

## **Informal mental health patients: what are they told of their legal rights?**

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**Informal mental health patients: what are they told of their legal rights?**

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## **Abstract**

**Purpose** – This study sought to determine what written information is given to informally admitted patients in England and Wales regarding their legal rights in relation to freedom of movement and treatment.

**Design/methodology/approach** - Information leaflets were obtained by a search of all National Health Service mental health trust websites in England and health boards in Wales and via a Freedom of Information Act 2000 request. Data were analysed using content analysis.

**Findings** - Of the 61 organisations providing inpatient care, 27 provided written information in the form of a leaflet. Six provided public access to the information leaflets via their website prior to admission. Although the majority of leaflets were accurate the breadth and depth of the information varied considerably. Despite a common legal background there was confusion and inconsistency in the use of the terms informal and voluntary as well as inconsistency regarding freedom of movement, the right to refuse treatment and discharge against medical advice.

**Research implications** - The research has demonstrated: the value of Freedom of Information Act 2000 requests in obtaining data. Further research should explore the effectiveness of informing patients of their rights from their perspective.

**Practical implications** - Work should be undertaken to establish a consensus of good practice in this area. Information should be consistent, accurate and understandable.

**Originality** - This is the only research reporting on the availability and content of written information given to informal patients about their legal rights.

**Keywords:** Informal inpatient, legal rights, Mental Health Act Code of Practice, voluntary patients, written information.

Paper type: Research

## **Introduction**

In England and Wales the Mental Health Act (Department of Health [DH], 2007) provides two possible routes by which a person can be admitted to hospital. The person can be admitted as a detained patient, that is; "... a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital" (DH, 2015, p. 408; Welsh Assembly Government [WAG], 2008, p. 220. Also see WAG, 2016a, p. 278). A person may also be admitted to hospital as an informal patient; "Someone who is being treated for a mental disorder and is not detained under the Act" (DH, 2015, p. 412; WAG, 2008, p. 222. Also see WAG, 2016a, p. 280). A significant number of patients are admitted informally. The Health and Social Care Information Centre (2015a, 2015b) reported that in the period 2014-2015 there were 70,716 informal admissions to hospital (65.2 per cent of the total number of admissions). During this period some informal admissions result in a subsequent detention under the Act, however 50,026 (46.1 per cent of the total number of admissions) of them did not.

The Act (DH, 2007) applies to both England and Wales, however national guidance on its implementation is provided in separate editions of the codes of practice for both countries. A further complication is that these codes of practice are revised independently. The English (DH, 2008) Code was revised in 2015 (DH, 2015) and the Welsh Code (WAG, 2008) in 2016 (WAG, 2016a).

All of these editions of the Code recognise that informal patients have two legal rights which detained patients do not. Firstly, the English editions state that: "Patients who are not legally detained in hospital have the right to leave at any time. They cannot be required to ask permission to do so, but may be asked to inform staff when they wish to leave the ward" (DH, 2008, p. 172, 21.36 and DH, 2015, p. 322, 27.38). Both editions of the Welsh Code (WAG, 2008; WAG, 2016a) echo these sentiments. Secondly, each edition recognises that informal patients may refuse consent to treatment and that they should be told that their consent to treatment can be withdrawn at any time (DH, 2008; WAG, 2008; DH, 2015; WAG, 2016a).

The Act (DH, 2007) does not impose any duty to provide information to informal patients about these rights. However, the 2008 editions of the Code made it clear

that; "...these patients should be made aware of their legal position and rights" (DH, 2008, p. 18, 2.45; WAG, 2008, p. 140, 22.36). In particular, both emphasised that information about informal patients' freedom of movement be clearly explained to avoid the potential of an unlawful deprivation of liberty. More recent editions of the Code (DH, 2015; WAG, 2016a) re-emphasise this.

Neither of the 2008 editions of the Code stated whether information should be in verbal and/or written form, however the Welsh edition stated that; "Hospital managers may consider developing patient information leaflets for informal patients" (WAG, 2008, p. 140, 22.37). Although this appears to place the onus on individual organisations, it is worth noting that alongside the revised Welsh Code (WAG, 2016a) is a new booklet outlining the nature of 'voluntary' (sic) admission (WAG, 2016b). However, hospitals in Wales have not been directed to use this (Gray, 2016). The 2015 edition of the English Code adds that information should be provided in; "...a format and language the patients understands..." (DH, 2015, p. 45, 4.51). It also clarifies that where the term 'should' is used in relation to guidance then a service provider would need to justify and record any departures from this guidance (DH, 2015, p. 13, IX).

There is little literature examining the information given to informal patients about their legal rights. Nevertheless, a range of studies have been undertaken that demonstrated that a significant number of informal patients were unaware of their rights to leave or refuse treatment (Rogers, 1993; Sugarman and Moss, 1994; Moss et al., 1999). Studies have also reported the value of information leaflets in addressing this issue (Sugarman, 1992; Sugarman et al., 1995; Moss et al., 1999; Lomax et al., 2012).

While earlier Codes of Practice in England (DH, 1990; DH, 1993; DH, 1999) made no reference to providing informal patients with information regarding their legal rights, as noted above more recent editions do. However, in 2005 the World Health Organisation (WHO) produced a detailed statement of human rights standards to be addressed by national legislation, including mental health. Kelly (2011) reported that the Act (DH, 2007) in England and Wales only met 90 (54.2%) of the 166 WHO standards.

One area of concern was that the Act (DH, 2007) itself (as opposed to the Codes of Practice) does not comply with the standards promoting the rights of informally admitted patients. Specifically, the Act (DH, 2007) does not state that informal patients should be informed, at the time of admission, of their right to leave and refuse treatment. Nor does it state they can only be prevented from leaving; “if they meet the conditions for involuntary care” (WHO, 2005, p. 130). More recently, the Care Quality Commission (2013) expressed concern that not all informal patients they interviewed were aware of their right to leave hospital. In addition, the Healthcare Inspectorate Wales (2012) reported that little or no information was available on the wards they visited advising informal patients of their right to leave the ward at any time. Also, they noted that some of the nursing staff they spoke to; “were of the view that an informal patient could only leave the ward if their doctor agreed to it” (2012, p. 14, 4.8).

Despite these specific concerns it is not known to what extent care providers at a local level in England and Wales give written information to informal patients on their legal rights.

## **Aim**

This study sought to determine what written information is given to informally admitted patients in England and Wales regarding their legal rights in relation to freedom of movement and treatment.

## **Methods**

Two methods were used to obtain data. Firstly, a search was undertaken of all the National Health Service (NHS) mental health trust (MHT) websites in England (n = 57) and the equivalent health boards (HBs) in Wales (n = 7). In addition, a request was made under the Freedom of Information (FOI) Act 2000 to all MHTs and HBs asking them to supply any written information they give to informally admitted patients explaining their legal rights. Since it came into full force in 2005, the FOI Act 2000 has been increasingly used to generate data in healthcare research (Fowler et al., 2013).

The Freedom of Information Act 2000 gives interested parties a statutory right to access information held by public authorities (including MHTs and HBs) in England, Wales and Northern Ireland, and by UK-wide public authorities based in Scotland. Applicants do not need to provide an explanation for why they are requesting the information. On receiving a freedom of information request an organisation must disclose; “whether or not it holds the information being requested and must disclose that information, unless the data are exempt, within 20 working days” (Fowler et al., 2013, p. 1).

All data were generated and analysed prior to the publication of the revised Mental Health Act Code of Practice for Wales (WAG, 2016a).

## **Ethics**

The study was reviewed and approved by Sheffield Hallam University’s Research Ethics Review Group. NHS ethical approval was not required as the study did not involve service users, NHS staff or premises or seek access to patients’ records or other confidential information. Although the Freedom of Information Act 2000 does not require it, all the findings reported in this study have been anonymised.

## **Analysis**

Data were analysed using content analysis (Stemler 2001). The analysis focused on both the manifest and latent content of the data (Hsieh and Shannon, 2005; Elo and Kyngäs, 2008). Manifest content analysis included some quantification of data, including frequency counting (Hickey and Kipping, 1996). Latent analysis focused on the meaning of the policy content.

Analysis consisted of a number of steps. Each information leaflet was read and re-read by each author line-by-line to identify words, sentences and paragraphs (meaning units) relevant to the study’s aim. Each meaning unit were discussed by the authors and an agreed code allocated to each one. Codes were then grouped together to form preliminary categories. Meaning units identified in subsequent leaflets were compared to those from previous documents. This constant comparative process led to some meaning units being re-categorised and the preliminary categories refined to produce the minimum number discussed below.

Following a number of recent qualitative studies, for example Muir-Cochrane (2012), the number of organisations providing the same information is given to demonstrate the convergence and divergence of content. Throughout the remainder of the article each organisation (O) is identified by a code number.

## **Findings**

FOI responses were received from all organisations contacted (n = 64). Based on the responses three organisations were excluded from the study as they stated that they did not provide inpatient services. Of the remaining 61 organisations (MHTs = 55, HBs = 6), 27 provided written information in the form of a leaflet to informally admitted patients (MHTs = 26, HB = 1).

Of the 34 organisations that did not have information leaflets, five stated that they were developing a leaflet but did not supply the draft. Section 22 of the Freedom of Information Act (2000) allows organisations, in certain cases, to withhold documents, for examples those in draft form. One other organisation replied that; “A sign is displayed clearly on the entrance/exit of ward (sic) that explains the rights of informal patients in respect to leaving the ward” (O4). The relevant part of the sign (titled; “Important Information”) stated; “Informal (voluntary) patients may normally leave the ward during waking hours if previously arranged.”

Of the 27 information leaflets received, 14 stated a date of publication (range = June 2008 – January 2014). One of these indicated a review date for the leaflet; however this had lapsed in 2011. Six organisations provided public access to the information leaflets via their website. One stated that their leaflet was developed in partnership with service users. One organisation highlighted they were a member of; 'The Information Standard' which certifies organisations as producers of; “...reliable health and social care information” (O34). Although only five leaflets had a stated aim, 26 clearly indicated their purpose through the title.

## **Legislation referred to in the leaflets**

All leaflets made general or specific reference to the Mental Health Act (DH, 2007) giving information relating to freedom of movement and treatment.



Ten leaflets referred to the Mental Capacity Act [MCA] (DH, 2005). Of these, eight explained the term 'capacity'. Seven included a general section on the MCA (DH, 2005) which alluded to the idea that staff could use it to prevent patients from engaging in "some" activities, but did not specify what they were. Three leaflets explained the specific relevance of the MCA (DH, 2005) to freedom of movement and treatment.

### **The use of the terms informal and voluntary**

Of the 27 information leaflets; 16 used both the terms; informal and voluntary to describe patients who are not detained. Eleven only used the term; informal. No organisation only used the term; voluntary.

Twenty-four organisations used the definition of an informal patient as defined above (DH, 2015; WAG, 2008). Of the remaining three: one described an informal patient as one who was; "not detained" (O12), one did not explain the term at all and one gave a definition of both informal and voluntary status (see below). Seven organisations pointed out that under UK common law and the Human Rights Act 1998 an informal patient had the right not to be held against their will.

Of the leaflets only using the term informal (n = 11), 10 either stated directly or strongly implied that as an informal patient they had agreed to be admitted voluntarily.

Fourteen of the remaining 16 leaflets used the terms informal and voluntary as though they are synonymous. Of the two remaining policies, one stated that; "You are an informal or voluntary patient..." (O44) but offered no further clarification. The other (O48) distinguished between the two terms as follows;

"A **Voluntary** patient is a person who has the ability to understand the treatment plan and has agreed to hospital admission.

An **Informal** patient is a person who does not have the ability to understand the treatment plan, or comprehend why hospital admission is necessary, but is not refusing either hospital admission or treatment."

Fourteen organisations indicated that as well as non-detained patients on the ward there may also be patients who are formally detained under the Act and who are not free to leave. Eight of the 14 used this as a rationale for why the exit doors from the ward were locked. However, they did stress that the doors were not locked to prevent informal patients leaving. Two policies referred to the fact that the recipient of the leaflet may be someone who had been admitted as a formally detained patient but whose status has been reclassified as being informal.

Twelve leaflets compared the rights of non-detained mental health patients to those of other inpatient groups. Four of these organisations stated that; "You have the same rights as any patient in an ordinary hospital." A further eight stressed that informal mental health patients have the same rights as "...any other voluntary hospital patient" (O26) or patients: "...in a medical hospital" (O34), "in a general hospital" (O28 and O48), in "any other types of hospital" (O16) or those admitted "for a physical reason" (O17, O18 and O30).

### **Freedom of movement**

Twenty-six leaflets correctly stated that an informal patient has the right to leave the ward at any time. Four of the 26 leaflets highlighted that a patient may leave the ward for; a short period (for example to go for a walk), a longer period (including overnight stay) or permanently (to take their discharge). Seven leaflets did not make it clear that an informal patient could take leave for short or longer periods, but did mention discharge. Four leaflets recognised leaving the ward may be for short periods or to take discharge but did not mention the possibility of leave involving an overnight stay. Two leaflets mentioned short and long-term leave but failed to mention the possibility of an informal patient taking their own discharge. Ten leaflets did not state an informal patient can leave on a short-term or long-term basis, nor take their own discharge.

All leaflets however qualified the informal patient's legal right to leave and suggested that they may in fact be prevented from doing so. Twenty-two leaflets highlighted that an informal patient may be prevented from leaving the ward under the Act (DH, 2007). Of these, nine specifically mention section 5 (doctors' and nurses' holding

powers) of the Act. All nine stated that these powers would be used to prevent harm should the patient attempt to leave. All but one mentioned that the use of these powers will trigger a full psychiatric assessment.

Five leaflets did not mention the above powers, however, one of these did say that; "... staff may stop you from leaving to ensure your safety and the safety of others" (O12). One mentioned that if the MCA (DH, 2005) applied to the patient then it may be used to prevent them leaving the ward.

Sixteen leaflets informed patients that the exit doors to the ward may be locked. All 16 leaflets stated that informal patients may request for the doors to be unlocked to allow them to leave. Seven organisations gave no specific reason for the doors being locked other than a general duty of care. Nine of the 16 offered a rationale for the doors being locked. They were (in varying combinations):

- Other patients are detained under the Act (n = 8);
- For the safety of visitors, staff and patients (n = 2); and
- to prevent "undesirable people entering the ward" (O29) (n = 1).

Seventeen organisations pointed out that they had a duty of care towards all patients and therefore need to know their whereabouts. In addition to these formal strategies outlined above, 20 leaflets included a simple request for informal patients to discuss with staff their wish to leave. In seven cases this request was sometimes more emphatic. One leaflet stated that a patient should; "...**always** tell a member of staff **before**..." (O50) they left the ward. Two organisations suggested that patients should; "co-operate with ward staff" (O2 and O16) if they wish to leave temporarily or otherwise.

The remaining four suggested that staff preferred patients to remain on the ward. Of these, one stated that; "... we do ask that you stay on the ward for the first few days so you and staff can get to know one another" (O33). Another suggested that; "... it is important for you to spend time on the ward..." (O54). It went on to state that if an informal patient asked to leave the ward for "longer periods" this would trigger a

discussion over whether inpatient care was appropriate for the patient. Two leaflets stated a patient who wished to leave may be asked; "...to wait and see a doctor if staff have concerns about their health" (O10 and O50).

One set of restrictions relate solely to an informal patient wishing to discharge themselves. Nine leaflets informed patients of their legal right to discharge themselves against medical advice (DAMA). Two of these suggested that patients *may* be asked to sign a DAMA form before leaving. Neither of these stated that a patient is *not* in law obliged to sign it. The other seven stated that a patient *will* be asked to sign a DAMA form. Only four of these seven mentioned that the patient is not legally obliged to sign the form.

### **Treatment**

All leaflets made reference to treatment although five did not explain what this actually meant. Four described treatment as including medication but omitted to mention any other alternatives that may be available. On the other hand 18 offered fuller descriptions of treatment. For example, one described treatment as; "... taking medication, talking and answering questions and perhaps getting involved with group work with other patients" (O1).

### **Refusing treatment**

Three leaflets did not notify informal patients of their legal right to refuse treatment. The remainder (n = 24) stated or strongly implied that informal patient can under UK law refuse treatment. Four also pointed out that in general terms a patient's right not to be mistreated is protected by the Human Rights Act 1998.

Nine recognised that treatment could be given without consent in an emergency, although none described what they meant by an emergency. In addition, three leaflets mentioned that should a patient lack the capacity to consent, treatment may be given if it was felt to be in their best interests.

### **Other issues relating to refusing treatment**

Some informal patients who lack capacity to consent to treatment may have previously made advanced directives regarding their care. Two leaflets recognised

these directives are binding, although these can be overridden in emergencies. They also recognised that if a welfare lasting power of attorney exists, doctors are required to seek consent from the identified person in that position.

## **Discussion**

This study sought to determine what written information was given to informally admitted patients in England and Wales about their legal rights. It is clear that presenting this information to individuals who may well be in a distressed state is not without challenge. It requires organisations to balance, for example the informal patient's legal right to freedom of movement against concerns of safety and the duty of care of mental health practitioners. These issues reflect a complex legal background that utilises sometimes confusing jargon and terminology. In the absence of any national guidance or consensus of good practice in this area, it is not surprising that some aspects of the leaflets examined here are open to criticism. Indeed although there may be some variation in local practices regarding informal patients (for example in relation to locked ward exit doors) we believe, as discussed below, there is value in the Welsh example (WAG, 2016b) of producing a standardised information leaflet.

Given the above, it is unsurprising that levels of detail varied considerably from leaflet to leaflet. It may be argued that some information was unnecessary or over complex, for example in relation to information on lasting power of attorney and advanced decisions. On the other hand there were also significant omissions in some leaflets (see below).

Turning to the findings, it is surprising that only 27 organisations gave information in written form. Although it is possible that some organisations could argue that they verbally inform patients of their rights, this is not easily auditable and is also less effective (Johnson et al., 2003). While Lomax et al. (2012) suggested further research was needed on the effectiveness of written and verbal information in this area; it is also hard to see verbal information alone being of value. Furthermore, it is worth noting that the Act (DH, 2007) requires *detained* patients to be given an explanation of their rights in both verbally and in writing.

Another issue relates to the availability of information. This research did not aim to discover exactly when information was made available but several points can be made. Firstly, we could not access 21 of the information leaflets without submitting a Freedom of Information request to organisations. In addition, no information for anyone considering admission appeared to be available. We concur with Godefroy (2015) who suggested that a person should be provided with this information prior to admission. The wording of leaflets appears to show that they were given out during or after the admission process. At this point individuals are already subject to any legal constraints that may refer to informal patients. It would appear difficult for a member of the public to find information locally that may help them decide whether to become an informal patient.

It is the case that some of this information is available in the UK via independent national mental health organisations. Rethink (2014) has a factsheet entitled: "Going into hospital?" which we feel is more accessible, however it sometimes appears oversimplified. For example, one key point states that as a 'voluntary patient' (sic); "This means that you can leave if you want to." It does not mention any of the caveats reported in the findings above. More recently Mind (2016) produced a booklet explaining the rights of 'voluntary' patients (sic) in England and Wales. This appears aimed at the general public rather than newly admitted or existing patients. In addition to this the Welsh specific booklet for 'voluntary' (sic) patients (WAG, 2016b) was produced in conjunction with Mind Cymru. Unfortunately this does not appear to be obviously accessible to patients prior to admission although, as stated above, if given out by each organisation offers consistency of information.

These developments indicate that the availability of information for informal patients at a national level is improving. One suggestion that may further improve the availability of information at a local level is that each Trust or Health Board has a publically accessible webpage outlining the nature of informal admission.

Turning to the content of the leaflets, a number of issues arise. Firstly, the use of the terms informal and voluntary to describe non-detained patients can be confusing and inconsistent. It is worth restating that the Act *only* refers to two types of patients admitted to hospital for the treatment of mental disorder; those detained under the

Act and informal patients (those not subject to the Act). The term; informal is the accepted term used in the Act for England and Wales that describes patients *with* capacity who consent to admission as well as those who *lack* capacity but do not *object* to being admitted (Jones, 2015). The term voluntary patient does not appear in the Act or the English Code of Practice (DH, 2015). The Welsh Code (WAG, 2008) and the previous English Code (DH, 2008) only used it in their glossary of terms to denote that it is synonymous with the accepted term informal. This is still the case in the revised Welsh Code (WAG, 2016a).

When used by itself the word informal is generally clarified in lay terms. The problems centre on the use of the term voluntary alongside the term informal. One reason this may happen is that prior to the introduction of the 1959 Mental Health Act (Department of Health and Social Security, 1959), the term voluntary was used to denote a non-detained patient (Jones, 1993). However, a more likely explanation may lay in arguments advanced in the legal case *R v Bournewood Community and Mental Health NHS Trust, ex parte L*. In this case Lord Goff recognised that there were both informal patients who had the capacity to consent to admission *and* informal patients who were actually compliant but lacked capacity. In order to advance his arguments he considered the first of these categories to be *voluntary patients* and the second *informal patients*. However, he also pointed out that both were admitted under section 131(1) of the Act and:

"Strictly speaking, therefore, both groups could be described as informal patients, but it is convenient to confine that description to those who are not voluntary patients"

As noted above however this 'convenience' has never been reflected in the Act, its revisions or the Codes of Practice (DH, 2008; WAG, 2008; DH, 2015; WAG, 2016a). As Andoh (2013, p. 214) notes informal is in fact the proper term to use, although he himself recognises the term voluntary is, "...still used widely".

A final reason why the term voluntary might be used is that, unlike the term informal, it has some meaning to the lay public. This probably explains the use of the term in recent documents such as Mind (2016) and WAG (2016b). However, use of the term voluntary masks the fact that some informal patients who have capacity do not

*voluntarily* come into hospital but feel coerced to do so (Gilboy and Schmidt, 1971; Rogers, 1993; Bindman et al., 2005; Szmuckler and Applebaum, 2008; Molodynski et al., 2010). We suggest that the term voluntary should not be formally used to describe categories of informal patients. The term informal appears relatively easy to clarify and does not make assumptions about voluntariness. If necessary it is possible to identify those informal patients who lack capacity.

Some leaflets were also unclear about an informal patient's right to leave the ward temporarily or to take their discharge. Most highlighted that patients are free to leave the ward at any time and many emphasised this by comparing informal patients to other non-detained patient groups, for example those in a medical hospital. This appears necessary because of the need to help informal patients understand their status as different to those legally detained patients who are likely present on the ward. This comparison with other patient groups may not however be useful, not least because informal patients may not have any experience or knowledge of what it means to be a medical patient.

Information leaflets that stated patients were free to leave at any time were correctly echoing the Codes of Practice (WAG, 2008; DH, 2015). However, the extent to which patients actually have freedom of movement has long been challenged, even before the existence of any Mental Health Act Code of Practice (Azuonye, 1998). More recently, Houlihan (2000, p. 865) has gone so far as to suggest that the rights associated with the informal patient are; "...no more than a legal fiction".

Houlihan's (2000) argument has substance. Mental health nurses and medical staff are obliged to assess any informal patient who wishes to leave the ward and establish whether they meet the criteria for detention under the Act (DH, 2007). This means that a patient may only leave the ward if they *do not* meet the criteria for detention under legislation that only exists for that purpose and which is unique to mental health settings. So, while patients admitted to general hospitals could be prevented from leaving under common law or the MCA (DH, 2005), the Mental Health Act (DH, 2007) offers significantly wider powers over informal patients in mental health settings. In addition, in the Rabone case the Supreme Court of the UK; "... ruled that the state has a special operational duty to protect the right to life in



informal psychiatric patients, in sharp distinction to general medical or surgical patients” (Szmukler et al., 2013).

Perhaps unsurprisingly some leaflets were not clear about the possibility of informal patients being prevented from leaving the ward. Despite stating that patients were free to leave many went on to spell out restrictions which challenged that very idea. This seems to represent organisations attempting to balance the safety of patients and others as against their right to freedom of movement but simply results in an apparent contradiction. It is clear from our findings that there is a real danger of organisations failing to adequately describe the very real restrictions that exist regarding the freedom of movement of informal patients. It would appear that there is a strong argument for a formal review at a national level of the claims made regarding the freedom of movement of informal patients.

The restrictions on freedom of movement faced by informal patients were outlined by many of the leaflets. Both the previous and current English Code of Practice (DH, 2008, p. 172, 21.36 and DH, 2015, p. 322, 27.38) state that patients; “...cannot be required to ask permission to do so, but may be asked to inform staff when they wish to leave the ward.” This statement appears to be reflected in the majority of leaflets. Few however stressed the benefits of staying on the ward and working together to promote recovery and the tone of some leaflets could be interpreted as coercive.

The majority of leaflets mentioned or alluded to section 5 of the Act (DH, 2007), although four did not. This is a significant omission and difficult to account for. It may be that health professionals fear that knowledge of these powers may discourage patients from coming into hospital informally. There may be evidence for this belief (Ashmore, 2012). However, even if true, there is no justification for omitting information on section 5 of the Act (DH, 2007).

Another restriction on freedom of movement is that of locked doors. Only 16 (59 per cent) leaflets stated that ward doors were locked. However, it is known that 86 per cent of wards in England, for example, are reported as being locked (CQC, 2014; CQC, 2015). While all the 16 leaflets did mention that the doors may be unlocked by

request, it is worth noting that literature suggests at least some informal patients believe that they are not free to leave the ward (CQC, 2015).

A significant omission which is also difficult to explain is that two thirds of the sample failed to mention the possibility of taking DAMA. Furthermore, only two leaflets made it clear that there is no legal obligation for a patient to sign a form to confirm their intention to take DAMA. One danger with this omission is that it may be construed as an attempt to discourage informal patients from leaving hospital.

Turning to the issue of treatment a similar pattern exists in terms of the breadth and depth of information. It is surprising that while some leaflets were expansive about the varying nature of treatment others were not. There is no guarantee for example, that "...talking and answering questions..." (O1) would be seen as treatment by any patient or member of staff. It would not seem unreasonable to imagine that all leaflets would include a simple and exhaustive list of treatment options.

In addition, while most organisations overtly mentioned the right to refuse treatment, three failed to do so. Combined with the sometimes lack of information regarding types of treatment, this could lead to patients feeling obliged to comply with treatment they feel unhappy with. Finally, there appears to be reluctance to mention the possibilities of patients being treated without consent in an emergency.

## **Limitations**

There are limitations to this study. Firstly, it is possible that some information on informal patients' rights may have been subsumed in documents not seen as relevant to our FOI request. Secondly, the study has focused on the content of documents and has not explored the readability and understandability of the leaflets from a patient's perspective.

## **Conclusion**

This study has examined written information given to informal patients in England and Wales regarding their rights. Despite the guidance given in the Codes of Practice (WAG, 2008; DH, 2015), our findings show that high numbers of organisations did not produce written information for this category of patient.

Although speculative this may be because organisations are not legally required to do so. Following the World Health Organisation (2005), we believe that this situation should be redressed and monitored by the Care Quality Commission (England) and in Wales, the Healthcare Inspectorate Wales. In addition, although patients' legal rights are nationally determined, it is apparent that many organisations developed their own interpretation. There is no consensus regarding good practice and the quality of information has been shown to vary considerably. Even if organisations produced information, few made it available to the general public prior to admission. Any potential patient and their significant others should be able to access clear and accurate information which may inform their decision to become an inpatient. The booklet recently published by the Welsh Government (WAG, 2016b) may, in these respects represent a significant step forward.

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