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Section 17 Leave of Absence under the Mental Health Act 1983

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Amend No	Issued	Section	Subject	Action Date
1		1.3	New guiding principles	February 2016
2		3.1.4	System one replaces Rio	February 2016
3		3.2.5	Replace 'ward round' with – disciplinary team (MDT)	February 2016
4		3.4.4	Include 'Although, this is not a requirement of the Act, it is evidence that the ward has received the form and that the nurse has ensured the patient has a copy.'	February 2016
5		3.4.6, 3.4.7, 3.4.8 and 3.5.3	Rio to system one	February 2016
6		3.4.7	Include a requirement to have an update to have a photograph, with consent, on file (see code 27.22)	February 2016
7		3.5.7	Include 'The code of practice states: 'Leave should not be used as an alternative to discharging the patient either completely or onto a CTO where that is appropriate.' (27.37) There may be cogent reasons to choose s17 leave for longer than 7 days. If is is chosen then these reasons must be clearly recorded.	February 2016
8		3.5.11	Remove section in light of new case law	February 2016

Review Log:

Version Number	Review Date	Lead Name	Ratification Process	Notes
2	February 2016	Richard Murphy	Current review	Review had been delayed due to a change in role of the lead and a need to wait for the new Mental Health Act Code of Practice.

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Executive Summary

This policy sets out how the powers and duties in relation to s17 Leave of the Mental Health Act will be discharged in Solent NHS Trust. Section 17 leve is the power of a patient's responsible clinician to grant, detained patients, leave from the hopsital. A detained patient is only allowed to leave the hospital with this leave in place. The responsible clinician may set any conditions or restrictions on that leave they consider necessary in the interest of the patient or the protection of other persons. This can iinclude that the person is escorted. If escorted, the patient is in the custody of the escort. Alternatively, the person may be given leave accompanied by others. In this case, they are not in that person's company.

The responsible clinician will normally grant leave in blocks and this will be managed on a day to day basis by registered nursing staff on the ward. The registered nursing staff may with hold leave on medical or risk grounds. This should lead to a review of leave by the responsible clinician.

Leave can be overnight and providing the ground sare met a person's detention may be renewed whilst they are on leave.

All wards granting leave should have a photograph of the person on file to identify them in the event of them not returning from leave.

The policy gives further guidance on recording leave when granted and on comencement and return, longer term leave and recall and care and treatment whilst on leave. The policy also has a standard form for grantign s17 leave.

1. INTRODUCTION & PURPOSE

1.1 Patients detained under the Mental Health Act 1983 (the Act) can only leave the hospital (see 2.7 for a definition of hospital) when granted leave of absence under s17, by the patient's Responsible Clinician. For restricted patients this must be within the limits of the leave agreed by the Ministry of Justice. Responsible Clinicians cannot grant leave of absence from hospital to patients who have been remanded to hospital under sections 35 or 36 of the Act or who are subject to interim hospital orders under section 38, these patients can only be given leave by the court.

1.2 Section 17 leave is an important part of a patient's care; it is often essential in promoting recovery but is also a time when risk issues and the extra demand that section 17 leave can put on carers and services needs to be considered. All decisions, in relation so s17 leave therefore, need to balance the various considerations and facts, including sound clinical assessments. These issues are discussed further in paragraph 3.1.5.

1.3 When making these decisions practitioners need to follow the statutory procedures and criteria and have regard to the guidance in the Mental Health Act 1983 Code of Practice, particularly the five guiding principles:

Least restrictive option and maximising independence
Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

Empowerment and involvement
Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

Respect and dignity
Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

Purpose and effectiveness
Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

Efficiency and equity
Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

1.4 For example, decisions should ensure the purpose of the leave is to promote recovery and rehabilitation whilst addressing risk issues, considering how this can be done in the least restrictive way for the patient, that respects the patient's individual circumstances and

involves them in decision making, whilst considering the needs of other patients, the limited resources of the ward, and ensuring those resources are effectively and fairly used.

1.5 In their management of section 17 leave, NHS Solent Trust staff will be carrying out duties on behalf of a public body. Section 6 of the Human Rights Act 1998 requires staff to carry out these duties, as far as the Mental Health Act 1983 allows, in a way that is not incompatible with a person's rights under the European Convention of Human Rights; in particular, Article 8: Right to Private and Family Life, Article 2: Right to Life and Article 5: Right to Liberty are relevant. This policy takes the requirements of the European Convention of Human Rights into account.

1.6 This policy sets out the procedures and responsibilities of the various professionals involved in the management of section 17 leave and identifies the considerations they need to take into account when making decisions regarding such leave.

1.7 Independent Mental Health Advocates (IMHA) play a crucial role in supporting the patient to have their voice heard in the negotiation of their care. They can also represent the patient's views and wishes when the patient is unable to. In terms of s17 leave, they can play a crucial role in ensuring participation of the patient, that the patient's goals are considered and that the conditions of any leave are unambiguous.

2. SCOPE & DEFINITIONS

SCOPE

2.1 This document applies to all directly and indirectly employed staff within Solent NHS Trust and other persons working within the organisation in line with Solent NHS Trust's Equal Opportunities Document.

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.

DEFINITIONS

2.3 **Approved Clinician (AC):** A practitioner who has been specially approved to undertake certain functions under the Mental Health Act 1983, including the role of RC. Solent NHS Trust has a register of all practitioners who have been given this approval by the Strategic Health Authority. Only practitioners with this approval can act as a patient's Responsible Clinician.

2.4 **Community Treatment Order (CTO)**: An amendment of the Mental Health Act, made in 2007, that enables the compulsory care of patients in the community without the need for an element of hospital treatment.

2.5 **Consent to Treatment Provisions**: The part of the Mental Health Act that sets out the requirements with regard to the treatment of detained patients.

2.6 **Detaining Sections:** Section 17 leave (s17) applies to patients detained under various sections of the Mental Health Act. These are s2,3,37 and 47. Section 2 lasts for up to 28 days and is for assessment and treatment. Section 3 is initially for up to six months, it is for treatment and can be renewed. Sections 37 and 47 apply in criminal justice cases and are orders of the court.

2.7 **Hospital Unit:** The ward to which a patient is admitted. For Psychiatric Intensive Care Units (PICU) and Low secure units this includes the secure garden area. The term hospital, on its own, includes the grounds in which the hospital unit is in.

2.8 **Independent Mental Health Act Advocate (IMHA):** Each detained patient has the right to support from an IMHA. They are independent of NHS Solent Trust and their role is to support the patient through the processes of accessing their rights and representing the patient's view, or supporting the patient to represent their own view.

2.9 **Longer term Leave**: Any period of s17 leave implemented at a time when the patient is no longer an inpatient. Although longer term leave is defined in the Act as leave that is for longer than 7 days, either in a single period or as a result of a cumulative effect, that is for the purpose of distinguishing it in order to establish a duty to consider a CTO. This policy uses a different definition as it needs to distinguish the differences in managing leave when a patient is an inpatient or not. If longer term leave is for more than 7 days then the Responsible Clinician must consider use of a CTO and record their reasons.

2.10 **Responsible Clinician (RC):** The Approved Clinician with overall responsibility for the patient's care. A patient can only have one RC at any one time. Only a practitioner with AC status can act as an RC. Every detained patient must have an RC appointed by Solent NHS Trust. An RC cannot delegate their roles with regard to s17 but Solent NHS Trust can direct another AC to temporarily take on the role if the normal RC is not available at the time a s17 leave decision needs to be made. This will be done in line with the Mental Health Act Procedures and Guidelines Policy.

2.11 **Restricted Patient:** A patient detained under Part III: Patients concerned in Criminal Proceedings or Under Sentence, of the Mental Health Act 1983, that have specific conditions attached to their detention. The granting of section 17 leave will require the approval of the ministry of Justice.

2.12 **Short Term Leave**: Any period of s17 leave implemented whilst the patient remains an inpatient.

3. PROCESS/REQUIREMENTS

3.1 GRANTING S17 LEAVE

3.1.1 Only the RC can grant s17 leave and only to patients detained under sections 2, 4, 3,37 or 47. If the patient is under a restriction order then the Ministry of Justice must agree to the boundaries within which leave can be granted.

3.1.2 The RC can grant leave for specific occasions or for specific or indefinite periods of time. They may also set any conditions they consider necessary in the interest of the patient or the protection of other people. These conditions should be a proportionate restriction to the end they seek to achieve or the risk they seek to manage. They should be negotiated with the patient, as much as is possible in achieving that end and they should be communicated as clearly as possible to the patient and the others involved in the patients care. This should include the likely outcome of the patient breaching the conditions. Special care should be taken to ensure that conditions are unambiguous as ambiguity can lead to a point of conflict between staff and the patient. The responsible Clinician should, as far as is practicable, take

steps to ensure the patient correctly understands the conditions. Further guidance on setting conditions is given in Appendix 1.

3.1.3 This can include the condition that a patient has leave with a specific family member. If this is the case, a distinction needs to be made between a person having leave with a family member and the patient being in the custody of the family member. The patient can only be in the custody of the family member if the family member is named as the escort and the requirements set out below are fulfilled. Otherwise, the condition is just that they are with the family member. Before making this condition Responsible Clinicians must clearly asses it is safe and appropriate to do so. This should include considering the view of the family member. When recording this condition on the form, Responsible Clinician's should not put 'family member' but clearly state their name and specific relationship. The family member must be given a copy of the form as detailed below.

3.1.4 Section 17 leave decisions should be made on sound clinical and risk assessments. Each patient who is granted s17 leave must have a risk assessment recorded on System 1. If leave is being agreed at the weekly multi-disciplinary care meetings then the risks considered, the benefits of leave and the rational for granting it should be clearly recorded. The RC may not be the one doing the recording but they are ultimately responsible to ensure adequate recording, in this regard.

3.1.5 The Mental Health Act 1983 Code of Practice (Code of Practice) sets out a number of factors that should be taken into account, by the RC, when considering granting leave:

- Consider the patient's previous experience of leave, their view on their s17 leave and any instances of absence without leave
- consider the potential benefits and any risks to the patient's health and safety of granting or refusing leave;
- consider the potential benefits of granting leave for facilitating the patient's recovery;
- balance these benefits against any risks that the leave may pose in terms of the protection of other people (either generally or particular people);
- consider any conditions which should be attached to the leave, eg requiring the patient not to visit particular places or persons;
- be aware of any child protection and child welfare issues in granting leave;
- take account of the patient's wishes, and those of carers, friends and others who may be involved in any planned leave of absence;
- consider what support the patient would require during their leave of absence and whether it can be provided;
- ensure that any community services which will need to provide support for the patient during the leave are involved in the planning of the leave, and that they know the leave dates and times and any conditions placed on the patient during their leave;
- ensure that the patient is aware of any contingency plans put in place for their support, including what they should do if they think they need to return to hospital early; and
- (in the case of mentally disordered offender patients) consider whether there are any issues relating to victims which impact on whether leave should be granted and the conditions to which it should be subject.

3.1.6 This list is not exhaustive and any decisions need to be taken in the wider context and recording of Care Programme Approach planning. The RC will need to identify any other relevant considerations from their knowledge of the patient and the patient's history, the views of the multi-disciplinary team and the views of any informal carers or third party organisations involved. When leave is being granted the views of any third parties involved should be clearly recorded in the RIO notes. If this is done at ward round then this is an essential component of the recording of that ward round.

3.1.7 Subject to the interests of the patient's welfare and issues of confidentiality, informal carers should be involved in decision making around section 17 leave. Further guidance is in Appendix 2. However, if a patient refuses for careers, who are directly involved in the leave, to be involved in decision making and informed of certain facts then the RC should consider if it is still safe to grant the purposed s17 leave.

3.1.8 Where the Ministry of Justice have decided a restricted patient is to be detained in a particular unit then they require s17 leave to visit other areas of the hospital.

3.1.9 Technically, non-restricted detained patients do not need s17 leave to cover periods in the hospital grounds. However, St James Hospital has extensive grounds that the public regularly access and there are a number of secluded areas that can present risk issues. In order to ensure the appropriate level of care is given to decisions regarding ground leave the Trust has taken the view that ground leave within St James hospital will require a s17 leave form for all detained patients. This does not include the gardens immediately attached to the units.

3.2 GRANTING LEAVE AT THE NURSES DISCRETION

3.2.1 Short term periods of leave may be granted by the RC to be managed at the discretion of registered nursing staff. This can enable flexibility in how leave is taken and ensure the most productive use of the leave for the patient and the most effective and equitable use of ward staff. However, the parameters of how leave is taken must be clearly set out: including, particular places to visit, any restrictions on the time of day the leave can take place, duration, purpose of leave or whether the leave is escorted or not.

3.2.2 The setting of these parameters should follow the same principles as setting conditions: be kept to what is necessary and proportionate to safely promote the patient's recovery. They should also be clear to all parties in order to prevent ambiguity and conflict. Registered Nursing staff can only implement leave within the parameters that the RC sets.

3.2.3 The RC may also set a wider condition that registered nursing staff can decide not to implement any authorised leave on medical grounds at their discretion. This is a standard statement on the Trust's s17 leave form, with regard to any short term leave. However, RCs can cross it out if they are of the view it should not apply. Short term leave is defined as any leave granted whilst the patient remains an inpatient in the detaining hospital.

3.2.4 In individual cases it may be appropriate for the RC to identify factors that nurses may need to pay particular attention to when deciding if leave should be implemented: for example, compliance with medication, self-harm or substance and alcohol use. These should be based on a clinical assessment of the specific patient. They are not an exhaustive list and the nurse will still need to assess the situation in front of them.

3.2.5 Section 17 leave should be reviewed at each multi-disciplinary meeting and before if clinically indicated.

3.3 ESCORTED LEAVE/ 'KEEPING A PATIENT IN CUSTODY'

3.3.1 Section 17(3) enables the RC to specify that a patient on s17 leave may be kept in the custody of certain people. Within this Trust this is referred to as escorted leave.

3.3.2 When the escort is a member of staff of the hospital then this should be recorded on the s17 leave form as ward staff and stating how many escorts are needed.

3.3.3 When the person is not a member of staff of the hospital, including family members, their details should be recorded on the form. In order for them to legally be the person's escort they must be given a copy of the form, had the responsibilities of being an escort explained to them and agreed to undertake the role. There is space to record that this has been done on the back of the s17 leave form in Appendix 3.They should be given a copy of the form before they first undertake the role as escort.

3.3.4 Due to the responsibilities of being an escort and the potential risks to the patient, the escort and the public, informal carers should not be requested to undertake this role unless it has been clearly assessed that they are able to. It is the responsibility of the Responsible Clinician to ensure this has occurred.

3.3.5 Alternatively, the person may be granted leave accompanied by others. In this case, they are not in the custody of those people.

3.4 RECORDING LEAVE ON COMMENCEMENT AND RETURN

3.4.1 Except where stated, section 3.4 applies to both short term leave and long term leave, as detailed below.

3.4.2 The RC must record leave on the form in appendix 3 . Any superseded forms must be crossed out. A copy of the form must be given to the patient and any non NHS Solent Staff who are involved in the leave. This should be recorded on the box on the form. A nurse should sign the box to confirm the form has been given to this person.

3.4.3 In cases where the family member is not an escort (see paragraphs 3.3.1 to 3.3.4) it may be posted if it is not practicable to give it in person. If the family member is an escort then it must be given to them in person before they undertake their role as escort.

3.4.4 A staff nurse accepts the form on behalf of the hospital managers and signs the back of the form to confirm this. Although, this is not a requirement of the Act, it is evidence that the ward has received the form and that the nurse has ensured the patient has a copy.

3.4.5 A copy should be kept in the patient's Mental Health Act folder and a copy to be sent to the Mental Health Act administration team.

3.4.6 Details of the s17 leave form will be recorded on System One by the Mental Health Act administration team. NHS Solent staff members are expected to look on System one or in the Mental Health Act folder for details of s17 leave. This includes community staff.

3.4.7 Individual units must have processes in place to ensure that before leave commences all risks are clearly considered and this is recorded. These processes must ensure:

- Registered nursing staff assess the patient's mental state and any risks associated with the leave. (For longer term leave this duty can be discharged by a doctors' assessment on the day, providing there is no deterioration before commencement, or by a nursing review immediately before commencement of the leave.)
- Risk assessments should be clearly recorded at the time they are undertaken and should consider any risk assessments recorded on RIO.
- For short term periods of leave an up to date description of the patient should be recorded, including the clothes they are wearing, in case they do not return.
- The patient and or any escorts should have clear details of how to contact the ward in the event of a crisis.
- The time of the patient went on leave and the time they returned must be clearly recorded.
- A photograph of the person should be available in their electronic records, providing they consent or are unable to consent but it is in their best interests.

3.4.8 If a nurse does not implement leave due to medical grounds then the shift leader should be informed and a decision made as to whether the RC needs to be requested to review leave arrangements before any further leave is implemented. This decision will depend on the specifics of each case and the risk assessment undertaken. Such decisions must be made in line with the five guiding principles and leave should not be stopped on punitive grounds. The plan agreed by the shift leader and their reasons must be clearly recorded on System One. If an immediate review is not requested then the RC must be informed, by the shift leader, of any leave that has not been implemented before they next review the patient.

3.4.9 If leave is not implemented due to a significant change in risk then a review must be requested before any further leave is granted. This should occur as soon as is possible to ensure the patient's rights are not disproportionately restricted. If the RC is not available in person then their view could be sought by phone or another AC can temporarily take on the role of the patient's RC, in line with Trust policy. If part of the leave is stopped then this should be crossed out and initialled on the form. If all of the leave is stopped then all of the form should be crossed out. The nurse will record the outcome of the discussion with the RC on RIO.

3.4.10 In the event of a patient absconding or not returning from leave at the specified time the Trust Missing Person policy should be followed.

3.4.11 The time of return from leave should be clearly recorded. The outcome of leave should also be recorded in order to inform future decision making. This should include what went well and what did not and any problems, benefits or risks identified.

3.4.12 On return from leave staff members should record how the leave has gone: the positives, as well as any difficulties or concerns.

3.4.13 Patients should be given time and support to reflect on their use of leave and this should be clearly recorded to inform future decision making. This could include directives about how to deal with crisis or goals to be achieved.

3.4.14 Third party views on leave should be clearly recorded. These should be acknowledged in the planning of future leave, including at ward round.

3.5 LONGER PERIODS OF LEAVE AND RECALL FROM THAT LEAVE

3.5.1 A patient can be discharged from being an inpatient whilst under s17 leave; in which case they remain liable to be detained under the section they were detained on. In these cases the RC can set a specific condition that the patient resides at a specified residence or at another hospital.

3.5.2 In the case of another hospital this could be to enable a short term period of treatment before returning to the original hospital or a trial period at a specialist treatment unit. However, the AC in the originating hospital will remain the RC, for the purpose of any s17 leave whilst there, and if the patient is to remain at the second hospital on a longer or more permanent basis then consideration should be given to transferring the patient there.

3.5.3 Longer term periods of leave should be planned in advance, in line with the Care Programme Approach planning processes. Community teams should be fully involved. Informal carers and other agencies involved in the long term plan should be consulted as appropriate and their views clearly taken into account and recorded on System One. If a patient does not consent to their involvement then the RC should assess if the plan can still be safely carried out or if an alternative needs to be identified.

3.5.4 Patients should be fully involved in the decision and Responsible Clinicians should be satisfied that patients are likely to be able to manage outside the hospital and that the necessary resources are available for them.

3.5.5 The RC should give consideration to use of their power under s17(3). This enables the RC, if they deem it to be necessary to do so in the interest of the patient or the protection of other persons, to specify that the person may be kept in the custody of those at the residence or hospital and combined with s18(1)(c) this would enable the person to be returned there if they absented themselves without permission. However, the current position of the Trust is that this does not authorise deprivation of liberty in that place.

3.5.6 If the conditions or restrictions on a person in that residence or hospital amount to a deprivation of liberty then consideration should be given to seeking appropriate authorisation; either by transferring the patient there under the Mental Health Act or seeking an authorisation under the Deprivation of Liberty Safeguards.

3.5.7 When considering granting s17 leave for more than 7 consecutive days or extending leave so the culmination is more than 7 days then the RC must consider the use of a Community Treatment Order (CTO). They should refer to the Trust guidance. 'The code of practice states: 'Leave should not be used as an alternative to discharging the patient either completely or onto a CTO where that is appropriate.' (27.37). It also states that 'Leave for a longer period should also be for a specific purpose or a fixed period, and not normally more than one month' There may be cogent reasons to choose s17 leave for longer than 7 days and

even for longer than a month. If it is chosen then these reasons must be clearly recorded. In addition, a decision to use longer term leave should be explained to the patient and fully documented, including why the patient is not considered suitable for a CTO, guardianship or discharge.

3.5.8 Whilst the patient is on s17 leave the RC is responsible for ensuring the criteria for detention continue to be met and discharging the patient onto a CTO or absolutely if not. One of those criteria is that there is an element of hospital treatment. This does not have to be inpatient treatment and can be met by the likelihood of immanent relapse, as in a trial period of leave. Furthermore, for patient's discharged on a more long term basis, the courts have taken a very wide view of the meaning of this term.

3.5.9 How long trail leave should last will depend on the circumstances of each case. Issues that may justify an extended period of trial leave include:

- a history of rapid relapse,
- high risks associated with relapse,
- significant change in circumstances,
- leave following a long period of inpatient stay,
- a period of recent instability,
- risk that discharging to a CTO or to informal status will create instability, and
- a history of disengagement.

3.5.10 For longer term periods of leave, attendance with the hospital needs to be significant in the context of the overall care plan. However, this is not about the actual time the person attends but the effect of that attendance in the effective and safe management of the patient's care, as they move towards recovery and discharge from the hospital regime. For example, it could be attending the hospital for reviews with the RC to monitor mental state and the care plan, when this re-enforces the authority of the section 3 (s3).

3.5.11 Providing the criteria are met a patient's detention can be renewed whilst they are on long term home leave; there is no requirement for them to be readmitted to hospital.

3.5.12 If the RC considers that it is necessary in the interests of the patient's health or safety or the protection of others then they may, by notice in writing, revoke the patient's leave and recall them to hospital. The notice must be given to the patient or the person, at that time, in charge of the patient. If the patient does not return they are considered to be Absent With Out Leave (AWOL) and can be conveyed back to the hospital, via a place of safety if necessary.

3.5.13 Breach of a condition, including a refusal to take medication, is not grounds for revoking leave, in itself. However, it should be brought to the attention of the RC and they should consider if in that case the grounds to recall the person to hospital are met and, if so, if it is the appropriate course of action. The rational for this decision should be clearly recorded and communicated orally to the person whose leave is being revoked

3.5.14 Any decision to revoke leave must, in order to comply with the patient's Article 5 rights to liberty, be based on up to date medical evidence of a mental disorder.

3.6 CARE AND TREATMENT WHILST ON LEAVE

3.6.1 Whilst on longer periods of leave it should be clear to all and at all times who is the RC, what the role of the care co-ordinator is and what, if any, is the role of the inpatient or acute care staff. This should be kept under review via the CPA process.

3.6.2 The patient's relapse indicators should be clearly recorded and they should have a copy of their crisis and contingency plan, detailing who to contact in a crisis or deterioration in their mental state. The patient should be informed of advance directives and supported to make one if they wish.

3.6.3 Others involved in the patients care should have information of who to contact in the event of concerns. Any contact made in this regard should be clearly recorded on RIO, including the response and reasons.

3.6.4 A patient on s17 leave continues to come under the Consent to Treatment provisions of the Mental Health Act. In effect, they can after 3 months of receiving treatment for a mental disorder, only be given medication by any route for their mental disorder if they consent and this is recorded on a T2; if they lack capacity to consent or refuse to consent, a Second Opinion Approved Doctor authorises it on a T3; or it is given under the urgent treatment provisions of s62.

3.6.5 Their GP should be informed of this and their medication regularly reviewed by their RC and care co-coordinator to ensure there is legal authority for their treatment.

3.6.6 If the patient refuses to accept treatment then the RC should consider the appropriateness of revoking their leave and if the criteria are met. Force should not be used in the community to administer treatment.

4. ROLES & RESPONSIBILITIES

4.1 The Responsible Clinician retains ultimate responsibility for granting and reviewing section 17 leave: for appropriately completing the form, for ensuring all superseded forms are crossed out, for ensuring the approval of the Ministry of Justice is gained where necessary, for ensuring conditions and parameters of leave and the consequences of breaking them are clear to all parties and clearly recorded and for ensuring the following are recorded: the risks and benefits associated with s 17 leave, the rational for s17 leave decisions, the third party, patient and carers views considered in decision making, the carers and third parties involved in leave and who should be given s17 leave forms, any decisions around granting or withholding leave when a patient refuses information to be shared, the risks and benefits associated with the revoking of any leave and the rational for revoking any leave.

4.2 Registered nursing staff are responsible for using their discretion in implementing s17 leave in line with the guiding principles, alerting the shift lead when the discretionary power not to implement leave is used, managing leave in line with the parameters and conditions as outlined by the RC, identifying any ambiguity between parties, areas of risk, concern or benefit and clearly recording these, recording the patient's description for short term leave, facilitating the patient to effectively reflect and care plan their leave, ensuring consideration of s17 leave is done as part of the CPA process and record: care planning, risk assessments, outcome of leave, third parties, informal carers and the patient's views.

4.3 The ward managers are responsible for the effective and safe management of resources with regard to s17 leave and the processes that safely manage s17 leave in their units.

4.4 The mental health act administrators are responsible for accepting the s17 leave forms on behalf of the hospital managers and recording their details on RIO.

4.5 The Mental Health Act Lead is responsible for facilitating a rolling monthly audit of s17 leave using the standard in the policy and for reporting this to the unit manager, the service manager and the Mental Health Act Scrutiny Committee.

4.6 The Mental Health Act Scrutiny Committee meet quarterly, oversee the safe management of the Mental Health Act in the organisation and report directly to the Board. They will be responsible for scrutinising the results of the ward audits, complaints, Care Quality Commission (Mental Health Act Commissioner) (CQC(MHAC)) visits and risk incidents and reports in relation to s17 leave and ensuring that services have effective plans to address any areas of concern.

5. TRAINING

5.1 Solent NHS Trust recognises the importance of appropriate training for staff. For training requirements and refresher frequencies in relation to this policy subject matter, please refer to the Training Needs Analysis (TNA) on the intranet. All records of attendances and DNA's will be sent to L&D and recorded onto the Trust central database (Oracle Learning Management), all DNA's will be managed as per the DNA process within the Trust's Learning and Development Policy.

5.2 Training will be delivered by the Mental Health Act Lead. A days training on the Mental Health Act is mandatory requirement for all inpatient staff working with detained patients. It must be repeated three yearly.

5.3 Lead Mental Health Act practitioners have been identified for each inpatient unit. They will receive extra support, either individually or as a group, from the Mental Health Act Lead. Their role will include overseeing the discharge of duties with regard to s17 leave.

5.4 The Mental Health Act Lead is supported to undertake appropriate training in relation to Mental Health Act Law and receives support from the Trust solicitors as required.

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1 The Equality impact assessment and Mental Capacity Act Assessment identified that this policy is unlikely to lead to discrimination against any particular group and that it takes the situations of service users who lack capacity to make decisions into account. The impact study is in Appendix 4.

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 The policy will be initially reviewed after one year by the Mental Health Act Lead. The tool in appendix 5 will be used to audit the practice on wards. The results of this will be considered

alongside complaints, SIRIs and visit reports from the CQC (MHAC). The results will be shared with the operational service groups that work with detained patients and with the Mental Health Act Scrutiny Committee.

7.2 The Mental Health Act Scrutiny Committee will have a role in on-going monitoring of the policy as described above.

7.3 Non-compliance with this policy should be reported immediately to the service manager concerned and Mental Health Act Lead.

7.4 The implementation of this policy should ensure effective and safe management of s17 leave that seeks a balanced promotion of patient recovery. It should be able to identify where the Trust are not legally or safely discharging its duties and inform an action plan to address this.

8. REVIEW

8.1 This document may be reviewed at any time at the request of either at staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a bi-annual basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

Statute

Mental Capacity Act 2005

Mental Health Act 1983

Human Rights Act 1998

Codes of Practice

Department of Health , *The Code of Practice: The Mental Health Act 1983* (TSO, London 2008)

Books

Bowen, P, *Blackstone's Guide To The Mental Health Act 2007* (OUP, Oxford 2007)

Fennell, P, *Mental Health: The New Law* (Jordan, Wiltshire 2007)

Hale, B, *Mental Health Law* (5th edn, Thomson Reuters (Legal Ltd), London 2010)

Jones, R, *The Mental Health Act Manual* (13th edn, Thomson Reuters (Legal Ltd), London 2010)

Gostin l, Bartlett P, Fennel P, McHale J and Mackay R, *Principles of Mental Health Law and Policy,* (OUP, Oxford 2010)

Other Sources

Care Quality Commission, *Monitoring the use of The Mental Health Act in 2009/10*

<http://www.cqc.org.uk/_db/_documents/CQC_Monitoring_the_use_of_the_Mental_Health_Act_in_200910_Main_report_Tagged.pdf>

Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended((ECHR)

Mental Health Act Commission, *Mental Health Act Commission Forth Biennial Report 1989-1991*

Mental Health Act Commission, *Mental Health Act Commission Sixth Biennial Report*

Solent NHS Trust Policies

Mental Health Act Procedures and Guidelines Policy

Appendixes

Appendix	Title
Appendix 1:	Guidelines for Setting Conditions to Section 17 Leave for Non-Restricted Patients
Appendix 2:	Section 17 leave and sharing information with a patients social support and professionals from other agencies
Appendix 3:	Section 17 Leave Form
Appendix 4:	Impact Assessment
Appendix 5:	Audit Tool
Appendix 6:	Section 17 Leave process flow chart
Appendix 7:	Summary of Responsible Clinician, nurses and care co-ordinators roles regarding s17 leave

Guidelines for Setting Conditions to Section 17 Leave for Non-Restricted Patients

Remember the five Guiding Principles in The Code of Practice
1) Purpose 2) Least Restriction 3)Respect 4)Participation
5) Effectiveness, Efficiency and Equity

Section 17 leave is an important part of a patient's care plan; it is often essential in promoting recovery; and it is a time when risk issues and the extra demand that it can put on carers and services needs to be considered. The weekly multi-disciplinary team meeting is the normal time when section 17 leave is reviewed and the maximum amount of section 17 leave for the week and any conditions are set.

When considering what section 17 leave to grant the following should be taken into account:

- the reasons connected to the patient's detention,
- the circumstances of their wider social network,
- the risks associated with the patient's care,
- the patient's need for recovery, self-determination and positive risk taking and
- the patient's negotiating style and engagement with the nursing staff.

The degree of restrictions on the amount of leave and the conditions attached to the leave need to be;

- proportionate to the nature and degree of risk,
- necessary to ensure that the patient and the public are safeguarded, and
- based on accurate clinical observation and assessment.

Therefore conditions need to be;

- flexible enough to ensure that the patient's recovery can be promoted in the least restrictive way that maximises their self-determination and that the limited resources of ward staff can be equitably managed, whilst
- ensuring that they are clear enough to enable staff, the patient and carers to be aware of the expectations on them and reduce confrontation through ambiguity, and
- considered enough to ensure the patient and the public are safeguarded.

It is essential that;

- the decision making process is as transparent as possible.
- the patient is informed of the nature of the conditions and the likely consequence of breaching the conditions,
- the team ensure that everyone has a shared understanding of what the conditions mean, and ambiguity is kept to a minimum.

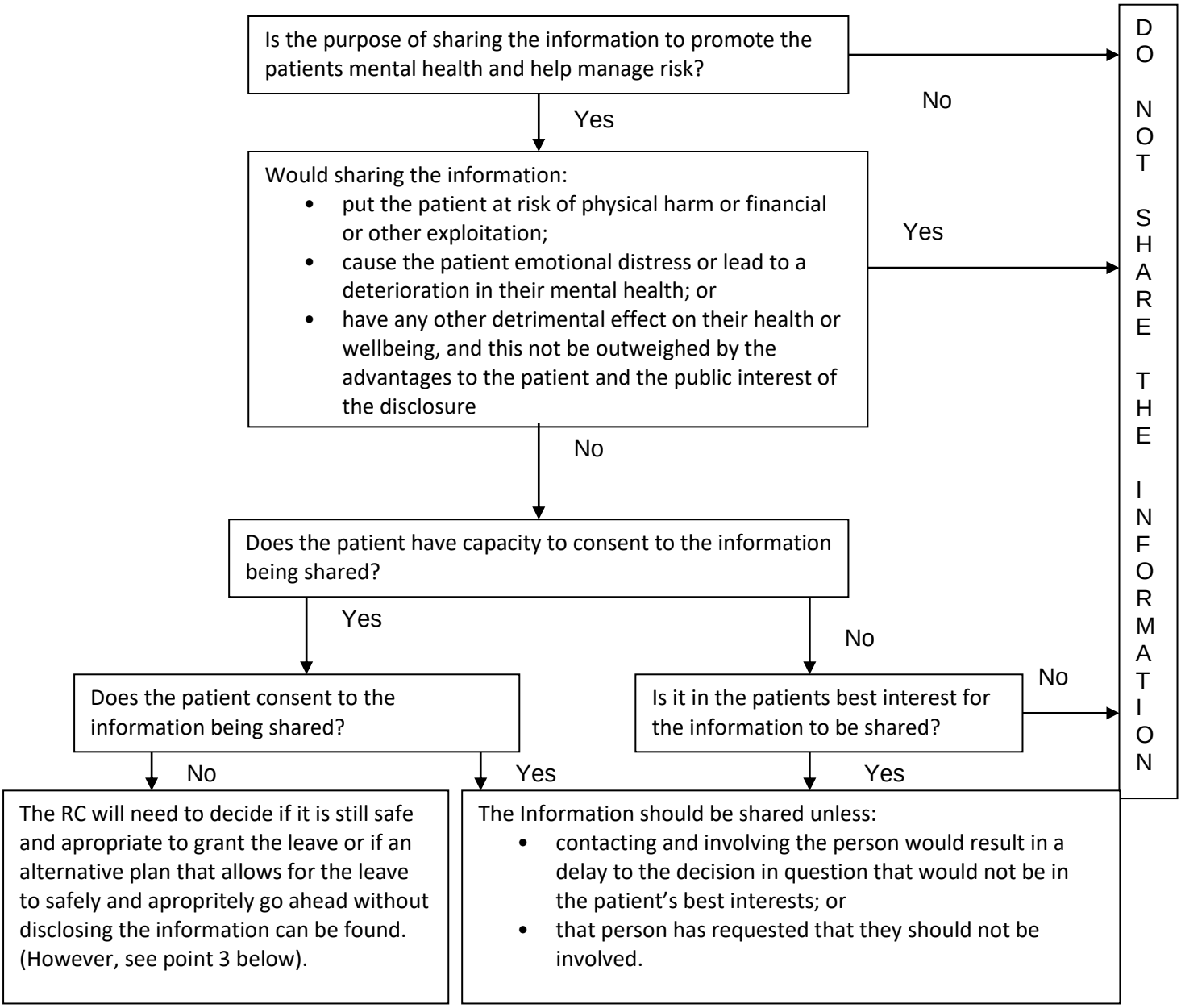
If registered nursing staff are instructed not to implement any authorised leave on medical grounds, at their discretion, then this should be clearly explained to the patient, re-enforced by the medical team and what the registered nursing staff will be assessing should be made as clear as possible. The issue of compliance with medication should be addressed.

Registered nursing staff are responsible for ensuring that any ambiguity of expectations by patients and risk are considered when monitoring, managing and recording leave and they are brought to the attention of medical staff at the MDT. They are also responsible for ensuring the patient and any other relevant person has a copy of the leave form.

Responsible Clinicians (RC) are responsible for ensuring these issues are explored when granting leave, setting conditions and clarifying these with the patient. The RC should weigh up and record the potential benefits and risks before making a decision about leave of absence (this is from case law).

Appendix 2

Section 17 leave and sharing information with a patients' social support and professionals from other agencies.



FURTHER POINTS

1) If carers share information about a patient then the patient should only be told who the information has come from with the carer's agreement. If the carer does not want the patient informed then staff should consider the risks before deciding whether, when and how to discuss the information with the patient.
2) Patients detained under Part III of the Act should be encouraged, in line with the Code of Practice for Victims of Crime issues under the Domestic Violence, Crime and Victims Act 2004), to agree for information to be shared with victims and families of victims.
3) If information regarding section 17 leave is to shared where the patient has capacity and does not consent this can only be done if there is specific legal obligation or it is in the overriding public interest. In these cases the reasons should be clearly recorded alongside the names of those involved in the decision. It should also be recorded why the section 17 leave could not be managed in a different way which avoided the need for the disclosure.
4) Finally, it may be that it is a condition of a person's leave that they are with a friend or family member. In these circumstances the friend or family member will need to know enough about the situation to meaningfully agree to this. In rare cases it may be a condition that the patient is in the legal custody of that person. 'A Responsible Clinicians should specify that the patient is to be in the legal custody of a friend or relative only if it is appropriate for that person to be legally responsible for the patient, and if that person understands and accepts the consequent responsibility.' This arrangement can only be authorised in writing by the managers of the hospital

MENTAL HEALTH ACT (1983)
Record of Granting Section 17 Leave of Absence

To the Managers of Solent NHS Trust

I _____ (full name)

am the Responsible Clinician in charge of the treatment of

_____ who is currently detained on _____

ward under Section of the Mental Health Act (1983).

Leave of absence is authorised as follows:

1) LEAVE TO OTHER NHS TRUSTS FOR URGENT TREATMENT

2) Short term leave (short term is leave in which the patient remains an inpatient) (include places, any specified times of leave, duration and purpose of leave)

Escorted leave: Escorted by:	

Unescorted leave	

Registered Nursing staff can decide not to implement any short term authorised leave on medical grounds at their discretion (delete if not appropriate).
The exact timing of the above leave is to be facilitated and managed at the nurses' discretion, taking into account the operational requirements of the ward.

Any specific issues registered nursing staff are to be aware of when considering not implementing leave (substance use, medication compliance, self-harm). This list is not exhaustive and nurses must use their professional discretion to assess the situation at the time:

_____

_____

_____

3) Overnight leave:
Address of any overnight leave: _____

Duration: _____ Conditions: _____

_____

_____

If leave is to last longer than seven days what is the reason for not using CTO?

_____

_____

These arrangements will continue until they are reviewed on or before:

(time/date)

_____

A copy of this leave form is to be given, by ward staff, to anyone who is escorting the patient and the name of any person this form has been given to has been recorded in the box below. Details of the leave and any conditions have been recorded on RIO, which community services have access to.

The following have been given this form:

Name	Position/Relationship	Staff member's signature and name: confirming the form has been given
		Name: Signature:
		Name: Signature:
		Name: Signature:
		Name: Signature:

IN THE EVENT OF CRISIS PLEASE PHONE 023 9282 2444 AND ASK TO SPEAK TO A NURSE ON THE WARD NAMED IN THE THIRD LINE ON THE FRONT OF THIS FORM.

Signed by: _____ Date: _____

Received on behalf of the Hospital Managers by: _____

Designation: _____ Date: _____

NB: COPY OF LEAVE FORM TO BE SENT TO MENTAL HEALTH ACT ADMINISTRATOR.

Conditions of Granting Leave

Section 17(3) states that the Responsible Clinician may direct that the patient remain in custody during his leave if it is necessary in the interests of the patient or for the protection of other persons. The patient may be kept in the custody of an officer on the staff of the hospital or any other person authorised in writing by the Managers of the hospital *[this form]*. If a patient is granted leave of absence on condition that he stays in another hospital, he may be kept in the custody of any officer on the staff of the other hospital.

MHA 1983 S17(3)

Appendix 4

Equality Impact Assessment

Step 1 – Scoping; identify the policies aims	**Answer**
1. What are the main aims and objectives of the document?	To ensure patient safety and a recovery focus in the management of section 17 leave.
2. Who will be affected by it?	Detained patients
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	The need for a policy has been highlighted in reviews following a complaint and a SIRI
4. What information do you already have on the equality impact of this document?	Nationally those from minority ethnic groups are disproportionately detained under the mental health act. Local data is difficult to identify but the data that can be identified indicates a similar pattern. There is nothing to indicate s17 leave is managed differently for different ethnic groups
5. Are there demographic changes or trends locally to be considered?	As in 4
6. What other information do you need?	none

Step 2 - Assessing the Impact; consider the data and research	**Yes**	**No**	**Answer** (Evidence)
1. Could the document unlawfully against any group?		x	The document ensures an objective standard is used in decision making that underpins the management of s17 leave. This should reduce the likelihood of arbitrary decision making that could lead to discrimination
2. Can any group benefit or be excluded?		x	All groups should have respect shown for their specific needs. This is a guiding principle of the policy.
3. Can any group be denied fair & equal access to or treatment as a result of this document?		x	As above
4. Can this actively promote good relations with and between different groups?	x		Respect for diverse needs and participation are guiding principles of the policy.
5. Have you carried out any consultation internally/externally with relevant individual groups?	x		All relevant staff have been consulted
6. Have you used a variety of different methods of consultation/involvement	x		A number of different Groups have been contacted.
Mental Capacity Act implications			
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)	x		MCA taken into account in the policy.

If there is no negative impact – end the Impact Assessment here.

Step 3 - Recommendations and Action Plans	**Answer**
1. Is the impact low, medium or high?	Low
2. What action/modification needs to be taken to minimise or eliminate the negative impact?	Ensure policy is followed in decision making
3. Are there likely to be different outcomes with any modifications? Explain these?	

Step 4- Implementation, Monitoring and Review	**Answer**
1. What are the implementation and monitoring arrangements, including timescales?	There will be an audit of a different ward each month. This will look at compliance with this policy**.**
2. Who within the Department/Team will be responsible for monitoring and regular review of the document?	MHA administration team. This will be reported to the MHA scrutiny group.
Step 5 - Publishing the Results	Answer
How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made).	Be kept with the policy

Appendix 5

SECTION 17

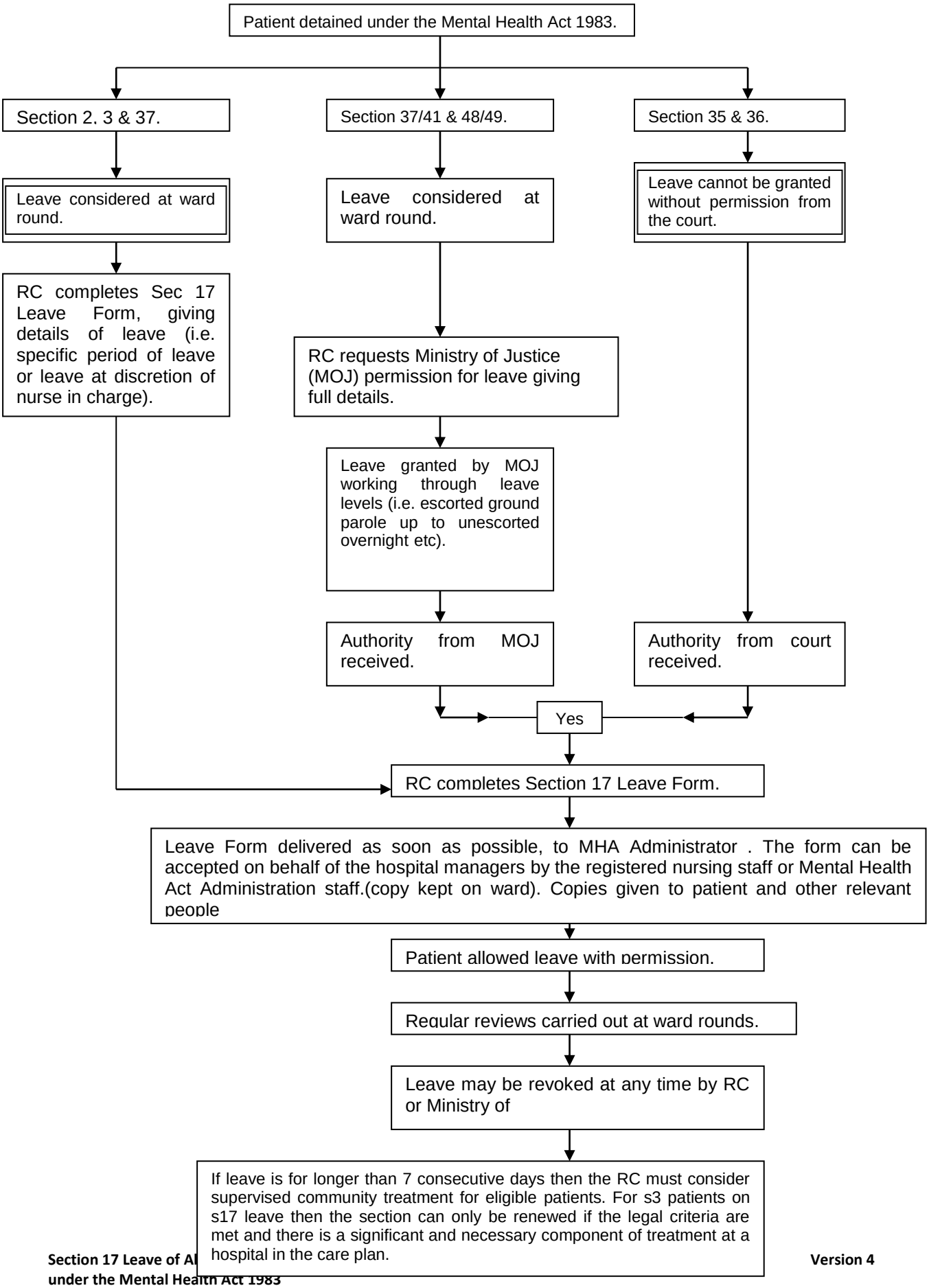
If a mistake is found during the audit, the following action must be taken:

- *Inform Mental Health Act Administrator for the area immediately.*
- *Inform ward staff at the end of the monitoring session.*

	CRITERIA	Y/N or n/a	CRIB
1	Was all Section 17 leave authorised by the current RC?		List of current RCs
2	Did the leave comply with any Ministry of Justice restrictions?		Check Ministry of Justice letter regarding leave
3	Is there a copy of the original Ministry of Justice restrictions with the S17 leave on the ward?		Is this the most up to date?
4	Is there a log book/sheet of patient's leave?		Check log book/sheet
5	Is there a copy of the current S17 leave in the log book/sheet?		
6	Was the log book properly completed? *If NO, please put details and number of omissions in Comments box below*.		Time in and out. Client/patient and Nurse's signatures.
7	Does the leave taken in the log book comply with the S17 leave granted?		Check against S17 leave form
8	Were all S17 leave forms properly completed? *If NO, please give details in Comments box below*		RC current? Date/Manager/Signatures?
9	Were obsolete S17 leave forms clearly cancelled and dated?		Clinical notes file
10	Were the terms of the leave explained to the patient by the RC?		RC signature on leave form
11	Was the S17 leave form accepted on behalf of the Managers within 24 hours?		Signature on leave form – within 24 hours?
12	If leave is lasting longer than 7 days has SCT been considered?		Comment on form
13	If family or non-nhs staff are involved in leave did the form indicate they had a copy?		On back of form
14	If family are the escort does the form record they have a copy		On back of form
15	Is there a photograph of the person on file?		Leave log book or System One
16	Is there evidence that how leave went is reviewed?		Leave log or System One
17	and the person's views recorded?		
18	Is there an up to date risk assessment on System One		
Comments:			

Appendix 6

Process Flow Chart for s17 leave



Summary of Nursing tasks

Ensure inpatients have an up to date risk assessment on RIO (lead nurse)

Ensure there is no ambiguity in conditions or parameters of leave

Ensure a copy of the s17 leave form is: given to the patient, put in the patient's Mental Health Act File, sent to the Mental Health Act Administrators, given or posted to those identified on the form and sign to evidence this.

Implement leave only within the parameters set by the RC and only after assessing the mental state and risks at the time leave is to be implemented.

Ensure, for short term leave, an up to date description of the patient is recorded.

If a nurse does not implement leave due to medical grounds then the shift leader should be informed and a decision made as to whether the RC needs to be requested to review leave arrangements and if leave should be withdrawn until this time. A significant change in risk must trigger an RC review. If a review is not requested then the shift leader must inform the RC of any leave withheld before the RC next review's the patient. Risk assessments, plans and reasons must be recorded.

If leave is implemented ensure the patient and any escort has details of who to contact in a crisis.

Implement the Absence Without Leave Policy in the event of the patient being AWOL.

Record the time a patient returns from leave

Record the outcome of leave: what went well, any difficulties, concerns and risks.

Ensure the patient has time to reflect on the use of their leave in the context of their recovery plan.

Ensure any third party views are recorded and made available for ward round.

Long term leave (Nurse and Care Coordinator)
The Lead nurse must liaise with the care coordinator and clarify the tasks of the care co-ordinator and the tasks of the inpatient unit.

Both must ensure any issues of deprivation of liberty have been considered.

The lead nurse is responsible for ensuring the patient has a crisis and contingency plan, that details relapse indicators and who to contact in a crisis. The care co-ordinator is responsible for reviewing this.

The care co-ordinator is responsible for liaising with the GP to ensure only duly authorised medication is prescribed.

Both the nurses involved and the care coordinator must clearly record any concerns expressed from informal carers or third parties. This should include a plan of action and details of how the Responsible Clinician is informed.

Summary of the Responsible Clinician's tasks

Completing the s17 leave form in line with this policy.

Ensure any superseded forms are crossed out.

Ensure conditions and parameters minimise ambiguity and are necessary and proportionate to achieve the end of recovery and risk management. (appendix 1)

Identify and record any specific factors for nurses to consider when assessing the appropriateness of implementing leave within their discretion: for example, self-harm, substance use, medication compliance.

Ensure, for decisions to grant s17 leave, the risks, benefits and reasons for granting leave are recorded on RIO. This could be part of ward round recording.

Ensure that third party views are considered and recorded on RIO: this could be at ward round.

Identify those to be given a copy of the s17 leave form. Record this on page 2 of the s17 leave form.

If a non- Solent NHS staff member is to be the escort then they must be given a copy, agree to the arrangements and their role explained. The RC must also ensure they have been assessed as suitable to undertake the role.

Follow the guidance in appendix 2 for sharing information with informal carers' and third parties, in relation to s17 leave decisions. If patient's refuse for relevant information to be shared with those involved review the appropriateness of s17 leave arrangements.

For longer term leave
The inpatient Responsible Clinician should ensure the community Approved Clinician agrees hand over arrangements and that the Care Coordinator is involved.

The inpatient approved clinician must ensure the patient is clear who the Responsible Clinician is.

Consider a Community Treatment Order if leave is longer than 7 days and record this on the s17 leave form.

Monitor the appropriateness of continuing to keep a person under liability for detention against the legal criteria.

When informed of concerns consider the appropriateness of revoking the leave and if the legal criteria are met.