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# Systematic Review of Therapeutic Leave in Inpatient Mental Health Services

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ABSTRACT

*Aim:* To identify, critically evaluate, and synthesise the empirical evidence about therapeutic leave from mental health inpatient settings.

*Background:* "Leave" occurs when a mental health inpatient exits the hospital ward with the appropriate authorisation alone, or accompanied by staff, family, or friends. Limited research has previously addressed therapeutic as opposed to unauthorised leave, and the evidence-base has not been systematically evaluated.

*Design:* Systematic review methodology following relevant Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement guidance.

*Data Sources:* Multiple electronic databases (CINAHL; Criminal Justice database; PsycARTICLES; Scopus; OpenGrey; Cochrane; GoogleScholar) for papers published from January 1967 to July 2017.

*Review Methods:* Information was extracted under the following headings: study, purpose/aims, sample, country, setting, design and data collection method(s), data collection instrument, and results. Papers were assessed, as per the hierarchy of scientific evidence, and where there was sufficient data, we calculated a range of standardised rates of leave incidence.

*Results:* Standardised leave rates in forensic settings reflect security level. There was little meaningful information on which to base calculation of rates for civil settings. The strongest evidence supports leave used for supervised discharge; other forms of leave lack an evidence base and decisions appear to be made on the basis of heuristic rules and unsupported assumptions. Clinical decision making about therapeutic leave cannot claim to be evidence-based.

*Conclusion:* Research is urgently needed to provide information about how leave is managed, the best ways to support leave, and what happens on leave.

## Introduction

"Leave" occurs when a mental health inpatient exits the hospital ward with the appropriate authorisation either alone, or accompanied by staff, family, or friends (Department of Health, 2007). Leave might be given for short periods, for example to go to the shops or spend a weekend at home, or for much longer periods (Care Quality Commission, 2010). Leave provides the clinical team with evidence to demonstrate that a patient is able to cope with the responsibility of managing their own safety, agitation levels and mental health symptomatology, for a pre-determined period of time (Department of Health, 2015). Whereas the responsible clinician has primary responsibility for granting leave for an individual and setting parameters, it is the responsibility of mental health nurses to facilitate and manage individual instances of leave within that framework using mental health risk assessment; by recording and evaluating leave; and by organising practical matters including transport and escorts (Central and North West London NHS Foundation Trust, 2015; Dorset HealthCare University NHS Foundation Trust, 2004; Solent NHS Trust, 2016).

'To give leave' is to allow 'someone to make a choice or decision about something, or to make someone responsible for something' (Cambridge Dictionary, 2017). From this perspective, leave is not merely a sanctioned activity but is potentially restorative and therapeutic, a view more congruent with recovery-oriented conceptualisations of mental health service delivery (Anthony, 1993) and notions of therapeutic risk-taking (Felton, Wright, & Stacey, 2017). It is reasonable to presume that discharge from hospital could be prolonged, should there be a delay in a patient being authorised "leave" from the ward. Given the disadvantages associated with mental health in-patient status, i.e. separation from family/friends, decreased control over daily choices, it is justified to expect an evidence-based process for facilitating an intervention that could decrease admission length. Despite

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this, there has to date been no systematic review of all the relevant empirical literature to synthesise knowledge about leave, how decisions are made and implemented, and whether they are conducted equitably across diverse groups. The intention of this paper is to address these questions.

Leave is a practice which occurs internationally; comparable principles are employed in the English-speaking world and Western Europe. Research has focused on *unauthorised* leave, its causes, antecedents, consequences, and prevention. Since it is associated with harm to self, to others, and reputational damage for mental health services (Stewart & Bowers, 2010) this is understandable. Adverse consequences of sanctioned leave are, however, not illusory; a fifth of all inpatient suicides in England occurred during authorised leave (Hunt et al., 2013). A focus solely on preventing unauthorised leave might be unwarranted, and could reflect risk-aversive or even coercive approaches that indicate interpersonal professional-patient mistrust (Robertson & Collinson, 2011).

### Background

#### Civil and Forensic Leave

Civil leave applies to informal patients [individuals who voluntarily agree to a hospital admission] or those detained under civil sections of relevant mental health legislation. Decisions about the scope and length of civil leave fall to the responsible clinician, most commonly the consultant psychiatrist (Department of Health, 2007). There is currently no UK national guidance mandating a standardised approach to leave, but direction is provided by local NHS Trust policies. It is usually the responsibility of mental health nurses to facilitate individual leave episodes.

Forensic leave, where guidance is more explicit, is for mentally disordered offenders detained under criminal legislation. In England & Wales, the National Offender Management Service (2017) 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 proposed leave, its context, purpose, potential risks, and proposed therapeutic benefits.

#### Supervised Discharge/Transfer

Leave is commonly employed in forensic services to structure transitions between security levels (supervised transfer), or - in forensic and civil services - from hospital to the community (supervised discharge). While ‘on leave’ the patient can be returned to the previous placement or 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 (Mohan, Jamieson, & Taylor, 2001).

## The Review

### Aims

Limited research has addressed therapeutic as opposed to unauthorised leave and the evidence-base has not been systematically evaluated. Therefore, we have identified, critically evaluated, and synthesised empirical evidence about therapeutic leave from mental health inpatient settings using systematic review methodology. The specific review question was 'for mental health inpatients, is therapeutic leave in comparison with any other intervention or none associated with specific objective (e.g., clinical, economic) or subjective (e.g. experiences, perceptions) outcomes'. Secondary questions related to how clinicians make leave-related decisions, how they understand or experience therapeutic leave, and how patients, their friends and families experience leave and its associated processes.

### Design

We employed a systematic review design using relevant components of the PRISMA statement (Liberati et al., 2009).

### Search Methods

We searched multiple electronic databases (CINAHL; Criminal Justice database; PsycARTICLES; Scopus; OpenGrey; Cochrane; GoogleScholar) for papers published from January 1967 to July 2017 using comprehensive search terms (see Table 2). Titles and abstracts were screened (author EMB); a proportion were screened (author: GLD) to assure reliable identification of includable papers. We made extensive efforts to source full text papers meeting inclusion criteria including via inter-library loan and, where possible, contacting authors directly. Full texts were examined by both authors for eligibility independently. Disagreements were resolved through discussion.

Inclusion criteria were English language, empirical studies that focused on therapeutic leave involving civil or forensic adult mental health inpatients. Studies which compared leave with any other intervention, treatment as usual, or no treatment were included. Studies describing any other relevant outcome or process (e.g., clinicians' perspectives or decision-making) were included. Participants in included studies were patients and/or staff; we included studies whose units of analysis were leave incidents. Non-English language studies and those whose focus was unauthorised leave were excluded.

### Quality Appraisal

Quantitative studies were categorised according to their standing on a hierarchy of research evidence (Ackley, Swan, Ladwig, & Tucker, 2008), and appraised against a 12-item quality checklist (University of York Centre for Reviews & Dissemination, 2008). Qualitative studies were assessed against a 14-item checklist (Tong, Sainsbury, & Craig, 2007), and mixed methods studies against a 16-item check list (O'Cathain, Murphy, & Nicholl, 2008). Since the number of includable studies was limited, we decided not to exclude on the basis of study quality; however, we carefully considered the overall level of evidence and individual study quality in our analyses and subsequent recommendations.

### Data Abstraction

Papers were read repeatedly and information extracted systematically. Studies employed non-equivalent methods and measures and therefore meta-analysis was not possible.

### Synthesis

Where information sufficed, we calculated standardised patient- and event-based rates for all types of leave described. These rates indicate, respectively, the number of patients who would have leave in any given month if the unit had 100 beds ([*n* patients with leave/Total *N* patients] / [Study length months] × 100); and the number of leave events in any given month if the unit had 100 beds ([*N* leave events/*N* beds] / [Study length months] × 100). Standardisation allows direct comparison across studies.

A qualitative synthesis approach was used to examine other study findings (Noblit & Hare, 1988); themes and concepts arising from different studies were compared, they were discussed by the authors to achieve agreement, and were incorporated into successive versions of the Results section until all major findings were accounted for.

## Results

The search strategy identified 28 papers published between 1968