Cumbria Partnership NHS
NHS Foundation Trust

GUIDELINES ON SECTION 17 LEAVE OF ABSENCE MHA (1983)

Document Summary

All in-patients detained under the Mental Health Act 1983 within Cumbria Partnership NHS Foundation Trust may only be granted Leave of Absence through the proper prescription and implementation of Section 17 of the Mental Health Act 1983.

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ACCOUNTABLE DIRECTOR	Executive Director of Nursing & Quality
POLICY AUTHOR	Head of MHLU & Legal Services

Important Note:

The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as “uncontrolled” and, as such, may not necessarily contain the latest updates and amendments.

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1 SCOPE

The operation of Mental Health Act (1983) Section 17 Leave within Cumbria Partnership NHS Foundation Trust including the role and responsibilities of staff and the rights and entitlements of patients.

2 INTRODUCTION

The Trust accepts that many patients in hospital care will benefit from periods of leave away from hospital. Section 17 of the Mental Health Act allows detained patients to be granted Leave of Absence from the hospital in which they are detained. Leave is an agreed absence, for a defined purpose and duration, and is accepted as an important part of the patients' treatment plan.

3 STATEMENT OF INTENT

To ensure compliance with the Mental Health Act (1983) and it's associated Code of Practice (2015).

4 DEFINITIONS

Leave is defined as any excursion, which takes the patient outside the hospital grounds for ANY period of time, even if members of hospital staff are escorting the patient.

AC	Approved Clinician
AMHAHM	Associate Mental Health Act Hospital Manager
AMHP	Approved Mental Health Professional
AWOL	Absent Without Leave
CoP	Code of Practice
CrtP	Court of Protection
CTO	Community Treatment Order
LSSA	Local Social Services Authority
MDT	Multi-disciplinary team
MHA (83)	Mental Health Act 1983
MHAA	Mental Health Act Administrator
MHAHM	Mental Health Act Hospital Manager
MHLO	Mental Health Legislation Officer
MHLU	Mental Health Legislation Unit
MHT	Mental Health Tribunal
MoJ	Ministry of Justice
RC	Responsible Clinician
SCT	Supervised Community Treatment

5 DUTIES

5.1 Mental Health Act Hospital Managers

The Mental Health Act (1983) requires the Trust's Mental Health Act Hospital Managers have in place policy, procedures and guidelines in respect of leave of absence granted under section 17 of the Act

5.2 Executive Director of Nursing & Quality

The Executive Director of Operations and Executive Nurse is the accountable Director for this policy.

5.3 The Responsible Clinician and Unit/Ward Manager

Only the patient's Responsible Clinician (RC) may authorise leave of absence under section 17.
The Responsible Clinician and Unit/Ward Manager have management responsibility for ensuring this policy is implemented.

6 DETAILS OF THE POLICY

6.1 GUIDELINES FOR DECIDING LEAVE

Leave should be planned in advance, agreed at the multi-disciplinary team meeting and consideration must be given to the legal status of the patient. Leave should only be granted after careful planning and risk assessment that involves the patient, carers, and the appropriate community teams. The patient should be fully involved in the decision to grant leave and must be asked to consent to the leave plan and to any consultation with others. If relatives/friends are to be involved in the patients care, but the patient does not consent to their being consulted, leave should not ordinarily be granted. The patient should be able to demonstrate to professional carers that he/she is likely to cope outside the hospital.

Section 17 (2A) requires that the RC (when considering granting leave for more than seven consecutive days, or extending leave so that the total period is more than seven consecutive days) must consider the use of a Community Treatment Order (CTO). This does not mean that Section 17 Leave can not be used for periods of longer than seven days but the RC must clearly document why such use is preferable and in the best interests of the patient. This clause does not apply to individuals detained under Section 2 as they are not eligible for a Community Treatment Order.

When leave is granted at short notice, this should be a joint decision between the patient's key worker or senior clinical nurse and the Responsible Clinician (RC). The key worker or senior clinical nurse at the first opportunity must communicate this decision to the patients Community Care Co-ordinator.

Prior to the commencement of leave, there should be a clear agreement of the action to be taken and by whom in the event of the following circumstance.

a) The patient fails to return from leave at the agreed time

b) The patient fails to turn up at the agreed destination

c) The patient absents themselves prior to the agreed leave date

For further guidance on factors to be considered when deciding on the appropriate use of Section 17 Leave please refer to the Code of Practice 27.10

6.2 TO WHOM DOES LEAVE OF ABSENCE APPLY

Section 17 does NOT apply to sections 5(4), 5(2), 4, 135 and 136. This is because they are short-term emergency assessments detention orders.

The Responsible Clinician can grant leave of absence for patients detained under Sections 2, 3, 37, 47 and 48. It is not good practice to grant extended leave of absence for patients detained under Section 2, as this is intended to provide for a short period of intensive assessment.

Individuals remanded to hospitals under Sections 35, 36 and 38 cannot be granted Leave of Absence.

People detained Sections 37/41, 47/49 and 48/49 with restrictions cannot be granted Leave of Absence without the permission of the Ministry of Justice.

Contact your local MHA Administrator (MHAA) before making contact with the Ministry of Justice for granting Leave of Absence for Section 35, 36, 38, 47/41, 47/49 and 48/49.

6.3 POWER TO GRANT LEAVE OF ABSENCE

Only the patient's Responsible Clinician can grant leave of absence to a patient detained under the Act. Responsible Clinicians cannot delegate the decision to grant leave of absence to anyone else. In the absence of the usual Responsible Clinician (e.g. if they are on leave), permission can be granted only by the Approved Clinician who is for the time being acting as the patient's Responsible Clinician. CoP 27.8

The Code of Practice defines the role of the Responsible Clinician in relation to this Section of the Act as

> *'The responsible clinician is the approved clinician who will have overall responsibility for the patient's case.'* Code of Practice Appendix A p416

The Reference Guide to the Mental Health Act states

> *'The functions of the responsible clinician may not be delegated. But the patient's responsible clinician may change from time to time and the role may be occupied on a temporary basis in the absence of the usual responsible clinician.'* 9.29

The Trust interprets the term 'absence' as referring to those times when the Responsible Clinician is on annual leave or unavailable within the trust during that day or the immediate future. If the RC is anywhere in the "Trust" on a given day – then they cannot delegate RC responsibility. It is therefore imperative that a clear

line of accountability is established, documented and appropriately communicated in all such instances. Absences as a result of annual leave and diarised commitments should be planned in advance and all detained patients care plans discussed with the alternative Responsible Clinician by the existing Responsible Clinician. In the event of unplanned absence the appropriate Clinical Director will nominate an Approved Clinician to undertake the duties of the Responsible Clinician.

The Responsible Clinicians' responsibilities for their patients remain the same while the patients are on leave.

As Section 17 Leave is a planned absence from inpatient care there is no requirement for it to be used for emergency medical treatment for a physical condition therefore recourse to the Out of Hours On-Call Responsible Clinician should not be necessary. However, it would be good practice for the RC to retrospectively complete the leave form (marking it as such) to ensure there is an accurate record of the patient's detention and as a prelude to further leave if required.

Any conditions, restrictions or limitations applicable during the leave period, along with the destination address for overnight leave, must be clearly documented on the leave form. Nursing staff are responsible for disseminating copies of said form to the following:

- MHA administrator
- Patient
- Patients Carer if applicable
- Appropriate community and crisis teams
- Clinical Notes
- Any other person (s) charged with the responsibility for the patient whilst on leave of absence.

A record of the outcomes of the any leave of absence should be documented in the individual's clinical notes and the patient encouraged to express any concerns or issues.

Leave of Absence can be extended in the patient's absence. One month should be the maximum amount of Leave granted by a Responsible Clinician on one form. Thereafter another form would need to be completed to extend the Leave of Absence for a further period. Leave of Absence can be granted until the end of a patient's detention period. In some cases this could be up for up to a maximum of 12 months. If a patient has not been recalled from leave at the end of the detention, he/she ceases to be liable to be detained.

No detained patient must be allowed to go beyond the perimeter of the hospital grounds escorted or unescorted without the appropriate Leave of Absence form being completed by the RC. The RC can authorise short leave (less than 24 hours) to be given at the discretion of nursing staff. For example, the RC could grant Leave of Absence for two hours escorted shopping at the discretion of nursing staff. Nursing staff then decides the time at which the shopping takes place.

The RC may instruct nursing staff not to implement any authorised leave on medical grounds at their discretion. In the event of deterioration in a patient's mental state, Leave of Absence can be curtailed at the discretion of the nurse in charge. Leave of Absence should not be curtailed for any other reasons.

Where Leave is allowed or declined by a nurse at their discretion a record of the use of such discretion should be entered on to the appropriate Leave of Absence form and recorded in the patient's notes.

6.4 CONSENT TO TREATMENT

A patient on Leave of Absence is still "liable to be detained" by the hospital and therefore still liable to the Consent to Treatment provisions of the Act. This means the normal three-month treatment period applies. Patients on extended leave with forms T1/T2/T3 (Consent to Treatment) must have their prescribed medication carefully monitored to ensure it complies with that legally allowed under those provisions

6.5 CONDITIONS OF LEAVE OF ABSENCE

Conditions usually apply when Leave of Absence is granted, for example the patient should:

- Live with a particular person
- Live at a specified place
- Attend a community centre regularly
- Allow visits from a member of any community team staff or an other professional
- Remain in the custody of a member of staff during their leave

The parameters within which this discretion may be exercised should be clearly set out by the responsible clinician, e.g. the particular places to be visited, any restrictions on the time of day the leave can take place, and any circumstances in which the leave should not go ahead. Responsible clinicians should regularly review any short-term leave they authorise on this basis and amend it as necessary. Code of Practice paras. 27/16/17.

6.6 RIGHTS OF PATIENTS ON LEAVE OF ABSENCE

Patients on Leave of Absence under Section 17 of the Act are still liable to be detained under the full provisions of the Mental Health Act. Such patients can therefore still appeal to the Mental Health Tribunal and Hospital Managers. They can also make complaints to the Care Quality Commission. Staff authorised by the Hospital Managers remain responsible for ensuring such patients are fully aware of their rights under the Act. Additionally, all patients must be provided with a copy of their Leave Plan.

6.7 REVOCATION OF LEAVE

The RC is entitled to revoke the patients at any time if he/she feels that it is necessary in the interest of the health or safety of the patient of for the protection of other people. Revocation of Leave of Absence must be made in writing to the patient or the person in charge of the patient. The letter must be signed by the RC or if this is not possible the RC must have given their verbal permission and this should be recorded in the letter. The patient must be given the letter revoking their Leave of Absence before they can be taken back to hospital.

A refusal to take medication would not on its own be a reason for revocation, although it would almost always be a reason to consider revocation.

If the RC recalls the patient the reasons for recall should be fully explained to the patient and a record of the explanation placed in the patient's notes. If the patient has ceased to be detained they cannot be recalled. It is unlawful to recall from Leave of Absence subject to Section 3 or 37 solely to renew the authority to detain the patient.

6.8 RENEWAL OF DETENTION

It is possible to renew a patient's detention while they are on leave if the criteria in section 20 of the Act are met. But leave should not be used as an alternative to discharging the patient either completely or onto CTO where that is appropriate.

6.9 ABSENCE WITHOUT LEAVE (AWOL)

Failure to return at the end of an authorised period of Leave of Absence; failure to return when recalled from leave; or failure to reside at an address agreed by all parties prior to the granting of Leave of Absence are grounds for the patient to be classed as Absent Without Leave.

For further information on dealing with missing patients please refer to the Trusts Policy for the Management of Service Users Missing or Absent Without Official Leave (AWOL) - POL/001/009

6.10 LEAVE TO OTHER HOSPITALS

It is lawful to use this section to grant a patient "trial leave" to a hospital other than the one in which he/she is formally detained. In these circumstances the RC at the base hospital continues to be the patient's responsible clinician. Although day-to-day functions relating to the care of the patient can be delegated to a consultant at the second hospital, the responsibilities of the RC to renew the patient's detention and to issue certificates under Part IV of this Act cannot be delegated. If it is thought that a clinician at the second hospital should be the RC then the patient should be transferred under Section 19. Approved Clinicians may come from either hospital.

If trial leave is successful the patient could then be transferred to the second hospital under section 19.

Patients on Section 17 leave, or AWOL, who are taken to a hospital other than the hospital that they are currently liable to be detained in, can be held by that hospital

while arrangements are made for their prompt return to the detaining hospital. A patient may be kept in the custody by an officer in the staff of the hospital where the patient is, or in the custody of any person on the staff of that hospital where the patient is, or in the custody of any person authorised in writing by the Hospital Managers of the detaining hospital.

If such a patient is inadvertently placed on a new Section by a hospital other than the hospital that they are currently liable to be detained, the new Section becomes null and void as soon as that hospital is aware of the original Section, which immediately takes precedence. Where this occurs, the original hospital should be informed, and arrangements for the patient's return made as soon as possible.

6.11 VICTIMS RIGHTS

When considering leave of absence for mentally disordered offenders the RC must take into consideration the impact of planned leave on the victim and ensure the appropriate conditions are applied

7 TRAINING

Training required to fulfil this policy will be provided in accordance with the Trust's Training Needs Analysis. Management of training will be in accordance with the Trust's Learning and Development Policy

8 MONITORING COMPLIANCE WITH THIS DOCUMENT

The table below outlines the Trusts' monitoring arrangements for this policy/document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

Aspect of compliance or effectiveness being monitored	**Monitoring method**	**Individual responsible for the monitoring**	**Frequency of the monitoring activity**	**Group / committee which will receive the findings / monitoring report**	**Group / committee / individual responsible for ensuring that the actions are completed**
Usage monitored by MHA Hospital Managers	Exception Reporting	Head MHLU	Quarterly	Network MH Legislation Compliance	MHA Hospital Managers & Associates Committee

9 REFERENCES/ BIBLIOGRAPHY

Human Rights Act 1998 c.42
Mental Health Act 1983 c.20

Department of Health, Code of Practice Mental Health Act 1983 (TSO 2015)
Reference Guide to the Mental Health Act 1983 (TSO 2015)
The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 S.I. 1184

10 RELATED TRUST POLICY/PROCEDURES

POL/001/005/013	Consent to Treatment, Part IV Mental Health Act 1983
POL/001/005/005	Informal Patients Leave Arrangements Guidelines
POL/001/005/007	Mental Health Act Guidelines on Receipt and Scrutiny of Section Papers
POL/001/005/003	Mental Health Act Guidelines on Section 5 (2) 72 Hour Holding Power
POL/001/005/015	Policy and Guidance on Section 132, 132A and 133 Patient's Rights
POL/001/008	Prevention and Management of Violence and Aggression (PMVA)

11 EQUALITY IMPACT ASSESSMENT

The Equality Act 2010 came into force on the 1st October 2010. Under the Act there is a legal obligation to undertake Equality Impact Assessments (EIAs). The Trust and its employees must have due regard of the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

EIAs assess the impact of the Trust's actions on people from the protected characteristics identified in the Act. In addition they should show how our policies and practices would further or have furthered the above aims. Demonstration of the engagement you have undertaken when doing the assessment will be a key part of this process. Engagement covers a range of different activities, from formal public consultations to direct engagement with people from protected groups. The level of engagement you undertake will depend on the scale of policy/ project/ activity you are developing or updating.

To comply with legislation EIAs must be a comprehensive, formal and structured process and the results must be published. These factors enable the Trust to demonstrate to all stakeholders and regulatory bodies that we have fully addressed Equality and Diversity within the Trust.

An Equality Impact Assessment must be done at the **development stage** of any policy, review, project, service change etc.

(Please refer to the Equality Impact Assessment Guidance available on the Equality and Diversity section of the Trust web site)

1	**Name and Job Title of person completing assessment**	**D Eldon** Head of MHLU
2	**Name of service, policy or function being assessed**	GUIDELINES ON SECTION 17 LEAVE OF ABSENCE MHA (1983)
3	**What are the main objectives or aims of the service/policy/function?**	Compliance with MHA (1983)
4	**Date**	September 2016

Stage 1: Initial Screening			
5	**What evidence is available to suggest that the proposed service/policy/function could have an impact on people from the protected characteristics? Document reasons, e.g. research, results of consultation, monitoring data and assess relevance as: *Not relevant or Relevant Low / Medium / High.***		
Protected Characteristic		**Relevence**	**Evidence**

a	Race	***Not relevant***	Legal requirement
b	Religion / Spirituality	***Not relevant***	
c	Gender	***Not relevant***	
d	Disability	***Not relevant***	
e	Sexual Orientation	***Not relevant***	
f	Age	***Not relevant***	
g	Pregnancy/maternity	***Not relevant***	
h	Gender Reassignment	***Not relevant***	
i	Marriage and Civil Partnership	***Not relevant***	

If you assess the service/policy/function as **not relevant**, please proceed to section 11.

If you assess the service/policy/function as **relevant**, continue to Stage 2, Full Equality Impact Assessment.

Stage 2: Full Equality Impact Assessment		
6	**Are there service user, public or staff concerns that the proposed service/policy/function may be discriminatory, or have an adverse impact on people from the protected characteristics?**	
a	Public	
b	Staff	

If there are **no concerns**, proceed to section 11.

If **there are concerns,** amend service/policy/function to mitigate adverse impact, consider actions to eliminate adverse impact, or justify adverse impact.

7	**Can the adverse impact be justified?**
8	**What changes were made to the service/policy/function as result of information gathering?**
9	**What arrangements will you put in place to monitor impact of the proposed service/policy/function on individuals from the protected characteristics?**
10	**List below actions you will take to address any unjustified impact and promote equality of outcome for individuals from protected characteristics. Consider actions for any procedures, services, training and projects related to the service/policy/function which have the potential to promote equality.**

Action	Lead	Timescales

11	Review date	
I am satisfied that this service/policy/function has been successfully equality impact assessed. Date: September 2016 Author: Head of MHLU		
Please send the completed assessment for scrutiny to: Project Co-ordinator, Cumbria Partnership NHS Foundation Trust, Trust Head Quarters.		