

A snap-shot of 'long-term' section 17 use in South-West England

Bob Jones¹ and Mat Kinton²

The Mental Health Act Commission (MHAC) does not have a culture of visiting patients in the community, having a primary statutory duty of visiting detained patients in hospital, and no remit over patients placed under Guardianship or Supervised Discharge (s.25A)³. The MHAC's statutory remit does, however, encompass patients who remain liable to be detained but are granted leave of absence from hospital, and will extend to patients who are subject to supervised community treatment upon the implementation of SCT powers in October 2008⁴, although proposals in the *Health and Social Care Bill*, which was passing through Parliament at the time of writing (March 2008) would merge the MHAC with the Healthcare Commission and Commission for Social Care Inspection, into a broad-based 'Care Quality Commission' effective from April 2009.⁵

Where MHAC visits to hospitals are announced in advance, it may already request that hospital administrators contact patients who are out on leave, letting them know that they could meet with a Commissioner if they attend hospital on the day of the visit. However, many MHAC visits are unannounced, or announced only at very short notice, making this difficult. In any case it is likely that some patients who are on leave would be unwilling, or unable, to attend hospital on the day of an MHAC visit just to speak with a Commissioner. Even patients who are detained in hospital may be initially hesitant in coming forward to speak with Commissioners, although such initial hesitance can often be overcome over the course of the visit, either through the encouragement of Commissioners themselves or through peer-support and example set by fellow patients: such mechanisms clearly do not apply when a patient is isolated from other detainees and away from the site of the visit. There are no general statistics on the numbers of such leave patients seen by the MHAC in the course of its routine activity, but we believe that number to be very small.

In an attempt to get a better understanding of patient and process issues that are likely when visiting community-based patients, the MHAC has been running some exploratory visits to detained patients on long-term section 17 leave. These visits have been carried out under the MHAC's statutory remit. This is a brief account of one such exercise in the South-West of England.

1 *Mental Health Act Commissioner*
2 *Senior Policy Analyst, MHAC; Senior Researcher in Mental Health Law, UCLAN.*
3 *Mental Health Act 1983, s. 120(1)*

4 *Ibid., as amended by the MHA 2007, schedule 3, para 26(2).*
5 *Clause 1 and Schedules 1 and 3 of the Health and Social Care Bill 2007.*

Defining 'long-term section 17 leave'

A patient who is liable to be detained under the Mental Health Act at a hospital can only be lawfully absent from that hospital if his or her responsible medical officer (RMO) grants leave of absence, using the powers vested in the RMO under s.17 of the Act. As discussed by Gledhill in the last issue of this journal⁶, over the last five years or so, case-law has interpreted the language of s.17 to allow for the renewal of a patient's liability for detention whilst that patient is on leave of absence from hospital, even where the continuing hospital treatment is only on an outpatient basis, and even where the RMO's "grasp" on the patient is "gossamer thin" during the process of staged discharge⁷. In recent years we have heard anecdotally that increasing numbers of patients are thus subject to 'long-term' s.17 leave of absence from hospital. Establishing a fixed point at which a period of leave becomes 'long-term' is necessarily arbitrary, especially if, as we have done in this exercise, we follow the assumed definition in the revised Act (which requires responsible clinicians to consider SCT as an alternative to any period of leave exceeding seven consecutive days)⁸. It may be possible to avoid such arbitrariness through attending to the intention and circumstances of the leave rather than to its duration, although retaining objectivity in such categorisation could be difficult. In this exercise we started from the crude but objective measure of 'long-term' leave as leave that had exceeded, or was intended to exceed, seven consecutive days.

Making contact with patients on long-term section 17 leave

One of the authors (Bob Jones) contacted two NHS Trusts in the South West of England and requested the details of all patients who were liable to be detained but on section 17 leave from hospital, and who had been granted s.17 leave for in excess of seven consecutive days. The larger of the two Trusts (Trust A) provided details of 18 patients; the smaller (Trust B) with the details of seven patients. We asked Trust A to contact the three patients who had been on leave for the longest period of time, and Trust B to contact four of its seven patients (one patient was excluded because of serious mental incapacity, and two others were due to be taken off leave). Altogether six of the seven patients that we asked to be contacted requested a meeting with the Commissioner (the one who did not had ceased to be detained). Meetings were arranged at a place of the patient's choosing, providing that this was not their home. Four patients chose to meet at the hospital where they remained liable to be detained, one chose the office of her home treatment team, and one chose to meet in a communal area of her supported housing unit. Although the MHAC had been prepared to reimburse travel expenses for patients, in the event the Trusts as, detaining authorities, had already made funding arrangements when the Commissioner met with the patients.

Matters raised in the patient meetings

The six patients raised several issues which provide some general indication of some of the process and patient problems which SCT and extended s.17 leave patients might experience:

- Due to a misunderstanding between professionals, one patient had not received his depot medication for some time (the patient thought three months, but staff informed the Commissioner that it was considerably longer).

6 Gledhill, K (2007) 'Community Treatment Orders', JMHL 16, Nov 2007, p.149-169 (p.149-153).

7 R (on the application of CS) v MHRT [2004] EWHC 2958, para 46; (see Thompson S and Marchant S (2005) "'Hospital treatment' further defined", JMHL 13; 191-198). See also R (on the application of DR) v Mersey Care

NHS Trust [2002] EWHC 1810, and discussion of that case in Hewitt, D (2003) 'There's no magic in a bed – the renewal of detention during a period of leave'. JMHL 9; 87-101 (July 2003).

8 Mental Health Act 1983, s.17(2A) and 17(2B), as introduced by the Mental Health Act 2007, s.33.

- The authority for treating one patient under section 58 was an 18-month old Form 39. This did not fully cover the medication that the patient was actually receiving.
- One patient had been resident in supported housing for some time, although this was not stated as a condition of his leave on the leave form. The manager of the supported housing had, we were told, asked him to vacate by Easter 2008. With nowhere else to go, this was causing some anxiety, not least because of the possible need to return to hospital. It was unclear who was helping him with this.
- The patient who was visited at her supported housing unit had, as part of her leave arrangements, the condition that she was allowed out for only 2 hours a day. Thus for the most part she was detained in the community.
- One patient had no traceable section 17 leave form, whereby staff could determine the agreed leave parameters.
- One patient stated that her RMO had advised her to withdraw her appeal to the Mental Health Review Tribunal (MHRT). This patient saw the Commissioner together with her advocate, who confirmed the RMO's comment. The RMO's comment left the patient feeling that exercising her right of appeal would be held against her in the long run.

Where appropriate, issues raised were dealt with either on the day of the visit or by writing to the Trust for comment.

The scale of long-term section 17 leave

To enable us to draw a profile of patients subject to long-term leave, we asked Trust B to supply us with details of their age, gender, and whether they were resident at home or at another place. The Trust's seven patients on long term S.17 leave had an age range between 35 and 64 years (mean age 50), and four were female. Two patients, aged 54 and 60, were recorded as living in residential care, but the remaining five patients resided at home. Trust A was not asked to supply the information detailed above, but we take the view that this sort of information should be routinely collected in future monitoring of community powers, including whether or not the place of residence is specified as a condition of leave or SCT.

We also asked for the length of time spent on leave. Of all 25 cases of 'long-term' leave notified to us by both Trusts, three had not yet been out of hospital for longer than a week, but had been authorised leave that would extend beyond such a time. Only one patient had been on leave for longer than eleven weeks, having been on leave for four and a half months. The mean length of time outside hospital for all patients was 35 days. The range of time spent on 'long-term' leave for all 25 patients is shown at table 1 below.

| time spent on leave | < 1 week | 1 – 2 weeks | 2 – 3 weeks | 3 – 4 weeks | 4 – 5 weeks | 5 – 6 weeks | 6 – 7 weeks | 7 – 8 weeks | 8 – 9 weeks | 9 – 10 weeks | 10 – 11 weeks | > 11 weeks |
|---------------------|----------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|--------------|---------------|------------|
| number of patients | 3 | 5 | 2 | 2 | 1 | 2 | 4 | 1 | 2 | 1 | 1 | 1 |

Table 1: time spent on leave of 25 patients classed as on 'long-term' leave at time of notification

We have sought to estimate what proportion of all patients who are liable to be detained in each Trust is made up of patients subject to long-term leave. Trust A operates approximately 300 inpatient beds, and Trust B approximately 130 beds⁹. In the South West of England, an average of two-thirds of psychiatric inpatients noted in the 2006 census had informal status¹⁰: so this implies a detained *inpatient* population of roughly 100 patients in Trust A, and 43 patients in Trust B.

As such, perhaps surprisingly, the numbers of patients who are on long-term section 17 leave *may* account for between 16 and 23 per cent of the population liable to be detained under the *Mental Health Act* in each Trust¹¹. However, this figure is perhaps inflated by the definition of 'long-term' leave that we used.

Implications for SCT numbers

The statutory and practical criteria for eligibility for SCT are discussed by Kinton elsewhere in this issue¹². In summary, the statutory criteria are that the patient's mental disorder warrants treatment which is available; that it is necessary for the patient's health or safety or the safety of others that such treatment is given, but that it can be given outside hospital; and that it is necessary that the responsible clinician should be able to exercise a power of recall over the patient¹³. Emerging guidance¹⁴ and ministerial statements in parliament¹⁵ suggest that patients need at the very least to be co-operative with treatment to be practically eligible for SCT. As SCT patients are not 'liable to be detained' whilst in the community¹⁶, the conditions set as a part of SCT should not amount to a deprivation of liberty, at least until the deprivation of liberty safeguards come into force.¹⁷

In our view, taking account of these criteria, only two or three of the six patients that met with the MHAC would have been likely to be deemed suitable for SCT.

In one case, which we suspect would have had echoes in the circumstances of some other patients whom we did not meet, SCT would not have provided the legal authority required for the patient's care whilst on leave, as the latter itself amounted (in our view) to a deprivation of liberty. A patient who is effectively deprived of his or her liberty at the place to which he or she had been sent on leave could, at least until the deprivation of liberty safeguards come into force¹⁸, only be subject to such a regime whilst retaining the legal status of 'liable to be detained' and under the broad discretionary powers of s.17 leave. Such

9 These numbers were supplied to the 'Count Me In' census team by the respective Trusts for the 2008 census as estimations of their bed capacity.

10 http://www.healthcarecommission.org.uk/_db/_downloads/xtabSHAS10MH.xls

11 This is calculated as follows: Trust A has 100 detained inpatients, of which 18 patients (18%) are on long-term leave. Trust B has 43 detained inpatients, 7 of whom (16%) are on long-term leave. In previous census returns, Trust A reported approximately 230 rather than the 300 beds reported this year: at the former level (i.e. assuming a detained inpatient population of about one-third of inpatients, or 77 patients), 18 patients on long-term leave would account for 23% of all patients liable to be detained. It should be emphasised that the detained inpatient figures are arrived at through the application of general statistical averages and not actual head-counts.

12 See Kinton M (2008) 'Towards an Understanding of Supervised Community Treatment', *JMHL* 17 pp. 7–20.

13 See MHA 1983 as amended by the MHA 2007, s.17A(5) for the exact wording of the criteria.

14 See Kinton, *op cit.* Table 1 in this issue, summarising advice at chapter 28 of the revised *Mental Health Act Code of Practice for England*.

15 See, for example, Hansard (Commons) 18 Jun 2007: Col 1199, cited in this issue at Kinton, *op cit.*, n.85.

16 MHA 1983 as amended by the MHA 2007, s.17D(1)&(2)

17 The deprivation of liberty safeguards are expected to come into force in April 2009. See revised *Mental Health Act Code of Practice for England*, para 28.8, which suggests that deprivation of liberty under the MCA can exist alongside SCT or such leave. We remain uncertain that it will be deemed permissible, should the matter be challenged in the courts, for the conditions of SCT to constitute deprivation of liberty, even if concurrently authorised under the MCA.

18 See n. 17 *supra*.

circumstances are perhaps most likely where s.17 is used for 'trial' transfers from one hospital to another, or for transfers to strict regimes in care homes or other supported accommodation, and where it is perhaps misleading to consider the use of long-term leave as a form of *community* treatment.

In the case of the other two or three patients for whom we doubted SCT would be deemed appropriate, this was largely because of the criteria for SCT and, most importantly, the assumption that SCT patients must be co-operative with the conditions set by their responsible clinician.

There are, of course, many limitations to this exercise as an empirical study (a purpose for which it was not initially designed). Although we started with a reasonably large baseline population across two NHS Trusts of considerable geographic area, a much more widespread survey would be required to capture the details of a suitably large number of long-term leave patients to enable statistical analysis. We have applied local statistical averages and not actual head-counts to provide a baseline population of patients liable to be detained against which to compare the numbers of patients on leave. This exercise (one of a number of exploratory meetings with patients on leave being conducted by the MHAC at the time of writing) took place in an area of England where particularities of geography and infrastructure may limit the potential for generalising our findings. Mindful of these limitations, these findings do, nevertheless, support the general view that long-term leave of absence from detention in hospital already plays a substantial role in the management (and indeed coercion) of people with serious mental disorder. Future monitoring arrangements (including local auditing arrangements by the detaining authorities themselves) could build on or learn from these tentative beginnings.

Following the implementation of the changes to the Act in November this year, professionals responsible for the care of such patients may prefer to engage with the perceived clearer legal boundaries of SCT than the vagaries of discretionary powers under s.17, but in any case will be required by law to consider SCT for them. However, this study has indicated to us that some patients on long-term s.17 leave will be ill-suited or ineligible for transfer across to the new community treatment regime.