Leave of absence and transfer under the Mental Health Act 1983

This guidance relates to England only

Previously issued by the Mental Health Act Commission and reviewed March 2010

This note provides guidance on Sections 17, 18 and 19 of the Mental Health Act 1983 regarding leave of absence, absence without leave and transfer between hospitals in relation to detained patients.

1. Introduction

Section 17 of the Mental Health Act 1983 (‘the Act’) makes provision for patients who are liable to be detained under various other sections of the Act to be granted leave of absence.

Section 17 applies to patients who are detained under ss.2, 3, 37, or 47 of the Act. It also applies, with modifications, to those patients who are subject to a restriction order granted under s.41 or s.49. However, the Act does not allow leave to be granted under its powers to patients detained under ss.35, 36, or 38.

A patient may become ‘absent without leave’ (‘AWOL’):

- by leaving the hospital without formal leave of absence;
- by failing to return at the end of an authorised period of absence; or
- by absconding from a “custodian” (see paragraph 2v).

Section 18 of the Act deals with the re-taking of patients who are absent from hospital without leave, or who are absent without permission from an address where they have been required to live either by the conditions of their leave of absence or by their guardian.

Section 19 of the Act deals with the transfer between hospitals of detained patients; with the transfer of detained patients into Guardianship; and with the transfer of people subject to Guardianship from one authority to another. This note only considers transfer of detained patients between hospitals.
2. Definitions

i. Patient

A patient is someone who is liable to be detained under the Act, following an application by an Approved Mental Health Professional (AMHP) or by the patient’s nearest relative. Any such application must be supported by medical recommendations completed by appropriately qualified medical practitioners. Particular conditions may apply to those patients who are detained under Part 3 of the Act, being patients concerned in criminal proceedings or under sentence of the court.

Informal patients (i.e. those who are not legally detained in hospital) have the right to leave at any time, and cannot be required to ask permission to do so, although they may be asked to inform staff when they are leaving the ward (Code of Practice, 21.36). In the MHAC’s view, it is not appropriate to refer to “leave” in the context of informal patients, as this can give the false impression that hospital staff have a right to prevent patients from leaving the ward1.

ii. Hospital

Applications for admission under the Act should state the name of the hospital to which the patient is to be admitted, whether or not they also name the NHS Trust that is “the managers” of that hospital for the purposes of the Act. It is from the named hospital that a patient is given leave to be absent under s.17.

Under s.145 of the Act, “hospital” has the meaning given to it by the National Health Service Act 2006 (s.275(1)), which encompasses "any institution for the reception and treatment of persons suffering from illness" and "any institution for the reception and treatment of persons during convalescence or persons requiring medical rehabilitation". The definition of ‘hospital’ includes an independent hospital’ under the Care Standards Act 2000.

When the Mental Health Act 1983 was originally drafted, it was thought that each ‘hospital’ would have a single managing body. It was not envisaged that one hospital could be divided into discrete units each of which was managed by a different body. However, as hospitals developed that were not coterminous with managers, uncertainty arose as to what constitutes a hospital and, crucially, how far a patient may stray before s/he requires formal leave of absence.

In general, there have been two schools of thought\(^2\), which see a ‘hospital’ as:

- either all the buildings on a site defined by a single perimeter, even though some of those buildings may have different NHS managers than others; or
- only those buildings on a particular site that are adjacent to each other and have the same NHS managers.

The predecessor organisation MHAC has previously taken the view that the former definition more closely reflected the legislative will and was therefore to be preferred\(^3\), but this view is no longer tenable in the light of the revised *Code of Practice*, which states at chapter 21.5 that:

> “What constitutes a particular hospital for the purpose of leave is a matter of fact which can be determined only in the light of the particular case. Where one building, or set of buildings, includes accommodation under the management of two different bodies (e.g. two different NHS trusts), the accommodation used by each body should be treated as forming separate hospitals. Facilities and grounds shared by both can be regarded as part of both hospitals”

In the light of the Code’s guidance, formal leave under s.17 is required for a patient to move from a part of the hospital site that was managed by one NHS body to a part of the site that was managed by another NHS body. Therefore, where buildings on a single ‘hospital’ site are managed by different NHS Trusts, formal leave of absence will be necessary where a patient is to move between Trusts, but not for a patient to go into the grounds shared by both sets of buildings.

Where two hospitals on the same site have the same managers, a detained patient may be transferred between them without formality under MHA 1983, s.19(3). Every Trust should be in no doubt as to the physical limits of the hospital(s) of which it is the managers for the purposes of MHA 1983, and it should take legal advice where necessary.

Where a detained patient is to move between hospitals on different sites, s/he will require formal leave of absence, even if the hospitals have the same managers.

Under the Crime Sentences Act 1995, the Courts and the Secretary of State may direct that a patient be detained in a *specific* part of a ‘hospital’, which will usually be chosen for its comparative security. In such cases, the place of detention has been


specifically identified, and the patient will require formal leave of absence to leave that place (even if s/he is to remain within the ‘hospital’ of which that place is a part).

In August 2007, the Ministry of Justice Mental Health Unit issued clarification on their interpretation of s.17 leave as it applies to restricted patients. The guidance is copied below

**Naming a ward**

When the Hospital Order or prison transfer warrant names a specific ward/unit within a wider hospital in which a patient must be detained, the [RC]’s discretion to grant the patient ground leave or transfer is limited.

In these circumstances, the [RC] can only grant the patient leave in the grounds of that particular unit, **not** the wider hospital. In addition, the [RC] cannot transfer the patient to another unit even if it is within the same hospital. For any leave or transfer outside the named unit the Secretary of State’s permission is needed, even if the leave or transfer is within the same hospital. [RC]’s should therefore pay close attention to the detail of detention authorities.

**iii. Leave of Absence**

A detained patient will require formal leave of absence under s.17 of the Act whenever s/he is to leave the hospital (however that word is defined). This is so whatever the purpose of his/her absence and however long it is expected to last. It is immaterial that the patient is to be escorted by hospital staff, or that the excursion is part of a specified treatment plan or arises in an emergency. Formal leave may be renewed in a patient’s absence, but it cannot continue after his/her detention has come to an end.

**iv. Responsible Clinician (RC)**

The RC is the Approved Clinician who has final clinical responsibility for the management of a patient detained under MHA 1983. There is nothing in MHA 1983 that would permit responsibility for the granting of leave to be delegated or transferred to another clinician. However, it is possible, for instance during periods of leave or illness, that another clinician may become the RC (see MHA 1983, s.34(1)). This nominee must also be an Approved Clinician.
v. Custody

Under s.17(3) of the Act, the RC of a detained patient may direct that s/he remain in custody while on leave. This provision might be used to allow a patient to receive treatment in another hospital or to have compassionate home leave while remaining under escort. In such circumstances, the custodian – who will usually be a qualified mental health nurse – has certain powers not usually available to others (for example, the power to detain and convey the patient). It is to be noted that if the patient absconds from the custodian’s care, s/he will become AWOL immediately, and it will not be necessary to wait until s/he fails to return to the hospital.

3. Good practice, including particular issues for nursing staff

The MHA 1983 Code of Practice advises on good practice in Chapter 21. In particular, it emphasises that:

- leave is an important part of a patient’s treatment plan;
- the patient should be involved in the decision to grant leave and should be asked to consent to any consultation with others that is considered to be necessary; and
- leave should be well planned, as far in advance as possible.

Those responsible for planning a patient’s leave should consult with his/her relatives and friends, and with other agencies. While s/he is absent from the hospital on leave a patient remains subject to the consent to treatment provisions in Part 4 of the Act. If s/he is detained under MHA 1983, s.3 or s.37, the patient will also be entitled to have after-care arrangements made for him/her under s.117.

Patients should only be granted leave if their clinical state permits it, if their care has been properly planned, and with due regard to their own safety and that of others. They should not be sent on leave to free up a bed, nor should they be asked to remain on leave solely for that purpose.

Every hospital should have a clear, written policy on s.17 leave of absence, which should be readily available to ward staff and should identify local definitions and procedures.

The fact that leave of absence has been granted should be recorded in a patient’s notes, together with any conditions to which the leave is subject. The length of leave - and, therefore, the time the patient is expected back on the ward – should also be recorded and known to staff.
Hospitals are encouraged to devise a simple form upon which these details might be recorded. The form should be accessible to staff, so that a patient’s leave status can be determined quickly and easily. At chapter 21.21, the MHA 1983 Code of Practice recommends that a copy of the leave record be given to the patient, and any carers, professionals and other people in the community who might need to know that the patient has been granted leave and any conditions attached to it.

Nursing staff have a vital role to play in the effective implementation, recording and evaluation of leave granted to patients under s.17, and in alerting the proper authority – which will usually be the police – when a patient has failed to return from leave on time.

It should be standard practice to note in the nursing records:
- every occasion when leave is taken;
- the circumstances under which leave is taken (for example, whether the patient is escorted, and if so, by whom);
- the date and time at which the patient departs; and
- the date and time by which the patient must return.

Nursing staff should assess a patient’s clinical state before each and every instance of leave, even if the taking of leave is not contingent upon their approval. They should pay particular attention to the risk that a patient poses to him/herself or to others (especially any children with whom s/he might come into contact). If staff have significant concerns they should withhold leave pending advice from the RC.

Leave of absence should be seen as an integral part of a patient’s treatment and management. Therefore, the patient’s nursing notes should contain a record of the outcome of each period of leave and an assessment of its relative success. Particular note should be made of concerns raised by any escorting staff, by the patient, or by relatives or friends. This will enable any future discussion of leave to be fully informed.

The Code of Practice also requires that a clear up-to-date description of the patient’s appearance should be available in the patient’s notes. This information should appear next to the current leave form.

Service providers should ensure that their policy on s.17 contains a clear statement of the action that must be taken if a detained patient fails to return from a period of authorised leave. A senior member of the nursing staff will often be given responsibility for taking such action. It is essential that a record be made in the nursing notes when a patient’s absence is notified to the proper authorities. A

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4 A sample form is attached to this Guidance Note. Service providers might prefer to use their own form, but they may adapt the attached form to suit their own local policies and procedures.
particular note should be made of the date and time of such notification and the name of the person to whom it was given.

4. Recall to hospital

Where a detained patient has been given leave of absence under s.17, the RC may recall him/her to hospital at any time, if s/he feels it is necessary in the interests of the patient’s health or safety or for the protection of other people (Code of Practice 21.31). In such circumstances, the RC is obliged to provide written notification to the patient and/or to any person in charge of the patient that the leave is being revoked. The full reasons for recall should be explained to the patient, and a record of this explanation should be kept in his/her notes.

A patient need not be recalled to hospital merely because s/he has refused to co-operate with some aspects of his/her treatment – and in particular, medication – unless co-operation was a condition of leave.

A patient’s detention may be renewed while s/he is on leave, even where the leave is of lengthy duration and the patient’s contact with the hospital modest. However, longer term leave may only be granted where the RC has first considered whether supervised community treatment would be more appropriate instead (s.17(2A)). “Longer term” here means either where the patient has been granted leave indefinitely, or where the leave granted is longer than seven days, either consecutively, or taken in total (s.17(2B)). For renewal to be lawful whilst a patient is on leave, medical treatment in a hospital must represent a significant component of the plan for the patient.

Whenever it becomes necessary to consider renewing or terminating the detention of a patient who is on leave, everyone concerned should ensure:

- that patients are cared for in a way that promotes their self determination and personal responsibility to the greatest practicable degree; and
- that they are discharged as soon as it is clear that detention is no longer justified (Code of Practice 21.35).

Where patients are assessed in preparation for this decision, practitioners should consider whether detention is still necessary, or whether alternative, less restrictive arrangements would meet the patient’s medical needs.

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In CQC’s view, it is not appropriate to detain a patient under s.3 for the sole purpose either of granting immediate long-term leave, or of placing him/her under supervised community treatment.

5. Section 18 – absence without leave

If a patient detained under MHA 1983 is absent from hospital without formal leave having been granted to him/her under s.17, or is absent from a hospital to which he is recalled under s.17E, the following may take him/her into custody and convey him/her to the hospital:

- any Approved Mental Health Professional;
- any officer on the staff of the hospital;
- any constable;
- any person authorised in writing by the managers of the hospital;
- any officer on the staff of a hospital to which a patient has gone on leave.

A patient who is absent without leave whilst under Guardianship may be taken into custody by:
- any officer on the staff of the local Social Services Authority;
- a constable; or by
- any person authorised in writing by the guardian or local Social Services Authority.

An AWOL patient may be taken into custody for up to six months after going absent or until the expiry date of the current period of detention, community treatment order or Guardianship (whichever is later). However, patients subject to s.2, s.4, or s.5(2) or 5(4) may not be retaken once their period of detention has expired.

Section 18 authorises the taking into custody of patients AWOL from an English Hospital who are found in Wales, and the taking into custody of patients AWOL from Welsh hospitals who are found in England. A patient who is AWOL from a hospital in England and is in Northern Ireland may be re-taken under MHA 1983, s.88. Patients absent without leave in Scotland, the Channel Islands or the Isle of Man may be retaken subject to local legislation, as described in the Reference Guide to the Mental Health Act 1983, pages 255-257. Some reciprocal powers are granted under MHA 1983, ss.87 and 89.

6. Section 19 – transfer of patients

Under MHA 1983, s.19, a detained patient may be moved to another hospital without a break in his/her detention or treatment. The requisite administrative arrangements where the hospitals are under different managers are set out in Regulation 7 of the
Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 (SI 2008/1184). Briefly, these require the managers of the transferring hospital to complete an authority for transfer in Form H4, having satisfied themselves that a bed is or will be available within 28 days. Where a patient is transferred in this way, the managers of the receiving hospital should ensure that:

- part 2 of Form H4 is completed;
- the patient is aware of his/her rights;
- appropriate relatives have been informed; and
- mechanisms are in place to ensure that renewal dates, opportunities for appeals to the Mental Health Review Tribunal and any consent to treatment events properly flagged.

Where the transfer is between hospitals that share the same managers, the formalities set out above are not required. Where the two hospitals do not share a site, however, it is our view that the Responsible Clinician should authorise leave of absence to provide authority for the journey between sites.

MHA 1983, s.19 also allows patients to be transferred from hospital to Guardianship, and for patients who are subject to Guardianship to be transferred from one Guardian to another, or to hospital. Section 19A allows for the transfer of responsibility for a community patient from one hospital to another.

7. Section 17 and section 19

Leave of absence is sometimes used to allow a patient who is detained in one hospital to be given medical treatment in another hospital. This may be appropriate where, for example, the patient requires a brief period of treatment in a general hospital, or where a patient is progressing to a unit with lesser security and leave is used to assess his/her suitability for such an environment.

If possible, patients who move from one mental health hospital to another should be transferred under s.19, in accordance with the Department of Health Guidance HSG(96)28.

It should be noted that if a patient is moved to another hospital under s.17, the relevant statutory powers remain with the RC of the originating hospital and the patient cannot be granted leave by anyone at the second hospital.
8. The position of patients under section 5(2)

The question sometimes arises whether a patient who is detained under s.5(2) may be moved to another hospital – for example, to experience a more appropriate environment or to obtain treatment not available in the detaining hospital.

Both the Mental Health Act Code of Practice (para 12.40) and Reference Guide (para 13.3) imply that a patient who is detained under s.5 of the MHA 1983 cannot be transferred under s.19 from one hospital to another. This is clearly the case when the transfer involves hospitals with different managers. For such transfers, the power to transfer (which is set out at s.19(1) of the MHA 1983) is contingent upon a patient having been detained “by virtue of an application”, and no application is made when a patient is detained under s.5 of the MHA 1983.

It has been argued to CQC that, notwithstanding the assumptions in the Code and Reference Guide, the power to transfer patients between hospitals under the same managers, which is provided at s.19(3) of the Act, can be interpreted to enable the transfer of a patient who is liable to be detained under Section 5(2). Section 19(3) provides that “any patient who is for the time being liable to be detained under this part of this Act” may be transferred without formality between hospitals under the same managers: it does not state explicitly that it applies only to patients who are liable to be detained by virtue of an application6.

In our view, even if (contrary to official guidance in the Code of Practice and Reference Guide) s.19(3) can be interpreted to authorise the transfer of a s.5 patient between hospitals that share the same management, it is of little practical use to do so as there are other difficulties regarding the legal authority over the patient:

- As stated above at §6 of this guidance, it is our view that the Responsible Clinician should authorise leave of absence to provide authority for the journey between sites when transferring detained patients. This is not possible in the case of patients detained under s.5, as the powers to grant leave of absence only apply to patients detained by virtue of an application.
- Section 5 provides authority for the patient to be detained only at the original hospital (i.e. that in which the holding power was initiated). The power to hold the

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6 Such an interpretation therefore disputes the interpretation of Professor Richard Jones (at para 1-272 of the Mental Health Act Manual, 12th Edition) which suggests that the power to transfer under s.19(3) does not apply to patients detained under s.5(2) on the grounds that
- s.19(2)(a) does not apply to patients detained under a holding power and
- the final wording of s.19(3) states that “paragraph (a) of subsection 2 above shall apply in relation to a patient so removed as it applies in relation to a patient transferred...”.

The alternative argument to that suggested by Professor Jones is therefore that the final wording in s.19(3) “is simply intended to cover the case of a patient transferred to a unit run by the same managers and also to ensure that the patient is detained there as if the application had originally been made to that unit, as would be the case with a patient detained under s.2 or s.3. This final wording does not affect the main thrust of s.19(3) which is to enable transfer of patients detained under Part 2 (including those detained under s.5(2) or 5(4)) without formality.”
patient under s.5 will no longer be effective once the transfer to another hospital has been made. In our view, the patient could not be re-detained under s.5 upon arrival as s/he would not properly be considered an in-patient at the new hospital at that point.

In CQC’s opinion, a patient held under s.5(2) might lawfully be taken to another hospital with his/her capable consent, although of course the holding power over that patient will cease once they leave the hospital in which they were initially detained. In the case of an incapable patient, there might be circumstances in which his/her transfer might be lawful in their best interests under the Mental Capacity Act – for example, in order to allow him/her to receive physical treatment that is necessary to save his/her life or prevent serious and/or permanent suffering. However, the Mental Capacity Act may not be used to transfer a patient between hospitals where, being capable, s/he objects to such a course. In such circumstances, if there was insufficient time to comply with the formalities of s.2, then and application under s.4 might be made.

Good practice dictates that patients are not moved during the assessment period. If they are moved, that fact should be documented and the move monitored by the managers. The authority to detain a patient that is provided by s.5 of the MHA 1983 will lapse whenever he or she is taken to another hospital.

Any questions about this guidance should be sent to:
CQC Mental Health Act
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA
Tel: 03000 616161
Email: MHAenquiries@cqc.org.uk

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7 We consider that a court might object to an authority treating a patient who has been forcibly removed from one hospital to another as an informal inpatient of the second hospital eligible to be detained under s.5. The current Code of Practice states at para 12.7 that “patients should not be admitted informally with the sole intention of then using the holding power”; the previous edition of the Code defined an inpatient as “usually voluntary patients, that is, those who have the capacity to consent and who consent to enter hospital for inpatient treatment. Patients who lack the capacity to consent but do not object to admission for treatment may also be informal patients”. The Welsh Code of Practice to the MHA (para 8.5) defines an informal inpatients as “a patient who has come to the ward and who has not acted to resist (verbally or physically) the admission procedure”.

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Sample Form

Mental Health Act (1983)
Record of Granting Section 17 Leave of Absence

___________________________ is currently detained in ____________ ward/hospital/unit
under Section _____ of the Mental Health Act (1983).

Leave of absence is authorised as follows:

EITHER (specified periods)

<table>
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<th>From (time/date)</th>
<th>To (time/date)</th>
<th>Conditions</th>
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AND/OR (specified occasions)

____________________________________________________________________________________

Conditions: ____________________________________________

Escorted? : Yes/No – if “yes” by: ______________________
Address of any overnight leave: ________________________

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

(____ time/date____)

Signed by¹: __________________________________________ Date: __________

The following have been notified of these arrangements:

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In case of difficulty please contact__________________________ Tel No:

¹ As this is not a statutory form, it is not a legal requirement that it is signed by the Responsible Clinician (RC), although only the RC may grant leave under s.17. This form therefore may be completed by someone other than the RC who is recording the RC’s authorisation (for example, when such authorisation is given over the telephone).
Notes

Leave of Absence applies only to absence from the Hospital – which is taken to mean accommodation managed by the detaining Trust, and grounds constituting that hospital’s site. A patient may only be out of that Hospital lawfully, for whatever purpose and whether escorted or not, if the RC has granted leave.

Section 17 of the Act states:

(1) “The (RC) may grant to any patient who is … liable to be detained in a hospital … leave to be absent from the hospital subject to such conditions (if any) that that clinician considers necessary in the interests of the patient or for the protection of other persons.

(2) Leave of Absence may be granted… either indefinitely or on specified occasions or for any specified period … (and) … that period may be extended by further leave granted in the absence of the patient.

(2A) But longer-term leave may not be granted to a patient unless the Responsible Clinician first considers whether a patient should be dealt with under [supervised Community treatment] instead”

The Code of Practice gives general advice in chapter 21. In particular, the Code emphasises the need to involve the patient and other professionals in the decision to grant leave; and states that leave should be well planned, and that aftercare arrangements will apply to patients on leave. Chapter 21.16 of the Code notes that the RC may grant short-term local leave, which may be managed by other staff (e.g., nurses).

The Code (chapter 21.8) also provides a checklist of considerations to be taken into account when planning leave, including that the RC ensures that arrangements are made to assess the patient’s health and social care needs. An after-care care plan should be drawn up in accordance with s.117.

Escort. The RC may direct that the patient remain in custody while on leave. Such an arrangement is often useful to enable patients to participate in escorted trips or to have compassionate home leave (see Code, chapter 21.26).

CQC Guidance Note, “Guidance for clinicians: Leave of absence and transfer under the Mental Health Act 1983” also considers the question of leave.

Local Policies:

It is advised that there is a local policy on Leave of Absence. This should define what constitutes the particular Hospital; what procedures to follow in an emergency (e.g., for physical treatment); under what circumstances the RC’s authorisation can be obtained rapidly (e.g., for urgent matters); and what steps are to be taken when a patient fails to return from leave or breaches any conditions. It is also suggested that this or other local record form is combined with a page in the nursing notes that records any periods of leave taken and an assessment of its outcome.