

52 Webster et al., 2009.

53 Kasmi & Brennan, 2015; D. Hearn, D. Ndegwa, P. Norman, N. Hammond & E. Chaplin, Developing the leave/abscond risk assessment (LARA) from the absconding literature: an aide to risk management in secure services, *Advances in Mental Health and Intellectual Disabilities* 6 (2012) 6, p. 280-290.

54 Lyall & Bartlett, 2010.

55 Newman et al., 1988.

56 Hilterman et al., 2011.

57 G. Bulechek, H. Butcher & J. Dochterman, *Nursing Interventions Classification (NIC)*, 5th edn., St. Louis, MO: Mosby Elsevier 2008.

58 F. Frauenfelder, M. Müller-Staub, I. Needham & T. Achterberg, Nursing interventions in inpatient psychiatry, *Journal of Psychiatric and Mental Health Nursing* 20 (2013), p. 921-931.

to prevent absconding, an inherently defensive position in accord with staffs' principal understanding of leave success as risk avoidance.⁵⁹ Other common nursing activities – including administration of *pro re nata* ('as required') medicines and de-escalation of aggression – have been subject to far greater empirical investigation. We conclude that leave and its management is long overdue for further examination.

Patients rely to varying extents on friends and family during their time on leave. However, carers' involvement in supporting a patients' leave is an unexplored topic; only one study referred to carers, suggesting they receive insufficient involvement and support.⁶⁰ This reflects studies outside the scope of this review, which suggest that carers more broadly perceive their knowledge of service users is often disregarded despite policy rhetoric.⁶¹

Future research

The only intervention to improve or increase leave identified in this review concerned Geo Positioning Satellite tracking of forensic patients on unescorted community leave.⁶² Preliminary results suggest the approach could help patients to progress through their in-patient stay at an accelerated rate due to the availability of a method to test patients with leave earlier in their admission with the technological safety net of Geo Positioning Satellite. This could potentially allow careful calibration of leave, tailored to the individual patient within the unique environment of their placement. The exponential increase in unescorted leave apparently resulting from this innovation⁶³ suggests it is highly acceptable to patients. Outside of forensic services, it might be wise to trial strategies involving telephone support or SMS text messaging to support leave. In addition, we suggest that architecture in mental health facilities should be shaped to be leave-facilitative. Ahern et al.⁶⁴ have evaluated an initially controversial new 'zoned' building design which required all patient and visitor ingress/egress to and from a 'public zone' to go through a single, manned 'portal'. A 'transition zone' (or 'galleria') provides a space in which inpatients, outpatients, and identified visitors can mix and in which clinical activities take place. Finally, the 'inpatient' zone is accessible only to inpatients but all wards are unlocked. Patients are assigned a level of 'therapeutic pass' (Inpatient '1'; Transition '2'; Public '3'). Concerns that patients would find it

59 Walker et al., 2013.

60 T. Barre, Evaluation of the use of leave of absence: An organisational case study, *Mental Health Practice* 7 (2003) 4, p. 34-36.

61 Stacey et al., 2015.

62 Hearn, 2013; Murphy et al., 2017; Tully et al., 2016.

63 Tully et al., 2016.

64 C. Ahern, P. Bieling, M.C. McKinnon, H.E. McNeeley & K. Langstaff, A recovery-oriented care approach. Weighing the pros and cons of a newly built mental health facility, *Journal of Psychosocial Nursing* 54 (2016) 2, p. 39-48.

stigmatising to leave using a public portal were largely dispelled by a mixed methods design study which found patient- and staff-reported benefits to outweigh risks and brought additional benefits including a sense of safety in the unit. While the innovation was reportedly costly, it suggests that building design which maximises therapeutic leave should be rigorously evaluated.

In studies of physical rehabilitation, research has examined how to provide information for service users and carers about their first therapeutic leave,⁶⁵ and development of a tool to evaluate the usefulness of leave.⁶⁶ Both might be usefully developed for use with mental health inpatients.

Limitations

The obvious limitation is the lack of relevant studies sourced despite our broad inclusion criteria. Further, the use of leave and its management are significantly different between forensic and civil settings and we have excluded evidence from the latter settings. Finally, we excluded non-English language studies, which could be a limitation.

Conclusion

Given the considerable disadvantages associated with secure mental health inpatient status including separation from family and friends and decreased control over daily choices, patients should expect a robust, systematic process with clear decision-making protocols to facilitate an intervention that could decrease admission length. In reality, very little is known about how decisions about leave are made and implemented, including whether such activities are conducted equitably across diverse patient groups.

65 E. Geets, G. Jégousse, B. Kertesz, C. Lenormand, M. Azcarate & P. Diard, Methods of information provision for the first therapeutic leave after brain injury – Opinions of patients and carers, *Annals of Physical and Rehabilitation Medicine* 58 (2011) 1, p. 103.

66 Newman et al., 1988.